

Making a Difference

An Educators' Guide to Child and Youth Mental Health Problems

Fourth Edition, September 2011

Developed by the Student Support Leadership Initiative,
Hamilton District Team

In partnership with the Offord Centre for Child Studies, McMaster University, the Evidence-Based Education and Services Team (E-BEST) at the Hamilton-Wentworth District School Board, and the Ontario Centre of Excellence for Child and Youth Mental Health.

Written by Don Buchanan, Patricia Colton, and Kristen Chamberlain
with contributions from FORCE Society for Kids Mental Health and
the Children's Hospital of Eastern Ontario



This publication is intended to provide general information to help educators understand mental health problems in children and youth; it does not replace professional consultation. The information is general in nature and may not apply to a particular child or youth.

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Mental Health in the Classroom

You may notice that students in your classroom are struggling. They may be acting out, or they may be withdrawn and not communicating. Whatever the cause, these behaviours are interfering with students' achievement at school, and preventing them from learning.

Sometimes, these issues are indicative of mental health problems. When mental health problems interfere with a students' ability to learn and achieve, their success in school suffers. Schools play an important role in identifying students who may be having mental health problems, and in connecting them with services that can help. In Ontario, schools' part in this process is outlined in the Ministry of Education's "Shared Solutions" document, available at: www.edu.gov.on.ca/eng/general/elemsec/speced/shared.pdf.

Teachers have busy work lives, and many competing priorities. While teachers cannot be expected to be experts in child and youth mental health problems, they have an important role to play. Teachers can ensure that their classrooms are safe and healthy environments for all students, they can recognize the signs that a student is struggling with mental health problems, and they can feel confident that they understand the next steps to take in seeking help for that student.

This guide is designed to help teachers understand more about mental health problems in children and youth, to outline the steps they can and should take to help those students, and to give them some ideas on how they can talk about mental health problems in their classrooms.

What are child and youth mental health problems?

Children and youth can experience mental health problems that range from mild to serious. For instance, some students in your class may have a little anxiety when they are facing a test, while others may be very anxious about the same test. When a problem lasts for more than a few weeks, and interferes with the student's daily life, then it becomes a concern that requires further help.

How common are child and youth mental health problems?

In a classroom of 30 students, about five to six students will be facing a mental health problem, and three to four of them will have a problem that interferes with their daily life.

Ontario Child Health Study, 1985, Waddell and Shepperd, 2002



What causes child and youth mental health problems?

Mental health problems are believed to result from a combination of factors, including: problems in the brain's 'wiring' process during early development, genetic influences, chemical imbalances, brain trauma, and severe life stress.

Mental health problems can be triggered by the stress of schoolwork, relations with peers, conflicts within the family, and difficulties adapting to the structure of school. Whatever the immediate trigger, mental health problems are usually sustained by a number of different factors. This is why it is important to work together with the school, the family, and the community.

What are the educational implications of child and youth mental health problems?

When mental health problems occur in childhood, the child may have difficulty maintaining regular progress at school. Children with severe mental disorders often struggle in school and may need special attention guided by an individualized education plan (IEP).

Educational programs for children with mental health challenges should include attention to developing social skills and to increasing the self-awareness, self-control, and self-esteem they need in order to succeed academically. While these skills are important to all students, mental health problems often hinder children from developing these skills at the same pace as other their peers.

Students with developmental problems, physical disabilities, and learning problems may also be at higher risk for mental health problems. These young people often need special support and remediation to build social and interpersonal skills.

Alertness to indications that a child may be struggling with a mental health problem can aid greatly in early intervention and minimize further disruptions to the child's schoolwork and social development. Information in this resource will help you to become more attuned to signs of mental health concerns and what you, as their teacher, can do to help students.

“My daughter’s teacher created a positive journal for her, so when something in school was bothering her she can get out her journal, write that negative thing down, and beside it she writes 6 things that happened that day that were positive so she can see visually there is much more to be positive about than to worry about the negative. It has really helped calm her down when she begins to worry.”

Parent of an 11-year-old girl

Basic facts about childhood mental health problems

- Approximately 1 in 5 children and youth have a mental health problem, which includes anxiety and depression (Waddell & Sheppard, 2002).
- Mental health problems can seriously impair children's ability to be successful at school and in their relationships with their peers.
- These children are not bad kids nor are their parents bad parents.
- Mental health problems are treatable. Early prevention is important.
- Treatment can assist in reducing symptoms but does not provide a cure – the child will still need understanding and support.

When should I be concerned?

Signs that children may be struggling with mental health problems include the following:

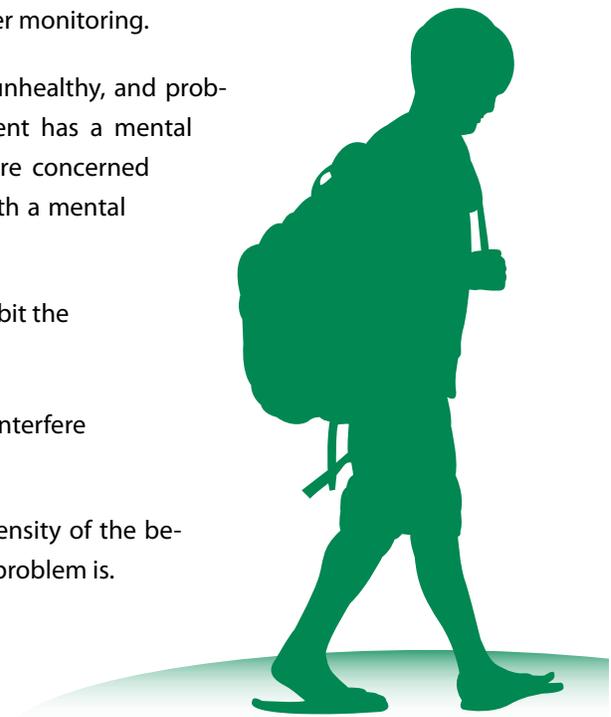
- They exhibit behaviours or moods that are not age-appropriate;
- Their behaviours are much more dramatic than in their peers or
- Their behaviours continue for longer than usual

These behaviours would indicate a need for closer monitoring.

Mental health is a continuum from healthy to unhealthy, and problematic behaviours are not 'proof' that a student has a mental health problem. Consider three things if you are concerned that one of your students may be struggling with a mental health problem:

- Frequency: how often does the student exhibit the behaviours of concern?
- Duration: how long do the behaviours last?
- Intensity: to what extent do the behaviours interfere with the child's activities?

Understanding the frequency, duration, and intensity of the behaviours will help to determine how serious the problem is.



What can I do?

A first step may be simply documenting the frequency, duration, and intensity of the behaviours that are causing you concern. We have included a sample form in Appendix 2 that may help you record this information. Your school board may have their own form to record this information as well.

Once you have gathered several observations of the behaviours that are causing you concern, you will want to share these observations with others who can help you develop a plan to manage the behaviours.

Who else should be involved?

Teachers play an important role in the identification of possible mental health problems, but they are not alone. A team approach, that involves parent(s)/guardian, other staff in your school, and sometimes, specialists from your Board and community, is important to solving these problems.

Each school and school board may have different procedures for what comes next. Turning to your school's Learning Resource Teacher (LRT), School Resource Teacher (SRT), counselor or principal may be the next step in identifying the problem and developing solutions. All schools are required to have a team that reviews students who are not achieving as expected.

Parents are important in helping to solve these problems as well. Speak to your principal or colleagues about the particular procedures for requesting additional help with a mental health problem in the classroom.

How do I know what mental health problem I'm dealing with?

Mental health problems in children and youth are often complex and overlapping. There is often no simple test or procedure to accurately diagnose mental health problems. As you will see in the following pages, many behaviours or symptoms that you observe in the classroom may be indicators for several different mental health problems.

In Ontario (under the Health Professionals Act), the only professionals who are qualified to diagnose mental health problems are physicians (including psychiatrists) and psychologists. Teachers have an important role in this process, though, as they can provide observations on the child's or youth's behaviour that may not be seen by the parent or in the professional's office.

Your school board may have professionals on staff who can make these sorts of diagnoses, but in most communities, a referral to children's mental health services is necessary. In Ontario, these services are funded by the Ministry of Children and Youth Services, and delivered by independent organizations. Many of these organizations are members of Children's Mental Health Ontario, which maintains a listing by geographic area on their web site, www.kidsmentalhealth.ca.

What else can teachers do?

Teachers can also (with the appropriate consent from the parent(s) or guardian) provide valuable observations on whether treatments are working in the school environment. The most effective treatment is delivered when the student, the parent(s)/guardian, the mental health professionals, and the school team are all working together to solve the same problem, using similar approaches.

Teachers also have a unique opportunity to influence all students' perceptions and understanding of mental health problems. Children, young people, and adults all agree that one of the major barriers to seeking help for mental health problems is stigma.

For further information on school-based programs that combat stigma about mental health problems, visit the web sites of the Mental Health Commission of Canada, www.mentalhealthcommission.ca or the Provincial Centre of Excellence for Child and Youth Mental Health, www.onthepoint.ca.

“Stigma is a mark of disgrace or discredit that sets a person apart from others. It involves negative stereotypes and prejudice. Stigma results from fear and mistrust of differences. It builds on repeated exposure to misinformation reinforcing negative perceptions and false beliefs that are intensely held and enduring. Stigma leads to social exclusion and discrimination. Discrimination, which is unfair treatment of a person or group on the basis of prejudice, affects people in many areas including employment, housing, health care, policy and funding neglect, coercive treatment and denial of basic human rights.”

Mental Health Commission of Canada



Signs your student may be experiencing a mental health problem

Emotional/Behavioural signs

- Overly withdrawn, quiet or doesn't engage
 - Low self-esteem, feelings of failure or worthlessness
 - Increased irritability, which can appear as disobedience or aggression
 - Feeling hopeless or overwhelmed
 - Unstable moods, such that teachers and other students don't know what to expect from them
 - A short fuse and lashing out when frustrated
 - Extreme worries or fears that interfere with friendships, schoolwork, or play
 - Severe mood swings affecting relationships with others
 - Drastic change in personality or behaviour
 - Extreme sadness lasting two weeks or more
 - Refusal to go to school on a regular basis
-

Academic signs

- Fidgeting, constantly moving around or seems 'always on the go'
- Despite best efforts, poor grades poor grades in school despite trying very hard or a noticeable decline in classroom participation
- Poor attention to detail and careless mistakes in schoolwork
- Does not appear to listen when spoken to directly
- Does not follow instructions or finish tasks
- Easily distracted
- Forgetful in daily activities
- Difficulty staying focused on one thing
- Bored easily
- Loses or forgets things often
- Difficulty attending to individual work or class activity
- Dreamy or unable to pay attention
- Afraid to participate in class or answer questions
- Difficulty managing during recess and free time, while unsupervised, and in larger groups

Signs your student may be experiencing a mental health problem, continued

Communication/Social Skills signs

- Spends most of their time alone
- Goes on and on about a subject and takes over a conversation
- Acts 'silly' in a group to get attention but doesn't fit in
- Plays too roughly in the playground and hurts other children
- Poor motor skills (e.g. can't catch or throw a ball)
- Other children may feel their schoolmate is being bossy or too rough
- Damages toys, etc. without meaning to
- Speaks without thinking
- Barges into games



Where to find further information about child and youth mental health problems

Centre of Knowledge on Healthy Child Development

www.knowledge.offordcentre.com

Developed by the Offord Centre for Child Studies, the site has evidence-based information about child and youth mental health problems.

Caring for Kids

www.caringforkids.cps.ca

Developed by the Canadian Paediatric Society, this site has health information for parents, about a number of child and teen health issues

Canadian Mental Health Association

www.cmha.ca/bins/content_page.asp?cid=2-29&lang=1

Some information about children's mental health problems.

Teen Mental Health

www.teenmentalhealth.org

Teen Mental Health has been developed by Dr. Stan Kutcher, at Dalhousie University, Halifax. The site contains information about teen mental health problems, and is directed towards youth, their parents, and others interested in young people.

When Something's Wrong Handbook: Ideas for Teachers

www.cprf.ca/publication/handbook_pdf.html

Developed by the Canadian Psychiatric Foundation, this guide helps teachers recognize and deal with mental health problems in the classroom.

Provincial Centre of Excellence for Child and Youth Mental Health

www.onthepoint.ca/index_e.htm

The Provincial Centre of Excellence for Child and Youth Mental Health at CHEO, along with other leaders, is working towards an integrated system that truly meets the mental health care needs of children, youth, and their parents and caregivers.

Anxiety Problems

Teachers may notice that a student seems nervous or fearful. These feelings may be related to a stressful event, such as performing in a school play or writing an exam. In such situations it is normal for a child to worry or feel nervous; these emotions can even help children memorize their lines or study longer for a test.

Children or teenagers may have a problem, however, if they are frequently nervous or worried and find it hard to cope with any new situation or challenge. Rather than being just 'nervous', the way they feel is better described as being 'anxious'. Anxiety is defined as a feeling of worry or unease.

When the level of anxiety is great enough to interfere with a child's or young person's everyday activities, we call this an Anxiety Disorder. Anxiety disorder is a psychiatric condition that may require medical or psychological treatment.

How common are anxiety disorders?

Roughly 6% of children and youth have an anxiety disorder that is serious enough to require treatment.

How long do they last?

Without treatment, some of the anxiety disorders that begin in childhood can last a lifetime, although they may come and go.

What causes anxiety disorders?

Anxiety disorders have multiple, complex origins. It is likely that genes play a role in causing anxiety. However, the home, the neighbourhood, school, and other settings can also contribute to anxiety.

For example, some babies or young children who live with too much stress can become anxious. Other children may 'learn' to respond in an anxious way to new situations because a parent or other caregiver shows anxiety. In most children and young people, a mix of these causes leads to an anxiety disorder.

What's normal and what's not?

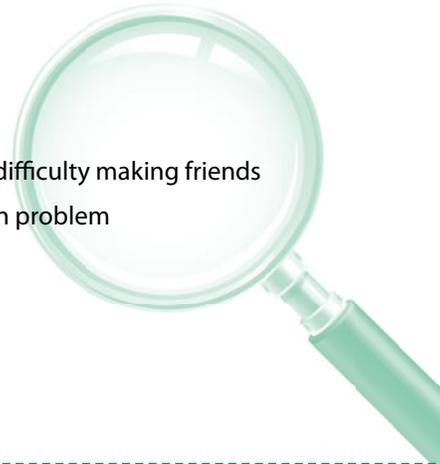
Being nervous about a single event, such as writing an exam, is normal. Trying to avoid any situation that causes anxiety is not normal, and may mean that the child or teen has an anxiety disorder.

Many young people with this disorder are quiet and not disruptive in the classroom, so it can be easy to miss signs they are struggling with anxiety. Children may not be able to identify or label their feelings as anxiety, which can make it even more difficult to recognize that it may be the problem.

In some situations, anxiety may be normal for a younger child, but not an older one. One common example is a young child who becomes upset when left at school for the first time. This separation anxiety is a normal reaction for a young child, but would not be normal for an older child. When the symptoms begin in later childhood or adolescence and continue for several weeks, then it may be time to seek professional help.

Some of the more common signs a child may be struggling with anxiety

- Frequent absences
- Refusal to join in school social activities
- Decline in grades or unable to work to expectations
- Often spends time alone, has few friends, or has great difficulty making friends
- Physical complaints that are not attributable to a health problem
- Excessive worrying about homework or grades
- Frequent bouts of tears
- Easily frustrated
- Fear of new situations



Educational implications

Anxiety can often be a primary contributing factor in poor school performance. Students who have an anxiety disorder can become easily frustrated and have difficulty completing their work; or they may simply refuse to do the work because they feel they won't do it right.

In classroom situations, these children may appear to be shy: they may be reluctant to do group work or speak out in class. Fears of being embarrassed or failing may result in refusal to go to school. Other children with anxiety at school may act out with troublesome behaviours. Obviously, the disruptive behaviour is not helpful in solving the problem, but in the moment, it is an alternative to the dreadful anxious feelings.

