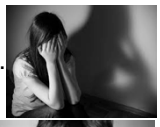
Addressing the Mental Health Needs of Our Students: Exploring School-Based Programming



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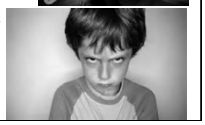


Research Supporting Need

The Great Smoky Mountain Study of Youth

- 27% of children 9, 11, and 13 years of age have mental health impairment and
- This study also found that only 21% of children with mental health problems receive mental health services.

Methodology for Epidemiology of Mental Disorders in Children and Adolescents study

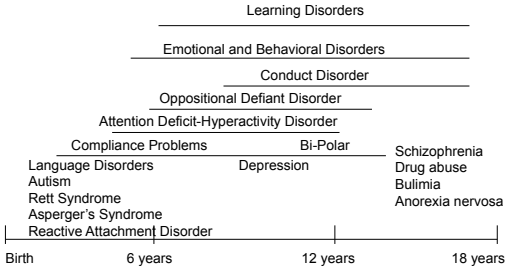
- 13% of children and adolescents have anxiety disorders,
- 6.2% have mood disorders,
- 10.3% have disruptive disorders, and
- 2% have substance abuse disorders,
- for a total of 20.9% having 1 or more mental health disorders.

- Over half of the individuals who will display mental health disorders sometime during their life, will begin to display symptoms between the ages of 11 and 14.

Types of Child and Adolescent Mental Health Disorders

- Disorders of Social Interaction
  - **Autism Spectrum Disorder** (ASD) - incorporates four disorders from the previous manual
  - **Social Communication Disorder** (SCD) is characterized by a persistent difficulty with verbal and nonverbal communication that cannot be explained by low cognitive ability
- Externalizing Disorders
  - Attention Deficit/ Hyperactivity Disorder
  - Oppositional Defiant Disorder
  - Conduct Disorder
  - **Disruptive Mood Dysregulation Disorder** (DMDD). It is characterized by severe and recurrent temper outbursts that are grossly out of proportion to the situation in intensity or duration. The outbursts occur, on average, three or more times each week for a year or more.
  - **Premenstrual Dysphoric Disorder**
- Internalizing Disorders
  - Anxiety Disorders
  - Depression
  - **Posttraumatic Stress Disorder** (PTSD) includes a new subtype for children younger than 6.
- Other Disorders
  - **Specific Learning Disorder** - no longer limits learning disorders to reading, mathematics and written expression.
  - Intellectual Disability Disorder
  - Eating Disorders
  - Substance Abuse
  - Self-Harming Behavior
  - Tic Disorders
- Early Onset Major Mental Illness
  - Schizophrenia
  - Bipolar Disorder

Time of Initial Occurrence for Common Behavior Problems



Wicks-Nelson & Israel, 2003

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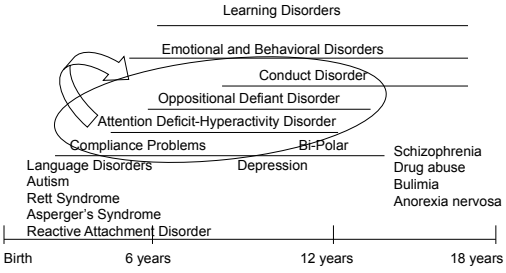


Wicks-Nelson & Israel, 2003

Contrasting Perspectives in School-Based Mental Health

	Education System	Mental Health System
Basis for Identification	Individuals with Disabilities Education Act (IDEA)	Diagnostic and Statistical Manual (DSM V)
Conceptual Framework	Emotional Disturbance, Behavioral Disorders. Challenging Behavior, Academic deficits	Psychopathology. Abnormal Behavior, Impaired Functioning
Theoretical Influences	Applied Behavior Analysis, Social Learning Theory	Psychoanalytic Approaches, Behavior Theory, Cognitive Psychology, Developmental Psychology, Biological/ Genetic Perspectives, Psychopharmacology
Focus of Intervention	Behavior Management, Skill Development, Academic Improvement	Insight, Awareness, Improved Functioning, Reduce Relapses
Both systems want to	improve social and	adaptive functioning.

