Embedding Mental Health Promotion Programs in School Contexts: The Aussie Optimism Program.

Clare Roberts
School of Psychology
Curtin University of Technology
Perth, Western Australia, Australia
E-mail: c.roberts@curtin.edu.au

Internalising problems such as depression and anxiety are the most common of childhood and adolescent mental health problems in Australia. Recent surveys of mental health problems in children and adolescents have found that 13% of 4-17 year olds show clinical levels of internalising problems (Sawyer et al., 2000), while 18% of adolescents report clinically significant levels of anxiety and/or depression (Prior, Sanson, Smart & Oberklaid, 1999). To reduce the prevalence and incidence of anxiety and depressive disorders developing in the adolescent years, targeted and universal school-based programs have been developed to promote the mental health of young Australians. In Western Australia a group called Promoting Optimism WA (POWA) was established in 1996 with the goal of reducing the prevalence of internalising problems and disorders through the implementation of school-based intervention programs. A collaboration between Curtin University's Schools of Psychology and Public Health, and the Western Australian Departments of Health and Education was heavily influenced by the Penn Optimism Program (POP), which had been shown to be effective in reducing depressive symptoms up to two years after intervention when run in small groups in schools with pre-adolescents targeted because of increased risk factors (Gillham, Reivich, Jaycox, & Seligman 1995). The POP was also associated with similar effects for low-income Latino American children (Cardemil et al., 2002) and Chinese children (Yu & Seligman, 2002).

An 8-session Australian adaptation of the POP was piloted with pre-adolescent girls in Western Australia and resulted in reductions in depression after the girls made their transition to high school (Quayle, Dziurawiec, Roberts, Kane & Ebsworthy, 2001). The full 12-session Penn Optimism Program was then implemented by school psychologists and nurses in rural communities, targeting pre-adolescents with elevated levels of depressive symptoms (Roberts, Kane, Thomson, Bishop, & Hart, 2003). The program was associated with reductions in anxiety up to three years after intervention, and reductions in anxiety mediated reductions in depressive symptoms at this three-year follow-up, but no direct effects were found for depression (Roberts, Kane, Bishop, Matthews, & Thomson, 2004).
To meet school requests for universal classroom implementation of mental health promotion programs, a new program based on similar theories and strategies was developed to suit Australian Primary Schools: the Aussie Optimism Program (Roberts, Kane, Bishop, Cross, & Fenton, 2004). This program is a mental health promotion strategy designed to prevent internalising problems in children and adolescents. The program is aimed at students aged 11-13 years who are preparing for transition to high school. It consists of twenty 1-hour weekly sessions conducted in school time, and can be implemented in the last two years of primary school, or the first year of high school. The program is based on cognitive-behavioural intervention procedures and has two components, the Optimistic Thinking Skills Program (Roberts, Roberts et al., 2002), which targets cognitive risk and protective factors for internalising problems, and the Social Life Skills Program (Roberts, Ballantyne, & van der Klift, 2002), which targets social risk and protective factors. The optimism component teaches children to identify and challenge negative thoughts about the self, current life circumstances, and the future that contribute to depressive and anxiety symptoms (Beck, Rush, Shaw & Emery, 1979; Kendall, 2000). In addition, attribution re-training (Seligman et al., 1988) is used to help children make more accurate and optimistic explanations for both positive and negative life events. Children are taught to accurately identify, label and monitor their feelings. The social component of the program involves teaching children listening skills, assertiveness, negotiation, social problem-solving skills, decision-making and perspective taking (Seligman, Reivich, Jaycox & Gilham, 1995). The children learn coping skills for dealing with a variety of controllable and uncontrollable life stresses, such as family conflict and making the transition to high school. These coping skills include strategies for actively solving problems, coping with negative emotions aroused by uncontrollable events, and seeking appropriate social support. Schools newsletter items and parent booklets are used to inform parents of the program content and to promote generalization of skills in the home setting (Roberts, Roberts et al., 2002; Roberts, Ballantyne et al., 2002).

In early studies using the POP program (Quayle, et al., 2001; Roberts et al., 2003), facilitators and co-facilitators, predominantly school psychologists and nurses, used a scripted manual to present didactic information, games, role plays, activities and worksheets which related to how the children think, feel and react when faced with challenges and stresses in their lives. The children completed class worksheets and homework exercises to reflect on their performance and practice skills in their home environment. The facilitators and co-facilitators of the POP program received approximately 30 hours' training from researchers involved in the development of the program (Andrew Shatte and Karen Reivich). With the transition to a more universal, school-based approach, a 16-hour training program is provided to train teachers to implement the Aussie Optimism Program as part of the Health Education curriculum. Additional coaching and support is provided to assist teachers with program implementation and support for parents. Teachers use the program to meet learning outcomes related to interpersonal and self-management skills as part of the Western Australian Curriculum Framework for primary schools. Teachers are provided with teacher resources, student workbooks and associated parent handouts, and newsletter items that support the program content.

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

The research conducted to date indicates that when used universally as part of the Health and Physical Education curriculum with schools in low socioeconomic areas in a randomised controlled trial, the Aussie Optimism Program was associated with lower levels of internalising problems as reported by parents and a lower frequency of clinical levels of anxiety and depression, compared to a usual care control group, after transition to high school (Roberts, Kane, Bishop, Cross et al., 2004).

