

# MENTAL HEALTH PROGRAMMES IN SCHOOLS

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This document is based on reviews of the published literature and on material prepared by experts in countries. It sets out models for mental health promotion in schools. The place of the promotion of mental well-being, mental health instruction and the prevention and treatment of psychosocial problems and mental illness are described.



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# MENTAL HEALTH PROGRAMMES IN SCHOOLS

## 1. Our Children's Mental Health

The mental health and well-being of our children requires our attention. Today, we can help young people live more productive and fulfilling lives through programmes that include life skills education, mental health education, school-based health interventions, and when indicated, professional treatment.

All young people today face significant stresses in their lives. Some changes are part of normal growing up, e.g. growth and hormonal changes, as well as the changes in relationships that young people experience with parents and society. Other stresses are more individual, involving pressures to advance in school and to earn a living, peer pressures, family moves, school changes, parental fighting and divorce, or pressure to engage in substance abuse. Sexual and physical mistreatment, AIDS, natural catastrophes and severe or chronic physical illnesses and hospitalizations may also cause significant stresses. Young people negotiate these stresses with varying degrees of resilience and mastery.

Many children make it through their youth without showing significant behavioural or academic difficulties. This is due to a combination of successful coping skills and to the amount of support available, as well as the degree of environmental stress encountered. Unfortunately, it is not always possible to determine which children will develop mental health problems before they occur. Therefore, programmes need to include all children and adolescents, with interventions ranging from skills for mental well-being to specific mental health interventions.

Nearly one in five children and adolescents will have an emotional/behavioral disorder at some time during their youth regardless of where they live and how well to do they are (7,22,42). Children with emotional disturbances exhibit their impairments in a variety of ways. They may fail academically, be socially rejected and have a poor self image. They may also have difficulties in relating to peers or adults and may have little respect for the laws of their society. In addition, they may live within financially and emotionally impoverished environments.

Academic failure and social rejection often have lasting consequences because the failure to learn in school limits a person's chances to succeed in the future. As a consequence such children are more likely to drift from main stream society and become targets for unemployment homelessness or other symptoms of social dysfunction (19).

Even by conservative estimates, 10% of all children have mental disturbances with serious associated impairments at some time during their childhood. These disturbances include learning problems, physical health problems, and substance abuse (50). Furthermore, at least 3% of school-aged children suffer from serious mental illnesses such as severe depression, suicidal thoughts, psychosis, serious attention problems or obsessive-compulsive disorder (32).

In many geographic regions, families and schools are the strongest social institutions in the child's life. Rapid population growth; geographic mobility and urban migration; increased numbers of single-parent families; technological change; and the easy access to potentially life-threatening mechanisms, substances and activities have weakened family and cultural structures that formerly protected and supported young people. Schools have a central position in many children's lives and potentially in their development, especially when families are unable to assume a leading role. Therefore, schools, for many children may be the most sensible point of intervention. However, not

all children attend schools. This is especially so for some of the most "at risk" children. It is therefore important to think of alternative strategies to engage these children, both to keep them in school and to reach them if they are not in school. Community-based organizations, youth organizations and agencies, religious institutions, adult service clubs, senior citizens groups, sports organizations, museums, libraries, and public parks should work together with families, schools, health agencies, the media and governments to address the needs of young people in the most appropriate settings (17). Many of the principles described in this monograph are applicable to community-based programmes.

The purpose of this monograph is to familiarize the reader with a model framework for a comprehensive approach to mental health promotion, prevention, and treatment in schools based on published literature and expert consultations from successful programmes throughout the world. Components of this model are reviewed including the importance of the promotion of mental well-being, mental health instruction, and the prevention and treatment of psychosocial problems and mental illness. Effective interventions for the child, the family, and the teachers as well as the appropriate use of mental health professionals are described. Finally, strategies to create effective mental health programmes for school-age children are offered. References are provided in the bibliography for those who are seeking more detailed information regarding any of the particular programmes or potential interventions.

## 2. The School's Potential for Promoting Mental Health

Schools have an unprecedented opportunity to improve the lives of young people. As nations have moved toward a commitment to universal education, schools are finding it necessary to expand their role by providing health services including mental health services to deal with factors interfering with schooling.

Schools, with the full support of families and the community, are currently the best place to develop a comprehensive mental health programme for children because:

- \* Almost all children attend school at some time during their lives.
- \* Schools are often the strongest social and educational institution available for intervention.
- \* Schools have a profound influence on children, their families, and the community.
- \* Young peoples' ability and motivation to stay in school, to learn, and to utilize what they learn is affected by their mental well-being.
- \* Schools can act as a safety net, protecting children from hazards which affect their learning, development, and psychosocial well-being.
- \* In addition to the family, schools are crucial in building or undermining self-esteem and a sense of competence.
- \* School mental health programmes are effective in improving learning, mental well-being, and in treating mental disorders.
- \* When teachers are actively involved in mental health programmes, the interventions can reach generations of children.
- \* Teachers have often received some training in developmental principles. This makes them potentially well qualified to identify and remedy mental health difficulties in school aged children.

A comprehensive mental health programme should be part of a comprehensive school health programme including health instruction at all grade levels, easily accessible health services, a healthful, nurturing and safe environment, and interaction with families and community organizations. The Healthy School (74), a report from the Scottish Health Education Group, identifies three main elements of a health promoting school - the formal curriculum, the school ethos (physical and social environment) and the relationship between the school, the home, and the surrounding community.

The aim of school-based interventions is to provide an experience that will strengthen the children's coping abilities to counter environmental stress and disadvantages with which they have had to cope in growing up (55). Comprehensive school health initiatives are available that result in higher school attendance rates, enhanced academic success, less school drop-out and reduced criminal behaviour (12). Mental health and life skills education has been demonstrated to reduce drug use, alcohol consumption, and cigarette smoking in children and adolescents (21,29).

School-based mental health interventions may be environment-centred or child-centred and one may lead to the other (26).

The school environment refers to the "living and learning" climate of the school. Environment-centred approaches aim at improving the educational climate and providing opportunities for the child to connect with a healthy school programme where they will find healthy

role models. This positive mental health atmosphere includes the structure of the school day, the structuring of playground activities, the physical structure of the school and the classroom decoration.

Environment-centred programmes also strive to enhance the ability of administrators, teachers and support staff to deal with the specific areas of emotional or behavioral disturbance they encounter and, when necessary, to understand how to make use of other agencies serving children (8).

