

## **Understanding the Critical Links between School Safety and Mental Health:**

### **Creating Pathways toward Wellness**

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## **Introduction**

School violence has been a source of national concern since the early 1970s (Morrison & Furlong, 1994). With researchers from multiple professions (public health, juvenile justice, and later education) working to grasp the dynamics behind school violence and victimization, the understanding of the contributing factors has come a long way. Violence, aggressive behaviors, and resulting victimization, contribute to a hostile school climate that can negatively impact the academic performance and the mental health of students. Students exposed to such problematic environments are more likely to disengage from school (Yang, Sharkey, Reed, Chen, & Dowdy, 2018) and experience higher levels of mental health concerns (Hurd, Hussain, & Bradshaw, 2015) than those students who are not exposed to such campus conditions. Given these outcomes, the school violence field has shifted focus from aggressive, disruptive, and violent behaviors, to an expanded consideration of the psychological and developmental aspects of safety. To achieve this sense of safety, students need to not only be resilient but thrive in the face of adversity (Morrison, Furlong, & Morrison, 2000). With the growing interest in psychological well-being and helping students thrive, it is recognized that a core goal of school safety and intervention practices is to reduce negative mental health outcomes and enhance the psychological well-being and development of all students. This focus on enhancing student well-being rather than the delivery of traditional deficit-focused mental health services can be seen in various programs and initiatives that have emerged over recent years.

This chapter examines the relation between disruptive and violent behaviors that impact school safety and student mental health and well-being, as well as the contributing role of ecological factors. We begin with a brief overview of what is known about the linkage between students' school safety experiences and their mental health. The discussion then addresses

factors that influence student risk and resiliency and offers examples of school-based initiatives designed to decrease school violence by promoting student mental health and well-being. In the conclusion we offer suggestions for continued efforts that promote overall well-being as a strategy to enhance mental health and increase school safety.

### **What is the Association between School Violence and Mental Health?**

Public awareness and concern about the linkages between school violence and mental health spikes after school shootings. This pattern has repeated itself since the Columbine shooting in 1999, when the Safe School Healthy Students (SS/HS) initiative was initially funded. After the Sandy Hook school shooting in 2012, there were calls to make “mental health part of the school safety solution” (Murray, 2013). As a result, President Obama proposed legislation to fund broad school safety efforts that included mental health services (Klein, 2013). With the school shooting at Parkland High School in March 2018, the public dialog again conjoined the act of school violence with the mental health status of the perpetrator.

With continued effort to reduce school violence, it is important to consider the association between a perpetrator’s mental health and an act of mass violence. However, focusing primarily on these rare acts of violence does not lead to a complete understanding of the negative effects that more common forms of school violence and victimization have on student mental health. Rather, we consider violence at school to be a much broader term that encompasses physical acts, verbal insults, social rejection, and other forms of victimization.

Some researchers have suggested that whether an act is experienced as “violent” does not depend solely the nature of the act itself, but on the meaning it has for the victim (Morrison, Furlong, & Morrison, 1994). Drawing from this perspective, a student’s judgment about how safe they feel at school has been used an indicator of their level of overall perceived risk on the

school campus. This risk perception can emerge out of direct physical victimization; vicariously, as in witnessing the victimization of others; and indirectly, as in being exposed to media and other reports of school violence (Williams, Schneider, Wornell, & Langhinrichsen-Rohling, 2018).

Although students' school safety beliefs are linked with mental health indicators (Nijs et al., 2014), there is surprisingly limited surveillance information about how students' school violence victimization experiences are associated with indicators of emotional distress and positive well-being. To provide a perspective on how students' perceptions of school safety are associated with their complete mental health, in this section of the chapter, we draw on an ongoing two-year survey of adolescent mental health being conducted in California<sup>1</sup>. This survey offers access to unique information about students' school safety/violence related perceptions, emotional distress experiences, and self-reported psychosocial well-being.

Table 1 shows the co-occurrence of students' school violence and mental health experiences. We note some generalizations and cautions about these relations. An important pattern is that most students report feeling safe at school. These students report that they are less likely to experience emotional distress and have positive daily psychosocial experiences. They report feeling positive affiliation with their school and high subjective well-being in general. For the majority of these high school students, schools were locations where their positive

