

CORE CONCEPTS FOR EDUCATORS
BOOK 1

MENTAL HEALTH LITERACY
**ELEMENTARY
SCHOOL RESOURCE**

Understanding Mental Health and Mental Illness



Land Acknowledgement

Mentalhealthliteracy.org is located on the traditional territories of the people of the Treaty 7 Region in Southern Alberta, which is home to the Kainai, Siksika, Piikani, Tsuut'ina and Stoney Nakoda First Nations. The City of Calgary is also home to the Metis Nation of Alberta, Region 3. We express sincere gratitude for these traditional lands where we live, work and play.

In support of reconciliation, we encourage schools and users of this resource to explore and become informed about the rich histories, stories and experiences of Indigenous peoples and communities in their area.

Elementary Mental Health Literacy Resource (EMHLR) Overview and Educator Guide

This document provides background information for the delivery of the EMHLR lessons found at:

<http://mhlcurriculum.org>

The password is: childh3alth

The Elementary Mental Health Literacy Resource has been written and created by:

Andrew Baxter, MSW RSW; Kyla Vieweger, MSW RSW CPT;
Deb Nunziata, M.Ed R.Psych; Dr. Yifeng Wei, MA PhD

Content review and editing:

Dr. Sterling Sparshu, MD FRCPC; Katherine Jarrell, MSW RSW;
Rob Mcweeny, B.Ed, M.Sc Candidate

Cover art and character illustration:

Rich Farr, B.Des

Graphic design and layout:

Therese Bianca Boyce, BCMM-ID; Crystal Bachura Cranston, BACMM-Epub

Special thanks to:

The Alberta Children's Hospital Foundation and Alberta Health Services

The EMHLR Steering Committee (educators and school mental health professionals who gave their time to provide valuable feedback throughout the EMHLR development process)

Dr. Wendy Carr, M.Ed PhD; Divinea Miller, BA; Darren Robinson (Web Dev);
Emmanuel Ho, B.Des; Dan Kim, B.Comm CFA; Hugo McLaughlin; Bryn Evans

This resource draws on foundational material by Dr. Stan Kutcher and the former *teenmentalhealth.org* team.

© This material is under copyright. It cannot be altered, modified or sold. It is meant for educational purposes only and is not a guide to diagnosis or treatment. If you are concerned about a mental health problem, please seek the advice of competent health professionals.



Table of Contents

6

Introduction and Background



12

Module 1: Understanding Mental Health



18

Module 2: The Stigma of Mental Illness



22

Module 3: Mental Health and the Brain



30

Module 4: Common Mental /
Neurodevelopmental Disorders



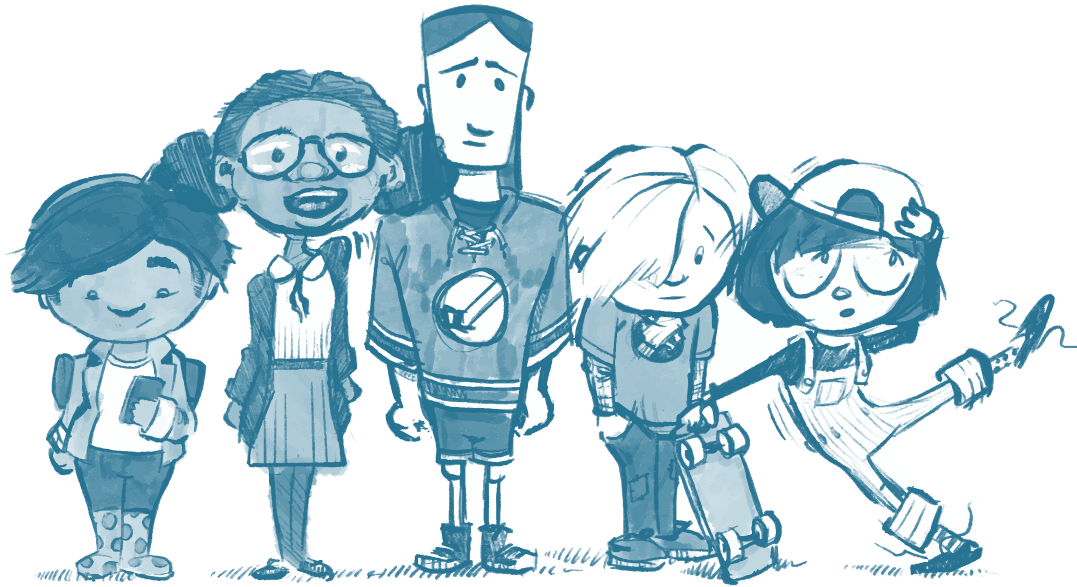
54

Module 5: Helping Self and Helping Others

60

Module 6: Getting Mentally Healthy

Elementary Mental Health Literacy Resource (EMHLR)



The Elementary Mental Health Literacy Resource (EMHLR) is the first of its kind classroom-ready resource designed for classroom teachers and related stakeholders to teach students in Grades 4 to 6 about mental health.

The conceptual framework of the EMHLR is drawn on an evidence-based mental health curriculum resource for the secondary school setting, *Mental Health & High School Curriculum Guide (the Guide)* (<http://mhlcurriculum.org/about-the-guide/download-the-guide/>). *The Guide* has been extensively implemented and researched in Canada and internationally. The development of the EMHLR is also informed by a Delphi study involving 106 stakeholders (classroom teachers, school mental health professionals such as counsellors, psychologists, social workers, school administrators, special education experts and curriculum design experts) from 13 provinces and territories in Canada as well as professionals from four other countries: Japan, the United Kingdom, Finland, and the United States. The EMHLR is further informed by an environmental scan of related Canadian mental health websites and an extensive and systematic literature search of evidence-based mental health literacy programs to develop its content and structure. The EMHLR was developed in response to the many requests from school partners familiar with *the Guide*, who recognised the importance of introducing mental health literacy concepts to younger students.

Why teach mental health literacy in the elementary classroom?

Childhood and early adolescence (ages 7 to 11) are a critical period when young people develop skills and competencies fostering healthy personal development and social relationships, ethical and responsible behaviours, and productive work skills for life success.

Childhood and early adolescence are also a critical period for the onset and identification of mental and neurodevelopmental disorders. For example, most cases of Autism Spectrum Disorder, Attention-Deficit / Hyperactivity Disorder (ADHD), Depression and Anxiety Disorder can be identified by early adolescence. While substantial work has been conducted in the secondary / post-secondary school setting, there is limited information addressing this topic in elementary / primary school settings. Therefore, it is imperative that a mental health literacy resource be created for use by educators for this age group.

What is the difference between social emotional learning (SEL) and mental health literacy (MHL)?

Schools have been a location where a plethora of interventions have been applied, often under the umbrella term 'social emotional learning' to address social and emotional skills (e.g. identifying emotions, perspective taking, self-control, interpersonal problem solving, conflict resolution and coping strategies, and decision making); attitudes towards self / others / school; pro-social behaviours; academic performance; conduct problems; emotional distress; and substance use. Mental health literacy differs from social emotional learning in addressing four interrelated components. While it may overlap with social emotional learning in building strategies to achieve good mental health, mental health literacy focuses on building competency in understanding the various states of mental health; in distinguishing and identifying between mental disorders and everyday life challenges; in breaking the barriers of stigma around mental illness; and in facilitating help-seeking behaviours when needed.



The terms mental disorder and mental illness are used interchangeably throughout this resource

What is the purpose of the EMHLR?

The EMHLR aims to help students:

- develop skills to obtain and maintain good mental health
- improve the understanding about mental health and mental / neurodevelopmental disorders
- reduce stigma against mental / neurodevelopmental disorders, and
- promote help-seeking intentions and behaviours when necessary

The EMHLR is flexibly designed for Grades 4 to 6 classroom teachers* to deliver the core concepts and classroom activities within diverse classroom settings. Teachers can adapt the activities using the pedagogies they are familiar with to best meet student needs.

EMHLR Components

The EMHLR provides teachers with classroom-ready lesson plans, activities and easily accessible resources to assist them in applying the content in the classroom (in-person, online and hybrid). The six modules are designed to be taught in sequence. Before delivering the resource, please review all of the modules to familiarise yourself with the content and delivery formats of the EMHLR. Each module is laid out in a similar manner and includes a number of features.

***Please note:
'teachers' refers
to anyone who
is delivering this
resource**

Core Concepts for Educators (Book 1) provides core knowledge to review before classroom delivery of the modules.

Lesson Plans (Book 2) includes various delivery format options to teach the concepts. You are entrusted to review and choose the activities that best fit the needs and context for your students.

- **Learning Objectives** lists competencies students should achieve after completing the module
- **Major Concepts** presents the central ideas that the module addresses
- **Teacher Preparation** provides instructions on what you need to prepare (e.g. required materials and resources) for conducting module activities



How long does it take to complete the EMHLR?

The EMHLR can be applied as a classroom resource within existing curriculum frameworks to enhance the mental health literacy of both students and teachers. The EMHLR can be integrated as part of a curriculum component within an appropriate subject area. It is recommended to teach EMHLR as a block (six modules taught consecutively over a period of 8 to 12 classroom hours). Each module is designed to be completed within 50 minutes of classroom time except for the module addressing specific mental / neurodevelopmental disorders (Module 4). This module takes approximately 3 to 5 classroom hours.

Are teachers required to take training to implement the EMHLR?

This book, *Core Concepts for Educators*, serves as the foundational learning and training material to prepare educators to deliver the EMHLR in their classrooms. In addition to this book, we have many supplemental learning resources for those wishing to take a deeper dive into the concepts and increase their confidence. Please visit the mental health literacy curriculum website (<https://mhlcurriculum.org/>) to access these additional materials. The MHL team is also standing by to respond to any questions or offer support.

What are the connections between the EMHLR and current school curriculum?

The EMHLR can be taught within an appropriate subject area that shares similar learning outcomes for the EMHLR. The educational jurisdiction in each province and territory in Canada may require Grades 4 to 5 or Grade 5 to 6 students to complete different subjects. Please see the following example of how the EMHLR aligns with Alberta school curriculum learning outcomes.