An example of a successful mental health intervention into the educational environment is one to prevent bullying in Norway (43). Instead of teaching individual children to cope with bullying by aggressive peers, a national campaign was developed and successfully carried out to reduce bullying throughout the entire school system. The intervention consisted of workshops for teachers and parents, booklets, videos, and problem solving and social skills training for students, all with a firm, non-aggressive message that bullying would not be tolerated.

Another example of an environment-centred model is the Yale Child Study Center Prevention Model (20) in the United States. The Yale model applies a systems approach to school problems. It focuses on improving the school's social environment by encouraging parent participation through a parent programme in support of school activities, and by establishing a multidisciplinary mental health team to provide consultation in the management of student behaviour problems. These activities are coordinated by a representative governing body composed of administrators, teachers, support staff, and parents. The governing body identifies and rates problems and opportunities within the school; distributes and promotes resources; establishes mechanisms to solve problems and use the existing opportunities; and monitors and evaluates the outcome, thus providing feedback so that appropriate modifications can be made to the programme.

The Yale model provides a coordinated, collaborative effort to improve communication, understanding, and respect between staff, students and parents. This provides a sense of direction and ownership of the programme. It also is found to improve student academic and behavioral performance over time (18).

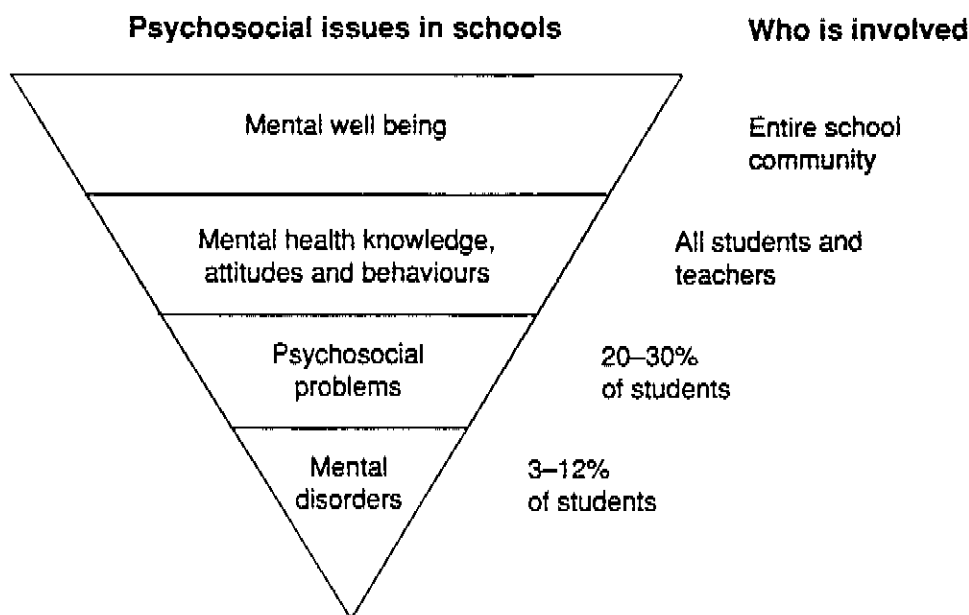
Child-centred activities, on the other hand, include individual mental health consultations and specific problem-focused interventions as well as more general classroom programmes to improve coping skills, social support, and self-esteem. With individual mental health interventions the mental health professional usually provides a consultation regarding a particular child and family having difficulty. The result of the consultation may involve recommendations being given to the parents, the teacher, and in some cases referral for treatment outside the classroom.

An example of a successful child-centred programme is the Primary Mental Health Project (PMHP) in the United States which seeks to prevent maladjustment early by locating at-risk children and involving them in an intensive goal-directed intervention that includes close contact with nonprofessional child-aides (24,64). This model concentrates on those students identified as at-risk and does not attempt more general alteration of the school environment.

The majority of the school-based mental health programmes presented in this monograph are child-centred in their approach. Implementation of any of these, however, must be supported by accompanying interventions in the school environment or system (12).

### 3. A Model Framework For School Mental Health Programmes

The following diagram illustrates the psychosocial and mental health issues present in all schools and indicates who is likely to be affected by these issues:



Issues of well-being and psychosocial competence affect the entire school community including students, teachers, school administrators, and members of the surrounding community. Specific mental health programmes addressing these issues improve coping skills, decrease stress, and increase support for a healthy school community. Mental health and learning go hand-in-hand. For example, a study in New Zealand found that behaviour problems pre-date reading disability, while reading failure further worsens existing behaviour problems (38).

**Mental health knowledge, attitudes and behaviours** affect all students and teachers. Educational interventions can make an important impact on the identification and handling of psychosocial and mental health problems.

It is important to identify children with **psychosocial problems** early and target them for intervention. These early problems in school frequently endure and predict later, more serious problems such as school failure and school dropout, too early pregnancy, drug and alcohol abuse, delinquency and low levels of adult earnings. Thus the cost of these problems to individuals, to families, and to a country is extremely high (31). Good pre-school and school programmes can counteract some of these risks and decrease the costs.

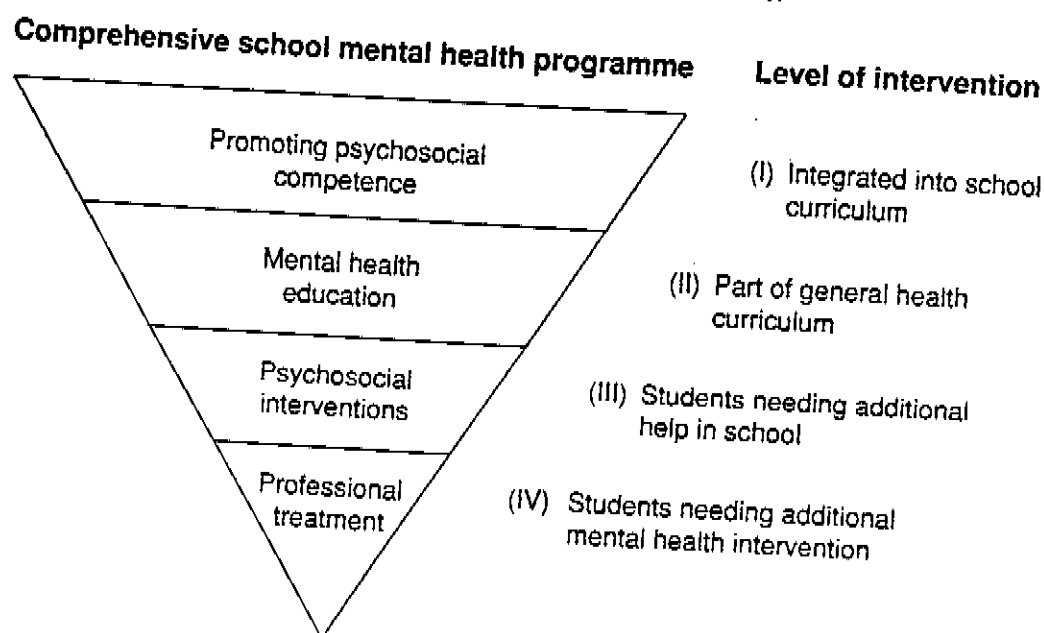
Children who are not doing well in school may be suffering from poverty, violence, hopelessness or mental illness in their families and may come to the attention of schools due to disruptive and disturbing psychosocial problems. Children with poor mental health skills and/or environmental stress such as family or emotional problems or the feeling that nobody cares - are unlikely to perform well in school or later in life.



