Supporting Minds

An Educator's Guide to Promoting Students' Mental Health and Well-being

Draft Version | 2013

support every child
reach every student

Ontario

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Une publication équivalente est disponible en français sous le titre suivant : *Vers un juste équilibre : Guide à l'intention du personnel scolaire pour promouvoir la santé mentale et le bien-être des élèves, 2013. Version provisoire.*

This publication is available on the Ministry of Education's website, at www.ontario.ca/edu.

Preface

In June 2011, the Ontario government released the document *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy,* which outlined a comprehensive strategy for addressing mental health and addiction problems. The aim of the strategy is to "reduce the burden of mental illness and addictions by ensuring that all Ontarians have timely access to an integrated system of excellent, coordinated and efficient promotion, prevention, early intervention, community support and treatment programs" (Ontario, Ministry of Health and Long-term Care, 2011, p. 7).

The focus for the first three years of the strategy is on children and youth, with supports targeting three key areas: fast access to high-quality services, early identification and support, and help for vulnerable children and youth with unique needs (see Appendix A). Because schools and school boards play an important role in promoting awareness, prevention, and early intervention, and in connecting students to community services, the strategy explicitly recognizes the need to build school-based capacity in this area.

The present document, *Supporting Minds,* was created in response to this need. It was developed on the basis of a comprehensive survey of current research as well as consultation with experts and practitioners in the field, It provides educators with the information they need to support students with mental health and addiction problems through early recognition and effective classroom strategies.

By offering strategies to assist some of our most vulnerable students, this guide reinforces the three core priorities for education in Ontario:

- high levels of student achievement
- reduced gaps in student achievement
- increased public confidence in publicly funded education

Supporting Minds is intended to complement, rather than supersede, school board initiatives related to promoting student mental health and well-being.

Part One

Introduction

Basic Facts about Childhood Mental Health Problems

- Approximately 20 per cent (one in five) of children and youth have a mental health problem (Waddell et al., 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.

Source: Adapted from CYMHIN-MAD, 2011

Mental health problems have a variety of causes and take a variety of forms. Their treatment may involve several types of intervention and support, which need to be delivered in an integrated and carefully coordinated way. The form of the response will be guided primarily by the insights and expertise of mental health professionals. However, because educators play an important role in the lives of most children and youth, they need to be aware of mental health issues that may affect students and understand how to contribute to a multifaceted response.

The Role of *Supporting Minds*

Concern is growing in our society about the number of children and youth who are experiencing mental health problems. At the same time, our education system in Ontario is focused on making schools safe and accepting, and on meeting the needs of *all* students by providing the kind of instruction and assessment that is "necessary for some and good for all".[1]

Every day, educators see students who are struggling – students who engage in challenging behaviour and act out, or who are withdrawn and anxious. Such behaviour may signal problems that can interfere with students' achievement at school and their social functioning. **While educators cannot and should not attempt to diagnose mental health problems, they have an important role in:**

- **promoting positive mental health at school;**
- **identifying students who may have mental health problems; and**
- **connecting those students with appropriate services.**

This resource guide is designed to help educators understand more about mental health in order to promote the mental health of all students. It provides information to help educators recognize students who may be experiencing distress and support them in their pathway to care. The guide discusses the role of educators in recognizing students who may be at risk of developing mental health problems and outlines ways in which educators can promote the mental health and well-being of all students. It offers suggestions for talking about mental health with parents[2] and students. It also provides information about the types of mental health problems children and youth may experience, including the signs, symptoms, causes, and frequency of different types of problems and their potential impact on student learning. Most importantly, it offers strategies for enhancing students' ability to function at school both academically and socially.

> "Removing the stigma around mental health and allowing for meaningful conversation about it between students and school officials could be the difference between life and death, between a successful adolescent and one who falls behind."
>
> *A school leader*

Guiding Principles

Supporting Minds was created as part of the Ontario government's comprehensive mental health and addictions strategy for the province, set out in the document *Open Minds, Healthy Minds* (2011). The following guiding principles have shaped the development of both documents:

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1. See the Ministry of Ontario's resource guide *Learning for All: A Guide to Effective Assessment and Instruction for All Students, Kindergarten to Grade 12* (Draft Version, 2011), available at http://www.edu.gov.on.ca/eng/general/elemsec/speced/learning.html.
2. The word *parent(s)* is used in this guide to refer to parent(s) and guardian(s). It may also be taken to include caregivers or close family members who are responsible for raising the child.

"Grade 7 was a difficult year. My anxiety had become worse. I was sad and felt like I didn't fit in, and missed a lot of school. This was the first time I went to see a doctor about it. My family and teachers were very supportive. By the end of the year, I was able to enjoy our class trip to a sports camp. While there, I recognized my gift and passion for sports and felt I had found myself through them."

An anonymous youth

Respect and understanding. People with lived experience of mental illness and/or addiction are valued members of their communities. They deserve to be treated with dignity and respect. It is important for communities and providers of services to work together to eliminate stigma and discrimination.

Healthy development, hope, and recovery. Individuals are resilient and have an inherent sense of hope for the future. Service providers will reinforce the personal strengths of children and youth to help them develop a sense of safety, self-worth, and mastery over their future, and to help adults achieve personal fulfilment, meaningful social roles, and positive relationships within the community.

Person-directed services. People with lived experience of mental illness or addiction, and their families, bring strength, wisdom, and resilience to their care plan. They must have a voice as essential partners in system design, policy development, and the provision of programs and services, as well as the opportunity to make informed decisions about their personal care and support.

Diversity, equity, and social justice. Individuals of all ages and at all stages of life must be offered culturally relevant services that meet their needs. They need equitable access to those services as well as opportunities to participate in their communities free from stigma. Ontario is working to eliminate the individual and social injustices that contribute to mental illness and addiction.

Excellence and innovation. Ontario is committed to continuous improvement in providing high-quality care that is tailored to individual needs, and that is timely, accessible, effective, collaborative, and safe. Service providers strive for excellence and encourage best practices and innovation.

Accountability. Ontario will build on effective mental health and addiction-treatment programs and services using the best available evidence from lived experience, practice, and research. The services provided must improve the quality of life for recipients in a sustainable way. Providers should be held accountable for the quality of the care they provide, and should continually monitor results.

(Ontario, Ministry of Health and Long-term Care 2011, p. 9)

How to Use *Supporting Minds*

It is important to recognize that a guide like *Supporting Minds* is only one among a variety of resources available to school boards to enhance the capacity of school

leaders and staff to support positive mental health among students. Because this is such a complex topic, capacity-building efforts will ideally include a range of evidence-based information.

Numerous resources that focus on mental health literacy are available to educators. However, these resources need to be carefully evaluated to determine their reliability and relevance to classroom practice and to assess how well their ideas align with existing directions in professional development.

Making curriculum connections where appropriate provides relevant opportunities to build capacity among students to promote their own and their peers' mental health. Students have opportunities to learn about different aspects of mental health and emotional well-being through the Ontario curriculum, from Kindergarten to Grade 12, in a range of programs, subjects, and courses (see Appendix A).

Supporting Minds is presented in two parts. **Part One** provides an overview of mental health and addiction problems and guidance about the role of educators in supporting students' mental health and well-being. **Part Two** contains eight sections, each dedicated to a particular mental health problem. Each section is structured to first provide educators the information they need to recognize mental health problems in their students and offer appropriate support (under such headings as "What Is Depression?", "What Do Symptoms of Depression Look Like?", and "What Can Educators Do?"). Background information about the particular type of mental health problem is given towards the end of each section. Hyperlinks to resources that provide more detailed information are included throughout.

To make best use of this guide, schools and/or boards may find it helpful to:

- arrange for an overview presentation by a school administrator and/or a mental health professional;[3]
- arrange for a follow-up presentation on sections of particular interest to the school (perhaps with guest speakers).

3. The term "mental health professional" refers to a broad category of health care practitioners, including (but not limited to) psychiatrists, clinical psychologists, clinical social workers, psychiatric nurses, and mental health counsellors. Practitioners must have documentation from an educational institution accredited in their field, showing that they have met the requirements of their discipline.

Understanding Child and Youth Mental Health and Addiction Problems

Overview of Child and Youth Mental Health and Addiction Problems

Classification

Children and youth can display a range of behavioural and emotional problems that may have a negative impact on their well-being and interfere with their functioning at school, at home, in the community, and in social settings. Things like academic achievement and relationships with family and friends may be affected. The range of behavioural and emotional problems experienced may place students at risk for the development of clinical mental health disorders and may also increase students' risk of developing physical illnesses such as diabetes and heart disease. Sometimes, these children and youth are also at increased risk for suicide (Gould et al., 2003; Weissman et al., 1999).

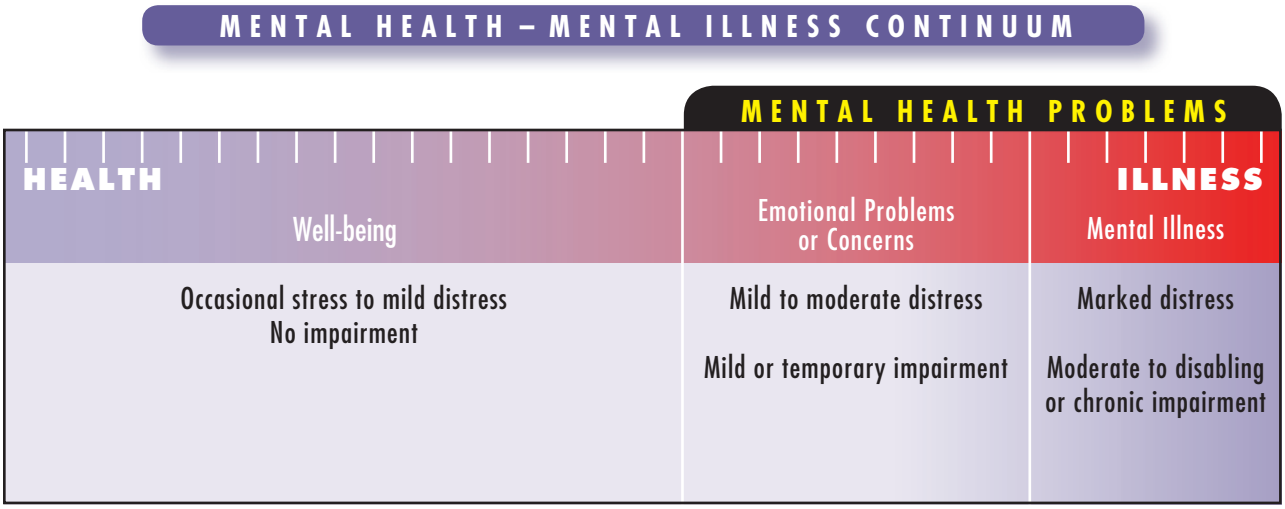
For the most part, child and youth mental health problems can be classified into two broad categories: *internalizing problems*, which include symptoms like withdrawal, anxiety, fearfulness, and depressed moods; and *externalizing problems*, which are characterized by such behaviours as aggression, defiance, rule-breaking, and destructive behaviour (Achenbach, 1991). In Canada, appropriate use of the diagnostic criteria requires a substantial degree of training; diagnostic assessments should be undertaken only by those registered to complete the controlled act of diagnosis. In Ontario, the Regulated Health Professions Act (RSO, 1991) dictates that only regulated health professionals such as physicians (e.g., psychiatrists, family physicians) and psychologists can provide a diagnosis. Currently, the *Diagnostic and Statistical Manual of Mental Disorders* (version DSM-IV-TR) is used to classify and diagnose disorders (APA, 2000). A revised version of this manual (DSM-V) is anticipated in spring 2013.

Continuum of Severity

Mental health exists on a continuum. The mental health and addiction problems that children and youth may experience can range from mild to serious. For instance, most students feel somewhat anxious or nervous when they face a test, while a few may have extreme and debilitating anxiety about any situation

in which they are being evaluated or tested. Early recognition of signs and symptoms of emotional and behavioural problems is important, as these may present a real risk for the development of a clinical disorder, and intervening early can reduce this risk. Early steps to address even mild symptoms can prevent the escalation of problems. Professional attention may be indicated when a child or adolescent experiences difficulty that is ongoing for more than a couple of weeks and that seems to interfere with the student's daily life activities.

The following diagram illustrates this continuum. Students may experience different aspects of the continuum throughout their academic lives.



Source: MHealthy – University of Michigan Health & Well-Being Services, "Understanding U: Managing the Ups and Downs of Life – What Is Mental Health?", 2012. **http://hr.umich.edu/mhealthy/programs/mental_emotional/understandingu/learn/mental_health.html.**

Co-morbidity

Children and youth may show signs of having several problems in combination. Many disorders show a strong tendency to co-morbidity – that is, they frequently occur together. For example, anxiety disorders and major depressive disorder often coexist in older children and adolescents; and children with oppositional defiant disorder (ODD) often also exhibit symptoms of attention-deficit hyper-activity disorder (ADHD). Mental health problems and substance use problems also frequently co-occur. It is estimated that 50 per cent of children experiencing a mental health disorder have two or more disorders at the same time (Waddell et al., 2002).

Co-morbidity of different emotional and behavioural problems varies with the age and developmental stage of the child or adolescent. When children and youth experience multiple problems or more than one disorder, they are more vulnerable, and treatment becomes more complicated. This underscores the

importance of identifying children and youth with early signs of a mental health problem – those with mild symptoms that signal a higher risk – prior to the emergence of more severe symptoms and complex problems.

How Common Are Mental Health Problems?

Most estimates suggest that 15 to 20 per cent of children and youth struggle with a mental health problem. This could mean that in a classroom of thirty students, five or six students may be experiencing a mental health problem, and three or four of them may have a problem that significantly interferes with their daily life.

Estimates based on research have shown that the most common problems among children and youth, from most to least frequent, are anxiety problems, behaviour problems (including ADHD and conduct disorder), mood problems (e.g., depressive disorders), and substance use problems (Merikangas et al., 2009; Boyle et al., 1987; Offord et al., 1987; Offord et al., 1989; Offord et al., 1992; Waddell et al., 2002, for a review of findings). There are also genuine cultural differences in the rates of mental health disorders seen in children and youth around the world. Evidence from research has generally shown that rates of mood and anxiety disorders are higher in girls, while rates of behaviour disorders are higher in boys. Boys and girls show equal rates of substance use disorders (Merikangas et al., 2009).

Causes of Problems

Research indicates that multiple genetic and environmental factors, interacting over time, lead to the development and persistence of child and youth mental health and addiction problems (Merikangas et al., 2009).

From a biological/genetic perspective, such things as problems in the brain's early development, genetic influences, chemical imbalances, and brain trauma may all contribute to problems. Other possible contributing factors or triggers include characteristics related to the child, his/her family and parents, and contextual influences such as the neighbourhood. Examples include cognitive and psychological disturbances, prenatal and postnatal challenges, severe life stress, problematic relations with peers, conflicts within the family, alcohol and drug use, and parent and family characteristics such as a family history of mental illness (see Merikangas et al., 2009, for a review of findings).

Regardless of the immediate trigger, mental health and addiction problems are usually sustained by a variety of environmental factors, which may include early experiences and/or stresses closer in time to the onset of a problem. Such things as age, gender, and stage of development may also influence the way in which mental health problems present themselves.

It is important to note that certain populations are at greater risk of developing mental health problems because of the circumstances they experience. Ontario's educators share a belief in the need to achieve an equitable and inclusive school climate and strive to ensure that all students feel safe, comfortable, and accepted (see p. 17 in this guide). However, some groups of students, such as recent immigrants, children from low-income families, Aboriginal students, and students with special education needs may be at heightened risk. To safeguard these students' chances of long-term success, both academically and personally, educators need to be mindful of the types of challenges they face.

Observing Signs and Symptoms of Problems

As was previously noted, in Ontario the only professionals who are qualified to diagnose mental health problems are physicians (including psychiatrists) and psychologists. School boards may have mental health professionals on staff who can diagnose, but many communities require a referral to children and youth mental health services. In Ontario, these services are funded by the Ministry of Health and Long-Term Care and the Ministry of Children and Youth Services, and are delivered by a variety of independent organizations. Many of these organizations are members of Children's Mental Health Ontario, which maintains a listing by geographic area on its website, at **http://www.kidsmentalhealth.ca/**.

Educators have an important *supporting* role in the diagnostic process, as they can observe aspects of a student's behaviour in the school setting that may not be evident to the parent or the mental health professional. These observations can help to provide a profile of how a child is functioning. The present document provides a list of signs and symptoms of common categories of student mental health and addiction problems that might be observed in the classroom. It is important to remember, however, that mental health problems in students are often complex and overlapping. Many types of behaviour or symptoms that educators observe in the classroom may be associated with a variety of mental health problems or disorders that can co-occur. For example, a child who has difficulty concentrating and who is tired, irritable, and has sleep problems may have major depressive disorder or general anxiety disorder or subclinical problems (symptoms associated with depression or anxiety but that do not meet the criteria for a diagnosis). Thus, similar symptoms may come from different causes and signal different needs (Garber & Weersing, 2010).

For this reason, observers need to avoid jumping to conclusions either about whether a student has a mental health disorder or about the type of disorder. Rather, they should record their observations as objectively as possible and attempt to determine if the symptoms appear to be interfering with the student's functioning. It is best to share these observations with the parent(s)

and/or guardian and/or the school support team or principal, as appropriate (see the boxed insert, below).

Privacy Considerations

Issues of privacy and access to personal information are paramount in matters concerning the mental health of students. School boards and Provincial Schools in Ontario operate within a legal environment in which various pieces of legislation govern decision making about access and privacy, including:

- the Freedom of Information and Protection of Privacy Act (FIPPA), available at http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90f31_e.htm
- the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA), available at http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90m56_e.htm
- the Personal Health Information Protection Act (PHIPA), available at http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_04p03_e.htm
- the Education Act, available at http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90e02_e.htm

Boards and Provincial Schools have policies and procedures in place that are informed by access and privacy legislation. In addition, board legal counsel and/or Freedom of Information Coordinators can provide assistance in matters relating to protection of privacy and access to information.

The following publications provide information about access and privacy legislation in the context of education:

- Information and Privacy Commissioner of Ontario, *A Guide to Ontario Legislation Covering the Release of Students' Personal Information* (2011), available at http://www.ipc.on.ca/images/Resources/educate-e.pdf
- Information and Privacy Commissioner of Ontario and Office of the Information and Privacy Commissioner for British Columbia, *Practice Tool for Exercising Discretion: Emergency Disclosure of Personal Information by Universities, Colleges and Other Educational Institutions* (2008), available at http://www.ipc.on.ca/images/Resources/ipc-bc-disclosure-edu_826594762500.pdf

When emotional or behavioural problems significantly interfere with a student's ability to function socially, academically, at home, or in the community, the student may need further support.

To help understand the behaviour or symptoms a student is displaying, it is important to understand child and adolescent development and what is typical behaviour across developmental stages and ages. A resource such as *The ABCs*

of Mental Health, prepared by the Hincks-Dellcrest Centre, includes information about typical development of children and youth (**http://www.hincksdellcrest.org/ABC/Welcome**).

Supporting Students Who Are Receiving Treatment

Treatments or interventions are intended to target the factors that are causing and maintaining particular symptoms and behaviour and preventing the child or adolescent from functioning in different areas of his or her life. Some of the goals of treatment are to reduce the severity of symptoms and distress and improve the student's ability to function in areas of daily living. Common treatments typically include the use of psychosocial interventions (such as cognitive-behavioural therapy), psychotherapy, and/or medication, singly or in combination. When a student is receiving treatment for a diagnosed mental disorder, educators need to work closely with the student's parents and with mental health professionals (if applicable) in order to understand how the treatment(s) being provided may affect the student's functioning at school and determine how educators and the school can best support the student.

Strategies/treatments are most effective when the student, the parent(s)/guardian, mental health professionals, and the school team work together to solve a problem, using similar approaches.

Educational Implications for Students

Students with mental health problems may have difficulty maintaining regular progress at school. Students with severe mental disorders often struggle academically and may need educational supports guided by an individualized education plan (IEP). Plans should include provision of supports to help students develop the social skills, self-awareness, self-control, and self-esteem they need to succeed academically. These skills are important to all students, but students with mental health problems often have difficulty developing them at the same pace as other students. As well, students with developmental, physical, or learning problems often need special support and remediation to enable them to build social and interpersonal skills.

Considerations Related to Immigrant and Refugee Children and Youth

Children and youth living in immigrant and refugee families represent the fastest-growing segment of the Canadian population (Statistics Canada, 2007).

In the thirty-five years between 1971 and 2006, the percentage of youth reared in immigrant families grew from 24 per cent to 34 per cent (Statistics Canada, 2006). Whereas the majority of immigrants previously came from Europe, the majority now come from Asia and the Middle East, resulting in a fourfold increase in the population of visible minority students since the early nineteen-nineties and a growing proportion of immigrants who speak a language other than English or French at home (Statistics Canada, 2007).

Stressful experiences arising from migration and resettlement may compromise the ability of immigrant children and youth to achieve and maintain optimal psychological functioning and well-being. Particular subgroups of immigrant children and youth, such as refugees, English language learners (ELLs), and recent immigrants, may represent vulnerable groups for experiencing mental health problems because of their disproportionate exposure to multiple risk factors. These factors may include family and neighbourhood poverty, parental unemployment, discrimination and social exclusion, exposure to violence and trauma, and prolonged separation from family members.

Supporting the Mental Health of Immigrant and Refugee Students

At present, very little is known about how extensively mental health services are used by immigrant and refugee children living in Canada. For a variety of reasons, immigrant families may be reluctant to seek services for their children. A lack, or perceived lack, of culturally sensitive mental health professionals is one possible deterrent. Others are: unfamiliarity with our systems for providing mental health services; and the stigma associated with treatment. In such cases, school-based supports for these children and youth may be particularly helpful.

Culture plays a very important role in how students may show signs of mental health difficulties and how they label these difficulties and communicate with others about them. Because of the influence of different cultural values and norms, students may not demonstrate the signs and symptoms identified for the various mental health problems exactly as described in this guide.

In particular, while fear of stigma affects all students, it may be more pronounced among specific ethnic and cultural groups. For this reason, it is especially important to foster a school environment that respects and values diversity, while ensuring that accurate information about mental health is provided to students and their parents. It is important for schools and communities to develop their "cultural competence" in order to meet the mental health needs of students and parents from diverse immigrant, ethnic, and linguistic backgrounds (see sidebar).

Cultural competence is acceptance of and respect for difference, developed through continuous self-assessment regarding culture, an attention to the dynamics of difference, the ongoing enlargement of cultural knowledge, and the willingness to adapt resources and procedures within service models to meet the needs of minority populations.

(Saldaña, 2001)

The Role of Educators in Supporting Students' Mental Health and Well-being

Creating a Positive Classroom Environment

Just as good physical health is more than the absence of disease, good mental health is much more than the absence of mental illness. Mental health exists on a continuum and can be enhanced through positive relationships with supportive friends, congenial social opportunities, involvement in meaningful activities, and the effective management of stress and conflict. Although healthy eating, physical activity, and getting adequate sleep don't guarantee good health, without them good health is hard to achieve. Similarly, friends, activities, and the ability to manage one's emotions won't guarantee good mental health but can contribute to it. Since children and youth spend more than six hours a day and more than 190 days a year in school, what happens at school can have a significant influence on a student's well-being. Schools can be key players in promoting the mental health, resilience, and overall healthy development of students.

> "School is a place where students go to learn and to grow as an individual, and it is important for them to know that there are resources available to them if they are struggling with their mental health."
>
> *An anonymous youth*

According to the Joint Consortium for School Health, positive mental health correlates with healthy development (JCSH, 2010). The promotion of positive mental health and healthy development is associated with:

- identification and effective management of emotions;
- promotion of normal and healthy child and adolescent development;
- exploration and use of children and youth's strengths and capacities;
- development of meaningful family, school, and community relationships;
- enhancement of positive coping and problem-solving skills;
- creation of meaningful and positive learning environments;
- increased participation in structured community recreational and leisure activities;
- enhanced respect and appreciation for diversity and individual differences;
- increased understanding and de-stigmatization of mental health conditions;
- enhanced opportunities for children and youth to demonstrate age-appropriate autonomy and choice;
- heightened sensitivity to the needs of others and demonstration of pro-social behaviours;
- increased involvement in structured and unstructured physical activities;
- reduction in high-risk behaviours (e.g., drug use);
- enhanced academic achievement and school attendance;

"The *school climate* may be defined as the learning environment and relationships found within a school and school community. A positive school climate exists when all members of the school community feel safe, included, and accepted, and actively promote positive behaviours and interactions. Principles of equity and inclusive education are embedded in the learning environment to support a positive school climate and a culture of mutual respect. A positive school climate is a crucial component of the prevention of inappropriate behaviour."

(Ontario, Ministry of Education, 2012, p. 2)

"Students learn best in an environment that is physically and emotionally safe."

(Ontario, Ministry of Education 2010, p. 6)

- decreased oppositional behaviour;
- increased academic confidence and engagement.

It is widely known that a safe, healthy, and accepting physical and social environment in schools and classrooms improves conditions for learning. The physical environment includes the school building and grounds, school board transportation, and materials and equipment used in school programs. In addition, a supportive social environment has a positive impact on students' learning, mental health, and healthy growth and development. The school environment is influenced by many factors, both formal (e.g., school and classroom policies, rules, clubs, support groups) and informal (e.g., unstructured peer interaction, free play). Community organizations, including public health, also play a role, offering access to resources and services to staff, students, and families within the school setting.

Through their teaching practices, Ontario educators already support students' healthy growth and development, including positive mental health. High-quality instruction provides students with a wide range of opportunities to learn, practise, and demonstrate knowledge and skills related to living a healthy life. Programs offered during the instructional day often lay the foundation for constructive activities that take place outside instructional time. Social and emotional skills that help students develop and maintain good mental health can be taught explicitly. A variety of class-wide instructional strategies can contribute to a supportive classroom climate and teach students the social and emotional skills that will help them form positive relationships. For example, educators can:

- maintain high academic expectations that all students will learn and achieve success;
- engage all students in the academic work of the classroom. This may include strategies such differentiated instruction (DI) and universal design for learning (UDL);
- establish clear and consistent behavioural expectations. These change as students become older and more able to manage their own behaviour. Addressing bullying and violence are vital steps in establishing behavioural "norms";
- praise good behaviour. Noticing positive behaviour can be a difficult skill to develop. Start by trying to find one good behaviour to notice each day, and soon you will see good behaviour increase;
- offer behaviour-specific praise. Saying "Good job" isn't nearly as effective as saying "Good job sitting still, Michael", or "Excellent work in showing how you solved that fraction problem, Naomi";
- engage parents and the community. Parents and community members can help to create and maintain a positive school climate through volunteering, mentoring, and simply modelling appropriate behaviour.

