

EVIDENCE SUMMARY

A REVIEW OF SECONDARY SCHOOL-BASED MENTAL HEALTH PREVENTION PROGRAMS

This evidence summary provides an overview of the current evidence for school-based mental health programs (SBMHPs). It is aimed at professionals who have a role in supporting the mental health of young people in secondary school, including health and mental health professionals, educators, school leaders, policymakers, funders, commissioners and researchers.

OVERVIEW

This evidence summary outlines:

- why secondary schools are important settings for youth mental health;
- the different types of school-based mental health programs;
- evidence for universal and targeted secondary school-based programs aimed at depression and anxiety;
- considerations for interpreting the evidence and for future research; and
- implications for practice.

For an overview of how this evidence summary was created, see section: [How this evidence summary was created](#). For practical tips and considerations for implementing a SBMHP, see the Orygen toolkit: [Implementing school-based mental health prevention programs](#). For tips on involving students in the design and delivery of SBMHPs, see the Orygen toolkit: [Including student voice in school-based mental health programs](#).

GOOD MENTAL HEALTH CAN HELP YOUNG PEOPLE TO LEARN AND ACHIEVE ACADEMICALLY, WHICH CAN SUPPORT THEIR LONG-TERM SOCIAL AND ECONOMIC WELLBEING

(NICE 2009)*

THE WORLD HEALTH ORGANISATION ACKNOWLEDGES THE IMPORTANCE OF SCHOOLS IN SUPPORTING ADOLESCENT MENTAL HEALTH

(WHO 2012)**

AUSTRALIAN DATA HAS SHOWN MORE THAN ONE THIRD (36%) OF YOUNG PEOPLE WOULD TURN TO A TEACHER AS A SOURCE OF HELP WITH IMPORTANT ISSUES AND THREE IN TEN (30%) WOULD TURN TO A SCHOOL COUNSELLOR

(MISSION AUSTRALIA 2019)***

* National Institute for Health and Care Excellence (NICE). Social and emotional wellbeing in secondary education. 2009.

** World Health Organisation. Adolescent Mental Health: Mapping actions of nongovernmental organizations and other international development organizations. 2012.

*** Carlisle E, Fildes J, Hall S, Perrens B, Perdriau A, Plummer J. Youth Survey Report 2019. Sydney, NSW: Mission Australia; 2019.

WHY ARE SCHOOLS IMPORTANT SETTINGS FOR YOUTH MENTAL HEALTH?

Schools are a natural environment for supporting youth mental health and wellbeing. Young people spend more time in school than in any other formal institution. For some, school may provide a more supportive setting than home for the development of resilience and coping skills to manage life challenges. Many schools have the opportunity to reach large numbers of young people, including those from culturally and linguistically diverse backgrounds who may not readily access mainstream mental health support.

The school environment can also increase the risk of psychological distress. Students may experience a range of preventable negative experiences at school – such as peer victimisation and relational violence, social exclusion, academic failure and performance stress, each of which exacerbate or contribute to the development of mental ill-health.

Schools are increasingly being recognised as ideal settings for implementing and evaluating programs designed to support youth mental health. Globally, the World Health Organization (WHO) acknowledges that schools support

adolescent mental health by providing a setting for large-scale implementation of interventions, including in low and middle-income areas.

(1) In Australia, the importance of schools in supporting student mental health is highlighted in national and state school frameworks, including recommendations on supporting the social and emotional wellbeing of Aboriginal and Torres Strait Islander young people.(2-10)

Schools have been identified as providing direct mental health support to young people through activities like counselling, as well as acting as referral points to the health system. (11) Good mental health can help young people to learn and achieve academically, which can support their long-term economic, social and emotional wellbeing.(12) Implementing school-based mental health programs (SBMHPs) can also provide additional benefits by upskilling the education workforce and school community in mental health literacy to improve early identification of risk and help referral pathways. Depression and anxiety have high prevalence in secondary school-aged young people, and can have a significant negative impact on their quality of life, and social and vocational functioning.(13) Therefore early intervention and prevention efforts for depression and anxiety are of growing importance across health and education settings.

SCHOOLS AS PART OF THE YOUTH MENTAL HEALTH SYSTEM

Schools are well-placed to form an important part of mental health support networks for young people. Schools can work together with health services, such as general practices, local youth services and hospitals; and people, such as doctors, teachers, school nurses, family, friends and community leaders.



