Student Mental Health and Psychological Interventions in a School Setting

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Mental Health of School-Aged Young People

The World Health Organization (WHO, 2007) defines mental health as a "state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her own community" (p. 1). Mental ill health and mental illness on the other hand broadly refer to a wide range of difficulties from stress, worries and loneliness to the more severe conditions of clinical depression, psychosis and substance abuse (Glozier, 2002). These conditions can have a significant effect on development, education and future adjustment (McGorry, Purcell, Hickie, & Jorm, 2007). Mental health difficulties are frequently comorbid with other mental illnesses, which make them more complex to identify and treat (Wilmshurst, 2005).

Mental health has become a growing problem in recent decades, as concerning figures reveal increasing numbers of young people experience mental ill health (McGorry et al., 2007). Mental health and substance use disorders now contribute over 50 % of the burden of disease in the age group 15–25 years, and 75 % of mental health disorders emerge by the age of 25 years (AIHW, 2008). The transitory changes appearing in young people in their adolescence may be normative and represent uneventful adjustment issues; however, they may be accompanied by signs of potentially significant disturbance that can have major consequences for development and future adjustment (McGorry & Goldstone, 2011). Mental health disorders also frequently occur in younger children, with studies showing prevalence rates of 1 in 7 children from 4 to 17 years (Lawrence et al., 2015). Research shows that young people are reluctant to seek help (Rickwood, Deane, & Wilson, 2007), and an Australian study found that of those children and adolescents who had emotional and behavioural problems, only 17 had attended a health service in the previous 12 months (Lawrence et al., 2015). However, early intervention has been shown to be important in reducing the incidence of relapse or recurrence (Allen, Hetrick, Simmons, & Hickie, 2007).

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The School as a Front-Line Service Provider

The school is a fundamental site for the social and emotional development of young people, setting a framework for constructive adaptation in their future lives. For example, the Australian curriculum addresses the need for young people to develop personal and social capacities as well as their academic learning, and notes the important role that school engagement plays in student well-being (ACARA, 2013). As students spend many hours each day in school, its role in their lives is clearly profound. Next to the family, the school provides the resources for students to manage their experiences.

Given the prevalence figures quoted above, many students in schools will experience severe difficulties. Understanding and supporting students with these problems and illnesses are an important task. Incidence figures have encouraged Australian communities to consider ways to enhance well-being of young people and develop a prevention focus instead of focusing on the presence or absence of a condition (Donovan et al., 2003). The school can also be considered a universal and accessible agency for implementation of prevention and early intervention in mental health disorders. The Department of Education and Training in Victoria, Australia's web page on mental health, asserts the role of all education staff in promoting mental health and provides considerable support materials (http://www.education.vic.gov.au/Documents/school/teachers/health/healthymindsfly.pdf, DET, 2015b). It encourages schools to create safe, inclusive and empowering environments; teach social and emotional learning; build family, community and service partnerships; and promote activities that engender positive mental health (DET, 2015b).

In both the United States and Australia, schools have effectively implemented universal programmes for all students focused on mental health and academic outcomes, such as the School-Wide Positive Behavioral Interventions and Supports, the Good Behaviour Game and the 4Rs Program in the United States (Vidair, Sauro, Blocher, Scudellari, & Hoagwood, 2013), and in Australia, programmes such as Mindmatters, KidsMatter, Act-Belong-Commit, Positive Behaviour Support, Positive Psychology and the National Safe Schools Framework (Crockett, 2012). These programmes reflect the importance of the relationship between student well-being and educational outcomes (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011).

Although some school-based mental health programmes have been successful, schools are intensely busy centres of activity delivering a broad range of programmes, developmental activities and supports for students. In the context of mental health, programmes provided in schools have been found to vary and often follow tradition, regardless of whether empirical support is available (Forman, Olin, Hoagwood, Crowe, & Saka, 2009). Even after a successful school-based mental health intervention study has been initially implemented, a school staff may have difficulty sustaining the programme (Forman et al., 2009). Unless the school has a structure that fosters the two elements of prevention and intervention, initiatives can fall away, and teachers can feel overwhelmed with yet another responsibility for which they are little prepared or trained. The support of the psychologist in these interventions can be most helpful in sustaining their maintenance.

