Report

A Comprehensive Student Support Program in Mental Health

برنامج دعم طلابي شامل للصحة النفسية

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Abstract

In response to an identified need to improve the emotional resilience of children in Palestine, the Palestinian Medical Education Initiative (PMED) developed a comprehensive program to support student mental health that was delivered at a private school in East Jerusalem in 2015-2016. This report describes the structure and function of the comprehensive program, in which training was provided for all school staff and for parents in a series of meetings and workshops, in addition to the establishment of a permanent school-based Taskforce, led by the trainer, consisting of two teachers, the principal, and the guidance counselor. The report also outlines the processes of outcomes measurement and evaluation of this program.

The aim of the Taskforce was to develop school-wide programming supporting student resilience and to make specific plans to address individual students who had been identified with behavioral or learning problems. The success of this pilot program demonstrates the effectiveness of the training/Taskforce model and suggests that future policy planning and research in Palestine consider adopting similar comprehensive student support programs.

Key Words: Palestine, students, schools, mental health, school-based, teachers, principals, guidance counselors, resilience, training, psychotherapy

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الملخص

استجابةً للاحتياجات المطروحة لدينا لتحسين الصلابة النفسية لدى الأطفال في فلسطين، طوّرت المبادرة التعليمية الطبية الفلسطينية (PMED) برنامجاً شاملاً لدعم الطالب صحياً ونفسياً في المدارس الخاصة في القدس في العام الأكاديمي ٢٠١٦/٢٠١٥. يصف هذا التقرير أساسيات البرنامج الشامل وبنوده كما جرى عقده والذي تم به طرح التدريب لجميع العاملين في المدرسة وأهالي الطلاب من خلال سلسلة من التدريبات وورشات العمل، بالإضافة إلى تأسيس لجنة في كل مدرسة مكونة من معلمين اثنين والمدير ومرشد المدرسة والمدرّبة نفسها. كما ويوضح التقرير طريقة تقييم المشروع وقياس نتائجه.

نتج عن هذه التدريبات تواصل حوار بين المعلمين وأعضاء اللجنة من خلال الاجتماعات الأسبوعية التي كانت تعقد بانتظام، وكان الهدف من ذلك هو تطوير البرنامج الداعم للصلابة النفسية لدى الطالب واعداد خطط خاصة تهتم بالأطفال الذين يعانون من مشكلات تعليمية وسلوكية فقط. ويؤكد نجاح المرحلة التجريبية للبرنامج نجاعة وأهمية نموذج التدريب المقترح ويوصي التقرير بضرورة وضع خطة وتبني سياسة مستقبلية وإجراء أبحاث في فلسطين عبر تبني برامج شاملة لدعم الطالب.

الكلمات المفتاحية: فلسطين، مدارس، الصحة النفسية، مدراء، مرشدون، معلمون، الصلابة النفسية، تدريب، العلاج النفسي.

لا تعبر الأفكار الواردة في المخطوطة عن أفكار هيئة تحرير المجلة أو عمادة البحث العلمي في جامعة بيت لحم. يعتبر المؤلف المسؤول الوحيد عن مضمون المخطوطة أو أية أخطاء فيها.

Introduction

The longstanding occupation of the West Bank, East Jerusalem, and Gaza has been the cause of immeasurable human suffering for the entire Palestinian community, but the impact of the occupation on children and adolescents has long been a matter of particularly grave concern. The developmental needs of children and youth for safety, continuity of family relationships, and hope for the future make this population particularly vulnerable to the widespread trauma that characterizes the Palestinian people under occupation.

Although the literature on child mental health in Palestine is not yet fully developed, improving the mental health of children everywhere else has received considerable attention; child mental health been put forward as a key element of a global public health agenda (World Health Organization, 2013). Recently, school-based mental health initiatives have come into focus as effective platforms for interventions targeting entire communities of children experiencing chronic stress and/or identifying at-risk or symptomatic individual children within these communities, especially in low and middle-income countries (Fazel, Patel, Thomas, & Tol, 2014). National non-governmental organizations and international organizations have frequently located their mental health interventions in schools, with 62% of national non-governmental and 86% of international organizations choosing school-based programs in 2012 as mental health interventions for children (World Health Organization, 2012).

