Questions

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Website
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Agenda

- Welcome
- District initiatives on Behavioral Health
- Mental Health matters in Reading
- Common mental health issues
- Living with a mental illness
- Strategies for the classroom
- Healthy Boundaries & Self-Care
- Resources & Closing
Town of Reading: Population 23,956

Ancestral Background for Whites
Irish (35%), Italian (26%), English (18%)

7% that reported a race other than White

Most Reported Ethnic Backgrounds

Income, Work & Housing
Reading is located 15 miles from Boston, MA

94% earned H.S. diploma

53% reported working in management

83% of housing is owner-occupied

Source: Reading, MA 01867, US Census Data, 2010
Note: Substance misuse, disordered eating and suicidality represent the average of multiple questions in that risk category, Reading YRBS
Substance misuse, disordered eating and suicidality represent the average of multiple questions in that risk category, Reading YRBS, 2015.
Disordered eating | Suicidality | Substance Misuse | Non-suicidal self-injury | Depressive symptoms | Been Bullied
--- | --- | --- | --- | --- | ---
6% | 8% | 19% | 21% | 22% | 22%
8% | 13% | 18% | 22% | 29% | 22%
8% | 11% | 21% | 22% | 25% | 26%
8% | 13% | 18% | 22% | 29% | 22%
8% | 11% | 21% | 22% | 25% | 26%

Differences between Reading 2013 and 2015
- 1% increase in bulimic behavior, 1% decrease in anorexic behavior
- Increase in suicidal ideation/planning, 3% decrease in attempts
- 12% decrease in underage drinking, 3% decrease in heroin use
- Anticipated increase in “reporting” depressive symptoms
- Decrease in school and cyber bullying

Note: Substance misuse, disordered eating and suicidality represent the average of multiple questions in that risk category, Reading YRBS
Multi-Tiered System of Support

- Reading is in year 3 of a 5 year grant program with the federal government to build a multi-tiered behavioral framework that organizes all the work we do for students into a more sustainable model that ensures students are identified faster and able to receive services immediately.
Multi-Tiered System of Support

- All buildings are moving toward an integrated or blended model where all students are supported through their academics and social emotional needs by quick identification, ease of evidence based intervention and sustainable models where staff have the training and support they need to meet student needs in this fashion.
Trauma Sensitive Schools

• Reading has trained over 75 teachers in the Impact of Trauma on Learning through the Lesley University Institute for Trauma Studies.
• 33 staff are enrolled in the Certificate in Trauma Studies Program and will be taking advanced studies in the subject. This group includes staff from preschool, elementary, middle school, high school and district representation.
• Lesley Institute for Trauma Sensitivity Courses
  www.lesley.edu
Trauma Sensitive Schools

• The district has twice received grant awards from the state to create Trauma Sensitive Schools, now renamed Safe and Supportive Schools which we have come to know as the MTSS work or safe and supportive schools task force recommendation reports.

• Killam Elementary is in their second year of a 2-year grant study with Harvard University and the American Institute of Research to test out what it takes to create a Trauma sensitive school.
Youth Mental Health First Aid

YMHFA is the help offered to a young person experiencing a mental health challenge, mental disorder, or a mental health crisis.

YMHFA does not teach people to diagnose or to provide treatment.
Why Mental Health First Aid for Those who Work With Youth?

- Mental health problems are common
- Problems often develop during adolescence
- Youth and young adults may experience mental health problems differently than adults
- Youth may not be well informed
- The sooner an individual gets help, the more likely they are to have a positive outcome
- Misunderstanding and discrimination are often associated with mental health problems
- Professional help is not always on hand
Building Capacity

Those who take the 8-hour course to certify as Mental Health First Aiders learn a 5-step action plan encompassing the skills, resources and knowledge to help an individual in crisis connect with appropriate professional, peer, social, and self-help care.

608 adults including Reading Public Schools staff and other adults that work or volunteer in the community have been certified.
Drugs Free Communities
Local problems require local solutions.

