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Supporting Marin County Youth Suffering from Anxiety and Depression

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Dominican University of California

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This thesis, written under the direction of the candidate's thesis advisor and approved by the program chair, has been presented to and accepted by the Department of Counseling Psychology in partial fulfillment of the requirements for the degree of Master of Science in Counseling Psychology.

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Supporting Marin County Youth Suffering from Anxiety and Depression

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Master of Science in Counseling Psychology

Dominican University of California

Supporting Marin County Youth Suffering from Anxiety and Depression

By

Victoria Grajeda

A culminating thesis submitted to the faculty of Dominican University of California in partial fulfillment of the requirements for the degree of Master of Science in Counseling Psychology

Dominican University of California

San Rafael, CA

May 2019

Abstract

This toolkit was created to help shed light on the impact a stressful high school environment can have on today's youth, and provide teachers, students, and parents with up-to-date information on what resources are available within the county of Marin. When working with adolescents, it is important to consider environmental threats to their mental health (i.e., lack of sleep) in order to make proper referrals and treatment plans. A study done by Kelley, Lockley, Kelley, & Evans (2017) implemented a 10:00 a.m. start time at an urban school in England. By delaying school start times, Kelley et al., found that absences related to illness were reduced by 50 percent compared to national rates. In general, school systems in the United States are not currently structured to ensure students can function at their maximum potential, and their academics, health, and relationships are deteriorating as a result. More importantly, suicide is becoming more prevalent in high schools within the United States, which means prevention programs need to be reevaluated or implemented to help Marin youth cope with academic and social stress. This guide will provide the community with psychoeducation on depression and anxiety; potential risk factors, how to help, and what treatment options are available.

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Terms and Definitions Used Throughout Manual

Chronic Absenteeism - a measure of how many students miss a defined number of school days (often around 15 or more days) for any reason (Chronic Absenteeism in the Nation's Schools, 2016).

Derealization - feelings of dissociation or detachment from someone's own body or mental processes. It is common among those who experience anxiety or panic, and is often difficult or sometimes impossible to ignore.

Dual Diagnosis - also known as co-occurring disorders. A person has a dual diagnosis when they are suffering from two disorders that need separate treatment plans as a result. Specifically, individuals will need help overcoming a substance abuse disorder while they are receiving treatment for a psychiatric disorder.

I Statements - any statement that begins with the word "I" and not the word "you" to put focus on the listener's feelings and beliefs about the speaker's experience. I statements can help foster positive communication by enabling speakers to be assertive without making accusations.

Sexually Transmitted Infection (STI) - Used interchangeably with Sexually Transmitted Disease (STD). STI is the modern-day terminology for when bacteria, viruses, or parasites are transmitted through sexual activity. The term was changed when it was realized that the infection does not always develop into a disease.

Sleep Hygiene - a variety of different practices and habits that are necessary to have good nighttime sleep quality and full daytime alertness (Sleep Hygiene, 2018).

Suicidal Ideation - thoughts about self-harm, with deliberate consideration or planning of possible techniques of causing one's own death (American Psychiatric Association, 2013).

Transitional Age Youth (TAY) - youth between the ages of 16 and 24 who are in transition from state custody or foster care. This group is considered to be at-risk because once they turn 18, they will no longer be able to receive assistance from the services that provided for many of their needs.

Preface

While working in higher education for the past four years, I have been able to observe the stress levels and coping techniques of high school and college students. As an Admissions Recruitment Officer and Student Ambassador Team supervisor, I was able to connect with students on a unique level and help them balance their personal and professional responsibilities. Students have approached me in tears because they failed to meet one small requirement for their preferred major. Students have walked into my office, plopped down in the seat across from my desk, and told me they just needed a minute to gather themselves. I have listened, comforted, advised, and motivated countless students who felt they did not have anyone else to confide in about their daily struggles and unrealistic expectations. Many of these students were not given the necessary tools to be successful in their transition to college, and it became apparent to me the more I heard from the tired, overworked individuals that sought my guidance. I realized there is a gap between the resources offered in Marin community and how they are communicated, and something needs to change.

I chose to write about anxiety and depression in Marin County youth because I want my students to know they are not alone. I want them to have the help and support they deserve, and I never want them to consider suicide as an option. I feel that each student should have enough support from their teachers, parents, counseling professionals, friends, and other important relationships to be able to cope with their mental health issues, and to know who to reach out to when they are feeling extreme distress and impairment. I think as a community, Marin does a great job of creating programs and services that benefit our youth, but could be better at

identifying those who are in need of them. I have created this manual to provide the appropriate training and resources to those dedicated to improving the wellness of our struggling youth.

Note: For the purpose of consistency in this paper, the term “parent” means any type of at-home caregiver, and the terms “students,” “children,” “adolescents,” and “youth” mean individuals between the ages of 13 and 18 (or any student in high school).

Introduction

According to the Mill Valley Herald, of the 56 deaths by suicide in Marin County during 2017, four were ages 13-19. Specifically, one was 17, two were 18, and one was 19. Among this youth was Jackson Talbott who had just reached his senior year at Novato High School. Jackson was described by his father as intelligent, athletically gifted, a friend to many, fun to be around, the life of the party, and compassionate toward his siblings. Both of Jackson's parents reported that there were no warning signs of suicidality present in their son (Marin Independent Journal). Warning signs are important to keep an eye out for, yet looking out for them should not be the only prevention strategy we implement in our schools. The reality is that many students diagnosed and undiagnosed with mental illness complete suicide each year, having a profound effect on the communities in which the tragedies happen. Even more students go on to contemplate or complete suicide as they transition into college because they are not given appropriate resources to cope while in high school. A research study by Surgenor, Quinn, and Hughes (2016) evaluated and recommended ten effective strategies for developing school-based, adolescent, suicide prevention programs. The recommendations include longer-term strategies, awareness of contextual factors, clearly defined learning outcomes, implementing a preparatory phase, a flexible design and delivery, use of external, expert facilitators instead of staff, targeting a broader range of factors to develop skills and awareness, resisting the urge to over-emphasize risk factors, varied, interactive, and engaging delivery, and reevaluating programs regularly. It is crucial for Marin County to implement appropriate suicide prevention tools and resources to combat the growing rate of teen suicides.

It is a terrifying reality that suicide is now the second leading cause of death for youth between the ages of 15 and 19 years old living in the United States (Heron, 2018), and there is still much confusion about how to broach the topic. Will talking about suicide increase the risk? Cigularov, Chen, Thurber, & Stallones (2008) suggest that seeking help can be a self-threatening experience because of the potentially negative response/evaluation from others. The threat of feeling embarrassed, inadequate, or inferior to the confidant becomes a barrier to seeking help. Researchers found that without properly teaching our school communities the most effective/efficient ways to respond to suicidal behavior, our suicidal prevention programs cannot carry out their intended goals (Cigularov et al., 2008). We need to talk about suicide in order to bring awareness to the important actions we should take to prevent it. The stigma surrounding mental illness remains much too prevalent, and schools in the United States are not having enough of the right kind of conversations to tackle this societal issue. Instead of deviating the conversation from the topic of suicide, let us be sensitive and knowledgeable about it. The goal of this project is to inform Marin County teachers and parents about the many resources available for youth struggling with anxiety and depression, and to offer a variety of tools that can help them reach out in a meaningful, supportive way.

Literature Review

Risk Factors of Adolescent Suicide

In considering what predicts a suicide reattempt in 13-18 year old adolescents, researchers Greene-Palmer, Wagner, Neely, Cox, Kochanski, Perera, & Ghahramanlou-Holloway (2015) looked to parent reactions after their child made their first attempt. Eighty-one mothers and 49 fathers were surveyed in the mid-Atlantic United States, and responded to questions regarding their reactions to their teen's suicidal behavior. The participants completed the Reactions to Attempt Scale, which specifically gathered whether they responded with care, sympathy, sadness, anxiety, fear, overwhelm, anger, frustration, guilt, and shame over three separate points: prior to attempt, upon discovering the attempt, and 24-hours after the attempt. Their choice of words were also assessed, noting whether they had said something comforting, supportive, or hostile, or whether they engaged in an argument post-attempt. Other verbalizations asked the group if they discussed the situation with their child, if they were careful in what they said, if they changed the subject, or said nothing at all. Survey results indicated the most common feeling throughout the three points was caring, and the most common verbalization was something supportive. Hostility was not commonly expressed by either parent, however fathers were more likely to have said nothing. About half of the parents surveyed discussed the suicide attempt with their teenager, and were careful in choosing the right words. Findings also indicated that only $\frac{1}{3}$ of the parents felt guilty in the aftermath of the attempt, and there was less anger and blame experienced the more severe the attempt was. Ultimately, if mothers verbalize hostility and fathers embody anger after the child attempts suicide, there is a higher risk of suicide reattempt (Greene-Palmer et al., 2015).

Brausch & Decker (2014) looked at three common risk factors for adolescent suicidal ideation; Depression, eating disorders, and body satisfaction. By surveying a total of 392 high school students in the Midwest, researchers were able to look further into these risk factors, and potential moderators (self-esteem, parent support, and peer support) that can be added to future prevention plans. In order to gather data on suicidal ideation, students were asked to complete the Suicidal Ideation Questionnaire (SIQ). Healthy eating was tested using Eating Attitudes Test (EAT-26), body satisfaction using The Multidimensional Body-Self Relations Questionnaire-Appearance Subscales (MBSRQ-AS), depression using the Reynolds Adolescent Depression Scale - 2nd Edition (RADS-2), self-esteem using Rosenberg Self-Esteem Scale (SES), and support by using the Child and Adolescent Social Support Scale (CASSS). What was found in terms of self-esteem was that body satisfaction and self-esteem did not significantly predict suicidal ideation, however, disordered eating and depression did. Only when a student presented low levels of self-esteem did depression become a significant risk factor, which proved that self-esteem effectively moderated the relationship between depression and suicidality. Disordered eating was found to be a risk factor on its own, and was unable to be moderated by self-esteem. Parent support appears to moderate depression and disordered eating, however low levels of parent support proved to be a significant risk factor for suicidal ideation. Perceived peer support was compared with the three risk factors as well, and only moderated depression and disordered eating. Findings indicated that it is important for adolescents to be connected to their family and friends, and that appropriate tools and resources should be provided for students to increase their self-esteem. Because evidence suggests there are ways to moderate severe risks to suicidal ideation, more action should be taken to make sure students are feeling supported and good about themselves (Brausch & Decker, 2014).

Mars, Heron, Klonsky, Moran, O'Connor, Tilling, Wilkinson, & Gunnell (2018) sent a survey to 4,772 of the Avon Longitudinal Study of Parents and Children members within the United Kingdom. The study's main goal was to examine the differences between 16-year-olds who reported no suicidal ideation or attempts, suicidal ideation only, and suicide attempts. Researchers asked questions about the individual's thoughts of suicide and self-harm behaviors such as, "Have you ever thought of killing yourself, even if you would not really do it?" and, "Have you ever hurt yourself on purpose in any way?" They were then able to identify those with suicidal intent by following up with, "On any of the occasions when you have hurt yourself on purpose, have you ever seriously wanted to kill yourself?" Depressive disorder, behavioral disorder, anxiety disorder, exposure to self-harm in others, friend/family self-harm, and smoking were found to be the strongest risk factors that differentiated between individuals who have thought of suicide and who have attempted suicide. The next category of risk factors that were less likely but still strongly associated with suicide attempts versus ideation were lower IQ, being female, higher intensity seeking, more life events, lower conscientiousness, body dissatisfaction, hopelessness, and illicit drug use (Mars et al., 2018). Findings suggest that exposure to self-harm in others and mental health related problems are likely contributions to an adolescents suicide attempt, and are important to consider in assessing risk of suicide in this age group. Even though depression is widely seen in those who attempt suicide, it should not be the only psychiatric disorder considered for suicide prevention efforts.

Treatment and Prevention

Researchers Cigularov, Chen, Thurber, & Stallones (2008) looked into the reasons adolescents are still prevented from seeking help after a suicide education program. Those

included in the survey were 854 high school students from Colorado. The students responded to two scenarios related to a suicidal student's reasons for not seeking help and a friend who knew about the situation but did not do anything about it. They were asked to indicate reasons as to why the student and friend did not utilize the skills/training/resources learned from the training to seek help. The perceived barriers to seeking help for self was measured using 26 different reasons why they would not seek help if they were suicidal, and the perceived barriers to seeking help for others was measured using 18 similar items for comparison purposes. It was found that the most prominent barriers to help-seeking for self were not knowing what to tell their parents about their problems, believing they could handle their own problems on their own, fear of hospitalization, not knowing how to approach the subject with their school counselor or teacher, and not feeling close to any adult at school. Statistics for barriers to help-seeking for a friend showed the most prominent barriers were worry that they would make the wrong judgement about their friend, difficulty in approaching an adult at school to talk about their friend's problems, fear of friend being hospitalized, concern that their friend would be angry with them, and belief that their friend does not mean it when he/she talks about suicide (Cigularov et al., 2008). After comparing the two scenarios, researchers found that the more critical barriers to seeking help for self included distrust of school resources, not believing school counselors and teachers could help, not knowing what to say to parents, counselors, and teachers, and believing they could handle their problems on their own. Difficulty with approaching an adult at school was a stronger barrier to seeking help for a friend than seeking help for self (Cigularov et al., 2008). Because research shows that adolescents who are at higher risk of suicide are less likely to seek help, it is important to take these findings seriously, and use them as a tool for strengthening prevention programs and strategies.

