

IMPACT OF IDENTIFYING MENTAL ILLNESS AND THE TEACHERS ROLE OF
IMPROVING MENTAL HEALTH THROUGH SOCIAL AND EMOTIONAL
LEARNING

by

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Abstract

Student mental health challenges have become a major area of concern. Research suggests that many mental health problems and disorders in children might be prevented or ameliorated with prevention, early detection and intervention. Unfortunately, traditional teacher training programs are insufficient and lack knowledge and skills to identify and intervene with students at risk for mental health. Educators need to be equipped with a fundamental knowledge of factors that influence not only the development of mental illness in those they serve, but also those proactive strength-based prevention efforts which promote mental health and resiliency. Addressing children's mental health is critical for school and life success. Evidence-based social and emotional learning (SEL) programs support aspects of mental health by developing fundamental emotional and social competencies to recognize and manage emotions; establish and initiate positive friendships; resolve conflicts respectfully and make ethical, safe and responsible decisions. In addition, findings demonstrate that social and emotional programs implemented by teachers improve children's behavior, attitudes toward school, and academic achievement.

Chapter 1: Introduction

This paper has three objectives. First, to review, analyze, and draw implications from current literature regarding the mental health of children and youth today. The second objective examines traditional training preparation for teachers proving they are insufficient and lack specific evidence-based knowledge and skills to identify and intervene with students at risk for mental illness. The final objective is to prove that teachers using comprehensive, evidence-based social and emotional (SEL) programming can help reduce or eliminate the progression of children inflicted with mental illness and promote positive mental health of all students.

Epidemiological research indicates a high prevalence of psychiatric disorders among children and adolescents. The United States Public Health Service (2000) estimated that approximately 21% of children and adolescents in America, ages nine to seventeen, had a diagnosable psychiatric disorder. The most common diagnosed mental illnesses that display symptomology in childhood and early adolescence include: impulse-control, mood, and anxiety disorders.

Increasingly, school-based personnel are faced with students who present with growing mental health concerns. While the rate of mental illness in youth continues unabated in the United States, and with the numerous contributing etiological factors, questions were raised about the training adequacy of school-based personnel to combat this growing concern in today's school environment (Morris, 2002). To illustrate, Rones and Hoagwood (2000) suggested that university-based pre-service educational training programs do not adequately prepare and thus provide sufficient knowledge, skill, or field experience to work with children in, schools who present with mental health problems.

Socially and emotionally competent classrooms and schools are at the core of effective learning (Kress, Norris, Schoenhotz, Elias, & Seigle, 2004). Social and emotional learning broadens the framework of education and addresses the complex interplay of emotions and cognition in learning, remembering, and understanding. Learning is a process closely linked to students' social and emotional needs, as well as the context of their learning environment (Brandt, 2003). When it comes to the impact of mental health on academic outcomes, the research is catching up with veteran teachers leaders' observations: developing social-emotional competence is the key to success in school and in life (Elias, O'Brien, & Weissberg, 2006).

It is important for schools to identify and effectively implement evidence-based approaches that promote children's social, emotional, and academic engagement and growth in the early years of school. According to Diekstra, (2008) research conducted during the past few decades indicated social and emotional learning (SEL) programming for elementary and middle-school students is a very promising approach to promoting positive adjustment, improving students' social-emotional skills. Scientific reviews also revealed a reduction in students' conduct problems and emotional distress. SEL programs proved successful across the K-8 grade range with racially and ethnically diverse students from urban, rural, and suburban settings. They also yielded multiple benefits for students with and without behavioral and emotional problems (Payton, et al., 2008).

Statement of Problem

Studies revealed one in five children has a diagnosable mental disorder. One in 10 youth, ages 12-17, has serious mental health problems that are severe enough to impair how they function at home, school, or in the community. Left untreated, childhood disorders are likely to persist and lead to a downward spiral of school failure, limited or nonexistent employment opportunities, and poverty in adulthood. No other illnesses harm so many children so seriously (New Freedom, 2003). Half of all lifetime cases of mental disorders begin by age 14 (National Institute of Mental Health [NIMH], 2005). Government agencies are increasingly aware of the prominence and depth of this problem, to date, no universal systematic changes have been made to mandate pre-service teacher competency in the recognition and early intervention of specific mental health needs of youth in schools (Koller & Svoboda, 2002).

Research Questions

Should teacher training programs include prevention, identification and intervention of mental health disorders? What can teachers do to promote positive mental health with their students?

Definition of Terms

Anxiety disorders – are characterized by an irrational fear of a situation of stimulus that is in excess of what would be considered reasonable and age appropriate. Common symptoms include restlessness, fatigue, difficulty concentrating, irritability, muscle tension, or sleep disturbances (McLoone, Hudson, & Rapee, 2006).