Children with perfectionist tendencies set impossibly high standards for themselves. They may show extreme anxiety over not achieving this perfection and dissatisfaction with their school performance. These expectations hinder completing an assignment or even attempting schoolwork (because there is 'always room for improvement').

Children who are perfectionists are consumed by fears, especially of social or academic failure. Perfectionism can have a crippling influence when coupled with a young child's immaturity and limited skills.

The irony is that those high standards can actually get in the way of peak performance; all of that trying to be perfect becomes an obstacle instead of a means of achieving a goal.



Anxiety Disorders: Suggestions for Supporting Your Student in School

- Slow steps are absolutely the key to sustaining progress. Avoid 'buying into' the anxiety, but on the other hand, don't push too hard.
- Reward brave, nonanxious behaviour: Catch them being brave doing something they normally wouldn't. Make a big deal about it. Label the action as fighting fear. Seeing they can fight fear will help build their self-confidence and make them feel better about themselves.
- By avoiding feared situations, children learn they are not able to cope with the situation or their worry. Encourage them to take little steps toward accomplishing the feared task.
- Check in with student at the beginning of the day.
- Learn what situations the student can handle and how you can respond when they are unable to cope.
- For school refusal, formulate a plan for when the student first arrives at school, such as providing an immediate reward for coming.
- Have the student check with the teacher or the teacher check with the student to make sure that assignments have been written down correctly.
- Reduce school workload or homework when necessary.
- Keep as much of the child's regular schedule as possible.
- To prevent absences, consider modifying the child's class schedule or reducing the time spent at school.
- Ask your student's parents what works at home to relieve their child's anxiety.
- Recognize and reward small improvements, e.g. finishing a task on time without continual erasing to make it perfect.
- Provide a learning environment where mistakes are viewed as a natural part of the learning process.
- Encourage and reward all positive steps in fighting anxiety.
- Provide advance warning of changes in routine.





More information

Websites

Anxiety Disorders Association of America

www.adaa.org/GettingHelp/FocusOn/Children&Adolescents.asp

Canadian Paediatric Society

<http://www.caringforkids.cps.ca/behaviourparenting/Fears.htm>

National Institute of Mental Health

www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml

Books for Teachers

School Phobia, Panic Attacks, and Anxiety in Children

Marianna Csoti, Jessica Kingsley Publishers (2003) ISBN: 1843100916

Your Anxious Child: How Parents and Teachers Can Relieve Anxiety in Children

John S. Dacey, Jossey-Bass (2001) ISBN: 0787960403

Books for Young People

I Don't Want to Go to School: Helping Children Cope with Separation Anxiety

Nancy Pando, New Horizon Press (2005) ISBN: 0882822543

The Anxiety & Phobia Workbook, Fourth Edition

Edmund J. Bourne, New Harbinger Publications (2005) ISBN:1572244135

Behaviour Problems

Difficulties in behaviour are often the most visible sign or symptom that a student is struggling. Sometimes there is an obvious reason for the difficult behaviour, such as frustration with an assignment, conflict with another student, or tiredness or irritability. At other times, the difficult behaviour is hard to understand, and may not have any reason that is apparent to others (or the student).

Almost every person has some episode of difficult behaviour in their childhood. Infants may cry and fuss if they are wet or hungry. This behaviour signals their parent/caregiver to change or feed them, and is an early way in which we all use our behaviour to communicate a message.

As children grow older, they learn better ways to communicate their thoughts, their desires, and their feelings. When they don't learn better ways, or revert to more childlike ways of behaving, we identify this as a behaviour problem. Since a behaviour that may be difficult at one age may be perfectly normal for another age, understanding child development is an important part of understanding behaviour problems.

Just as children learn language and motor skills by listening, observing, and practicing these skills, they require practice and encouragement to develop social skills, self-control, and good behaviour. Deficits in any of these skills may be due to lack of practice, limited opportunities to observe other children's behaviour, or insufficient encouragement.

Teachers working in early primary settings are familiar with the wide range of social skills, self-control skills, and behaviours that students arrive with when they first enroll. If kindergarten is a child's first opportunity to observe, practice, and develop these skills, they may lag behind others who have had the chance to work on these skills in day care or play settings.



As with other skills, not all children learn new skills at the same rate. Children and young people with developmental disabilities may learn these skills at a slower rate, or may never learn some of the more subtle and sophisticated social skills. Learning difficulties may impact acquiring these skills, as well as academic skills. It is easy to see how a child who arrives for the first day of school with learning problems, behaviour that is less mature than their peers, and a difficult home situation can quickly fall behind in so many areas.

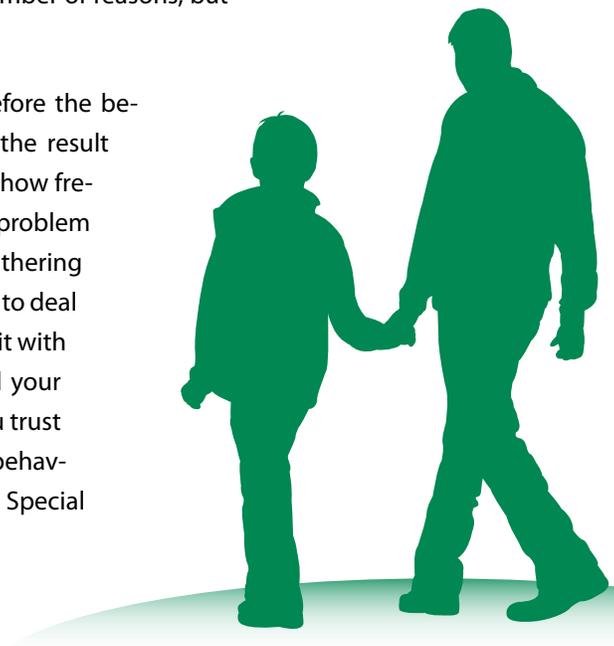
Some other problems can also compound behaviour difficulties. Children and young people with Autism have great difficulty understanding social cues and behaviours; those with physical disabilities or chronic illnesses may have less exposure to social situations in which they can observe and model age-appropriate behaviour. Other mental health challenges such as substance abuse, attention problems, anxiety, and mood problems may also contribute to behaviour difficulties.

Many behaviour difficulties are short-lived, and may be the result of a particular situation or problem the student is facing. It is important to remember that all of us 'regress' to behaviours we learned earlier in life when we are tired, or stressed, or because our more sophisticated 'mature' behaviours don't seem to be effective. Often we communicate with behaviour when our words don't seem to make a difference!

When students who usually behave well begin to have behaviour problems, it is helpful to gather some information, and to try to understand what the student is trying to achieve with the behaviour. You might want to note what was happening in the classroom when the behaviour became problematic, and what the result of the behaviour was.

For instance, if a student becomes disruptive whenever a particular activity is scheduled, and the result of the disruption is that they don't participate in the activity, then it might be reasonable to conclude that they are avoiding that activity. They may not be able to express the desire to avoid the activity for a number of reasons, but their behaviour has the desired effect.

In addition to noting what was happening before the behaviour problem (the antecedent), and what the result was (the consequence), it is also useful to note how frequently the problem occurs, how severe the problem is, and how long the behaviour lasts. If, after gathering this information, you still don't understand how to deal with the behaviour, it may be helpful to discuss it with someone else. Depending on your school and your Board, this might be another teacher whom you trust and respect, the school principal, or perhaps a behaviour consultant, Learning Resource Teacher or Special Resource Teacher.



Signs a child may be struggling with a behaviour problem

Most all children and young people misbehave at some time when they are growing up. Some children, however, have more serious behaviour problems that may require additional help. The signs to look for include:

- The child continues to behave badly for several months or longer, is repeatedly disobedient, talks back, or is physically aggressive.
- The behaviour is out of the ordinary, and seriously breaks the rules accepted in their family and community.
- The behaviour is much more than childish mischief, or adolescent rebelliousness.

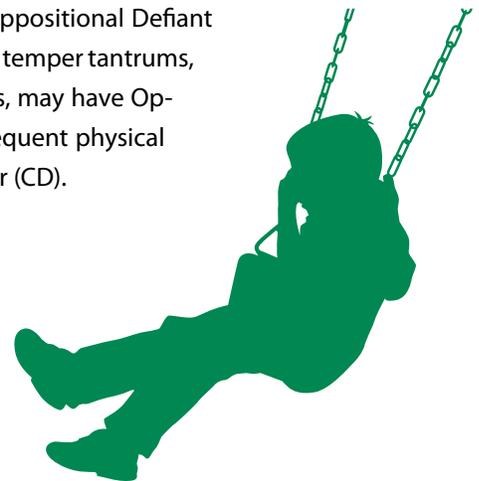
What are Behaviour Disorders?

When a behaviour problem becomes severe and chronic, it may become a behaviour disorder. This is a serious mental health problem, and that diagnosis should only be made by someone who has a good deal of experience in assessing young people. Behaviour disorders affect about 3.3% of Canadian young people (Waddell, Shepherd, 2002) so the chances are high that you will have at least one student with a behaviour disorder in your classroom.

There are two main types of disruptive behaviour disorders — Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD). A child who has a lot of temper tantrums, or is disobedient or argues with adults or peers on a regular basis, may have Oppositional Defiant Disorder (ODD). More serious problems like frequent physical aggression, stealing or bullying may be a sign of Conduct Disorder (CD).

Children with Conduct Disorder often have trouble understanding how other people think. They may have trouble talking to others. They may think that other people are being mean to them or wish them harm when that isn't the case at all. Their language skills may be impaired, which means they have trouble using words and may act out instead. They may not know how to make friends with other children, and may feel sad, frustrated, and angry as a result.

Children with this condition are aggressive all the time in a way that causes problems for them and their family. They may threaten or actually harm people or animals, or they may damage or destroy property. They may steal or shoplift, or even be involved in breaking and entering. They often lie or try to 'con' other people. They frequently skip school.



Types of Behaviour Disorders

Oppositional Defiant Disorder (ODD)

Oppositional Defiant Disorder (ODD) is a type of behaviour problem in which children are openly hostile, uncooperative, and irritable. They lose their tempers and are mean and spiteful towards others. They often do things to deliberately annoy other people. Most of their defiant behaviour is directed at authority figures, but they also sometimes behave the same way towards their siblings, playmates, or classmates. Their home life, school life, and peer relationships are seriously negatively affected because of the way they think and behave.

Conduct Disorder (CD)

Conduct Disorder (CD) is sometimes a later, more serious, phase of Oppositional Defiant Disorder (ODD). A child with CD is not just a child being 'bad'; CD is a serious psychiatric disorder that requires professional help.

What's normal and what's not?

It is important to understand that children can start acting out when there are other stresses in their lives. It may be that there has been a death in the family, or their parents are having arguments, or they are being bullied at school. Reassuring the child and providing extra care may help to get them through these stressful times. But if the child doesn't feel better and their behaviour doesn't improve, it is important to seek professional help, particularly if the problems are severe and last many months.

What causes behaviour problems?

Many children with Oppositional Defiant Disorder (ODD) have other mental health problems like depression, anxiety, or Attention Deficit/Hyperactivity Disorder (AD/HD). Their difficult behaviours are often a reaction to the symptoms of these conditions.

Children with ODD are more likely than other children to have a family history of behaviour problems, mood problems, or substance abuse. Sometimes if caregiving is poor, supervision is lacking, or there is family discord or exposure to violence, children will respond by developing the symptoms of ODD. Having a mother with untreated depression also makes children more likely to have ODD. Both ODD and CD are associated with harsh parenting practices.

How common are they?

Disruptive behaviour disorders appear to be more common in boys than in girls, and they are more common in urban than in rural areas. It is difficult for everyone to agree on how to measure behaviour problems, but between 5% and 15% of school-aged children have Oppositional Defiant Disorder (ODD). A little over 4% of school-aged children are diagnosed with Conduct Disorder (CD).

How long do they last?

Behaviours that may signal the beginnings of ODD or CD can be identified in preschoolers. Some children with ODD may eventually mature and gain better control of their symptoms, but some do not. Some may go on to develop CD. Children and adolescents with CD whose symptoms are not treated early are more likely to fail at school and have difficulty holding a job later in life. They are also more likely to commit crimes as young people and as adults.

Educational implications

Behaviour problems can disrupt the education of both the student with the problem, and of other students in the classroom. Time spent out of the classroom because of behaviour problems may mean that a student misses instructional time.

Students who have trouble understanding or following the behavioural expectations in the class may also be having learning problems. Students who are struggling to understand their schoolwork may be frustrated and irritable, and have a lower tolerance for events that other students could ignore.

Conversely, these students may find it more acceptable to 'act out' behaviourally, rather than acknowledge that they don't understand their schoolwork. This behaviour can irritate and alienate other students in the classroom, and make them less likely to provide help with the schoolwork.

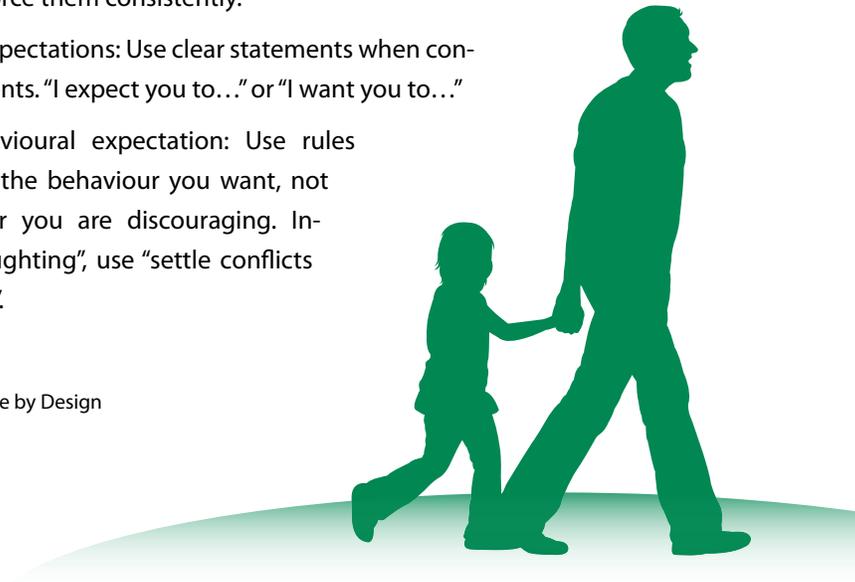




Behaviour Problems: Suggestions for Supporting Your Student in School

- Focusing: Be sure you have everyone's attention before you start your lesson.
- Direct Instruction: Begin by telling the students exactly what will be happening.
- Monitoring: Get up and go around the classroom to ensure that everyone has started, and is on the right page.
- Modelling: Model the quiet respectful behaviour you want from your student.
- Non-verbal Cuing: Try hand gestures, facial expressions, or other signals that can let a student know their behaviour is not acceptable, without involving the entire classroom.
- Environmental Control: Think about how you can make your classroom a warm and inviting environment. Some students may need a quieter corner with fewer distractions.
- Low-Profile Intervention: Many major problems start out as minor problems that escalate. Ensure that students are not rewarded for misbehaviour by becoming the centre of attention.
- Assertive Discipline: Ensure you communicate the expectations and enforce them consistently.
- Personalize Expectations: Use clear statements when confronting students. "I expect you to..." or "I want you to..."
- Positive behavioural expectation: Use rules that describe the behaviour you want, not the behaviour you are discouraging. Instead of "no fighting", use "settle conflicts appropriately".

Adapted from Discipline by Design
www.honorlevel.com





More information

Books

The Difficult Child

Stanley Turecki, Bantam; 2nd Rev. Ed. (2000) ISBN: 0553380362

Your Defiant Child: Eight Steps to Better Behavior

Russell Barkley, Guilford Press (1998) ISBN:1572303212

Responding to Problem Behavior in Schools: The Behavior Education Program

Deanne A. Crone, The Guilford Press; (2003) ISBN-13: 978-1572309401

Functional Assessment: Strategies to Prevent and Remediate Challenging Behavior in School Settings

Lynette K. Chandler, Prentice Hall; (2009) ISBN-13: 978-0138126926

School-Based Interventions for Students with Behavior Problems

William R. Jenson Springer; (2003) ISBN-13: 978-0306481147

Websites

American Academy of Child and Adolescent Psychiatry

www.aacap.org/cs/root/facts_for_families/facts_for_families

Canadian Paediatric Society

www.caringforkids.cps.ca/behaviourparenting/Misbehaves.htm

Mood Problems

Mood problems affect a person's thoughts, how they feel about themselves and the way they think about things. The most common mood problem is depression. Even very small children can experience depression, although the way they express the feeling may not be the same as an adult.

