Report of a Pilot Project

Mental Hygiene Seminars for School Personnel

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A MENTAL HEALTH pilot project involving six Baltimore junior and senior high schools was organized in 1964 by the Psychiatric Adolescent Service of Johns Hopkins Hospital with the assistance of the Department of Public Health and the Board of Education of Baltimore City.

The project was initiated because the psychiatric adolescent service became concerned about numerous referrals to its clinic and the shortage of personnel to deal with them. Many of the referrals were made by the schools. It was felt that the schools needed guidance in appraising the behavior of troublesome students—which students to refer to psychiatric facilities and which to handle within the school. It was felt also that school personnel needed help in how to handle, within their facilities, the adolescent in trouble. A long-term objective was to prevent mental illness among adolescents.

The board of education's department of special services, staffed by psychologists, social workers, and psychiatrists, tests children referred to it by the schools and provides psychiatric consultation and social work sessions when required for these children. Because it too had a large number of referrals and a small staff, the backlog of the department was, and still is, heavy.

The department of public health was most receptive to the project proposal and made arrangements with the Board of Education of Baltimore City to discuss the operation of such an enterprise and to consider possible problems.

Questions raised about the advisability of providing mental health services to children referred by the schools were:

1. Would the proposed project duplicate the services of the board of education's department of special services?

2. If a child needed treatment, would the school have to attempt to deal with a problem outside its area of competence?

The first question was resolved by the decision that no children known by or referred to the department of special services would be discussed. The school would choose, from among the students in trouble, two whom they felt would be suitable for presentation and whom they had not referred to special services.

The second contingency was eliminated by the psychiatric adolescent service, which agreed to evaluate or to take into treatment any child who would need either of these services.

This commitment was prompted by the fact that the psychiatric adolescent service is the only mental health facility treating adolescents in the area. It was hoped that this commitment could be rescinded gradually when other centers opened and eventually adolescents could be referred to other clinics, provided the psychiatric adolescent service would guarantee treatment to any child from the school project.

The program, started in October 1964, was completed in May 1965, and 14 meetings were held. The meetings were attended by the principal or vice principal, counselor or social worker, nurse, and physician from each of the six schools as well as personnel from the psychiatric adolescent service, the health depart-

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ment, and the board of education (including psychologists from department of special services). The teacher and other school personnel directly concerned with the events which led to a child's referral were asked to attend the seminar in which that child would be discussed. A total of about 70 people attended.

The seminars were held in the conference room of the psychiatric adolescent service on alternate Fridays from 9 to 10:30 a.m. A staff member from a school described a "difficult child," and each presentation was followed by a question and answer period and a general discussion of the child's difficulty. A followup of children presented at previous sessions ended the meetings.

The psychiatric adolescent service reserved time on alternate Fridays for consultation or treatment of any child whom the psychiatrist in charge of the seminar felt needed more complete evaluation or psychotherapy. At the end of each semester the psychiatrist in charge of the seminar lectured briefly on the problems of adolescence and ways of handling them, illustrating the talk with clinical examples.

Results

During the year two meetings were held with the heads of the department of education (including special services) and the department of health and the school principals to evaluate and appraise the program. The nurses were very enthusiastic. Personnel of special services were satisfied with the way the project was conducted.

The school principals agreed unanimously that the program had been useful. They felt that for the first time the "problem child" could be helped by school personnel working as a team. The nurses, social workers, physicians, and teachers, having cooperated in compiling material for a presentation, experienced the advantages of working together. They also felt it had been useful to show teachers that the difficult child is not reacting to just the present situation but that he has a past with which he has to cope and which can explain part of his behavior. The principals also reported that the teachers, supported by a psychiatrist, felt more at ease in handling difficult children. However, they felt the teachers did not feel sufficiently comfortable to share what they had learned with other teachers.

