School Materials for a Mental Health Friendly Classroom: Training Package

Eliminating Barriers for Learning: Social and Emotional Factors That Enhance Secondary Education

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RECOMMENDED CITATION

Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, Eliminating Barriers for Learning; Social and Emotional Factors that Enhance Secondary Education, SAMHSA Pub. No. P040478M. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2004.

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SAMHSA Publication No. P040478M 2004

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Background

Eliminating Barriers for Learning is a packaged continuing education program for secondary school teachers and staff that focuses on mental health issues in the classroom. Its overall aim is to help eliminate barriers to learning by understanding and addressing mental health issues in the school environment. Developed by the Substance Abuse and Mental Health Services Administration, part of the U.S. Department of Health and Human Services, it offers information on adolescent social-emotional wellness and provides specific skill-based techniques for classroom use. It aims to—

- Increase knowledge of adolescent mental health, including risks and protective factors;
- Show teachers and staff how to develop strategies to help students who need additional support;
- Suggest ways to promote a mentally healthy learning environment through instructional techniques that take into account individual styles of learning and classroom climate; and
- Help teachers and staff identify school and community resources and partnerships to promote youth mental health.

Serious emotional disturbances affect 5-9 percent of American children and adolescents each year.[1] That means, on average, that one or more students in every high school classroom could be affected.

Obviously, the impact of children's mental health on schools—teachers, classrooms, students, and staff—can be significant. However, the impact of school practices that promote mental health can also make a difference. This set of materials can help teachers and staff make a difference in the lives of their students and in the learning climate of their classrooms.

1 Farmer, E.M.Z., et al. The Epidemiology of Mental Health Programs and Service Use in Youth: Results From the Great Smoky Mountains Study. In M.H. Epstein et al. (eds.) Outcomes for Children and Youth With Behavioral and Emotional Disorders and Their Families. 2nd edit. (2003)

About the Training Package

This training manual consists of four modules which can be delivered together or at different times. Each one contains:

- A trainer's outline, with instructions for each step of the training;
- Trainer preparation notes with background information and, where necessary, more detailed instructions for specific activities or discussions;
- Slides, in a PowerPoint presentation (hard copies of the slides can be reproduced as overhead transparencies); and
- Reproducible handouts for participants.

Because they are designed to stand alone, the modules contain some repetitions. For example, the definition of serious emotional disturbances is given twice. Trainers can tailor modules according to their own time tables. Like most forms of in service education and professional development training, Eliminating Barriers for Learning emphasizes knowledge and skill development.

Module I: Eliminating Barriers for Learning: The Foundation
This module describes the links between teen social-emotional development, mental health, and learning. It also addresses the impact of the stigma and discrimination that surround mental health issues and explores the teacher's role in helping students with mental health needs. It lays the foundation for, and is a prerequisite for, the three modules that follow.

Module II: Social-Emotional Development, Mental Health, and Learning
This module gives an overview of common mental health issues among adolescents and their potential effects on learning and behavior. It provides information on risk factors and protective factors for mental health and emotional problems, and signs indicating when teens may need help.

Module III: Making Help Accessible to Students and Families
This module provides practice in formulating a plan to help students with mental health needs. It encourages the creation of sustained school-home-community partnerships to meet the educational and developmental needs of these adolescents.

Module IV: Strategies To Promote a Positive Classroom Climate
This module addresses strategies to create an accepting classroom climate that promotes learning for all students, including those with mental health needs.

Delivering the Training

The training includes a variety of learning activities, including large group discussions, individual work with handouts, and small group brainstorming sessions.

Here are some key points to consider when planning the sessions:

Audience. The training is designed primarily for secondary school teachers. However, other school staff members who interact with students could benefit from the training as well.

Trainers. Trainers should know the school in which the training is given, especially the resources available for teens with mental health needs. The modules are designed for delivery by a member of the pupil services staff (a school psychologist, social worker, guidance counselor, or nurse, for example). Co-training with others such a as mental health professional (Module II) and a teacher (Module IV) is recommended.

Trainer preparation. Trainer preparation notes in each module provide background information on the topics presented, as well as detailed instructions for directing activities and facilitating discussions when needed. Trainers can prepare for the sessions by reading the trainer outline and notes with the slides and handouts alongside. Add notes about personal anecdotes or ideas for discussion in the margins.

Part of preparation is tailoring each module to the policies and practices of specific school buildings and districts. For example, a school's policy regarding teacher contact with parents can be woven into the development of an action plan (Module III). Or a State initiative on emotional and behavioral problems and schools can be discussed when introducing the links between mental health and learning (Module I).

A third preparatory step is to recruit guest trainers for help with specific areas. It is strongly recommended that an experienced teacher help deliver Module IV, which focuses on classroom strategies. Module II, which gives an overview of teen mental health issues, offers opportunities for a guest trainer who has first-hand experience with mental or emotional problems in adolescence.

Module III could be delivered with a school or community social worker.

A fourth step is to prepare participant materials. Each participant should have:

- Agenda for the session
- Photocopies of the slides and handouts

See the [Trainer Preparation Checklist](#) for more detailed instructions.

Length of training. The entire training package should take about 4 hours to deliver. However, each of the modules has been designed to stand alone, with the exception of Module I, which is a prerequisite for all or any of the following modules. This flexible format allows for training in specific areas or for ongoing training as time permits.

Training equipment. Equipment needed is an easel or chalkboard and a projector for overhead transparencies or PowerPoint slides.

At least 4 weeks in advance of training:

Trainer Preparation Checklist

- Consider recruiting others to help train certain modules. These specialists can help lead the activities and discussions, contributing their own expertise as they interact with the participants.
  - ○ Module II: A school psychologist or other mental health professional who is familiar with the impact of mental health problems on learning; also a youth or family member who can speak from personal experience about the impact of a mental health problem on learning.
  - ○ Module III: A school or community social worker who is familiar with local and district resources.
  - ○ Module IV: A teacher with experience or a special interest in mental health issues who can speak from experience about classroom strategies and their influence on mental health.
- Set date, time, and place.
- Recruit participants. Place poster (Mental Health: It's Part of Our Classrooms) in a prominent spot in teacher's lounge or other place where teachers congregate. In the white space at the bottom of the poster, add information about time and place; include contact information.

At least 2 weeks in advance of training:

- Begin study of trainer outlines and preparation notes, including a preview of slides and handouts.
- Prepare participant materials:
    - Photocopy handouts for each module.
    - Photocopy slides (optional).
    - Prepare participant agendas, using the trainer outline as a guide; allow for breaks!
    - Make overhead transparencies if a laptop and projector are not available for PowerPoint slides.
- Arrange for equipment. You will need:
    - A laptop and projector for PowerPoint slides or an overhead projector.
    - Flipchart (easel and newsprint) and markers or chalkboard and chalk.

Two days before the training:

- Confirm room and equipment availability; test the equipment.
- Confirm that participant materials are ready.
- Confirm any arrangements for refreshments.

Module I: Eliminating Barriers for Learning: The Foundation

Overview for Trainers

Module I is designed around a vignette of a student who is having problems with social-emotional development. As the module progresses, you will use this vignette to explore:

- The links between teen social-emotional development, mental health, and learning;
- The role of the teacher in addressing mental health needs.

Following participant introductions and orientation to the training, the module begins with a brief review of adolescent development. You can use the vignette, Caleb's Story, to draw participants into a discussion of how social and emotional development interacts with learning and achievement, inside and outside the classroom.

The module continues with a discussion of mental health and emotional problems and stigma, introducing basic definitions and concepts. Caleb's Story again serves as a framework for discussion as participants explore how stigma could be affecting his situation, creating a barrier to getting help.

The final exercise focuses on the teacher's role in helping a student with mental health needs, again using Caleb's Story as the framework for discussion.

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Module I: Goal

The goal of Module I is to describe the links among social-emotional development, mental health, and learning.

Module I: Objectives

At the end of this module, participants will be able to:

- Relate social-emotional development to academic and nonacademic success;
- Define serious emotional disturbances;
- Define the teacher's role in relation to mental health and emotional problems; and
- Describe the stigma surrounding mental health issues and the impact of stigma and discrimination on help-seeking behavior.

Module I: Trainer's Outline

I-1 Introduction: Why Are We Here?
A. Participant and trainer introductions (icebreaker)

- Ask participants, as they introduce themselves, to tell whether they have had any classroom experience with mental health issues.

B. Show Slide I-A (What Would You Do About?) and ask:

- How would you cope with a student who has frequent asthma attacks?
- How would you cope with a student with diabetes? Or food allergies?
- How would you cope with a student with severe depression?

Make the point: Mental and emotional problems among teens are common and need to be addressed, just like asthma and diabetes. But often, teachers are not as well prepared to deal with mental and emotional problems as they are with physical health problems.

C. Show Slide I-B (Why Focus on Mental Health Issues?). Make the points:

- Mental and emotional problems are common and have a serious impact on learning and the classroom.
- The stigma surrounding mental health issues keeps people—students, parents, teachers—from coping with these issues as easily as they cope with asthma or diabetes.
- The benefits for schools that address mental health issues are significant (*Trainer Note I-1*).

D. Show Slide I-C: The overall purpose of the training is to help eliminate barriers to learning by understanding and addressing mental health issues in the school environment.

E. Give overview of all four modules.

- Show Slide I-D (Overview of Modules) and briefly explain the content of each module (*Trainer Note I-1*).

F. Introduce Module I.

- Show Slides I-E and I-F (Goals and Objectives).

I-2 Social-Emotional Development in Adolescence
A. On a flipchart or chalkboard write the three areas of development: physical, intellectual, and social/emotional/behavioral; refer to Handout I-A (Adolescent Development).

B. Clarify what is meant by social-emotional development (*Trainer Note I-2*).

C. Ask participants to read Caleb's Story (Handout I-B), and then to discuss Caleb's social-emotional development, using the description and milestones on the handout. Ask how Caleb displays:

- A sense of identity;
- An understanding of consequences; and
- An idea of appropriate behavior and responses.

I-3 Social-Emotional Factors Related to Academic and Nonacademic Success
A. Ask participants:

- Knowing the background in Caleb's case, what kind of behavior would you expect to see from a student like him inside the classroom? How about in the halls at school?
- Would Caleb's behavior get in the way of learning or being successful in the classroom? How? How about in the halls at school?

B. Use these answers to make the following points:

- The behavior of teens can transfer across academic and nonacademic settings.
- Social-emotional development has ties to academic and nonacademic success.

C. Transition to the following section by making the point:

- Some youth have great difficulty adjusting to areas of social-emotional development and may be at risk for mental or emotional problems.

I-4 Mental Health, Stigma, and Discrimination
A. Refer to Slide I-G (Serious Emotional Disturbances: Definition) and corresponding Handout I-C (Definitions: Serious Emotional Disturbances and Stigma); define serious emotional disturbances (SED) (*Trainer Note I-4*).

B. Make the following point:

- The greater the difficulty experienced by a youth in adjusting, the more likely it is that a problem exists.

C. Show Slide I-H (What Is Stigma?). Make the following point:

- Responding to stigma, people with mental health problems internalize public attitudes and become so embarrassed or ashamed that they often conceal symptoms and fail to seek treatment.[1]

D. Show Slide I-I (Stigma, Discrimination, and Help-Seeking Behavior) and refer to Handout I-D (How Stigma and Discrimination Keep Teens and Families From Getting Help). Make the following points:

- Students generally find it easier to ask for help with academic work than with nonacademic concerns.
- Stigma and discrimination often keep people, particularly youth, from asking for help. (*Trainer Note I-4*).

E. Refer back to Caleb's Story. Ask:

- What examples of stigma and discrimination can be found in this story? How does it occur in the behavior of Caleb's peers and his teachers?
- Why might Caleb or his parents avoid talking with the school about Caleb's difficulties?
  - Ask participants to relate these reasons to the three areas of WHAT, WHY, and WHERE as listed on Handout I-D.
- *How does stigma affect your classrooms? The school?*

[1] New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America. Final Report. DHHS Pub. No. SMA-03-3832: Rockville, MD: 2003.

I-5 The Teacher's Role
A. Refer to Caleb's Story again and ask participants how an educator might help Caleb. First make the following points:

- No teacher is expected to identify or diagnose a serious emotional disturbance, and
- No teacher is expected to refer a student to an external mental health professional.
- Teachers, however, can take action.

B. As participants suggest other ways to help Caleb, try to group them under the teacher's roles shown in Slide I-J (The Teacher's Role).

C. Show Slide I-J and refer to corresponding Handout I-E; continue to brainstorm ways teachers could help Caleb in the various roles.

D. Ask participants if they perceive barriers in playing these roles.

I-6 Closing
A. Summarize major points of the module, referring to objectives.

B. Ask for comments and questions.

C. Ask participants to complete evaluation form.

I-1 Introduction: Why Are We Here?
Overview. This module begins with a discussion of the rationale and aims of the entire training package. It then goes on to describe the links among teen social-emotional development, mental health, and learning. It also addresses the impact of the stigma and discrimination that surround mental health issues and explores the teacher's role in helping students with mental health needs.

Background. Eliminating Barriers for Learning is part of a broad initiative that is working to reduce the stigma and discrimination surrounding mental illnesses. Developed by the Substance Abuse and Mental Health Services Administration, part of the U.S. Department of Health and Human Services, the Elimination of Barriers Initiative focuses on stigma and discrimination because these are serious barriers that keep people from getting the help and support they need to cope with mental and emotional problems.

Serious mental and emotional problems affect 5-9 percent of American children and adolescents each year. That means, on average, that one or more students in every high school classroom could be affected. The impact on schools can be significant. Children with these problems have the highest rate of school failure. Only about 42 percent of these students graduate from high school, compared with 57 percent of all students with disabilities.[1]

The benefits of addressing mental health issues include higher academic achievement, lower absenteeism, and fewer behavioral problems.[2]

The overall purpose of the training is to help eliminate barriers to learning by understanding and addressing mental health issues in the school environment.

Module I: This module describes the links among teen social-emotional development, mental health, and learning. It also addresses the impact of stigma and discrimination that surround mental health issues and explores the teacher's role in helping students with mental health needs.

Module II: This module gives an overview of mental health issues among adolescents and their potential effects on learning and behavior. It provides information on risk factors and protective factors for mental and emotional problems, and on signs indicating when teens may need help.

Module III: This module provides practice in formulating a plan to help students with mental health needs. It encourages the creation of sustained school-home-community partnerships to meet the educational and developmental needs of adolescents.

Module IV: This module addresses ways to create an accepting classroom climate that promotes learning for all students, including those with mental health needs.

I-2 Social-Emotional Development in Adolescence
Background. As teachers well know, adolescence is a time of rapid development, the second time since infancy that changes occur at an accelerated rate. The purpose of this section is to review and discuss one developmental area—social-emotional development—and how it impacts learning.

Expanded information about social-emotional development:

- Social-emotional development is the process of acquiring information, values, and beliefs about self, others, and the world at large, as well as the evolution of how individuals behave to express these qualities.
- Social-emotional development affects how youth make decisions, manage the consequences of their decisions, cope with internal and external stress, and communicate with others.

- Social-emotional development increases awareness of one's own and others' behavior, appropriate emotional responses, and styles of communication. Because they are so aware of these often awkward changes, adolescents look to their peers to validate their behavior, responses, and communication as "normal."

I-3 Social-Emotional Factors Related to Academic and Nonacademic Success

Notes on facilitating group discussion. Participants have observed youth in a variety of contexts: the classroom, hallways, cafeteria, sports, and assorted situations. It is through the process of observation that they begin to really see the effects of development across age ranges and between individuals. In the discussion of Caleb's Story, you will be asking participants to consider social-emotional development and its impact on performance in the classroom as well as success outside of it. Use their responses to illustrate the far-reaching impact of social-emotional development and mental health.

Examples of the relationship between social-emotional development and academic and nonacademic success. The following examples may reflect some participants' observations during this discussion. Keep in mind that the relationship between social-emotional development and success in and out of the classroom is not limited to the following; nor is the boundary between "academic" and "nonacademic" a rigid one.

- The **formation of identity** leads to **self-direction** and **self-efficacy** (the feeling that one can accomplish a particular task) in the classroom, and **self-expression** and a **sense of purpose** outside the classroom.
- An **understanding of consequences** develops adolescents' **critical thinking** and **problemsolving** skills in academic work, as well as **conflict resolution** and **decisionmaking** skills outside the classroom. It also develops a sense of **autonomy**.
- A developing **sense of appropriateness and normalcy** can impact **classroom conduct**, including **attentiveness** and **concentration**. It will also influence **self-esteem** and **social interactions with peers**.

I-4 Mental Health, Stigma, and Discrimination

NOTE: More details about specific disorders are in Module II. Here, the definition is supplied in order to introduce the concept of stigma surrounding mental health issues.

SED Definition and Information. Serious emotional disturbances (SEDs) are diagnosable disorders *in children and adolescents* that severely disrupt daily functioning in the home, school, or community.

"Serious emotional disturbance," not "mental illness," is the preferred term when referring to these disorders in children and adolescents.

In a given year, about 5-9 percent of children (up to 18 years of age) have a serious emotional disturbance.[3] Unfortunately, as many as 25 percent of youth who may have a serious emotional disturbance do not receive mental health services of any kind.[4]

The 1999 report of the Comprehensive Community Mental Health Services for Children and Their Families Program of the Center for Mental Health Services reports that students with serious emotional disturbances showed significant difficulties in school: 14.1 percent of students had school attendance lower than 50 percent, and 43.3 percent of students were listed with below average or failing grades.

About Stigma. In these modules, stigma refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses. Stigma is not just a matter of using the wrong word or action. Stigma is about disrespect. It is the use of negative labels to identify a person living with mental illness. Stigma is a barrier. Fear of stigma and the resulting discrimination discourages individuals and their families from getting the help they need.

Stigma can cause discriminatory treatment toward youth and their families by their peers as well as by educators and community members. It also is dangerous because it can prevent people from seeking help and meeting their own needs. It does this by causing:

- Reluctance to recognize a problem;
- Inability or reluctance to seek treatment; and
- Reluctance to ask how to seek services.

These are noted as WHAT, WHY, and WHERE on Slide I-I and Handout I-D. A more detailed explanation follows:

- *Reluctance To Recognize a Problem (WHAT).* Emotional and behavioral problems influence the skills youth are developing. Stigma can prevent recognition of that influence. Some advice-givers may suggest that certain behaviors are not linked to mental health issues, but are related to other factors such as laziness, lack of discipline, personality, or immaturity. Nonprofessionals may say that a youth will grow out of the problem or that it is part of being a teenager. This can give youth and families mixed messages about the importance of treatment.
- *Inability or Reluctance To Seek Treatment (WHY).* Youth and their families may avoid mental health care services because they do not want confirmation that the youth is "crazy." Others may be afraid to discuss the possibility of an emotional or behavioral problem, because they think they will be blamed or suffer other social consequences.
- *Reluctance To Ask How To Seek Services (WHERE).* Sometimes lack of knowledge about mental health care services is a barrier to treatment. Stigma and fear of discrimination can prevent people from asking questions that will lead to successful access to services. The fear that others cannot be trusted with confidential information can make asking for help a threat to privacy.

[3] Farmer, E.M.Z. et al. The Epidemiology of Mental Health Programs and Service Use in Youth: Results From the Great Smoky Mountains Study. In M.H. Epstein et al. (eds.) Outcomes for Children and Youth With Behavioral and Emotional Disorders and Their Families. 2nd edit. (2003)

[4] Hoagwood, K., & Johnson, J. (2003). School psychology: A public health framework I. From evidence-based practices to evidence-based policies, Journal of School Psychology, 41(I), 3-21.

Module I: Slides

Slide I-A: What Would You Do About...

- A student with asthma?
- A student with diabetes?
- A student with food allergies?
- A student with severe depression?

Slide I-B: Why Focus on Mental Health Issues?

- They are common and can affect learning
- Stigma creates barriers to getting help
- Teachers can help remove barriers
- Benefits for schools, classrooms, students:
    - Higher academic achievement
    - Lower absenteeism
    - Fewer behavioral problems

Slide I-C: Overall Purpose of Training

The overall purpose of the training is to help eliminate barriers to learning by understanding and addressing mental health issues in the school environment.

Slide I-D: Overview of Modules

Module I: Eliminating Barriers for Learning: The Foundation

- Social-emotional development, stigma, and discrimination

Module II: Social-Emotional Development, Mental Health, and Learning

- Overview of disorders, effects on learning, and risk factors

Module III: Making Help Accessible to Students and Families

- Formulating a plan to help students with mental health needs

Module IV: Strategies To Promote a Positive Classroom Climate

- Creating a climate that promotes learning and mental health

Slide I-E: Goal
The goal of Module I is to describe the links among social-emotional development, mental health, and learning.

Slide I-F: Objectives

- Relate social-emotional development to academic and nonacademic success
- Know the definition of serious emotional disturbances
- Understand the teacher's role in relation to mental health and emotional problems
- Understand the stigma surrounding mental health problems and the impact of stigma and discrimination on help-seeking behavior

Slide I-G: Serious Emotional Disturbances: Definition
Diagnosable disorders in children and adolescents that severely disrupt their daily functioning in the home, school, or community. These disorders include:

- Depression
- Attention-deficit/hyperactivity disorder
- Anxiety disorders
- Conduct disorder
- Eating disorders

Slide I-H: What Is Stigma?

