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Educational Model for Mental Health: Serving Children in School.

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Mental health is critical for learning. Children must have a sense of wellbeing to access new learning challenges and changing social/community expectations. For school-aged children, success at school is a critical protection that mediates other life risks. Mental health problems have been identified as a primary causal factor for children's learning problems, difficult behavioral patterns, and social isolation and estrangement. Understanding and addressing mental health needs within schools therefore becomes a compelling challenge.

To effectively meet the mental health needs of students, I propose that schools implement an educational model for mental health. This is a new paradigm for thinking about schools and mental health, one that addresses the needs of distressed children at school, supports learning, increases teacher effectiveness, and supplements other mental health services students may receive.

Mental Health and Mental Distress

Mental health describes a relative sense of wellbeing. For children, mental health describes feeling secure, being comfortable with adults and peers in their lives, having motivation and resources to learn and adapt to new challenges, and experiencing 'myself' as competent in developmentally appropriate ways. Mental health happens within the context of development: children increase their abilities to meet new demands and master new skills. Abilities refer both to conscious knowledge and skills, but also foundational capacities such as positive relational engagement, emotional and behavioral regulation, social/emotional awareness, and motivation for cognitive learning.

Mental health services are intentional interventions that provide needed adult help, relieve children's distress and repair functioning by activating new learning and decreasing maladaptive accommodations that have evolved from earlier efforts to manage.

Mental distress describes the internal experience of children who do not feel or function well. Mental distress can be evident through physical symptoms, changes in perception and concentration, expressions of persisting fear and other strong emotions, compromised functioning, confusing behaviors, and relationship disruptions. At school, children's mental distress can disrupt learning and social involvement. Mental distress results from extreme stress. Stress is the internal feeling of pressure to manage something new or difficult; it is inevitable and even necessary for growth and learning. Stressors are the environmental or relational experiences that trigger children's reactivity. When stress is matched to children's developmental resources and mediated with kind and reliable adult help, children can weather distress and regain wellbeing.

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When stressors persist and become unmanageable, or when there is insufficient adult help, children become overwhelmed and stress shifts from tolerable and useful to intolerable and endangering. Intolerable or toxic stress changes how children perceive, remember and function.

Mental distress has different causes. Sometimes mental distress signals changing biological processes that disrupt wellbeing, similar to causes of physical illness. Emerging mental illness refers to clusters of symptoms that predict specific and often life-long symptoms. Children with emerging mental illness can feel extremely vulnerable at school when stress exacerbates their symptoms.

Mental stress results from experiences or events that overwhelm a child's resources and deplete their ability to function and learn because of perceptions of threat. Many children have experienced too much stress or continue to live in very stressful situations. These children remain distressed in ways that compromise learning and social participation. When stress is unmanageable, children become preoccupied with feelings of danger and become distressed and vulnerable. Many children exposed to intolerable or toxic stress over time present with symptoms of mental illnesses and continue to struggle even when stressors are eliminated or reduced.

All children need adult mediation to manage stress; childhood is a time when children need adults for reliable support to make stressors of all kinds manageable and understandable. Distressed children must have remedial adult help at school. There are three primary ways that adults mediate stress: first, they protect children from experiences that are dangerous, frightening or overwhelming; they regulate how much the child is exposed to environmental events and supplement children's abilities to stay regulated or regain regulation balance after stressful experiences. Second, when children are exposed to threats or danger, adults make sense of these experiences in ways that help the child understand what happened so they can know what to do. And third, adults support children's developmental energies for learning to moderate stress effects and encourage resilience.

Regulation describes the neuropsychological capacity to feel balanced or secure despite internal and environmental changes, and is at the core of mental health. Self-regulation is the ability to stay relatively regulated (internally soothed) to permit new learning, and the ability to regain regulation (soothed back to balance) after a distressing experience. Stressed children become dysregulated and, without adult help, often find ways to self-right that are maladaptive or that prevent ongoing learning.