Attention deficit hyperactivity disorder - (ADHD) is an illness characterized by inattention, hyperactivity, and impulsivity. The most commonly diagnosed behavior disorder in young persons, ADHD affects an estimated three percent to five percent of school-age children (Jensen, 2003)

Bipolar disorder - Children and teenagers with bipolar disorder have manic and/or depressive symptoms. Some may have mostly depression and others a combination of manic and depressive symptoms. Highs may alternate with lows. Research has improved the ability to diagnose bipolar disorder in children and teens. Bipolar disorder can begin in childhood and during the teenage years, although it is usually diagnosed in adult life. The illness can affect anyone. However, if one or both parents have bipolar disorder, the chances are greater that their children may develop the disorder (Bipolar Disorder, 2004).

Conduct disorder - In psychiatry, conduct disorder is a pattern of repetitive behavior where the rights of others or the social norms are violated. Possible symptoms are over-aggressive behavior, bullying, physical aggression, cruel behavior toward people and pets, destructive behavior, lying, truancy, vandalism, and stealing. The diagnostic criteria for conduct disorder as listed in the DSM-IV-TR are as follows: a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as

manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past six months: aggression to people and animals; destruction of property; deceitfulness or theft; serious violations of rules; the disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning; or if the individual is age 18 years or older, criteria are not met for Antisocial personality disorder (APA, 1994).

Depression – Depression is a disorder characterized by persistent depressed (sad) mood which may last months or even years. It can occur at any age through the lifespan. Signs that frequently help parents or others know that a child should be evaluated for depression include: the child talking about feeling persistently sad or blue, the child who talks about suicide or being better off dead, the child who is suddenly much more irritable, has a marked deterioration in school or home functioning, or no longer engages in previously pleasurable social interactions with friends (Ryan, 2003).

DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*) -

An official manual of mental health problems developed by the American Psychiatric Association. Psychiatrists, psychologists, social workers, and other health and mental health care providers use this reference book to understand and diagnose mental health problems. Insurance companies and health care providers also use the terms and explanations in this book when discussing mental health problems (APA, 1994).

Dysthymia - According to the DSM-IV, dysthymia is characterized by an overwhelming yet chronic state of depression, exhibited by a depressed mood for most of the days, for more days than not, for at least two years. (In children and adolescents, mood can be irritable and duration

must be at least one year.) The person who suffers from this disorder must not have gone for more than two months without experiencing two or more of the following symptoms: poor appetite or overeating; insomnia or hypersomnia; low energy or fatigue; low self-esteem; poor concentration or difficulty making decisions or feelings of hopelessness (APA, 1994).

Evidence-based programs - programs that have identified standards to determine their effectiveness and must share a common set of core characteristics including having been tested in a well-designed and methodologically sound study, and have been shown to produce significant reductions in poor outcomes or associated risk factors. (In the health care field, evidence-based practice (or practices), also called EBP or EBPs, generally refers to approaches to prevention or treatment that are validated by some form of documented scientific evidence. What counts as "evidence" varies. Evidence often is defined as findings established through scientific research, such as controlled clinical studies, but other methods of establishing evidence are considered valid as well. Evidence-based practice stands in contrast to approaches that are based on tradition, convention, belief, or anecdotal evidence (National Registry of Evidence-based Programs and Practices [NREPP], 2008).

Generalized anxiety disorder -- Chronic, exaggerated worry about everyday, routine life events and activities Children and adolescents with this disorder usually anticipate the worst and often complain of fatigue, tension, restlessness, or sleeplessness (APA, 1994).

Impulse-control disorders - according to the DSM-IV, impulse control disorders are a loosely grouped set of conditions that have in common that they all centrally feature behavior that is acted out in an uncontrolled, and impulsive manner that often has self-destructive consequences (APA, 1994).

Intermittent explosive disorder (IED) - according to the DSM-IV, IED describes several discrete episodes of failure to resist aggressive impulses that result in serious assaultive acts or destruction of property. The degree of aggressiveness expressed during the episodes is grossly out of proportion to any precipitating psychosocial stressors (APA, 1994).

Mental health - is not simply the absence of detectable mental disease but a state of well-being in which the individual realizes his or her own abilities, can work productively and fruitfully, and is able to contribute to his or her community (World Mental Health, 1995).

Mental illness - is the term that refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning (APA, 1994).

Mood disorder - Mood disorders are among the most common mental disorders and affect millions of people each year. Simply put, a mood disorder is a malfunction of your moods or emotions. This can mean changes in anger, sadness, etc. The two major types of mood disorders are depression and bipolar disorder. Most mood disorders are highly treatable, but some serious ramifications can occur if left untreated. Suicide can result from an untreated mood disorder so it is important to seek help if you think you are suffering from a mood disorder (Bell, 2006).

No Child Left Behind Act - The No Child Left Behind Act of 2001 (NCLB) reauthorized the Elementary and Secondary Education Act (ESEA) -- the main federal law affecting education from kindergarten through high school. NCLB is built on four principles: accountability for results, more choices for parents, greater local control and flexibility, and an emphasis on doing what works based on scientific research (Department of Education, 2001).

National Institute of Health (NIH) - The NIH is an important U.S. health agency. It is devoted to medical research. Administratively under the Department of Health and Human Services (HHS), the NIH consists of 20-some separate Institutes and Centers. NIH's program activities are represented by these Institutes and Centers.

