The role of remote modalities in implementing mental health and psychosocial support programs and services in the education sector
Acknowledgements

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Participating Organisations

Many experts involved in the design, implementation, delivery, and evaluation of current remote MHPSS interventions were interviewed as part of this study, with the following organisations consulted:

- Beyond Blue (Australia)
- BRAC
- International Rescue Committee
- MINDS Foundation (India)
- Norwegian Refugee Council
- People in Need
- Plural Consultancy (Ecuador)
- Regional Psychosocial Support Initiatives (PEPSSI)
- Save the Children
- Sesame Workshop
- Social Ventures (Australia)
- United Nations High Commission of Refugees (UNHCR)
- United Nations Relief and Works Agency for Palestinian Refugees (UNRWA)
- War Child Holland
- World Vision International

All quotes presented in this report are anonymous and based on the individual perspectives of interviewees.
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## Abbreviations

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<th>Full Form</th>
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<tr>
<td>FCDO</td>
<td>United Kingdom Foreign, Commonwealth and Development Office</td>
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<td>GEC</td>
<td>Global Education Cluster</td>
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<tr>
<td>IASC</td>
<td>Inter-Agency Standing Committee</td>
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<tr>
<td>INEE</td>
<td>Inter-Agency Network for Education in Emergencies</td>
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<tr>
<td>LMIC</td>
<td>Low and middle-income country contexts</td>
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<td>MHPSS</td>
<td>Mental health and psychosocial support</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
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<tr>
<td>SEL</td>
<td>Social-emotional learning</td>
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<td>UNCRRC</td>
<td>United Nations Convention on the Rights of the Child</td>
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<tr>
<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>UNRWA</td>
<td>United Nations Relief and Works Agency for Palestine Refugees</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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### Definitions

The following definitions are used for the purposes of this report:

<table>
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<th>Term</th>
<th>Definition</th>
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<tr>
<td><strong>Caregiver</strong></td>
<td>Those responsible for the care of children, and may include mothers and fathers, grandparents, siblings and others within the extended family network, as well as other child caregivers outside of the family network, such as educators and other education staff.</td>
</tr>
<tr>
<td><strong>Child and adolescent</strong></td>
<td>According to the Convention on the Rights of the Child (CRC), child is defined as all children and adolescents aged 0–18 years of age. Adolescents are individuals in the 10–19 years age group.</td>
</tr>
<tr>
<td><strong>Disability</strong></td>
<td>Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.</td>
</tr>
<tr>
<td><strong>Early childhood</strong></td>
<td>The early childhood period encompasses several quite distinct phases: from ‘conception to birth’ and from ‘birth to 3 years’, with emphasis on the first 1,000 days (from conception to 24 months), followed by the ‘preschool and pre-primary years (3 years to 5 or 6 years, or the age of school entry).</td>
</tr>
<tr>
<td><strong>Early intervention</strong></td>
<td>Relates to the supporting of children and young people, usually in educational setting, with clear referral pathways and processes. The frameworks support engagement and connectedness and facilitate help-seeking and seek to prevent or minimize psychological suffering and mental health consequences after exposure to potentially traumatic events or distressing situations. Early intervention encourages effective partnerships with specialised support to ensure a child or young person's learning and development is integrated and holistic.</td>
</tr>
<tr>
<td><strong>Educator</strong></td>
<td>This term relates to staff working in education settings, including school leaders, teachers, teaching assistants, and other support staff, whose role is to educate children and adolescents.</td>
</tr>
<tr>
<td><strong>Evidence-base</strong></td>
<td>The best available evidence from systematic research.</td>
</tr>
<tr>
<td><strong>Families</strong></td>
<td>This term encompasses parents, caregivers, guardians, and other adults responsible for the care of children and young people.</td>
</tr>
<tr>
<td><strong>Learner</strong></td>
<td>This term relates to children and adolescents aged 3 to 18 years in formal (early learning, pre-primary, primary, and secondary schools), and informal education settings, including the home during COVID-19.</td>
</tr>
<tr>
<td><strong>Learning environment</strong></td>
<td>A collective term that can refer to an educational approach, cultural context, or physical setting in which teaching and learning occurs. This could include traditional contexts like classrooms or home but can also include digital context.</td>
</tr>
<tr>
<td><strong>LGBTIQ+</strong></td>
<td>LGBT is an initialism that stands for lesbian, gay, bisexual, trans/transgender, intersex, queer, and other sexuality, gender, and bodily diverse people and communities.</td>
</tr>
<tr>
<td><strong>Mental health</strong></td>
<td>A state of wellbeing in which every individual realises their potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to their community. Like ‘wellbeing’, mental health is a positive concept which refers to the social and emotional wellbeing of people and communities. It relates to enjoyment of life, ability to cope with stress and sadness, fulfilment of goals and potential, and sense of connection to others.</td>
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<td>------------------</td>
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<tr>
<td><strong>MHPSS</strong></td>
<td>Mental health and psychosocial support (MHPSS) is a composite term used to describe any type of local or outside support that people receive, aimed to protect or promote psychosocial wellbeing and/or prevent or treat mental health conditions.</td>
</tr>
<tr>
<td><strong>Mental Health Prevention</strong></td>
<td>The practice of reducing risk factors and enhancing protective factors associated with mental health difficulties. Intervening to reduce the incidence, prevalence and recurrence of mental health problems. It may involve universal, targeted or indicated preventive strategies by addressing determinants of mental health problems before a specific mental health problem has been identified in the individual, group, or population of focus with the ultimate goal of reducing the number of future mental health problems in the population.</td>
</tr>
<tr>
<td><strong>Mental Health Promotion</strong></td>
<td>Intervening to optimise positive mental health and psychosocial wellbeing by intentionally creating a learning environment that supports mental health and address determinants of positive mental health before a specific mental health problem has been identified, with the ultimate goal of improving the positive mental health of the population.</td>
</tr>
<tr>
<td><strong>Online</strong></td>
<td>Refers to the various ways in which an intervention is situated in online environments. This may include professional learning modules, email, online phone calls, videoconferencing, webinars, blogs and social media. It may also refer to the location of support tools and resources.</td>
</tr>
<tr>
<td><strong>Positive School Climate</strong></td>
<td>A positive school climate refers to the quality and character of school life. In the context of MHPSS, a positive school climate has shown to create perceptions of social, emotional, physical and psychological safety. A positive school climate is also linked to lower levels of loneliness, anxiety, depression, and suicidality for both educators and learners.</td>
</tr>
<tr>
<td><strong>Professional learning</strong></td>
<td>Generally, refers to e-learning for educators to enrich and improve their professional practice.</td>
</tr>
<tr>
<td><strong>Program intervention</strong></td>
<td>A collective term used to describe a program, framework, initiative, service, approach, process, treatment or app used to improve mental-health related outcomes. This includes all the tools, resources, support, and any other inputs that are part of the intervention.</td>
</tr>
<tr>
<td><strong>Protective factors</strong></td>
<td>Characteristics that reduce the likelihood of poor mental health either on their own or when risk factors are present. For example, being physically healthy, having positive family relationships, peer role models and student-educator relationships.</td>
</tr>
<tr>
<td><strong>Psychosocial</strong></td>
<td>Considers individuals in the context of the combined influence that psychological factors and the surrounding social environment have on their physical and mental wellness and their ability to function.</td>
</tr>
<tr>
<td><strong>Pupils or students</strong></td>
<td>Collectively used to describe children and young people enrolled in either a primary, elementary, secondary high school or college, and other learning environments.</td>
</tr>
<tr>
<td><strong>Remote learning Modality</strong></td>
<td>The mode of remote delivery of interventions using distance-based, digital, radio, tele or online methods. These solutions facilitate learning for children and adolescents, from a distance.</td>
</tr>
<tr>
<td><strong>Risk factors</strong></td>
<td>Characteristics that increase the likelihood of poor mental health. Risk factors include characteristics relating to the individual, family circumstances, peers, school and broader community. For example: exposure to or witnessing of traumatic events or severely distressing situations, poor social skills, different types of violence in the home, lack of access to essential services such as health and education, and poor peer role models or student-educator relationships.</td>
</tr>
<tr>
<td><strong>Self-care</strong></td>
<td>Self-care refers to activities that preserve and maintain an individual’s physical, emotional, and mental health. It is an ongoing commitment to look after oneself through helpful behaviours that protect health during periods of stress.</td>
</tr>
<tr>
<td><strong>Social and emotional learning (SEL)</strong></td>
<td>Social and emotional learning (SEL) is a process of acquiring social and emotional values, attitudes, competencies, knowledge, and skills that are essential for learning, being effective, well-being, and success in life. Research shows that social emotional learning enhances children's academic success while preventing mental health conditions. For this reason, SEL is seen as a key component of MHPSS in this report.</td>
</tr>
<tr>
<td><strong>Wellbeing</strong></td>
<td>Wellbeing describes the positive state of being when a person thrives. In children and adolescents, it results from the interplay of physical, psychological, cognitive, emotional, social and spiritual aspects that influence a child’s and adolescent’s ability to grow, learn, socialize, and develop to their full potential. Wellbeing is commonly understood in terms of three domains: personal wellbeing, interpersonal wellbeing and skills and knowledge.</td>
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</table>
The role of remote modalities in implementing mental health and psychosocial support programs and services in the education sector
1. Overview

The purpose of this report is to inform policymakers and practitioners about current interventions that promote the mental health and psychosocial wellbeing of learners, delivered a distance or through a blend of remote and face to face learning approaches, including support to educators and caregivers through schools and other learning environments.

The findings and recommendations are based on a global rapid review of available evidence to identify promising mental health and psychosocial support (MHPSS) programs that have characteristics suitable for remote delivery in low, middle-income contexts and emergency contexts. The delivery modes focus on paper-based, radio, phone, TV and digital approaches, and consider the advantages, constraints and risks in using these remote modalities to support MHPSS needs in the education sector.