For some students, their first opportunity to learn the skills necessary for interacting with other children is when they attend some form of pre-school program (such as a daycare program). For others this opportunity happens when they begin their formal education in school. Early-childhood-education programs, play groups, and childcare centres all provide opportunities for children to interact and learn how to get along with their peers. Children learn these skills more easily if they have consistent rules for behaviour and consistent consequences when they misbehave. Some children may not have had this experience prior to school, and may arrive with limited social skills. Some children may have more difficulty than others in understanding and learning social skills and appropriate behaviour, just as some children have more difficulty learning to read. Whatever the cause, students who arrive at school with few of the social and behaviour skills that are needed to manage a brand-new, complex social environment may have difficulty adapting. They may demonstrate this through their behaviour.

It is especially relevant for educators to be mindful of mental health and well-being in very young students. However, very young children often cannot fully express their thoughts and feelings, so making a diagnosis can be difficult. The signs of a mental illness in a young child may be quite different from those in an older child or adult.

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 behaviour they show may change, problem behaviour can still be a good indicator that a student doesn't understand how to behave, or hasn't had the practice necessary to develop and integrate the necessary social skills. Explicit instruction, practice, and feedback help students build literacy and numeracy skills, and the same is true for social and emotional skills. While instruction in social and emotional skills is seldom explicitly called for in education curricula, there is clear evidence that students receiving such instruction show improved academic outcomes.

A number of programs have been developed for teaching social and emotional skills and strategies that enhance resilience. Because these skills evolve as students grow and mature, it is important to tailor the program to suit the age and developmental stage of the students. Many of these programs are designed to be used by a classroom teacher for all students in the class. Some are meant 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 for the classroom teacher to be involved in the program.

"The ability to self-regulate, or to set limits for oneself, allows a child to develop the emotional well-being and the habits of mind, such as persistence and curiosity, that are essential for early learning and that set the stage for lifelong learning."

(Ontario, Ministry of Education, 2010–11, p. 7)

"Positive mental health and emotional well-being are closely related to the development of psychological and emotional resilience. Resilience involves being able to recover from difficulties or change – to function as well as before and then move forward. It is often referred to as the ability to 'bounce back' from difficulties or challenges."

(Ontario, Ministry of Education, 2010, p. 33)

Reducing Stigma: Talking in the Classroom about Mental Health

Despite the fact that mental health problems affect one in five young people, fewer than 25 per cent of children and youth with mental health problems receive specialized treatment. Recent studies show that mental health problems that cause significant distress and impairment are found in 14 per cent of children and adolescents (Waddell et al., 2002). Children, young people, and adults all agree that one of the major barriers to seeking help for mental health problems is fear of being stigmatized or negatively perceived by others. Educators have a unique opportunity to influence all students' perceptions and understanding of mental health problems. Teachers can help reduce the stigma associated with mental health problems by discussing mental health issues in class and helping students to find and use reliable, in-depth information on the topic.

The Mental Health Commission of Canada (MHCC) recognizes that educators have a unique opportunity to help raise awareness about mental health issues, and has made anti-stigma programs aimed at children and youth one of its priorities. The MHCC is working with a number of resource providers to develop effective programs for the classroom. Further information on school-based programs designed to combat the stigma against those with mental health problems is available from the websites of the Mental Health Commission of Canada (**www.mentalhealthcommission.ca**) and the Ontario Centre of Excellence for Child and Youth Mental Health (**www.onthepoint.ca**).

Knowing Your Students

Caring adults can make an important difference in a child's life (Luthar et al., 2000; Meichenbaum, 2005, for a summary of research). Caring adults make themselves available to students, listen attentively, and reflect meaningfully on the concerns students raise, sometimes offering advice for students to consider. Educators who make an effort to know their students are well positioned to notice changes in behaviour that may signal escalating social-emotional difficulties.

It is important to reiterate that while educators play an important role in identifying signs of potential mental health problems, they do not work alone. A team approach by the parent(s)/guardian, other school staff, and sometimes specialists from the board and community is imperative in addressing these problems. Each school board will have its own procedures to follow, but all boards have a process educators can use to raise concerns about students who are experiencing difficulty. As well, it is essential to involve parents/guardians in planning how best to address the needs of the student.

A first step in recognizing whether a student has a mental health problem may be simply documenting the behaviour that is causing concern. School boards may have their own forms on which to record this information. Once several observations of the particular behaviour have been gathered, educators can share these with others who can help to develop a plan to manage the behaviour. Educators should look for three things when considering whether a student is struggling with a mental health and/or addiction problem:

- *Frequency:* How often does the student exhibit the behaviour?
- *Duration:* How long does the behaviour last?
- *Intensity:* To what extent does the behaviour interfere with the student's social and academic functioning?

Other general signs that a student may be struggling are when the student's emotions and behaviour are not age appropriate, the behaviour is dramatically different from that of the student's peers, and the duration of the behaviour appears to be excessive. These signs indicate a need for closer monitoring, because they suggest that the behaviour a student is exhibiting is beyond the typical manifestations of healthy growth and development. Assessing developmental appropriateness is also important. For example, there are times when students' emotions are a normal manifestation of their developmental stage and not a symptom of an underlying condition such as depression. Accurate information about the frequency, duration, and intensity of the behaviour will help to determine the potential seriousness of the problem and whether intervention is called for.

Talking about Mental Health with Parents and Students[4]

Because educators provide an important contact point for students, parents, and often other professionals involved in student's lives, it is important for them to know how to communicate well with all partners. Communicating with students, parents, and other professionals can be difficult and confusing. Parents may not agree with an educator's perception of their child's behaviour. Mental health professionals may use language and terms that are unfamiliar to educators. Students may raise questions and concerns that are difficult to address. This section provides some advice that educators may find helpful when talking with parents and the children about mental health problems.

"Research shows that increasing families' engagement in their children's learning reaps powerful benefits … when relationships with families are based on mutual trust and respect and are sensitive to family culture, values, language and composition …".

(Ontario, Ministry of Education, 2010–11, p. 31)

4. For important information relevant to this section, about legislation governing access to information and protection of privacy, see the boxed insert entitled "Privacy Considerations" on page 13.

Informing and Supporting Parents

Because educators spend considerable time with students, they are well placed to distinguish typical, age-appropriate behaviour from inappropriate behaviour that is disruptive or that is interfering with a student's development and learning. Educators' experience with a range of student behaviour helps them identify when a particular student's behaviour goes beyond what is expected in students of that age. Parents may not have regular contact with other young people and may not be aware that their child's behaviour is different. Also, stress related to academic work, peer relations at school, and school structure can trigger in-school student behaviour that may not be apparent outside school.

Sometimes, parents who know that the student has a problem may be reluctant to reveal this to the teacher or school for fear that it will change the teacher's perception of or expectations for the student. It is important to remember the role that fear of stigma can play when discussing concerns about students with either the parent(s)/guardian or the students themselves. In discussions with parents, it is important to begin by recognizing their child's strengths and accomplishments, in order to build trust. Talking to parents about their child's problems can be difficult: many teachers report that it is one of the most stressful parts of the job. It is often helpful to consult a school counsellor, principal, or vice-principal before engaging parents in difficult discussions. It can also be helpful to practise such discussions with colleagues before a meeting with parents.

Educators need to reflect carefully on how best to phrase their concerns when talking with parents/guardians about a student. It can be difficult for parents to hear that their child is struggling with a potential mental health challenge. It is important to find relatively neutral, non-judgemental ways of describing and discussing a student's behaviour. For example:

> "I've noticed that Tanya 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."
>
> "Arvin seems very quiet in class, and finds it difficult to answer questions when I call on him, even though he knows the answer. Have other teachers mentioned this before?"

Both of these questions ask about a specific behaviour that was noticed, without making a judgement about the cause. If the parent agrees that the child exhibits that behaviour at home or in other settings, then the teacher can begin to work with the parent to solve the problem.

If the parent disagrees, then an appropriate follow-up comment might be: "I see this behaviour often in class, and it's affecting Tanya's learning. Do you have any

suggestions about what we can do to help Tanya manage this behaviour?" Again, this approach allows the teacher to recruit the parent as a partner in solving the problem, and avoids an argument about whether the problem exists.

Talking with Students about Mental Health

Educators are important mentors in the lives of their students. An educator may be the supportive adult to whom students turn when they have a problem. However, some educators may feel uncomfortable talking about students' problems, even though the students have chosen to speak with them. If this is the case, the educator can offer to help the student find another trusted adult to speak to.

Conversations about personal problems and/or mental health problems can be difficult. Sometimes the educator has little knowledge about the issues students raise. Consulting with colleagues, a resource teacher, a public health nurse, or a school counsellor can be helpful.

Some Guidelines for Talking with Students

Educators need to follow some basic ground rules in student-teacher conversations about students' personal difficulties. For example, they should:

- find an appropriate place to have the conversation, so the student can talk freely in a safe, private setting;
- start the conversation by explaining that there are limits to what can be kept confidential;
- offer information about what they have observed in an objective, non-judgemental way;
- ask if the student would like to talk about the teacher's observations;
- indicate that they are there to listen and, if the problem feels too big, suggest the possibility of involving someone else who might be better able to help;
- if appropriate, talk about involving the student's parent/guardian in the solution.

Here are two examples of how to approach such conversations:

> "James, I've noticed that you seem quieter than usual. Is this only happening in this class, or are you feeling this way in other classes?"

> "Najla, you've been having difficulty paying attention since you joined us last semester. Do you have this difficulty in other classes?"

Both of these statements focus on the behaviour that was noticed and invite the student to reflect on it. If the student acknowledges a problem, the teacher may want to arrange a meeting with the student, a parent, and a school resource

> "Some topics within the Healthy Living strand [of the Ontario health and physical education curriculum] can be challenging to teach because of their personal nature and their connection to family, religious, or cultural values… It is important that both teachers and learners have a comfort level with these topics so that information can be discussed openly, honestly, and in an atmosphere of mutual respect."
>
> *(Ontario, Ministry of Education, 2010, p. 30)*

person who can help with the problem. Sometimes, a student may acknowledge a problem and disclose that he or she is already seeing a counsellor or therapist. In such a case, the teacher might ask if there is any action he or she can take to support the counselling or therapy. For example, "Michel, what sorts of things can we do in the classroom to help you manage this behaviour?"

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Part Two

Recognizing and Responding to Mental Health Problems among Students

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) lists a number of clinical disorders that interfere with optimal child and adolescent functioning. Some of these are more common than others in the school setting. The most common problems are described in the sections that follow. Each section is written as a stand-alone guide, with typical signs related to the problem and ideas for how the student can be supported at school. Educators are encouraged to print out and use the sections to help in understanding the problems generally and in applying them to particular students who may be struggling.

1 Anxiety Problems

What Is Anxiety?

Many children and adolescents typically experience worries and fears from time to time, and these worries and fears can change as young people progress through different developmental stages. For example, young children often become distressed when separated from loved ones, and adolescents worry at times about "fitting in" with peers as they explore their identity during the stressful adolescent years.

The school setting itself can trigger anxiety for many students. Many common situations, such as test-taking, giving a speech, trying out for a team, interacting with other students, or participating in class, can make students feel nervous. Anxiety in these situations is not unusual and may even serve an adaptive function, strengthening the child or adolescent's motivation to succeed and helping him or her to perform well (Petri, 1991). For example, an upcoming stressful event such as writing an exam or performing in a play may cause the student to be nervous. Some level of concern or anxiety in these cases is a reasonable response and may help motivate the student to study or to memorize lines. Learning to cope with and adapt to stressful situations in spite of anxious feelings is a natural part of healthy growth and development.

Sometimes, however, anxiety changes from a typical adaptive response into a more exaggerated reaction that can interfere with the student's social, academic, and/or emotional functioning. Anxiety-related problems exist on a continuum from mild to severe. Mild worries and fears are usually transient and manageable. However, when feelings of worry become persistent and intense, they can have a paralysing effect, disrupting the student's engagement in classroom activities, learning potential, performance, and social relationships.

What Do Anxiety Problems Look Like?

The experience of anxiety is primarily internal. Outward signs of anxiety may be difficult to detect because the behaviour and/or symptoms do not necessarily show themselves in obvious or disruptive ways. Students may not tell their parents or teachers that they are worried because they may not recognize it themselves. When they feel distressed, they may believe they should struggle in silence. For example, students who believe that they are going to fail may deal

with their worries by choosing not to go to school. Anxiety may manifest itself as perfectionism, avoidance, procrastination, feelings of being overwhelmed, worries about time limits or changes in routine, and physical aches and pains such as headaches or stomach-aches. Anxiety-related symptoms can often contribute to poor school performance. Students who have anxiety problems may become easily frustrated or have difficulty completing their work. Or they may simply refuse to do the work for fear of failure or may avoid particular situations and tasks. On the other hand, many individuals who have mild levels of anxiety can be highly motivated to succeed and may be superb achievers (Petri, 1991). It is also important to note that there are several subtypes of anxiety problems, and these may be associated with somewhat different symptoms (see "Types of Anxiety Disorders" in the box below).

TYPES OF ANXIETY DISORDERS

Generalized Anxiety Disorder is generally characterized by worrying that is excessive, chronic, and/or difficult to control for a significant number of days over a period of time. The focus of the worry may be a variety of events or circumstances, such as schoolwork, appearances, or the future. Associated symptoms may include restlessness, fatigue, difficulty concentrating, and trouble sleeping, which in turn may impair daily functioning at school, in social situations, and with family.

Separation Anxiety Disorder begins before age eighteen and is generally characterized by extreme anxiety or worry about separation from the home or caregiver that interferes with the student's ability to function.

Social Anxiety Disorder is generally characterized by extreme worry or fear in social situations with unfamiliar people. The person may also fear ridicule, humiliation, being laughed at, or being embarrassed in social situations. Social anxiety disorder can take different forms depending on the focus of the anxiety.

Panic Disorder is generally characterized by repeated unprovoked episodes of intense fear of danger associated with symptoms such as rapid heart rate, shortness of breath, choking sensation, sweating, or feelings of depersonalization. Individual panic attacks may develop into panic disorder. Panic disorder typically has its onset in late adolescence/early adulthood.

Specific Phobia is generally characterized by excessive fear of such things as a specific object, animal, activity, or situation that causes extreme distress or avoidance that affects functioning. Phobic disorders typically begin in childhood.

Obsessive Compulsive Disorder is generally characterized by recurrent, persistent, intrusive thoughts (obsessions) or repetitive acts (compulsions) that the person feels he or she must do. Examples in children include cleaning or checking routines that take up a significant amount of time.

(continued)

TYPES OF ANXIETY DISORDERS *(continued)*

Post-traumatic Stress Disorder, unlike other diagnosed mental health disorders, is diagnosed based on evidence that the person has experienced a traumatic event. Symptoms or behaviours generally include re-experiencing the traumatic event, avoidance of associated events or places connected to the trauma, numbness and reduced responsiveness, and increased physiological arousal (exaggerated startle reactions, difficulty falling asleep). Symptoms may be different in children.

(Based on information from: APA, 2000; Evans et al., 2005, p. 165)

Note: These summaries provide only a brief description and are not to be used for diagnostic purposes.

COMMON SIGNS OF ANXIETY

Although different signs of anxiety occur at different ages, in general, common signs include the following. The student:

- has frequent absences from school;
- asks to be excused from making presentations in class;
- shows a decline in grades;
- is unable to work to expectations;
- refuses to join or participate in social activities;
- avoids school events or parties;
- exhibits panicky crying or freezing tantrums and/or clingy behaviour before or after an activity or social situation (e.g., recess, a class activity);
- worries constantly before an event or activity, asking questions such as "What if …?" without feeling reassured by the answers;
- often spends time alone, or has few friends;
- has great difficulty making friends;
- has physical complaints (e.g., stomach-aches) that are not clearly attributable to a physical health condition;
- worries excessively about things like homework or grades or everyday routines;
- has frequent bouts of tears;
- is easily frustrated;
- is extremely quiet or shy;
- fears new situations;
- avoids social situations for fear of negative evaluations by others (e.g., fear of being laughed at);
- has dysfunctional social behaviours;
- is rejected by peers.

(Based on information from: CYMHIN-MAD, 2011; Hincks-Dellcrest-ABCs, n.d.)

Note: This list provides some examples but is not exhaustive and should not be used for diagnostic purposes.

It should be remembered that the ways in which children and adolescents show anxiety vary with their age, developmental stage, and particular events going on in their lives. For example, anxiety related to separation from parents is a common reaction in early childhood, and those who are vulnerable often become visibly distressed in the parent or caregiver's absence (for example, they may cry, have tantrums, and/or demonstrate clingy behaviour). A similar reaction in later childhood or adolescence would not be typical, but older children may act out this type of anxiety by refusing to go to school, constantly seeking reassurance, or complaining of physical aches and pains.

For more detailed information about anxiety-related behaviour in children and adolescents (ages three to eighteen years), see *The ABCs of Mental Health* at www.hincksdellcrest.org/ABC/Welcome.

What Can Educators Do?*

To Promote Positive Mental Health in the Classroom …

Some students excel in the school environment and thrive on challenges related to performance, evaluation, and social interaction. For many, however, the school setting can be stressful and may cause some students distress. This may be particularly true for those who, for one reason or another, struggle with learning, social interactions, or a feeling of "not belonging" or "not fitting in" within the school culture. Students who experience significant stress at school may not all develop anxiety-related symptoms, but they are at risk of doing so and would certainly benefit from strategies to create classroom environments that reduce potential sources of severe stress for all students. (It should be noted, however, that for some students a moderate degree of stress can increase motivation and enhance learning.)

* For important information about privacy considerations, see the boxed insert on page 13 of this guide.

STRATEGIES TO REDUCE STRESS FOR ALL STUDENTS

- Create a learning environment where mistakes are viewed as a natural part of the learning process.
- Provide predictable schedules and routines in the classroom.
- Provide advance warning of changes in routine.
- Provide simple relaxation exercises that involve the whole class.
- Encourage students to take small steps towards accomplishing a feared task.

(Based on information from: CYMHIN-MAD, 2011; Hincks-Dellcrest-ABCs, n.d.)

To Support Students with Anxiety-related Behaviour and Symptoms …

While educators (and parents) cannot diagnose an anxiety problem, they are in a position to observe and document whether the anxiety-related behaviour is affecting the student's functioning at school, with friends, or in the community/home setting. This information will help them to decide whether the student is in need of further support and/or referral to a mental health professional.

When observing and documenting a student's behaviour, teachers should note the following information:

1. when the behaviour or symptoms tend to occur
2. what circumstances or conditions trigger the behaviour
3. the frequency of the behaviour
4. the duration of the behaviour
5. the intensity of the behaviour

It is also helpful to note if the behaviour is becoming more frequent or severe and/or if it is affecting the student's ability to function in a number of areas such as school work and relationships with peers or family.

Other relevant points to consider when trying to understand how serious the student's problems with anxiety may be are whether the student has difficulty recovering from the stressful experience that has taken place (e.g., a social gathering or test), has a significant amount of anxiety before a specific event occurs, has continued feelings of anxiety when there is no apparent cause, or is unable to stop worrying about how he or she behaved in a particular situation. Having such reactions could cause the student to avoid similar situations in the future (e.g., to adopt a strategy of avoiding most social gatherings or interactions with peers). It is also helpful to observe whether the student has the flexibility to adapt to situations that he or she finds stressful. For example, a student who is extremely shy and inhibited in social situations may nevertheless have been

able to find a small group of friends and adapt without distress; that student is functioning well.

When the level of anxiety is great enough to interfere with a student's everyday activities, this may be further evidence of an anxiety disorder and indicates that the student needs specific supports or strategies. The determination of whether the anxiety is a reasonable response to stress or is cause for concern depends on a number of factors and involves understanding the individual child. Mental health professionals will examine the degree of distress and dysfunction, while keeping in mind such factors as the developmental stage of the student and relevant cultural and familial expectations and influences (Evans et al., 2005, p. 162).

If the anxiety-related behaviour is affecting the student's learning and/or social functioning, it may be helpful for the school team, in collaboration with the parents and any invited mental health professionals, to establish a plan to help the student moderate the behaviour. It is important to include the student as a participant in developing the plan, in order to encourage the student's engagement and active cooperation. A method of regular communication (for example, by e-mail), conducted in accordance with board policies and procedures, should be established between the school, parents, and any mental health professionals who may be involved. Such regular communication enables the team to track whether progress is being made or not, and helps them determine whether the student needs further intervention and/or professional support (Manassis, 2012). The sharing of information should be carried out in accordance with the requirements of board policies and procedures.

A number of studies have been done to identify approaches and strategies that have been used successfully in the classroom to help reduce sources of anxiety for students. These studies focus on three main areas: (1) the classroom environment; (2) the context outside the classroom; and (3) strategies related to specific behaviour or symptoms shown by the student. By determining which behaviour and symptoms are having the greatest impact on the student's functioning in daily activities, educators can identify which strategies are most likely to be helpful to the student. Table 1.1 outlines specific strategies that educators can use to support students who demonstrate different types of anxiety-related behaviour.

Table 1.1	Specific strategies for supporting students with anxiety-related symptoms
Symptom or behaviour	**Classroom Strategies**
A range of anxiety-related behaviour	• Work with parents, the school team, and others involved with the student to establish consistent expectations for the student at school, at home, and in other areas of activity. This provides predictability and reduces confusion for the student. • Reward brave, non-anxious behaviour. Notice when the student is being brave in attempting something he/she finds challenging. • Check in with the student at the beginning of each day. • Learn what situations the student can handle and determine how to respond when she/he is unable to cope. • Check with the student that assignments have been written down correctly. • Reduce schoolwork and/or homework based on information from parents and the school team about how much stress the student can handle. • Maintain the student's regular schedule as much as possible. • Ask the student's parents what strategies work at home to relieve the student's anxiety. • Encourage and reward all positive steps in managing anxiety.
Perfectionism *Example:* The student worries about making minor mistakes or doing work that is less than perfect; is overly critical of his/her performance; and works slowly, erases repeatedly, delays starting and/or completing assignments, or avoids attempting tasks altogether.	• Communicate the message that mistakes are normal, or reframe mistakes as learning opportunities. • Reassure the student that "everyone makes mistakes sometimes" or "nobody's perfect". • Encourage the student to produce rough drafts and use brainstorming. • Work with parents and the school team to establish strategies suited to the academic and mental health needs of the student (e.g., a focus on quantity rather than quality of work; flexibility about deadlines). • Avoid drawing unnecessary attention to mistakes (e.g., avoid posting test scores or publicly commenting on mistakes). • Recognize and reward small improvements (e.g., finishing a task on time without continual revising to make it perfect).
Fear of large assignments *Example:* The student feels overwhelmed by a large assignment, may assume it is too difficult, and may not attempt it at all.	• Help the student break the project or large assignment into manageable chunks. • Help the student make a schedule to do each chunk. • Have the student hand in one chunk at a time (rather than trying to meet one final deadline), and provide positive reinforcement for each submission. • Reduce the size of the chunks if the student continues to have difficulty. • Build the student's confidence by rewarding partial success or evidence of effort (instead of praising only complete pieces of work). • Help the student focus on his or her strengths and ability to improve performance with effort. *(continued)*

Table 1.1 *(continued)*

Symptom or behaviour	Classroom Strategies
Test anxiety *Example:* The student exaggerates the consequences of doing poorly on tests and may think that even one bad mark will mean that he/she could fail the year.	• Engage in dialogue with parents and the school team to determine if the student would benefit from different arrangements for taking tests (e.g., provision of a separate, quiet room for a student who is upset by distractions). • Clearly indicate (when appropriate) how much a test or exam will count towards the final grade (all students). • Allow extra time to complete tests for students who are upset by time pressure. • Avoid giving surprise quizzes or tests. • Encourage the student to take a few slow, deep breaths before starting. • Encourage the student to identify an easy question to start with.
Anxiety about time pressure *Example:* The student worries that he/she will not have enough time to finish tasks.	• Avoid "minute math" or other tests with time pressure. • Provide incentives to encourage the student to work at an appropriate pace (e.g., "When you finish working on x, you can go back and work on the computer."). Flexible time limits will help decrease anxiety. • Encourage the student to finish one task at a time before starting another (i.e., discourage multitasking).
Intolerance of uncertainty *Example:* The student has difficulty functioning when he/she is uncertain about exactly what is required or expected.	• Provide information to increase the student's ability to predict events and outcomes wherever possible. • Provide clear daily schedules and clear deadlines. • Warn the student if something out of the ordinary is planned and help him or her to prepare for it. • Provide checklists and other visual reminders for tasks and upcoming events. • Develop a coping plan for unexpected events (e.g., if there is a fire drill; if there is a substitute teacher) that the student can keep at his/her desk. The plan may include a pause for slow, deep breathing, sitting next to a chosen buddy (who knows about the plan), and referring to a summary of the student's needs and daily routines. (Such a plan could be used to help a substitute teacher ensure that the student's routines are maintained in the absence of the regular teacher.)
Excessive reassurance seeking *Example:* The student may repeatedly ask questions in class or seek reassurance in other ways.	• Try to respond calmly (this may help to decrease anxiety). • Answer questions with a simple explanation and repeat once, using the same words (to minimize chances of confusion). • Encourage the student to save further questions for a specific time, and then be available at that time. • Positively reinforce any progress towards increased independence. • Provide realistic but reassuring information about specific worries or fears. • Encourage the student to write down his/her worries before seeking help from an adult. *(continued)*

Table 1.1 *(continued)*

Symptom or behaviour	Classroom Strategies
Physical Symptoms *Example:* The student may have frequent headaches, stomach-aches, or washroom breaks, or may have episodes of hyperventilating when under stress.	• Practise relaxation exercises with the whole class (beneficial for all). • Encourage slow, deep breathing when the student appears stressed. • Have a quiet place where the student can go for a few minutes if he/she is feeling overwhelmed. • Agree on a signal the student can use when he/she needs to go to the washroom. Encourage the student to try to extend the time between washroom visits and to return to class within a few minutes. • As appropriate, discuss with parents under what circumstances the student could be allowed to call home or ask to be picked up from school.
Interpersonal sensitivity *Example:* The student is overly worried about/sensitive to possible negative feedback from others.	• Maintain a calm, patient tone of voice when talking to the student. • Avoid penalizing the whole class when a few students misbehave. • Set firm limits for misbehaviour and remain calm while enforcing them. • Set reasonable academic expectations that take anxiety into account but are not too low and do not single out the student who is anxious. • Quickly address any teasing or bullying among students. • Positively reinforce efforts to seek help by students who are usually afraid to ask for help (perhaps for fear of being criticized or looking stupid).
Social anxiety *Example:* The student fears/ avoids social situations; situations where he/she will be evaluated; and/or situations that involve performing in small or large groups, participating in class, or giving oral presentations.	• Connect with the student's parents to determine if the same behaviour occurs at home and in other situations and to learn what successful approaches they use to help their child. • Work to develop an atmosphere of acceptance throughout the classroom. • Talk openly about the fact that everyone feels nervous about speaking in front of a class. • Resist pressure to allow the student to avoid social interactions. • Encourage autonomy, to allow the student to develop effective coping and problem-solving skills. • For a student who fears answering questions in class, first try providing the student with the answer to the question before class. Gradually work up to rehearsing questions and answers with the student before class, to prepare the student to answer out loud in class. • If a student is extremely worried about responding to questions in class, have the student answer yes/no questions first (instead of open-ended ones). • Create an environment in which students feel welcome to speak up and socialize. • Provide opportunities for students to work, socialize, and speak in small groups, first with one other person, then with two, three, or four people. • Identify activities the student can do that will help increase his/her level of comfort (e.g., returning forms to the school office, helping with the school newspaper, working in the library). • Pair the student with another student who is open and welcoming. • Encourage the student to participate in extra-curricular activities. *(continued)*

Table 1.1 *(continued)*

Symptom or behaviour	Classroom Strategies
Separation worries	• Develop a plan for the student's arrival at school (e.g., provide an immediate reward for attending) with appropriate staff (with parental permission). • Provide consistent and predictable arrival routines. • Maintain regular communication with the parents and encourage their participation in classroom activities. • Arrange for a buddy to greet the child in the playground and help with the transition into the classroom. • Provide positive reinforcement for brave behaviour and refrain from commenting on anxious behaviour. • Work with the parents to identify positive ways to reward non-anxious behaviour (e.g., allow the student to take home a special book or toy as a reward for not crying).
Specific fears	• Recognize any progress, however small, that the student makes towards confronting the fear. Connect with the parents to determine how the fears are managed at home. • Try not to allow the student to avoid an activity because of the fear. • Observe the student's behaviour to make sure that the student is not avoiding participating in everyday activities.

