2008

Promoting Mental Health in Missouri's Children: A Guide for Schools, Families, and Communities

Missouri Coordinated School Health Coalition

The Missouri Coordinated School Health Coalition (MCSHC) developed *Promoting Mental Health in Missouri's Children: A Guide for Schools, Families, and Communities* to address the increasing levels of mental health issues in our schoolchildren. In fact, when the Coalition surveyed Missouri educators and school health professionals about their greatest issue or challenge related to school health, nearly 52 percent noted the rising number of children with mental health issues. We responded by developing this white paper examining the impact of mental health on student health and academic achievement and proposing the use of coordinated school health programs to intervene early and improve outcomes for students. We recognize that a mentally healthy child is more likely to be academically motivated, alert, and successful in school and in life.

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INTRODUCTION

Mental health concerns in children are becoming increasingly common and widespread. Approximately 20 percent of children and adolescents suffer from mental health problems that result in mild functional impairments, and an estimated 10 percent have moderate to severe impairments (Duchnowski, Kutash, and Friedman, 2002; Power et al., 2005). A fraction of these children (less than 50 percent) receive adequate (or any) services, especially minority children (Kataoka, Zhang, and Wells, 2002; Leaf et al., 1996). Since emotional, behavioral, and social difficulties diminish the capacity of children to learn and benefit from the educational process (Rones and Hoagwood, 2000), expanding school mental health programs and services is critical for fostering school success (Greenberg et al., 2003; Massey et al., 2005; Paternite, 2004; Weist, 1997).

THE EFFECTS OF MENTAL HEALTH ON ACADEMIC ACHIEVEMENT

Students with emotional disturbances[1] consistently have the lowest graduation rates of all students age 14 and older with disabilities, with rates falling between 25 and 35 percent (U.S. Department of Education, 2005). After leaving school, they often lack the necessary social skills to be successfully employed (U. S. Department of Education, 2001). The pervasiveness of academic deficits does not appear to improve over time (Mattison, Hooper, and Glassberg, 2002), and may even deteriorate (Greenbaum et al., 1998) as students progress through school.

CHARACTERISTICS OF MENTALLY HEALTHY CHILDREN THROUGHOUT THE LIFESPAN

Mental health throughout the lifespan is measured by gains in the cognitive, social, and emotional developmental domains (U.S. Department of Health and Human Services, 2001). Beginning in infancy, early relationships and secure attachment patterns provide the foundation for the development of positive mental health, influencing how children view themselves and others (Seifert and Hoffnung, 2000). In fact, researchers suggest developing secure attachments with caregivers a crucial component to further development (U.S. Department of Education, 1999). Various characteristics are important to the development of such relationships, including the unique characteristics the infant brings to the relationship, such as temperament, or the child's style of responding to his or her world, as well as parent characteristics, such as level of warmth, responsiveness, and engagement.

Children who form secure attachments with caregivers typically display the capacity for also developing trusting relationships with other children and adults (Seifert and Hoffnung, 2000). For example, in the preschool years, mentally healthy children may show signs of anxiety upon [*their]* initial separation from his or her caregiver, but typically exhibit effective coping skills by adjusting to and exploring the new environment. Mentally healthy children also develop positive self-esteem and self-worth, making them better able to resist negative influences and make

[1] The initial diagnosis was serious emotional disturbances under the Individuals with Disabilities Education Act (IDEA). The current diagnostic terminology is emotional disturbances.

positive life choices. As they get older, mentally healthy children increasingly show the ability to express their needs and feelings appropriately and show empathy towards others. They grow up to become independent adolescents and adults who display effective coping skills, adaptation to change, and the ability to build and maintain satisfying relationships with others.

MENTAL HEALTH RELATED ISSUES AFFECTING MISSOURI STUDENTS

Mental health and physical health

When discussing health, most people think only in terms of physical health, or health related to the body (Donnelly, Eburne, and Kittleson, 2001). However, physical and mental health are enmeshed components of an individual's overall well-being. The U.S. Surgeon General has stated that the connection between mind and body are closely related (1999). Physical well-being pertains to healthy behavior practices as well as nutrition, rest, exercise, and preventive measures against disease. Issues such as self-esteem, stress management, and coping with emotional responses center on physical health (Donnelly, Eburne, and Kittelson, 2001). There is a reciprocal relationship, both positively and negatively, between a person's mental health status and his or her physical well-being.

THE EFFECTS OF MENTAL HEALTH ON PHYSICAL HEALTH

- Results from one study of young people with a history of both mental and addictive disorders demonstrated that the mental disorder is usually reported to have occurred first. The onset of mental health problems may occur about 5 to 10 years before substance abuse disorders (Kessler et al., 1996).
- The Center for Mental Health Services (2006) states, "Traumas can affect your health in ways you may not recognize. If you have experienced trauma, violence, or abuse in your life, it may act as a hidden cause of physical and mental disorders. These include depression, panic disorder, and post-traumatic stress disorder. It can also lead to unhealthy habits like smoking, drug or alcohol use, unhealthy weight, unsafe sex, or thoughts of suicide."

Mental health and social/behavioral success

Individuals with a high level of social well-being have the ability to connect with others, and formulate and maintain close interpersonal relationships (Donnelly, Eburne, and Kittelson, 2001). Socially healthy individuals are effective in managing disagreements with others and using problem-solving skills. However, some of the largest detriments to mental health can arise from difficulties with social interaction. Children that face difficult social situations, such as bullying, losing an intimate friend, or difficulty developing and maintaining more than one close relationship, are at higher risk for developing emotional problems, conduct disorder, and poor social functioning (Ornstein and Sobel, 1989).

By definition, students identified with emotional disturbances are likely to display inappropriate behaviors or suffer from behavior deficits and, as a result, have significant problems with school functioning and interpersonal relationships. According to the National Longitudinal Transition Study-2 (Wagner and Cameto, 2004), almost three-fourths of students with emotional

disturbance disabilities[2] in high school report having been expelled or suspended from school at least once. During any single school year, the parents of 44 percent of these students report that their child has been suspended, which is twice the rate of students with other disabilities. Further, during any single school year, 42 percent of parents report that their child with ED was involved in a fight, whereas a similar percentage of parents report that their child with ED was bullied.

The results from the National Adolescent and Child Treatment Study (Greenbaum et al., 1998) are likewise discouraging. For example, 66.5 percent of the 753 children with ED who were followed in the study and had complete data on contact with law enforcement were reported to be involved in crimes in which they were the perpetrator. Furthermore, 43.3 percent of children in the study were arrested at least once, 49.3 percent made a court appearance before a judge, and 34.4 percent were adjudicated for a crime. Other studies demonstrate that, in general, youth with ED have more difficulty adjusting to the social demands of adult life, are more likely to be unemployed, and more likely to develop substance abuse problems than their typically developing or mildly disabled peers (Frank, Sitlington, and Carson, 1995; Kauffman, 2001).