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<sup>1</sup> The data used in this section include the responses of 4,806 students attending five geographically dispersed California high schools (Grades 9-12). The sample included characteristics are as follows (largest subgroup shown): female (52.1%), White (40.8%), parent college graduate (38.8%), home language English (77.6%), and not eligible for subsidized school lunch program (51.9%). Items included in this study's comprehensive survey were drawn from the Youth Risk Behavioral Surveillance Survey (Frieden et al., 2016), The School Connectedness Scale (Furlong et al., 2011), the Mental Health Continuum-Short form (Keyes, 2005), the Social Emotional Distress Scale-Secondary (Dowdy et al., 2018), and the Brief Multidimensional Life Satisfaction Scale (Funk et al., 2006). See Project CoVitality for more information ([www.project-covitality.info](http://www.project-covitality.info))

psychosocial development was fostered, which is consistent with similar research (Lester & Cross, 2015). Although the patterns reported in the section of the chapter are based on a regional sample, they demonstrate that a meaningful subgroup of students, (up to one-third) report having direct school violence experiences (physical bullying, fighting, and threats of personal harm). These victimized students were substantially more likely to report that they feel unsafe at school, experience the school context as being less supportive, and to more frequently experience emotional distress. Only about one-third of these students reported having flourishing psychosocial well-being because they were less likely to feel positive affect, they experienced positive self-perceptions less often, and infrequently had feelings that society in general was moving in a positive direction. When considering school safety, it is essential to consider both rare acts, as well as more common forms of violence, and the implications of student mental health.

### **Bullying, Mental Health, and School Safety**

Bullying, the most common form of victimization students experience at school, has gained attention in the popular media and in schools in large part because of increased recognition that students who experience bullying are at heightened risk for a wide range of negative psychosocial outcomes, including mental health problems and suicidality. While in the past bullying was considered a harmless or “normal” childhood experience, high-profile cases where targets of bullying committed suicide or acts of violence have brought the mental health implications of bullying to the forefront of public discourse. Consistent with popular media, researchers have been clear that exposure to bullying is strongly and consistently associated with diminished mental health and increased risk of suicide. Early research on this topic focused on mental health outcomes of targets (i.e., victims) of bullying; however, recent research has found

that bullying involvement is also linked to worsened outcomes for aggressors (i.e., bullies) and for bystanders who observe but are not directly involved in bullying.

Bullying is defined as aggression that is repeated, intentional, and involves an imbalance of power between the target and the aggressor, such that the target is unable to defend themselves or make the bullying stop (Gladden, Vivolo-Kantor, Hamburger, & Lumpkin, 2014; Olweus, 1993). Bullying can be physical (e.g., hitting, pushing), verbal (e.g., name-calling, teasing), or relational (e.g., gossiping, purposeful exclusion) in form, and can also occur online or electronically (i.e., cyberbullying). These defining characteristics of bullying distinguish it from the broader class of peer victimization (i.e., aggression that includes one-time acts of aggression and fighting between equal friends) and, because of these characteristics, bullying is thought to be a particularly harmful form of peer victimization due to its inherent chronicity and tendency to target the most vulnerable students.

Studies estimate that approximately one-third of youth are involved in bullying as a target, an aggressor, or both (Due & Holstein, 2008; Modecki et al., 2014; Nansel et al., 2001). Other students who are neither targets nor aggressors are present up to 80% of the time that bullying occurs (O'Connell, Pepler, & Craig, 1999). Together, these results suggest that the most school-aged students will be involved in bullying at some point (and likely at several points) throughout their schooling. As such, from a school safety perspective understanding the association of bullying involvement with mental health has important implications for prevention and intervention efforts in schools.

**Mental Health and Types of Bullying Involvement.** The most robust research on the association of bullying involvement with mental health outcomes has focused on the mental health of students involved as targets of bullying. Studies have generally found that targets of

bullying report greater rates of depression and anxiety in childhood than their uninvolved peers (Hawker & Boulton, 2000; Klomek, Marrocco, Kleinman, Schonfeld, & Gould, 2008). Further, cross-sectional and longitudinal studies indicate that adults who were bullied in childhood are at increased risk for adult depression and anxiety (Holt et al., 2015; Takizawa, Maughan, & Arseneault, 2014). Although studies have tended to focus on mental health among targets, researchers have similarly found that aggressors are also at heightened risk for mental health problems (Swearer, Song, Cary, Eagle, & Mickelson, 2001). Further, the group of students who are involved as bully/victims (i.e., are both targets AND aggressors in bullying situations) are at greater risk for both internalizing and externalizing disorders than youth who are either targets or aggressors only (Kaltiala-Heino, Rimpela, Rantanen, & Rimpela, 2000; Swearer et al., 2001).

In addition to research on students directly involved in bullying — as targets, aggressors, and bully/victims — some studies have investigated the mental health of the larger population of youth who are involved in bullying as bystanders, or witnesses. For example, in a study of over 2,000 adolescents in England, Rivers et al. (2009) found that witnessing bullying was associated with increased risk for mental health problems and that this association persisted even after the researchers statistically accounted for whether youth were also directly involved in bullying as a target or aggressor. This finding mirrors broader research that has documented that witnessing violence is associated with decreased youth mental health (Mohammad, Shapiro, Wainwright, & Carter, 2014) and suggests the importance of schools attending to the impact of serving in a bystander role on student well-being.