Sources: Adapted from Table 1: "Manifestations of generalized anxiety and corresponding classroom strategies", from K. Manassis, "Generalized Anxiety Disorder in the Classroom", in J.Q. Bostic and A.L. Bagnell, eds., issue titled "Evidence-based School Psychiatry", *Child and Adolescent Psychiatric Clinics of North America,* 21, no.1 (January 2012); with additional information from Ryan & Warner, 2012; CYMHIN-MAD, 2011; Hincks-Dellcrest-ABCs, n.d.

Background Information

What Are the Causes of Anxiety?

Anxiety-related symptoms may result from a number of factors, including the individual's personality and temperament (e.g., genetic influences), traumatic or stressful events or circumstances (e.g., abuse, family conflict, or parental separation), a change in living situation, delays in an area of skill development (e.g., verbal, social skills), bullying, or a medical condition (Manassis, 2012).

It is important to be aware that the observable symptoms of anxiety may have multiple causes that may be difficult to identify without the help of a mental health professional. Anxiety symptoms may also arise as a result of particular circumstances or conditions (e.g., medical conditions such as thyroid problems, use of substances such as caffeine) or other mental health problems. In these

cases, symptoms mimic those that occur with an anxiety disorder (Manassis, 2004, 2012). ADHD and learning problems may also evoke anxiety-related symptoms and behaviour. If a student struggles academically and only shows anxiety in the school setting (and not at home or socially), it may suggest that the child has a learning problem or another type of disorder. Different types of anxiety disorders (e.g., general anxiety disorder, social phobia, separation anxiety disorder) often co-occur in children and adolescents. Symptoms of anxiety also commonly occur with other mental health problems such as depression or autism spectrum disorder. Because it is important to try to understand the functioning and behaviour of the student in relation to a broad range of possible causes, students need to be assessed by a mental health professional (Manassis, 2012).

How Common Are Problems with Anxiety?

Anxiety is one of the most common mental health disorders and is experienced by children, adolescents, and adults alike (Merikangas et al., 2011). While some anxiety disorders are more likely to begin in childhood (e.g., some phobias and separation anxiety disorder), many begin in adolescence and early adulthood (Kessler et al, 2007).

Recent research findings show that approximately 8 per cent of people have an anxiety disorder of some type at some time in their lives (Costello et al., 2005). Two of the most common anxiety disorders are general anxiety disorder (GAD) and social anxiety disorder (SAD). General anxiety disorder affects up to 10 per cent of children and adolescents (Keeton et al., 2009), and social anxiety disorder affects approximately 6 per cent of children (Ruscio et al., 2008) and 12 per cent of adolescents (Merikangas et al., 2011). Anxiety disorders are more common in females than in males across all ages. While anxiety disorders begin at around the same time for boys and girls, the rates increase more rapidly for girls (Merikangas et al., 2011).

These rates suggest that at least two or three students in any classroom may experience anxiety-related symptoms that cause significant distress and affect their functioning socially and academically. If students with milder symptoms or symptoms that cause some distress but without significant impairment are included, the number increases (Manassis, 2012).

While anxiety is associated with a range of mental health disorders, it is most commonly associated with mood disorders, particularly depression (Merikangas et al., 2011). Anxiety and major depressive disorder (MDD) occur together in 30 to 75 per cent of pre-adolescents and 25 to 50 per cent of adolescents (Garber, 2006; Avenevoli et al., 2001).

Without treatment or intervention strategies, some anxiety disorders that begin in childhood may last a lifetime, although symptoms may come and go

depending on factors such as the presence or absence of stress. Despite the negative outcomes associated with anxiety, estimates indicate that fewer than 20 per cent of adolescents with anxiety disorders are treated (Merikangas et al., 2011). If left untreated, some anxiety disorders can lead to chronic impairment that extends into adolescence and adulthood. Children and adolescents may struggle with having few friends, be reluctant to participate in classroom activities (e.g., group work), and have difficulty in social settings (e.g., group extracurricular activities, interactions with peers). In adults, anxiety problems may lead to inability to work, social impairment, and increased risk for other mental health disorders, such as depression, substance abuse, and suicidal thoughts (Ryan & Warner, 2012).

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2 Mood Problems: Depression and Bipolar Disorder

(A) DEPRESSION

What Is Depression?

In general, "depression" is the term we use to describe a feeling of sadness, irritability, or loss of interest in activities that the person has typically enjoyed. Most children and youth will, from time to time, experience feelings of sadness as they move through life. These feelings may be related to temporary setbacks, such as receiving a bad mark, having a disagreement with friends, or not making a sports team. Feelings of this type usually do not last long and, as children and youth mature, they learn a range of coping strategies to deal with and adapt to such difficulties. However, when sadness, irritability, or lack of interest are associated with more long-lasting issues, such as sustained conflict with peers, lack of engagement in activities, ongoing academic struggles, or difficulties at home, there may be a need for supports or intervention.

Students who experience many symptoms that significantly affect their behavioural, emotional, physical, and/or cognitive functioning may be struggling with a depressive disorder (Evans, 2002). It is more than "just sadness" when problems with mood persist and affect students' thoughts, how they feel about themselves, and the way they behave and interact with others.

Sometimes students show some depression-related symptoms, but their low mood does not appear to affect their day-to-day functioning, or it affects their functioning to only a limited degree. In these cases, while they may not be experiencing a mood disorder, they are at increased risk for the development of depression or depression-related problems. It is important to monitor these students carefully.

TYPES OF DEPRESSIVE DISORDERS

Major depressive disorder is generally characterized by a number of symptoms such as depressed or irritable mood, lack of interest or pleasure in activities, low energy, difficulty concentrating, and/or sleep or eating disturbances. Symptoms are present for a significant period of time over a number of days and cause clinically significant impairment in functioning.

Dysthymic disorder or dysthymia is less severe than major depressive disorder. This form of depression is generally characterized by mild to moderate symptoms of depression that are present for a year or longer and that cause some impairment in functioning. Symptoms include irritability and problems with appetite, sleep, energy, self-esteem, and decision making. Other symptoms and criteria must also be present.

(Based on information from: APA, 2000)

Note: These summaries provide only a brief description and are not to be used for diagnostic purposes.

Research shows that the early onset of depression is associated with serious lifetime psychosocial impairment (Castaneda et al., 2008), educational difficulties (Fergusson & Woodward, 2002; Fergusson et al., 2007), and risk of severe depression later in life (Zisook et al., 2007; Forbes et al., 2006). Depressive disorder is also a strong risk factor for suicide, which, after accidents, is the second leading cause of death for young people between ten and thirty-four years of age (Public Health Agency of Canada, 2012). As well, youth who are depressed are at increased risk for substance use problems.

Early-onset major depressive disorder may occur before key developmental milestones have been reached and may lead to interpersonal and academic difficulties and impairments in social, emotional, and cognitive development (Miller, 2007). These difficulties could continue into adulthood and affect the individual's employability and relationships (Zisook et al., 2007; Silk et al., 2007).

What Do Depression-related Symptoms Look Like?

Students who are experiencing a depressive disorder demonstrate a cluster of symptoms that reflect their low mood and lack of interest in things that they used to enjoy. At school, signs of depressive symptoms in a student might include difficulty concentrating in the classroom, fatigue, incomplete work, frequent absences, and irritability or feelings of frustration. This cluster of symptoms can affect a student's school performance and may lead to further difficulties with mood.

Substance use is associated with mental health problems such as depression. Sometimes substances such as alcohol or drugs are used as a way to cope with and relieve feelings of low self-esteem, sadness, worry, or fear.

It is often difficult for educators and parents to determine whether such symptoms are a cause for serious concern or are, instead, temporary behaviour typical of the developmental period or a reasonable response to a stressful or negative event (acute or chronic). Adolescence is a unique period of development where significant changes occur and youth are faced with multiple sources of stress. It is only to be expected that students will experience a certain amount of moodiness and irritability as they navigate through this period (Thapar et al., 2012). However, depressive symptoms or signs of depressive disorder in children and youth are often missed precisely because symptoms are attributed to normal youth stress (Saluja et al., 2004; Thapar et al., 2012). It is important not to *assume* that symptoms are "just a phase" (e.g., "teenage phase"), because of the known association between depressed mood, interpersonal and academic difficulties, and impairments in development (Miller, 2007), as well as the association between depression and risk for suicide.

COMMON SIGNS OF DEPRESSION

Some common signs associated with depression include the following:

- ongoing sadness
- irritable or cranky mood
- annoyance about or overreaction to minor difficulties or disappointments
- loss of interest/pleasure in activities that the student normally enjoys
- feelings of hopelessness
- fatigue/lack of energy
- low self-esteem or a negative self-image
- feelings of worthlessness or guilt
- difficulty thinking, concentrating, making decisions, or remembering
- difficulty completing tasks (e.g., homework)
- difficulty commencing tasks and staying on task, or refusal to attempt tasks
- defiant or disruptive behaviour; getting into arguments
- disproportionate worry over little things
- feelings of being agitated or angry
- restlessness; behaviour that is distracting to other students
- negative talk about the future
- excessive crying over relatively small things
- frequent complaints of aches and pains (e.g., stomach-aches and headaches)
- spending time alone/reduced social interaction; withdrawn behaviour and difficulty sustaining friendships
- remaining in the back of the classroom and not participating

(continued)

COMMON SIGNS OF DEPRESSION *(continued)*

- refusal to do school work, and general non-compliance with rules
- negative responses to questions about not working (e.g., "I don't know"; "It's not important"; "No one cares, anyway")
- arriving late or skipping school; irregular attendance
- declining marks
- suicidal thoughts, attempts, or acts
- change in appetite
- loss of weight or increase in weight
- difficulty sleeping (e.g., getting to sleep, staying asleep)

(Based on information from: Calear, 2012; CYMHIN-MAD, 2011; APA, 2000; Hincks-Dellcrest-ABCs, n.d.)

Note: This list provides some examples of symptoms or signs but is not exhaustive and should not be used for diagnostic purposes.

For more detailed information about depression-related symptoms in children and adolescents, see *The ABCs of Mental Health* at www.hincksdellcrest.org/ABC/Teacher-Resource/The-Sad-Child.aspx.

What Can Educators Do?*

To Promote Positive Mental Health in the Classroom …

Given that all secondary school students are learning to navigate through the adolescent period and may be faced with a variety of sources of academic and social stress, schools can play an important role in teaching students about coping with challenges and stress, dealing with peer pressure, problem solving, and strengthening the social skills they need to build successful relationships with peers and others.

Because many of the signs and symptoms associated with depression are internal, it can sometimes be difficult to recognize when a student is depressed. For example, if a student is withdrawn or quieter than usual, the teacher or parent may not notice immediately because the behaviour is not disruptive (Calear, 2012). Children and adolescents may also keep their feelings to themselves out

* For important information about privacy considerations, see the boxed insert on page 13 of this guide.

of embarrassment or shyness; or they may not fully understand what they are feeling and why. As a result, they may not ask for help.

Schools can play a key role in encouraging students to seek help (Calear, 2012), in providing a safe and caring environment in which students can talk about how they are feeling, and in monitoring students during times of increased stress (e.g., exams). Strategies for creating a supportive school and classroom environment for all students are outlined below.

STRATEGIES THAT CAN HELP ALL STUDENTS DEVELOP AND MAINTAIN A POSITIVE OUTLOOK

- Support class-wide use of coping strategies and problem-solving skills.
- Provide all students with information about normal growth and development and ways to cope with stress (e.g., ways to address peer pressure, build friendships, address depressive feelings, maintain good sleep hygiene, build exercise into each day).
- Write instructions on the board to provide a visual cue for students who are having trouble focusing on spoken information.
- Model and teach optimistic and positive attitudes, language, and actions.
- Work with students' strengths and build on them when they complete activities in class.
- Provide students with responsibilities and tasks that they may enjoy (e.g., allow students who enjoy computer use to incorporate a computing component into tasks; allow art-loving students to choose illustrated reading materials).
- Provide a space in the classroom for students to go to when they are feeling overwhelmed.
- Help students to chunk assignments and prepare for tests well in advance of deadlines.

(Based on information from: Evans et al., 2002; Hincks-Dellcrest-ABCs, n.d.)

To Support Students with Depression-related Symptoms and Behaviour …

Educators (in cooperation with parents) are in a position to notice when a student is having trouble functioning at school, with friends, or in the community/home setting, and to help discover whether there is something distressing in the student's life that may be contributing to the symptoms. While educators are not in a position to diagnose, they have an important role to play in helping to determine that a student may be in need of further support and/or may require a referral to a mental health professional.

When documenting a student's symptoms and behaviour, educators should consider the following information:

1. when the behaviour or symptoms occur
2. the frequency of the symptoms
3. how long the symptoms last
4. the intensity of the symptoms

It is also helpful to note if the symptoms are becoming more frequent or severe and/or are affecting functioning in multiple areas such as school work and relations with peers and/or family.

For students exhibiting signs of depressed mood, it is particularly helpful to note whether any of these symptoms are new or "out of character" for the student (e.g., a previously well-motivated student stops doing school work or begins skipping class). However, the behaviour of some students may not show a particularly noticeable change from their usual behaviour. Instead they may suffer from a number of lower-grade mood problems such as irritability, low energy, and poor concentration. Symptoms of this type may be a sign of dysthymia, or dysthymic disorder, a chronic type of depression lasting a year or more and characterized by persistently low mood but less severe symptoms than major depressive disorder.

Being successful and accomplishing tasks increases students' self-esteem. For students with depression, opportunities to achieve are extremely beneficial, even though the student may have less energy or motivation than usual and reduced ability to concentrate. For students who are struggling with memory problems, testing formats may need to be adapted to allow them to demonstrate what they have learned. Educators can work with the student's parents and the school team to help students plan or complete goal-directed activities that can give them a feeling of success and accomplishment.

Table 2.1 outlines specific strategies that educators can use to support students who demonstrate depression-related symptoms.

Table 2.1 **Strategies for supporting students with depression-related symptoms**

- Seat the student near the front of the classroom where the teacher can readily provide assistance or the student can easily leave as part of a coping strategy.
- Allow frequent breaks to help students with concentration problems.
- Work with the student's parents and the school team to modify the student's program if the student is experiencing extreme tiredness, difficulty remembering things in class, or difficulty concentrating. Modifications could include:
  - adjusting the student's workload;
  - scheduling study periods for times when the student is most likely to be alert;
  - determining a schedule that encourages attendance;
  - using multiple-choice questions instead of open-ended questions or oral questions;
  - providing extra time for the student to complete tests.
- Work with the student to develop clear expectations that he/she feels are reasonable.
- Provide ongoing feedback on progress.
- Help the student to set realistic goals and to monitor his/her progress.
- Work with the parents and school team to help the student plan and complete goal-directed activities.
- Provide the student with guidance on how to organize and plan the day (e.g., use of a checklist or agenda).
- Establish a format and routine for regular communication between the school, parents, and any mental health professionals who may be involved, using a daily agenda or e-mail "check-in".
- Work with the student on developing his/her problem-solving skills.
- Assign one task at a time.
- Help the student break a project or large assignment into smaller, manageable chunks and make a schedule for completing each chunk.
- Have the student hand in one chunk at a time. Provide positive reinforcement when each unit is completed.
- Make sure the student has all relevant class notes and study information prior to a test.
- Ask open-ended questions for which there is no specific, correct answer, to enable the student to contribute to discussions without fear of "being wrong" in front of others.
- Find ways to increase the student's self-esteem; for example:
  - Identify and focus on the student's strengths and make positive statements about the student's past successes.
  - Help the student to identify character strengths that enable him/her to perform well on a daily basis in many fields of activity.
  - Provide positive feedback and compliments, focusing on specific things the student has done well (i.e., giving individualized rather than merely general praise).
- Strategically introduce opportunities for the student to participate in structured positive social interactions with peers (e.g., group assignments, small-group work).
- Work with the parents to find ways to increase the student's interest and involvement in a range of activities to help decrease his/her preoccupation with negative thoughts.
- Check in with the student each day (e.g., greet the student at the door and ask a question about something of interest to the student).
- Correct errors or suggest improvements in the context of offering praise and support, as the student may be unusually sensitive to criticism.
- Check to find out whether the student has a network of support (e.g., parents, friends, relatives).

(continued)

Table 2.1 *(continued)*

- Find ways to connect a student who is socially isolated to peers with similar interests.
- Provide the student with opportunities to participate in making decisions about class activities and assignments, to help increase his/her motivation, interest, and feelings of success.
- If a student is returning to school after a hospitalization or a prolonged absence, be prepared to develop a plan for the student's reintegration and create a manageable strategy (both for teacher and student) for catching up on classes and assignments and addressing potential issues related to stigma among peers. Establish a support person whom the student can contact and who will check in with the student regularly during the initial weeks of the transition to school.
- **Be aware of and familiar with your board's procedures for dealing with students who are expressing suicidal thoughts.**

Source: Based on information from: Calear, 2012; CYMHIN-MAD, 2011; Hincks-Dellcrest-ABCs, n.d.

Background Information

What Are the Causes of Depression-related Symptoms?

A number of factors, often genetic and environmental factors in combination (Rutter 1986), can place a child or youth at increased risk for depression (Thapar et al., 2012). Known risk factors include:

- genetic/biological factors;
- negative personality traits;
- a family history of depression;
- distressing family and social environments (e.g., weak parenting practices; absence of supportive structures);
- early life experiences; and
- community characteristics (e.g., neighbourhood violence).

(Based on information from: Thapar et al., 2012; Beardslee et al., 1998; Hammen et al., 2008; Waddell et al., 2005)

Symptoms may occur as a result of such things as recent stressful life events (e.g., a death in the family, a move or other transition) (Kessler, 1997), exposure to traumatic events and adversity (Widom et al., 2007), the cumulative effect of many minor stressful events over time, or chronic stress (e.g., abuse,

poverty, family discord) (Thapar et al., 2012). Further factors associated with the development of MDD include such things as substance abuse, early-onset anxiety or conduct disorder (Kessler et al., 2001), and past depressive episodes (Lewinsohn et al., 1988). When several such factors occur in combination and interact they can influence the developing brain; affect emotional, social, behavioural, and cognitive functioning; and place the individual at risk for developing a depressive disorder or a variety of other health problems (Offord & Bennett, 2002; Waddell et al., 2005; Spenrath et al., 2011).

On the other hand, positive experiences and factors that occur at the individual, family, and community levels help to promote resilience in the child or adolescent (Waddell et al., 2005) and lead to positive outcomes. As well, the way in which individuals interpret and respond to stress (e.g., how they regulate emotion and use coping strategies; their thinking styles) and the quality of their interpersonal relationships (Thapar et al., 2012) may reduce their likelihood of developing depression-related symptoms.

How Common Is Depression?

Depression is common, particularly among adolescents. Prevalence rates in middle to late adolescence are around 4–5 per cent (Costello, 2005, 2006). However, in late adolescence the chances of experiencing depression can be as high as 20 per cent (study findings vary depending on a number of factors) (Lewinsohn, 1999; Hankin, 1998). Among children, it is estimated that fewer than 1 per cent experience depression (Kessler, 2001). Prevalence rates for children and youth are higher if milder problems or problems with less impairment are included (Waddell et al., 2005).

Some mood problems may go away by themselves; however, if left untreated, these difficulties can become a lifelong struggle. Research suggests that the average age for onset of major depressive disorder or dysthymia is between eleven and fourteen years of age (Lewinsohn et al., 1993). Younger children may express their depressed mood differently than youth or adults do. For example, they may not be able to tell people how they feel, but instead may say they have a stomach-ache, a headache, or other aches and pains. The rates are similar for boys and girls in childhood (Rutter, 1986; Nolen-Hoeksema, 1990) but increase significantly for girls during the adolescent years, with females twice as likely as males to develop the disorder beginning at puberty (Kessler et al., 2001; Offord et al., 1989; Moskvina et al., 2007).

Despite the fact that depressive disorder is relatively common among youth, it often goes unrecognized and underdiagnosed. This is worrisome given its association with social and educational impairments, substance use problems (Keenan-Miller et al., 2007; Thapar et al., 2012), and an increased risk of suicide.

(B) BIPOLAR DISORDER

What Is Bipolar Disorder?

Bipolar disorder is a major mental illness that is associated with lifelong consequences for the individual. In adults, bipolar disorder may be characterized by episodes of mania or hypomania (e.g., elation, grandiose thoughts, racing thoughts) alternating with episodes of depression.

Evidence from research suggests that bipolar disorder can emerge in children and adolescents (Perlis et al., 2004; Pavuluri et al., 2005) with negative consequences for their psychosocial development (Sala et al., 2009). If symptoms are present, it is important for the child or adolescent to receive clinical attention from a mental health professional (e.g., a psychiatrist or a psychologist) (Youngstrom et al., 2009).

In children and adolescents, some of the more common symptoms displayed include moodiness, irritability, and reckless or aggressive behaviour (McClellan et al., 2007). Non-euphoric mood states may also be characterized by irritability or grandiosity (i.e., feeling important, feeling able to do anything) (Offord Centre, 2007; Mick et al., 2005).

Symptoms associated with bipolar disorder may affect functioning at school, in the family and community, and with friends. As well, bipolar disorder is associated with suicidal thoughts and behaviour, suicide, and substance use problems (Sala et al., 2009), underlining the importance of early recognition, intervention, and treatment (Sala et al., 2010).

What Does Bipolar Disorder Look Like?

Students may experience periods of sadness and distress. Similarly, students may experience manic periods that include symptoms that are more than "just a good mood". They may feel as though they can do anything or have special powers. They may feel especially self-confident or smart. They may feel extremely irritable or angry, or full of energy and not tired. They may speak rapidly, or mention that they cannot get thoughts out quickly enough. They may jump from thought to thought or from topic to topic. They may have grandiose ideas (e.g., about becoming a movie star or a famous musician) and may appear to need little sleep. Educators may notice that these students have trouble concentrating or seem prone to get into trouble (e.g., ranging from joking around to serious risk-taking behaviour). They may also alternate between periods of being highly productive at school and periods of having trouble completing school assignments. Such behaviour can be difficult for other students to understand and manage. Psychotic symptoms may also be present.

Some of the symptoms associated with bipolar disorder are also experienced to some degree as part of typical development or as a response to particular situations and environments. It is important for educators, parents, and caregivers to observe symptoms and behaviour in relation to the student's stage of development, usual behaviour and moods, and the context in which the symptoms are occurring (e.g., only at school, at both home and school) (Sala et al., 2009; Sala et al., 2010). **Careful assessment by a mental health professional is needed to determine if the symptoms are those of bipolar disorder.**

It is also important to consider symptoms not in isolation but within the broad context of the student's circumstances, environment, and overall personality, since some symptoms that are consistently present with bipolar disorder are also experienced with other mental health problems. For example, irritability, distractibility, and excess energy are found across a range of disorders, including depression, attention-deficit/hyperactivity disorder, conduct disorder, oppositional defiant disorder, and general anxiety disorder (Sala et al., 2010; Merikangas et al., 2009). It is important to note the severity of the symptoms and whether the symptoms are a departure from the student's usual mood and behaviour. **Again, careful assessment by a mental health professional is needed to determine if the symptoms are those of bipolar disorder.**

COMMON SIGNS OF BIPOLAR DISORDER

Some common signs to watch for include the following:

- extremely abnormal mood states (generally lasting weeks or more) and involving a depressed or manic mood
- depressive symptoms (*see the section on depression*)
- manic symptoms, including:
  - feeling extraordinarily self-confident, in a manner that is out of character for the student
  - extreme irritability or changeable, "up and down" (labile) moods that are not typical for the student
  - grandiose and illogical ideas about personal abilities (e.g., the student believes he/she has supernatural powers)
  - extremely impaired judgement compared to usual ability
  - a perception that thoughts are racing
  - extreme changes in speech, particularly very fast speech or talking as if he/she can't get the words out fast enough
  - explosive, lengthy, and often destructive rages that are out of character for the student
  - new or marked hyperactivity, agitation, and distractibility
  - "dare-devil", risk-taking behaviour

(Based on information from: CYMHIN-MAD, 2011)

Note: This list provides some examples but is not exhaustive and should not be used for diagnostic purposes.

What Can Educators Do?*

To Support Students with Symptoms Associated with Bipolar Disorder …

Students with a diagnosis of bipolar disorder should be under the care of a doctor or mental health professional. A student who has been diagnosed with bipolar disorder may already be receiving some form of treatment or intervention. If the behaviour and symptoms associated with bipolar disorder and possible treatments are affecting the student's learning and functioning, academically or socially, it is important for educators to work in collaboration with the family and medical and/or mental health professionals to establish a plan that will best support the student.