Researchers explored the ways a school-based wraparound approach combined with a school-wide systems approach for youth with emotional and behavioral disorders (EBD) can create more effective school environments and improved outcomes for a student in need. In their research, Eber, Sugai, Smith, & Scott (2002) emphasize the fact that students with EBD are unlikely to be successful in their school environment with too much discipline and not enough intervention from school, family, and community supports. Providing appropriate wraparound services through schools and community-based transitional programs yields positive results such as increased rates of school completion, career focus, job performance, and other post school indicators. With wraparound services comes many integral pieces that come together to improve the overall support and services already available for children and their families. The steps to building a successful wraparound plan start with engaging the adolescent's support systems in individual conversation about their ideas, frustrations, views, values and dreams. Next, start the initial meeting with strengths that were identified about the family and other support members in the individual conversations. Step three involves developing a strong mission statement that guides the team's actions to ensure that action steps are connected to the mission. Next, identify all needs that should be met to ensure student success and prioritize them. Develop actions as part of the strategy for meeting needs and clearly defined outcomes. Next, it is important to assign these tasks to team members, and have them confirm commitment and understanding to their role. The final step includes documenting the plan by evaluating, refining, monitoring, and transitioning the needs and strategies of the team. In order to integrate a wraparound plan, it is important to use a highly trained facilitator, focus on strengths, needs, and perspectives, thoroughly prepare for each team meeting, develop comprehensive plans, and adhere to the value base during implementation (family voice and choice, unconditional commitment, flexibility,

and cultural competence). Eber et al., conclude their research with future directions for practice and research, one of which questions why schools remain over reliant on negative interactions, exclusion, and punishment to address issues with EBD's when we know a proactive, structural approach is a better strategy (2002).

Researchers Suter & Bruns (2009) examined the effectiveness of the wraparound process, a team-based, collaborative plan for youth in need of emotional and behavioral support from multiple systems. The meta-analysis involved the review of seven wraparound program studies conducted in the United States with participants ranging from 42 to 204. Living situation, effect size, youth functioning, school functioning, juvenile justice, assets and resiliency, and mental health were measured in adolescents receiving wraparound services versus those receiving conventional services. It was found that when directly comparing overall effect size between the control and test groups, those that received wraparound services were better off than 63% of those that were receiving conventional services. Another significant find in this study was that adolescents referred to out-of-home placements for mental health services were more negatively impacted than those maintained in their homes, schools, and local communities. When this study took place, there was an estimated 1,000 wraparound programs in the United States with only seven comparing their effectiveness with control groups. This suggests that wraparound services are innovated directly by the communities themselves rather than empirical testing. Following the basic principles of wraparound (meeting regularly to plan and review progress), making sure the wraparound is an equivalent version to other communities, researching the effectiveness of your wraparound compared to conventional services, and having adequate knowledge of the

local community is essential in our ability to determine whether or not wraparound services have a positive impact (Suter & Bruns, 2009).

A study was conducted on American adolescent knowledge of depression and social anxiety disorder signs and symptoms. A self-reported study conducted by Coles, Ravid, Gibb, George-Denn, Bronstein, & McLeod (2015) was administered to 1,104 high school students including case vignettes portraying individuals with major depression, social anxiety disorder, and major life stressors. The *Friend in Need Questionnaire—Revised* by Burns & Rapee (2006) was used to portray a depressed male first followed by a socially anxious female to 53% of the group. The situation was reversed for 47% of the group. Questions included: In five words or less, what do you think the problem is; if they were your friend, how worried would you be about his/her emotional wellbeing; how long do you think it would take for them to feel better again; do you think he/she needs help from another person to cope with their problems; and who specifically do you think they need help from? Each vignette met the requirements of depression and social anxiety criteria in the DSM-5. Participants were instructed to complete the *Strengths and Difficulties Questionnaire* in order to measure mental health symptoms in adolescents age 11 or older. Results concluded that females had a higher mental health literacy than males. It was also found that increased mental health symptoms were significantly associated with depression scale scores, scaled scores for depression were significantly correlated with conduct and hyperactivity symptoms as social anxiety scores were with depressive and anxious symptoms (Coles et al., 2015). In terms of recognizing the disorders, more students correctly identified that the person in the vignette was experiencing depression than they did when it was social anxiety. However, less than half of the participants correctly labeled the depression vignette, and only one

percent correctly labeled the social anxiety vignette. Because successful identification of the issue can influence treatment seeking, helping students understand what they are experiencing is important to getting them the help they need. Even though a significant amount of students could not identify the disorder, half of the adolescents still recommended to seek help for both problems. The authors conclude that mental health literacy can improve from incorporating prevention education programs within more school settings, and that educators need to regularly provide information about the help available to students for treatment seeking and peer recommending to occur.

Sleep and Stress in Adolescents

Van Schalkwijk, Blessinga, Willemsen, Werf, & Schuengel (2015) investigated the link between stress and sleep, and the benefits social support can have in students' lives. Van Schalkwijk et al., (2015) hypothesized that parent, friend, and supervisor support can be helpful to an adolescent's emotional wellbeing. It was expected that social support would assuage the effects of academic stress on sleep, and that sleep would be reduced by academic stress. One hundred fifty-two Dutch students completed a questionnaire with questions related to academic stress, sleep reduction and quality, and social support. A scale ranging from 0 "not stressed/tense" to 10 "extremely stressed/tense" was used to address the question, "How stressed or tense did you feel the previous week of school?" A horizontal line was also provided for students to indicate their experienced academic stress level, providing Van Schalkwijk et al., (2015) with a distance to measure in centimeters. The Chronic Sleep Reduction Questionnaire – Short Form (CSRQ-SF) was used to assess sleep reduction in students, while quality was assessed by asking, "How would you rate your sleep quality?" and offering a Visual Analog

Scale (VAS) ranging from 0 “not good at all” to 10 “excellent.” This study also used the Dyadic Coping Inventory for Adolescents, Parents, and Peers (DCI-APP) as a way to assess satisfaction in the support systems of participants. This 21-question inventory looked specifically at the perceived support from mother, father, and friends while the short version of the Teacher As Social Context questionnaire was given to the participants as a way to investigate their relationship with their class supervisor. It was found that higher sleep quality was the result of social support from a friend, mother, and class supervisor. Sleep reduction was lower when the participants had higher social support from mother and father. The results support the research hypothesis that social support from mothers, fathers, friends, and class supervisors contributes positively to adolescent sleep quality and duration (Van Schalkwijk et al., 2015).

In a research study by Doane, Gress-Smith, & Breitenstein (2015), the objective was to investigate the impact a student’s transition to college has on sleep, and the link this has to anxiety/depression. Doane et al., (2015) put together a longitudinal study consisting of eighty-two students making the transition from high school to college. Participants were instructed to press a button on the Actiwatch provided to them each time they rose in the morning and got into bed in the evening for four nights and three days. The watch tracked each student’s total sleep minutes, sleep onset latency, sleep efficiency, and sleep start time variability (Doane et al., 2015). The Pittsburgh Sleep Quality Index (PSQI) was used to measure subjective sleep, scaling sleep duration, sleep onset latency, sleep disturbance, daytime dysfunction, sleep efficiency, sleep quality, and use of sleep medications. Anxiety symptoms were measured using the Depression, Anxiety and Stress Scale-Anxiety Subscale (DASS) which determined anxiety based on fourteen questions with an attached four-point Likert scale. The Center for Epidemiologic

Studies Depression Scale (CES-D) was used to assess symptoms of depression, again involving the participants to complete a four-point Likert scale. This study showed that students experience depressive symptoms before making the transition to college. This negatively affected the student's subjective sleep, time in bed before sleep, and start time once the transition was made. Another finding illustrated that symptoms of anxiety increased while making the transition, and were related to the subjective and objective sleep problems that were reported and tracked post-transition. Finally, the students who subjectively identified sleep problems in high school experienced post-transition anxiety, thus prompting "concurrent and prospective subjective sleep problems," (Doane et al., 2015). It is suggested that high school and university administrators implement and promote wellness tools for students to utilize as they adjust to college life (Doane et al., 2015).

Kelley, Lockley, Kelley, & Evans (2017) looked at a group of 2,049 English students aged 13-18 years and the impact a delayed start time had on their academic performance and school absences related to illness. The researchers in this observational study chose a delayed start time of 10:00 a.m. and compared it to a normal school start time of 8:50 a.m. over the period of two years. A natural, unexpected group was observed in this study which included students that reverted from a 10:00 a.m. start time to an 8:50 a.m. start time. The General Certificate of Secondary Education (GCSE) was used to measure academic performance, classifying good academic ability as receiving a letter grade of a C or above in five subjects total. Data regarding absence due to illness was collected from the school and differentiated from other types of absences. A large decline in student absences was seen as a result of instituting a later start time. Specifically, absences related to illness were reduced by 50% compared to national

rates in the group that started at 10:00 a.m., and increased by 30% for those who returned to a start time of 8:50 a.m. Similarly, academic performance improved significantly in the 10:00 a.m. starters seen by the 12 percentage-point gain in their exam scores and school value, amounting to 20% of the national benchmark. This research concluded that there are significant academic and health benefits to be gained from delaying school start times, and even the recommended start time of 8:30 a.m. (supported by the American Medical Association) should be breached (Kelley et al., 2017).

Minges & Redeker (2016) were crucial in examining how having a delayed school start time positively impacts student sleep, academics, and health. Based on the review of six articles, the researchers found important evidence which corroborates that schools should push back start times to the recommended time of 8:30 a.m. or later. The articles pulled were made sure to include key pieces of information such as inclusion of reported sleep time and that the same participants were used in comparing non-delayed start times with delayed start times. Data gathered from the six studies showed that delayed starters increased their total sleep time to an additional 25 to 77 minutes during the week with no significant difference in bedtimes, and an increase in wake times that averaged 21 to 66 minutes later. The studies also looked at daytime sleepiness and satisfaction during sleep, finding perceived quality of sleep to be improved in delayed starters accompanied by improved alertness throughout the day. In one particular study, health was examined by the number of visits to the school health clinic which was cut in half after implementing a delayed start time. Results found significant decreases in depression scores, body mass index, caffeine usage, oversleeping, falling asleep in class, tardiness, and distractibility across various studies. Because all of these factors/behaviors could have negative

effects on health and academic success, it is important to consider delayed start times as a realistic and acceptable solution to improve the well-being of our youth (Minges & Redeker, 2016).

Lo, Chong, Ganesan, Leong, & Chee (2016) capture the specific ramifications lack of sleep has on learning and memory in their recent study. Specifically, false memory is tested on a group of young, healthy adults after one night of total sleep deprivation and seven nights of partial sleep deprivation, and on a group of 54 secondary school students who were given a specific bedtime regime (nine hours in bed the first night, and five the second) to follow. The researchers paired stories of two different types of crimes with 50 photographs that were not consistent to the narrative on 24 occasions (the misinformation phase). The participants were tasked with paying close attention to both the series of photographs and narratives. Twenty minutes after the participants reviewed the information, 36 questions were asked related to the participants' memory of the photos. The majority of the questions asked pertained to the misinformation phase; however, six questions addressed the scenarios when the narrative matched with the pictures. It was crucial for the researchers conducting the study to discern whether their answer was based on the story, the photographs, or just a guess. Participant performance was measured by counting the response time, and instructing the students to respond to the Psychomotor Vigilance Task (PVT) as quickly as possible. Next, the Karolinska Sleepiness Scale (KSS) was administered to measure subjective sleepiness in participants. It was found that adolescents showed increased false memory after partial and total sleep deprivation, whereas the memory of young adults seemed to be negatively affected by total sleep deprivation.

Self-perceived sleepiness and vigilance did not have a factor in the formation of false memories between these two groups (Lo et al., 2016).

Meldrum & Restivo (2014) analyzed a total of 15,364 American high school students' self-reported behavior and health using the Youth Risk Behavior Survey (YRBS). The survey questioned each student's reported engagement in risky and potentially dangerous behaviors, experienced depression and self-harming tendencies, physical health, and hours of sleep they averaged per night. The results of the survey indicated that negative effects of behavior and health typically emerge when students report fewer hours of sleep at night. Specifically, 17% of high school students reported getting less than six hours of sleep at night (Meldrum & Restivo, 2014). To support this claim, the survey results included significant increases in ten of the twelve outcomes measured when students reported getting five hours of sleep, and twelve of the twelve when getting less than five hours. The specific outcomes on the survey included drunk driving, weapon carrying, fighting, contemplating suicide, smoking, alcohol use, binge drinking, marijuana use, sexual risk-taking, texting while driving, and obesity. Survey results showed that only the most severe cases of sleep deprivation showed a statistically significant relationship to obesity. This study stressed the negative effects of getting less than five hours of sleep, and how risky/harmful behavior scores were considerably larger than the students who had reported five hours or more. There were only two categories (texting and driving, and alcohol use) that did not vary as drastically as the others. This study puts evidence behind the claim that severe lack of sleep plays a significant role in problematic behavioral and health-related outcomes, however it also addresses that we cannot attribute moderate lack of sleep to behavior and health related issues (Meldrum & Restivo, 2014).