Chapter 1 of this report provides a brief overview of the study, while Chapter 2 explains the importance of mental health and psychosocial support in the education sector. Chapter 3 explores uses of remote modalities in supporting MHPSS. Chapter 4 presents characteristics of effective MHPSS interventions in education sector, and examples of promising interventions. Chapter 5 concludes the report with a series of recommendations for policy makers and practitioners wishing to implement MHPSS interventions in their own contexts.

The report is accompanied by a full bibliography of references and studies reviewed (Chapter 7) an extended literature review (Annex 1), study methodology (Annex 2), detailed examples of promising practices in the field of MHPSS in education (Annex 3). A list of innovative MHPSS interventions (Annex 4) and self-care interventions for educators and caregivers (Annex 5) is also provided.

Research questions

Three research questions guide the focus of the study.

1. What evidence do we have on the use, advantages and constraints of using remote modalities to implement mental health and psychosocial support services for learners, caregivers, and teachers in the education sector?

2. What are the promising interventions that can respond to the mental health and psychosocial wellbeing needs of children and adolescents while learning at a distance or as an alternative for blending remote and face to face learning approaches?

3. What are the key recommendations and considerations for policymakers seeking to introduce mental health and psychosocial support services into remote learning modalities?

The rapid review covers learners aged 3 to 18 years in formal (early learning, pre-primary, primary, and secondary schools), and informal education settings, including the home during COVID-19. The review focuses on MHPSS support for learners, caregivers and educators.

The study is based on a global review of mental health programs and practices in the education sector, with a focus on low-and-middle-income contexts and different types of humanitarian contexts, supported by data focused on disadvantaged populations in high-income contexts. The impact of COVID-19 on the mental health of learners, education professionals, and caregivers is also considered throughout this study.

Framework and definitions

The study draws upon the IASC MHPSS intervention pyramid, as adapted from the WHO Optimal Mix of Services for Mental Health and the IASC MHPSS Guidelines, outlined in Figure 1. MHPSS interventions relevant to Tiers 1-3, as noted below, are included in this study. Interventions requiring external specialized services (outside of a school setting) have been excluded, although it’s important for schools and other learning environments to have mechanisms in place to refer learners to this type of service when the need arises.

This study uses UNICEF’s adaptation of the IASC’s definition of MHPSS, as outlined in the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support, which notes “mental health and psychosocial support is used to describe any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental health conditions.” However, it is important to acknowledge that many different terms are often used in relation to MHPSS depending on context, and the breadth of work related to MHPSS is vast.
Methodology

Evidence has been drawn from research, policy, and current examples of practice in educational settings, as listed in the key activities below:

**Phase 1:** Scan of academic literature to establish an evidence base for promising MHPSS interventions that use remote modalities in the education sector. This phase highlighted characteristics of remote MHPSS interventions that policy makers and practitioners might consider when implementing MHPSS interventions and identified numerous examples of promising interventions.

**Phase 2:** A review of grey (non-academic) literature, policy, and other planning documents focused on MHPSS implementation, to identify additional programs against the characteristics established in Phase 1. Several additional promising MHPSS interventions delivered using remote modalities were identified during this phase. A review of MHPSS implementation practices identified as effective was also undertaken during this phase.

**Phase 3:** Stakeholder interviews with policy makers, implementing organizations, and other mental health experts were undertaken to investigate levels of understanding, experiences of MHPSS implementation, and current barriers and enablers to supporting mental health of learners in the education sector. Additional promising interventions were also identified during this phase.

It must be acknowledged that evidence based MHPSS interventions that originate from LMICs and emergency contexts are scarce. Accordingly, only interventions or studies from high income contexts that are currently being used in LMICs, or that aim to support low-income or marginalized populations, were considered as part of this review.
2. Mental health and psychosocial support in the education sector

Children experience different degrees of positive mental health and wellbeing throughout their lives. Many will also face mental health challenges. It is now estimated that more than 13 per cent of adolescents aged 10–19 live with a diagnosed mental disorder, and that 50 per cent of all mental disorder’s onset by the age of 14. Learners with mental health issues are at greater risk of school failure and absenteeism, disruptive classroom behaviour, and suspensions and expulsions from school.

Early childhood education, schools, and learning environments play a critical role in promoting, protecting and caring for learners’ mental health, and are more influential on learners’ development than any other social institution besides the caregiver. At critical moments of child development, experiences and environments can represent a risk to mental health or help to protect it. There are many protective factors that are likely to contribute to positive mental health outcomes for learners. Opportunities for skills development, positive relationships with peers and educators, participation in school and community activities, and learning in a safe and nurturing environment in which learners of all ages and genders feel included, supported, and valued, are some examples of the positive role schools can play. It’s also important to note that schools can also expose learners to different stressors that can be detrimental to their mental health and wellbeing, such as violence from peers, racism, and stress over academic performance.

For learners at risk of poor mental health, early intervention can provide crucial support for them and their caregivers, siblings, and other family members. For this reason, there has been a strong emphasis in the policies of many education systems on school-based prevention and early intervention programs, including socioemotional learning programs. However, investment in promoting and protecting mental health – as distinct from caring for learners facing the greatest challenges – is extremely low. In fact, despite demand for support, median government expenditure on mental health globally is a mere 2.1 per cent of the median government expenditure on health in general.

Positive mental health is predictive of later life satisfaction, personal wellbeing, flourishing, and all four domains of quality of
life: physical health, psychological wellbeing, social relationships, and environmental health. In contrast, mental health issues in childhood and adolescence can result in impairments in social, emotional, and behavioural domains, and can lead to poor academic, educational, and employment outcomes, and disadvantages and poor health across the life span. There is also an established link between poverty and mental health; poverty increases the risk of mental health problems and can be both a causal factor and a consequence of poor mental health. Finally, children are too often on the front lines of humanitarian crises. The impact of such emergencies is an additional risk of increased severity of mental health conditions.

The COVID-19 pandemic has disrupted education systems globally. Emerging research also indicates that mental health conditions have increased across all age groups due to the COVID-19 pandemic. Although there was already an urgent need to support the mental health of children globally,9 stressors such as increased isolation, disconnection from others, and rising anxiety about the future prompted by the COVID-19 pandemic and school closures are impacting greatly the mental health and wellbeing of learners. The pandemic has also created a unique opportunity to strengthen and develop national policies and practices to support learners’ caregivers and educators’ mental health and wellbeing in schools and other learning environments. As a result, different remote or blended approaches to supporting mental health and psychosocial wellbeing needs during the COVID-19 pandemic recovery, and beyond, have rapidly accelerated.

Implementing MHPSS initiatives in the education sector

Several factors can support the mental health of learners in learning environments and build capacity in the educators and caregivers that support them. A systemic approach that includes policy initiatives, system capacity building, increased focus on mental health promotion and prevention services, and dedicated budgets is crucial. It is also important to note there are specific conditions needed for successful implementation of MHPSS programs, particularly in low-income and humanitarian educational contexts. Table 1 provides an overview of these factors. For a more detailed discussion of the factors that support MHPSS implementation in the educator sector, please see Annex 2.
Table 1: Barriers and Enablers to MHPSS implementation

<table>
<thead>
<tr>
<th>What helps implementation</th>
<th>What hinders implementation</th>
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<tbody>
<tr>
<td>Widespread understanding of the importance of mental health and its link to learning outcomes</td>
<td>Mental health literacy and support</td>
</tr>
<tr>
<td>Political recognition and commitment to MHPSS as essential for improving learning and child protection/safety</td>
<td>Public financing for MHPSS</td>
</tr>
<tr>
<td>Stable, widespread, affordable access to resources</td>
<td>Access to resources</td>
</tr>
<tr>
<td>Empowered educators with capacity to embrace and implement change</td>
<td>Educator wellbeing</td>
</tr>
<tr>
<td>Whole-of-learning community engagement, bringing in services and resources to build the collective capacity of the school</td>
<td>Involvement of community and local partners</td>
</tr>
<tr>
<td>Programs that are culturally well suited or highly adaptable to the context, often developed in context</td>
<td>Contextual appropriateness</td>
</tr>
<tr>
<td>Effective programs that are validated in-context or show promise and are underpinned by solid evidence-based theory</td>
<td>Program design underpinned by theory</td>
</tr>
<tr>
<td>Wholistic approach identifying the most appropriate blend of programs to meet all levels of need</td>
<td>Program goals, universal or targeted</td>
</tr>
<tr>
<td>Program aligns with school improvement framework and policy</td>
<td>Mainstreaming MHPSS into educational practices</td>
</tr>
<tr>
<td>A blend of face-to-face with access to online resources and professional learning</td>
<td>Face-to-face adaptability</td>
</tr>
</tbody>
</table>
3. Remote modalities and MHPSS

Although remote modalities have long been utilised in low income and humanitarian contexts to support learning continuity during periods of disruption due to conflict, natural disasters, illnesses, and epidemics, they have arguably not been given adequate support to capitalize upon their potential. However, interest in remote learning modalities has significantly increased globally because of school closures and disruptions brought on by the pandemic. It is estimated that approximately 1.6 billion school aged learners have been impacted by the COVID-19 pandemic, with school closures affecting around 80 percent of the world’s student population. As a result, many learners have received or are still now receiving some form of remote learning.

Remote learning modalities can be broken into three categories, as outlined below:

- No tech learning modalities are defined as paper based and printed materials.
- Low-mid tech modalities are defined as TV/Radio/Phone based interventions, as well as home visits. Phone based practices at this level are basic, such as calls or texts.
- High technology modalities include Online/Digital. Examples include phone apps, learning platforms, digital classrooms, online games, video conferencing, virtual reality, augmented reality, and social media.