Students who have been diagnosed with bipolar disorder often need specific support at school, especially when they are currently experiencing or recovering from an acute mood episode. 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 and may complain of feeling tired or not having any energy. During manic episodes, they may have a great deal of energy, be more involved with friends than usual, have difficulty focusing on the task at hand, and make grandiose plans. They may also engage in unsafe behaviour, such as physically dangerous stunts or very risky sexual behaviour. These fluctuations in mood can be difficult for other students to understand and cope with and can lead to interpersonal conflicts and social isolation for the student with the disorder. Educators should use strategies for keeping interpersonal conflicts from escalating in order to limit the social consequences for both the affected student and his or her peers.

Sometimes the treatment for bipolar disorder can affect a student's school performance. Generally, medication is required, and the student may experience side effects that can interfere with the ability to function. Many medications can have a sedating effect, causing sleepiness or inattentiveness in class or difficulty completing homework. Sometimes, if dosages need adjusting, students may feel restless or agitated and have difficulty sitting still and focusing.

In addition, the cognitive functioning of students with diagnosed bipolar disorder may be affected, so that they have difficulty:

- paying attention;
- remembering and recalling information;
- using problem-solving skills;
- using critical thinking skills and categorizing and organizing information;

* For important information about privacy considerations, see the boxed insert on page 13 of this guide.

- quickly coordinating eye-hand movements;
- staying focused on a topic.

(Based on information from: CYMHIN-MAD, 2011)

Table 2.2 outlines specific strategies that educators can use to support students diagnosed with bipolar disorder.

Table 2.2 Strategies for supporting students diagnosed with bipolar disorder

- Establish a method for regular communication between the school and parents about the expectations for the student and/or homework tasks.
- Consult with parents and mental health professionals (if involved) to identify strategies they recommend and to determine what strategies may best help the student.
- Provide clear, simple instructions to the student, in small chunks, since complex instructions may intimidate or confuse the student.
- Consult with parents and mental health professionals (if involved) for information about the student's symptoms and to learn if there are any limitations that may affect his or her ability to learn.
- For students who are taking medication, it may be appropriate to try to discuss with the student and/or parents whether there are any potential side effects, how they may affect the student's learning, and how to adjust instruction to compensate.
- Check in with the student on arrival to determine how the student is feeling and, where possible, provide alternatives to stressful activities on difficult days. Adjust the homework load to prevent the student from becoming overwhelmed.
- Adjust expectations until symptoms improve. Helping a student choose and focus on attainable goals when symptoms are more severe will improve the student's chances of success.
- Set up a procedure to allow the student to exit quickly and safely from an overwhelming situation.
- Allow extra time for the transition to a new activity or location. Refusal by a student with bipolar disorder to follow directions or move on to the next task may be caused by anxiety and may not be intended as defiance.
- Use strategies at school that are consistent with those used at home.
- If a student is thinking that everything is going wrong, help him or her to focus on things that are going right (e.g., have the student write about something that has gone wrong and on the opposite page write about things that have gone right).
- Work with the parents and the school team to develop supervision and safety plans to address behaviour that may put the student or others at risk.
- Monitor what takes place within the classroom and between classes (if possible) to help students for whom transitions are difficult.
- If a student is returning to school after a hospitalization or prolonged absence, be prepared to develop a plan for the student's reintegration and create a manageable strategy (both for teacher and student) for catching up on classes and assignments and addressing potential issues related to stigma among peers (e.g., whether and how to explain the illness to peers; managing fall-out from extreme behaviour or behaviour that is perceived as bizarre by the student's peers). Establish a support person whom the student can contact and who will check in with the student regularly during the initial weeks of the transition to school.

Source: Based on information from: Hincks-Dellcrest-ABCs, n.d.; CYMHIN-MAD, 2011

Background Information

What Are the Causes of Bipolar Disorder?

A consistent risk factor for the development of bipolar disorder is family history. For children and adolescents with a first-degree relative with bipolar disorder, the risk of developing the disorder is approximately five times as great as for members of the general population (Youngstrom et al., 2009).

How Common Is Bipolar Disorder?

The rates for bipolar disorder are low, between zero and approximately 2.1 per cent in adolescents, with similar rates for males and females (Merikangas et al., 2009). Overall, rates for people of all ages are approximately 3 or 4 per cent (Merikangas et al., 2007). The lower rate in adolescents may be either because the disorder does not occur as often in adolescents or because it is difficult to diagnose accurately until several cycles of symptomatic behaviour have been seen (CYMHIN-MAD, 2011).

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3 Attention and Hyperactivity/ Impulsivity Problems

What Are Attention and Hyperactivity/ Impulsivity Problems?

Many children and youth will, at times, have difficulty paying attention, act impulsively, get overly excited, and/or fail to follow through on requests made by adults. Some children may have more difficulty than their peers in concentrating on school work, completing tasks, and ignoring distractions.

It is often difficult to determine if inattention or hyperactivity/impulsivity are typical for a child's developmental stage and/or age or whether they are cause for concern. A further complicating factor is that some children and adolescents find it hard to stay focused in settings where it is important to pay attention, such as school, but have no problems in other contexts. Behaviour that appears to be out of the normal range for the child's developmental stage may not necessarily mean that the child has an attention disorder; the behaviour may last for only a short time and may reflect development that is within a normal range (Sonuga-Barke et al., 2003). At the same time, inattention should never be ignored and should always be recognized as potential at-risk behaviour. Students who have difficulty paying attention during a task may miss important learning opportunities and fall behind other students in their peer group. Once a learning gap develops, it can be very difficult to close and may increase throughout the school years.

Some students continually have difficulty with attention, to the point where the inattention or hyperactivity/impulsivity interferes significantly with their functioning and interactions at home, at school, and/or in the community (Eiraldi et al., 2012). It is important for educators, parents, and mental health professionals to observe the student's behaviour and functioning in multiple areas, across multiple contexts, and in relation to typical developmental stages and milestones (Holmbeck et al., 2003) in order to determine whether the behaviour is cause for concern, whether additional support is needed, and/or whether the student needs to be assessed by a mental health professional. Students whose problems with attention appear significant and persistent should be assessed by a mental health professional to determine whether a diagnosis of attention-deficit/hyperactivity disorder (ADHD) is warranted (see below, pages 68–70 for a description of ADHD).

For specific information about attention problems in children and adolescents, see *The ABCs of Mental Health* at www.hincksdellcrest.org/Home/Resources-and-publications/The-ABC-s-of-mental-health.aspx.

Although both inattention and hyperactivity/ impulsivity can affect the educational achievement and social functioning of children and adolescents, research findings suggest that academic deficits are more clearly associated with attention problems than with hyperactivity/impulsivity (Rabiner & Coie, 2000; Rogers et al., 2011). Recent findings also show that attention problems strongly predict failure to graduate from high school (Pingault et al., 2011) and that even a few problems with attention, if persistent, predict poor academic outcomes (Warner-Rogers et al., 2000; Massetti et al., 2008; Breslau et al., 2009; Rodrigues et al., 2007; Dally, 2006). In fact, academic impairment has been observed across all age groups in students who have attention problems but who do not necessarily meet the criteria for a diagnosis of ADHD (Fergusson et al., 1997; Currie & Stabile, 2006).

Attention problems, while a core element of ADHD, are also a feature of many other neurodevelopmental disorders such as anxiety or depressive disorders (e.g., difficulty with concentration and decision making), autism spectrum disorders, specific learning disabilities, and vision- or hearing-impairment disorders. Attention problems are also common school-age outcomes of such conditions as fetal alcohol exposure, pre-term birth, complex congenital heart disease, and acute lymphoblastic leukemia. In fact, problems with attention may be a key component associated with the academic difficulties experienced by students with a range of conditions (Breslau et al., 2009).

What Do Attention and Hyperactivity/Impulsivity Problems Look Like?

Because attention problems in the early years can put a child at risk of later educational difficulties, it is important to provide preventive and corrective interventions as early as possible (Pingault et al., 2011; Breslau et al., 2009). Unfortunately, while the more visible behaviour of hyperactivity is readily flagged by educators, problems with attention are less noticeable and less likely to be identified in a timely fashion.

Some students with attention problems struggle with cognitive difficulties and have impairments in areas such as executive functioning (e.g., deficits in working memory, planning, and response inhibition) (Rogers et al., 2011).

In the classroom, this may translate into such things as difficulty remembering and using information, planning, and acquiring new skills and knowledge in reading, oral and written language, and mathematics (Rogers et al., 2011; Daley & Birchwood, 2010).

The work of students with attention difficulties may appear messy, as students often rush through assignments, struggle with attention to detail, and make careless mistakes (APA, 2000). Students with attention problems may have problems with working memory that may lead them to make mistakes (Young, 2012). They may also have difficulty with such things as focusing on classroom activities (Achenbach, 2005), staying on task, completing assignments, adhering to classroom rules, and following the teacher's instructions accurately (Eiraldi, 2012). These problems may make them inefficient learners (Schweitzer et al., 2000), causing them to fall behind their peers (Alloway et al, 2009) and affecting their ability to learn basic skills – particularly in reading, mathematics, and science – that are necessary for more complex learning in later grades (Breslau, 2009; Alloway et al., 2009; Gathercole & Alloway, 2008).

Students with attention problems and hyperactivity may have difficulty remaining in their seat during classroom activities, playing or working quietly, or waiting their turn to speak; they may be fidgety, talk excessively, or appear to be constantly "on the go". The behaviour of adolescent students with hyperactivity is commonly characterized by restlessness and difficulty in persevering with quiet activities (APA, 2000). Students who are impulsive frequently interrupt, make comments out of turn, blurt out answers, are impatient, and do not listen well to directions (APA, 2000); they may be prone to accidents and may find themselves in dangerous situations through failing to consider the consequences of their actions.

COMMON SIGNS OF ATTENTION DISORDERS

Some common signs of attention problems and/or hyperactivity/impulsivity include the following:

Attention problems:

The student:

- is easily distracted;
- fails to pay attention to details and makes careless mistakes;
- forgets things (e.g., pencils) that are needed to complete a task;
- loses things often;

(continued)

COMMON SIGNS OF ATTENTION DISORDERS *(continued)*

- has difficulty organizing tasks;
- finds it hard to concentrate;
- follows directions incompletely or improperly;
- frequently doesn't finish tasks;
- does not listen to what is being said when spoken to;
- avoids or shows strong dislike for schoolwork or homework that requires sustained mental effort (dedicated thinking).

(Based on information from: CYMHIN-MAD, 2011; APA, 2000; CAMH, 2007)

Hyperactivity/Impulsivity:

The student:

- has difficulty sitting still or remaining in seat;
- fidgets;
- has difficulty staying in one place;
- talks excessively or all the time;
- is overly active, which may disturb peers or family members;
- has difficulty playing quietly;
- is always on the move;
- has feelings of restlessness (for adolescents);
- is unable to suppress impulses such as making inappropriate comments;
- interrupts conversations;
- shouts out answers before the end of the question or without being called on;
- hits others;
- has difficulty waiting for a turn;
- is easily frustrated;
- displays poor judgement.

(Based on information from: CYMHIN-MAD, 2011; APA, 2000; CAMH, 2007)

Note: This list provides some examples but is not exhaustive and should not be used for diagnostic purposes.

What Can Educators Do?*

To Promote Positive Mental Health in the Classroom …

Strategies for helping all students, and particularly those who struggle with attention problems, to focus their attention and develop the skills needed for purposeful academic activity are outlined below.

* For important information about privacy considerations, see the boxed insert on page 13 of this guide.

STRATEGIES THAT PROMOTE A CALM CLASSROOM ATMOSPHERE TO HELP ALL STUDENTS PAY ATTENTION

- Provide a structured environment and a consistent daily routine.
- Provide advance warning of changes in routines or activities.
- Establish a routine and set of rules for moving from one activity to the next.
- Establish procedures that allow all students equal opportunities to participate in activities (e.g., establish rules for turn taking; arrange for everyone to get a chance to be first).
- Provide easy-to-follow directions and instructions (e.g., explain one step at a time; chunk multi-step directions).
- Post rules where everyone can see them.
- Reinforce positive behaviour such as raising a hand before speaking, engaging in quiet work.
- Provide opportunities to learn by doing to give students an outlet for excess energy.
- Limit visual and auditory distractions in the classroom as much as possible while considering the needs of all students.
- When talking to students, address them directly and use eye contact. Wait until a student is paying attention before continuing a conversation.
- Avoid a focus on competition, as students' urge to win or be first can increase the likelihood of impulsive behaviour.

(Based on information from: House, 2002; CAMH, 2007)

To Support Students with Attention and/or Hyperactivity/Impulsivity Problems …

Attention problems are rooted in neurobiological causes. Children and youth with difficulty in this area require consistent support and structure in order to manage their behaviour and reach their academic potential. Students with problems with attention and/or hyperactivity/impulsivity are most successful in structured settings, with posted schedules and few distractions (e.g., away from windows and doors but not isolated). They need predictable routines (Eiraldi et al., 2012), and modelling of good organizational skills. At times, teachers may need to alter tasks and instructions to accommodate a short attention span (e.g., decrease task length, divide tasks into small units, modify the mode of delivering instruction, use peer assisted learning). Classroom structures (e.g., seating arrangements) may need to be modified to reduce sources of distraction, and extra supports may be needed to encourage the student's active engagement in learning. It is important to remember that students with attention problems do not take in as much information as other students, and educators should monitor the learning of these students to ensure that they are not missing important skills and knowledge. Clear rules

for behaviour and conduct and clear and consistently reinforced consequences can also be helpful, particularly with students who are impulsive (Eiraldi et al., 2012). It is also helpful if similar strategies are in place in a range of settings, such as at home and at school. Educators will need to work closely with parents/caregivers to maintain a consistent approach.

The strategies provided in this guide are appropriate mainly for elementary-age children with attention, hyperactivity, or impulsivity problems. To date, research with a focus on pre-school-age children and adolescents has been limited (Eiraldi et al., 2012). However, we do know that the increased academic demands of secondary school along with the reduced amount of structure, increased autonomy, and increased social pressures that occur during adolescence create new challenges both for the student and for educators (Young & Amarasinghe, 2010). It is important for secondary school teachers to work to understand the special challenges that attention, hyperactivity, or impulsivity problems can cause, and help the student develop and use strategies that can assist with time management, work completion, and organization.

Table 3.1 outlines specific strategies that educators can use to address a range of problems associated with inattention and hyperactivity/impulsivity.

Table 3.1 Specific strategies for supporting students with attention and hyperactivity/impulsivity problems

Purpose	Specific Classroom Strategies
To improve executive functioning (e.g., ability to plan, problem solve, do more than one thing at a time)	• Reduce the amount of information students have to retain and process. • Provide direct instruction in specific academic skills. • Chunk critical instructions, allow time for mental processing, and repeat. • Use advance organizers, structured note-taking sheets, manipulatives, and visual representations. • Use teaching/learning strategies such as mnemonics. • Use class-wide peer tutoring.
To improve students' ability to pay attention	• Determine students' strengths and needs and adjust instructional practice accordingly. • Find ways to support active engagement in learning through understanding students' interests. • Provide activities that capitalize on students' strengths and abilities. • Monitor student learning to detect gaps in skills and knowledge, as students with poor attention may not take in as much information as their peers. *(continued)*

Table 3.1 *(continued)*

Purpose	Specific Classroom Strategies
To improve students' ability to pay attention *(continued)*	• Create a structured and predictable classroom environment. • Break down tasks into smaller chunks or units; gradually introduce tasks that take longer. • Assign only one task at a time. • Give smaller assignments. • Help students to record each day's homework and what they need to do in a planner or journal. Check to ensure they have recorded the information accurately. • Teach the student to use checklists and check items off as they are completed. (Lists provide a prompt for tasks to be done and provide the satisfaction of checking things off once they are completed.) • Ask the student to repeat instructions (e.g., "OK, so, tell me what you must do"). • Provide encouragement such as stars or small, frequently changing rewards for younger students. • Write assignments and homework on the board and repeat them aloud to the class. • Reward prosocial behaviour with positive attention and tangible rewards. • Seat students with attention problems close to the teacher and away from distractions such as windows, doors, or other students with attention problems. • Use peer-assisted learning. • Use an attention cue to prompt students to remain on task. • Provide extra time for completing tests. • Allow test taking in a quiet room (if feasible). • For adolescents: Chunk units of learning in 10- to 15-minute blocks, followed by rapid review to consolidate learning. • Use daily communication books to inform parents about positive things that occur in the student's day and challenges the student faces.
To reduce/manage behaviour associated with hyperactivity/ impulsivity	• Create a structured and predictable classroom environment. • Establish short work sessions. • Break down tasks into several smaller chunks or units. • Assign only one task at a time. • Suggest the use of fidget toys for students who are fidgeting or squirming. • For young children: Ensure that consequences for undesirable behaviour follow immediately after inappropriate behaviour so the child understands the connection. • Clearly outline the consequences for undesirable behaviour ahead of time and apply them consistently. *(continued)*

Table 3.1 *(continued)*

Purpose	Specific Classroom Strategies
To reduce/manage behaviour associated with hyperactivity/ impulsivity *(continued)*	• Provide encouragement such as stars or small, frequently changing rewards for younger students. • Provide activities that capitalize on students' strengths and abilities. • Create a monitoring system, such as counting the number of times in and out of seat. (Note: this may be done by an educator or the student, depending on the stage of development.) • Provide activities that appeal to multiple senses. • Find out what the students are interested in or what motivates them. • Reward prosocial behaviour with positive attention and tangible rewards. • Establish clear rules for behaviour and conduct. • Seat students close to the teacher and away from distractions such as windows, doors, or other students with attention problems. • For young children: Have the student do simple errands that allow him/her to get up, move around with a purpose, and feel helpful. • Use daily communication books to inform parents about positive things that occur in the student's day and challenges the student faces.

To reinforce positive behaviour	• Provide tangible rewards (such as points, tokens, or stickers) for on-task behaviour and appropriate classroom behaviour. The following aspects should be considered in setting up a rewards system:
	  • Rewards could be given immediately or at a specified time.
	  • The behaviour being rewarded should be specifically identified (e.g., raising hand before speaking) rather than generic "good" behaviour.
	  • Tokens or points could be exchanged for a favourite activity or a prize chosen by the student. A variation is to have students lose points for undesirable behaviour but earn back points for desirable behaviour.

Source: Based on information from: Tannock, 2007; Rowe et al., 2005; Eiraldi et al., 2012; Hincks-Dellcrest-ABCs, n.d.; CAMH, 2007; Parker, 2005; Lewandowski et al., 2007

It is often difficult to determine whether academic underachievement is a result of learning problems or attention problems or both. In many cases, the classroom teacher will need to provide support for both the learning problems and the attention problems. In either case, students may need direct support to help them complete assignments successfully and meet age-appropriate learning expectations. Table 3.2 suggests strategies teachers can use to address behaviour that interferes with students' learning.

Table 3.2 Strategies to address behaviour that hinders learning

Behaviour	Classroom Strategies
The student makes careless errors or does not pay attention to important details.	• Find a way to make the task more interesting for a student who does not like the task and may be trying to avoid it. • Provide the student with finished examples of assignments to let him/her know exactly what the finished product should look like. • Provide the student with a concrete visual reminder of key steps, such as a sequence chart listing important actions.
The student cannot focus attention on a task long enough to progress with it.	• Strengthen the student's engagement by providing increased opportunities to respond (e.g., through peer tutoring and/or the use of response cards). • Encourage active learning through discussions, group activities, and activities that draw on the special talents or skills of the student.
The student is procrastinating about starting a task.	• Discuss the student's plan for the work to make sure he or she knows what the steps are. • Prompt the student to get started. • Walk the student through the first portion of the task to get him or her started. • Write down the time when the student starts and the time the student will stop work. • Teach the student to estimate how much time the task will take and then monitor how long it actually takes. • Teach the student to notice when he or she is not on task. Teach him or her to take a break for 10 minutes and then return to the task.
The student has difficulty following through on instructions.	• Use small-group instruction or peer-assisted learning strategies to provide the student with guided, proactive instruction. • Simplify instructions and outline steps one at a time. • Provide concrete examples and scoring rubrics so the student will know what a good completed assignment looks like. • Teach the student how to use a calendar and an assignment planner. • Provide visual reminders of instructions, coach the student with guided practice, and provide visual cues for the steps needed to complete assignments (for example, help the student break the assignment into manageable chunks).
The student appears to be forgetful or loses things.	• Provide the student with visual reminders of key actions or materials.
The student is distracted by extraneous details.	• Provide the student with a visual checklist to guide academic work. • Increase opportunities for the student to respond and get feedback through response cards, small-group work, peer-assisted learning strategies, and computer-assisted learning activities.

Source: Based on information from: Hincks-Dellcrest-ABCs, n.d.

Developmental Note

For children of pre-school age, helpful strategies might include allowing the child to play creatively and without specific instructions (Webster-Stratton, 2005). Reinforcement strategies should consist of concrete rewards that are distributed immediately after positive behaviour. If removal of an object is used as a form of consequence (e.g., removal of a toy), the length of time of removal should be brief (DuPaul & Kern, 2011).

For adolescents, strategies might include negotiating the terms of an agreement in advance with the student so that expectations are clear. For example, points can be awarded for desired behaviour and can be traded in for a later reward (e.g., a favourite weekend activity).

Attention-Deficit/Hyperactivity Disorder

Attention-deficit/hyperactivity disorder (ADHD) is a clinically significant and common neurodevelopmental disorder that is characterized by persistent and high levels of inattention as well as hyperactivity and impulsivity symptoms that impair daily functioning in a range of contexts, including school, home, work, and social situations (Biederman & Faraone, 2005; APA, 2000). It is important to clarify that inattention does not cause hyperactivity/impulsivity. However, if a student's attention is focused on a task, the student's hyperactivity and impulsivity may be less evident. The type of behaviour exhibited is not necessarily related to the child's stage of development (Zwi et al., 2011).

SUBTYPES OF ADHD

The following three subtypes of ADHD have been identified:

(1) predominantly inattentive (without symptoms of hyperactivity/impulsivity)

(2) predominantly hyperactive/impulsive (without symptoms of inattention)

(3) predominantly combined (symptoms of both inattention and hyperactivity/impulsivity) (Eiraldi et al., 2012).

The combined type (inattention and hyperactivity/impulsivity) is the most common of the three. (Based on information from: APA, 2000)

ADHD begins early in childhood and may persist throughout life. A diagnosis is based on several types of behaviour that occur over a specific period of time beginning before a certain age. ADHD occurs not only in school-age children but also in pre-school-age children, adolescents, and adults (Daley & Birchwood, 2010). It is often difficult to diagnose children under the age of four or five years

because their behaviour is variable and they are not in situations that require sustained attention as often as older children (APA, 2000).

There is evidence that the early onset of ADHD may be associated with social and academic difficulties and impairments (Taylor, 1999). For this reason, early recognition of symptoms of possible ADHD is very important so that the child can receive a proper assessment by a mental health professional. Appropriate intervention can help to minimize the effects of ADHD on the child and adolescent over time (Greenhill et al., 2008).

Students who have ADHD may have difficulty regulating their emotions, have a low tolerance for frustration, and have difficult relationships with peers (Barkley, 1998). ADHD is also commonly associated with other mental health problems, including depression and anxiety disorders (Egger et al., 2006), and can also co-occur with disorders such as oppositional defiant disorder and conduct disorder (Zwi et al., 2011). In adolescence, ADHD is associated with higher rates of alcohol, nicotine, and other drug abuse, especially if the co-occurring emotional and behavioural problems of the adolescent are not addressed.

Findings have shown that school-age children with ADHD present symptoms similar to those of pre-school children with ADHD but may also display problematic behaviour such as defiance, disobedience, and aggression (Young & Amarasinghe, 2010). In adolescents, however, symptoms of ADHD may look different from those observed in children. Hyperactivity is known to decrease in adolescence, while symptoms of inattention remain and significantly affect academic achievement (Biederman et al., 2000).

For many students, problems with ADHD are compounded by problems with learning; about half of students with ADHD also have a diagnosable learning disorder.

Background Information

What Are the Causes of ADHD?

There is strong evidence to suggest that ADHD is associated with a combination of genetic and environmental risk factors (Galera et al., 2011). Attention problems tend to run in families. About 25 per cent of parents whose children have attention problems also have or had similar difficulties or other mental health problems such as depression. Specific genes that cause ADHD have yet to be identified.

The most consistent environmental risk factors associated with ADHD include events that occur during the prenatal, perinatal (right before or after birth), or

early postnatal period (Galera et al., 2011; Thapar et al., 2011). Factors shown to contribute to ADHD in children also include smoking during pregnancy (Cornelius & Day, 2009; Zwi et al., 2011) and alcohol or heroin use during pregnancy (NICE, 2008). There is still more to understand regarding the impact of risk factors such as the use of alcohol or illegal drugs during pregnancy, low birth weight, and birth complications.

How Common Is ADHD?

Research findings show that approximately 10 per cent of children have persistent attention problems (Gathercole & Alloway, 2008; Young, 2012), but this number does not include children who are thought to meet diagnostic criteria for ADHD (Polanczyk & Rohde, 2007).The prevalence rates of ADHD in children and adolescents vary from study to study depending on who is in the sample, where the study was conducted, and the particular criteria used to assess ADHD symptoms. However, systematic review findings have generally shown rates between 5 and 10 per cent (Polancyzk & Rohde, 2007; Polancyzk & Jensen, 2008). It is well established that rates of ADHD are significantly higher in boys than in girls, with estimates ranging from 3:1 to 9:1 (Staller & Faraone, 2006). However by adulthood, the rates among males and females are equal, suggesting that earlier symptoms of ADHD in girls may tend to be overlooked (Polanczyk & Rohde, 2007). Roughly 50 per cent of children with ADHD will continue to have symptoms in adolescence, but the symptoms may look different (Young & Amarasinghe, 2010). About half of these adolescents will still have symptoms as adults. The prevalence rate for ADHD in adulthood is between 1 and 4 per cent (Kessler et al., 2006).

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4 Behaviour Problems

What Are Behaviour Problems?

It is not uncommon for children and youth to "break the rules" or "act out" from time to time. In fact, it can be a part of healthy development for a child to test limits occasionally and express differences of opinion. There are predictable times and stages in a child's growth when oppositional behaviour is relatively common (e.g., among toddlers and teens). Since a specific behaviour may be problematic at one age but perfectly typical at another age, understanding child development is an important part of understanding behaviour problems. As well, occasional outbursts of disruptive behaviour are often a response to specific causes, such as frustration with an assignment, conflict with another student, tiredness, or an attempt to show off for peers. Some students may be slower than their peers to learn social and self-regulation skills, resulting in difficulties in behaviour control at school.