Seriousness of the Problem

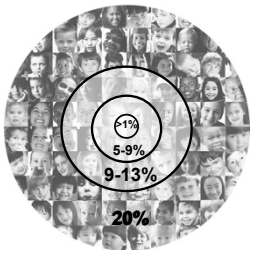
Prevalence of Emotional Behavioral Disturbance (EBD) Population Proportions (9 to 17 year-olds)

20% Youth with any diagnosable disorder (1 in 5 students in your classroom likely display a diagnosable mental health disorder).

9-13% Youth with EBD, with substantial functional impairment.

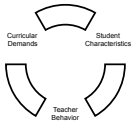
5-9% Youth with EBD & extreme functional impairment.

0.8-1% Youth identified as EBD in the public schools of this nation



Diagnostic Dilemma

- Regardless of the presenting symptoms, children and adolescents are most often initially referred for an evaluation for ADHD.



ADHD Criteria

- Symptoms must be present for 6 months to a degree that is maladaptive and inconsistent with the developmental level of the child.
- Clear evidence of clinically significant impairment aligned with several symptoms present in two or more settings.
- Onset of impairment must be before age 12 (was 7), even if it was not diagnosed until later.

ADHD – Inattentive Symptoms

(Must display 6 of 9)

- Frequent careless mistakes.
- Difficulty sustaining attention in task or play.
- Often fails to listen when spoken to directly.
- Fails to follow through on tasks or follow directions.
- Difficulty organizing tasks and activities.
- Avoids tasks that require sustained attention.
- Often loses things.
- Is easily distracted by extraneous stimuli.
- Forgetful in daily activities.

ADHD – Hyperactive Impulsive

(Must display 6 of 9)

- Often fidgets with hands or feet – squirms in seat
- Often leaves seat when required to sit
- Runs about or climbs excessively.
- Often has difficulty playing or engaging in leisure activities quietly
- Is often 'on the go' or acts 'as if driven by a motor'
- Often talks excessively
- Blurts out answers before questions are completed
- Difficulty waiting his or her turn
- Often interrupts or intrudes on others

ADHD Diagnosis

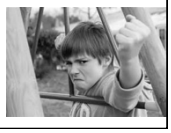
- ADHD- Primarily Inattentive Type – if 6 months of 6 or more inattentive symptoms.
- ADHD – Primarily Hyperactive-Impulsive Type – if 6 months of 6 or more hyperactive-impulsive symptoms.
- ADHD – Combined Type – if 6 months of displaying 6 or more inattentive symptoms AND 6 months of displaying 6 or more hyperactive-impulsive symptoms. MOST COMMON

ADHD Epidemiology

- Occurs in 3 – 12 % of school aged children and adolescents.
- Boys are 4 to 9 times more likely to display ADHD than girls. Girls more likely to be diagnosed with ADHD Inattentive Type.
- Thirty to 50% of individuals with ADHD display a co-morbid disorder (e.g., ODD, CD, ASD, LD, Mood Disorders, Anxiety Disorders)

Oppositional Defiant Disorder

- A pattern of negativistic, hostile and defiant behavior lasting greater than 6 months of which you have 4 or more of the following:
  - Extreme loss of temper
  - Argues with adults
  - Actively defies or refuses to comply with rules
  - Often deliberately annoys people
  - Blames others for his or her mistakes
  - Often touchy or easily annoyed with others
  - Often angry or resentful
  - Often spiteful or vindictive



ODD and the Brain

- The development of oppositional defiant disorder is associated with changes in the neurotransmitters of the brain.
- Neurotransmitters are chemical transmitters of impulses between nerve cells.
- Raising or lowering the level of neurotransmitters (i.e., deviation from the norm) leads to a sudden change in mood and changes in the thinking process because of impaired transmission of nerve impulses.
- That's why people with ODD have:
  - a sense of irritation,
  - they have no fear of punishment,
  - they often cannot adequately perceive the reality and communicate normally,