Remote Learning Modalities Matrix

<table>
<thead>
<tr>
<th>Low &amp; no tech, offline</th>
<th>High tech, online</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main focus for reaching disadvantaged children and youth</td>
<td></td>
</tr>
</tbody>
</table>

- 1. Printed materials, books
- 2. Radio Interactive Radio
- 2. TV Interactive TV
- 4. Home visits
- 5. Calls Interactive Voice Responsive (IVR)
- 6. SMS Interactive SMS (RapidPro)
- 7. eBooks & audio books
- 8. Feature phone apps
- 9. Other apps/platforms
- 10. Social messaging apps
- 11. Video conferencing
- 12. Digital classrooms

*Ideally supported by parents/caregivers

Source: UNICEF (2020c)

Remote learning modalities can be one-way (educator-learner) or two-way (a loop between educator and learner). Two-way modalities allow learners to continue to stay in touch with their educators via phone, SMS, and social messaging apps like WhatsApp; which was one of the most commonly used learning modalities in LMICs during the pandemic.

In most low-income and middle-income country settings, a combination of remote learning modalities is often used given significant digital divides. These include printed kits, TV and radio streaming services, offline digital interventions, internet and mobile-based programs (including WhatsApp), mobile broadcasting, and other internet-based technologies have. In both LMIC and high-income settings, adoption of remote learning programs designed to mitigate the effects of education disruption, have also become more common because of the pandemic.
There is extensive evidence on MHPSS interventions in educational settings, particularly in high income contexts. However, there is little research into the role remote modalities play in supporting mental health and wellbeing, particularly in low income and humanitarian contexts.

While much research has focused on remote modality use in supporting continuity of learning and mitigating the impact of learning loss during the pandemic, the potential of remote modalities for supporting mental health and social and emotional learning is also increasing. Remote modalities, particularly online/digital applications, have previously been used to support MHPSS in the education sector, particularly in high income settings such as in Australia, the UK, and Finland. Remotely delivered MHPSS support is also becoming increasingly innovative globally, including in LMICS and humanitarian spaces, thanks to renewed attention on the MHPSS needs of learners, caregivers, and educators during the pandemic.

Paper-based and printed

In the delivery of remote learning programming, print-based materials are considered the most familiar medium to all learners and educators worldwide. Print materials are easy to use and do not require access to technology or the internet and thus are identified as the most equitable means of reaching learners in low resource settings. However, printed material alone is not sufficient to promote the learning and mental health and psychosocial wellbeing of learners as the interaction with educators (virtually or face to face) and other learners is fundamental. Print-based material should be accompanied by mechanisms and resources that ensure regular and direct interaction with educators or other educational professionals for support, such as through mobile phones (SMS, calls, and social messaging apps were most used for educator interaction and support in low and lower middle-income countries). Guidance materials for caregivers when learners are learning at home should also be available to support learners’ learning and wellbeing.

Print-based materials can be used for universal mental health promotion activities, such as programmes to increase mental health literacy as well as to help learners to continue building socio-emotional skills while schools are closed due to emergencies. Ideally, print-based materials should be delivered with other instructional and support methods such as tv and radio broadcasts, audio-visual content on digital platforms, telephone follows up, small group learning, etc.

During emergencies, print-based material, together with radio and TV broadcasting, can be helpful to disseminate key messages for educators and caregivers to promote mental health and psychosocial wellbeing. Dissemination of key messages can encourage communities to have open discussions around the importance of taking care of their mental health, sharing cultural appropriated ways to normalize stress reactions after confrontation with great adversity and promote positive coping mechanisms. It is also important to disseminate information on when, how and where to access mental health and psychosocial support services.

When designing print-based material, it is crucial to have the material available in the different learner’s mother tongues and develop material with simplified language with visual content for the youngest readers. Visual content and illustrations can help support learners with low literacy and low reading fluency levels, and support learners who are neurodiverse. Print based materials can also be adapted to support learners who are visually impaired, or who experience other intellectual disabilities. It is also important to consider the cost and logistical resources needed to distribute print material to learners in remote and hard to reach communities.

Box 1. A multi-modal and multi-component intervention that used paper-based and printed materials for mental health promotion

La Aldea: Stories to stay at home
multi modal SEL intervention delivered in Colombia, Mexico and Venezuela

La Aldea is a comprehensive printed, digital, and radio SEL curriculum. This multi-platform curriculum based on fables aims to educate children in citizenship and socio-emotional skills, encouraging them to have fun while reflecting on their reality. During 2020, and in partnership with UNICEF, La Aldea reached 87,667 Colombian families and 4,220 teachers. Since 2016, the strategy has reached 150,000 learners and 5,000 teachers in Colombia, Mexico and Venezuela. La Aldea aims to integrate real-life, current themes into mainstream curriculum through carefully crafted stories for children in a playful manner. The stories and activities create a springboard for integrating interdisciplinary learning: socio emotional, curricular in different areas: language, maths, science. La Aldea also supports teachers in different contexts with support resources, printed and digital content, lesson plans and virtual accessories to implement La Aldea into their classrooms.

La Aldea: Stories to stay at home
multi modal SEL intervention delivered in Colombia, Mexico and Venezuela

Box 1. A multi-modal and multi-component intervention that used paper-based and printed materials for mental health promotion
There are a number of useful programs that use paper-based and printed resources, such as Accessing Quality Basic Education in Iraq by Catholic Relief Services, which printed out paper handbooks and distributed to caregivers during the pandemic (and focused on CASEL competencies); and Right to Play, which distributed paper leaflets on play-based SEL and wellbeing. There is limited information on the scale to which programs that used paper-based resources have been implemented in LMICS and humanitarian spaces, particularly during the pandemic, however, it is likely only a matter of time.

Radio

Radio is widely available and accessible in many parts of the world, including some of the hardest-to-reach areas. During the COVID-19 pandemic and schools’ closure, many countries broadcasted radio lessons to ensure learning continuity for learners. Radio has proven to be a cost-effective option to reach learners living in communities with limited access to digital devices and connectivity. However, the weak broadcast signal and the additional and recurrent cost of batteries and electricity can restrict access to learning via radio. For the most disadvantaged learners, when there are many radio users in a household, it is not certain that learners will be given priority to use a radio. Some learners with special educational needs and disabilities may face additional barriers when learning through radio, however, for learners who are visually impaired, radio can be an effective method. Other limitations of the radio are the low interactivity when listened to via a live broadcast and the difficulty of monitoring its usage.

Broadcast radio programs around mental health and psychosocial wellbeing can potentially expand the mental health literacy of learners, educators and caregivers. Broadcast radio programs can also be used in the aftermath of an emergency to help communities understand normal and common stress reactions, promote culturally and age-appropriate coping mechanisms, and provide accurate information about learner and caregiver MHPSS services. During emergencies, regular live radio sessions can allow learners and caregivers to be connected with mental health professionals that can answer some of their questions and provide practical tips to radio listeners about how to care for their mental health and wellbeing. Recording radio programs can also support educators when delivering activities to promote learners’ mental health and the psychosocial wellbeing of learners in classrooms, such as socio-emotional learning programmes.

When designing radio programs to promote the mental health and psychosocial wellbeing of learners, it’s crucial to create context-appropriate and compelling content that is adapted for each age group. A blended approach of complementary support, such as using paper-based and radio broadcasts to promote mental health and helplines to deliver remote mental health care, can be practical during emergencies.

Radio-based interventions have widely been used to support continuity of learning during periods of disruption, and some interventions also support MHPSS and wellbeing. Podcasts have been administered to support those working with learners. Radio programs have also been used to support mental health and wellbeing in India, Malawi, and Tanzania. School-based listening clubs, in which learners gather to listen to radio programs designed to support mental health are listened to collectively by learners, have also been implemented in Malawi and Tanzania, an interesting example of a remote modality being used when schools are open. There have also been several additional radio-based interventions delivered during the COVID-19 pandemic to support the mental health and wellbeing of learners affected by the pandemic. For example, Save the Children also developed a set of activities in English and Spanish to support distance learning opportunities for learners during the pandemic. SEL activities in radio education programming, home based relaxation activities, and suggestions for measuring learning and wellbeing were also provided.
Mobile phone access and use are becoming increasingly widespread, and mobile phones are by far the most widely available technology in households, even in the poorest homes. Smartphones are becoming increasingly common, however, access to mobile phones varies widely among and within countries, depending on gender, age, household income, location, etc. When caregivers have access to smartphones, mobile apps can offer a wide range of options to deliver learning and mental health promotion, prevention and care programs. Simpler mobile devices can be used to reach the most marginalized caregivers through WhatsApp, SMS and phone calls.

Different mental health promotion materials, such as storybooks and audio, can be shared with learners, educators and caregivers via SMS or WhatsApp using simple mobile devices. Mobiles phones can also facilitate the provision of tele mental health services by a mental health provider. Smartphones applications may also assist learners with mental health information and practical tips to improve mental health and wellbeing. Here is essential to note that mental health professionals delivering tele-mental health services should apply the same ethical and professional standards of care and professional practice that are required when providing in-person services in each context.

When developing/adapting MHPSS mobile phone interventions, it’s crucial to analyze how and why mobile devices have been used in this context by learners and/or their caregivers for education and health, including mental health. This information will be relevant to strengthening any existing programme with MHPSS content or designing a new one to address the mental health continuum of care for school-age learners and their caregivers and educators.

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BRAC’s Remote Play Labs are adapted from the Play Labs model (which are play-based learning centres for children ages 3-5 in low-resource settings) and support remote learning through radio and telecommunications. The program resources support children’s social, cognitive, and language development and ensure caregivers are equipped to support children’s wellbeing, through the provision of regular radio sessions run through local stations. During the sessions, play leaders and educators facilitate interactive activities focused on learning and wellbeing. Family members are also encouraged to participate to promote a playful environment in the home that builds resilience during periods of crisis. The Radio Play Labs component reached millions of children with play-based learning content through local radio stations and will continue to expand in 2022.