The Medical Model for Mental Health.

The traditional model for mental health is similar to physical health models: there is assumption of disease, or disruption of wellbeing. The medical model has traditionally focused on specific symptoms that can be categorized and treated with specificity (DSM-IV, DSM-5, ICD-10). Medication is often a component of treatment for many children, targeting specific symptom reduction and compromised physiological functions (such as arousal, inattention and agitation). While the medical model may include awareness of psychosocial factors, such as poverty, these are often considered secondary to symptoms. Medical mental health providers treat the child, help the child to change, and rely on parents to complement treatment objectives.

Recently this model has been expanded to provide school-based mental health care. This adaptation allows mental health providers (therapists) to be located within school buildings, expanding access for many children. But their work remains case-specific: clinicians see individual children identified with needs, with parent permission. And within this model, mental health providers remain tied to scheduled and time-specific appointments, individual treatment plans, billable revenue and limited time for consultation.

This medical model for mental health cannot adequately respond to all children's challenges at school. Because medical model interventions occur in offices rather than within children's daily experiences, circumstances that exacerbate symptoms may not be addressed. Children, especially young children, cannot report or remember what happened. Nor is there opportunity to prevent stressors. While expanded mental health access has been very positive, in many schools the need for mental health support far exceeds the capacity for school-based mental health care.

The Educational Model for Mental Health.

An educational model for mental health complements the medical model but also allows schools to expand their understanding of learning ~ and teaching ~ to include social/emotional functioning and stress management. With this model, schools provide active support to increase children's abilities to learn, and decrease or modify children's mental health distress.

This model recognizes that schools are skilled at remediation. Schools have the unique opportunity and knowledge to reduce stressors and provide direct and sensitive instruction for what the child must learn to become educationally successful. Success in school is predicated on a child feeling secure enough to join in group learning and use teachers to master new learning. The educational model recognizes that life circumstances ~ especially unmediated stress caused by difficult life circumstances or trauma ~ distract a child's energies from learning tasks.

Schools hold a universal promise: *when distressed, learning can help children feel better.* Adult instruction and support that is positive, encouraging, instructive and patient helps children stay engaged in things other than difficult events. When learning is compromised because children lack pre-learning abilities ~ such as regulation, organization, attention, social monitoring, negotiation, curiosity, motivation, perseverance and tenacity ~ schools must repair these prerequisites for complex learning and remediate age appropriate coping skills.

Distressed children disrupt learning ~ their own and others ~ because they don't know how else to manage their stress. This is where learning must start. This model is consistent with education's mission to help each child access learning within a social group of peers. It is also compatible with special education's understanding that learning obstacles must be remediated or minimized to allow children to learn. This model supports the school community: schools build a learning environment that includes all children and protects their opportunities to feel safe at school.

This model includes parents and caregivers in different ways than they are included in the medical model. Parents are asked to support the school community, to provide encouragement for their child's learning and

to help their child actively participate in school rules and expectations. It requires educators to be open to community expectations and norms but also asks parents to support educators' intentions to be kind and committed to all children learning. The troubling achievement gaps reflect many factors but remediation must start with active inclusion.

Integrating Care Throughout the School.

The first premise of the educational model for mental health is that **all children belong in school and are accepted as learners**. Some children may need to be taught how to belong, or need help learning skills that allow them to manage stress at school. All learning must be recognized as equal and integrated; making social/emotional learning different from academic learning denies the realities of a child's brain. Learning is a whole brain activity and when children are preoccupied with emotional distress or social confusion, they cannot fully participate in academic learning.

