Chapter 26

A Special School Community: An Inclusive Setting For Addressing The Mental Health Needs Of Students With An Intellectual Disability

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Introduction

A collaborative framework that includes education, health, disability, and other service areas is critical for mental health promotion and prevention, and early intervention for students with an intellectual disability. Most students attend primary and secondary school for a cumulative total of approximately 15 000 hours and public funding for education is the greatest financial investment that a society makes in terms of the future potential and wellbeing of children (Rutter, Maughan, Mortimore, Ouston & Smith, 1980). Research suggests that almost half (40.7%) the number of children and adolescents with an intellectual disability will experience mental health problems and disorders (Einfeld & Tonge, 1996b). This constitutes 14% of the mental health burden for children and adolescents in our society (Emerson & Hatton, 2007). Special purpose schools provide a unique opportunity for collaboration between education, health, and disability professionals to ensure that students with an intellectual disability meet their full potential. Schools are a vital setting to promote mental health and well being for students. Students with an intellectual disability however, are often not well catered for. This chapter will focus on schools as mental health settings and the importance of prevention, promotion, and early intervention programs to address mental health problems and disorders for students with an intellectual disability.

Schools As Mental Health Settings

In today's society, schools have an essential role to play in mental health promotion which can promote positive mental health outcomes of students and in turn their school performance. Students' behaviour and attitudes are influenced by their experiences at school and by the characteristics of the school itself (Rutter et al., 1980). Research

suggests that the school has an important impact on students' development with a strong indication that the positive social features of a school afford success (Rutter et al., 1980).

As schools have such an influence on students, they are in a special position to intervene to promote the mental health and wellbeing of children and adolescents. Hendren, Birrell, Weisen and Orley (1994) reported that the World Health Organization (WHO) had identified that schools were the best place to universally promote mental health as almost all children and adolescents attend school. They described schools as strong social bodies that can be safety nets for protecting a child or adolescent's psychological wellbeing but can build or undermine a student's capacity and self esteem (Hendren et al., 1994). Similarly, findings from the National Survey of Mental Health in Australia discussed how access to schools provided the opportunity to target large numbers of students with various interventions. This is especially important as many mental health problems emerge during the school years (Sawyer et al., 2001). Although there is substantial evidence to suggest that mental health promotion, prevention, and early intervention is likely to have some effect on students in general, there is little research on such interventions and their affects in special schools that cater for students with an intellectual disability.

Mental Health Promotion, Prevention, And Early Intervention Programs For Students With An Intellectual Disability

Mental health promotion, prevention, and early intervention programs are imperative for students with an intellectual disability for three main reasons. Firstly, successful interventions may lead to a reduction in the incidence of new cases of mental health

problems and disorders for students with an intellectual disability. Secondly, successful interventions may lead to a reduction in prevalence rates i.e., the number of students with intellectual disability presenting with mental health problems and disorders at any point in time. Finally, early intervention may reduce the social and financial burden of mental health as, if it is left untreated during childhood or adolescence, mental health problems and disorders can become acute in early adulthood and may develop into serious and chronic psychiatric disorders (Hurley, 1996).

Approximately 70% of all secondary schools in Australia currently utilise MindMatters, a whole school mental health promotion, prevention, and early intervention program (Rowling, 2007). Unfortunately, there are a lack of resources that are suitable for use with students with an intellectual disability. This is reflected by a much lower utilisation rate (less than 10%) of similar programs by specific schools that cater for students with intellectual disability (Dossetor, Caruana, Goltzoff & Saleh, 2009).

A recent literature review by Dossetor et al. (2009) highlighted the paucity of mental health promotion, prevention, and early intervention programs available to schools for specific purposes that cater for students with an intellectual disability. They examined over 103 programs or resources recommended by two national whole school mental health promotion programs that were aimed at general primary (KidsMatter Primary; Commonwealth Department of Health and Ageing, CDHA, n.d.) and secondary schools (MindMatters, CDHA, n.d). Only ten programs were identified as being suitable for students with special needs and only five of these programs were for students with a mild intellectual disability. These programs included: Stop Think Do,

Triple P Stepping Stones, PATHS, Social Decision Making/ Social Problem Making Program, Alert Program™, and will be discussed later in this chapter.

