

Good mental health is foundational to staying healthy, maintaining a state of emotional security and wellbeing, and to the socio-economic options that are available to a person across their life (Barry et al., 2013). With that being said, the state of mental health and access to mental health services in Lower- and Middle-Income Countries (LMICs) is dire. Children and adolescents make up a large part of the population in most LMICs, and depression and anxiety among this demographic constitutes a sizable portion of the mental health burden (Barry et al., 2013; Osborn et al., 2021). However, access to the necessary care is scarce in the communities that need it the most (Osborn, Venturo-Conerly, et al., 2020; Osborn, Wasil, et al., 2020; Osborn et al., 2021). It is necessary to find interventions that are financially efficient and easily scalable within strained budgets, and which are able to circumvent the social barriers to care (Osborn, Venturo-Conerly, et al., 2020). Universal mental health promotion programmes in schools have the potential to address some of the core problems outlined above, at the efficiency that is necessary for effective deployment in a LMIC like South Africa. However, there are still significant barriers to the implementation of these programmes.

Mental health promotion refers to interventions that focus on giving participants the tools they need to live mentally healthy lives, and creating an environment which naturally lends itself to positive mental health (O'Reilly et al., 2018). Because these programmes aim to prevent the development of mental illness rather than treating problems after they have developed, they can be employed universally, across an entire population rather than only the people who are already at risk (Osborn, Wasil, et al., 2020; Rivet-Duval et al., 2011).

In the countries that have the greatest share of the mental health burden, there simply is not enough funding for mental care services. Structural issues inhibit access to the services, and stigma surrounding mental health issues prevents people from seeking care out of shame (Barry et al., 2013; O'Reilly et al., 2018; Osborn, Venturo-Conerly, et al., 2020). In South Africa specifically there is a severe under-allocation of the health budget towards mental healthcare and an overreliance on specialised facilities for treatment. This means an otherwise progressive mental health policy is not actually implemented in areas that need it most (Docrat et al., 2019). Interventions need to be effective while also remaining financially feasible for national

budgets that are already under immense strain. They must also effectively manage the stigma surrounding receiving mental health care, to avoid alienating people who need that care (Osborn, Venturo-Conerly, et al., 2020; Osborn, Wasil, et al., 2020; Osborn et al., 2021).

Another limitation that interventions employed in LMICs need to navigate is the majority of measures in existing interventions have been overwhelmingly developed for high income countries and Western contexts (Barry et al., 2013; O'Reilly et al., 2018; Osborn, Wasil, et al., 2020).

There are a number of universal mental health promotion programmes that attempt to meet these challenges. By focusing on promoting good mental hygiene and positive psychological concepts rather than relying on psychopathology, these interventions can improve students' general mental health, and skills for dealing with difficult emotional circumstances (Barry et al., 2013; O'Reilly et al., 2018; Osborn, Wasil, et al., 2020; Osborn et al., 2021; Rivet-Duval et al., 2011). Some interventions have been specifically tested in LMICs and multicultural contexts, but there needs to be a continual effort to develop better suited measures (Barry et al., 2013; Osborn, Wasil, et al., 2020).

Two of the more promising programmes, the Shamiri group intervention and the Resourceful Adolescent Program (RAP-A), were both delivered by a limited number of trained lay-persons in a classroom context, mostly teachers who did not require lengthy or expensive training to be able to effectively implement them. They both included students who reported high depression and anxiety symptoms and those who did not (Osborn, Venturo-Conerly, et al., 2020; Osborn, Wasil, et al., 2020; Osborn et al., 2021; Rivet-Duval et al., 2011).

Shamiri was tested in Kenya, based on the idea of "wise interventions", interventions that focus on singular concepts that contribute towards positive mental health rather than teaching complicated systems all at once (Osborn, Venturo-Conerly, et al., 2020; Osborn, Wasil, et al., 2020; Osborn et al., 2021). The intervention taught three concepts over a four week period: (1) Growth mindset, internal characteristics such as skill and character traits are malleable rather than fixed; (2) gratitude, teaching students the value of contemplating aspects of their lives that they are grateful for; and (3) values or virtues, affirming the importance of positive values and the

protective power in cleaving to those values (Osborn, Venturo-Conerly, et al., 2020; Osborn et al., 2021). This intervention had significant positive effects on students' general wellbeing, and significant reductions in depression and anxiety symptoms (Osborn, Venturo-Conerly, et al., 2020; Osborn et al., 2021).

RAP-A was implemented in a multicultural school in Mauritius, and focused on teaching students strategies built on cognitive behavioural concepts to bolster their self-esteem, problem solving skills, engaging with support networks, and more over 11 one-hour sessions (Barry et al., 2013; Rivet-Duval et al., 2011). After a follow-up, it was found that students who participated, whether originally experiencing symptoms of depression or anxiety or not, reported much greater resilience and general mental health (Rivet-Duval et al., 2011).

Both of the programmes discussed were able to make a positive impact on the students' lives, and were able to navigate the significant challenges they face. Because they were generalized, both of the programmes circumvented the stigma attached to their functions. Because they were implemented in school, they were easily accessible to the students. Because they were facilitated by only a few teachers who did not require intense training, they were financially and logistically feasible (Osborn, Venturo-Conerly, et al., 2020; Osborn et al., 2021; Rivet-Duval et al., 2011). With that being said, more work must be done on refining these types of programmes so that they are better able to withstand financial strain and failures to correctly train teachers, and to further develop measures that reflect many different South African (and other LMIC) contexts (Barry et al., 2013; O'Reilly et al., 2018). Even so, classroom-based mental health promotion programmes seem to be one of the most promising avenues for use in South African school. These interventions have consistently shown that they can be used at a low cost, with low logistical considerations, and with impressive results.

South Africa and other LMICs face unique challenges to the implementation of effective mental health care. Lack of funding, logistical challenges, social issues and inequalities prevent mental health policies which are laudable on paper from actualizing. Children and adolescents are especially vulnerable to the gap in mental care. Universal mental health promotion, especially in schools, are a potential answer to these challenges, as they focus on lowering the potential incidence of mental ill-

ness among young people in the first place. While these programmes need more refinement for the South African context, the future for youth mental health could be bright.

References

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