In these modules, stigma refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses. Stigma is not just a matter of using the wrong word or action. Stigma is about disrespect. It is the use of negative labels to identify a person living with mental illness. Stigma is a barrier. Fear of stigma and the resulting discrimination discourages individuals and their families from getting the help they need.

Slide I-I: Stigma, Discrimination, and Help-Seeking Behavior

- WHAT (Identification)
- WHY (Referral)
- WHERE (Treatment)

Slide I-J: The Teacher's Role

- Observer
- Catalyst
- Team member
- Educator
- Role model
- Collaborator

Handout I-A: Adolescent Development

Area	Description	Milestones
Physical	- Increase in height/weight - Hormonal changes - Maturation of brain/neural system	- Secondary sex characteristics - Strength/dexterity
Intellectual	- Reasoning - Abstract thinking "Thinking about thinking"	- Logic/consequences - Concepts/ideas - Metacognition
Social-Emotional	- Formation of attitudes, beliefs, and values (identity development) - Recognition of consequences of decisions made - Awareness of one's own and others' behavior; formation of ideas of appropriateness	- Self-direction - Sense of purpose - Autonomy - Conflict resolution - Self-esteem and self-efficacy

Handout I-B: Caleb's Story

Caleb was asked to leave Mrs. Parker's class for the third time this week. As he waited in the main office to see the assistant principal, Caleb started to think about what his mother might say. It was already the fifth week of the second marking period and nothing about Caleb's behavior had changed. He was talking in class, twirling his house keys, and Mrs. Parker, according to Caleb, had it in for him. How could he explain any of this to the assistant principal? To his mother? He just seemed to always stand out somehow.

Caleb thought about the years of getting into trouble at school. He had attention-deficit/hyperactivity disorder and had taken medicine from first grade to sixth grade. He switched medicines at different times and he remembered how many headaches and stomach aches went along with those medicines. Sometimes he fell asleep in class or he felt really jumpy or upset. In sixth grade, he stopped taking the medicine. It just didn't seem to keep him focused anymore. "So what!" Caleb mumbled to himself. No more headaches.

Yet Caleb remembered how bad sixth grade had been. He was in trouble every day. He recalled how he accidentally got stuck in his chair, falling in between the seat and the backrest. How on earth did he do that? The other students had laughed and the teacher was so mad! So many things had happened and his grades just kept going down.

The school said they couldn't help him, but Caleb told the other kids he got kicked out. Caleb's mother had told him that he didn't have to pretend he was a bad kid to get others to like him. He told her that being bad was better than being sick.

Middle school had felt like a big zoo with all the guys acting like gorillas. Caleb felt angry thinking about how many fights he had to avoid. He just seemed to annoy people for no reason. To top it off, his teachers just seemed to hate him. He lost his work or didn't write down the assignments. Detention was a weekly event. He ended up going to the guidance office to eat his lunch so he could avoid all the guys who made his life

miserable. Once he took two pints of chocolate milk out of the cafeteria and put them in his backpack. That was a big mistake! When he walked down the hallway, one of the guys kicked his backpack. By the time Caleb made it to the guidance office the pints were crushed open and milk was on all of his schoolwork. The secretary yelled at him for making a mess and kicked him out of the office.

All anyone ever told Caleb was that he didn't try hard enough. They would tell him he was smart but an underachiever, whatever that meant. Caleb decided he was just lazy. It seemed like each time, he would decide to keep his mouth shut, and then he would forget. His teachers wrote that he was disruptive, talkative, and didn't follow the rules of the class.

Caleb was called into the assistant principal's office. The assistant principal told Caleb that detention just didn't seem to have any consequences, so he was given two days of in-school suspension because the number of incidences was escalating. Caleb thought about his failing grades. At least in suspension he could catch up on his work, he imagined. *Wait until my mother sees my grades,* Caleb worried to himself. *I don't think I have above a 30 in math and I am failing English, too.*

The bell rang. Caleb was going to be late for Earth Science and he'd forgotten to ask for a pass. Of course, the teacher probably wouldn't believe that he was at the office. Caleb decided he was in trouble anyway, so he might as well take his time. No one believed him, he decided. He thought maybe he should just do whatever he wanted. What was the point, anyway?

Handout I-C: Definitions: Serious Emotional Disturbances and Stigma

Serious emotional disturbances:
Diagnosable disorders in children and adolescents that severely disrupt their daily functioning in the home, school, or community. These disorders include depression, attention-deficit/hyperactivity disorder, anxiety disorders, conduct disorder, and eating disorders.

Source:
Glossary of Terms, Child and Adolescent Mental Health, Center for Mental Health Services;
www.mentalhealth.samhsa.gov/publications/allpubs/CA-0005/default.asp

Stigma:
In these modules, stigma refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses. Stigma is not just a matter of using the wrong word or action. Stigma is about disrespect. It is the use of negative labels to identify a person living with mental illness. Stigma is a barrier. Fear of stigma, and the resulting discrimination, discourages individuals and their families from getting the help they need.

Sources:
Anti-Stigma: Do You Know the Facts? Child and Adolescent Mental Health, Center for Mental Health Services; www.mentalhealth.samhsa.gov/publications/allpubs/OEL99-0004/default.asp

New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America. Final Report. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.

Handout I-D: How Stigma and Discrimination Keep Teens and Families From Getting Help

Youth, parents, and educators all too often do not take steps toward seeking help because they do not know WHAT, WHY, or WHERE, as follows:

WHAT (Identification)

- They are reluctant to recognize behavior, thoughts, or feelings that impair youths' functioning.

WHY (Referral)

- They are aware of problems but believe they will pass.
- They do not encourage intervention/treatment because it would mean youth is "crazy."*
- They are aware of impairment but "it has nothing to do with school/job/sports."
- They are unsure how to address the concern.

WHERE (Treatment)

- They are unaware treatment is available.
- They are hesitant to reveal personal information because they fear a breach of confidentiality.
- They are afraid of being blamed.
- They feel ashamed or embarrassed.

* "Crazy" is a stigmatizing term that reflects misunderstanding of mental illnesses and serious emotional disturbances. It should be avoided.

Handout I-E: The Teacher's Role

The teacher's role as a supportive adult is critical to a student with mental health and emotional problems. Specific functions within a supportive adult role include:

- **Observer**—Notice social and academic behaviors that appear inappropriate or distressing. Take note of intensity, duration, frequency, and impact.
- **Catalyst**—Speak with the student; refer the student to a member of the pupil personnel support staff, such as a social worker, psychologist, or counselor; and partner with this professional to voice concerns to the parents/caregivers of the student. Make a referral to the school's intervention team or committee if academic or social difficulties are substantial.
- **Team member**—Be willing to work with parents, the student, the school, and others involved to provide feedback about the student's progress, any impact of medications, and what seems to be working.
- **Educator**—Refer to the student's Individualized Education Plan (IEP) if one exists. Modify coursework as indicated. Ask for assistance from special education coordinators, if necessary, and let them know if the student seems to need more support than what is written in the IEP.
- **Role model**—Demonstrate empathic, encouraging, and hopeful responses when others are discouraged by the student's behavior, lack of progress, or "willfulness." When in doubt about how to respond, think before speaking out of anger, frustration, or discouragement. Youth with special needs can act in ways that make adults feel inadequate or incompetent. Don't take it personally. Separate the behavior from the person.
- **Collaborator**—Work with the student and school support staff to come up with ways to assist the student and identify what benefits the student most.

Part I: Please answer the following questions by circling a number on the scales provided.

1) Was the content of this module *relevant and applicable* to your classroom/school?

Not at all relevant   Somewhat relevant   Extremely relevant
    1   2   3   4   5   6   7

2) Was the information presented *too simplistic* or *too involved*?

Too simplistic   Just right   Too involved
    1   2   3   4   5   6   7

3) Was the information *new* to you?

All previously known   Some new information   Mostly new information
    1   2   3   4   5   6   7

4) Was the module *well-organized*?

Not well-organized   Somewhat well-organized   Very well-organized
    1   2   3   4   5   6   7

5) Was the module an appropriate *length*?

Too short   Comfortable length   Too long
    1   2   3   4   5   6   7

6) Was there a sufficient *variety* of activities?

Not enough   A good number   Too many
    1   2   3   4   5   6   7

7) Were the *materials* (slides, handouts) clear and concise?

Not clear   Somewhat clear   Very clear
    1   2   3   4   5   6   7

8) Were the materials *helpful* as supplements to the information presented?

Not helpful   Somewhat helpful   Very helpful
    1   2   3   4   5   6   7

Part II: Please give us your comments:

I liked:

_____

_____

I didn't like:

_____

_____

I wish there had been more:

_____

_____

The most important thing I learned was:

_____

_____

Other comments:

_____

_____

_____

_____

Module II: Social-Emotional Development, Mental Health, and Learning

Overview for Trainers

This module gives a brief overview of mental health issues among teens and their potential effects in the classroom. It begins with a discussion of factors that can put teens at risk for, or protect them from, mental and emotional problems. It then looks at the continuum of problems, from wellness at one end to serious emotional disturbances at the other, and moves on to the various components of learning and behavior that can be affected by these problems. Next, slides describe the most common disorders among teens, while discussion centers on the ways that each one affects those components of learning and behavior. The final sections describe indicators that a teen may need help. An action plan for helping a student is briefly introduced. (This segment can be omitted if Module III is to follow immediately after.)

- Note: Information on specific disorders is provided at three different levels. The slides provide a brief overview; the Trainer Preparation Notes give more background information; and the Appendix provides fact sheets for participants to take home for future reference.

Contents

The goal of Module II is to give an overview of mental health issues among adolescents and their potential effects on learning and behavior.

At the end of this module, participants will be able to:

- Identify social-emotional factors related to positive youth development, including risk and protective factors;
- Understand the range of social-emotional development and its relationship to mental health;
- Name the most common serious emotional disturbances in adolescence and their potential impacts on learning and behavior; and
- Describe indications that a student needs additional support.

II-1 Introduction
A. Remind participants that the overall purpose of the training is to help eliminate barriers to learning by understanding and addressing mental health issues in the school environment.

B. Show Slides II-A (Goal) and II-B (Objectives).

C. Give overview of the module, linking it to themes from Module I (*Trainer Note II-1*).

II-2 Risk and Protective Factors
A. Show Slide II-C (What Are Risk Factors?).

B. Refer to Caleb's Story from Module I (Handout I-B). Give participants time to re-read the vignette.

C. Ask participants what risks are present in Caleb's Story. Write responses on a flipchart and relate them to categories on the next slide.

D. Show Slide II-D (Risk and Protective Factors) and refer to corresponding Handout II-A (Risk and Protective Factors) (*Trainer Note II-2*).

E. Summarize areas of potential risk and protective factors that help to reduce the likelihood of negative developmental outcomes, making the following points:

- Resilient youth are those who demonstrate favorable development despite exposure to a variety of risk factors.
- The promotion of mental health is a way to strengthen protective factors and bolster resilience for all youth.

II-3 The Adolescent Mental Health Continuum
A. Show Slide II-E (Mental Health: Definition).

B. Refer to Handout II-B (Adolescent Mental Health Continuum) (*Trainer Note II-3*).

C. Explain the continuum, making the following points:

- The majority of youth experience overall wellness despite occasional difficulties.

- Behaviors of youth occupy a range of what would be expected for them during their early, middle, and late stages of adolescent development. This range can be illustrated by a continuum.
- Mental health and emotional problems are a concern when they disrupt developmental growth.
- The severity of a problem depends on three factors: the frequency (how often), duration (how long), and intensity (to what degree) of symptoms.
- Co-occurring substance use disorders can affect where youth fall in this continuum. In comparison to individuals with primary mental or substance use disorders, individuals with co-occurring disorders tend to be more symptomatic, have multiple health and social problems, and require more costly care, including hospitalization.

II-4 The Impact of Mental Health Problems and Disorders on Learning and Social Functioning
A. Show Slide II-F (Serious Emotional Disturbances: Definition).

B. Refer to Handout II-C (Serious Emotional Disturbances).

- Emphasize that SED, as used in this training, refers to a clinical diagnosis. It does not necessarily mean "qualifies for special education."

C. Ask participants to consider how mental health and emotional problems may affect academic and nonacademic activities. Write participants' responses on a flipchart and relate them to the categories on the next slide and handout (*Trainer Note II-4*).

D. Show Slide II-G (Adolescents With Mental Health and Emotional Problems) and refer to Handout II-D (Problems Associated With Serious Emotional Disturbances).

E. Emphasize themes, contributions, and areas that are directly related to classroom learning.

F. On the easel or chalkboard, write the following components of learning affected by mental health and emotional problems:

- Attentiveness
- Concentration
- Opportunities to rehearse
- Demonstration of mastery
- Classroom conduct
- Ability to organize
- Ability to communicate

II-5 Common Mental Health and Emotional Problems in Adolescence
A. Show Slides II-H?II-N to give a brief overview of the most common problems among teens. Refer participants to the appendix handouts for more detailed information (*Trainer Note II-5*).

- As you show each slide, mention some of the most important ways serious emotional disturbances affect learning and behavior, referring back to the list on your easel or chalkboard. (You can find this information in Handouts II-E, II-F, II-H, and II-I.)
- Ask participants about classroom experiences that illustrate the impact of these problems on learning and behavior.

II-6 Other Disorders

- Schizophrenia: Make the point that schizophrenia is rare in adolescence but that symptoms do occasionally appear; more information is available in the appendix handouts.
- Tourette syndrome, autism, and Asperger syndrome: Make the point that these are not mental health issues and will not be addressed.

II-7 When Youth Need Additional Support
A. Show Slide II-O (Indicators of Need) and refer to Handout II-J (Indicators of Need).

- Make the point: There is no clear dividing line between mental health and serious emotional disturbances; they are points on a continuum.
- Remind participants they are not expected to be diagnosticians (*Trainer Note II-7*).

B. Show Slide II-P (Action Plan).

C. Show Slide II-Q (Stages of an Action Plan) and summarize the components of a plan (*Trainer Note II-7*).

II-8 Closing
A. Summarize major points of the module, referring to objectives.

II-1 Introduction

Background. Module II gives a brief overview of the serious emotional disturbances most common among adolescents and their potential effects on learning and behavior. It begins with an overview of risk and protective factors, and goes on to describe specific disorders. The module concludes with a discussion of "indicators of need"—signs suggesting that a student may need additional support. A brief introduction to an action plan, to be devised when a student needs additional support, leads to the next module, in which participants practice creating an action plan. (This last section can be omitted if Module III is to follow immediately.)

Note on presentation: There are opportunities within this module to include youth speakers, family speakers, and other members of a two-member or three-member presentation team (e.g., mental health professionals, family members, school professionals). A guest speaker can discuss the impact of mental health problems on learning and other areas important to the school environment. Consider Section II-5 as especially adaptable for speakers with personal experience of mental health problems during adolescence.

II-2 Risk and Protective Factors

Background. The exact cause of mental disorders is not known, but most experts believe that a combination of factors—biological, psychological, socio-cultural—are involved.

While the same key events mark adolescencent development, youth develop at different rates. These differences sometimes are associated with their cultural, social, and economic groups, and/or their gender. Youth also differ in the degree to which they are insulated or protected from medical, environmental, and familial or personal events that could disrupt their developmental growth. When a group of factors have the potential to impede healthy development they are known as risk factors. Risk factors may be related to biology or environment (e.g., family, community).

Further information on risk and protective factors. Risk does not predict poor outcomes. It simply means that a number of conditions or situations can solidify a pathway that becomes increasingly difficult to shape toward positive results.

The areas of risk summarized on Slide II-D (Risk and Protective Factors) pertain to factors that are associated with delinquency, pregnancy, dropout, and crime. Some risk factors not mentioned include those related to individual differences, such as temperament and intelligence. Males appear more vulnerable to risk factors, as do children and youth with difficult, temperamental styles and lower IQs.

Protective factors include relationships, and opportunities to be involved and recognized for the skills and contributions made. Relationships with youth need to be genuine, authentic, and ongoing. Opportunities to be involved and contribute must match the youth's actual skill set. To fail at an opportunity due to insufficient skill sets the youth up for discouragement, frustration, and disillusionment.

The President's New Freedom Commission on Mental Health defines resilience as "the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses—and to go on with life with a sense of mastery, competence, and hope."[1] Resilient youth demonstrate favorable development despite exposure to a variety of risk factors. The promotion of mental health by building on strengths is a way to develop protective factors and bolster resilience for all youth.

[1] New Freedom Commission on Mental Health. Achieving the Promise: Transforming Mental Health Care in America. Final Report. (DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003) 5.

II-3 The Adolescent Mental Health Continuum
Background. The majority of youth experience overall wellness despite occasional difficulties. Mental health problems or disorders are a concern when difficulties disrupt developmental growth. Behaviors of youth occupy a range of what would be expected for them during their early, middle, and late stages of adolescent development. This range can be illustrated by a continuum, that depicts variation in behavior frequency (how often), duration (how long), and intensity (to what degree). Along this continuum, the American Academy of Pediatrics (1996) identifies various kinds of behaviors, including behaviors expected during adolescence; behaviors that are serious enough to disrupt day-to-day functioning, representing a mental health problem; and behaviors that would suggest a mental disorder is present.

Co-occurring substance use disorders can affect where youth fall along this continuum. In comparison to individuals with primary mental or substance use disorders, individuals with co-occurring disorders tend to be more symptomatic, have multiple health and social problems, and require more costly care, including hospitalization.

While secondary school teachers and staff are not expected to pinpoint where each student falls along the continuum, it is helpful to understand that problems of emotion and behavior are not merely absent or present, but are more differentiated by the frequency, duration, intensity, and impact to self and others.

About Handout II-B (Adolescent Mental Health Continuum). It is important to realize that the columns below the continuum line represent areas of functioning that have impact on life domains. These areas, more often than not, are not neatly clustered as shown in the columns and rows. Typically, some symptoms can show up at one level with other symptoms at a more intense level, and a completely different set of symptoms at an extreme level. That is, separate areas can be linked diagonally with each other. For example, a youth may show very appropriate social functioning but experience severe distress in biological patterns, as with an eating disorder.

II-4 The Impact of Mental Health Problems and Disorders on Learning and Social Functioning
Background. About 5?9 percent of children ages 9 to 17 have a serious emotional disturbance[2].

Serious emotional disturbances (SEDs) are diagnosable mental disorders *in children and adolescents* that are severe enough to disrupt daily functioning in school and non-school settings. SED, rather than mental illness, is the preferred term for severe mental health problems among children and adolescents. SEDs include mood disorders, attention-deficit/hyperactivity disorder, anxiety disorders, conduct disorders, and eating disorders.

The term SED, or serious emotional disturbance, as used in this training, refers to a clinical diagnosis. It does not necessarily mean "qualifies for special education." Specific school/district policies regarding SEDs vary. In Module III, there will be an opportunity to address local policies regarding serious emotional disturbances.

Information about serious emotional disturbances' impact on academic activities. These disorders can affect important components of classroom behavior and learning, particularly attentiveness, concentration, and opportunities to rehearse and demonstrate new knowledge or skills. Self-appraisal, which is a set of attitudes and expectations about one's own ability and performance, is another important component of learning that can be affected by a serious emotional disturbance. Mastery of a skill, the prize of learning, is difficult to obtain when any or all the components of attention, concentration, self-appraisal, and rehearsal are affected by a serious emotional disturbance. Learning is a behavior, as are the social elements of conduct both inside and outside the classroom. While it might not be apparent how a disorder affects learning, the symptoms will show up in other ways, namely through behavioral conduct in the classroom and interactions with peers and adults.

Serious emotional disturbances also may affect classroom learning in more tangible ways, such as missed instruction time due to hospitalization or doctor's appointments.

[2] Farmer, E.M.Z. et al. The Epidemiology of Mental Health Programs and Service use in Youth: Results From the Great Smoky Mountains Study. In M.H. Epstein et al. *(eds.) Outcomes for Children and Youth With Behavioral and Emotional Disorders and Their Families. 2nd edit. (2003)

II-5 Common Mental and Emotional Problems in Adolescence

In this section you will show Slides II-H?II-N, giving a very brief overview of the most common disorders among teens. The following bullets will give more background for the trainer. Much more complete information is available in the Appendix for participants' use after the training.

Discussion during this overview should center on the disorders' effects on learning and behavior. This information is included in the following handouts:

- Handout II-F (Depressive Disorders: Effects on Learning and Behavior)
- Handout II-H (Anxiety Disorders: Effects on Learning and Behavior)
- Handout II-I (Eating Disorders: Effects on Learning and Behavior)

NOTE: There is no handout on the impact of disruptive behavior disorders; the impact on behavior is part of the description of the disorder.

You can refer to the list of potential effects you have written on the easel or chalkboard as you present this section. Consider asking participants to draw on their classroom experience to illustrate some of the effects. A guest speaker could also contribute to the presentation/discussion in this section.

• **Mood Disorders**

Mood disorders are persistent disturbances of mood that affect an individual's ability to conduct basic life tasks. Major depressive disorder, dysthymic disorder, and bipolar disorder are the most frequently diagnosed mood disorders in children and youth.

- **Major depressive disorder** involves a pervasive sense of sadness and/or loss of interest or pleasure in most activities. This is a severe condition that can affect thoughts, sense of worth, sleep, appetite, energy, and concentration. The condition can occur as a single debilitating episode or as recurring episodes. Approximately 4 percent of adolescents experience major depression each year.[3]
- **Dysthymic disorder** involves a chronic disturbance of mood in which an individual feels little satisfaction with activities of life most of the time. Dysthymia may be one of the major pathways to recurrent depressive disorder. The average length of an episode of dysthymia is about 4 years, and children who experience dysthymia generally experience their first major depressive episode 2 to 3 years after the onset of dysthymia.
- **Bipolar disorder** is a type of mood disorder characterized by recurrent episodes of depression and mania. These episodes involve extreme changes in mood, energy, and behavior. Mania or manic symptoms include extreme irritable or elevated mood, a very inflated sense of self-importance, risky behaviors, distractibility, increased energy, and a decreased need for sleep.