The psychologist brings unique expertise to a school, as well as a breadth of knowledge and skills that overlap with other allied health professionals (Gilmore, Fletcher, & Hudson, 2013). Psychological training spans learning and development across the lifespan and addresses counselling, intervention and consultancy across a range of issues for individuals, groups and systems (Frydenberg & McKenzie, 2007). Psychologists working in schools are identified in different ways as a function of employment labels and professional training. Professional titles for psychologists working in schools in Australia can range from educational psychologist, guidance counsellor, developmental psychologist to school psychologist (Gilmore et al., 2013), and in the United States, the psychologist

working in a school can have a different degree and type of certification compared to other psychologists (Jimerson, Graydon, Curtis, & Saskal 2007). For the purposes of this chapter, the title school psychologist will be used to identify the professionals accredited in psychological practice who are working in schools.

The Connection Between Mental Health and Academic Outcomes

A valuable way for the school psychologist to foster and maintain school-based mental health programmes is to consider the school's top priorities. Because schools are principally focussed on educating children, they are typically evaluated based on their students' academic performance (e.g. standardised test scores; No Child Left Behind, Section 1116, http://www2.ed.gov/nclb/overview/intro/guide/index.html, My School website, http://www.myschool.edu.au). Given this focus, school-based mental health programmes that demonstrate a positive effect on academic outcomes are likely to be the programmes adopted and sustained. Student mental health has been shown to be associated with academic outcomes (Roeser, Eccles, & Freedman-Doan, 1999; Wagner et al., 2006). For example, children's anxiety can impair their test-taking performance, and child behaviour can disrupt classroom functioning. There is also evidence that mental health problems combined with dropping out of school can have substantial long-term negative consequences (Esch et al., 2014). In the meta-analysis of over 200 school programmes fostering social and emotional learning undertaken by Durlak et al. (2011), participants showed an average 11 % gain in academic achievement compared with control school students. If school psychologists aim to obtain support and approval from key school stakeholders (e.g. principals, superintendents, politicians, parents) to implement mental health programmes, it is important they demonstrate that these programmes have the capacity to foster improvements in students' academic performance.

Hoagwood et al. (2007) conducted a systematic review comparing studies of school-based mental health programmes that assessed academic and mental health outcomes with studies that only assessed mental health outcomes (i.e., emotional and behavioural disruption, mental health diagnoses and problems with functioning). Academic outcomes included grades, special education placement, attendance and suspension records. Of the studies that assessed both academic and mental health outcomes, 62.5 % showed significant improvements in both domains. The efficacious studies were time intensive and included the participation of multiple individuals (students, teachers, parents) across multiple domains (school, home). Undoubtedly these findings suggest that school psychologists are facing a complex endeavour; however the results demonstrate the positive impact that can be made on the student's mental health while addressing the academic priorities of the school.

Expanding on Hoagwood's review, Vidair et al. (2013) examined United States studies that assessed the effects of school-based mental health programmes from June 2006 to April 2012. Of the studies that assessed both academic and mental health outcomes, 69.6 % had significant improvements in both domains. The studies that demonstrated some significant outcomes were primarily universal (i.e., general programmes for all children), included children in primary school, focused on disruptive behavioural or social-emotional problems, were administered in class by teachers or school staff, lasted 1 year or longer and assessed outcomes via teacher reports. Both reviews demonstrate that effective programmes typically need to include teachers and be provided over a long period of time in order to impact both mental health and academic outcomes.

Vidair et al.'s (2013) review highlighted the growing number of studies focused on school-based mental health programmes that included an assessment of academic outcomes. Specifically, within a 6-year period there was approximately the same number of these studies as Hoagwood

et al. (2007) found in the prior 16-year period. These numbers indicate that the mean number of school-based mental health programme studies that assessed academic outcomes conducted per year has more than doubled. Ideally, this increase in programmes that focus on assessing both academic and mental health outcomes will move from the research arena into standard school practice. School psychologists are in a unique position to bridge the gap between research and practice by educating themselves about effective mental health programmes and appealing to school stakeholders' interest in implementing them by demonstrating their effects on students' academic performance.