THE RELATIONSHIP BETWEEN EDUCATION AND INCARCERATION

Numerous statistics, including the following, demonstrate that individuals who achieve low levels of education face heightened risk of incarceration.

- Seventy-five percent of America's state prison inmates and 59 percent of America's federal prison inmates did not complete high school (Harlow, 2003).
- High school dropouts are 3.5 times more likely than high school graduates to be arrested in their lifetime (Alliance for Excellent Education, 2003a).
- A one percent increase in high school graduation rates would save approximately $1.4 billion in incarceration costs (Alliance for Excellent Education, 2003a).
- A one-year increase in average education levels would reduce arrest rates by 11 percent (Alliance for Excellent Education, 2003a).

Risk of comorbidity for children

The National Institute of Mental Health (NIMH) reports that mental illness begins very early in life with nearly half of all lifetime cases beginning by age 14 and three-quarters by age 24 (2005). Even worse, most individuals suffering from a mental illness report waiting a long time, sometimes years, after symptoms arise before seeking some form of treatment. Untreated disorders can lead to failure in school, violence, lack of employment opportunities, and maladaptive social behavior. The study also reveals that an untreated mental disorder can lead to a more severe, more difficult to treat illness, and to the development of a comorbid condition. Issues pertaining to mental health in youth are of critical importance, and proactive strategies of early intervention and prevention are imperative to limiting the long-term effects of mental illness and reducing the stigma of receiving mental illness treatment.

Individuals currently suffering from one mental disorder are at severe risk for developing a comorbid condition. Forty-five percent of individuals participating in the NIMH-funded research with one mental disorder met criteria for two or more disorders (2005). Nearly three-quarters of adolescents with co-occurring disorders are Caucasian and nearly 40 percent of all comorbid

[2] In this study, the diagnostic terminology used was Serious Emotional Disorders (SED). The text uses current diagnostic terminology of Emotional Disturbance (ED).

cases are adolescent females (Substance Abuse and Mental Health Services Administration, 2005). Between 1995 and 2001, the frequency of substance abuse treatment admissions with co-occurring substance abuse and psychiatric disorders reported to Substance Abuse and Mental Health Services Administration's (SAMHSA) Treatment Episode Data Set increased from 12 to 16 percent (Substance Abuse and Mental Health Services Administration, 2004b). Adolescents who experienced a major depressive episode in the past year were twice more likely to have used illicit drugs in the past month than their peers who had not experienced a major depressive episode in the past year (Substance Abuse and Mental Health Services Administration, 2004a).

Mental health and future employment

Children are the future workforce. Unfortunately, the majority of individuals who experience a childhood mental disorder continue to be challenged by the disorder in adulthood (Kessler et al., 2005). Yet many adults, for a variety of reasons, go untreated. According to the National Mental Health Association (2001), fewer than one in five adults who report symptoms of depression and anxiety actually seek treatment. Untreated mental illness in the U.S. costs businesses billions of dollars each year in lost days of productivity alone (National Mental Health Association, 2001).

The employment of individuals with psychiatric disabilities is gaining attention in the field of mental health (Cook and Pickett, 1995). Vocational rehabilitation models are evolving, but the vast majority of mental health consumers remain excluded from the mainstream labor market (Akabas, 1994). Obstacles preventing employment extend beyond individual disability, such as discrimination, local economy, and service delivery (Harnois and Gabriel, 2000).

> In today's workplace, only 40 percent of adults who dropped out of high school are employed, compared to 60 percent of adults who completed high school and 80 percent for those with a bachelor's degree (Alliance for Excellent Education, 2003b).

Regardless of current unemployment rates, people with disabilities still face high rates of unemployment throughout the country. Approximately 54 million Americans have disabilities and 17 million of these are working age (ages 16 to 64), yet only 29 percent are employed full or part time. Even though employers have increased their awareness of bringing diversity into the workplace, individuals with disabilities are still overlooked in new employment practices. Physical and mental disabilities carry a stigma in today's society, and this misperception often causes employers to forfeit the talents, skills, motivation, and willingness to work that people with disabilities possess (Substance Abuse and Mental Health Services Administration, 2004a).

Economic costs of mental illness

Funding for mental health services is declining even though research shows that proactive mental health treatment is effective and beneficial for individuals and society as a whole (National Mental Health Association, 2006). Studies indicate that the U.S. mental health care system is not keeping up with the needs of consumers and improvements are needed to speed initiation of treatment and enhance the quality and duration of treatment (National Institute of Mental Health, 2005). There is an enormous disparity in insurance coverage for mental disorders in contrast to other illnesses, and families must cover a larger percentage of costs for mental health treatments than any other form of health care. Recent legislative efforts to mandate equitable insurance coverage for mental health services are steps forward to reducing financial barriers to mental health treatment. However, such measures will be of no use for the more than 44 million Americans who lack *any* health insurance (Office of Public Health and Science, 2000).

Children constitute about 28 percent of the population, but account for about 14 percent of health expenditures, and only about seven percent of mental health expenditures (U.S. Department of Health and Human Services, 1999). Between 1997 and 2000, the overall use of medications to treat mental illness in children under age 17 increased around five percent, but in those three years, the actual dollars spent on drug treatments increased 65 percent (Kirchmeier, 2003). The allocation for the cost of untreated and mistreated mental illness to American businesses, the government, and families has grown to $113 billion annually (Rice and Miller, 1998). Clinical depression costs the U.S. $43.7 billion annually, including workplace absenteeism and lost productivity, costs of treatment and rehabilitation, and lost earnings due to depression-induced suicides (Greenberg et al., 1993). More than 90 percent of people who commit suicide have a diagnosable mental disorder, commonly a depressive disorder or a substance abuse disorder. Costs to society of suicide include medical expenses, lost productivity, and quality of life expenses. For example, in California, the medical costs of alcohol-attributable youth suicide are more than $7.6 million; lost productivity, more than $39 million; and quality of life, more than $110 million (Children's Safety Network Economics and Data Analysis Resource Center, 2000).

The indirect costs of failing to appropriately address mental health issues not only affect the individual, but are collectively absorbed by society via increased burdens on health care and educational systems, business and industry, and the justice system (National Institute of Mental Health, 2004). As the prevalence of mental illness in children and the cost of treating mental illnesses continue to increase, more emphasis must be placed on programs for mental illness prevention and on increasing the availability of early mental health interventions.