National Institute of Mental Health (NIMH) – its mission in the United States is to "provide national leadership dedicated to understanding, treating, and preventing mental illnesses through basic research on the brain and behavior, and through clinical, epidemiological, and services research."

Obsessive-compulsive disorder (OCD) – Obsessive-compulsive disorder (OCD) is an illness that causes people to have unwanted thoughts (obsessions) and to repeat certain behaviors (compulsions) over and over again. We all have habits and routines in our daily lives, such as brushing our teeth before bed. However, for people with OCD, patterns of behavior get in the way of their daily lives. Most people with OCD know that their obsessions and compulsions make no sense, but they can't ignore or stop them (Obsessive-Compulsive Disorder, 2006).

Oppositional-defiant disorder (ODD) – there is an ongoing pattern of uncooperative, defiant, and hostile behavior toward authority figures that seriously interferes with the youngster's day to day functioning. Symptoms of ODD may include frequent temper tantrums; excessive arguing with adults; active defiance and refusal to comply with adult requests and rules; deliberate attempts to annoy or upset people; blaming others for his or her mistakes or misbehavior; often being touchy or easily annoyed by others; frequent anger and resentment; mean and hateful talking when upset; and seeking revenge. The symptoms are usually seen in multiple settings, but may be more noticeable at home or at school. Five to fifteen percent of all school-age children

have ODD. The causes of ODD are unknown, but many parents report that their child with ODD was more rigid and demanding than the child's siblings from an early age. Biological and environmental factors may have a role (Children With Oppositional Defiant Disorder, 1999).

Panic Disorder - panic disorder is an anxiety disorder. Panic disorder affects about 2.4 million adult Americans and is twice as common in women as in men. It most often begins during late adolescence or early adulthood. People with panic disorder have feelings of terror that strike suddenly and repeatedly with no warning. They can't predict when an attack will occur, and many develop intense anxiety between episodes, worrying when and where the next one will strike. If you are having a panic attack, most likely your heart will pound and you may feel sweaty, weak, faint, or dizzy. Your hands may tingle or feel numb, and you might feel flushed or chilled. You may have nausea, chest pain or smothering sensations, a sense of unreality, or fear of impending doom or loss of control (Kuhn, n.d.).

Post-traumatic stress disorder (PTSD) – is an anxiety disorder that can occur after you have been through a traumatic event. A traumatic event is something horrible and scary that you see or that happens to you. During this type of event, you think that your life or others' lives are in danger. You may feel afraid or feel that you have no control over what is happening. Anyone who has gone through a life-threatening event can develop PTSD. These events can include: combat or military exposure; child sexual or physical abuse; terrorist attacks; sexual or physical assault; serious accidents, such as a car wreck or natural disasters, such as a fire, tornado, hurricane, flood, or earthquake. After the event, you may feel scared, confused, or angry. If these feelings don't go away or they get worse, you may have PTSD. These symptoms may disrupt

your life, making it hard to continue with your daily activities (National Center for PTSD [NCPTSD], n. d.))

Phobias – “Fear” is the normal response to a genuine danger. With phobias, the fear is either irrational or excessive. It is an abnormally fearful response to a danger that is imagined or is irrationally exaggerated. People can develop phobic reactions to animals (e.g., spiders), activities (e.g., flying), or social situations (e.g., eating in public or simply being in a public environment) (American Psychiatric Association, 2005).

Separation anxiety disorder – children demonstrate excessive levels of anxiety when separated or threatened with separation from a major attachment figure, most commonly the child’s parents (McLoone et al., 2006).

Social anxiety disorder - the current DSM-IV definition includes: persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others; the individual fears that he or she will act in a way (or show anxiety symptoms) that will be embarrassing and humiliating; the person recognizes that this fear is unreasonable or excessive; the feared situations are avoided or else are endured with intense anxiety and distress; the avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, individuals under age 18 years, the duration is at least 6 months (APA, 1994).

Social phobia – children with social phobia fear and frequently avoid social situations most commonly involving interactions with others or situations where they may become the object of scrutiny. As a result many social situations will be avoided to prevent the possibility of

embarrassment, or endured with discomfort due to the anxiety they elicit (Dadds & Barrett, 2001).

Specific phobia – is characterized by a distinct and extreme fear associated with a single stimulus or situation, occurring invariably upon its presentation. Common specific phobias include a fear of animals, fear of the natural environment (heights) or situational type fears (riding the bus) (APA, 1994).

Chapter II: Review of Literature

Child and Adolescent Mental Health

Of growing concern, a significant number of youth in the United States experience mental health problems to a degree that impairs daily functioning. Approximately one in five children, or 15 million in the United States, experiences significant symptoms of a diagnosable mental disorder in the course of any one year (Adelman & Taylor, 2000a). Five to nine percent of children can be classified with a diagnosis of a serious emotional disturbance requiring substantive mental health support in a school setting (New Freedom Commission on Mental Health, 2003). Yet, most children and youth, 75% to 80%, who are in need of mental health services, do not receive them (Kataoka, Zhang, & Wells, 2002).