The Multifaceted Role of the Psychologist in Schools

There is variation in the professional and service delivery activities undertaken by school psychologists in the Australian school systems, where the school psychologist may operate as a visiting specialist or an on-site integral member of staff (Bell & McKenzie, 2013). Professional bodies such as the Australian Psychological Society (APS) in Australia and the National Association of School Psychologists (NASP) in the United States direct best practice service delivery of school psychologists through the provision and development of practice guidelines. The Department of Education and W. A. (2010) developed a school competency framework that establishes agreed dimensions of effective school psychology practices. Key to this framework is the development of professional competency described in three phases: Phase 1 independent application of competencies, Phase 2 higher-level individual competencies and the capacity to instruct and mentor their colleagues and Phase 3 exemplary skills, with the capacity to influence the system and the school psychology profession (Department of Education & W. A., 2010). These levels indicate how school psychologists are ideally placed to be effectors of change and to influence policy at a leadership level. The West Australian government document demonstrates how school psychologists are increasingly being called upon to advise and consult with school management teams to advocate for the mental health and well-being of young people at all levels of identification and intervention. Many mental health programmes are initiated by schools and delivered by teachers (DET, 2015b), which reminds us of the need for the psychologist's distinctive role in the school to enhance and guide the delivery of such interventions.

There are a number of factors that may impact on the role and function of school psychologists (Fagan & Wise, 2007). These factors are demonstrated in the following diagram (Fig. 1), which provides an overview of some of the main clusters of variables determining the role and practice of the psychologist in a school. Individual factors are influenced by tertiary pathways and educational backgrounds, personal attributes and level of competency that impact on individual performance. Work and external factors are dependent on a number of variables but, namely, work setting, region and educational system. The financial resources of a setting as well as population dynamics (e.g., socio-economic status) can dramatically impact on the nature of the school psychologist prevention and intervention initiatives. Policy at the workplace, organisational and government levels also significantly influences the work of school psychologists and can often dictate practice.

Although there is likely to be significant variability between service delivery by school psychologists on an individual level, as a profession, the scope of activity is broad, with an increasing emphasis on fostering well-being and positive mental health (Bell & McKenzie, 2013). Impetus has grown for school psychology to shift from the more traditional role of 'test and assess' to also encompass expanded services such as consultation, intervention, prevention and in-servicing of staff (Pagan, 2002).

In the role of consultant, the psychologist in a school can hold a pivotal position to impact school policy and to impact on school practice through building constructive relationships

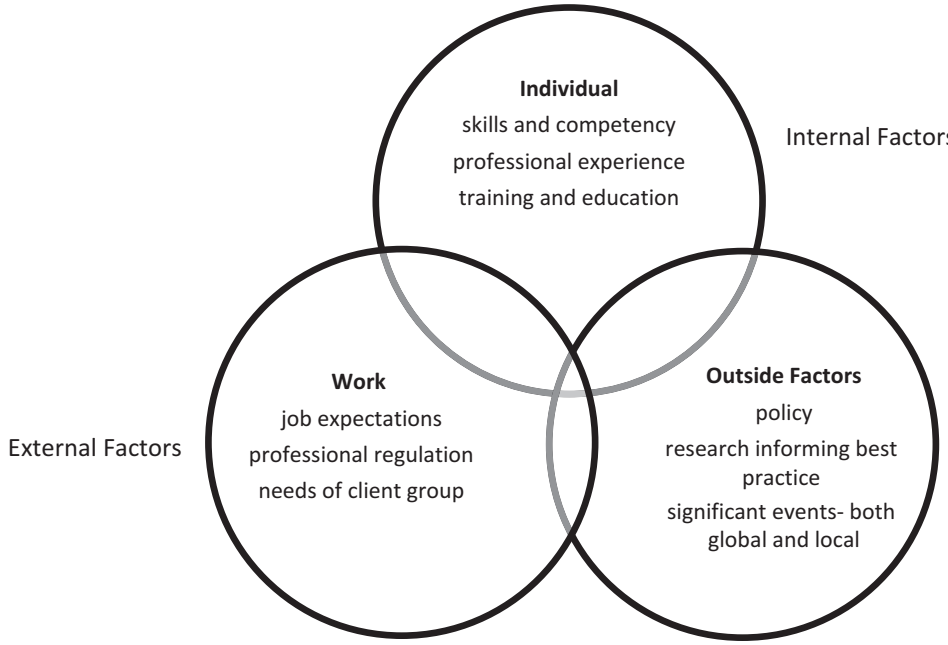

Fig. 1 Factors that influence the role of the school psychologist

across the school and its community (Shapiro, 2006). Drawing on knowledge of evidence-based practice, the psychologist can develop and support school initiatives to assist students with a broad approach alongside typical individual case model intervention. Combining this broader approach with core skills in interpersonal relationships, the school psychologist has the skills to use a networking model to build a connection with leadership groups in the school where school-wide policy and practice can address such issues as school connectedness and resilience (Dawson, 2000).