The second premise of this model is that a **predictable, reliable and consistently safe school climate fosters security and group cohesion**. School learning is group learning. Children must be able to share staff, be reciprocal with peers, and monitor emotions and behavior to meet the group norms. Safe schools are not created by banishing the children who initiate danger; they are created by adults at the school providing sufficient structure and organization so that all children can feel safe. This requires school staff to understand how mental distress compromises children's perceptions and abilities. Some children require specific help to experience school as safe. Children who have been exposed to danger struggle with expectations of ongoing danger; school can easily become infected with their fear when structure is unpredictable or erratic.

The third premise involves **experiential learning, learning that happens in-the-moment or close to the experience of distress**. The educational model for mental health operates in the *here and now* moments at school, when a child is struggling and needs relief from distress. When children feel distress, their thinking and remembering are impaired. This is why they make limited use of learning too far after the moment (such as days later, in a session with a mental health professional). Schools excel in experience-near (versus experience-far) learning because children are right there and available to practice something new.

Experiential learning presumes the child is sharing an experience with others, so others can help them make sense of *what is happening.* Adults need to be curious rather than reactive: *what could be going on for this child that I cannot see?* By joining in the child's perception the adult is able to look beneath behavior and better understand their distress. Adults can then wonder *how can I help you manage right now so you can feel better and keep learning?* This helps the child learn to manage stress without staying distressed. This assistance is parallel to direct instruction for academic subjects; children in distress need direct and sensitive support to practice social/emotional learning in real time.

The educational model for mental health is organized around a **different understanding of behavior**. Educators have often experienced disruptive and distressed students as a threat to classroom stability. Children with challenging behaviors undermine teaching, distract other students and can jeopardize expected academic outcomes. It is an understandable instinct to want to banish these children from the classroom and the school. But schools cannot and should not remove children; instead they must find different ap-

proaches, new concepts and better skills to include all children. Rather than see behaviors as intentional and directed at school staff ~ *she did that to anger me; he is doing that for attention* ~ it is necessary to understand that all behavior has purpose. Most distressed behaviors are complex efforts to manage fear, confusion and agitation triggered by experiences in that moment. In fact, many behaviors are unintentional or instinctive efforts to *protect myself.* Sometimes this threat is real (adult anger, adult actions) and sometimes the threat is perceived within the child's mind.

The educational model for mental health appreciates that distressed children disrupt school and need help. But this model also recognizes that when we help these children, everyone at school benefits.

The Critical Role of Educators

For the educational model to work, **all educational staff must have the capacity and willingness to use this model** and acquire skills for experiential remediation or repair. Teachers have described feeling overwhelmed by children's needs and without resources to help. But teachers are trained to help children learn and this model builds on teacher strengths. *Learning can help you feel better* becomes the organizing mental health message, and *I can help you learn* is the teaching imperative.

To support teachers in this changing paradigm, the educational model presumes the **availability of competent and available professionals with mental health training in the school community,** including school social workers, school psychologists, school counselors and nurses. The role of these professionals is threefold: to provide support and consultation to teachers about challenged children, to intervene with students who are distressed during these experiential learning moments, and to translate knowledge about causes of children's mental distress to the educational team so help can be individualized and monitored for effectiveness. The second and third tasks are already established, but the first task becomes critical if this model is to work. Teachers need ongoing training about strategies that promote learning and repair, child-specific help to be sensitive and effective in their direct instruction/direct support and ongoing consultation with professional colleagues with mental health expertise.

Critical to the educational model is what is best described as **adult reflective capacity**. (Reflective capacity is what most parents do intuitively: consider what is happening inside their child when they seem distressed at home.) Being interested and concerned about *what is going on inside the child* is a necessary ingredient for adults to be responsive to stressed children. Too often a child's behaviors are assessed by the impact onto others. But without an equally strong assessment of the causes of the negative behaviors, the struggling child is bereft of adult help. Being reflective does not mean educators should ignore behavior or permit negative behaviors to persist. It does mean that adults will be equally interested in causes or triggers of behavior.