External Factors Impacting the Development of ODD

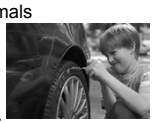
- The major familial external factors that contribute to the development of ODD disorder:
  - domestic violence,
  - abuse (physical or sexual abuse),
  - indifference of parents,
  - disastrous financial situation (poverty), or poor quality of life,
  - drug and alcohol use by parents.
- The major school-based external factors include:
  - excessive punishment or punishment for behavior outside the control of the student,
  - abuse by adults and peers, and/or
  - Indifference on the part of teachers

Transition of ODD to Conduct Disorder

- Oppositional Defiant Disorder in childhood years can develop into serious Conduct Disorder by adolescence.
- Young students with ODD have a 2 to 3 fold likelihood of becoming juvenile offenders.
- Conduct Disorder – Adolescent Onset – behaviorally typical until middle school – more favorable prognosis and more likely to respond to treatment.

Conduct Disorder

- Repetitive behaviors that violate the rights of others and/or societal laws, with 3 or more of the following in the past 12 months, with one in the last 6 months:
  - Aggression or cruelty to people or animals
  - Destruction of property
  - Theft
  - Running away
- Affects 12% of boys and 7% of girls



Oppositional Defiant Disorder and Conduct Disorder Treatment

- Clear, brief, rules and expectations
- Consistent and predictable consequences
- Family therapy
- Behavior management training
- Social skills intervention
- Social problem solving skill instruction

Generalized Anxiety Disorder

- Excessive anxiety or worry that is difficult to control, lasts at least 6 months and creates impairment in functioning. Accompanied by at least one of the following:
  - Restlessness
  - Fatigue
  - Difficulty concentrating
  - Irritability
  - Muscle tension
  - Sleep disturbances
- Mean age of onset between 10–13 years of age.

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Worry themes:
- Academics
- Natural Disasters
- Social Life
- Physical Assault

Generalized Anxiety Disorder: Core Treatment Elements

- Information
- Applied Relaxation
- Cognitive Restructuring (probability estimates, coping estimates)
- Cue-Controlled Worry (worry times + problem solving)
- Worry Exposure (including existential topics)
- Mindfulness

Depression Criteria

- Depressed mood, feels sad or empty, (irritability in children) by self report or observation.
- Diminished interest or pleasure in most activities.
- Weight gain or loss – in children failure to make expected weight gain.
- Insomnia or hyper-somnia nearly every day.
- Psychomotor agitation or retardation nearly every day, observable by others.
- Fatigue or loss of energy.
- Feelings of worthlessness or guilt (which may be delusional).
- Inability to concentrate; inattentiveness.
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan.

Depression

- At least 5 of 9 symptoms for a 2 week period, representing a change in previous functioning.
- At least one of the symptoms must be depressed mood (irritable in children) or loss of interest or pleasure in usual activities.
- The symptoms cause clinically significant distress or impairment.
- Impacts 3-8% of children and adolescents.

Depression Symptoms

- Symptoms that Increase with Age:
  - Sleep/Appetite changes
  - Fatigue
  - Boredom (Anhedonia)
  - Psychomotor retardation
  - Hopelessness
  - Delusions
- Symptoms that Decrease with Age:
  - Somatic complaints
  - Behavioral problems
  - Guilt, irritability
  - Hallucinations

Common Symptoms of Depression

(Consistent across age Groups)

- Depressed Mood
- Impaired concentration
- Suicidal ideation

Suicide

- Fourth (4th) leading cause of death in children aged 10-15 years.
- Third (3rd) leading cause of death in adolescents and young adults (aged 15-25 years).
  - Rates of suicide attempts are 3 times higher in females.
  - Rates of completed suicides are 5 times higher in males.