Some of these school-based programs focus on resilience and positive development with the aim of building psychological health in general ways; whereas others emphasize awareness of mental health issues as a strategy for universal prevention, selective interventions for at-risk subpopulations, and indicated interventions for children with identified mental health problems (Fazel et al., 2014; O'Connell, Boat, & Warner, 2009). While assessment of school-based programs has been problematic, some programs have seemed promising; a 2015 study indicated that the largest school-based mental health program in the world, located in Chile, generated significant positive results (Guzman et al., 2015; Polanczyk, 2015).

Problem Statement

In a community context of limited resources, the challenge of supporting mental health for children and youth is pressing; there is a need to develop models of service delivery which do the most good in the most cost-effective manner possible.

Significance of the study: This paper reports on a school-based clinical program designed and carried out by clinicians, which represents—to our knowledge—a uniquely comprehensive approach.

Present Study

The school-based program supporting student mental health focused on three interrelated populations. The first is the entire school staff including administrators, principals, guidance counselors, and teachers. The second is the parents of all students enrolled in the school. The third is the group of students themselves. By means of the “training the trainer” model, the school staff and the parents were encouraged through training programs to engage with students in ways supportive of their emotional well-being. The trainings were evaluated through quantitative and qualitative outcome measurements. In addition, students with identified individual problems were managed through the development of a permanent Taskforce of school staff led by the trainer. The outcomes of these particular students were tracked over time through quantitative observations by the Taskforce. Our report here includes analysis of these measurements.

Conceptual/ Theoretical Context

In the absence of clear public health data reflecting needs assessment in Palestine, the authors have relied here on their practical experience as a team responding to local needs in the occupied territory. Our theories reflect the professional domains of the authors—as physicians, psychiatrists, psychotherapists, and teachers—as well as the current theories and concepts underlying each of these disciplines.

Research Methodology and Procedures

The one-year pilot program was carried out in East Jerusalem during 2015-2016 through a partnership between a private school and the Palestinian Medical Education Initiative (PMED), an international non-governmental organization based in the United States and Ramallah. The program was delivered by a PMED team of clinicians: One of us (S.A.), a psychotherapist

and trainer based in East Jerusalem and the PMED Palestine Program Director, was responsible for implementing all aspects of the year-long program at the schools; another (E.B), a child psychiatrist based in New York and the PMED US Medical Director, provided weekly supervision and consultation through Skype. Other PMED staff provided valuable consultation regarding various aspects of the program.

The partner institution, i.e. the private independent school in East Jerusalem, is composed of three semi-autonomous branches, each with its own principal and teaching staff. One branch serves 170 kindergarten students, both girls and boys. Another branch serves 150 boys in grades 4 through 8. A third branch serves 460 students in grades 1 through 8; at the third branch, the students in grades 1-3 are girls and boys and the students in grades 4 through 8 are girls. There are 780 students enrolled altogether.

In the spring of the school year preceding program implementation, the PMED trainer met several times with the administrative leadership of the schools (i.e. the principals and the chair of the schools' board of directors) to share perspectives on needs and program logistics. The school administrators expressed great eagerness to receive help for students with mental health issues—one principal estimated that more than one quarter of the students had been referred to the school guidance counselor the previous year and that no family had followed up on referral to professionals outside the school. The planning sessions generated a detailed list of the kinds of concerns that the schools wanted the program to address—for example, skills for counselors to improve school morale and classroom discipline, skills for teachers/guidance counselors to recognize and to manage students presenting learning problems and emotional/ behavioral issues, and skills for the school to work more effectively with parents. The planning sessions also provided an opportunity for the trainer to clarify what would be needed from the school in order for the program to be successful, such as the availability of teachers to participate in various aspects of the program and the substantial amount of time overall that would be needed to be dedicated to the program by school staff. Emerging from these discussions, the three structured components of the program were designed.

The Training for School Staff: The first component of the program was an intensive training in student mental health for all school staff members including teachers, guidance counselors, and principals (forty-two staff members in all). The initial staff training was held at the schools in August before classes began, in a format that divided the participants into two groups and delivered the six-hour training to each group separately over five days. The participants were

divided into two groups and the six-hour training was delivered separately to each group over five days. The curriculum involved an overview of common mental disorders found in children and young adolescents and their symptoms, including Learning Disorders, Attention Deficit/Hyperactivity Disorder (ADHD), Conduct Disorder, and Oppositional Defiant Disorder. The curriculum also presented an overview of common classroom problems such as poor academic performance, disruptiveness, and failure to follow directions as well as common school-wide issues such as bullying and demoralization due to the occupation. The trainer then provided specific skills to respond to these various challenges in the classroom, in the school overall, in communication with families, and in referrals to the school guidance counselor or professionals in the community. A lecture format was integrated with case examples, role-playing, and question-and-answer exchanges with participants.