According to a survey conducted by Vollmer, Jankowski, Diaz-Morales, Itzek-Greulich, Wüst-Achermann, & Randler (2017) on 3,201 German students enrolled in 28 different schools, going to bed late and starting school early is detrimental to adolescent health. The Composite Scale of Morningness (CSM) was used to measure each student's morningness-eveningness, the Adolescent Sleep-Wake Scale (ASWS) measured five subscales of sleep quality, and the Adolescent Sleep Hygiene Scale (ASHS) measured five subscales of sleep hygiene. The study recognizes the preference for late/early bedtimes or wake times as morningness-eveningness, which is based on an individual's circadian rhythm (energy rises and dips throughout a 24-hour cycle). Vollmer et al., (2017) also identified "social jetlag" as the result of people going to bed later and sleeping in on the weekends, causing confusion and conflict in the body because of the routine they became accustomed to during the week. Morning-eveningness, social jetlag, electronic screen media use, sleep time and sleep length, sleep quality, and sleep hygiene were all measured in order to pinpoint the predictors of sleep issues in this specific population. The results indicated that morningness-eveningness predicted each variable tested, but had the most impact on social jetlag, issues going to bed, and problems in falling and returning to sleep. Because students are required to start school at the same time each weekday, students spend less time in bed which in turn reduces the duration of their sleep. It was also found that morningness-eveningness was not related to issues in sleep hygiene or sleep quality, but more so in problems returning to wakefulness due to early school start times. Students are forced to wake up before their body is truly ready, creating a difficult adjustment from sleep to wakefulness in the mornings. Because students typically have more control over bedtime, fewer problems are reported in the evening as opposed to in the morning. Additional data was found in the study by Vollmer et al., which included: females tend to report more sleep related problems than males, as

age increases so do reported problems with sleep, screen media hinders the ability for most students to implement appropriate bedtimes, and socioeconomic status plays a key role in the ability to cope with early start times. Researchers concluded that implementing delayed start times in school can ultimately benefit student ability to practice adequate sleep hygiene, and give them more energy to focus and perform throughout the day (Vollmer et al., 2017).

The authors Meltzer, Shaheed, & Ambler (2016) compared sleep hygiene and sleep patterns in homeschooled students to students who attend public/private schools. A survey was conducted to compile data on sleep times, wake times, and school times to study how each variable affects symptoms of depression and influences technology usage. In order to measure sleep, this study used the National Sleep Foundation (NSF) Sleep in America poll as part of the questionnaire. It was found that homeschooled students were receiving an average of four additional hours of sleep per week in comparison to public/private school students, which translates to an additional 49 minutes per night. The students who reported more depressive symptoms on the survey were the students who had a shorter sleep duration. However, there was no correlation between depressive symptoms and school start time, nor depressive symptoms in public/private students versus homeschooled students. There was a significant increase in weekend oversleep, an increased tendency to nap, and increased usage of technology before bed for public/private school students. In regard to sleep hygiene, this research considered doing homework, watching television, phone conversations, and internet usage late at night to be poor sleep habits. It was found that public/private school students engaged in these activities more often than homeschooled students within the hour before bedtime. It is also important to note that caffeine intake was found to be increased for students who had a later bedtime, but did not

vary significantly between homeschooled students versus public/private (Meltzer et al., 2016).

With this information, we can better provide adequate resources to help students practice healthier sleep habits or catch up on sleep if adjustments are unable to be made to their lifestyle or schedule.

A group of adolescent, sleep-restricted nappers were compared to a group of adolescent sleep-restricted non-nappers in a study conducted by Lim, Lo, & Chee (2017). What experimenters wanted to determine was the impact that napping has on cognitive performance in healthy 15-19 year old participants. The experimental group and the control group were asked to restrict their sleep to five hours during the night, however the experimental napping group was provided one hour of recovery sleep each afternoon. Each day, participants were given a series of tasks which tested their ability to map symbols with corresponding letters, decode symbols with speed and accuracy, and assess subjective sleep. The tasks were administered using the Blocked Symbol Decoding Test (BSDT), and their sleep was measured using the Karolinska Sleepiness Scale (KSS). The data from this research indicated that nappers received 37-53 more minutes of sleep each day, and reported less overall tiredness. In relation to speed, nappers were significantly faster and benefitted from the repetition of tasks throughout the duration of the study in comparison to non-nappers. Time spent on continuous performance (time-on-task) had steeper declines in the non-nappers, however non-nappers showed significant improvement in their continuous tasks after being given a break. In fact, compared to nappers, non-nappers showed greater recovery on tasks once given the opportunity to pause. This means that for students who are sleep-restricted and not given an opportunity to nap, it is important to explore other means of resting and recovering throughout the busy school day. However, combining

naps with more rest time was not proven to enhance cognitive function throughout the day, showing the importance of a healthy balance in time allotted for sleep and/or rest (Lim et al., 2017).

Limitations of Literature

There were several limitations in the existing literature regarding mental health issues in high school adolescents. First, it should be noted that not every high school student has the dream or plan to attend college. This should specifically be considered when reviewing the research by Doane et al., (2015) at Southwestern University. The college transition will not be relevant to a significant population of students in Marin County. However, I believe this study still maintains its importance as senior year of high school can bring about other post-graduation stressors such as applying for a job, not having a certain path in life, serving in the military, etc.

Another limitation can be noted in several sleep studies cited; many youth were required to track their own subjective sleep in the studies, and thus could have reported back falsified or incorrect information. Although anonymity was guaranteed on studies that included surveys, reporting does sometimes tend to be invalid. In reviewing the results by Meldrum et al., (2014), many risky, unhealthy, and aggressive behaviors are seen in students who report sleep deprivation. However, this study is limited by the perspective that lack of sleep causes the problematic behavior, disregarding the possibility that students that are predisposed to this kind of negative behavior may just naturally sleep less. We cannot assume the behavior causes the sleep deprivation, if the sleep deprivation causes the behavior, or if there is a confounding variable affecting both.

In some of the longitudinal studies conducted (such as *How Parental Reactions Change in Response to Adolescent Suicide Attempt*), participants were asked to think back to their previous experiences/feelings and report them to the best of their recollection. This research would have been much more accurate if the parents of suicidal adolescents had been surveyed immediately upon entering each phase (pre-attempt, immediately after attempt, and 24-hours post-attempt). It is understandable why this study required a significant gap between parents entering the phase and completing the survey. It should also be noted that the participants included in literature reviewed extended outside of the United States, and there may be some cultural factors influencing the results of the data. Finally, any confounding variables such as abuse, family dysfunction, addiction, etc., could influence poor academics or concerning behaviors in high school students.

Conclusion

As stated in the introduction to the manual, suicide is the second leading cause of death for American youth between the ages of 15 and 19 (National Vital Statistics Reports). The percentage of suicidal youth will only continue to grow if counties like Marin remain silent on important mental health issues and factors contributing to teen stress. By reinforcing school prevention programs, delaying school start times, and teaching parents and teachers how to address their student's symptoms of anxiety and depression, the Marin community can begin to heal from the traumatic losses they have experienced in the past few years. When a person dies by suicide, it does more damage to treat it like a crime than it does to treat it like a societal flaw. When a person is fired, expelled, criminally detained, or penalized for attempting suicide, we are only exacerbating stigma and building up harmful social constructs that isolate this growing group of suffering individuals. It takes a lot of courage and trust to come forward with thoughts of suicide, and we should not do anything to thwart that effort. The following tool-kit will emphasize the importance of addressing mental health concerns with Marin County adolescents, and recommend helpful prevention tactics and resources to ensure the community feels understood and supported.

Section 1: For Teachers

Stories, warning signs, and action steps for teachers to consider when helping their student cope with symptoms of anxiety and depression.

Stories and Testimonials from Adolescents and Families Living with Mental Illness

Fatigue. Difficulty concentrating. Slowness. Weight gain or loss. Have you ever noticed a change (slight or drastic) in the behavioral or physical characteristics of a student? These are common indicators and symptoms experienced in an individual suffering from mental health issues such as—but not limited to—anxiety and depression. For some families, it is a long and painful process finding the right diagnosis for their loved one struggling with mental illness. In the book *Behind the Wall: The True Story of Mental Illness as Told by Parents*, Esme became aware that her daughter Jennifer was suffering from Borderline Personality Disorder after years of receiving misguided information. She witnessed her spiral into a deep loneliness and depression, creating a damaging and chaotic environment for those around her. Esme explains,

During the high school years she continued to be moody, volatile, and had behavior that continued to be concerning. When she's in a state, she's irrational. You can't reason with her. You could say the wrong things at any time that would set her off. That phrase—"walking on eggshells"—used to describe her illness is spot-on because you never know what is going to happen. (Widdifield & Widdifield, 2015, pg. 13)

These intense behaviors and emotions are not only observed in the home environment. Many adolescents struggling with mental illness will often show signs and symptoms in the classroom. If left untreated, it is possible for the disorder to negatively affect their academics or completely interrupt their education all together. In Jennifer's case, the school discontinued her tutoring sessions because she was not committed, and could not focus on the information.

We had to meet with the school administration. We said, “Look, this is the situation: she can’t be here; it’s too difficult for her.” The counselor agreed, “Yes, she’s definitely experiencing anxiety.”.... Now we had a child who couldn’t cope in school. This was like having a different child. It was as if one day we opened the door to find someone else had moved in. (Widdifield & Widdifield, 2015, pg. 18)

Esme and Jennifer’s stories are extreme, and accurately depict the often complicated life of a mother dedicated to finding answers and solutions to her daughter’s severe mental illness. But what if the student does not have a committed parent or guardian to advocate for them? Even though society always tells teens they are not alone, it is important to be specific and transparent when suggesting who they can turn to. Many mental health publications and guides, such as the National Institute of Mental Health (NIMH), encourage struggling youth to speak to an adult. In fact, the first step toward seeking help on the NIMH website is, “Try talking to a trusted adult, such as your parent or guardian, your teacher, or a school counselor,” (“Teen Depression,” n.d.). As a teacher, the likelihood a student will come to you for guidance when something is not feeling right is extremely high. An article written by Claudia Turner on the website *The Mighty* describes the impact that a teacher can have on a teenager with anxiety and depression:

I somehow thought if I didn’t come to class, my less than 2.0 GPA wasn’t real. I didn’t feel worthy of you or your time, so I pushed you away. Despite all of this, you still tried to help me. Then came my diagnosis. You didn’t show me pity, but instead treated me with dignity and respect. I’m not sure you even intentionally did this, but you validated my pain and acknowledged that what I was going through was real. In a school where

you could have let me become a just a face in a sea of students, you never let me feel secluded. You put a name to my face and you reminded me I wasn't alone. You noticed things about me I didn't know anyone saw, and used these things as ways to help motivate me to do my work. You cheered me on during my hardest days and laughed with me on the rare days I felt rain drops [sic] of hope. (Turner, 2017, para. 2, 3, & 4)

When students are struggling with alienation, academic failure, sleep deprivation, etc., it is important for teachers to pay attention. These indicators of anxiety and depression have visible warning signs that, with adequate care and attention, can be moderated by your support. The National Alliance on Mental Illness captured the visible side of mental illness through Sierra's story;

The trouble started in 8th grade. As soon as I started the year, I knew something was wrong with my body. I was exhausted all the time and losing weight. By December, I was only doing half-days at school because I was too tired to stay the whole day... 9th grade came with a surge of anxiety. I was anxious all the time, crying when I had to go to bed because I feared another day. It was crippling. I didn't recognize these as panic attacks at the time. In school, I asked to go to the bathroom in every class just to get out of the room because I felt like I couldn't breathe. Anxiety became my middle name, following me everywhere I went. (Sierra's Story, n.d.)

We see disruption in this student's education due to leaving early and seeking a private place to manage her anxiety alone. Be willing to confront your students when you notice prolonged absences and irregular dismissals from school. Many times the reason they are absent is out of their control, and could be a strong indicator that they need help and support. The Department of

Education released information on chronic absenteeism in 2013 and 2014, suggesting one in seven students miss 21 or more days of school out of the year (Chronic Absenteeism, 2016). Their research goes on to suggest that reasons vary from poor health, to limited transportation, to a lack of safety. School can be a negative place for some, and a place of refuge for others. In May 2018, a Washington teacher's social media tweets went viral when he detailed why he let a student sleep in his class.

Meg fell asleep in class yesterday. I let her. I didn't take it personally. She has zero-hour math, farm-girl chores, state-qualifying 4X400 fatigue, adolescent angst, and various other things to deal with. My class is only a part of her life, not her life. (Syrie, 2018)

The teacher, Monte Syrie, later explained that letting his student sleep in class was not an invitation for others to do so, but rather a message that they could come to him in a time of need.

Our students are tired. The Centers for Disease Control and Prevention recommend teenagers receive a minimum of eight hours of sleep per night (How Much Sleep Do I Need, 2017). When schools require their students to arrive at 8:00 a.m. (and sometimes earlier), they are interrupting their sleep cycle and causing more serious issues to manifest as a result. Because students are expected to engage in extracurricular activities, keep up with their homework, and maintain their relationships with friends and family, this leaves minimal time to develop healthy sleep hygiene. Add these expectations on top of a debilitating mental illness, and students are left with hardly any time to recover from their exhausting daily routine. Oftentimes, students who are most affected by an endless cycle of high school stress and anxiety can seem the most put together.

I have worn a mask since my freshman year of high school. And, if I do say so myself, I am extremely good at it, too good at it. They say practice makes perfect and I have had a lot of practice. Back in high school, I would lay in my bed curled up in a tiny ball under all the covers, silently sobbing into my pillow for hours, after reading horrible messages on Facebook from both people I considered “friends” and from people I had never even met before. I would hear my cell phone’s ringtone next to my bed and wait for the torturous notification sound to go off after, letting me know I received another voicemail from a *67 anonymous caller, telling me no one liked me, that I was ugly, or that I should kill myself. After pulling myself together, I would “put on my mask” and walk downstairs into the kitchen, acting completely normal, as if I had just finished my homework. My mom and dad would usually be cooking dinner and my brothers and sister were talking about what happened to them that day. I joined right into the conversation, ate dinner, went back up to my room, and proceed to cry myself to sleep every single night. I thought by asking for help, it showed weakness, so I buried it all inside, keeping a fake smile across my face. (Taking Off My Mask, n.d.)