Each module is intended to be 50 minutes, over a total of 8 to 12 class hours. Except Module 4, which takes about 3 to 5 class hours



In Alberta, the EMHLR responds to Alberta's revised Teaching Quality Standard (ABED, 2018) that requires all educators to be aware of and able to facilitate 'responses to the emotional and mental health needs of our students.' Here are examples in Alberta where Grades 4 to 5 students take eight required subjects: Art, English Language Arts, Health and Life Skills, Mathematics, Music, Physical Education, Science and Social Studies. The learning outcomes of the EMHLR are linked with the following subjects:

English Language Arts (2000):

- Use talk, writing and representing to examine, clarify and assess understanding of ideas, information, and experiences (Clarify and Extend, 1.2)
- Select and focus relevant ideas from personal experiences and prior knowledge to understand new ideas and information (Use Strategies and Cues, 2.1)
- Ask questions or make comments that elicit additional information; probe different aspects of ideas, and clarify understanding (Present and Share, 4.3)

Health and Life Skills (2002):

- Compare personal health choices to standards for health (W 7.1)
- Identify characteristics of resiliency (W 7.11)
- Analyze how thinking patterns influence feelings (R 7.1)

Physical Education (2000):

- Understand the connection between physical activity, stress management and relaxation (B7-8)

Social Studies (2006):

- Propose and apply new ideas and strategies, supported with facts and reasons, to contribute to problem solving and decision making (7.S.4)
- Consider the needs and perspectives of others (7.S.5.)
- Integrate and synthesise concepts to provide an informed point of view on a research question or issue (7.S.7.)

You may match the learning outcomes of the required subjects designed for Grades 4 to 6 students in your region with those of the EMHLR and identify strategies to embed the EMHLR into your current school curriculum



What are the major concepts for each module?

Module 1: Understanding mental health

- Everyone has mental health
- Mental health includes a wide range of states, including no distress, mental distress, mental health problems and mental disorders / illness
- Mental health is more than a positive mood (good mental health isn't just feeling happy)
- It is important to use appropriate words to describe our feelings and emotions

Module 2: The stigma of mental illness

- Stigma involves negative thoughts, feelings and behaviours towards mental illness (a conceptual understanding of stigma)
- People with mental illness can live a fulfilling life
- Stigma acts as a barrier to people seeking help
- We can all help to reduce stigma around mental illness (e.g. using appropriate words to describe thoughts and feelings and life events)

Module 3: Mental health and the brain

- The brain changes over time
- Our thoughts, feelings, behaviours and reactions to the environment are linked with the brain
- The brain and the body are connected
- Mental health is a component of physical health

Module 4: Common mental / neurodevelopmental disorders

- All mental disorders reflect difficulties in thoughts, emotions and feelings, daily activities, physical health, behaviours and signalling
- People with mental disorders can be treated and the sooner people receive proper treatment and support, the better the outcome

Module 5: Helping self and helping others

- Everyone has mental health that can be supported and promoted
- There are many ways of seeking help for mental health problems and mental disorders
- People with mental illness can live a healthy life with appropriate treatment

Module 6: Getting mentally healthy

- What is good for physical health is good for mental health
- Coping with stress appropriately will help to build resilience and new skills
- 'The Big 5' pillars of health (restorative sleep, strong social connection, vigorous physical activity, healthy eating and helping others)

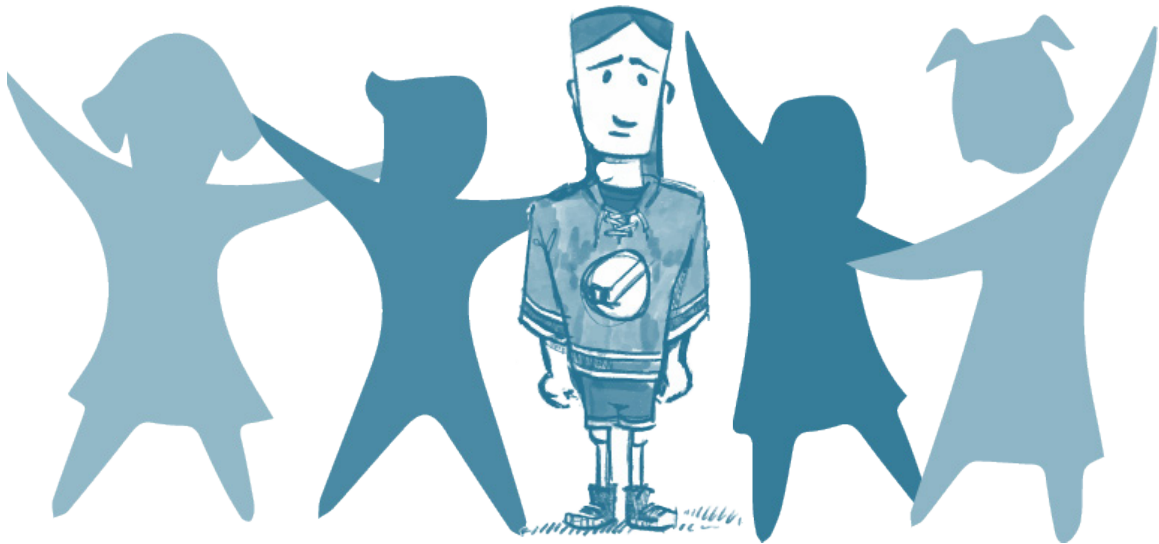
Module 1:

Understanding Mental Health

- Everyone has mental health
- Mental health includes a wide range of states, including no distress, mental distress, mental health problems and mental disorders / illness
- Mental health is more than a positive mood (good mental health isn't just feeling happy)
- It is important to use appropriate words to describe our feelings and emotions



Understanding Mental Health



Mental health is part of our overall health and includes health aspects related to our thinking / cognition, emotions and behaviours. There are two widely accepted definitions of mental health. The World Health Organisation (WHO) defines mental health as “a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.” The Surgeon General of the USA provides a definition of mental health: “Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with people and the ability to change and cope with adversity.” The Surgeon General’s definition underlines the importance of developing competencies to meet life’s challenges while the WHO’s definition focuses more on the state of wellbeing.

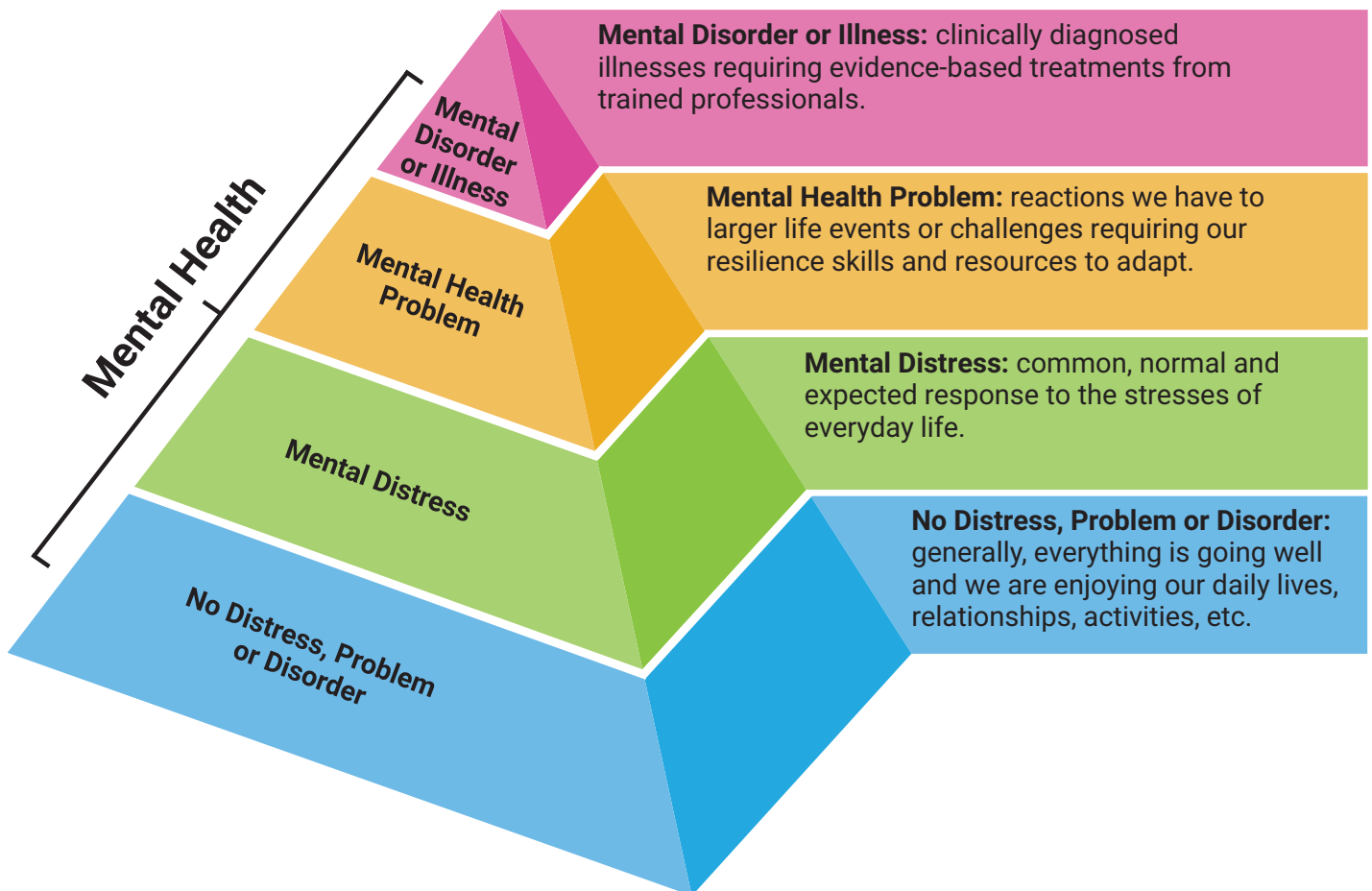


It is essential to help students understand that everyone has mental health which involves a number of states

Mental Health is...

- 📌 A state of wellbeing in which every individual realizes their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community.
- World Health Organization
- 📌 A state of successful performance of mental function, resulting in productive activities, fulfilling relationships with people and the ability to change and cope with adversity.
- Surgeon General of the USA

To deliver this module, it is essential to help students understand that everyone has mental health which involves a number of states, including: no distress, mental distress, mental health problems, and mental disorders / mental illness.



You can download a printable PDF on the pyramid of mental health states from:

<https://mentalhealthliteracy.org/product/using-the-right-words/>

Mental distress / stress is the common, expected, and normal response to the stresses of everyday life.

This may include starting at a new school, writing a test, presenting in front of a class, or making new friends. Dealing with mental distress doesn't require professional interventions. We are usually able to adapt and respond to mental distress naturally by ourselves along with support from our family and community. For example, a student may feel distressed for not making a sports team and this may be alleviated by encouraging more practice for the next opportunity or choosing another sport or activity. Learning new skills from managing stressful life events will help us deal with similar life events in the future with more competence, thereby building our resiliency. A parallel to this is that of the body's immune system. Every day our bodies are invaded by a multitude of germs (bacteria and viruses) but most of the time our bodies shrug them off. We may feel a little unwell at times, and may cough or sneeze or have a mild headache or stomach ache, but these are merely indicators that our bodies are doing exactly what they have evolved to do. We don't need to go see a healthcare provider for help. We can help ourselves by actions such as good hand hygiene, but note that our body handles all these stressors on its own, naturally. Once our bodies have encountered a germ, they're more prepared to cope with it in the future.