The goals of the coalition in Reading are to establish and strengthen community collaboration in support of local efforts to prevent youth substance use.
LONG-TERM RESULTS

Reduce Substance Use & Improve Collaboration

Significantly less Rx and alcohol access in local homes
1.1 million pills collected through Rx Round Up.
Alcohol access reduced through compliance and policy

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2015</th>
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<tbody>
<tr>
<td>Alcohol free (lifetime)</td>
<td>33%</td>
<td>45%</td>
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<tr>
<td>Alcohol free (past 30 days)</td>
<td>55%</td>
<td>62%</td>
</tr>
<tr>
<td>Alcohol free (no binge drinking)</td>
<td>71%</td>
<td>78%</td>
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2015 Reading YRBS, H.S.

Interdepartmental programming diverted 167 youth from
court system and provide alternatives to school
suspension.
15,000 people reached

ACCESS  PREVENT  UNDERSTAND  IDENTIFY
BREAKING THROUGH THE NOISE

RX Round Up

Mental Health First Aid (608 adults referred 352 youth)

- Rx bottles processed
- First Aiders Trained
- Youth Referred

Introducing
hello
YOUTH MENTAL HEALTH FIRST AID
www.MentalHealthFirstAid.org
New Resource Rolled Out - 11/1/16

Need help finding mental health care?

WILLIAM JAMES COLLEGE
INTERFACE Referral Service

The Town of Reading has contracted with a unique HELPLINE service staffed by licensed clinicians that can help children, teens, & adults in Reading become connected with mental health care. Get provider matches that meets your specific needs, accepts your insurance & has available appointments.

Call 1-888-244-6843 (toll free) - M-F - 9am-5pm

https://interface.williamjames.edu/
Dealing with sub-conscious stigma

Sprain

Broken Bone

Severe damage

What would you do?

Tried alcohol

Use every weekend

Alcohol poisoning, OD, Accident
How does addiction develop?

- Family background (40-50% of cases)
- Environmental Factors (culture)

Disease of Addiction

- Lifestyle Choices
- *Co-occurring disorders
Students need stable environments

- It helps to have consistent, positive adults
- What are the challenges in walking in as a sub?
- What are the issues that you find the most challenging in schools?
- Have you noticed any mental health concerns?
## Erik Erickson’s Stages of Development

<table>
<thead>
<tr>
<th>Psychosocial Crisis Stage</th>
<th>Life Stage</th>
<th>age range, other descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Trust v Mistrust</td>
<td>Infancy</td>
<td>0-1½ yrs, baby, birth to walking</td>
</tr>
<tr>
<td>2. Autonomy v Shame and Doubt</td>
<td>Early Childhood</td>
<td>1-3 yrs, toddler, toilet training</td>
</tr>
<tr>
<td>3. Initiative v Guilt</td>
<td>Play Age</td>
<td>3-6 yrs, pre-school, nursery</td>
</tr>
<tr>
<td>4. Industry v Inferiority</td>
<td>School Age</td>
<td>5-12 yrs, early school</td>
</tr>
<tr>
<td>5. Identity v Role Confusion</td>
<td>Adolescence</td>
<td>13-18 yrs, puberty, teens*</td>
</tr>
<tr>
<td>6. Intimacy v Isolation</td>
<td>Young Adult</td>
<td>18-40, courting, early parenthood</td>
</tr>
<tr>
<td>7. Generativity v Stagnation</td>
<td>Adulthood</td>
<td>30-65, middle age, parenting</td>
</tr>
<tr>
<td>8. Integrity v Despair</td>
<td>Mature Age</td>
<td>50+, old age, grandparents</td>
</tr>
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</table>
Lets Visit Ages 6 to 12

Think about your experiences in 3rd Grade

• Where did you live?
• Who was your best friend?
• What games did you like to play?
• Where did you go to school? Who was your teacher? What expression did he or she have on his or her face in greeting you each day?
• What game or technology was the newest thing?
• What was your favorite thing to eat at school?
• Was there a particular smell that you can remember to your school?
Developmental Goals (6 to 12)

• Ages 6 to 12
  – To develop industry
    • Begins to learn the capacity to work
    • Develops imagination and creativity
    • Learns self-care skills
    • Develops a conscience
    • Learns to cooperate, play fairly, and follow social rules
Normal Difficult Behavior
Ages 6 to 12

• Arguments/Fights with Siblings and/or Peers
• Curiosity about Body Parts of males and females
• Testing Limits
• Limited Attention Span
• Worries about being accepted
• Lying
• Not Taking Responsibility for Behavior
Cries for Help/More Serious Issues
Ages 6-12