Hence the psychologist has a multifaceted role in schools. Direct service can be provided for students on a range of individual issues from difficulties in learning and socialisation to day-to-day upsets and stresses. In the United States, over 70 % of children receiving mental health services receive them in school (Burns et al., 1995). On a wider scale, the school psychologist might work with teachers to enable more effective learning and adjustment in individual students or contribute to greater numbers of students where appropriate in applying psychological knowledge to curriculum and school processes and procedures. More structurally, the psychologist might participate in school committees impacting on the wider school community (Hawkins, Barnett, Morrison, & Musti-Rao, 2010). In Australian schools this is often titled the well-being team consisting of a deputy principal, teachers or coordinators, school nurse, support staff, psychologist, social worker and perhaps a speech pathologist (Department of Education and Training, 2015a). In the United States, a similar team serves to facilitate the implementation of Individualized Education Programs (IEPs) provided for students eligible for special education services (US Department of Education). Parents are also considered prominent members of the team, as they are able to provide information about their child's learning style, ability to conduct academic work at home and strengths.

Some have argued that the traditional and persistent emphasis of school personnel on assessment of learning difficulties and disabilities, particularly given the volume of referrals made to

school psychologists, increasingly poses the risk that school psychologists remain caught in a primarily reactive medical model service aimed at assessment of individual deficits, with little time to attend to wider initiatives such as mental health intervention (Roffey, 2012). Although individual work with children's learning problems is a crucial and critical role, school psychologists have a necessary role in mental health and well-being in schools at an individual, early intervention and preventative/systemic level (Roffey, 2012).

Establishing a clear identity in the school is a prerequisite for the school psychologist to develop impact, as schools often are not fully informed of the role psychologists can take and operate according to a perception based on the medical model of their expected tasks (Bell & McKenzie, 2013). The consultative and collaborative role of the school psychologist needs to be established and allowed for the multisystemic partnerships between families, community agents, the individual and the school to effectively address the mental health needs of young people (Cole & Siegel, 2003; Shapiro, DuPaul, Barnabus, Benson, & Slay, 2010). In this regard the school psychologist is well placed to provide a 'triage' approach, providing an initial assessment of risk, engaging the young person in a therapeutic alliance, consulting with family and school personnel, providing mental health services when feasible, and where necessary facilitating referrals to external agencies for ongoing intervention and support. Consultation is the most effective way for school psychologists to reach large numbers of students, combining direct treatment with indirect work with relevant parties to improve the climate of schools and foster positive mental health outcomes at a universal level (Fagan & Wise, 2007).

The employment of the psychologist to a single school or as a visiting specialist to a number of schools significantly impacts the type of support that the psychologist will be able to provide. Proctor and Steadman (2003) found that psychologists based in a single school reported greater caseload diversity, stronger psychologist-teacher relationships, a higher level of integration into school activities and a greater understanding by school administrators of their skills than those who were placed across a group of schools. Bell and McKenzie (2013) found that psychologists dealing with a number of schools tended to be more involved in and loaded up with psychological assessment than their counterparts in independent schools where there was greater provision of counselling services to young people. Eckersley and Deppeler (2013) found that school principals in the government system in Victoria, Australia, tended to view systemic intervention as a secondary function of the school psychologist due to their limited awareness of the breadth of skill that psychologists possess. Bell and McKenzie (2013) encourage school psychologists to take an advocacy approach to this, encouraging a broader perspective in teachers, parents and principals by educating users of the numerous skills involved in the preparation of psychologists.

Tiers of School-Based Mental Health Programmes

Reference has been made to three tiers of psychological intervention—direct treatment with individual students, early intervention for select students at risk and broad-based, universal/preventative programmes (Shapiro et al., 2010). Examples of the focus of each tier of intervention can be found in Fig. 2.

