10th Winston Rickards Memorial Oration

Mental Health and Schooling: The Education Challenge

Professor Field Rickards, Dr Lisa McKay-Brown, Associate Professor Peggy Kern

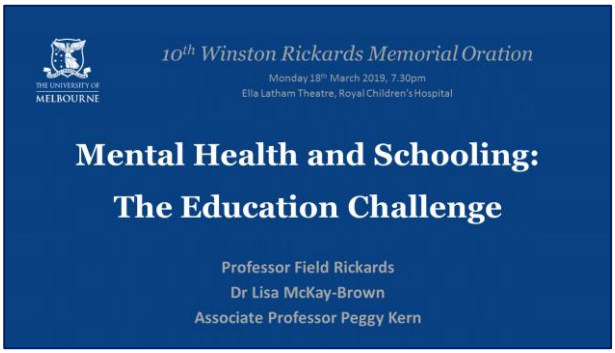
Monday 18th March 2019, 7.30pm
Ella Latham Theatre, Royal Children's Hospital

Summary

Across development, from birth to the end of schooling, the child is at the interface of education and health. Research clearly demonstrates that the academic success of young people at school and beyond is inextricably linked to healthy social and emotional development. But many young people are struggling, with mental illness and disengagement in learning being two of the biggest challenges facing youth. Risk factors and key symptoms are present even in a child's early years, and educators have the opportunity for early intervention and prevention of illness. This Oration will discuss the innovative transformations within the Melbourne Graduate School of Education over the last 15 years which recognise the teacher as a clinical practitioner who focusses on the needs of individual learners and facilitates growth and optimal development in all students. A detailed discussion of current research in first, the impact of mental health on school refusal and barriers to and facilitators of re-engagement and second, the creation of school environments that support the development of the whole child. The evolving critical role of teachers as 'program implementors' and 'clinical connectors' will be discussed.

Opening Remarks

Professor Field Rickards



Suzie. Thank you for your introduction and for the opportunity to honour the work of Winston Selby Rickards in this way. I am delighted that my expert colleagues, Drs Lisa McKay Brown and Peggy Kern, without hesitation, agreed to be joint orators and to present "mental health and schooling: the education challenge". Each of us in our own way work at the interface of health and education.

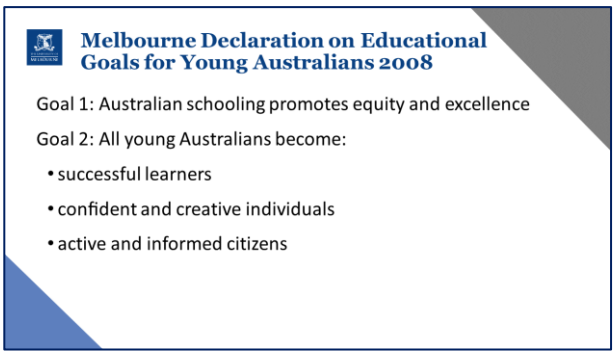
Words about Winston

I would like to begin by saying a couple of things about Winston. I can say with a great deal of confidence that I knew Winston longer than anyone else in this room. Winston, and his elder brother Field, my father, were incredibly close. Field would have insisted that Winston welcomed his newborn nephew into the world the day he arrived. That was in 1949. Lacking imagination, they christened me Field Winston! It doesn't stop there. Winston Thomas Field Rickards is in the front row. I was personally pleased to be part of the celebrations for his Doctorate where, at the age of eight months, I was introduced to the delights of champagne and crayfish. Needless to say, Winston was not yet the Director of Psychiatry here.

Winston worked extraordinarily hard, but he never forgot the importance of a balanced life. Nothing was more important than family. On his return from overseas in the mid 50's, when he was appointed foundation Director of the Department of Psychiatry, his brother Field and I saw Uncle Winston regularly in spite of his heavy work, his cricket and even pennant squash commitments. It was often at Blairgowrie or at his home in town. He was a man ahead of his time. He introduced me to espresso coffee, stereophonic opera, takeaway Chinese food and the delights of King and Godfrey. He was a regular in Lygon Street. I first met aunty Anne at Blairgowrie in the mid-60s. I would take them yacht racing and this was the one occasion I could actually tell Winston what to do. But Winston and Field, rarely told me what to do. I remember visiting his department in 1964 when I was in year 10 and he introduced me to his multidisciplinary team, to give me a sense of working in the health field. At the time, this was of no interest to me. Strangely, 9 years later, I was appointed to be the first lecturer/director of the Melbourne University graduate audiology program, but that is another story

Setting the Scene

In 2008, all ministers of education signed the Melbourne Declaration on Educational Goals for Young Australians. It declared that the two goals should be first, that Australian schooling promotes equity and excellence and second, that all young Australians become successful learners, confident and creative individuals and active and informed citizens.

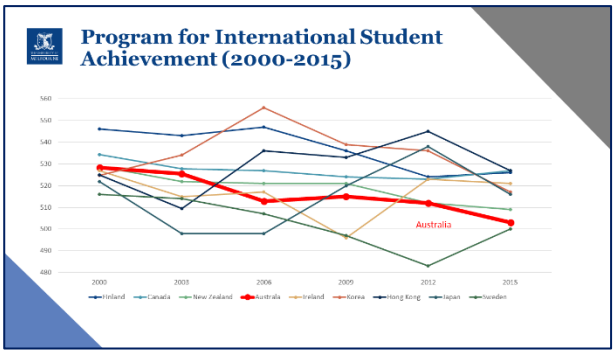


What do we want young people to get out of schooling? We want them to grow as learners. To continue to develop cognitively, socially, physically and emotionally. While school education cannot be solely responsible for growth of young people, it provides a secure context in which students can flourish both within and outside the classroom and create foundations for rich and meaningful lives and participation in society. Teachers are fundamental to this kind of learning. The value of education is more than skills learned and employability. Great teaching changes lives. It sees the potential in students, respects their ability, inspires a passion for learning, and provides the young with a trustworthy setting in which to set aside personal fears.

Government Priorities

The Melbourne Declaration was one of several federal and state initiatives in education over the last 15 years. These have been under the broad heading of a National Reform Agenda. The reforms included plans for improved literacy and numeracy, improved early childhood, smarter schools' national partnerships focussing on teacher quality, low socio-economic school communities, establishment of Australian Curriculum Assessment and Reporting Authority, and Australian Institute for Teaching and School Leadership.

How Are We Going?