We can expect to experience mental distress almost daily. Examples of words used to describe mental distress may include: agitated, nervous, stressed, worried, unhappy, disappointed, disgruntled, uneasy, and fretful, etc.



Watch *Mental Health Literacy Pyramid Explained*:
<https://youtu.be/VgYmlsYmUIU>

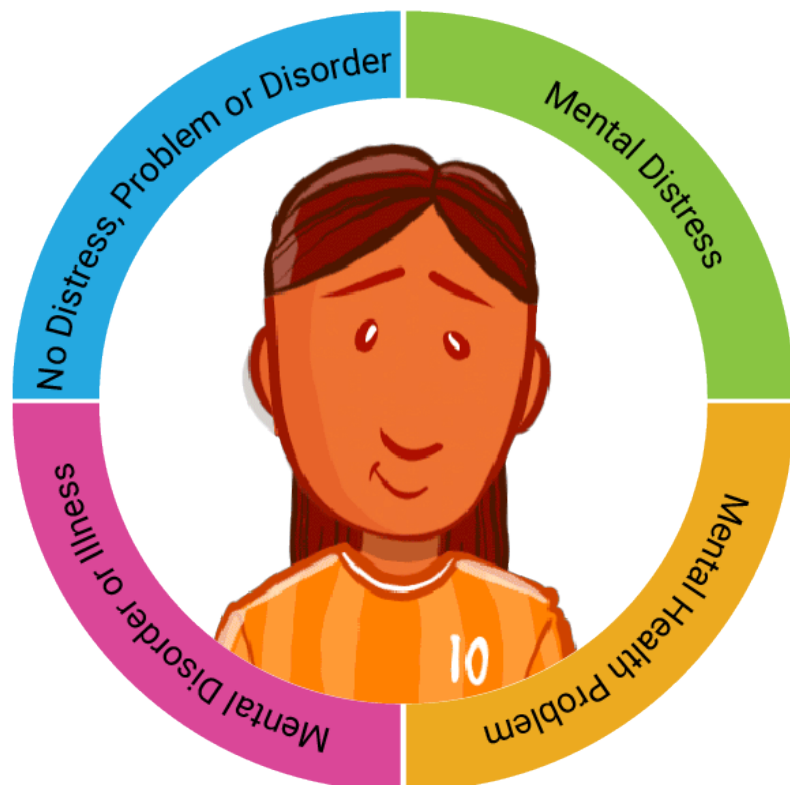


Mental health states are not a continuum and people DO NOT necessarily progress from mental distress to developing a mental illness

Mental health problems indicate that our adaptation to the environment is being significantly challenged.

They are characterised by negative emotions, thinking / cognition, and behaviours that can be severe at times and of either short or long durations. Examples of events leading to a mental health problem could include the death of a loved one, a divorce, loss of a friendship or career, or moving to a new country with insufficient support. To manage mental health problems, we may benefit from professional help such as counselling in addition to family and community support. Returning to the metaphor of a powerful new germ attacking our immune system, our health may be temporarily compromised and we would experience some significant and substantial symptoms (e.g. fever, sore throat, fatigue, muscle aches and pains, etc.). However, most of the time with the proper interventions (such as rest, fluids and over-the-counter medications) our health is restored and we return to our usual self within a few days to a week. Medical treatment is not usually necessary unless complications such as pneumonia develop. Similarly, almost everyone will experience mental health problems at various times throughout their life. These experiences are described with language appropriate to the situation, such as: grief, demoralisation, devastation, etc.

“ Sometimes a person may be in multiple states at the same time.



Mental Illness / Disorders

The current edition of the Diagnostic and Statistical Manual, of the American Psychiatric Association (DSM-5-TR) defines mental illnesses or mental disorders as dysregulation of mood, thought and / or behaviours. Mental disorders / illnesses are diagnosed according to internationally agreed upon criteria such as the DSM-5-TR or the International Classification of Diseases 11, and require best available evidence-based treatments / interventions from properly trained healthcare providers. These treatments are provided in addition to the support often given to people who experience mental distress or a mental health problem. The parallel is that of a disease such as HIV / AIDS or Tuberculosis, where the invading organism overwhelms the body's defences. In these cases, we may experience many of the same kinds of symptoms that characterise a bad cold or the flu. However, unlike a cold, without the proper medical interventions (rapid access to evidence-based treatment), the outcomes are poor. In this case, professional help is both needed and necessary. Clinical terms such as Major Depressive Disorder, Generalised Anxiety Disorder, and Schizophrenia are used to connote specific disorders / illnesses.

In summary, every person will experience three mental health states (no mental distress, problem or illness; mental distress; mental health problems) throughout their lives. These three states are all part of usual life. Added to this, about 20% of people worldwide will experience a mental disorder / illness. Therefore, a good many of us will experience mental illness as one component of our overall mental health. Taken together, these states constitute our mental health. Please note: Mental health states are not a continuum and people DO NOT necessarily progress from mental distress to developing a mental illness.

Any person can experience some or all of these mental health states within a short period of time (such as an hour), or over a longer period of time (weeks, months or even years). Sometimes a person may be in multiple states at the same time.



Download a PDF handout on the pyramid of various mental health states from: <https://mentalhealthliteracy.org/product/using-the-right-words/>

Module 2:

The Stigma of Mental Illness

- Stigma involves negative thoughts, feelings and behaviours towards mental illness
- People with mental illness can live a fulfilling life
- We all can help to reduce stigma around mental illness



The Stigma of Mental Illness



In ancient Greece, the term stigma was used to signify a tattoo or mark used for decorative or religious purposes, or to brand slaves to indicate their ownership, and criminals to indicate their social transgressions. A sharp stick called a 'stig' was used for tattooing, hence the origin of the word stigma and its subsequent association with a mark or a brand of shame (Oxford Dictionary).

Mental illnesses are only one of many medical conditions that have been stigmatised over the years. Others include diseases such as leprosy, epilepsy, HIV / AIDS, cancer, etc. There are many similarities amongst stigmas across these different conditions. Reflecting on what changed to reduce stigma around other medical conditions may lend insight useful in reducing stigma around mental illness.

There are many definitions of stigma related to mental illness and most of them focus on negative attitudes and behaviours towards people with mental illness. For example, the Mental Health Commission of Canada (2009) states:

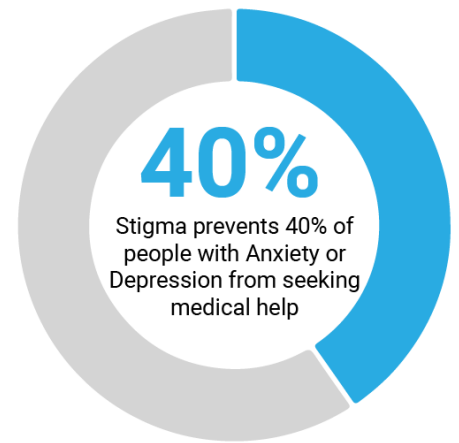
“ Stigma refers to beliefs and attitudes about mental health problems and mental illnesses that lead to the negative stereotyping of people living with mental health problems and illnesses and to prejudice against them and their families.

Stigma related to mental illness involves negative feelings, thoughts and attitudes (prejudice) and behaviours (discrimination) towards people with mental illness. Mental illness affects approximately 1 in 5 people worldwide with a similar proportion in Canada (Mental Health Commission of Canada). People with mental illness include our acquaintances, friends, family members, coworkers and celebrities. Statistically, approximately 1 in 5 people who are teachers in Canada will have a mental illness. However, we tend to think of people who have a mental illness differently without even realising it.

Stigma is prevalent in everyday life, including among service providers. Stigma can come from an individual person (e.g. 'I don't think students with mental illness should be in a regular classroom') or from the general public (e.g. 'A person who is mentally ill should not get married nor run for public office'). Stigma can present as emotional negativity (e.g. 'I am embarrassed that my child has an Anxiety Disorder') or can target the treatment of mental illness (e.g. 'Psychotherapy is nothing but talk').



The stigma of mental illness may have significant impacts on people with the disorders. They may feel hopeless and ashamed (self-stigma), have difficulty finding a job or making friends, and lack access to medical care or housing. This may further prevent them from seeking the help they need. Stigma prevents about 40% of people with Anxiety Disorders or Clinical Depression from seeking medical help (Thornicroft, 2007). Stigma can also lead to social isolation and discriminative behaviours from others such as social distancing (e.g. 'I don't want people with mental illness living in my community').



Teachers can play an important role in helping students and others change how people with mental illness are perceived and treated. The following strategies are effective in helping ourselves and students fight stigma against mental illness:

- Educating about mental health and mental illness with information based on the best available scientific knowledge. Evidence backs up this approach for teachers and students in the school setting
- Using appropriate words. Avoid labelling people with mental illness using stigmatising language such as 'crazy', 'psycho', or 'insane'
- Speaking up when hearing someone use stigmatising language. Support your students through your words and actions. When someone you know misuses a psychiatric term (such as Schizophrenia, Bipolar, OCD, etc.), let them know and educate them about the correct meaning. When someone tells a ridiculing joke, or makes disrespectful comments about mental illness, express that this is hurtful and you find such comments offensive and unacceptable
- Supporting and advocating for organisations that fight stigma

Sources:

- Mental Health & High School Curriculum Guide:
<http://teachmentalhealth.org>
- The Centre for Addiction & Mental Health (CAMH):
<https://camh.ca/en/driving-change/addressing-stigma>