A report by the U.S. Surgeon General made it clear that equality between mental health coverage and other health coverage, a concept known as “parity,” is an affordable and effective objective (Office of Public Health and Science, 2000). In states in which legislation requires parity of mental health and general coverage, cost increases are nearly imperceptible as long as the care is managed. In Minnesota, Blue Cross/Blue Shield reduced its insurance premiums by five to six percent after one year’s experience under the state’s comprehensive parity law (Levin et al., 1998). In North Carolina, overall health insurance expenses have decreased every year since comprehensive parity for state and local employees was passed in 1992 (Bachman, 2000). The cost of providing mental health coverage commensurate to physical health coverage would, in fact, save the nation over $2.2 billion annually (Pardes, 1993). Comprehensive community-based mental health services for children and adolescents can cut public hospital admissions and lengths of stay and reduce average days of detention by approximately 40 percent (National Mental Health Association, 2006).

CONTRIBUTING TRENDS

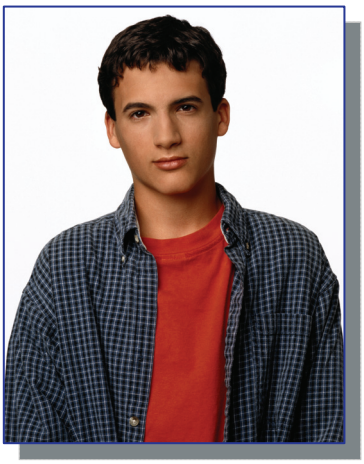
Mental health is recognized as a critical part of a child's existence that can greatly affect all aspects of learning and overall well-being. "Growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met by those very institutions which were explicitly created to take care of them," (U.S. Department of Health and Human Services, 1999). The trend toward increased mental illness among children and adolescents is described below.

National Trends

National trends indicate a growing crisis in children's mental health:

- Approximately 20 percent of children and adolescents suffer from various mental health problems that mildly impair daily function, and an estimated 10 percent suffer from moderate to severe impairments (Duchnowski, Kutash, and Friedman, 2002; Power et al., 2005). This translates to at least two to three students with serious mental health problems in every classroom.
- Less than 50 percent of children receive adequate (or any) services, especially minority children (Kataoka, Zhang, and Wells, 2002; Leaf et al., 1996). Unmet need for services remains as high now as it was 20 years ago. Recent evidence compiled by the World Health Organization indicates that by the year 2020, childhood neuropsychiatric disorders will rise proportionately by over 50 percent, internationally, to become one of the five most common causes of morbidity, mortality, and disability among children.
- Childhood mental disorders persist into adulthood: 74 percent of 21-year-olds with mental disorders report experiencing symptoms as a child (Roberts, Attkisson, and Rosenblatt, 1998).
- Primary care physicians report that about 19 percent of all children they see are currently experiencing behavioral and emotional problems. Yet that overlapped by only seven percent with what parents identified as problems (Child Behavior Study, 1997).
- Attention deficit hyperactivity disorder (ADHD) is one of the most common mental disorders in children, affecting three to five percent of school-age children. In a classroom of 25 to 30 children, it is very likely that at least one student will have ADHD (National Institute of Mental Health, 2006).
- At any time, 10 to 15 percent of U. S. children and adolescents have *some* symptoms of depression. Once a major depression has been experienced, he or she is at risk of developing another depression within the next five years. This young person is also at risk for other mental health problems (Substance Abuse and Mental Health Services Association, 2003).
- Among school-age children, those with an emotional disturbance are often misdiagnosed as having a learning disorder (Galscoe, 2000).
- More than 35 percent of children exposed to a single traumatic event will develop mental health problems (Center for Substance Abuse Prevention/National Prevention Network, 2008).

- Suicide is the third leading cause of death for 15- to 24-year-olds and the sixth leading cause of death for 5- to 14-year-olds. Each year more than 5,000 U.S. teenagers commit suicide. The number of attempted suicides is even higher (American Academy of Adolescent and Child Psychiatry, 2004).



- Twenty-five percent of children are exposed to family alcoholism, addiction, or alcohol abuse before becoming an adult. These children are higher risk for alcohol and drug use, delinquency, depression, and poor school performance than their peers (Center for Substance Abuse Prevention/National Prevention Network, 2008).
- Children and adolescents with ED exhibit externalizing and internalizing behaviors, which often interfere with academic success. These students, compared to typically developing peers, display moderate to severe academic deficits (Greenbaum et al., 1998). In addition, these students earn lower grades across *all* academic areas in comparison to their typically developing peers (Reid et al., 2004), have a higher course failure rate, and are more likely to drop out of school than any other disability group (U.S. Department of Education, 1994).
- Physical assault and neglect, contact sexual abuse, and supervision neglect before sixth grade are linked with drug, cigarette, and alcohol use; violence; and depression (Center for Substance Abuse Prevention/National Prevention Network, 2008).
- Evidence suggests that a relationship between academic failure and social failure emerges early in life (Kauffman, 2001).

Trends in Missouri's Children

The state of mental health among children and adolescents in Missouri is similar to U.S. averages. However, several indicators on mental illness among Missouri youth represent a cause for concern and require further attention.

- The number of Missouri children that have received mental health services for serious emotional disorders has nearly doubled from 23,310 in 2000 to 45,449 in 2005 (Office of Social and Economic Data Analysis: Missouri State Profile, 2005).
- According to the National Survey of Children's Health, conducted by the Child and Adolescent Health Measurement Initiative (2003), 8.7 percent of children ages 3-17 in Missouri have moderate or severe difficulties with emotions, concentration, behavior, and getting along with others compared to 9.2 percent nationally.
- Antisocial behavior trends have remained relatively stable from 2004 to 2006 among Missouri's middle, junior, and high school students. In 2006, physical fighting (36.4 percent), suspension from school, (17.6 percent) and weapon use (7.6 percent) were reported as the most frequent antisocial behavior with taking a weapon to school being the least (1.8 percent) (Evans et al., 2006).
- According to a *Step by Step* report by the Office of Social and Economic Data Analysis (2008), "in 2003, the Missouri Department of Mental Health provided mental health services to three percent of children and youth between 0 and 18 years of age for serious emotional disturbances (SED) (Markward and Klein, 2005). While these data suggest that a

relatively small number of children are diagnosed as emotionally disturbed[3], the number of children who experience mental health problems and receive treatment in other settings (e.g., the pediatrician's office), or do not receive treatment, is unaccounted for by the data."

- To illustrate the magnitude of the impact on Missouri public schools, in 2006 there were over 900,000 students enrolled, which means that approximately 81,000 children with moderate or severe difficulties were in attendance. An additional 90,000 students with less severe problems—but significant enough to impact school functioning—were in attendance.

LOW-INCOME CHILDREN IN MISSOURI

Children living in low-income families, defined as income below 200 percent of the federal poverty level (FPL), are particularly vulnerable to mental health problems. In 2008, the FPL was defined as $21,200 for a family of four. Families need resources that are double the FPL (or $42,400 a year) to meet basic needs. The following statistics depict the prevalence of Missouri children living in low-income families in 2007.