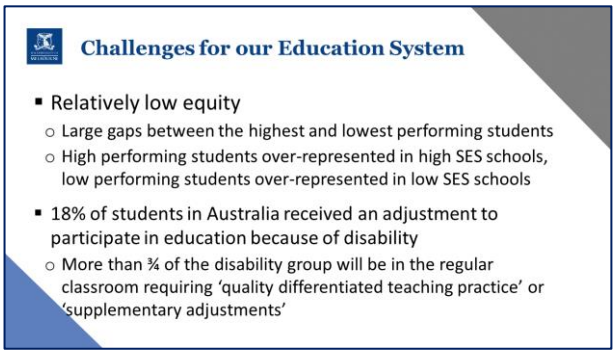
So how are we going? In short, not well. In relation to learning outcomes, the 2015 PISA (Program for International School Achievement) results for 15-year olds indicated that for Science, Mathematics and Reading, Australia was above the OECD average but has steadily declined since 2006 in all three, as highlighted by the red line in the graph.. . Moreover, in all three areas there is a three-year gap in performance between our high and low SES students and a 2.5-year gap between indigenous and non-indigenous students.

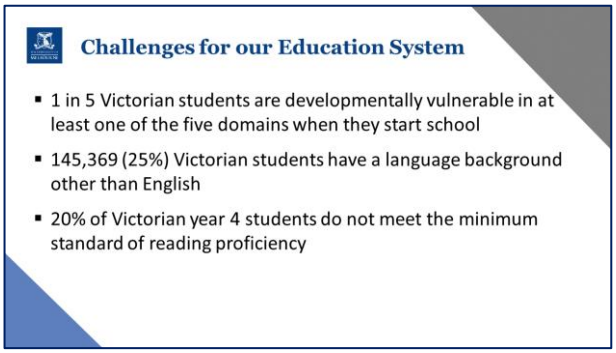
Most worrying is the increase in the percentage of Low Performers and the decrease in percentage of High Performers in science, mathematics and reading.

Second, beyond the PISA results, there is increasing disengagement with education for students in years 9-12. In the US, only 40% of students report that they are engaged with their education, and studies in Australia that suggest similar findings. It seems that schools are less able to cater for the needs of the developing adolescent.

Third, poor school completion rates. Only around 80% of students complete secondary education. There are many theories as to why. Is it the teachers? Is the curriculum boring? Is it overcrowded? Are there too many facts and not enough deep learning? Is it the easy access to iPhones and ipads? These indicators, taken together, suggest strongly that it is time to reboot.

There is little doubt that our education system has several challenges, as indicated by PISA and other surveys:





- Australia has relatively low equity, with a large gap between the highest and lowest performing students (Thomson et al., 2010). Moreover, our high performing students are over-represented in high SES schools and low performing students are over-represented in low SES schools.
- 18% of students in Australia received an adjustment to participate in education because of disability (physical, cognitive, sensory or socio-emotional). More than ¾ of that disability group will be in the regular classroom requiring 'quality differentiated teaching practice' or 'supplementary adjustments' led by the classroom teacher with some specialised support.
- The Australian Early Childhood Development Census indicates that 1 in 5 Victorian students are developmentally vulnerable in at least one area when they start school (physical development; social competence; emotional competence; language and cognition; communication).
- 145,369 (25%) Victorian students have a language background other than English (over a quarter of students).
- 20% of Victorian year 4 students do not meet the minimum standard of reading proficiency (Thomson et al., 2012).

So how is Australia going in Mental Health? The second Australian child and adolescent survey on mental health and wellbeing released in 2015 highlights:

- Almost one in seven (13.9%) 4-17-year-olds were assessed as having mental disorders in the previous 12 months. This is equivalent to 560,000 Australian children and adolescents.
- ADHD was the most common mental disorder in children and adolescents, followed by anxiety disorders, major depressive disorder and conduct disorder.
- Almost one third of children and adolescents with a disorder had two or more mental disorders at some time in the previous 12 months.

- Just over one in seven (14.7%) of those 4-17 year-olds with a mental disorder were assessed as having a year-olds with a mental disorder had a severe disorder compared with 8.2% of 4-11 year-olds with a mental disorder.
- Students with a mental disorder in Year 3 were, on average, seven to 11 months behind students with no mental disorder but by Year 9 they were an average 1.5 to 2.8 years behind.

Furthermore, there is growing and recent international evidence that vulnerability in socio emotional functioning at school entry is associated with early-onset mental health conditions (Thomson et al in Canada 2019). Indeed, positive social and emotional skills, are essential for good mental health.

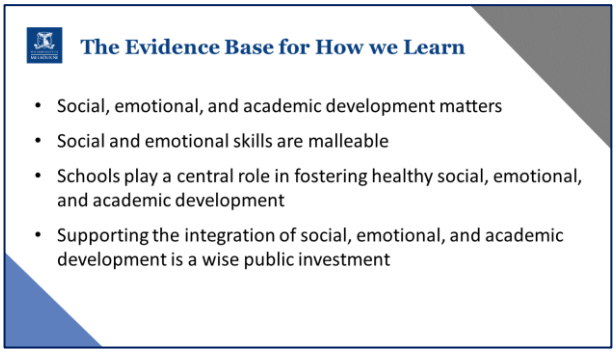
The Australian Early Childhood Development Census gives us insights into those kids who are at risk at the population level. It is clear that socio-economic status can have an impact on a child's development. Children living in socio-economically disadvantaged Australian communities are most likely to be vulnerable in social and emotional learning, and it is these populations that are most challenged with education outcomes.

Research demonstrates the strong association between socio emotional learning and academic learning.

The Evidence Base for Learning

In September 2017, the Council of Distinguished Scientists of the Aspen Institute issued The Evidence Base for How We Learn—a brief on the connections among social, emotional, and academic development. Drawing from research in brain science, medicine, economics, psychology, and education, these 28 scientists concluded that learning, by its very nature, is both social and emotional. Cognitive abilities, emotional competencies, and social and interpersonal skills intertwine in the learning process. Strength or weakness in any one of these three areas can foster or impede growth in the others.
The scientists also agreed that the research provides clarity on several deeper issues:

- Social, emotional, and academic development matters. These interdependent competencies are essential to success in school, workplace, home, and community. Their integration also improves school climate and teacher effectiveness, and children benefit regardless of where they live, their racial/ethnic background, or their socio-economic status.



- Social and emotional skills are malleable. As with cognitive skills, we can teach and develop them throughout childhood, adolescence, and beyond.
- Schools play a central role in fostering healthy social, emotional, and academic development, particularly when their work is reinforced by safe and supportive family and community environments.

The panel also noted that supporting the integration of social development, emotional development, and academic development is a wise public investment, well worth the expenditure of effort and resources. Higher social and emotional competencies are associated with wage growth, job productivity, and long-term employment. Moreover, such competencies can reduce violence, drug use, delinquent behaviour, and mental health problems and provide internal support for children who experience the stress of poverty, violence, and trauma in their families and neighbourhoods. They have the potential to help create a more equitable society where all children can succeed.