Very young children show that they are depressed by the way they behave. They may not be able to tell people how they feel. Instead, they will say they have a stomachache, a headache, or other aches and pains.

In teenagers, a certain amount of moodiness is to be expected. Sometimes, though, teenagers can become seriously depressed.

Children and adolescents who are depressed may seem as though they are not paying attention in class, or that they are ignoring what their parents say. These behaviours, if combined with others, like feeling sad all the time or crying easily, are often symptoms of depression.

Other symptoms of depression include irritability and loss of interest in activities the child used to enjoy, like sports or going out with friends. Anxiety is often present, too.

Depressed teens are at high risk for suicide. It is very important that parents, other caregivers, and teachers are aware of the symptoms of depression in children and adolescents. Depression that is not treated can also lead to long-term health problems.

How common are mood problems?

Roughly 3.5% of children and youth have an mood disorder that is serious enough to require treatment.

How long do they last?

While some mood problems may go away on their own, untreated mood problems can become a life-long struggle. There are effective treatments available for mood problems, including medication and therapies.

What causes mood problems?

A number of things may lead to symptoms of depression in children and adolescents: they can be triggered by a sad or painful event like a death in the family, can develop in children who observe constant fighting between their parents, and can also result from parental neglect or abuse. However, the tendency toward more serious kinds of mood problems can also be passed along genetically, likely because chemicals in the brain that help regulate mood are not working properly. The combination of a genetic pre-disposition and a triggering event may bring about the depression.

What's normal and what's not?

There is a difference between feeling sad and being depressed. Sadness tends to be felt over a short period of time and is related to a specific event; it has milder effects on one's day-to-day life.

Some of the more common signs a child or youth may be struggling with depression

- Prolonged sadness that persists for weeks or months
- Low energy and loss of interest in activities
- Low self-esteem
- Isolated, quiet
- Irritable
- Defiant or disruptive
- Fidgety or restless, distracting other students
- Negative talk about self, the world, or the future
- Excessive crying over relatively small things
- Frequent complaints of aches and pains
- Social isolation/difficulty sustaining friendships
- Avoids interacting with other children
- Difficulty thinking, concentrating or remembering
- Difficulty getting things done, such as homework
- Difficulty commencing tasks, staying on task or refusal to attempt tasks
- Sits in the back of the classroom and does not participate
- Refusal to do schoolwork, and general noncompliance with rules
- Responds with, "I don't know", "It's not important", or "No one cares, anyway" when asked about incomplete work
- Showing up late or skipping school
- Frequent absence from school
- Drop in grades

Educational implications:

Children and youth who are experiencing a mood disorder may have difficulty focusing in the classroom, and in completing assignments. They may be easily frustrated by tasks that they have previously completed without difficulty. This can affect their school performance, and lead to further difficulties with mood.

In the classroom they may appear sad or withdrawn. They may avoid other students at break, and in the playground, may complain of feeling tired, or of not having any energy.

Students who are experiencing mood problems also may not enjoy activities they enjoyed in the past. They say things like, “What’s the use?” or “It just doesn’t matter anyway.”

While all students may express some of these thoughts, when this is a change from their usual mood, and when it lasts for several weeks, it may be time to share your observations and concerns with others.



Depression: Suggestions for Supporting Your Student in School

- Being successful and accomplishing tasks increases self-esteem, so find ways to ensure the student has chances to achieve, even with his/her lower energy level and reduced ability to concentrate.
- Eliminate less important work until the student is in recovery.
- Make positive statements that reflect his/her own past successes.
- Make a special contact with the student each day – maybe a specific greeting at the door followed by a question about something that has been of interest to the student.
- Give more time, break assignments into smaller pieces, offer extra help in setting up schedules or study habits, or pair the student with others who express an interest in helping.
- Depression impairs students’ ability to learn and concentrate; they may work more slowly than other students. Shorten assignments or allow more time for them to be completed.
- Children and adolescents who are depressed are more sensitive to criticism. Corrections should be accompanied by plenty of praise and support.
- Depressed students often feel as if they have little to contribute. It is helpful to show confidence, respect, and faith in the student’s abilities.
- Ask open-ended questions in class. With no clearly correct answers, these kinds of questions minimize any chances for embarrassment.
- Check your Board’s procedures for dealing with students who are expressing suicidal thoughts. Seek direction from your principal if you have questions about what to do.



More information

Websites

American Academy of Child and Adolescent Psychiatry

www.aacap.org/cs/root/facts_for_families/the_depressed_child

National Institute of Mental Health

www.nimh.nih.gov/health/topics/depression/depression-in-children-and-adolescents.shtml

Mood Disorders Canada

www.mooddisorderscanada.ca

Books

More Than Moody: Recognizing and Treating Adolescent Depression

Harold Koplewicz, G.P. Putnam's Sons (2002) ISBN-13: 978-0399529122

Lonely, Sad and Angry: How to help your unhappy child

Barabara Ingersoll and Sam Goldstein, Specialty Press/A.D.D. Warehouse (2001) ISBN-13: 978-1886941458

Books for Young People

What's Your Mood: A Good Day, Bad Day, In-Between Day Book

Kimberly Potts, Adams Media Corporation (2004) ISBN-13: 978-1593372170

Attention Problems

Children can seem not to be paying attention when they should because they are daydreaming or are distracted by something going on in their life. They may run around simply because they have a lot of energy to burn.

Some children may appear not to have attention problems in some settings. In other settings, especially those in which it is more important to pay attention, such as school, they may have difficulty.

There is a small group of children, however, who continually have difficulty paying attention and staying still. Their behaviour gets them into trouble at home, at school, and in the neighborhood. It can affect their social skills and make it difficult for them to make and keep friends. As a result, they can experience sadness and feelings of rejection. Their impulsive behaviour and lack of judgment may also bring them into conflict with the law. These young people need to be seen by a health professional to find out whether or not they have Attention Deficit Hyperactivity Disorder (ADHD).

Children with ADHD are at high risk of school failure. Many also have other psychiatric conditions. They may suffer from anxiety, mood problems, oppositional defiant disorder (uncooperative and defiant behaviour) and conduct disorder (seriously aggressive behaviour that can include theft, bullying, and vandalism). They also have higher rates of alcohol, nicotine, and other drug abuse in adolescence, especially if their emotional and behavioural problems are not addressed.



What's normal and what's not?

All children can get very excited at times. They may make lots of noise and run around. Children also day-dream and may ignore requests – to do their homework or make their bed, for instance. This is normal. What's not normal is regularly being unable to sit still for any length of time, running into the road without thinking, or having problems paying attention at all. These behaviours may or may not indicate ADHD, but they are a sign that the child should be seen by a health professional.

There is no test that can say with certainty that a child has a serious attention problem. A diagnosis of ADHD is usually made based on the health professional's own observations as well as reports from parents, teachers, and others who know the child.

How common is ADHD?

About 5% of school children have ADHD. More boys than girls have the condition.

How long does ADHD last?

About 80% of children with ADHD will still have symptoms when they are in high school. About half of those teens will still have symptoms as adults.



What causes ADHD?

Studies of twins have shown that there is likely a genetic basis for ADHD. Genes that actually cause the disorder have yet to be identified, although many possibilities have been proposed. ADHD does tend to run in families: about 25% of parents whose children have ADHD also have, or have had, ADHD or another condition such as depression.

As teachers, we know that you usually have more than one student in your class with ADHD, and that can be very challenging. It is important to remember that ADHD is a mental health issue.

Signs of hyperactivity

- Not being able to sit still; fidgets
- Talking non-stop
- Leaving seat when sitting is expected/instructed
- Difficulty playing quietly



Signs of inattention

- Easily distracted
- Failing to pay attention to details and making careless mistakes
- Forgetting things such as pencils, that are needed to complete a task
- Rarely following directions completely or properly
- Not listening to what is being said
- Avoiding or showing strong dislike for schoolwork or homework that requires sustained mental effort

Signs of impulsivity

- Inability to suppress impulses such as making inappropriate comments
- Shouting out answers before a question is finished
- Hitting other people
- Difficulty waiting for their turn
- Low boiling point for frustration
- Poor judgment

Educational implications

Attention problems have a major impact on educational achievement. Students who have difficulty focusing their attention may not hear important instructions in the classroom, may have difficulty concentrating on the task before them, and often have difficulty completing tasks.

While some students with attention problems are very intelligent, about half of students with attention problems also have a diagnosable learning problem (you can be very intelligent and have a learning problem). It is often difficult to sort out which problem is causing a specific difficulty the student is experiencing, so the classroom teacher will need to focus on both the learning problem and the attention problem.

Students with attention problems do best in structured settings, with predictable routines. For suggestions on managing students with ADHD in the classroom, see Teach ADHD at www.teachadhd.ca.





ADHD: Suggestions for Supporting Your Student in School

Students with ADHD:

- Respond best to immediate rewards and consequences.
- Are visual learners
- Will do best in classrooms with well-defined rules, posted schedules, reduced stimulation (away from windows, doors), but without isolation. Without guidance, they may get lost in thoughts.

How you can help your student succeed in the classroom:

- Find out what they love – tap into the ‘emotional side of learning.’
- Break goals down into many smaller goals.
- Record each day’s homework in a journal.
- Provide encouragement such as stars or small, frequently-changing rewards.
- Use checklists.
- Provide a specific, organized ‘place’ for all activities.
- Create a self-monitoring system, like counting the number of times out of seat, in seat, etc.
- Give smaller assignments, less homework.
- Break down task or assignment into manageable parts.
- Record each day’s homework in a journal or notebook for the student to take home.
- Write the assignment and rewards on the board and repeat the assignment aloud. Appealing to multiple senses works well for children with ADHD.



More information

Websites

Teach ADHD

www.teachadhd.ca

Centre for ADHD/ADD Advocacy, Canada

www.caddac.ca

Children with Attention Deficit Disorder

www.chadd.org

National Institute of Mental Health

<http://www.nimh.nih.gov/health/topics/attention-deficit-hyperactivity-disorder-adhd/index.shtml>

Books

ADD/ADHD Behaviour Change Resource Kit: Ready-to-Use Strategies & Activities for Helping Children with Attention Deficit Disorder

Grad L. Flick, Jossey-Bass (2002) ISBN: 0876281447

How to Reach and Teach Children With ADD/ADHD

Sandra F. Rief, Jossey-Bass (2005) ISBN: 0787972959

Taking Charge of ADHD

Russell A. Barkley, Guilford Press (2000) ISBN:1572305606

Academic Success Strategies for Adolescents with Learning Disabilities and ADHD

Esther Minskoff & David Allsop (2003). Paul Brookes Pub. ISBN-13: 978-1557666253

Teaching Teens With ADD and ADHD: A Quick Reference Guide for Teachers and Parents

Chris Zeigler-Dendy Woodbine House (2000) ISBN-13: 978-1890627201

Books for Young People

The Survival Guide for Kids with ADD or ADHD

John F. Taylor Free Spirit Publishing (2006) ISBN-13: 978-1575421957



More information, continued

Cory Stories: A Kid's Book About Living With ADHD

Jeanne Kraus, Magination Press; (2004) ISBN-13: 978-1591471547

The "Putting on the Brakes" Activity Book for Young People With ADHD

Patricia O. Quinn, Judith M. Stern Magination Press; (1993) ISBN-13: 978-0945354574

Books for Teens

A Bird's-Eye View of Life with ADD and ADHD: Advice from Young Survivors

Chris A. Zeigler Dendy Cherish the Children (2003) ISBN-13: 978-0967991139

Does Everyone Have ADHD?: A Teen's Guide to Diagnosis And Treatment

Christine Petersen Children's Press(CT) (2007) ISBN-13: 978-0531179758



Drug and Alcohol Problems

There are many reasons why teenagers might use drugs. Some do it as a form of rebellion against authority. Others may be trying to fit in with a group of friends who use drugs. They may do it out of curiosity, because it feels good, or because it provides relief from unpleasant emotions and makes them feel better.

Teens, and even older children, may use 'legal' substances like tobacco, alcohol, glue, gasoline, diet pills, over-the-counter cold remedies, or prescription pain killers (like OxyContin®). Some may then go on to use illegal drugs like marijuana, LSD, cocaine, crack cocaine, heroin, PCP, amphetamines, methamphetamine, or Ecstasy.

Substance use becomes substance *abuse* when a person continues to use drugs or other substances even when it may lead to serious personal consequences, including: family problems, losing friends, expulsion from school, losing a job, or getting into trouble with the law. Some people continue to use drugs because they want to. Others become psychologically or physically dependent on them.

Dependence (also called "addiction") is considered by some researchers to be a kind of brain disorder in which chemical changes in the brain that occur at the onset of drug use then make further use difficult to resist. As the dependence worsens, not using the substance can cause severe withdrawal symptoms like restlessness, inability to sleep, or nausea. People who are dependent on drugs can even feel driven to engage in criminal acts to get money for their next dose. Property crimes like break and enter, theft from family members, shoplifting, or even armed robbery are often related to drug abuse.



There have been many reports of teens being injured or dying when swimming or driving after drinking or using other drugs. Injecting drugs can lead to hepatitis (a serious liver disease), HIV-AIDS, tetanus (a potentially fatal disease that causes serious muscle spasms), or blood poisoning. Inhaled drugs like cocaine can 'burn' a hole inside the nose, or cause heart attacks or strokes.

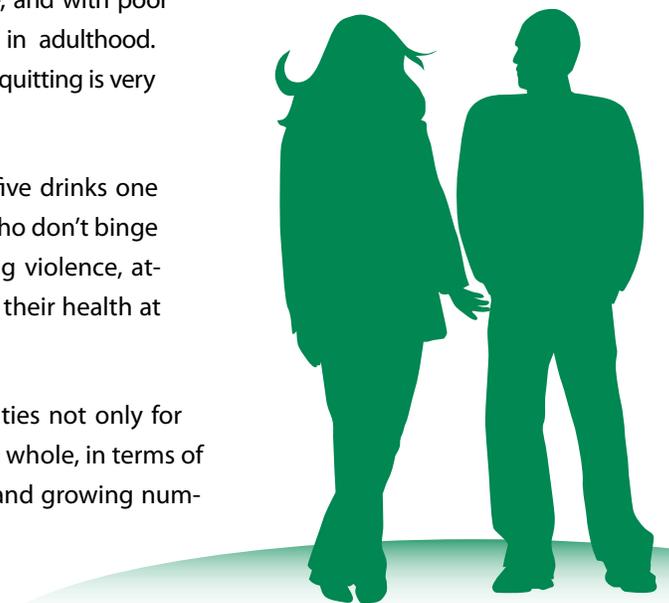
Marijuana may cause some vulnerable teenagers to become psychotic. Being psychotic involves having hallucinations (hearing voices or seeing things that aren't there), having trouble thinking clearly, or having thoughts that don't make sense to other people. So, even though it may not seem as 'toxic' as other drugs, for some people, marijuana use can lead to serious conditions that will require long-term treatment.

In the past few years, teens have begun using an extremely addictive synthetic drug called "crystal meth." Methamphetamine is a prescribed stimulant medication that is used legitimately to treat attention deficit disorder or the sleep disorder narcolepsy. Crystal meth is a type of methamphetamine that is 'cooked up' using toxic and volatile substances like paint thinner, drain cleaner, or the lithium from batteries. When smoked or inhaled, crystal meth has serious physical and mental consequences that may not get better over time. Irregular heartbeat, damage to brain blood vessels that can cause strokes, severe depression, or symptoms of Parkinson's Disease related to brain damage can occur. Withdrawal is very difficult for the addicted individual and relapse is frequent. Another distinct feature of crystal meth use is the number of children who are neglected or abused by their addicted parents. Crystal meth use is a growing problem in North America, but in comparison to other drugs, its use is still fairly rare.