• Excessive Aggressiveness
• Serious Injury to Self or Others
• Excessive Fears
• School Refusal/Phobia
• Fire Fixation/Setting
• Frequent Excessive or Extended Emotional Reactions
• Inability to Focus on Activity even for Five Minutes
• Patterns of Delinquent behaviors
Let’s Visit Ages 13-18

Think about your experiences in 10th grade

- Who was your favorite teacher?
- Were you dating or not dating?
- Who was your best friend?
- How would you have described your parent/caregiver?
- What did you do for fun?
- What was the latest and greatest technology?
- What was your favorite movie, song, or tv show?
Developmental Goals

- Developing Identity - the child develops self-identity and the capacity for intimacy
  - Continue mastery of skills
    - Accepting responsibility for behavior
    - Able to develop friendships
    - Able to follow social rules
Typical Difficult Behavior

- Moodiness!
- Less attention and affection towards parents
- Extremely self involved
- Peer conflicts
- Worries and stress about relationships
- Testing limits
- Identity Searching/Exploring
- Substance use experimentation
- Preoccupation with sex
Cries for Help - Ages 13-18

- Sexual promiscuity
- Suicidal/homicidal ideation
- Self-mutilation
- Frequent displays of temper
- Withdrawal from usual activities
- Significant change in grades, attitude, hygiene, functioning, sleeping, and/or eating habits
- Delinquency
- Excessive fighting and/or aggression (physical/verbal)
- Inability to cope with day to day activities
- Lots of somatic complaints (frequent flyers)
Discussion

• How do you make the distinction between typical versus abnormal development?
  – How can you tell?

• We using the guiding principle of functional impairment...LLL
TOP 3 COD BY AGE GROUP

5 to 9 years:
- Accidents (unintentional injuries)
- Cancer
- Developmental and genetic conditions that were present at birth

10 to 14 years:
- Accidents (unintentional injuries)
- Cancer
- Suicide

15 to 24 years
- Accidents (unintentional injuries)
- Suicide
- Homicide

Overview of Children’s Mental Health Needs

- Between 20% to 38% of youth in the U.S. have diagnosable mental health disorders
- Between 9% to 13% of youth have serious disturbances that impact their daily functioning
- Between one-sixth to one-third of youth with diagnosable disorders receive any treatment
- Schools provide a natural, universal setting for providing a full continuum of mental health care
Depression

Epidemiology

• 2.5% of children, up to 5% of adolescents
• Prepubertal-1:1/F:M; adolescence-4:1/F:M
• Average length of untreated Major Depressive Disorder – 7.2 months
• Recurrence rates-40% within 2 years

Heredity

• Most important risk factor for the development of depressive illness is having at least one affectively ill parent
What depression may look like:

- Negative thinking – “I can’t, I won’t”
- Social withdrawal
- Irritability
- Poor school performance (not just grades)
- Lack of interest in peer activities
- Muscle aches or lack of energy
- Reports of feeling helpless a lot of the time.
- Lowering their confidence-level about intelligence, friends, future, body, etc.
- Getting into trouble because of boredom.
What Works for Depression

- Psychoeducation
- Cognitive/Coping
- Problem Solving
- Activity Scheduling
- Skill-building/Behavioral Rehearsal
- Social Skills Training
- Communication Skills
Cognitive/Coping

• Change cognitive distortions
• Increase positive self talk
• Identify the type of event that will trigger the irrational thought.
• Help students become aware of their thoughts
• Recognize and get rid of negative self talk
• Counter negative thoughts with realistic positive self talk
• Believe the positive self talk!
Cognitive Distortions

• **Exaggerating** - Making self-critical or other critical statements that include terms like never, nothing, everything or always.

• **Filtering** - Ignoring positive things that occur to and around self but focusing on and inflating the negative.

• **Labeling** - Calling self or others a bad name when displeased with a behavior

Adapted from: Walker, P.H. & Martinez, R. (Eds.) (2001) *Excellence in Mental Health: A school Health Curriculum - A Training Manual for Practicing School Nurses and Educators*. Funded by HRSA, Division of Nursing, printed by the University of Colorado School of Nursing.
Cognitive Distortions

- **Discounting** - Rejecting positive experiences as not important or meaningful.

- **Catastrophizing** - Blowing expected consequences out of proportion in a negative direction.

- **Self-blaming** - Holding self responsible for an outcome that was not completely under one's control.