You rarely know what is going on inside a student’s home or social circle. Statistics from the Centers for Disease Control and Department of Education indicate that between 1 in 4 and 1 in 3 U.S. students report having been bullied at school in 2014. However, 15% of high school students (grades 9–12) were cyberbullied in the past year—55.2% being LGBTQ students (Stop Bullying, n.d.). Many of these students will not seek help from anyone because they do not feel validated in their desire to seek help. There is fear of getting in trouble for articulating suicidal thoughts in an unsafe environment, fear of looking naive or stupid for attempting to

utilize resources, and fear of being judged or ridiculed for coming forward about harmful coping strategies (substance abuse, self-harm, etc.). Students do not know how to ask for help, or which environments are safe to explore their pain and symptoms. Brooke Johnson shared her personal story through NAMI:

When I was 13, I started to harm myself. This lasted for a few years between middle school and high school. Many people ask me, “How could you do that to yourself? How did that make you feel better?” Well, I was hurting so much inside. I didn’t know how to come up from that dark place. I lost interest in everything. I was constantly feeling guilty about everything I did. I felt inadequate. I had negative thoughts racing through my head every second of every day. I didn’t know how to stop it. So, to me, outside pain was the only pain I could control.... Later on, I made an appointment with my guidance counselor. I was crying as she asked me if I ever had suicidal thoughts or if I had ever harmed myself. I said “no” because I felt that if I told her “yes,” I would get in trouble. I didn’t feel safe telling her everything. I left and went back to class with dried tears and a sense of hopelessness. (Being The Person My 13-Year-Old Self Needed, n.d.)

When it comes to mental illness, trust your students and their families. This is crucial to the process, and makes it easier for families to cope and advocate for their child in perhaps the most stressful time of their lives. When families are feeling unheard and disbelieved, a sense of hopelessness sets in and weakens the familial support system. Sometimes you have to make the difficult decisions for your students’ well-being so their parents do not have to. Kerri explains her desire for school support in the book *Behind the Wall: the True Story of Mental Illness as Told by Parents*:

My hands were tied; I had warned the school, he had a history, and nobody was concerned. But Thomas was passing his classes until the end of February despite everything. “No red flags,” were the words his counselor used. There was nothing more I could do. I even met with the psychiatrist to see whether he could help me enforce hospitalization. He gave me a legal form that I could take to the police and they would forcibly take him. But if I forced the issue in that way I would lose Thomas’ trust completely. (Widdifield & Widdifield, 2015)

As you arrive to the end of this section, take a moment to reflect on the type of teacher you are. Consider how you would react if a student came to you for help. Consider what your next steps would be. Remember to treat every student with patience and respect because you never know what hardships they may face. Utilize the worksheet in **Appendix A** to formulate an appropriate response to your student’s distress indicators.

The next section of this tool kit will dive deeper into the warning signs and symptoms you should look for when assessing your students for potential mental illness. Keep in mind that as a teacher, your job is not to diagnose and treat your student. You should, however, develop a habit of advocating for their safety and wellbeing by keeping your eyes and ears open for potential warning signs that a student may be struggling, and referring them to a professional who can help.

Warning Signs: What to Look For in the Classroom

There is not one sure sign or symptom that indicates an adolescent may be struggling. There are currently 265 diagnoses in the fifth Diagnostic Statistical Manual of Mental Disorders (DSM-5) with mixed, unique symptoms that manifest as a result. Because the risk of suicide is not only limited to those experiencing symptoms of anxiety and depression, the researcher will provide a general overview of the most common warning signs reported from students.

Table 1 Visible Warning Signs in High School Students

Warning Sign	What it Can Look Like
Excessive worrying or fear	<ul style="list-style-type: none"> ● The day of/before a large project, test, or presentation, the student might ask to be excused ● Student appears fixated on receiving the perfect score or grade ● Frequent negotiating for extra credit ● Student turns to substances to ease symptoms <ul style="list-style-type: none"> ○ Students eyes are red/glossy ○ Missing or skipping classes ○ Decrease in academic participation or performance ○ Disinterest in school or other activities ○ Neglecting personal appearance ○ Changes in appearance, such as weight loss or gain

	<ul style="list-style-type: none"> ○ Slurring words, impaired speech ○ Confusion ○ Scent of alcohol on the breath ○ Irritability or bouts of violent behavior
Feeling excessively sad or low	<ul style="list-style-type: none"> ● Giving up on schoolwork. ● Disinterest in participating. ● Student approaches you or another student with their thoughts of suicide.
Extreme mood changes or feeling irritable	<ul style="list-style-type: none"> ● Inability to perceive changes in one's own feelings, behavior, or personality ● Multiple complaints from other students about their attitude ● Difficulty understanding or relating to others
Changes in school performance	<ul style="list-style-type: none"> ● Failing grades and incomplete assignments
Fatigue and low energy	<ul style="list-style-type: none"> ● Falling asleep at desk ● Dark circles under eyes ● Inability to complete homework assignments ● Frequent tardiness or absence ● Inability to carry out daily activities or handle daily problems and stress <ul style="list-style-type: none"> ○ Student quits clubs and teams ● Avoiding friends and social activities ● Confused thinking or problems concentrating

Physical ailments without obvious causes	<ul style="list-style-type: none">● Frequent visits to the nurse due to:<ul style="list-style-type: none">○ Headaches○ Stomach aches○ Vague ongoing aches and pains● Frequent requests to leave the classroom to go for a walk/get fresh air
Noticeable changes in physical appearance	<ul style="list-style-type: none">● Wearing long sleeve shirts and baggy clothes in warm weather to hide self-harm behaviors● Abrupt weight loss or gain.● Visible marks on body such as marks/bruises.

What Students Want You to Know

Begin each year with reasonable expectations, and without assuming your students do not care. Not every student is a natural at public speaking, and many students struggle with test taking. You will have students who enroll in your class to fulfill a requirement; not because it is an easy subject for them or because they enjoy it, but because they need it to graduate. Be as flexible and understanding *as you can* when it comes to assignments and grading. Students often have much more going on internally than they let show, and taking six classes each day (plus extracurricular activity) is overwhelming and exhausting. Are there alternative assignments you can give to students who are showing signs of distress? Is your classroom technique applicable to all learning styles? Students are speaking out about their mental health struggles and telling educators exactly how they can improve their teaching style. All you have to do is listen and adapt.

“When I lack participation, it is not because I do not care.” Withdrawal is an important symptom of mental illness to recognize since it could be a sign your student is struggling with anxiety and/or depression. Quietness and inactivity can be observed in those who are currently struggling with mental illness or in people who are recovering, and it can be easy for others to misinterpret these symptoms as laziness and disinterest. It is important to remember that the quiet student in your classroom could be silently struggling, and nagging or pressuring the student to participate is not helpful. Be patient and careful when you are asking your quiet students to answer a question or give a presentation in front of the class. Forcing them out of their comfort zone can be triggering, and may result in a setback. It is not easy to ask for space

and time to heal, so meet the student halfway in this regard. Make sure you are not amplifying the pressure for your already distressed student.

“It would be helpful for my teacher to let us know it is okay to approach her with feelings of anxiety.” If you care about your students’ mental health, let them know. If you are transparent with your students, they will likely be transparent back. It is okay to be strict about due dates and grading rubrics, but make yourself available to create a plan with the students who are falling behind. If you show compassion and understanding, your students are less likely to make excuses. Keep in mind that your students are tired, overworked, and stressed due to constant pressure. Be someone who takes care of them, and wants to see them succeed. If every teacher were to foster a safe environment to learn and grow, students would feel less pressure to be perfect and be better prepared to handle the aftermath of failure. If a student is too overwhelmed to finish an assignment by the deadline, consider helping them learn from the situation instead of punishing them. It works wonders to give them feedback and tools to do better next time.

“It is too difficult to have absences excused.” If your students have the flu or obtain a physical injury, a short note from the doctor is enough for the teacher to excuse an absence. However, when a student is struggling with a mental illness, it is not as easy to prove. This is part of the mental health stigma we are continuing to experience in our society today. Most students do not want to put a spotlight on their mental illness, especially when it is in an intimate classroom setting. It is not easy to focus on a lecture when you are fighting back tears or experiencing a panic attack. Do not expect your students to come to class if they are suffering emotionally—it is not helpful for anyone. What students really need to learn is how to cope with

their anxiety or depression by taking a moment to step away from their responsibilities. By holding them in class, schools are implying that mental health is not as important, and that you must go on with your day without attuning to the problem. Our adolescents are taught to suppress the heavy thoughts and emotions that come up, resulting in their uncontrolled/unhealthy and negative responses later in adulthood. Advocate for your student's needs so they are able to effectively cope for the remainder of their life.

“Everyone is on their own unique path in life.” College is not written in the stars for everyone, and sometimes graduation takes a little longer than originally planned. Do not confuse your personal agenda with your student's agenda. For some, anxiety and depression are crippling, and just getting out of bed requires maximum effort. Be an advisor for your students and help them navigate their future by offering support and guidance, leaving out any pressure to become someone more or less than they desire to be. Ask questions, offer assistance, and be proactive in preparing your students for life after high school.

The next section will provide action steps for how to support a student showing symptoms of anxiety and depression. Because a stressful environment can heavily impact a student's emotional health, this toolkit includes information on how to report a child abuse or neglect suspicion, and how to effectively intervene in a case of bullying.

Action Steps: When a Student Shows Signs and Symptoms of Mental Illness

What to Say. It should be noted that although warning signs and symptoms are important to look out for, they are not always present. In many deaths by suicide, the friends and family will later describe that the person appeared happy, relaxed, academically/athletically successful, and/or “normal.” Oftentimes the family is left feeling as if they missed something, or could have done more to help. This is why it is extremely important for schools to provide the entire student body with appropriate tools and resources to understand what they’re going through, and help relieve feelings of hopelessness and helplessness. Schools must provide a safe, caring environment that fosters a sense of community and openness in order to thrive. With the lingering presence of stigma in home and school environments, it is likely that students will be hesitant to confide in a school official or family member about their mental health concerns. In order to combat this, we should be educating our students on appropriate ways to respond when their friends confide in them about suicidal thoughts/intentions. The material in **Appendix B** is intended to help all individuals support someone who feels the urge to self-harm.

Helping someone cope with suicidal ideation is not an easy task, and can be overwhelming and stressful. It is extremely important that you take care of yourself during this process by identifying your own support systems, and making sure you reach out for help when needed. You are not expected to drop everything to help a student through their pain, but you must ensure that you are doing as much as you can manage. If you do not have time to be there for the person right now, make sure you refer the student to someone who can (**see Appendix C**).

There can be a lot of fear and stress in confronting a student about your concerns as a teacher. It is normal to be overwhelmed since there is a sudden increase in responsibility. What happens if I find out a student is being abused in their home? Will bringing up my concerns do more harm than good? If I am wrong, will I be at risk of losing my job? Take special care to familiarize yourself with the legal/ethical policies and procedures set in place within your county and school to handle particularly difficult scenarios that could arise.

Abuse and Neglect. It may help to know that if you suspect child abuse or neglect is happening in the home of a student under the age of 18, you are mandated to report your reasonable suspicions. The California Child Abuse and Neglect Reporting Law (2019) explains, “Child abuse must be reported when a mandated reporter, ‘in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect.’” In Marin County, it is required that you file an official report to Children and Family Services (CFS) Emergency Response. Simply telling a supervisor does not count as fulfilling your duties as a mandated reporter, however you may call CFS at any time to seek appropriate counsel about your claim. Remember that you are not just at school to teach. You have a legal and ethical obligation to ensure that your students are safe in their home and school environments from their family, their classmates, other school officials, and themselves. If reasonable suspicions of abuse come to your attention, reporting steps include:

1. Call (415) 473-7153 immediately.
2. Download the Suspected Child Abuse Report Form and complete it within 36 hours. (see

Appendix D)

3. Fax report to (415) 473-3279 (this is currently the only way to send the form).

Although you are not legally required to inform the child's guardian(s) about the report, it may be a good idea to have the school notify their guardians to maintain a trusted, supportive relationship. However, you must use your best judgement in deciding to confront the family to avoid increasing the level of violence in the home environment. It should be noted that the majority of cases reported do not end up going to trial, and it is CFS's last resort to remove the child from their home. Typically the allegation is investigated, and appropriate referrals are made to families in order to ensure the caregiver is able to adequately care for their children. Only in the event of severe abuse and neglect will the Department of Justice determine that the student(s) need to be removed from the home.

There is no punishment for submitting a suspected child abuse report even if nothing is found upon the investigation. However, you could be liable for *failing* to report reasonable suspicion of abuse or neglect. The website Child Abuse Mandated Reporter Training explains, "A mandated reporter who fails to make a required report of child abuse is guilty of a misdemeanor punishable by up to six months in jail or by a \$1,000 fine or by both a fine and imprisonment," (California Child Abuse and Neglect Reporting Law, 2019). If you even *slightly* suspect a student is being maltreated in their home, call. Calling CFS does not mean you are making a judgement about the family. You are simply being careful and suspicious. Your suspicions may not warrant an investigation, but they might. If the situation requires a second look, qualified investigative authority will take it from there. If a parent is wrongly accused and questioned as a result, they are most often still grateful that the teacher cared enough to protect

their child. You should never second guess your intuition. You are always better off making the call.

Bullying. Throughout the transformative development of the internet, bullying has taken on a new face. Harassment is no longer confined to the schoolyard, and has breached the home life of many teens through electronic means. According to the Centers for Disease Control and Prevention, “Bullying can result in physical injury, social and emotional distress, self-harm, and death. It also increases the risk for depression, anxiety, sleep difficulties, lower academic achievement, and dropping out of school.” Bullying of many different forms is rampant in the United States, affecting one in five high school students in 2018 (Preventing Bullying, 2018). Many more cases of bullying go unreported due to the scary and confusing nature of the physical, verbal, or social aggression. Victims of bullying commonly feel:

- Shame
- Embarrassment
- Fearful that the bully will become more violent if they tell someone
- Isolated and alone

Many victims commonly think:

- They will not be taken seriously if they come forward
- They will be labeled a tattletale by others
- They should be able to handle the situation on their own
- They deserve the bullying

- They will have to change or give up important aspects of their lifestyle (i.e. phone privileges, transfer schools, etc.)
- They need to endure the aggression in order to maintain their social status

Not every student who is being bullied will ask for help, and not every student will know that what they are experiencing *is* a form of bullying. That is why it is important to familiarize yourself with the warning signs for bullying, and prepare to intervene if you suspect a student is being physically or emotionally harassed by their peers. Warning signs of bullying include:

- Declining grades or missing assignments
- Lack of participation or interest in course material
- Increase in absences/leaving the classroom
- Missing or damaged school supplies/clothing
- Avoidance of social situations or isolation
- Tearful or gloomy demeanor
- Trouble concentrating in class or daydreaming

Do not be afraid to approach a student privately and directly ask them if they are being bullied at school. Immediate intervention is crucial to ensure the student is safe and supported.