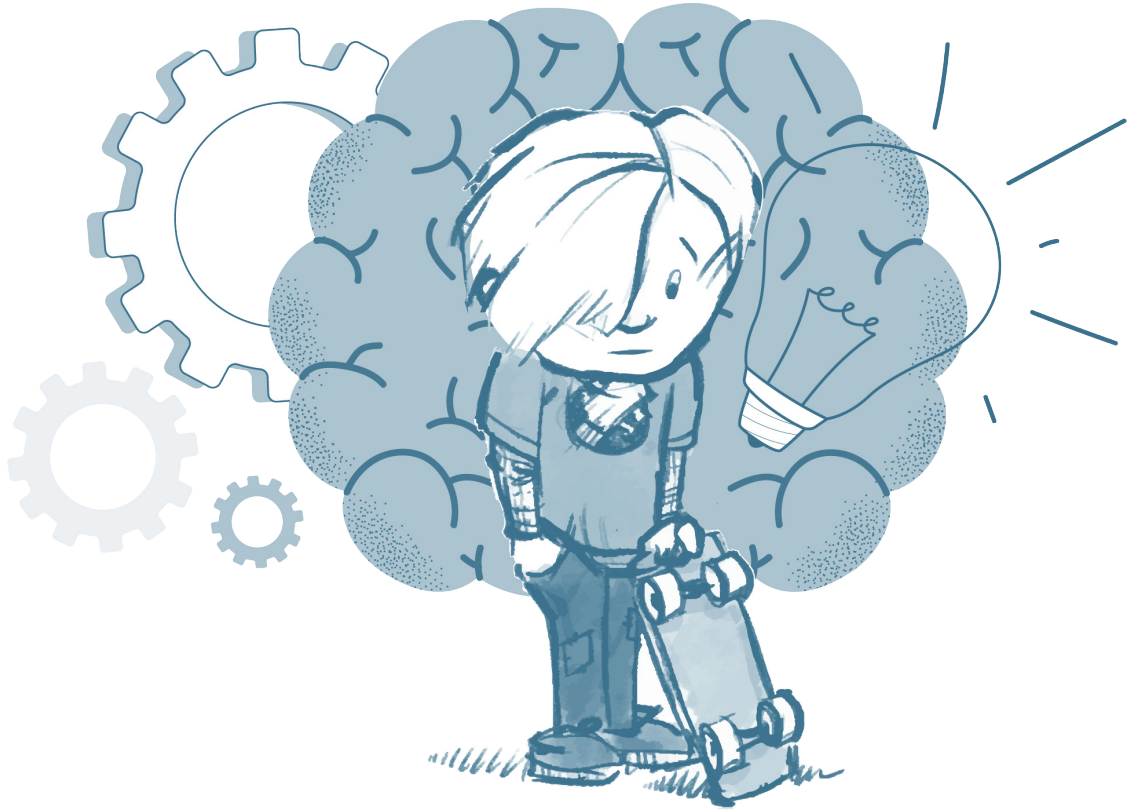
Module 3:

Mental Health and the Brain

- The brain changes over time
- Our thoughts, feelings, behaviours and reactions to the environment are linked with the brain
- The brain and the body are connected
- Mental health is a component of health



Mental Health and the Brain



Mental health is brain health. It is important to understand the brain's structure and function as we explore topics like mental health and mental illness. Everything that we do, feel, think or experience involves our brain and the functions it performs. The brain is a remarkable organ that controls the complex activities which help define our humanity. It is never fully developed because it is constantly evolving and reshaping as a result of our experiences.

The brain is made up mostly of water and fat, which are the building blocks of cells called neurons; glial cells which support neurons and perform various brain functions and other components as well. Neurons send and receive information through chemicals (called neurotransmitters) and electrical signals. Neurons are connected in complex networks called circuits. These circuits control specific brain functions and are connected directly or indirectly to most other circuits within the brain and the central nervous system. The early years are the most active period for

establishing neural connections, however new connections can form throughout life and unused connections continue to be pruned, allowing brain circuits to become more efficient. Our experiences interacting with the environment leads to continual reorganising and changing of connections in our brains at any age so that new connections are made (e.g. learning and remembering new concepts in the classroom), existing connections are strengthened (e.g. mastering a previously learned skill), or existing connections are weakened (e.g. forgetting information no longer perceived as important).

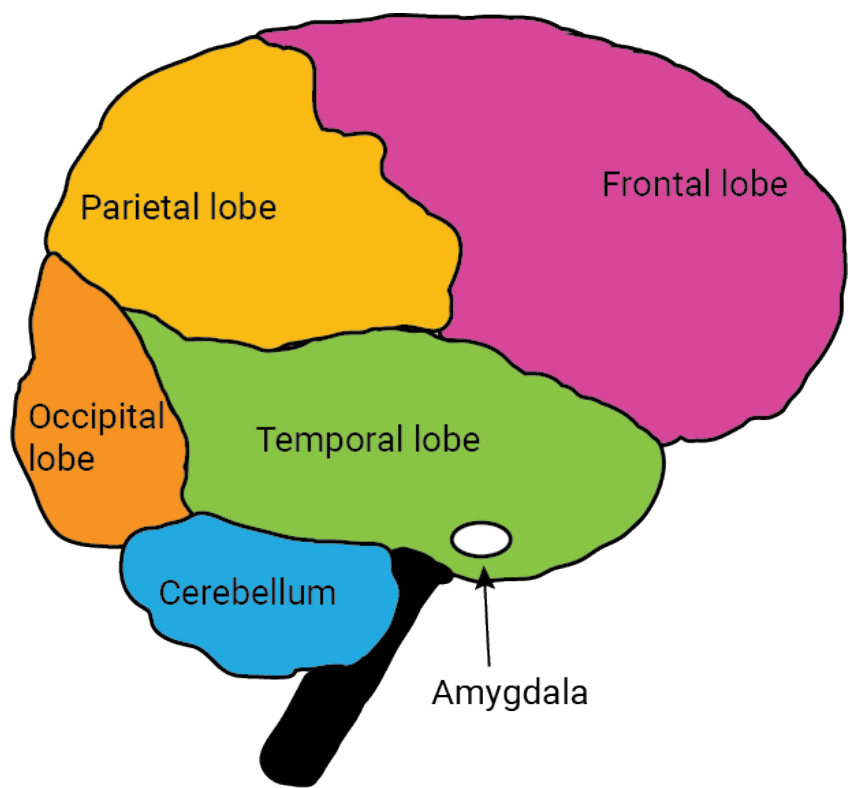
Although genes provide the blueprint for the formation of brain circuits and turn on and off in response to their own internal clocks, we now also know that our environments play a role in how these genes work. This is called 'epigenetics'.

Epigenetic processes alter the activity of genes without changing a gene's DNA sequence, or 'instruction manual' that tells a gene what to do in the body. Essentially, our experiences and circumstances in life can either 'turn on' or 'turn off' combinations of genes that can lead to illness, whether it be mental or physical. The human genome can be described as the 'cookbook of life'. Our genome is the cellular recipe for each person to look, act, and exist as human beings. Similarly, we can think of epigenetics as a cook; different cooks will prepare the recipe of life differently. The study of epigenetics can help to explain why some people are more susceptible to mental illness, while others are more resilient even in harsher environments – it is always a combination of nature and nurture factors, with many more insights left to be discovered.



“ Our genome is the cellular recipe for each person to look, act, and exist as human beings. Similarly, we can think of epigenetics as a cook; different cooks will prepare the recipe of life differently.

The cerebral cortex is the wrinkly outer layer of the brain that is responsible for higher cognitions and processing sensory information. The wrinkles maximise the surface area of the brain, allowing for more neurons and increased connections between them. The cortex is divided into four areas called 'lobes' that carry out different functions. The frontal lobe is primarily responsible for processing cognitive tasks such as planning, reasoning, speech, movement and problem solving. The parietal lobe processes sensory information such as smell, touch, pressure, temperature, pain and certain motor information.



The temporal lobe is important for memory, learning, hearing, and language. The occipital lobe is the visual processing centre of the brain. These areas are all responsible for conducting certain brain functions. However, most brain functions actually involve many different areas that work together.

We can break down the main functions of the brain into six separate but integrated components. These include: 1) thinking or cognition, 2) perception or sensing, 3) emotion or feeling, 4) signalling, 5) physical or somatic and 6) behaviour.

1. Thinking / Cognition

Thinking or cognition includes all of our internal mental processes and functions. As the 'master control centre', the brain is constantly working by receiving and sending signals to put together the different pieces of our world. This includes:

- Planning
- Reasoning
- Calculating
- Decoding symbols
- Self-awareness
- Focusing
- Sequencing
- Paying attention
- Making judgments
- Memory storage
- Comprehension
- Contemplation
- Social understanding
- Social decision-making

2. Perceptions / Senses

Perceptions and senses are complementary processes that determine how we experience our world. Sensation is when our senses gather information from our environment through sight, sound, smell, taste, and touch and send that information to the brain via the peripheral nervous system. Perception is the way our brain interprets these sensations to make sense of what is around us. Our individual experiences shape how we perceive external stimuli, which makes our own sense of perception somewhat unique from others. It is important to understand that the brain creates the perception that we experience. We do not see with our eyes, we see with our brains. We do not touch with our fingers, we touch with our brains.



3. Emotions / Feelings

Our brain is responsible for our ability to experience, label, describe and express feelings and emotions. It also helps us perceive how others may be feeling. While our emotions are personal and subjective, the human brain processes our experiences into feelings we all experience, for example:

- Joy
- Shame
- Anger
- Loneliness
- Sadness
- Guilt
- Consternation
- Resentment
- Demoralisation
- Serenity
- Happiness
- Annoyance

We have developed a rich lexicon to categorise and describe nuances in our emotional states. For example, disgruntled and disappointed are somewhat similar yet very different emotional states. Increasing our emotional literacy helps us name and manage our emotions better. Helping children expand their vocabulary of feeling words helps them to regulate their emotional responses more effectively.



4. Signalling / Alarm

Signalling / alarm is our hard-wired response mechanism to external stimuli. Our brains are constantly experiencing and responding to inputs from the environment. One of the most important jobs our brain performs is to create appropriate responses. We then learn which responses worked well and which did not, for future reference. This is called 'adaptation'.

Our signalling / alarm mechanism is what allows us to employ our 'fight-or-flight' mechanisms and our 'excite and delight' mechanisms. It is the signal that our brain uses to tell us adaptation is needed for either a challenge or an opportunity.

Our signalling / alarm system is important to consider in the context of mental health because it is directly related to stress and anxiety disorders. Experiencing usual daily stressors is necessary for growth and development. The 'stress response' is actually our friend, not our enemy. It drives us to adapt and learn – to become resilient. However, a dysfunction in one or more of the neural circuits of the signalling mechanism may lead to an Anxiety Disorder.

5. Physical control of the body

All of our physical functions are under the control of our brain. This includes the respiratory, circulatory, genitourinary, digestive, musculoskeletal, endocrine and immune systems.

Examples include:

- Regulation of our breathing (respiratory system)
- Regulation of heart rate and blood pressure (circulatory system)
- Sensory information from our bladder (genitourinary system)
- Drinking and eating behaviours, and conscious control of our muscles for eating and elimination (digestive system)
- Sensory receptors in our body that send signals between the brain and muscles to keep our body balanced and moving

6. Behaviour

Behaviour is the way we act; it is our ability to interact with others and our environment through 'doing'. Our behaviour includes our actions in response to internal or external stimuli. Every behaviour is the result of a complex interplay between all of the other brain functions. Our brain integrates all of these functions to enable us to do tasks every second of every day.