WHAT ARE THE DIFFERENT TYPES OF SCHOOL-BASED MENTAL HEALTH PROGRAMS?

School-based mental health programs (SBMHPs) vary widely in terms of intervention type, delivery, the provision of ongoing support and involvement of young people. SBMHPs may be delivered by school personnel, such as teachers or wellbeing staff, or by external providers with expertise in youth mental health and/or facilitation. While programs have traditionally been delivered face-to-face, programs are being developed that are delivered digitally or involve digital components. Programs can be designed for individual delivery or in group settings, as part of curriculum or outside regular class time, and can involve students, parents, teachers, the school environment and the broader community. (14) Though research on school-based programs for anxiety and depression often investigates the efficacy of structured psychological programs, such as cognitive behavioural therapy (CBT), studies have also looked at yoga, exercise, mindfulness, resilience and life skills training, as well as a range of bespoke programs.

SBMHPs can be broadly classified into two types, mental health promotion programs and mental health prevention programs. Mental health

promotion programs typically focus on positive development and wellbeing, such as social inclusion, social and emotional skills and problem-solving. Mental health prevention programs focus on preventing the development of common mental disorders.

School-based prevention programs can be further classified as universal approaches and targeted approaches. Universal approaches involve all students, regardless of their experience, identity, or level of risk for developing a mental disorder. Targeted ‘selective’ approaches are aimed at particular groups of young people who are identified as having a higher risk of developing a mental disorder – for example, students who live with parents experiencing mental ill-health, or students with a neurodevelopmental condition. Targeted ‘indicated’ approaches are aimed at students who are already experiencing mental ill-health, without necessarily having a diagnosed mental disorder.

This evidence summary focuses on the evidence for prevention programs for depression and anxiety, as these are two of the most common mental health disorders experienced by secondary school-aged young people.(15)



WHAT IS THE EVIDENCE FOR UNIVERSAL AND TARGETED PREVENTION PROGRAMS DELIVERED IN SECONDARY SCHOOL?

This section presents a pragmatic overview of current evidence for the effectiveness of universal and targeted programs delivered in secondary schools with outcomes for depression and/or anxiety. Findings have been summarised from systematic reviews and meta-analyses, which are considered the highest level of research evidence. For more information on evidence quality, see Orygen's [Quick reference guide to evidence translation](#). Six systematic reviews, which included a total of 315 studies, were used to consider the evidence from randomised controlled trials of universal and targeted school-based mental health programs (SBMHPs) for depression and/or anxiety.(14, 16-20) While all six reviews considered universal approaches, only two(19, 20) considered targeted as well as universal approaches.



EVIDENCE FOR UNIVERSAL APPROACHES

Findings for universal programs are mixed. There is evidence from two reviews that structured psychological interventions such as cognitive behavioural therapy (CBT) or interpersonal therapy (IPT) are more effective for depression and anxiety outcomes than control conditions in the short-term, although these group differences were small or came from only a small number of studies.(19, 20) However, two reviews of studies focused on CBT-based programs to enhance resilience found no positive effects for either depression or anxiety outcomes immediately after the intervention.(17, 18) There was no difference in outcome when findings for primary and secondary school-aged young people were combined(17), or when secondary school-aged (11-18-year-olds) young people were considered separately(18). Another two reviews of positive mental health-focused programs, for example life skills training, wellbeing programs and yoga, also found no positive effects for depression and anxiety outcomes across age groups (7-18-year-olds).(14, 16)

Only one review conducted a meta-analysis specifically for secondary schools (separate to primary schools), and at different time-points after program delivery - up to two years later.(20) This analysis of secondary school studies found a positive effect for mindfulness and relaxation programs and a positive but weak effect for CBT-based programs on anxiety outcomes, but no positive effects for depression outcomes. However, the positive effects for anxiety were not consistently maintained in the longer term.

EVIDENCE FOR TARGETED APPROACHES

There have been fewer studies on targeted prevention programs for anxiety and depression compared to universal interventions, but the existing evidence suggests more positive and robust effects for these programs.(19, 20) For depression outcomes, targeted programs showed positive effects in the short-term, though these appear not to be maintained over the longer term. For anxiety outcomes, targeted programs showed only weak positive effects in the short and longer term. Promising results for the effectiveness of exercise for anxiety outcomes were based on findings from only one study.(20)

Reviews on targeted programs included findings primarily from CBT-based programs, as well as IPT, psychoeducation or other psychosocial programs. Notably, neither of the two reviews that considered targeted programs separately examined findings for selective and indicated programs. Although there were many more studies of indicated programs than selective programs, the overall number was relatively low. This makes it very difficult to draw any conclusions about the relative effectiveness of these different approaches.