Be calm and collected when you converse with the victim, and remind them that their safety is your number one priority. It is always okay to involve other adults at your school in order to appropriately handle the situation. Create a plan with another reliable staff member to meet with the victim and the bully separately, and avoid blaming or judging those involved. If there is

serious danger such as intent to harm with a weapon, threats of physicality, hate speech or violence, sexual abuse, or serious legal concerns, immediately contact authorities to intervene.

If you have assessed the situation and determined you do not need law enforcement to respond, the next step is to work with the child (and other crucial support systems) to develop a game plan. If the adolescent will feel relief from moving seats in the classroom or switching partners in a group project, then proceed to make the necessary accommodations. If the situation is causing enough distress that the victim needs a bigger intervention strategy (such as changing classes or schools), the bully should be relocated instead of the victim. Only in situations of extreme violence, persistence, and/or danger should the bully be suspended or expelled from school since this form of punishment rarely reduces the behavior. Instead, consider collaborating with the student and their support systems to help them understand the negative impact their behavior has on other people.

You feel inclined to come to the rescue of the bullied student, but being there for the bully is equally as important. In fact, students who bully others have an increased risk of mental health and substance abuse issues later in life. It is also not uncommon that those who bully are often victims of bullying or other forms of violence themselves. Understanding the reasons why the student is harming someone else is just as important as helping them understand their actions result in consequences. The student may be bullying others to fit in at school or because they need additional support. Depending on the reason(s) you gather from the student, your intervention strategies will vary. In most cases of bullying, simply punishing the offender rarely solves the problem because their underlying behavioral or emotional issues fail to be addressed. Do not hesitate to consult with school leadership in order to map out the appropriate course of

action. Your fellow staff and school leaders are there to support you when difficult situations arise.

At the end of the day, always be sure to promote a safe environment in your classroom so your students know they can approach you with any concerns. If you suspect bullying of any form is taking place, make an effort to listen, educate, and follow-up. Your ability to effectively respond to the situation will ingrain an invaluable perspective/lesson for both the bully and the victim; one that will follow them for the rest of their lives.

Self-harm. Safety is, of course, the number one priority if you suspect a student is engaging in self-harming behaviors (otherwise known as non-suicidal self-injury [NSSI]). If you observe that a student is in danger of infection, other life-threatening injuries, or death related to self-harm, please take immediate action by notifying a reliable school leader. Raychelle Lohmann, a certified licensed professional counselor and author of numerous help books for teens, says some indications that a student may be self-harming include:

- Having many cuts/burns on wrists, arms, legs, back, hips, or stomach.
- Wearing baggy or loose clothes (e.g., wearing hoodies or long sleeves during hot days to conceal the wounds).
- Making excuses for having cuts, marks or wounds on the body.
- Finding razors, scissors, lighters or knives in strange places.
- Leaving class for prolonged periods of time.
- Avoiding and isolating oneself from others.
- Expressing self-anger or self-disgust.
- Having fresh wounds or lots of unexplainable bruises (Lohmann, 2017).

If you have a positive, secure relationship with the student, consider approaching them yourself. If you can help the student feel safe and supported in the process of seeking help, they will be more open about what is going on for them. When approaching a self-harming student, be honest, relaxed, empathetic, non-judgmental, and supportive. A way to portray these characteristics is to use I statements. The Cornell Research Program on Self-Injury and Recovery suggests statements such as:

I'm concerned about you and want to be sure you have the support you need, or I'm worried about you. I've seen these scars on your arms and I think you might be hurting yourself. If you are, I want you to know that you can talk to me about it. If you can't talk to me about it, I hope you will find someone else you trust to talk to. (Bubrick, Goodman, & Whitlock, 2010)

It is important to show compassion because internally, those engaging in NSSI can be experiencing dark and complex emotions. An anonymous source shared her story on the NAMI website:

I can't remember what made me decide to cut myself. I remember reading a story in my teen bible about a girl who cut herself and she didn't really know what had happened. I tried it and it provided a couple minutes of help. It became my secret. This continued until my best friend found out. She encouraged me to stop and I did for some time. The stress of high school took its toll on me. I had to have good grades and stay thin and attractive. I punished myself when I didn't feel pretty. At this point it escalated from scratches to cuts. I could no longer use the cat scratch excuse. That's when my parents found out. They were not happy and I was threatened and yelled at and this only made it

worse. Eventually they learned to handle it with some understanding and support. (Self-Harm Struggle, n.d.)

Self-harm on its own does not guarantee your student is suicidal. When you approach someone about their NSSI, they might not have a reason for their behavior or completely understand what is contributing to their urge to self-harm. It is a complicated act—to deliberately inflict pain on yourself—with many complex things all happening at once. In most cases, the self-harming person already knows that what they are doing is dangerous and looked down upon by society. They already feel much shame from using this method to cope. Adding more judgement and disappointment to their experience is likely to make the situation worse. Some support systems are blinded by their intense fear and concern for the person struggling, and react angrily when they discover the self-inflicted wounds. Approaching someone with compassion is more beneficial than ambushing them with anxiety-inducing questions and assumptions. Between the person that notices the marks or scars and the person that has them, there is extreme fear, confusion, and unease. Recognizing that your student may be experiencing these overwhelming emotions too can help you maintain a supportive presence and foster a nurturing environment.

NSSI behaviors can be extremely dangerous if not addressed immediately. Severe forms of this coping mechanism can leave permanent marks on the body or result in fatality if not quickly treated. Although it is not mandatory for teachers to report NSSI to law officials in California, a strategy should be set in place to address your concerns with trusted and responsible members within your school. In Marin County, there is a specific protocol for seeking support for students in crisis. In severe cases of self-harming behavior, utilize the Marin County System

of Support Flowchart included in **Appendix E**. After you have notified your school's Crisis Intervention Team (CIT) and they have responded accordingly, make sure to routinely check-in with the student and provide additional assistance if needed.

Recommended Prevention Strategies and Toolkits

Wraparound Services. A wraparound service is a powerful and often overlooked support tool that schools can offer their struggling families. Customizing the treatment plan to include a child's most important support systems can result in a mended relationship between school and family if executed correctly. Research by Suter and Bruns (2009) evaluated the effectiveness of wraparound services for children with emotional and behavioral disorders. Evidence suggests that students receiving wraparound services are likely to benefit more than those receiving conventional services, but more research needs to be compiled in order to truly understand the impact these programs have. By implementing the correct components of a wraparound service, educators, parents, and other team members can be instrumental in providing adequate support and care. For more information, visit the National Wraparound Initiative (2019) website. The following is a testimonial from Katherine Schwartz, LCSW who had spent 12 years overseeing the wraparound programs at Seneca Family of Agencies (a California nonprofit mental health agency) in 2014:

It was ultimately the family partner, who was also a recovering drug addict, who was able to connect with the mom and help her think about what was underlying her feelings and behavior toward her daughter.... The family partner helped Brandi's mom also feel more comfortable with the idea of family therapy. Subsequently, the family therapist was able to work with Brandi and her mom on communication and on helping the mom set more consistent limits, despite the guilt she felt over the past. Brandi and her mom were able to rebuild trust slowly and things between them began to improve.... It seems clear that the program's capacity to build relationships and address the underlying mental health

issues simultaneously ultimately resulted in good outcomes. It is my experience that assigning a skilled clinician to each family allows the wraparound service to go that extra mile and offer interventions that help foster greater functionality, which in turn helps the family take advantage of the wraparound service being offered. It is also clear that relationship and connectedness are essential ingredients in the success of both of these cases. (Schwartz, 2014)

Preventing Suicide: A Toolkit for High Schools. The Substance Abuse and Mental Health Services Administration (SAMHSA) aims for this toolkit to help schools and their partners:

- Assess their ability to prevent suicide among students and respond to suicides that may occur
- Understand strategies that can help students who are at risk for suicide
- Understand how to respond to the suicide of a student or other member of the school community
- Identify suicide prevention programs and activities that are effective for the needs of individual schools
- Promote the importance of cultural competence and respond to the needs and cultures of each school's students (Substance Abuse and Mental Health Services Administration, 2012)

The complete toolkit is available for free download on the SAMHSA website.

After a Suicide: A Toolkit for Schools. The American Foundation for Suicide Prevention (AFSP), the Suicide Prevention Resource Center (SPRC), and the Education Development Center (EDC) recently published the second edition of *After a Suicide: A Toolkit for Schools* (American Foundation for Suicide Prevention, 2018). This toolkit helps school staff and administrators in implement a coordinated response in the event of a student suicide, while also providing the community with information and tools to enhance coping strategies and reduce the overall risk of suicide. Having a clear protocol is essential to community healing as it helps ensure your team is offering support to everyone who may be feeling emotionally overwhelmed. The aftermath of a suicide can leave an entire community feeling devastated and afraid, which is why having clear, concise steps to take can help ground the school staff and administrators who are expected to respond. The complete toolkit is available for free download on the American Foundation for Suicide Prevention website.

Mental Health First Aid Training. The Marin County Behavioral Health and Recovery Services Mental Health Services Act offers a course in how to help adolescents (age 12-18) who are experiencing a mental health related challenge or issue. This free one-day training, “introduces common mental health challenges for youth, reviews typical adolescent development, and teaches a 5-step action plan for how to help young people in both crisis and non-crisis situations. Topics covered include anxiety, depression, substance use, disorders in which psychosis may occur, disruptive behavior disorders (including AD/HD), and eating disorders,” (Marin Health and Human Services, 2019). Participants must register in advance for the training, and must attend the full day. For more information, please contact Veronica Alcala at VAlcala@marincounty.org.

Section 2: For Parents

Stories, warning signs, and action steps for parents to consider when helping their adolescent cope with symptoms of anxiety and depression.

Stories and Testimonials from Adolescents and Families Living with Mental Illness

It is rare to be prepared for mental illness to enter your life and family. It is non-discriminatory, and touches the lives of approximately 57.7 million Americans each year. On top of the overwhelming prevalence, the different types and levels of severity are extremely complex. Our world is far from a place where we can say, “It is going to be okay. I know exactly what to do,” when our children receive their first diagnosis, and we’re even farther from a place where we can be satisfied with each diagnosis and appropriate course of treatment. Noticing your child is struggling and coping with their discomfort is a process. Seeking help is a process. Treatment is a process. No matter where you may be along the journey, know you are not alone. Esme is interviewed in the book, *Behind the Wall: The True Story of Mental Illness as Told by Parents*, and speaks to the complexity and confusion often present at the beginning:

I always feared in the back of my mind that mental illness would hit me, my family, my *kids*. It is prevalent. It hit two nephews who now have life-impacting mental illnesses and another who has depression. My mother had mental illness but never acknowledged it and would never go on medication. I never had the tools to address mental illness, nor did my siblings. She ignored it, or “dealt with it.” Not in a good way because there was dysfunction in our family. I’ve lived through other really bad scenarios with my brother’s schizophrenia. Because of things that he experienced, I knew the situation could be worse than whatever we were dealing with. But until we got the diagnosis, I didn’t know what to do for Jennifer, and that was frustrating. For a long time, I didn’t know what *it* was in terms of a specific diagnosis. I recognize that she had depression

and anxiety. But I thought her behavior was hormonal. I really did. (Widdifield & Widdifield, 2015)

Whatever is happening behind the walls of your home, you do not have to stifle it. Speaking out and having honest, open conversations with others about your experience with mental illness could positively contribute to someone else's healing within your community, and reduce the stigma surrounding mental illness as a whole. Confiding in someone about your child's moods and sensitivities may shed light on important warning signs that you would have otherwise ignored. Working in collaboration with your student's teachers can also help you determine the best course of action for your family. If you have nothing to compare your child's behavior to, oftentimes teachers can help you understand the typical behavior of this developmental age.

Jennifer was never good with transitions. I'd always have to tell her in advance if I was going to stop to pick up milk after daycare. If I didn't warn her, she would be very unsettled. Looking back, I recognize there were signs of her sensitivity while in daycare, as she would often complain that someone wasn't nice to her. But I really started noticing her sensitivity when she was in kindergarten, though I didn't think it any different than what a typical child might experience. She's my first, so I had yet to have a comparison. Later, Jennifer's sensitivity affected her interactions with teachers and coaches. Of course, hindsight is twenty-twenty. At the time you just think, "Well, she's a sensitive child." (Widdifield & Widdifield, 2015)

One way to include a variety of professionals who interact and evaluate your child on a regular basis is to hire a wraparound team. Wraparound services typically consist of a facilitator,

a clinician, and a family partner (i.e., family members, service providers, agency representatives, etc.). As there are many different team members that can become involved, there are many different services that can be provided within a wraparound depending on the support your family needs. An example of services families have utilized as part of their wraparound plan include therapy, case management, facilitated family meetings, mentoring, and/or help in accessing alcohol/drug services and health services (Marin Health and Human Services, n.d.). If a wraparound seems like a good option for you and your loved one, it may be worth a conversation with your adolescent's school for more information on compiling a team.