Information on the importance of treatment. Identification of a mood disorder and referral to treatment can be significant first steps in restoring a youth's functioning. Fortunately, the majority of those who receive treatment for depression are treated successfully. Treatment not only alleviates symptoms, it also prevents further complications. Youth with severe depression may experience profound withdrawal from social activities, feel intense isolation and loneliness, and become at high risk for suicide.

3 **Kovacs, M., Kral, R., and Voti, L. (1994). Early onset psychopathology and the risk for teenage pregnancy among clinically referred girls. Journal of the American Academy of Child and Adolescent Psychiatry, 33: 106-113.**

• **Anxiety Disorders**

Anxiety disorders are characterized by excessive fears, worries, and preoccupations that are a reaction to a perceived sign of danger. Anxiety itself is considered essential to adaptive functioning because it protects people from harm through a "flight or fight" biological response. An anxiety disorder, however, is a recurrent alarm that can tax the body excessively. Anxiety disorders include generalized anxiety disorder, separation anxiety disorder, panic disorder, phobias, obsessive-compulsive disorder, and post-traumatic stress disorder. If left untreated, anxiety disorders can have a significant and debilitating impact on an individual's life.

- **Obsessive-compulsive disorder** (OCD) is an anxiety disorder that is characterized by intrusive thoughts and/or behaviors that are recurrent and distressing. The thoughts act like a warning to take an action or not take an action. Compulsions are the actions undertaken to relieve the intrusive thoughts. However, these actions provide only temporary relief and may create more problems, such as taking time from obligations, responsibilities, or recreation. Actions also can have an impact that requires medical attention, such as treatment for the skin due to excessive hand washing. Obsessive thoughts, even when action is not involved, can impact functioning in critical ways.
- **Post-traumatic stress disorder** (PTSD) is anxiety that can occur in response to a threatening event that was witnessed or experienced. The event is re-experienced through nightmares, flashes of memory, or other patterns of remembering. An individual with PTSD may startle easily, experience forgetfulness, or report feeling "numb."

• **Disruptive Behavior Disorders**

Disruptive behavior disorders are a complicated group of behavioral and emotional problems that manifest as difficulty following rules and behaving in socially acceptable ways. The impact of the disruptive behavior is distressing to others and can interfere with establishing trusting and supportive relationships.

- **Conduct disorder** is a disruptive behavior disorder that can have serious consequences for youth and society. Youth with conduct disorder outwardly express their feelings about others through destructive behaviors that harm property, people, or animals. They may lie, steal, or physically fight with others. They engage in criminal or rule-violating behaviors that can lead to involvement with juvenile justice. Often they report little empathy or remorse for destructive behaviors. They may have unidentified symptoms of depression or have another diagnosable disorder, such as attention-deficit/hyperactivity disorder (ADHD) or a learning disability.

• **Eating Disorders**

Eating disorders refer to patterns of thoughts and behaviors about one's body, foods, and the intake of foods that lead to severe health, social, and school problems. Eating disorders negatively affect physical and psychological health, and if left untreated, can lead to damaging medical consequences, including death. Eating disorders include anorexia nervosa, bulimia nervosa, and binge-eating disorder.

- **Anorexia nervosa** is characterized by a refusal to maintain body weight at a level that is normal for one's height and age; fear of becoming overweight, even if well below normal weight; perception of body weight or body shape that is distorted; denial of being underweight; and the absence of menstrual cycles. Individuals with anorexia nervosa can become dangerously thin but continue to control their weight gain. Eating or weight gain becomes an obsession, as shown by peculiar habits, such as ritualistic food preparation, measuring food, or eating very tiny portions. Other behaviors include ways to control

weight gain such as rigorous and strict exercise regimens or abuse of laxatives, enemas, and diuretics. Medical complications associated with anorexia nervosa include disturbances in the heart's rhythm, dangerously low blood pressure and body temperature, osteoporosis, and hair loss.

- **Bulimia nervosa** involves disordered eating that is typically characterized by normal weight but a distorted body image and an intense fear of gaining weight. Individuals with bulimia nervosa experience binge eating, which is the intake of large amounts of food during a specific interval of time, or they perceive a general lack of control over eating. These symptoms are coupled with behaviors to prevent weight gain, such as self-induced vomiting, misuse of laxatives or enemas, fasting, or excessive exercise.

- **Binge-eating disorder** refers to repeated episodes of binge eating, such as eating more rapidly than normal; eating until feeling uncomfortably full; or eating large amounts of food when not feeling physically hungry. The episodes are recurrent and usually occur at least two days a week for six months. Unlike bulimia nervosa, binge-eating disorder does not include ways to purge weight gain. Individuals with binge-eating disorder are usually overweight and experience extreme self-disgust or distress over their body shape and size.

II-6 Other Disorders

Note on developmental disorders. Pervasive developmental disorders (PDD) are neurobiological disturbances that range from very mild to extremely severe. These impairments affect one or more areas of intellectual, language, motor, and social functioning. Pervasive developmental disorders are sometimes referred to as autistic spectrum disorders.

These disorders are **not** classified as serious emotional disturbances, although they can co-occur with these disorders.

Disorders that fall under the pervasive developmental disorder umbrella term include autistic disorder, childhood disintegrative disorder, and Asperger syndrome. These disorders are different from one another in the magnitude of delay or deviance from normal development.

More information on each of these disorders is available from the Web sites listed on the handouts, or from the National Institutes of Health (www.nih.gov) or the Substance Abuse and Mental Health Services Administration's National Mental Health Information Center (www.mentalhealth.samhsa.gov), which also offers an online mental health services locator.

II-7 When Youth Need Additional Support

Background. Indicators of a need for intervention include behaviors, thoughts, or feelings that limit the youth's ability to maintain positive relationships, cope with the demands of home and school life, and continue healthy development.

There is no clear dividing line between mental health, mental health problems, and serious emotional disturbances and thus no easy way to tell when a student needs additional support. The indicators shown on Slide II-O (Indicators of Need) are general guidelines. Some more specific signs that youth may need help are listed in Handout II-J (Indicators of Need). You can also refer to the Adolescent Mental Health Continuum (Handout II-B) during this discussion. Note that in both handouts there are numerous references to frequency (how often a sign occurs), duration (how long it lasts), and severity. These can be clues to when a teen may need help.

Information on stages of an action plan. Detailed information on an action plan is included below for the trainer's benefit. The information is included in Handout III-A of Module III, in which it is discussed in more

detail. If you have elected not to use Module III in your trainings, provide participants with the handout at this point.

Stage I: Know your building and district policies, procedures, and resources. This sounds obvious, but schools do not have the time to advertise every support service available. Every district has procedures in place to work with students and staff. For example:

- Pre-referral teams, student support teams, or other working groups may be in place.
- School psychologists, social workers, nurses, special educators, and counselors may be available within the building or at the district level.

The key for staff is to learn how to access these professionals and other school resources.

Stage II: Voice your concern. This part is hardest. Tips for teachers and other staff:

- Set aside private one-to-one time with the student, and let the student know right at the beginning of the time together that this conference is about your observations of his or her need for assistance.
- You may want to reassure the student that this conference is not a punishment or act of discipline.
- Also make known to the student that in order to help, you may have to share your concern with others, but will not share details of the conversation unless there is an immediate threat to the student's well-being.
- Discuss with the youth what action you will take together to obtain assistance.
- If you have doubts about having a one-to-one conference with the youth, seek support from internal resources or caregivers first.

Stage III: Follow up. It is important to stress that helping students isn't about shifting the problem to someone else. Following up reassures youth that you are someone who DOES care. Tips for teachers and other staff:

- Work with the youth and others involved to intervene at the classroom level. Make modifications where necessary to promote successful learning.
- Refrain from public statements that will violate the youth's privacy and confidentiality.
- Obtain support from internal resources to ensure that classroom modifications are appropriate and monitor whether adaptations are working for the youth.
- Check with internal resources to ensure that help is being accessed.

The action plan should be tailored to the needs of the student and his or her family and should include all the resources inside and outside the school that can meet his or her needs. Not all students will show an immediate beneficial response to intervention. Continue to provide support for the student within the classroom and provide feedback to the student at every hint of progress.

Researchers and educators have identified a number of specific intervention strategies and options. Functional behavior assessment and Positive Behavioral Interventions and Supports (PBIS) are among the practices that may be employed by teachers and schools. Find out your own school's policy for interventions, and see the Resource List, included as an appendix to this training, for more information.

Slide II-A: Goal

The goal of Module II is to give an overview of mental health issues among adolescents and their potential effects on learning and behavior.

Slide II-B: Objectives

- Learn social-emotional factors related to positive youth development, including risk and protective factors
- Understand the range of social-emotional development and its relationship to mental health
- Know the most common serious emotional disturbances in adolescence and their potential impacts on learning and behavior
- Learn indications that a student needs additional support

Slide II-C: What Are Risk Factors?

Risk factors make it more likely that a teen will develop a disorder.

Protective factors make it less likely that a teen will develop a disorder.

- *May be biological, psychological, or social*

Slide II-D: Risk and Protective Factors

Risk factors include:

- Problems in community environment
- Problems in family environment
- History of behavior problems
- Negative behavior and experiences
- Biology

Protective factors include:

- Caring adults
- Genuine youth-adult relationships
- Recognition
- Opportunities for involvement

Slide II-E: Mental Health: Definition

A state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. It is indispensable to personal well-being, family and interpersonal relationships, and contribution to community or society.

Slide II-F: Serious Emotional Disturbances: Definition

Diagnosable disorders in children and adolescents that severely disrupt their daily functioning in the home, school, or community.

Slide II-G: Adolescents With Mental Health and Emotional Problems Are More Likely To Experience:

- Co-occurring social-emotional problems
- Other health risks
- Restricted opportunities

Slide II-H: Mood Disorders

- Also called affective disorders because they refer to emotions
- Treatable medical conditions
- Most frequently diagnosed mood disorders in children and youth are:
    - Major depressive disorder
    - Dysthymic disorder
    - Bipolar disorder

Slide II-I: Any threat of suicide should be treated seriously.

Slide II-J: Anxiety Disorders

- **Excessive** fears, worries, and preoccupations that are a reaction to a perceived sign of danger
- Include obsessive-compulsive disorder and post-traumatic stress disorder

Slide II-K: Attention-Deficit/Hyperactivity Disorder

- Inability to focus one's attention
- Often impulsive and easily distracted
- Difficult to remain still, take turns, keep quiet
- Most commonly diagnosed behavioral disorder among youth

Slide II-L: Disruptive Behavior Disorders

- Complicated group of behavioral and emotional problems
- Show as difficulty following rules and behaving in socially acceptable ways
- Impact of the disruptive behavior is distressing to others and can interfere with establishing trusting and supportive relationships

Slide II-M: Disruptive Behaviors and Other Disorders

Youth who show disruptive behaviors may have:

- Unidentified symptoms of depression and/or anxiety
- One or more diagnosable disorders

For example, a youth may have both ADHD and a learning disability

Slide II-N: Eating Disorders

- Patterns of thoughts and behaviors about one's body, foods, and the intake of foods
- Lead to severe health, social, and school problems
- Include anorexia nervosa, bulimia nervosa, and binge-eating disorder

Slide II-O: Indicators of Need

Indicators of need for intervention include behaviors, thoughts, or feelings that limit a youth's ability to:

- Maintain positive relationships
- Cope with demands of home and school
- Continue healthy development

Problem behavior may be an indicator of need.

Slide II-P: Action Plan

- A way to direct your behavior and to problem-solve with individual students
- Each is unique to the individual needs of the student, his or her family, and the resources available

Slide II-Q: Stages of an Action Plan Include:

- **Stage I:** Know your resources
- **Stage II:** Voice your concern
- **Stage III:** Follow up

Handout II-A: Risk and Protective Factors

Risk Factors

for mental health problems

Community
Drugs
Firearms
Crime
Media
Violence
Mobility
Poverty

Family
Family history of behavior
Family conflict
Family history of mental illness

School
Early antisocial behavior
Academic failure in late elementary school
Lack of commitment to school
Individual/peer alienation and rebelliousness
Friends who engage in a problem behavior
Early initiation of a problem behavior

Protective Factors

against mental health problems

An adult, such as a community leader, church member, schoolteacher, or parent, who cares about the youth and his/her future

A genuine relationship with an adult who expresses clear and consistent rules and expectations about the youth's behavior, and discusses disappointments, poor decisions, and mistakes

Recognition for involvement, accomplishments, and worth as a person

Opportunities to be involved and to show skills that contribute

An adult who shows consistent dedication to the youth's overall health and development

Adapted from Hawkins, J. D., & R. F. Catalano. Communities that care: Action for drug abuse prevention. San Francisco: Jossey-Bass, 1992.

Handout II-B: Adolescent Mental Health Continuum

	Less Severe	>	>>>	More Severe
Social Adjustment	Adjusts to social situations	Some ups and downs in adjustment to social situations	Adjustment difficulties in social situations	Severe impairment in social situations
Environment/ Coping Skills	Adapts to environment	At times shows difficulty coping with environment	Ineffective or inconsistent coping with environment	Restricted coping, dependency, or crisis
Emotional Responses	Appropriate emotional responses	Emotional Responses inconsistent	Emotional responses are restricted, extreme, or inappropriate	Emotional responses are severely disproportiontate
Mood Control	Controls mood	Some fluctuation in ability to control mood	Mood swings, sad mood, or consistent irritability	Mood seriously impairs day-to-day functioning
Thought Patterns	Thoughts consistent with goals, intentions, beliefs	Preoccupations, worries, or frustrations	Intrusive thoughts or obsessions	Bizarre or illogical thoughts
Biological Patterns*	Regular biological patterns	Minor disruptions to biological patterns	Consistent disruptions of biological patterns	Severe disruptions of biological patterns

*includes sleep cycles, eating patterns, etc.

About the Continuum:

- There is *no clear line* between mental health, mental health problems, and serious emotional disturbance. Behavior patterns run along a continuum.
- All symptoms do not appear with the same level of severity. Areas can be linked diagonally with each other—a youth with an eating disorder, for example, may adjust to social situations well but have disrupted biological patterns.
- Symptoms always should be looked at within the context of chronological and developmental age, as well as within the context of existing risk and protective factors.
- The continuum is a representative sample of symptoms and degrees of severity. Symptoms are not limited to the categories and behaviors described above.

Handout II-C: Serious Emotional Disturbances

Diagnosable disorders in children and adolescents that severely disrupt their daily functioning in the home, school, or community. These disorders include depression, attention-deficit/hyperactivity disorder, anxiety disorders, conduct disorder, and eating disorders.

The term SED, or serious emotional disturbance, as used in this training, refers to a clinical diagnosis by a mental health professional. It does not necessarily mean "qualifies for special education." Specific school/district policies regarding SEDs vary. In Module III, there will be an opportunity to address local policies regarding serious emotional disturbances.

Source:

Glossary of Terms, Child and Adolescent Mental Health, Center for Mental Health Services;
www.mentalhealth.samhsa.gov/publications/allpubs/CA-0005/default.asp

Handout II-D: Problems Associated With Serious Emotional Disturbances

Adolescents with these problems are more likely to experience co-occurring social-emotional problems, face other health risks, and experience restricted opportunities. Each of these can manifest itself in the ways listed below.

Co-Occurring Social-Emotional Problems

- Higher incidences of other psychiatric conditions
- Impulsiveness
- Low self-esteem
- Poor social skills
- Limited interpersonal relationships, social supports, and social networks

Health Risks

- Drug use/abuse
- Alcohol use/abuse
- Higher rates of HIV/AIDS and sexually transmitted diseases
- Unwanted pregnancies
- Driving while intoxicated

Restricted Opportunities

- Low academic achievement
- Lower high school graduation rates
- Limited postsecondary entry
- Fewer employment opportunities
- Less financial independence

Handout II-E: Signs of Depression

The following signs may be symtoms of depression in children and adolescents if they persist for over 2 weeks:

- Suicidal thoughts
- Feelings of hopelessness
- Sad or irritable mood (irritability is more common in children and adolescents)
- Frequent crying
- Loss of interest or pleasure in social activities or previously enjoyed hobbies
- Withdrawal from others
- Self-injurious behavior (e.g., cutting, burning, or inflicting pain)
- Low self-esteem
- Feelings of worthlessness
- Physical complaints
- Change in body weight (gain or loss)
- Restlessness or agitation
- Change in appetite
- Difficulty falling asleep or sleeping too much
- Excessive fatigue
- Difficulty concentrating

Handout II-F: Depressive Disorders: Effects on Learning and Behavior

Attention: Attention can be disrupted by discomfort and physical symptoms such as headaches or stomach aches.

Concentration: Concentration is difficult to maintain for extended periods of time and affected by fatigue or intrusive thoughts related to guilt, hopelessness, or suicide.

Self-appraisal/expectations: Lack of enjoyment, feelings of low self-worth, expectations of failure, sensitivity to feedback, and negative thoughts about the future impede motivation and effort.

Rehearsal: Deficits in attention, concentration, and motivation may make it difficult to retain and retrieve information for the purpose of rehearsal.

Mastery: Cognitive and emotional impairments may interfere with the mastery of material.

Behavior: Excessive absences; sleepiness or restlessness during class; slow responding or no participation; overall avoidance of social interaction or typical activities of peers; crying or expressions of excessive guilt and sadness.

Handout II-G: Risks for Suicide

- A current **plan** to commit suicide
- Past attempts
- Reported feelings of hopelessness
- Thoughts about death
- Special arrangements for possessions or giving away possessions
- Severe emotional distress
- Substantial change in behavior accompanied by negative feelings and thoughts
- Access, use, or abuse of drugs or alcohol
- History of impulsive, reckless, or dangerous behavior
- A sense of isolation
- No perceived support from others
- Inability to generate alternatives to solve a difficult problem or conflict, or a sense of "no way out."

Information on suicide prevention can be found at the Substance Abuse and Mental Health Services Administration's National Strategy for Suicide Prevention Web site: www.mentalhealth.samhsa.gov/suicideprevention

Schools are encouraged to develop a comprehensive plan for suicide prevention. A detailed description of such a plan can be found in Keith A. King, "Developing a Comprehensive School Suicide Prevention Program," *Journal of School Health,* April 2001, Vol 71, No. 4, pages 132-137.

Handout II-H: Anxiety and Attention-Deficit/Hyperactivity Disorder: Effects on Learning and Behavior

Anxiety Disorder

Attention: Attention can be disrupted by a sense of impending doom or the feeling that something is wrong.

Concentration: Concentration is difficult to maintain during moments of intense anxiety, or is affected by irritability, restlessness, or a feeling of being out of control.

Self-appraisal/expectations: Expectations of poor outcomes or a sense of inability to bring about good results.

Rehearsal: Disruptions in attention or worries about performance can interfere with effective rehearsal.

Mastery: It often is difficult to retrieve or demonstrate previously learned information when feeling acute anxiety.

Behavior: Freezing during exams; asking for help when unnecessary; talking about worries, "what if" statements, or exaggerated/irrational fears; being overly prepared for tasks or exams; seeming upset or frantic when worries escalate.

Attention-Deficit/Hyperactivity Disorder

Attention: Problems with attention are the hallmark of this disorder. Either the youth is overly attentive to insignificant details or completely inattentive. The youth often misses information due to daydreaming, overactivity, or attention to other aspects of the environment.

Concentration: Highly distractible or impulsive but concentration improves when task has full attention.

Self-appraisal/expectations: Often fails to use prior experiences to accurately predict abilities; may overestimate or underestimate the demands of tasks and skills required; prior negative social feedback can impact motivation and sense of competence.

Rehearsal: Lack of organization and attention often interferes with time on task; frustration can come from missing important information regarding the procedures involved; patience and persistence weakly linked to rehearsal.

Mastery: May show lopsided skills or have certain elements mastered but not other elements important to whole concepts; gaps in knowledge can lead to difficulty with building on previous learning.

Behavior: Excessively talkative during class; hard to redirect or has difficulty following verbal or written directions; impulsive social behavior; annoying others or poor acceptance by peers; disorganized with materials; forgetful and missing multiple assignments.

Handout II-I: Eating Disorders (Anorexia): Effects on Learning and Behavior

Attention: Targeted attention appropriate to task, note-taking, and other skills associated with high performance.

Concentration: May show very intense concentration and self-discipline.

Self-appraisal/expectations: Perfectionist; overly hard on or punitive toward oneself; may assign more work to self than necessary.

Rehearsal: High expectations for mastery and repeated rehearsal.

Mastery: Information typically mastered to high degree but seemingly not good enough.

Behavior: High expectations; may be involved in rigorous athletic or physical competition; ritualistic with food or avoidance of meals; underweight; voices concerns about body size, shape, or weight; discusses dieting or avoidance of food.