A few children will develop serious mental disorders based on specific biological vulnerabilities, just as some children will develop other medical disorders such as diabetes, cancer, and asthma. Treatment by a mental health professional is important, as is a receptive and supportive school environment.

## Intervention Model

Successful models of intervention can be found at four levels:



In regions where mental health has not been a focus of attention, officials wishing to develop a mental health programme might decide to focus on only one or two levels at first. However, to be maximally effective, an integrated programme at all four levels is required.

Levels I through IV can be likened to primary, secondary, and tertiary prevention efforts. Primary prevention and health promotion (Levels I and II) target the causes of healthy and unhealthy conditions with interventions which to promote healthy behaviours and prevent a disorder from developing. Secondary prevention (Level III) targets a more selected population of high-risk people to protect against the onset of the disorder. Tertiary prevention (Level IV) targets people who already have developed the disorder with the intent of treating the disorder, reducing the impairment from the disorder, and /or preventing relapse (55).

Level I (Promoting psychosocial competence) is described in Section 4 of this monograph and Level II (Mental Health Education/Instruction) in Section 5. These are for all young people in the school.

Models for Level III (Psycho-social Interventions) and Level IV (Professional Treatment Interventions) are described in Section 6.

#### 4. Promoting Psychosocial Competence

Psychosocial competence is a person's ability to deal effectively with the demands and challenges of everyday life. The most significant interventions for the promotion of psychosocial competence in schools are those which enhance the child's own coping resources and competencies. This is most often done by the teaching of skills; such skills are referred to as life skills.

Although the exact definition of life skills is both culturally and situationally determined, analysis of the intervention programmes in this field indicates that there is a core set of life skills that cut across the different programmes. These are:

- \* decision making and problem solving;
- \* critical and creative thinking;
- \* communication and interpersonal relationship skills;
- \* self-awareness and empathy; and
- \* skills for coping with emotions and stressors.

Life skills of this nature are being taught in a wide variety of school-based interventions in different countries, including: health education (60), peace education (48), drug abuse prevention (16, 51), prevention of adolescent pregnancy (61) and HIV/AIDS (4), prevention of bullying (44), as well as for the promotion of intelligence (25), self-confidence and self-esteem (59).

Recognition of the role of life skills in the promotion of mental well-being forms the conceptual basis for the teaching of life skills for a wide variety of promotion and prevention objectives. Life skills are taught to enhance coping with life stresses and pressures that can otherwise give rise to negative health behaviours and social problems.

In programmes that help to foster life skills, the children should be actively involved in the learning process. A typical lesson may start with a teacher asking pupils what their ideas are about a particular life skill or situation in which such a skill can be used. The children may be asked to discuss the issues raised in more detail in a small group or with a partner. Then the pupils may be engaged in short role play scenarios, or take part in activities that illustrate the use of the skills in different situations.

In teaching life skills, it is often found useful to base the lesson around a series of steps that have been mapped out to describe what action is required of the child. This is particularly important for the teaching of problem solving and decision making skills. For example, problem solving is often based on steps such as 1) defining the problem, 2) thinking of the alternative solutions to the problem, 3) comparing the advantages and disadvantages of different solutions, and 4) acting on the chosen solution.

Modelling of skills is also used, and usually involves a teacher or pupil demonstrating for the class the use of the skill that is being taught. This is particularly useful for teaching communication and interpersonal relationship skills.

The teaching of life skills is likely to require the introduction of new teaching methods, and the success of the programmes will depend greatly on the availability of effective teacher training in these methods.

The introduction of life skills teaching will require input from the school and education authorities, for teacher training and the development of teaching manuals, as well as for the ongoing support of teaching programmes once they are in place. This investment is worthwhile considering that the potential gains of life skills teaching are so far reaching, and can have an impact on several levels, including:

- i) for the child; protecting the child's health (e.g. by preventing cigarette smoking (13), abuse of alcohol (15,47) and other drugs (14)), and promoting the child's social interests (eg., by improving relationships with peers) (63);
- ii) for the teacher; improved relationships with pupils (44), and fewer classroom behaviour problems (63); and
- iii) for the school; improved academic performance (65), and a possible effect on levels of truancy and school drop-out.

Some skills are significantly focused on the prevention of a specific behaviour (e.g. how to refuse a cigarette when offered). It is however, preferable for the skills to be taught in such a way that they are relevant to the prevention of a number of different harmful behaviours. As such therefore, the teaching of life skills can underpin and integrate health education classes focused on specific problems. For example, the teaching of skills for dealing with peer pressure in general is applicable to a broad range of behaviours initiated by such pressure.

Given the potential impact of teaching life skills in schools for all spheres of health, physical, mental and social, life skills teaching should be included in the school curriculum and made available to all children beginning at school entry. Life skills teaching is an important way of preventing health problems as well as promoting mental well-being in a most positive and non-stigmatising way.

WHO has prepared a document to guide countries in the development of life skills programmes in schools (70). It also issues a "Skills for Life" Newsletter (69). This newsletter describes and makes available information about life skills teaching programmes and new initiatives in this field from around the world.

## 5. Mental Health Education/Instruction

General health education should be comprehensive and address the interrelatedness of biological, environmental and emotional factors that influence health (66). Mental health education, including the value of positive mental health attitudes and the causes and effects of mental illness, should be part of an overall school health education programme (74).

Mental health education should provide information about mental health and illness to students. In addition it can help them clarify their attitudes, understand their values and recognize their behaviours and emotions as they apply to mental health and mental illness. Mental health education should be taught as part of general health education and in addition, can be coupled with life skills education (Section 4).