The first tier, direct treatment, refers to situations where specific students are in need, and the school psychologist is likely to conduct an individual assessment and intervention (for instance, individual therapy, group programme in the school and/or parent training). Students' personal problems, such as bullying, friendship issues, work pressures and personal issues, which could develop into more severe mental health issues, can be treated by the school psychologist in the school, without recourse to a more clinical setting. Studies have found positive outcomes of interventions for depression and anxiety, using a CBT approach, interpersonal psychotherapy (IPT) or psychoeducation (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012; Neil & Christensen, 2007). The standards of practice for supporting

Fig. 2 Focus of intervention

Client	*School psychologist activity/intervention*
Individual student Individual student with specific difficulty	Treatment or referral to relevant professional service
Selected students 1. Selected group focussed on specific problem 2. Selected group targeted as at risk of developing mental health problems (such as school refusers).	Group treatment E.g., group to improve social behaviour Psychologist runs group or works indirectly by training teacher or parents.
Whole school School climate or policy and practice (Universal preventative program) E.g., Mental health awareness, restorative justice program	Work with leadership of school Implement classroom-wide intervention Participate in teacher development Parent programs Community liaison

children in schools recommend a ratio of 1 psychologist to 500 students (APS, 2009); however, this is rare and in some systems has led to training teachers, school nurses and well-being personnel as additional front-line supports for students. When such students require more intensive treatment outside of what can be provided in a school setting, the psychologist may find it appropriate to refer them for clinical psychological services outside the school.

The second tier refers to identifying students in need because they have or are at risk of developing a mental health problem. When a group of students is selected, the school psychologist can implement a group intervention (e.g. social skills classes, anxiety/depression groups, externalising behaviour groups) or train school personnel to manage specific problem behaviours (Wilson & Lipsey, 2007). For example, the Penn Resiliency Program for Children and Adolescents targets children with high levels of depression and/or anxiety and is designed to teach cognitive-behavioural and problem-solving skills (Gillham et al., 2006). There is also a parent intervention component. Gillham et al. evaluated this programme among middle school students with high levels of depression and/or anxiety and found that the intervention group had significantly lower levels of depression and anxiety at 6 months and 1 year follow-ups when compared to the control group. In addition, Kasari, Rotheram Fuller, Locke and Gulsrud (2012) evaluated two versions of a social skills intervention for elementary school children with autism spectrum disorders: an intervention involving direct instruction to the child and a peer-mediated intervention. Results indicated that children who attended both groups or peer intervention only had significant improvements on a variety of social skills as compared to a child intervention only or a control group. Compared with studies of individual treatment modalities in schools, systematic evaluation of interventions has been more frequently applied to group, early intervention and preventative programmes, such as the FRIENDS programme (Neil & Christensen, 2007). The Cochrane Depression, Anxiety and Neurosis Group (Merry et al., 2011), in a review of interventions, found that both targeted and universal depression prevention programmes may prevent the onset of depressive disorders compared with no intervention. This review also commented on the heterogeneity of the studies, with reference to the need for sound methodology.

The third tier focuses on universal, preventative programmes that are implemented to all students as a classroom or school-wide programme intended to enhance the capacity of individuals to cope with resilience in general and when difficulties arise. These programmes are constructed on research outcomes that demonstrate there are clear protective factors that promote well-being and academic achievement while identifying risk factors that are associated with negative outcomes (Kids Matter, 2013-4). Key protective factors lie in positive relationships at school and home and using a strengths-based model. According to Patton et al. (2000), schools have increasingly acknowledged and supported their obligation to provide a safe environment in which young people can learn and apply the skills and understanding that contribute to mental health and well-being. School psychologists can promote this knowledge and assist teachers in creating behaviour plans or positive reinforcement systems that can be implemented in the classroom setting or as part of the classroom curricula to promote positive behaviour and attitudes. For school-wide mental health interventions, school psychologists can advise on reform of policy of the school, enabling positive relationships and engagement of students, through assisting in the creation of new school rules, expectations and school-wide positive reinforcement systems and plans for dealing constructively with student relationships.