Telephone and mobile phone services have long been used to support mental health in some developing countries and across many developed countries. The prevalence of mobile phones and smart phones across the world has also seen increases in the use of phone counselling services, with MHPSS services being provided in various formats, such as varying from SMS (text messaging) based, to phone calls, and WhatsApp. During the pandemic, many mental health providers also moved to telehealth/phone counselling appointments. For example, during the pandemic, phone counselling was used in Ecuador by UNICEF and Plural Consultancy to support the mental health and wellbeing needs of learners and caregivers. WhatsApp was also used widely in many countries for supporting both MHPSS and education provision, and was used extensively by UNICEF and the WHO in 20 languages for delivering COVID-19 health updates.
However, at this stage, there is limited research on the efficacy of phones to support mental health and wellbeing in educational settings, particularly in LMICs.

### TV/video/film streaming

Educational television, which uses the medium of video through broadcast technologies, has been used for decades to increase access to learning opportunities for marginalized learners. Videos support distance or remote learning in various ways: videos can be broadcast live via satellite or cable transmissions or streamed via the internet. Video might also be delivered as a recording, provided on storage media such as DVDs or USBs.

The main advantage of educational TV is that many educators and learners in most countries can easily access it. Even in lower-middle-income countries, TV ownership in rural populations is relatively high compared to access to the internet. The World Bank reports that 79% of all households worldwide have access to a television, and 72% in developing countries. During the COVID-19 school closures, educational television was the most popular technology governments chose in formulating their remote learning response. The main limitation is that learners cannot interact directly with the content on broadcast TV, and there is no immediate feedback or communication between the educator/provider and the learner. Other media and technologies need to be added to make television more interactive.

Education television, using the different ways of delivery, could be a valuable medium for disseminating key mental health and psychosocial wellbeing promotion programs for learners and their caregivers when learning at home. Recorded videos can also supplement classroom activities around mental health promotion and socio-emotional learning and supplement professional development programmes for educators with MHPSS content.

### Schoolwide Positive Behaviour Intervention and Support (SWPBIS)

*telehealth counselling, delivered by phone in Jamaica during the pandemic*

The Schoolwide Positive Behaviour Intervention and Support (SWPBIS) framework has been piloted by the Ministry of Education, Youth and Information (MOEYI) in some 60 schools across Jamaica, with support from UNICEF. SWPBIS is a whole-school approach that aims to increase positive values and behaviours in learners and to curb in-school violence and was delivered via telephone during the pandemic. During Covid-19 and with the school closures, many of the learners struggle with mental health issues such as depression, suicidal thoughts and post-traumatic stress disorder (PTSD) and require ongoing support, so UNICEF provided 50 mobile phones to learners – with monthly unlimited data and telephone service plans – through the Guidance and Counselling Unit of the MOEYI to the Ministry of Health and Wellness. This provided learners with the opportunity to access telehealth services via Child Guidance Clinics across the island.
Online/digital

Digital solutions have the potential to provide diverse opportunities to deliver learning material and deliver promotive, preventive and responsive mental health and psychosocial support services, as some platforms can also facilitate the contact and interaction between learners and mental health providers. However, the biggest constraint of digital technologies is that two-thirds of the world’s learners – 1.3 billion learners aged 3 to 17 years – do not have an internet connection in their homes. Moreover, learners from lower-income households are less likely to have the digital literacy that would help them to benefit from digital solutions. However, the access to mobile phones and smartphones is changing rapidly, and it might be possible that more low-income households will have access to digital devices in a few more years.

Programs that used digital technology are mainly delivered through six modes - (1) websites, (2) games and computer-assisted programs, (3) apps, (4) robots and digital devices, (5) virtual reality, and (6) mobile text messaging. Most of these digitally supported interventions are aimed at transmitting specific mental health information/messages to a targeted population, focused on prevention, or helping adolescents to stay connected and seek help from others online.

There are now more than 10,000 digital interventions for supporting the mental health and wellbeing of learners and their caregivers, many of which are increasingly innovative. Although it is not possible to highlight every digital intervention in this report, there are several useful examples from low-income contexts, including web-based self-help platform for high school learners in Kenya, learners with depression in Iran and secondary school learners in China.

Sesame Street

*Video, film, tv delivered in the Unites States with additional multi-modal resources in English and Spanish*

In the United States, Sesame Street has developed resources on mental health and wellbeing, trauma, help seeking, recovery after crisis, and psychological safety, available in English and Spanish. While the resources use video streaming as their main mechanism to engage children and parents/caregivers, there are many free resources available that use paper based, video, and online/digital modalities, including games, to complement the delivery of video content. Younger children can participate in the creation of art with Elmo, to help them process their emotions, and educators, parents/caregivers, and community members can download free printable resources to share more broadly. There are also training and support videos, and classroom resources spanning a broad range of MHPSS related topics for educators.

**Box 4.** An awareness building/promotion program delivered through TV/film broadcasting
Online Health, Kazakhstan
(Internet-based) online counselling platform

In Kazakhstan, since 2012, UNICEF has collaborated with the Government of Kazakhstan to develop and implement the Adolescent Mental Health and Suicide Prevention (AMHSP) programme. This programme is an intersectoral, school-based response that aims to strengthen the national education and health system’s ability to respond to adolescents’ mental health and psychosocial needs. Most recently, UNICEF, with the support of USAID, developed a joint action plan with the Ministry of Education and Science and the Ministry of Healthcare to ensure continued access to psychological counselling services during the COVID-19 pandemic and meet the emerging capacity building needs of school counsellors. UNICEF has partnered with the National Centre for Mental Health of the Ministry of Healthcare (NCMH) to launch an online counselling platform. Addressing the existing demand for professional capacity building and development among psychologists, the launch of the online counselling platform also includes an educational program for specialists. The site is available in Russian and Kazakhstan.

The Learning Passport
Mixed modality Online/Digital platform

The Learning Passport (LP) is an education solution developed by UNICEF and partners to enable continuous access to quality education and address the challenges faced by learners, facilitators and education providers, including those impacted by emergencies. The LP is highly flexible and can be adapted to fit local contexts and meet a variety of learner needs including supporting early childhood education, skills development, formal education, technical & vocational education and more. Working with industry leaders, the LP has created a comprehensive resource hub of mental health and psychosocial support (MHPSS), social and emotional learning (SEL) and other critical and supplementary learning materials focused on promoting the mental health and psychosocial wellbeing of children, adolescents and their caregivers and teachers. The Learning Passport has reached over 2 million learners in 24 countries since its launch in 2020.
Benefits of using remote modalities for MHPSS in education settings

There are many benefits for remote modality use in the field of MHPSS. While remote learning modalities have primarily been used to support continuity of learning during the COVID-19 pandemic, they also offer opportunities to support the MHPSS needs of learners during and after the pandemic; particularly in settings where access to services is limited. As the previous section highlighted, remote modalities can meet a variety of MHPSS needs, from the provision of basic educational and promotional MHPSS services during periods of crisis, through to support for communities, caregivers, and individuals in the education sector. Since the pandemic began, there has also been an increase in the use of modalities (particularly telephone/telehealth mechanisms) to supplement specialised services during periods of face-to-face disruption.

Increased access

The largest benefit relates to the potential of remote modalities to provide continual and more equitable support to learners, particularly during emergencies, in which face to face learning cannot continue or be provided. Learners and their caregivers who cannot access face to face services may be afforded opportunities to engage in MHPSS programs and practices within educational settings, including when schools and traditional learning environments are closed or have restricted access. This is also true in LMICs and humanitarian spaces, though additional resourcing and support for delivery and participation of MHPSS programs is often needed.

Support for learners with disabilities

Remote modalities can also be effective for increasing participation and mental health amongst diverse populations, due to the flexibility of modes, and the ability to access services and support remotely. However, remote provision must be fully accessible so that all learners, regardless of ability, can benefit. Recent studies have demonstrated that remote modalities can be used successfully to engage young people who may otherwise be excluded in traditional education settings, and can also be helpful in facilitating social connection, socioemotional learning, and self-regulation. Moreover, remote modalities offer opportunity for enhanced participation in MHPSS practices for many learners excluded from school-based programs, with associated capacity building and mental health and

Box 7. A MHPSS intervention adapted to be delivered online during the pandemic

The Adolescent Kit

Mixed modality Online/Digital platform

The Adolescent Kit for Expression and Innovation enhance adolescents’ resilience, well-being, and learning readiness. The Adolescent Kit is a package of guidance, tools, activities, and supplies that support life skills development and community engagement while developing key competencies and skills that help adolescents cope with stressful circumstances in humanitarian and vulnerable development contexts. Tools like “inspiration cards” and “emotion cubes” help engage adolescents in a range of activities that build on their strengths, and provide them with opportunities to learn new skills, develop positive relationships, build their self-esteem and coping skills, and give back to their communities. In its original form, the Adolescent Kit activities are meant to be carried out through in-person interactions between adolescents in facilitated group sessions. During Covid-19, the kit was adapted to offer activities that can be self-administered by the adolescents themselves wherever they are. Additionally, the package offers instructions for parents/caregivers and facilitators to apply the activities at home or through platforms such as radio/WhatsApp. The Adolescent Kit has been used in 21 countries around the world, reaching 160,000 adolescent girls and boys since it was launched in 2017. It is used in a range of humanitarian and protracted emergencies, in countries affected by armed conflict, natural disasters and protracted crises, in fragile and vulnerable development contexts, and among migrants, refugees, internally displaced people and host communities.

iv USAID (2020) Best Practices on Effective SEL/Soft Skills Interventions in Distance Learning (edu-links.org)

v Remote modalities have shown particularly effective to support the socioemotional needs of children and adolescents with autism (Clare et al., 2019, Tanaka, 2010).
wellbeing practices that can support caregivers and community members involved in implementing programs and practices in the home. Remote support can also facilitate inclusion into school for learners who may not be able to participate in education fully due to unavailability of MHPSS services in their school.