Specific content areas in the curriculum should be based on a model of health which includes the interaction of physical, mental, social, and environmental aspects (74). Specific topic areas to be covered in the overall curriculum throughout the school years can include:

- \* the brain and behaviour
- \* psychological and emotional development
- \* the effects of stress
- \* successful coping strategies (ideally linked to life skills classes)
- \* common psychological problems in youth and families
- \* risk factors
- \* how and where to seek assistance
- \* healthy relationships between the sexes (including sex education as appropriate)

Efforts should also be made to foster tolerance of disability and difference and to destigmatize illness. Providing knowledge about an illness is not very effective unless accompanied by examples and stories from individuals who have the disease or disability. Interventions which provide actual contact with an individual who has had an illness over a period of time show the most promise for improving attitudes and decreasing stigma (5). Mental health education is thought to be the most effective when (54):

- \* the content of teaching is in the present and is relevant to the student's own life
- \* young people take responsibility for and participate in the development and implementation of classroom activities
- \* young people acquire health knowledge, health promoting values, and practice health promoting behaviour

Schools can be the centre for a number of community enhancement projects including programmes to improve health and mental health. They can serve as training centres for parenting skills where parents learn more about child development and parent effectiveness skills and receive support to enhance feelings of self worth and competence. These educational programmes are most effective when groups of parents meet together.

The use of parents as teacher's aides can be a helpful learning experience for the parents, the teacher and the child (10). Working in the classroom provides parents with a new perspective of their child as they observe other children and talk with other parents and the teacher. Working with each other, parents and teachers can gain a greater appreciation for the issues each face. Parents and

grandparents can be especially useful in providing information regarding cultural norms and variations in culturally diverse classrooms.

For the necessary knowledge and skills to be a part of a comprehensive, integrated health education programme, they should be included in the curricula of teacher training institutions, field placements, in-service training, and special courses. They include:

- \* Life skills education
- \* Basic knowledge of risk factors
- \* Basic knowledge of mental disorders
- \* Ability to recognize psychosocial and mental disorders
- \* Classroom management of psychosocial problems
- \* Mental health interventions
- \* Use of referral resources

The knowledge and skills should be maintained or updated through workshops and continuing education activities.

Teachers need to be knowledgeable about child development and the development of good interpersonal behaviours. When children with special educational needs are integrated into regular classes, teachers need basic skills for teaching children with disabilities as well as special knowledge about the resources available in their community.

Providing emotional support and guidance to children along with classroom teaching is both physically and emotionally challenging. Teachers also need ongoing support to promote their own positive health behaviours to enhance their ability to serve as role models for children as well as for parents and family members.

Teacher manuals should help teachers adjust styles and activities to culture and situation specific factors. Lack of cultural sensitivity may cause students to feel that they are not really part of the programme (46).

Engaging educational methods for use in mental health instruction include group discussion, the use of audiovisual aids, visits from outside mental health professionals, essays and picture competitions and the development of slogans related to mental health.

An example of a mental health education programme used to promote mental health comes from Egypt. School teachers, school health physicians and social workers received a mental health education course of 8-10 hours by a team from a Psychiatry Department at a nearby medical school in Alexandria. The course content was directed toward improved communication between the child and his family, changing the teachers' attitudes towards mental disorders and providing basic knowledge of common mental disorders and their treatments. The teachers then provided mental health education to students for short periods every day. The mental health team provided ongoing support and the programme was strengthened through the use of a parent/teacher association (57).

In Rawalpindi, Pakistan, pupils work together to promote their own health as well as that of their families and communities (40,41). The programme is reinforced through the use of slogans, essay and speech contests, mental health committees, parent/teacher associations and managerial training workshops for district education officers. Programme evaluation indicates improved grades, increased attendance and decreased dropouts, and increased general and mental health case referrals.

Another innovative mental health education curriculum has been developed in Uganda as part of overall health education for secondary school students (62). The extensive curriculum includes the relationship between physical and mental illness; the effects of stress and culture on mental disorders; the etiology, prevention and treatment of mental disorders throughout the life cycle; substance abuse; sexual disorders; mental retardation; suicide; and mental disorders associated with AIDS.

Yet another example of mental health education has been developed in Australia (76). People who have had a mental illness collaborate with a mental health worker and the teacher in directing the course. The curriculum includes engaging students in discussions of values they hold regarding mental illness and the stigma which may be associated with it. Myths and misconceptions are then corrected. The course also includes information regarding the types of mental health problems encountered by young people and class visits to the agencies where mental health services are provided.

In Bangalore, India mental health education has been used effectively with children as young as five years of age (33). Both direct interventions and interventions through teachers are utilized.

To complement mental health instruction, programmes that may contribute to the promotion of mental well-being and mental health knowledge, such as parenting education are important. Parenting education courses could be introduced in the curriculum for the entire school population, as well as to provide comprehensive parenting education and targeted interventions for students who are at high risk of pregnancy, are already pregnant, or are parents of young children. A bibliography of descriptions of such programmes is available from WHO (67). A particularly successful approach for students who are neither pregnant nor parents is to have them work with small children in creches or nursery schools in or near the school. School parenting education courses taught by trained teachers, can enable young people to learn about child development, discipline, tolerance of misbehaviour, and respect for a child's individuality (which may be useful in decreasing future child abuse).

## 6. Psychosocial and Mental Health Problems - Identification and Intervention

Mental health problems range from relatively minor and transient disturbances to serious and long term disorders. Schools are often places where mental health problems are first identified as needing special attention. If children with potential mental health problems are identified early and appropriate interventions made, the problems are more likely to improve.

### 6.1 Identification of Psychosocial Problems and High Risk Populations

Risk taking behaviours such as smoking, substance abuse, too early sexual activity and life endangering adventures may be an early indication of a young person in danger of more serious problems. Early interventions with risk taking behaviours such as these may prevent serious consequences. Psychosocial problems become evident through changes or deviations in emotions and/or behaviours. This may include such things as aggressiveness, excessive shyness, the worsening of interpersonal relationships, poor school attendance, a decline in academic performance, irritable and widely fluctuating moods, changes in peer groups, frequent risk taking behaviours, obsessive and compulsive behaviours, and unusually exaggerated or repressed feelings associated with physical illness. Learning problems can also lead to behavioural problems and to school failure, a very important life stress.

Risk factors (50) affecting the child can include developmental delay (late walking and talking), difficult temperament, history of physical or sexual abuse, poor peer relationships, substance abuse, too early sexual activity, chronic illness and disability, scholastic underachievement and placement out of the home. It should also be recognized that children with visual and hearing problems as well as those with specific learning problems (e.g. dyslexia) are at special risk of also having mental health problems. Extra care needs to be taken by health professionals in screening for these disorders.

