SCHOOL ORGANISATIONAL CLIMATE: MENTAL HEALTH PROMOTION, IMPLICATIONS AND PROPOSED PROCESS FOR ADDRESSING MILD PSYCHOSOCIAL PROBLEMS IN SCHOOLS

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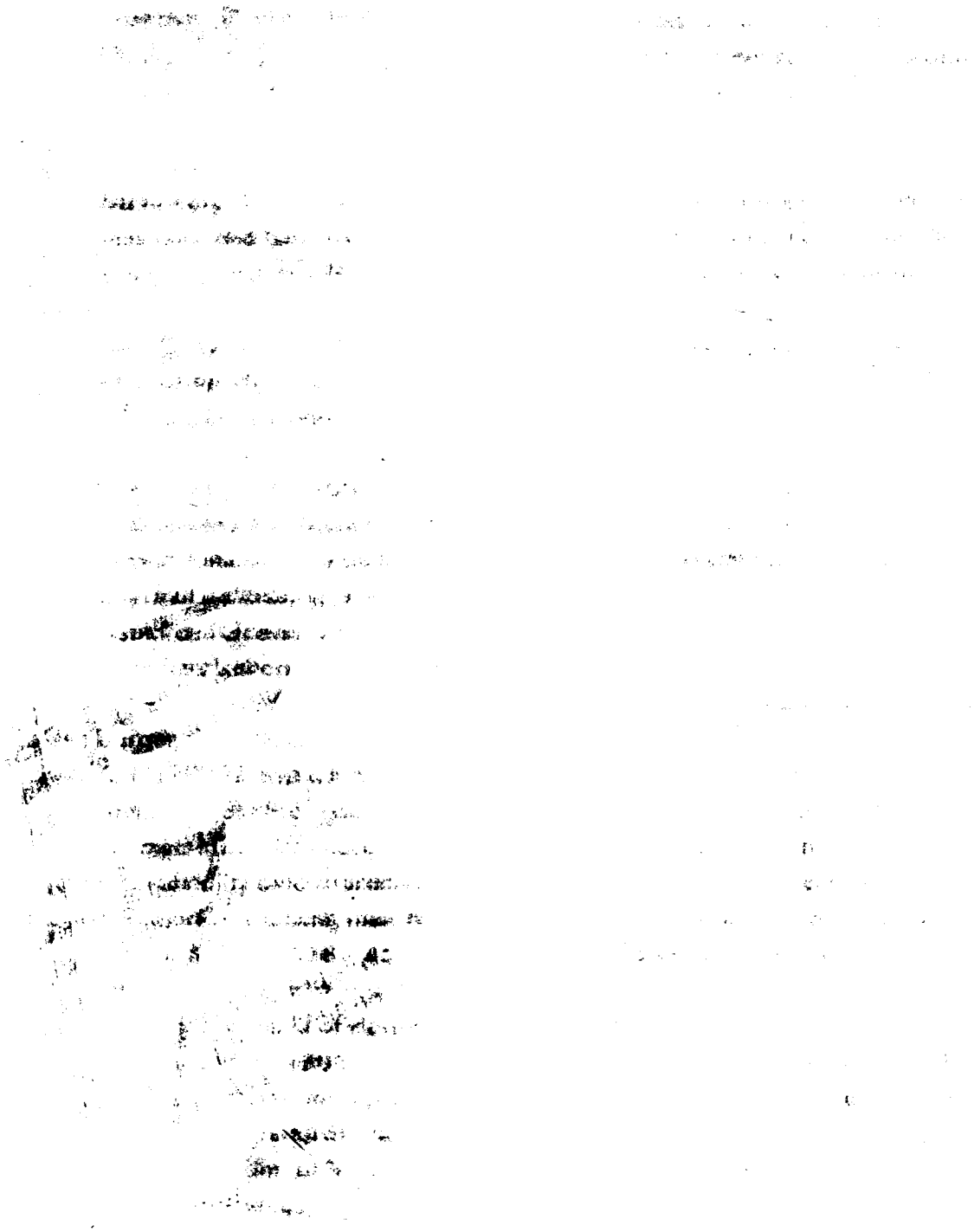
Abstract

This paper is concerned with how school organizational climate affects mental health and its potential usefulness in offering mental health services to school children. A review of literature established that organizational climate has been recognized as a concept which can be helpful in understanding the functions of organization. The extent to which a school organizational climate is "open" or "closed" as indicative of a positive or negative mental health orientation was therefore discussed. Types of psychosocial and mental health problem categories ranked by students as the most frequently seen problems for male and female students were highlighted. The paper presented some possible warning signs of mental health problems the school should be alerted to. Evidence was cited to support the proposal for the use of interrelationship of schools organizational climate as a focus for mental health preventive strategies. The expected outcome measures for the proposed mental health prevention through school organizational climate were 'illustrated. The paper offered specific recommendations on what should be included in school policies as a strategy for mental health prevention in schools.