Anxiety

- Panic Disorder
- Obsessive Compulsive Disorder
- Specific Phobias
- Separation Anxiety Disorder
- Posttraumatic Stress Disorder
- Generalized Anxiety Disorder
Anxiety - Prevalence

- 13% of youth ages 9 to 17 will have an anxiety disorder in any given year
- Girls are affected more than boys
- ~1/2 of children and adolescents with anxiety disorders have a 2nd anxiety disorder or other co-occurring disorder, such as depression
Specific Phobias

- Marked and persistent fear of a specific object or situation with exposure causing an immediate anxiety response that is excessive or unreasonable.
- In children, anxiety may be expressed as crying, tantrums, freezing, or clinging.
- Animal phobias most common childhood phobia.
- Also frequently afraid of the dark and imaginary creatures.
- In older children and adolescents, fears are more focused on health, social and school problems.
- Adults recognize that their fear is excessive. Children may not.
- Causes significant interference in life, or significant distress.
- Under 18 years of age – symptoms must be ≥ 6 months.
Impact of trauma on learning

- Decreased IQ and reading ability (Delaney-Black et al., 2003)
- Lower grade-point average (Hurt et al., 2001)
- More days of school absence (Hurt et al., 2001)
- Decreased rates of high school graduation (Grogger, 1997)
- Increased expulsions and suspensions (LAUSD Survey)
Effective Practice Strategies

• Modeling
• Relaxation
• Cognitive/Coping
• Exposure
What is **Modeling**?

• Demonstration of a desired behavior by a therapist, confederates, peers, or other actors to promote the imitation and subsequent performance of that behavior by the identified youth
ADHD Prevalence

- Range from 1-16% depending on criteria used
- 3-5% prevalence in school-age children
- Male: female ratio is 3:1 to 10:1
- Occurs more frequently in lower SES
ADHD

- 6 or more inattentive items
- 6 or more hyperactive/impulsive items
- Persistent for at least 6 months
- Clinically significant impairment in social, academic, or occupational functioning
- Inconsistent with developmental level
- Some symptoms that caused impairment before the age of 7
- Impairment is present in two or more settings (school, home, work)
Inattention

1) Often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities
2) Often has difficulty sustaining attention in task or play activities
3) Often does not seem to listen when spoken to directly
4) Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositionalitity or failure to understand instructions)
5) Often has difficulty organizing tasks and activities
6) Often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort
7) Often loses things necessary for tasks or activities
8) Is often easily distracted by extraneous stimuli
9) Is often forgetful in daily activities
Hyperactivity

1) Often fidgets with hands or feet or squirms in seat
2) Often leaves seat in classroom or in other situations in which remaining seated is expected
3) Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
4) Often has difficulty playing or engaging in leisure activities quietly
5) Is often “on the go” or often acts as if “driven by a motor”
6) Often talks excessively
Impulsivity

1) Often blurts out answers before questions have been completed
2) Often has difficulty awaiting turn
3) Often interrupts or intrudes on others
Basic Principles for Effective Practice for ADHD

- Clear and brief rules
- Swift consequences
- Frequent consequences
- Powerful consequences
- Rich incentives
- Change rewards
- Expect failures
- Anticipate
Praise

- Praising correctly increases compliance in youth with ADHD
  - Praise can include
    - Verbal praise, Encouragement
    - Attention
    - Affection
    - Physical proximity
Giving Effective Praise

- Be honest, not overly flattering
- Be specific
- No “back-handed compliments” (i.e., “I like the way you are working quietly, why can’t you do this all the time?”)
- Give praise immediately
Ignoring and Differential Reinforcement

- Train staff and teachers to **selectively**
  - Ignore mild unwanted behaviors

**AND**

- Attend to and **REINFORCE** alternative positive behaviors
Differential reinforcement

**Step One:** Ignore (stop reinforcing) the child’s undesirable behavior

**Step Two:** Reinforce the child’s desirable behavior in a systematic manner
- The desirable behavior should be a behavior that is incompatible with the undesirable behavior

**Example:**
- **Target behavior:** Interrupting
- **Desirable behavior:** Working by himself
- **Reward schedule:** 5 minutes
  - If child goes 5 minutes without interrupting, the child receives reinforcement
  - If child interrupts before 5 minutes is up, the child does not receive reinforcement and the reward schedule is reset
Defining Disruptive Behaviors