However, alcohol and tobacco, both legal substances that are readily available and widely used, can cause even greater harm to physical health and social development than many illegal substances. Cigarette smoking is a primary contributing factor in death from heart disease, stroke, cancer, and lung disease in adults. The addiction to cigarettes often starts in adolescence, or in some people, even in late childhood. Early, continued use is associated with depression and anxiety during adolescence, and with poor academic and social-emotional outcomes in adulthood. Nicotine is a highly addictive substance and quitting is very difficult.

Teens who binge drink (have more than five drinks one after another) are more likely than teens who don't binge to do badly at school, be victims of dating violence, attempt suicide, or do other things that put their health at risk, like having unprotected sex.

Substance abuse results in lost opportunities not only for those directly involved, but for society as a whole, in terms of lowered productivity, higher crime rates, and growing numbers of homeless people on our streets.



What's normal and what's not?

It's not unusual for a teenager to try alcohol, tobacco, or other drugs occasionally. However, if the drug use is chronic and causes personal or family problems, it can be a sign of something more serious, including a psychiatric disorder.

How common is substance use?

Overall, nearly 6 in 10 students in grades 7 to 12 report using alcohol in the prior year. The number of students reporting that they use alcohol rises from 23% in Grade 7 to 83% by Grade 12. Nearly half (48%) of Grade 12 students report they had five or more drinks on at least one occasion in the past year.

Like alcohol use, reported cannabis use in the prior year increases as students move through the grades. Only 1 in 1000 (0.1%) of Grade 7 students report using cannabis in the past year, while 45.6% of Grade 12 students report they have used cannabis in the past year.

Other substances that students reported using include opioid pain relievers (17.8%), cigarettes (11.7%) and solvents (5.3%). These numbers are from the Ontario Student Drug Use and Health Survey conducted in 2009. Complete results are available at: www.camh.ca/Research/osdus.html



What causes substance abuse?

Children and adolescents with disruptive behaviour disorders (Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorders, or Conduct Disorder) are most likely to use drugs or sniff gasoline or glue. Teens using substances may have other mental health problems, including depression or anxiety disorders, such as a fear of social situations. Some have post-traumatic stress disorder – a type of anxiety disorder caused by serious trauma, usually related to early history or current experience of physical or sexual abuse. Substance use is also frequently seen in adolescents with bulimia (an eating disorder) or with schizophrenia, a very serious mental health disorder.

Drug use and mental health problems seem to go together, but no one knows which comes first. Some kids who are anxious or depressed use drugs to try to make themselves feel better. On the other hand, it is possible that using drugs brings about these feelings. When teens feel bad about themselves and feel they don't fit in anywhere, they may find a like-minded group of friends who use drugs. Not knowing how to resist peer pressure, or choosing not to resist it, increases the likelihood of engaging in substance abuse. Teens who were lonely and without friends during middle childhood also seem to be more likely to abuse drugs or other substances during adolescence.

There are also environmental and social factors that increase the likelihood that a child or teen will engage in substance abuse. Some have a family history of alcoholism or drug abuse, and are exposed to drinking and drugs in the home. Others come from low income/low education families, from families who are involved in domestic violence, or where there are parental mental health problems. Peers' influence can be just as strong as the family's. Children and teens who befriend substance-using peers are more likely to use drugs and other substances themselves. Growing up in a poor or crime-ridden neighbourhoods also contributes to high rates of substance abuse in children and teens.



Signs of a Possible Substance Abuse Problem

- Change in personality or baseline mood
- Drop in grades and classroom performance
- Increase in absences from school or classes
- Dropping old friends and getting 'new' friends
- Loss of interest in sports or other extra-curricular activities
- Deterioration of personal grooming habits
- Forgetfulness or difficulty paying attention
- Sudden aggressive behaviour, irritability, nervousness, or giddiness
- Increased secretiveness or heightened sensitivity to inquiry



How long do substance use problems last?

Some older children and teens try illicit drugs only once or, at most, a few times. A smaller group may go on to become chronic users, becoming addicted to cocaine, heroin, tobacco, or alcohol, and may need long-term treatment. Substance abuse that begins in late childhood or early adolescence tends to persist and be more severe in adulthood. Tobacco use that begins in adolescence is associated with poor outcomes in adulthood, including depression, poor physical health, reduced income compared to non-smoking peers, and fewer years of education.

What treatment is effective?

First of all, prevention is the ideal way to deal with the problem of substance abuse. It is also important to know that some treatments, like group therapy with other young people who have been engaged in criminal activity, may do more harm than good by causing more drug use or antisocial behaviour.

Comprehensive programs have, however, been found to work best to treat established substance abuse problems. These programs include all or some of the following components:

- Medications or cognitive behavioural therapy (CBT) that address underlying mental health problems have shown promise in the treatment for substance abuse.
- Family therapy should be used in addition to other treatments to reduce family conflict.
- Interventions that help increase motivation may help teens stay in recovery.
- Long-term follow up of any treatment is recommended because substance use is a chronic disorder.

Educational implications

Students who are having problems with abusing alcohol or other substances may have difficulty focusing on classroom activities, or may behave in inappropriate ways. They may also have increased absences from school, and fall behind in their schoolwork. They may present a safety hazard in courses that involve using machinery or require good judgment.

Check your Board's procedures for dealing with students who appear to be intoxicated or under the influence of drugs. Seek direction from your principal if you have questions about what to do.



Substance Abuse: What Teachers Can Do

Teachers have a unique opportunity to provide preventive education, by providing children with the substance use/abuse knowledge and skills they need to make healthy lifestyle choices.

- Incorporate lessons about alcohol and other drugs into the curriculum.
- Talk to students about why people may use drugs and alternative things they could do.
- Examine personal values and beliefs related to substance use and abuse.
- Reflect on personal or familial experiences with alcohol and other drugs.
- Be a strong role model for students by modeling positive behaviours, providing guidance and support, and helping student to make smart decisions.
- Know the general signs or symptoms indicating that a young person may have a substance use problem and/or a mental health concern.



More information

Website

The Centre for Addictions and Mental Health

The Centre for Addictions and Mental Health has many helpful resources for teachers on mental illness and substance use problems. Visit their website at www.camh.net.

Books

Preventing Addiction

John C. Fleming, CrossHouse Publishing, ISBN-13: 978-0929292458

Drinking and Drugs in My Family: A Child's Workbook About Substance Abuse in the Family

Wendy Deaton, Hunter House, ISBN-13: 978-0897931526

Parenting 911: How to Safeguard and Rescue Your 10- to 15- Year-Old from Substance Abuse, Sexual Encounters, Violence, Failure in School, Danger on the Internet, and Other Risky Situations

Charlene C. Giannetti, Broadway, ISBN-13: 978-0767903219

Adolescent Drug & Alcohol Abuse: How to Spot It, Stop It, and Get Help for Your Family

Nikki Babbit, Patient Centered Guides, ISBN-13: 978-1565927551

Drug Abuse: A Family Guide to Detection, Treatment & Education

A. James Giannini, Practice Mgt Information Corp, ISBN-13: 978-1885987112

A Teen's Guide To Living Drug-Free

Bettie B. Youngs, HCI Teens, ISBN-13: 978-0757300417

Addiction: An Information Guide

Centre for Addition and Mental Health, ISBN-13 978-0-88868-483-7

Self-harm (or the official term, non-suicidal self-harm) is the deliberate attempt to harm oneself and in most cases, is done without conscious intent to commit suicide.

The most common type of non-suicidal self-harm behaviour is self-injury, which is the deliberate damaging of one's body.

Although cutting is the most common type of self-harm, the behaviour can also include self-poisoning, burning, scalding, and self-inflicted hitting. Young people engage in self-harm as a way of coping with problems and emotional distress.

What's normal and what's not?

Very little is known about self-harm behaviour, especially in young people. Many young people who harm themselves report that it provides a way to manage intolerable feelings such as sadness, anxiety, or emotional numbness. Once the behaviour is started, the endorphins – natural pain relieving substances produced in our bodies – can provide an additional stimulus to continue the behaviour.

How common is self-harm?

On average, self-injury behaviours start at age 15, and are most commonly seen in teenagers and young adults. In one study of Canadian youth aged 14-21, 17% were shown to have self-harmed, and the behaviour is twice as common in females (21%) than in males (8.7%).

Many adults worry that adolescents engage in self-injurious behaviour because of a positive social status connected with self-harm. Most young people report that they started the behaviour on their own, and had neither read nor known about self-harm behaviour before they started.

What causes self-harm problems

It is believed the people self-harm in order to cope or deal with some stress. Some of the underlying reasons given include:

- Getting relief from painful or distressing feelings
- Dealing with feelings of numbness
- Communicating pain or distress to others

All of these underlying reasons are actually quite healthy; it is just that the self-harm is an unhealthy way to achieve these goals.

Risk Factors Include:

- Eating disorders
- Physical, emotional, or sexual trauma or abuse
- Depression, paranoia, or obsessive-compulsive disorder
- Low self-esteem and self-worth
- Bullying
- Feelings of shame, humiliation, and rage

Signs of Possible Self-Harm

Self-injury is often kept secret, making it difficult to detect. The young person often feels so ashamed, guilty, or bad that they can't face talking about it.

- Refusal to wear short sleeves or to remove clothing for sports
- Numerous unexplained scars, burns, or cuts
- May voice concerns that others do not listen and that they feel patronized





Self Harm: How Teachers Can Help

- Prevention efforts include helping students to express and identify their feelings, while also developing healthy behavioural coping skills.
- Simply being available, whenever possible, to talk to a child who self-harms can make all the difference, as feelings of isolation are often part of the problem.
- Consult with your school counsellor.
- Let the young person know that self-harm is common and that they are by no means alone.
- Make sure that they know who they can go to in your local area for professional help.
- Encourage the young person to think about what changes they would like in their life and environment in order to stop harming themselves.
- Support the young person in understanding triggers of self-harm and techniques they can use if they feel the urge to hurt themselves.
- Encourage students to let you know if someone in their group is in trouble, upset or shows signs of harming themselves. Help them to understand that, if their friend is in danger of seriously harming themselves, it's okay to tell someone.

Self-harm is generally an attempt to cope with a stress, and is distinct from actual attempts to end one's life.

Self-harm behaviours can continue over time if the underlying stresses are not adequately dealt with, and, in some cases, can even progress to active thoughts of suicide. The presence of self-harm behaviours should, therefore, lead to a more in-depth professional assessment to look for suicidal thoughts.

If you have any concerns that a student may be self-harming, you should discuss them with the resource staff or your principal. Professional help to deal with this problem will likely be required.

Bipolar Disorder

In bipolar disorder, episodes of depression alternate with episodes of mania. These periods of depression and mania may last for months, or they may 'cycle' more rapidly, with moods changing from high to low over weeks or days.

Many of the symptoms are similar to those seen with ADHD. Careful assessment and diagnosis is needed to ensure that the child gets the help they need.

Bipolar disorder and depression are often classed together as "mood disorders". Most young people will experience a depressed episode first, with the first manic episode appearing months or even years later. There is considerable controversy about how rapidly these moods can cycle.

What's normal and what's not?

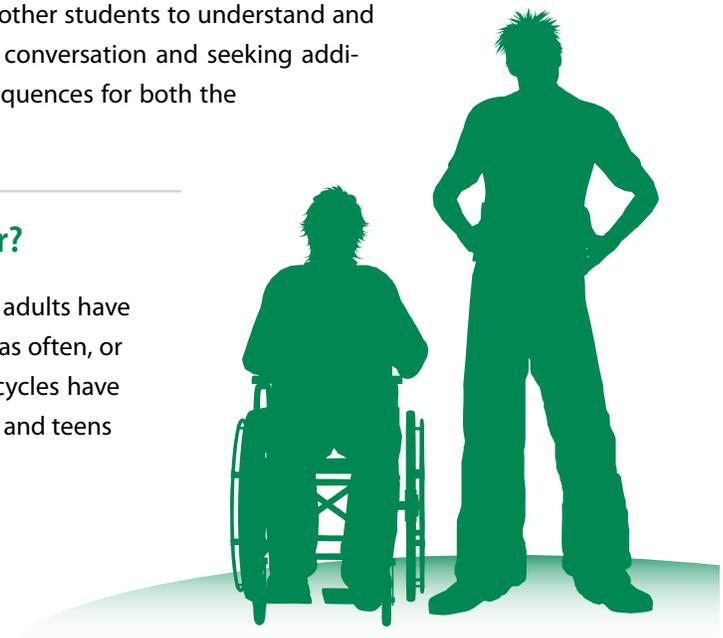
Many students will experience occasional periods of sadness and distress. Similarly, many students will feel in a very good mood for some extended periods of time. When the periods of sadness last for more than eight weeks, further help should be sought.

Manic periods may include some symptoms that go well beyond a 'good mood'. The student may speak rapidly, as though they can't get their thoughts out quickly enough. They may have grandiose ideas; for instance, that they are about to become a movie star or a famous musician. They may insist that they know more about a subject than an expert on the topic.

All of these behaviours can be difficult for other students to understand and manage. Setting appropriate limits to the conversation and seeking additional help may help limit the social consequences for both the affected student and their peers.

How common is bipolar disorder?

It is estimated that between 3% and 5% of adults have bipolar disorder. Because it may not occur as often, or not be accurately diagnosed until several cycles have been seen, the rate of diagnosis in children and teens is lower.



How long does bipolar disorder last?

Bipolar disorder is a major mental illness, with lifelong consequences. Students with a diagnosis of bipolar disorder will most likely, or should be, under the care of a doctor or mental health professional.

What causes bipolar disorder?

Bipolar disorder is a disorder that runs in families, but has a complex pattern of inheritance. If one identical twin has a bipolar disorder, the other twin has a 43% chance of also having the disorder. If they are fraternal twins, the chances drop to 6%. If one parent has bipolar disorder, about one quarter of their children will have a mood disorder. These mood disorders will be split about 50-50 between bipolar disorder and depression.

Some of the more common signs a child may be struggling with bipolar disorder

- 
- Rapidly changing moods lasting a few minutes to a few days
 - Separation anxiety
 - Crying for no apparent reason
 - Strong and frequent cravings, often for carbohydrates and sweets
 - Hyperactivity, agitation, and distractibility
 - Depression
 - Expansive or irritable mood
 - Excessive involvement in multiple projects and activities
 - Impaired judgment, impulsivity, racing thoughts, and pressure to keep talking
 - Impulsive, talkative, distractible, withdrawn, unmotivated, or difficult to engage
 - Grandiose belief in personal abilities that defy logic (ability to fly, knows more than the teacher)
 - Explosive, lengthy, and often destructive rages
 - Defiance of authority
 - 'Dare devil' behaviours

Even when moods are stable, the condition often causes cognitive deficits, including the ability to:

- Pay attention
- Remember and recall information
- Use problem-solving skills
- Think critically; categorize and organize information
- Quickly coordinate eye-hand movements

Educational implications

Students with bipolar disorder may fluctuate considerably in their ability to attend school, concentrate in the classroom, and complete assignments. During depressive episodes, they may appear sad or withdrawn. They may avoid other students at break, and in the playground. They may complain of feeling tired, or of not having any energy. During manic episodes, they may have a great deal of energy, have difficulty focusing on the task at hand, and make grandiose plans.

This fluctuation in mood can alienate other students and lead to interpersonal conflicts and social isolation.

If you have any concerns that a student may be suffering from a bipolar disorder, you should discuss those concerns with the resource staff or your principal. Professional help to deal with this problem will likely be required.