Efficacious universal programmes in the United States typically focus on the prevention and reduction of problem behaviours and social-emotional well-being (Vidair et al., 2013). For example, the Good Behaviour Game (GBG), a classroom behaviour management programme, focuses on team behaviour-contingent reinforcement (Kellam et al., 2008; Wilcox et al., 2008). It was implemented in 41 elementary school classrooms, and over 900 children were followed until the ages of 19–21. Results found that children who had participated in the GBG had significantly lower rates of substance use and suicidal ideation and attempts in comparison to controls. Head Start REDI (Research-Based, Developmentally Informed) is a classroom programme that focuses on social-emotional, self-control and problem-solving skills as well as language and literacy (Bierman et al., 2008). Implemented in 44 Head Start classrooms, results showed significant improvements for the intervention group in emotion recognition, social problem-solving skills and aggression in comparison to controls. Both programmes were administered in the school setting with the involvement of school staff.

Similar universal programmes can be found in the Australian school system. For example, KidsMatter is an Australian national primary school mental health promotion, prevention and early intervention initiative. Slee et al. (2009) evaluated KidsMatter based on data from implementation in 100 schools. KidsMatter uses a whole-school approach that provides schools with a framework, implementation process and key resources to develop and implement evidence-based mental health promotion, prevention and early intervention strategies. Changes in mental health were assessed using parent and teacher reports on the Strengths and Difficulties Questionnaire (SDQ; Goodman, 2005). A significant overall reduction in mental health difficulties was identified on average across all students. Gains were made in emotional symptoms, conduct problems, peer problems and hyperactivity. Furthermore, the students gained in mental health strengths during the programme. The KidsMatter programme is an example of operating on the three tiers: universal/prevention by improving the mental health and well-being of students, selective early intervention by achieving greater support for students at risk or experiencing mental health problems and intervention by reducing the incidence of mental health problems.

Slee et al. (2009) report that the outcomes of the Australian KidsMatter evaluation are consistent with emerging literature that has identified universal ‘whole-school’ approaches as protective for student well-being. KidsMatter promotes a positive shift in mental health for the whole school population and enhanced academic and social competencies through more positive interactions between members of the broader school community (students, parents, teacher, community groups). Importantly, across the

2-year KidsMatter trial, there were increases in the teachers' ratings of their knowledge, competence and confidence with respect to teaching students about social and emotional competencies. The evaluation demonstrated a number of gains for the participating children and built confidence in staff and positive connections between schools and parents. There are numerous other programmes gaining popularity in Australian schools which have been evaluated, such as coping skills training and the Resourceful Adolescent Program, which have shown improvements in depression scores (Frydenberg, Care, Chan, & Freeman, 2009, Shochet & Hoge, 2009), and the positive psychology programmes introduced in a growing number of schools (Waters, 2011).

There is consistent evidence that prevention programmes which are carefully designed and implemented can be effective in preventing many of the problems facing children and adolescents (Nation et al., 2003). Characteristics of successful programmes include comprehensiveness (multicomponent interventions), sufficient dosage (enough of an intervention to produce the desired effect plus follow-ups), timing (initiated early enough to have an impact on the development of the problem) and a skill development focus. Programmes that engage children in their environmental context are also most likely to produce change (Nation et al., 2003).

Teachers and psychologists on-site in the schools can have a powerful role in assisting students gain the professional help that is needed (Mazzer & Rickwood, 2013). However due to the limited availability of psychologists compared with referrals, the direct treatment tier needs can dominate demand and thereby inadvertently restrict the range of consultative and preventative services (Farrell, 2010). This challenges school psychologists, and the universities that train them, to establish strong skills in consultancy and systems thinking, to enable the psychologists to fully inform school communities of the broad base of skills they are able to contribute and to educate their community about their capacity to contribute to well-being and mental health intervention (Frydenberg & McKenzie, 2007).

In the United States, both universal and selective school-based mental health programmes have been found to be effective. Universal programmes are administered to all children in a classroom or school-wide setting, and selective programmes target a specific group of at-risk students (e.g. aggressive behaviour, depressive symptoms). Among the programmes in Vidair et al.'s review (2013), differences were found to exist between effective universal and selective programmes (Sauro, Vidair, Blocher, Scudellari, & Hoagwood, 2014). For example, teachers and school staff most often implemented universal programmes, whereas outside researchers or professionals were more likely to implement selective programmes that targeted a specific need. It may be likely that outside researchers alone implemented selective interventions because they are typically highly trained to focus on the alleviation of specific, already present, mental health symptoms. However, the reliance on outside researchers to execute mental health programmes in the school may reduce the feasibility of sustaining the programmes over time. In fact, the universal programmes tended to last longer, possibly because teachers and other school personnel engaged in the integration of the programmes into the classroom curricula. It is recommended that school psychologists help build a bridge between outside researchers and school personnel, where researchers can train school staff to implement evidence-based protocols with fidelity while at the same time learning from school staff about how to best adapt programme components to fit the needs of a particular school climate.

