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Mental Health, Children, and Schools: A Call to Action

Ask virtually any teacher, school counselor, or principal to describe the challenges that interfere with students' ability to succeed in school, and high on the list will be the increasing number of diagnosed and undiagnosed mental health disorders impacting students. This is more than just a perception: Research indicates that substantial numbers of children and adolescents are experiencing mental health problems. Indeed, national studies show that almost one in five youth aged 9 to 17 has a diagnosable mental disorder with at least minimal impairment, with about one in twenty youth having mental disorders with extreme impairment (U.S. Department of Health and Human Services, 1999). A recent household survey of over 9,000 homes reveals that about half of all Americans will meet diagnostic criteria for a mental disorder at some point in their lifetime, with the age of onset usually occurring during childhood or adolescence (Kessler, Berglund, Demler, Jin, & Walters, 2005). If we project the prevalence rates among youth for mental disorders associated with at least mild impairment of functioning (Shaffer et al., 1996) onto a middle school or high school with 1,000 students, on average that school would have around 130 students with an anxiety disorder, about 100 students with a disruptive behavior disorder, and over 60 students with a mood disorder. This does not even count students with less-prevalent disorders such as

Asperger syndrome or early-onset personality disorders. No wonder school counselors, teachers, and other school personnel are so concerned about students' mental health needs!

While the overall prevalence rates tell us that a significant segment of the K–12 student population is dealing with mental health disorders, the picture becomes even more concerning when the rates of mental health disorders among certain subgroups are examined. For example, as many as 70% of youth in the juvenile justice system have been found to display some level of mental health concerns (Osterlind, Koller, & Morris, 2007). Other subgroups of children and adolescents exhibiting elevated levels of mental health problems include youth in substance-abuse treatment facilities (Chan, Dennis, & Funk, 2008), youth exposed to mass violence and large-scale disasters (Endo, Shiori, Someya, Toyabe, & Akazawa, 2007; Hoven et al., 2005; Murthy, 2007), youth experiencing victimization (Turner, Finkelhor, & Ormrod, 2006), and even students who have been suspended from school (Stanley, Canham, & Cureton, 2006).

Adding to these alarming facts is the reality that large numbers of children and adolescents have undiagnosed mental disorders, and many of those youth whose disorders are properly diagnosed do not receive appropriate treatment. Studies of both urban (Mennen & Trickett, 2007) and rural (Angold et al., 2002) populations indicate that less than half of children and adolescents with mental health needs receive mental health services. For example, in a study of rural African American and White youth aged 9 to 17, researchers found that only one in three youth with a psychiatric diagnosis had received mental health care in the previous three months, and less than 15% had received specialty mental health care during that time (Angold et al.). Youth with depressive disorders seem particularly at risk for not receiving appropriate mental health services; a large-scale epidemiological study found that children and adolescents with disruptive disorders were about three times more likely than youth with depressive disorders to receive mental health services (Wu et al., 1999). Furthermore, while mental health services are often unavailable to youth in need of those services, at times mental health services are directed to youth who do not seem to be in high need. A study of urban youth found not only that over half of the youth with clinical levels of mental health symptoms did not receive services, but also that some of the children who did *not* display clinical-level symptoms *did* receive services (Mennen & Trickett). All in all, the research indicates that mental health services are frequently unavailable or misdirected, leading to a situation where children and adolescents with mental health needs are routinely not receiving the services they need.