#### **EXAMPLE: Substance Abuse:**

Young people abuse drugs (including alcohol and tobacco) for a variety of reasons including addiction, "self-medication" or numbing emotional pain (e.g. depression), peer pressure, and/or family substance abuse. Substance abuse often results in poor school performance, poor family and peer relationships, and at times delinquency.

Joseph is a 17 year old boy who experienced a recent drop in his school performance. His teacher noticed that he had widely varying moods and had recently changed friends. At school he began wearing T-shirts promoting alcohol, drugs, cigarettes, and heavy metal rock groups. Joseph's father is known as an alcoholic in the small community where they live. Joseph's teacher and school staff arranged for him to attend an after school group for children of alcoholics and a special effort was made to increase his involvement in after school and community activities. Joseph's grades have improved, his moodiness has decreased, and he has found new friends in the after school groups who do not abuse substances.

Family risk factors affecting the child can include family dysfunction, parental death, parental divorce, as well as parental psychiatric illness and/or substance abuse.

**EXAMPLE: Conduct Disorder:**

Conduct disorder refers to a repetitive and persistent pattern of destructive or hostile behaviour that violates the rights of others or deviates significantly from age-appropriate norms and rules. The conduct is far more serious than ordinary mischief and is often dangerous to the child or others. Depression may underlie conduct disorder.

Kurt is a 15 year old boy who has a long history of trouble with authorities both in and out of school. He is frequently truant and has been caught lying and stealing at the school. He is barely passing his subjects although he is intelligent. Recently he has begun spending a great deal of time with a "gang". Kurt's parents are very defensive at school meetings and deny or blame the school for his problems. Both of his parents have a history of delinquency and substance abuse. Kurt's teacher and the school authorities arranged to have Kurt attend an after school community-based programme which his parents attend also. In addition, school officials and Kurt's parents worked with the law enforcement officer assigned to Kurt's case to insure that he attended school regularly and had planned afternoon and week-end activities.

Social factors that interfere with the functioning of children and their families include poverty, learned dysfunctional family behaviour and low socioeconomic status, overcrowding, violence, and catastrophes.

**EXAMPLE: Post Traumatic Stress Disorder:**

Long-lasting emotional and behavioural symptoms can follow a traumatic event. Symptoms include mentally re-experiencing the stressful event, avoidance of reminders of the event, generalized emotional numbing, and increased arousal which may include physical symptoms, sleep disturbance and hypervigilance. Traumatized children may develop a sense of pessimism and hopelessness about the future.

Shanti is a 10 year old girl living in a country that recently experienced a civil war. During the war she witnessed her brother's murder and the destruction of her home. After the war ended, Shanti became very anxious, withdrawn, and experienced a drop in her school performance as well as difficulty falling asleep at night. These symptoms continued over a period of two months. Shanti's father is in the military and is frequently away from home. Shanti's school developed a special programme for children and their parents to discuss and learn about stress reactions in group and individual meetings with crisis specialists.

Not all children with these or other risk factors develop psychosocial problems. Whether or not psychosocial problems in high risk groups lead to more serious mental disorders depends upon the interaction of:

- \* quantity of environmental stress or crisis
- \* timing and nature of the stresses
- \* biologic and genetic vulnerability to illness
- \* strengths and coping abilities of the child
- \* strengths of the family and community
- \* access to and use of support

Mental health programmes in schools have the potential to influence these factors and thus improve outcome.



## 6.2 Identification of Mental Disorders Seen in Schools

Some children developmental disorders that require special attention and professional attention. Teachers usually require special training in recognition and management of these disorders. The following descriptions give brief examples of some of the mental disorders of concern that occur among young people together with creative interventions that different school systems have developed.

### Depression:

Depressed young people may experience the typical symptoms of sadness, tearfulness, sleep and appetite disturbance, and feelings of helplessness. Often, however, the depressed young person initially exhibits other symptoms such as irritability, conduct disturbances, school refusal, somatic complaints, eating disorders, or substance abuse all of which may be accompanied by an initial denial of depression. Suicidal thoughts and attempts are more common in depressed youth, but may occur with any emotional disturbance.

Nilum is a 12 year old girl. Her teacher noticed that her school performance recently declined and that she was frequently absent from class. She also experienced increased fighting with her group of friends and seemed withdrawn in class. When asked about this by her teacher, Nilum said only that she often has headaches. When asked about recent stresses, Nilum related that her parents are divorcing. Nilum's teacher consulted with the school mental health professional and suggested a referral for family counselling to her parents. With her teacher's encouragement, Nilum also became involved in school drama which has helped her express her emotions, find support from others, and feel better about herself.

### Attention problems:

Youngsters who are excessively impulsive, have serious trouble paying attention, and find it difficult to focus on a task, may be suffering from what is known as attention deficit hyperactivity disorder (ADHD). They are easily distracted and often cannot organize work or cooperate in sports.

Gerard is a 7 year old boy who was noted by his teacher to have trouble paying attention, controlling his impulses and sitting still. Due to his impulsive, active nature, he has poor peer relationships and his inability to pay attention interferes with his academic performance. Gerard's teacher worked with the mental health consultant and Gerard's parents to design a structured programme at school and at home which decreases the distractions in Gerard's environment when he is trying to learn, provides praise for desired behaviour when it occurs and avoids emphasizing negative aspects of his behaviour.

### Psychosis:

A psychotic disorder is a severe mental disorder characterized by an extreme impairment in the person's ability to think, respond emotionally, remember, communicate, or understand reality. Individuals who are psychotic often have hallucinations (seeing or hearing things that do not exist) or they may regress into behaviour appropriate for a younger child.

Mohammed is a 15 year old boy. He is known at his school as a loner who has poor social and communication skills. Although he has always had trouble paying attention, at times he became even more distant in class and often did not seem to know what was happening. When asked to speak, he at times gave bizarre and unrelated responses. Other adolescents stayed away from Mohammed and called him "crazy". Mohammed's teacher helped arrange a mental health evaluation through the school health clinic. In addition to psychiatric treatment, the consultant at the clinic helped design a special school programme to increase Mohammed's social skills and to decrease the stress he experiences.

### **Anxiety Disorders:**

Anxiety in young people may be expressed by reluctance to be apart from parents resulting in school refusal, extreme shyness around strangers, or excessive worrying and fearful behaviour that does not have a specific focus which may be associated with physical complaints such as headaches or stomach aches.

Patricia is an 8 year old shy girl who refused to attend school over a period of 5 months. As a result of her absences, she was a risk of failing the school year. Patricia's mother says Patricia has frequent physical complaints that keep her home, although no medical disorder has been found. A special programme was designed by Patricia's teacher and the mental health consultant to have Patricia's mother work in several classrooms at the school as a part-time aid. Since this has been instituted, Patricia attends school regularly and her physical complaints have not interfered with her attendance.