Capacity building of caregivers and educators

“Parents’ mental health and psychosocial support is fundamental for building that environment of support and provide nurturing care to the child” — INGO

Free webinars, tv programs, radio programs, paper-based resource packs, and online or home-based supports from MHPSS practitioners are examples of mechanisms that can support caregivers and educators to learn about and receive mental health and wellbeing supports during periods of disruption or school closure, which in turn enhances caregiver capacity to support learners in the home.

The Ready to Come Back: Teacher Preparedness Training Package developed by UNICEF for use in the Middle East and North Africa for example, aimed to support educators to implement home-based learning while also providing practical tips and recommendations on how to support the mental health and wellbeing learners. Insights from these programs can be leveraged for MHPSS mechanisms using remote modalities.

Risks and limitations of using remote modalities for MHPSS

Remote delivery cannot always replace face to face

In the most disadvantaged communities that have limited access to any form of digital technology, face-to-face support often remains the best option. Particularly over the course of the pandemic, connectedness and social interaction has become particularly important, with increased recognition of the social needs of individuals. Face to face support can also be helpful for learners with disabilities who may not be able to utilise remotely delivered MHPSS mechanisms.

Child safety

During periods when schools are closed and support structures for learners are lost, child protection risks increase. Many learners have experienced reduced safety in the home during the pandemic. Furthermore, in situations where one-on-one educator support is needed, learners can be placed at additional risk of sexual abuse from educators, especially in LMICS. Girls are at greater risk of online exploitation and abuse, particularly in periods of instability and disruption, although programs like the Girls Education Challenge have attempted to mitigate barriers to girls participating in education, while monitoring engagement levels amongst female learners.

Access and equity of access

“One of the very important things they have to face is the population’s ability to access the internet; so, they have different places where people cannot afford it, or the signal does not get there, or they do not have cell phones or smart phones” — NGO

Accessibility, to devices and data, is the largest limitation when it comes to the implementation of remote modalities for MHPSS in educational settings, particularly digital interventions. There is a wide disparity regarding access to the internet and information communication technologies in low-income and humanitarian contexts, and growing risks of disruption to learning, but also growing opportunities for learning continuity measures. In many cases, there may be reduced access to technological or digital devices at home, learners may need to share a common device with their siblings, or male learners may be given preference over others, leading to further exacerbating the digital divide.

vi Home safety can be compromised due to increases in gender-based abuse (Mittal & Singh, 2020) and family violence (Humphreys et al., 2020). Vulnerable children and their families are also at much greater risk in terms of cyber safety (Leach, 2015; Masters et al., 2020).
their siblings in terms of access. Connectivity is a major challenge, particularly for those programs that rely on digital modalities, and amongst marginalised groups.

There are also gender differences both in relation to device access and connectivity, often driven by patriarchal and cultural restrictions placed on girls and women in many low-income countries. Women are 7% less likely than men to own a mobile phone, and 15% less likely to use mobile internet. There are still 234 million fewer women than men accessing mobile internet\(^\text{vii}\). These accessibility challenges are made more challenging by a lack of literacy and digital skills, and social norms influencing women and girl’s uses of mobile technology. Weekly access to information media is also substantially lower among adolescent girls in low income and humanitarian settings.\(^\text{viii}\) Such access is a major barrier to the delivery of remote MHPSS initiatives. Access to devices and materials for receiving MHPSS programs is a particularly problematic issue for learners in low income and humanitarian contexts.

Even in contexts where access to devices and data are possible, not all remote modalities are cost effective. Online modalities require major investment and may not be an appropriate fit for resource delivery. While some programs identified are free, others may charge a sign-up fee for organizations/participants. It should also be noted that few programs also cover the cost of devices or provide data to participants, which can be a major barrier, particularly due to the cost of internet access in many LMICs. Challenges of access are also not only limited to digital resources, but also in relation to paper-based resources. Printing, translation and distribution costs are a logistical challenge, especially during COVID-19.

**Digital fatigue and device use**

“...you can hear all over the world stories about how children using digital platform are disconnected and experience social media fatigue as a result of digital interventions or digital means to connecting for MHPSS in education setting...” — NGO

COVID-19 has seen a marked shift in the way education systems provide learning, and a change in learning environments. While remote teaching and learning has become more common over the past two years, and in contexts where learners, educators, and caregivers can access digital platforms, fatigue has been reported. A reliance on digital learning environments is likely to continue beyond the pandemic, which could have implications for the ways in which learners connect, learn, and develop socioemotional skills. Excessive time spent on devices can also impact mental health and physical health negatively, and impact on self-esteem and self-regulation.

**Remote by delivery or design?**

Insights into what works and for whom, in relation to the use of remote modalities for MHPSS, have accelerated during the COVID-19 pandemic. Many of these insights are relevant for supporting MHPSS implementation in the education sector. However, due to the rapid nature of development, it is extremely difficult to distinguish between effective remotely delivered interventions by design, and those interventions that have been modified to be remotely delivered\(^\text{viii}\). Considering the modality, and what works for different types of users, is a key component in supporting service delivery and sustainable provision.

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\(^\text{viii}\) Some interventions are designed to be delivered via a mixture of modes. This could include a mix of any of the above modes, usually selected to ensure maximum engagement and collaboration among the target participants. Potentially, there could be many variations of multi-mode delivery, particularly as a result of shifts during the pandemic.
The role of remote modalities in implementing mental health and psychosocial support programs and services in the education sector
4. Promising remote MHPSS interventions in the education sector

A wide range of high-quality literature was reviewed to determine the characteristics of effective remote MHPSS programs and practices. The review examined MHPSS interventions used globally in early learning, primary, and secondary schools, and non-formal education. Programs and practices that provide support for caregivers and educators were also reviewed. Studies examining the impacts of COVID-19 on the mental health of learners, educators, and caregivers were also considered.

A total of 5,577 studies and reviews were identified, regarding mental health interventions aimed at preventing, promoting, and/or responding to mental health and psychosocial needs in educational, home, specialised mental health services, or other relevant settings. Although the vast majority of MHPSS interventions in education can be found in high income countries, particularly in Australia, UK and US respectively, great care was taken to only use studies that were focused on LMICs, or disadvantaged populations, low-income communities, or communities without access to resources, in high income settings.

These interventions were examined to determine their appropriateness in supporting the mental health and psychosocial needs of learners, educators, and caregivers in educational settings in LMICs, and humanitarian contexts, and to establish common characteristics of effective MHPSS interventions. These characteristics were used to review programs and practices from the academic and grey literature, and stakeholder interviews. Only interventions or studies from high income contexts that are currently being used in LMICs, or aim to support low-income or marginalized populations, were considered for review.

As noted throughout the report, it is very difficult to find evidence on MHPSS interventions developed and implemented in LMICs. This is not to say that these programs do not address the needs of stakeholders in the education sector, but rather, that the evidence is still beginning to emerge. As a result of this process, 21 interventions were identified as ‘promising’, and as aligned to with UNICEFs MHPSS Circle of Support (Table 2). The full review process is available in Annex 3, Phase 1.

Table 2. UNICEFs MHPSS Circle of Support

<table>
<thead>
<tr>
<th>OUTPUTS AND UNICEF INTERVENTIONS</th>
<th>9 circles of support</th>
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<tbody>
<tr>
<td><strong>Child</strong></td>
<td></td>
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<tr>
<td>1 Safe, nurturing environments</td>
<td></td>
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<tr>
<td>Safe spaces, safe and supportive school environments, support to vulnerable families and violence reduction</td>
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<tr>
<td>2 Positive relationships</td>
<td></td>
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<tr>
<td>Peer-to-peer groups for adolescents, cultural and expressive activities for children, mother-baby groups</td>
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<tr>
<td>3 Stimulation, learning, skills development</td>
<td></td>
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<tr>
<td>ECD activities, building teacher capacities in SEL, vocational training for adolescents</td>
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<tr>
<td><strong>Family/Caregiver</strong></td>
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<tr>
<td>4 Supporting caregiver wellbeing</td>
<td></td>
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<tr>
<td>Focused care for distressed caregivers, specialized MHPSS care for parents with MNS disorders, support in coping for parents and teachers</td>
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<tr>
<td>5 Positive parenting</td>
<td></td>
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<tr>
<td>Awareness-raising of distress reactions among children of different ages and developmental stages, promotion of positive parenting knowledge and skills, support for parents/caregivers in caring for children with MNS disorders</td>
<td></td>
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<tr>
<td>6 Family and community support networks</td>
<td></td>
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<tr>
<td>Caregiver/women’s/men’s support groups facilitation for inclusion and participation of vulnerable families in communal activities</td>
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<tr>
<td><strong>Community</strong></td>
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<tr>
<td>7 Wellbeing and protection awareness-raising</td>
<td></td>
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<tr>
<td>Stigma reduction campaigns for people with MNS disorders, CP messaging</td>
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<tr>
<td>8 Activated natural community supports</td>
<td></td>
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<tr>
<td>Engagement, monilization and support to community organizations (communication for development activities), support to community leaders in promoting child and family wellbeing</td>
<td></td>
</tr>
<tr>
<td>9 Strengthened care systems</td>
<td></td>
</tr>
<tr>
<td>Training of professional and lay staff in coordinated MHPSS care for children and families and development of functional referral systems for at-risk children and families</td>
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</table>
Characteristics of promising interventions

Our research suggests that any effective or promising MHPSS intervention\(^ix\) that uses remote modalities in the education sector should ideally:

1. Support and respond to different mental health and wellbeing needs amongst learners, educators, and caregivers
2. Provide a safe and positive environment for learners and adult participants / trainers and other stakeholders
3. Support the development of high-quality relationships between participants and program delivery staff, and build community knowledge and engagement
4. Offer relevant, appealing, and engaging activities for learners, which can support learners at different stages of development
5. Be inclusive, culturally responsive, and appropriate for learners of different ages, abilities, and genders

\(^ix\) These characteristics are intentionally general, as every country will have unique needs that will require adjustments based on the needs of children, adolescents, educators, and caregivers.