Table 1. Content of the Universal Aussie Optimism Program Modules

<table>
<thead>
<tr>
<th>Session</th>
<th>Optimistic Thinking Skills</th>
<th>Social Life Skills</th>
<th>Parents &amp; Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Identification of feelings</td>
<td>Introduction &amp; feelings</td>
<td>Dealing with transitions</td>
</tr>
<tr>
<td>2</td>
<td>Identification of thoughts</td>
<td>Decision making</td>
<td>Working together as a family</td>
</tr>
<tr>
<td>3</td>
<td>Linking thoughts &amp; feelings</td>
<td>Communication skills</td>
<td>Optimistic thinking</td>
</tr>
<tr>
<td>4</td>
<td>Different thinking styles</td>
<td>Assertiveness I</td>
<td>Friends</td>
</tr>
<tr>
<td>5</td>
<td>Putting it together</td>
<td>Assertiveness II</td>
<td>Preparing for high school</td>
</tr>
<tr>
<td>6</td>
<td>Generating alternatives</td>
<td>Negotiation</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Looking for evidence</td>
<td>Coping skills</td>
<td></td>
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<tr>
<td>8</td>
<td>Challenging unhelpful thoughts</td>
<td>Networks</td>
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<tr>
<td>9</td>
<td>De-catastrophising</td>
<td>Friends &amp; family</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Review &amp; action plans</td>
<td>Transition &amp; review</td>
<td></td>
</tr>
</tbody>
</table>

The Aussie Optimism Program's content is based on well-validated theories of depression and anxiety, incorporates empirically validated techniques to change emotions, cognitions and behaviour (Compton, Burnes, Robertson, & Egger, 2002), and has been integrated into existing classroom activities. Currently, the development of the program has been towards dissemination, with parental involvement and a 'train-the-trainer' program being established so that the program can be embedded within the curriculum and the whole school system. To understand how Aussie Optimism can be promoted effectively in the education system, a large-scale dissemination trail is currently being conducted. Based on diffusion theory (Rogers, 1995), the program is being implemented in 63 schools from three urban areas of Western Australia including 3275 children and their parents, and 401 teachers. The research has four aims: to develop strategies to enhance the dissemination of a mental health promotion strategy aimed at preventing internalizing problems in young adolescents; to assess the effectiveness of these strategies in terms of school and teacher adoption of the program, implementation quality, and maintenance of program implementation over time; to assess the impact of the dissemination strategies and the program on student mental health outcomes; and to identify organisational and program factors that facilitate adoption, implementation and institutionalization of the Aussie Optimism Program (Bishop & Roberts, 2005).
To be effective, and to promote embedding within the local education system, Aussie Optimism had to be modified to be consistent with the pedagogical and practical constraints of teachers and the Department of Education. The Western Australian Department of Education uses an outcome-focused approach with individual level assessment of achievement. The program had to be consistent with this focus and designed so that it could be implemented by teachers with little psychological training. Department of Education staff had to be trained as trainers to support teachers in their implementation of the program, and program material had to be produced to support classroom teachers.

The early outcomes of this research indicate that there are high adoption and implementation rates for the Aussie Optimism Program. Sixty-three out of 91 (69%) of the eligible schools adopted the program. Evaluation of the teacher training workshops indicates that teachers who participated in the training workshops significantly increased their knowledge of mental health promotion, increased their confidence to teach mental health promotion lessons, and increased their awareness of and concern for their students' mental health. In the first year of program implementation, the Social Life Skills Program was taught in 113 of the 115 (98%) Year 6 classes that agreed to participate in the dissemination project. Eighty-five classes (74%) received all 10 Social Life Skills modules (100% implementation). In the second year, 59 out of 63 (94%) schools implemented the Aussie Optimism Program, either Optimistic Thinking Skills with Year 7 students, or Social Life Skills with Year 6 students. Sixty Year 7 classes (58.8%) received all 10 Optimistic Thinking Skills modules, while only 10 classes received no modules. In addition, 989 families received the Aussie Optimism for Parents & Families program in 2004 to assist them in preparing their children for the transition to high school.

The mental health outcomes for students who have participated in the intervention as part of the dissemination trial will be available in late 2006, as will the results relating to sustainability of the program in schools. Information has been gathered on the psychological and social adjustment of the students over three years from 2003 to 2005, using the Strengths and Difficulties Questionnaire (Goodman, 1999), and on the prevalence and incidence of depressive and anxiety disorders using the Diagnostic Interview for Children and Adolescents IV (Reich, Welner & Herjanic, 1997), a computerised psychiatric interview suitable for children aged 6-16 years.

In conclusion, it is possible to develop mental health promotion programs to prevent internalising problems in young adolescents that can be implemented universally as part of the regular school curriculum. Dissemination processes need to take care to contextualise the intervention within the host organisation, to provide adequate training and support to the host organisation, to ensure that the goals of the intervention are presented in a way that meets the goals of the host organisation, and to continuously value the efforts of staff in the host organisation. Without such dissemination processes, evidenced-based interventions to prevent mental health problems will not be able to reach enough young people to impact on the incidence of internalising problems.
References