Recent evidence compiled by the World Health Organization indicated that by the year 2020, childhood neuropsychiatric disorders will rise proportionately by over 50 percent, internationally, to become one of the five most common causes of morbidity, mortality and disability among children (Kessler, et al., 2007).

Common mental health illnesses that manifest in childhood and early adolescence include: anxiety, impulse-control, and mood disorders.

Anxiety Disorders

Anxiety disorders are one of the most prevalent childhood mental disorders (Ford, Goodman, & Meltzer, 2003) affecting about 13% of children aged nine to 17 (U.S. Department of Health and Human Services, 1999). Anxiety not only causes distress, but it is also related to higher rates of depression, attention and concentration difficulties, poor self-esteem and increased difficulty developing peer relationships and social behaviors (Costello, Mustillo,

Erkani, Keeler, & Angold, 2003). Therefore, of great importance that people involved in the supervision, emotional growth and well-being of children and adolescents be equipped to recognize anxiety disorders and either provide adequate assessment, treatment or referral in cases of need. One large-scale study, Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA), revealed 13 percent of nine to 17 year olds has an anxiety disorder in a given year (Lahey, Flagg, Bird, Schwab-Stone, Canino, Dulcan, et al., 1996). Common anxiety disorders experienced childhood are specific phobias; social phobias; panic disorders (PD); post-traumatic stress disorder (PTSD); generalized anxiety disorders (GAD) and separation anxiety disorders.

According to the NIMH, fears and phobias are common in young children. Referral rates tend to increase in mid-to-late childhood and early adolescence. Approximately seven to nine percent of children have been estimated to have specific phobia. Specific phobia typically begins in childhood; the median age of onset is seven years. Social phobia begins in childhood or adolescence, typically around 13 years of age (Kessler, Berglund, Demler, Jin Merikangas & Walters, 2005).

Chang (2006) declared that untreated childhood social phobia typically continues into adulthood.

Panic disorder and its estimated age of onset varied among studies. In a recent study (Ost, 2001) reported a mean age of onset for panic disorder across several studies to be 11.6-15.6 years. However, panic disorder tends to be most frequent in late adolescence and young adulthood, with a mean peak onset of 15-19 years.

Post-traumatic stress disorder (PTSD) is the response to some extreme traumatic event and affects more than five million children each year in United States. Studies indicated that 15 to 43% of girls and 14 to 43% of boys have experienced at least one traumatic event in their lifetime. Of those children and adolescents who have experienced a trauma, three to 15% of girls and one to six percent of boys could be diagnosed with PTSD. Studies have shown that as many as 100% of children who witness a parental homicide or sexual assault; 77% of children exposed to a school shootings; and 90% sexually abused (Hamblen, n. d.).

Generalized anxiety disorder (GAD). (n. d.) usually affected children between the ages of six to eleven. Onset is usually before age 20, and a history of childhood fears and social inhibition may be present. Over 80% of patients with GAD also suffered from major depression, dysthymia, or social phobia. Separation anxiety disorder, according to the Saint Louis Behavioral Medicine Institute, affects approximately four percent of children over the age of four. Onset is most common between seven to nine years of age.

If not treated early, anxiety disorders lead to: repeated school absences or an inability to finish school; impaired relations with peers; low self-esteem; problems adjusting to work situations; and predict increased risk for mental disorders and substance use problems later in life (Kendall, Safford, Flannery-Schroeder, & Webb, 2004).

Impulse-Control Disorders

Impulse control disorders include: attention deficit hyperactive disorder (ADHD); obsessive compulsive disorder (OCD); oppositional-defiant disorder (ODD); conduct disorder (CD) and intermittent explosive disorder (IED).

Impulse-control disorders have an extremely narrow age range of onset risk. For example, 80% of all lifetime ADHD begins in the age range four to eleven. ADHD is a condition that becomes apparent in some children in the preschool and early school years. It is hard for these children to control their behavior and/or pay attention. (NIMH, 2000) estimated that between three and five percent of children have ADHD, or approximately two million children in the United States. This means that in a classroom of 25 to 30 children, it is likely that at least one will have ADHD. Obsessive compulsive disorder has become much more prevalent in the past decade. Community surveys of adolescents suggested that at any given time, one percent to over three percent are experiencing symptoms of OCD. Children as young as five or six can show full-blown OCD. Between 30% and 50 % of adults with OCD reported that their symptoms started during or before mid-adolescence (Watkins, n. d.). Approximately one million children and adolescents in the United States suffer from OCD. This can mean three to five youngsters with OCD per average-sized elementary school and about 20 teenagers in a large high school (Rapoprt, 1997). Oppositional defiant disorder (ODD) is a pattern of disobedient, hostile, and defiant behavior toward authority figures with the age of onset between seven to fifteen years, but typically starts by age eight. These children are often stubborn and non-compliant, have outbursts of temper, or become belligerent. They argue with adults and refuse to obey. Some studies have shown that 20% of the school-age population is affected (Steiner, & Remsing, 2007).