- Forty-one percent (565,216) of children in Missouri live in low-income families.
- Fifty percent (117,107) of children in urban areas, 30 percent (191,723) of children in suburban areas, and 56 percent (169,190) of children in rural areas live in low-income families.
- Nineteen percent (106,113) of children in low-income families do not have an employed parent.
- Fifty-six percent (318,040) of children in low-income families live with a single parent.

At 300 percent of the FPL, Missouri's income eligibility for health insurance is among the highest in the country. Unfortunately, income eligibility for childcare subsidies is 110 percent of the FPL – the lowest in the nation.

Source: National Center for Children in Poverty. 2007. *Demographics of Low-Income Children*. http://www.nccp.org/profiles/state_profile.php?state=MO&id=6

WHAT TO DO IF YOU SUSPECT A CHILD HAS A MENTAL HEALTH PROBLEM

According to the Missouri Department of Mental Health, parents and educators are the most likely to detect a mental illness or emotional disorder because of their constant contact with children. Warning signs include:

- A noticeable drop in school performance
- Unwarranted and persistent worry or anxiety
- An inability to cope with day-to-day problems
- Frequent outbursts of anger
- Frequent or severe aggression toward others
- An excessive fear of getting fat or of not being liked beyond the normal adolescent anxieties
- A pattern of deliberate disobedience

[3] The initial diagnosis was serious emotional disturbances under the Individuals with Disabilities Education Act (IDEA). The current diagnostic terminology is emotional disturbance.

- Fidgeting or constant movements beyond regular playtime activities
- Pronounced difficulties with attention, concentration, and organization
- A pattern of truancy, theft, or vandalism
- Alcohol or drug abuse
- Early sexual activity or sexual promiscuity
- Persistent nightmares or physical complaints
- Marked change in eating or sleeping habits
- Strange thoughts or feelings tied to unusual behaviors
- Self injury or talk of suicide
- Pronounced sadness lasting longer than several weeks

See Appendix A for more information on common emotional and behavioral disorders seen in children and adolescents.

Facing a mental health problem in a child can be difficult and scary for parents. Professionals in schools and community agencies need to support parents and welcome them as equal partners in developing and carrying out plans for their child's mental health care. Parents, teachers, and others who work on a daily basis with children should be given information so that they can recognize problems before they become severe. If a problem is suspected, information and help can be sought from the following resources:

- The school counselor, school nurse, school social worker, or school psychologist
- The child's family doctor or pediatrician
- The local department of health
- The Missouri Department of Mental Health Network of Care. (The website, http://missouri.networkofcare.org/home_state.cfm?stateid=30, can help locate mental health services in a specific location.

MENTAL HEALTH PREVENTION AND PROMOTION IN SCHOOLS

While the literature demonstrates that the prevalence of mental illness, including the incidence of major psychiatric disturbances, in children and adolescents is increasing, a major paradigmatic shift has occurred toward mental health *prevention* and *promotion*. Many recognize that "childhood is an important time to prevent mental disorders and promote healthy development" (U.S. Department of Health and Human Services, 2001). Research findings throughout the past decade indicate that prevention programs in schools effectively promote mental health, reduce problem behaviors, and enhance youth competence (Greenberg et al., 2004). Evidence also suggests that providing proactive, prevention-based mental health programs in schools can significantly improve educational outcomes (Jennings, Pearson, and Harris, 2000; Koller and Svoboda, 2002). Furthermore, practices targeting social and emotional health contribute to eight of the 11 significant learning influences, such as teacher-student relationships, school culture and climate, student motivation, and school engagement (Wang, Haertel, and Walberg, 1997). Schools ignoring these factors "miss reaching an entire population of children whose academic

ability is affected by emotional distress" (Hoganbruen et al., 2003). Currently, however, most school efforts to combat mental health concerns tend to be reactive, occurring after the fact, rather than being proactive and preventative (Greenberg, Domitrovich, and Bumbarger, 2000).

PROMOTING MENTAL HEALTH: A COORDINATED APPROACH TO SCHOOL HEALTH

The Coordinated School Health Program (CSHP) model is designed to promote mental health in schools by addressing the physical, social, and general health needs for student well-being (Comb-Orne, Heflinger, and Simpkins, 2002). Schools offer an environment for multiple service agencies to combine resources and work towards expanding mental health services in schools and enhance learning opportunities for students. The emergence of mental health promotion in schools denotes a major change in thinking, which requires both school and community resources to collaborate and develop more comprehensive strategies for advancing mental health models in all schools (Adelman and Taylor, 2006). The ultimate goal of a school is to educate all students, and mental health concerns overlap with this mission. A school cannot provide the best educational opportunities for students unless the barriers to learning are addressed. Schools must create an environment that cultivates student resiliency, shared support, caring for self and others, and a sense of community. To foster student resiliency, schools must focus on the unique strengths and assets possessed by each child. According to the President's New Freedom Commission on Mental Health (2003), school mental health programs have shown improved educational outcomes by decreasing absences, decreasing discipline referrals, and improving test scores.

The Missouri Coordinated School Health Coalition encourages schools to adopt the eight-component CSHP model to address mental health issues for Missouri school-aged children. This model has been the focus of the Division of Adolescent and School Health (DASH) for over 10 years. The CSHP model provides areas of opportunity and engagement with mental health intervention and promotion. Schools are urged to work with their families, communities, and policymakers to establish local policies and create environmental supports that encourage positive social and emotional development in children. The following guidelines for promoting lifelong resilience and emotional health are based on the eight components of the CSHP Model.

1. Healthy School Environment

- Implement a bullying and violence prevention curriculum, beginning in the early grades and extending throughout high school.
    - Train staff to recognize and intervene in nonverbal violence as well as physical violence.
    - Instruct staff in evidence-based practices for de-escalating aggressive behavior.

- Develop prevention and intervention plans for psychiatric crises, such as suicide.
- Create clear, consistent, school-wide behavior and discipline plans that are based on "best-practices" research.
    - Teach children social and behavior skills when they have difficulties in the same way that they are taught academic skills.
- Coach staff on ways to increase school engagement and bonding.
- Provide a safe spot (not used for discipline) for students with emotional difficulties to use when needing time to calm down.
- Promote tolerance for individual differences
    - Set a zero tolerance rule for "put downs."
    - Teach students healthy, positive communication skills.
- Make a special effort to help friendless children establish positive relationships.
- Equip staff with the skills to build positive relationships with students.
- Reduce stigma surrounding mental illness.

2. Comprehensive Health Education Curriculum

- Incorporate a comprehensive health education curriculum across all grade levels that provides students with opportunities to acquire knowledge, attitudes, and skills about mental and emotional problems, as well as opportunities for development of prosocial and life skills (see http://www.mcce.org).
- Ensure that children understand that sometimes they hurt on the inside in ways that others cannot see and it is okay to ask for help. In other words, remove the stigma surrounding mental illness by equating it to physical illness and encouraging open dialogue about "unhealthy" emotions.
- Discuss the brain as an organ that can sometimes get sick, just as a heart or kidney or liver can get sick.
    - Talk about the brain chemicals that sometimes do not work as they should.