Our extensive review of documents, coupled with interview with experts and implementing organisations in the field, suggests that the most effective mental health and psychosocial support interventions share several key characteristics. These characteristics are valuable for intervention planning and design and allow policy makers and practitioners to consider ways to include these characteristics in the design and implementation of future programs, when contextually and culturally appropriate. These characteristics are presented in more detail below, along with examples of MHPSS interventions that feature these characteristics.

Evidence-based

There are many MHPSS interventions now available, yet not all have a strong evidence base. This is particularly true of interventions designed to support younger learners, and learners with disabilities and/or gender considerations, as well as their caregivers. Ideally, interventions should draw upon evidence from trials or studies that evaluate their effectiveness to ensure their feasibility in the real world.
Accessible
Cost and accessibility are major barriers for the implementation of MHPSS programs. Most free and low-cost remote applications are effective for reaching large groups of people. However, in order for remote MHPSS programs to be accessible, interventions must be tailored to what is most accessible in a particular community.

Includes training and support for educators and caregivers
In low-income contexts, remote learning mechanisms can be enhanced by providing better educator training around their use in the educational sector, and providing education, training, and support for caregivers. Although the primary aim of an intervention may be to improve student mental health and wellbeing, components which train/guide educators, caregivers and other relevant groups on how to support learners can have a higher impact.

Targeted support
Remote MHPSS interventions that target all learners in an education setting (also known as universal programs) offer a low-cost, direct, and scalable way of accessing learners and improving their mental health in the education sector. However, programs that target specific issues or groups appear to have a higher impact.

Co-designed interventions
Interventions which are co-designed with young people, educators, caregivers, and clinicians or through stakeholder involvement workshops and interviews are more easily accepted and have better engagement/participation rates.

Effective use of technology
Interactions and human connectedness are vital for learning. However, for MHPSS interventions to provide genuine opportunities to connect, interventions must be flexible in their design and delivery, and respond to the needs and preferences of those who use them. Design and interactivity are key to continued use, particularly with learners. Flexibility of modes, ease of use, engagement with content and other users, and practical and interactive learning activities, help keep participants engaged.

Promising interventions
After an initial review of academic literature to establish characteristics of effective interventions, a review of grey literature, including policy and planning documents, was reviewed against the characteristics identified in the academic search (Annex 3, Phase 2). All interventions presented use some form of remote modality and are free to access. Restricting the search to interventions that employed some form of remote modality/flexible technological requirements and were relevant for low income and humanitarian contexts (and no cost to users) excluded many good programs/practices that align to existing educational practices. Face to face programs were excluded from the scope of the review (unless they had been adapted for remote delivery during the pandemic).

Further interventions were identified from the grey literature which met the criteria for a promising intervention. The characteristics established by the academic review, and supported by the review of grey literature, were then examined against insights generated from interviews with expert consultants (Annex 3, Phase 3). Several of the interventions identified in the grey literature were also highlighted by stakeholders during this phase, in addition to other suggested interventions. Not all interventions met all the criteria required to be considered as a promising intervention. Nevertheless, we included them because they did present innovative distance-delivered characteristics that might be readily adapted to the LMIC context. The Table 3 below summarizes the resulting selection of promising interventions.

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x In contexts with access to the internet or cellular connections, internet-based interventions can be more accessible and cost-effective than conventional face to face school-based programs (Anderson & Titov, 2014; Ip et al., 2016). Although most of the research was conducted in high income settings, there are many programs designed in Hi settings that are being used in LMICs spaces. Further, in LMICs, a proportion of the population will have access to the internet; for example, 13 per cent of the population in Bangladesh has access to the internet (which is a vast number given the overall population). Cellular phone connections are also widely used in LMICs, including in Afghanistan, where mobile cellular subscriptions per 100 people number 58.

xi Programs targeting specific issues or at-risk groups appear to have a higher impact than universal programs (Feiss et al., 2019; Stjerneklar et al. 2019, Werner-Seidler et al., 2017; Zhou et al., 2021), particularly in lower income settings. Targeted early intervention programs can also be particularly impactful, and are more likely to have more influence on young children and build stronger and resilient populations (Murano et al., 2020). However, targeted programs are also generally more complex in design and delivery, more expensive to implement, and often rely on support from external experts as part of referral processes and integrated programs.

xii Bradshaw et al., 2021; Clarke, et al., 2021; Bergin et al., 2020; Edbrooke-Childs et al., 2019; Stallard et al. 2018, Major & Watson, 2018, Reeves & Pedula, 2013; Bergin et al., 2020; Sasna & Savage, 2018, Lynch et al., 2019; Major & Watson, 2018; Reeves & Pedula, 2013; Bergin et al., 2020

xiii Moore, 1989; Zimmerman, 2012
### Table 3. The resulting list of ‘promising’ interventions

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Where</th>
<th>Country reach</th>
<th>MHPSS tier</th>
<th>Delivery modality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>7 Cups: Anxiety &amp; Stress Chat</strong></td>
<td>School, Home, Other</td>
<td>191 countries</td>
<td>Prevention, Early intervention</td>
<td>Phone Online/digital</td>
</tr>
<tr>
<td><strong>Be Strong Online</strong></td>
<td>School</td>
<td>11 countries</td>
<td>Promotion</td>
<td>Online/digital</td>
</tr>
<tr>
<td><strong>Better Learning Program</strong></td>
<td>School, Home</td>
<td>Jordan, Lebanon, Palestine</td>
<td>Prevention, Early intervention</td>
<td>Phone Radio Online/digital</td>
</tr>
<tr>
<td><strong>Colors of Kindness</strong></td>
<td>Home</td>
<td>Bangladesh, India, Kenya, Palestine</td>
<td>Promotion</td>
<td>Paper based Online/digital</td>
</tr>
<tr>
<td><strong>Girl Rising</strong></td>
<td>School</td>
<td>144: USA, India, Pakistan, Kenya Guatemala, Thailand</td>
<td>Promotion</td>
<td>TV / video/film</td>
</tr>
<tr>
<td><strong>habaybna.net</strong></td>
<td>all</td>
<td>8: Jordan, countries in MENA region</td>
<td>Promotion</td>
<td>Phone Online/digital TV</td>
</tr>
<tr>
<td><strong>Inside Out –We All Belong</strong></td>
<td>School</td>
<td>28 countries, New Zealand, others</td>
<td>Promotion</td>
<td>TV / Video Paper based</td>
</tr>
<tr>
<td><strong>La Aldea</strong></td>
<td>School, Home</td>
<td>Colombia, Mexico, Venezuela</td>
<td>Promotion</td>
<td>Paper based Online/digital Radio</td>
</tr>
<tr>
<td><strong>MeeToo</strong></td>
<td>School, Home</td>
<td>UK</td>
<td>Promotion</td>
<td>Online/digital</td>
</tr>
<tr>
<td><strong>MindUP 2.0</strong></td>
<td>School</td>
<td>USA, 13 countries including Uganda</td>
<td>Promotion</td>
<td>TV / Video Online/digital</td>
</tr>
<tr>
<td><strong>Play at Home Games</strong></td>
<td>Home</td>
<td>15 countries around the world</td>
<td>Promotion</td>
<td>Paper based</td>
</tr>
<tr>
<td><strong>Pure Edge</strong></td>
<td>School, Home</td>
<td>USA</td>
<td>Promotion</td>
<td>Online/digital</td>
</tr>
<tr>
<td><strong>School Day Wellbeing</strong></td>
<td>School</td>
<td>26: Finland, Africa, 5th America, China, India</td>
<td>Promotion</td>
<td>Online/digital</td>
</tr>
<tr>
<td><strong>SEL Kernels</strong></td>
<td>Early Learning, School</td>
<td>Brazil, Canada, Niger, Nigeria, Sierra Leone, USA,</td>
<td>Promotion</td>
<td>Mixed Mode TV / Video Paper based</td>
</tr>
<tr>
<td><strong>SESAME Workshop</strong></td>
<td>Early Learning, Home</td>
<td>USA, other counties</td>
<td>Promotion</td>
<td>TV / Video Online/digital</td>
</tr>
</tbody>
</table>

# Reported in USAID Best practices on effective SEL/soft skills interventions in distance learning 2020.
Innovations in MHPSS interventions

Although innovation is not a characteristic established by the document review, it is important to acknowledge that current developments in the field of MHPSS are increasingly rapidly, particularly in relation to digital innovation. Some of the programs uncovered through the academic literature search are only in feasibility trial stages, and therefore not demonstrated to show evidence yet, although they have shown good potential and may become highly successful in the future. There are also numerous examples of interventions that are currently being used in high income, LMIC and humanitarian settings, such as chatbots and educator wellbeing interventions, as discussed by experts during stakeholder interviews. Some of these innovations are also being adapted for or used in educational sector, as discussed in more detail below.