The Practice Base

In a subsequent report in 2018, a panel of expert teachers provided the practice base for supporting students' social, emotional and academic development. They noted:

- Learning and teaching are social and emotional
- The social and emotional environments of the classroom and school have a profound impact on students' ability and willingness to learn.
- Social, emotional, and academic development is for all students
- Their integration shifts the emphasis to learning environments and promotes equity
- Social, emotional, and academic learning for students starts with adults
- Professional and collegial support for integrating the three dimensions of learning enhances educators' effectiveness in the classroom.
- Strong leadership is central
- Explicit and embedded instruction and a caring classroom and school climate develops social, emotional, and academic competencies
- And finally, Home-school-community partnerships matter

Advances at MGSE 2008 - 2018

Before handing over to Lisa and then Peggy, let me set a linking context where MGSE has set about developing programmes aimed at meeting the needs of individual leaners through the transformation of teaching into a genuine clinical practice profession and through recognising the importance of learning interventions and wellbeing.

As many of you know, in 2008, the Melbourne Graduate School of Education embarked on a radical reform to Initial Teacher Education through the Master of Teaching: a clinical pre-service program. We wanted a paradigm shift in Initial Teacher Education.

A clinical approach, while innovative as an overarching frame for Initial Teacher Education, was not new to us. We had been using a clinical approach to the education of children with impaired hearing. Indeed, my own background in clinical teaching in the field of audiology and in the educational intervention of young children with impaired hearing were critical perspectives.

There were two catalysts for our reform of Teacher Education.

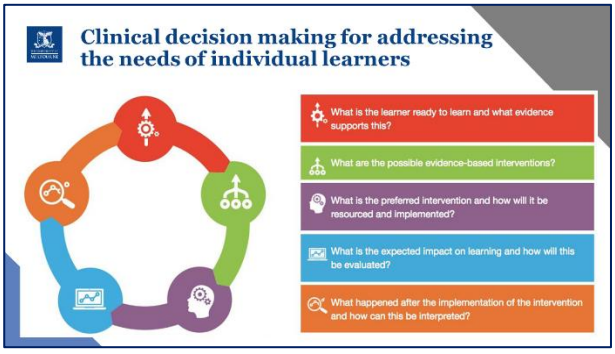
The first was radical curriculum reform across the entire University, known as the 'Melbourne Model', where all professional training was moved to the graduate level. This was a circuit breaker that gave us the opportunity to consider conceptualising teacher education at a Masters level, and to respond to the persistent criticisms of teacher education, which followed, to a large extent, an apprenticeship model and teaching was more about teachers than learners.

The second catalyst was the report Teachers for a New Era from the Carnegie Corporation of New York. Specifically, the report recognised teaching as an 'academically taught, clinical practice profession'. This notion of teaching as clinical practice was one that resonated with me personally.

Thus, with clinical practice in mind, we wanted "a new generation of teachers who would be analytic interventionist practitioners, capable of using data (evidence) to identify and meet the learning needs of individual learners".

In some ways, all of us are the same, but we each have unique capabilities, interests and beliefs. Our similarities are greater than our differences, but our differences are sufficiently great that the 'one size fits all' model of education does not meet the needs of every learner.

For full inclusion, teachers must employ clinical reasoning and clinical decision making to maximise growth in every student.



We develop teachers to ask and integrate these questions into their thinking processes: What does the student already know and what can they do? What does each individual student need to advance their learning? What are effective practices according to the evidence base from research? What evidence of learning can be gathered during and after the teaching intervention?

What happened and how can this be interpreted, or what does it show? What does this mean for next steps and future interventions?
This is clinical thinking and while it is about diagnosis, intervention and evaluation, it is not about fixing a problem, it is about developing the capabilities of every child. Teachers are best placed to do this, provided we give them the professional capabilities to achieve this goal.

It was a key underlining principle that with a data-driven, evidence-based approach to teaching and learning, teachers can manipulate the learning environment and scaffold learning for every student, regardless of the student's development or intellectual capacity

The overarching aim of the introduction of this clinical Masters degree was to start the process of transforming teaching into a true clinical practice profession, one that commands the same esteem as psychologists, paediatricians, speech pathologist and the range of professionals that support kids who are being challenged. And one that uses the same language as the clinical specialists.

The Master of Teaching is complemented by other graduate programs at MGSE that are built on clinical thinking to address the needs of individual learners.

First, in the master of **Student Wellbeing**, we have graduated over 1200 teachers in the past fifteen years. Independent research has demonstrated teachers completing the course report enhanced relationships with students, higher levels of confidence and empowerment, enhanced leadership capacity and the feelings of professional renewal and challenge.

Second, the master of **Learning intervention**, which develops the skills of practicing teachers to diagnose, implements effective learning interventions to optimise learning and promote inclusive education in primary and secondary schools. Every child can learn is an underpinning principle. We no longer refer to 'special education' which can have the effect of limiting the learning horizons for each child. Lisa is from our Leaning Intervention team.

Third, the master of **applied positive psychology.** The idea of establishing a Centre of Positive Psychology in MGSE, which Peggy is a part of, probably goes to 2008 when I first heard Martin Seligman speak, but it was actually my childhood experiences that predisposed me to pursuing this. I think I connected with Positive Psych in a deep and personal way because I think that my father, albeit a legal practitioner, was a gifted 'positive psychologist'.

I think that Dad was engaging in what Professor Carol Dweck from Stanford University now calls 'Process Praise'. He taught me that character and persistence were important virtues to cultivate in order to have a successful life and he taught me how to find the good in all situations. I remember Winston's advice would have been 'to seek, to strive, to find and not to yield'.

One of the consequences of mental health issues is school refusal. I now hand over to Lisa to delve into this more.

Tackling School Refusal

Dr Lisa McKay-Brown

Twelve-year-old Georgia wakes up every morning and her first thought is, "I can't do this. I feel sick, I can't breathe. I'm just going to crawl under my covers and hide in my cave". Georgia represents a group of young people invisible to our society. In fact, internationally 2% of students and 5-16% of clinic referred young people fall into this group, disengaged from education due to their mental health needs. They can't go to school.

Georgia's story describes a problem called school refusal. It impacts not only the young person through the loss of educational opportunities, isolation from their peers and the wider community, but also their families. The future for these young people is bleak, with ongoing mental health issues, unemployment, poverty and relationship breakdowns. So, what happens to young people like Georgia and where can they go for support?

Before we answer this question, let us backtrack a bit. The number of young people disengaging from education is a growing concern. Disengagement can be defined as "detaching from school, disconnecting from its norms and expectations, … and withdrawing from a commitment to school and to school completion" While mental health can be a factor, socio-economic status, high family mobility, poor home-school relationships, family dysfunction, and bullying can also contribute. Disengagement from education can lead to school attendance problems (SAPs) for young people and internationally, it has been noted that this is a critical public health problem for educators, health and mental health professionals with the short and long-term adverse outcomes noted earlier.

Tonight, I will be talking about one type of SAPs, namely school refusal (SR). SR is characterised by emotional distress associated with school attendance with many youth meeting diagnostic criteria for anxiety or depressive disorders. SR is a reluctance and often outright refusal to go to school with emotional and somatic complaints manifesting when young people are faced with attending school. Generally, they do not display antisocial behaviour and do not conceal their non-attendance from their parents. In fact some prefer to stay close to parental figures.