3. Nutrition Services

- Provide nutrition information for students, families, and staff that emphasizes the link between healthy eating and emotional well-being.
- Train staff to spot students in the cafeteria who consistently avoid food.
- Educate students and staff to recognize the physical signs of anorexia and bulimia, and encourage students to contact the school nurse or school counselor if they suspect a friend might have an eating disorder.
- Know the relationship between mental health and eating disorders, including obesity.
- Provide opportunities for children struggling with weight issues to receive individual nutritional guidance along with self-esteem enhancement.
- Offer healthy or non-food lunchtime rewards for students who make healthy choices from the lunch line; celebrate healthy eating school-wide.

4. Physical Education

- Emphasize the link between physical activity and emotional well-being.
- Use physical education as a stage for teaching life skills, such as teamwork and social competence.
- Offer physical challenges as a means to build confidence and self-esteem; make sure that every child experiences success.
- Minimize competition and structure activities carefully so that no student is made to feel awkward or left out.
- Facilitate team teaching between the school counselor and physical education teacher in order to create opportunities for adventure-based counseling.
- Provide close adult supervision in locker rooms and on playing fields, as bullying and sexual harassment often occur in these locations.
- Incorporate physical activity into programs that meet the needs of special populations.

5. Health Services

- Provide students with opportunities to meet with school health personnel who can provide services for mental or emotional factors related to health problems (e.g., psychological adjustment to asthma).
- Train school health personnel to recognize early signs of mental illness (in particular, the chronic physical complaints associated with emotional difficulties).
- Teach school health personnel how to respond to psychiatric crises.
- Involve the school nurse in student support teams and in consultation to teachers about individual children.

6. Guidance and Counseling for Emotional and Social Health

- Fully implement the Missouri Comprehensive Model School Guidance Program (see http://missouricareereducation.org/).
- Train all school staff how to recognize the early warning signs of mental illness, how and where to refer suspected problems, and how to effectively communicate with families about mental health related concerns. (See NAMI's *Parents and Teachers as Allies* publication and in-service education program at http://www.nami.org/caac)
- Initiate a transition program for students returning to school after being absent for treatment and ensure that school staff are able to provide supports for these students.
- Provide transition services for students with a mental health concern (or at-risk) as they move between different grade levels and schools.
- Present multiple opportunities for students to build developmental assets and resilience to stressors.

- Offer research-based and effective school-based mental health services and develop an effective link to the community mental health system for students with more intensive mental health service needs.
- Employ intervention strategies that address peer and conduct problems in children that not only decrease risk factors but also improve protective factors.
    - Teach skills for building resilience: coping, empathy, and social competence.
- Enhance students' self-esteem by focusing on students' strengths.
- Use programs that focus on both reducing maladaptive behaviors (e.g., aggression, bullying, disruptiveness) and increasing socially appropriate skills (e.g., anger management, assertiveness, cooperation) (Walker et al., 1996) for children with peer relationship problems. Practicing social skills with a teacher, pairing child with positive peer models, and positively reinforcing socially appropriate behavior are simple strategies that can be implemented for children at-risk or currently displaying maladaptive behavior (Kline and Silver, 2004).
- Incorporate long-term interventions that sustain throughout the child's development. These are programs that provide intervention in the home, school, and community, and involve the collaboration of multiple systems to focus on the school environment as central arena for intervention (Greenberg, Domitrovich, and Bumbarger, 2001).
- Treat cases of mental illness early before the illness becomes more severe, and before co-occurring mental illnesses develop, which only become more difficult to treat as they accumulate.
- Provide opportunities for *every* child to experience academic success in order to reduce the unacceptably high dropout and failure rates of students with behavior or emotional disorders. This includes preparing teachers and school health personnel to provide effective supports for students who present with social and emotional needs that may interfere with their academic success. For example, students may need additional time to complete school work, flexibility in their schedule throughout the school day, and tutoring and mentoring in school. Schools should provide individual accommodations even if the student does <u>not</u> have an IEP or 504 plan.

In general, the earlier that intervention methods are implemented the greater long-term outcome of mental health for children.

7. School Staff Wellness

- Create opportunities for all school personnel to become more involved in CSHP, which fosters a greater personal commitment to building a more mentally healthy school environment and reduces stigma associated with mental health problems.
- Stress the importance of modeling self-care for students (e.g., using coping strategies, anger management techniques, and simple stress reduction practices).
- Address teacher burnout, a major impediment to teaching effectiveness.
- Provide health and mental health programming for school staff (e.g., pay for local gym membership, provide individual and group counseling support, and reward staff member with an afternoon off).
- Form a standing committee to assess employee and school needs, identify resources, and evaluate the impact and outcomes of school-site health promotion efforts.

8. Family and Community Involvement

- Involve schools, families and communities in comprehensive mental health promotion efforts (American Academy of Pediatrics, 2004). More specifically, school-based personnel, community mental health workers, and families should collaboratively plan prevention and intervention strategies in accordance with one another, rather than in isolation.
- Advance mental health as a framework that allows new models of care that address multiple areas critical to proper development in children simultaneously by focusing on resiliency, social and development, healthy lifestyle, and personal well-being (Adelman and Taylor, 2006).
- Develop effective partnerships with families that recognize the value of their input about how a student's illness impacts their academic work, peer relationships, and interaction with others in the school community.
- Create opportunities for parents to network with one another and receive information on effective parenting strategies and skills.
- Provide Family Resource Centers in schools and community facilities with literature, audio-visual resources, and games that support and affirm families in fostering healthy social-emotional development.
- Promote community awareness of children's mental health issues (e.g., celebrate Children's Mental Health Week) and reduce stigma associated with mental illness.
- Monitor access to and coordination of *quality* mental health care services; eliminate racial, ethnic, and socioeconomic disparities in access to mental health care services; and advocate for improvements in the service infrastructure, including support for scientifically proven interventions across professions.
- Raise public awareness that individuals with disabilities are qualified and available to work, which represents a critical step to overcoming barriers for employment of this population. Individuals with mental health issues *can* improve their mental health and return to productive and engaging lives.

New models of mental health promotion focus on methods to involve resources throughout the community for promoting mental health and preventing the development of mental health problems.

APPENDIX A: COMMON EMOTIONAL AND BEHAVIORAL DISORDERS

Because research demonstrates that the early identification and intervention of mental health needs is critical for optimal development of the child and for school success, the following list of common emotional and behavioral disorders has been provided. It is offered as additional information and serves as a guideline only. The diagnostic criteria presented in this listing are not the same as the educational criteria used for a special education diagnosis. Should you have questions or concerns about the mental health of any student, the best action to take is to consult with the school psychologist, counselor, social worker, or nurse.