Cyberbullying has received attention as a particularly harmful form of bullying given its (a) large audience, (b) constant access that youth have to technology, and (c) possible anonymity of aggression (Sticca & Perren, 2013). Contrary to popular perception, studies generally find that

cyberbullying is less common than other forms of bullying victimization. For example, Modecki et al. (2014) found that across 80 studies the mean prevalence rate for cyberbullying bullying involvement as a target or aggressor was 15%, compared to 35% for traditional bullying involvement. Further, youth who were targets of cyberbullying are frequently also targets of traditional forms of bullying victimization (Modecki et al., 2014). However, results of a U.S. nationally-representative study of adolescents found that targets of cyberbullying reported higher rates of depression than targets of other forms of bullying (Wang, Nansel, & Iannotti, 2012), suggesting that it might indeed be more harmful than other forms.

**Suicide and Bullying.** One question that has come out of research on bullying and its mental health implications is whether bullying is specifically associated with increased risk for suicidal thoughts and behaviors. A number of studies, including a recent large-scale meta-analysis, have found that childhood bullying has a moderate-sized positive association with suicidal behaviors in childhood (Holt et al., 2015). Most notably, Holt et al. (2015) reported that targets of bullying had increased risk for suicidal thoughts and behaviors, but so too did aggressors. Several longitudinal studies have found that associations of bullying involvement and suicide persist into adulthood (Lereya et al., 2015; Takizawa, Maughan, & Arseneault, 2014). Although studies consistently find an association between bullying and suicide, there is no evidence of a causal link. Most youth involved in bullying do not report suicidality and a number of other factors, such as mental health problems (e.g., depression), are associated with both bullying and suicide, potentially explaining the linkage (Duong & Bradshaw, 2017).

**Bullying and Other Forms of Victimization.** Research on victimization has consistently found that victimization exposures tend to co-occur, such that some people are exposed to many forms of violence and victimization, while others are exposed to none or only a few (Finkelhor,

Ormrod, & Turner, 2007). Youth who experience more victimization in childhood are at greater risk of poor mental health outcomes than those who experience only a few. Consequently, researchers have demonstrated the importance of simultaneously examining multiple forms of victimization, so that the impact of any one form is not over-estimated (Green et al., 2010). Studies find that bullying, specifically, is highly co-occurring with other forms of child victimization (e.g., physical assault, family violence; Finkelhor, Turner, Hamby, & Ormrod, 2011). Given this high degree of overlap, a question has emerged regarding the relative importance of bullying as a risk factor for mental health problems as compared to other forms of victimization and maltreatment that bullied youth may have experienced.

Studies that have specifically examined bullying in relation to other forms of victimization have generally found that bullying is significantly and independently associated with key mental health outcomes. For example, using two longitudinal samples, Lereya et al. (2015) found that being bullied in childhood was more strongly associated with mental health in young adulthood than childhood maltreatment by adults. Takizawa et al. (2014) similarly found an association of bullying with suicidality, when controlled for childhood adversity.

**Reciprocal Relationships between Bullying and Mental Health.** Whereas the majority of studies have focused mental health as an outcome of bullying involvement (e.g., depression, anxiety, suicidality), some studies have also explored the potential role of mental health problems as a precursor to bullying. For example, researchers have studied ADHD in relation to self-control and have found that ADHD is associated with both being a target and aggressor in bullying situations and also that early signs of ADHD are associated with later involvement in bullying aggression (Holmberg & Hjern, 2008; Unnever & Cornell, 2003). This research suggests that the association between mental health and bullying might be both complex and

reciprocal (Turner, Finkelhor, & Ormrod, 2010). As such, consideration of ecological factors can help one better understand the intricate nature of mental health as it relates to school safety.

### **Ecological Factors**

Despite this correlation between childhood bullying exposure and mental health problems, not all children involved in bullying experience negative outcomes. It is important to consider additional ecological risk and protective factors that may impact the experiences of perpetrators, victims, and witnesses of childhood bullying. In a systematic review of protective factors, researchers found that strong academic and social skills, a stable family environment, attachment to parents, and prosocial friends all helped disrupt the link between bullying perpetration/victimization and internalizing/externalizing problems later in life (Ttofi, Bowes, Farrington, & Lösel, 2013). Similarly, Brendgen and Poulin (2018) found that friendship support decreased the link between school victimization and subsequent depression symptoms. Together, these studies indicate that strong relationships with others may protect from both incidence of victimization as well as mental health outcomes as a result of victimization.