Responding to School Refusal

Responding to SR is time-consuming for teachers and other school staff with schools reporting that they don't have the expertise or resources to respond adequately. SR also presents a considerable challenge to mental health professionals because treatment is frequently ineffective.

Clinical interventions generally focus on the reduction of symptoms with cognitive-behavioural strategies being the most used. However, research has found that while improved school attendance may be achieved using cognitive-behaviour therapy (CBT), there were no differential effects on anxiety

outcomes at post-treatment. Medication has also been suggested as an addition to CBT, however, results from studies of medication for anxiety-based SR have been ambiguous.

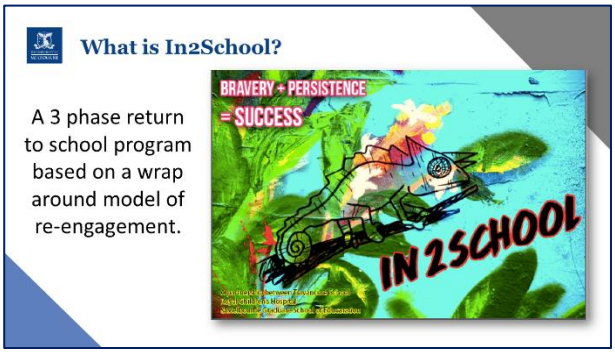
So, what can we do differently that will achieve ongoing school re-engagement? Recent research suggests the most effective interventions for SR are ones that include clinicians, parents, and school professionals working together in multidisciplinary teams. When professionals work together it provides the opportunity to target complex needs. In fact, multidisciplinary collaboration has been found to be critical in improving youth mental health as well as social and academic outcomes for young people.

Young people who are school refusing may have multiple domains of problematic functioning including mental health problems, academic problems, social problems, and school disengagement. Therefore, interventions that target these domains delivered by experts from different fields may provide the comprehensive approach required to address individual, family, school, and community variables.

One solution

In this presentation I will be speaking about an intervention that has been designed and delivered in partnership with MGSE, RCH MH and Travancore School (a mental health focussed special education setting). It grew out of concerns from clinicians and teachers from RCH MH and Travancore, that young people being referred for school refusal were increasing and that successful return to school outcomes using standard care were variable. Prior to the development of In2School, treatment for SR typically involved assigning a clinician and teacher to support a young person. Mental health and educational interventions were undertaken by professionals, and while there was some level of joint work, there was no standardised approach to supporting the young person, their family, and the staff at the young person's school. The return to mainstream school was often not being sustained. This led to us needing to do something different and In2School was created.

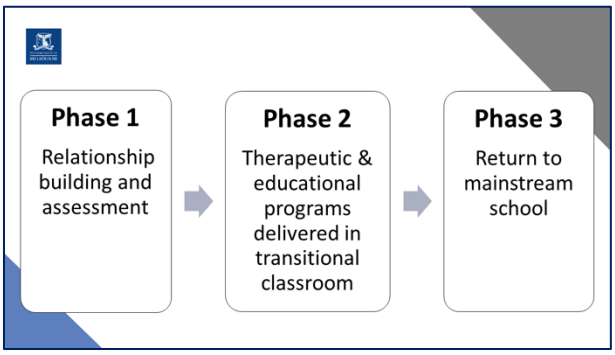
What is In2School



In2School is a three-phase intervention implemented over 6 months. Young people eligible for the program are aged between 11and 15 years, have mood disorder, somatoform disorders or anxiety disorders, and have missed at least 50% of total school time for at least six weeks. There must be a commitment to return to a mainstream school setting and parental involvement is required. The program started in 2015 and 6 intakes of young people (47 in total) have completed the 6-month program. The team of professionals consists of a mental health clinician, teachers and researchers.

On this slide you can see the In2School logo. The students from an early intake chose a chameleon to represent their experience as it can hide or be visible. In2School is a about supporting out students to show their colours.

In2School Phases



The first phase (up to four weeks long) focuses on the administration of mental health and educational assessments, building rapport between the young person and each team member, and gradual introduction to the transitional classroom which I will explain in a moment. Students commence by attending individually in one-to-one lessons with the program teachers and clinician. Sessions last approximately one hour and involve short learning tasks and playing games. The In2School classroom is referred to as a transitional classroom because it is used to provide an interim space where the young people are prepared for a return to mainstream school. We know that young people returning to school after a period of disengagement need a safe and structured environment to build their stamina for learning, and to re-learn how to engage socially and academically with schooling. The transitional classroom also provides a space for young people to engage with their educational and therapeutic recovery plans. After four individual sessions, the students complete lessons in dyads and triads. The activities include a combination of playing games, undertaking academic work, and going out for lunch. Building social connections is particularly important here as the students have often become socially isolated.

Phase two (up to 10 weeks long) is the classroom and therapeutic intervention phase, involving young people attending the In2School transitional classroom four days a week for up to ten weeks. During this phase participants are engaged in education and therapy based on the needs assessed during phase one. The lessons include independent learning projects, social skills, coping skills, literacy, math, art, and physical education. The young people also spend one day each week 'out and about' with teachers. During this time, they undertake community-based activities to foster their social connection and help them learn how to get around independently.

The clinician provides individual therapy to the young people during phase two. Therapeutic procedures include cognitive therapy together with other techniques such as exposure therapy, social skills education, psychoeducation, and behaviour modification. Interventions such as social skills training and psychoeducation are also undertaken in the classroom with the teachers and clinician working in partnership. This supports students to learn skills in situ and facilitates the transfer of these learned skills to the mainstream school setting. This also enables the clinician to observe how the young people react to different educational situations and to immediately prompt and support specific coping skills, following up with the young person during individual sessions.

Phase three (up to six weeks long) involves a supported return to the mainstream school setting. This involves the teachers and clinician working with the students to re-engage with their mainstream school. The team sees the student in the new environment and can help problem solve concerns. There is also professional learning for mainstream school staff in understanding the needs of the student and interventions that will support continued attendance.

In2School Outcomes

As noted earlier, we have had 47 young people complete the program with over 80% of them returning to mainstream schooling with attendance being maintained during the six-month follow up period.

The mental health and social functioning of young people participating in In2School has improved, alongside improvements in their school attendance. Mental health recovery has been particularly good with most students being discharged from the RCH MH service four months after return to mainstream schooling. Reports from parents and young people in the In2School program also indicate adaptive changes, suggesting that the psychological wellbeing of the young people had improved across the course of the intervention.

The quality of life (QoL) of students and families has improved. These are important findings as the In2School project is the first to evaluate QoL in relation to the treatment for SR. The reports of parents and young people in the present study indicate that the greatest areas of improvement in QoL are psychological wellbeing and school environment.

The team-based approach with an equal focus on education and health is innovative and our program is the only one of its kind in Australia. Having teachers and clinicians working in partnership with the young person and family means that the complex dimensions of school refusal are being addressed concurrently. Using a transitional classroom to re-engage the students with education while including therapeutic responses in situ, gives students the opportunity to practice new skills with support from professionals who have in depth knowledge of school refusal interventions.