EVIDENCE FOR DIFFERENT PROGRAMS

Though a diverse range of SBMHPs have been researched in secondary school settings, the most common approach across studies is CBT. It is possible that this over-representation may have skewed findings, making it difficult to assess what therapeutic approach or active component is likely to be most effective. Notably, universal programs aiming to support positive mental health appear to be consistently less effective across both depression and anxiety outcomes. However, these programs may have wider benefits that have not been evaluated, for example increasing a young person's general quality of life or enhancing their interpersonal skills. The potential value of focusing separately on positive mental health and mental ill-health is outlined in the section: Promoting positive mental health, preventing mental ill-health.



SUMMARY OF FINDINGS FOR UNIVERSAL AND TARGETED APPROACHES

There is stronger evidence for the effectiveness of universal programs for anxiety than for depression. Conversely, there is stronger evidence for the effectiveness of targeted programs for depression than anxiety. When the effectiveness of targeted and universal programs are compared directly, targeted programs have greater potential than universal programs in reducing anxiety and depression symptoms. (19, 20) However, these findings are based on a limited number of studies. Importantly, the longer-term benefits of both universal and targeted programs are not clear.

'Overall, recent systematic reviews indicate a lack of strong, consistent evidence for the effectiveness of universal or targeted SBMHPs in preventing anxiety or depression'

PROMOTING POSITIVE MENTAL HEALTH, PREVENTING MENTAL ILL-HEALTH

Positive mental health encompasses subjective experiences of positive emotions, full functioning, life purpose or meaning, or positive interpersonal relationships. By comparison, mental ill-health focuses on mental health problems including diagnosable mental disorders, such as depression and anxiety. The 'dual-continua' model suggests that positive mental health and mental ill-health reflect separate spectrums, rather than two ends of a continuum.(21) This model supports an idea of mental health as more than just the absence of mental ill-health, but a state of wellbeing in which people can flourish. There is some evidence to suggest that this model might apply to young people.(22)

In the education literature, a distinction is increasingly being made between strengths-based promotion of mental health and wellbeing, which is often embedded in usual educational practice, and programs that focus on preventing or treating mental ill-health.(23) This approach is consistent with a dual-continua model and is a useful framework for schools considering student wellbeing. Future research on school-based programs should aim to include measures of both positive mental health and mental ill-health, to provide a more holistic overview of impacts on student wellbeing.



A MORE CRITICAL APPRAISAL OF THE EVIDENCE

A large number of studies have been conducted on school-based universal and targeted prevention approaches to anxiety and depression, providing some basis for continuing delivery and evaluation of these programs. The research indicates that these approaches do not do any harm to young people, meaning that any benefit, however small, is at least unlikely to come at any cost to the health and wellbeing of young people. However, these findings should be interpreted with caution for the following reasons.

INCLUSIVITY

Relatively few reviews have specifically assessed whether programs are effective with populations from diverse backgrounds and underrepresented communities. Most research has been conducted in high-income countries such as Australia, the USA and Canada, making it difficult to generalise findings across different economic and cultural settings. Notably, one systematic review showed that programs delivered in lower socioeconomic status secondary school settings were less effective than those delivered in higher or mixed socioeconomic status settings.(20) Understanding the appropriateness and effectiveness of school-based mental health programs (SBMHPs) for students from diverse backgrounds, including students Aboriginal and Torres Strait Islander, CALD and LGBTIQ+ identities, is particularly important given that these groups face a range of barriers to seeking help for their mental health and have unique mental healthcare needs.(24)

Evidence from other literature highlights some of the key needs of diverse student groups that are not usually captured by systematic reviews. This includes grey literature that is not published through an academic peer-review process, and qualitative literature that uses research methods to capture subjective experiences. For example, this literature shows that Aboriginal and Torres Strait Islander students may be best supported by programs that include a focus on identity and connection to Country.(23, 25) For students with diverse sexuality or gender identity, school can be a site of homophobia and transphobia from staff as well as peers,(26) suggesting that wellbeing initiatives might show the best outcomes when they involve the whole school. To encourage diversity and inclusivity in the evidence for SBMHPs, students should be given a central voice in program design, implementation and evaluation.