### **Eating Disorders:**

The condition called anorexia nervosa involves a refusal to eat an adequate diet resulting in significant weight loss. This is associated with a fear of becoming fat and is mainly limited to adolescent girls in developed countries. Without treatment, the self-induced starvation can lead to death. Bulimia nervosa is characterized by the compulsion to consume large quantities of food and then, fearing fatness, to get rid of the food by self-induced vomiting or laxatives. This disorder is accompanied by depression and also has serious physical consequences.

Anna is a 16 year old girl who has been noted by her teacher to be quite moody. She is very interested in the approval of others especially boys. Anna was slightly overweight at the beginning of the school year, then lost a great deal of weight, and now is slightly underweight. One of Anna's friends told the teacher that Anna makes herself throw up after meals. Anna's teacher discussed this information with Anna's mother, and with the help of the mental health consultant, a referral for counselling was arranged. A team of school staff arranged for Anna to participate in school exercise activities, and to increase her involvement in the social skills programme where she learns to identify and express her feelings.

### 6.3 Instruments for Identification of Psychosocial Problems and Mental Disorders

Schools may at times wish to obtain a general measure of the psychosocial and mental health problems in their classroom. Several screening instruments are available for use to determine if children have (or are at risk of having) significant mental health problems. A danger from using screening instruments however, is that some children will be falsely identified as "mentally disturbed" with all the dangers that this brings of "labelling" and stigma. Nevertheless, the following instruments might be used with extreme care.

The Children's Behaviour Questionnaires are designed for completion by teachers (52) and parents (53). The teacher version (Scale B) is a 26 item questionnaire covering a variety of behavioral problems that can be completed quickly. It has been used reliably in a diversity of settings including Jamaica (27), Italy (75), Uganda (39), Mauritius (63), Beijing, China (58), and New Zealand (38).

The AML Behaviour Rating Scale is an 11 item screening scale designed for teachers to use in identifying young children experiencing early school adjustment problems (23). It is designed to provide a measure of acting out (A), moodiness (M), and learning difficulty (L). It requires only about 30 seconds per child to complete.

The Classroom Adjustment Rating Scale (CARS) is a behaviourally oriented scale designed to provide in-depth information about a child's school adjustment problems (36). It provides detailed data regarding the severity of a child's adjustment problems.

The Health Resources Inventories (HRI) is a 54 item rating scale designed to measure a variety of school-related competencies of primary grade children (28). The HRI's emphasis is on children's positive adaptive functioning.

The Child Behaviour Checklist (CBCL) is a 113 item questionnaire that can be completed by a parent, teacher, or adolescent (1). It provides a scaled score based on children's behaviour, but requires some training in scoring, and requires about 15-20 minutes to complete.

The Brief Pupil Evaluation Inventory consists of 9 items and involves students' identification of other students who have characteristics that are predictive of aggression, likability, and withdrawal (35).

### 6.4 Deciding on an Intervention

Persistent and serious problems such as aggressive and antisocial behaviour, psychotic reactions, poor relationships with classmates, depression and suicidal feelings all require prompt intervention. A decision process for deciding on the nature and extent of an intervention needed is as follows:

#### *Step 1: Student Identification*

Identification of a student in need of help and the severity of the need through the observations of the teacher or school personnel, the concerns expressed by the student and possibly the use of screening instruments is the first step.

### *Step 2: Identifying and Understanding the Problem*

Further information about the nature of the psychosocial problem should be evaluated and possibly discussed with a mental health consultant, if available. If the student/family is judged to warrant specialized evaluation, the counsellor makes contact with the student's parents and informs them of the nature of the problem and the recommendation for further evaluation. Whenever possible the entire family should be engaged in the consultation and a treatment plan devised based on the child's and the family's strengths and needs.

### *Step 3: Intervention*

The corrective intervention may include school-based psychosocial intervention or out-of-school professional treatment such as family therapy, individual therapy, group therapy, medication, residential treatment or a combination of these. Whatever the method of intervention chosen, the people in the school with whom the child has contact should be appropriately involved in the treatment plan.

### *Step 4: Follow-Up*

To insure that the evaluation occurred and that the school is appropriately involved in the comprehensive treatment plan, follow-up by the teacher and/or appropriate school personnel is essential.

## **6.5 Psychosocial and Mental Health Interventions**

Psychosocial and mental health interventions may take place in or out of the classroom. Classroom interventions include health promotion, primary prevention (health education) and early problem identification. As mentioned in Section 2, the intervention may be directed toward the entire classroom or school environment or it may be directed toward an individual child. It is usually desirable to make use of interventions that affect both the school environment and the child.

Assessment, secondary prevention (identification, reduction of risk and early intervention), and referral for psychiatric treatment take place out of the classroom, but should be coordinated with the teacher, school nurse and school administration. When teachers and other school personnel understand the nature of a child's problem, they can work effectively with mental health professionals in designing classroom and school programmes that provide support and enhance the coping abilities of vulnerable children. A valuable resource in this respect is a WHO manual on child mental health and psychosocial development, produced by the WHO Regional Office for South East Asia. Parts I and II are aimed at health professionals, Part III is for teachers and Part IV is for workers in children's homes. The information for teachers and workers in children's homes is presented in a way that ensures that it is compatible with the instructions for health professionals (72).

Psychological treatment programmes for children needing additional help in the classroom have been shown to be of benefit. Shorter term treatments such as group therapy, play groups, and behaviour modification have given promising results in children with psychosocial disorders by enabling them to remain in regular classrooms and advance educationally (34). Peer counselling, often

done by older children or adolescents, has also been found to be helpful both for those who give it and for those who receive it. The positive role modelling, problem solving strategies and prosocial behaviour are often accepted more readily when they come from peers rather than authority figures.

### **School-based Health Centres**

Health centres located within the school have an important role in supporting better health care and social services for children and adolescents since they utilize a community-based model for health care. School-based health clinics usually provide primary health care services needed by young people including health maintenance examinations, assessments, diagnosis, and treatment of acute and chronic illness, screening for infectious diseases, immunizations, family planning, and mental health and substance abuse counselling.

The clinics are accessible to the students and the students are accessible to the clinics. Because they are located within the daily environment of most youth, they offer particular benefit to young people who might not otherwise receive assistance, by decreasing the economic and psychological barriers. Clinics can facilitate and support positive relationships among students, their families, the schools, and other community services (56).