Etiology of Depression

- Psychosocial models
- Life stressors
- Organic etiologies – infections, medications, endocrine disorders, neurological disorders.
- Lifetime risk of depression in children of depressed parent(s) is 15-45%.
  - Pre-pubertal depression onset – 30% become bi-polar
  - Adolescent onset depression – 20% become bipolar

Treatment for Depression

- Cognitive Behavioral Therapy
  - identifying negative automatic thoughts,
  - recognizing distorted thinking, and
  - cognitive restructuring
- Family therapy
- Medication
  - Reserved for moderate to severe depression
    - Fluoxetine is FDA approved anti-depressant for child and adolescent depression (down to age 8)
    - Escitalopram is approved for treatment of depression in 12-17 year olds.

Challenge of Child and Adolescent Mental Health Disorders

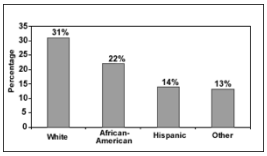
- Symptoms of the disorder often worsen the disorder.
- Impact development and overall skill acquisition.
- Affect and symptoms are affected by family relationships and family behavior.
- Early recognition and early effective treatment significantly reduce mortality and morbidity.
- Sources of resilience and risk strongly influence the occurrence and course of child and adolescent mental health problems.

Treatment

- Typically multimodal treatment involving:
  - Effective Academic and Social Emotional Instruction – curriculum and instruction must be designed to motivate and promote success.
  - Behavioral Interventions – clear expectations and predictable contingencies designed to reduce problem behaviors and to facilitate student success.
  - Cognitive Behavioral Interventions – (e.g., self-regulation, attributional retraining, cognitive restructuring)
  - Medication – (e.g., anti-depressants, mood elevators, anti-anxiety medications, stimulant medications).

Children and Youth Receiving Needed Mental Health Service

- More than 70% of children and adolescents with mental health disorders fail to receive mental health services.
- Minorities have less access to mental health services and are less likely to receive needed care. Minorities in treatment often receive a poorer quality of mental health care.



Sources: RAND Health Research Highlights. Calculations are based on data from the National Health Interview Study, 1998.
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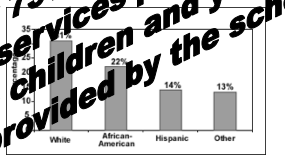
Over 75% of mental health services provided to children and youth are provided by the school.



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Why the School?

- Achievement-focused school reform = increasing accountability for student performance, the prominence of psychosocial barriers to learning, and the gap between need and service delivery gained increased attention from the education system (Adelman & Taylor, 1998).
- Catron and Weiss (1994) found that when mental health services were implemented in schools, 98% of referred students entered service, while only 17% of similar students who were referred to traditional clinic-based programs entered treatment.

Approaches to Implementation

- The School District uses its own pupil services personnel to deliver mental health services.
- The school contracts with a mental health services provider to supply a discrete service such as individual therapy to students, but there is no provision for collaboration or interaction with school staff.
- A program can be the product of a mental health services provider collaborating with a school district to implement an integrated program of services.

What Are Schools Doing?

- One-Third of School Districts report that exclusively use school-or district-based staff to provide mental health services.
- One-Fourth of school districts only used outside agencies for the provision of mental health services.
- Approximately 17% of school districts reported having an agreement with a school-based center operated by a community-based organization to provide mental health services

Foster et al., 2005

Financing Mental Health Services in Schools

- 58% of school district mental health budgets are designated for paying the salaries of mental health staff,
- 26% are allocated to pay community-based organizations for the services they provide in schools.
- The remaining budget goes to providing technical assistance, professional development and training (8%), and various administrative expenses (8%).
- Funding from the Individuals with Disabilities Education Act (IDEA) is the most frequently used federal source to finance mental health services (63%).
  - Over half (55%) of respondents reported using state special education funds to pay for mental health services,
  - 49% use local funds,
  - 41% use State general funds, and
  - 38% reported Medicaid reimbursement.

Building a Partnership with Community Service Providers

- The goal of building partnerships with community mental health providers is held by many school districts, but often difficult to achieve due to limited resources.
- One effective model employed by some school districts involves seeking policy changes from local community funding organizations (e.g., United Way)
  - The United Way added a requirement that agencies seeking funding for children and youth services needed to report how they were working with their local public schools.