Sometimes, a pattern of negative, non-compliant behaviour can develop in a child or youth. When students are frequently argumentative, oppositional, and/or aggressive, this may signal that they are struggling with their emotional health. Patterns that are characterized by non-compliance and defiance are sometimes referred to as oppositional defiant disorder (ODD). Clusters of behaviour that are associated with violence and such things as aggression towards people and animals, destruction of property, deceitfulness or theft, and serious violations of rules fall into a category called conduct disorder (CD). Sometimes children and youth with ODD continue into the more serious CD category. **A diagnosis of ODD or CD can only be made by a mental health professional, such as a psychologist or psychiatrist.**

TYPES OF DISRUPTIVE BEHAVIOUR DISORDERS

Oppositional defiant disorder (ODD) is generally characterized by a recurrent pattern of negative, defiant, disobedient, and hostile behaviour towards authority figures that occurs over a specific period of time. Children and youth often lose their temper, argue with adults, refuse to obey the requests or rules of adults, deliberately do things to annoy other people, blame others for their own mistakes, and can be touchy or easily annoyed, angry, resentful, spiteful, or vindictive. Much of the defiant behaviour is directed at authority figures but may sometimes target siblings, playmates, or classmates. The child's home life, school life, and peer relationships

(continued)

TYPES OF DISRUPTIVE BEHAVIOUR DISORDERS *(continued)*

must be significantly impaired. ODD usually appears before eight years of age and no later than early adolescence.

Many youth with ODD have other mental health problems, such as depression, anxiety, or attention difficulties. Their behaviour problems often develop as a result of these conditions.

Conduct disorder (CD) is generally characterized by severe and persistent antisocial behaviour and is associated with a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated. Problem behaviour may include aggressive conduct, disruptive but non-aggressive conduct (such as theft or deceit and serious rule violations), bullying, cruelty, stealing, weapons use, fire setting, lying, running away, and truancy. Conduct disorder is diagnosed when the behaviour has been present for a certain amount of time, begins at specific ages, and is causing significant impairment in social, academic, or occupational functioning. The behaviour is typically seen across a range of settings, including home, community, and school.

Conduct disorder may also be associated with other disorders, including learning disorders and mental health problems such as ADHD, substance use disorders, anxiety, and depression. Conduct disorder usually begins in late childhood or early adolescence, but has been seen in children as young as age five. It rarely develops after sixteen years of age.

Treatment of ODD and CD is difficult, given the range of risk factors and the fact that these disorders are often co-morbid with other mental health disorders such as ADHD, depression, and substance use problems.

(Based on information from: Waddell et al., 2001; APA, 2000; Offord & Bennett, 1994; Burke et al., 2002)

Note: These summaries provide only a brief description and are not to be used for diagnostic purposes.

Untreated disruptive behaviour disorders are associated with highly negative outcomes, such as worsening of conduct/criminal behaviour, low academic achievement and school failure, further disengagement with school, involvement with antisocial peers, and increased risk for the development of other mental health problems. A student with multiple risk factors in his or her life (e.g., poverty, a difficult home environment, harsh and inconsistent parenting) may be more likely than other students to develop a behaviour disorder. A student whose disruptive behaviour is increasing in severity or persisting over time is at high risk for a range of negative outcomes in adolescence and adulthood (Lee, 2012). Research has shown that the more severe the symptoms are in childhood, the worse the outcomes can be in adulthood.

Significant behaviour problems are among the most difficult mental health problems to manage at school. Persistent oppositional behaviour can be disruptive in the classroom, interfering not only with the student's own learning but with that of the other students. Early assessment and intervention are extremely important because of the negative impact of disruptive behaviour in the school, home, and community settings and the potential difficulties the individual will face in adolescence and adulthood if the behaviour is not treated and managed. If not addressed in a timely fashion, the problematic behaviour may worsen and become enduring (Lochman et al., 2011).

What Do Problems with Behaviour Look Like?

Disruptive behaviour can take different forms, ranging from minor displays, including yelling or temper tantrums, to more serious misconduct such as aggression, violence, vandalism, and stealing (McMahon and Frick, 2007).

Many episodes of problem behaviour are short-lived and may be the result of a particular stressful situation or difficulty the student is facing. For example, a student may start acting out as a result of stresses at home (e.g., a death in the family, parental conflict) or at school (e.g., being a target of bullying). In many cases, simply offering reassurance and providing extra support and coping strategies to the student will end the behaviour. If the student's behaviour does not improve, however, the problem may be serious enough to require professional help.

COMMON SIGNS OF BEHAVIOUR DISORDERS

Some common indicators of problem behaviour include the following:

- defiance (persistent stubbornness; resistance to following directions; unwillingness to compromise, give in, or negotiate)
- persistent testing of limits (by ignoring, arguing, not accepting blame)
- persistent hostile mood
- lack of empathy, guilt, or remorse, and a tendency to blame others for his/her own mistakes
- low self-esteem that may masquerade as "toughness"
- acting aggressively
- disobedience
- oppositional behaviour (e.g., challenging or arguing with authority figures)
- bullying, threatening, or intimidating others
- initiating fights or displaying physical violence/cruelty
- using weapons
- stealing

(continued)

COMMON SIGNS OF BEHAVIOUR DISORDERS *(continued)*

- deliberate destruction of property
- frequent lying
- serious violations of rules (e.g., in early adolescents, staying out late when forbidden to do so)
- skipping school often
- outbursts of anger, low tolerance for frustration, irritability
- recklessness; risk-taking acts

Signs that the problem may be serious include the following:

- The student shows problems with behaviour for several months, is repeatedly disobedient, talks back, or is physically aggressive.
- The behaviour is out of the ordinary and is a serious violation of the accepted rules in the family and community (e.g., vandalism, theft, violence).
- The behaviour goes far beyond childish mischief or adolescent rebelliousness.
- The behaviour is not simply a reaction to something stressful that is happening in the student's life (e.g., widespread crime in the community, poverty).

(Based on information from: APA, 2000; CPRF, 2005; Hincks-Dellcrest-ABCs, n.d.)

Note: These lists provide some examples but are not exhaustive and should not be used for diagnostic purposes.

For more detailed information about behaviour problems in children and adolescents, see *The ABCs of Mental Health* at www.hincksdellcrest.org/ABC/; and the Offord Centre for Child Studies pamphlet *Behaviour Problems in Children and Adolescents,* at http://www.knowledge.offordcentre.com/.

What Can Educators Do?*

To Promote Positive Mental Health in the Classroom …

Educators can create classroom environments that reduce stress and promote positive behaviour for all students. Such an environment will help all students, including those who are at high risk for behaviour disorders.

* For important information about privacy considerations, see the boxed insert on page 13 of this guide.

A number of studies have been done to identify approaches and strategies that have been used successfully in the classroom to help prevent and address disruptive behaviour. Effective practices include the following:

- the use of class-wide prevention strategies to reduce the overall number of children who develop problem behaviour
- a focus on building students' social and problem-solving skills, ability to regulate their emotions and control anger, and ability to see another person's perspective and feel empathy
- the use of consistent classroom routines so that students have a clear understanding of the expectations for behaviour
- the use of a range of instructional methods, learning opportunities, and learning settings to give students opportunities to apply new skills in a variety of situations and environments
- the use of flexible groupings and a focus on group outcomes for small-group activities to enable high-risk students to interact with different groups of peers, improve their social and academic skills, and build positive relationships and support networks
- for students demonstrating disruptive behaviour: avoidance of harsh discipline for negative behaviour, coupled with positive reinforcement for desired and prosocial behaviour (Note: providing negative attention and trying to suppress disruptive behaviour may result in the student's refusal to invest in prosocial classroom behaviours and may drive the student to hide disruptive behaviour.)
- for students demonstrating disruptive behaviour: establishing regular communication with parents/caregivers to develop a coordinated approach to help the student achieve positive educational and behavioural goals

(Based on information from: Lee, 2012)

Strategies that educators can use to promote positive behaviour in the classroom are outlined below.

STRATEGIES THAT PROMOTE POSITIVE BEHAVIOUR AMONG ALL STUDENTS

- Provide predictable schedules and routines in the classroom.
- Focus the students' attention before starting the lesson.
- Use direct instruction to clarify what will be happening.
- Model the quiet, respectful behaviour students are expected to demonstrate.
- Create an inviting classroom environment that may include a quiet space, with few distractions, to which a student can retreat.
- Be aware of the range of needs of the students in the class in order to provide an appropriate level of stimulation.

(continued)

STRATEGIES THAT PROMOTE POSITIVE BEHAVIOUR AMONG ALL STUDENTS *(continued)*

- Communicate expectations clearly and enforce them consistently. Use clear statements when speaking to students: "I expect you to …" or "I want you to…".
- Focus on appropriate behaviour. Use rules that describe the behaviour you want, not the behaviour you are discouraging (e.g., Instead of saying "No fighting", say "Settle conflicts appropriately").
- At the beginning of the school year, clearly and simply define expectations for honesty, responsibility, and accountability at school. Repeat these expectations often to the entire class, especially when violations occur.
- Don't focus too much attention on children who blame others, since that might inadvertently reinforce the behaviour.
- Begin each day with a clean slate.
- Facilitate the transition from the playground to the classroom by calmly telling students when there are five minutes left and then one minute left in recess, encouraging them to prepare to come in, and helping them settle in class when recess is over. Schedule a predictable classroom activity that most students will enjoy to follow recess, to help provide a smooth transition.

(Based on information from: CYMHIN-MAD, 2011; Hincks-Dellcrest-ABCs, n.d; Lee, 2012)

To Support Students with Behaviour Problems …

Behaviour problems in the classroom have a number of negative effects. The education of both the student and that of others in the classroom can be adversely affected.

When students who usually behave well begin to misbehave, educators need to observe the student carefully to gather information that may give insight into the student's thinking and help identify the reason for the behaviour (for example, whether the student is having difficulties at home or with peers). The following information should be noted:

1. when the problem behaviour started
2. when the behaviour occurs (e.g., throughout the day, during recess, during transitions between activities, during a specific classroom activity)
3. what was happening before the behaviour began (the antecedent)
4. the result of the behaviour (e.g., the effect on classmates and/or the teacher)

It is also useful to note the frequency of the behaviour, its intensity or severity, and how long it lasts. This type of information may be helpful in discussions about the student's behaviour. **(Note: When and how this information about the student is shared, and with whom, will be determined by school and board protocols for dealing with disruptive behaviour.)**

Gathering and analysing information about the behaviour and its context is a first step that can help educators and parents/caregivers understand the behaviour and find ways to address the chain of events that occur around it. For example, the teacher can remove specific identified triggers, or make changes to classroom routines or the student's activities to prevent the behaviour from occurring. Additional specific strategies are outlined in table 4.1.

Table 4.1 Strategies for supporting students with behavioural problems in the classroom

Types of Behaviour	Classroom Strategies
Behaviour problems such as: • verbally or physically threatening others • fighting with other students • refusal or inability to stop an activity or behaviour	• Use non-verbal cuing, such as hand gestures, proximity, facial expressions, or other signals to let a student know in a low-key way (without drawing the attention of the whole class) that the behaviour is not acceptable. • Use low-profile interventions for minor problems so that students are not rewarded for misbehaviour by becoming the centre of attention. • Work with the student to solve problems, to encourage the student to take responsibility for and ownership of his/her behaviour. • Model positive behaviour. • Use a neutral, non-confrontational tone (e.g., "I notice that you have been …") when talking about behaviour with the student. • Arrange a quiet, safe place where the student can go to calm down when angry or frustrated. • For the aggressive student: Encourage him/her to participate in sports activities. • For young children: Help them to express their anger or frustration verbally. This may require the educator to write out the words for the student. • Help the student to practise using "self-talk", to talk him/herself through times when things are going wrong. For example, "I have the right to be mad, but I am not going to lose it." • Give positive reinforcement to the student for showing self-control in situations that would normally make him/her angry, annoyed, or upset (e.g., give a tangible reward such as a classroom privilege or free time). • Structure classroom seating arrangements to reduce opportunities for conflict. Experiment with different seating arrangements in the classroom to find the optimal location for the student. • Teach alternative ways of dealing with anger or frustration (e.g., walking away, talking). • Provide a quiet space away from peers where the student can work independently (but do not isolate the student as a form of punishment). *(continued)*

Table 4.1 *(continued)*	
Types of Behaviour	**Classroom Strategies**
	• Maintain consistent expectations and daily routines. • Avoid behaviour that could be stressful for the student (e.g., publicly announcing test scores, or requiring the student to read out loud in class). • Plan a full schedule of activities to avoid periods of unstructured time. • Provide clear instructions and make sure the rules are understood before an activity begins. • Establish clear classroom rules, review them often, and post visual reminders of what they are. • Discuss alternative solutions with a student who has behaved/is behaving inappropriately. • Provide enough time for the student to complete work or activities. • Clearly communicate what the time limits are for tasks and activities and check to ensure that the student understands what they are. Keep the student informed about how much time is left (e.g., use a signal such as turning off lights). • Develop strategies to support the student during the transition between activities. • Give the student brief assignments to start with and longer ones as the student's ability to cope with work improves. • Reinforce the student's efforts to clear away his/her materials after a task is finished (workbook, pencil). • Allow the student to begin a new activity when he/she demonstrates self-control. • Model socially acceptable behaviour.

Source: Based on information from: House, 2002; CYMHIN-MAD, 2011; CPRF, 2005

Problems with behaviour can be the most visible symptoms of a student who is struggling. Behavioural difficulties that are often seen in the classroom may signal – or result from – learning problems. However, given the complexity of disruptive behaviour and the fact that the behaviour often occurs unexpectedly, it is sometimes difficult to determine why the student is acting in a certain way. Determining the (conscious or unconscious) reason for the behaviour, however, will be extremely helpful for determining strategies that will address the behaviour effectively. For example, if a student becomes disruptive whenever a particular classroom activity is scheduled and the disruptive behaviour leads the teacher to excuse the student from participating in the activity, it is reasonable to conclude that the student wants to avoid that activity. The student may not be able to communicate directly that he/she wishes to avoid the activity, but the behaviour has the desired effect. It should also be remembered that

there can be a number of reasons why a particular behaviour occurs, so that different strategies may be needed to address a behaviour that different students demonstrate for different reasons (Lee, 2012).

When trying to determine the cause of the behaviour, it is helpful to know whether the student has other risk factors, whether there are any identifiable "triggers" (e.g., a sequence of events or stimuli) for the behaviour, and what the student was thinking and feeling before and after the behaviour occurred (Lee, 2012).

Possible reasons for disruptive behaviour include the following:

- to get attention
- to get help
- to get feedback or approval
- to gain power or control
- to communicate something
- to avoid something or someone
- to get something specific
- as a response to confusion (lack of understanding)
- to reduce boredom
- to reduce worry
- to continue a specific activity

(Based on information from: Lee, 2012)

Table 4.2 provides examples of strategies that are tailored to address different reasons for a particular behaviour.

Table 4.2 Strategies that address possible different reasons for a behaviour

Behaviour and Reasons	Classroom Strategies
Behaviour 1: Aggression – pushing peers on the playground at recess.	
Reason (a): The student wants to get in the front of the line for the slide. The student has difficulty waiting for his/her turn.	• Teach turn taking. • Have the student practise skills with peers, including the target behaviour of waiting in line while other children go down the slide. Reinforce learning by having the student practise using turn-taking skills in a variety of other settings.
Reason (b): The student is frustrated with not getting passed the ball at recess. The student has difficulty using words to express anger.	• Give direct anger-management instruction to help the student identify when he/she is becoming frustrated, learn to use self-calming techniques to manage angry feelings, and use words to communicate feelings and needs. • Teach the student to get adult help when feeling frustrated. • Encourage peers to try to include the student.

(continued)

Table 4.2 *(continued)*	
Behaviour and Reasons	**Classroom Strategies**
Behaviour 1 (continued)	
Reason (c): The student wants to continue playing, and does not want to come in from recess. The behaviour delays having to come in from recess.	• Outline for the student in clear, simple terms the activities that need to take place during the school day and the need to stick to the schedule.
Behaviour 2: Calling out in class	
Reason (a): The student wants to avoid being called on because of worries about speaking in front of the class.	• Help the student rehearse being called on and answering questions first with the teacher alone, then in small groups, and then in a whole-class activity. • Rehearse answers to questions with the student ahead of time, and then invite the student to answer in class.
Reason (b): The student wants to avoid an assignment that he/she does not understand.	• Teach the student appropriate ways to let the teacher know that he/she does not understand material and to ask for help. Explain to the student that requests for help and clarification will be welcomed and valued and will not have negative consequences. • Rehearse with the student ways of asking for help and letting the teacher know when he/she is feeling overwhelmed.
Behaviour 3: Out-of-seat behaviour	
Reason (a): The student is seeking help.	• Teach the student appropriate ways to get teacher attention and ask for help (e.g., staying seated and raising his/her hand). • Help the student practise appropriate behaviour by at first responding quickly to the student's signals, then gradually increasing response time to help the student get used to waiting longer. • Record the student's goal and the steps to achieve it on a piece of paper and tape it on the student's desk as a reference and reminder. • Use positive reinforcement to reward desired behaviour.
Reason (b): The student is hyperactive and easily distracted.	• Break tasks into small chunks and use teacher proximity to help the student remain on task. Assign small tasks that don't require elaborate steps or take a long time to complete.

Table 4.2 *(continued)*	
Behaviour and Reasons	**Classroom Strategies**
Behaviour 4: Not handing in homework	
Reason (a): The student has difficulty with organization, and there is a weak family-school link.	• Meet with parents/caregivers to discuss the student's progress, focusing on desired outcomes and praising the student's and parents' efforts and skills. • Work with the student and parents to develop channels and routines for school-home communication. • Suggest use of a daily journal by the student to help the teacher and the student communicate and keep track of academic assignments and expectations. • Sit down with the student at the end of each school day to go over the journal. Ask the student to share each day's entry with parents/ caregivers after school.
Reason (b): The student no longer has confidence in his/her academic ability to complete the assignment.	• Help the student to fully understand the assigned tasks. • Provide supports that strengthen the student's ability to complete the task as assigned and provide positive reinforcement around abilities and achieved goals (e.g., "I knew you could do it").

Source: Adapted from Table 1: "Disruptive behaviors, possible functions, and potential interventions" from T. Lee, "School-based Interventions for Disruptive Behavior", in J.Q. Bostic and A.L. Bagnell, eds., issue titled "Evidence-based School Psychiatry", *Child and Adolescent Psychiatric Clinics of North America, 21*, no. 1 (January 2012)

Background Information

What Are the Causes of Behaviour Problems?

A number of influences can lead to the development of a behaviour disorder. Biological factors (e.g., genetic makeup, prenatal influences, temperament, verbal functioning) appear to play a role, and environmental circumstances (e.g., a harsh, inconsistent parenting style, a disorganized school environment, rejection by peers) can have a significant effect. Multiple risk factors in combination can aggravate problem behaviour. Research evidence shows that students with behaviour problems may be viewed more negatively by parents, teachers, and peers and may receive less positive reinforcement or recognition than other students. Protective factors and positive influences can work to break the counterproductive cycle that many students with behavioural difficulties become trapped in.

In addition to the factors noted above, a student's behaviour problems may be associated with and/or aggravated by other developmental or mental health problems such as ADHD, substance use problems, anxiety, and mood disorders.

Behaviour problems may also develop among students with autism, who can have great difficulty understanding social cues and behaviour, and among students with physical disabilities or chronic illnesses, who may have limited experience with social situations in which they can observe and practise age-appropriate behaviour. It can be especially difficult to find effective strategies to treat and support students who demonstrate a combination of disruptive behaviour and other mental health problems (Hinshaw, 1992).

How Common Are Behaviour Problems?

Approximately 5.5 per cent of children and adolescents in Canada are diagnosed with conduct disorder, which means that it is fairly common (Offord, 1989; Waddell et al., 2001). Between 5 and 15 per cent of children are diagnosed with oppositional defiant disorder (Offord Centre, n.d.). These rates indicate that in any given classroom there could be at least one or two students with behaviour problems.

Conduct disorder is roughly three to four times more common in boys than in girls (Burke et al., 2002). The findings for ODD are mixed; some studies show equal rates in boys and girls, and others show higher rates in boys (Loeber et al., 2000; Merikangas et al., 2009). Disruptive behaviour disorders appear to be more common in urban than in rural areas.

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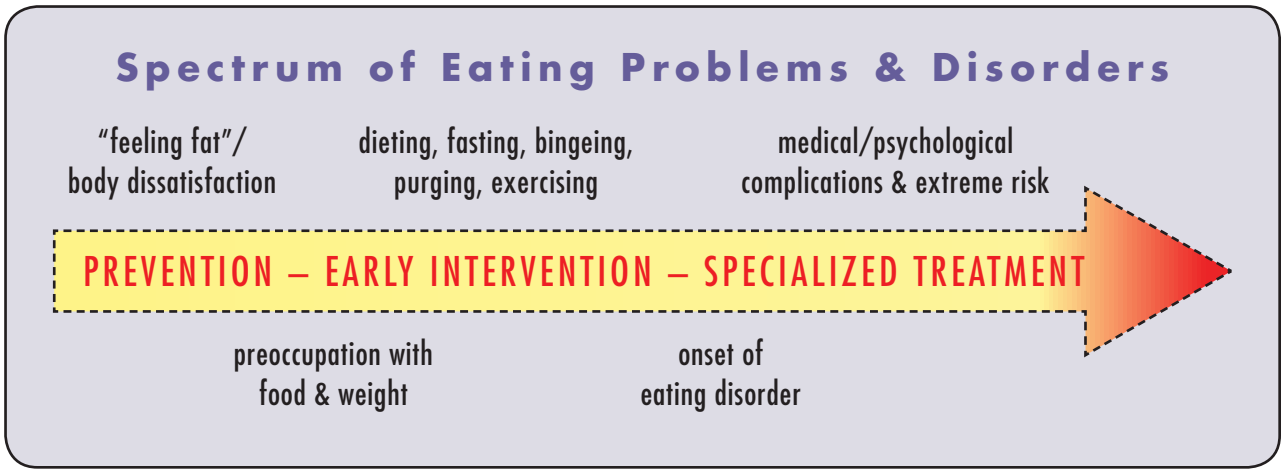
5 Eating and Weight-related Problems

What Are Eating Problems and Weight-related Problems?

Eating satisfies a basic human need and provides essential energy and nutrition. Adolescence is a period of important growth and development during which boys and girls require balanced nutrition and increased caloric intake. Societal pressures and media messages that promote lean bodies over health encourage thoughts of needing to lose weight and prompt many young people to engage in dieting, rather than eating a balanced diet that reflects the nutritional requirements of the developmental stage. Sometimes young people become very preoccupied with food, weight, or body image in a way that interferes with their performance at school, their social life, and their health. This preoccupation may be a sign of disordered eating (CYMHIN-MAD, 2011).

Eating problems and disorders occur along a continuum from relatively mild disruptions of normal eating patterns to behaviour with serious consequences for the student's health.



Source: Gail McVey, unpublished materials prepared for the Ontario Community Outreach Program for Eating Disorders. Adapted with permission from Friedman, 1999.

Canadian research reveals that 30 per cent of girls and 25 per cent of boys between the ages of 10 and 14 years are engaging in restrictive dieting, despite being within a healthy weight range.

(McVey et al., 2004, 2005).

Symptoms along the continuum range from body dissatisfaction or negative body image to restrictive dieting, disordered eating patterns such as binge eating, and compensatory behaviours that are used to counteract the ingestion of calories (e.g., self-induced vomiting, laxative use, excessive exercise). Eating problems may begin with seemingly minor changes in eating behaviour (e.g., eating smaller amounts of food) but can spiral out of control and develop into patterns of eating that can negatively affect young people's growth and development and put their health at risk (Stice et al., 2010).

Disordered eating can be life-threatening, and students showing signs of eating problems should be assessed by a mental health professional. Eating disorders can affect the body's physiological systems and may lead to medical problems (Katzman, 2005; Katzman & Pinhas, 2005; Rosen et al., 2010). For this reason, medical monitoring by a family physician or paediatrician is highly recommended. The effects of eating problems are especially critical during key developmental periods such as adolescence (Boachie & Jasper, 2006; Rosen et al., 2010).

What Does the Spectrum of Eating and Weight-related Problems Look Like?

Many students, especially young women, report that they are concerned about their weight and may engage in purging or binge eating from time to time (CYMHIN-MAD, 2011). There is also a growing amount of evidence that many males are troubled about their body size (i.e., about being underweight or overweight), leading to dissatisfaction with their body image, disordered eating, and unhealthy attempts at muscle building (McCabe & Ricciardelli, 2003; McVey et al., 2005). As well, eating and weight-related problems are being identified at earlier ages, with children under the age of twelve (both male and female) being referred to programs for treating eating disorders (Jasper & Boachie, 2005).

Dieting, talking about body appearance, and worries about gaining weight are common at different stages of development, especially in the adolescent years. It is important to observe whether the student's daily activities, mood, and functioning in school and social settings are affected, as changes in these areas could indicate potential problems with eating (Hincks-Dellcrest-ABCs, n.d.).

Some young people go on to develop full-syndrome eating disorders, with the most common in adolescence being "eating disorder not otherwise specified" (ED NOS), followed by bulimia nervosa (BN), and anorexia nervosa (AN). It is important to note that across the spectrum the different types of eating disorders are characterized by very similar symptoms and types of behaviour, including an extreme fixation on weight and shape, extreme dissatisfaction with one's

body, weight fluctuation or weight loss, and the use of dangerous weight-control methods (e.g., restrictive food intake, excessive exercise, use of laxatives, self-induced vomiting) (APA, 2006; Bravender et al., 2007; Rosen et al., 2010).

Many young people with eating problems do not believe or will not acknowledge that there is anything wrong and therefore do not seek the help they need. Students may have a sense of accomplishment about staying thin, or they may deny that they fear gaining weight, even though their patterns of behaviour and actions suggest otherwise. There can be an obsessive quality to their attempts at weight control (Evans et al., 2005, pp. 259–60).

It is important to note that eating problems can affect a student's appearance and weight in different ways. For example, students with eating disorders may not look significantly underweight or overweight, while students whose weight is a bit above or below the average for their age and body type may nevertheless demonstrate healthy eating habits and attitudes (Boachie & Jasper, 2005).

In Ontario, a diagnosis of an eating disorder can only be made by a physician (who may be a psychiatrist) or a psychologist (APA, 2006; Bravender et al., 2007; Rosen et al., 2010). However, it is helpful for educators to know about the warning signs and to have a broad understanding of disordered eating behaviour, as they are in a position to help support students who may be showing early warning signs or struggling with problems related to disordered eating. Young people who have an eating problem often require encouragement to seek help, and support in doing so.