For more information and practical tips on integrating student voice into school-based mental health programs, see the Orygen toolkit: [Including student voice in school-based mental health programs](#). For considerations around tailoring SBMHPs to meet diverse student needs, see the Orygen toolkit: [Implementing school-based mental health prevention programs](#).

TRIAL DESIGN

Prevention research requires very large groups of participants to show significant results, as the research aims to detect clinical outcomes, such as depression or anxiety, in non-clinical settings.(27) But small differences or effects in these programs can have significant real-world impacts. This contrasts with studies of targeted programs, which often require smaller numbers of participants and more readily demonstrate effects on mental health outcomes by including young people with higher levels of need. This makes it difficult to meaningfully compare the benefits of targeted and universal programs, and it also biases targeted programs towards appearing more effective. That is, if targeted programs show more consistent effectiveness, this may be due to young people with symptoms or overt problems having greater potential for improvement. This may mean that the effects of universal programs are not adequately represented in the current research.

MEASURES OF MENTAL HEALTH

Studies would also benefit from using consistent, standardised measures of positive mental health and mental ill-health (such as symptoms of depression and anxiety). This would enable better comparisons of outcomes across studies and prevention programs. Measures should ideally involve multiple perspectives, including not only young peoples' experiences, but their teachers' and/or parents' experiences. Research also needs to focus on what active therapeutic components(28) (e.g. cognitive restructuring, problem-solving, interpersonal skills) or what program delivery components (e.g. duration, mode of delivery) are most important for achieving positive student outcomes in the school setting.

Few studies on targeted or universal approaches have assessed long-term outcomes. Since SBMHPs aim to prevent longer term emergence of mental ill-health in young people, future research needs to consider what effects are maintained over time (such as 12 months or more post-intervention) or influence outcomes in other areas of life, for example physical health, social and educational functioning.(19) Long-term evaluation would also help to support program sustainability by providing opportunity for continuous improvement. Positively, the school setting lends itself well to long-term evaluation as students typically attend one school for most, if not all, of their higher schooling years. Further, while most SBMHPs are brief (i.e. several weeks' duration), longer programs might be expected to achieve longer term gains and should be a focus of future research.

PROGRAM IMPLEMENTATION

There is growing recognition of the value of understanding how program implementation or delivery affects student-level outcomes (e.g. depression, anxiety, wellbeing) in SBMHPs. The programs included in the systematic reviews in this evidence summary were most commonly delivered by mental health professionals or teachers. While one review found evidence that externally-delivered programs had better outcomes for depression than those delivered by school staff, this effect was not maintained over time.(19) Another review also suggested a slight preference for facilitation by mental health professionals, but concluded overall that there was no evidence of impact on depression or anxiety outcomes.(20) Conversely, one review of universal programs found no evidence that delivery by mental health professionals was superior to delivery by school staff.(17) While there is considerably more evidence for face-to-face programs, there is growing literature on digital mental health platforms that may be appropriate for school settings, with available findings suggesting similar effectiveness to face-to-face approaches.(19, 20, 29, 30) However, current findings do not clearly identify the best approach to facilitation of SBMHPs.

Overall, research would be improved by consensus on what implementation fidelity and adaptability of school-based programs,(31) so this could be better measured. This would result in a more nuanced understanding of how and why prevention programs are effective for improving mental health outcomes. Research designs should also be expanded to include other measures known to influence delivery (e.g. leadership, social networks, culture), to better understand what specific factors mediate mental health outcomes.(31) While standard measures can be helpful for making comparisons across studies, qualitative research methods like interviews and focus groups are valuable for understanding subjective experiences of implementation, including barriers to student participation in SBMHPs such as concerns about stigma, confidentiality, choice, and disruption to regular schooling.(32-34) Inclusion of cost-effectiveness analysis will also provide evidence around the cost of implementation compared to savings gained by preventing mental ill-health. Notably, there is some evidence from the Australian context that the cost-effectiveness of school-based programs depends on systemic implementation.(35) However, the evidence for cost-effectiveness of SBMHPs is currently limited. Understanding the implementation factors that make SBMHPs cost-effective in the long-term is important for large-scale, sustainable roll-out.

WHAT DOES THIS MEAN FOR PRACTICE?