Student Stories

This story isn't complete without hearing from our In2School students and honouring their experiences. One area in school refusal that is very under-researched is student voice, with research usually presented from clinical or education perspectives. An innovation of In2School has been finding out from the students the reasons for their school disengagement, and the factors that help them return to school. We believe that this data will support us in the creation of more targeted interventions to support school re-engagement. So, what do out students tell us?

Our students speak about barriers to school attendance with themes centring around social connections including the impact of social anxiety, school organisation and school work/homework. We have also found out that all of our students had early warning signs for SR that weren't identified. As noted by Field, early intervention is paramount, and this is an area that needs to be addressed more systematically by health and education.

Social Connections

Our students note that a lack of social connections cause barriers and issues include bullying and not having friends. There are particular concerns about what other students might think of them, and questions about their absence. For instance, students noted:

- 'I get worried what people are going to think of me'
- 'Staying away from school because it's hard to speak with other kids'
- 'Because it's all girls and I think girls my age get really rude and I got embarrased [sic] on transition day and fainted and sorta stressed me out a lot. I got realy [sic] stressed and my body couldn't take it and I collapsed. I am scared if I go back this could happen again. I don't know many of the girls and scared kids will remember'

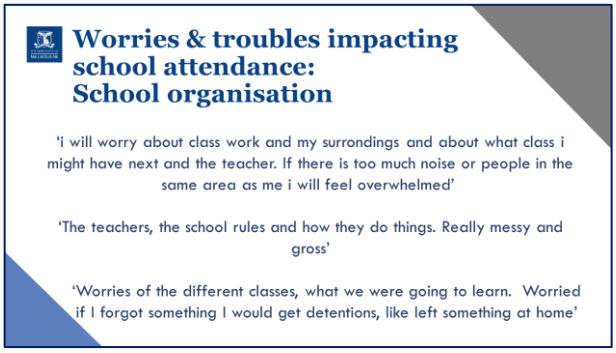
Impact on Existing Mental Health Disorders

Concerns around mental health and level of social anxiety also feature, with worries about its impact in the school setting. As these students are consumers of a mental health service, they have an awareness about their mental health needs and barriers it may present for schooling.

- 'I have social anxiety, this is preventing me from going to school. My anxiety makes me sick'
- '[my] social anxiety and lack of social skills'
- 'Feeling of anxiety, nervous or tired'
- 'Had a lot of separation anxiety from mum. Hated using the bathrooms at school. Germ phobias

School Organisation

School organisation, school work and homework for those returning to a secondary school setting was noted by young people as a barrier to attending school:

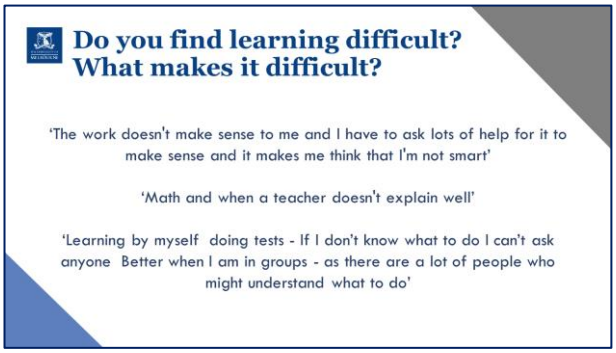


- 'i will worry about class work and my surrondings and about what class i [sic] might have next and the teacher. If there is too much noise or people in the same area as me i will feel overwhelmed'
- 'The teachers, the school rules and how they do things. Really messy and gross'
- 'Worries of the different classes, what we were going to learn. Worried if I forgot something I would get detentions, like left something at home'

What Makes Learning Difficult

The young people were asked about self-perceived difficulties with learning. The subjects most linked to difficulties in this cohort was maths, followed by science and then English. Concentration and completing tasks independently were also noted as contributing to their difficulties with learning:

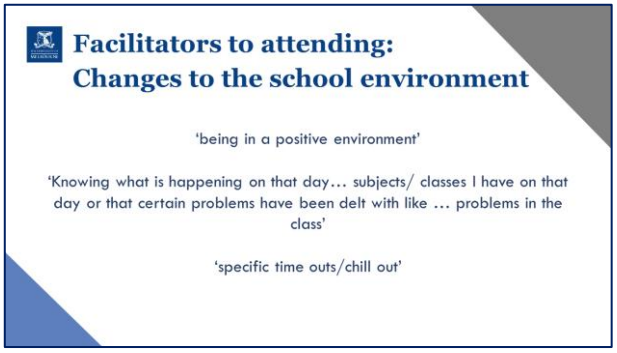
- 'The work doesn't make sense to me and I have to ask lots of help for it to make sense and it makes me think that I'm not smart'
- 'Math and when a teacher doesn't explain well'
- 'Learning by myself doing tests - If I don't know what to do I can't ask anyone Better when I am in groups - as there are a lot of people who might understand what to do'



Facilitators to Attending: Change to the School Environment

Changes to the school environment and improved mental health are the predominant facilitators noted by the young people. Students want school environments that are safe and predictable. They need to have prior warning about changes to the day and have places they can access when feeling overwhelmed by the environment. Also, a graduated return to school that is flexible is needed for students and must be planned with the student not for the student. Students noted that:

- 'being in a positive environment'
- 'Knowing what is happening on that day… subjects/ classes I have on that day or that certain problems have been delt [sic] with like … problems in the class'
- 'specific time outs/chill out'



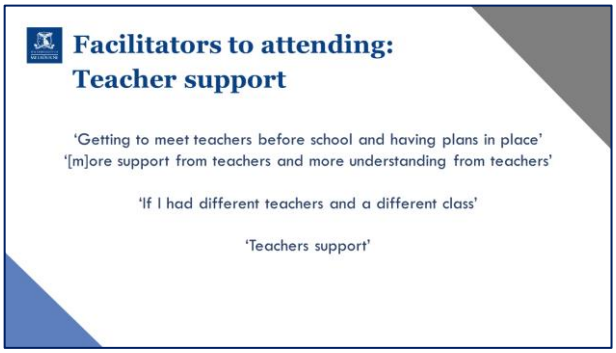
Facilitators to Attending: Improved Social Connections

Improved social connections is a high priority for students. The In2School students have learnt how to engage with others within the transitional classroom and transferring these skills to a mainstream school with students who have not had the same experiences can be challenging. Students may need assistance to facilitate social situations and having peers who can provide support is helpful:

- 'Being able to be more social'
- 'develope new social skills'
- 'Talking to my friends that go to X. Sitting with them in the office'

Facilitators to Attending: Teacher Support

Teacher support was important, and students are report that they need teachers who understand school refusal and its impact on them. This includes building relationships with students, reminding students about coping supports and having key contacts who can facilitate entry to the school in initial stages:

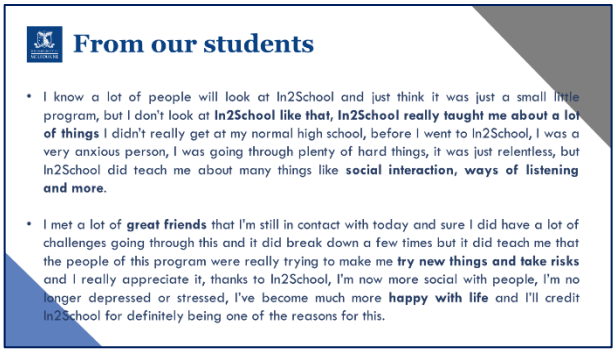


- 'Getting to meet teachers before school and having plans in place'
- '[m]ore support from teachers and more understanding from teachers'
- 'If I had different teachers and a different class'
- 'Teachers support'

Improved mental health made a difference and students report the use of medication to help with anxiety and depression, improved sleeping at night and having a planned morning routine to assist with getting up for school all helped with returning to school.