• Types of Disruptive Behavior Disorders (DBD):
  – ADHD
  – Oppositional Defiant Disorder (ODD) – loses temper, argues with adults, easily annoyed, actively defies or refuses to comply with adults.
  – Conduct Disorder (CD) – aggression toward peers, destruction of property, deceitfulness or theft, and serious violation of rules.
A pattern of negativistic, hostile and defiant behavior lasting greater than 6 months of which you have 4 or more of the following:

- Loses temper
- Argues with adults
- Actively defies or refuses to comply with rules
- Often deliberately annoys people
- Blames others for his/her mistakes
- Often touchy or easily annoyed with others
- Often angry and resentful
- Often spiteful or vindictive
Oppositional Defiant Disorder (ODD)

• Prevalence-3-10%
• Male to female -2-3:1
• Outcome-in one study, 44% of 7-12 year old boys with ODD developed into CD
• Evaluation-Look for comorbid ADHD, depression, anxiety & Learning Disability/Mental Retardation
Conduct Disorder (CD)

- Aggression toward people or animals
- Destruction of property
- Deceitfulness or Theft
- Serious violation of rules
Conduct Disorder (CD)

- Prevalence: 1.5-3.4%
- Boys greatly outnumber girls (3-5:1)
- Co-morbid ADHD in 50%, common to have LD
- Course: reverts by adulthood in 2/3. Others become Antisocial Personality Disorder
- Can be diagnosed as early onset (before age 10) or regular onset (after age 10)
Practices that Work with DBD

- Praise
- Commands/limit setting
- Tangible rewards
- Response cost
- Psychoeducation
- Problem solving
Steps to Making Effective Commands

1. To make eye contact with the child before giving command
2. To reduce other distractions while giving commands
3. To ask the child to repeat the command
4. To watch the child for one minute after giving the command to ensure compliance
5. To immediately praise child when s/he starts to comply
Effective Commands/Limit Setting with Adolescents

- Praise teens for appropriate behavior
- Tell teen what to do, rather than what not to do
- Eliminate other distractions while giving commands
- Break down multi-step commands
- Use aids for commands that involve time
- Present the consequences for noncompliance
- Not respond to compliance with gratitude
Setting up a Reward System for Children at School

• School staff tracks the child’s behavior and reports it to the parent daily.
  – Rewards can be given at home or at school
• Choose a few target behaviors at school
  – Choose one that the child will be successful with most of the time
  – Set up a system for school report card or school/home note system
• Set up a daily report card targeting one to three behaviors
• Can also set up guidance counselor, tutor or peer as “coach” for organizational skills or other targets
Acting Out Cycle

- Trigger
- Agitation
- Peak
- De-escalation
- Recovery
- Caim

Adapted from The Iris Center: http://iris.peabody.vanderbilt.edu
James is a first grader who has been identified by his teacher as having problems in the classroom. The teacher reports that he never finishes his classroom assignments, never does his homework, does not stay in his seat, and regularly disrupts other students when they are trying to do their work. She added that he is a bright young boy who seems to understand what needs to be done, but cannot focus his attention long enough to complete needed tasks. His parents are coming in for an appointment with you today and have told the teacher they'll do anything to make the situation better for their son. He has no prior treatment history.

What are your suggestions about how to intervene?
Case Example – High School

Tyler is a 17 year old senior who self referred to the school mental health clinician. He has always done well in school, but reports that he has lost interest in school and all his activities in the past year. He has gone from an “A” student to a “D” student. He reports that he has been feeling sad for a year and doesn’t really know why. He has lost significant weight from his lack of appetite and reports problems concentrating and sleeping. He is confused by why he is so sad, but feels he just can’t “snap out of it” and wants help. He blames himself for not being able to handle senior year as well as his other friends. He stated to you that “I’m the only one who is going through problems and it is my fault that I can’t handle it better.”

What are some ideas about how to intervene?
General Strategies

- Use active listening
- Don’t be afraid to show that you care
- Be a good role model
- Take the time to greet students daily
- Show genuine interest in their lives and hobbies
- Find and reinforce the positives
- Move beyond labels and leave assumptions at home!
- Smiles are contagious
- Take the time to problem solve with students
- Involve families in a child’s education
- Instill hope about the future
Healthy Boundaries

• Where is the line?
Questions

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