The teachers, at the end of each semester, were asked to appraise the program and again the comments expressed were most favorable. One teacher felt that he had learned not to see the child as necessarily reacting to him personally and, therefore, not to be hurt by the child's misbehavior. Another realized for the first time that a child's disobedience may arise from incompatability of a request with the child's needs. Many teachers also reported being helped in situations similar to those discussed during the program. The psychiatrists conducting the project (the author and a part-time psychiatrist) were encouraged by these responses.

Attendance was excellent—approximately 35 people attended each seminar. The participation of the audience was very active, and as the year went by the participants felt more free to express their feelings.

The presentations were, for the most part, excellent. The problems discussed ranged from bizarre behavior to factors precipitating school dropouts: teenagers with crushes, sexual problems, schizophrenia, physical defects, learning problems, and so forth.

Twelve children were discussed. At first all children were interviewed at the psychiatric adolescent service after the presentation because the teachers wanted to make sure the staff evaluated the problem accurately. However, the last three children were not interviewed individually because the school personnel felt more confident about their presentations by that time. Two of the nine children interviewed were taken into psychotherapy during the year; one child was schizophrenic and one had a severe identification problem. The children not referred for therapy were handled by the school in accordance with the psychiatrists' recommendations. Most of the 10 children handled within the school showed marked to satisfactory improvement.

The difficulties of the program were twofold.

1. *Adverse reaction of the parents when the child was offered an evaluation in the clinic.* Teachers found it difficult to persuade parents to accept the decision that their child should

be seen in a psychiatric facility. However, they always managed to get parental acceptance. The difficulty seemed related to the practice of selecting a child for presentation before any groundwork regarding possible psychiatric referral had been done with the parents. Staff at the psychiatric adolescent service feel, however, that the parents did not show any greater opposition to referral to the service than they would have to referral to a private psychiatrist.

2. *Financing the psychotherapy.* The department of health paid a small consultant fee for the psychiatrist's time, and this fee was set aside to pay the clinic cost for the evaluation of all cases. If, however, a child needed treatment, his parents were asked to pay clinic fees for therapy. The parents of one child offered treatment refused to pay clinic fees. It was felt that many parents accepted consultation at the psychiatric adolescent service only because of its "free" character.

Conclusion

We considered this project a success. With minimal time away from school and a limited number of psychiatric personnel, staff members of six Baltimore junior and senior high schools participated in a mental health seminar. During the 1964–65 academic year no children except those who were presented at the seminars were referred from the participating schools to the psychiatric adolescent service.

The project thus served its initial goals.

1. Decrease the number of referrals from the schools by helping teachers understand the dynamics of the child's problem, evaluate better the cases which need to be referred to psychiatric clinics, and cope with most problems within the school facilities.

2. Increase school personnel's awareness of mental health problems and help the school prevent them. This, we felt, was achieved by recognizing the problems early and, so far as possible, modifying the environment to avoid greater conflicts by reducing school personnel's anxiety when confronting behavior problems and thereby increasing their effectiveness in handling such situations.

In view of the success of this program the psychiatric adolescent service has undertaken a similar project with houseparents and caseworkers of various local residential centers for adolescents.

It is hoped that in time various organizations working with adolescents will employ their own psychiatrists and that this type of pilot project will become a continuous inservice training for such personnel.

Division of Regional Medical Programs

A new Division of Regional Medical Programs has been established at the National Institutes of Health, Public Health Service, and Dr. Robert Q. Marston has been appointed chief of the division.

The division will administer grants authorized by Public Law 89–239, the "Heart Disease, Cancer, and Stroke Amendments of 1965." The grants will encourage and assist the establishment of regional cooperative programs involving the nation's medical institutions and members of the health professions. These programs will offer the medical community increased opportunities to make the latest advances in the diagnosis and treatment of heart disease, cancer, and stroke more widely available to all Americans. These diseases account for nearly 70 percent of all deaths in the United States each year.

Under regional cooperative programs medical schools, hospitals, and research institutions may join to carry out research, training, and demonstrations of patient care directed toward accomplishing the objectives of the legislation. Because local initiative in planning and organization will be emphasized, the exact nature of an individual regional program will vary according to the needs and resources of that region.