IT'S NOT JUST ABOUT DIAGNOSES

While the overt focus of this book is on students with diagnosable mental disorders such as attention-deficit/hyperactivity disorder (ADHD) and

Asperger disorder, it is important to understand that many students have significant mental health needs even though their social, emotional, or behavioral difficulties may not fit in a formal diagnostic category. A student may be highly impulsive and distractible but not meet diagnostic criteria for ADHD, or a student may be plagued by persistent sadness and low self-esteem but not meet diagnostic criteria for a depressive disorder. We can look at surveys that ask youth to offer simple, basic descriptions of their behavior and mood to gain an understanding of the numbers of youth who are struggling. For example, a well-designed survey of over 130,000 sixth-, ninth-, and twelfth-grade students in the state of Minnesota found that about 10% of the students reported that they are often irritable and angry; 15% reported that they often have trouble concentrating; and around 8% reported that they are often unhappy, depressed, or tearful (Minnesota Department of Health, 2007). The Minnesota survey results present a revealing picture, indicating that there is a substantial segment of students who experience pervasive sadness, discouragement, and hopelessness, often accompanied by thoughts of suicide. There is also a significant percentage of both boys and girls who report physically assaulting others, often multiple times. This is not unique to Minnesota. National surveys indicate that 13% of adolescents reported having at least one major depressive episode in their lifetime (Substance Abuse and Mental Health Services Administration [SAMHSA], 2007). (A *major depressive episode* is defined as two weeks or longer during which there is either depressed mood or loss of interest or pleasure and at least four other symptoms that reflect a change in functioning, such as problems with sleep, eating, energy, concentration, and self-image; SAMHSA.) Furthermore, 28% of high school students report experiencing at least a two-week period in the past year during which they felt so sad or hopeless almost every day that they stopped engaging in usual activities, and 8% of high school students have attempted suicide (Centers for Disease Control and Prevention, 2006).

It is important not to lose sight of the fact that this discussion of survey results has been a glass-half-empty discussion, as the focus has been on those students reporting troubling emotions and antisocial behaviors. While it is necessary to examine these negative responses to understand the numbers of struggling students in our schools, it is also important to recognize the positive aspects the surveys reveal: Most students are *not* pervasively unhappy, most do *not* feel crushed by discouragement, and most do *not* assault others. The sky is not falling. Neither, however, is it a rare occurrence for a student to be aggressive, anxious, or miserable. The numbers do not lie. But the numbers tell just part of the story.

IT'S NOT JUST ABOUT NUMBERS

While the numbers of youth with diagnosed and undiagnosed mental health problems are alarming, the true impact of the numbers is fully

understood only when one considers the multiple layers of negative consequences experienced by children and adolescents with mental health problems. Mental health problems generally interfere with school functioning, including academic achievement and relationships with teachers. Some mental health disorders (oppositional defiant disorder, for example) are by their very nature accompanied by resistance to rules and authority at school and tend to elicit strong negative reactions from teachers and school staff, which is obviously not a good situation for either the student or the adults. Other disorders, such as depressive disorders and anxiety disorders, require so much emotional energy to manage that often little energy is left over to devote to doing homework and paying attention in class. Many mental health disorders are associated with problems with organization and planning, making it very difficult for those afflicted students to set and complete the short-term and long-term goals and tasks required for school success. In sum, students with mental health problems typically find school a daunting and often unsuccessful experience.

While students with mental health disorders often find it hard to deal with school, the reverse is also true: Schools often find it hard to deal with the challenging behaviors that sometimes accompany mental health disorders. Students with disruptive behavior disorders can create havoc in classrooms, particularly if supports are not in place for those students. Teachers can find themselves stressed and dispirited trying to manage the behavior of these students, while at the same time trying to meet the needs of the other students in the room. And it is not just disruptive behaviors that present a challenge for teachers. Just as difficult, though in a very different way, are behaviors that are often associated with mood disorders. Students with mood disorders may seem so lost in their own distress that they lack any kind of motivation in the classroom—or manifest their unhappiness through a prickly irritability. School counselors, administrators, and other school staff can experience the same frustration and helplessness as classroom teachers and are often at a loss for how to assist teachers who are pleading for ideas to help students with mental health disorders.