How to Facilitate the Implementation of School-Based Mental Health Programmes

With the mental health struggles facing youth in our schools, the good news is that a variety of effective school-based mental health programmes exist (Hoagwood et al., 2007; Vidair et al., 2013). The next step is to determine how to integrate

these programmes into the typical school setting. Forman et al. (2009) interviewed developers of evidence-based school mental health programmes to determine which factors can facilitate their implementation. The developers focused on several facilitators, including the need to gain support from school administrators, financial assistance to foster programme sustainability, high-level training and consultation to obtain fidelity to programme protocols, alignment with school mission, goals and policies and active involvement from parents and students. Rones and Hoagwood (2000) also recommended the use of multiple modalities (e.g. school and family components), the integration of the protocol into the classroom and the use of developmentally appropriate information.

As part of the systematic review by Vidair et al. (2013), 43 recent studies of school-based mental health programmes were examined to determine the types of implementation facilitators reportedly included. Results indicated that almost half of studies integrated programme material into the classroom. In two-thirds of all studies, specific training as well as supervision or support was provided for the programme staff. Over half of all studies reported some measure of programme fidelity, such as protocol adherence or quality of programme implementation. This demonstrated an increase in the importance placed on ensuring a programme is provided as intended, as only 9 % of studies had reported measuring fidelity at the time of Hoagwood et al.'s (2007) review. In studies of programmes that involved parents, the majority reported activities that appeared designed to engage or retain them (e.g. provision of child care, flexible programme hours). Of note, none of the studies discussed the use of specific facilitators related to programme sustainability. Only 5 % provided the school with some funding, the lack of which could hinder the possibility of a programme being sustained in the school over time. It is possible that more facilitators were included than were reported in these studies.

Based on the above findings regarding implementation facilitators, the following steps are recommended for school psychologists aiming to implement effective school-based mental health programmes in their settings:

- Focus on finding programmes that can be integrated into the school curriculum.
- Advocate for the implementation of mental health programmes to school administrators, explaining how addressing mental health issues can positively affect academic outcomes.
- Contact researchers to express interest in potential collaboration on a project with the school. School psychologists are in the best position to help researchers understand the school's missions, goals and policies and to help school administrators understand the value of systematically implementing school-based mental health programmes.
- Once collaboration with researchers is developed, advocate the importance of building funding options to ensure that the school has the capacity to both implement the programme and sustain it over time.
- Take time to inform parents and teachers about the value of the programme and ways they can become actively involved. Encourage the use of teachers to implement the programme. Help find time during the school day to train them.
- If parents are able to be involved, determine ways to engage them, such as offering flexible programme hours, childcare and compensation.
- Assess parent/teacher/student satisfaction with the programme and make changes based on their input.
- Play an active role in assessing fidelity to the programme throughout to ensure that it is being implemented the way it is intended.
- Document factors that appear to facilitate the programme's adoption and sustainability.
- Develop an evaluation process and consider input from the numerous stakeholders impacted by the programme.

Universal programmes do not exclude the need to make supports available to particular students in need of intensive treatment via direct intervention. In such cases, a school psychologist can still turn to evidence-based treatments to

determine the most effective intervention, using a combination of efficacious programmes found in the literature, clinical judgement and expertise and client characteristics, culture and preferences (APA, 2005). To do this, the school psychologist will be informed by evidence-based programmes focused on the primary problem the student appears to be experiencing, select the most appropriate intervention, determine any modifications needed for the school setting and consult with the child and parent about various options (e.g. therapy in school, therapy referral, medication referral). Evidence-based interventions for individuals can be used in school settings, and subsequent chapters will review clinical interventions that have been assessed in schools.