The KidsMatter (CDHA, n.d) program is a whole school mental health promotion and prevention program, aimed at primary school students. This program has recently undergone a two year trial and evaluation. The program contains four dimensions of intervention, i) a positive school community; ii) social and emotional learning for students; iii) parenting support and education; and iv) early intervention for students experiencing mental health difficulties. These four areas provide an excellent framework and supportive structure for mental health promotion in schools.

The final evaluation of the two year trial reported that the KidsMatter program reduced mental health difficulties and increased mental health strengths, particularly for those students who displayed higher levels of mental health difficulties at the start of the program (Slee et al., 2009). However results were not reported by specific school or for students with an intellectual disability. The four components of the mental health framework utilised by KidsMatter will be further explored in relation to special schools that cater for students with an intellectual disability and the role of interagency collaboration in this process.

A Positive School Community

Various protective factors have been identified as influencing the development of mental health problems and disorders in children (see Table 26.1). The majority of mental health promotion, prevention, and early intervention programs attempt to address the various individual, family, school, and community related protective factors. Schools are a vital element in any broad based mental health promotion strategy. It is

crucial that programs and materials are available for teachers in special schools to enable them to develop and enhance protective factors of students regardless of their level of intellectual disability.

[Insert Table 26.1 here]

Positive Behaviour For Learning

In Australia, Positive Behaviour for Learning (PBL) is derived from the Positive Behaviour Interventions and Supports (PBIS TA Center, n.d.) program developed in the United States (Mooney, Dobia, Barker et al., 2008; Mooney, Dobia, Yeung et al., 2008). There are four main elements to PBIS and these are, i) supporting student behaviour; ii) supporting staff behaviour; iii) supporting decision making; and iv) supporting social confidence and academic achievement. These elements are underpinned by behavioural science, practical interventions, lifestyle outcomes, and systems perspective (PBIS TA Center, n.d.; Sugai et al., 2000).

More generally, PBIS are used to attain socially significant behaviour change (Sugai et al, 2000). For example, a study by Hetzroni (2003) focused on the effect of communication techniques on behaviour in a special school where the majority of the 67 students had a moderate intellectual disability. The study concluded that while the student's communication abilities increased, the behaviour problems (e.g., hitting, biting) decreased. Additionally, a meta-analysis of interventions for challenging behaviours by Harvey, Boer, Meyer, and Evans (2009), highlighted the effectiveness of PBIS. They found that behavioural treatments reduced challenging behaviours in children and youth with developmental disabilities. They noted that interventions that

changed whole systems (i.e., schools) were mostly used in combination with other interventions and should not be evaluated on their own. Harvey et al. (2009) also reported that in combination with other intervention types, systems change was moderately effective with self injurious and aggressive behaviour and highly effective with inappropriate social and destructive behaviour.

PBL is an emerging whole school intervention that supports building a positive school community, addresses numerous protective factors in the school context, and has been linked to improved behaviour outcomes. Internationally, schools are utilising a positive behaviour framework to create a supportive school environment to improve academic and behaviour outcomes for students. A critical component of PBL, especially for students with complex needs, is the active involvement and training of the whole school community in developing and implementing strategies. Behaviour management is planned collaboratively with parents and other agencies where possible, explicitly taught, and reviewed regularly. Core values and agreed behaviours are also made explicit by using a common language within the school community and augmentative and alternative communication strategies (e.g. pictures, symbols).

A practical example of PBL in an Australian context is at a special school in South Western Sydney for students with an intellectual disability where the school rules, *We Learn, We are Safe, We Care* have been implemented. This whole school system has included strategies for defining, teaching, and supporting appropriate behaviours and creating positive school environments. Following PBL implementation at the beginning of 2008 (Term 1), data on specific problem behaviours (e.g., kicking, spitting, throwing objects) were collected over approximately eighteen months (until Term 3, 2009). Analyses of the data indicated that problem behaviours significantly

declined over this period, for example, throwing objects declined by 80%, spitting and kicking declined by 75%, and hair pulling declined by 72% (Fleming, 2010). In addition, there was a significant increase in staff using PBL materials in noticing and rewarding appropriate student behaviours.