As difficult as it can be for teachers and school counselors, however, the greatest share of negative consequences falls directly on the students with mental health needs. For students with disruptive behavior disorders, these negative consequences include impaired relationships, a higher incidence of juvenile delinquency, and a greater risk of substance-abuse problems. As adults, they have a greater likelihood of imprisonment, as well as stunted educational and career outcomes (Barkley, Fischer, Smallish, & Fletcher, 2006; Elkins, McGue, & Iacono, 2007; Ferguson, Horwood, & Ridder, 2005). For students with mood disorders, these negative consequences can include difficulties with social relationships, an increased risk of substance abuse, and a higher rate of suicide. Negative adult outcomes

include an elevated risk of mental health problems and a diminished sense of basic happiness (Birmaher et al., 1996; Colman, Wadsworth, Croudace, & Jones, 2007; Rao, Weissman, Martin, & Hammond, 1993; Rohde, Lewinsohn, & Seeley, 1994; Weissman et al., 1999). Other mental health disorders also come with their own negative consequences. Finally, for many students with mental health problems, there is an immediate and crippling consequence: a pervasive sense of pain, frustration, and discouragement.

WHAT IF EVERYTHING IS BEING DONE RIGHT?

Even in the best of circumstances, school counselors and other school professionals can benefit from knowledge of intervention guidelines and strategies for working with students with mental health problems. Let's imagine the best possible situation for a child with a mental health disorder, taking the case of a child we will name David. We will assume David's disorder is attention-deficit/hyperactivity disorder (ADHD).

David's ADHD was properly diagnosed by a child psychiatrist following a thorough medical and behavioral assessment. As a part of the medical portion of the assessment, the question of whether to prescribe medication was discussed and a thoughtful decision about medication was made based on the nature of the behaviors and the wishes of David and his parents. David's parents were referred to an ADHD parent-support group, where they are learning how to support David as well as learning behavioral strategies to manage his behavior. David is seeing a community-based licensed professional counselor who is providing emotional support and teaching him organizational and self-management strategies.

The assessment process and the multifaceted support described are excellent. Shouldn't that be enough? Well . . . probably not. Even though David receives ample professional and family support *outside* of school, he still needs additional support for time *inside* of school. He spends six or more hours a day in school and very likely displays behaviors in the classroom that detract from his academic and social success. Because of the pervasive neurobiological impact of ADHD—in other words, the way ADHD has affected the way his brain is wired—David struggles to pay attention in class, tends to blurt out answers that disrupt the class and annoy his classmates, has trouble organizing his material, and becomes easily frustrated and unhappy. And this even with much support from his family and from community health professionals!

Needless to say, many students with mental health problems do not enjoy the kind of support that David receives. In fact, the students with the greatest mental health needs are often the ones most lacking in

out-of-school support. This is partly because demands associated with mental health problems exert stress on families—and stress tends to exacerbate symptoms (Hanson et al., 2006). The resulting cycle (stress intensifies symptoms, which leads to increased stress, which intensifies symptoms, and so on) increases the student's need for mental health support.

All of these reasons—the large numbers of students with mental health problems, the way mental health disorders lead to suffering and reduced opportunities, the lack of coordinated out-of-school support for many of these students, and the fact that they spend many hours each week in classrooms—illustrate the importance of finding ways to assist students with mental health needs *in schools and in classrooms*. The ensuing chapters provide many ideas for ways school counselors can work directly with students with mental health problems, both in individual and group settings. Guidelines and strategies for effectively working with students with mental health problems in classrooms are also presented, giving school counselors tools to share with teachers who are struggling to assist students with ADHD, depressive disorders, anxiety problems, or other mental health problems that are so prevalent in today's schools. Dedicated school counselors, teachers, administrators, and other school personnel *can* make a difference in the lives of students with mental health problems.

A CHILDREN'S MENTAL HEALTH MINIPRIMER

To best respond to the mental health needs of youth, school counselors and other educators need some basic knowledge of mental health services and issues. This section will discuss the two systems in this country intended to address children's mental health needs, the diagnostic manual used by virtually all community-based mental health providers, and the best way to think about mental health labels. First, let's begin by examining the current systems in place to address the mental health needs of youth.