This evidence summary points to a number of considerations for the implementation of school-based mental health programs (SBMHPs). For further detail on what to consider when implementing SBMHPs, see the Orygen toolkit: [Implementing school-based mental health prevention programs](#).

SHOULD SCHOOLS PRIORITISE UNIVERSAL OR TARGETED PROGRAMS?

While the existing evidence appears to favour targeted approaches, there is a pragmatic benefit of programs offered to students universally (particularly since these programs have been shown not to cause harm). For instance, students who may later develop symptoms are offered an early preventative intervention; potential stigma or disruption that young people may experience in attending groups away from their peers is minimised; and there is relative ease of administration to whole-class groups. If delivered early enough, universal prevention programs can prevent the onset of mental ill-health by helping to establish protective factors such as instilling coping skills in young people, improving emotional regulation processes or contributing to creating a more positive school environment. This can minimise social risks for mental ill-health, such as bullying or poor teacher-student relationships.(27) Since even small effects of universal programs can have significant real-world impact, there is a strong argument in favour of these programs. (19, 36) Finally, offering universal programs early in young peoples' education may be beneficial given that young people with mental ill-health are at a greater risk of subsequent disengagement from school. (37)



WHO SHOULD BE INVOLVED

SBMHPs are typically facilitated by external mental health professionals, teachers or school wellbeing staff. As the evidence is not clear about which approach works best, schools could base decisions about delivery on factors such as availability of support and infrastructure for the professional to facilitate programs, existing relationships with student participants and ability to maintain fidelity to the program model. SBMHPs that are primarily led by the education workforce may have the advantage of being better integrated into school structures and processes(38) and may ultimately be more sustainable.

Schools should also consider the different needs of students, particularly those from diverse backgrounds, such as culturally and linguistically diverse, LGBTIQ+ and Aboriginal and Torres Strait Islander communities, when choosing program facilitators to ensure the cultural safety and appropriateness of programs.

Irrespective of personnel involved, the support of mental health professionals towards implementation of SBMHPs is essential. As natural champions of youth mental health and evidence-based practice, mental health professionals, including nursing and all allied health professionals, can support successful implementation through providing supervision and training to facilitators and wider school staff, and encouraging evaluation and monitoring to ensure sustainability and continuous improvement.(39)

ENGAGING THE WHOLE SCHOOL COMMUNITY

In Australia, national and state-based education frameworks emphasise whole-school approaches to support student learning and wellbeing.(2-10) Whole-school approaches to student wellbeing should involve all members of the school community (e.g. school students, teachers, staff, families) and consider curriculum, teaching and learning, as well as school ethos, organisation, environment and partnerships. (40) High-quality academic evidence for these approaches for youth mental health outcomes is limited.(41) However, researchers have suggested that involving the whole school in mental health initiatives may promote positive outcomes by supporting student and organisational readiness.(31)

Building partnerships across the local community may also help schools to act as effective referral points into the health system when needed. Findings from the second Australian Child and Adolescent Survey of Mental Health and Wellbeing indicate that just over one in five (22.6 per cent) of young people who used health services, including a psychologist or psychiatrist, had been referred by their school.(13) Schools and mental health services should work together to create clear referral pathways, so that schools understand the criteria and information needed to make an effective referral, and mental health services are aware of opportunities to promote local pathways for young people into their service. By strengthening connections between schools and local services, whole-school community approaches may support timely and effective communication between education and health systems and help prevent young people slipping through the cracks between services.



WHAT DOES THIS EVIDENCE SUMMARY TELL US?

Despite the mixed evidence for the effectiveness of school-based mental health programs (SBMHPs), they hold promise as frontline strategies in the prevention of mental ill-health as schools are ideal settings for reaching large numbers of young people. As two of the most prevalent mental health conditions among school-aged young people,⁽¹⁵⁾ understanding the evidence for prevention of anxiety and depression in schools is important for professionals involved in the design, commission and delivery of programs, as well as for students themselves. As SBMHPs continue to be supported by health and education policy, this evidence summary provides a map to advocate for positive change in the way programs are designed, delivered and evaluated.