At least 20 percent, and at times as high as 60 percent of young people seeking health services at school-based clinics have mental health problems needing attention. Users of clinics are found to be at high risk for a variety of psychosocial problems including drug use, depression and school drop out (6).

Professionals at school-based mental health clinics should reach out to develop a working relationship with school staff both to coordinate psychosocial programmes and to increase the number of children they reach. Ways to expand the scope of student impact include providing teachers with mental health consultation and in-service education, and giving mental health presentations to students and parents.

Clinic-based mental health professionals may have time to offer only a limited amount of direct intervention (e.g. group and brief individual counselling, including student support groups and peer counselling). Because school-based programmes cannot meet all student needs, referral patterns to community services must also be established and maintained (2).

### **Crisis Intervention**

Mental health problems can result from intense and/or prolonged stress associated with various traumatic occurrences at home, in the community or at school and may include a natural disaster, war, or the death of a family member, a classmate or community member. Symptoms include anxiety, depression, flashbacks of horrifying experiences, recurring nightmares, and sleep disorders.

Schools can be enlisted in crisis management. Parents, teachers and children can be involved in preventively oriented trauma recognition and response (49). The school is an optimal site both because of its convenience to parents and children and because the stigma of using a mental health service is avoided.

Elements of crisis intervention include consultation with school administrators, training of teachers, and education of parents and children. Identifying and addressing rumours, misconceptions, and fears helps minimize anxiety in the school community. Classroom drawing exercises and symbolic reconstruction of the crisis can be effective initial interventions with younger children. Special procedures are needed to reintegrate hospitalized or severely traumatized children into the classroom, to deal with bereaved children, and to monitor school behaviour and performance.

### Referral Resources

Schools need ready access to supportive mental health resources in the community, if there are any available. A clearing house of information should be established. This might include (2):

- \* diagnostic protocols and at risk surveys (e.g. for suicide or substance abuse) to screen children who may need referral
- \* descriptions of existing or possible interventions (e.g. crisis intervention, coping with gangs, teen parenting)
- \* curriculum and mental health education aids
- \* regional mental health phone numbers and contact persons
- \* mental health professionals who can assist with school mental health problems

The development of collaborative relationships with community agencies and service providers is essential. It is also important to have health, education, and social services coordinated by a lead agency that could be based at the school.

For example, in South Australia, a mechanism for integrating health, education, and welfare services to school-aged populations with serious social and behavioral difficulties is known as the Interagency Referral Process (77). The goals of this process are to provide an integrated, holistic approach to case management and review through: 1.) referral by the interagency referral manager; 2.) assessment; 3.) case planning and management; and 4.) case review. The Education Department of South Australia allocates salaries for the interagency referral managers. This whole process involves experimental research design and evaluation.

In many regions of the world, however, referral resources are not available. Establishing a consultative link to the nearest health centre may provide guidelines and training for crisis intervention, support and triage.

## **7. Steps For Programme Development and Implementation**

The approach or combination of methods chosen to develop a mental health programme is likely to vary from country to country and must be tailored to the needs and strengths of the particular region where they will be implemented. Recognizing that there will be individual variations, the following steps for programme development and implementation are suggested:

### **Step 1: Establishment of a team**

Planning for a comprehensive school mental health programme begins with the collaboration of school personnel, family members, community members, mental health professionals, and students who work together to create an environment that is productive, positive and supportive.

#### **Family Members**

The fundamental unit of all societies is the family. Thus, the key factor in the success of any school mental health programme is the degree of family commitment to the programme (11). The importance of the family environment in children's school performance and mental health has been recognized in many regions and increasing efforts are being made to involve family members as active partners with the school.

The most important place for children's development is in the home, under the guidance of their family. It is important that parents and other family members are appreciated for the powerful influence they have with their children in the adoption of attitudes, values and beliefs related to health behaviour and lifestyle. Parents and families then may have a fuller understanding of their complimentary role with the school in the mental health education and promotion of their children (74). Parent-Teacher Associations, for example, offer the potential of creating an environment of collaboration and cooperation.

#### **School and the Community**

A healthy school is an important part of the community that surrounds it. Community members should feel that their neighbourhood school is open and receptive to their ideas and participation. Schools, in turn, should be supported by community members through their participation in school programme development and through their support for adequate financial backing to carry out the school's mission. It is very important that any school mental health programme has the support of the governing board of the school and the headteacher.

#### **Teachers**

Teachers, with family support, are the key to the successful implementation of a comprehensive school mental health programme. Teacher's perceptions are essential in planning and implementing life skills education, mental health education, psychosocial interventions, and professional referral when necessary. It is important to understand their perspectives and support their needs (30).

## **Mental Health Professionals**

Mental health professionals can have a variety of environment-centred and child-centred roles in a comprehensive school mental health team and in many cases, may have more than one role.

The mental health professional may serve as a consultant for teachers in programme development and implementation and for parents regarding their relationships with their child and their child's teacher. The role of the consultant focuses not only on providing mental health expertise during the direct evaluation of the student and the family, but also on serving as a resource person to the teacher, the counsellors, the disciplinarians and the parents to establish procedures for dealing with potential problems (9).

The mental health professional can be of benefit as a consultant to a school, a school district, educational administrators, and educational commissions. This consultation can help schools provide the best mental health programmes within their budget, help the interpersonal relationships within the school system to function the most effectively, and increase the awareness of the mental health issues of children, families and teachers among people who may be removed from daily contact with these groups.

The mental health professional can also serve as an outside consultant member of the school team where the needs of individual children, families and teachers are met by mental health staff members within the system. The outside mental health professional is available for individual consultation, group discussions, or in-service teaching sessions. For example, providing seminars in behavioral management to school staff, rather than working directly with referred children provides the staff with skills they can use with subsequent groups of children.

## **Step 2: Assessment of school and community environment**

Basic information regarding regional demographics, health risks, and resources should be available for the team to consider. When possible, an assessment focusing on community strengths and available resources, as well as needs should be done to provide the planning team with the information they require to develop objectives.

When considering the various options for implementation, an important consideration is that the effectiveness of a preventive intervention requires a fit between it and the cultural, geographic, and social-political characteristics of the region (3). The most appropriate choice within the model framework presented in this monograph depends on the culture of the region, the resources available, the educational system, the political will, the interests of the school administration and teachers, and the point of entry available into the educational system.

## **Step 3: Development of a plan**

Once the needs and potentials for school mental health programmes are appreciated and ideas for the most suitable elements of the model framework are being discussed among parents, educators, students, community members, and mental health professionals, the next task is to develop a specific plan of action including clearly stated objectives, assignment of responsibilities, a time-line and a coordinating mechanism for agency (sectorial) linkages.