DSM Versus IDEA: Two Sides of the Same Coin

There are two main systems in place in the United States to describe and address the mental health needs of children and adolescents (see Table 1.1). The school-based system most often used for addressing the mental health needs of youth is the special education system (some student mental health needs are addressed through plans developed in accordance with Section 504 of the Rehabilitation Act of 1973). The special education system, as governed by the Individuals With Disabilities Education Act (IDEA 2004) is the system mandated in U.S. public schools to provide for the educational needs of students with disabilities. Some of these disabilities are characterized

Table 1.1 DSM Versus IDEA

DSM	IDEA
Main purpose: provide a reliable and valid classification of mental disorders	Main purpose: insure that all children have equal access to public education
Deals with mental disorders	Deals with educational disabilities
Broad scope, addresses all mental health problems	Narrower scope, addresses only problems that affect educational progress
Includes specific criteria for disorders but does not discuss how to assess disorders	Does not include specific criteria for disability areas but does present requirements for assessment (e.g., the assessment must be completed by a multidisciplinary team)
Describes specific disorders (e.g., generalized anxiety disorder)	Describes broad families of problems (e.g., emotional/behavioral disorder)
Classifies patterns of behavior	Classifies patterns of behavior

Source: Adapted from concepts in House, 2002.

by emotional and behavioral problems. In fact, one of the disability categories described in IDEA is specifically intended for students with emotional and behavioral needs. Different states use slightly different labels for this category; some use ED (emotional disturbance), some use BD (behavioral disorder), and my home state of Minnesota uses EBD (emotional/behavioral disorder).

The community counterpart to the school-based special education system is the community-based mental health system. This is the system with which families interact when they take their child to their doctor with concerns about the child's hyperactive behavior, or depressed mood, or anxiety, or other emotional or behavioral concerns. This is the system families interact with when they take their child to a local counseling clinic or a clinic specializing in child and adolescent emotional and behavioral problems. Professionals in these settings generally conceptualize and diagnose mental health problems using the *DSM* (*Diagnostic and Statistical Manual of Mental Disorders*, American Psychiatric Association [APA], 2000), which is a diagnostic manual that describes scores of mental disorders.

A DSM PRIMER

Terminology

Depending on the level of precision of the speaker, you may hear the terms *DSM*, *DSM-IV*, or *DSM-IV-TR*. These expressions are often used interchangeably to refer to either the manual or the classification system (based on criteria in the manual):

- *DSM: Diagnostic and Statistical Manual of Mental Disorders*. The original American Psychiatric Association manual was published in 1952. The classification of disorders, based on criteria in this manual, became known simply as the DSM system.
- *DSM-IV: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*. The fourth edition, published in 1994, updated criteria for the classification system. Speakers still often refer to the well-known DSM-IV system.
- *DSM-IV-TR: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*. This revision, published in 2000, is the most current edition. The criteria remain unchanged from the fourth edition; however, updated supporting research and clinical findings were included.

Why so many acronyms? Partly because *DSM*, by design, is periodically revised to reflect new research findings and clinical advancements. The diagnostic criteria that are the core of *DSM* are currently in their fourth incarnation, hence the label *DSM-IV*. However, in 2000, six years after *DSM-IV* was published, a text revision (the *TR* part) was published that did not change the diagnostic criteria but did include updated research and clinical findings regarding the disorders. Thus, the label *DSM-IV-TR*. Some people, though, may want to refer to the ongoing system of DSM rather than a specific edition, for example, if they were to say, "For the past 50 years, the categorization of mental disorders in the United States was most often done using the DSM." Other people may just want to speak in shorthand. Both groups would use the label *DSM*. For purposes of this book, I will use *DSM* to refer to the general classification system and simply *DSM* (with italics) to refer to the manual *DSM-IV-TR* (APA, 2000), which includes the most-current DSM criteria for mental disorders and the most-current supporting literature.

Purpose

DSM is intended to be a universally agreed-upon system of classifying and describing mental disorders. This is an important purpose; if disorders can be reliably and validly identified and classified, then they can be researched and disorder-specific treatments can be developed and delivered. An effective classification system also enhances professionals' ability to communicate with each other regarding clients and patients, as it provides a common language to describe problems.