Introduction

Hundreds and millions of people worldwide are affected by mental, behavioural and neurological and substance use disorders. According to World Health Organisation Report (2001), about 450 million people alive today suffer from mental disorders. Estimates made by WHO show that 154 million people globally suffer from depression and 25 million from schizophrenia. About 91 million people are affected by alcohol use disorders and 15 million by drug use disorders. In a study of mental retardation in Nsukka zone of Nigeria, Nweke (1995) found a rapid increase in the number of mentally sick pupils. He found that 500 pupils were officially known to have suffered permanent brain set back within 18 months while 1000 others were in the off and on group of patients of psychiatric institutions. According to WHO (2001), one



person in every four will be affected by a mental disorder at some stage of his/her life. It is estimated that by the year 2020, depression will become the second leading cause of disease burden (Murray & Lopez, 1996). More than 20% of children and adolescents already have mental health problem. Given this grim scenario, it is not hard to understand that the best place for prevention of mental disorder is the school; hence preventing mental disorders through school organizational climate is of immense interest to this author.

Mental health is the emotional and spiritual resilience which enables one to enjoy life and to survive pain, disappointment and sadness. It is a positive sense of well-being (Health Education Authority, 1997). It is a state of well-being in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (Bhatia, 2007).

"To prevent" literally means "to keep something from happening". Something here is identified as the risks for a disorder. (Mrazek & Haggerty, 1994). Historically, the public health concept of disease prevention has viewed prevention as primary, secondary or tertiary depending on whether the strategy prevents the disease itself, the severity of the disease or the associated disability (Shakhar, 2001). Mental disorders often occur due to the interaction of environment and genetic factors at specific periods of life.

Mental disorders affect the functioning of the individual, resulting in not only enormous emotional suffering and a diminished quality of life but also alienation, stigma and discrimination. This burden, extends further into the community and society as a whole, having far-reaching economic and social consequences.

The determinants of mental health include not only factors related to actions by individuals, such as behaviours and lifestyles, coping skills and good interpersonal relationships, but also social and environmental factors like good physical health, access to appropriate health services, social status, income and education. This paper is therefore concerned with how school organizational climate affects mental health and its potential usefulness in

offering mental health services to school children.

The extent to which a school organizational climate is "open" or "closed" as indicative of a positive or negative mental health orientation

Some observers have come to judge some school organizations as pleasant, bearable and jail-like. The feelings associated with interpersonal and day-by-day relationship between administrators, staff and students serve as a basis for this judgment. Such feelings are associated with what is sometimes called the organizational climate of the school (Jenne & Green, 1996). "Open climate" schools are perceived as energetic, lively organizations, moving toward their goals and as well provide social needs satisfactions and promote mental health for the school population. Conversely, "closed climate schools" are considered stagnant organizations that have apathetic members (Ponder & Mayshark, 1994). Fox (1993) suggests that "closed school climate" is associated with high student absenteeism, cliques, vandalism and theft, a high incidence of suspensions and expulsions and a host of other ills. The author views a "humane or open organizational climate" as characterized by achievement of productivity and satisfaction by students and teachers, development of basic skills, constructive attitudes of processes of inquiry and problem solving. Members gain a sense of personal worth, enjoy living and working in the school and enjoy participation in worthwhile activities. Other qualities include self respect and respect for others, ability to trust others, high morale, cohesiveness and caring, conflict identification and resolution.

In the promotion of an atmosphere conducive to mental health in the classroom, Coopersmith (1998) indicated desirable teacher-pupil relationship in terms of the following advice to the teacher:

1. Have genuine interest in children
2. Respect children's personality
3. Strive to give each child a feeling of security, of belonging and of being of value to his group.
4. Have a sense of humour so that children will be happy and live in an atmosphere of happiness.
5. Be impartial in relating with all pupils.

Thus, the quality of interactions that occur within a school is determined in part by the mental health of its members and also affects their mental health.