Conduct disorder (CD) as a behavior disorder, sometimes diagnosed in childhood, that is characterized by antisocial behaviors which violate the rights of others and age-appropriate social standards and rules. The diagnosis for children ages nine to 17 years old who have conduct

disorders is estimated to be as high as 10 percent (American Academy of Child & Adolescent Psychiatry [AACAP], n. d.). Intermittent explosive disorder (IED) tends to first manifest itself during adolescence, with the average age of the first episode found to be 14 years of age.

Although the majority of people with IED (60.3%) obtained professional treatment for emotional or substance problems at some time in their life, only 28.8% ever received treatment for their anger, while only 11.7% of 12-month cases received treatment for their anger in the 12 months before interview. Fully half of all lifetime IED begins in childhood or adolescence (Kessler, 2006).

Mood Disorders

The most common mood disorders of children and youth are bipolar disorder and depression. Bipolar disorder can occur in children and adolescents and has been investigated by federally funded teams in children as young as age six. Although once thought rare, caseloads of patients examined for federally funded studies have shown that approximately seven percent of children seen at psychiatric facilities fit bipolar disorder using research standards (Child and Adolescent Bipolar Disorder, n. d.). Until recently, young people were rarely diagnosed with this disorder. Doctors now recognize and treat the disorder in young people, but it is still an under-recognized illness. (Roberts, 2007) indicates the number of visits to a doctor's office that resulted in a diagnosis of bipolar disorder in children and adolescents has increased by 40 times over the last decade. Scheffer, Kowatch, Carmody, and Rush (2005) suggested as many as 60 percent of children diagnosed with bipolar disorder in most studies also have attention deficit hyperactivity disorder (ADHD).

On the mental health of children and adolescents, large-scale research studies have reported that up to three percent of children and up to eight percent of adolescents in the U.S. suffer from depression, a serious mental disorder that adversely affects mood, energy, interest, sleep, appetite, and overall functioning (Lakeside, 2002).

At any point in time, 10 to 15 percent of child and adolescents have some symptoms of depression. Major depression strikes about one in twelve adolescents. Among those adolescents that developed major depression, one in 14 will commit suicide as a young adult (Weissman, Wolk, Goldstein, Moreau, Adams, Greenwald, et al. 1999). Statistics showed that children with mental disorders, particularly depression, are at a higher risk for suicide. Lubell, Kegler, Crosby, & Karch, (2007) reported in 2004 suicide was the third leading cause of death for 15-to-24-year-olds, and the fourth leading cause of death for 10-to-14-year-olds. In addition, more than 5,000 U.S. children and adolescents committed suicide and an additional 171,870 non-fatal self harm injury cases were reported.

However, while adolescents and young adults were more likely to use firearms than suffocation, children were dramatically more likely to use suffocation. Gender differences among young people were - almost four times as many males as females ages 15 to 19 and more than six times as many males as females ages 20 to 24 died by suicide. More than 90% of youth suicide victims had at least one major psychiatric disorder, although younger adolescent suicide victims had lower rates of psychopathology (Gould, Greenberg, Velting, & Shaffer, 2003). Half of all lifetime cases of mental illness begin by age 14, three-quarters by age 24 (Kessler, et al, 2005).

Teacher Preparation Programs

With the alarming increase number of children and youth experiencing mental health problems, Rones et al (2000) suggested that university-based pre-service educational training programs do not adequately prepare and thus provide sufficient knowledge, skill, or field experience to work with children who present mental health problems. In addition, they do not include competence in the recognition and early intervention of specific mental health needs of youth in schools (Koller et al., 2002). Increasingly, more children with a variety of emotional needs are included in the general classroom setting, placing increased demands on both the special education and general education teacher. The educator's challenge then, is to not only teach academic content required by the school district, but also the ability to create a classroom environment where all learners' academic and emotional needs are addressed. The recent report of New Freedom Commission (2003) formally recommended that all "Federal, State, and local child-serving agencies fully recognize and address the mental health needs of youth in the educational system" (p. 62), thereby clearly placing emphasis on the involvement of the schools in the promotion of mental health services. According to the report: Schools are where children most of each day. While schools are primarily concerned with education, mental health is essential to learning as well as to social and emotional development. Because of this important interplay between emotional health and school success, schools must be active partners in the mental health care of our children (p. 58).

As stated earlier approximately one in five children, or 15 million in the United States, experiences significant symptoms of a diagnosable mental disorder in the course of any one year (Adelman et al., 2000a); five to nine percent of children can be classified with a diagnosis of a serious emotional disturbance requiring substantive mental health support in a school setting.

(New Freedom Commission on Mental Health, 2003); and yet, most children and youth, 75% to 80%, who are in need of mental health services, do not receive them. (Kataoka et al., 2002).

Although federal and state government agencies are increasingly aware of the prominence and depth of this problem, to date, no universal system systematic changes have been made to mandate pre-service teacher competency in the recognition and early intervention of specific mental health needs of youth in schools (Koller et al., 2002).