Social And Emotional Learning For Students

In recent years, schools have recognised that many students with an intellectual disability, while learning to express their wants and needs, still struggle to recognise and express their emotional states. Increasing independence for students with an intellectual disability can significantly improve both their ability to reach their potential and quality of life. One key component of developing independence is self regulation of behaviour.

Teachers in some special schools have begun incorporating elements of emotional self regulation into lessons, initially as part of Positive Behaviour and Learning programs. Currently these lessons may include use of photos, symbols, signs to help students learn to recognise, and express feelings appropriately, pair feelings with appropriate behaviours; and pair feelings with behavioural choices. The use of computer programs such as *The Transporters* (Golan et al., 2006) developed in the UK, and other resources such as *Mind Reading* (University of Cambridge, 2002, an interactive CD-ROM), resources initially developed to assist students with ASD, are being utilised.

In addition, the review conducted by Dossetor et al. (2009) identified five programs that had empirical evidence for effectiveness in schools and were suitable for students with an intellectual disability for addressing their social and emotional learning needs. Four of these programs are described below with the addition of a description of a new program developed by The Children's Hospital at Westmead.

Stop, Think, Do Social Skills Training Program

The *Stop, Think, Do* program (Petersen, 2002, 2004; Petersen & Adderley, 2002) is an Australian program that focuses on problem solving and resolving conflicts. This program is implemented in groups and Beck and Horne (1992) reported on its effectiveness in a special school, catering primarily for secondary students with mild to moderate intellectual disability and emotional-social problems. Specific applications for this program include anxiety, ADHD and Aspergers Syndrome. A parent program is also available.

Promoting Alternative Thinking Strategies (PATHS)

The *PATHS* program (Greenberg & Kusche, 1998) developed in the United States consists of classroom lessons that teaches primary school children how to change behaviours and attitudes that contribute to violence and bullying, how to express and control their emotions, and how to develop effective conflict-resolution strategies. This program has been shown to be effective with a number of special groups including deaf and hearing-impaired students, behaviour disordered, learning disabled, and gifted students, as well as students from a wide diversity of ethnic, cultural, socio-economic, and family backgrounds (Kam, Greenberg & Kusché, 2004).

Social Decision Making/Social Problem Solving Program

The *Social Decision Making/Social Problem Solving* program (Elias & Bruene Butler, 2005) was developed in the United States and consists of a series of classroom lessons. The program is designed to help children recognise and use their emotions in effectively

solving problems in a wide range of real-life situations inside and outside the classroom. The program focuses on teaching self-control and social awareness skills as important tools for decision-making (Elias, 2004).

Alert Program™ For Self-regulation

The *Alert Program*™ (Williams & Shellenberger, 1996) was developed in the United States. It promotes awareness of how to regulate arousal states and encourages the use of sensorimotor strategies to manage levels of alertness. The program targets students with sensory processing and/or learning impairments and can be implemented with individual students or in groups.

Emotion Based Social Skills Training (EBSST)

A more recent program, EBSST (Ratcliffe, Grahame, & Wong, 2010), is a skill building curriculum for students with Autism Spectrum Disorders (ASD) and a mild intellectual disability. It aims to teach emotional recognition, theory of mind, and problem solving and therefore skills in relationships. This new program is being implemented in partnership with the Department of Education and Training as a school based intervention in primary schools in NSW in 2010.

Parenting Support And Education

In special school settings, schools successfully collaborate with parents and carers for a variety of matters. At a special school in South Western Sydney for example, such collaboration ranges from sharing information through visual home to school diaries and communication books, to the collaborative development of learning and

behavioural programs, and as needed, collaboration across family, school, and other services. Seminars and workshops are often run collaboratively with disability services and other non-government agencies on topics such as communication, managing behaviour, healthy activities to do with your child, and accessing support services. This valued strategy needs to be expanded and utilised with mental health programs to ensure that the family based protective factors for positive mental health are developed (see Table 26.1).

A Cochrane review by Diggle and McConachie (2002) found that there was some evidence that supported the benefits of parent training with children with ASD and their parents. Schools may be the best place to promote parent training as part of building their alliance with parents and promoting community integration. One mental health promotion program, specifically for students with an intellectual disability and their parents is the Standard Stepping Stones Triple P program (Sanders, Mazzucchelli, & Studman, 2003). This parenting program can be implemented for individual children with intellectual disability by an accredited practitioner within a school environment. Alternatively, there is Group Triple P or Group Teen Triple P (Triple P International, n.d.) that are group based parent training that could be run within school, however these are not specific to children with intellectual disability.