Involving other people in your child's treatment can feel very invasive and intrusive at times. However, keeping mental illness hidden behind closed doors sends the wrong kind of message to those suffering. Topics that are avoided and dismissed tend to have a lot of shame attached, and they are also areas that people tend to lack knowledge and understanding about. As a result, those in need of immediate help and support are convinced that it is better to hold their pain inside. Being there for someone requires a different kind of strength and vulnerability, giving the distressed person space to be honest about thoughts and feelings they may have never shared with anyone else before. An anonymous NAMI source describes living with social anxiety and depression, and how isolating it can be:

People tell me to just get a job without understanding that this fear is crippling. The fear immobilizes me to the point where I have panic attacks just thinking about it. All of these issues have made me feel worthless. Have made me feel like I don't belong and in turn have given me depression... I get the same responses too. The "you're just shy" or "just get up and stop moping around" or even "you're not really going to kill yourself,

stop being ridiculous.” The fact of the matter is that I haven’t suffered in silence. My family knows. They just think it’s ‘all in my head’ and it is. That’s why it’s called mental illness. They don’t understand that you’re not mentally strong enough to overcome these things. They don’t understand that it’s not a switch you can just turn on and off. (The Struggles of Depression and Anxiety, n.d.)

A parent’s reaction to their child coming forward about their experience is impactful. Your ability to support and advocate for your child during this time is crucial to their road to recovery. Making assumptions about your child’s self-sufficiency or ability to handle their issues on their own can have negative consequences. Adolescents who feel helpless and desperate to end their pain may turn to reckless behaviors and dangerous coping mechanisms to stifle their symptoms. Charlotte Underwood, a mental health advocate and blogger, detailed her personal experience growing up with chronic anxiety and depression on the NAMI website:

I cannot help but feel that if I had treatment and support from the start, if as a child, I was given support for my growing anxiety and depression, then maybe I would have managed my illnesses better. I could have possibly avoided some of the reckless behaviors and attempts at my own life. While talking and learning about mental health would not have prevented my battles with mental illness, it could have provided me with vital tools to start my recovery much sooner. I could have given me the knowledge that I was not alone, and that I am not a problem. (Underwood, 2019)

You may feel incredibly close to your child as they enter their adolescent years, or you may feel distant. Either way you may not be fully aware of the challenges they are facing. The decision to approach parents about anxiety and depression can be daunting and challenging,

especially if the adolescent has been successful in hiding their pain. Some adolescents fear that revealing their distress will disappoint their family, while others do not want to cause them unnecessary stress or worry. An anonymous source who submitted their personal story on NAMI explained their reason for shielding their suicidal ideation from their parents:

One night, I confided in my best friend who also suffers from mental illness. I was feeling suicidal and wanting to talk to her. That night she convinced me to tell my parents what was going on. She told me I needed to go to the hospital. My parents had no idea- they thought I was a happy, honors student, worry free teenager. I was scared out of my mind. Telling them was the hardest part. The fear, feeling like you're ruining their lives, wanting to keep it a secret to make it seem like you're okay, everything.

(Recovery: The Hardest Thing in Life, n.d.).

With the drastic increase of expectations and responsibilities in today's high school students, there exists an enormous need for openness, empathy, and understanding when discussing mental health. Parents can be influential in the fight to end stigma by teaching their children essential help-seeking behaviors and self-care practices early on. This manual will provide helpful tools and resources to help students feel supported during their critical period of adolescent development. The next section will cover at-home warning signs and symptoms that could be indicative of mental illness.

Warning Signs: What to Look For in the Home

Mood/personality: Depending on the mental health condition, your child's mood can be affected in a variety of ways. Some common symptoms seen in those suffering from anxiety and depression include sadness, fatigue, seemingly “empty” mood, pessimism, loss of interest in hobbies and activities, irritability, withdrawal, and persistent complaints of physical/emotional discomfort or pain.

Physical appearance/behaviors: Alongside changes in mood/personality, other physical or behavioral changes can often indicate an underlying mental health issue. Self-medicating, weight gain or loss, wearing long sleeves in warm weather, too much or too little sleep, and reckless behaviors have been commonly observed in adolescents with symptoms of anxiety and depression.

It is important to remember that along with changing hormones and increased responsibilities, these symptoms may manifest as a result of life stress and could be alleviated by having an open, honest conversation with your child. However, if these symptoms persist for a long time and are severe enough, it is likely that your child could be suffering from symptoms related to mental illness. Take some time to review the following warning signs and specific examples of how they may appear in your home.

Aches/pains

- If your child constantly complains of aches/pains that offer no obvious cause, they might be experiencing a somatic symptom of anxiety or depression. It is common for headaches, migraines, backaches, chest aches, stomachaches, muscle aches, dizziness, stiffness, or dyspnea to be reported in individuals suffering from a

mood disorder. Oftentimes, people with depression seek treatment because of the somatic symptoms that are vague and ongoing—not necessarily because they are noticing a change in their mental state.

Agitation/irritability

- A teenager expressing an extreme bout of agitation/irritability can appear hostile, tense, violent, uncooperative, dismissive, and/or angry. It is important to assess the interaction you had with your teen, and keep track of how often they behave this way. If the temper outbursts persist, on average, three or more times per week, this may indicate a depressive disorder. Many individuals diagnosed with anxiety and depression have reported feeling out of control, and inexplicably agitated/irritable with friends, family, and others.
- Fidgeting with or picking at skin, hair, or belongings could also be indicators that your teen is feeling agitated/irritable. Body-focused repetitive behaviors such as dermatillomania (picking the skin) or trichotillomania (hair pulling) tend to be exacerbated by anxiety and should be closely monitored.

Appetite/weight changes

- A sudden, severe change in eating habits could be an indicator of an underlying issue. Situational symptoms are common in this age group, whether it is due to increased exercise, boredom, or changes in their body, however there may be a more serious underlying cause. Stress, sadness, illness, and body image can also have a large impact on appetite—whether your student is under-eating or over-

eating. Routine physical exams are important to ensure your child has a healthy appetite and body weight.

- Changes in eating are not always perceptible by the naked eye, however if you notice sudden weight loss/gain in your adolescent, it is important to address your concerns right away. Eating too much or too little can result in more serious medical issues that pose a risk to your child's life. Be careful when addressing this delicate topic to avoid contributing to negative self-perception issues that may exacerbate unhealthy/destructive coping mechanisms.

Clothing

- Self-injury/harm is a symptom of both anxiety and depression and is used as a means to cope with emotional pain. By hurting their body, those who self-harm often report they do so to feel alive, a release from their internal pain, pain they are convinced they deserve, or distant from others. It is common for those who self-harm to cut or burn places on the body that are not easily visible and are easily covered up. If you notice your child is wearing long sleeves and/or long pants in hot weather, this may be a sign that they are engaging in self-harming behavior.

Concentration

- When an individual is suffering from anxiety/depression, their mood disorder often overpowers their ability to pay attention. Their thoughts are overwhelmed with extreme fear and worrying, making it difficult for students to be successful in their classes. If you notice a sudden decline in your child's grades or inability to

complete assignments, there may be an underlying cause affecting their concentration.

- All forms of bullying (i.e., verbal, social, physical, cyber) are known to have a severe effect on a student's ability to focus on daily tasks and responsibilities, and could lead to other serious or lasting problems. Consider healthy monitoring of technology use and screen time to ensure their engaging in safe and appropriate online/texting behaviors.

Fatigue

- Feeling exhausted, sluggish, and unmotivated are common symptoms reported among people suffering from anxiety and depression. If your child is sleeping for abnormal periods of time and/or has been falling asleep in the classroom, check in with them to ensure they are receiving enough nourishment, exercise, water, and rest. If each of these needs are being met, further investigating should be done to determine why your child is excessively tired.

Helplessness/hopelessness

- Feeling helpless is commonly reported among those suffering from anxiety/depression. Helplessness often means that the person is lacking appropriate support or resources to recover from their mental illness. As a crucial support system, it is very important to understand that a person with anxiety and depression will not always ask for help directly. Helplessness comes from a need not being met, and it is common for a helpless person to be skeptical that anyone

can help meet that need. Trusting a person with deep, sensitive concerns is not an easy task, and pain and betrayal are daunting potential outcomes.

- Hopelessness is holding the negative view that nothing will get better. That pain and suffering will never end, and all hope is lost. Individuals with this perspective are more likely to consider extreme methods of putting an end to their pain such as leaving everything behind or ending their life. If an adolescent comes to you with feelings of hopelessness, it is important that you listen, offer hope, and take them seriously. Talking about death/suicide is not just a warning sign that someone might be planning to end their life, but a courageous step in their quest to seek help.

Loss of interest

- Giving up activities or interests that your child has previously engaged with could be a sign that they are experiencing a symptom of anxiety/depression. When individuals leave their interests behind, it can be very isolating and anxiety inducing. Having anxiety/depression is a constant and exhausting battle, rarely leaving time for a person's passions. It is not their choice to give up what they love, but their illness takes over in a way that forces them to. It can be heartbreaking and debilitating to let go of the things that previously sparked curiosity and enjoyment in life, and takes immense strength and support to regain control of. As much as possible, make sure your child's hobbies are accessible, safe, and supported as they could lead to a greater sense of fulfillment.

Panic attacks

- Panic attacks are different for everyone, and sometimes are not easily identifiable.

Not knowing what's happening to your body is a scary feeling, often startling the people going through the experience and those that are observing. Jenny, a mental health advocate and blogger, wrote to the National Alliance on Mental Illness that the first time she had a panic attack, "a strange and terrifying sensation came over me. Am I really here? Is this me or someone else I'm watching? Is this real?" She goes on to describe her symptoms as common, explaining that she experienced rapid heart-rate, sweating and shakiness, shortness of breath, lightheadedness and dizziness, tunnel vision, and feeling her throat close. However, it was the derealization she experienced that scared her the most. "The best way I can explain how it felt is that I was detached from myself, like I was living in a fog or dream and didn't know whose body I was in....I felt removed from the world and it was a struggle to bring myself back," (The Scariest Panic Symptoms that People Don't Talk About, n.d.). If your child is having strange thoughts and concerns about their ability to connect with the world, you may want to have them tested for an anxiety related disorder.

Reckless behavior

- It is common for parents to struggle with a balance between giving their child enough freedom to establish a healthy sense of independence while still keeping a close eye on them. It is normal for adolescents to be curious about adult behaviors during their high school years, sometimes even experimenting with

sensation seeking behaviors. However, there are instances where their experimentation becomes reckless and dangerous, requiring parental or professional intervention. Some examples of reckless behavior include (but are not limited to) regularly using drugs, alcohol, or other substances, receiving multiple tickets or traffic violations, having unprotected sex, stealing, ignoring curfews, hiding weapons, self-harm, and/or skipping school. Setting limits with your child is very important as it introduces them to a structured/responsible lifestyle and helps them understand that there are consequences to their actions. View the worksheet in **Appendix F** to help set reasonable/attainable expectations for your family. Discipline is not about punishment, but helping your teen understand how to appropriately behave in the world. If your child breaks a rule or engages in inappropriate/destructive behavior, how do you address it? Is there a plan set in place for your household to implement consequences for your child's actions? A worksheet is provided in **Appendix G** to help organize your disciplinary strategy in a positive, effective way.

Self-medicating

- When a person turns to methods or substances that temporarily reduce pain or intrusive thoughts, they are using a technique called self-medicating. Self-medicating is a very dangerous coping mechanism that can lead to overdosing, long term medical issues, and/or addiction. The documentary *Warning: This Drug May Kill You* follows a young adult named Stephany and her sister Ashley. When Stephany was 15 years old, her doctor prescribed her pain medication to

help alleviate the pain of kidney stones. Stephany would often share her medication with Ashley to help with menstrual cramps, sleep, headaches, and other issues. The two sisters eventually became dependent on the powerful medication, and realized they could not function without opioids. Once the medication stopped being prescribed by Stephany's doctor, she began using heroin as it seemed to be a less-expensive, easily attainable solution (Weiss, Bills, & Peltz, 2017). It is a devastating reality that young children are being given these strong prescription medications to cope with their pain, but never informed about the risk of addiction or prolonged use. If you suspect your child regularly consumes drugs or alcohol to help with daily functioning, it is important to seek treatment for their substance abuse. If your adolescent is suffering from dual diagnosis (such as anxiety/depression alongside substance abuse), they will need separate treatment for both health issues.

- According to a study on Genetic and Environmental Contributions to Nicotine, Alcohol and Cannabis Dependence in Male Twins, alcohol dependence is connected to genetic factors by 50-60%, nicotine dependence is connected by 60-70%, and cannabis usage by 35-58% (Xian, Scherrer, Grant, Eisen, True, Jacob, & Bucholz, 2008). The remaining factors lie in the environment and presenting trauma throughout a person's life. Some environmental factors that make an adolescent particularly susceptible to substance abuse include mental illness, peer pressure, accessibility to the substance, physical or sexual abuse, or witnessing violence. It is important to discuss the potential risks of addiction with your

children early enough as many adolescents are participating in underage drinking as early as 11 years old. Be open to discussing the serious risks that can come from using alcohol and drugs, while also answering their questions honestly and non-judgmentally. The age of adolescence is a time for seeking guidance and answers to difficult questions. The more open you are to discussing these issues with your teen, the more trust and appreciation they will have for your advice and perspective about the world.

Sleep changes

- Sleeping too much could be an indicator that your adolescent is feeling overwhelmed with anxiety or depression. With the increased responsibility and the added stress of academic achievements/expectations, it is becoming more and more common for students to pick up unhealthy sleeping habits. However, if your student seems abnormally debilitated or consumed by the desire to sleep, they may need additional help or support. The Centers for Disease Control and Prevention recommend teenagers receive a minimum of eight hours of sleep per night (How Much Sleep Do I Need, 2017). In order to maintain a healthy circadian rhythm over the weekend, adolescents should only sleep one to two hours past when they normally wake during the week. If your child sleeps until midday or regularly falls asleep during inopportune times, they may need a professional evaluation (Find out When Sleeping in is Normal and When It Is a Red Flag, 2018).