Multiaxial Format

While the most familiar parts of *DSM* are the diagnostic criteria it includes, it is more than just a collection of disorders and diagnostic criteria. In an effort to provide a more comprehensive portrayal of individuals, *DSM* includes five main components, or *axes*, that can be used to examine and describe a person's problems:

- **Axis I:** This axis includes the majority of clinical disorders that bring people to the attention of mental health professionals, such as mood disorders, anxiety disorders, and disruptive behavior disorders. It also includes "other conditions that may be a focus of clinical attention," which are conditions such as parent-child relational problems and bereavement.
- **Axis II:** This axis is for lifelong conditions that impact multiple aspects of a person's functioning. Included in Axis II is mental retardation and an array of personality disorders, such as borderline personality disorder and antisocial personality disorder. Some mental health clinicians use *Axis II* as a shorthand way of saying that a client has some fundamental personality characteristics that cannot be expected to change (e.g., "I think this client has some Axis II stuff going on").
- **Axis III:** This axis includes medical conditions that are relevant to a person's Axis I or Axis II disorder. Note that there must be a connection between the medical condition and the mental disorder. A person may have ADHD and have been recently diagnosed with breast cancer; however, if there is not a connection between the two, there would be no reason to list the cancer diagnosis on this axis. If a person was diagnosed with breast cancer and subsequently became severely depressed, and the cancer diagnosis contributed to the depression, then it would be included on Axis III.
- **Axis IV:** This axis is for psychosocial and environmental problems that impact a person's Axis I or Axis II disorder. This is *DSM's* attempt to move beyond a straight medical model and acknowledge the many outside influences that impact people's mental and behavioral functioning. Examples of psychosocial and environmental problems that could be listed on Axis IV for a child or adolescent are parental divorce, extreme poverty, and being the victim of an assault. As with Axis III, problems listed on Axis IV must be related to the person's mental disorder.
- **Axis V:** This axis provides a *Global Assessment of Functioning*, or GAF. GAF consists of a single number that describes a person's overall level of functioning. It is on a scale of 1 to 100; scores below 70 indicate some level of distress or impairment, with scores below 50 indicating very serious problems. The GAF score can be used in a variety of ways, such as giving both a current measure of overall functioning and indicating the highest level of functioning the person has displayed in the past year. Some treatment facilities provide GAF scores at admission and at discharge to portray the amount of progress patients have achieved.

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Specifiers and NOS

DSM uses *specifiers* to provide additional information about some Axis I and Axis II diagnoses. Specifiers can be used to reflect the severity of some disorders (mild, moderate, or severe) and describe the course of disorders (e.g., in partial remission or in full remission).

One unique type of specifier is NOS, which stands for *not otherwise specified*. This designation is used when the symptom presentation does not meet full criteria for a disorder, yet significant concerns remain. For example, a person may only display three symptoms of a disorder even though the criteria require at least four specific symptoms. In the hands of a wise and experienced clinician, the NOS label can be a helpful tool to acknowledge real problems that just don't quite fit the formal criteria; in other cases, it can lead to sloppy and imprecise labels. A school counselor who learns that a student has, for example, a depressive disorder NOS label can presume that the student has some depressive symptoms but also should be careful not to place too much weight on the label.

DSM Critique

While *DSM* is the standard diagnostic system for mental disorders in the United States, it is not without critics. Even with its efforts to create a multiaxial system that accounts for medical, social, and environmental influences on behavior, it is still at its core a system that locates problems within the individual. In addition, it has been criticized for not accounting for cultural variations in behavior and emotional expression and, thereby, identifying a disproportionate number of minority group members with mental disorders (White Kress, Eriksen, Rayle, & Ford, 2005). Finally, some researchers suggest that a categorical system like *DSM* does not reflect human behavior as well as a dimensional approach that places individuals' behavioral and emotional symptoms on a continuum. In other words, rather than relying on an either-or way of thinking (I am either depressed or not depressed), it is more accurate to describe *how much* of a collection of symptoms a person has (I am more depressed than most people but not as depressed as some).