Additional studies have looked specifically at the school environment and its role as both a risk or protective factor. Schools with inferior teacher support and poor classroom management, as well as those lacking antibullying norms, experience higher incidence of bullying (Machado Azeredo, Rinaldi, Leite de Moraes, Bertzzi Levy, & Rossi Menezes, 2015), whereas having a safe and supportive school environment can help foster the development of individual resilience. Rather than serving as a direct protective factor in itself, research indicates that schools provide the space for children to develop their own personal protective factors and resilience (Jackson, Chou, & Browne, 2017). High perceptions of the school environment are linked to engagement in learning, academic achievement, and hope, all of which may protect

against victimization and subsequent negative mental health outcomes (Van Ryzin, 2016). In fostering individual resilience, therefore, it is important for schools to promote prosocial relationships with peers and develop a safe and supportive learning environment.

### **School Safety and Mental Health**

It is crucial that schools are safe places for children, families and educators. While many school teams are successful in providing a safe environment, they also recognize that safety must successfully align with the primary purpose of schools: to provide developmentally appropriate instruction, experiences, and support in order to achieve academic and social-emotional learning competencies for all (Lane, Menzies, Parks Ennis, & Bezdek, 2013). With this in mind, many schools have turned to a multi-tiered system of supports (MTSS) framework that addresses academic, social-emotional, and behavioral concerns. MTSS pulls strongly from the three-tiered public health model, including early identification and prevention (universal intervention), targeted intervention (secondary), and intensive intervention (tertiary) to ensure all individuals are receiving an appropriate level of support. For most students, universal interventions (e.g., schoolwide positive behavioral interventions and supports; social-emotional learning) provide sufficient support to foster appropriate development. However, some students require more intensive supports (e.g., mental health counseling, check-in check-out, special education services; Lane et al., 2013).

In addressing school climate and student behavior specifically, positive behavioral interventions and supports (PBIS) has become one of the most prominent applications of the three-tiered MTSS framework. At the universal intervention level, PBIS helps foster a safe school environment by developing positively-worded expectations, explicitly teaching the expectations to staff and students, rewarding students when they meet schoolwide expectations,

and establishing a continuum of logical consequences for student misbehavior (Burke, Davis, Hagan-Burke, Lee, & Fogarty, 2014; Kincaid et al., 2016). Schools implementing PBIS use various sources to make data-based decisions regarding implementation fidelity, effectiveness of interventions, and level of support for individual students.

Similarly, social-emotional learning (SEL) has become a prominent prevention strategy in teaching students core competencies in: recognizing and managing emotions, setting and achieving positive goals, appreciating others and their perspectives, and establishing and maintaining healthy relationships (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011). SEL can be employed to facilitate academic engagement, work ethic, commitment, and overall school success through explicitly teaching social-emotional skills. SEL programs aim to increase positive social behaviors and decrease conduct problems and emotional distress (Durlak et al., 2011).

While programs such as PBIS and SEL, which utilize the MTSS framework, foster a safe and supportive school environment, many of the more serious mental health and safety concerns require Tier 3 intensive supports. As a result, Tier 3 has become more well established in terms of intervention and response, and Tiers 1 and 2 need to be established more clearly as they relate to promotion of safety and prevention of school violence. In an attempt to operationalize the MTSS framework approach, particularly at the Tier 1 level, various initiatives have been implemented in the school setting to promote safety and mental health.

**Safe Schools/Healthy Students.** Beginning in 1999 and for more than a decade, the Safe Schools/Healthy Students (SS/HS) initiative concentrated on decreasing violence and promoting a safe and secure school environment for all students. It emerged out of an awakening of consciousness after the violence that occurred at Columbine (see Insert 1) and aimed to

operationalize concerns and issues related to school violence at a national level. This cross-agency federal initiative provided more than \$2 billion in funding to 365 communities. It is the longest running, most comprehensive approach that has examined the link between school violence and mental health to date. The design of the SS/HS Initiative was based on the research identifying family-school-community partnerships as critical components of strategies to foster safe, respectful school environments, healthier development, and that ultimately improved academic success for students (Modzeleski et al., 2011). From this initiative, communities collaborated to implement comprehensive models of intervention to prevent violence and promote mental health among students. Projects covered many areas including prevention of violence, bullying, and suicide, as well as the promotion of student mental health and wellness. According to Modzeleski et al. (2011), in a national cross-site evaluation of the initiative, findings revealed encouraging results. Following implementation, investigators found that fewer students reported experiencing and witnessing violence. Most school staff (96%) indicated that school safety had improved due to the initiative. Related to mental health, data indicated a significant increase in access to mental health services, specifically there was a 263% increase in the number of students accessing mental health services in the schools, and a 519% increase in students receiving mental health services in the community.