Bipolar Disorder: Suggestions for Supporting Your Student in School

- Check in on arrival to see if the child can succeed in certain classes that day. Where possible, provide alternatives to stressful activities on difficult days.
- Schedule classes later in the day when the student may be more alert and better able to learn.
- Allow more time to complete certain types of assignments.
- Adjust the homework load to prevent the child from becoming overwhelmed.
- Adjust expectations until symptoms improve. Helping set more attainable goals when symptoms are more severe is important, so that the child can have the positive experience of success.
- Set up a procedure that allows the child to quickly and safely exit from an overwhelming situation.
- Ask about their medications and side effects.
- Learning and cognitive difficulties can vary in severity from day to day. Despite normal or high intelligence, many children with bipolar disorder have processing and communication deficits that hinder learning and create frustration.
- Because transitions may be particularly difficult for these children, allow extra time for moving to another activity or location. When a child with bipolar disorder refuses to follow directions or to shift to the next task, schools and families should remember that anxiety is likely the cause of this behaviour, and that it is not intentional.
- Use strategies at school that are consistent with those used at home.
- Encourage the child to help develop interventions. Enlisting the child will lead to more successful strategies and will develop the child's problem-solving ability.



More Information

National Institute of Mental Health

www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml

Eating Problems

Eating is a basic human activity that everyone must undertake for energy and nutrition. When young people, especially young women, become so concerned with what they are eating that it interferes with their schooling, their social life, and their health, there is the possibility that they may have an eating disorder. Eating disorders are life-threatening conditions that should be assessed by an experienced mental health professional.

Eating disorders centre around a preoccupation with food, weight, and personal body image; they include *anorexia nervosa* and *bulimia nervosa*. Both are serious mental health disorders that can have life-threatening consequences. Understanding the 'warning signs' helps teachers to support early intervention for students at risk for eating disorders. Young people who have an eating disorder require medical and emotional support.

An excellent resource for teachers on eating disorders is available to read or download through the BC Ministry of Education website at www.bced.gov.bc.ca/specialed/edi/welcome.htm.

Types of Eating Disorders

Anorexia nervosa is self-starvation. Young people with this disorder intentionally deprive themselves of food, even though they may be very thin. They have an intense and overpowering fear of body fat and weight gain.

Bulimia nervosa is characterized by cycles of binge eating and purging, either by vomiting or taking laxatives or diuretics (water pills). The young person has a fear of body fat even though their size and weight may be normal.

Overexercising is exercising compulsively for long periods of time as a way to burn calories from food that has just been eaten.

Binge eating involves eating large amounts of food in a short period of time, usually alone. The eating is often accompanied by feeling out of control and followed by feelings of depression, guilt, or disgust.

What's normal and what's not?

Many students, especially young women, report that they are concerned about their weight, and may purge or binge eat from time to time.

How common are eating disorders?

Eating disorders are more common in females (about 90-95% of those diagnosed), but not unknown in males. About 8% of females suffer from either anorexia nervosa or bulimia nervosa, and 27% of young women ages 12-18 are reported to be engaged in severely problematic food and weight behaviour.

What causes eating disorders?

Eating disorders are likely the result of a complex interaction between psychological, biological, and social factors. There is evidence that genetics contributes to the development of eating disorders. Other psychological factors such as perfectionism, poor self-esteem, impulsive behaviour, anger management difficulties, and family conflicts may also contribute to the development of eating disorders.

All of these disorders can have serious and life threatening consequences. Many young people with eating disorders don't believe there is anything wrong, and, therefore, don't acknowledge the problem and seek the help they need. Continued support and encouragement to seek help is often needed.

Warning signs of an eating disorder

- A marked increase or decrease in weight
- Development of extreme or unusual eating habits such as severe dieting, withdrawn or ritualized behaviour at mealtime, or secretive bingeing
- An intense preoccupation with weight and body
- Engaging in compulsive or excessive exercising
- Self-induced vomiting, periods of fasting, or abuse of laxatives, diet pills, or diuretics
- Low self-esteem
- Evidence of shakiness, dizziness, or feeling faint
- Frequent trips to the toilet to purge
- Mood changes such as irritability, anxiety, or depression
- Decline in concentration, memory, or academic performance
- Withdrawal from social contact, interests, and hobbies
- Difficulty completing tasks or assignments because of need for 'perfectionism'
- Short attention span and poor concentration
- Lack of energy and drive to complete assignments or homework
- Absences from school for treatment of health problems
- Lethargy, forgetfulness, and poor judgment as a result of malnutrition

Educational implications

Students with eating disorders may have difficulty concentrating, and may complain of not having any energy to participate in activities. Absences from school may result in students falling behind.



Eating Disorders: What Teachers Can Do

- Encourage class discussions about positive self-image.
- Avoid lessons that focus solely on eating and dieting, as these can reinforce negative body images.
- Referral to school counsellor if you suspect a student has an eating disorder.
- Encouragement, caring, and persistence, as well as information about the dangers of eating disorders, may be needed to convince the young person to get help and stay in treatment.



More information

Canadian Paediatric Society

www.caringforkids.cps.ca/teenhealth/DietingInfo.htm

National Eating Disorders Information Centre

www.nedic.ca

National Institute of Mental Health

www.nimh.nih.gov/health/topics/eating-disorders/index.shtml

Psychosis is a serious medical condition in which a person has trouble telling the difference between what is real and what is not; symptoms such as delusions and/or hallucinations (see below) can signify this struggle. Initially, psychosis may also present with more subtle changes in behaviour, such that a person 'just doesn't seem to be acting like their normal self'.

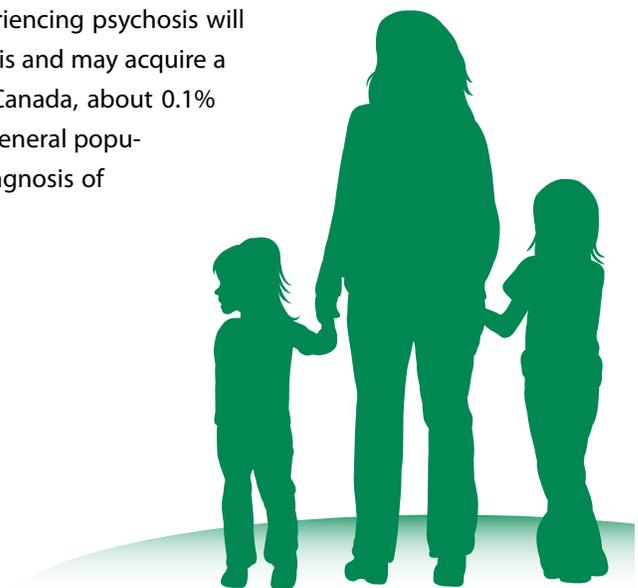
Psychotic symptoms, such as hallucinations and delusions, commonly occur in men in their late teens and early 20s, and in women, in their mid-20s to early 30s; they rarely occur before puberty or after age 45.

First episode psychosis refers to the first time that a person outwardly shows symptoms of psychosis. These symptoms may be very distressing for both the individual and their family. Symptoms which can result in bizarre or unusual behaviour include:

- **Delusions:** fixed, false beliefs, which do not have a basis in reality. There are many types of delusions, some quite bizarre. Paranoid delusions are one common type, where a person may become suspicious of others and afraid of being spied on, followed, or harmed by others.
- **Hallucinations:** seeing things (visual hallucinations) or hearing things (auditory hallucinations) that aren't there.

How common is psychosis?

There are many medical causes of psychosis. About 3-5% of the population will experience some form of psychosis in their lifetime (World Health Organization). A small proportion of people experiencing psychosis will go on to have longer-term problems with psychosis and may acquire a diagnosis of schizophrenia. According to Health Canada, about 0.1% of children and youth have schizophrenia. In the general population, it is generally accepted that 1% has the diagnosis of schizophrenia.



How long do they last?

Without treatment, psychotic disorders can last a lifetime. Even with effective treatment, psychotic disorders can have lifelong impact.

What causes psychotic disorders?

Psychotic disorders result from abnormalities in the brain, particularly at the level of the chemical messenger systems, such as dopamine and serotonin. The exact cause of psychotic disorders is not known. A family history of psychosis increases the risk that a young person will experience a psychotic disorder.

The young person may not understand what is happening to them, and symptoms can be very disturbing and distressing. It is easy to mistake signs of psychosis as just normal challenges that many young people go through. Psychosis is a serious illness, however, and early intervention is needed. With treatment and support, most young people will recover from psychosis.

Early warning signs of psychosis

- Emotional signs, such as irritability, suspiciousness, or paranoia, anxiety, depression
- Loss of motivation, difficulty concentrating, mood swings
- Noticeable change in activity level; school performance deteriorates
- Severe problems making and keeping friends
- Vivid and bizarre thoughts and ideas
- Perceptual changes – the feeling that things around them have changed or are somehow different; their thoughts are sped up or slowed down.

Educational implications

Students who are experiencing a psychosis may have great difficulty managing classroom settings and day-to-day social interactions. They may have difficulty focusing on tasks, completing assignments, and getting along with other students. Their peers may have difficulty understanding their erratic behaviour, and, as a result, they may be isolated. Once the psychosis has been treated, it may be very difficult for the student to regain the friendships they once had.



Psychosis: Suggestions for Supporting Your Student in School

- Help to create a non-stigmatizing environment by raising awareness about mental health issues and encouraging other students to be supportive.
- Teach students about the brain and disorders like psychosis.
- Be aware that changes in a student may be signs of impending psychosis.
- Refer students who show early warning signs to school counsellors.
- Understand that a student dealing with psychosis may require modifications in their school program.
- Be aware that symptoms can fluctuate.
- Capitalize on a student's strengths to enhance their learning; educational testing may help to clarify these strengths.
- Break down tasks into smaller pieces; minimize distractions; have a plan to redirect the student to help him/her return to the task at hand.
- Assist the student with planning and organizational skills.
- Give short, concise directions.



More information

Canadian Mental Health Association: www.cmha.ca

Information on psychosis and early intervention psychosis treatment

Canadian Schizophrenia Association: www.schizophrenia.ca

Information on psychosis and substance abuse

Prevention and Early Intervention Program for Psychosis: www.pepp.ca

Information on early psychosis intervention programs

Talking about Mental Health Problems

Teachers are the contact point for students, for parents, and often, for other professionals involved in students' lives. Communicating with parents and other professionals can be difficult and confusing. Sometimes, parents don't agree with your understanding of their child's problems. Professionals may use language and terms that are unfamiliar to you as a teacher. Even students can raise questions and concerns that are difficult to deal with.

The aim of this section is to make you feel more comfortable with talking to students, their parents, and your in-school team about mental health problems.

Your Board will have policies and procedures that outline the process for talking with parents and professionals. There are likely clear guidelines for some conversations, such as talking about suicide threats, pregnancy, or abuse. This guide is not meant to replace those guidelines, or change them. You should seek help from your principal or colleagues if you are unclear about your Board's guidelines, policies, or procedures in these areas.



Informing and Supporting Parents

The Teacher's Unique Point of View

As a teacher, the amount of time you spend with your students helps you to distinguish typical age-appropriate behaviour from atypical behaviour that is disruptive or impairing a child or adolescent's development and learning. You encounter a range of behaviours that helps you compare a particular student to others their age. Parents may not have regular contact with other young people, and may not recognize that their child's behaviour is different.

Stress resulting from academic work, peer relations, and the general structure of school can trigger behaviours and problems that may not have been noticeable prior to beginning school or at home. Parents may not be aware of the difficulties their child is experiencing in school.

If you have an opportunity to first discuss the things that the student is doing well, these positives can build trust with the parent that helps in further conversations.

Talking to parents about their child's problems can be a difficult and tense experience. Many teachers report that this is one of the most stressful parts of their job. You may find that other teachers and/or your principal can help you practice these discussions.

You could say something like:

"I've noticed that Susan is having a hard time settling in class. She is easily distracted and often has difficulty focusing. I'm wondering if you've noticed this at home?"

Or, you could say something like:

"Alison seems very quiet in class, and finds it difficult to answer questions when I call on her, even though she knows the answer. Have other teachers mentioned this before?"

Both of these questions ask about a specific behaviour you have noticed, without making a judgment about what the cause of the behaviour might be. If the parent agrees that the student may show the behaviour at home or in other settings, then you have started the discussion of how you can work together to solve the problem.

If the parent says that they never see the behaviour at home or in other settings, then you can follow up with a question like:

"I see this behaviour often in class, and it's affecting Alice's learning. Do you have any suggestions on what we can do to help Alice manage this behaviour?"

Again, you have recruited the parent as your partner in solving the problem, and avoided an argument about whether the problem exists.

It can be difficult for parents to hear that their child is struggling with a possible mental health problem. As a teacher, it can be a challenge to have to tell a parent about your observations. It is often helpful to speak with your school counsellor, principal, or vice-principal about ways to talk with parents about these kinds of situations.

Sometimes, parents know that their child has a problem, and may not reveal this to the teacher or school, for fear that it will affect the way their child is treated or change the expectations for their child. Many parents report that they feel 'blamed and shamed' for having a child with a mental health problem.

School transitions can be triggers for stress

- School entry to JK or SK, with the introduction of new routines and social interaction
- Senior Kindergarten to Grade 1, when less time is spent on play
- Starting to rotate classes and classrooms during the day (usually Grades 7 to 9)
- Elementary or Middle School to High School



Talking with students about mental health problems

Teachers are important people in the lives of their students; They may be the best, most supportive adults that they know. This can sometimes mean that they turn to teachers when they have a personal problem with which they need help. Teachers may feel uncomfortable talking about personal problems that their students are having. There may be a reason the student has chosen to speak to you, and you can help them find someone else they can talk to.

There are certain conversations with students that must happen. If a student tells you that they are being physically, emotionally, or sexually abused, or they are being neglected, then you have an obligation under the law to report that conversation. Your School Board should have a policy and procedure that will guide you on how to report this.

Similarly, if a student reports that they are pregnant, or that they are thinking about harming themselves or another person, your Board should have a policy and procedure that will guide you on the next steps you must take. Links to these policies and procedures can be found in Appendix 1 of this guide.

Suggestions for talking to students

- Use everyday language that students will understand.
- Remind students that there is a continuum of problems. Not every problem is a disaster!
- You may want to start the conversation by letting them know there are limits to what you can keep confidential.
- Privacy is important for talking about sensitive topics.
- Hallways and classrooms full of students are not good places for these conversations.
- Offices and meeting rooms are probably available in your school, and may make it easier for the student to talk, and for you to hear them.

Other conversations about personal problems and/or mental health problems may be more difficult. Each individual teacher will set their own boundaries around what they are and are not comfortable discussing with a student.

Sometimes, students raise issues that you don't know anything about, and you won't want to answer their questions until you know more about the problem. Talking with your colleagues, a resource teacher, a public health nurse, or a school counsellor may help you learn more. You may want to suggest that the student speak directly with that person, or you may want to set-up a three-way conversation.

Other times, the student may raise issues that are ‘too close to home’ for an individual to feel they can talk about. Like all members of society, teachers struggle from time to time with maintaining their own good mental health. Redirecting that student to another person in your school with whom the student agrees they are comfortable speaking may be the best course of action.

What about when you suspect a mental health problem, especially in older students? Again, you can say something like:

“James, I’ve noticed that you seem quieter and more withdrawn than usual. Is this only happening in this class, or are you having similar difficulties in other classes?”

Or something like:

“Alice, you’ve been blurting things out in class, and are having difficulty paying attention since you came into this class last semester. Do you have this difficulty in other classes?”

Both of these statements focus on the behaviour you have noticed, and invite the student to reflect on whether they have this problem in other settings.

If the student acknowledges they are experiencing a problem, then you may want to arrange a meeting with the student, their parents, and school resources that can help them with that problem.

Sometimes a student may acknowledge they have a problem, and are already seeing a counsellor or therapist about it. You might want to ask something like:

“Charles, what sort of things can we do in the classroom to help you manage this behaviour?”



Sharing Information

Sharing information about health problems is governed by a different set of rules than sharing information about educational matters. When a student has a mental health problem that affects their schoolwork, then the rules around sharing information can be quite complex.

Often it is helpful to have a conversation about the limits of confidentiality, before you get into the conversation. You might want to say something like this:

“I can keep this conversation confidential, unless you share information that you are pregnant, are being abused, or are likely to harm yourself or someone else. In those cases, I will have to share what you tell me to ensure your safety and the safety of others.”