General knowledge of *DSM*, the disorders it describes, and the way it is used by mental health professionals is very helpful for school personnel for purposes of both communication and credibility (Jones, 1997). Knowledge of *DSM* allows school personnel to speak the language of mental health professionals, thereby facilitating communication. While it is not part of school counselors' role to use *DSM* to diagnose students, knowing enough about *DSM* to be conversant with the language of the mental health system also enhances the credibility of school personnel

with both mental health professionals and families, who often learn the jargon of the mental health system through the popular media and through dealings with the mental health system. School counselors who are able to have knowledgeable conversations with parents about children's mental health issues come across as being much more credible and helpful.

THE MEANING OF A MENTAL HEALTH DIAGNOSIS

In addition to developing enough familiarity with mental health diagnoses to be able to talk intelligently with mental health professionals and parents, it is also important that school personnel understand what a mental health diagnosis does and does not mean. It is not unusual for students in K–12 schools to have diagnoses of mental disorders. And yet, these diagnoses are often viewed by teachers, administrators, and even school counselors as being mysterious and unsettling. Particularly in the case of students with more-obscure diagnoses, such as reactive attachment disorder or intermittent explosive disorder, school personnel often know that the diagnoses indicate that something is seriously wrong, but they do not know exactly what the problems are or what can be done about them.

It does not need to be that way. Mental health diagnoses should not elicit fear and anxiety from school personnel. Oftentimes, the negative reaction that school personnel have upon hearing about a diagnosis is not due as much to questions about the specific diagnosis as it is to a general lack of understanding about what mental health diagnoses mean and do not mean. While it is not realistic for school personnel to have a deep and thorough understanding of the detailed criteria and research base for a specific diagnosis, it is possible for them to generally begin thinking about mental health diagnoses in a way that is more useful and realistic. This involves striking a balance. It is a mistake for school personnel to place too much emphasis on a diagnosis, but it is also a mistake to dismiss mental health diagnoses as having no relevance to the schools. First, there are some reasons why school personnel should not overvalue mental health diagnoses:

- *Diagnoses can be influenced by the requirements of insurance companies.* Insurance companies may not reimburse mental health providers unless there is a *DSM* diagnosis and may only provide reimbursement for some *DSM* diagnoses. Accordingly, some mental health providers may shade their diagnostic decisions in a way that provides maximum insurance reimbursement. This is not ethical, but it happens.
- *The diagnostic process is taken more seriously by some clinicians than others.* Some clinicians are more invested in making an accurate diagnostic

decision than others. This may be a function of the agency where the child is seen; the purpose of some agencies is individual and family counseling, and diagnoses may be viewed as necessary evils that are done as expediently as possible. Other clinics or hospital programs have the identification of an accurate diagnosis as their main purpose and specialize in thorough, multidisciplinary assessments.

- *The time devoted to developing a diagnosis differs depending on the agency.* Some agencies or clinics require clinicians to develop at least a working diagnosis after the first session. Others allow more time.
- *Diagnoses often change over time.* It is not unusual for adolescents to have had multiple, and changing, mental health diagnoses over the course of their lives. A file review may show that a 16-year-old with a diagnosis of bipolar disorder had a diagnosis at age 7 of oppositional defiant disorder and a diagnosis at age 12 of dysthymic disorder. This does not necessarily mean that the earlier diagnoses were wrong. They were probably the diagnoses that best fit the array of symptoms displayed at those earlier points in time.
- *The diagnostic criteria and categories are constantly undergoing professional debate, and there is not complete agreement among professionals about the validity of the current criteria.* There is a reason why the DSM system is revised on a regular basis. As researchers learn more about the nature of mental disorders, the criteria should be updated and refined accordingly. But the ongoing revision process illustrates that the current criteria are not perfected.
- *Even if a diagnosis is 100% accurate, it cannot dictate specific school-based interventions.* There is not a one-to-one correspondence between diagnoses and specific school interventions.