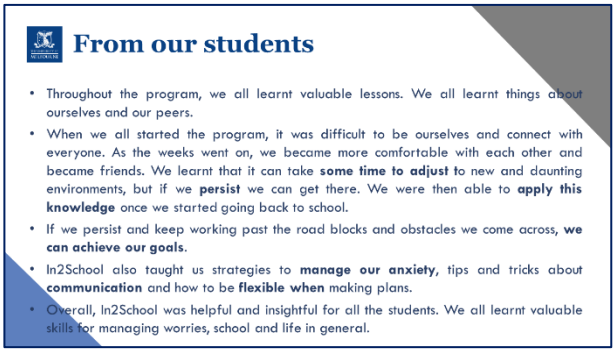
The Voices of Our Students

Lastly, the In2School students have provided us with pieces of writing to describe their experience of the program and how it has helped them to return to school:



- I know a lot of people will look at In2School and just think it was just a small little program, but I don't look at In2School like that, **In2School really taught me about a lot of things** I didn't really get at my normal high school, before I went to In2School, I was a very anxious person, I was going through plenty of hard things, it was just relentless, but In2School did teach me about many things like **social interaction, ways of listening and more**.
- I met a lot of **great friends** that I'm still in contact with today and sure I did have a lot of challenges going through this and it did break down a few times but it did teach me that the people of this program were really trying to make me **try new things and take risks** and I really appreciate it, thanks to In2School, I'm now more social with people, I'm no longer depressed or stressed, I've become much more **happy with life** and I'll credit In2School for definitely being one of the reasons for this.
- Throughout the program, we all learnt valuable lessons. We all learnt things about ourselves and our peers.
- When we all started the program, it was difficult to be ourselves and connect with everyone. As the weeks went on, we became more comfortable with each other and became friends. We learnt that it

can take **some time to adjust** to new and daunting environments, but if we **persist,** we can get there. We were then able to **apply this knowledge** once we started going back to school.

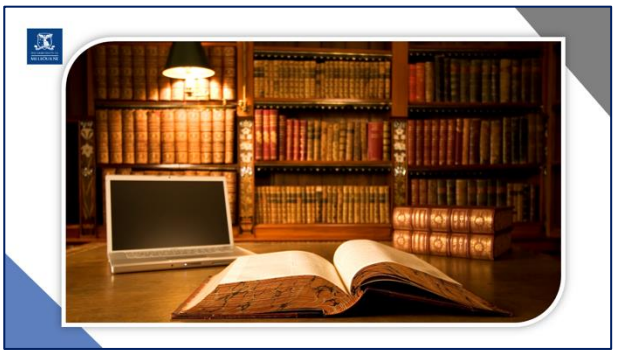


- If we persist and keep working past the road blocks and obstacles we come across, we can **achieve our goals**.
- In2School also taught us **strategies to manage our anxiety,** tips and tricks about **communication** and how to be **flexible** when making plans.
- Overall, In2School was helpful and insightful for all the students. We all learnt valuable skills for managing worries, school and life in general.

I now turn it over to Peggy, who will present positive psychology approaches for supporting social and emotional learning within schools.

Proactively Supporting Student Mental Health

Associate Professor Peggy Kern



Good evening, it's a pleasure to be joining my esteemed colleagues and you tonight. Over the years, we have seen considerable advancements in education. We have moved from an industrial age to one of technology, creativity, and entrepreneurship. Society is advancing rapidly, and education underlies the future development and advancement of our society – locally, nationally, and internationally. Through initiatives such as incorporating the clinical teaching model into teacher education, my colleagues at MGSE have made numerous important contributions to both the academic advancements of our young people, as well as addressing the many other emotional, social, cognitive, physical, and psychological needs that young people bring to the classroom. Programs such as In2School are critical for providing young people with support that they need.

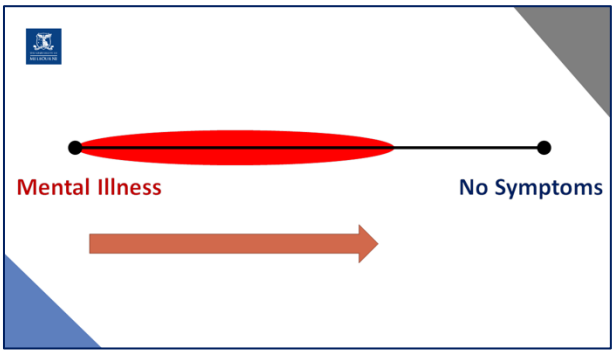
Despite the many advances that have been made over the past century, the reality is that many young people are struggling. As Field described in detail, many of our young people are struggling with varying degrees of mental disability. One in five adolescents experience mental illness. Many engage in self-destructive behaviours, including self-harm or disordered eating. Bullying, both on and off line, is an ongoing issue. In the US (and sadly even closer recently in New Zealand), young people are afraid to go to school, because the reality is that they could be shot by a classmate. And students report high levels of disengagement, with nearly 1 in 5 young people reporting active detachment from learning.

All of this impacts learning. Like Georgia in Lisa's opening story, when you are dealing with overwhelming anxiety, even if you show up in class, learning is nearly impossible.

And these issues impact our teachers, our parents, and our communities as a whole. Teachers are trained to focus on the academic development of students, but often have to also serve as counsellor, boxing referee, coach, disciplinary, parent, and many other roles. They are time poor, with growing curriculum demands and pressure from parents. And when another round of NAPLAN scores is released, and scores remain stable or decline, teachers are blamed. Sadly, teachers are leaving the profession in large numbers, despite undergoing considerable time and expense in training.

This paints a pretty disheartening reality for our schools. How do we address these many problems?