ANXIETY DISORDERS[4]: Including Panic Attack, Agoraphobia, Specific Phobias, Social Phobias, Obsessive-Compulsive Disorder (OCD), Posttraumatic Stress Disorder (PTSD), Acute Stress Disorder, and Generalized Anxiety Disorder	
Description	Anxiety is future oriented and a normal response to stress. Anxiety is associated with a perception of uncontrollability and unpredictability about potentially negative events. It causes attention to focus on the potential for these negative events and/or on one's feelings and response to these events. When the anxiety becomes excessive, irrational, and debilitating, it is considered an anxiety disorder. In general, anxiety disorders include clinically significant feelings of anxiety that come about from exposure to specific stimuli that lead to an avoidance response. A number of anxiety disorders exist, each with varying diagnostic criteria.
Prevalence	• Specific phobias: 3 to 4%, somewhat more common in girls • Social anxiety disorder: 1 to 2% • Separation anxiety: 3 to 12% • School refusal: 1 to 2% • Generalized anxiety disorder: 2 to 14% overall with a prevalence of 3.7% to 7.3% in adolescents • Panic attacks: 16% • One third of youth exposed to traumatic events may develop PTSD
Functioning Deficits	The functional limitations of children may vary based on their specific disorders. However, within a general "anxious/depressed" syndrome (i.e. internalizing disorders), a child's general behavior problems may include crying often, fears at school, fear of doing bad, perfectionist tendencies, feelings of worthlessness and guilt, self-conscious, anxious to please, and chronic worrying.
More Information	See National Institute of Mental Health Resources About Anxiety Disorders at http://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml

[4] Sources: Morris, R. J, and T. R. Kratochwill. 2008. *The Practice of Child Therapy.* New York: Lawrence Erlbaum Associates; Wicks-Nelson, R. and A. C. Israel. 2009. *Abnormal Child and Adolescent Psychology, Seventh Edition.* Upper Saddle River, NJ: Pearson/Prentice Hall; American Psychiatric Association. 2000. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision.* Washington, D.C.: American Psychiatric Association.

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)[5]	
Description	Attention Deficit Hyperactive Disorder is characterized as a person who has an inability to pay attention or control their behavior. Some symptoms of ADHD include: 1. Failing to give close attention to work, making careless mistakes 2. Difficulty sustaining attention 3. Appearing not to listen when spoken to directly 4. Poor follow through on instructions, chores, and work 5. Difficulty organizing tasks 6. Disliking and avoiding tasks that require sustained mental effort 7. Often losing things necessary for tasks 8. Easily distracted 9. Forgetful in daily activities Symptoms of hyperactivity include: 1. Often fidgeting with hands or feet and squirming in seat 2. Leaving seat in classroom 3. Running or climbing excessively in inappropriate situations 4. Difficulty playing or engaging in leisure activities quietly 5. Always "on the go," acts as if "driven by a motor" 6. Talking excessively Symptoms of Impulsivity include: 1. Blurting out answers before questions are completed 2. Difficulty waiting turn 3. Interrupting or intruding on others
Prevalence	• Approximately 3 to 8% of school-aged population. • There is a large gender difference – 3.4 boys are diagnosed for every girl.
Functioning Deficits	Infants at risk for ADHD demonstrate difficult temperaments, are excessively active, demonstrate sleeping and eating problems, have negative moods, and show a higher rate of clumsiness. Toddlers and school-aged children demonstrate significant overactivity, noncompliance, and poor attention spans. They may demonstrate poor social skills and demonstrate higher levels of aggression. Children will also demonstrate poor impulse control, difficulty following school rules, excessive motor activity (especially in structured situations), poor frustration tolerance, difficulty with peers, underachievement in school, learning disabilities, and conduct problems. ADHD is often conceptualized as a developmental disorder with deficits in executive functioning (e.g. planning, organizing, and implementing goal-directed behavior, self-management and regulation, and behavioral inhibition).
More Information	See National Institute of Mental Health Resources about ADHD at http://www.nimh.nih.gov/health/publications/adhd/complete-publication.shtml

[5] Sources: Morris, R. J, and T. R. Kratochwill. 2008. *The Practice of Child Therapy.* New York: Lawrence Erlbaum Associates; Wicks-Nelson, R. and A. C. Israel. 2009. *Abnormal Child and Adolescent Psychology, Seventh Edition.* Upper Saddle River, NJ: Pearson/Prentice Hall; American Psychiatric Association. 2000. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision.* Washington, D.C.: American Psychiatric Association.

AUTISM SPECTRUM[6]	
Description	Autism Spectrum is a group of developmental disorders characterized by impaired social interaction, communication problems, and unusual, repetitive, or severely limited activities and interests. Impairment in social interaction may manifest in the following manner: 1. Impairment in the use of nonverbal behaviors (e.g., eye contact, facial expressions, body posture) 2. Failure to develop age-appropriate relationships 3. Lack of seeking others to share enjoyment and interests 4. Lack of social and emotional reciprocity Impairments in communication may present in the following ways: 1. Delay in language development or impairment in initiating and maintaining conversations 2. Stereotypic, repetitive use of language 3. Lack of make-believe and social play Examples of repetitive, stereotypic behavior patterns, interests, and activities include: 1. Preoccupation with stereotyped interests that are abnormal in intensity or focus 2. Inflexibility to routine, especially nonfunctional or ritual routines 3. Repetitive motor actions 4. Preoccupation with parts of objects as opposed to the whole object
Prevalence	It is estimated that one in every 500 children may be found on the autism spectrum. It is four times more prevalent in boys than girls.
Functioning Deficits	Children with an autism spectrum disorder demonstrate delayed communication, speech, and language development. In fact, approximately 50 percent of youth with autism will never develop speech. Echolalia (the repetition or echoing of verbal utterances made by another person) and pronoun reversal (e.g., a child using the following phrase to ask for a cookie, "Can you have a cookie?") are common. Autistic children also exhibit rigid insistence on sameness and repetitive behavior. Some children may display self-injurious behavior (e.g., hair pulling, head banging, or scratching). Additionally, autistic children tend to demonstrate lower IQ scores, although they show specific strengths in visual-spatial skills and rote memory. Language impairments tend to suppress IQ test performance and it can be difficult to gain an accurate understanding of an autistic child's ability levels.
More Information	See National Institute of Neurological Disorders at http://www.ninds.nih.gov/disorders/autism/detail_autism.htm

[6] Sources: Morris, R. J, and T. R. Kratochwill. 2008. *The Practice of Child Therapy.* New York: Lawrence Erlbaum Associates; Wicks-Nelson, R. and A. C. Israel. 2009. *Abnormal Child and Adolescent Psychology, Seventh Edition.* Upper Saddle River, NJ: Pearson/Prentice Hall; American Psychiatric Association. 2000. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision.* Washington, D.C.: American Psychiatric Association.