Preparing School Psychology Trainees for Changing Demands in Practice

There is continual pressure for professional development and training programmes to keep up with the expanding knowledge base necessary for effective psychology practice in schools. This training is expected to embrace new professional standards, broadening of assessment to include curriculum based assessment, twenty-first century skills, school reform, evidence-based practice and developing psychologists as agents of social justice (Dawson, 2000; Moi et al., 2014; Shapiro, Angello, & Eckert, 2004). It is important to prepare school psychologists to intervene in mental health disorders. The skills enabling psychologists to understand and effectively straddle the three tiers of intervention to deal with these disorders and their prevention, to help schools solve problems by collaborating and building effective teams and to promote the specific contribution that psychologists bring to schools as they link their mental health knowledge with the understanding they have of effectively working in educational institutions and practice are challenging for the field of school psychology and have the potential to bring some new demands for relevant professional development.

Case Studies

The following case studies demonstrate the content of this chapter in application to experiences in schools.

Case 1: Individual Intervention

Presenting Concern

Jesse is referred to the school psychologist by the year level coordinator responsible for student well-being issues. Jesse is new to the school and has a history of school refusal. The school psychologist meets with the family and then conducts an initial assessment with the student and identifies high levels of generalised and social anxiety. Jesse identifies making friends as the main goal.

Intervention

- Within the school setting, the school psychologist involves the student in a cognitive-behavioural social skills group and connects Jesse with other like-minded students.
- To support Jesse in the classroom, the school psychologist (along with the student and key staff) develops an individualised support plan outlining learning goals and strategies.
- Concerned about continuing difficulties, the school psychologist refers Jesse to an external psychologist for assessment. The student is diagnosed with clinical depression and anxiety and begins a treatment programme.
- The school psychologist consults with the external psychologist to provide collaborative support for the student.
- The school psychologist continues to monitor and consult with the family and the external psychologist as required.

Case 2: Whole-School Intervention

Presenting Concern

The school psychologist provides psychological services to a network of schools. One of these schools is concerned about the prevalence of self-harm in their school and is creating a school policy in responding effectively to this issue. They invite the school psychologist to provide specialist consultation.

Intervention

- Drawing on knowledge of best practice, adolescent development and research, the school

psychologist develops a draft policy and collaborates with key stakeholders in the school, e.g. leadership and student support staff.
- Teachers are identified as requiring training in how to respond appropriately to student disclosures of self-harm and the correct mental health referral procedure should they identify a student engaging in self-harm.
- The school psychologist develops and delivers a professional development training session for teachers in the school.

Case 3: Targeted Group Intervention

Presenting concern: The school psychologist has had several teachers reporting aggressive behaviour in their classrooms and at recess.

Intervention:
- The school psychologist decides that Coping Power (CP), a programme for children exhibiting aggressive behaviours (Lochman et al. 2009), would be feasible to implement. CP focuses on addressing social-cognitive deficits such as emotional awareness and anger management through group sessions, monthly individual sessions and parent groups.
- The school psychologist gains approval from the principal and teachers for the programme by explaining the improvements expected from the programme.
- The school psychologist has the teachers rate the students' aggressive behaviour on a standardised questionnaire to identify students with at-risk and clinically significant levels of aggressive behaviour. These are the students that will be invited to participate in the programme.
- The students (with parental permission) are invited to participate.
- The programme is implemented by the school psychologist.
- At the end of the programme, the school psychologist has the teachers rate the students' aggressive behaviour on the same standardised questionnaire to assess if the students' aggressive behaviours have decreased.

Conclusions

This chapter has considered the contextual role of the school psychologist and demonstrated how intervention may be important and relevant at an individual, selective and universal level. The following chapters will explore evidence-based treatments as applied to specific mental health problems to support positive student mental health and well-being outcomes.

Test Yourself Quiz

1. It is estimated that 75 % of mental health disorders emerge before the age of 25. Why is mental health prevention and intervention important for school psychologists to address in school settings?
2. School psychologists perform a multifaceted role. Name several roles that school psychologists can play and factors that you think would affect their role (consider in terms of your own region or workplace or in general).
3. Name the three tiers of school-based intervention and describe.
4. What tier of school-based intervention is being implemented in each of the case studies? What factors do you think could facilitate their implementation in your school?
5. Refer to the case study regarding Jesse. List intervention opportunities for this student at the individual, selective and universal level.

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