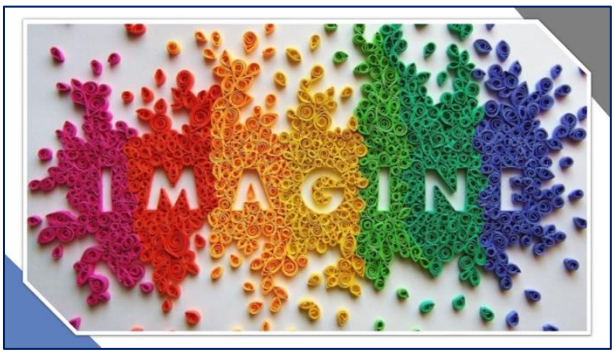
Approaches to Mental Health Challenges



Our typical approach involves diagnosing problems when they occur and treating symptoms to restore "normal" functioning. If you get strep throat, you might go to your GP and get some anti-biotics, restoring health. When symptoms of depression or anxiety occur, we might send a student to the school psychologist for support or give medication to manage symptoms. This works well enough for acute diseases, but is insufficient when we consider about mental health.

I remember when I lived in Philadelphia in the US. There was a busy road along the river. When there was bad weather, people seemed to become worse drivers (sounds like drivers here in Melbourne too). Tow trucks would sit along the road, waiting for crashes to occur – and they indubitably would. Cars would be totalled, people injured or killed, and traffic would be delayed while things got cleaned up. While the tow trucks were prepared to rapidly clean up the mess and get traffic flowing again, it's a lot better for people, vehicles, and the morning commute if the crashed were prevented in the first place.

Similarly, psychology, medicine, and related areas have made a lot of advances in terms of treating mental illness. We can address the symptoms, but that's after there's already been a lot of struggle for the child, teacher, parents, and everyone involved. And like other chronic conditions, for many people, it becomes a lifelong battle with mental health. Wouldn't it be better if we could prevent or at least minimize mental illness before it occurs?



But beyond this need for preventing mental illness from occurring in the first place, take a moment and imagine a world in which we've actually been completely successful in the battle against mental illness. Treatments and prevention have been so pervasively and perfectly implemented that no young person displays any symptoms of a disorder. This would eliminate considerable amounts of individual suffering, and provide substantial economic benefits. But such a society is still not a psychological utopia. There are huge differences between a young person who is not depressed or anxious versus one who bounds out of bed in the morning with twinkling eyes, or between an adolescent who says no to drugs versus one who says yes to meaningful involvement in family, school, and community activities. Parents want their children to not only survive the choppy waters of adolescence, but also to truly thrive – being safe, healthy, happy, moral, fully engaged in life, and productive contributors to the communities in which they live.

This is the premise of positive psychology. Officially founded as a field in 1998 by Professor Seligman, whom Field mentioned earlier, positive psychology focuses on understanding, building, and supporting optimal functioning in individuals, organisations, and communities. The driving premise of positive psychology is to empirically identify ways to promote positive attitudes, behaviours, skills, and character. Through this, it helps people be resilient when problems come, and aims to bring out the best in each person.

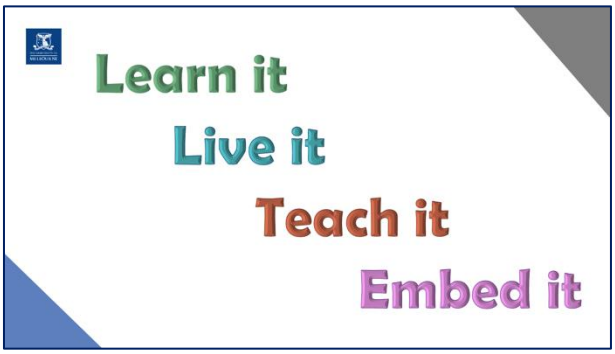
Importantly, positive psychology does not ignore problems, but places a greater emphasis on the positive side of life – what makes life worth living, what we are good at, possibilities to develop, and bringing out the best of each individual. Imagine if every young person was the best he or she could be – in terms of their fulfilling their academic potential, enjoying life, physically and mentally healthy, engaged with learning, optimistic about the future that they will bring about? Perhaps that's a big vision, but I think one that's worth working towards.

Positive Education

What does this look like in schools? In what has been called "positive education", we work with educators to build both traditional academic skills as well as non-academic skills, including ways to understand and manage emotions, positive social skills, healthy ways of thinking and coping with challenges.

We target and build many of what have been identified as core skills needed to be successful in the 21st century workplace, including collaboration and teamwork, creativity and imagination, critical thinking, and problem solving.

Positive education ranges from specific curricula and programs to whole school approaches that are transforming what traditional education looks like in exciting ways. It includes both explicit teaching of positive psychology principles and implicit ways of embedding wellbeing throughout the school environment. We focus on developing healthy ways of thinking, feeling, and behaving in both our students and staff, as well as creating supportive environments that help all members of the educational community to thrive.



Generally, the incorporation of positive education into the school includes learning about positive psychology and relevant concepts and strategies, trying different things out, explicit teaching, and ultimately embedded wellbeing concepts throughout the school environment.

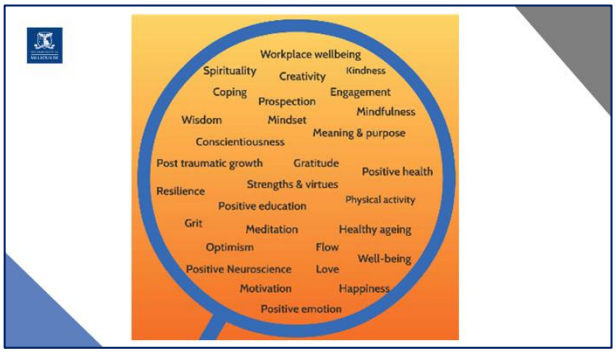
Be A Learner First

Students are our core business, and so positive education curricula and many wellbeing efforts target students. When schools want to target student wellbeing, they might choose a curriculum that teachers can easily pick up and implement. But with wellbeing skills, we find that if teachers don't understand and believe in the concepts, they won't teach it well, and can do more harm than good. Indeed, when our teachers are stressed, burned out, and exhausted, it doesn't matter how good the curriculum is, they won't teach wellbeing skills well – and can be quite toxic to already high-risk students.

Different topics also resonate with people in different ways. For example, there has been a lot of recent excitement about meditation and mindfulness. Some people love mindfulness, others do not. Some teachers are told that they now need to teach mindfulness. But they don't understand what it is or why it matters, they teach it poorly, students don't take it seriously, and it becomes simply a waste of valuable time. Just like some teachers are really good at teaching maths but would make a poor art teacher, and matching the teacher with their right subject is useful for learning, matching teachers with non-academic areas that they resonate with is beneficial.

So we begin with teaching teachers about positive psychology. For instance, for the past 4 years I have led a professional certificate in positive education program through our centre. My students learn all about positive education principles, and assignments challenge them to directly apply relevant concepts to their lives and teaching.

Positive psychology includes a wide array of topics, including emotions, engagement, character strengths, hope and optimism, positive relationships, purpose in life, mastery, autonomy, leadership, connection, mindset, perseverance, and more. There are many ways to apply these concepts and more within our own lives, with our families, in classrooms, communities, and beyond.