The school staff responded to the initial staff training in August with tremendous enthusiasm and a host of specific questions and concerns. The school administration requested additional staff training and workshops which were delivered later throughout the school year.

Core themes throughout the school staff training included the effectiveness of positive feedback rather than punishment in dealing with students and the value of actively fostering a culture within the school community based on empathy, cooperation, and mutual respect.

The Training for Parents: The second component of the program was an intensive training in student mental health for parents. The principal of each of the three branches of the school invited all parents to attend and specifically reached out individually to the parents of children with special difficulties, stressing the importance of their attendance. The initial eight-hour parent training was held in December 2015 over four days, and delivered to approximately forty parents each day. All of the attendees of the parent training were mothers.

The training program curriculum involved an introduction to various common diagnoses in childhood, problems that children might present in their academic performance, and the potential role of psychological factors in these problems. Specific parenting skills and relaxation techniques were taught. Psychoeducation was offered to reduce stigma and to help parents view student difficulties as problems that can be solved through ongoing communication and planning with teachers, guidance counselors, and/or mental health professionals. The parent training emphasized the overall themes of positive feedback and empathy between parents and their children. The parents engaged in a lively exchange of question-and-answer. The school requested additional training for parents at a later date

with a plan to include a larger proportion of the schools' families, as well as to schedule a parent training in the evening to allow fathers to attend.

The Development of Taskforce Teams: The third component of the program was the creation within each of the school's three branches of a separate and permanent Student Support Taskforce Team consisting of two teachers, the school principal, and the school guidance counselor. Led by the PMED trainer, each Taskforce team met for two hours every week throughout the school year with the long-term goal that the Taskforce would be capable of functioning independently of the trainer in subsequent years.

The mission of each Taskforce was two-fold: to enhance psychological resilience among all students on a school-wide basis and to address specific emotional/behavioral or learning problems posed by individual students. To function in this problem-solving role for the entire school branch, each Taskforce established a communication network with all of the teachers within that branch. Each member of the Taskforce was assigned to a small group of teachers and met weekly with that group, so that every teacher within the school had a formal relationship with a designated Taskforce member. A pyramid of communications focusing on emotional well-being was thus put into place that captured the input from students, teachers, and Taskforce members with responsive feedback and communication in both directions.

Early in the school year, the Taskforces developed and implemented a daily Fifteen Minute Activity for the entire school which was scheduled to take place early in the morning after the students arrived, replacing a period of time ordinarily filled by unstructured activity on the school yard. Each week, the teachers and the Taskforce members would decide upon the theme of the Fifteen Minute Activity; some of these themes, for example, reflected the question of how the students felt about their relationships with various family members, with teachers, or with peers, or what students wanted their classrooms to be like. Each student would write a response and the responses would be collected by the teacher, who might take action within the individual classroom or communicate salient themes to the Taskforce. These activities resulted in tangible results—for example, certain classrooms developed standards and rules for classroom clean-up, with students taking on more responsibility for their own environment than previously.

Through this communication network, the teachers and the Taskforce members became aware of significant issues within the lives of students that could be addressed by classroom discussion as well as through special workshops for parents and for teachers. Students were

asked, for example, to write down answers to the question, "How do I feel when someone yells at me, calls me names, or hits me?" or "How do I feel about bullying at this school?" The students' responses then formed the basis for classroom discussions. Responding to the issue of bullying among students, one Taskforce called for a special workshop on bullying for school-wide staff, a plan which was implemented. Similarly, another Taskforce asked for a special parent workshop focusing on the benefits of communication over corporal punishment, a plan which was likewise carried out. There was a special seven-day school-wide activity for students on empathy, bullying, and healthy ways to promote conflict-resolution.

A pressing issue with profound impact on student well-being was the escalating political/military violence relative to the occupation that emerged in October 2015 in the East Jerusalem vicinity. The students were observed to be both anxious and sometimes recklessly agitated by these violent events and also to seem to feel demoralized and hopeless in reaction to them.