Handout II-J: Indicators of Need

Children and adolescents with mental health issues need to get help as soon as possible. A variety of signs may point to mental health disorders or serious emotional disturbances in children or adolescents. Pay attention if a child or adolescent you know has any of these warning signs persisting for longer than seems appropriate:

A child or adolescent is troubled by feeling:

- Sad and hopeless for no reason, and these feelings do not go away;
- Very angry most of the time and crying a lot or overreacting to things;
- Worthless or guilty often;
- Anxious or worried often;
- Unable to get over a loss or death of someone important;
- Extremely fearful or having unexplained fears;
- Constantly concerned about physical problems or physical appearance; or
- Frightened that his or her mind either is controlled or is out of control.

A child or adolescent experiences big changes, such as:

- Showing declining performance in school;
- Losing interest in things once enjoyed;
- Experiencing unexplained changes in sleeping or eating patterns;
- Avoiding friends or family and wanting to be alone all the time;
- Daydreaming too much and not completing tasks;
- Feeling life is too hard to handle;
- Hearing voices that cannot be explained; or
- Experiencing suicidal thoughts.

A child or adolescent experiences:

- Poor concentration and is unable to think straight or make up his or her mind;
- An inability to sit still or focus attention;
- Worry about being harmed, hurting others, or doing something "bad";
- A need to wash, clean things, or perform certain routines hundreds of times a day, in order to avoid an unsubstantiated danger;
- Racing thoughts that are almost too fast to follow; or
- Persistent nightmares.

A child or adolescent behaves in ways that cause problems, such as:

- Using alcohol or other drugs;
- Eating large amounts of food and then purging, or abusing laxatives, to avoid weight gain.
- Dieting and/or exercising obsessively;
- Violating the rights of others or constantly breaking the law without regard for other people;
- Setting fires;
- Doing things that can be life threatening; or
- Killing animals.

Source:

Child and Adolescent Mental Health, Center for Mental Health Services,
http://www.mentalhealth.org/publications/allpubs/CA-0004/default.asp

Part I: Please answer the following questions by circling a number on the scales provided.

1) Was the content of this module *relevant and applicable* to your classroom/school?
Not at all relevant   Somewhat relevant   Extremely relevant
   1   2   3   4   5   6   7

2) Was the information presented *too simplistic* or *too involved*?
Too simplistic   Just right   Too involved
   1   2   3   4   5   6   7

3) Was the information *new* to you?
All previously known   Some new information   Mostly new information
   1   2   3   4   5   6   7

4) Was the module *well-organized*?
Not well-organized   Somewhat well-organized   Very well-organized
   1   2   3   4   5   6   7

5) Was the module an appropriate *length*?
Too short   Comfortable length   Too long
   1   2   3   4   5   6   7

6) Was there a sufficient *variety* of activities?
Not enough   A good number   Too many
   1   2   3   4   5   6   7

7) Were the *materials* (slides, handouts) clear and concise?
Not clear   Somewhat clear   Very clear
   1   2   3   4   5   6   7

8) Were the materials *helpful* as supplements to the information presented?
Not helpful   Somewhat helpful   Very helpful
   1   2   3   4   5   6   7

Part II: Please give us your comments:

I liked:
_____
_____

I didn't like:
_____
_____

I wish there had been more:
_____
_____

The most important thing I learned was:

_____

_____

Other comments:

_____

_____

_____

_____

Appendix

What Is A Depressive Disorder?

A depressive disorder is an illness that involves the body, mood, and thoughts. It affects the way a person eats and sleeps, the way one feels about oneself, and the way one thinks about things. A depressive disorder is not the same as a passing blue mood. It is not a sign of personal weakness or a condition that can be willed or wished away. People with a depressive illness cannot merely "pull themselves together" and get better. Without treatment, symptoms can last for weeks, months, or years. Appropriate treatment, however, can help most people who suffer from depression.

TYPES OF DEPRESSION

Depressive disorders come in different forms, just as is the case with other illnesses such as heart disease. This pamphlet briefly describes three of the most common types of depressive disorders. However, within these types there are variations in the number of symptoms, their severity, and persistence.

Major depression is manifested by a combination of symptoms (see symptom list) that interfere with the ability to work, study, sleep, eat, and enjoy once pleasurable activities. Such a disabling episode of depression may occur only once but more commonly occurs several times in a lifetime.

A less severe type of depression, dysthymia, involves long-term, chronic symptoms that do not disable, but keep one from functioning well or from feeling good. Many people with dysthymia also experience major depressive episodes at some time in their lives.

Another type of depression is bipolar disorder, also called manic-depressive illness. Not nearly as prevalent as other forms of depressive disorders, bipolar disorder is characterized by cycling mood changes: severe highs (mania) and lows (depression). Sometimes the mood switches are dramatic and rapid, but most often they are gradual. When in the depressed cycle, an individual can have any or all of the symptoms of a depressive disorder. When in the manic cycle, the individual may be overactive, overtalkative, and have a great deal of energy. Mania often affects thinking, judgment, and social behavior in ways that cause serious problems and embarrassment. For example, the individual in a manic phase may feel elated, full of grand schemes that might range from unwise business decisions to romantic sprees. Mania, left untreated, may worsen to a psychotic state.

SYMPTOMS OF DEPRESSION AND MANIA

Not everyone who is depressed or manic experiences every symptom. Some people experience a few symptoms, some many. Severity of symptoms varies with individuals and also varies over time.

Depression

- Persistent sad, anxious, or "empty" mood
- Feelings of hopelessness, pessimism

- Feelings of guilt, worthlessness, helplessness
- Loss of interest or pleasure in hobbies and activities that were once enjoyed, including sex
- Decreased energy, fatigue, being "slowed down"
- Difficulty concentrating, remembering, making decisions
- Insomnia, early-morning awakening, or oversleeping
- Appetite and/or weight loss or overeating and weight gain
- Thoughts of death or suicide; suicide attempts
- Restlessness, irritability
- Persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain

Mania

- Abnormal or excessive elation
- Unusual irritability
- Decreased need for sleep
- Grandiose notions
- Increased talking
- Racing thoughts
- Increased sexual desire
- Markedly increased energy
- Poor judgment
- Inappropriate social behavior

CAUSES OF DEPRESSION

Some types of depression run in families, suggesting that a biological vulnerability can be inherited. This seems to be the case with bipolar disorder. Studies of families in which members of each generation develop bipolar disorder found that those with the illness have a somewhat different genetic makeup than those who do not get ill. However, the reverse is not true: Not everybody with the genetic makeup that causes vulnerability to bipolar disorder will have the illness. Apparently additional factors, possibly stresses at home, work, or school, are involved in its onset.

In some families, major depression also seems to occur generation after generation. However, it can also occur in people who have no family history of depression. Whether inherited or not, major depressive disorder is often associated with changes in brain structures or brain function.

People who have low self-esteem, who consistently view themselves and the world with pessimism or who are readily overwhelmed by stress, are prone to depression. Whether this represents a psychological predisposition or an early form of the illness is not clear.

In recent years, researchers have shown that physical changes in the body can be accompanied by mental changes as well. Medical illnesses such as stroke, a heart attack, cancer, Parkinson's disease, and hormonal disorders can cause depressive illness, making the sick person apathetic and unwilling to care for his or her physical needs, thus prolonging the recovery period. Also, a serious loss, difficult relationship, financial problem, or any stressful (unwelcome or even desired) change in life patterns can trigger a depressive episode. Very often, a combination of genetic, psychological, and environmental factors is involved in the onset of a depressive disorder. Later episodes of illness typically are precipitated by only mild stresses, or none at all.

Depression in Women

Women experience depression about twice as often as men.[1] Many hormonal factors may contribute to the increased rate of depression in women—particularly such factors as menstrual cycle changes, pregnancy, miscarriage, postpartum period, pre-menopause, and menopause. Many women also face additional stresses such as responsibilities both at work and home, single parenthood, and caring for children and for aging parents.

A recent NIMH study showed that in the case of severe premenstrual syndrome (PMS), women with a preexisting vulnerability to PMS experienced relief from mood and physical symptoms when their sex hormones were suppressed. Shortly after the hormones were re-introduced, they again developed symptoms of PMS. Women without a history of PMS reported no effects of the hormonal manipulation.[6,7]

Many women are also particularly vulnerable after the birth of a baby. The hormonal and physical changes, as well as the added responsibility of a new life, can be factors that lead to postpartum depression in some women. While transient "blues" are common in new mothers, a full-blown depressive episode is not a normal occurrence and requires active intervention. Treatment by a sympathetic physician and the family's emotional support for the new mother are prime considerations in aiding her to recover her physical and mental well-being and her ability to care for and enjoy the infant.

Depression in Men

Although men are less likely to suffer from depression than women, 3 to 4 million men in the United States are affected by the illness. Men are less likely to admit to depression, and doctors are less likely to suspect it. The rate of suicide in men is four times that of women, though more women attempt it. In fact, after age 70, the rate of men's suicide rises, reaching a peak after age 85.

Depression can also affect the physical health in men differently from women. A new study shows that, although depression is associated with an increased risk of coronary heart disease in both men and women, only men suffer a high death rate.[2]

Men's depression is often masked by alcohol or drugs, or by the socially acceptable habit of working excessively long hours. Depression typically shows up in men not as feeling hopeless and helpless, but as being irritable, angry, and discouraged; hence, depression may be difficult to recognize as such in men. Even if a man realizes that he is depressed, he may be less willing than a woman to seek help. Encouragement and support from concerned family members can make a difference. In the workplace, employee assistance professionals or worksite mental health programs can be of assistance in helping men understand and accept depression as a real illness that needs treatment.

Depression in the Elderly

Some people have the mistaken idea that it is normal for the elderly to feel depressed. On the contrary, most older people feel satisfied with their lives. Sometimes, though, when depression develops, it may be dismissed as a normal part of aging. Depression in the elderly, undiagnosed and untreated, causes needless suffering for the family and for the individual who could otherwise live a fruitful life. When he or she does go to the doctor, the symptoms described are usually physical, for the older person is often reluctant to discuss feelings of hopelessness, sadness, loss of interest in normally pleasurable activities, or extremely prolonged grief after a loss.

Recognizing how depressive symptoms in older people are often missed, many health care professionals are learning to identify and treat the underlying depression. They recognize that some symptoms may be side effects of medication the older person is taking for a physical problem, or they may be caused by a co-occurring illness. If a diagnosis of depression is made, treatment with medication and/or psychotherapy will help the

depressed person return to a happier, more fulfilling life. Recent research suggests that brief psychotherapy (talk therapies that help a person in day-to-day relationships or in learning to counter the distorted negative thinking that commonly accompanies depression) is effective in reducing symptoms in short-term depression in older persons who are medically ill. Psychotherapy is also useful in older patients who cannot or will not take medication. Efficacy studies show that late-life depression can be treated with psychotherapy.[4] Improved recognition and treatment of depression in late life will make those years more enjoyable and fulfilling for the depressed elderly person, the family, and caretakers.

Depression in Children

Only in the past two decades has depression in children been taken very seriously. The depressed child may pretend to be sick, refuse to go to school, cling to a parent, or worry that the parent may die. Older children may sulk, get into trouble at school, be negative, grouchy, and feel misunderstood. Because normal behaviors vary from one childhood stage to another, it can be difficult to tell whether a child is just going through a temporary "phase" or is suffering from depression. Sometimes the parents become worried about how the child's behavior has changed, or a teacher mentions that "your child doesn't seem to be himself." In such a case, if a visit to the child's pediatrician rules out physical symptoms, the doctor will probably suggest that the child be evaluated, preferably by a psychiatrist who specializes in the treatment of children. If treatment is needed, the doctor may suggest that another therapist, usually a social worker or a psychologist, provide therapy while the psychiatrist will oversee medication if it is needed. Parents should not be afraid to ask questions: What are the therapist's qualifications? What kind of therapy will the child have? Will the family as a whole participate in therapy? Will my child's therapy include an antidepressant? If so, what might the side effects be?

The National Institute of Mental Health (NIMH) has identified the use of medications for depression in children as an important area for research. The NIMH-supported Research Units on Pediatric Psychopharmacology (RUPPs) form a network of seven research sites where clinical studies on the effects of medications for mental disorders can be conducted in children and adolescents. Among the medications being studied are antidepressants, some of which have been found to be effective in treating children with depression, if properly monitored by the child's physician.[8]

DIAGNOSTIC EVALUATION AND TREATMENT

The first step to getting appropriate treatment for depression is a physical examination by a physician. Certain medications as well as some medical conditions such as viral infection can cause the same symptoms as depression, and the physician should rule out these possibilities through examination, interview, and lab tests. If a physical cause for the depression is ruled out, a psychological evaluation should be done, by the physician or by referral to a psychiatrist or psychologist.

A good diagnostic evaluation will include a complete history of symptoms, i.e., when they started, how long they have lasted, how severe they are, whether the patient had them before and, if so, whether the symptoms were treated and what treatment was given. The doctor should ask about alcohol and drug use, and if the patient has thoughts about death or suicide. Further, a history should include questions about whether other family members have had a depressive illness and, if treated, what treatments they may have received and which were effective.

Last, a diagnostic evaluation should include a mental status examination to determine if speech or thought patterns or memory have been affected, as sometimes happens in the case of a depressive or manic-depressive illness.

Treatment choice will depend on the outcome of the evaluation. There are a variety of antidepressant medications and psychotherapies that can be used to treat depressive disorders. Some people with milder forms may do well with psychotherapy alone. People with moderate to severe depression most often benefit from

antidepressants. Most do best with combined treatment: medication to gain relatively quick symptom relief and psychotherapy to learn more effective ways to deal with life's problems, including depression. Depending on the patient's diagnosis and severity of symptoms, the therapist may prescribe medication and/or one of the several forms of psychotherapy that have proven effective for depression.

Electroconvulsive therapy (ECT) is useful, particularly for individuals whose depression is severe or life threatening or who cannot take antidepressant medication.[3] ECT often is effective in cases where antidepressant medications do not provide sufficient relief of symptoms. In recent years, ECT has been much improved. A muscle relaxant is given before treatment, which is done under brief anesthesia. Electrodes are placed at precise locations on the head to deliver electrical impulses. The stimulation causes a brief (about 30 seconds) seizure within the brain. The person receiving ECT does not consciously experience the electrical stimulus. For full therapeutic benefit, at least several sessions of ECT, typically given at the rate of three per week, are required.

Medications

There are several types of antidepressant medications used to treat depressive disorders. These include newer medications—chiefly the selective serotonin reuptake inhibitors (SSRIs)—the tricyclics, and the monoamine oxidase inhibitors (MAOIs). The SSRIs—and other newer medications that affect neurotransmitters such as dopamine or norepinephrine—generally have fewer side effects than tricyclics. Sometimes the doctor will try a variety of antidepressants before finding the most effective medication or combination of medications. Sometimes the dosage must be increased to be effective. Although some improvements may be seen in the first few weeks, antidepressant medications must be taken regularly for 3 to 4 weeks (in some cases, as many as 8 weeks) before the full therapeutic effect occurs.

Patients often are tempted to stop medication too soon. They may feel better and think they no longer need the medication. Or they may think the medication isn't helping at all. It is important to keep taking medication until it has a chance to work, though side effects (see section on Side Effects on page 13) may appear before antidepressant activity does. Once the individual is feeling better, it is important to continue the medication for at least 4 to 9 months to prevent a recurrence of the depression. *Some medications must be stopped gradually to give the body time to adjust. **Never** stop taking an antidepressant without consulting the doctor for instructions on how to safely discontinue the medication.* For individuals with bipolar disorder or chronic major depression, medication may have to be maintained indefinitely.

Antidepressant drugs are not habit-forming. However, as is the case with any type of medication prescribed for more than a few days, antidepressants have to be carefully monitored to see if the correct dosage is being given. The doctor will check the dosage and its effectiveness regularly.

For the small number of people for whom MAO inhibitors are the best treatment, it is necessary to avoid certain foods that contain high levels of tyramine, such as many cheeses, wines, and pickles, as well as medications such as decongestants. The interaction of tyramine with MAOIs can bring on a hypertensive crisis, a sharp increase in blood pressure that can lead to a stroke. The doctor should furnish a complete list of prohibited foods that the patient should carry at all times. Other forms of antidepressants require no food restrictions.

Medications of any kind—prescribed, over-the counter, or borrowed—should never be mixed without consulting the doctor. Other health professionals who may prescribe a drug—such as a dentist or other medical specialist—should be told of the medications the patient is taking. Some drugs, although safe when taken alone can, if taken with others, cause severe and dangerous side effects. Some drugs, like alcohol or street drugs, may reduce the effectiveness of antidepressants and should be avoided. This includes wine, beer, and hard liquor. Some people who have not had a problem with alcohol use may be permitted by their doctor to use a modest amount of alcohol while taking one of the newer antidepressants.

Antianxiety drugs or sedatives are not antidepressants. They are sometimes prescribed along with antidepressants; however, they are not effective when taken alone for a depressive disorder. Stimulants, such as amphetamines, are not effective antidepressants, but they are used occasionally under close supervision in medically ill depressed patients.

Questions about any antidepressant prescribed, or problems that may be related to the medication, should be discussed with the doctor.

Lithium has for many years been the treatment of choice for bipolar disorder, as it can be effective in smoothing out the mood swings common to this disorder. Its use must be carefully monitored, as the range between an effective dose and a toxic one is small. If a person has preexisting thyroid, kidney, or heart disorders or epilepsy, lithium may not be recommended. Fortunately, other medications have been found to be of benefit in controlling mood swings. Among these are two mood-stabilizing anticonvulsants, carbamazepine (Tegretol®) and valproate (Depakote®). Both of these medications have gained wide acceptance in clinical practice, and valproate has been approved by the Food and Drug Administration for first-line treatment of acute mania. Other anticonvulsants that are being used now include lamotrigine (Lamictal®) and gabapentin (Neurontin®): their role in the treatment hierarchy of bipolar disorder remains under study.

Most people who have bipolar disorder take more than one medication including, along with lithium and/or an anticonvulsant, a medication for accompanying agitation, anxiety, depression, or insomnia. Finding the best possible combination of these medications is of utmost importance to the patient and requires close monitoring by the physician.

Side Effects

Antidepressants may cause mild and, usually, temporary side effects (sometimes referred to as adverse effects) in some people. Typically these are annoying, but not serious. However, any unusual reactions or side effects or those that interfere with functioning should be reported to the doctor immediately. The most common side effects of tricyclic antidepressants, and ways to deal with them, are:

- **Dry mouth**—it is helpful to drink sips of water; chew sugarless gum; clean teeth daily.
- **Constipation**—bran cereals, prunes, fruit, and vegetables should be in the diet.
- **Bladder problems**—emptying the bladder may be troublesome, and the urine stream may not be as strong as usual; the doctor should be notified if there is marked difficulty or pain.
- **Sexual problems**—sexual functioning may change; if worrisome, it should be discussed with the doctor.
- **Blurred vision**—this will pass soon and will not usually necessitate new glasses.
- **Dizziness**—rising from the bed or chair slowly is helpful.
- **Drowsiness as a daytime problem**—this usually passes soon. A person feeling drowsy or sedated should not drive or operate heavy equipment. The more sedating antidepressants are generally taken at bedtime to help sleep and minimize daytime drowsiness.

The newer antidepressants have different types of side effects:

- **Headache**—this will usually go away.
- **Nausea**—this is also temporary, but even when it occurs, it is transient after each dose.
- **Nervousness and insomnia (trouble falling asleep or waking often during the night)**—these may occur during the first few weeks; dosage reductions or time will usually resolve them.
- **Agitation (feeling jittery)**—if this happens for the first time after the drug is taken and is more than transient, the doctor should be notified.
- **Sexual problems**—the doctor should be consulted if the problem is persistent or worrisome.

Herbal Therapy

In the past few years, much interest has risen in the use of herbs in the treatment of both depression and anxiety. St. John's wort (*Hypericum perforatum*), an herb used extensively in the treatment of mild to moderate depression in Europe, has recently aroused interest in the United States. St. John's wort, an attractive bushy, low-growing plant covered with yellow flowers in summer, has been used for centuries in many folk and herbal remedies. Today in Germany, Hypericum is used in the treatment of depression more than any other antidepressant. However, the scientific studies that have been conducted on its use have been short-term and have used several different doses.

Because of the widespread interest in St. John's wort, the National Institutes of Health (NIH) conducted a 3-year study, sponsored by three NIH components—the National Institute of Mental Health, the National Center for Complementary and Alternative Medicine, and the Office of Dietary Supplements. The study was designed to include 336 patients with major depression of moderate severity, randomly assigned to an 8-week trial with one-third of patients receiving a uniform dose of St. John's wort, another third sertraline, a selective serotonin reuptake inhibitor (SSRI) commonly prescribed for depression, and the final third a placebo (a pill that looks exactly like the SSRI and the St. John's wort, but has no active ingredients). The study participants who responded positively were followed for an additional 18 weeks. At the end of the first phase of the study, participants were measured on two scales, one for depression and one for overall functioning. There was no significant difference in rate of response for depression, but the scale for overall functioning was better for the antidepressant than for either St. John's wort or placebo. While this study did not support the use of St. John's wort in the treatment of major depression, ongoing NIH-supported research is examining a possible role for St. John's wort in the treatment of milder forms of depression.

The Food and Drug Administration issued a Public Health Advisory on February 10, 2000. It stated that St. John's wort appears to affect an important metabolic pathway that is used by many drugs prescribed to treat conditions such as AIDS, heart disease, depression, seizures, certain cancers, and rejection of transplants. Therefore, health care providers should alert their patients about these potential drug interactions.

Some other herbal supplements frequently used that have not been evaluated in large-scale clinical trials are ephedra, gingko biloba, echinacea, and ginseng. Any herbal supplement should be taken only after consultation with the doctor or other health care provider.