The *Triple P – Positive Parenting Program*® 'draws on social learning, cognitive-behavioural and developmental theory, as well as research into risk and protective factors associated with the development of social and behavioural problems in children' (Triple P International, n.d.; The Triple P System section, ¶ 1). The Standard Stepping Stones program has been adapted for parents of children and adolescents who have a disability. The approach has been demonstrated to be effective

for children with intellectual and physical disabilities who have disruptive behaviour (Roberts, Mazzucchelli, Studman & Sanders, 2006).

Early Intervention For Students Experiencing Mental Health Difficulties

Early intervention programs target students who display early signs and symptoms of mental health problems and disorders. Early intervention is essential, as a psychiatric disorder that is left untreated from childhood or when it first appears, tends to develop into a more serious disorder in adulthood (Hurley, 1996). Indeed it has been suggested that it is the failure of early detection and early intervention of mental health problems that leads to the long-term psychiatric morbidity and high costs particularly in out of home residential care. For students with an intellectual disability, the identification and screening of mental health problems and disorders is particularly difficult. This is due to communication limitations and diagnostic overshadowing whereby the symptoms of mental health are attributed to the student's intellectual disability and not a possible mental health problem or disorder.

Another major barrier to early mental health intervention for students with an intellectual disability is the capacity of professionals working with students to identify early symptoms of mental health problems or disorders. A study from the United Kingdom by Rose, Howley, Fergusson and Jament (2009) surveyed 48 schools to examine the mental health issues of young people with special needs. The study identified that school staff faced problems in identifying between the features of intellectual disability, challenging behaviour and mental health indicators as the boundaries were often unclear, and staff felt ill prepared in dealing with the mental health needs of this group. A major finding of this study was the need to provide

professional development on identification of mental health problems or disorders in students with learning disabilities (as intellectual disability is termed in the UK). School staff such as teachers, require this professional development as they are often the best placed to detect changes in mood or behaviour in students. In addition, the need to develop curriculum materials that address mental health and well-being issues for students with special needs was highlighted.

Professional development for school staff working with students with an intellectual disability who may have co-existing mental health problems and disorders needs to be inclusive of all school staff, not only the school psychologist or counsellor. Professional development also needs to be extended to others who work with or care for children and adolescents with an intellectual disability to ensure that the presenting problems are treated early and do not lead to more serious disorders that can impact on the quality of life of both child and carer.

Collaboration Between Professionals

A fundamental element of mental health prevention and promotion programs within a special school setting for students with an intellectual disability, is collaboration between professionals. A collaborative framework that includes education, health, disability, and other service areas is essential to ensuring effective prevention and treatment of mental health problems and disorders. Figure 26.1 outlines the array of staff that may be available to students with an intellectual disability in New South Wales (NSW) government schools and highlights the potential for interagency collaboration as numerous school and professional staff are recognised and valued as supports within an inclusive framework for students with disabilities.

[Insert Figure 26.1 here]

Professional Roles

It is important to understand the resources that are available within each school to maximise the effectiveness of collaboration. The core members of a support system for a student with a disability is identified as the parent/carer, principal, classroom and support teachers, and school counsellor (see Figure 26.1). The core members and various advisers to the left of the circle are located within the education system, whilst those advisers listed to the right are located outside education, for example, within the health and disability sectors. The roles of the professional involved in the collaborative process for students with intellectual disability are detailed below.

i) *Learning Support Teams* in schools address the learning needs of students. The team ensures that collaborative planning and programming occur by bringing together key personnel within the school community to address students' many needs (e.g., curriculum, communication, social skills, personal care, safety, mobility) (NSW Department of Education (DET), 1998).

ii) *School Counsellors* share the responsibility for student welfare. They are responsible for a variety of assessments, counselling, and working in consultation with other professionals (such as teachers, the school, its management and administrators, parents or caregivers and other agencies) to improve student learning and behaviour (NSW DET, 1998). In an Australian study, it was found that

students were more likely to access a school counselling service than any other mental health service provider (Sawyer et al., 2001). The provision of school counselling differs across government and non government sectors, however very few school counsellors would have a full time allocation to one school.