Types of Mental Health Problems Most Frequently Presented by Students

In a survey conducted by the U.S. Department of Health and Human Services (2002-2003), the following psychosocial and Mental Health Problem categories were ranked by students as the most frequently seen problems for students:

1. Adjustment issues
2. Social, interpersonal or family problems
3. Anxiety, stress or school phobia
4. Depression, grief reactions
5. Aggression or disruptive behaviour
6. Behaviour problems associated with neurological Disorders
7. Delinquency or gang related behaviour
8. Suicide or homicidal thoughts or behaviour
9. Substance use / abuse
10. Eating disorders
11. Concerns about gender or sexuality
12. Physical or sexual abuse
13. Sexual aggression
14. Major psychiatric or developmental disorders.

Warning Signs that a Student has a Mental Health Problem

Mental ill health can reveal itself indirectly, through changes in a student's work, behaviour or appearance. The possible warning signs that the school should be alerted to include:

(i) A sudden deterioration in academic performance or motivation

(ii) Persistent lateness for, or absence from tutorials

(iii) Obsessional attitude to work and or unrealistic pre-occupation with failure

(iv) Withdrawal from social, cultural or sporting activities once considered important.

(v) Mood swings and irritability

(vi) Difficulty in sleeping

(vii) Misuse of alcohol or drugs

(viii) Changes in appearance, weight, and decline in personal hygiene.

Evidence to support a proposal for the use of interrelationship of schools organizational climate as a focus for mental health preventive strategies in Nigerian Schools.

Organization of a school is the formal relationships through which two or more people pull their resources to achieve a goal or given purpose (Jenne & Green,

1996). Administration occurs in every organization. Simply, administration refers to an essential means of mobilizing the efforts of people and human resources such as time, ideas and materials in the area of health education and health to achieve a said goal. Here, the school administrator has a major role to play in drawing up an organizational climate which must relate to the needs, interests and capabilities of students or pupils. Increasingly, education and mental health experts recognize a definition of mental health in schools that includes not only treatment, but promotion of social and emotional development and efforts to address psychosocial and mental health problems as barriers to learning (School Mental Health Services in the U.S, 2002-2003). Schools in Nigeria should therefore begin to direct resources to school - wide and / or curriculum - based programmes intended to reach the broader student population as a means to address mild psychosocial problems quickly and thereby prevent unnecessary entry into special education. Therefore, information is required to identify and assess those programmes that seem to hold the greatest promise and are supported by adequate evidence-based research.

1. It is possible to improve self esteem and life skills through pro-social behaviour school-based curricula and improvement of school climate. Training teachers to improve detection of problems and facilitate appropriate intervention provides additional advantages.

An example is the Perry-Pre-School Programme (Schweinhart & Weikart, 1992) where 123 selected African-American 4 year old children were randomly assigned to daily participation in a High/Scope curriculum in preschool over a 1-2 year period along with weekly home visits by trained teachers. The risk factors being addressed were academic failure, early behavioural problems and low commitment to school. The intervention was associated with positive effects on academic performance and social adjustment. Follow up at 19 years of age showed lower deviant behaviour and greater social competence.

In another study Gottfredson and Gottfredson (1992), found that improving the structure of training in school using innovative methods of increasing co-operation between the students and teachers helped in reducing

drug use, delinquent behaviour and increased attachment to school.

11. Aggressive behaviour and violence can be reduced through parent training "good behaviour" focused interventions in elementary schools and comprehensive mental health promotion in primary and junior secondary schools.

    Example, the social skills group training for aggressive children (Pepler, King, Craig, Byrd & Bream (1995) provided broad-based skills, targeting children's aggressive behaviours within the school, family and peer systems. Seventy-four aggressive children were randomly allocated to an experimental group and a delayed intervention group (Wait List Control group). Children in the intervention group were reported by teachers to have fewer externalizing behaviour problems compared to the control group.

III. Psychosocial interventions like cognitive behaviour therapy and family based group intervention for children (7-14 years) have been found to prevent development of anxiety disorder among those children who are anxious but have not existing anxiety disorder (Dadds, Spence, Holland, Barrett & Laurens, 1997).

IV. Depression at adolescence has a high risk for recurrence into adulthood and is also associated with the risk of development of personality or conduct disorders (Harrington & Dubicka, 2002). A residence building school-based programme for secondary school children found that adolescents in the programme had lower levels of depression and hopelessness in comparison to the control group (Shochet, Dadds, Holland, Whitfield, Harnett & Osgarby, 2001). Proactive Teaching of cognitive Techniques to "at risk" school children was found to reduce depressive symptoms and conduct problems and improved academic achievement (Jaycox, Reivich, Gillham & Seligman, 1994).