PSYCHOTHERAPIES

Many forms of psychotherapy, including some short-term (10-20 week) therapies, can help depressed individuals. "Talking" therapies help patients gain insight into and resolve their problems through verbal exchange with the therapist, sometimes combined with "homework" assignments between sessions. "Behavioral" therapists help patients learn how to obtain more satisfaction and rewards through their own actions and how to unlearn the behavioral patterns that contribute to or result from their depression.

Two of the short-term psychotherapies that research has shown helpful for some forms of depression are interpersonal and cognitive/behavioral therapies. Interpersonal therapists focus on the patient's disturbed personal relationships that both cause and exacerbate (or increase) the depression. Cognitive/behavioral therapists help patients change the negative styles of thinking and behaving often associated with depression.

Psychodynamic therapies, which are sometimes used to treat depressed persons, focus on resolving the patient's conflicted feelings. These therapies are often reserved until the depressive symptoms are significantly improved. In general, severe depressive illnesses, particularly those that are recurrent, will require medication (or ECT under special conditions) along with, or preceding, psychotherapy for the best outcome.

HOW TO HELP YOURSELF IF YOU ARE DEPRESSED

Depressive disorders make one feel exhausted, worthless, helpless, and hopeless. Such negative thoughts and feelings make some people feel like giving up. It is important to realize that these negative views are part of the depression and typically do not accurately reflect the actual circumstances. Negative thinking fades as treatment begins to take effect. In the meantime:

- Set realistic goals in light of the depression and assume a reasonable amount of responsibility.
- Break large tasks into small ones, set some priorities, and do what you can as you can.
- Try to be with other people and to confide in someone; it is usually better than being alone and secretive.
- Participate in activities that may make you feel better.
- Mild exercise, going to a movie, a ballgame, or participating in religious, social, or other activities may help.
- Expect your mood to improve gradually, not immediately. Feeling better takes time.
- It is advisable to postpone important decisions until the depression has lifted. Before deciding to make a significant transition—change jobs, get married or divorced—discuss it with others who know you well and have a more objective view of your situation.
- People rarely "snap out of" a depression. But they can feel a little better day-by-day.
- *Remember*, positive thinking will replace the negative thinking that is part of the depression and will disappear as your depression responds to treatment.
- Let your family and friends help you.

How Family and Friends Can Help the Depressed Person

The most important thing anyone can do for the depressed person is to help him or her get an appropriate diagnosis and treatment. This may involve encouraging the individual to stay with treatment until symptoms begin to abate (several weeks), or to seek different treatment if no improvement occurs. On occasion, it may require making an appointment and accompanying the depressed person to the doctor. It may also mean monitoring whether the depressed person is taking medication. The depressed person should be encouraged to obey the doctor's orders about the use of alcoholic products while on medication. The second most important thing is to offer emotional support. This involves understanding, patience, affection, and encouragement. Engage the depressed person in conversation and listen carefully. Do not disparage feelings expressed, but point out realities and offer hope. Do not ignore remarks about suicide. Report them to the depressed person's therapist. Invite the depressed person for walks, outings, to the movies, and other activities. Be gently insistent if your invitation is refused. Encourage participation in some activities that once gave pleasure, such as hobbies, sports, religious or cultural activities, but do not push the depressed person to undertake too much too soon. The depressed person needs diversion and company, but too many demands can increase feelings of failure.

Do not accuse the depressed person of faking illness or of laziness, or expect him or her "to snap out of it." Eventually, with treatment, most people do get better. Keep that in mind, and keep reassuring the depressed person that, with time and help, he or she will feel better.

WHERE TO GET HELP

If unsure where to go for help, check the Yellow Pages under "mental health," "health," "social services," "suicide prevention," "crisis intervention services," "hotlines," "hospitals," or "physicians" for phone numbers and addresses. In times of crisis, the emergency room doctor at a hospital may be able to provide temporary help for an emotional problem, and will be able to tell you where and how to get further help.

Listed below are the types of people and places that will make a referral to, or provide, diagnostic and treatment services.

- Family doctors
- Mental health specialists, such as psychiatrists, psychologists, social workers, or mental health counselors
- Health maintenance organizations
- Community mental health centers
- Hospital psychiatry departments and outpatient clinics
- University- or medical school-affiliated programs
- State hospital outpatient clinics
- Family service, social agencies, or clergy
- Private clinics and facilities
- Employee assistance programs
- Local medical and/or psychiatric societies

FURTHER INFORMATION

Please visit the following link for more information about organizations that focus on depression:

- http://www.nimh.nih.gov/HealthInformation/ResourceList.cfm?Flowstate=4&DisOrdID=6

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Child and Adolescent Bipolar Disorder: An Update from the National Institute of Mental Health

Research findings, clinical experience, and family accounts provide substantial evidence that bipolar disorder, also called manic-depressive illness, can occur in children and adolescents. Bipolar disorder is difficult to recognize and diagnose in youth, however, because it does not fit precisely the symptom criteria established for adults, and because its symptoms can resemble or co-occur with those of other common childhood-onset mental disorders. In addition, symptoms of bipolar disorder may be initially mistaken for normal emotions and behaviors of children and adolescents. But unlike normal mood changes, bipolar disorder significantly impairs functioning in school, with peers, and at home with family. Better understanding of the diagnosis and treatment of bipolar disorder in youth is urgently needed. In pursuit of this goal, the National Institute of Mental Health (NIMH) is conducting and supporting research on child and adolescent bipolar disorder.

A Cautionary Note

Effective treatment depends on appropriate diagnosis of bipolar disorder in children and adolescents. There is some evidence that using antidepressant medication to treat depression in a person who has bipolar disorder may induce manic symptoms if it is taken without a mood stabilizer.

In addition, using stimulant medications to treat attention deficit hyperactivity disorder (ADHD) or ADHD-like symptoms in a child with bipolar disorder may worsen manic symptoms. While it can be hard to determine which young patients will become manic, there is a greater likelihood among children and adolescents who have a family history of bipolar disorder.

If manic symptoms develop or markedly worsen during antidepressant or stimulant use, a physician should be consulted immediately, and diagnosis and treatment for bipolar disorder should be considered.

Symptoms and Diagnosis

Bipolar disorder is a serious mental illness characterized by recurrent episodes of depression, mania, and/or mixed symptom states. These episodes cause unusual and extreme shifts in mood, energy, and behavior that interfere significantly with normal, healthy functioning.

Manic symptoms include:

- Severe changes in mood, either extremely irritable or overly silly and elated
- Overly-inflated self-esteem; grandiosity
- Increased energy
- Decreased need for sleep, ability to go with very little or no sleep for days without tiring
- Increased talking, talks too much, too fast; changes topics too quickly; cannot be interrupted

- Distractibility, attention moves constantly from one thing to the next
- Hypersexuality, increased sexual thoughts, feelings, or behaviors; use of explicit sexual language
- Increased goal-directed activity or physical agitation
- Disregard of risk, excessive involvement in risky behaviors or activities

Depressive symptoms include:

- Persistent sad or irritable mood
- Loss of interest in activities once enjoyed
- Significant change in appetite or body weight
- Difficulty sleeping or oversleeping
- Physical agitation or slowing
- Loss of energy
- Feelings of worthlessness or inappropriate guilt
- Difficulty concentrating
- Recurrent thoughts of death or suicide

Symptoms of mania and depression in children and adolescents may manifest themselves through a variety of different behaviors.[1,2] When manic, children and adolescents, in contrast to adults, are more likely to be irritable and prone to destructive outbursts than to be elated or euphoric. When depressed, there may be many physical complaints such as headaches, muscle aches, stomachaches or tiredness, frequent absences from school or poor performance in school, talk of or efforts to run away from home, irritability, complaining, unexplained crying, social isolation, poor communication, and extreme sensitivity to rejection or failure. Other manifestations of manic and depressive states may include alcohol or substance abuse and difficulty with relationships.

Existing evidence indicates that bipolar disorder beginning in childhood or early adolescence may be a different, possibly more severe form of the illness than older adolescent- and adult-onset bipolar disorder.[1,2] When the illness begins before or soon after puberty, it is often characterized by a continuous, rapid-cycling, irritable, and mixed symptom state that may co-occur with disruptive behavior disorders, particularly attention deficit hyperactivity disorder (ADHD) or conduct disorder (CD), or may have features of these disorders as initial symptoms. In contrast, later adolescent- or adult-onset bipolar disorder tends to begin suddenly, often with a classic manic episode, and to have a more episodic pattern with relatively stable periods between episodes. There is also less co-occurring ADHD or CD among those with later onset illness.

A child or adolescent who appears to be depressed and exhibits ADHD-like symptoms that are very severe, with excessive temper outbursts and mood changes, should be evaluated by a psychiatrist or psychologist with experience in bipolar disorder, particularly if there is a family history of the illness. This evaluation is especially important since psychostimulant medications, often prescribed for ADHD, may worsen manic symptoms. There is also limited evidence suggesting that some of the symptoms of ADHD may be a forerunner of full-blown mania.

Findings from an NIMH-supported study suggest that the illness may be at least as common among youth as among adults. In this study, one percent of adolescents ages 14 to 18 were found to have met criteria for bipolar disorder or cyclothymia, a similar but milder illness, in their lifetime.[3] In addition, close to six percent of adolescents in the study had experienced a distinct period of abnormally and persistently elevated, expansive, or irritable mood even though they never met full criteria for bipolar disorder or cyclothymia. Compared to adolescents with a history of major depressive disorder and to a never-mentally-ill group, both the teens with bipolar disorder and those with subclinical symptoms had greater functional impairment and higher rates of co-occurring illnesses (especially anxiety and disruptive behavior disorders), suicide attempts, and mental health services utilization. The study highlights the need for improved recognition, treatment, and prevention of even the milder and subclinical cases of bipolar disorder in adolescence.

Treatment

Once the diagnosis of bipolar disorder is made, the treatment of children and adolescents is based mainly on experience with adults, since as yet there is very limited data on the efficacy and safety of mood stabilizing medications in youth.[4] The essential treatment for this disorder in adults involves the use of appropriate doses of mood stabilizers, most typically lithium and/or valproate, which are often very effective for controlling mania and preventing recurrences of manic and depressive episodes. Research on the effectiveness of these and other medications in children and adolescents with bipolar disorder is ongoing. In addition, studies are investigating various forms of psychotherapy, including cognitive-behavioral therapy, to complement medication treatment for this illness in young people.

NIMH is attempting to fill the current gaps in treatment knowledge with carefully designed studies involving children and adolescents with bipolar disorder. Data from adults do not necessarily apply to younger patients, because the differences in development may have implications for treatment efficacy and safety.[4] Current multi-site studies funded by NIMH are investigating the value of long-term treatment with lithium and other mood from adults do not necessarily apply to younger patients, because the differences in development may have implications for treatment efficacy and safety. 4 Current multi-state studies funded by NIMH are investigating the value of long-term treatment with lithium and other mood stabilizers in preventing recurrence of bipolar disorder in adolescents. Specifically, these studies aim to determine how well lithium and other mood stabilizers prevent recurrences of mania or depression and control subclinical symptoms in adolescents; to identify factors that predict outcome; and to assess side effects and overall adherence to treatment. Another NIMH-funded study is evaluating the safety and efficacy of valproate for treatment of acute mania in children and adolescents, and also is investigating the biological correlates of treatment response. Other NIMH-supported investigators are studying the effects of antidepressant medications added to mood stabilizers in the treatment of the depressive phase of bipolar disorder in adolescents.

Valproate Use

According to studies conducted in Finland in patients with epilepsy, valproate may increase testosterone levels in teenage girls and produce polycystic ovary syndrome in women who began taking the medication before age 20.[5] Increased testosterone can lead to polycystic ovary syndrome with irregular or absent menses, obesity, and abnormal growth of hair. Therefore, young female patients taking valproate should be monitored carefully by a physician.

For more information

Visit the following link for more information on NIMH.

  - http://www.nimh.nih.gov/about/nimh.cfm

Please visit the following links for more information about organizations that focus on child and adolescent mental health and bipolar disorder.

  - http://www.nimh.nih.gov/HealthInformation/ResourceList.cfm?Flowstate=4&DisOrdID=23

  - http://www.nimh.nih.gov/HealthInformation/ResourceList.cfm?Flowstate=4&DisOrdID=4

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Facts About Anxiety Disorders

Most people experience feelings of anxiety before an important event such as a big exam, business presentation, or first date. Anxiety disorders, however, are illnesses that fill people's lives with overwhelming anxiety and fear that are chronic, unremitting, and can grow progressively worse. Tormented by panic attacks, obsessive thoughts, flashbacks of traumatic events, nightmares, or countless frightening physical symptoms, some people with anxiety disorders even become housebound. Fortunately, through research supported by the National Institute of Mental Health (NIMH), there are effective treatments that can help.

How Common Are Anxiety Disorders?

Anxiety disorders, as a group, are the most common mental illness in America. More than 19 million American adults are affected by these debilitating illnesses each year. Children and adolescents can also develop anxiety disorders.

What Are the Different Kinds of Anxiety Disorders?

- **Panic Disorder**—Repeated episodes of intense fear that strike often and without warning. Physical symptoms include chest pain, heart palpitations, shortness of breath, dizziness, abdominal distress, feelings of unreality, and fear of dying.
- **Obsessive-Compulsive Disorder**—Repeated, unwanted thoughts or compulsive behaviors that seem impossible to stop or control.
- **Post-Traumatic Stress Disorder**—Persistent symptoms that occur after experiencing or witnessing a traumatic event such as rape or other criminal assault, war, child abuse, natural or human-caused disasters, or crashes. Nightmares, flashbacks, numbing of emotions, depression, and feeling angry, irritable or distracted and being easily startled are common. Family members of victims can also develop this disorder.
- **Phobias**—Two major types of phobias are social phobia and specific phobia. People with social phobia have an overwhelming and disabling fear of scrutiny, embarrassment, or humiliation in social situations, which leads to avoidance of many potentially pleasurable and meaningful activities. People with specific phobia experience extreme, disabling, and irrational fear of something that poses little or no actual danger; the fear leads to avoidance of objects or situations and can cause people to limit their lives unnecessarily.
- **Generalized Anxiety Disorder**—Constant, exaggerated worrisome thoughts and tension about everyday routine life events and activities, lasting at least six months. Almost always anticipating the

worst even though there is little reason to expect it; accompanied by physical symptoms, such as fatigue, trembling, muscle tension, headache, or nausea.

Anxiety Disorders
One-Year Prevalence (Adults)

	%	*
Any Anxiety Disorder	13.3	19.1
Panic Disorder	1.7	2.4
Obsessive-Compulsive Disorder	2.3	3.3
Post-Traumatic Stress Disorder	3.6	5.2
Any Phobia	8.0	11.5
Generalized Anxiety Disorder	2.8	4.0

* Population Estimate (Millions)
Based on 7/1/98 U.S. Census resident population estimate of 143.3 million, age 18-54

What Are Effective Treatments for Anxiety Disorders?

Treatments have been largely developed through research conducted by NIMH and other research institutions. They help many people with anxiety disorders and often combine medication and specific types of psychotherapy.

A number of medications that were originally approved for treating depression have been found to be effective for anxiety disorders as well. Some of the newest of these antidepressants are called selective serotonin reuptake inhibitors (SSRIs). Other antianxiety medications include groups of drugs called benzodiazepines and beta-blockers. If one medication is not effective, others can be tried. New medications are currently under development to treat anxiety symptoms.

Two clinically-proven effective forms of psychotherapy used to treat anxiety disorders are behavioral therapy and cognitive-behavioral therapy. Behavioral therapy focuses on changing specific actions and uses several techniques to stop unwanted behaviors. In addition to the behavioral therapy techniques, cognitive-behavioral therapy teaches patients to understand and change their thinking patterns so they can react differently to the situations that cause them anxiety.

Do Anxiety Disorders Co-Exist with Other Physical or Mental Disorders?

It is common for an anxiety disorder to accompany depression, eating disorders, substance abuse, or another anxiety disorder. Anxiety disorders can also co-exist with illnesses such as cancer or heart disease. In such instances, the accompanying disorders will also need to be treated. Before beginning any treatment, however, it is important to have a thorough medical examination to rule out other possible causes of symptoms.

For more information

Please visit the following link for more information about organizations that focus on anxiety disorders.

  - http://www.nimh.nih.gov/HealthInformation/ResourceList.cfm?Flowstate=4&DisOrdID=2

QUIZ

How Much Do You Know About Anxiety Disorders?

Fear and anxiety are a necessary part of life. Whether it's a feeling of anxiety before taking a test or a feeling of fear as you walk down a dark street, normal anxiety can be protective and stimulating. Unfortunately, more than 19 million Americans with anxiety disorders face much more than just "normal" anxiety. Instead, their lives are filled with overwhelming anxiety and fear that can be intense and crippling. Although anxiety disorders can be disabling, research supported and conducted by the National Institute of Mental Health (NIMH) has provided insight into their causes and has resulted in many effective treatments.

1. Which of the following are disorders of the brain?

    a.   Stroke, epilepsy, multiple sclerosis
    b.   Anxiety disorders, schizophrenia, depression, alcohol addiction
    c.   Autism, anorexia, learning disabilities, dyslexia, migraines
    d.   Alzheimer's disease, Tourette syndrome, Parkinson's disease, brain tumor
    e.   All of the above

2. True or False?
Post-traumatic stress disorder, once referred to as shell shock or battle fatigue, is a condition that only affects war veterans.

3. True or False?
Someone who feels compelled to spend a great deal of time doing things over and over again such as washing their hands, checking things, or counting things has an anxiety disorder.

4. What is the most common mental health problem in the United States?

    a.   Depression
    b.   Schizophrenia
    c.   Anxiety disorders

5. Which of the following diseases/disorders are real medical illnesses?

    e.   Anxiety disorders
    f.   Diabetes
    g.   High blood pressure
    h.   All of the above

6. Which of the following are symptoms of an anxiety disorder known as panic disorder?

    a.   Chest pains
    b.   Dizziness
    c.   Nausea or stomach problems

d. Fear of dying
e. All of the above

7. True or False?
Anxiety disorders often occur with other illnesses.

8. True or False?
Most people successfully take control of the symptoms of anxiety disorders by sheer willpower and personal strength.

ANSWERS TO QUIZ

1. Which of the following are disorders of the brain?

Answer: e. All of the above.

Brain research demonstrates that disorders as different as stroke, anxiety disorders, alcohol addiction, anorexia, learning disabilities, and Alzheimer's disease all have their roots in the brain. Every American will be affected at some point in his or her life, either personally or by a family member's struggle, with a brain disorder.

2. Post-traumatic stress disorder, once referred to as shell shock or battle fatigue, is a condition that only affects war veterans.

Answer: False.

Individuals who have experienced or witnessed a traumatic event or ordeal, such as a terrorist attack, a tornado, a rape or mugging, or a car accident, can be at risk for developing post-traumatic stress disorder (PTSD). Many people with this anxiety disorder repeatedly relive the trauma in the form of nightmares and disturbing recollections during the day. They may also experience sleep problems, depression, feeling detached or numb, or being easily startled.

3. Someone who feels compelled to spend a great deal of time doing things over and over again such as washing their hands, checking things, or counting things has an anxiety disorder.

Answer: True.

A person plagued by the urgent need to engage in certain rituals, or tormented by unwelcome thoughts or images, may be suffering from an anxiety disorder called obsessive-compulsive disorder (OCD). Most healthy people can identify with having some of the symptoms of OCD, such as checking the stove several times before leaving the house. But the disorder is diagnosed only when such activities consume at least an hour a day, are very distressing, and interfere with daily life. OCD affects men and women equally. It can appear in childhood, adolescence, or adulthood, but on the average, it first shows up in the teens or early adulthood.

4. What is the most common mental health problem in the United States?

Answer: c. Anxiety disorders.

Anxiety disorders are the most common mental health problem in America. More than 19 million Americans suffer from anxiety disorders, which include panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, phobias, and generalized anxiety disorder.

5. Which of the following diseases/disorders are real medical illnesses?

Answer: d. All of the above.

Anxiety disorders, diabetes, and high blood pressure are all real medical illnesses. Brain scientists have shown that anxiety disorders are often related to the biological makeup and life experiences of the individual, and they frequently run in families. Unfortunately, misconceptions about mental illnesses like anxiety disorders still exist. Because many people believe mental illness is a sign of personal weakness, the condition is often trivialized and is left untreated. The good news is that effective treatments are available for anxiety disorders.

6. Which of the following are symptoms of an anxiety disorder known as panic disorder?

Answer: e. All of the above.

Panic disorder is characterized by unexpected and repeated episodes of intense fear accompanied by physical symptoms that may include chest pain, heart palpitations, shortness of breath, dizziness, or abdominal distress. These sensations often mimic symptoms of a heart attack or other life-threatening medical conditions. Left untreated, people with panic disorder can develop so many phobias about places or situations where panic attacks have occurred that they become housebound.

7. Anxiety disorders often occur with other illnesses.

Answer: True.

It is common for an anxiety disorder to accompany depression, eating disorders, substance abuse, or another anxiety disorder. Anxiety disorders can also co-exist with illnesses such as heart disease, high blood pressure, irritable bowel syndrome, thyroid conditions, and migraine headaches. In such instances, the accompanying disorders will also need to be treated. So, it is important, before beginning any treatment, to have a thorough medical examination to determine the causes of symptoms.

