



Depression

Ready or not, your schools must face children's mental health problems

BY KATHLEEN VAIL

Twenty-five years ago, people believed it was impossible for children to be depressed. Now, of course, we know that's not true. In fact, one in every 33 children and one in eight adolescents may be suffering from depression, according to the federal Center for Mental Health Services. And while we're getting better at recognizing depression in children and teens, a majority still are not getting help.

Up to 70 percent of children with diagnosable mental, emotional, or behavioral disorders are not receiving mental health services, according to the Surgeon General's Report on Mental Health. Within that scope of disorders, depressed children are the least likely to get treatment. But some of the help they are getting is coming from their schools.

"Most kids are not making it to the traditional settings of mental health care," says Mark Weist. "Schools are becoming de facto mental health centers."

Weist, director of the Center for School Mental Health Assistance at the University of Maryland, says educators are beginning to recognize that mental health is essential to learning and that they can and should play a role in prevention, screening, and even treatment of mental and emotional disorders such as depression.

WHERE SCHOOLS FIT IN

It's not clear whether there are more depressed children these days or simply more awareness of childhood depression. What is clear is that schools increasingly are called on to step in.

"Schools are becoming increasingly attuned to the fact that children have mental health issues, and depression is not just an adult pathology," says Janice Hootman, president of the National Association of

School Nurses and nursing supervisor for the Multnomah Education Service District in Portland, Ore.

The notion that schools ought to play a role in student mental health has gotten a boost from the federal government. In 2002, President Bush formed the President's New Freedom Commission on Mental Health. Its task was to recommend ways to reform mental health care in the United States. Among the commission's recommendations: improve and expand school mental health programs.

For schools already overburdened by requirements and struggling to raise student achievement, dealing with mental health might seem to be piling things on. But as mental health advocates remind us, depressed children do not do well in school. Their grades drop. They stop participating in class. They lash out in anger at their classmates and teachers. In more severe cases, they may hurt themselves or others.

"Schools are faced with huge chal-

lenges, and they have a great deal of responsibility to succeed academically. That needs to be the priority of the school," says Steven Adelsheim, director of New Mexico's School Mental Health Initiative. "But students with unaddressed mental health issues won't succeed academically."

WHAT DOES DEPRESSION LOOK LIKE?

Johnny has stopped turning in his homework and quit the basketball team because he says he's too tired to play.

Mary constantly gets into fights with classmates over little bumps and jostles.

Jimmy is the class clown, and his loud antics get him sent to the office frequently.

Which of these children is depressed? The answer: all three.

Because it is experienced internally, depression can be hard to spot in other people, especially younger children. We traditionally picture a depressed person as withdrawn, sad, and sluggish. But that's only one way children might show they're depressed. Other symptoms can be extreme irritability, anger, or restlessness.

"Depression in children and adolescents can be frustrating," says Bruno Anthony, associate professor of psychiatry at the University of Maryland. "The child is unresponsive, tired, not getting his work in." Adults, he says, often respond by telling the child, "'Oh, get with it'—especially with kids who they know can do the work."

While adolescents seem to experience depression in ways similar to adults, younger children do not, and that can make it difficult to spot the problem. To be diagnosed with depression, adults must show such symptoms as sadness, lack of energy, and hopelessness consistently for two weeks.

You don't see that in younger children, says Anthony. The symptoms are the same, but the frequency, intensity, and duration are different. For children, the diagnostic criterion is to show such symptoms for three or four hours a day, three times a week.

Other symptoms of depression in children and adults alike include distorted thinking, feelings of worthlessness, guilt, anxiety, and loss of pleasure or interest in things they used to enjoy. Children may feel helpless and hopeless. They may cry frequently or be overly anxious. Physically, they may show changes in weight and sleep patterns, eating and sleeping too much or too little. They may be sluggish. They may be clingy and demanding or restless, and they may hurt themselves by taking excessive risks or by self-mutilation.

Depressed children—especially those whose thinking is distorted—can be a danger to themselves and to others. Suicide is a risk, and so is homicide. Depressed children also are more likely to abuse drugs and alcohol and engage in risk-taking behaviors.