Clearly, there are reasons why mental health diagnoses should be viewed with a touch of skepticism. However, it is also true that diagnoses can provide useful information for school personnel. So, given the points made above, let's talk about how diagnoses should be viewed. Mental health diagnoses can be viewed as the best attempt on the part of community-based practitioners, such as psychologists, licensed social workers, licensed counselors, and psychiatrists, to make sense of the unique set of behaviors and emotions displayed by a child or adolescent. Stated differently, diagnoses are practitioners' best attempt to filter the behavioral and emotional symptoms of their young clients through the lens of a set of standard diagnostic criteria (the DSM system) and determine which, if any, diagnoses fit the symptom presentation. A mental health diagnosis is best viewed as a snapshot—a shorthand label that best describes the way a child or adolescent is thinking, feeling, and behaving at one point in time. A diagnosis made at age 7 should not be expected to accurately describe the child at age 16, though it can be a useful marker of the child's mental health history.

There are potent benefits that can come with a mental health diagnosis. Diagnoses can help families, teachers, and school counselors develop a better understanding of why the affected children and adolescents are behaving the way they are. Take the example of a child who seems to ignore directions, spends class time blurting out answers, bothers nearby children, stares out the window, and routinely forgets to complete homework. This child's parents and teachers likely feel considerable frustration and may find themselves taking out their irritation on the child. Imagine now that the student is evaluated and is diagnosed with ADHD. Parents and teachers may look at the child's behavior in a much different light and feel much more apt to respond to challenging behavior with patience and understanding. Perhaps most important, the child may form a more positive self-image, and begin to feel less like a failure and a bad kid and more like a person with a medical condition. The reality is that in the absence of an explicit label such as ADHD, children and adults tend to develop and assign their own unstated labels, which are often pejorative labels such as "willful," "lazy," and "irresponsible." These informal, unconscious labels can be much more stigmatizing than formal mental health labels.

Mental health diagnoses can be used to inform—but not prescribe—school-based interventions. A diagnosis can suggest general intervention approaches and can be viewed as a starting point for the development of more-specific interventions. As noted above, the diagnostic process is not an exact science, so the intervention direction that is suggested by the diagnosis should be viewed as tentative. But that is one of the guiding principles of intervention planning anyway; it is always best to constantly monitor the effectiveness of interventions and modify them if they are not working well.

FINAL THOUGHTS

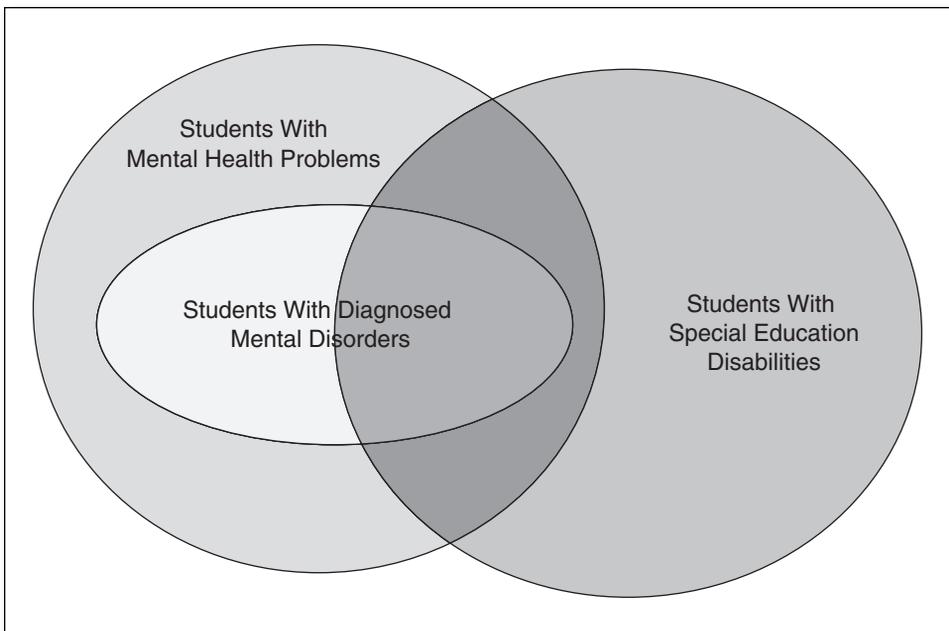
The two systems designed to help children with mental health problems—the community-based system using *DSM* (APA, 2000) and the school-based special education system—have some similarities and also important differences. Perhaps the most important reason a working knowledge of *DSM* and the mental health system is useful for school counselors and other school personnel is because it helps them serve as better guides for parents and families who are trying to navigate these two similar-but-different systems. It is not unusual for community mental health professionals to have an incomplete or distorted understanding of the programs schools have for assisting youth with mental health needs. It is also not unusual for school counselors and other school personnel to lack a thorough understanding of the community mental health system. So it is very understandable, and even predictable, that parents struggle to make sense of these two systems.