Disordered eating can be life-threatening, and students showing signs of eating problems should be assessed by a mental health professional.

COMMON SIGNS OF EATING AND WEIGHT-RELATED PROBLEMS

Common warning signs to watch for include the following:

Emotional

- a persistent concern about, or preoccupation with, weight and/or body shape
- frequent references to worries about gaining weight, being fat, having any fat on the body, or needing to lose weight
- low self-esteem
- mood changes such as irritability, anxiety, or depression

Behavioural

- frequent monitoring of body size and changes in weight
- extreme or unusual eating habits such as stringent dieting, withdrawn or ritualized behaviour at mealtime, or secret bingeing
- continual attempts to diet or lose weight while already being a normal or low weight
- refusal to eat foods that most children would enjoy because they are "bad", have too many calories, or are "unhealthy"

COMMON SIGNS OF EATING AND WEIGHT-RELATED PROBLEMS *(continued)*

- a preference for baggy clothing that is out of step with the fashion choices of the peer group
- compulsive or excessive exercising
- reluctance to eat in front of peers
- declining participation in activities that involve food or eating
- periods of fasting
- self-induced vomiting, frequent trips to the washroom to purge
- use of diet pills
- overuse of laxatives and diuretics
- regular episodes of overeating or "bingeing" (eating past the point of fullness); references to feeling sick because of overeating
- decline in concentration, memory, attention span, and/or academic performance
- withdrawal from social contact, interests, and hobbies
- perfectionist behaviour
- absences from school for treatment of health problems

Physical

- episodes of shakiness, fainting or dizziness, chest pain, or heart palpitations
- blood in vomit (the student should be seen immediately by hospital emergency department personnel or a physician)
- a marked increase or decrease or significant fluctuations in weight
- significant hair loss; hair falling out in clumps
- frequent references to being cold when the temperature is warm and no other student feels cold
- lethargy, forgetfulness, and poor judgement
- lack of energy and drive to complete tasks, assignments, or homework

(Based on information from: CYMHIN-MAD, 2011; Hincks-Dellcrest-ABCs, n.d.)

Note: These lists provide some examples but are not exhaustive and should not be used for diagnostic purposes.

What Can Educators Do?*

To Promote Positive Mental Health in the Classroom …

When discussing healthy eating or a healthy weight in the classroom or team setting, be aware that these topics can unintentionally trigger weight and shape preoccupations for students.

* For important information about privacy considerations, see the boxed insert on page 13 of this guide.

Precautionary Note

Providing advice or lessons that focus on weight, "healthy" eating, or dieting can be harmful, as the messages can reinforce desires to try to use food and dieting to compensate for poor self-esteem and negative body images. These topics are triggers for all students but particularly for someone with an eating disorder or someone recovering from an eating disorder.

Students' preoccupation with eating, weight, or body image can be intensified if the adults around them, including educators and parents, focus unduly on their own appearance and/or talk a lot about dieting and weight loss in front of them. Experts in the field of adolescent eating disorders recommend that parents and educators model a flexible approach to eating and exercise, while not commenting on a child or adolescent's weight, in order to create an environment that is conducive to healthy eating. As well, they point out that it is usually not helpful to focus attention on the eating habits or lack of activity of individual students who may be larger than average for their age and gender (Neumark-Sztainer, 2005). Strategies educators can use to help all students adopt and maintain a healthy approach to eating are outlined below.

STRATEGIES THAT SUPPORT HEALTHY ATTITUDES TO BODY IMAGE AND EATING HABITS AMONG ALL STUDENTS

- Emphasize healthy eating and active living for all, regardless of weight and shape, instead of focusing on weight.
- Include lessons that promote balanced eating that supports normal growth and development.
- Continue to incorporate activities into the classroom that build self-esteem and confidence for all students.
- Ensure that adolescents of all shapes, sizes, and appearance are equally valued and respected.
- Introduce students to diverse images of beauty and health through reading materials, posters, and homework assignments. Challenge and encourage discussion about conventional notions of beauty that equate health and success with thinness.
- Be aware that some adolescents will not be comfortable changing their clothing in the presence of others. Ensure that there is enough time to change and that there are options to change in cubicles or with more privacy.

Research suggests that it can be harmful to provide/teach information in class about eating disorders, facts about the dangers of dieting, nutrition information, and information challenging media and cultural stereotypes about ideal body types. Focusing attention on these topics can foster rather than counteract the development of eating problems in some children and adolescents.

(O'Dea, 2000)

STRATEGIES THAT SUPPORT HEALTHY ATTITUDES TO BODY IMAGE AND EATING HABITS AMONG ALL STUDENTS *(continued)*

- Avoid situations in which team captains are required or allowed to choose their teams. This can mean that some students are always chosen last, with a negative impact on their self-esteem.
- Discourage dieting in a non-judgemental way and encourage and model balanced, moderate eating from a wide range of foods

(Based on information from: Hincks-Dellcrest-ABCs, n.d.)

Implementing strategies such as these on a school-wide basis can help create a supportive school environment that is free from weight bias, weight-based bullying, rigid rules about healthy eating, and other practices and attitudes that can trigger eating problems among students and lead to eating disorders.

To Support Students with Eating Problems …

Educators are in a position to notice symptoms such as those mentioned above. In particular, educators need to be alert for symptoms that are observable over a period of time (e.g., withdrawn behaviour, changes in weight, declining school performance). It is important to keep track of your observations and discuss them with the school team or designated individuals within the school (depending on the requirements of school protocols). While educators are not in a position to diagnose, they have an important role to play in determining that a student may be in need of support and/or may require referral to a mental health professional. Educators are also well-placed to support the student at school if a specific treatment plan has been developed for the student by a mental health professional. Table 5.1 outlines strategies to help support such students.

Table 5.1 Strategies for supporting students with eating or weight-related problems/disorders

General strategies

- Promote a climate/milieu at school that is free from "fat talk".
- Do not let the student's anger or distress prevent you from telling a principal, guidance counsellor, or parent about symptoms you observe, as this information can be life-saving.
- Stand up – don't stand by. If you witness weight-related bullying, don't ignore it. Intervene to stop the behaviour, discuss the negative effects of such bullying with students, and strongly reaffirm the school's policy of zero tolerance for weight bias/bullying.

(continued)

Table 5.1 *(continued)*

- If an adolescent occasionally chooses not to eat, it is okay to ask why, but this should be done in a neutral way that causes no embarrassment. It is important not to make an issue of it or draw attention to it. Educators need to be aware of possible cultural and/or religious observances in their community that may involve practices such as fasting or dietary restrictions.
- Be aware that an adolescent who has an eating disorder may be very upset at being discovered or having his/her parents know about the problem.
- Be aware that changes in eating habits may be related to sources of stress in the student's life and may be a sign of deeper underlying problems.
- Inform students about the dangers of eating problems, persist in trying to convince them to seek help, and encourage them to stay in treatment.

Strategies related to specific problems

Specific Problem	Strategy
The student complains of abdominal pain regularly after eating	• Discuss with the parents what they do to support their child. If the student has not seen a doctor, strongly encourage him/her to seek medical advice.
The student skips meals regularly, has cut out important food staples from the diet, will eat only one or two foods, and refuses to change the behaviour.	• Speak to the student in a calm and non-judgemental way. Let him or her know what you have observed and that you are worried about the behaviour you see. You should also inform the principal and parents, since the behaviour could have serious consequences for the student's health. • Do not assume that the student is skipping meals by choice. In some poor families, the student may not have a lunch at school because there is not enough food. The student may be too embarrassed to admit that, and will say that he or she is not hungry or forgot to bring lunch.
The student refuses to participate in gym class.	• Speak to the student to find out why, and then work with the student to find a solution that enables him/her to rejoin the class. Be sure to conduct the discussion in private and in a supportive manner.
The student refuses to change clothes in front of other students.	• Speak to the student to find out why. Work with the student to find a solution that enables the student to maintain his/her privacy but also to feel accepting of his/her body. Be sure to conduct the discussion in private and in a supportive manner.
The student uses self-induced vomiting, laxatives, diet pills, caffeine pills, antihistamines, or water pills as a way to lose weight.	• Speak with the student in private and in a supportive and non-judgemental way. Explain what you have observed and that you are worried about the student's behaviour. You should also inform the principal or guidance counsellor and the parents, since the behaviour could have serious consequences for the student's health. If the student does not want you to let anyone else know, talk with him/her about the seriousness of the behaviour. Let the student know that you have a professional responsibility to share information about behaviour that is dangerous to the student's health.

Table 5.1 *(continued)*

Strategies related to specific problems

Specific Problem	Strategy
The student complains of feeling sick as a result of overeating.	• Speak with the student to learn how often this happens. If it happens regularly, help the student plan how to tell the parents and get their support to seek professional help. Discuss your concerns with the principal or guidance counsellor.
The student has been observed throwing out lunches without eating them, or vomiting in the bathroom at school.	• Ask the student to explain why this is happening and/or have the student talk to a counsellor or administrator about it. If the student is reluctant to have his/her parents told, work with the guidance counsellor and the principal to help the student plan how to tell the parents and get their support to seek professional medical or mental health advice.

Source: Based on information from: Hincks-Dellcrest-ABCs, n.d.

Background Information

Research shows that children who receive negative comments about their weight or physical appearance are more likely to develop a negative body image and unhealthy eating practices.

What Are the Causes of Disordered Eating?

An increased risk of developing disordered eating is associated with a variety of psychological, biological/genetic, and social factors. However, research has yet to identify the precise connection between the various factors and eating problems. In adolescents, the influence of significant adults and peers, societal pressures, and media messages that place a high value on thinness can have a strong influence and lead students to engage in behaviour and thinking associated with disordered eating (Story et al., 2002). Other contributing risk factors may include personality and temperamental characteristics such as perfectionism, low self-esteem, and obsessive tendencies. As well, adverse life events or participation in sports and activities with a focus on talking about weight may also increase students' risk of developing eating problems (Buchholz et al., 2008; Levine & Smolak, 2006).

How Common Are Eating Disorders and Eating and Weight-related Concerns?

The eating disorders that are typically seen in children and adolescents are ED NOS (eating disorder not otherwise specified), AN (anorexia nervosa), and BN (bulimia nervosa). ED NOS is more common in children and adolescents, is associated with more co-morbid disorders, and is at least as dangerous as AN or BN, and possibly more so.

Full-blown (i.e., diagnosable) eating disorders of all types appear to affect 2 to 3 per cent of the population and 5 per cent of adolescent girls and young women. This translates to 600,000 to 990,000 Canadians with symptoms sufficient for an eating disorder diagnosis at any one time (Levine & McVey, 2012). Research findings suggest that many adolescents who may not meet diagnostic criteria for an eating disorder show early signs of disordered eating that indicate a risk of developing a disorder. Up to 27 per cent of young women between the ages of twelve and eighteen are reported to be engaged in severely problematic eating and weight-control behaviour (Jones et al., 2001).

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6 Substance Use Problems

What Is Problem Substance Use?

Types of Substances and Their Effects

"Substance use" refers to the use of a range of drugs that alter how the user functions physically and psychologically. They can change how we think, feel, act, and perceive the world around us. While substances are often categorized as legal or illegal or "hard" or "soft", they can be more accurately grouped according to their effects on the central nervous system. For example, depressants (e.g., alcohol and opiates) slow down central nervous system activity; stimulants (e.g., caffeine, cocaine, amphetamines) increase activity in the central nervous system; and hallucinogens (e.g., cannabis, psilosybin mushrooms, LSD) affect central nervous system activity and create distortions in perception.

Drugs often talked about include alcohol, tobacco, and marijuana. Other drugs include cocaine (and other stimulants); heroin (and other opioids); MDMA (ecstasy); inhalants (e.g., gasoline, felt-tip markers, glues, hairspray, deodorant); rohypnol ("roofies"); phencyclidine ("angel dust"); Ketamine ("Special K"); prescription medications or narcotics (e.g., OxyContin, Vicodin, Tylenol 3, Percocet); products containing caffeine (e.g., pop, coffee, energy drinks); and over-the-counter medications such as cough syrup.

These categories can often be confusing. For example, some substances fall into more than one category, while other substances don't fit into any category (JCSH, 2009). Moreover, the categories do not necessarily identify the type and severity of effects that each substance can have on an individual. The substances often highlighted in the media or considered illicit are not necessarily the ones most commonly used by young people or the ones that are potentially the most harmful.

The Continuum of Substance Use

Substance use occurs along a continuum that reflects variations in the frequency of use and the quantity and types of substances used.

Substance use can be complex. For example, the same youth might smoke tobacco daily (dependent user), drink alcohol on weekends (regular user), and sometimes experiment with ecstasy (CAMH, 2004, p. 57). The Centre for Addiction and Mental Health (CAMH) has produced a "Substance Use Continuum" (see p. 100) that illustrates substance use along a continuum from non-use to dependent use.

Substance use can be harmful at any point on the continuum because serious consequences can occur from risky behaviour that may result from use of the substance. For example, even one-time use of alcohol can lead to driving under the influence or unprotected sex.

DIAGRAM 6.1 SUBSTANCE USE CONTINUUM

Non-use:
Never used a particular substance.

Experimental use:
Has tried a substance once or several times. Use is motivated by curiosity about the substance's effect.

Irregular use:
Use is infrequent and irregular, usually confined to special occasions (holidays, birthdays, etc.) or when opportunities present themselves directly.

Regular use:
Use has a predictable pattern, which may entail frequent or infrequent use. The young person actively seeks to experience the substance effect, or to participate in the substance-using activities of the peer group. Usually the person feels in control of the substance use (i.e., he or she can take it or leave it).

Dependent use:
Use is regular and predictable and usually frequent. The young person experiences a physiological and/or psychological need for the substance. The person feels out of control vis-à-vis its use, and will continue to use despite adverse consequences.

Harmful use:

Use has resulted in harmful consequences.

Use has resulted in high-risk behaviours.

Source: Figure 3.1: "Continuum of substance use", from CAMH (Centre for Addiction and Mental Health), *Youth and Drugs and Mental Health: A Resource for Professionals* (Toronto: CAMH, 2004), p. 57.

Most adolescents who experiment with substance use will not go beyond that stage and develop a dependence/addiction, although there may be unintended negative consequences from involvement with the substance (e.g., drinking and driving; unlawful behaviour). Repeated use of a substance (e.g., daily) is considered problematic for any adolescent, and can lead to the development of dependence or strong habit. The type of substance being used is also a very important factor. For example, weekly use of cocaine would be of much greater concern than weekly use of tobacco, although the latter is more common (CAMH, 2004, pp. 57–58; CARBC, n.d., Q&A).

Negative Effects Associated with Substance Use

Negative effects associated with substance use can include, for example, emotional problems, relationship problems (e.g., with parents or peers or coworkers), academic or work performance problems, money or legal issues, unwanted pregnancy, unwanted/unplanned sexual activity, exposure to or com-

mission of violent acts, injuries resulting from accidents or overdose, death, chronic health conditions, and psychological and/or physical dependence/addiction (CARBC, n.d., Q&A). In youth with mental health problems, even relatively light use of a substance may lead to serious problems (CAMH, 2004, p. 58). Harmful consequences resulting from heavier use may include dropping out of school and/or involvement in street crime (CAMH, 2004, pp. 57–58). Research findings show that students who have dropped out of school, or who are at risk of dropping out, have higher rates of tobacco, alcohol, and marijuana use than other students (Yule & Prince, 2012).

The physical effects and degree of harm caused by substance use vary with the substance. For example, a fatal overdose while using cannabis is extremely unlikely. However, a fatal overdose is possible with many other substances. The effects of any substance will also vary from person to person. The chemical used to produce many synthetic substances, such as MDMA/ecstasy, can adversely affect individuals in different ways, with the same substance producing different results/risks in different people, especially when combined with alcohol or other substances. In many cases, a substance has been mixed (or "cut") with other unknown substances that can cause serious harm.

What Does Problem Substance Use Look Like?

Generally, substance use is considered a problem when it is associated with harmful consequences (e.g., feelings of anxiety, injury, relationship difficulties, problems with thinking clearly) and loss of control (CAMH, 2010).

In many cases, adolescents do not think they have a problem and believe their substance use to be "normal". They may not know how their substance use compares with that of their peers (Yule & Prince, 2012). Adolescents who are in the process of adjusting to increased autonomy may think that decisions about substance use are theirs alone to make. They may also associate substance use with particular benefits or desired outcomes.

It is important to note that people do not choose to develop a substance-use problem. Problematic use can develop slowly, and early signs are often easy to miss. Too often, substance use can become repetitive and turn into problematic use. It is important to focus on the actual influences that might lead a person to use a substance, since a range of environmental factors affect choices through a complex set of mechanisms.

To help determine if there is cause for concern or if the use is risky, professionals and others will often look at the individual's level of risk while using the substance (Yule & Prince, 2012). Factors that influence the level of risk include the type of substance used (e.g., caffeine versus alcohol versus cocaine), the method of use,

the purpose for the use, the quantity used, the pattern of use, and the context in which the use is occurring (e.g., community attitudes to use of the substance; availability; presence or absence of parental supervision; use in conjunction with other hazards such as while driving, boating, or hiking). Individual factors (e.g., problems with depression or anxiety, or thrill-seeking tendencies) may also increase the level of risk (JCSH, 2009, pp. 7–8).

The following key questions can be helpful in determining whether a student's substance use may involve significant risk.

"Have you [i.e., the student] experienced any or all of the following:

- driving while 'high' or under the influence of alcohol or drugs and/or being driven by someone in that condition?
- using alcohol or drugs to relax, feel better about yourself, or fit in?
- using alcohol or drugs while alone?
- forgetting events and actions that occurred during alcohol or drug use?
- having family or friends suggest that you need to cut down on your drinking or drug use?
- getting into trouble with the law while using or as a result of using alcohol or drugs?"

(Knight et al., 2003)

A CONTINUUM OF WARNING SIGNS

Signs that the student's substance use has become risky and could cause harm include the following:

- substance use at an early age (e.g., before age thirteen or fourteen) (This may affect brain development.)
- early regular use (in particular, early regular intoxication)
- use of larger amounts or amounts in higher concentrations (e.g., binge drinking)
- increasingly frequent or daily use
- use before school or during school or work
- use during certain activities (e.g., driving or physical activity)
- use as a way of coping with emotions
- use of multiple substances at the same time
- use that is becoming more of an activity/major recreation
- change in academic performance
- change in school attendance (e.g., increased absences)
- change in peer or family relationships
- change in behaviour
- avoidance of old friends and getting "new" friends

(continued)

A CONTINUUM OF WARNING SIGNS *(continued)*

- change in personality or baseline mood
- loss of interest in usual activities
- deterioration in personal grooming
- forgetfulness or difficulty paying attention
- increased secretiveness or heightened sensitivity to inquiry

(Based on information from: JCSH, 2009, p. 11; CARBC, n.d., iMinds, Quick guide; CYMHIN-MAD, 2011; Yule & Prince, 2012; American Academy of Pediatrics, Council on School Health, Committee on Substance Abuse, 2007)

Signs that the student *may have a substance dependence/addiction* include the following:

- a need for larger amounts (doses) to get the same effects (signs of increased tolerance)
- psychological and physiological difficulty when trying (or when forced) to cut back or stop (withdrawal symptoms)
- an increased focus on or obsession with using the substance and/or getting the substance that interferes with other activities

(Adapted from: JCSH, 2009)

Note: These lists provide some examples but are not exhaustive and should not be used for diagnostic purposes.

What Can Educators Do?*

To Promote Positive Mental Health in the Classroom…

Alcohol and cannabis use is common among students in Canada, and even low-risk, occasional users may be exposed to health and social harms associated with substance use (Spurling & Vinson, 2005). As well, we know that early regular alcohol or tobacco use can increase the chance of later problems with substance use (Brook et al., 1998). For these reasons, schools have a key role to play in raising awareness of the importance of healthy behaviour, especially the avoidance of substance use, among all students.

A number of school-based prevention programs targeting late elementary and secondary students have been implemented in an effort to prevent substance use problems and associated mental health issues. The programs focus on character development for students and on shaping the social and physical environment to increase students' resilience and reduce risk. Such programs are usually interactive and focus on skill acquisition (Griffin & Botvin, 2010).

* For important information about privacy considerations, see the boxed insert on page 13 of this guide.

The school environment has a substantial influence not only on the intellectual and academic development of children and adolescents but on their social and emotional development as well. Educators have a unique opportunity to provide preventive education by equipping students with the knowledge and skills they need to make intelligent and informed decisions about substance use. Research indicates that factors such as school connectedness, students' attachment to school, interaction between individual students and educators, and student engagement in learning and in the life of the school are associated with a decreased use of tobacco, alcohol, and marijuana among students (Bond et al., 2007; Henry & Slater, 2007). In addition, approaches that enhance students' cognitive, social, and emotional skills can help students improve their ability to make intelligent choices later in life (JCSH, 2009, p. 25).

Evidence from research suggests that information provided to students about substance use should be relevant – that is, it should focus on substances that are in common use and that reflect their current experience (Midford et al., 2002).

Efforts to help students avoid substance use and/or substance use problems begin with measures to create a classroom environment that promotes the mental and emotional well-being of all students, as outlined below.

STRATEGIES FOR CREATING A SUPPORTIVE CLASSROOM ENVIRONMENT FOR ALL STUDENTS

- Become familiar with the general signs and symptoms associated with substance use problems and/or mental health concerns.
- Avoid modelling positive views about the pleasures of substance use. Students are inundated with media messages that present substance use in a positive light, and schools should be free from these messages.
- Be a positive role model for students by modelling appropriate, respectful behaviour, providing guidance and support, and helping students to make good decisions.
- Integrate information about substance use into the regular classroom curriculum (see the Healthy Living strand in the Ontario health and physical education curriculum) and provide students with opportunities to discuss the information, understand the consequences of substance use, and develop problem-solving and decision-making skills.
- Expand after-school academic, recreational, and enrichment opportunities (e.g., tutoring, sports, clubs, art, music, peer leadership and mentoring programs) that can help students develop the positive sense of self they need to make choices that will contribute to their health and well-being.

(Based on information from: CYMHIN-MAD, 2011; Hincks-Dellcrest-ABCs, n.d.)

To Support Students Who Are at Risk of Substance Use Problems …

Educators are well placed to recognize signs of problematic substance use and/or to identify students who may be starting to develop a problem.

Educators need to find out about school and board policies and procedures for dealing with students who appear to be intoxicated or under the influence of substances. Seek direction from your principal if you have questions about what to do. If a problem or potential problem related to substance use by a student is identified, the school should work closely with the parents and mental health professionals to determine the best course of action for supporting the student. The student may also have other mental health problems that should be addressed. If information regarding the student's needs is being provided to the school, then a range of supports may be put in place.

It should also be noted that students' ability to learn and concentrate, their cognitive functioning, and their emotional development may be significantly impaired by the use of substances such as alcohol or cannabis, with effects that could include decreased verbal memory, slow processing of information, short attention span, weakened executive functioning (e.g., reduced decision-making, planning, organizing, and strategizing ability), and relationship problems (Hanson et al., 2011; Wills et al., 2006; Jacobus et al., 2009).

In discussing their substance use with students, educators should avoid an exclusive focus on the risks associated with using and the need to stop, as this may increase some students' unwillingness to quit (Erickson et al., 2005). Instead, educators should encourage students to think critically about what may be happening in their lives that is contributing to their substance use, to identify and discuss some of their immediate and long-term goals, and to consider how the substance use may affect their ability to reach these goals (CARBC, n.d., Q&A). Educators may wish to consider learning about different approaches that have been found to be effective in talking to students about their substance use. For example, a motivational approach, based on helping a student identify goals and the actions needed to achieve those goals, can be designed to take account of the student's stage of substance use and whether the student also has symptoms of mental health problems (CAMH, 2004, p. 59) (see, for example, *The Art of Motivation,* a resource professionals can use to help students examine their situation, explore making positive changes to their behaviour, and decide if and what *they* would like to change [CARBC, n.d., *The Art of Motivation*]).

Table 6.1 provides a brief outline of key strategies for dealing with students who appear to be at risk of substance-use problems.

Table 6.1 **Specific strategies to support students who may have problems with substance use**

- Become familiar with your school and board procedures for dealing with students who appear to be intoxicated or under the influence of substances.
- Seek direction from the principal if you have questions about what to do.
- Work with the school team and parents to determine ways to best support the student.
- Identify appropriate community resources and put the student in touch with them.
- Provide the student with accurate, factual information, rather than information based on hearsay or anecdotal evidence or personal opinion. Be careful not to provide incorrect information.
- Be aware of the potential harm of "scare" tactics.
- Help the student to explore the reasons why he or she is using the substance(s).

Source: CARBC, n.d., iMinds, Quick Guide to Drug Use

Background Information

What Are the Causes of Substance Use and Substance Use Problems?

Young people use substances for many reasons, including the following:

- experimentation
- as a way of coping with certain social situations or fitting in with a peer group
- as a way of coping with stress and/or mental health concerns
- as an escape from boredom
- as a way to get to sleep, stay awake, or lose weight

Substance use can be a part of normal growth and development, as teens develop independence and autonomy and test various limits set by society. Substance use may also reflect immature judgement, risk- or thrill-seeking tendencies, and/or pleasure-seeking behaviour (if the substance is associated with a positive experience).

There is also evidence of a strong association between substance use and mental health problems (referred to as concurrent disorders) such as depression, anxiety, oppositional defiant disorder (ODD), or conduct disorder (CD), indicating that drug use contributes to the onset of mental health problems and mental health problems contribute to substance use problems (Evans et al., 2005; Degenhardt et al., 2010). Substance use may represent a way to cope with feelings of low self-esteem, sadness, worry, or fear and their associated symptoms. Unfortunately, substance use may actually worsen the symptoms the person is trying to relieve

or may cause feelings of depression or anxiety in children and youth who didn't previously struggle with these issues.

The causes of substance use problems are complex, with biological, social, and environmental factors all contributing. A variety of social and contextual factors increase the likelihood that young people will start using substances and influence whether they continue and possibly increase their use (Griffin & Botvin, 2010). However, predicting who will go on to have problem use is extremely difficult.

Factors that increase the risk of substance use[5] include the availability of the substance(s); whether the student is exposed to substance use by parents, siblings, and peers; the presence of other mental health problems; regular use before age fourteen or repeated intoxication before age sixteen; a disadvantaged background; poor parent-child relationships and parental conflict; a family history of substance use disorders (Sullivan & Kendler, 1999; Schuckit, 2000); and exposure to trauma.

Other risk factors include being male, certain personality traits (e.g., sensation, seeking), and academic difficulties (e.g., poor academic performance, low commitment to education, early school leaving). Another strong risk factor for adolescent substance use is association with substance-using peers.