"The majority are not receiving treatment of any kind—medication or psychological treatment," says Kevin Stark, a professor of educational psychology at the University of Texas at Austin. "The assessment research shows that teachers and parents are not good at picking up on depression in children. Since people don't know, children are not being identified or treated."

When mental health professionals screen for depression in schools, says Stark, the results often surprise the adults in students' lives. "A common reaction from parents and teachers is, 'I had no idea,'" he says.

Although families may not recognize the symptoms in their children, depression has a strong genetic component; many children

who suffer from depression also have parents and other relatives with the same illness. Depression is not all heredity, though. Home life and environment play a part, too. Some kids are living with post-traumatic stress disorder from witnessing domestic violence. Some are dealing with the effects of extreme poverty. Those circumstances, not surprisingly, can trigger depression, as can abusive parents, sexual abuse, divorce, death, and other family trauma.

Children who have behavioral problems such as attention deficit/hyperactivity disorder (AD/HD), problems with anxiety, obsessive-compulsive disorders, or other emotional issues often suffer from depression as well.

Evidence suggests that if children with depression don't get help, the condition could persist into adulthood, taking the joy out of their lives and sapping their ability to be productive and happy.

SCREENING AND PREVENTION

Adults who work in schools can help troubled kids get the attention they need. Teachers, counselors, administrators, coaches, and advisers who see students every day are in a position to spot trouble before it gets out of control. But they need help to know what to look for. That's where the school counselor, psychologist, or other health professionals such as nurses come in.

Anne Erickson, a counselor at Mahomet High School in Mahomet, Minn., wrote a grant five years ago along with the school psychologist to screen students for depression. Since then, the screening has grown into a program of depression prevention and awareness at the high school.

The program includes presentations to 10th-graders during a mental health unit in health class. Erickson invites a panel of students to discuss depression and their experiences with the illness. She shows PET scans of depressed brains to emphasize that the problem is physical and real.

The screening itself consists of approximately 30 questions about how the students are feeling. Those who score at risk of depression—or even marginally at risk—are asked to speak with Erickson. She calls the parents of students in the risk category and

helps them get their children referred to a medical doctor. Because depression screening for children and teens has been controversial, students whose parents object are allowed to opt out. But in five years, Erickson says, only two parents have objected.

Erickson also runs support groups for students with depression and brings in speakers. She meets twice a month with teachers and other staff members to talk about any questionable behavior or warning signs they might be seeing in their students.

As a result of her work, Erickson says, students know they can talk to her about their own problems or those of friends. "We have a culture here that is open to talking about these things—kids know how to talk about them," says Erickson. "If you get a reputation and are consistent, the kids know they can report these things."

Janice Tkaczyk, a counselor at the Cape Cod Technical High School in Massachusetts, also conducts depression screenings. She makes presentations to small groups of ninth-graders, with the school health staff in attendance so the students know whom they can go to if they have problems. Before the screening, Tkaczyk sends notices home announcing it and alerting parents about possible signs that their children are having problems.

Unlike the Minnesota students, those in Cape Cod don't sign their screening surveys. Tkaczyk tallies the information for research purposes, rather than to identify students at risk. She lets the students know they can come see her or the school nurse at any time if they want to talk about the screening or other problems.

And students have taken her up on the offer. One student told the school nurse about a friend who was signing her Internet instant messages with a picture of a noose. Tkaczyk and other school officials got in touch with the girl's mother, who then followed up.

"This student was suicidal," says Tkaczyk. "She had a plan and was going to kill herself."

BEYOND MEDICATION

Treatment for childhood depression can involve therapy or drugs or both. But using

antidepressants to treat depression in children and teens has become especially controversial since the Food and Drug Administration decided this past fall to put warning labels on antidepressants saying that they may not be appropriate for children and teens.

The FDA decision followed widely publicized findings that antidepressants meant for adults could in rare cases lead to suicide in children and teenagers.

Since the FDA warning, interest in therapy, rather than medication, has grown. One approach of interest is a therapy technique called cognitive behavioral therapy, according to Stark, the author of *Childhood Depression: School-Based Intervention*.