- Sleeping too little is also an indicator that something more serious may be going on. Extreme worrying or anxiety can commonly affect a person's ability to get a healthy quantity or quality of sleep. Other factors such as excessive technology usage, too much caffeine, unhealthy eating, and lack of exercise can negatively affect your teenager's sleeping habits. If you have excluded these factors as reasons your child may be sleep deprived, you may want to rule out the possibility of mental illness or a sleep disorder through medical evaluation.

Uncontrollable emotions

- When it comes to teenagers and their rapidly changing moods, it is difficult to distinguish normal hormonal changes from warning signs of mental illness. During this stage of development, it is common for adolescents to distance themselves from their parents because they are suddenly confused and uncomfortable with the changes happening to their bodies—just remember what it was like going through this stage yourself. There may be sudden outbursts and disrespectful comments that come from your teenager, but this will subside with your patience and understanding. It is difficult to witness the distance growing between you and your child, but giving them space and time to establish their identity will only improve your relationship with them for the future. Sometimes major changes in attitude persist to the point where it is negatively affecting all major aspects of their life, and may be an indicator of mental illness. Withdrawal from friends or social groups, poor hygiene, regular tearfulness and sense of hopelessness, and/or expressing thoughts of suicide are all concerning behaviors

that should be addressed immediately. Periods of feeling sad, lonely, or irritable are normal for teenagers, but may indicate depression if these periods persist over a week or two (Monroe, 2017).

Worrying/Fears/Phobias

- With immense pressure to live up to the high university standards of grades and extracurricular activities, it is normal for your teen to be worried about their upcoming responsibilities. They are worried about letting themselves and others down, and often fear they will become a disappointment. Sharing concerns about their successful future is normal, and more mild expressions of anxiety are expected. However, more severe symptoms such as sweating, trembling, rapid heartbeat, dizziness, physiological pain, difficulty breathing, numbness, and delusion/derealization are common among people with an anxiety disorder.
- Phobias or irrational fears can also indicate dysfunction in your child's life. If the fear is so overwhelming that it interferes with your teen's everyday tasks, they may need to see a medical professional for help regulating/understanding their thoughts and feelings.

Withdrawal

- Usually, teenagers experiencing typical hormonal moodiness won't withdraw from their friend groups and social situations. Spending time with peers is important as it helps your teenager build a sense of identity and belonging. Connecting with others provides comfort and support through their remaining high school years, and alleviates feelings of loneliness and inadequacy.

Navigating the System

Seeking treatment for your child. If you are feeling frightened and overwhelmed in the stage of seeking treatment for your family member, you are not alone. Seeking services to help your child can be a frustrating and daunting process with a sudden whirlwind of resources and conversations to sift through and consider. As difficult as it may seem at the time, it is important to stay calm and continue to take good care of yourself. Mental health issues are treatable, and there are extraordinary people in your community who are committed to helping your family find a solution that works for you. As a concerned parent, you are already doing an extraordinary amount for your child's ability to be successful in their journey toward wellness.

Acknowledging and advocating for your child's symptoms will help them realize they have the love and support of the people who mean most, while also allowing for a safe space to explore different ways to cope with their distress. The following steps are important to consider when beginning the mental health journey with your child.

Step 1: Open up About Your Concerns. If you have noticed a sudden change of behavior or routine in your child's life, communicate your concerns to them. Your child may be able to provide some insight as to why there has been a change, or acknowledge they have not been feeling their normal self. If this is the case, you can work together to determine next steps, and move forward in the process together. Sometimes it is difficult for adolescents to articulate what they are feeling, and it is possible they feel relieved when a trusted adult makes the first move to start the conversation.

Alternatively, your teen may deny that anything is going on, or feel defensive about your concerns. It is possible that they truly have no insight into what is happening internally, or

perhaps feel ashamed, fearful, and/or confused about their symptoms. If this is the way your child responds, it is important to remain supportive and patient. They may need some time to collect their thoughts and feelings about their experiences, and will confide in a trusted adult when they are ready. If your child decides to approach someone outside the family with their concerns, remember that the fact they are confiding in anyone is what is most important. It is natural to feel sad, frustrated, or hurt when a loved one keeps their pain from you. It is completely understandable to feel that way, but it is important to recognize that their secrecy is not meant to be vindictive or malicious. Oftentimes children shield their struggles from their parents in attempt to assuage feelings of worry or guilt. In this case, make it a point to reassure your adolescent that you are always available and ready to listen. Let them know you that are here for them, and that you are proud of them for reaching out to someone about their mental health—even if that person is not you.

Step 2: Create a Safety Plan. Sit down with your teen and help them pinpoint their suicidal thoughts and feelings (if any), identify any triggers or situations when/where they feel unsafe, and help them recognize their reasons for living or things they can do to find comfort. Next, make a lengthy list of trusted adults or contacts your child can reach out to when they feel out of control. This should include people they can call, places they can go, and medical providers/organizations where they can seek professional advice. Keep checking in on your child's safety, and never substitute real life professional help for the Safety Plan you create together. A Safety Plan template is included in **Appendix H**.

Step 3: Physical Examination. During the initial conversation with your child, it is important that you plan a time to visit your primary care provider for a physical exam. If you

and your child decide it is the best option to seek psychological treatment for the symptom they are experiencing, the counseling professional may make a referral to test for any medical conditions that could be contributing to your child's anxiety or depression. Diseases and ailments such as high blood pressure, diabetes, or Lyme disease are common conditions that can affect mood and functioning, and should be ruled out during the initial stage of seeking treatment. Give your child time to speak with the doctor privately as they may withhold valuable information if you remain in the room. If nothing is found during medical examination, then it is possible your child will need to proceed with a psychological evaluation.

Step 4: Determine Treatment Options. The good news is also the bad news. There are many different programs, groups, therapists, medications, and wellness initiatives in Marin County to help your teen. There are so many options that many families feel overwhelmed with where to go, and need help sifting through them in order to uncover the services that best fit their specific needs. Oftentimes the services that will best suit your family will depend on affordability, and what's covered by your medical insurance. If you are a resident of Marin and are seeking information/resources from an organization over the phone, there's a good chance they will direct you to the BHRS (Behavioral Health and Recovery Services) Access Team in order to assess your child's needs for the most appropriate referrals. The Access Team is available 24/7 to point you and your child in the right direction, and perhaps set up an in-person appointment to assess and screen for mental health and substance abuse issues.

BHRS offers prevention and early intervention, suicide prevention and crisis services to all residents of Marin County. BHRS also provides outpatient, residential and hospital care addressing specialty mental health and substance use service needs of Marin Medi-

Cal beneficiaries and uninsured residents. (Behavioral Health and Recovery Services, n.d)

It may be helpful to familiarize yourself with the services of BHRS at this time, and start a conversation with a team member. Refer directly to your insurance provider if you are unsure what service you and your family qualify for.

Step 5: Information to Gather Before the Call. In order to get the most out of your phone call to a mental health service provider, organize the information and questions you have about your adolescent. During the initial intake, the health professional will want to know why you are calling, and what symptoms your child has been experiencing. Being prepared to answer questions prior to the assessment can help the counseling professional better understand what might be going on with your adolescent. If your child will be present during the initial interview, make sure you take some time to phrase your observations in a supportive way. For example, instead of saying, “She is doing terrible in school,” you can alter your language to, “Her grades have recently dropped, and she has lost interest in her favorite studies.” A thorough list of important information to consider gathering is included in **Appendix I**.

Step 6: Resource Guide. There are many services and prevention programs in place to support you and your family through the mental health and stigma-related challenges that may arise. Please see **Appendix C** for Marin County resources gathered in 2019.

Community Programs and Services

Behavioral & Mental Health Support

TAY Space: *Youth Drop-In Center* - San Rafael. “TAY Space is a community center for youth ages 16-25 (transitional age youth, or TAY) who struggle with mental, behavioral, and/or emotional disorders including bipolar, schizophrenia, anxiety, and depression. The transition from childhood into adulthood presents many challenges that are only exacerbated for young people with mental health diagnoses. Many TAY Space clients also navigate poverty, homelessness, and histories of foster care, incarceration, hospitalization, abandonment, and/or abuse. TAY Space is specifically designed to support this age group in managing their mental health; connecting to resources for housing, education, and employment; and building on their strengths to forge a self-sufficient future. The goal of TAY Space is to help vulnerable, transitional age youth gain the foothold they need to thrive beyond their diagnoses and histories. TAY Space also functions as a drop-in center for our FSP clients as well as any other youth in need of a safe place and a community of other transitional age youth. On a drop-in basis, TAY Space provides job coaching; substance use services; workshops on stress reduction and mindfulness, money management, and independent living skills; as well as critical social opportunities such as games, hikes, movies, sports, and cultural events.” Contact TAYSpace@sidebysideyouth.org for more information, or drop-in at 615 B St, San Rafael.

Huckleberry Youth. *Health Education Workshops* - Visiting Service. “Huckleberry Teen Health Program in Marin, provides Health Education workshops to young people throughout middle schools and high schools and at various community-based organizations. Our workshops

are offered free of charge to public schools and organizations serving public school students.

Topics include: Alcohol, Tobacco and Other Drugs; Anti-Homophobia Workshops; Body Image; Communication About Sex and Drug Use; Contraception and Pregnancy Prevention; Diversity; Eating Disorders; Family Dynamics; Healthy Relationships; Sexual Decision-Making; Oppression Issues; Puberty; Rape and Abusive Relationships; Reproductive Anatomy; STI Prevention Education; Self-Esteem; Suicide Prevention; and Violence Prevention.” Request program through the Director of Community Health, Jaclynn Davis; jdavis@huckleberryyouth.org, 415-258-4944.

Parent’s Turn - San Francisco. “A free 6-week skill building and support group for parents of teens and young adults. Parent’s Turn offers effective tools and real solutions to help: stop destructive teen behavior, deal with adolescent attitude, end arguing with your child, heal family relationships, reinstate appropriate parental authority, improve your child’s grades, address drug and alcohol use, get support from other parents facing this tough job.” Contact Christina Velasco; cvelasco@huckleberryyouth.org, 415-919-7641 to inquire about the next six-week cycle of this workshop.

Teen Tuesday Drop-In Clinic - San Rafael. “The Teen Tuesday drop-in clinic every Tuesday afternoon from 1 PM to 5 PM offers health services at no cost to teenagers. These services include health education, pregnancy testing and options counseling, HIV and other STI testing, male and female exams, short-term counseling, and case management.” Location at 361 Third Street, Suite G, San Rafael.

Family Support Groups

National Alliance on Mental Illness Marin: *Family Support Group* - San Rafael and Novato.

“NAMI Marin Family Support Groups are peer-led support groups for family members, non-professional caregivers and loved ones of individuals living with mental illness. Gain insight from the challenges and successes of others facing similar circumstances. NAMI Marin Support Groups are unique because they follow a structured model, ensuring everyone has an opportunity to be heard and to get what they need. The groups are free of cost to participants, designed for adult loved ones (18+) of individuals living with mental illness, led by family members of individuals living with mental illness, meets bi-weekly, no specific medical therapy or medication is endorsed or recommended, and confidential. By sharing your experiences in a safe and confidential setting, you gain hope and develop supportive relationships. This group allows your voice to be heard, and provides an opportunity for your personal needs to be met. It encourages empathy, productive discussion and a sense of community. You’ll benefit through other’s experiences, discover your inner strength and learn how to identify local resources and how to use them.”

Table 2 NAMI Marin Family Support Group Meetings

San Rafael	Novato	Central Marin (Español)
<p>Meetings are held on the second and fourth Tuesdays of the month, 6:00-8:00pm with Kay Browne, MD. and Jack Lieberman</p> <p>Enterprise Resource Center, 3270 Kerner Blvd., Building A, Suite C, San Rafael</p> <p>For more information, please call the NAMI Marin office at (415) 444-0480.</p>	<p>Meetings are held on the first and third Wednesdays of the month from 7:00-8:30 pm with Adam Edell, United Methodist Church, Room 7, 1473 South Novato Blvd, Novato.</p> <p>For more information, contact Adam at adam.edell@gmail.com.</p>	<p>Meetings are held on the first and third Thursdays of each month from 7:00-8:30 pm, Enterprise Resource Center at the Wellness Center Campus, 3270 Kerner Blvd, San Rafael. For more information call Gloria McCallister at 1-415-473-2261.</p>

LGBTQ

The SPAHR Center: *SPAHR Center Youth Drop-In Groups* - Novato, Mill Valley, and San Rafael. “These are inclusive spaces where LGBTQ teens can have fun and informative conversations about gender identity, sexual orientation, questioning and coming out, as well as general life, family and school issues. Come meet other young people in your community, make new friends, and connect with others’ shared experiences. We provide snacks and a safe space to engage with others and just be yourself. Each group has one or two facilitators including Nina Friedman, Q’d In Program Manager; Cammie Duvall, LMFT and Deborah Spake, LMFT.” - visit thespahrcenter.org for more information.

Table 3 SPAHR Center Youth Drop-In Group Meetings

Novato	Mill Valley	San Rafael
This group meets on the 1st and 3rd Wednesdays at The Margaret Todd Center, 1560 Hill Road, from 5:00 – 6:30.	This group meets on the 1st and 3rd Tuesdays at The Mill Valley Community Center, 180 Camino Alto, from 5:00 – 6:30.	This group meets on the 2nd and 4th Wednesdays at The First Presbyterian Church of San Rafael, 1510 Fifth Ave in the Stewart Room from 5:30 – 6:30.