**SAMHSA Advancing Wellness and Resilience in Education (AWARE).** Building on the success of the SS/HS initiative, Project Advancing Wellness and Resilience Education (AWARE) was developed to focus on student wellness and resilience. Project AWARE is a Substance Abuse and Mental Health Services Administration (SAMHSA) grants program dedicated to the promotion of youth mental health awareness in schools and communities. The program intends to build capacity across systems to effectively implement science-based

prevention and intervention practices and scale these practices up. Project AWARE has a direct link to previous school safety efforts; yet seek to take it a step further by addressing wellness promotion. Specifically, Project AWARE aims to assist state and local agencies in improving mental health awareness, training educators and other providers in identifying and intervening with mental health issues, as well as connecting youth and their families with needed services. This project works to improve, expand, or implement a variety of systems level programs and services with an emphasis on: outreach, increased access, enhanced coordination and collaboration, improved screening and identification practices, and implementation of culturally specific and developmental appropriate mental health practices. (Project Advancing Wellness and Resilience Education, n.d.)

A program developed from Project AWARE is Project Cal-Well (Project Cal-Well, n.d.), established in California by a consortium of educators including the California Department of Education, select school districts, and a County Office of Education. The purpose is to promote mental health awareness and wellness among students in K-12 settings. Through cross-system collaboration this consortium is focused on promoting awareness, early identification, and intervention for students within their local education agencies. Cal-Well has implemented Youth Mental Health First Aid (YMHFA) training with a goal training at least 3,000 providers by the end of the grant period. Further, the project promotes positive school climate practices by using evidence-based prevention and intervention programs within their schools.

Nevada was another one of the 20 states awarded the Project AWARE grant and have collected some encouraging implementation data. The Nevada State Department of Education partnered with a tri-county Frontier Community Coalition (FCC), three county school districts and the University of Nevada, Reno (one district eventually dropped out). Activities in the first

year included: hiring mental health professionals, providing mental health awareness training, developing a triage and referral system for referrals, and implementing mental health services in the schools. Data indicated that within six months, 101 adults were trained in YMHFA and 181 students (out of approximately 4,200 students) were referred for mental health services. A survey of 231 teachers, school district administrators, mental health providers, and community members indicated referral patterns of these providers, and found that 50% of these providers felt that AWARE had improved access to services. Investigators reported ongoing challenges such as: (a) the high volume of referrals, (b) challenges in coordination across agencies, and (c) concerns with long-term sustainability of the program (Ryst, Rock, Albers, & Everheart, 2016).

As can be seen with both Project AWARE efforts, there has been some change in the communities regarding establishing systems and approaches for connecting students with mental health services; however, more work is needed to create sustainable models that address the broad community mental health needs and monitor the outcomes of such programs. Some institutions have focused on creating systems for schools to collect data and monitor such outcomes. A key institution, in support of collaborative comprehensive approaches and multi-tiered intervention to improve mental health programming in schools, is the National Center for School Mental Health (CSMH) at the University of Maryland School of Medicine. The CSMH has developed and hosts a School Health Assessment and Performance Evaluation (SHAPE) System. This free, private, web-based tool can be used by school mental health teams to collaboratively assess, plan, and document mental health services and supports offered. The system also offers access to targeted evidence-based resources and materials. In addition, data entered the Shape System is used in the National School Mental Health Census, which supports the center's goal of mapping the status of school mental health at a national level (School Health

Assessment and Performance Evaluation System, n.d.).

Many of the current school-based mental health initiatives are not only dedicated to improving school safety but include the promotion of student wellness as a primary emphasis. There are some common themes and identified needs that run across these emerging programs, with focus on mental health planning and integration, programs seek to: (a) enhance coordination and collaboration across providers, agencies, and policy makers; (b) improve awareness and access to needed services; and (c) effectively implement screening and identification practices within a multi-tiered system of evidence-based intervention. While these initiatives are reputable, there is a need to have an established framework and theory in place when determining how to approach mental health in schools that includes looking at distress alongside wellness.

### **Theoretical Frameworks for Research, Policy, and Practice**

Although the importance of students' mental well-being to positive school experience is widely accepted, little consensus exists on what it means for youth to be mentally well in school. Traditional mental health approaches have primarily targeted and addressed mental health dysfunction among youth such as disruptive emotions and behaviors. Little emphasis is placed on positive indicators of mental health such as hope, happiness, and gratitude (Seligman & Csikszentmihalyi, 2000). These approaches are based on a unidimensional view of illness-health, which conceptualizes positive mental health and psychopathology as two extremes on a continuum and expects people with low psychopathology to have high positive mental health (Lyons, Huebner, Hills, & Shinkareva, 2012). However, current research provides evidence for a multidimensional view of mental health-illness (i.e., a dual-factor model of mental health), indicating that a decrease in one is not necessarily related to an increase in the other (Greenspoon & Saklofske, 2001). According to Brunzell, Stoke, and Waters (2016), a dual-factor approach

suggests that school-based mental health support can be conceived from both a deficit perspective (e.g., what deficiencies or struggles do students face?) and a strengths perspective (e.g., what psychological strengths and resources do students have to build upon for future success?). Furthermore, recent studies argue that positive indicators of mental health can act as protective factors against emotional and behavioral distress among youth, indicating the need for a more balanced approach in mental health support in school settings.