Adolescents who have several of these risk factors together may begin using tobacco, alcohol, and other substances earlier than others – behaviour that increases the chances for problem substance use (Degenhardt & Hall, 2012; Yule & Prince, 2012; Evans et al., 2005, Chapter 17, "Defining Substance Use Disorders").

Protective Factors

Concerned adults may act to reduce a student's likelihood of developing substance use problems in a number of ways – both by seeking to remove or weaken risk factors as much as possible and by focusing on protective factors that can help to mitigate risk. Protective elements may include opportunities for the student to become involved in community and school activities, positive parenting practices, and family cohesion. Although the risk factor of being male or female cannot be altered, the presence of positive male or female role models may act as a beneficial counterweight. Likewise, efforts to strengthen a student's self-esteem, coping skills, and life skills and to provide a supportive environment may mitigate the effects of a genetic predisposition to substance use problems.

5. This discussion relies heavily on Degenhardt & Hall (2012), which includes a review of the literature on illicit drug use and dependence and their contribution to the global burden of disease. See the article for relevant primary studies and reviews.

The association between risk and protective factors is dynamic and complex. Educators are well positioned to help students by maximizing protective factors.

How Common Are Substance Use Problems?

In Canada, the substances most frequently used by students are tobacco, alcohol, cannabis, and caffeine (JCSH, 2009, p. 19). The Ontario Student Drug Use and Health Survey indicates that alcohol is the most commonly used substance (55 per cent of students in Grades 7 to 12 have used alcohol), followed by high-caffeine energy drinks (50 per cent of students), and cannabis (22 per cent of students) (Paglia-Boak et al., 2011). Substance use increases with age, and is more prevalent in northern regions of the province. Longitudinal analysis of the Ontario Student Drug Use and Health Survey shows that substance use has significantly declined since 1999 in Ontario. Anecdotal reports, however, suggest that this may not be the case for substances such as opiates (a category that includes prescription medications).

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7 Gambling

What Is Problem Gambling?

Gambling has been around for centuries. It has always had critics, but in today's society, it is generally considered acceptable (for example, the occupation "professional gambler" is regarded as a possible career option), and is widely promoted as a form of entertainment and recreation. Although society does not necessarily consider youth gambling to be a problematic or high-risk activity and often encourages it, problem gambling among youth is becoming a growing cause for concern (Problem Gambling Institute of Ontario [CAMH], n.d., "Youth and Gambling: Barriers to Prevention"). Research evidence shows that adolescents have higher rates of pathological gambling and at-risk problem gambling than adults (Delfabbro et al., 2009; Derevensky, 2007).

In Ontario, young people who are age eighteen and older can legally participate in lotteries and play bingo; from age nineteen, they can engage in casino gambling (Problem Gambling Institute of Ontario [CAMH], n.d., "Youth and Gambling: Barriers to Prevention"). Although children and adolescents under age eighteen are not legally allowed to participate in any forms of legal, regulated gambling, many underage youth do engage in a range of gambling activities, with a small but non-negligible number developing significant gambling-related problems (Gupta & Derevensky, 2000).

An activity is considered to be gambling when a sum of money or an object of value is risked for the chance of winning money based on the outcome of an unpredictable event such as a game or a race (International Centre for Youth Gambling Problems and High-risk Behaviors [McGill], n.d.). Gambling activities take many forms. Money may be gambled on games of skill, where practice can increase the chances of winning and a person's knowledge or skill can change the results of the game. Games of chance or luck include those where winning depends not on practice or skill but partly or completely on luck. People tend to believe they have more control over such games than they actually do. For example, understanding the rules and techniques of a card game such as poker is helpful to a degree, but there are factors that the players (and bettors) have no control over (e.g., the cards that are dealt). Similarly, with sports betting (a popular activity among adolescents), although knowledge about the game, teams, and players is helpful up to a point, random events in a game, such as injuries, are things the players and bettors have no control over (International Centre for Youth Gambling Problems and High-risk Behaviors [McGill], n.d.).

FORMS OF GAMBLING

Forms of gambling include (but are not limited to) the following:

- betting on games of skill (various sports games, video games, games of pool)
- betting on card games
- buying lottery tickets or scratch tickets
- betting at video lottery terminals (VLTs)
- shooting dice with friends
- playing casino games (e.g., roulette, blackjack, dice)
- playing slot machines
- playing bingo and keno
- betting on horse races
- Internet gambling and other types of online gaming
- playing games on electronic gambling machines

(Based on information from: Hodgins et al., 2011; International Centre for Youth Gambling Problems and High-risk Behaviors [McGill], n.d.; Problem Gambling Institute of Ontario [CAMH], n.d.,"What Is Gambling?")

For some people, gambling is a non-threatening "social" or occasional activity. However, when significant time and money are dedicated to gambling, it can be dangerous, putting a strain on relationships with family and friends, interfering with work, and causing serious financial problems (Hodgins et al., 2011).

Like many types of problem behaviour, problem gambling or pathological gambling occurs on a continuum ranging from gambling as an occasional recreational activity or pastime, to regular gambling, to problem gambling of varying degrees of severity (Brezing et al., 2010). Some research suggests that problem gambling may develop faster in adolescents than in adults (Brezing et al., 2010).

Gambling disorders are commonly classified as either problem gambling or pathological gambling. "Problem gambling" is a term used when a person is showing signs of losing control of his or her gambling behaviour, with evidence of negative effects on things like school work or relationships with family and friends. "Pathological gambling" is used when a person has clearly lost control and is not able to stop gambling (International Centre for Youth Gambling Problems and High-risk Behaviors [McGill], n.d.). A diagnosis of pathological gambling is based on criteria outlined in the American Psychiatric Association's *Diagnostic and statistical manual of mental disorders* (DSM-IV-TR) (APA, 2000). However, the DSM-IV-TR criteria may be of limited value for diagnosing the condition in youth, as problem gambling can look different and have different effects in adolescents than in adults (Brezing et al., 2010).

What Do Problems with Gambling Look Like?

Adolescent gambling is still a relatively new area of study, despite the fact that rates of gambling in adolescents are high.

Adolescents choose to gamble for a variety of reasons, including for excitement, for fun, and to alleviate boredom. The chance of making money without having to work for it is also an attraction. However, some adolescents gamble to relieve the stress of difficult situations and emotions. Innocent gambling can quickly turn into problem gambling that threatens the student's social, psychological, economic, and interpersonal well-being (Derevensky, 2007).

Adolescent problem gambling is associated with poor outcomes in many areas of functioning, depending on the type of gambling activity, as well as an increased risk for a variety of mental health problems (Desai et al., 2005; Brezing et al., 2010). Research findings show that children and adolescents who have problems with gambling may also have higher rates of conduct disorders, anxiety, depression, substance use problems, and related symptoms or difficulties such as cognitive difficulties (Faregh & Derevensky, 2011). Gambling has been found to have a strong association with substance use disorders (Hodgins et al., 2011). A recent large-scale study indicated that those with pathological gambling problems had a 5.5 times higher risk of having a substance use disorder than non-gamblers, a 3.7 times higher risk of having a mood disorder, and a 3.1 times higher risk of having an anxiety disorder (Kessler et al., 2008).

Recent findings also suggest that mood and anxiety disorders can predict gambling disorders (rather than the other way around), while gambling disorders predict substance use disorders (rather than the other way around) (Kessler et al., 2008).

If between 4 and 8 per cent of adolescents have a gambling problem, then up to two students in a class could be seriously struggling with gambling-related problems. However, the signs of gambling dependence are often difficult for parents and educators to recognize (Derevensky, 2007).

COMMON SIGNS OF PROBLEM GAMBLING

Common signs that a person's gambling is becoming a problem or is already a problem include the following (not all of these signs will be present at the same time):

- thinking about gambling activities at random times during the day and planning the next time to play; an inability to stop thinking about gambling
- spending more money or playing longer than originally planned
- choosing or wanting to gamble instead of going to school or carrying out other responsibilities
- gambling to escape or cope with other problems, or to feel alive or important
- gambling secretly and/or lying to family and friends about how much one is gambling
- continuing to gamble in an effort to win back lost money (more than half the time)
- using money for gambling-related activities that is needed for other things (e.g., lunch or bus fare)
- taking money from a family member or friend to use for gambling
- spending more and more money on gambling activities
- stealing money from a non-family member or a store to use for gambling (in the past year)
- restlessness, anxiety, or irritability when trying to stop or decrease the amount of gambling
- worries about money or money troubles as a result of gambling
- problems with family or friends as a result of gambling

(Adapted from Derevensky, 2007)

Signs specific to adolescents that may indicate a problem with gambling include the following:

- skipping school
- a preoccupation with video arcades, Internet gambling sites, sports results, or TV poker
- having no money or less money than usual without an adequate explanation
- borrowing or stealing money from friends and family
- selling or losing possessions
- sometimes having large unexplained amounts of cash
- having fake ID, casino entry cards, or racetrack receipts among their belongings
- an Internet trail of visits to gambling sites

(Adapted from Problem Gambling Institute of Ontario [CAMH], n.d., "Youth and Gambling: Signs and Indicators of Problem Gambling")

Note: These lists provide some examples but are not exhaustive and should not be used for diagnostic purposes.

What Can Educators Do?*

While there is clear evidence of gambling-related problems among youth and a growing recognition of the need to increase awareness, knowledge about effective measures for the prevention and treatment of these problems is still limited (Problem Gambling Institute of Ontario [CAMH], n.d., "Youth and Gambling: Treatment Considerations and Recommendations"; Gupta & Derevensky, 2000; Blinn-Pike et al., 2010).

Treating youth with gambling problems can be difficult, as many youth do not see gambling as problematic and are reluctant to seek help (Brezing et al., 2010). Educators have an important role to play in raising awareness by providing students with accurate information about gambling and encouraging prudent gambling practices among those students who do choose to gamble.

Intervention and prevention initiatives should be appropriate for the age and developmental level of the student and should focus on strengthening students' coping and problem-solving skills (including helping them develop strategies to decrease risk during gambling activities and deal with gambling-related difficulties) and on providing resources and supports when youth need help. The latter might include involving the student's parents, since protective factors within the family and community may help to enhance the student's resilience (Dickson et al., 2002; Problem Gambling Institute of Ontario [CAMH], n.d., "Youth and Gambling: Prevention").

Prevention strategies should promote "harm reduction and minimization" rather than abstinence, and should emphasize responsible gambling and informed use (e.g., by providing accurate information about gambling). For youth, a focus on abstinence may not be realistic or effective, since different forms of gambling are so widely available (Brezing et al., 2010).

Background Information

What Are the Causes of Problems with Gambling?

A variety of factors are known to increase a person's risk of developing problems with gambling. These include: being young, male, and in a low socio-economic bracket; genetic factors; peer and family influences; and childhood exposure to gambling, to name a few. Other factors that may play a role include the type of gambling activity and unfounded beliefs about the extent to which an individual can control probabilities, odds, and gambling outcomes (Delfabbro et al., 2009; Hodgins et al., 2011).

* For important information about privacy considerations, see the boxed insert on page 13 of this guide.

How Common Are Problems with Gambling?

Research findings show that 77 to 83 per cent of adolescents between ages twelve and seventeen engage in some form of gambling; 10 to 15 per cent of adolescents are at high risk for developing problem gambling; and 4 to 8 per cent have a serious gambling problem (Derevensky, 2007; Messerlian et al., 2004; Shaffer & Hall, 1996; Blinn-Pike et al., 2010).

Research findings related to prevalence rates may vary as a result of the availability of different forms of gambling and other environmental factors. Rates of pathological or problem gambling are also influenced by such things as differences in survey methodology and reporting periods (Hodgins et al., 2011). The recent proliferation of forms of gambling (e.g., online) is causing concern that rates of problem gambling may increase, especially among vulnerable populations such as adolescents (Faregh & Derevensky, 2011).

Rates of problem gambling are three to five times higher in boys than in girls (Jacobs, 2004). Research findings also show that boys play a wider range of games, do so more often, commit more money to gambling, and are more prone to risk-taking behaviour than girls. These findings may reflect family and societal expectations related to male behaviour (Brezing et al., 2010). Among girls, gambling is associated with symptoms of depression, suggesting that girls may be more likely than boys to gamble as way of dealing with depression (Desai et al., 2005; Bergevin et al., 2006).

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8 Self-harm and Suicide

Both self-harm and suicidal thoughts and behaviour are covered in this section because they can co-occur. However, it is important to note that at present the relationship between self-harm and suicidal thoughts and behaviour is complex and not well understood.

(A) SELF-HARM

What Is Self-harm?

Self-harm or self-injury is a deliberate attempt to cause injury to one's body without the conscious intent to die (Cloutier et al., 2010). Such behaviour includes, for example, self-cutting, burning, biting, chemical abrasion, head banging, and embedding objects under the skin (see Hamza et al., 2012, for a summary of studies; Nixon et al., 2008; Nock, 2010). Often the behaviour is kept hidden and may become chronic (Mental Health Foundation, 2006).

What Does Self-harm Behaviour Look Like?

Self-injury is often kept secret, making it difficult to detect. Students may feel ashamed of, guilty about, or confused by their behaviour, and thus may be unwilling to reach out for help. In many cases, self-harm behaviour is associated with mental health problems.

COMMON SIGNS OF SELF-HARM BEHAVIOUR

Some general and specific signs to be aware of include:

- complaints that others do not listen or that the student feels patronized;
- low self-esteem;
- problems handling or expressing emotions;
- problems with peer and/or family relationships;
- "loner" behaviour (e.g., avoiding contact with others);
- refusing to wear short sleeves or to change for sports or physical education class;

(continued)

COMMON SIGNS OF SELF-HARM BEHAVIOUR *(continued)*

- wearing long pants and long-sleeved tops in warm weather;
- frequent unexplained injuries, scars, burns, or cuts.

(Based on information from: CYMHIN-MAD, 2011; Hincks-Dellcrest-ABCs, n.d.)

Note: This list provides some examples but is not exhaustive and should not be used for diagnostic purposes.

For more detailed information about the types of self-harm behaviour that may occur at different ages, see *The ABCs of Mental Health* at: www.hincksdellcrest.org/ABC/Welcome.

What Can Educators Do?*

To Promote Positive Mental Health in the Classroom …

Educators are well-placed to notice the signs of self-harm and to help students get the professional help they need. Because the behaviour typically begins in adolescence (between thirteen and fifteen years of age), secondary school educators, in particular, have an important role to play in recognizing students who may be engaging in self-harm (Hamza et al., 2012). Signs that a student is involved in this practice must be taken very seriously. Such students must be assessed by a mental health professional, who will be able to determine the level of risk and suggest appropriate action (CYMHIN-MAD, 2011). Educators need to ensure that they understand their school and board protocols for getting help for students displaying these and other signs of mental health problems.

Strategies for creating a supportive classroom atmosphere for all students are outlined below.

* For important information about privacy considerations, see the boxed insert on page 13 of this guide.

STRATEGIES TO PROMOTE POSITIVE MENTAL HEALTH IN THE CLASSROOM

- Focus on creating a safe and positive school climate and a classroom environment in which students feel able to express their feelings. Encourage students to let you know if they or their peers seem to be in trouble, upset, or showing signs of harming themselves.
- Model healthy coping skills and share ideas for managing academic (and other) stress.
- Focus on helping students to develop healthy adaptive skills that can be considered protective factors (e.g., social, conflict-resolution, coping, problem-solving, and help-seeking skills).
- Find ways to increase students' sense of connection to the school (e.g., by offering them roles as office, classroom, or hallway helpers or as representatives on school committees).
- Be available to listen to students in a supportive way.
- Promote the development of good communication skills, including the ability to be open about emotional difficulties.
- Provide opportunities for students to participate in activities they find meaningful, which will help to promote wellness and decrease physical and mental health risks.
- Find ways to connect students to social or extracurricular activities that could give them a sense that they have an important contribution to make.

(Based on information from: CYMHIN-MAD, 2011; Joiner & Ribeiro, 2011; Doan et al., 2012, *Issue brief 5)*

To Support Students Who Show Signs of Self-harm Behaviour …

Table 8.1 focuses on specific strategies for helping students who show signs of self-harm behaviour.

Table 8.1 Strategies to support students who may be engaging in self-harm

If a student discloses self-harm behaviour …

- Provide supportive and active listening.
- Acknowledge the pain the student is feeling.
- Be empathetic and interested (try to understand).
- Don't overreact, but do show concern.
- Suspend judgement, try to avoid showing bias, and be aware of any negative reactions you may be having.
- Put the student in touch with the staff member identified in school protocols for dealing with such concerns (e.g., principal/vice-principal, guidance counsellor, student success teacher, special education teacher).

(continued)

Table 8.1 *(continued)*

- Make sure students know whom they can go to in your school and community for professional help.
- Be available at school whenever possible to talk to the student. This can make a great difference in alleviating feelings of isolation the student may be experiencing.
- Maintain a supportive relationship with the student.

Notes:

- Educators are not in a position to assess risk when self-harm behaviour is observed or students disclose self-harm. This determination should only be made by a mental health professional.
- Do not promise confidentiality. If a student asks you to keep confidential the information that he/she is engaging in self-harm, you should tell the student that the information will be shared with school administration, parents, and/or the student's guardian, as appropriate. Tell the student that this information needs to be shared to ensure the safety of the student (and/or others). This could be an opportunity to empower the student and help him or her to disclose the information to a mental health professional.

Source: Based on information from: CYMHIN-MAD, 2011

Background Information

What Are the Causes of Self-harm Behaviour?

There are many possible reasons why a child or youth may be engaging in self-harm behaviour. It may be used as a coping mechanism or a means of reducing internal tension, feelings of distress, or other difficult emotions. It can be a way to take the person's mind off a threatening, harmful, or intolerable situation (e.g., experience of abuse). It may be a cry for help, a form of self-punishment, or a form of sensation seeking. Self-harm behaviour may also be associated with personality disorders (e.g., borderline personality disorder) and other mental health problems (Nixon et al., 2008; Jacobson et al., 2008; Muehlenkamp, 2005; CYMHIN-MAD, 2011, p. 45; Sellen, 2010).

Certain conditions may also put children and youth at increased risk for self-harm behaviour. For example, body-image issues, sexual/physical abuse, and loss have all been associated with self-harm. However, not all students who engage in self-harm have experienced these sorts of challenges. Occasionally, the behaviour is precipitated by more immediate life events, such as a conflict with parents or peers, or other sources of stress.

As well, although non-suicidal self-harm behaviour is usually a private and hidden practice, contagion has also been known to occur – for example, in psychiatric inpatient units where the behaviour may be more overt.

How Common Is Self-harm (non-suicidal) Behaviour?

Research findings from community samples indicate that between 13 and 29 per cent of adolescents engage in self-harm (Baetens et al., 2011; Hamza et al., 2012), with higher rates for adolescents in clinical inpatient settings. This behaviour typically begins between thirteen and fifteen years of age but increases in frequency in later adolescence (Hamza et al., 2012). It has been suggested that rates of self-harm appear to be highest in adolescent girls (see Hamza et al., 2012, and Sellen, 2010, for a summary), although the data are inconclusive.

The Relationship between Non-suicidal Self-injury/ Self-harm and Suicidal Thoughts and Behaviour

Although non-suicidal self-harm and suicidal behaviour (i.e., suicide attempts) both fall under the category of deliberate self-harm, they differ in important ways. With non-suicidal self-harm behaviour, there is no firm intention to die, and the person does not think the behaviour will lead to death (Andover & Gibb, 2010). With suicidal behaviour, there is some level of intent to die, although the strength of the intent may vary from person to person (Muehlenkamp, 2005).

Despite some significant differences between non-suicidal self-harm and suicidal thoughts and behaviour, research findings indicate that the two types of behaviour can co-occur, though there is no firm agreement about how they are related (Cloutier et al., 2010; Stanley et al., 2001). It is unclear whether non-suicidal self-harm behaviour actually increases the risk of later suicide attempts (Hamza et al., 2012); however, research findings have shown that a history of self-harm behaviour is a risk factor for suicide attempts.

It is also important to note that both types of behaviour have a strong link to various types of mental illness. Though not necessarily suicidal, a student who engages in self-harm is experiencing distress that requires professional help. Because of the potential link between self-harm and suicidal behaviour, it is imperative for all cases of self-harm to be referred for assessment by a mental health professional.

(B) SUICIDE

What Are Suicidal Thoughts and Behaviour?

Suicidal thoughts (also known as suicidal ideation) include both thinking of killing oneself and planning actions (e.g., having a plan) that will result in death (Nock, 2010; Hamza et al., 2012; Hill et al., 2011). Although suicidal thoughts are more common than suicide attempts and dying by suicide (Cusimano & Sameem, 2011), they are strongly associated with suicide attempts and should be recognized as an important sign of the need for intervention and prevention measures (Fergusson et al., 2005).

Suicidal behaviour is self-harming behaviour that includes an intention to die. Suicide attempts and death by suicide are both included in this definition (Andover & Gibb, 2010; Hamza et al., 2012). Although suicidal behaviour involves some level of intent to die, the strength and clarity of the intent may vary. Youth who are suicidal are often ambivalent about living and dying and have doubts about whether suicide is a solution to their problems. This ambivalence is an important focus of intervention for people who are risk of suicide.

Myths about Suicidal Thoughts and Behaviour

Misinformation about suicidal thoughts and behaviour can interfere with educators' ability to respond appropriately to signs that a student is at risk. Some common myths about suicide are outlined below, along with factual information to set the record straight.

MYTH	FACT
Myth 1 – Providing students with information about suicide and methods of suicide, or asking them if they think about suicide, may put the idea of suicide in their head, suggest suicide methods to them, and increase the likelihood of suicide attempts.	***Evidence from research shows that this is false***. Providing information in the proper manner and asking the student about his/her state of mind are evidence of care and concern that may be very much needed by the student.
Myth 2 – Talk about suicide by someone who has never attempted it means it is unlikely that he/she will attempt suicide.	***This is false***. Talk that indicates a person is thinking about suicide should be taken very seriously, as this is one of the most important warning signs. Research findings show that repeatedly talking about one's own death is a significant warning sign.

(continued)

MYTH	FACT
Myth 3 – Most adolescent suicides occur unexpectedly, without warning.	***This is not necessarily true***. Warning signs may be difficult to detect, but research evidence suggests that, nine times out of ten, risk factors or warning signs are present before a suicide attempt.
Myth 4 – All adolescents who show suicidal behaviour have a mental illness.	***This is false***. However, it is true that approximately 90 per cent of all adolescents who successfully commit suicide (i.e., who die by suicide) are likely to have had a mental health disorder of some type (e.g., depression, ADHD, conduct disorder, PTSD, addictions).
Myth 5 – Suicidal behaviour is determined by a person's genetic make-up.	***This is false***. To date, no genes associated with a predisposition to suicide have been identified. However, higher rates of suicidal behaviour have been found in identical twins if one twin has died by suicide. Studies of identical twins reared apart are needed to understand the role of genetic versus environmental influences. Risk factors for certain mental health problems that are also known to increase the risk of suicidal behaviour, such as depression, do have a genetic component.
Myth 6 – Suicidal behaviour occurs only among adolescents who are poor.	***This is false***. Suicidal behaviour occurs among people at every socio-economic level.

Source: Based on information from: Doan et al., 2012d, *True/False checklist*; Sellen, 2010

What Do Suicidal Thoughts and Behaviour Look Like?

Signs of suicidal thoughts and behaviour can be subtle and hard to recognize (Sellen, 2010). As well, suicidal thoughts and behaviour can be acute or chronic. Signs and behaviour may differ from person to person depending on the level of stress experienced. Many youth who are suicidal do provide some indication of their distress or admit to having suicidal thoughts and feelings. Research indicates that approximately 80 per cent or more of youth who die by suicide provided some clues to their state of mind prior to the act (Sellen, 2010; Doan et al., 2012d, *True/False checklist*) and that, when adolescents have suicidal thoughts, they are most likely to talk about them to their peers (Gould & Kramer, 2001). Nevertheless, research also indicates that 33 per cent of young women and 45 per cent of young men with suicidal thoughts and/or behaviour do *not* talk about it to anyone.

Warning Signs

Warning signs are moods and behaviour that indicate a child or adolescent may harm him/herself in the near future.

Given students' frequent reluctance to talk about suicidal thoughts and behaviour, it is important for parents, educators, peers, and mental health professionals to recognize and understand warning signs that a student may be at risk. Signs that are noticeable to others may include oral or written communications (including online texts), specific types of behaviour, changes in behaviour, or stressful events or crises in the student's life that may act as triggers. Common warning signs for suicidal thoughts and behaviour are outlined below. However, no matter how alert we may be for such warning signs, no one can predict suicidal behaviour with any certainty.

Some of the warning signs listed below are the same as or similar to those that may be shown by a student who is experiencing symptoms of sadness, worry, or depression. Symptoms associated with depression are also risk factors that may contribute to suicidal thoughts and behaviour (Doan et al., 2012b, *Issue brief 3a*).

WARNING SIGNS

Changes in how the student relates to work, interests, and other people, such as:

- withdrawal from friends and family;
- loss of interest in social activities;
- not wanting to be alone;
- not wanting to be touched;
- a decline in the quality of school work and academic performance;
- frequent absences from school;
- indifference to appearance.

Symptoms and/or changes that reflect depression or other mental health problems, such as:

- irritability
- a change in eating and sleeping habits;
- loss of interest in pleasurable activities or things the student is known to care about;
- frequent complaints about physical symptoms, such as stomach-aches, headaches, or fatigue, that may be linked to emotional difficulties;
- a marked personality change and serious mood changes;
- feelings of sadness, emptiness, or hopelessness (these may be expressed in written assignments);
- difficulty concentrating;

WARNING SIGNS *(continued)*

- problems with judgement and memory;
- difficulty sleeping;
- strong expressions of anger and rage;
- substance use problems;
- conduct disorder.

Impulsive and risk-taking behaviour, such as:

- excessive use of drugs and/or alcohol;
- sexual promiscuity;
- violent actions and/or uncharacteristic rebelliousness, and/or thrill-seeking behaviour;
- engaging in accident-prone or risky behaviour; putting self in a vulnerable position (e.g., playing chicken on road);
- fearlessness.

Suicidal behaviour, such as:

- seeking out ways to harm or kill him/herself;
- giving away favourite possessions;
- planning for death and making final arrangements;
- agitation, insomnia, and nightmares (in a student who is close to making a suicide attempt);
- previous suicide attempts;
- self-harm behaviour (e.g., cutting).