Such behaviours might include:

- Social interactions
- Sexual activity
- Acts of kindness
- Acts of aggression
- Goal-directed activities
- Relaxation activities

All these functions indicate that the brain and body are connected. Our thoughts, feelings / emotions, behaviours and physical sensations are all controlled by the brain. For example the cortical limbic system (made up of smaller structures in the brain such as the Amygdala, the Hippocampus, the Corpus Callosum and the Thalamus) activates the fight, flight or freeze response during a stressful event, which leads to a series of physical reactions such as: dizziness, difficulties focusing, tunnel vision, blushing, dry mouth, difficulties swallowing, breathing problems, chest tightness, heart pounding, muscle tension, trembling, sweating, butterflies in the stomach, and nausea.

Imagine that you are hiking and you come across a bear. Your **senses** see and hear it, your **thoughts** recognize the bear as a dangerous threat, you start to **feel** scared, your fight-or-flight reaction is triggered, your body sends **signals** to increase your breathing rate and heart rate and your **behavioural** response is to run away.

Sources:

- Mental Health & High School Curriculum Guide:
<http://mhlcurriculum.org/about-the-guide/download-the-guide>
- Dana Organization | Brain Awareness Week:
<http://brainawareness.org/handouts-resources/>
- SickKids | Mind-Body Connection:
<http://aboutkidshealth.ca/article?contentid=3667>



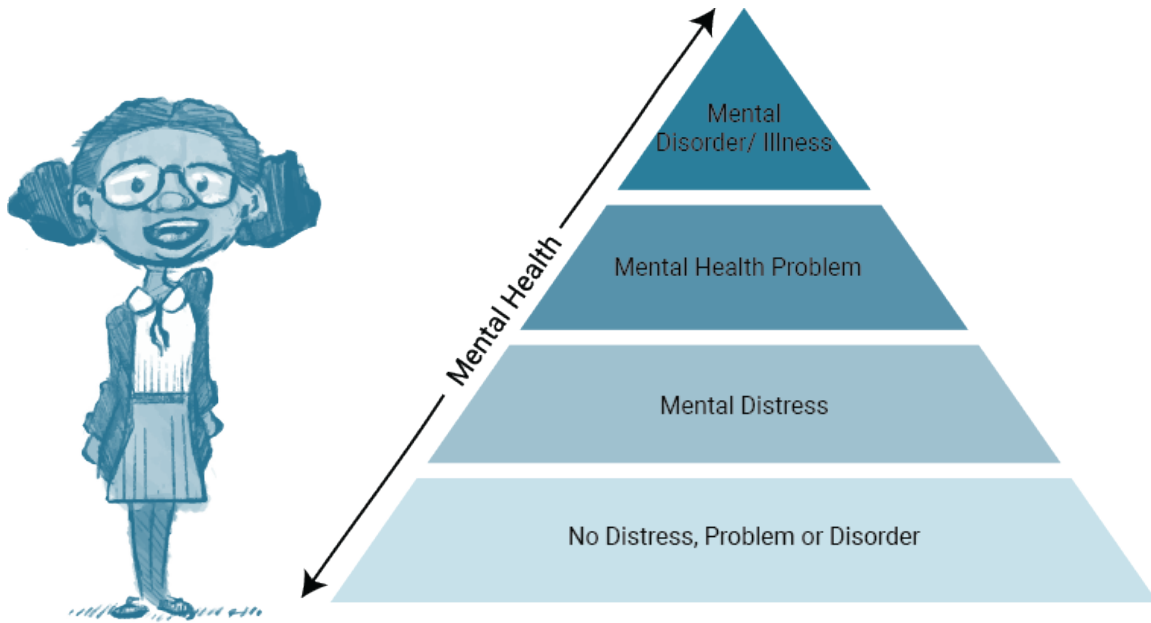
Module 4:

Common Mental / Neurodevelopmental Disorders

- All mental disorders reflect difficulties in thoughts, emotions and feelings, daily activities, physical health, behaviours and signalling
- People with mental disorders can be treated and the sooner people receive proper treatment and support, the better the outcomes



Common Mental / Neurodevelopmental Disorders



Mental illnesses are common medical conditions that often emerge during childhood and adolescence. Approximately 50% of all mental disorders have an onset by age 14, making childhood a critical time to promote mental health, reduce stigma against mental illness and enhance access to mental health services for young people. In Module 3, we learned that the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-5-TR) defines mental illnesses and mental disorders as dysregulation of mood, thoughts, and / or behaviours. Mental disorders and illnesses are diagnosed by licensed clinicians who use internationally agreed upon criteria, such as the DSM-5-TR or International Classification of Diseases 11 (ICD-11). Treating¹ these disorders requires the best available evidence-based interventions planned and coordinated by properly qualified healthcare professionals. Note that treatment is most successful when multiple stakeholders such as teachers, doctors and family members work together to support the treatment plan of a young person living with one or more mental disorders.

¹ Information regarding the following disorders is primarily based on the DSM-5-TR all statistics, such as prevalence rates or inheritability index are quoted from DSM-5.

Mental illnesses and mental disorders involve disturbances of usual brain function. As described in Module 3, the brain has six key functions: thinking, perception, emotion, signalling, physical movements, and behaviour. A mental illness or mental disorder may occur when one or more of these brain functions work differently than they should. To date, there are no independent biological markers that appear on diagnostic tests (such as blood tests or brain scans) to indicate the onset or presence of a mental disorder. Instead, diagnoses are assigned on the basis of signs (what an independent observer can see) and symptoms (what the person experiences). Mental health professionals identify signs and symptoms that occur together in 'clusters,' which informs diagnosis and treatment.

In previous modules we have learned to identify different emotional states and how to use appropriate language to distinguish between them.

In this module, we will teach students how to distinguish between 'normal stress' arising from everyday life challenges and mental illnesses / disorders. We will focus on Generalised Anxiety Disorder, Autism Spectrum Disorder, Attention-Deficit / Hyperactivity Disorder, Major Depressive Disorder, Specific Learning Disorder, Specific Phobia and Obsessive-Compulsive Disorder based on information from the DSM-5-TR. Teachers play a crucial role teaching mental health in the classroom and providing support for students in need of help.

However, the teachers' role is NOT to diagnose or treat, but rather to recognize potential mental health problems or disorders, refer students to appropriate services, and collaborate with other professionals (e.g. school-based mental health professionals, school counsellors, community mental health clinicians) to support children and adolescents identified as having a mental health problem or disorder.

As teachers, do not diagnose! Instead describe concerning behaviour, offer support and link to clinical professionals.



Anxiety Disorders

Anxiety Disorders are some of the most common mental illnesses among children. This class of disorders refer to a number of specific conditions, including but not limited to Separation Anxiety Disorder, Generalised Anxiety Disorder, Panic Disorder, Social Anxiety Disorder and Specific Phobia.

Anxious feelings are normal human emotions that everyone experiences from time to time. People may feel anxious when facing problems, challenges, changes, or difficult decisions. Additionally, it is common for children and adolescents to have some fears throughout their development. For example, many young children are afraid of the dark, monsters, or separation from their parents. Children and youth often have more fears than adults; this is normal as they try to make sense of their world. Most childhood fears will diminish over time.

It is also important to remember that an Anxiety Disorder is not the same thing as the stress response, which is the brain-body signal that alerts us to an environmental challenge we need to address. Furthermore, Anxiety should not be confused with shyness or a 'slow-to-warm up' temperament.

Anxiety Disorders are characterised by disproportionate responses (e.g. increased frequency, intensity or duration) to a situation that causes severe distress and interferes with someone's ability to function.

In this resource, we will focus on Separation Anxiety Disorder, Specific Phobias, Panic Disorder, Social Anxiety Disorder and Generalised Anxiety Disorder.



Feeling nervous and apprehensive is not the same as having an Anxiety Disorder

Separation Anxiety Disorder

Separation Anxiety Disorder is the most prevalent Anxiety Disorder in children younger than 12 years of age. It is characterised by developmentally inappropriate and intense fears related to separation from one's home, parents or other attachment figures. In any given year it is estimated that about 4% of children would qualify for the disorder. Separation Anxiety Disorder decreases in prevalence from childhood through adolescence and adulthood.

Children with Separation Anxiety Disorder may experience:

- persistent and excessive worries that something bad might happen to a caregiver (e.g. illness, injury, death)
- refusal to leave home, go to school or elsewhere
- excessive distress (e.g. throwing tantrums) when anticipating or experiencing separation from home or from major attachment figures
- fear that they may be kidnapped or otherwise taken away from their caregiver
- refusal to be alone or go to bed at night
- refusal to sleep away (e.g. sleepovers)
- nightmares about separation
- physical symptoms (e.g. nausea, headache, stomach aches) in response to separation

These symptoms may indicate the presence of a Separation Anxiety Disorder if they are pervasive, severe and last for at least four consecutive weeks. Both genetic and environmental factors contribute to the risk of developing Separation Anxiety Disorder. The genetic basis of Separation Anxiety Disorder can be demonstrated by the heritability index, which is approximately 70%, and even higher in girls (DSM-5-TR). Exposure to certain stressful or negative life events in early childhood may increase the risk of developing Separation Anxiety Disorder, along with how adults around the child respond to anxious behaviours.



The following animated video on Separation Anxiety Disorder is available to share with students
<https://youtu.be/jEkFp0Ux40Q>

Specific Phobias

Everyone has some mild, irrational fears, however phobias are intense fears about particular objects or situations, such as heights, animals, seeing blood, and enclosed spaces. People with Specific Phobias avoid these objects or situations to an extent that interferes with daily living. Most Specific Phobias develop in childhood, with the majority of cases developing prior to age ten.

Children with a phobia may experience the following:

- Extreme fear or anxiety about a specific object or situation
- The phobic object or situation almost always provokes immediate fear or anxiety
- The phobic object or situation is actively avoided or endured with intense fear or anxiety
- The fear or anxiety is proportionally greater than the actual danger posed by the specific object or situation given an individual's sociocultural context
- The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more
- The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

Approximately 5% of children and 16% of 13 to 17 year olds meet the criteria for having at least one Specific Phobia. Roughly 75% of individuals with Specific Phobia fear more than one situation or object. Phobias develop as the result of the interaction of genetic (inherited) and environmental factors.



Panic Disorder

A panic attack is a period of extreme fear or discomfort that develops abruptly and reaches a peak within a few minutes. Symptoms include intense physical sensations and catastrophic thoughts. Sometimes there is a clear trigger for a panic attack (e.g. an exam), however, sometimes panic attacks seem to occur randomly.



During a panic attack, four (or more) of the following symptoms occur:

- Palpitations, pounding heart, or accelerated heart rate
- Sweating
- Trembling or shaking
- Sensations of shortness of breath or smothering
- Feelings of choking
- Chest pain or discomfort
- Nausea or abdominal distress
- Feeling dizzy, unsteady, light headed, or faint
- Chills or heat sensations
- Numbness or tingling sensations
- Feelings of unreality or being detached from oneself
- Fear of losing control or 'going crazy'
- Fear of dying

Panic attacks are essentially the body's fight-flight-freeze response gone awry. Episodes can be triggered, especially with conditions like Specific Phobias, or occur repeatedly and randomly, which is called Panic Disorder. The frequency and severity of panic attacks can vary greatly among individuals.