Because maintaining regulation is central to mental health repair, teachers must understand how they can join children who are dysregulated. Joining means standing with the child to supplement their efforts. Traditionally, educators expect disruptive children to manage alone and then accept the perspective of the adult or other children. But dysregulated children cannot do this when they are overwhelmed by their own distress. The adult must stay with the distressed child *so the child can then come with the adult to new learning.* Interventions that remove adult support perpetuate impaired regulation, or reinforce faulty regulating ef-

forts (for example, causing children to dissociate or keep fighting). School staff have unique opportunities to be responsive in ways that repair regulation and protect learning.

What Schools Must Understand.

The educational model for mental health focuses on the school experience. Support for this model is inherent in innovative educational reforms throughout the county, including the recent federal mandate to move from zero tolerance to a better understanding of student need, remedial teaching and positive behavior modeling. This task to help distressed children requires educators to recognize how children carry their fear and reactivity to school.

- Development is innate and experiential momentum to greater adaptation. Development supports new learning. For many stressed children, development becomes compromised or stuck: many children try to solve problems with resources that are no longer matched with age expectations. They appear developmentally delayed or disrupted.

- Stress is experienced within children's bodies and minds. When stress is intolerable or toxic, children expect more danger and more stress. Instead of having energy for new learning, they remain reactive to real and imagined stressors and their behaviors reveal how distressed they still feel.

- Intolerable stress distorts perception and influences how a child interacts with others. Distressed children perceive danger when it is not intended or present, which often confuses their teachers and peers. They remember past events in ways that contaminate new experiences. They struggle to know when their perceptions are reliable in the here and now, and often cannot wait long enough to find out. Perceived danger triggers reactivity; they fight to protect themselves.

- Unmediated stress causes neurological and psychological changes in children's brains and bodies that persist even when the stress is eliminated. Stress-related changes cause learning difficulties that are not quickly remediated. Sometimes their behaviors demonstrate ways they have learned to alleviate or manage toxic stress but sadly cause additional stress when they violate school expectations.

- Some very stressed children have not experienced adequate adult mediation in dangerous situations and have learned not to expect new adults to be helpful. In fact, many see adults as endangering. They need to learn that adults at school can and will help to manage their stress before they can learn to do this for themselves. Isolating children without adult help abandons them to repeat maladaptive coping. Harsh consequences are experienced as threats rather than learning incentives.

- For stressed children, learning must start with shared experiences. Children who have never felt calm must experience the feeling of calm with people at school before they repeat this independently. Children who feel excluded or shunned need active experiences of inclusion. Children who live in dangerous situations cannot feel safe on command; they must learn how to feel safe at school, with adult help.

- Estrangement from the peer group exacerbates stress, making it significantly harder for children to use school as a positive experience. Suspensions for distressed children often backfire, causing more distrust.

Aggregating children with behavior problems robs them of positive peer models. It also imposes additional stress when they trigger one another's reactivity.

- Cultural experiences cause many families to remain suspicious of mental health interventions. But school support, with a focus on learning, and cultural restoration, can transcend fear and suspicion and help families access further help for their children.

Benefits of the Educational Model for Mental Health

The educational model is beneficial for children who experience stress and need extra adult support; educators and other children will also benefit from more effective and inclusive classrooms. Providing intentional support for children experiencing mental distress is congruent with education's primary mission to help children learn.

Schools have worked hard to be very accommodating for children with physical illnesses, and the same efforts are needed for children struggling with mental distress. For children with symptoms of mental illness this model assures that school does not become an obstacle to recovery or health. This model supports children experiencing moderate but persistent stress, such as family change, high mobility and economic peril. This model is critical for children who live with overwhelming experiences of environmental stress and for children who have experienced endangering traumas. These children are disproportionately identified as having behavioral difficulties.

Efforts to expand access to mental health interventions must be matched with more sensitive school environments. Some children can benefit from school based mental health services but this educational model would help all children. When learning becomes the hallmark of positive mental health, then it is clear why schools must support learning and learning remediation in all areas.

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