The key point is that there is partial, but not complete, overlap between the way schools and the way physicians and community mental health professionals describe mental health problems. As represented in Figure 1.1, some students with a mental disorder may also receive special education services at school. However, it is also possible for a student with a mental disorder to receive no special education assistance. And it is possible for a student to receive special education services—even in the emotional-behavioral domain—but have no diagnosed mental disorder.

In one sense, the distinctions between educational disabilities, mental health disorders, and subclinical mental health problems are irrelevant for the purposes of intervention. School counselors who want to help students with mental health problems are most in need of practical interventions that they can effectively implement during individual and small-group counseling. Likewise, teachers are most in need of realistic and effective intervention strategies that they can implement in the classroom. The best assessment, one that results in a valid assignment of a special education disability label or a mental health diagnosis, is of little use if it is not followed by effective intervention.

It is critically important that parents, students, and school personnel understand that *the child comes first and the label comes second*. It is crucial that school counselors and other school personnel view labels in the context of the many facets of each individual student. *Labels do not define those*

Figure 1.1 Relationships Among Special Education Disabilities, Diagnosed Mental Disorders, and Mental Health Problems



to whom they are applied. Labels can tell us some important things about a student, but the information a label can provide is not nearly as important as knowing what the student likes, how she enjoys spending her free time, what his interests are, what she is good at, and what he worries about. Two students with an identical mental health diagnosis can behave in vastly different ways and respond to school and teachers and interventions very differently. The art and science of mental health diagnoses and interventions is highly individualized.

Finally, it is important to note that even though children's mental health problems are often addressed by distinct and separate school and community-based systems, there are a growing number of programs and initiatives designed to coordinate the efforts of schools and community mental health services in order to better serve children (Weist & Evans, 2005). Good work is being done both in the United States (e.g., Paige, Kitzis, & Wolfe, 2003) and internationally (e.g., Wyn, Cahill, Holdsworth, Rowling, & Carson, 2000) to develop schoolwide systems that promote positive student mental health, including the development of school-based mental health programs. Hopefully, these programs will continue to proliferate, providing students in K–12 schools with better and more-accessible mental health services.

SUMMARY POINTS

- Large numbers of students in K–12 schools have diagnosable mental health disorders, and many more have mental health issues that while not rising to a diagnosable level still create significant problems.
- Mental health disorders come with an array of negative consequences, including social, emotional, and academic problems.
- Mental health disorders among youth are often undiagnosed and untreated. Even when disorders are correctly diagnosed and adequately treated, school-based and classroom-based interventions and supports can still be helpful.
- School counselors are well positioned to provide support to students with mental health disorders or mental health problems, as well as to work with these students' teachers and parents.
- General knowledge about specific mental health disorders is helpful, but learning about the strengths, areas of need, and individual personalities of the student is always more important than knowing the name of the student's mental health disorder.