To have a Panic Disorder, a person must have:

- Recurrent, unexpected panic attacks

One or more of the attacks followed by ≥ 1 month of:

- Persistent concern of having additional attacks
- Worry about the implications of the attack or its consequences
- A significant change in behaviour as a result of the attacks
- Agoraphobia (fear of being in places where escape is difficult)
- Panic attacks that are not due to substance abuse, medications or a general medical condition
- Panic attacks that are not better accounted for by another mental disorder

Although panic attacks occur in children, the overall prevalence of Panic Disorder is low before the age of 14 ($<0.4\%$). Although Panic Disorder is very rare in childhood, the development of Panic Disorder can often be traced back to 'fearful spells' first experienced during childhood. Both genetic and environmental factors (often in combination) can lead to Panic Disorder. Studies of children, families, and twins indicate that the heritability of panic disorder is around 43%.



Experiencing a panic attack does not mean you have a mental illness



It is always important to consider the unique context for each child before determining if the patterns of behaviour are the product of Social Anxiety Disorder or another mental disorder

Social Anxiety Disorder (Social Phobia)

People with Social Anxiety Disorder experience significant fear or anxiety about social situations where they might be judged negatively by others. Examples of situations that can trigger Social Anxiety include:

- having a conversation (e.g. talking to classmates and adults)
- going to social events (e.g. going to birthday parties or school dances)
- meeting unfamiliar people
- being observed (e.g. eating or drinking)
- performing in front of others (e.g. giving a speech)

Individuals with Social Anxiety Disorder tend to be intensely fearful of judgement and humiliation or of acting in ways that could lead to rejection. They may also be fearful of showing signs of anxiety, such as blushing, trembling, sweating, stumbling over one's words, or staring. Individuals experiencing Social Anxiety Disorder greatly overestimate the threat of social situations, often second guess or replay their performance after the fact or avoid potentially triggering situations altogether (e.g. school avoidance). These symptoms are persistent, lasting a minimum of 6 months, and often intensify over time.

Children with Social Anxiety Disorder may present very differently than adults; they may cry, have tantrums, freeze, cling or hide, lash out or become temporarily mute. It is always important to consider the unique context for each child before considering if the patterns of behaviour are the product of Social Anxiety Disorder or another mental disorder.

In any given year around 4% of youth ages 14 to 25 will meet the criteria for Social Anxiety Disorder. About 75% of individuals who are eventually diagnosed experienced the onset of their symptoms between the age of 8 and 15 years of age. Genetics in combination with environmental factors can put an individual at higher risk of developing Social Anxiety Disorder. For example, an individual has a two to six times greater risk of developing Social Anxiety Disorder if a first degree relative has the condition.

Generalised Anxiety Disorder (GAD)

At times, we all feel anxious about challenges in our daily life and figure out ways to deal with these feelings. However, Generalised Anxiety Disorder (GAD) is characterised by persistent and excessive worry across multiple domains of life (such as work or school performance) that the individual finds difficult to control. In any given year, 0.4% to 3.6% of people will meet the criteria for GAD globally. Females are twice as likely as males to experience Generalised Anxiety Disorder. Children and youth with GAD tend to have excessive worries and anxiety that span multiple topics and life areas (for more days than not for at least 6 months) for example:

- school performance
- doing tasks perfectly
- what people think of them
- bad events happening (disaster, environmental concerns, disease, war, robbery, accidents)
- health or illness (fearing a cold or flu may be a more serious illness)
- safety and well being of loved ones (family, friends, pets)
- everyday stressors (being on time, what to wear, where to go, family finances)

GAD also can impact mood and the functioning of the body, resulting in symptoms such as:

- Restlessness or feeling on edge
- Being easily fatigued
- Difficulty concentrating or mind going blank
- Irritability
- Muscle tension, increased heart rate, sweating and shakiness or shortness of breath
- Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep)



People with GAD are often preoccupied with thoughts about real or potential sources of danger. They tend to ask a lot of 'what if...' questions and seek constant reassurance from others. To be diagnosed with GAD, the intensity and frequency of anxious feelings, worry, and physical symptoms needs to cause significant suffering and impairment that cannot be better attributed to other causes like substance use, a medical condition, or another mental disorder.

Although there have been few investigations into the disorder's heritability, a summary of available family and twin studies suggests that genetic factors play a moderate role in the development of GAD. Genetic heritability may account for as much as 30% of one's risk of experiencing Generalised Anxiety Disorder. The most carefully studied treatment that demonstrates effectiveness with all Anxiety Disorders is Cognitive Behavioural Therapy (CBT). This helps people change the way they think about and respond to situations that cause symptoms, which in turn lowers the anxiety they feel and impairment they experience. For moderate to severe cases of Anxiety Disorders, medication may be used in combination with CBT. The most effective class of medications used in youth for anxiety disorders are Selective Serotonin Reuptake Inhibitors (SSRIs).

Teachers may be involved in supporting behavioural interventions. Avoidance of treatment or support can be common in individuals experiencing GAD. It is important for teachers to understand that struggling students who appear avoidant may be preoccupied, overwhelmed, or not quite ready to accept support for their GAD. Building mutually trusting relationships with students is a great first step to reducing avoidant behaviours. While persistent avoidance may exacerbate GAD over time, it is crucial that teachers build relationships to deter avoidance rather than simply confronting students.



Autism Spectrum Disorder (ASD)

Autism Spectrum Disorder (ASD) is a neurodevelopmental disorder that affects a person's social skills, communication / interaction and behaviour. It affects about 1% of the population and the diagnosis is usually made in the first 2 to 5 years of life.

Children with ASD may exhibit challenges related to social communication and interactions, including:

- difficulties understanding that others may think, feel and perceive the world differently from them
- lack of awareness of social norms (eg. responding less to their own name)
- deficits in non-verbal communication (e.g. limited eye contact, unusual facial expressions, limited use of gestures)
- absent, delayed or unusual use of verbal language (e.g. seemingly meaningless repetition of other people's spoken words, repeating words from TV, movies, commercials, stories)
- difficulties following the 'rules' of typical back-and-forth conversation (e.g. not taking turns speaking, focusing on own interests, trouble sharing interests, thoughts and feelings with others)
- difficulties forming and sustaining age-typical relationships

Children with ASD also commonly exhibit unusual or restricted patterns of behaviour which may include:

- repetitive movements, such as hand flapping or body rocking
- an insistence on sameness and extreme resistance or distress to even minor changes in routine
- highly restricted interests that are unusual in their intensity, depth, or focus
- being more sensitive or less sensitive than others to sensory experiences (pain, temperature, texture, smell, taste, lights or sound)
- self-injury (e.g. skin picking, hand biting, head banging)

The best outcomes in Autism Spectrum Disorder occur through early interventions when the brain is more plastic and changeable



These signs and symptoms must be present in the early developmental period; cause significant impairment; and are not better explained by intellectual disability. While specific causes of ASD have yet to be found, many risk factors have been identified in the research literature that may contribute to its development. These risk factors include genetics and environmental factors (e.g. a sibling with ASD, very low birth weight, and older parents). ASD has a genetic basis involving many different genes, but the exact pattern or patterns of heritability has not yet been fully established. Heritability estimates for Autism Spectrum Disorder have ranged from 37% to higher than 90%, based on twin concordance rates.

The best outcomes in ASD occur through early interventions when the brain is more plastic and changeable. These may include programs to assist with communication, social skills, and sensory processing such as Applied Behavioural Analysis. It is also important to recognize and nurture the unique strengths of youth with ASD, which may include exceptional memory or an aptitude for creative expression (e.g. art, music). Specialised ASD diagnostic and treatment centres (usually associated with paediatric hospitals and universities) are available in most Canadian provinces.

Classroom strategies for students with ASD need to be developed based on the needs, capabilities and strengths of each individual child. Information about teaching tips and strategies have been developed by many credible educational organisations and are easily found online. An example is one hosted by the Ontario Teachers Federation, which can be found at:

<http://teachspeced.ca/teaching-strategies-students-special-needs>.



Attention-Deficit/Hyperactivity Disorder (ADHD)

Children are naturally active and inquisitive – some more so than others. One of the main differences between a normally active child and one with ADHD is that the disorder significantly interferes with a child’s ability to function and thrive in school and social situations.



ADHD is a neurodevelopmental disorder characterised by substantial and persistent difficulties sustaining attention for non-preferred activities. Many, but not all, youth with ADHD also struggle with levels of hyperactivity and impulsivity that are beyond what is typical for people their age. This can interfere with normal functioning at school, home and with peers. ADHD begins early in life, affects about 3 to 7% of school-aged children and continues into adolescence and potentially into adulthood. The incidence is about three times higher in boys than in girls.

ADHD has two core areas of signs and symptoms. People living with ADHD may struggle predominantly with inattention or hyperactivity / impulsivity or some combination of both. The signs and symptoms must be present for at least 6 months and to a much greater degree than others of the same age.

You may notice the student:

- making numerous errors and overlooking or missing details
- having trouble sustaining attention (unless something is highly stimulating, such as video games or social media)
- failing to listen when spoken to directly as their mind is often elsewhere (e.g. daydreaming)
- being easily sidetracked and struggling to finish tasks
- procrastinating or avoiding activities requiring sustained mental effort
- struggles with disorganisation, messiness and time management often losing, forgetting or misplacing belongings
- being easily distracted
- being forgetful for day-to-day activities (e.g. keeping appointments, doing chores)
- struggles with estimating time accurately

Typical signs and symptoms of Hyperactivity and Impulsivity may include:

- fidgeting or squirming
- having difficulties staying seated or frequently finding reasons to get up and move around
- running or climbing in situations where it is inappropriate
- an inability to play or engage in leisure activities quietly
- seeming to be always 'on the go', or needing to do something
- excessive talkativeness
- blurting out an answer before a question has been completed or speaking over others in conversations
- impatience when waiting their turn
- butting into conversations or taking over what others are doing



As is the case with many psychiatric disorders, most researchers agree that an interaction between genetic and environmental factors can lead to ADHD. Genetics determine about 75% of all ADHD cases. Environmental factors also play an important role, such as exposure to cigarette smoke, recreational drugs, alcohol or other toxins in utero or premature delivery with very low birth weight.

The most effective and commonly used treatment is stimulant medication, which helps increase the student's ability to pay attention and focus and decreases their impulsivity and hyperactivity. Stimulants are safe, effective and fast acting for most people but side effects may be problematic for some. In this case a healthcare provider may prescribe a different medication.