As a result, teachers are increasingly faced with students who lack the optimal social and emotional resources to focus and, therefore, benefit from academic instruction in the classroom (Koller, Osterlind, Paris, & Weston, 2004). As well, regarding in-service assistance for teachers already employed, Greenburg, Domitrovich, and Bumbarger (2000), found inadequate assistance to combat today's behavioral and mental health problems found in schools. That is, most school-based efforts are reactive rather than proactive. Thus, as training standards for teachers which are typically established by state accrediting agencies and/or national professional organizations and teacher quality becomes ever more narrowly defined by subject matter pedagogical skills, the development of positive social and emotional skills of youth are left to chance or not addressed. According to Oddone (2002), "pressures to demonstrate progress in school performance, as illustrated by improved test scores, threaten to relegate mental health, safety, and other issues that reflect overall student well-being to the sidelines, as though these concerns are not relevant to the mission assigned to schools" (p. 274). In addition, due in part to the federal enactment of the No Child Left Behind Act, schools, and as a result, teachers, are increasingly pressured to demonstrate student academic progress. This is especially apparent in the mandates to increase student state and local achievement test scores. In the process, however, this pressure had a

negative effect on the classroom teacher by raising his or her stress level to improve student performance by increasing the focus on academic achievement.

However, according to the National Board for Professional Teaching (2003), a teachers' mission "extends beyond developing the cognitive capacity of their students" implying that teachers are also concerned with student development in other areas including the development of positive mental health and character. In addition, National Council for Accreditation of Teacher Education standards (2002) stated that new teachers graduating from NCATE-accredited institutions "are able to handle the demands of a classroom on day one--hot through on-the-job training" (p. 2). However, with the increasing prevalence of students with mental health concerns in schools today and the lack of specific pre-service preparation in the area of mental health prevention, new teachers are not able to meet the overwhelming individual demands of all students in the classroom (Koller et al., 2004).

In fact, Koller and his colleagues (2004) found that, overall, both first-year baccalaureate teachers (both regular and special education) graduating from NCATE-approved colleges of education and their experienced mentors/many with graduate teaching degrees through the doctoral level, felt unprepared to recognize and/or intervene in typical mental health issues confronting today's teachers. This included daily problems such as identifying and assisting with an anxious student, recognizing potential signs of childhood depression and/or stress, or helping the friendless child. Yet, all teachers, both first-year graduates and their experienced mentors, regardless of their academic preparation, unanimously agreed that knowledge of the mental health needs of youth are critically important for all teachers to experience success in today's classroom. Interestingly, both the first-year and mentor teachers rated their own mental health

(e.g., teacher stress, pressure to raise student achievement test scores, fear of classroom violence, or how to communicate with an irate parent) as being a significant concern, yet felt unprepared to recognize and manage the signs and symptoms of their own stress and burnout.

In addition, Morris (2002) reported that both pre-service and in-service general elementary education teachers hold a strong interest and desire for more basic information regarding children's mental health issues, but this information is not typically offered in the regular or special teacher education program at a level requiring competence. The teachers questioned in this study came from two large Midwestern university-based NCATE-approved teacher education programs and the results defy common perceptions that only special education teachers need training in the area of mental health. In point of fact, the results strongly supported that special education trained teachers are not exempt from pre-service instruction in mental health.

As children are increasingly placed in the general education classroom setting, due, in part, to factors including mandated inclusion, an increased emphasis is placed upon the general education teacher to be prepared for issues other than academic content (Gable & Van Acker, 2000). In addition, since children spend the majority of a school day in the classroom where the teacher is the only adult present, the teacher assumes an influential role in the development of the child from both an academic as well as personal, social and emotional perspective (Koplewicz, 1996). Hence, it is essential that teachers are equipped with a fundamental knowledge of factors that influence not only the development of mental illness in those they serve, but also those proactive strengths-based prevention efforts which promote mental health and resilience.

Similar to pre-service teacher mandated requirements, pre-service standards also lack for

school administrators in the areas of student and staff mental health promotion. According to the National Policy Board for Educational Administration (2002), "successful educational leaders must be able to identify, clarify, and address barriers to student learning and communicate the importance of developing learning strategies for diverse populations." (p. 6). Although this standard stated the importance of addressing barriers to student learning, specific issues related to the prevention of mental health problems are not recognized as one of these barriers. This suggested that administrators, who are the leaders of the school, may not be adequately prepared to identify, intervene or prevent the common mental health concerns of their students and staff. For example, a review of the research literature suggested that teachers who are isolated from other colleagues, who encountered difficult relationships with students and parents, who experienced a lack of consistent support from parents, or who experienced a lack of understanding, support, and leadership from administrators are at high-risk for burnout (Brock & Grady, 2000). In fact, teachers reported reluctance to confide in school administrators about their own stress problems for fear of reprisal, and/or job loss (Koller et al., 2004). Without the support and endorsement of the school administrator, evidence-based practices in school are typically not integrated. Therefore, if the administrative leaders of the school have not been trained in, are not committed to, or do not know how to integrate mental health practices, it will be difficult to create a positive school environment that fosters the mental health of students and staff (Brock et al., 2000).