CHILD MALTREATMENT/ABUSE[7]	
Description	Child Maltreatment and Abuse is categorized as physical abuse, sexual abuse, physical neglect, and emotional abuse and neglect. Specific legal definitions and evidentiary requirements that constitute child maltreatment and abuse vary from state to state. Physical abuse is defined as occurring when a child younger than 18 experiences injury or risk of injury as a result of being hit with a hand or other object, or from being kicked, shaken, thrown, burned, stabbed, or choked by a parent or parent substitute. Sexual abuse is defined as any sexual act between an adult and a child. It can be physical (e.g., inappropriate fondling or touching) and/or emotional (e.g., a child who is forced to undress). Physical neglect is defined as harm or endangerment resulting from inadequate nutrition, clothing, hygiene, and supervision. Emotional abuse includes verbal abuse, harsh nonphysical punishments, or threats of maltreatment. Emotional neglect is defined as failure to provide adequate affection and emotional support or permitting a child to be exposed to domestic violence.
Prevalence	In 2004, approximately 3.5 million referrals were filed toward Child Protective Service Agencies. Just over sixty percent (62.4%) were filed for neglect, 17.5% were for physical abuse, 9.7% were for sexual abuse, 7% for emotional or psychological maltreatment, and 2.1% for medical neglect. These are likely underestimated because of weaknesses in collect methodologies and the many cases that are unreported.
Functioning Deficits	Children that have been physically abused may show intellectual, academic, and cognitive problems; difficulties with social competence; poor problem-solving abilities; increased aggression and externalizing problems; a tendency to make hostile attributions; and increased internalizing symptoms. They may also show poor moral development and increased rates of psychosocial problems. Children that have been sexually abused may demonstrate fearfulness, PTSD, behavior problems, poor self-esteem, and sexualized behaviors. Children that have been neglected may display difficulties in cognitive, social, and emotional development. They may also demonstrate language delays, impaired school performance, and later emotional and behavior problems.
More Information	See the HelpGuide.com at http://www.helpguide.org/mental/child_abuse_physical_emotional_sexual_neglect.htm

[7] Sources: Morris, R. J, and T. R. Kratochwill. 2008. *The Practice of Child Therapy.* New York: Lawrence Erlbaum Associates; Wicks-Nelson, R. and A. C. Israel. 2009. *Abnormal Child and Adolescent Psychology, Seventh Edition.* Upper Saddle River, NJ: Pearson/Prentice Hall; American Psychiatric Association. 2000. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision.* Washington, D.C.: American Psychiatric Association.

CONDUCT DISORDER (CD)[8]	
Description	The essential feature of Conduct Disorder is a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated. Diagnostic criteria include: 1. Aggression: bullying, threatening, intimidating others; physical fighting; using a weapon to cause harm to others (e.g. bat, brick, knife, gun); being physically cruel to people and to animals; stealing while confronting victim; and forcing someone into sex 2. Destruction of property: fire setting with intent of causing damage and destroying property 3. Deceitfulness and theft: breaking into a house, car, and/or building; lying; stealing non-trivial items 4. Serious violations of rules: staying out at night despite parent rules before age 13; running away from home at least twice for a lengthy period; and becoming truant from school before age 13
Prevalence	Prevalence in a school-aged children ranges from 2 to 6%. Boys demonstrate a prevalence rate 3 to 4 times higher than girls. Conduct disorder is also more frequently found in adolescents than younger children, though the prognosis for early-onset conduct disorder is more severe than the adolescent onset variety.
Functioning Deficits	Conduct disorder is highly comorbid with ADHD and other disorders, such as anxiety, depression, and substance abuse. Children with conduct disorder have poor interpersonal skills and social skills and have experienced high levels of adult and peer rejection. Additionally, children diagnosed with conduct disorder generally show academic deficits and are at risk for dropping out of school. They demonstrate cognitive distortions and problem-solving skills. Frequently, they will attribute hostile intent to others and frequently appear resentful and suspicious.
More Information	See SAMHSA information about Conduct Disorder at http://mentalhealth.samhsa.gov/publications/allpubs/Ca-0010/default.asp

[8] Sources: Morris, R. J, and T. R. Kratochwill. 2008. *The Practice of Child Therapy.* New York: Lawrence Erlbaum Associates; Wicks-Nelson, R. and A. C. Israel. 2009. *Abnormal Child and Adolescent Psychology, Seventh Edition.* Upper Saddle River, NJ: Pearson/Prentice Hall; American Psychiatric Association. 2000. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision.* Washington, D.C.: American Psychiatric Association.

DEPRESSION[9]	
Description	Depression is a brain disorder that is persistent and interferes with a child's or adolescent's ability to function. Children and youth who are stressed, experience loss, or have attentional, learning, conduct, or anxiety disorders are at a higher risk for depression. To be diagnosed with depression, a child must present five of the following nine criteria during a single two-week period, of which one symptom must be depressed mood or loss of interest/pleasure: 1. Depressed mood (required) 2. Diminished interest or pleasure 3. Significant weight/appetite change 4. Sleep changes 5. Psychomotor agitation/retardation 6. Fatigue/loss of energy 7. Feelings of worthlessness/guilt 8. Poor concentration 9. Recurrent thoughts of death/suicide In addition to the five above, two of the following symptoms must also be present: 1. Significant weight/appetite change 2. Sleep changes 3. Fatigue/loss of energy 4. Poor self-esteem 5. Poor concentration 6. Feelings of hopelessness
Prevalence	Rates of depression increase from childhood to adolescence to adulthood. Rates for different developmental periods include: • Preschool: < 1% • Pre-puberty: 0.3% to 2.5% • Adolescence: 2.5% to 15.3% for major depression and 9.9% for minor depression. In middle childhood, rates of depression are comparable in boys and girls. In adolescence, girls may be twice as likely to experience depressive symptoms.
Functioning Deficits	Children and adolescents experiencing depression may show low activity levels; poor social and social problem-solving skills; negative attributional styles; negative view of self, the world, and the future (i.e. negative cognitive triad); faulty or poor self-monitoring, self-evaluation, and self-reinforcement; and poor social relationships.
More Information	See National Institute of Mental Health Resources About Depression at http://www.nimh.nih.gov/health/publications/depression/complete-publication.shtml

[9] Sources: Morris, R. J, and T. R. Kratochwill. 2008. *The Practice of Child Therapy.* New York: Lawrence Erlbaum Associates; Wicks-Nelson, R. and A. C. Israel. 2009. *Abnormal Child and Adolescent Psychology, Seventh Edition.* Upper Saddle River, NJ: Pearson/Prentice Hall; American Psychiatric Association. 2000. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision.* Washington, D.C.: American Psychiatric Association.