Key considerations include:

- student voice – youth participation should be included in all aspects of SBMHPs; see the Orygen toolkit: [Including student voice in school-based mental health programs](#);
- flexibility – SBMHPs must have the flexibility to meet individual school community needs; this includes tailoring programs according to best practice for supporting students with diverse experiences of culture, language, gender, sexuality;
- evaluation – data collection should include measures for implementation, mental health, wellbeing and psychosocial functioning, with monitoring and continuous improvement built-in to collect outcomes over the long-term; by playing a lead role in the design and collection of data, schools can help to shape programs that consider the needs of their local school community;
- time – building readiness for change requires time for preparation of the school, community, local health and mental health services, as well as people (e.g. students, school staff, families, health professionals, community leaders); and
- systemic implementation – wide-scale availability of SBMHPs that integrate with local health and community services can support sustainability long-term; see the Orygen toolkit: [Implementing school-based mental health prevention programs](#).

TABLE 1. SUMMARY OF RESEARCH EVIDENCE AND IMPLEMENTATION CONSIDERATIONS FOR UNIVERSAL AND TARGETED PROGRAMS AIMED AT PREVENTING DEPRESSION AND ANXIETY IN SECONDARY SCHOOL

	UNIVERSAL APPROACH	TARGETED APPROACH
Research evidence	<p>Mixed findings</p> <p>Small effects, but may have significant real-world impact for many young people</p> <p>Relatively large amount of evidence compared to targeted</p> <p>Outcomes not consistently maintained long term (>12 months)</p>	<p>More consistent positive findings</p> <p>Larger effects, but for smaller populations of young people compared to universal</p> <p>Overall amount of evidence is smaller than for universal</p> <p>Outcomes not consistently maintained long term (>12 months)</p>
Implementation considerations	<p>No burden of ‘screening’ students for program inclusion</p> <p>Students are not ‘singled out’ for participation, potentially reducing risk of stigma</p> <p>Readiness to implement may be easier to achieve across whole school</p>	<p>Coordination may be easier for smaller number of students</p> <p>Programs may be more easily tailored to diverse student groups (e.g. Aboriginal and Torres Strait Islander, sexuality or gender diverse, or culturally diverse students)</p> <p>Integration with local support services may be easier for students experiencing higher need for services</p>



HOW THIS EVIDENCE SUMMARY WAS CREATED

This evidence summary used knowledge translation principles to combine findings from across academic and non-academic literature with expert opinion. Data from controlled trials of universal and targeted approaches was summarised from systematic reviews found using Orygen's Evidence finder.⁽⁴²⁾ Included reviews focus on preventing depression, anxiety, general mental health or wellbeing for secondary school-aged young people. Reviews were only included if they were published in the last five years (2015–2020), included only randomised controlled trials, and authors considered the quality of studies. Reviews with both children and adolescents were included if more than 50 per cent of the individual studies were conducted in a secondary school setting or with secondary school-aged participants, or if overall mean participant age was 12–18 years. Data on implementation of school-based mental health programs was summarised from systematic reviews found through custom searches using Google Scholar. Qualitative data was found through a search of mental health and education-related databases and followed inclusion criteria for relevant studies. Grey literature was compiled from Australian and international websites related to youth mental health, priority populations and wellbeing in secondary school. Additional academic and grey literature was included on the suggestion of expert collaborators. Evidence was then synthesised and reviewed by young people, researchers and mental health clinicians including clinicians with experience working in a school setting.



ADDITIONAL RESOURCES

ORYGEN RESOURCES

Toolkit, [Including student voice in school-based mental health programs](#)

Toolkit, [Implementing school-based mental health prevention programs](#)

[Quick reference guide to evidence translation](#)

[Co-designing with young people for program design](#)

[How to partner with young people for research](#)

AUSTRALIAN RESOURCES

[Suicide intervention in schools](#): Evidence Summary. headspace School Support.

[Interim map of key student wellbeing interventions and supports](#). Victorian State Government.

[Wellbeing Hub](#). Resources for educators, students and parents. Education Services Australia.

[Be You](#). Information and resources related to Australia's national school mental health initiative. Beyond Blue, Early Childhood Australia, headspace.

[The Teaching and Learning Toolkit](#). A comprehensive summary of evidence-based approaches that can improve academic outcomes in primary and secondary school students. Evidence for Learning.

INTERNATIONAL RESOURCES

[Wellbeing for success: a resource for schools](#), New Zealand Government, Education Review Office, 2016.

[Schools in Mind](#), Anna Freud Centre, UK.

[A whole school framework for emotional wellbeing and mental health](#), National Children's Bureau, UK, 2017.

[Health promoting schools](#), World Health Organization, 2017.

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