Social and Emotional Learning

Many mental health problems and disorders in children might be prevented or ameliorated with prevention, early detection and intervention (Centers for Disease Control and

Prevention, 1999). In addition, Karoly (1998) implied that overall, prevention and early intervention efforts targeted to children and youth have been shown to be beneficial and can improve school readiness, academic achievement and reduced the need for grade retention and special education services, and welfare dependency.

Many of today's prevention and promotion initiatives are uncoordinated, fragmented and assume that when a problem arises the fix can and should be simple or quick, which does not contribute to their collective effectiveness. When students fail or an unexpected outbreak of negative behavior among students occurs, often the first question the public asks is, "Who is to blame?" typically the next step is to adopt programs to "target" the problem. Schools nationally implement a median of 14 practices (among them, metal detectors, advisory periods, recreational activities, architectural features of the school, school change management practices, and informational posters and brochures) to prevent problem behavior and promote safe environments (Gottfredson & Gottfredson, 2001).

Social and emotional learning is related to other national youth development and prevention initiatives, such as character education and school-based health promotion programs. But SEL is significantly different because it systematically addresses the numerous social and emotional variables that place youth at risk for school failure, such as a lack of attachment to a significant adult or the inability to manage emotions. SEL provides educators with a common language and framework to organize their activities. Instead of focusing on a single subject or problem, such as drug abuse or suicide, SEL in an inclusive approach that covers the entire spectrum of social and emotional competencies that has lead a student to destructive behavior (CASEL, 2007).

Social and emotional learning (SEL) involves processes through which children develop fundamental emotional and social competencies to recognize and manage emotions, develop caring and concern for others, establish positive relationships, make responsible decisions, and handle challenging situations constructively. These skills, for example, allowed children to calm themselves when angry, initiate friendships and resolve relationship conflicts respectfully, and make ethical and safe choices. It is based on the knowledge that our emotions and relationships affect how and what we learn. It is grounded in research findings that social and emotional skills can be taught and that they promoted positive development, reduced problem behaviors, and improved children's academic performance, citizenship, and health-related behaviors (Greenberg et al., 2003).

The meta-analysis of SEL programs summarized the following benefits for students: 9% decrease in conduct problems, such as classroom misbehavior and aggression; 10% decrease in emotional distress, such as anxiety and depression; 9% improvement in attitudes about self, others, and school; 23% improvement in social and emotional skills; 9% improvement in school and classroom behavior; and 11% improvement in achievement test scores. There were three other key findings from the analysis. Students achieved significant gains across the six areas only when the SEL program were well-implemented; classroom teachers were the primary implementers; and programs characterized as sequenced, active, focused and explicitly "S.A.F.E.", and targeted particular skills (Payton et al., 2008).

There is extensive evidence that the two key elements of evidence-based SEL programs—(1) creating positive school learning environments (Elias, 2006) and (2) providing SE competency instruction—result in greater academic performance and better long-term life

outcomes (Payton, Graczyk, Wardlaw, Bloodworth, Tompsett, & Weissberg, 2000). These two key elements of SEL programs are mutually reinforcing. Classrooms filled with socially and emotionally skilled students are more caring and safe, and positive learning environments provide opportunities for students to use and further develop SE competencies.

Chapter III: Results and Analysis to the Problem

One of every five children and adolescents has a mental disorder, and one in ten has a serious emotional disturbance that affects daily functioning during a given year (National Institute for Health Care Management [NIHCM], 2005). Mental disorders in children are diagnosed based on signs and symptoms; however, diagnosing mental illness in children can be especially difficult.

Many behaviors that are seen as symptoms of mental disorders, such as shyness, anxiety (nervousness), strange eating habits and outbursts of temper, can occur as a normal part of a child's development. Behaviors become symptoms when they occur very often, last a long time, occur at an unusual age or cause significant disruption to the child's and/or family's life. Without early and effective identification and interventions, childhood disorders can persist and lead to a downward spiral of school failure, poor employment opportunities, and poverty in adulthood (President's New Freedom Commission on Mental Health, 2003).

Currently at the pre-service level teachers receive little, if any, specific competency-based training regarding their role in knowing how to identify mental health issues facing students today. They indicated that their pre-service college courses did not address mental issues in the classroom. Consensus among school staff reported they have insufficient knowledge about mental health issues and that they have a strong interest in additional training and resource materials (Perez, 2000). This further supported the conviction that many learners, regardless of their educational placement in the school setting, will likely exhibit mental health concerns, thereby requiring assistance from general and special education school personnel to effectively identify and intervene with the non-academic barriers that hinder optimal student learning.

Childhood and adolescence are critical periods for promoting social and emotional development and preventing mental disorders—many major mental health disorders now are recognized to have their onset in childhood. Fortunately, prevention and early intervention efforts can minimize negative consequences for children and their families, as well as costs to society (National Institute for Health Care Management [NIHCM], 2005).