Once teachers learn about and experience relevant concepts, they go on and teach and share the information with students in amazing ways. Here are a few ways our teachers have incorporated positive psychology concepts into their classrooms, including:

Learning about emotions. Here, a teacher used Kimochi dolls, which are a series of characters that portray different emotions. Through stories, role play, and more, students learn how to label and understand different emotions that they experience, understand the effect that their actions have on others, and learn how to regulate their emotions effectively. Here they have portrayed different emotions through art projects.

Programs often include a considerable focus on character strengths. So often children hear about all the ways they fail, the things they do wrong. In positive psychology, we focus on their strengths – what are they good at? Things like humour, kindness, leadership, perseverance, and more. Teachers create visual reminders to focus on strengths, such as a strengths tree – where students identify their strengths and "grow" a forest, as a constant visual reminder to look for the good in others.

Gratitude and appreciation are another core part of positive education. So often we focus on all the negatives of the day. Activities encourage students and teachers to focus on the little wins and good things that happen – learning to notice and appreciate things, and not taking things for granted. Students are encouraged to identify what went well, an attitude of gratitude.

An area of considerable interest is mindfulness and meditation, such as guided meditations, mindful colouring, and more. We see that such activities can help calm students down, focus attention amongst a very distracted world, and more.

And some schools have incorporated collaborative project, in which older and younger students come together to work collaboratively. The older students support and mentor the younger students, developing connection and skills and all

Often, we focus on training teachers, but what about allowing the students themselves to be teachers? That's exactly what we did at a government school in South Australia. A group of students learned about positive psychology, and then they developed and drove the implementation of the program in the school. The students developed their own logo, created a positive education video, and developed other interesting ways to teach positive psychology concepts to others. We worked with them to study the impact, both on them and on others at the school. Students reported a growing sense of confidence, improved their communication and research skills, and became more critical thinkers. They appreciated having a voice in how things happened at the school. Their involvement helped other students buy into the positive education programs at the school. Student involvement also enriched the quality and depth of findings, as they had more intimate knowledge of the adolescent world than we do as adults.

Embedded Positive Education

While learning, living, and teaching about positive psychology appears beneficial, for efforts to be sustained in the school, ultimately it needs to be embedded into the school. This includes prioritising staff and student wellbeing in strategic plans and visions, consideration of the language used throughout the school, the visual design of the school, time tabling, and curriculum considerations. It includes not only explicit teaching on wellbeing skills, but also implicitly emphasising and supporting wellbeing, including the attitudes and behaviours modelled by leaders, school priorities within a very busy curriculum, and financial support. It also means bringing parents and the local community on board. In schools that have done this well, positive psychology is thriving. They are happy places to visit. Students are engaged and excited about learning. A sense of thriving resonates throughout the school.

A Word of Caution

Still, positive psychology is not a silver bullet. Even in the most successful schools, students and staff members struggle. Positive education is a universal approach, aimed at generally upskilling people across the communities, but for a variety of reasons, some students will still need additional support. Programs such as In2School are critical to support these students. Just as some students need additional support in learning, some students need additional supports for their mental health. It's important that excitement over building wellbeing does not ignore these students, leading to inequities and harm.

A Final Thought

At its core, the application of positive psychology within education challenges us to reconsider the purpose of education, extending beyond academic performance to encompass holistic student development. Ultimately, we aim to foster socially minded individuals that care for themselves, others, and the world around them, both now and in the future.

I hand it back to Field now to conclude.

Closing Remarks

Professor Field Rickards

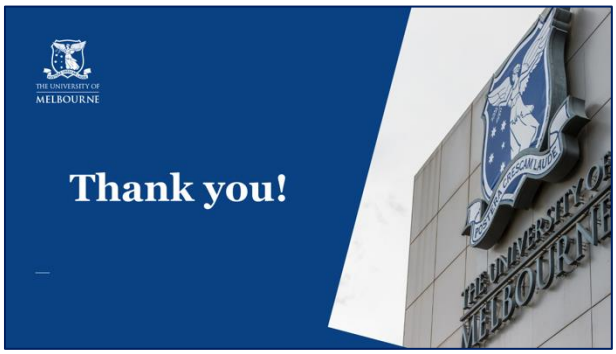
Health and education are intrinsically intertwined. Health, in its broadest sense, can impact on learning at any time. There are many complex issues facing many children and families in Victoria and Australia that impact student learning. The prevalence of mental health disorders is a significant issue. It is not clear the degree to which mental health is contributing to our education challenges, or how much our high stakes, high pressure education system is the cause of mental health conditions. Clearly there will be a range of factors outside the school that come into play. For example, homelessness is a major issue. To solve these challenges, a system approach that covers the health, education and social service systems is required. For most families, quality programs across Early Childhood Education and Care, maternal and child health, school medical and other support programs are sufficient for optimal student growth. But for many young people, there needs to be a coordinated and targeted alignment of support programs.

There are many examples of this occurring. These are place-based interventions. Logan Together, which aims to have kids on track by age 8, and the Geelong Project, which is focussed on homeless youth, are based on the principles of 'prevention science' and 'collective impact'. Services are aligned and coordinated and those 'at risk' are identified and supported. These approaches are likely to succeed. The Geelong Project, which has strong school partnerships, has reduced the incidence of homeless youth by 50% over the last eight years.

But moreover we believe the 'new generation' teacher is a key and schools can be the hub for cross sectorial approaches. Schools are well placed to be our most effective public health intervention system. To be effective, the teacher has a key role in identification and coordination of services. The OECD, in **one** of its future scenarios for schooling, suggested **Schools as core social centres.** In this scenario, the walls around schools come down, sharing responsibilities with other community bodies. There is high public support for schools ensures quality environments, and teachers enjoy high esteem.

Collaborative problem solving is one of the 21st century skills that is being emphasised in today's education. We need some collaborative problem solving now to address the challenges that face health and education.

It is time to remove the silos that separate health, education, social and other services.



Thank you for your attention and the opportunity to present the education perspective on mental health issues.

Speaker Bios:

Field Rickards concluded 13 years as Dean of Education in August 2017. He academic background is in audiology, deaf education and teacher education. As Dean, he guided the transformation of the Faculty of Education to a Graduate School and has reformed the professional training of teachers through the new clinical Master of Teaching program which develops graduates with the capabilities to meet the needs of individual learners and recognises teaching as a true clinical practice profession.

Lisa McKay-Brown is program coordinator of the Master of Learning Intervention. Prior to this, Lisa was a leading teacher at Travancore School, a mental health focussed special education setting. Lisa has over 25 years' experience working in education, including primary, secondary and special education settings. Her current research includes wraparound interventions for re-engaging severe school refusers and including the voice of students with mental health diagnoses in their education.

Peggy Kern is Associate Professor at the Centre for Positive Psychology. Her research examines questions around who thrives in life and why, including: (a) understanding and measuring healthy functioning, (b) identifying individual and social factors impacting life trajectories, and (c) systems informed approaches to wellbeing.