Oral or written communications, such as:

- talking about suicide or about a "plan";
- saying things like: "I'm going to kill myself", or "I shouldn't have been born";
- oral or written comments about the desire to die (e.g., "I wish I were dead"; written comments in notes or poems suggesting that the student is struggling; interactive suicide notes on the Internet);
- a preoccupation with death in writing, art, or conversation;
- complaints about being a bad person or feeling "rotten inside";
- statements about feeling hopeless, helpless, worthless, or "beyond help";
- statements that life is meaningless, pointless, and/or filled with misery;
- statements that reveal impossibly high, unrealistic expectations of self;
- verbal "hints" such as, "I won't be a problem for you much longer", "Nothing matters", "It's no use", or "I won't be seeing you again";
- statements that indicate sudden cheerfulness after a period of depression. (This may mean that the student feels relief at having decided to escape all problems by ending his/her life and committing self to action.)

(Based on information from: Doan et al., 2012b, *Issue brief 3a*; Sellen, 2010; HWDSB, 2009)

Note: This list provides some examples but is not exhaustive and should not be used for diagnostic purposes.

What Can Educators Do?*

Recognizing warning signs is important, but appropriate action also depends upon knowledge of the necessary steps for getting the child or youth the proper help. Schools are in a good position to focus efforts on supporting students who may be struggling with mental health problems in order to intervene before it is too late.

Educators are well placed to notice signs that students are exhibiting mental health problems or suicidal thoughts and behaviour. Because 90 per cent of all deaths by suicide are associated with having an untreated mental illness, it is critically important to recognize signs associated with mental health problems (e.g., symptoms of depression, substance use problems) (Conwell et al., 1996; Harris & Barraclough, 1997; Shaffer et al., 2001). Research findings show that 40 to 80 percent of youth who have had suicidal thoughts or who have attempted suicide and 60 percent of youth who have died by suicide have had symptoms of depression (Barbe et al., 2004). Substance use problems and conduct disorder are also indicators that a student may be at risk for suicidal behaviour (Shaffer et al., 2001).

Educators can help individual students gain access to sources of support and treatment. Schools should ensure that information about resources such as crisis centres and help lines or hotlines is widely available. Help lines, in particular, provide quick and easy access while ensuring confidentiality (Doan et al., 2012c, *Issue brief 5*).

There are prevention programs and training programs available to help educators learn more about how to identify and support students who may be at risk. Some school jurisdictions also have programs to raise awareness among students through focused suicide-awareness education. However, to date there is limited information about the effectiveness of such programs (Doan et al., 2012c, *Issue brief 5*, p. 3). There is some evidence that school-based suicide-prevention programs can help to raise awareness and promote help-seeking behaviour; however, there are no data to indicate whether such programs actually decrease rates of suicide (Cusimano & Sameem, 2011).

To Support Positive Mental Health in the Classroom …

Efforts to help students at risk begin with measures to create a classroom environment that will promote mental and emotional well-being among all students, as outlined below.

* For important information about privacy considerations, see the boxed insert on page 13 of this guide.

STRATEGIES FOR CREATING A SUPPORTIVE CLASSROOM ENVIRONMENT FOR ALL STUDENTS

- Focus on creating a safe and positive school climate and a classroom environment in which students feel able to express their feelings. Encourage students to let you know if they or their peers seem to be in trouble, upset, or showing signs of harming themselves.
- Model healthy coping skills and share ideas for managing academic (and other) stress.
- Focus on helping students to develop healthy adaptive skills that can be considered protective factors (e.g., social, conflict-resolution, coping, problem-solving, and help-seeking skills).
- Find ways to increase students' sense of connection to the school (e.g., by offering them roles as office, classroom, or hallway helpers or as representatives on school committees).
- Be available to listen to students in a supportive way.
- Promote the development of good communication skills, including the ability to be open about emotional difficulties.
- Provide opportunities for students to participate in activities they find meaningful. These will help to promote wellness and decrease physical and mental health risks.
- Find ways to connect students to social or extracurricular activities that could give them a sense that they have an important contribution to make.

(Based on information from: CYMHIN-MAD, 2011; Joiner & Ribeiro, 2011; Doan et al., 2012c, *Issue brief 5*)

To Support Students Who Show Signs of Suicidal Thoughts and Behaviour …

School boards should have a protocol in place for reporting concerns. Both the school administration and educators should know what to do if a student appears to be at risk.

In the tables that follow, table 8.2 and table 8.3 outline prevention and support strategies for dealing with students who show signs of suicidal thoughts and behaviour. Table 8.4 focuses on actions that could have negative consequences and that should therefore be avoided.

Table 8.2	What TO DO to support students who show signs of suicidal thoughts and behaviour

- Prepare in advance by finding out what resources are available in your school to assist students at risk.
- Know who on your school team to go to in a crisis situation or if a concern arises.
- Make sure that the student is not left alone if there appears to be an immediate risk or if you feel concerned for the student's safety.
- Tell the the principal or vice-principal and together tell the student's parent and or guardian.
- Remain calm (even if you are inwardly upset or alarmed).
- Be empathetic (try to understand and care) rather than sympathetic (feeling sorry for the student).
- Listen supportively and take your time. Allow the student an opportunity to speak, even if there are long periods of silence. Supportive listening can have a direct impact on decreasing immediate suicidal risk.
- Try to avoid giving advice, judging, or suggesting solutions. Repeat back the feelings that you hear the student expressing (e.g., "You sound frustrated", or "You sound as if today feels hopeless").
- Always take the student's concerns/warning behaviour seriously. Do not downplay the student's concerns. This is especially important if the student has a previous history of suicidal thoughts or behaviour.
- Restrict the student's access to any means of self-harm.
- Make sure that at each stage of the process, the student knows what is going on. Do not, for example, surprise the student by escorting him/her to a room where a ten-member crisis team is waiting. Make sure that you explain to the student what events and responses he/she can expect. Remember that a suicide crisis is a chaotic and confusing situation. By not providing and communicating structure in your response, you may unintentionally create more chaos and confusion, thereby increasing the likelihood that the student will refuse to cooperate.
- Ask questions to determine what supports (formal and informal) are available to the student that may help prevent a future crisis.

Table 8.3	What TO DO for students who have returned to the classroom following a suicide attempt and/or hospitalization for mental health concerns, who have a previous history of suicidal thoughts or behaviour, or who may be at risk of a repeat attempt

- Work with the parents, the school team, and appropriate mental health professionals to determine how best to support the student.
- Plan and implement actions to strengthen the student's self-esteem.
- Plan and implement actions to increase the student's support network. A possible risk-reduction strategy might be to help the student reconnect with an existing support or resource.
- Acknowledge that it may be difficult to restart communication with a student after a suicide attempt or a return from hospitalization for mental health concerns.

Source for tables 8.2, 8.3, and 8.4: Adapted from (1) J. Doan, A. LeBlanc, K.J. Lazear, and S. Roggenbaum, *The Youth Suicide Prevention School-based Guide – Issue Brief 6c: Intervention Strategies: Responding to a Student Crisis* (FMHI Series Publication #218-6c-Rev-2012) (Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, 2012); available online at http://theguide.fmhi.usf.edu/; and (2) Hamilton-Wentworth District School Board, *Suicide Prevention: School Quick Reference Guide* (April 2009)

Table 8.4 **What NOT to do when students show signs of suicidal thoughts and behaviour**

- Do NOT promise to keep quiet about a student's suicidal behaviour.
- Do NOT give pat answers or hollow reassurances that "everything will be all right".
- Do NOT attempt to use "reverse" psychology such as, "If you want to commit suicide so badly, go ahead."
- Do NOT assume that the person isn't the suicidal "type". Anyone can be suicidal.
- Do NOT panic.
- Do NOT act shocked. This reaction could make the student feel worse (e.g., assume that the situation is so bad that no one can help), destroy any chance for rapport, and put distance between you and the student.
- Do NOT preach to the student about the value of life or the effect of such a tragic act on the student's family and friends. Some of these people may be contributing to the student's suicidal crisis and the student may see suicide as a way to hurt them.
- Do NOT worry about silence during discussion. Let the student know that you are there for him/her and are willing to listen.
- Do NOT under-react or minimize the seriousness of the problem. Under-reacting communicates that you don't really respect the student's feelings and/or don't believe the student is serious. Under-reacting may reinforce the student's feeling that no one understands or cares. Do not assume that there is an element of attention seeking in the student's behaviour. You should assume that the danger is real. The benefits of taking the student seriously far outweigh the costs of not acting.

Source: See source note on p. 132.

Postvention Strategies

The whole community needs to be involved in the response to a suicide. Boards and community partners need to work very closely together to establish plans to ensure a systematic, timely, and appropriate response to a student's death by suicide (Doan et al., 2012c, *Issue brief 5*). The response may include a trauma/crisis response team deployed to the school to provide differentiated support to students and staff, as well as a wider team of support personnel to help with logistics, media response, and decision making. Research evidence shows that there can be a "contagion" effect – that is, students who may already be susceptible to suicidal thoughts and behaviour are at increased risk after a peer's death by suicide. Because of the risk of contagion, postvention must be planned and managed carefully.

The actions that educators can take will be part of a larger response. Educators should familiarize themselves with their board and school policies and procedures for responding after a death by suicide. In addition, they should:

- be aware that it is common to feel uncomfortable, unprepared, sad, guilty, and/or anxious following a death by suicide;
- pay particular attention to their own reactions and practise self-care strategies to maintain their personal well-being;

- work with school colleagues to formulate appropriate responses to questions that students may ask. If you are not sure how to respond, it is acceptable – and preferable – to tell a student that you don't know the answer to a question. Refer students to a mental health professional who is trained to respond in such situations;
- let students know that their feelings are respected, and that it is okay to talk about their feelings, no matter how scary the feelings may be.

(Based on information from: McTaggart & Szatmari, 2012)

Background Information

What Are the Causes of Suicidal Thoughts and Behaviour?

Risk factors are those that increase the likelihood that someone will have thoughts of suicide, attempt suicide, or die from suicide. Risk factors can include recent events or sources of stress in the child or adolescent's life, as well as problems that may have been present over a period of time.

A variety of risk factors interacting in complex ways may trigger suicidal thoughts or behaviour. Some of these are outlined below.

"Imagine juggling one, then two, then three and then four tennis balls … Now imagine each tennis ball represents a risk factor. As young people are exposed to more and more risks there comes a time when they can no longer function normally."

(Sellen, 2010, p. 11)

Individual Risk Factors

These can include:

- previous experience of suicidal thoughts and/or behaviour (Note: Suicide attempts are the strongest predictor of later suicide attempts and death by suicide in adolescents);
- poor physical health and/or disability (e.g., chronic illness);
- experience of physical, emotional, or sexual abuse;
- poor mental health (e.g., depression, substance use, conduct disorders) (Note: There is evidence to show that death by suicide occurs most frequently in adolescents with depressive disorders or undiagnosed mental disorders);
- feelings of hopelessness, isolation, or alienation;
- feelings of rejection, humiliation, shame, rage, or wanting to get even;
- risk-taking behaviour;
- poor school performance;
- being homeless or having run away from home;
- aggressive or impulsive behaviour;

(continued)

- stress related to problems at home or school (e.g., break-up of a relationship);
- legal or disciplinary problems;
- access to firearms or other means of self-harm;
- experience of being bullied (Note: Suicidal thoughts and behaviour are common in students who are victims of bullying).

Demographic Risk Factors

These can include:

- being male (for death by suicide);
- being female (for suicide attempts);
- being lesbian, gay, bisexual, transgendered, or queer (LGBTQ);
- being Aboriginal.

Family and Environmental Risk Factors

These can include:

- having a parent with a history of mental health problems;
- family problems (e.g., a hostile separation/divorce, family violence, death of a parent);
- parental alcohol/substance abuse;
- having very high or very low expectations;
- parental unemployment and/or poverty;
- exposure to suicidal behaviour among friends or acquaintances or through social media (Note: Susceptibility to suicidal thoughts and behaviour may be increased by exposure to a suicide attempt or death. This "contagion" factor is more likely to affect youth than people in other age groups);
- changes in relationships (e.g., death of a friend/family member; break-up of a relationship);
- experience of being victimized and/or bullied (e.g., in person or through social media);
- lack of support (actual or perceived) by family members;
- loss of status (actual or perceived) among friends;
- a transient lifestyle;
- stress related to specific, recent events or pressures (Note: Specific events or risk factors [e.g., failing an exam, parental divorce] that act as a trigger are not usually the sole cause of suicidal thoughts and behaviour, but may act as the "last straw" for a child or adolescent who is under stress for a variety of reasons).

(Based on information from: Spirito & Esposito-Smythers, 2006; Bridge et al., 2012; CDC, 2001; HWDSB, 2009; Sellen, 2010. And see Doan et al., 2012b, *Issue brief 3a*, for additional relevant references.)

Protective Factors

Factors that increase a student's susceptibility to suicidal thoughts and behaviour may be counteracted by a number of **protective factors** that enhance a student's ability to cope with stress.

Protective factors typically have the effect of enhancing the child or adolescent's self-esteem, competencies, social skills, and coping skills, and helping to decrease the likelihood that a child or adolescent will have thoughts of suicide or will attempt suicide.

Protective Factors

These can include:

- family cohesion and secure attachment to family/caregivers who provide emotional support;
- access to supportive and caring adults;
- a feeling of being connected with and belonging in the school and community;
- positive relationships with pro-social peers;
- social integration/opportunities to participate;
- an environment that provides appropriate discipline, structure, and limit setting;
- limited access to the means for committing suicide;
- a stable living environment;
- access to effective care for mental/physical/substance use disorders;
- having responsibilities for other people and/or for pets;
- religious or cultural beliefs that discourage self-harm;
- participation in sports, especially team sports;
- having a resilient personality;
- being sociable;
- having good mental health;
- having good coping skills;
- having opportunities to develop self-esteem;
- being willing to seek help or advice;
- reasonably good impulse control;
- reasonably good problem-solving/conflict-resolution, life, and communication skills;
- a sense of self-worth/confidence in ability to succeed.

Source: Adapted from J. Doan, A. LeBlanc, S. Roggenbaum, and K.J. Lazear, *The Youth Suicide Prevention School-based Guide – Issue Brief 3a: Risk Factors: Risk and Protective Factors, and Warning Signs* (FMHI Series Publication #218-3a-Rev 2012) (Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, 2012); available online at http://theguide.fmhi.usf.edu/

How Common Are Suicidal Thoughts and Behaviour?

In Canada, suicide is the second leading cause of death, after accidents, for young people between ten and thirty-four years of age (Public Health Agency of Canada, 2012). Suicide rates are known to increase among adolescents between twelve and eighteen years of age (CDC, 2011; for detailed information on the number of deaths resulting from suicide among children and youth in Canada, see Statistics Canada, 2009).

There are strong differences between rates of suicidal thoughts and behaviour in males and females, with adolescent girls being up to twice as likely to have suicidal thoughts as adolescent boys and three to four times more likely to attempt suicide. However, adolescent boys are up to five and a half times more likely to die by suicide than girls (Hamza et al., 2012).

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Appendix A:
Related Provincial Initiatives

Initiatives with a Mental Health Focus

In 2010, the Ontario Centre of Excellence for Child and Youth Mental Health released a policy paper, *Taking Mental Health to School: A Policy-Oriented Paper on School Mental Health in Ontario,* and a companion paper, *Scanning the Practice Landscape in School-Based Mental Health*. The former provides a review of the academic literature on school mental health and points to several evidence-based practices and programs that are associated with positive mental health and well-being for students. The Practice Scan is based on interviews with key senior leaders in Ontario schools and highlights both strengths and needs in school mental health in the province. These papers include policy and practice recommendations related to supporting student well-being in Ontario school boards.

Collaborative Initiatives

Another initiative to support school boards and community agencies in forming and enhancing partnerships is the Student Support Leadership Initiative (SSLI), begun in 2007–2008. This is a cross-sectoral initiative by the Ministry of Children and Youth Services, the Ministry of Health and Long-term Care, and the Ministry of Education. It involves collaboration by boards across the province with community agencies and health providers in twenty-nine clusters. The goal is to improve communication and the integration of systems of care for child and youth mental health and to provide non-academic supports for promoting positive student behaviour. Many important local initiatives have been started using SSLI funding, and clusters have shared their innovations through the Ontario Centre of Excellence for Child and Youth Mental Health Community of Practice.

The Ministry of Children and Youth Services reinforced the SSLI initiative with the introduction of a pilot program, Working Together for Kids' Mental Health, in four communities. The program was designed to consolidate community partnerships through procedures to facilitate early intervention and assist people in navigating the system and gaining access to appropriate services. Both SSLI and the Working Together program are foundational to new cross-ministry initiatives that are tied to the Ontario Mental Health and Addictions Strategy.

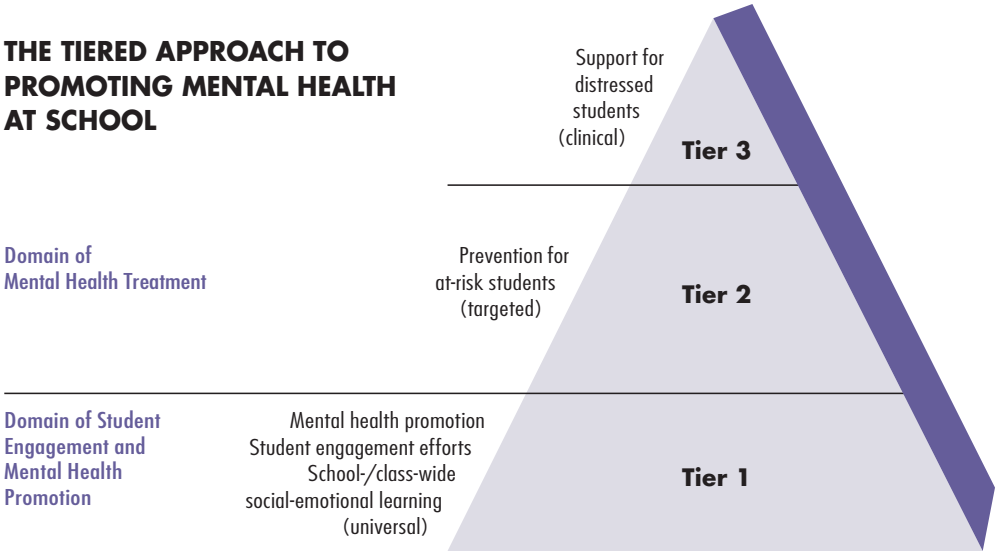
Instructional Initiatives

Both *Education for All: The Report of the Expert Panel on Literacy and Numeracy Instruction for Students with Special Education Needs, Kindergarten to Grade 6* (2006) and the draft *Learning for All: A Guide to Effective Assessment and Instruction for All Students, Kindergarten to Grade 12* (2011) provide important information about supporting student mental health at school. These documents outline three instructional approaches – universal design for learning (UDL), differentiated instruction, and the tiered approach to prevention and intervention – that can also be used to promote positive mental health in the classroom.

Used in combination, UDL and differentiated instruction enable teachers to respond effectively to the strengths and needs of all students. UDL provides the teacher with broad principles for planning instruction for a diverse group of students, and differentiated instruction allows teachers to address specific skills and difficulties. Both approaches recommend providing a range of instructional strategies, resources, activities, and assessment tools in order to meet the different strengths, needs, readiness levels, and learning styles or preferences of the students in a class.

The tiered approach is readily applied to student mental health. It calls, first, for the creation of a positive and supportive environment in the school and classroom that will benefit all students; second, for prevention programming for students at risk; and third, for intervention, including outside referrals, for students in distress. The present document, *Supporting Minds,* outlines strategies that are most relevant at the level of universal and prevention programming, and is designed to help educators identify students who may be in need of extra support from a trained mental health professional.

THE TIERED APPROACH TO PROMOTING MENTAL HEALTH AT SCHOOL



Mental Health in the Ontario Curriculum

Students have opportunities to learn about different aspects of mental health and emotional well-being within the Ontario curriculum from Kindergarten to Grade 12. Through the curriculum review process, these topics have been strengthened in the revised elementary curriculum document *Health and Physical Education (Interim Edition)*, in *The Full-Day Early Learning–Kindergarten Program,* and in the draft revised secondary curricula for health and physical education and for social sciences and humanities.

Beginning with our youngest learners, as evidenced in the document *The Full-Day Early Learning–Kindergarten Program (Draft Version, 2010–11),* there is an emphasis on helping students develop self-regulation skills, establishing their own internal motivation for adapting to and understanding social and emotional demands.

In the revised elementary health and physical education curriculum policy document (Interim Edition, 2010), the concept of mental health has been integrated across the curriculum. The focus is on mental health and emotional well-being rather than on mental illness, although an understanding of mental illness from the perspective of care for others and reducing stigma is included. Building resiliency skills and learning about protective and risk factors are a part of the learning. Substance use, misuse, addictions, and related behaviour, including gambling, are also included.

This same approach is being used in the revised health and physical education curriculum for Grades 9 to 12 (2013). Learning about mental health is also addressed in a variety of courses in the forthcoming revised social sciences and humanities curriculum.

Initiatives Related to Student Behaviour

The school environment has a considerable influence on student mental health. The document *Caring and Safe Schools in Ontario: Supporting Students with Special Education Needs through Progressive Discipline, Kindergarten to Grade 12* (2010) highlights the importance of promoting positive behaviour through a caring and safe school culture. Students with mental health problems often demonstrate behaviour that is troubling and confusing to educators. Many of the recommendations in *Caring and Safe Schools* are relevant to *Supporting Minds*, particularly with regard to students who struggle with externalizing disorders (i.e., those who exhibit oppositional behaviour, aggression, impulsivity, and other challenging behaviour). The present guide expands on topics in *Caring and Safe Schools* to provide a greater level of detail with respect to the signs and symptoms of mental health problems and classroom strategies that can be used to support students' mental health and well-being.

The Ontario Full-Day Kindergarten Program (**www.edu.gov.on.ca/eng/curriculum/elementary/kindergarten.html**) fosters the social, emotional, and cognitive development of Ontario's youngest students; helps them acquire the reading, writing, and math skills they need for future success; and smooths their transition to Grade 1. Consideration of the mental health and well-being of these very young students is central to the program. However, educators need to be mindful of the fact that very young children cannot fully express their thoughts and feelings and that this can make recognizing potential problems a challenge. Educators also need to be aware that the signs of mental health problems in a young child may be quite different from those in an older child or adult.

Other Ministry of Education Initiatives

Supporting children and youth in school is a multifaceted undertaking. Each of the ministry policies and initiatives identified below addresses one or a number of elements that contribute to or have a bearing on the mental health and well-being of students:

- the Aboriginal education strategy
  www.edu.gov.on.ca/eng/aboriginal/
- the equity and inclusive education strategy
  www.edu.gov.on.ca/eng/policyfunding/equity.html
- the Early Learning Framework
  http://www.edu.gov.on.ca/childcare/oelf/
- the Ontario leadership strategy
  www.edu.gov.on.ca/eng/policyfunding/leadership/actionPlan.html
- the parent engagement policy
  www.edu.gov.on.ca/eng/parents/policy.html
- Safe and Healthy Schools
  www.edu.gov.on.ca/eng/teachers/healthyschools.html
  www.edu.gov.on.ca/eng/parents/safeschools.html
- Student Voice
  www.edu.gov.on.ca/eng/students/speakup/index.html
- the School Effectiveness Framework
  www.edu.gov.on.ca/eng/literacynumeracy/framework.html

A Resource from the Ministry of Children and Youth Services

- *Stepping Stones: A Resource on Youth Development* (2012)
  www.children.gov.on.ca/htdocs/English/topics/youthopportunities/steppingstones/youth_policy.aspx

Designed to support those who work with youth aged 12 to 25, this resource guide was developed by the Ontario government in broad consultation with researchers, youth, community leaders, and service providers.

Appendix B:
The National and International Context

A number of national and international organizations have a strong focus on school mental health. Resources and links associated with mental health in schools can be found on sites hosted by the Mental Health Commission of Canada, the Public Health Agency of Canada, the Canadian Mental Health Association, the School Mental Health Project (UCLA, Center for Mental Health in Schools), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Collaborative for Academic, Social, and Emotional Learning (CASEL). As well, the International Alliance for Child and Adolescent Mental Health in Schools (Intercamhs) has commissioned an *International Survey of Principals Concerning Emotional and Mental Health and Well-being,* and results from several countries are posted on its website. Increasingly, these groups are working together to ensure that their efforts are complementary.

Appendix C:
Mental Health Action Signs

The Action Signs listed below are "a set of indicators of potentially serious emotional, mental or behavioral difficulty", developed in response to a "call to action" issued by the U.S. Surgeon General in 2001, which urged the development of "a crisp set of warning signs that, when present, warrant additional professional evaluation and possible intervention" (The Reach Institute, *The "Action Signs" Project*, 2011, p. 4).

The Action Signs and an accompanying toolkit were developed as part of the "Action Signs" Project, funded by the Center for Mental Health Services and the National Institute of Mental Health at Columbia University/New York State Psychiatric Institute, and completed by the investigators at the REACH Institute and Mayo Clinic. The toolkit provides guidelines for using the Action Signs effectively in clinical and school settings as well as tools for disseminating the information (e.g., sample scripts for introducing discussions about the Action Signs with students, informational handouts for parents and youth, and a sample poster). The toolkit developers emphasize that, "the information, resources, literature cited, and internet links are not intended as a diagnostic guide, and should not be viewed as a substitute for mental health evaluation by a competent, licensed professional". The "Action Signs" Project and toolkit can be found at: **http://www.thereachinstitute.org/files/documents/action-signs-toolkit-final**

ACTION SIGNS

Your behavioral health is an important part of your physical health. If you are experiencing any of these feelings, let your doctor know. You are not alone … not 1 in a 1000, but 1 in 10, because many kids have similar problems! Getting help is what counts. Help is available, and treatments work! Don't wait. Talk with a helpful adult, such as your family, doctor, school nurse or counsellor, or religious leader, if you have one.

1. Feeling very sad or withdrawn for more than 2 weeks
2. Seriously trying to harm or kill yourself, or making plans to do so
3. Sudden overwhelming fear for no reason, sometimes with a racing heart or fast breathing
4. Involvement in many fights, using a weapon, or wanting to badly hurt others
5. Severe out-of-control behaviour that can hurt yourself or others
6. Not eating, throwing up, or using laxatives to make yourself lose weight
7. Intense worries or fears that get in the way of your daily activities
8. Extreme difficulty in concentrating or staying still that puts you in physical danger or causes school failure
9. Repeated use of drugs or alcohol
10. Severe mood swings that cause problems in relationships
11. Drastic changes in your behaviour or personality

Source: The Reach Institute, The "Action Signs" Project, p. 6. Retrieved from http://www.thereachinstitute.org/files/documents/action-signs-toolkit-final.pdf

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