Psychosocial interventions can be a helpful addition to medication. Behaviour Therapy can help improve the student's academic and social functioning. Parental Behaviour Training can help parents better understand how to work with their child. Classroom interventions can help adapt the classroom and learning environment to suit a student with ADHD.

Classroom strategies should be developmentally appropriate and teachers can often participate in assessing the impact of medication interventions. Specific classroom interventions need to be tailored to the needs of the student. Here are some examples:

- ADHD in the classroom | CDC: <https://www.cdc.gov/ncbddd/adhd/school-success.html>
- ADHD General Information | CADDAC: <https://caddac.ca/about-adhd/in-general/>
- ADHD Symptoms, Impairments and Accommodations in the Elementary School Environment | CADDAC: <https://caddac.ca/wp-content/uploads/Elementary-Impairment-Accomm-chart-with-check-boxes-FINAL-1.pdf>



Emotional states (sad, unhappy, disappointed, dismayed, demoralized, and disenchanting) are not the same as Depression

Depressive Disorders

Occasionally feeling sad or hopeless is a normal part of life for both children and adults. Specific diagnostic criteria separate Depressive Disorders from feelings and behaviours that are normal and age appropriate. Children experiencing a clinical depression may exhibit a low mood that lasts for more than a few weeks and makes it difficult for them to function at school, with friends, or in their daily lives (e.g. sleeping, studying, eating, and enjoying pleasurable activities).

Children with Major Depressive Disorder may:

- feel or appear numb, bored, tired, empty or irritable
- be unhappy even when good events happen
- be very sensitive to rejection or failure
- not enjoy their interests as much as they used to
- spend less time with friends, family, or in after school activities
- be absent from school often or not perform to their potential
- have difficulty concentrating and making decisions
- feel hopeless and pessimistic about the future
- feel helpless and think that everything is unfair
- feel like everything is their fault or they are not good at anything
- think negatively about most things
- have thoughts of suicide or want to die
- sleep more or less than usual
- have changes in appetite and / or weight
- have frequent headaches or stomach aches

For a mental health clinician to diagnose Major Depressive Disorder, the symptoms must be substantial and different from the emotional, cognitive and physical challenges of everyday life. Symptoms should not be attributable to the physiological effects of a substance or to another medical condition.

Depressive Disorders are among the most common mental illnesses due to a combination of factors. Certain people's genetics (including personality traits) may make them more susceptible to developing a mood disorder following major life stressors. Depression also runs in families, making it more likely that someone will develop Major Depressive Disorder if a first-degree relative (parent or sibling) also has the same disorder, even in the absence of a major life stressor. Heritability index for Clinical Depression is approximately 40%. Adverse childhood experiences (e.g. neglect, abuse, poverty, or violence) and stressful life events may also contribute to the occurrence of Major Depressive Disorder.



There are several effective treatments for Major Depressive Disorder. These include psychotherapy (e.g. cognitive behavioural therapy); interpersonal psychotherapy (IPT); and a class of antidepressant medication called Serotonin-Specific Reuptake Inhibitors (SSRIs). These treatments may be combined for more severe presentations of the illness.

If you are concerned that your student may have Clinical Depression, it is necessary to discuss this with the most appropriate mental health provider in your school (e.g. counsellor or psychologist). The school-based health provider can provide counselling and support (including suggestions for self-help strategies). If the disorder is more intense or the person is suicidal, the school counsellor should immediately refer the person to the health professional best suited to treat the disorder. In acute situations this may include the emergency department or urgent care centre. Once an intervention occurs and the student is back at school, it is important that the teacher be part of the ongoing treatment team and help develop and address learning needs. You may also need to collaborate with school-based and non school-based professionals to provide emotional support and positive experiences for the student.



If you're concerned that your student may have Clinical Depression, it is necessary to discuss this with the most appropriate mental health provider in your school

Specific Learning Disorder (SLD)

Many children struggle with reading, writing or mathematics, but some students may experience profound difficulty acquiring and refining specific educational skill sets. A Specific Learning Disorder (SLD) is a neurodevelopmental disorder diagnosed when there are specific deficits in an individual's ability to perceive or process information efficiently and accurately. An SLD is characterised by persistent and impairing difficulties with learning foundational academic skills in reading, writing, and / or mathematics, that is not due to sensory issues, a lack of learning opportunities, or intellectual impairment. Types of Learning Disorders include difficulties in reading (e.g. dyslexia), mathematics (e.g. dyscalculia), and writing (e.g. dysgraphia). The prevalence of specific SLD across the academic domains of reading, writing, and mathematics is 5% to 15% among school-age children across different languages and cultures.

A person with SLD may present at least one of the following symptoms that have persisted for at least 6 months, despite the provision of interventions that target those difficulties:

- Inaccurate or slow and effortful word reading (e.g. reads single words aloud incorrectly or slowly and hesitantly, frequently guesses words, has difficulty sounding out words)
- Difficulty understanding the meaning of what is read (e.g. may read text accurately but not understand the sequence, relationships, inferences, or deeper meaning of text)
- Difficulties with spelling (e.g. may add, omit, or substitute vowels or consonants)
- Difficulties with written expression (e.g. makes multiple grammatical or punctuation errors within sentences; employs poor paragraph organisation.
- Difficulties mastering number sense, number facts, or calculation (e.g. has poor understanding of numbers, their magnitude, and relationships; counts on fingers to add single-digit numbers instead of recalling the math fact as peers do)
- Difficulties with mathematical reasoning (e.g. has severe difficulty applying mathematical concepts, facts, or procedures to solve quantitative problems).

While the causes of Specific Learning Disorders are not well understood, some potential contributing risk factors include heredity and environmental factors. Heritability estimate values are greater than 60% for reading disabilities (Dyslexia) and the risk of Specific Learning Disorder in mathematics is about 5 to 10 times higher in first-degree relatives of individuals (e.g. parents and siblings) with these learning difficulties compared with those without them. Environmental factors, such as premature birth, very low birth weight, prenatal exposure to nicotine or alcohol, head injuries, malnutrition, or toxic exposure may also increase the risk for a Specific Learning Disorder.

Individuals with Learning Disorders face unique challenges that may persist throughout their lives. Depending on the type and severity of their disorder, interventions may be used to help the individual learn strategies to foster future success. School psychologists and other qualified professionals often help design and manage such interventions. Social support may also improve learning for students with Learning Disorders.



Obsessive-Compulsive Disorder (OCD)

Occasional intrusive thoughts or repetitive behaviours are common in the general population (e.g. double-checking that a door is locked). Everyone has unwanted or unplanned thoughts at times. Similarly, lots of people have idiosyncrasies and preferred ways to do tasks (e.g. routines, superstitious habits) however OCD is far more than that. It is a mental illness that leaves people feeling trapped in a cycle of distressing thoughts and / or behaviours that become so extreme they get in the way of daily life, consume large amounts of time (e.g. more than one hour a day) and attention, or result in significant suffering.

Obsessions are recurrent and persistent thoughts, urges, or mental images that are intrusive and unwanted.

Common obsessions may include:

- Concerns about cleanliness or contamination
- Bad events happening (e.g. violence, horrible scenes, or being attacked)
- Doubts about whether an action was performed
- Possessions or actions having to be in a specific order (e.g. symmetry and order)



Compulsions (or 'rituals') are repetitive behaviours or mental acts to reduce distressing feelings associated with an obsession; the person feels driven to perform according to extremely rigid rules. However, these behaviours or mental acts only work for a short time so they need to be continuously repeated, thereby interfering with daily life. They are time consuming (e.g. more than 1 hour per day) or cause clinically significant distress or impairment. Common compulsions may include:

- Repetitive behaviours (e.g. washing hands; tapping a desk; repeatedly checking to make sure a task has been completed (e.g. the oven turned off))
- Placing items in a specific order or requiring symmetry
- Asking for reassurance pertaining to their compulsions
- Mental acts (e.g. counting items, repeating words silently)



Children with OCD may avoid friends, quit sports they like, experience rejection from peers, struggle to concentrate at school, fight with family members, spend more time on tasks than others, and have trouble enjoying hobbies and life in general. The prevalence of OCD is 1.1% to 1.8% in any given year. Genetic factors (e.g. a concordance rate of 57% for identical twins) contribute to the development of OCD. People with immediate family members with OCD are twice as likely to have OCD, and ten times as likely if they developed OCD as a child or adolescent.



Liking a tidy desk is not the same as OCD

OCD is treated with psychotherapy, psychoeducation and / or medication. Exposure and response prevention (a type of CBT) helps people face the obsession without giving in to the compulsion in a safe and supported environment. Medications are also an important part of treatment for some people with OCD, with SSRIs being the most commonly prescribed.

If you are concerned that a student may have OCD, refer the student to the school counsellor or school-based health professional who can then refer the student to a professional best suited to provide treatment. As a teacher, continue to provide emotional and learning support to the student as part of their 'circle of care'. It is important to know if any academic modifications need to be made to enhance learning opportunities for young people with OCD, so including the teacher in treatment planning and monitoring is usually necessary.

Sources:

- Mental Health & High School Curriculum Guide:
<http://teachmentalhealth.org>
- Kelty Mental Health Resource Centre:
<http://keltymentalhealth.ca/>
- National Institute of Mental Health:
<https://www.nimh.nih.gov/health/topics/>
- American Academy of Child and Adolescent Psychiatry:
<http://aacap.org/>

Module 5:

Helping Self and Helping Others

- Everyone has mental health that can be supported and promoted
- There are many ways of seeking help for mental health problems and mental disorders
- People with mental illness can live a healthy life with appropriate treatment



Helping Self and Helping Others



Almost all young people experience negative emotions, cognitions and behavioural challenges that are not necessarily due to a mental illness. Usually, a compassionate ear, usual support and some helpful suggestions are all that is needed. Many mental health promotion activities may be helpful to enhance student mental health (see Module 6). However, if your student is facing a mental health problem, then additional support and counselling may be very helpful to them. Likewise, if your student is dealing with a mental illness, then professional treatment is what is needed. Being able to differentiate between these needs is important but not always easy.



Getting help early for yourself and others increases positive mental health outcomes

For a young person receiving mental healthcare, school life can be a challenge. Having teachers and students who understand best evidence-based treatments for mental disorders can be a big help. The word 'treatment' describes what a healthcare provider will do to help a person with mental illness. It has a number of components, including:

- helping a person decrease their symptoms and improve how they are functioning
- impacting and changing the functioning of the brain
- being based on best available evidence for effectiveness, tolerability and safety
- being provided by a health professional who has the training and competencies to apply and evaluate the treatment



For a young person receiving mental healthcare, school life can be a challenge. Having teachers and students who understand best evidence-based treatments for mental disorders can be a big help

Such treatments are called **standard treatments**, meaning that they meet the standards of numerous credible professional organisations due to the substantial amount of scientific research that supports its use. Often standard treatments have received regulatory approval such as medicines approved by Health Canada.