Box 8. A digital intervention that offers flexibility, interaction, and practical guidance

East African Child Helpline MHPSS Chatbot Initiative

*Eastern and Southern Africa region; conversational agent/chatbot*

The initiative running in parallel across Kenya, Uganda and Tanzania, is in early prototype stage (May 2022) and will provide immediate mental health supportive response to users and support and helpful, self-care and supportive advice and information; screen/triage. Incorporating some basic AI technology messages will be screened to be able to identify those requiring an immediate focused psychosocial support (PSS) response including extremely vulnerable children and women, who will be directed to a human responder/counsellor. The chatbot, which is an extension of existing telephone-based child helpline services aim to ensure both service efficiency, improved speed of response and appropriate allocation of resources while still reaching mass populations with support. It will also capture and generate meaningful data on the most prevalent types of support requests which can inform local and national (and possibly regional) responses for example mental health promotion campaigns, advocacy etc.). The approach will also strengthen linkages between the existing Child Helpline and the social welfare system at the sub-national level.

Chatbots

Due to increasing levels of awareness as to the importance of child and adolescent mental health, and recognition of the impact of the pandemic on access to resources, many countries are now developing increasingly innovative digital mental health resources that can prevent, promote, and respond to the mental health needs of learners and caregivers. The majority of digitally delivered interventions provide cognitive-behavioural therapy (CBT) for preventing depression and/or anxiety symptoms in at-risk populations. Some chatbots, or conversational agents, are one example of a remote modality being used to support mental health in education contexts where users do not have access to mental health practitioners, due to cost, location, or staffing shortages.

Some chatbots have demonstrated evidence of effectiveness, such as WOEBOT, which is now being adapted for use in tertiary college and graduate school education, though they have not yet been used in the school sector. Other MHPSS focused chatbots are now also being developed by UNICEF for use in Kenya (through the East African Child Helpline MHPSS Chatbot Initiative), Tanzania, Uganda, and Nepal, and are worth featuring as examples of world leading developments in the field of remote modalities for MHPSS, even if not embedded in educational practice yet.

Educator focused MHPSS interventions

“It’s very hard to look at teacher wellbeing as an important topic on its own. It’s only looked at in terms of children” —INGO

Research shows that building educator mental health literacy and capacity first, can be more effective than interventions that focus on building student social-emotional capacity. However, there are extremely few programs dedicated to educator mental health anywhere in the world, despite recognition from the education sector on the importance of educator wellbeing. For this reason, BeYou, a world-first, educator focused mental health intervention, is included to demonstrate the way in which remote modalities can support the MHPSS of educators in diverse settings.

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xvi A chatbot is a software application that is designed to engage users in human conversation in a natural way. Chatbots are used across many different industries, including in customer service, health, and more recently, MHPSS and education.

xvii In a recent systematic review looking at mental health training programs for secondary school educators, Anderson et al. (2019) reported on six programs: Mental Health High School Curriculum Guide, The Guide Pre-Service Professional Development Program, Mental Health First Aid, Go-to Educator Training, Teachers As Accompaniateurs, and African Guide: Malawi Version that support educator mental health and wellbeing. Two programs (MHHSCG; GPPDP) were delivered using a combination of face-to-face and online components, but none were fully remote. We have therefore included an example of a high-income intervention which offers online professional development modules for supporting the mental health of educators in Australia, which may be useful for supporting targeted educator wellbeing in LMICs in the future.
Limitations of current research on MHPSS in the education sector

1. Much research on MHPSS focuses on high income settings and not LMICs or humanitarian spaces. Further, given the rapid development of remote MHPSS interventions globally, not all promising remote MHPSS interventions can be captured in this study. However, the characteristics presented in this report are common in those MHPSS interventions that demonstrate a positive impact on learners, educators, and their caregivers, in low-income educational settings. The list of interventions we present as “promising” therefore is not exhaustive, but illustrative.

2. There is a dearth of literature on school-based mental health prevention programs for learners, educators, and caregivers in LMICs which can been attributed to the scarcity of professionals, acceptability of interventions, poor funding for mental health promotion and prevention by LMICs and sometimes a shortage of open access publications.

3. There are numerous MHPSS related activities currently occurring in low income and humanitarian settings. However, most LMIC and humanitarian MHPSS intervention programs had weaker evidence of impact than high income MHPSS programs. It is possible that the weaker effects may be partly related to differences in implementation models, rather than program content.

4. Few studies report evidence of improving mental health and behavioural outcomes among diverse population groups, and even fewer are specifically designed for or trialled with minority ethnic groups. This is important, as discrimination based on minority status can also contribute to child and adolescent mental health conditions.

5. Many remote MHPSS interventions do not have sufficient evidence of impact due to a lack of research in the area. Program evaluation is still a developing field of educational research, even in high-income countries. Changing government policy that requires programs to provide evidence of positive impact to receive ongoing funding, will drive high quality, well-funded process and impact evaluations.

6. Few MHPSS interventions reviewed in this study demonstrated evidence of alignment to existing school programs and practices, or integration into daily practice, even in high income contexts. Given the established link between mental health and learning, more research needs to be undertaken, particularly in low-income contexts and humanitarian settings, to determine if remote modalities can support the specific needs of learners in diverse contexts.

Be You

*Australia: teacher professional development wellbeing resource*

Guided by online professional learning for educators, the BeYou framework provides an umbrella that encourages schools and early learning services to seek out, identify and implement existing social-emotional learning programs and interventions to support and promote student wellbeing specific to their needs and context. Accordingly, schools may be implementing multiple interventions within a broader framework of whole-school wellbeing promotion, in addition to embedding their local jurisdictions’ wellbeing improvement framework as part of daily practice. BeYou has been widely used to support educators across Australia, including those working in disadvantaged, Indigenous, rural, and remote education communities.

xviii While this is true also in high income settings and should be considered more broadly in future research, it is particularly important in low-income context where the impacts of discrimination due to gender, socioeconomic status, sexuality, migrant status, religion, or cultural background, can be profound.
The role of remote modalities in implementing mental health and psychosocial support programs and services in the education sector
5. Conclusion and recommendations

Early childhood education, schools and learning environments play a critical role in promoting, protecting, and caring for learners’ mental health. The complexity of the linkages between health, mental health and psychosocial wellbeing and learning has been exposed during the COVID-19 pandemic and the school closures that negatively impacted millions of learners. This crisis has presented the education community with a unique opportunity to strengthen and develop national policies and practices to support learners’, caregivers and educators’ mental health and psychosocial wellbeing in schools and other learning environments, including the delivery of MHPSS programs and services using remote or blended approaches. The following recommendations are informed by a review of academic literature, grey literature, and stakeholder consultations conducted during this study. They support the implementation of remote MHPSS mechanisms in the education sector and build on broad recommendations on the integration of MHPSS in education.

**Policy makers**

**Mainstream remote delivery services in the integration of MHPSS in the education sector**

MHPSS should not be a separate focus of education reform agendas. Schools and other learning environments can play a vital role in promoting learners’ mental health; however, this potential has not been fully used as there is not sufficient and sustained engagement and financial support from government and donors. Given the likelihood of new emergencies and the exacerbation of mental health issues associated with them, the mainstreaming of remote delivery forms of MHPSS may serve as an essential mechanism to facilitate access to promotive and preventive services in the education sector.

**Enhance the digital literacy of educators, caregivers, and learners**

Enhancing various aspects of digital literacy (such as using the internet, searching for information, online collaboration, etc) amongst educators, caregivers, and learners, is key to effective implementation of MHPSS remote modalities that rely on digital technologies.

**Improve professional capacities and competences**

Developing the capacity of the education workforce to promote the mental health and wellbeing of learners when learning remotely, helping to reduce stigma around mental health, identifying learners in need, and supporting educators through pathways of care and delivering mental health content in remote learning curricula.

**Adapt and contextualise MHPSS interventions**

There is no one remote MHPSS intervention to support mental health across all contexts, and any promising practice should be adapted for context in close collaboration with in-country stakeholders. User preferences around modality, access to resources, and the linguistic and cultural appropriateness of existing programs should also be considered in the adaptation of design and delivery. Exploring which programs and practices could work in an individual context allows for MHPSS programs and practices to become more appropriate and embedded in school practices.

**Develop innovative and engaging solutions**

Investing in the development and implementation of engaging and innovative remotely delivery MHPSS solutions to strengthen the capacity of the education sector to promote and protect learners’ mental health and psychosocial wellbeing and promote MHPSS as part of educational practice. Piloting established interventions that recognise community need and offer the potential to support individuals at scale through flexible delivery modalities, can maximise reach and engagement. Mental health solutions that have been co-designed with the community they aim to support can also be highly effective.

**Invest in evidence generation and knowledge sharing**

Considering that many of remote MHPSS modalities have only emergent level of evidence, it is important to include a strong monitoring and evaluation component that considers outcomes as well as cost is needed to ensure scale. Ensuring a knowledge management system is in place to help educators reflect on their experiences, extract the lessons and help transfer those to others is critical to continuously improving the implementation of remotely delivery MHPSS solutions in the education sector.
Prioritise educator wellbeing
The wellbeing of educators, school leaders, and support staff must be prioritised in the education sector, particularly during crisis situations. Remote MHPSS programs that are specifically designed to support educators are important, and can promote connection between educators during periods of challenge and disruption. While there are currently few educator focused MHPSS programs, there are many good remote applications (particularly digital and online) targeted at adults, that can encourage self-care, resilience, and wellbeing, particularly during times of uncertainty and crisis.\textsuperscript{xix}

Learners are protected from violence
Ensuring learners are safe is always a key priority in MHPSS programming. Risks could be significantly minimized through proper safeguarding measures, for example by ensuring educators have the necessary knowledge and skills related to GBV risk mitigation; ensuring educators have mandatory prevention of Sexual Exploitation and Abuse (PSEA) and child safeguarding training that includes how to perform safe referral practices. Caregivers should also be informed about the risks and strategies for staying safe on the internet.