8. Most people successfully take control of the symptoms of anxiety disorders by sheer willpower and personal strength.

Answer: False.

Many people misunderstand anxiety disorders and other mental illnesses and think individuals should be able to overcome the symptoms by sheer willpower. Wishing the symptoms away does not work—but there are treatments that can help. Treatment for anxiety disorders often involves medication, specific forms of psychotherapy, or a combination of the two.

In recent years, attention deficit hyperactivity disorder (ADHD) has been a subject of great public attention and concern. Children with ADHD—one of the most common of the psychiatric disorders that appear in childhood—can't stay focused on a task, can't sit still, act without thinking, and rarely finish anything. If untreated, the disorder can have long-term effects on a child's ability to make friends or do well at school or work. Over time, children with ADHD may develop depression, poor self-esteem, and other emotional problems.

- ADHD affects an estimated 4.1 percent of youths ages 9 to 17 in a 6-month period.[1]
- About 2 to 3 times more boys than girls have ADHD.[2]
- Children with untreated ADHD have higher than normal rates of injury.[3]
- ADHD often co-occurs with other problems, such as depressive and anxiety disorders, conduct disorder, drug abuse, or antisocial behavior.[4,5]
- Symptoms of ADHD usually become evident in preschool or early elementary years. The disorder frequently persists into adolescence and occasionally into adulthood.[6]

Diagnosis and Treatment

Effective treatment depends on appropriate diagnosis of ADHD. A comprehensive medical evaluation of the child must be conducted to establish a correct diagnosis of ADHD and to rule out other potential causes of the symptoms. ADHD can be reliably diagnosed when appropriate guidelines are used.[7,8] Ideally, a health care practitioner making a diagnosis should include input from both parents and teachers. But some health practitioners diagnose ADHD without all this information and tend to either overdiagnose the disorder or underdiagnose it.

Research has shown that certain medications, stimulants in most cases, and behavioral therapies that help children with ADHD control their activity level and impulsiveness, pay attention, and focus on tasks are the most beneficial treatments.[9] Stimulants commonly prescribed for ADHD include methylphenidate (Ritalin®), dextroamphetamine (Dexedrine®), and amphetamine (Adderall®). Despite data showing that stimulant medications are safe,[8] there are widespread misunderstandings about the safety and use of these drugs, and some health care practitioners are reluctant to prescribe them. Like all medications, those used to treat ADHD do have side effects and need to be closely monitored.

Problems Faced by Families

Parents need to carefully evaluate treatment choices when their child receives a diagnosis of ADHD. When they pursue treatment for their children, families face high out-of-pocket expenses because treatment for ADHD and other mental illnesses is often not covered by insurance policies. In schools, treatment plans are often poorly integrated. In addition, there are few special education funds directed specifically for ADHD. All of these factors lead to children who do not receive proper and adequate treatment. To overcome these barriers, parents may want to look for school-based programs that have a team approach involving parents, teachers, school psychologists, other mental health specialists, and physicians.

Research Findings

Brain imaging research using a technique called magnetic resonance imaging (MRI) has shown that differences exist between the brains of children with and without ADHD.[10] In addition, there appears to be a link between a person's ability to pay continued attention and the use of glucose—the body's major fuel—in the brain. In adults with ADHD, the brain areas that control attention use less glucose and appear to be less active, suggesting that a lower level of activity in some parts of the brain may cause inattention.[11]

Research shows that ADHD tends to run in families, so there are likely to be genetic influences.[12] Children who have ADHD usually have at least one close relative who also has ADHD. And at least one-third of all fathers who had ADHD in their youth have children with ADHD. Even more convincing of a possible genetic link is that when one twin of an identical twin pair has the disorder, the other is likely to have it too.

Data from 1995 show that physicians treating children and adolescents wrote 6 million prescriptions for stimulants.[13] Of all the drugs used to treat psychiatric disorders in children, stimulant medications are the most well studied. A 1998 Consensus Development Conference on ADHD sponsored by the National Institutes of Health and a recent, comprehensive scientific report confirmed many earlier studies showing that short-term use of stimulants is safe and effective for children with ADHD.[8,14]

In December 1999, NIMH released the results of a study of nearly 600 elementary school children, ages 7 to 9, which evaluated the safety and relative effectiveness of the leading treatments for ADHD for a period up to 14 months.[9] The results indicate that the use of stimulants alone is more effective than behavioral therapies in controlling the core symptoms of ADHD—inattention, hyperactivity/impulsiveness, and aggression. In other areas of functioning, such as anxiety symptoms, academic performance, and social skills, the combination of stimulant use with intensive behavioral therapies was consistently more effective. (Of note, families and teachers reported somewhat higher levels of satisfaction for those treatments that included the behavioral therapy components.) NIMH researchers will continue to track these children into adolescence to evaluate the long-term outcomes of these treatments, and ongoing reports will be published.

For More Information

Please visit the following link for more information about organizations that focus on attention deficit hyperactivity disorder.

- http://www.nimh.nih.gov/HealthInformation/ResourceList.cfm?Flowstate=4&DisOrdID=14

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NIH Publication No. 01-4589

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Childhood-Onset Schizophrenia: An Update from the National Institute of Mental Health

A child's stage of development must be taken into account when considering a diagnosis of mental illness.[1] Behaviors that are normal at one age may not be at another. Rarely, a healthy young child may report strange experiences—such as hearing voices—that would be considered abnormal at a later age. Clinicians look for a more persistent pattern of such behaviors. Parents may have reason for concern if a child of 7 years or older often hears voices saying derogatory things about him or her, or voices conversing with one another, talks to himself or herself, stares at scary things—snakes, spiders, shadows—that are not really there, and shows no interest in friendships. Such behaviors could be signs of schizophrenia, a chronic and disabling form of mental illness.[2]

Fortunately, schizophrenia is rare in children, affecting only about 1 in 40,000,[3] compared to 1 in 100 in adults. The average age of onset is 18 in men and 25 in women. Ranking among the top 10 causes of disability worldwide,[4] schizophrenia, at any age, exacts a heavy toll on patients and their families. Children with schizophrenia experience difficulty in managing everyday life. They share with their adult counterparts psychotic symptoms (hallucinations, delusions), social withdrawal, flattened emotions, increased risk of suicide and loss of social and personal care skills. They may also share some symptoms with—and be mistaken for—children who suffer from autism or other pervasive developmental disabilities, which affect about 1 in 500

children. Although they tend to be harder to treat and have a worse prognosis than adult-onset schizophrenia patients, researchers are finding that many children with schizophrenia can be helped by the new generation of antipsychotic medications.[5]

Symptoms and Diagnosis

While schizophrenia sometimes begins as an acute psychotic episode in young adults, it emerges gradually in children, often preceded by developmental disturbances, such as lags in motor and speech/language development. Such problems tend to be associated with more pronounced brain abnormalities. The diagnostic criteria are the same as for adults, except that symptoms appear prior to age 12, instead of in the late teens or early 20s.[6] Children with schizophrenia often see or hear things that do not really exist, and harbor paranoid and bizarre beliefs. For example, they may think people are plotting against them or can read their minds. Other symptoms of the disorder include problems paying attention, impaired memory and reasoning, speech impairments, inappropriate or flattened expression of emotion, poor social skills, and depressed mood. Such children may laugh at a sad event, make poor eye contact, and show little body language or facial expression.

Misdiagnosis of schizophrenia in children is all too common. It is distinguished from autism by the persistence of hallucinations and delusions for at least 6 months, and a later age of onset—7 years or older. Autism is usually diagnosed by age 3.[7] Schizophrenia is also distinguished from a type of brief psychosis sometimes seen in affective, personality, and dissociative disorders in children. Adolescents with bipolar disorder sometimes have acute onset of manic episodes that may be mistaken for schizophrenia. Children who have been victims of abuse may sometimes claim to hear voices of—or see visions of—the abuser. Symptoms of schizophrenia characteristically pervade the child's life, and are not limited to just certain situations, such as at school. If children show any interest in friendships, even if they fail at maintaining them, it is unlikely that they have schizophrenia.

Treatment

Treatments that help young patients manage their illness have improved significantly in recent decades. As in adults, antipsychotic medications are especially helpful in reducing hallucinations and delusions. The newer generation "atypical" antipsychotics, such as olanzapine and clozapine, may also help improve motivation and emotional expressiveness in some patients. They also have a lower likelihood of producing disorders of movement, including tardive dyskinesia, than the other antipsychotic drugs such as haloperidol. However, even with these newer medications, there are side effects, including excess weight gain that can increase risk of other health problems. The NIMH is conducting research studies to improve treatments (www.clinicaltrials.gov). Children with schizophrenia and their families can also benefit from supportive counseling, psychotherapies, and social skills training aimed at helping them cope with the illness. They likely require special education and/or other accommodations to succeed in the classroom.

Causes

Although it is unclear whether schizophrenia has a single or multiple underlying causes, evidence suggests that it is a neurodevelopmental disease likely involving a genetic predisposition, a prenatal insult to the developing brain, and stressful life events. The role of genetics has long been established; the risk of schizophrenia rises from 1 percent with no family history of the illness, to 10 percent if a first degree relative has it, to 50 percent if an identical twin has it. Prenatal insults may include viral infections, such as maternal influenza in the second trimester, starvation, lack of oxygen at birth, and untreated blood type incompatibility. Studies find that children share with adults many of the same abnormal brain structural, physiological, and neuropsychological features associated with schizophrenia.[6] The children seem to have more severe cases than adults, with more pronounced neurological abnormalities. This makes childhood-onset schizophrenia potentially one of the clearest windows available for research into a still obscure illness process.

For example, unlike most adult-onset patients, children who become psychotic prior to puberty show conspicuous evidence of progressively abnormal brain development. In the first longitudinal brain imaging study of adolescents,[8] magnetic resonance imaging (MRI) scans revealed fluid filled cavities in the middle of the brain enlarging abnormally between ages 14 and 18 in teens with early-onset schizophrenia, suggesting a shrinkage in brain tissue volume.[9] These children lost four times as much gray matter, neurons and their branchlike extensions, in their frontal lobes as normally occurs in teens. This gray matter loss engulfs the brain in a progressive wave from back to front over 5 years, beginning in rear structures involved in attention and perception, eventually spreading to frontal areas responsible for organizing, planning, and other "executive" functions impaired in schizophrenia.[10] Since losses in the rear areas are influenced mostly by environmental factors, the researchers suggest that some non-genetic trigger contributes to the onset and initial progression of the illness. The final loss pattern is consistent with that seen in adult schizophrenia. Adult-onset patients' brains may have undergone similar changes when they were teens that went unnoticed because symptoms had not yet emerged, suggest the researchers.

In addition to studies of brain structural abnormalities, researchers are also examining a group of measures associated with genetic risk for schizophrenia. Early-onset cases of illness have recently proven crucial in the discovery of genes linked to other genetically complex disorders like breast cancer, Alzheimer's, and Crohn's diseases.[3] Hence, children with schizophrenia and their families may play an important role in deciphering schizophrenia's molecular roots. Evidence suggests that the rate of genetically-linked abnormalities is twice as high in children as in adults with the illness. Similarly, schizophrenia spectrum disorders, thought to be genetically related to schizophrenia, are about twice as prevalent among first-degree relatives of childhood-onset patients. In one recent study, a third of the families of individuals with childhood onset schizophrenia had at least one first-degree relative with a diagnosis of schizophrenia, or schizotypal or paranoid personality disorder.[11] This profile of psychiatric illness is remarkably similar to that seen in parents of adult-onset patients, adding to the likelihood that both forms share common genetic roots. Other anomalies associated with adult schizophrenia, such as abnormal eye movements, are also more common in families of children with the illness.

Families of children with schizophrenia who are interested in participating in research are encouraged to fill out the NIMH Childhood-Onset Schizophrenia Survey, to help determine eligibility for studies.

For More Information

Please visit the following link for more information about organizations that focus on schizophrenia.

- http://www.nimh.nih.gov/HealthInformation/ResourceList.cfm?Flowstate=4&DisOrdID=11

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Module III: Making Help Accessible to Students and Families

In this module you will guide participants through steps to take to help a student with mental health needs. Using a case study (Juanita's Story), participants will form an action plan, including:

- Identifying local resources
- Voicing concern/asking for help
- Following up

The first section of the module is devoted to identifying local resources. Participants will divide into small groups to brainstorm about resources in their own building and district with help from two handouts, a list of potential partners and a worksheet. They will then read the first part of Juanita's Story and, again in small groups, talk about what actions they would take if they had a student like Juanita. Next, they will read the rest of the case study to learn what steps Juanita's teacher took. Discussion of these steps leads into a discussion on which local resources would be the most helpful and how they could be accessed. A final section delineates confidentiality issues.

Contents

- Module Goal
- Module Objectives
- Trainer's Outline
- Trainer Preparation Notes
- Slides
    - Slide III-A: Goal
    - Slide III-B: Objectives
    - Slide III-C: Action Plan
    - Slide III-D: Confidentiality
- Handouts
    - Handout III-A: Action Plan
    - Handout III-B: Worksheet: Toward Capacity Building
    - Handout III-C: Potential Partners
    - Handout III-D: Juanita's Story
- Evaluation

Module III: Goal

The goal of Module III is to help teachers break down barriers to learning by formulating a plan to assist students with mental health needs.

Module III: Objectives

At the end of this module, participants will be able to:

- List a number of internal resources and external partnerships available to support teachers, students, and families;
- Understand how to access those resources and partnerships;
- Identify the elements of a successful action plan to help students with mental health needs; and
- Describe the appropriate limits of educators' roles with regard to outside involvement and confidentiality.

III-1 Introduction
A. Remind participants that the overall purpose of the training is to help eliminate barriers to learning by understanding and addressing mental health issues in the school environment.

B. Show Slides III-A (Goal) and III-B (Objectives).

C. Give overview of the module (*Trainer Note III-1*).

III-2 Action Plan: Know What Resources Are Available
A. Show Slide III-C and refer to corresponding Handout III-A (Action Plan). Explain that you will be moving through the action plan step by step, starting with the first item, "Know What Resources Are Available."

B. Divide the participants into small groups of three or four. Ask them to use Handout III-B (Worksheet: Toward Capacity Building) to brainstorm about resources in their own building and district (*Trainer Note III-2*). Suggest most relevant resources from Handout III-C (Potential Partners) for help in brainstorming. For each resource, have participants answer:

- What needs does the resource meet for students, families, and/or staff?
- When does it make sense to access the resource?
- How would an educator access the resource?

C. Reconvene and pool groups' suggestions. Write them on a flipchart or chalkboard.

III-3 Action Plan: Voice Your Concern
A. Note that you are moving on to the second stage of the action plan, "Voice Your Concern/Ask For Help."

B. Refer to Handout III-D (Juanita's Story) and allow time for participants to read Part I.

C. Ask participants to form the same small groups to discuss the case study and decide:

- How would they work with Juanita after she disclosed that she had bipolar disorder?
- What would be their next step within the classroom?
- Would they try to involve a school social worker or other pupil services professional at this point?

D. Reconvene and discuss answers. Use answers to the final question to lead into the next stage of the action plan, "Follow Up."

III-4 Action Plan: Follow Up
A. Refer to Handout III-D (Juanita's Story) and allow time for participants to read Part II.

B. Focus attention on the section describing Mrs. Farrell's contact with Juanita's parents. Ask participants:

- Was this an effective way to involve parents?
- Are there other ways, either teacher- or school-based, to involve Juanita's parents?

C. Ask the group what next steps they might take if Juanita were their student. Use resources listed on flipchart or chalkboard as possibilities. Summarize and facilitate consensus on which resources might be the most helpful and how participants would access those resources.

D. Stress the importance of continued involvement, even after the initial referral has been made or the initial resources accessed. Discuss ways in which an educator could remain actively involved with Juanita's care within the scope of local policies (*Trainer Note III-4*).

III-5 Confidentiality and the Limits of Educator Involvement
A. Show Slide III-D (Confidentiality).

B. Make the following points (*Trainer Note III-5*):

- When in doubt, treat information as if it is confidential unless the information violates the limits of confidentiality.
- The limits of confidentiality are related to safety. Confidentiality must be broken when the student discloses an intention to cause harm to self or to others; or when the student reports neglect, or physical, sexual, or psychological abuse.
- As mentioned in the action plan, when voicing concern, educators are expected to inform students of the limits of confidentiality.

C. Remind educators that their job is to voice concern and to access resources, not to diagnose or act as a mental health professional. If applicable, discuss or point out specific school- or district-wide policies that may limit an educator's involvement.

III-6 Closing
A. Summarize major points of the module, referring to objectives.

B. Ask for comments and questions.

C. Ask participants to complete evaluation form.

III-1 Introduction
Background. In Module III, your role is to help participants recognize and know how to access resources in their own school and community. It is important to be aware of local resources before the training begins. Use Handout III-C to help you consider what resources are available. This knowledge will help facilitate participant discussion.

Overview. Module III is different from the other modules in that it is school- and community-specific. This module uses a case study to help participants devise an action plan based on the resources in their own school and community. Participants should think as they read the case study about how they might take action to meet the student's needs and help her succeed.

III-2 Action Plan: Know What Resources Are Available
Resources and policies. Resources identified should include not only partners, but also policies, specifically existing school programs related to mental health. Your school may employ such methods as functional behavior assessment or Positive Behavioral Interventions and Supports (PBIS). See the Resource List, included as an appendix to this training, for more information.

III-4 Action Plan: Follow Up
Continued involvement. It is important to stress that helping students isn't about shifting the problem to someone else. Following up reassures youth that you are someone who DOES care. The information on Handout III-A (Action Plan) provides some ideas for continued involvement:

- Work with the youth and others involved to intervene at the level of the classroom. Make modifications where necessary to promote successful learning.
- Refrain from public statements that will violate the youth's privacy and confidentiality.
- Obtain support from internal resources to ensure that classroom modifications are appropriate and monitor whether adaptations are working for the youth.
- Check with internal resources to ensure that help is being accessed.

The idea of continued and individualized involvement by teachers and other community partners is the basis of the Systems of Care approach. In a system of care, mental health, education, child welfare, juvenile justice, and other agencies work together to ensure that children with mental, emotional, and behavioral problems and their families have access to the services and supports they need to succeed.[1] For more information on this and other forms of intervention, please see the Resource List included as an appendix to this training.

III-5 Confidentiality and the Limits of Educator Involvement
Additional information on confidentiality. Confidentiality is a promise of trust to safeguard personal and private information that is shared openly, either through written, spoken, or another form of communication. The purpose of confidentiality is to honor an individual's right to privacy and to show respect for the vulnerability that underlies the process of sharing private information.

Confidentiality must be broken when the student discloses an intention to cause harm to him/herself or to others; or when the student reports neglect or physical, sexual, or psychological abuse.

NOTE: **Suspicion of abuse** is justification to break privacy. All teachers are mandated reporters of suspected child abuse.

1 Systems of Care—A Promising Solution for Children With Serious Emotional Disturbances and Their Families. Center for Mental Health Services, www.mentalhealth.samhsa.gov/publications/allpubs/CA-0030/default.asp

Slide III-A: Goal

The goal of Module III is to help teachers break down barriers to learning by formulating a plan to assist students with mental health needs.

Slide III-B: Objectives

- Know a number of internal resources and external partnerships available to support teachers, students, and families
- Understand how to access those resources and partnerships
- Learn the elements of a successful action plan to help students with mental health needs
- Know the appropriate limits of educators' roles with regard to outside involvement and confidentiality

Slide III-C: Action Plan

An action plan is a way to direct your behavior and problem-solve with individual students. Every action plan is unique to the individual needs of the student and the resources available.

The basic stages of an action plan include:

- Stage I: Know your resources
- Stage II: Voice your concern/ask for help
- Stage III: Follow up

Slide III-D: Confidentiality

- The purpose of confidentiality is to honor an individual's right to privacy and to show respect for the vulnerability that underlies the process of sharing private information.
- RULE: When in doubt, treat information as if it is confidential unless the information violates the limits of confidentiality.

Limits of Confidentiality:

- The student discloses an intention to harm him/herself or others.
- The student reports neglect or physical, sexual, or psychological abuse.

SAFETY PRECEDES PRIVACY.

Handout III-A: Action Plan

Stage I
Know your building and district policies, procedures, and resources. This sounds obvious, but schools do not have the time to advertise every support service available. Every district has procedures in place to work with students and staff. For example:

- Pre-referral teams, student support teams, or other working groups may be in place.
- School psychologists, social workers, nurses, special educators, and counselors may be available within the building or at the district level.

The key for staff is to learn how to access these professionals and other school resources.

Stage II
Voice your concern/ask for help. This part is scariest. Tips for teachers and other staff:

- Set aside private one-to-one time with the student, and let the student know right at the beginning of the time together that this conference is about your observations of his or her need for assistance.
- You may want to reassure the student that this conference is not a punishment or act of discipline.
- Also make known to the student that in order to help, you may have to share your concern with others, but will not share details of the conversation unless there is an immediate threat to the student's well-being.
- Discuss with the youth what action you will take together to obtain assistance.
- If you have doubts about having a one-to-one conference with the youth, seek support from internal resources or caregivers first.

Stage III
Follow up. It is important to stress that helping students isn't about shifting the problem to someone else. Following up reassures youth that you are someone who DOES care. Tips for teachers and other staff:

- Work with the youth and others involved to intervene at the level of the classroom. Make modifications where necessary to promote successful learning.
- Refrain from public statements that will violate the youth's privacy and confidentiality.
- Obtain support from internal resources to ensure that classroom modifications are appropriate and monitor whether adaptations are working for the youth.
- Check with internal resources to ensure that help is being accessed.

