

SCHOOL INTERVENTION

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The Process of Embedding and Sustaining Mental Health Promotion Programs in School Contexts

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The prevalence of internalising problems such as depression and anxiety is high in Australian children and adolescents. Prior, Sanson, Smart & Oberklaid (1999) found that 18% of pre-adolescents in Australia reported clinically significant levels of these problems, making them the most common of childhood and adolescent mental health problems. In a study of the health wellbeing of Australian children and adolescents, Sawyer et al. (2000) found 12.8% of 4-17 year olds showed clinical levels of internalising problems. To remedy this problem and reduce the incidence of clinical disorders developing in the adolescent years, targeted and universal school-based programs have been developed to promote the mental health of young Australians. In Western Australia a group called Promoting Optimism WA (POWA) was established in 1996 with the goal of reducing the prevalence of internalising problems and disorders through the implementation of school-based intervention programs. POWA involved collaboration between the Western Australian Departments of Health and Education and the Schools of Psychology and Public Health at Curtin

University of Technology. Recently, a large-scale trial has been undertaken to investigate the dissemination and diffusion of school-based mental health promotion programs.

Promoting optimism was the basis of the Penn Optimism Program, which has been shown to be effective in reducing depression, improving classroom behaviour and reducing pessimism six months after intervention (Jaycox, Reivich, Gillham & Seligman, 1994). In a follow-up study, the effects were found to be maintained after two years (Gillham, Reivich, Jaycox, & Seligman 1995). A limited 8-session Australian adaptation of this program was piloted with pre-adolescent girls (Quayle, Dziurawiec, Roberts, Kane & Ebsworthy, 2001). The full Penn Optimism Program was then trialed in rural communities, targeting pre-adolescents with elevated levels of depressive symptoms (Roberts, Kane, Thomson, Bishop, & Hart, 2003; Roberts, Kane, Bishop, Matthews, & Thomson, 2004). To meet school requests for universal classroom implementation of mental health promotion programs a new program based on similar theories and strategies was developed to suit Australian Primary Schools, the Aussie Optimism Program (Roberts, Kane, Bishop, Cross, & Fenton, 2004). This program has been trialed in urban communities, particularly in communities that are socially disadvantaged.

The Aussie Optimism Program is a mental health promotion strategy designed to prevent internalising problems in children and adolescents. The program is aimed at students aged 11 – 13 years who are preparing for transition to high school. It consists of 20 one-hour weekly sessions conducted in school time, and can be implemented in the last two years of primary school, or the first year of high school. The program is based on cognitive-behavioural intervention procedures and has two components, the Optimistic Thinking Skills Program (Roberts et al., 2002), which targets cognitive risk and protective factors for internalising problems, and the Social Life Skills Program (Roberts, Ballantyne, & van der Klift, 2002), which targets social risk and protective. The optimism component teaches children to identify and challenge negative thoughts about the self, current life circumstances and the future that contribute to depressive and anxiety symptoms (Beck, Rush, Shaw & Emery, 1979; Kendall, 2000). It also includes attribution re-training (Seligman et al., 1988) to help children make more accurate and optimistic explanations for both positive and negative life events. In addition, children were taught to accurately identify, label and monitor

their feelings. The social component of the program involves teaching children listening skills, assertiveness, negotiation, social problem-solving skills, decision-making and perspective taking (Seligman, Reivich, Jaycox & Gilham, 1995). The children were also taught coping skills for dealing with a variety of controllable and uncontrollable life stresses, such as family conflict and making the transition to high school. These coping skills included strategies for actively solving problems and coping with negative emotions, and seeking appropriate social support. Schools also use a series of newsletter items and parent booklets to inform parents of the program content and to promote generalization of skills in the home setting (Roberts, Roberts et al., 2002; Roberts, Ballantyne et al., 2002).

In early studies (Quayle, et al., 2001; Roberts et al., 2003), facilitators and co-facilitators, predominantly school psychologists and nurses, used a scripted manual to present didactic information, games, role plays, activities and worksheets which related to how the children think, feel and react when faced with challenges and stresses in their lives. The children were provided with class workbooks and homework exercises to practice the concepts in their daily lives. The facilitators and co-facilitators had received approximately 30 hours training in the program. More recently, a 16-hour training

program is provided to teachers to implement the program and additional coaching and support is provided to assist teachers to implement the program as part of their regular Health Education classes. Teachers are provided with teacher resources, student workbooks and associated parent handouts, and newsletter items.

The program has been augmented with the development of a family-based module (Drake-Brockman & Roberts, 2002) for parents. This program targets family risk and protective factors, relating specifically to the transition to adolescence and high school. It includes a self-directed parent booklet, school newsletter items and short presentations for teachers to use at parent-teacher nights or individual student case conferences. The enhanced program content is shown in Table 1.