iii) The *School Principal* is a key link for interagency collaboration, especially in more specialised settings when a school counsellor's availability may be limited. The NSW Minister for Education and Training in a media statement about increased support for principals of specific purpose schools stated, 'They [school principals] have a unique responsibility to care for some of our most vulnerable children and the challenges they face. They need time to speak with parents and external agencies about each student's learning needs' (Firth, 2008). Furthermore, Rowling (2007) highlighted that the planning and delivery of mental health promotion and prevention approaches within schools require the critical support of the principal and the executive team.

iv) *Teachers* cater for the diverse range of individual learning needs in classrooms and are the best placed staff members within a school to detect changes in students' behaviours (Rose et al., 2009). However, in relation to mental health prevention and promotion activities within the classroom, Rowling (2007) argued that teachers need to be convinced of the link between the mental health of students and connectedness to school and academic performance.

Working with students with complex requires close collaboration across the whole school community, including parents and carers. Enhancing communication with parents allows consistency in strategies used in both the school and home. Without this collaboration outcomes for students will decline.

Although Figure 26.1 is helpful in conceptualising the array of supports available to students, it does not completely capture the considerable web of professionals available to students with an intellectual disability and mental health problems and disorders. Additional ‘advisers’ that can be added to create an even more inclusive framework include, but are not limited to, education officers, education specialists, family doctors, developmental paediatricians, paediatric neurologists, geneticist, psychiatrists, family therapists, clinical psychologists, speech pathologists, social workers and others etc. It is encouraged that these group of advisors are consulted and utilised in interagency collaboration for not only the management of a student with a recognised mental health problem or disorder but when developing or implementing promotion, prevention or early intervention programs.

Baruch (2001) noted that, as special schools usually cater for a smaller number of students, there is greater possibility than in mainstream schools for formal and informal contact between the school psychologist or counsellor and school staff, students and parents. Opportunities for collaboration therefore between external services and staff in the special school setting may also be greater. This may assist in the implementation of mental health promotion, prevention, and early intervention programs in this context for students with an intellectual disability and complex needs.

A Way Forward

There are a number of ways of focusing on the mental health of students with an intellectual disability in schools. Firstly, there is a clear need for education on the range of mental health problems that can be identified. Secondly, there is a need for systematic training in skills that enhance mental health including the recognition of multidisciplinary subspecialty skills. The need for clear cross agency pathways to collaboration also needs to be established. Lastly, more emphasis on mental health promotion, prevention, and early intervention is needed. Dossetor et al. (2009) indicated that there were some valuable approaches being developed that need further promotion and development. Programs that cater for the complex support needs of students with an intellectual disability in more specialised settings need further developing as the majority of programs outlined in this chapter are more suitable for students with a mild intellectual disability.

It has been identified that there are opportunities within the special school setting for external professionals to work collaboratively in improving the learning, support, and mental health needs of students with an intellectual disability. Professionals working with this client group need to identify opportunities at various local, regional, state and even national levels to collaborate with a variety of sectors to best cater for this population. Schools need to remain inclusive in their approach to supporting students and be recognised for their key role in the partnership with other professionals and agencies that share a responsibility of the optimal mental health in these young people.

A vital element in supporting students with an intellectual disability to realise their full potential, is the recognition of the important role of mental heath promotion and prevention strategies as outlined this chapter. Exciting opportunities exist for

interagency support and collaboration at the mental health preventative level. If an evidence base is developed for students with an intellectual disability attending special schools, these resources will have a much wider applicability and include students with an intellectual disability and complex mental health needs in mainstream as well as special school settings.

Table 26.1

Protective Factors Potentially Influencing The Development Of Mental Health Problems And Mental Disorders In Individuals