The action plan should be tailored to the needs of the student and his or her family and should include all the resources inside and outside the school that can meet his or her needs. Not all students will show an immediate beneficial response to intervention. Continue to provide support for the student within the classroom and provide feedback to the student at every hint of progress.

Handout III-B: Worksheet: Toward Capacity Building

Resource	What needs does this resource meet for students? Families? Staff?	When should an educator access this resource?	How should an educator access this resource?

Handout III-C: Potential Partners

- School social workers
- School psychologists
- School wellness coordinators
- School nurses
- School counselors
- School-based mental health clinic
- School-based health clinic

- Families
- Parent advocates
- Family liaisons
- Outreach workers
- Peer mentors

- Principal
- Vice principals
- Instructional leaders
- School board
- Superintendent

- Committee on special education
- Intervention team or committee
- Special educators
- Physical, speech, occupational therapists

- Attendance office
- Truant officers
- Transportation department

- System of care partners
- Case managers
- Family/private psychologist
- Mental health providers outside school

The resource list included with this training package also includes Federal and federally funded resources that may serve as partners.

Handout III-D: Juanita's Story
Part I

Juanita ran into several difficulties in the latter part of elementary school and her grades deteriorated when she transitioned into middle school. Her family was unsure about the ups and downs that Juanita showed. She had always been bouncy, energetic, and creative, but she seemed at times unusually animated. Just before starting high school Juanita's behavior was a tremendous concern for the family. She would stay up all night, rarely eat, and seem to possess a ton of energy. Other times she slept all day, hardly spoke to anyone, and locked herself in her room. At first the family thought she might be using drugs. This created a lot of tension and conflict in the family. Many arguments took place at home about Juanita's talkativeness, her insomnia, and the way she seemed to snap at people in a grumpy and even hostile tone. The family grew even more concerned for Juanita after she ran away for three days. She said she wanted to live the life of an artist and that rules didn't apply to her life.

Juanita's family sought help by going to their church. Their minister referred them to a counseling center. The family and Juanita discovered that much of Juanita's behavior was not typical for a teenager. Her behavior really showed symptoms of a bipolar mood disorder. Juanita improved with medication. She participated in family counseling and attended a group with other teenagers who experienced emotional disturbances.

Although Juanita showed improvement, her work at school was uneven. She skipped some classes and received excellent grades in other classes. Math was her least favorite class. Her teacher, Mrs. Farrell, noticed that Juanita would show up to class without assignments, often tardy, and disorganized. Mrs. Farrell also noticed that Juanita possessed certain flair: she painted her notebooks, wore handmade jewelry, and seemed to invent her own style. Mrs. Farrell decided to discuss what she observed with Juanita.

Mrs. Farrell approached Juanita at her desk while the other students were taking a pop quiz. The teacher guessed that Juanita was unprepared for the quiz because she had missed the last two days of class and didn't have the assignments. She whispered to Juanita and asked her to quietly step out into the hall for a moment. In the hallway, Mrs. Farrell told Juanita that she noticed Juanita seemed to be artistic and wondered if Juanita may not enjoy math. Juanita boldly told her she hated it. Mrs. Farrell asked if Juanita could meet with her after school to find ways to make the class work for her. Mrs. Farrell was unsure how to discuss the topic with Juanita but she was willing to spend the time with her.

When Juanita met Mrs. Farrell after school she immediately asked the teacher how Mrs. Farrell was going to "make her" like math. Mrs. Farrell told Juanita that it seemed that they couldn't resolve Juanita's dislike for math

in one day. However, they might be able to find ways to see how math may not be so different from other things Juanita does like. And even if they couldn't agree on that, they could agree that it was within Juanita's power to come to class and ask for help with the work if she was confused.

Juanita agreed with Mrs. Farrell about asking for help. She told Mrs. Farrell that she knew about what it meant to ask for help because of having emotional problems and more specifically, bipolar disorder. She described the last few years to Mrs. Farrell and told her about living with side effects from medication.

Part II

Mrs. Farrell was not prepared for what she heard, but knew that Juanita was sharing something very real, very personal, and very important for her success as student. Mrs. Farrell asked Juanita if she ever felt that bipolar disorder got in the way of schoolwork. Juanita confessed that sometimes she felt very tired or worn out. She also said that she sometimes felt really hyper, but didn't mind that as much. Some classes make her feel more relaxed, like art class. Math wasn't one of those classes.

Mrs. Farrell told Juanita she felt that they could make progress by making a plan to help Juanita with math. She and Juanita agreed to pay attention to when Juanita felt jumpy and confused in class. They also agreed that Juanita could ask for help with the class.

Juanita showed up to class on time the next day. After class she asked Mrs. Farrell if they could meet to talk about her assignments. Mrs. Farrell agreed to meet with Juanita. They developed a small plan for Juanita to follow. The plan included a built-in way for Juanita to reward herself for handing in assignments. The plan also included a way for Juanita to work on math without distractions from television, the telephone, and things Juanita said took her away from her work.

Juanita seemed genuinely ready to take a new approach to class. Mrs. Farrell, however, noticed that Juanita seemed very talkative in class over the next few weeks. When she saw Juanita in the hallway, she seemed rowdy and loud. She asked Juanita to meet with her. When they met, Mrs. Farrell told Juanita that she would like to talk with her parents, too. She told Juanita that the plan had seemed to help at first but now something else seemed to be getting in the way. Juanita told Mrs. Farrell not to call her parents. She said they were fighting a lot lately. Mrs. Farrell said she couldn't do that because she was much too concerned about Juanita.

Mrs. Farrell held a conference with Juanita and her parents. Juanita's parents were upset with Juanita, and they were concerned about whether she was taking her medication. Mrs. Farrell asked Juanita's parents to consult with their daughter's doctor.

Juanita was absent for one week after the conference. Mrs. Farrell was very concerned. When Juanita returned, she went to Mrs. Farrell and told her that she had been hospitalized, and that they were trying new medicine for her. She said she felt unstable and scared. Mrs. Farrell told Juanita that the adults in her life would be there to support her. Mrs. Farrell realized that Juanita would need reassurance to build her confidence back. During the weeks that followed, Juanita seemed to do her best with getting back on track in class.

At the end of the term she received a 70 percent on her report card. The grade was a huge improvement from the 50 percent she received the previous quarter.

Part I: Please answer the following questions by circling a number on the scales provided.

1) Was the content of this module *relevant and applicable* to your classroom/school?
Not at all relevant   Somewhat relevant   Extremely relevant
          1   2   3   4   5   6   7

2) Was the information presented *too simplistic* or *too involved*?
Too simplistic   Just right   Too involved
          1   2   3   4   5   6   7

3) Was the information *new* to you?
All previously known   Some new information   Mostly new information
          1   2   3   4   5   6   7

4) Was the module *well-organized*?
Not well-organized   Somewhat well-organized   Very well-organized
          1   2   3   4   5   6   7

5) Was the module an appropriate *length*?
Too short   Comfortable length   Too long
          1   2   3   4   5   6   7

6) Was there a sufficient *variety* of activities?
Not enough   A good number   Too many
          1   2   3   4   5   6   7

7) Were the *materials* (slides, handouts) clear and concise?
Not clear   Somewhat clear   Very clear
          1   2   3   4   5   6   7

8) Were the materials *helpful* as supplements to the information presented?
Not helpful   Somewhat helpful   Very helpful
          1   2   3   4   5   6   7

Part II: Please give us your comments:

I liked:
_____
_____

I didn't like:
_____
_____

I wish there had been more:
_____
_____

The most important thing I learned was:

_____

_____

Other comments:

_____

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_____

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Module IV: Strategies To Promote a Positive Classroom Climate

Overview for Trainers

This module addresses ways to help create a classroom climate that promotes learning and mental health for all students. It begins with a general discussion of classroom climate, which leads into two case studies, one on stigma (Mrs. Rogers and a Lesson on Stigma) and one on bullying (Brett's Story).   Most of the rest of the module is devoted to strategies that take advantage of adolescent development to improve classroom climate.   After walking through a case study with the trainer, participants will break into small groups to brainstorm about effective ways to cope with specific behaviors, using their knowledge of teen social and emotional development. In the final section, participants discuss how specific strategies, already part of the teaching tools they know and use, can benefit students with mental health needs.

Contents

Module IV: Goal

The goal of Module IV is to help increase awareness of strategies to create an accepting classroom climate that promotes learning for all students, including those with mental health needs.

Module IV: Objectives

At the end of this module, participants will be able to:

- Discuss the relationship among classroom climate, learning, and mental health;
- Give examples of strategies that promote a positive classroom climate by taking advantage of adolescent social-emotional development;
- Describe strategies for maintaining an accepting, stigma-free classroom climate; and
- Describe instructional strategies that promote a positive classroom climate and mental health.

Module IV: Trainer's Outline

IV-1 Introduction
A. Remind participants that the overall purpose of the training is to help eliminate barriers to learning by understanding and addressing mental health issues in the school environment.

B. Show Slides IV-A (Goal) and IV-B (Objectives).

C. Give overview of the module (*Trainer Note IV-1*).

D. Make the point: This module does not teach new skills; participants already have the skills that they need. The next hour they will explore ways to use those skills to create a classroom climate that promotes mental health.

IV-2 Classroom Climate, Learning, and Mental Health
A. Show Slide IV-C (The Context of Learning).

B. Point out the many different elements that make up the context of learning, including classroom climate.

C. Show Slide IV-D (Positive Classroom Climate). Make the following points (*Trainer Note IV-2*):

- Classroom climate refers to students' perceptions about the overall setting where instruction and learning take place.
- The primary goal of establishing a positive classroom climate is to be able to instruct to a range of individual learning styles—including those of students who have or may be at risk for mental health and emotional problems—while sustaining a caring atmosphere.
- Positive classroom climate helps provide the protective factors of supportive relationships, consistent expectations, opportunities to contribute, and recognition for accomplishments that promote youth resilience.

D. Make participants aware of the concept of cultural competence and its importance to classroom climate (*Trainer Note IV-2*). Cultural competence involves:

- Being aware and respectful of the values, beliefs, traditions, and customs of students and their families
- Recognizing the impact of one's own culture on the teacher/student relationship
- Taking these factors into account when planning and implementing classroom policies and activities

E. Refer to Module I. Remind participants that students who have difficulty adjusting to social-emotional development may be at risk for mental health and emotional problems. Make the following point:

- By encouraging adjustment through classroom practices, the teacher is promoting mental health.

IV-3 Assess Classroom Environment for Barriers to Learning
A. Show Slide IV-E (Apply S.U.C.C.E.S.S.) and refer to Handout IV-A (S.U.C.C.E.S.S.).

B. Discuss each area and ask for suggestions (*Trainer Note IV-3*).

IV-4 Promote Mental Health by Maintaining a Stigma-Free Climate
A. Refer to Handout IV-B (Mrs. Rogers and a Lesson on Stigma). Ask participants to read only the first paragraph.

B. Ask for ideas on how to handle this situation, and write them on a flipchart or chalkboard.

C. Have participants read the rest of the handout. Discuss the pros and cons of Mrs. Rogers' approach versus those suggested by the group.

D. Make the following suggestions:

- Use opportunities within the curriculum, school events, and student-shared experiences to talk candidly about "in groups" and "out groups" and the importance of acceptance of individual differences (*Trainer Note IV-4*).
- Observe whether stigmatization of students with social-emotional difficulties occurs through language, social behavior, and/or other exchanges between students, and intervene.
- Model respectful communication.
- Allow participants to share observations and discuss how beliefs are formed.

IV-5 Bullying
A. Refer to Handout IV-C (Brett's Story). Ask participants:

- What clues can you gather from Brett's story?
- Which, if any, of those behaviors can be called bullying?
- What was the impact on Brett?
- Who, if anyone, do you think was aware of Brett's problem?
- Do you know anyone in your class or school that may have this problem?
- What would you do to help Brett? In the classroom? In the school environment?

B. Make the following points (*Trainer Note IV-5*):

- Bullying occurs in the absence of intervention.
- Bullying is a form of violence that affects the social and learning climate.

C. Ask participants: What steps would you take in this and similar situations? Make the following points or suggestions:

- Send a clear message about intolerance for this type of violence.
- Determine the nature and extent of the school's bullying problem by speaking with students, staff, school bus drivers, and other personnel who observe students routinely.
- Set the objective to reduce and eliminate existing bullying problems among students.
- Voice clear expectations to students, such as "No students will bully or victimize other students." Define bully and victimization for the students. Discuss the topic and allow students to speak about how bullying has impacted them (e.g., not sure what to do; tried to stop it but got hurt, etc.).
- Voice expectations for help-seeking and assistance, such as "Students will help other students who are victimized and put an end to bullying by telling adults about the problem."
- Work as a team member with other school staff to develop schoolwide strategies to reduce bullying.

IV-6 Take Advantage of Adolescent Development To Improve Classroom Climate
A. Refer to Handout IV-D (Adolescent Development and Classroom Climate).

B. Make the following points:

- Despite outward appearances, high school students continue to rely upon others to help them interpret themselves, social events, and the world around them.
- Teachers can take advantage of these factors to develop a stronger community of learners within the classroom.

C. Ask participants to read Handout IV-E (Mr. Fox and Tardiness). Show how the behaviors relate to teen development and how Mr. Fox took advantage of one aspect of teen developement to address tardiness (*Trainer Note IV-6*).

D. Divide participants into small groups. Write the following behaviors and related aspects of development on the easel or chalkboard.

- Behavior: Headphones on during lecture.
  Aspect of Development: Youth endeavor to define themselves.
- Behavior: Students seem to be seated by cliques and several students are openly excluded.
  Aspect of Development: Youth compare themselves to peers.
- Behavior: One student insults another.
  Aspect of Development: Youth learn from social interactions.

Assign one of these behaviors to each group and let them brainstorm specific strategies, referring to the general strategies suggested on Handout IV-D (Adolescent Development and Classroom Climate).

E. Reconvene the whole group and ask each group to report on their efforts. For further discussion, you may ask:

- Are these common situations in your school?
- What resources in your school could you call on for help with these situations/strategies?

IV-7 Promote a Positive Climate Through Instructional Strategies
A. First, make the point: Participants don't need to learn new strategies; they already know them.

B. Briefly review strategies suggested by the UCLA Resource Center for Mental Health in Schools, using Slides IV-E and IV-F (Classroom-Focused Enabling: Instructional Strategies) (*Trainer Note IV-7*).

C. Discuss how one or more of these strategies could be useful in teaching students with mental health needs. For example:

- Depressive disorders can make students highly sensitive to negative feedback and lead them to expect to fail. What strategies might be helpful for such students?
- A student with an anxiety disorder may have trouble concentrating. Which of these strategies might be helpful?
- Problems with attention are the hallmark of ADHD. Could any of these strategies be particularly useful with a student with ADHD?
- Ask participants to share their own experiences with these or related strategies in their own classrooms.

IV-8 Closing
A. Summarize major points of the module, referring to objectives.

B. Ask for comments and questions.

C. Ask participants to complete evaluation form.

IV-1 Introduction

Overview. This module does not teach new strategies or skills. Instead, participants will focus on the teaching skills and strategies they already use, exploring ways that they influence the climate of their classrooms and schools, support a safe and orderly environment, and promote mental health. These skills are specially important when teaching teens with mental health needs.

Note on presentation. It is highly recommended that this module be presented in partnership with a teacher, especially one who has experience with or an interest in mental health issues.

IV-2 Classroom Climate, Learning, and Mental Health

Further notes on classroom climate. The following is provided for the trainer's background information. Participants already may be familiar with these concepts. As a trainer, you can shorten or lengthen this section, as appropriate.

Positive educational climates:

- Maximize instruction time and individual learning;
- Emphasize proactive strategies to prevent academic failure;
- Stress prevention of behavioral problems to uphold student behavioral competency;
- Encourage a developmental perspective;
- Increase opportunities for student involvement and success; and
- Deploy systematic procedures to address the learning and behavioral needs of students.

This is accomplished through coordination of efforts at the building and classroom levels.

Developing a positive classroom climate requires efforts beyond behavior management. (Behavior management refers to a set of techniques applied to observable behavior in order to achieve a desired outcome.) Classroom climate is, in essence, the perceptions about the overall setting where instruction and learning take place. The primary goal of establishing a positive classroom climate is to be able to instruct to a range of individual differences while sustaining a caring and accepting atmosphere.

Refer to Module II's discussion of risk and protective factors and youth resilience. Note the protective factors that also are included in the discussion of positive classroom climate. As you progress through this module, continue to address how each aspect of positive classroom climate promotes youth resilience and thus mental health.

About cultural competence. Individual differences can stem from cultural differences, which is why cultural competence is an essential part of positive classroom climate. Cultural competence differs from cultural awareness or sensitivity in that it entails not just being aware of and accepting cultural differences, but implementing policies and attitudes that work in cross-cultural situations. More information on cultural competence is available at www.air.org/cecp/cultural/default.htm.

IV-3 Assess Classroom Environment for Barriers to Learning

Background. The S.U.C.C.E.S.S. handout suggests various ways of assessing classroom environment for barriers to learning. The components of the S.U.C.C.E.S.S. strategy, which was designed specifically for this training, are based on the work of Sprick, R.S., Borgmeier, C., & Nolet, V. (2002). Prevention and Management of Behavior Problems in Secondary Schools.[1]

1 Sprick, R.S., Borgmeier, C., and Nolet, V. (2002). Prevention and Management of Behavior Problems in Secondary Schools. In Shinn, M., Walker H.M., and Stoner G. (eds). Interventions for Academic and Behavioral Problems II. Bethesda, MD: National Association of School Psychologists.

IV-4 Promote Mental Health by Maintaining a Stigma-Free Climate
Background. Stigma refers to how individuals or groups of people can be discounted, shamed, or otherwise "marked" because of their social status. At the core level, it entails an "in group" and an "out group." Stigma comes about from false ideas, myths, or inadequate information. To maintain a stigma-free learning environment means replacing misconceptions with knowledge and providing alternative perspectives.

IV-5 Bullying
Background. Bullying is a form of harassment and abuse that takes place both in and out of school. Bullying creates a climate of fear that affects the social and learning environment. It can contribute to long-term negative outcomes, behavioral and emotional difficulties, and violence. The Substance Abuse and Mental Health Administration provides information about bullying, as well as prevention and intervention resources, at www.mentalhealth.samhsa.gov/15plus/aboutbullying.asp.

IV-6 Take Advantage of Adolescent Development To Improve Classroom Climate
Background. Students at the secondary school level are experimenting with independence and coming to an understanding of where they fit in the world. Communication provides feedback to youth regarding their physical, intellectual, and social-emotional competencies. Despite outward appearances, high school students continue to rely upon others to help them interpret themselves, social events, and the world around them. Teachers can take advantage of these inclinations to develop a stronger community of learners within the classroom.

Activity IV-6. This activity uses the example of student tardiness to illustrate one of the strategies in the handout regarding adolescent development. The behavior, tardiness, is related to the first aspect of development listed: "Youth strive for independence." Mr. Fox's response shows him taking advantage of this need for independence through the strategies shown on the handout, i.e., supporting autonomy and innovation; stressing order through consistency, fairness, and respect; and promoting involvement in classroom governance.

Divide participants into small groups to work on developing strategies to respond to other behaviors and to take advantage of teen development.

- Behavior: Headphones on during lecture.
  Aspect of Development: Youth endeavor to define themselves.
- Behavior: Students seem to be seated by cliques and several students are openly excluded.
  Aspect of Development: Youth compare themselves to peers.
- Behavior: One student insults another.
  Aspect of Development: Youth learn from social interactions.

Encourage participants in the groups to discuss a response to the behavior indicated that capitalizes on the aspect of teen developement and promotes a positive classroom climate. The purpose of this activity is for participants to think creatively, to share how they have responded historically to certain behaviors, and to hear about other ways to respond. They may wish to "check" their responses against the classroom strategy column on Handout IV-D to see how well responses match elements of a positive classroom climate. They can reconvene to discuss their responses, and the ease or difficulty with which they were able to formulate positive responses to undesired behaviors.

IV-7 Promote a Positive Climate Through Instructional Strategies
Facilitating brainstorming activity. Emphasize that the strategies reviewed in this section are already known to

teachers; in this activity, participants will discuss these strategies with specific reference to teens with mental health needs.

The activity starts with a review of Classroom-Focused Enabling (Slides IV-F and IV-G), which comes from the UCLA Resource Center for Mental Health in Schools. This is one of several national resources on mental health and learning (see Resources at the end of this trainer's manual). Participants then brainstorm about ways to use these strategies or others to help students with specific mental health needs. To help them get started, use the questions in the Trainer's Outline. (Note: These questions use information on how specific disorders affect learning and behavior, which is found in Module II, Handouts II-F, II-H, and II-I.)

Slide IV-A: Goal

The goal of Module IV is to help increase awareness of strategies to create an accepting classroom climate that promotes learning for all students, including those with mental health needs.

Slide IV-B: Objectives

- Understand the relationship among classroom climate, learning, and mental health
- Learn strategies that promote a positive classroom climate by taking advantage of adolescent social-emotional development
- Learn strategies for maintaining an accepting, stigma-free classroom climate
- Learn instructional strategies that promote a positive classroom climate and mental health

Slide IV-C: The Context of Learning

Classroom Climate		
Peers	Student Characteristics	Instructional Strategies
Community	Caregiver Expectations	School Characteristics

Slide IV-D: Positive Classroom Climate

- **Definition:** Perceptions about the overall setting where instruction and learning take place
- **Primary goal:** To instruct to a range of individual differences while sustaining a caring atmosphere

Slide IV-E: Apply S.U.C.C.E.S.S.