As a type of treatment, medications are chemical messengers that help the brain improve its functioning when it has been impacted by a mental illness and should lead to decreases in the associated signs and symptoms. This helps to improve the functioning of the individual with the illness. This reset may also help decrease the likelihood that the illness will come back.

Not every youth who has a mental illness will require medication to treat it. Medications should rarely, if ever, be provided without concurrent provision of psychotherapy or psychosocial support. Based on the scientific evidence available, medications can be a necessary, but not sufficient treatment for young people who have a mental illness.

Another type of standard treatment for mental illness is psychotherapy / talk therapy that can be effective on their own and in combination with medications to help people with mental illnesses. Psychotherapy involves more than just talking, it is a collaborative process that helps people with mental illness problem-solve, learn and use healthy coping strategies and adaptively change their negative and harmful thoughts, emotions and behaviours. Through this process, psychotherapy can even impact the chemistry and structure of parts of the brain affected by mental illness. Psychotherapy is provided in isolation for mild forms of certain mental illnesses, like Anxiety Disorders and Depressive Disorders. For more severe types of illness or more severe forms of these illnesses, psychotherapies are combined with medications to obtain better outcomes. There are many different types of psychotherapies, but some of those which hold the strongest evidence in youth include Cognitive Behavioural Therapy (CBT) and Interpersonal Therapy (IPT).



In addition to the standard treatment, there is **complementary treatment** that has not met the standard of numerous credible professional organisations and / or received regulatory approval. These are provided in addition to standard treatments. There is some evidence that a complementary treatment may enhance the effectiveness or add additional health benefits to a standard treatment. An example of this is adding vitamin D at a dose of 1000 IU daily to SSRI and CBT treatment of Major Depressive Disorder. A complementary treatment cannot adequately replace a standard treatment.

Further, there are **alternative treatments** for which there is insufficient evidence that they are safe or effective when used instead of standard treatments. Alternative treatments are not typically recommended in evidence-based treatment guidelines.

How can you help:



- identify and refer students at risk of mental illness



- talk to students about your concerns and encourage them to seek help



- adjust academic expectations for students



- help student build relationships necessary to provide support



- establish appropriate interactions with parents when addressing mental health and mental illness

There are many strategies that teachers can apply to help students. One of the best ways you can help your student is to reduce stigma in your classroom. A great way to do this is to watch what kind of language you use around your students and others. What we say and how we phrase it reflects our beliefs and the way we view people. People living with mental illness or addictions (including your students) are often put down, discouraged, demoralised and marginalised. Don't let your students feel that way in your classroom where you control the environment. By choosing the words that you use, you can fight stigma in your classroom and help your students feel safe and supported. For more information on useful strategies, please refer to <http://teachmentalhealth.org>. This resource includes a comprehensive mental health literacy learner resource for pre-service and practising teachers.

Teachers can assist students and their families by connecting them with mental health professionals working in the school and by teaching about the healthcare services and groups in the community who provide treatment or healthy coping strategies. As a teacher, you can act as a trusted and knowledgeable adult, providing pathways to resources and support.



As a teacher, you can act as a trusted and knowledgeable adult, providing pathways to resources and support

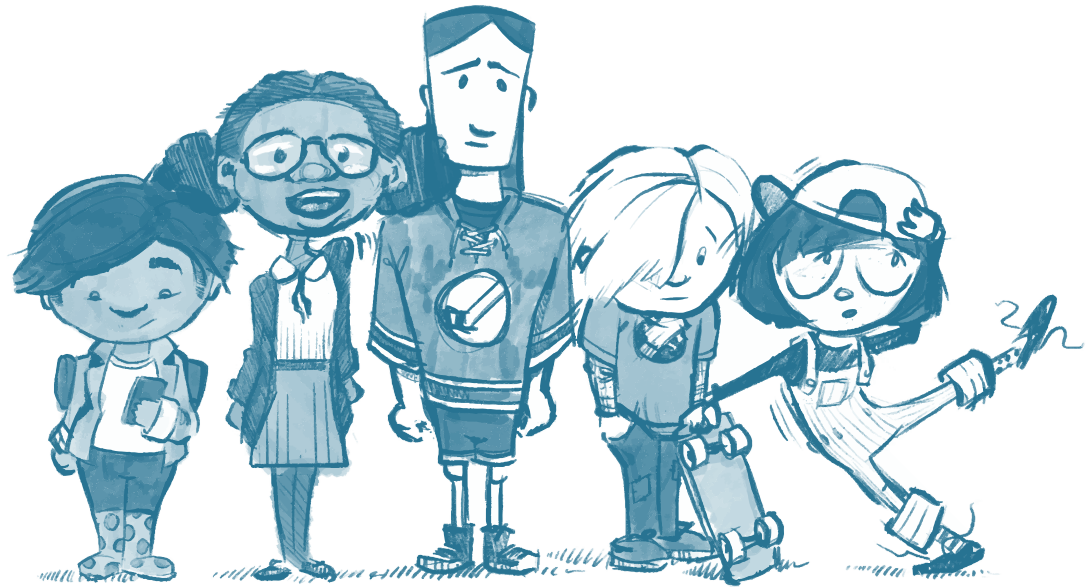
Module 6:

Getting Mentally Healthy

- What is good for physical health is good for mental health
- Coping with stress appropriately will help build resilience and new skills
- 'The Big 5' pillars of health promote both physical and mental health



Getting Mentally Healthy



Everyone has mental health that can be promoted and sustained through healthy lifestyle techniques and evidence-based mental health promotion activities. Our mental health can also be enhanced by learning how to deal with negative emotions and feelings as well as dealing with stress and everyday life challenges.



The Big 5 pillars of health

- restorative sleep
- strong social connection
- vigorous physical activity
- healthy eating
- helping others

The following is a set of healthy lifestyle techniques that everyone* can apply to promote mental health:

*Students come from a variety of backgrounds (e.g. from households that may experience income instability, food insecurity, insufficient social support networks, etc.). When engaging in classroom activities, it is important to consider the many factors that are outside of a student's control, which may influence what The Big 5 looks like for them.



Exercise

Thirty minutes of daily vigorous exercise (e.g. going for a run, playing soccer) is recommended. However, any amount and kind of movement is better than none at all. Being active has many physical, social, emotional and mental health benefits and is universally necessary for growth and development in children. Physical activity can also play an important role in the treatment of mental problems or disorders in children and youth.



Sleep

Consistent, restorative sleep is essential for our physical and mental health. Establishing a sleep routine and taking steps for positive 'sleep hygiene' can help (e.g. no cell phones in the bedroom and stopping screen time at least half hour before going to bed). Restorative sleep helps children and youth better retain new information and manage their emotions.



Healthy Eating

Good nutrition supports mental health and well-being, giving our bodies and brains the power and nourishment they need. Eating a balanced diet and following published food guidelines – such as Canada’s Food Guide (<http://food-guide.canada.ca/en/>) – and avoiding fad diets, can help keep us physically and mentally strong.



Supportive Social Connections

Good quality relationships (e.g. with friends, family, trusted adults) can help us live happier lives and cope better when mental distress and mental health problems arise.



Helping Others

Helping others can also benefit our own mental health and wellbeing (e.g. volunteering, being part of a team). Sounds like a win-win! Helping out in big or small ways can reduce stress as well as improve mood, self-esteem and overall happiness.



Remember: The Big 5 looks different for each of us!

Understanding, Managing and Embracing Stress

Applying effective strategies to cope with stress is an essential approach to help students learn new skills and build resilience in the long run. Stress is the body's reaction (physical, cognitive, and emotional responses) to any change that requires an adjustment or response. This reaction is based on the brain signalling function (see Module 3, 'Mental Health and the Brain') and alerts us not only to life-threatening danger (where we can experience the 'fight or flight' response), but also to numerous life challenges and opportunities (including what is called the 'excite and delight' response). It is a fundamental error to consider the stress response to always be of the fight or flight variety. Indeed, unless we live in circumstances such as conflict zones, poverty or experience severe and persistent traumas (such as abuse or neglect) our stress response is not considered toxic stress. In these situations, the stress response can be so severe or prolonged that for some (but not all) people, it can lead to negative health outcomes.

Most daily stress doesn't merit a fight or flight response. Instead it is a signal that we need to change something in our environment or how we are responding to it. If we do that successfully, the stress response goes away and we are said to have adapted. Then we remember successful adaptations and apply these to new challenges, demonstrating we have learned a new skill. Successful adaptations bring multiple new skills which build resilience. So, most daily stress is normal, adaptive, and can be health-promoting. The Harvard Centre for the Developing Child (<https://developingchild.harvard.edu/>) has created a useful table which illustrates differences in types of stress. It is noted that even with toxic stress, there are protective factors that help mitigate potential negative impacts. These factors can be both biological (some people are more 'stress-resistant' by nature) or environmental (particularly the presence of a caring, trusted person – such as a parent, grandparent, spouse, partner, friend, etc.).

We all need some degree of stress to perform well. The degree of stress we need to perform well varies from person to person and we need to practice to find that 'sweet spot'.

When faced with a stressor (challenge, opportunity, threat, etc.) our brain and body initiates the stress response. If we avoid the stressor, the next time that we encounter similar stressors, the stress response will become more intense and severe, resulting in maladaptive outcomes. Our challenge is to help our students (and ourselves) learn how to better manage our stress response: not by avoiding stressors and not by focusing solely on stress response reduction, but by building skills and coping strategies that help us use the normal stress response for our growth and development.

**Positive**

Brief increases in heart rate, mild elevations in stress hormone levels.

Tolerable

Serious, temporary stress responses, buffered by supportive relationships.

Toxic

Prolonged activation of stress response systems in the absence of protective relationships.¹

The Big 5 pillars of health discussed above are fundamental ways to help students manage stress, improve their mood, optimise their performance and enjoy life. In addition, there are the three-step stress management techniques:

1. Focusing on what you are thinking when you feel the stress response

This is the difference between thinking that the stress signal is 'bad' or 'negative' and thinking that what you are experiencing is a cue to alert you to a challenge or opportunity in your environment to deal with.

2. Determine what the stress signal is alerting you to and figure out how to address it effectively

We need to determine what is the challenge or opportunity and then figure out how to successfully address it or problem-solve

3. If necessary, apply specific techniques to modify the intensity of the stress response

There are different ways to decrease stress signals, such as controlled breathing and progressive muscle relaxation.

1 The Harvard Centre for the Developing Child
(<https://developingchild.harvard.edu/>)

The field of mental health is extensive and there is much to learn about the brain, mental illness, treatments and prevention. While not exhaustive, we hope this background information has increased your confidence to deliver the EMHLR modules in your setting. For more information and support please go to <http://mentalhealthliteracy.org>



© Mental Health Literacy 2022