In order to build safe school environments for students to learn and thrive, every school should implement a process to monitor and screen for students' mental health and safety. However, well-being still remains a narrowly defined term in education, complicating efforts to monitor it effectively in schools (Ereaut & Whiting, 2008; Fraillon, 2004). Specifically, evaluations of youth well-being in schools frequently involve grades, attendance records, or number of discipline incidents (Soutter, O'Steen, & Gilmore, 2014). However, emerging policy and research has conceptualized student well-being in broader terms and placed increased attention to physical and mental wellness, risk prevention and resilience, as well as social-ecological contexts that facilitate safe schooling (Soutter et al., 2014). For example, with increased need for positively-framed models that represent a more holistic view of student well-being, the Student Well-being Model (SWBM) was developed and implemented in New Zealand schools, a framework for the development of well-being indicators among students (Soutter et al., 2014). Foundations of the SWBM were identified through an extensive review of the well-being literature (Soutter, Gilmore, & O'Steen, 2011). Its seven domains include having, being, relating, feeling, thinking, functioning, and striving (see Soutter et al., 2014 for more information); each domain is worthy of considered attention in schools to support effective promotion of student well-being. The SWBM also draws from Bronfenbrenner's (1979)

ecological framework in that its seven domains are considered to be embedded in the ecological systems of students' lives, such as school, family, and community (Davis & Simmt, 2003). In such models, school can recognize themselves as an important part of each child's ecological system that plays a meaningful role in giving shape to the well-being of each student.

With this broader conceptualization of student well-being, an important question must be addressed. How is well-being addressed in educational contexts? Currently, only 12.6% of school/district-level administrators across the nation report conducting schoolwide mental health screening with their students (Bruhn, Woods-Groves, & Huddle, 2014). However, most of them still take a traditional, imbalanced approach to mental health by searching for evidence of mental distress concerns among students, but not their psychological strengths and resources. A recent literature by Kim, Furlong, Dowdy, and Felix (2014) found that when a strength-based instrument and a symptom-based instrument were used in combination, prediction of students' subjective well-being was significantly better than using only one of the instruments. This balanced mental health approach in schools can help educators improve students' well-being by building students' psychological strengths, while reducing their mental health concerns. Thus, frequently and widely used general surveillance tools such as the Youth Risk Behavior Surveillance Survey (YRBSS, Kaan et al., 2016) are limited; although they provide meaningful information regarding current risky behaviors students engage in, they do not provide the opportunity to identify and promote psychological strengths and resources that may reduce students' risky behaviors, and in turn, create a safer school environment for them.

The Social Emotional Health Survey-Secondary (SEHS-S; Furlong, You, Renshaw, Smith, & O'Malley, 2014) is an example of strength-based tool that measures positive psychological traits such as self-awareness, gratitude, and optimism, but also measures social-

ecological strengths and resources such as family, peer, and teacher support. In addition to using a deficit-based measure identifying psychological distress, schools could utilize a strength-based measure that examines students' socioemotional strengths and resources. School-based mental health practice based on these dual-factor and social-ecological models can support research focusing on the development of student well-being indicators, which can inform policy and practice development for positive youth mental health.

### **Summary and Conclusions**

School violence is an ongoing concern, and with this concern remains a need for the development and implementation of comprehensive programs that address school safety. As the link between violence and mental health becomes more clearly established, there is an urgent call to address the social emotional needs of students. Although it is understandable to cite school shootings as a motivation for expanding school mental health services, it is an incomplete approach to addressing the needs of students in schools and understanding the effects that more common forms of violence and victimization have on mental health.

We know that student mental health is impacted by incidents of school violence. For example, in the ongoing study of California high school students in this chapter, the majority of students (55%) who believed their school was unsafe also experienced sad/unhappy feelings in the past year. This suggests substantial psychosocial vulnerability in regard to low perceptions of school safety. In contrast, just 29% of students who feel safe at a school experience similar internalizing distress. In addition to students who directly experience violence and victimization, students who witness victimization or are exposure to violent media may also feel that school is unsafe and subsequently develop vulnerabilities. When it comes to understanding adolescent mental health, it is important to note that a number of students at any given school experience

emotional distress, which may or may not be precipitated or exacerbated by school violence and victimization experiences.