S: Spend time scanning the classroom.

U: Use school resources.

C: Check out what feedback is most favorable to students.

C: Choose times, such as academic quarters, to determine the need for mini-lessons.

E: Evaluate the need for additional support.

S: Set up a systematic way to gauge effort against performance.

S: Size up your own progress.

Slide IV-F: Classroom-Focused Enabling: Instructional Strategies*

- Plan to use a range of instructional techniques to present material.
- Envision alternative methods to teach the same concepts.
- Keep all learning styles in mind.
- Vary instructional approaches and methods throughout a lesson.

* UCLA Resource Center for Mental Health in Schools

Slide IV-G: Classroom-Focused Enabling: Instructional Strategies* (cont.)

- Use different media.
- Nest concepts into current events or relevant themes.
- Practice.
- Encourage students to be active participants in the learning process.
- Create opportunities for student evaluations.

* UCLA Resource Center for Mental Health in Schools

Module IV: Handouts

Handout IV-A: S.U.C.C.E.S.S.

"S.U.C.C.E.S.S." is a method to assess the classroom environment for barriers to learning.

Spend time scanning the classroom during group and individual work assignments. Make a note of areas for improvement, such as problem solving skills of individual learners, conflict-resolution skills during group work, and level of respect among learners. Also make a note of areas that show improvement and provide feedback.

Ask school resources, such as the principal, volunteers, aides, other teachers, or senior students to observe the classroom and provide feedback about the quality of instructional methods, the variety of presentation of lesson concepts, and the flow of information.

Check with students on the types of feedback most favorable to them. Have them fill out an index card that completes this sentence: "My teacher knows I am learning when _____." Next, find out how they provide their own feedback. Have them complete this sentence: "I can tell I am learning when_____." This will allow students to reflect on the process of learning. If grades are the most cited outcome, help students identify other ways they may observe their own learning (i.e., being able to speak at length about a topic, teaching to someone else, relating concepts to life outside the classroom, etc.).

Choose times, such as academic quarters or easy-to-remember intervals during each term, to determine the need for mini-lessons on organization and study skills.

Evaluate the need for additional support for individual learners and access resources for these students.

Set up a systematic way to gauge effort against performance. Consider students' effort in your evaluation of their performance and provide constructive feedback with the purpose of praise or incentive
to encourage consistent effort.

Size up your own progress. Monitor your skills and celebrate success!

Handout IV-B: Mrs. Rogers and a Lesson on Stigma

Here is how Mrs. Rogers handled stigmatizing behavior in her 11th grade English class:

"Jessica handed Carl her paper. We were grading them in class. I overhead her tell Carl, 'Don't touch it. I don't want your freakiness. Just don't touch it.' Carl sometimes stood out because he covered his hands with the sleeves of his shirt. His neighboring classmates were most prone to notice this behavior. Jessica was particularly verbal about Carl. I wanted to take action before but never knew exactly what to say. Things get said so fast and I am moving along with the lesson. This time I was prepared to take action.

"I told all the students to stop what they were doing. I said that I wanted to try something different. Rather than passing their papers to a neighbor to grade them, I told the students to pass their papers forward. Once the papers were stacked at the head of all the rows I announced that we would have a new grading policy. All papers would either get a zero or 100, but it wouldn't be based on whether the paper was correct or incorrect. It would be up to the class to decide how we would first make two stacks and then give one stack of papers a zero and the other 100. At first the students seemed confused. Of course, not one student liked the idea. They mostly stated that it was unfair. There was no good way to make that decision. I agreed with them and asked them whether or not they ever witnessed this type of unfairness in the way people act toward each other. One student likened unfair behavior to ways that others stereotype and gave an example about kids who live in a trailer park. Another student said, 'It's like when we have different groups in the cafeteria.' I let them give examples and then referred back to the stacks of papers. I said that as a class we should agree to not judge these stacks and more importantly, to not judge each other. I handed back the papers and we started again. It took up some class time but it was very memorable."

Handout IV-C: Brett's Story

Brett's High School Report Card: "Assignments Missing"

Teachers see that Brett hardly ever turns in his homework assignments. While he is shy and quiet, he seems capable of understanding and carrying out the assignments. Mrs. Harris decides to take a few minutes to ask Brett about his missing work. A frustrated Brett pours out his story:

"I try to go to another bus stop in the morning. Sticky Fingers—that's what I call him, he's always stealing something from somebody—he's there with the other guys. They either throw stuff or smoke or mess with the mailboxes that are on an island right at the stop. I took a cab to school yesterday just to get away from them. But I forgot some work and the driver didn't want to wait for me to go get it so I just left it. It was due and I'll probably get a zero.

"When I do take the bus, they try to start a fight by saying stupid junk. They are loud and they are always saying something to somebody. I see them in the hall at school but I avoid them. Sometimes they yell, 'Yeah, we're going to get you later, dude.'I take the late bus so I won't fight with them. I sit in class thinking about how I can get some big kid to scare them or punch Sticky Fingers or something. He's a real dummy. Last week he took my book bag and chucked it across the street. All the papers blew out. They all laughed because I had to pick up all the junk. I only picked up my book bag and left a bunch of papers. I really got into trouble because I didn't know what to say when I had to hand in my biology project."

Handout IV-D: Adolescent Development and Classroom Climate

Aspect of Development	Classroom strategy
Youth strive for independence	- Support autonomy and innovation in the classroom - Stress order through consistency, fairness, and respect - Promote involvement in classroom governance through shared values, needs, and goals
Youth endeavor to define themselves	- Differentiate between the behavior and the person - Use attribution statements regarding intrinsic desire to feel successful
Youth compare themselves to peers	- Model positive attitude, acceptance, and respectful behavior - Forbid ridicule, sarcasm, or inequality to exist in the classroom - Make obvious the worth of all students
Youth learn from social interactions	- Develop collaborative and cooperative learning activities - Seize opportunities to directly teach conflict resolution - Directly teach how to accept and learn from mistakes; and stress improvement as the yardstick to measure success - Model trust, empathy, and appropriate risk taking
Youth experiences shape future learning	- Promote critical thinking - Expect success; put forth obtainable goals - Give immediate and consistent feedback - Show how to build on strengths - Help others to view students positively

Handout IV-E: Mr. Fox and Tardiness

Aspect of Development: Youth strive for independence
Behavior: Late for class
Classroom Strategy:

- Support autonomy and innovation in the classroom.
- Stress order through consistency, fairness, and respect.
- Promote involvement in classroom governance through shared values, needs, and goals.

Mr. Fox's response to tardiness: "I have noticed that some of the students in this class are arriving late. I usually hear that it takes too long to get from the last class to my classroom. On the other hand, some students are coming from the same area of the building and they arrive on time. What I also notice is that when we start late, I have to teach right up until the bell rings. Some of you are still writing down your assignments for the next day. That doesn't seem fair. Do you all think that tardiness for class is acceptable?

"What I would like to do is to take about five minutes of our class time today to talk about hallway routes to my classroom." Mr. Fox starts to hand out index cards. "I want each one of you to write down on this index card

where your class before this one is located in the building. Are you coming from the West Wing? Write that down. Are you coming from the gym? Write that down. Hand your cards up, please. I am going to look over these cards. Tomorrow, I will ask about which routes the students who travel the furthest take and how long it takes to get to this class."

In this example Mr. Fox is capitalizing on students' know-how in getting from point A to point B and the level of individual responsibility that is part of getting to class on time. Students choose their own routes, decide to avoid quick chats with friends or a feverish dash to their locker, and ultimately show respect for coming to class on time. Students are navigators of their own routes, so to speak. Mr. Fox develops this line of reasoning with his students during his "mini-lesson" on punctuality.

Part I: Please answer the following questions by circling a number on the scales provided.

1) Was the content of this module *relevant and applicable* to your classroom/school?

Not at all relevant   Somewhat relevant   Extremely relevant

    1   2   3   4   5   6   7

2) Was the information presented *too simplistic* or *too involved*?

Too simplistic   Just right   Too involved

    1   2   3   4   5   6   7

3) Was the information *new* to you?

All previously known   Some new information   Mostly new information

    1   2   3   4   5   6   7

4) Was the module *well-organized*?

Not well-organized   Somewhat well-organized   Very well-organized

    1   2   3   4   5   6   7

5) Was the module an appropriate *length*?

Too short   Comfortable length   Too long

    1   2   3   4   5   6   7

6) Was there a sufficient *variety* of activities?

Not enough   A good number   Too many

    1   2   3   4   5   6   7

7) Were the *materials* (slides, handouts) clear and concise?

Not clear   Somewhat clear   Very clear

    1   2   3   4   5   6   7

8) Were the materials *helpful* as supplements to the information presented?

Not helpful   Somewhat helpful   Very helpful

    1   2   3   4   5   6   7

Part II: Please give us your comments:

I liked:

_____

_____

I didn't like:

_____

_____

I wish there had been more:

_____

_____

The most important thing I learned was:

_____

_____

Other comments:

_____

_____

_____

_____

Resources and Publications

Federal Government Resources

Substance Abuse and Mental Health Services Administration (SAMHSA)
SAMHSA sponsors the National Mental Health Information Center, which provides a wide array of information on mental health to people, including users of mental health services and their families, the public, policymakers, providers, and the media.
www.mentalhealth.samhsa.gov
1-800-789-2647 (English/Spanish) or 866-889-2647 (TDD)

SAMHSA's Elimination of Barriers Initiative (EBI)
This is a 3-year initiative launched in September 2003 aimed at identifying effective public education approaches to counter the stigma and discrimination associated with mental illnesses. The Eliminating Barriers For Learning training package and other school-related materials are available through the EBI web site.
www.allmentalhealth.samhsa.gov

SAMHSA's Safe Schools/Healthy Students
The Safe Schools/Healthy Students Initiative is a grant program designed to develop real-world knowledge about what works best to reduce school violence. These services are designed to promote healthy childhood development, foster resilience, and prevent youth violence.
www.mentalhealth.samhsa.gov/safeschools/default.asp

SAMHSA's 15+ Make Time to Listen ... Take Time to Talk
The 15+ Make Time to Listen ... Take Time to Talk Campaign is based on the premise that parents who talk with their children about what is happening in their lives are better able to guide their children toward more

positive, skill-enhancing activities and friendships. The campaign provides practical guidance for parents and caregivers on how to strengthen their relationship with their children by spending at least 15 minutes of daily, undivided time with them and focusing on them.
www.mentalhealth.samhsa.gov/15plus

SAMHSA's Caring for Every Child's Mental Health Campaign
The Campaign helps families, educators, health care providers, and young people recognize mental health problems and to seek or recommend appropriate services. It also strives to reduce the stigma associated with mental health problems.
www.mentalhealth.samhsa.gov/child

U.S. Office of Special Education Programs Technical Assistance Center on Positive Behavioral Interventions and Supports
The Technical Assistance Center on Positive Behavioral Interventions and Supports (PBIS) was established by the Office of Special Education Programs, US Department of Education to give schools capacity-building information and technical assistance for identifying, adapting, and sustaining effective schoolwide disciplinary practices.
www.pbis.org

National Institute of Mental Health
NIMH is the lead Federal agency for research on mental and behavioral disorders. Its website includes information on mental illnesses for the general public.
www.nimh.nih.gov

Additional Resources

Following are some other resources that may be helpful. This list is not exhaustive, and inclusion does not imply endorsement by the Substance Abuse and Mental Health Services Administration or the U.S. Department of Health and Human Services.

General Mental Health Resources

National Alliance for the Mentally Ill
www.nami.org

National Mental Health Association
www.nmha.org

American Academy of Child and Adolescent Psychiatry
www.aacap.org

Prevention and Intervention Programs

General

Safeguarding Our Children: An Action Guide
This is a 61-page resource book designed to help local school and community leaders and parents choose the prevention measures that are appropriate for their settings.
http://cecp.air.org/guide/actionguide.htm

Center for Effective Collaboration and Practice
Supports and promotes a reoriented national preparedness to foster the development and the adjustment of

children with or at risk of developing serious emotional disturbance.
www.air.org/cecp

Research and Training Center for Children's Mental Health
The Center's field research projects focus on enhancing understanding of policy as it pertains to improving outcomes for children with emotional disturbances and their families.
http://rtckids.fmhi.usf.edu

Functional Behavioral Assessment

Functional behavioral assessment is generally considered to be a problem-solving process for addressing student problem behavior. It relies on a variety of techniques and strategies to identify the purposes of specific behavior and to help Individualized Education Plan (IEP) teams select interventions to address the problem behavior directly.[1]

Addressing Student Problem Behavior: Functional Behavioral Assessment
A series of working papers on developing and implementing functional behavioral assessments and behavior intervention plans. It is intended to be used by school personnel who participate in a student's IEP meetings.
www.air.org/cecp/fba/default.htm

Multimodal Functional Behavioral Assessment
Describes the process of conducting a Functional Behavioral Assessment and subsequently writing a Behavior Intervention Plan that is theoretically inclusive and naturally supportive of group problem-solving.
http://mfba.net

1 Addressing Student Problem Behavior: Functional Behavioral Assessment. The Center for Effective Collaboration and Practice, 1998. www.air.org/cecp/fba/default.htm

Positive Behavioral Interventions and Supports (PBIS)

Positive Behavioral Interventions and Supports (PBIS) is an application of a behaviorally based systems approach. It is based on research regarding behavior in the context of the settings where it occurs. Schools, families, and communities work with this approach to design effective environments to improve behavior. Such environmental interventions, in turn, serve to make problem behavior less effective, efficient, and relevant and desired behavior more functional. In addition, the use of culturally appropriate interventions is emphasized.[2]

2 "Positive Behavioral Interventions and Supports," U.S. Office of Special Education Programs Technical Assistance Center on Positive Behavioral Interventions and Supports, www.pbis.org

School-Based Wraparound

Wraparound is a process of delivering services for children and their families that emphasizes the following values: community-based services and supports; individualized and strength-based planning; cultural competence; families as full partners; flexible funding and approaches to delivery; balanced community and conventional services; and a "no reject, no eject" policy of unconditional commitment.[3]

Center for Effective Collaboration and Practices: Wraparound
Here you can find resources related to Wraparound Planning, including article citations, an online discussion, links, and training and presentation materials.
www.air.org/cecp/wraparound/default.htm

Promising Practices in Wraparound for Children With Serious Emotional Disturbance and Their Families
This monograph was developed with the support of the Child, Adolescent, and Family Branch of the Center for Mental Health Services as part of an effort to increase understanding about the status of wraparound as a relatively new and innovative approach within a system of care.
www.mentalhealth.samhsa.gov/cmhs/ChildrensCampaign/1998execsum4.asp

Systems of Care: Promising Practices in Children's Mental Health—
Wraparound: Stories from the Field, 2001 Series (Vol.1)
This booklet uses the stories of 6 families to explore the conviction among providers, advocates, and families that Wraparound is better, cheaper, and more humane than conventional service delivery processes for families of children with serious emotional disturbance.
http://media.shs.net/ken/pdf/2001Monographs/AIR_Monograph.pdf

3 Kendziora, K., Burns, E., Osher, D., Pacchiano, D., and Mejia, B. (2001) Systems of Care: Promising Practices in Children's Mental Health—Wraparound: Stories from the Field, 2001 Series (Vol. 1) Washington, D.C.: Center for Effective Collaboration and Practice, American Institutes of Research.
http://media.shs.net/ken/pdf/2001Monographs/AIR_Monograph.pdf

Multisystemic Therapy

Multisystemic Therapy (MST) is an intensive family- and community-based treatment that addresses the multiple determinants of serious antisocial behavior in juvenile offenders. The multisystemic approach views individuals as being nested within a complex network of interconnected systems that encompass individual, family, and extrafamilial (peer, school, neighborhood) factors. Intervention may be necessary in any one or a combination of these systems.[4]

MST Services
This web site provides an introduction to Multisystemic Therapy and the qualifying factors for its successful implementation.
www.mstservices.com

4 "Multisystemic Therapy Treatment Model," MST Services, www.mstservices.com/text/treatment.html

Multidimensional Treatment Foster Care (MTFC)

Multidimensional Treatment Foster Care (MTFC) is a cost effective alternative to group or residential treatment, incarceration, and hospitalization for adolescents who have problems with chronic antisocial behavior, emotional disturbance, and delinquency. Community families are recruited, trained, and closely supervised to provide MTFC-placed adolescents with treatment and intensive supervision at home, in school, and in the community; clear and consistent limits with follow-through on consequences; positive reinforcement for appropriate behavior; a relationship with a mentoring adult; and separation from delinquent peers.[5]

Treatment Foster Care (TFC)
A summary of TFC provided by Strengthening America's Families, a joint program of the Office of Juvenile Justice and Delinquency Prevention (OJJDP) and the Substance Abuse and Mental Health Services Administration (SAMHSA).
www.strengtheningfamilies.org/html/programs_1999/07_TFC.html

Multidimensional Treatment Foster Care, Maryland Blueprints
A fact sheet about MTFC from Maryland Blueprints, a Web site designed to help Maryland community

planning groups select youth-focused prevention programs.
www.marylandblueprints.org/blueprints/programs/Multidimensional Treatment Foster Care.pdf

Blueprints for Violence Prevention
The Center for the Study and Prevention of Violence (CSPV), at the University of Colorado at Boulder launched Blueprints for Violence Prevention to identify violence prevention programs that are effective. The project has identified 11 prevention and intervention programs, including MTFC, that meet a strict scientific standard of program effectiveness.
www.colorado.edu/cspv/blueprints/model/programs/MTFC.html

5 Blueprints for Violence Prevention, Center for the Study and Prevention of Violence, Institute of Behavioral Science, University of Colorado at Boulder.
www.colorado.edu/cspv/blueprints/model/programs/MTFC.html

Positive Classroom Climate and Instructional Techniques

General

Teaching and Working With Children Who Have Emotional and Behavioral Challenges
This comprehensive resource—based on research funded by the U.S. Department of Education—is designed to help educate students with emotional and behavioral difficulties. Parents can also use this guidebook to learn how to address their children's needs and to work effectively with the educators in their children's lives.
www.air.org/cecp/teachingchildren.htm

Safe, Supportive, and Successful Schools Step by Step
This product offers descriptions, data, and contact information for thirty programs that are currently operating in schools across the nation.
www.sopriswest.com/swstore/product.asp?sku=872

Social and Emotional Learning (SEL)

Social and emotional learning (SEL) refers to knowledge, habits, skills and ideals that are at the heart of a child's academic, personal, social, and civic development. This type of learning enables individuals to recognize and manage emotions, develop caring and concern for others, make responsible decisions, establish and maintain positive relationships, and handle challenging situations effectively.[6]

The Collaborative for Academic, Social, and Emotional Learning (CASEL)
CASEL enhances children's success in school and life by promoting coordinated, evidence-based social, emotional, and academic learning as an essential part of education from preschool though high school.
www.casel.org

Safe and Sound: An Education Leader's Guide to Evidence-Based Social and Emotional Learning (SEL) Programs
Based on a three-year study funded by the Institute of Education Sciences (IES) and the Office of Safe and Drug-Free Schools (OSDFS) in the U.S. Department of Education, Safe and Sound provides a road map for schools and districts that are launching or adding social, emotional, and academic learning programs.
www.casel.org/projects_products/safeandsound.php

6 "What is SEL?" The Collaborative for Academic, Social, and Emotinal Learning, www.casel.org

Research and Technical Assistance

Arthur, M. W., Hawkins, J. D., Pollard, J.A., Catalano, R.F., & Baglioni, A.J. Jr. (2002). Measuring risk and protective factors for substance use, delinquency, and other adolescent problem behaviors. The Communities That Care Youth Survey. Eval Rev. 26(6):575-601.

King, Keith A. Developing a Comprehensive School Suicide Prevention Program. (2001). Journal of School Health, Vol 71, No. 4, pp. 132-137.

National Longitudinal Transition Study
The NLTS describes the experiences and outcomes of youth with disabilities nationally during secondary school and early adulthood.
www.sri.com/policy/cehs/publications/dispub/nlts/nltssum.html

National Agenda for Achieving Better Results for Children and Youth With Serious Emotional Disturbance: The Problem
A set of statistics about secondary school outcomes for children with serious emotional disturbances, published by the U.S. Department of Education.
http://cecp.air.org/resources/ntlagend.html#problem

Center for School Mental Health Assistance
csmha.umaryland.edu

Federation of Families for Children's Mental Health
www.ffcmh.org

National Mental Health and Education Center
www.naspweb.org/center

Research and Training Center on Family Support and Children's Mental Health
www.rtc.pdx.edu

UCLA School Mental Health Project
smhp.psych.ucla.edu

Systems of Care Partners

In a system of care, mental health, education, child welfare, juvenile justice, and other agencies work together to ensure that children with mental, emotional, and behavioral problems and their families have access to the services and supports they need to succeed.[7]

7 Systems of Care: A Promising Solution for Children With Serious Emotional Disturbances and Their Families. Center for Mental Health Services, 1998.
www.mentalhealth.samhsa.gov/publications/allpubs/CA-0030/default.asp

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Source: Child Adolescent & Family Grant Communities, Center for Mental Health Services; www.mentalhealth.samhsa.gov/cmhs/childrenscampaign/grantcomm.asp

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