V. Studies have shown that it is possible to prevent suicide through a comprehensive school-based prevention programme. In a 5 year longitudinal study done

in Miami (Zenere & Lazarus, 1997), 330,000 public school children and adolescents were selected. A comprehensive strategy aimed at reduction of suicide was developed. It included components to modify school policy, provided teacher training, parent education, stress management and life skills curriculum and introduced a crisis team in each school. The result showed 63% reduction in suicide rates and 64% reduction in suicide attempts.

VI. Reducing alcohol consumption and smoking in youths through intervention during the early elementary and junior secondary school years had been found to be effective in the adolescent Alcohol Prevention Trial (Hansen & Graham 1991).

VII. Life Skills training has been found to enhance self-efficacy and to prevent substance abuse and behavioural problems (WHO, 1993). Bruene-Butter, Hampson, Elias and Clubby (1997) evaluated the effects of Improving Social Awareness - Social Problem Solving (ISA-SPS). This programme focused on promoting social competence in children during their transition to middle school. Improvements were found in coping with stressors related to middle school transition and behaviour and decrease of psychopathology at six-year follow up in the experimental group.

VIII. School Mental Health Services in the U.S (2002 - 2003) survey reported that the following types of mental health prevention and early intervention strategies proved successful:

a.) School-wide screening for behavioural and emotional problems (63%)

b.) Team and family meetings for students with behavioural problems (59%)

c.) School-wide strategies to promote safe and drug-free schools (78%)

d.) And to prevent alcohol, tobacco and drug use (72%)

e.) Peer counselling and mediation and peer support groups (47%)

f.) Outreach to parents regarding mental health issues (34%)

IX. Curriculum-based programmes and classroom guidance to

enhance social and emotional functioning have also proved successful approaches.

Topics for such programmes include anger management, prevention of violence and bullying, conflict resolution, resisting peer pressure, communication skills, substance abuse and character education (e.g. developing citizenship skills, responsibility, honesty, fairness, patience).

Expected outcome measures of the proposed mental health promotion through school organizational climate

The following outcome measures have been used commonly in studies involving prevention and promotion in mental health.

1. **Health Impact**

a. Reduction of incidence and prevalence of mental disorders
b. Improvement of quality of-life
c. Improvement of physical and mental health of children
d. Increased coping skills and self-efficacy
e. Better psychological adjustment

2. **Social Impact**

a. Increase in Social skills, social support and peer attitude
b. Better academic performance
c. Reduction in substance abuse, delinquency, school drop-out, child abuse and absenteeism
d. Reduction in stigmatization and better understanding and acceptance of the mentally ill by the school, family and the society.

3. **Economic impact**

a. Reduction in patient days in hospital
b. Increase in productivity
c. Reduction in costs incurred for treatment.

Specific Recommendations on what should be included in School Policies for Mental Health promotion

School Policies may cover the following issues:

1. Helping children who have been abused or abandoned, orphaned by HIV and AIDS and those with disabilities through services that promote respect and care and foster compassion by valuing their human basic desires.

2. Free education to orphans and or street children.
3. Providing AIDS affected orphans and disadvantaged children with basic needs and building their life skills through early childhood school activities.
4. Sexual harassment and abuse prevention in schools.
5. Improving the basic infrastructure of poor rural primary schools.
6. Providing access to learning and enhancement of lives of children and youths where formal structures for education are absent or have been broken down by conflict.
7. Re-orienting youths who have fallen out of the mainstream of education, training them in vocation, technical and small business careers, enabling them to become self sufficient, upstanding citizens who can assist in the economic recovery of the nation.
8. Non-profit feeding scheme for malnourished children in the school.
9. Helping vulnerable youths through educational scholarships.
10. Prevention of discrimination related to differences in religion, outcaste or ethnic origin.

Conclusion

This paper highlighted some of the basic issues in the field of promoting mental health with special reference to the evidence base. It is hoped that the information given here will assist in wider utilization of appropriate and effective interventions on prevention towards reducing the burden of mental disorders and in enhancing the mental health of the school population. The paper provided an overview of some of the important issues that are often debated among policy makers with respect to mental health. Thus, policy makers will also find the paper useful.

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