To be successful, programmes must be based on the recognition of needs that are perceived to be important to the people in charge (for example, teachers, principles, public officials, community leaders). Local leaders must develop and/or adapt a programme so that it fits with their own strengths and needs. If a programme is adapted from another culture, it is important to understand which elements of the programme are not culturally limited and can remain unchanged, and which portions must be changed to make it culturally relevant (46).

The most accessible and appropriate point of entry into the educational system should be determined in order to introduce, develop and maintain a comprehensive approach to mental health programmes. Mental health interventions may be accepted most readily if they are:

- \* Part of the general educational system;
- \* Implemented through routine health care in the school;
- \* Supported and developed by families and parent groups;
- \* Brought in through the support of school counsellors and/teachers who recognize that poor social functioning interferes with learning; and
- \* Brought in through a Commission or Board of Education who recognize schools as the best setting to improve the functioning of the children in their country and thus to improve their children's and their country's future.

The greatest task in developing a comprehensive school mental health programme often is establishing stable financial support for such a programme. Collaboration with other community and governmental agencies may lead to a pooling of resources directed toward the mental health of young people. However, in many communities, additional financial resources may be necessary.

As an example, a comprehensive school health programme in the slums of Bangalore, India is based on a "shoestring budget" and reports success through efforts by voluntary agencies, teachers, and other health professionals (33). In this project, mental health is one component of a total school health project.

#### **Step 4: Monitoring and evaluation**

All programmes require thoughtful evaluation including the measurement of outcome. This is important not only to determine whether or not a particular programme is effective but also because good research helps to improve already effective programmes and retain support for existing programmes. In addition, it is important to disseminate those aspects of a programme that are effective, to other communities.

When designing a mental health programme, the evaluative outcome study should be designed at the same time. Obtaining baseline data on the mental health of the children, the quality of school health services, the environment of the school and the health knowledge, skills and practices of students, are all essential for evaluating the effectiveness of a planned intervention.

The methods used to measure the effectiveness of the intervention, the research design, and the type of statistical analysis used, may influence the evaluation of a variable as a potential risk factor, an important mediating factor, or a measure of outcome.

- \* Meaningful outcome research should look not only at changes in attitudes and values as expressed pre- and post-intervention but at changes in actual behaviours.
- \* Programme objectives, interventions to be assessed, outcome measurements as well as plans for data collection, analysis and dissemination should be specified during the planning stage.
- \* Rating scales chosen to evaluate outcome (for example, those listed in section 6.3) must be easy to administer and score, and deal with relevant and important areas for teachers, students, parents, and funding agencies.
- \* Descriptive indicators of outcome such as positive written and verbal feedback from students should also be collected.

One approach to measuring outcomes which may be particularly applicable to school-based mental health programmes, utilizes goal attainment changes as the unit of measurement (37). Initially the team of school professionals, students, parents and community members meet with a professional skilled in outcome research, to define how successful outcomes will be defined in a way that can be measured reliably. The evaluation process is then planned, implemented and the outcome data analyzed and disseminated. The initial planning team meets again and discusses whether or not the goals were met and makes appropriate modifications.

A well designed outcome study is not possible in every community. However, it is possible to collect information that will help in the evaluation of programme effectiveness such as parent, pupil and teacher satisfaction questionnaires, testimonials, criticisms from people involved, and a careful recording of the process of implementation for later review.

### **Step 5: Coordination and modification of programmes**

Developing a comprehensive, integrated mental health programme in the school is an ongoing process that requires constant attention, evaluation, and adaptation. Successful programmes are rewarding for all who are involved with them, as they lead to healthier and more productive children and adults.

Schools should work together with families, other community-based organizations, health care agencies, public service groups, the media and governments to develop coordinated health promoting activities for young people. The initial planning team may become a permanent coordinating body or may meet intermittently with a coordinating team composed of the key providers in the school mental health programme.

As the team proceeds through these steps it is useful to monitor whether the following characteristics have been developed or are planned for the programme.

#### **Characteristics of Effective School Mental Health Programmes**

- \* Takes into account the relationship between the school and the community environment as well as any unique cultural values and identities
- \* Identifies the socio-political conditions and processes likely to be associated with the establishment and survival of a comprehensive mental health programme in the school
- \* Involves families and community members as active partners in planning, implementation, and ongoing evaluation
- \* Utilizes the skills of school and community mental health professionals
- \* Intervenes at multiple levels
- \* Has a coordinating mechanism
- \* Focuses on teacher training and parent training
- \* Evaluates its effectiveness and utilizes this information in programme modification

## 8. Recommendations

Now is the ideal time for families, communities, and young people to rally around their schools to develop and support a comprehensive school-based mental health programme. Schools recognize that mental health and well being go hand-in-hand with learning. Communities recognize that many young people today need additional assistance in managing the stress in their lives. Family members realize that they can benefit from additional support from the schools and want to be involved as partners in their children's development. Young people are looking for additional guidance and support and find that school is the most accessible place to find it. Input and support from all potential resources are essential in the development of a comprehensive mental health programme for young people. The greatest resources in the development of healthy children are the young people themselves along with their families, teachers and communities.

The authors of the document, having consulted with a broad range of experts regarding this topic, would like to reiterate the following recommendations are for countries, governments, ministries of health and education and others with an interest in the well-being of their youth put forward at a WHO consultation on this topic (71):

**Recommendation 1:** All countries should develop school mental health programmes as part of their current national health/mental health plans. The school mental health programmes should be multisectorial involving health, education, and other related departments (sectors).

**Recommendation 2:** In countries where some school mental health programmes already exist, efforts should be made to expand these programmes to reach wider geographic regions and to include additional components of school mental health programmes.

**Recommendation 3:** A comprehensive school mental health programme should be concerned not only with the prevention and management of emotional and psychological problems of children, but also with the promotion of the value of healthy lifestyle and improvement of the "ethos" of the school and of the educational atmosphere.

**Recommendation 4:** Mental health training should be arranged for individuals working in schools (school health professionals, teachers, social workers, counsellors, etc.) and should be included in teacher training courses.

**Recommendation 5:** Mental health education should be included in the school health education programmes at the regional and country levels.

**Recommendation 6:** Resource centres should be developed for mental health services for young people, training, consultation, and research to support emerging school mental health programmes.

**Recommendation 7:** Any national mental health programme should extend school mental health programmes to include activities for children not attending school (the neglected, drop-outs, those in remote areas, the poor, etc.)

**Recommendation 8:** Nongovernmental organizations with an interest in youth at the community, country, and regional levels should be involved in school mental health programmes.

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