In cognitive behavioral therapy, depressed students learn coping skills and problem solving. “We teach them to think in a more realistic and positive way,” says Stark, who runs screening and therapy programs at several Texas schools. If the students are in a bad home situation that they can’t change, for example, they learn ways to cope, he explains. If they have a problem they can change, they learn problem solving. Children with distorted thinking learn ways to think more realistically. Sometimes the students need all three strategies.

This therapy technique tends to be most helpful for children who are depressed because of life circumstances—the kind of children Margaret Shingle, a counselor at Hawkins Mill Elementary School in Memphis, Tenn., works with. Many of these children, among the poorest in the city, come to school dirty. They don’t have toothbrushes or toothpaste or soap. Their only regular meals are provided at school. In this population, not surprisingly, Shingle sees a lot of depression.

“Our depressed youth show a lot of irritability, anger, and rage,” she says. “Kids don’t seem to have any personal space at home.” As a result, the normal jostling and bumping that occur during the day are seen as threats, Shingle says. Even the smallest incident can result in a blowup. “Our kids think, ‘I have to fight this person,’” she says. “The children have no tolerance for other people.”

Shingle works with the children in groups. She teaches anger management, so-

cial skills, conflict resolution, and mediation skills. The children learn deep breathing and other relaxation techniques, as well as figuring out when and how to walk away from a conflict and find an adult they can talk to.

“We focus on them controlling themselves,” she says. “There are so many things they can do.”

SCHOOL-BASED HEALTH CENTERS

When children are identified as having a problem with depression, many schools refer them to mental health services in the community. However, a shortage of mental health services, a lack of insurance, and other issues—such as lack of transportation and concern over possible stigma—keep many students from getting the help they need.

To the extent that they are able to do so, schools can help students overcome these barriers to treatment.

Some districts that have school-based health care—now available in about 1,500 schools nationwide—also form partnerships with mental health professionals to provide some kinds of prevention and treatment for their students.

In New Mexico, the state is pushing to expand mental health services in schools. “A large number of kids [have] unaddressed mental health issues, Steven Adelsheim says, “and most are getting no treatment.” Turning to the school for medical care is less threatening to children and families than going to a mental health clinic. Students might come in with a physical complaint, and after the third or fourth time, the real problem might surface, says Adelsheim. That issue often has to do with mental health.

Having mental health professionals working in the schools has other advantages as well, he says. Trained adults can gather important diagnostic information by watching children in the lunchroom, on the playground, and in the classroom. They can work with special education teachers on IEPs and help train staff and teachers how to recognize signs of mental health problems.

Olga Acosta is the director of school

mental health programs at the District of Columbia’s Department of Mental Health, which operates mental health programs in 30 public schools in the city.

The program started in some charter schools with a mental health grant and has expanded into the public schools as well, funded by the city. The first expansion was to a cluster of schools, starting with the elementary schools and middle schools that all feed to the same high school. Acosta says that with the cluster system, the program can be a support for students through their academic careers. The program also has expanded to what are known as transformation schools, the lowest performing and most violence ridden in the city.

The program, Acosta says, has a three-tiered approach: prevention, early intervention, and clinical services. It offers group and family counseling, parent and teacher consultation, staff development, and classroom observation. “We are there full-time in the schools,” she says.

One focus of the program is to catch problems early enough to prevent children from requiring special education for emotional disorders. “For some people, special ed is what they might need,” Acosta says, “but in many cases, we can find the kinds of supports needed so they don’t have to be labeled.”

Not only can addressing students’ mental health reduce the number of children in special education, says the University of Maryland’s Weist, it can help schools narrow the achievement gap.

“When schools pay more attention” to mental health problems, he says, “we see a decline in office referrals and other responses that detract from [the school’s] academic mission.”

Schools are already dealing with these problems, whether they know it or not. Helping children recognize and get treatment for depression allows them to achieve even more in their lives.

“These issues are at the heart and soul of why kids aren’t doing well,” says counselor Erickson, “There’s always something beneath those layers.”

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