OPPOSITIONAL DEFIANT DISORDER (ODD)[10]	
Description	In general, Oppositional Defiant Disorder represents a recurrent pattern of negative, defiant, disobedient, and hostile behavior toward authority figures for at least six months. It is characterized by: 1. Losing temper 2. Arguing with adults 3. Actively defying or refusing to comply with adults 4. Deliberately doing things to annoy other people 5. Blaming others for own mistakes and misbehavior 6. Being touchy and/or easily annoyed 7. Being angry and resentful 8. Being spiteful and vindictive
Prevalence	Community samples report rates between 2 and 16%. Like conduct disorder, boys are diagnosed with ODD at a much higher rate than girls, typically 3:1 or 4:1. Many consider ODD to be a precursor to CD. Most individuals diagnosed with CD would have previously met criteria for ODD. However, not all children with ODD will later develop CD.
Functioning Deficits	The development of ODD is frequently preceded by ADHD. Functional deficits of ODD are similar to conduct disorder and include problems with peers and adult relationships, academic difficulties, and cognitive distortions, especially those that attribute hostility to others.
More Information	See WebMD at http://www.webmd.com/mental-health/oppositional-defiant-disorder

[10] Sources: Morris, R. J, and T. R. Kratochwill. 2008. *The Practice of Child Therapy*. New York: Lawrence Erlbaum Associates; Wicks-Nelson, R. and A. C. Israel. 2009. *Abnormal Child and Adolescent Psychology, Seventh Edition*. Upper Saddle River, NJ: Pearson/Prentice Hall; American Psychiatric Association. 2000. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision.* Washington, D.C.: American Psychiatric Association.

SOMATIC PROBLEMS[11]	
Description	A person with Somatic Problems is characterized by a person's psychological needs being expressed in physical symptoms. For our purposes, we will include eating disorders, enuresis, and encopresis. Somatic complaints in children may also include headaches and stomach aches Anorexia Nervosa is characterized by excessive weight loss without any organic cause. In comparison, Bulimia Nervosa can be characterized by binge eating and inappropriate compensatory methods to prevent weight gain from the binges. Enuresis and encopresis are functional difficulties in bladder and bowel control, respectively. They include the following symptoms: 1. Repeated loss of bladder and bowel control during the day or night into bed or clothes either voluntary or involuntary 2. At least three months of two or more weekly wetting or bowel movement problems with distress or impairment in important areas of functioning, 3. The absence of medical conditions that may account for these problems, and 4. A chronological or developmental age of five or older.
Prevalence	Eating disorders appear to have a prevalence rate of 0.5% to 2.1% in the general population and are increasing in prevalence. Enuresis seems to be a common problem, with 7 to 10 million children demonstrating some form of it. Twenty percent of 5-year-olds wet their bed and half will remain enuretic when they are 10. The disorder is twice as common in boys as in girls. Somatic complaints can be a common concern. By age 15, 75% of people have experienced headaches.
Functioning Deficits	Anorexia nervosa can consist of severe weight loss and has a mortality rate of 15 percent. It is associated with a lack of menstruation in women, serious electrolyte imbalances, and other medical problems. It is also associated with distorted body perceptions, preoccupation with food and food preparation, unrealistic fears of obesity, and a lack of sensitivity to body cues related to hunger. Regarding somatic complaints, extreme cases may result in absenteeism from school and have a negative impact on academic performance.
More Information	See National Institute of Mental Health Information on Eating Disorders at http://www.nimh.nih.gov/health/publications/eating-disorders/complete-publication.shtml

[11] Sources: Morris, R. J, and T. R. Kratochwill. 2008. *The Practice of Child Therapy*. New York: Lawrence Erlbaum Associates; Wicks-Nelson, R. and A. C. Israel. 2009. *Abnormal Child and Adolescent Psychology, Seventh Edition*. Upper Saddle River, NJ: Pearson/Prentice Hall; American Psychiatric Association. 2000. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision.* Washington, D.C.: American Psychiatric Association.

APPENDIX B: MEMBER ORGANIZATIONS

American Academy of Pediatrics, Missouri Chapter
American Cancer Society - Heartland Division
American Diabetes Association
American Heart Association - Heartland Affiliate
American Lung Association of Western Missouri
Archdiocese of St. Louis Catholic Education Office
Association of Community Taskforces (ACT) Missouri
Cardinal Glennon Children's Hospital
Children's Trust Fund
Citizens for Missouri's Children
Columbia/Boone County Health Department
Epilepsy Foundation of the St. Louis Region
Family and Community Trust
Governor's Council on Physical Fitness and Health
KC Healthy Kids
Kennett School District
Lutheran Church, Missouri Synod, Missouri District School Health Services
Midwest Dairy Council
Missouri Association for Health, Physical Education, Recreation and Dance
Missouri Association of Elementary School Principals
Missouri Association of School Nurses
Missouri Association of School Psychologists
Missouri Center for Safe Schools
Missouri Dental Association
Missouri Department of Elementary and Secondary Education
Missouri Department of Health and Senior Services
Missouri Department of Mental Health, Division of Alcohol and Drug Abuse
Missouri Department of Social Services
Missouri Department of Public Safety, Division of Highway Safety
Missouri Foundation for Health
Missouri Hospital Association
Missouri Juvenile Justice Association
Missouri National Education Association
Missouri Nurses Association
Missouri Primary Care Association
Missouri Public Health Association
Missouri School Boards Association
Missouri State High School Activities Association
Missouri State Medical Association
ParentLink
Parents as Teachers National Center, Inc.
Parkway C-2 School District
Practical Parenting Partnerships
Rockwood R-VI School District
Show-Me State Games
St. Louis District Dairy Council
Truman State University, Department of Health and Human Performance
University of Central Missouri, Department of Health and Physical Education
University of Missouri Extension

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NOTES

TELL US WHAT YOU THINK!

We welcome suggestions and comments about this publication. They should be sent to the Missouri Coordinated School Health Coalition at PO Box 309, Columbia, Missouri, 65205.

Dialogue guide

1) How can this white paper be used by schools?

2) What information from this white paper is most beneficial to you?

3) What other information would you like to see in this white paper?

4) What other mental health resources, besides the white paper, would you like to see provided by the MO Coordinated School Health Coalition?

5) What other mental health related topics would you like to see presented at next year's conference?

Hot topics

1) This white paper does not include a discussion of *mental health screening*. What are your thoughts on using routine screening in schools for emotional health problems in the same way that we use routine screening for physical health problems?

2) What will it take to design a system of mental health service delivery in schools that decreases stigma for the child and family?

3) Who should deliver mental health services in the school setting—school personnel or community agency personnel?

4) How do we integrate mental health promotion into the health education curriculum in schools?

Missouri Coordinated School Health Coalition

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