There are different rules about confidentiality, depending on to whom the young person is talking. If a young person identifies that they have a mental health problem that they don't want their parent(s)/guardian to know about, the rules will be different depending on the professional they approach.

For instance, if they go to a hospital or family physician, and request that their problem not be shared with their parents, that request will be honoured. A young person has the right to seek health services without their parents' knowledge or permission at any age, if they are judged to be competent to make that decision. Most health professionals will discuss the value of including parents in solving problems, but ultimately, it is the young person's decision.

If that young person turns to a CAS worker or a children's mental health agency about that same problem, then a different set of rules apply. A young person age 12 years and older may seek counselling services from a child or family agency funded under the Child and Family Services Act, without their parents' knowledge or permission. These include children's mental health centres, child welfare agencies, and family service organizations. Again, most of these agencies will discuss the value of involving parents to solve problems.

Finally, if they bring that same problem to an educator or other member of the school team, another set of rules may apply. Young persons under the age of 18 must have their parents' permission to seek counselling services, psychological assessment, or communication services from a Board of Education. The exception to this is if that young person has signed a declaration that they are no longer under the control of their parents.

All of these professionals have the same duty and obligation to report concerns about abuse or potential for harm to the young person or others.

Many Boards have established protocols with community organizations that spell out the circumstances and legislation that govern information sharing. An example of these protocols is included in Appendix One.

Talking about Mental Health Problems in the Classroom

In spite of the fact that mental health problems affect one in five young people, less than 15% of those young people ever receive any help. Many parents and young people say that stigma about mental health problems is the main reason they don't seek help.

Teachers can play an important part in reducing the stigma of mental health problems. The Mental Health Commission of Canada recognizes this, and has made anti-stigma programs aimed at children and youth one of their two priority areas. They are working with a number of groups to develop effective programs, some of which are designed to be delivered in the classroom.

Teachers can help reduce the stigma about mental health problems by discussing them in class, and helping students to find and use high-quality information about these problems. You will find a list of these resources in Section L, "Provincial and National Resources".



Promoting Good Mental Health in the Classroom

Mental health is a continuum. When we talk about physical health, we understand that good physical health is not just the absence of disease. Good health includes eating well, exercising regularly, and getting enough sleep. These habits all combine to make us physically healthy, and better able to resist illness and disease.

In a similar way, we understand that good mental health is not simply the absence of mental illness. We can work to improve our mental health through constructive thoughts and actions, including building supportive social networks, involvement in meaningful activities, and management of stress and conflict in our lives.

Just as nutrition, exercise, and sleep don't guarantee good physical health, friends, personal interests, and managing emotions don't automatically lead to good mental health. They will, however, increase the odds in your favour.

So, how do we promote good mental health in the classroom, and how do we teach the social and emotional skills that help students develop and maintain good mental health? We need to focus on class-wide strategies that improve classroom climate and on teaching students the social and emotional skills that will help them to get along and form relationships with others.

Classroom Climate

Classroom climate is a broad concept that is affected by many different factors. We know that individual traits of students, relationships and social interaction between students, and relationships and social interaction between students and teachers all impact classroom climate.

A caring and safe school is a place where all partners – students, staff, parents, and community members – treat others fairly, respectfully, and kindly, and act in a socially responsible way towards all members of the school community, including students with special education needs. For more resources on this kind of positive school environment, look at “Safe and Caring Schools in Ontario” at http://www.edu.gov.on.ca/eng/general/elementary/sec/speced/Caring_Safe_School.pdf

It is generally agreed that a positive classroom climate exists in a classroom where students co-operate with the teacher and with each other, where there are orderly working conditions, where students feel an emotional bond with their class and their school, and where students and teachers are treated respectfully.



Several measures have been developed to gauge classroom climate, and these consider a combination of factors. The more important factors include: cooperative learning, teacher academic support, teacher emotional support, student academic support, student personal support, achieving for social approval, and alienation.

School climate can impact classroom climate, and classroom climate can also impact school climate. Teachers have the greatest ability to impact the climate in their classroom, and principals have the responsibility to positively impact school climate. Establishing classroom (and school) climate does not happen automatically; it is a skill that educators must develop.

Why is classroom climate important?

Extensive research has shown links between positive classroom climate and academic achievement. Poor classroom climate reduces academic achievement in all students, but has a proportionally larger impact on students who are already struggling academically.

There is also evidence that poor classroom climate increases the likelihood of mental health problems, especially behaviour problems. As well, students who are having difficulty managing their behaviour can have a negative impact on classroom climate.

What can teachers do to positively impact classroom climate?

The Ontario Ministry of Education has created a document, “Caring and Safe Schools in Ontario”, that presents ideas for improving school climate, background information on understanding student behaviour, and specific strategies, tools, and resources. An easy-to-use guide to the document has also been developed and can be found at: <http://caringandsafeschools.commonshwdsb.on.ca>

There are also a number of interventions that teachers can use, which evidence suggests are effective in improving classroom climate. A listing of these programs, along with the level of evidence supporting their use, is available at the Office for Juvenile Justice and Delinquency Prevention website at: <http://www.ojjdp.gov/mpg/progTypesSchoolClassroom.aspx>

Many of these programs feature common elements or practices that seem to be the active ingredients that bring about the desired changes in classroom climate. These ingredients include:

- **High academic expectations.** All students are expected to learn and achieve.
- **Engaging students in the academic work of the classroom.** This may include academic skills enhancement for students who are developing their skills at different rates than their classmates.
- **Establishing clear and consistent behavioural expectations.** These expectations change as students become older and more able to manage their own behaviour. Addressing bullying and violence are vital steps in establishing behavioural “norms”.

- **Praising good behaviour.** Noticing good behaviour can be a difficult skill to develop when you feel like you are surrounded by poor behaviour. Start by trying to find one good behaviour to acknowledge each day, and soon, you will see good behaviour increase.
- **Behaviour-specific praise.** Saying “good job” isn’t nearly as effective as saying “Good job sitting still, Michael”, or “Excellent work showing how you solved that fraction problem, Julie.”
- **Engaging parents and the community.** Parents and community members can support positive classroom and school climate through volunteering, mentoring, and by simply modelling expected behaviour. Ensuring committed involvement requires training and support for volunteers – it goes beyond making photocopies or fund-raising.

Social and emotional learning

As Robert Fulghum wrote in his essay, “All I Really Needed to Know I learned in Kindergarten”, learning to share, to get along with others, and to take turns are important lifelong lessons.

For some children, their first opportunity to learn these skills comes when they start school; they may not have had the chance to interact with other children. Early childhood education, playgroups, and child care centres all provide avenues for children to interact and to learn how to get along.

Children learn these skills more easily if they have consistent rules for behaviour, and consistent consequences when they misbehave. Some children do not have this experience, and may arrive at school without these skills.

Some children may simply have more difficulty understanding and acquiring social skills and behaviour, just as some children struggle more than others when learning to read.

Whatever the cause, young children who arrive at school without the social and behavioural skills to manage a brand-new, complex social environment may have difficulty adapting; their behaviour may reflect this struggle.

As students grow and mature, their understanding of emotions and social skills may not keep pace with their grasp of reading and mathematics. While the behaviours students exhibit may change, problem behaviour can still be a good indication that they don’t understand how to behave, or haven’t had the practice necessary to develop and integrate those skills.

We provide explicit instruction, practice, and feedback to build literacy and numeracy skills. This same approach works for teaching social and emotional skills as well. While instruction in social and emotional learning is seldom covered in education programs, there is clear evidence that social and emotional learning can improve academic outcomes.

Teaching social and emotional learning

A number of programs have been developed to teach social and emotional skills. Because these skills change as students grow and mature, it is important to match the program with the developmental ages and stages of your students.

Many of these programs are designed to be used by a classroom teacher for all students in their class. Some are designed to be delivered by a classroom teacher and a specially trained professional, such as a social worker, psychologist, or behaviour therapist. For any of these programs to be effective, it is vital that the classroom teacher be involved in the program.

Social and emotional learning programs can be built into the regular curriculum, or offered as “stand-alone” programs. They range from 8-10 sessions over a few weeks, to year-long programs that happen several times a week. For a listing of programs with good evidence of effectiveness, see the Coalition for Academic, Social, and Emotional Learning (<http://casel.org/>). You can also find a brief overview of the effectiveness of these programs at <http://10.148.32.115/e-best/wp-content/uploads/2011/03/RIB-Social-Emotional-Learning.pdf>

Many school boards are already delivering social and emotional learning initiatives; “Roots of Empathy” and “Tribes” are two of the more commonly offered programs. In order to be effective, these programs require training for educators, and a well thought-out plan for implementing them. Programs which are implemented poorly are not as successful as those that are implemented well.

Some educators feel their role is to teach academic subjects, and not to “waste” classroom instructional time with non-academic programs such as social and emotional learning. Other educators may not feel comfortable talking about emotions and social rules, as these are subjects that may depend on individual values and beliefs. Research clearly shows, however, that teaching social and emotional skills will improve academic achievement, as well as reduce behaviour problems in the classroom and improve class climate.





Additional Resources

School Climate

Transforming School Climate and Learning: Beyond Bullying and Compliance

W. Prebble & R. Gordon, Corwin Press (2011), pp. 184. ISBN: 978-1412992688

Classroom Climate

The New Teacher's Survival Guide to Behaviour (2nd Ed.)

S. Roffey, Sage Publications (2011), pp. 160. ISBN: 978-1849207447

Classroom Behaviour: A Practical Guide to Effective Teaching, Behaviour Management and Colleague Support (3rd Ed.)

Rogers, B., Sage Publications (2011), pp. 280. ISBN: 978-0857021670

School Discipline and Self-Discipline: A Practical Guide to Promoting Prosocial Student Behaviour

G.G. Bear, New York: Guilford Press (2010), pp. 256. ISBN: 978-1606236819.

Understanding Pupil Behaviour: Classroom Management Techniques for Teachers

R. Lewis, David Fulton Pub. (2009), pp. 184. ISBN: 978-0415483537

Bullying Prevention: Creating A Positive School Climate and Developing Social Competence

P. Orpinas & A.M. Horne, Washington D.C.: APA Books (2005), pp. 293. ISBN: 978-1591472827



Additional Resources, continued

Social and Emotional Learning

Social and Emotional Learning in the Classroom: Promoting Mental Health and Academic Success

K.W. Merrell & B.A. Gueldner, New York: The Guilford Press (2010), pp. 192. ISBN: 978-1606235508.

Strong Start/Strong Kids, K. W. Merrell, Baltimore Md: Brookes Publishing (2007)

Strong Start (Pre K) pp. 160 ISBN: 978-1557669889

Strong Start (K-2) pp. 132 ISBN: 978-1557669292

Strong Kids (grades 3-5) pp. 176 ISBN: 978-1557669308

Strong Kids (grades 6-8) pp. 192 ISBN: 978-1557669315

Strong Teens (grades 9-12) pp. 176 ISBN: 978-1557669322

Safe & Caring Schools: Skills for School, Skills for Life, K. Petersen, Champaign Ill: Research Press (2005)

Pre K-Grade 2 pp. 142 ISBN: 978-0976146704

Grades 3-5 pp. 159 ISBN: 978-0976146711

Grades 6-8 pp. 189 ISBN: 978-0976146728

National and Provincial Resources on Mental Health for Young People and Parents

For young people

Kids Help Phone 1-800-668-6868

www.kidshelpphone.ca

On the phone, Kids Help Phone provides immediate, bilingual, professional counselling to kids 24-hours a day. We receive calls from young people between the ages of five and 20 who call from almost 3,000 Canadian communities every year.

On the web, Kids Help Phone provides counselling to young people in the “Ask a Counsellor” section. Kids can also get help through our online “Help Yourself” services: reading questions from other kids in the “Ask a Counsellor” section and benefiting from the counsellors’ responses; visiting the “Express Yourself” section; and visiting the informational topic library.

Mind Your Mind

www.mindyourmind.ca

mindyourmind.ca is an award-winning site for youth, by youth. This is a place where you can get information, resources, and tools to help you manage stress, crisis, and mental health problems. Share what you live and what you know with your friends. That’s what we’re about.

For parents and educators

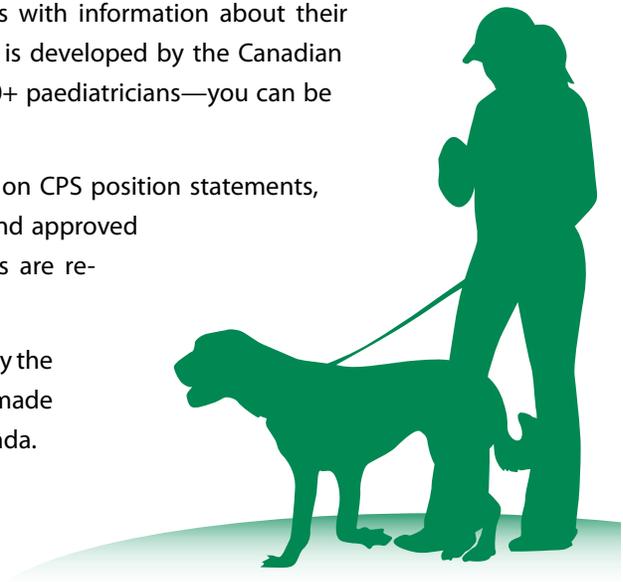
Caring for Kids

www.caringforkids.cps.ca

Caring for Kids is designed to provide parents with information about their child’s health and well-being. Because the site is developed by the Canadian Paediatric Society—the voice of Canada’s 2,000+ paediatricians—you can be sure the information is reliable.

Most documents on Caring for Kids are based on CPS position statements, which are created by our expert committees and approved by our Board of Directors. Position statements are reviewed each year to ensure they are up-to-date.

Other documents are developed and reviewed by the CPS Public Education Subcommittee, which is made up of practicing paediatricians from across Canada.



Centre of Knowledge on Healthy Child Development

www.knowledge.offordcentre.com

The Centre of Knowledge on Healthy Child Development gives readers access to important and up-to-date information that is based on the best scientific research currently available. It's designed to sift through all the conflicting information about what promotes, and what hinders, healthy child development so better choices that will result in better outcomes for children can be made by parents and professionals.

The Centre of Knowledge on Healthy Child Development was designed by the Offord Centre for Child Studies to focus on certain disorders, behaviour problems, and life circumstances that can have a significant impact on children's health and well-being.

Children's Mental Health Ontario

www.kidsmentalhealth.ca

Children's Mental Health Ontario (CMHO) works to improve the mental health and well-being of children and youth and their families.

We represent and support the providers of child and youth mental health treatment services throughout Ontario.

Our website includes links to member organizations who provide child and youth mental health services in Ontario, as well as useful information for parents and others interested in children's mental health.

eMentalHealth.ca

www.ementalhealth.ca

Looking for mental health help? Looking for mental health events like workshops and conferences? Looking for information about mental health topics like depression and anxiety? We'll help you find it...

eMentalHealth.ca is a non-profit initiative providing information about mental health services and resources to Canadians of all ages. We provide online anonymous, confidential information, 24 hours a day, 365 days a year.

We help families and professionals with the Where, When, and What of mental health:

- Where to go for local mental health help,
- When local mental health events are happening and
- What: information about various mental health topics and conditions.



The Provincial Centre of Excellence for Child and Youth Mental Health at CHEO, along with other leaders, is working towards an integrated system that truly meets the mental health care needs of children, youth, and their parents and caregivers.

The Centre:

- Facilitates and engages in partnerships, networks and collaboration.
- Funds new research and new research partnerships through a comprehensive grants and awards program.
- Provides consulting services to encourage more organizations to conduct research and to support their use of research to improve services.
- Fosters the development of the next generation of mental health professionals by targeting grants and awards to students at all levels and in relevant fields.
- Builds, synthesizes, and mobilizes credible child and youth mental health evidence.
- Generates opportunities for knowledge exchange to promote evidence-informed practice and community mobilization.
- Supports the critical role of youth engagement through partnerships, project funding, youth-specific grants and awards, and youth representation on its advisory committees.