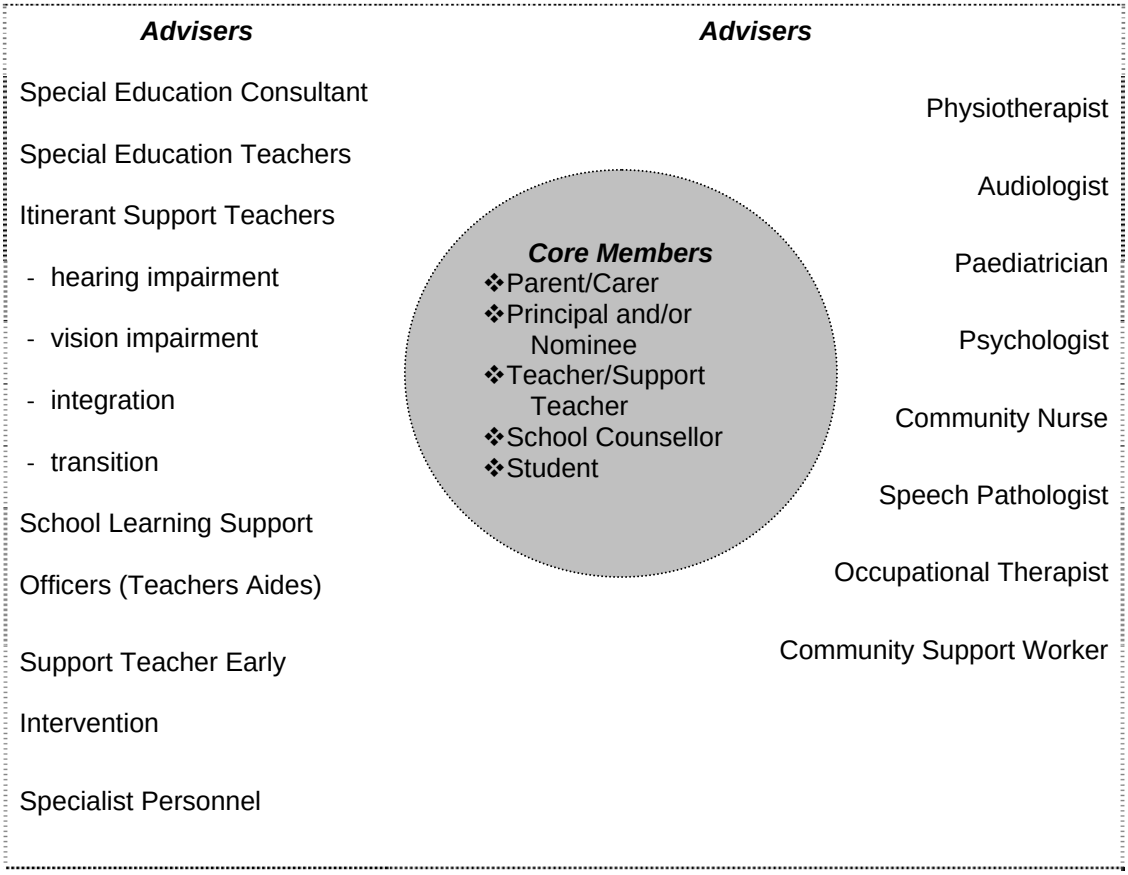
Individual Factors	Family Factors	School Context	Life Events And Situations	Community And Cultural Factors
▪ Easy temperament ▪ Adequate nutrition ▪ Attachment to family ▪ Above-average intelligence ▪ School achievement ▪ Problem solving skills ▪ Internal locus of control ▪ Social competence	▪ Supportive caring parents ▪ Family harmony ▪ Secure and stable family ▪ Small family size ▪ More than two years between siblings ▪ Responsibility within the family (for child or adult)	▪ Sense of belonging ▪ Positive school climate ▪ Prosocial peer group ▪ Required responsibility and helpfulness ▪ Opportunities for some success and recognition of achievement	▪ Involvement with significant other person (partner/mentor) ▪ Availability of opportunities at critical turning points or major life transitions ▪ Economic security ▪ Good physical health	▪ Sense of connectedness ▪ Attachment to and networks within the community ▪ Participation in church or other community group ▪ Strong cultural identity and ethnic pride

▪ Social skills ▪ Good coping style ▪ Optimism ▪ Moral beliefs ▪ Values ▪ Positive self related cognitions	▪ Supportive relationship with other adult (for a child or adult) ▪ Strong family norms and morality	▪ School norms against violence		▪ Access to support services ▪ Community/ cultural norms against violence

Source: Adapted from Commonwealth Department of Health and Aged Care (CDHAC, 2000).

Figure 26.1

Supports Available to Students with Disabilities in NSW Schools



Source: Adapted from NSW Department of Education (1998)