United Way

Four General Strategies to Facilitate Re-Engagement

- Clarifying student perceptions of the problem – talk openly to students about why they have become disengaged so that steps can be planned for how to alter the negative perceptions.
- Reframing school learning – exceptional efforts must be made to have these students view the teacher as supportive (rather than controlling and/or indifferent) and (b) perceive content, outcomes, and activities as personally valuable and obtainable. Stress real-life applications and build on previous learning rather than concentration on grades and other extrinsic and often threatening evaluative measures.
- Renegotiating involvement in school learning – new and mutual agreements must be developed and evolved over time through discussions and conferences with the student and when appropriate the parents. The intent is to affect perceptions of choice, value, and probable successful outcome.
- Reestablishing and maintaining an appropriate working relationship – creating a sense of trust, open communication, and support/ direction as needed.

http://smhp.psych.ucla.edu for *Classroom Changes to Enhance $ Re-engage Students in Learning*

Effective Instructional Practices

- Start with an understanding of student needs and abilities.
- Promote academic success – competence.
- Clear and brief rules – developmentally reasonable, understandable and enforceable.
- Simple and predictable consequences – ideally instructional consequences.
- Acknowledge and reinforce desired alternative behaviors – specific praise – differential reinforcement strategies.
- Anticipate problems – use pre-correction
- Change reinforcers over time – planful use of reinforcement schedule. Higher ratio of praise to reprimand.

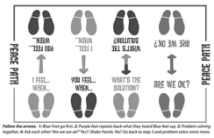
We Learn Behavior Just Like We Learn Academics: It is a process not an event

Do we use:

Warnings
Threats / Embarrassment
Escalating Consequences
Removal of Instruction / Practice

Simple and Instructional Consequences

- It is not the power of the consequence that matters but the predictability with which it is delivered.
- Simple clear consequences are more effective.
- Consequences should instruct in the desired response



Promoting Alternative Thinking Strategies (PATHS)

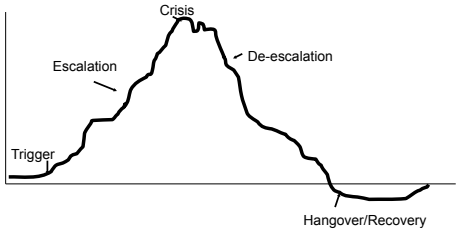
http://www.colorado.edu/cspv/blueprints/model/programs/PATHS

What to do???

Careful Observation to Identify Triggers

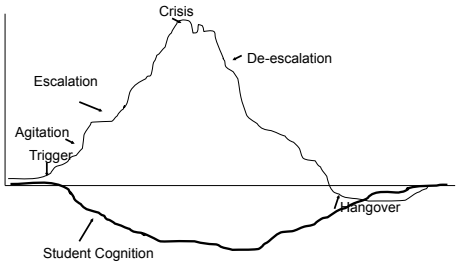
- Often as one of the people who spends the most time directly interacting with a student, you may quickly become aware of when a student moves away from his or her typical or 'baseline' behavior.
- This may be signaled by an increase or a decrease in behavior.
- A critical skill in working with children is to be good at observing triggers that may serve to move a student into a potential crisis situation.

Understanding the Crisis



Adapted from: *Managing the Cycle of Acting-Out Behavior in the Classroom*
By Dr. Geoff Colvin

Understanding the Crisis



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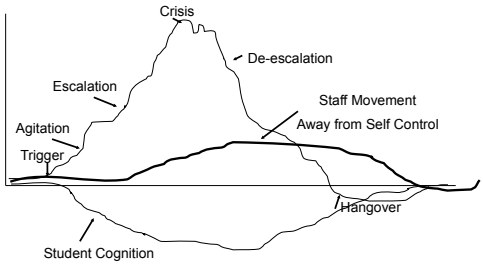

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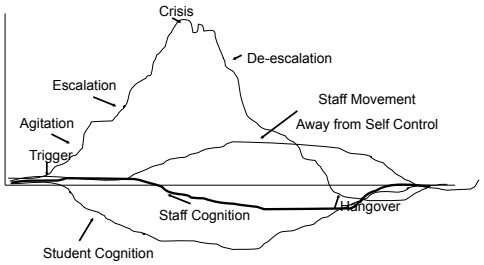