Several hundred well-designed studies have documented the positive effects of SEL programming on students of diverse backgrounds, from preschool through high school, in urban, suburban, and rural settings. This research indicated that well-planned and well-implemented SEL programming can positively affect a broad range of student social, health, behavioral, and academic outcomes (Greenberg et al., 2003).

Universal school-based social and emotional learning (SEL) programs yielded benefits in three major areas: feelings and attitudes, indicators of behavioral adjustment, and school achievement. More specifically, youth showed improvement in social and emotional skills, school bonding, pro-social norms, self-perceptions, positive social behaviors, and academic achievement and significant reductions occur in such areas as conduct problems, substance use, and internalizing symptoms. Social and emotional competency promotion addresses the risk and protective factors common to a broad range of problem behaviors (risky, disruptive, and delinquent). Studies suggested it is an effective prevention program that can serve as a coordinating framework for universal prevention programming that met the needs of all students (Greenberg, 2007).

Chapter IV: Recommendations and Conclusion

To maximize the quality of educational services provided to today's youth, including those with mental health concerns, a paradigm shift is necessary to change the current pre-service training trends in educating school-based personnel. There will be a need for research literature on identifying evidence-based practices and how to implement these practices into pre-service training programs and to introduce and encourage the adoption of prevention-based mental health services for school-based personnel. The promotion of resiliency and wellness will need to be systematic in order to be effective across all training and service delivery avenues at the university level, in addition to, the certification and licensing levels. Addressing the mental health needs of children, adolescents and the school-based personnel who serve them are fundamental necessities for school success in today's classroom.

To have successful and sustained social and emotional programming, a school specifically requires leadership that makes SEL a priority. This can be accomplished by advocacy and visibility for the entire school community. There has to be adequate preparation of staff for change and have supports in place throughout the process. This includes proper modeling of the social and emotional competencies expectations for teachers to model and students to learn. Social and emotional programs that are most effective are: grounded in theory and research; build connections to school through caring, engaging classroom and school practices; provide developmentally and culturally appropriate instruction; help schools coordinate and unify programs that are often fragmented; enhance school performance by addressing the affective and social dimensions of academic learning; provide high-quality staff development and support and incorporate continuing evaluation and improvement. In addition,

more intense programs of longer duration, preschool and continued through high school, typically have greater effect than shorter less intense programs.

Further Research

Although it is thought that timely interventions with early-onset cases might help reduce severity of primary disorders and prevent, reduce or delay onset of secondary disorders, much preclinical and clinical is needed on the long-term consequences of early interventions for long-term secondary prevention. Progress has started with the implementation of some of these programs into the school setting, but further research is necessary to replicate the treatment outcome data and barriers pertinent to mental health delivery in this unique setting. Despite the clear benefits a school setting provides, including access to at-risk students, financial parity for service delivery to all students this does not come without substantial costs and demands on staff time. However, cost-effectiveness studies of the future may reveal the fiscal benefits of providing mental health programs for youth in their schools which will reduce or prevent mental disorders in childhood, adolescence and adulthood, and reduce associated costs to the community.

For now the research remains encouraging that schools can play a valuable role in the treatment and prevention of childhood mental disorders. More research is needed to continue to strengthen the evidence and impact of preventive interventions. First, there is a need to add qualitative research though the empirical support for prevention programs to understand how, why and for whom these programs are effective. Second, there is a need for further replications, or development of many of these programs, including those students with different ethnic and cultural backgrounds. Finally, there are still a variety of outcome areas for which there are few or

no evidence-based programs (for example, the prevention of anxiety disorders or maladjustment due to exposure to violence). Although a growing body of research supports the efficacy of SEL programming, further research is needed to advance the quality of future practice.

Future studies will help to determine, for example, which combinations of social-emotional skills most effectively influence which outcomes for various subgroups of students; how to prolong program impacts; how best to support school staff as they implement interventions; and whether combining SEL programs designed for different time periods or student populations would produce even greater benefits than implementing a single program.

Conclusions

There is an alarming increase in mental health needs for children and youth today. Yet there is a large gap between those that need mental services and those that actually receive services. Mental health is a key component in health development. Children and youth need to be healthy in order to learn, grow and lead productive lives. It clearly states that the first onset of mental disorders usually occurs in childhood or adolescence. Teachers need to be equipped with a fundamental knowledge of factors that influence not only the development of mental illness in those they serve, but also those proactive strength-based prevention efforts which promote mental health and resiliency.

Without early and effective identification and interventions, childhood disorders can persist and lead to a downward spiral of school failure, poor employment opportunities, and poverty in adulthood. Childhood is a critical time for promoting social and emotional development, and preventing mental disorders. Given schools' unique ability to access large

numbers of children they are identified as the best place to provide support and promote universal mental health of children. With the increasing national emphasis on the prevention of mental illness, the critical importance of competency-based training for teachers at the pre-service level is of foremost importance.

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