Specific crisis-intervention programs were initiated for the whole school in response to the violence experienced by the community, such as relaxation and deep-breathing exercises. An art project helped students express their emotions regarding the crisis. Children took part in an activity involving balloons attached to their legs, after the children had written onto the balloons various names or images symbolizing things they disliked. They then ran around a room bumping into one another and bursting the balloons. This activity seemed to release aggressive impulses in a harmless way and to dramatically raise their spirits. The school reached out to parents through its Facebook page, encouraging parents to prepare special foods or to engage their children in special activities during these difficult days. Parents through Facebook postings and school staff both reported that these measures were very effective in improving demoralization among the students through defusing emotion in symbolic play and restoring a sense of cohesion within the school.

In addition to the mission to address resilience within the student body overall, each Taskforce took on a pivotal role in meeting the needs of individual students who presented learning problems, behavioral issues, or emotional difficulties in each of the schools' three branches. In preparation for this undertaking, the entire school staff was trained to maintain strict confidentiality in all communications and in record-keeping regarding any individual student.

The communication network and weekly meetings between teachers and their assigned Taskforce members became the mechanism by which students who posed special problems were referred to the Taskforce. Many of these students who had been recognized by the

school for a considerable length of time as demonstrating academic, behavioral, peer-related, or emotional difficulties that had not been adequately resolved through previous staff efforts. The problems of other students now being referred to the Taskforce had previously escaped notice; the school staff training had enhanced the teachers' skills in identifying troubled children. The Fifteen Minute Activity and other Taskforce projects had proven themselves to be sensitive instruments to alert teachers to youngsters needing attention: for example, a child might pass in a paper saying, "I hate my father" during a writing exercise focused on family relationships or draw a picture illustrating a disturbingly morbid theme.

Each student referred to the Taskforce was entered onto a list for use by the Taskforce and the date and severity of the student's problem rated on a one-to-ten score. The Taskforce would then elicit information regarding the referred student, discuss the situation, and develop a plan which would be communicated to the child's teacher. Sometimes the plan would be quite simple—for the class to focus on a student who appeared to have low self-esteem, for example, creating a list of all the likeable things that the classmates observed about that student and vowing to take a friendly, encouraging role towards him or her. These very simple measures often had remarkable impact on unhappy youngsters and sometimes led to impressive sustained improvements in their observed mood.

For other students, the Taskforce plan might involve referring the student to the guidance counselor for a certain number of individual sessions or inviting the parents to school for a discussion. As to be expected in any community setting which involves a large number of families (the total number of students at the school was 780), there were some students involved in difficult situations at home impacting their mental health; for these troubled families, the appropriate interventions were implemented by the Taskforce members, with close follow-up.

Some students were referred to a mental health professional outside of the school—usually a psychiatrist. These were often students whom the Taskforce judged as needing a formal evaluation to establish a diagnosis (e.g. ADHD or Autism Spectrum Disorder), students who already had been taking a psychotropic medication that the Taskforce felt might benefit from an updated adjustment, or students who had not improved with the in-school plan.

The written system allowed the Taskforce to address in an organized and systematic manner each of the students who had been referred. The system also involved tracking over time each student's progress or lack of progress, measured on a one-to-ten scale. The Taskforce's

ongoing plan for the student was then modified whenever a student was assessed as not having improved.

Results

All quantitative measurement instruments such as questionnaires were developed in Arabic by PMED and are available upon request. These data were not subject to formal statistical analysis because the numbers were quite small (e.g. quantified measure of outcomes regarding approximately 40 school staff members and 40 parents); however, trends are reported here.

The school staff training was perceived by participants as very effective in teaching how to make referrals and effective in teaching how to design targeted interventions for problematic student issues. Technical knowledge about specific mental disorders demonstrated a trend toward improvement following the staff training. The core training message—that praise and encouragement of students is more effective than punishment—was successfully taught. The training was evaluated by 100% of the participants as either “good” or “very good;” the school administration requested additional training and workshops.

The parent training was perceived by participants as very valuable; quantitative measures indicated a high level of enthusiasm, appreciation, and practical benefit claimed by parents who attended the training sessions. A large majority of the participants called for additional training. School guidance counselors noted that after the parent training, parents spontaneously began to telephone the school requesting appointments to discuss concerns about their children—a new behavior for parents.