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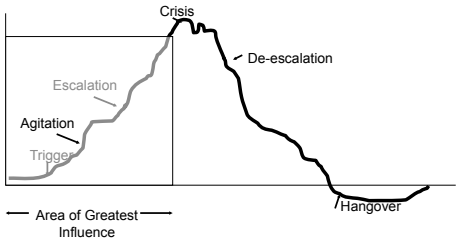

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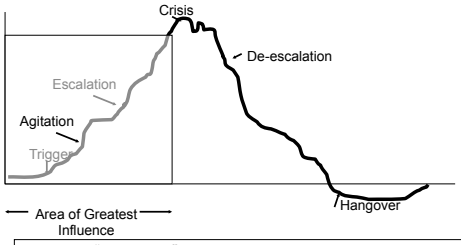
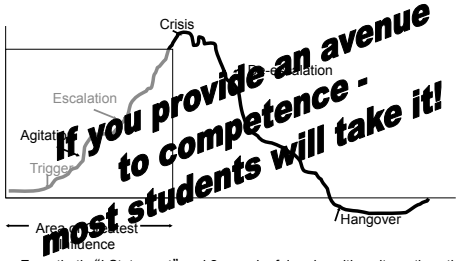


Empathetic "I Statement" and 2 meaningful and positive alternatives the student is likely and capable of doing.

Understanding the Crisis



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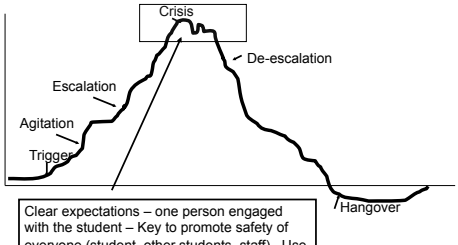
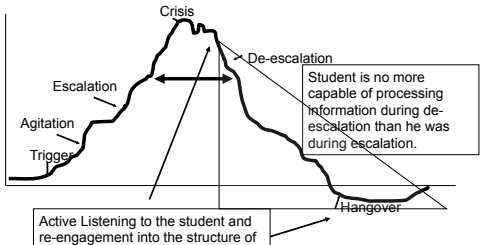


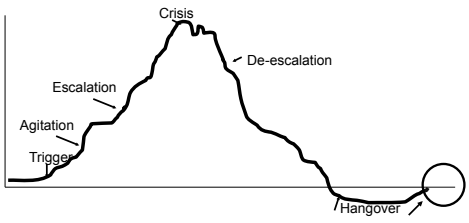
Clear expectations – one person engaged with the student – Key to promote safety of everyone (student, other students, staff). Use crisis communication – simple statements of what you want student to do. Stay calm and positive.

Understanding the Crisis



Active Listening to the student and re-engagement into the structure of the classroom instruction. Provide 'hurdle help' as needed to promote successful reintegration.

Understanding the Crisis



Whenever possible wait for student to return to baseline prior to processing event and delivery of consequences.

Do Not Engage in a Power Struggle

- When confronted with challenging or non-compliant behavior, quickly revert to a "curriculum of control"
- They forget what they were attempting to accomplish with the student and switch to the goal of getting the student to "do what he was told!"
- Often they give situational control to the student and simply follow their challenging behavior attempting to gain the upper hand.

Identification of Interventions that Hurt

- Not all interventions help – some well meaning interventions can actually cause more harm – iatrogenic effects.
  - 'Deviancy training' – (Dishion, McCord, & Poulin, 1999)
    - Clustering high risk adolescent youth together for intervention may be harmful as the peer influences in early adolescence may serve to reinforce negative behaviors, normative beliefs, and attitudes.
      - Detention
      - In-school suspension
      - Self-contained classrooms for students with emotional, behavioral, and mental health disorders w/o therapeutic milieu

http://k12engagement.unl.edu