Integrate training support for caregivers
The most effective remote MHPSS programs involve community members and should therefore encourage buy-in by engaging caregivers. Flexible and ongoing guidance on how to support the mental health and wellbeing of their learners should be included in any remote MHPSS. Resources should be easily available and free access should be ensured. Such access to resources can promote the establishment of caregiver networks and relationships focused on mental health and wellbeing, especially when learners are learning at home.

Considerations for Education in Emergencies
The negative effect of school closures on learners’ education, health, mental health and well-being has been demonstrated during the pandemic. This global crisis has highlighted the need for education systems to have remote learning and MHPSS options that are accessible and effective for all learners when schools are forced to close. The development of effective remote MHPSS interventions is increasingly important as climate change increases the severity and frequency of natural disasters, likely to result in more frequent and prolonged school closures.

During periods of crisis that result in schools being closed and/or learners learning remotely, it is important that remote learning solutions also include components that support the mental health and psychosocial wellbeing of learners. Continuous and robust monitoring systems must also be in place to ensure access to learning and MHPSS services support and monitor the most vulnerable learners, regardless of the modality of MHPSS programs and practices employed in the education sector.

While the recommendations offered in this section target education in emergency contexts, reflecting on considerations during emergencies are relevant to all education sectors seeking to be better prepared and more resilient. In light of the greater need for building resilient education systems that can respond to the learning and MHPSS needs of learners, the following section outlines several key considerations:

Prioritise learners affected by emergencies
When delivering remote MHPSS in education in emergencies, it’s critical to assess the barriers for remote learning and MHPSS services for the most vulnerable and marginalized groups, such as girls, learners with different abilities, LGBTIQ+, non-accompanied learners, etc. Measures should be taken to assess the needs, resources and priorities of the most vulnerable and ensure that there is a wide range of opportunities that respond to their learning and MHPSS needs. Ensuring that the most vulnerable learners have access to remote learning modalities that integrate practices to promote and respond to their mental health and psychosocial support needs is also crucial.

Invest in preparedness
Preparation for provision of MHPSS remotely should occur in advance, rather than in response to an emergency, for example having teacher training resources ready to be deployed rapidly to emergency sites. Remote MHPSS solutions adapted to the context and educators’ training should be carried out in advance and current or new disaster response plans should include MHPSS components for learners and educators. Embed MHPSS programmes into existing educational practice and disaster planning and coordinate with other sectors of emergency response.

\textsuperscript{xix} See Annex 6 for a selection of examples.
Assessment
MHPSS should be included in education needs assessment in humanitarian contexts from planning phase to inform education in emergencies response programming, plans and funding. These assessments can help identify individual MHPSS needs and support the selection of appropriate interventions modalities in emergency response and recovery planning.

Support educators and foster accountability
Educators are often required to support the short-term mental health challenges that arise immediately following a crisis, as well as long term mental health conditions amongst learners. Educators must therefore be given time and support for their own mental health and wellbeing and encouraged and supported to practice self-care. Shared accountability for and between educators should also be encouraged to promote child safety during periods of crisis.

Maximise reach and relevance
Effective MHPSS interventions must be responsive to emergencies and adapted quickly to support recovery and build resilience. Remote modalities should be adapted on the basis of need, resourcing, and context, which are necessary in supporting the most vulnerable learners and caregivers, many of whom do not have access to data, devices, and who may be displaced. Assessing which solutions are best to reach learners at scale is also important.

Educators
The following are recommendations for educators to promote mental health and psychosocial wellbeing in the education sector. All recommendations follow a strength-based approach to MHPSS implementation in the classroom (or in the home during periods of disruption to schooling) and aim to cultivate resilience and allow learners to gain confidence in their skills and abilities.

Enhance your capacities to deliver MHPSS remotely
As blended learning models will most likely be permanently applied in many education settings, educators must develop their pedagogical capacities to effectively deliver through those approaches. Digital literacy is a pre-cursor to be able to effectively implement such modalities, as is flexibility in using different modalities to support learners.

Support the development of policies and procedures to promote learner and educator mental health and psychosocial wellbeing
School leaders play an important role in making educators, learners, and caregivers aware of available supports for mental health and wellbeing. School leaders can also develop and enact clear policies and procedures within schools to promote learners’ and educators’ mental health and wellbeing, including special consideration and guidance when education programs are delivered remotely.

Practice self-care
School leaders and educators should engage in self-care strategies so they can care for their own mental health and respond to the needs of learners. Self-care can be promoted by understanding, acknowledging, and responding to individual MHPSS needs, as well as participation in activities that foster connections with others and build adaptive coping strategies. School leaders and educators should make self-care a priority, particularly during and after emergencies. There are also number of online and digital MHPSS interventions that can support the mental health needs of educators and promote connection with others and allow for personal learning and reflection (see Annex 5).

xx Assessment should also identify gaps in MHPSS programme design and delivery capacity of the context, learning environments, education ministries, educators and other education personnel, and relevant in-country stakeholders. This can guide Education Clusters and partners involved in emergency response in understanding which capacity gaps can be addressed immediately as part of the emergency response, as well as develop capacity building strategies for recovery and future preparedness.
**Stay connected**
In periods of school closures, maintaining connection is important, for both educators and learners. Public and private finance is needed to ensure teachers and learners can access devices, free internet connection and IT support as needed. For learners, remote learning mechanisms can also ensure that positive mental health and positive relationships are encouraged, among learners as well as educators. For school leaders and educators, MHPSS remote modalities can support them in monitoring their and can be further complemented by context specific check-ins or activities focused on positive mental health and connections within the education community.

**Use remote modalities to continue supporting social and emotional learning**
Social and emotional skills including particularly understanding and managing emotions, are often seen as an important pre-condition for positive mental health, and as critical for overcoming periods of challenge and stress associated with learning. Fortunately, there are many good remotely facilitated programs that can be used by educators (as well as caregivers), to ensure these skills can be explicitly targeted, including during periods of disruption.

**Try different methods and modalities to promote and protect the mental health of learners**
As per recommendation 4 in the previous section, it is important for educators to consider how applicable a particular solution is to their context in terms of evidence, language, culture, target age group, level of technology, and cost. Working with other educators to test out different solutions to determine which one is more effective can support this endeavour.

**Engage caregivers**
Caregiver engagement by educators and school leaders is often key to enhancing educational and mental health outcomes. Caregivers are very important in supporting the development of learners’ digital and mental health literacy and skills. In extended school closures, caregivers become central in supporting the challenges of learners, and remote mechanisms can allow caregivers to support continuity of learning. Adopting a parents-as-partners mechanism can also support the MHPSS experiences of learners and allow for a sharing of care during periods of crisis.

**Strengthening referral pathways**
While remote modalities offer much potential for supporting MHPSS needs in the education sector, there are sometimes in which referral and treatment by mental health specialists are needed. Procedures need to be in place to refer learners with significant psychological distress or mental health conditions to the required specialised services. It is not the job of educators to diagnose, but educators have an important role to play in the referral process. Familiarity with mental health referral can help school leaders and educators support learners who require the support of specialist intervention and engage mental health experts and caregivers during the process. In emergencies, it’s essential to strengthen referral pathways developed through coordination among relevant government and humanitarian agencies across sectors.
6. References

Endnotes


Bibliography

Agyapong, V. I. O., Hrabok, M., Vuong, W., Gusnowski, A., Shalaby, R., Mrklas, K., ... & Greenshaw, A. J. (2020). Closing the psychological treatment gap during the COVID-19 pandemic with a supportive text messaging program: protocol for implementation and evaluation. JMIR Research Protocols, 9(6), e19292. https://doi.org/10.2196/19292


The role of remote modalities in implementing mental health and psychosocial support programs and services in the education sector


Additional resources, reports, and toolkits

- GBV AOR Resource List gbvaor.net/tools-and-resources-thermic-areas/covid-19
- Education Cannot Wait Reports - educationcannotwait
- IASC COVID Response Site interagencystandingcommittee.org/covid-19-outbreak-readiness-and-response
- IASC COVID MHPSS RG resources interagencystandingcommittee.org/mental-health-and-psychosocial-support-resources-covid-19
- IFRC Resource Center Resources related to COVID
- IFRC Resource Center Back in school during COVID-19
- INEE Minimum Standards INEE Minimum Standards | INEE
- MHPSS and EiE toolkit app.mhpss.net/?get=57/mhpss-and-eie-toolkit.pdf
- MHPSS.net COVID Toolkit app.mhpss.net/toolkit4covid19
- MHPSS.net COVID Group app.mhpss.net/groups/current-mhpss-emergency-responses/novel-coronavirus-international-health-emergency-2020/
- Mental Health Innovation Network www.mhinnovation.net/resources/mental-health-resources-coping-during-covid-19-outbreak
- Save the Children COVID Site: kayaconnect.org/
- UNICEF Adolescent Kit Adolescent Kit
- UNICEF Adolescent Mental Health Matters: Landscape analysis of UNICEF’s response and agenda for action | UNICEF
- UNICEF Core Commitments for Children | UNICEF
- UNICEF Education Strategy Every child learns | UNICEF
- UNICEF Global Multisectoral Operational Framework | UNICEF
- UNICEF Mental Health and Psychosocial Technical Note | UNICEF
- UNICEF Remote Learning Readiness Index
- UNICEF LSCE Reimagining Life Skills and Citizenship Education in the Middle East and North Africa | UNICEF Middle East and North Africa
- UNICEF The State of the World’s Children 2021 | UNICEF
- USAID Best Practices on Effective SEL/Soft Skills Interventions in Distance Learning (edu-links.org)
- USAID Social and Emotional Learning and Soft Skills | Education Links (edu-links.org)
- USAID Delivering Distance Learning in Emergencies
- World Health Organization Adolescent mental health fact sheet. www.who.int/news-room/fact-sheets/detail/adolescent-mental-health