The research conducted to date, indicates that an 8-session version of the Aussie Optimism Program is effective in reducing depressive symptoms and enhancing self-esteem in girls compared to a usual care control group, six months after the intervention (Quayle, et al., 2001), and in reducing and preventing anxiety symptoms in a randomised controlled trial with rural students selected for elevated levels of depression, (Roberts et al., 2003). The prevention of anxiety symptomology mediated

the impact of the program on depressive symptoms three years after the completion of the intervention (Roberts, Kane, Bishop, Matthews et al., 2004). When used universally as part of the Health and Physical Health Education curriculum with schools in low socioeconomic areas in a randomised controlled trial, the program was associated with lower levels of internalising problems and a lower frequency of clinical levels of anxiety and depression, compared to a usual care control group, after transition to high school (Roberts, Kane, Bishop, Cross et al., 2004).

While the program's content is based on well-validated theories of depression and anxiety, incorporates empirically validated techniques to change emotions, cognitions and behaviour, and has been integrated into existing classroom activities, it is still a psychological intervention. The development of the program has been towards greater contextualisation of the program, with parental involvement and a 'train-the-trainer' program. To understand how Aussie Optimism can be promoted effectively in the education system, a large-scale dissemination trial is currently being conducted. Based on diffusion theory (Rogers, 1995), the program is being implemented in 63 schools from three urban areas of Western Australia including 3,288 children and their parents, and 401 teachers. The research has four aims: 1) to develop dissemination strategies to enhance diffusion of a mental health promotion strategy aimed at preventing internalizing problems in young adolescents; 2) to assess the effectiveness of these strategies in terms of school and teacher adoption of the program, implementation quality, and maintenance of program implementation over time; 3) to assess the impact of the dissemination strategies and the program on student mental health outcomes; and 4) to identify organizational and innovation factors that facilitate adoption, implementation and institutionalization of the Aussie Optimism Program.

To be effective, and to promote embedding within the local education system Aussie Optimism had to be modified to be consistent with the pedagogical and practical constraints of teachers and the Department of Education. The Western Australian Department of Education uses an outcome focussed approach with individual level assessment of achievement. The program had to be modified so that it was consistent with this focus and could be implemented by teachers with little psychological training, Department of Education staff had to be trained as trainers to support teachers in their implementation of the

Table 1. Content of the Universal Optimism Program Modules

Session	Cognitive Life Skills	Social Life Skills	Aussie Optimism for Parents & Families
1	Identification of feelings	Introduction and feelings	Dealing with transitions
2	Identification of thoughts	Decision making	Working together as a family
3	Linking thoughts and feelings	Communication skills	Optimistic thinking
4	Different thinking styles	Assertiveness	Friends
5	Review and quiz	Assertiveness II	Preparing for high school
6	Generating alternative thoughts	Negotiation	
7	Looking for evidence	Coping skills	
8	Challenging unhelpful thoughts	Networks	
9	De-catastrophizing	Friends and family	
10	Review and action plans	Transition and review	

program, and program material had to be produced to support classroom teachers.

The early outcomes of this research indicate that there are high adoption and implementation rates for the Aussie Optimism Program. 63 out of 91 (69%) of schools adopted the program. Evaluation of the teacher training workshops indicates that teachers who participated in the training workshops significantly increased their knowledge of mental health promotion, increased their confidence to teach mental health promotion lessons and increased their awareness and concern for their students' mental health. In the first year of program implementation the Social Life Skills Program was taught in 113 of the 115 (98%) Year 6 classes that agreed to participate in the dissemination project. Eighty-five classes (74%) received all 10 *Social Life Skills* modules (100% implementation), 101 (88%) classes received at least 8 modules (80% implementation), and 110 (96%) classes received at least 6 modules (60% implementation). In the second year of the program 59 out of 63 (94%) schools continued to implement the

Optimistic Thinking Skills Program with their Year 7 students. The mental health outcomes for students who have participated in the intervention are likely to be available in 2006, as are the results relating to sustainability of the program in schools.

In conclusion, it is possible to develop mental health promotion programs that prevent internalising problems in young adolescents that can be implemented universally as part of the regular school curriculum. Dissemination processes need to take care to contextualise the intervention within the host organisation, to provide adequate training and support to the host organisation, to ensure that the goals of the intervention are presented in a way that meets the goals of the host organisation, and to continuously value the efforts of staff in the host organisation. Without such dissemination processes, evidenced based interventions to prevent mental health problems will never be able to reach enough young people to impact on the incidence of internalising problems.

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