Glossary of terms and abbreviations

Most of these terms don't appear in *Making a Difference: An Educators Guide to Child and Youth Mental Health Problems*, because we have tried to avoid the technical language that is often used by child and youth mental health professionals. This glossary is included to help you understand reports and discussions with mental health professionals.

Acquired Brain Injury (ABI)

A permanent brain injury that results in impairment to an individual's physical, cognitive (ability to think and reason), behavioural or emotional functioning. The injury may be caused by accident, infection, disease, overuse of alcohol, stroke, brain tumour or other medical illnesses.

Acquired brain injury is not a mental illness and requires very different specialist skills from those offered by mental health services. However, people with acquired brain injury can also suffer from a mental illness.

Activities of Daily Living (ADL)

Term referring to measures of independence in ability to perform personal care and other basic daily tasks; for example: eating, washing, dressing, getting in and out of bed, climbing stairs, etc. The assessment of the extent of a person's physical impairment or disability is often undertaken using scales based on these activities.

Acute Mental Illness

Acute mental illness is characterised by significant and distressing symptoms of a mental illness requiring immediate treatment. This may be the person's first experience of mental illness, a repeat episode or the worsening of symptoms of an often continuing mental illness. The onset is sudden or rapid, and the symptoms usually respond to treatment.

Acute Treatment

The intensive treatment provided to the person who is experiencing acute mental illness. Depending on the person's needs, acute treatment can be offered in the person's own environment or by a psychiatric inpatient service. Depending on the severity of symptoms, the distress involved for the person, and the risk of harm to self or others, acute treatment may be provided in the community by a crisis outreach and support team, by a community mental health centre or in a psychiatric inpatient service.

Advocate

An advocate is someone who helps people express their point of view in difficult situations where they might feel vulnerable or overwhelmed.

Affect

This word is used to describe observable behaviour that represents the expression of a subjectively experienced feeling state (emotion). Common examples of affect are sadness, fear, joy, and anger. The normal range of expressed affect varies considerably between different cultures and even within the same culture. Types of affect include: euthymic, irritable, constricted, blunted, flat, inappropriate, and labile.

Agitation/Agitated

Restless, repeated activity arising from a person's anxiety or frustration. For example, the person may be unable to stand or sit still, and may be noticeably upset. It is important to note that a side effect of antipsychotic medication is physical restlessness, usually first noticed as shaking in the arms and legs, which can mimic agitated behaviour.

Agoraphobia

Anxiety about being in places or situations in which escape might be difficult or embarrassing, or in which help may not be available should a panic attack occur. The fears typically relate to venturing into the open, of leaving the familiar setting of one's home, or of being in a crowd, standing in line, or travelling in a car or train. Although agoraphobia usually occurs as a part of panic disorder, agoraphobia without a history of panic disorder has been described.

Antidepressant Medication

Medication used for the treatment of depression.

Antipsychotic Medication

Medication for the treatment of psychoses such as schizophrenia. These drugs tend to reduce delusions and hallucinations, and have a calming effect.

Anxiety

The apprehensive anticipation of future danger or misfortune accompanied by a feeling of uncomfortable mood or somatic symptoms of tension. The focus of anticipated danger may be internal or external. Anxiety is often distinguished from fear in that fear is a more appropriate word to use when there exists threat or danger in the real world. Anxiety is reflective more of a threat that is not apparent or imminent in the real world, at least not to the experienced degree.

Anxiety Disorder

A mental disorder characterized by feelings of unease, tension, and distress, with an exaggerated fear of possible danger or misfortune, and often associated with significant disruption to a person's life, such as inability to hold down a job or use public transport. Examples of such disorders may include, phobias, panic attacks, and obsessive compulsive disorder.

Apathy

A lack of feeling, emotion, interest, or concern.

Asperger's Syndrome

Asperger's syndrome or Asperger disorder is an autism spectrum disorder that is characterized by significant difficulties in social interaction, along with restricted and repetitive patterns of behaviour and interests.

It differs from other autism spectrum disorders by its relative preservation of linguistic and cognitive development.

Attention

The ability to focus in a sustained manner on a particular stimulus or activity. A disturbance in attention may be manifested by easy distractibility, difficulty in finishing tasks or in concentrating on work.

Attention Deficit Hyperactivity Disorder (ADHD, ADD)

Attention Deficit Hyperactivity Disorder is a medical diagnosis disorder of executive functioning or the inability to plan ahead or consider consequences, which can affect the ability to concentrate and learn. It is characterized by impulsivity, inattention, and hyperactivity in various combinations.

Auditory hallucination

A hallucination involving the perception of sound, most commonly of voices.

Autism Spectrum Disorder (ASD)

Autism Spectrum Disorder (or Autism) is a spectrum of psychological conditions characterized by widespread abnormalities of social interactions and communication, as well as restricted interests and repetitive behaviours.

Bi-Polar Affective/Mood Disorder

Bipolar disorder or manic-depressive disorder, also referred to as bipolar affective disorder or manic depression, is a psychiatric diagnosis that describes a category of mood disorders defined by the presence of one or more episodes of abnormally elevated energy levels, cognition, and mood with or without one or more depressive episodes.

The elevated moods are clinically referred to as mania or, if milder, hypomania. Individuals who experience manic episodes also commonly experience depressive episodes, or symptoms, or a mixed state in which features of both mania and depression are present at the same time. These events are usually separated by periods of "normal" mood; but, in some individuals, depression and mania may rapidly alternate, which is known as rapid cycling.

Blunted affect

An affect type that represents significant reduction in the intensity of emotional expression.

Borderline Personality Disorder

A specific type of personality disorder which is characterised by a lifelong pattern of behaviour which may include unclear and disturbed self-image, brief psychotic episodes, involvement in intense, unstable relationships, repeated emotional crises, fear of abandonment, and a series of suicidal threats or acts of self-harm without apparent cause.

Case Management

Case management is a process which aims to ensure the client receives the best possible treatment and support through the identification of needs, planning individual goals and strategies, and linking to appropriate services to meet these needs.

Case Manager

A mental health professional employed by a mental health service who is primarily responsible for case management of a particular client. The client's case manager may be a social worker, psychiatric nurse, psychiatrist, occupational therapist, physician or psychologist.

Child and Adolescent Mental Health Services (CAMHS)

Specialist public mental health assessment and treatment services provided for children and adolescents up to 18 years of age. These are provided by community-based, multi-disciplinary services and psychiatric inpatient services.

Child and Youth Workers

Professionals who have received training in child and youth development and child and youth mental health problems, usually at a community-college. In Ontario, they may be members of the Ontario Association of Child and Youth Counsellors.

Cognitive

Pertaining to thoughts or thinking. Cognitive disorders are disorders of thinking; for example, schizophrenia.

Continuity of Care

Provision of mental health services to a client in a way that ensures care is continued when there is a change of service or case manager. An example is when a person leaves a psychiatric inpatient service and his/her care is transferred to the community mental health centre, or when the client moves to a new area.

Comorbidity

The simultaneous appearance of two or more illnesses, such as the co-occurrence of schizophrenia and substance abuse, or of alcohol dependence and depression. The association may reflect a causal relationship between one disorder and another, or an underlying vulnerability to both disorders. Also, the appearance of the illnesses may be unrelated to any common cause or vulnerability.

Compulsion

Repetitive ritualistic behaviour such as hand washing or ordering, or a mental act such as praying or repeating words silently that aims to prevent or reduce distress or prevent some dreaded event or situation. The person feels driven to perform such actions in response to an obsession or according to rules that must be applied rigidly, even though the behaviours are recognized to be excessive or unreasonable.

Concrete thinking

Thinking characterized by immediate experience, rather than abstractions. It may occur as a primary, developmental defect, or it may develop secondary to organic brain disease or schizophrenia.

Conduct Disorder (CD)

Conduct disorder is a mental illness marked by a pattern of repetitive behaviour wherein the rights of others or social norms are violated. Symptoms include, verbal and physical aggression, cruel behaviour toward people and pets, destructive behaviour, lying, truancy, vandalism, and stealing.

Cognitive Behavioural Therapy (CBT)

Cognitive behavioural therapy is a psychotherapeutic approach, a type of talking therapy that aims to solve problems concerning dysfunctional emotions, behaviours, and cognitions through a goal-oriented, systematic procedure. CBT is used in individual therapy as well as group settings, and the techniques are often adapted for self-help applications. CBT was primarily developed through a merging of behaviour therapy with cognitive therapy. While rooted in rather different theories, these two traditions found common ground in focusing on the “here and now”, and on alleviating symptoms.

Coping mechanisms

Ways of adjusting to environmental stress without altering one’s goals or purposes; includes both conscious and unconscious mechanisms.

Constricted affect

Affect type that represents mild reduction in the range and intensity of emotional expression.

Crisis Outreach and Support Team (COAST)

These services provide urgent assessment and short term intervention throughout the community to people in crisis due to a mental illness. Availability of these services varies in each community.

Cultural competency

The understanding of the social, linguistic, ethnic, and behavioural characteristics of a community or population, and the ability to translate systematically that knowledge into appropriate practices in the delivery of behavioural health services; assessment includes network providers’ policies and readiness to address the cultural needs of members

Delusions

Delusions are psychotic symptoms of particular types of mental illness, such as schizophrenia. They are firmly held beliefs which are not held by other members of the person’s social group. Those who experience delusions may offer bizarre explanations for experiences or circumstances. For example, they may believe they are being spied upon, followed, poisoned or that they possess great unrecognised talent.

Depression

A lowering of mood which includes feelings of sadness, despair, and discouragement, ranging from mild to severe, and is sustained over a period of time. Mild depression is an emotional state that many people experience during their life. Severe depression is a serious mental illness producing symptoms such as slowness of movement, loss of interest or pleasure in most activities, sleep and appetite changes, and agitation. People experiencing severe depression will have intense feelings of worthlessness and may experience delusions; for example, a person may believe they are the cause of the world’s problems. Severe depression can lead to suicidal ideas and actual suicidal actions.

Diagnosis

A medical term meaning the identification of symptoms which are consistent with a particular illness or disorder. Specific tests and a medical examination can sometimes prove that physical illness is present. Diagnosis of a mental illness, however, is based on interviews with the client and others who know them, and on clinical observations. In Ontario, a mental health diagnosis may only be made by a physician or psychologist.

Disinhibition

Freedom to act according to one’s inner drives or feelings, with less regard for restraints imposed by cultural norms; removal of an inhibitory, constraining, or limiting influence, as in the escape from higher cortical control in neurologic injury, or in uncontrolled firing of impulses, as when a drug interferes with the usual limiting or inhibiting action of GABA within the central nervous system.

Disorientation

A symptom of some illnesses which affects the person’s ability to know where he/she is, have some idea of time of day, date, and year, and remember familiar people.

Distractibility

The inability to maintain attention; that is, the shifting from one area or topic to another with minimal provocation, or attention being drawn too frequently to unimportant or irrelevant external stimuli.

Drug Induced Psychosis

A mental illness involving distorted or imaginary sensations caused by the one-off or repeated use of a drug (such as marijuana or amphetamines), or the use of a drug over a long period of time. The symptoms of a drug induced psychosis will usually appear quickly and can last for up to four weeks until the effects of the drug wear off.

Dysphoric mood

Dysphoria is an unpleasant or uncomfortable mood, such as sadness (depressed mood), anxiety, irritability, or restlessness. It is the opposite of euphoria.

Dysthymia

A mood disorder characterized by chronic mild depression.

Elevated mood

An exaggerated feeling of well-being, or euphoria or elation. A person with elevated mood may describe feeling “high,” “ecstatic,” “on top of the world,” or “up in the clouds.”

Epilepsy

A disorder of the brain characterised by periodic and temporary loss of consciousness with or without involuntary muscle movements (seizures). Epilepsy is not a mental illness, and requires very different specialist skills from those offered by mental health services. However, people with epilepsy can also suffer from a mental illness.

Euthymic

Mood in the “normal” range, which implies the absence of depressed or elevated mood.

Exceptional student

The Ontario Education Act defines an exceptional student as “a pupil whose behavioural, communicational, intellectual, physical or multiple exceptionalities are such that he or she is considered to need placement in a special education program...”. Students are identified according to the categories and definitions of exceptionalities provided by the Ministry of Education.

Expansive mood

Lack of restraint in expressing one’s feelings, frequently with an overvaluation of one’s significance or importance. Those affected may be irritable and easily annoyed or angered.

Extraversion

A state in which attention and energies are largely directed outward from the self as opposed to inward toward the self, as in introversion.

Fantasy

An imagined sequence of events or mental images (e.g. daydreams) that serves to express unconscious conflicts, to gratify unconscious wishes, or to prepare for anticipated future events.

Flashback

A recurrence of a memory, feeling, or perceptual experience from the past.

Flat affect

An affect type that indicates the absence of signs of affective expression.

Flight of ideas

A nearly continuous flow of accelerated speech with abrupt changes from topic to topic that are usually based on understandable associations, distracting stimuli, or plays on words. When severe, speech may be disorganized and incoherent.

Grandiose delusion

A delusion of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person.

Grandiosity

An inflated appraisal of one’s worth, power, knowledge, importance, or identity. When extreme, grandiosity may be of delusional proportions.

Hallucination

A sensory perception that has the compelling sense of reality of a true perception but that occurs without external stimulation of the relevant sensory organ. Hallucinations should be distinguished from illusions, in which an actual external stimulus is misperceived or misinterpreted. The person may or may not have insight into the fact that he or she is having a hallucination. One person with auditory hallucinations may recognize that he or she is having a false sensory experience, whereas another may be convinced that the source of the sensory experience has an independent physical reality. Transient hallucinatory experiences may occur in people without a mental disorder.

Inappropriate affect

An affect type that represents an unusual affective expression that does not match with the content of what is being said or thought.

Incoherence

Speech or thinking that is essentially incomprehensible to others because words or phrases are joined together without a logical or meaningful connection. This disturbance occurs within clauses, in contrast to derailment, in which the disturbance is between clauses. This has sometimes been referred to as “word salad” to convey the degree of linguistic disorganization. Mildly ungrammatical constructions or idiomatic usages characteristic of particular regional or cultural backgrounds, lack of education, or low intelligence should not be considered incoherence.

IEP (Individual Education Plan)

A written plan describing the special education program and/or services required by a particular student, based on a thorough assessment of the student’s strengths and needs. Every student who is deemed an exceptional student will have an Individualized Education Plan.

IPRC (Identification, Placement, and Review Committee)

In Ontario, the Education Act requires all school boards to setup Identification, Placement and Review committees. The purpose of the committee is to determine if a student should be identified as an exceptional pupil, and states the exceptionality and the appropriate special education placement that will best meet the student’s needs.

The Committee is composed of at least three people. One member will be either a supervisory officer or principal who acts as chairperson. Two or more members could include another principal, a vice-principal, a Learning Resource Teacher (LRT), a classroom teacher, or a Special Education Consultant. After the initial meeting, the identification and placement are reviewed by an IPRC at least once yearly.

Informed Consent

In the context of mental health, this means that the client provides permission for a specific exchange of information, assessment, or treatment to occur based on their understanding of the nature of the procedure, the risks involved, the consequences of withholding permission, and their knowledge of available alternative treatments.

Insomnia

A subjective complaint of difficulty falling or staying asleep or poor sleep quality.

Intake Assessment

The process which occurs when a person first becomes a client of a mental health service. The person will have an initial psychiatric assessment in order to determine the nature of their psychiatric problem, their treatment needs, and the most appropriate service required.

Integration of Services

Coordination and linkage between services to ensure clients receive continuity of care.

Intellectual Disability

People with intellectual disabilities have learning difficulties and develop at a slower than normal rate. The condition is usually identified at birth or in early childhood. Intellectual disability is not a mental illness and requires very different specialist skills from those offered by mental health services. However, people with intellectual disabilities can also experience a mental illness. Formerly called “mental retardation”.

Intellectualization

A mental mechanism in which the person engages in excessive abstract thinking to avoid confrontation with conflicts or disturbing feelings.

Intervention

A planned action taken by a mental health worker which occurs in the context of treatment. Examples are: counselling, intensive support, referral or prescribing medication.