As this chapter highlights, it is not enough to address student mental health alone. Rather, there is a need to enhance student overall well-being as a means to positively impact school safety. Although schools are the primary place in which students access mental health services, school-based services often go underfunded and student needs remain unmet (Cummings, Wen, & Druss, 2013). As educators, our ultimate goal is to help students thrive. Therefore, students need access to high quality services that will support their overall well-being and place them on a positive trajectory. Ultimately, healthy children and adolescents in safe schools will be less likely to engage in violent behaviors. When challenges arise, these students will have the ability to cope with difficulties in a healthy and adaptive way.

It is essential that efforts to fund increased and enhanced school mental health services recognize the importance of fostering a student body that is characterized by high levels of affective, psychological, and social well-being as one of the best antidotes to school violence. Students with flourishing mental health feel energized, engaged, and contribute to the school community. These students are better able to cope with their own life challenges and reach out to and support other students in need.

In order to foster student well-being, we need to begin taking essential steps toward building a healthy school environment. First, we must utilize an MTSS framework in our design and implementation of interventions that focuses on the whole child and includes ecological components that impact the child beyond the individual and school levels. This framework should include mental health and/or wellness screening, the use of data to make decisions regarding levels of support, and funding to support a sufficient number of highly-qualified

personnel to carry out the plan.

In February 2018, the Interdisciplinary Group on Preventing School and Community Violence put forth a Call for Action to Prevent Gun Violence in the United States of America that stresses the need for a more comprehensive approach. Among the recommendations, this plan calls for strategies that include: (a) the assessment of school climate in all schools and that all schools maintain physically and emotionally safe conditions; (b) sufficient staffing including counselors, psychiatrists, psychologists, etc. to coordinate school- and community-based mental health services for individuals with identified risk factors; (c) reduce exclusionary practices of school discipline as another strategy to and foster positive social, behavioral, emotional, and academic success; and (d) train and maintain threat assessment teams that include mental health and law enforcement partners (Call for Action to Prevent Violence in the United States of America, 2018). As we move forward with the development of strategies to decrease school violence, it is imperative that mental health and mental wellness are at the forefront of the discussion. Programs that address the needs of those who are both directly and indirectly involved in violence and victimization can have a powerful impact on the safety of schools and the overall well-being of students.

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**Insert 1**

Post Columbine High School

Safe Guarding our Children: An Action Guide

Safe Schools/Healthy Students (Five main components, including mental health)

All schools desire to be the safest places for children, families, and educators. Most schools are successful in providing that safety, and most also recognize that safety must successfully align with the primary purpose of schools: to provide developmentally appropriate instruction, experiences, and support in order to achieve academic and social-emotional learning competencies for all. Balancing these priorities is critical.

During the 1990s, a series of mass school shootings occurred that captured headlines and the 24/7 television news media, leaving many among the public with the impression that in general, schools were not safe.. A series of three school shootings in 1997-1998 (Health High School, Kentucky; Wayside Middle School, Arkansas & Thurston High School, Oregon) where multiple deaths (11) and woundings (38) occurred confirmed this belief, despite the facts that schools were generally safer than a decade earlier. Communities responded to the heightened media with requests for more school policing, use of metal detectors, and secure entry and lock-down procedures (Altheide, 2009). These incidents also resulted in President Clinton requesting that his Secretary of Education, Richard Riley, and Attorney General, Janet Reno, assemble a group of experts and academics from the fields of education, mental health, and juvenile justice to create preventive solutions and interventions to guide schools in their development of safe school plans for the 1998-99 school year and beyond. *Early Warning, Timely Response: A Guide to Safe Schools* (Dwyer, Osher & Wager, 1998), was thus designed and distributed to provide the

practical research-based guidance to help schools “keep every child in school out of harms way.” The *Guide* was produced and distributed to every public school in the nation, and provided guidance for improving school climate, universally supporting social-emotional and coping skills, and intervening early for children needing support. It also helped with identifying and addressing warning signs and imminent signs of violence. Within two years, the follow-up “how to” guide: *Safeguarding Our Children: An Action Guide* (Dwyer & Osher, 2000) was endorsed by Secretary Riley and General Reno. This action guide provided practical steps that had been vetted by school, community representatives, and applied research-to-practice experts to help schools design comprehensive safety action plans. These documents helped reframe the problem of safety and tragic violence into one of mental health promotion. Caring and connection in a positive school climate were the focus of resources, training, and strategic plans.

### **School Violence: A Public Health Issue**

These documents enabled policymakers, researchers, practitioners, and advocates to convert school safety concerns into positive mental health promotion and prevention goals and practices. These documents, through their supporting organizations, now defined school violence as a public health issue subject to the public health prevention and intervention paradigm. Rather than a focus on hardware and criminalizing student behaviors, the focus turned to universal promotion of mentally healthy behaviors and prevention of negative behaviors through positive policies and practices, as well as early intervention. These guides encouraged schools to evaluate and, when necessary, improve their school climate and the conditions for learning for all students, including those receiving special education or English as a Second Language (ESL) services.