The three Taskforce Teams were referred 54 students altogether during a reporting period of four months. Of these, teacher ratings of problem severity tracked over time were available for 33 students—with the ratings of 24 (73%) of these students demonstrating improvement. Of the total number of students referred to the Taskforces, thirteen students were referred to psychiatrists. Initially, no family followed up on referrals; on repeated encouragement by the school, eight families eventually followed through, demonstrating that the programs had helped the Taskforce members to become substantially more skillful in communicating with parents.

In sum, the data indicate that making a specific plan for all problematic students and tracking the outcomes of these interventions is an effective strategy for reducing the severity of the

problem for the majority of students referred to the Taskforce. Despite great improvement in the rates of successful referral to psychiatrists following parent and school staff training, there was still resistance to follow-up on this recommendation, indicating that stigma surrounding obtaining mental health services remains a problem for many families.

Discussion

Improving student mental health in Palestine faces two serious obstacles: the ongoing damage imposed on the community by the occupation and a tradition of stigma against mental disorders already present within the community (Jabr, Morse, Awidi, & Berger, 2014). These obstacles together contribute to an atmosphere in which student problems—whether everyday problems or symptoms of mental health disorders—are often met by their parents, their teachers, and their peers with a degree of impatience and criticism. To improve student resilience and mental health, this project undertook the mission of constructive culture change within a school through an intensive year-long program of training for parents and staff and the establishment of a leadership Taskforce within each school branch.

Training of parents and teachers was seen as laying essential groundwork for culture change. The project made the assumption that student resilience is mediated by two psychological factors: self-esteem and robust relationships with others—and that interaction with adults that raise student self-esteem and support meaningful relationships will thereby enhance resilience. The specific skills and lessons for parents and teachers within the training were thus designed to shift the emphasis from punishment to praise and to foster a commitment to understanding the other person's point of view—two necessary steps towards constructive conflict resolution and enhanced morale.

Establishing the Taskforce team as a pivotal structure for mental health in the school was the most fundamental and innovative element of the program, insofar as the Taskforce played a key leadership role with regard to culture change within the school overall. The Taskforce network of communication with all teachers created a forum by which both school-wide problems such as bullying and individual problems indicating student distress could be brought to the Taskforce in a systematic way and addressed with specific plans which were monitored for outcomes. The Taskforce was thus able to redefine mental health in new terms through a positive message about healthy human relationships. The importance of self-respect and respect for others were put forward as everyone's issues, in which everyone participates and everyone bears responsibility. These intangibles were made concrete for

students through specific activities focused on helpfulness to others and active involvement in addressing collective challenges.

The training model was viewed as very valuable by parents and teachers—particularly the element of sustained intensive supervision of Taskforce members; the students overall were observed to seem happier and the students with identified problems who did not improve through school-based interventions were increasingly referred successfully to professionals in the community. Limitations of this program were its small sample size and perhaps a degree of dependence upon the personal qualities of an individual PMED trainer.

Recommendations

We encourage replication of this model elsewhere with the application of more rigorous research standards. At the same time, the success of this program leads us to urge the scaling-up of this school-based student support program and the integration of its training model within educational and mental health program and policy planning in Palestine.

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References

- Fazel M., Patel V., Thomas S., & Tol W. (2014). Mental health interventions in schools in low-income and middle-income countries. *Lancet Psychiatry*, 1, 388-98.
- Guzman, J., Kessler, R. C., Squicciarini, A. M., George, M., Baer, L., & Canenguez, K. M. (Oct. 2015). Evidence for the effectiveness of a national school-based mental health program in Chile. *Journal of the American Academy of Child and Adolescent Psychiatry*, 54(10), 799-807.
- Jabr S, Morse M, Awidi B, & Berger E. (Spring 2014). Mental health care in Palestine: barriers to excellence. *Washington Psychiatrist*, 13-18.
- O'Connell M.E., Boat T., & Warner K.E., eds. (2009). National Research Council (Washington, D.C.) and Institute of Medicine (Washington D.C.) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. Preventing mental, emotional, and behavioral disorders among young people: progress and possibilities. Washington DC: National Academies Press.

Polanczyk, G.V. (Oct 2015). Addressing the evidence gap on preventive interventions. *Journal of the American Academy of Child and Adolescent Psychiatry*, 54(10), 793-794.

World Health Organization. (2012). Adolescent mental health: mapping actions of nongovernmental organizations and other international development organizations. Geneva: World Health Organization.

World Health Organization. (2013). Mental Health Action Plan 2013-2020. Geneva: World Health Organization.