Introversion

Preoccupation with oneself and accompanying reduction of interest in the outside world. Contrast to extraversion.

Involuntary Admission

Admission, without the person's consent, to a psychiatric inpatient service for the treatment of a severe mental illness. For an involuntary admission to occur, a person must meet all of the specific criteria set out in the Mental Health Act and be admitted under the procedures set out in the Act.

Learning Resource Teacher (LRT or SRT)

A special education teacher assigned to a school or schools to provide special education resource support.

Least Restrictive Environment/Setting

The principle of treating a client in the least restrictive environment/setting possible recognises that all clients of public mental health services should be treated in an environment and manner that respects each client's individual worth, dignity, and privacy, and enhances their personal autonomy.

Labile affect

An affect type that indicates abnormally sudden and rapid shifts in affect.

Long-term memory

The final phase of memory, in which information storage may last from hours to a lifetime.

Loosening of associations

A disturbance of thinking shown by speech in which ideas shift from one subject to another that is unrelated or minimally related to the first. Statements that lack a meaningful relationship may be juxtaposed, or speech may shift suddenly from one frame of reference

to another. The speaker gives no indication of being aware of the disconnectedness, contradictions, or illogicality of speech.

Major Depressive Disorder (MDD)

Major depressive disorder (MDD) (also known as recurrent depressive disorder, clinical depression, major depression, unipolar depression, or unipolar disorder) is a mental disorder characterized by an all-encompassing low mood accompanied by low self-esteem, and by loss of interest or pleasure in normally enjoyable activities. The term "depression" is ambiguous. It is often used to denote this syndrome, but may refer to other mood disorders or to lower mood states lacking clinical significance. Major depressive disorder is a disabling condition which adversely affects a person's family, work or school life, sleeping and eating habits, and general health.

Magical thinking

A conviction that thinking equates with doing. Occurs in dreams in children, in primitive peoples, and in patients under a variety of conditions. Characterized by lack of realistic relationship between cause and effect.

Manic Episode

A state of elevated mood which is out of keeping with a person's normal behaviour, and may vary from cheerfulness to almost uncontrollable excitement or irritation. It typically results in overactivity, rapid speech, decreased need for sleep, being easily distracted, and a loss of social inhibitions. A person may embark on extravagant schemes, spend money recklessly, become aggressive or flirtatious, or believe they possess extraordinary powers.

Medical Sedation

The prescribing and administration of medication that has a tranquilising, calming effect.

Memory consolidation

The physical and psychological changes that take place as the brain organizes and restructures information that may become a permanent part of memory.

Mental Health

Describes the capacity of an individual to interact with other people and with his or her environment in ways that promote the person's sense of well-being, enhance his or her personal development, and allow the person to achieve his or her life goals.

Mental Health Professional

Staff of mental health services with professional training and qualifications, and experience in working with clients who have a mental illness. Mental health professionals include: social workers, psychiatric nurses, child and youth workers, psychiatrists, occupational therapists, and psychologists.

Mental Illness

A mental disorder or mental illness is a psychological or behavioural pattern generally associated with subjective distress or disability that occurs in an individual, and which is not a part of normal development or culture. Such a disorder may consist of a combination of affective, behavioural, cognitive, and perceptual components.

Mental retardation

See Intellectual Disability

Middle insomnia

Awakening in the middle of the night followed by eventually falling back to sleep, but with difficulty.

Mood

A mood is a relatively long-lasting emotional state. Moods differ from emotions in that they are less specific, less intense, and less likely to be triggered by a particular stimulus or event. Common examples of mood include: depression, elation, anger, and anxiety. In contrast to affect, which refers to more fluctuating changes in emotional "weather," mood refers to a more pervasive and sustained emotional "climate." Types of mood include: dysphoric, elevated, euthymic, expansive, irritable.

Mood Disorder

Mood disorder is the term designating a group of diagnoses where a disturbance in the person's mood is hypothesized to be the main underlying feature.

Two groups of mood disorders are broadly recognized: there are depressive disorders, of which the best known and most researched is major depressive disorder (MDD), commonly called clinical depression or major depression, and bipolar disorder (BD), formerly known as manic depression, and characterized by intermittent episodes of mania or hypomania, usually interlaced with depressive episodes.

Multidisciplinary Team

Mental health professionals employed by a public mental health service who work together to provide treatment and care for people with mental illness. They include: social workers, psychiatric nurses, psychiatrists, child and youth workers, occupational therapists, and psychologists.

Nervous Breakdown

A lay term commonly used to describe an emotional disturbance or mental illness. This term is not used by mental health professionals.

Neuroleptics

This term is frequently used to refer to antipsychotic medication.

Neuroses/Neurotic Disorders

Mental disorders commonly associated with distressing symptoms of anxiety and depression. Neurotic disorders are different from psychotic disorders in that the person does not experience a loss of reality. Neuroses/Neurotic disorders has been largely replaced by more specific terms such as anxiety disorders and mood disorders.

Obsessive Compulsive Disorder (OCD)

A disorder in which the person may experience strong impulses to perform certain acts over and over again, even though they realise this is illogical. They are the result of recurrent and persistent thoughts and urges that cannot be easily controlled or ignored. This can cause great distress to the individual and interfere with their ability to perform life activities. For example, a person may continually wash their hands or check to see if the door is locked.

Obsession

Recurrent and persistent thought, impulse, or image experienced as intrusive and distressing. Recognized as being excessive and unreasonable even though it is the product of one's mind. This thought, impulse, or image cannot be expunged by logic or reasoning.

Occupational Therapists

Occupational therapists are health professionals who work in community mental health services and psychiatric inpatient services. They are part of the multidisciplinary team and their role is to help people to develop confidence and skills in daily living using a variety of techniques, such as creative therapies and training in practical tasks.

Oppositional Defiant Disorder (ODD)

Oppositional defiant disorder is a diagnosis described as an ongoing pattern of disobedient, hostile, and defiant behaviour toward authority figures which goes beyond the bounds of normal childhood behaviour. Those affected may appear very stubborn and angry. Common features of Oppositional Defiant Disorder (ODD) include excessive, often persistent, anger, frequent temper tantrums or angry outbursts, and disregard for authority.

Children and adolescents with this disorder often annoy others on purpose, blame others for their mistakes, and are easily annoyed. Parents often observe more rigid and defiant behaviours than in siblings. In addition, these young people may appear resentful of others, and when someone does something they don't like, they often take revenge on them.

Panic attacks

Discrete periods of sudden onset of intense apprehension, fearfulness, or terror, often associated with feelings of impending doom. During these attacks there are symptoms such as: shortness of breath or smothering sensations; palpitations, pounding heart, or accelerated heart rate; chest pain or discomfort; choking; and fear of going crazy or losing control.

Panic attacks may be unexpected (uncued), in which the onset of the attack is not associated with a situational trigger and instead occurs "out of the blue"; situationally bound, in which the panic attack almost

invariably occurs immediately on exposure to, or in anticipation of, a situational trigger ("cue"); and situationally predisposed, in which the panic attack is more likely to occur on exposure to a situational trigger but is not invariably associated with it.

Paranoia/Paranoid State

In common use, this term means suspicion or mistrust of others. Mental health professionals use the term paranoia to describe persecutory ideas held by a person which are not quite as intense as delusions. For example, a person may believe someone close to them is poisoning their food.

Persecutory delusion

A delusion in which the central theme is that one (or someone to whom one is close) is being attacked, harassed, cheated, persecuted, or conspired against.

Perseveration

Tendency to emit the same verbal or motor response again and again to varied stimuli.

Personality Disorder

A group of disorders characterised by patterns of disruptive and dysfunctional behaviour well-established by early adulthood, and continuing throughout a person's life. The person with a personality disorder typically has marked problems and frequent crises in personal and social relationships, including threatened or actual selfinjury. People with this disorder often have a history of inadequate or abusive parenting. See also: borderline personality disorder; severe personality disorder.

Phobia

A persistent and unreasonable fear of specific places, events or objects which leads to avoidance of that situation and significantly impacts upon a person's life; for example: fear of crowds, public places, public speaking, insects or blood.

Pressured speech

Speech that is increased in amount, accelerated, and difficult or impossible to interrupt. Usually, it is also loud and emphatic. Frequently, the person talks without any social stimulation and may continue to talk even though no one is listening.

Prevalence

Frequency of a disorder, used particularly in epidemiology to denote the total number of cases existing within a unit of population at a given time or over a specified period.

Prodrome

An early or premonitory sign or symptom of a disorder.

Prognosis

The predicted course of a person's mental illness or their interpersonal, emotional or social functioning, based on specialised psychiatric knowledge, assessment of the client's current mental state, and an understanding of his/her personal circumstances and environment.

Psychiatric Assessment

A thorough assessment of a client by a mental health professional which includes identifying a person's current mental state, personal and social history, social situation, and any relevant past psychiatric history. The psychiatric assessment enables selection of the most appropriate form of treatment for the client. See also, intake assessment.

Psychiatric Crisis

Psychiatric crisis describes the situation in which a person with a mental illness or severe mental disorder experiences thoughts, feelings or behaviours which cause severe distress to him/her and those around him/her requiring immediate psychiatric treatment to assess and manage risk and alleviate distress. The acute stage of a mental illness is characterised by infrequent yet severely distressing symptoms that require immediate treatment. This may be the person's first experience of mental illness, a repeat episode or the worsening of symptoms of an often continuing mental illness.

Psychiatric Disability

The effects of mental illness that severely impair functioning in different aspects of a person's life, such as the ability to live independently, maintain friendships or maintain employment.

Psychiatric Inpatient Admission

A voluntary or involuntary hospital admission for the treatment and management of a person who has a severe mental illness.

Psychiatric Inpatient Service

Publicly funded psychiatric hospitals and psychiatric units of general hospitals able to admit involuntary and security patient, as well as voluntary patients.

Psychiatric Nurse

A psychiatric nurse is a registered nurse who specialises in the nursing care and treatment of people with mental illness. Psychiatric nurses work in community mental health services and psychiatric inpatient services. Their role includes: administration of medication, counselling, and long-term support, and may involve psychological therapies.

Psychiatrist

A psychiatrist is a physician who specializes in the diagnosis and treatment of mental disorders. All psychiatrists are trained in diagnostic evaluation and in psychotherapy. Some psychiatrists receive additional training to specialize in child and adolescent psychiatry.

Psychologist

A psychologist is a professional designation identifying persons with advanced training in psychology. They may be clinical psychologists who work with patients in a variety of therapeutic contexts. They may also be scientists conducting psychological research or teaching psychology in a college or university. In Canada, they must be registered with their Provincial Psychological Association.

Psychomotor agitation

Excessive motor activity associated with a feeling of inner tension. When severe, agitation may involve shouting and loud complaining. The activity is usually nonproductive and repetitious, and consists of such behaviour as pacing, wringing of hands, and inability to sit still.

Psychomotor retardation

Visible generalized slowing of movements and speech.

Psychosocial Assessment

An assessment procedure that is used to identify a person's abilities and difficulties in his/her personal, domestic and social functioning, and that assists in the development of his/her individual service plan.

Psychosocial Rehabilitation

A range of interventions aimed at improving a client's personal, domestic, and social functioning, so that they can live independently in the community.

Psychotic

A term used to describe a condition in which a person is unable to tell what is real from what is imagined, as occurs with the experience of hallucinations or delusions. The condition may also include features of thought disorder, disorientation or confusion.

Psychotropic medication

Medication that affects thought processes or feeling states.

Schizophrenia/Schizophrenic Disorder

A group of mental illnesses of which the essential and most obvious features is the presence of psychotic symptoms during the active phase of the illness. There may also be a loss in the person's ability to perform some life tasks, such as relating to others, maintaining employment, and domestic duties.

Separation anxiety disorder

A disorder with onset before the age of 18 consisting of inappropriate anxiety concerning separation from home or from persons to whom the child is attached. Symptoms may include: unrealistic concern about harm befalling or loss of a major attachment figure; refusal to go to school (school phobia) in order to stay at home and maintain contact with this figure; refusal to go to sleep unless close to this person; clinging; nightmares about the theme of separation; and development of physical symptoms or mood changes (apathy, depression) when separation occurs or is anticipated.

Severe Mental Illness

A mental illness in which a person's ability to think, communicate, and behave appropriately is so impaired that it interferes with the person's ability to deal with ordinary demands of life. Without effective treatment and support, the outcome for the person may be significant impairment, disability, and/or disadvantage.

Severe Personality Disorder

A term frequently used to describe a serious form of personality disorder. See also: borderline personality disorder.

Social Workers

Social workers are health professionals who have a qualification in social work and may have specialised in mental health. They form part of the multidisciplinary team and typical functions include: counselling, advocacy, family work, and social and community development. Social workers in Ontario must be registered with their Provincial College.

Stereotyped movements

Repetitive, seemingly driven, and nonfunctional motor behaviour (e.g. hand shaking or waving, body rocking, head banging, mouthing of objects, self-biting, picking at skin or body orifices, hitting one's own body).

Substance Related Disorders

Changes to a person's physical health and behaviour associated with the overuse of alcohol or drugs. For example, there may be an inability to perform their job or household duties, problems in personal and social relationships, and faulty memory. There may also be frequent legal problems, such as drunk driving or disorderly conduct.

Substance related disorder is not a mental illness and requires very different specialist skills from those offered by mental health services. However, people with a substance related disorder often also suffer from a mental illness, and others with longstanding substance abuse can develop symptoms of a mental illness.

Suicidal

A person is regarded as suicidal when they have given strong indications or have intentions of taking their own life.

Symptom

Changes in a person's mind or body that indicate they may be suffering from a particular illness. Symptoms are reported by the affected individual rather than observed by the examiner.

Syndrome

A grouping of signs and symptoms, based on their frequent co-occurrence, that may suggest a common underlying pathogenesis, course, familial pattern, or treatment selection.

Tactile hallucination

A hallucination involving the perception of being touched or of something being under one's skin. The most common tactile hallucinations are the sensation of electric shocks and formication (the sensation of something creeping or crawling on or under the skin).

Temperament

An individual's constitutional predisposition to react in a particular way to stimuli.

Tic

An involuntary, sudden, rapid, recurrent, nonrhythmic, stereotyped motor movement or vocalization.

Thought Disorder

A symptom most often seen in schizophrenia and other psychoses. It describes a disturbance in a person's thought patterns and is usually shown in abnormal speech. For example, a person may jump from topic to topic in conversation, their answers may be quite unrelated to a question or they may use strikingly unusual words or phrases.

Treatment

The use of professional knowledge and skill to bring about an improvement in a person's mental illness or to lessen the ill effects of a mental illness, and the distress and suffering that may accompany it.

Trichotillomania

The pulling out of one's own hair to the point that it is noticeable and causing significant distress or impairment.

Visual hallucination

A hallucination involving sight, which may consist of formed images, such as of people, or of unformed images, such as flashes of light. Visual hallucinations should be distinguished from illusions, which are misperceptions of real external stimuli.

Voluntary Admission

A voluntary patient who consents to treatment from a psychiatric inpatient service and is accepted for treatment with the approval of the authorised psychiatrist or other health care professional.

Developed with thanks to:

www.wikipedia.org/

www.abess.com/glossary.html

www.health.vic.gov.au/mentalhealth/terminology.htm

Feedback Form

This guide is designed to be changed and updated regularly. We welcome your suggestions and ideas for improving the guide and for making it more useful to educators. Most revisions are made during July and August, with new editions released in early September. You may e-mail your comments or fill out this form and mail your comments to:

Don Buchanan
Patterson Building - CH
Offord Centre for Child Studies
1280 Main St. West
Hamilton, ON L8S 4K1
e-mail: buchanan@hhsc.ca

1. What is your role in using this guide?

- Educator in the classroom
- Mental health professional working in schools
- Trainer of educators or mental health workers
- Other _____

2. Have you used this guide in your work?

- Yes
- No

3. What parts of the guide are most useful?

4. What parts of the guide could be improved?

5. Are there additional resources that would help you use the guide in your work? If so, what are they?