Although the *Warning Guide* was distributed in September 1998 its impact increased

after another tragic school shooting. The horrific violence at Columbine High School that occurred during the 1998-99 school year (April 20<sup>th</sup>) resulted in the death of 12 students and one teacher, and left 21 wounded. The two assailants, students in the school, committed suicide. This tragedy heightened the public's anxiety, leading to more cries for security and mental health services (Altheide, 2009). It also resulted in further Federal reports, including reports by the Federal Bureau of Investigation (O'Toole, 2000) and the Secret Service, that focused more on the behavioral characteristics and histories of assailants and their environments. Even in these reports, the school climate was seen as a part of the four-pronged assessment to gauge the level of the student's threat to use violence. These four prongs included the student behaviors, family dynamics, school climate and connectedness, and the community culture (Ibid). The FBI report implied that a trusting school environment, where there is caring and connection, is a positive factor in preventing serious school violence. These reports also supported early interventions and the value of peer support (avoiding the *code of silence* among students) in helping identify youth who are troubled. The reports also cautioned schools to avoid seeking a "check-list" of symptoms that may stigmatize some and produce false positives, impacting trust and depleting school mental health resources. In relation to threat assessment and intervention, the FBI report recommended schools have procedures that are consistent and that students have access to qualified mental health assessment and treatment services. Assessing threats requires trained personnel who can utilize a decision-making tree to determine if the threats are transient or serious. The Virginia Student Threat Assessment Guidelines (Cornell & Sheras, 2006) provides such a process. In addition, to using these guidelines in practice, professionals must consider all relevant ethical implications when conducting such threat assessments (Griffiths, Sharkey, & Furlong, 2008). Since the initial increase of school safety concerns in the 1990s, several

strategies have been developed and implemented nationwide to help create safe school environments that focus on prevention and early intervention. Through the identification of student risk behaviors and the implementation of prevention and intervention efforts, we can continue in the promotion of safe school environments that foster academic achievement and social-emotional learning for all students.

**Insert 1** References

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Table 1

*Associations between high school students' perceptions of school safety and school connectedness, psychosocial distress, and psychosocial well-being*

Item	How safe do you feel when you are at school?			phi <sup>e</sup>
	Unsafe <i>n</i> = 484	Neutral <i>n</i> = 1228	Safe <i>n</i> = 3049	
<i>Direct school violence</i>				
...been pushed, shoved, slapped, hit, or kicked by someone who wasn't just kidding around (% yes) <sup>a</sup>	36.2%	21.2%	11.3%	.24
...been in a physical fight? (% yes) <sup>a</sup>	21.8%	8.8%	5.4%	.19
...been threatened with harm or injury? (% yes) <sup>a</sup>	21.9%	9.6%	4.7%	.22
<i>School connectedness</i>				
I feel like I am part of this school (% agree or strongly agree)	19.4%	30.4%	65.7%	.51
I feel close to people at this school (% agree or strongly agree)	33.5%	46.2%	80.9%	.38
<i>Psychosocial distress</i>				
...did you ever feel so sad or hopeless almost every day for two weeks or more that you stopped doing some usual activities? <sup>b</sup>	55.0%	47.7%	29.2%	.19
...did you ever seriously consider attempting suicide? <sup>b</sup>	34.5%	24.3%	13.4%	.19
...I had a hard time breathing because I was anxious. <sup>c</sup>	36.0%	27.7%	20.3%	.18
...it was hard for me to cope and I thought I would panic <sup>c</sup>	39.5%	30.8%	20.8%	.18
<i>Psychosocial wellness</i>				
I would describe my satisfaction with my school experience as: (% satisfied or very satisfied)	19.7%	24.3%	54.6%	.40
My life is going well (% moderately or strongly agree)	40.0%	58.8%	68.4%	.27
% with flourishing mental health <sup>d</sup>	27.3%	31.1%	54.6%	.28

<sup>a</sup> During the past **12 months**, how many times on school property have you...

<sup>b</sup> During the past 12 months...

<sup>c</sup> In the past month...

<sup>c</sup>Based on responses to 14 items included in the Mental Health Continuum-Short Form (Keyes, 2006). Students were grouped as having flourishing mental health when they reported experiencing at least 1 of 3 affective well-being items almost every day or every day in the past month AND they reported experiences 6 or 11 social and psychological well-being items almost every day or every day in the past month.

<sup>e</sup>phi is presented as an effect size indicator: small effect = .10–.30; moderate effect = .30–.50; large effect >.50.