SPAHR Center Parent Support Groups - Corte Madera and Mill Valley. “This Support Group for parents of trans/non-binary/gender questioning children is a great resource for parents and caregivers, to talk about parenting LGBTQ and/or Gender-expansive children and teens. Come share your experiences in a place where you can speak openly and be heard. Find and give support to others. Express feelings and get information. Explore how best to support the child. Facilitated by Janna Barkin, parent and author of *He’s Always Been My Son*, Cammie Duvall, LMFT. There are two separate groups that meet monthly, one in Corte Madera and the other in Mill Valley.” Visit thespahrcenter.org/events to view the calendar for dates and times.

Substance Abuse

Huckleberry Youth. *Adelante (Moving Forward) Substance Abuse Intervention and Treatment for Young Adults - San Rafael.* “Huckleberry’s Adelante program supports youth and young adults as they strive to reduce or eliminate substance use and abuse in their lives. Adelante means “Moving forward” in Spanish and that is the ultimate goal of the program: to help youth move toward a healthy, balanced life with positive coping strategies, goals and plans for their future, and supportive relationships. Adelante components include: outreach to youth and young adults who may be at risk for substance abuse, screening for substance abuse through several of

our program components, assessment by a Certified Drug and Alcohol Counselor, and brief Intervention for youth/young adults who are using substances periodically and wish to reduce or eliminate use.” Call (415) 258-4944 for more information.

Conclusion

As this project reached its final month, another Marin County high school student died by suicide. The loss of this student is just as painful, scary, and shocking as the many suicide completions that came before. Upon hearing about these tragic losses, NAMI Marin and many other support programs in the community have been deliberate and purposeful in their mission to reduce the stigma of mental illness. As a result, we are starting to have crucial conversations with our youth about important topics like anxiety, depression, and suicide. We are learning that coming together to talk about these sensitive issues is *helping*. By shedding light on the warning signs and symptoms of mental illness, we are giving others the opportunity to ask questions and speak out about an often misunderstood topic. Wherever you may be in the world, no matter how many resources you have or how organized the information may be, there is no way to press onward after a tragedy without community-based healing. If we continue to tackle treatment and recovery on an individual level, those suffering from anxiety and depression within Marin County will continue to feel isolated and alone. We need to help high school students with anxiety and depression realize they are not broken. They, like everyone else, have needs that are not being met. We are constantly having reactions to our surrounding environment because something has gone wrong with the way we are living. Johann Hari, a Swiss-English writer and journalist that has also struggled with depression, writes in his book *Lost Connections*:

Depression and anxiety might, in one way, be the sanest reaction you have. It's a signal, saying—you shouldn't have to live this way, and if you aren't helped to find a better path, you will be missing out on so much that is best about being human. (Hari, 2018)

Anxiety and depression will always exist. Instead of muffling, silencing, or pathologizing the pain that these disorders cause, we need to listen to it. We need to show our surrounding community love, understanding, and reassurance in order to build back the connection we have lost. If we cannot change the pain that our youth are experiencing as a result of their stressful academic and social environments, we need to change the way we are supporting them. The goal of this project is to inform Marin County teachers and parents about the many resources available for youth struggling with anxiety and depression, and to offer a variety of tools that can help them reach out in a meaningful, supportive way.

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Appendix A

Teacher Checklist to Organize/Plan Next Steps

Teacher Checklist to Organize/Plan Next Steps

1. Have I requested to speak with the student privately?	Yes	No
2. Observations and perceptions that student is distressed:		
•		
•		
•		
3. Concerns you have for the student's well-being:		
•		
•		
•		
•		
4. Ways I can relieve the pressure on student in my own class:		
•		
•		
•		
•		
5. I will refer the student to these people/services for additional help/resources:		
•		
•		
•		

If your student expresses **suicidal ideation**, please provide them with the following information:

National Suicide Prevention Hotline: 1 (800) 273-8255

Speak to a Marin County Buckelew Crisis Counselor: 1 (415) 499-1100

Appendix B

Helping Someone Else

Helping Someone Else

Step One:	<p>Contact a Lifeline Center:</p> <p>Never keep it a secret if a friend tells you about a plan to hurt themselves. Call 1-800-273-TALK (8255) so that you can find out what resources are available in your area, or encourage your loved one to call. Calls are routed to the Lifeline center closest to your area code that can provide you with local resources.</p>
Step Two:	<p>The Do's and Don'ts:</p> <ul style="list-style-type: none"> ● Be direct. Talk openly and matter-of-factly about suicide. ● Be willing to listen. Allow expressions of feelings. Say things like, "It makes me sad that you are feeling this way," and "I am here for you, and I'm so glad you came to me with this." ● Be non-judgmental. Do not debate whether suicide is right or wrong, or whether feelings are good or bad. Do not lecture them. ● Show your support but get someone else involved (a teacher, parent, or other trusted adult). ● Do not dare them to go through with it. ● Do not act shocked - this might put distance between you. ● Do not be sworn to secrecy. Seek support. ● Offer hope that alternatives are available but do not be insincere. ● Take action. Tell someone if your friend is in possession of

	<p>dangerous weapons or pills.</p> <ul style="list-style-type: none"> ● Get help from people or agencies specializing in crisis intervention and suicide prevention.
Step Three:	<p>Ask</p> <p>Asking the question “Are you thinking about suicide?” communicates that you are open to speaking about suicide in a non-judgmental and supportive way. Asking in this direct, unbiased manner, can open the door for effective dialogue about their emotional pain and can allow everyone involved to see what next steps need to be taken. Other questions you can ask include, “How do you hurt?” and “How can I help?” Do not ever promise to keep their thoughts of suicide a secret.</p> <p>The flip side of the “Ask” step is to “Listen.” Make sure you take their answers seriously and not to ignore them, especially if they indicate they are experiencing thoughts of suicide. Listening to their reasons for being in such emotional pain, as well as listening for any potential reasons they want to continue to stay alive, are both incredibly important when they are telling you what’s going on. Help them focus on their reasons for living and avoid trying to impose your reasons for them to stay alive.</p>
Step Four:	<p>Keep Them Safe</p> <p>It is important to find out a few things to establish immediate safety. Have they already done anything to try to kill themselves before talking with you? Does the person experiencing thoughts of suicide know how they would kill themselves? Do they have a specific, detailed plan? What’s the timing for their plan? What sort</p>

	<p>of access to do they have to their planned method?</p> <p>Knowing the answers to each of these questions can tell us a lot about the imminence and severity of danger the person is in. For instance, the more steps and pieces of a plan that are in place, the higher their severity of risk and their capability to enact their plan might be. Or if they have immediate access to a firearm and are very serious about attempting suicide, then extra steps (like calling the authorities or driving them to an emergency department) might be necessary.</p>
Step Five:	<p>Be There</p> <p>This could mean being physically present for someone, speaking with them on the phone when you can, or any other way that shows support for the person at risk. An important aspect of this step is to make sure you follow through with the ways in which you say you'll be able to support the person – do not commit to anything you are not willing or able to accomplish. If you are unable to be physically present with someone with thoughts of suicide, talk with them to develop some ideas for others who might be able to help as well (again, only others who are willing, able, and appropriate to be there). Listening is again very important during this step – find out what and who they believe will be the most effective sources of help.</p>
Step Six:	<p>Help Them Connect</p> <p>Helping someone with thoughts of suicide connect with ongoing supports (like the Lifeline, 800-273-8255) can help them establish a safety net for those moments they find themselves in a crisis.</p>

	<p>Additional components of a safety net might be connecting them with supports and resources in their communities. Explore some of these possible supports with them – are they currently seeing a mental health professional? Have they in the past? Is this an option for them currently? Are there other mental health resources in the community that can effectively help?</p> <p>One way to start helping them find ways to connect is to work with them to develop a safety plan. This can include ways for them identify if they start to experience significant, severe thoughts of suicide along with what to do in those crisis moments. A safety plan can also include a list of individuals to contact when a crisis occurs.</p>
Step Seven:	<p>Follow Up</p> <p>After your initial contact with a person experiencing thoughts of suicide, and after you have connected them with the immediate support systems they need, make sure to follow-up with them to see how they're doing. Leave a message, send a text, or give them a call. The follow-up step is a great time to check in with them to see if there is more you are capable of helping with or if there are things you have said you would do and have not had the chance to get done for the person.</p> <p>This type of contact can continue to increase their feelings of connectedness and share your ongoing support.</p>
Step Eight:	<p>Listening Technique</p> <p>OARS: Open-ended questions, affirmation, reflective listening,</p>

	<p>and summary.</p> <ul style="list-style-type: none"> ● Open-ended question examples: <ul style="list-style-type: none"> ○ How can I help you with ____? ○ How would you like things to be different? ○ What are the good things in your life? ○ Help me understand why you are feeling this way. ● Affirmation examples: <ul style="list-style-type: none"> ○ I'm so glad you came to me with this. ○ You are so strong for seeking support through this. ○ I'm proud of you. ○ I'm right here beside you. I'm here to help with the weight you are carrying. ● Reflective Listening: <ul style="list-style-type: none"> ○ I understand that you are feeling ____. ○ It sounds like you ____. ○ It must have been really hard when ____ happened. ● Summarize: <ul style="list-style-type: none"> ○ Here's what I'm understanding. Tell me if I've missed anything. (Provide summary of discussion)
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(How the 5 Steps Can Help Someone Who is Suicidal, n.d.)

(Help Someone Else, n.d.)

Appendix C

Marin County Resources and Support Programs

Marin County Resources and Support Programs

Table 4 Marin County Resources and Support Programs 2019

<p>NOTE: Immediate Medical Attention</p> <p>Police - 911</p> <p>Marin General Emergency Room: 250 Bon Air Rd, Greenbrae, CA 94904</p> <p>If you or someone you know is having a mental health crisis, call 911. Give the operator as much information as you can, and ask for a CIT (crisis intervention team) member to respond to the situation. Police can transport a person to the hospital willingly and involuntarily, or conduct a welfare check on someone you are concerned about or cannot reach.</p>	
Service Needed	Who to Contact
Assessment	<p>Access Team</p> <p>888-818-1115</p> <p>NAMI Marin</p> <p>415-444-0480</p>
Crisis/Psych Emergency	<p>Crisis Stabilization Unit</p> <p>415-473-6666 ext. 24</p> <p>Marin General</p> <p>415-925-7200</p>
Family Services	<p>BHRS</p> <p>888-818-1115</p> <p>Family Member Intervention Training</p> <p>Chandrika Zager</p> <p>415-473-6844</p>
Financial Services	<p>BHRS</p> <p>415-473-6816</p> <p>Social Services (Medi-Cal, Food Stamps)</p> <p>English: 415-473-3400</p> <p>Spanish: 877-410-8817</p>
Food Services	<p>Marin Food Bank</p> <p>415-883-1302</p>

	St. Vincent de Paul Dining Hall 415-454-3303
Housing	Center for Domestic Peace English: 415-924-6616 Spanish: 415-924-3456 Men: 415-924-1070 Family Emergency Center 415-454-7418 Marin Assisted Independent Living 415-457-6966 ext. 1 Homeward Bound 415-457-2115 Mill Street Center 415-457-9651 800-428-1488 Transition-Age Sunny Hills Services 415-473-2167
Insurance	Department of Insurance 213-897-8921 Department of Managed Health Care 888-466-2219 Health Insurance Counseling & Advocacy 800-434-0222
Language	Canal Alliance (Latino) 415-454-2640
School Counseling Services (Marin HS)	Branson School Main Office 415-454-3612 Madrone Main Office 415-485-2435

	<p>Marin Academy</p> <p>Joani Lacey jlacey@ma.org</p> <p>Marin Catholic</p> <p>Main Office 415-464-3898</p> <p>Marin Oaks</p> <p>Roxanne Edwards-Georges redwardsgeorges@nUSD.org</p> <p>Tara Clare tclare@nUSD.org</p> <p>Dave Mariani dmariani@nUSD.org</p> <p>Marin School</p> <p>Main Office 415-339-9336 ext. 1000</p> <p>North Bay Christian</p> <p>Dawn Holiday-Bruner 707-774-5811</p> <p>Nova Independent Study</p> <p>Main Office 415-897-7653</p> <p>Novato</p> <p>Arezu Iranipour airanipour@nUSD.org</p> <p>Oracle Independent Study</p> <p>Please refer to your district of residence mental health team and services.</p> <p>Redwood</p> <p>Jen Kenny-Baum 415-945-3663 jkennybaum@tamdistrict.org</p>
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	<p>San Andreas</p> <p>Main Office 415-945-3770</p> <p>San Domenico</p> <p>Main Office 415-258-1900</p> <p>San Marin</p> <p>Main Office 415-898-2121</p> <p>San Rafael</p> <p>Please reach out to your student's assigned Academic Counselor for a referral to be made.</p> <p>Sir Francis Drake</p> <p>Please reach out to your student's assigned Academic Counselor for a referral to be made.</p> <p>Star Academy</p> <p>Natalie Harvey natalie.harvey@staracademy.org</p> <p>Tamalpais</p> <p>Hannah Wright hwright@tamdistrict.org</p> <p>Elizabeth Lane elane@bacr.org</p> <p>Tamiscal</p> <p>Main Office 415-945-3750</p> <p>Terra Linda</p> <p>Eric Thompson ethompson@srcs.org</p> <p>Susan Gatlin sgatlin@srcs.org</p>
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	<p>Matt Moore mmoore@srcs.org</p> <p>Tomales</p> <p>Rachael Kobe 707-878-2286 ext. 207</p>
Sexually Transmitted Diseases	<p>HIV Testing 415-457-2002</p> <p>Marin AIDS Project 415-457-2487</p>
Substance Abuse/Detox	<p>AlAnon and Alateen 415-455-4723</p> <p>Alcoholics Anonymous English: 415-499-0400 Spanish: 415-824-1834</p> <p>Cocaine Anonymous 415-226-1300</p> <p>Detox Helen Vine Recovery Center 415-492-0818</p> <p>Marijuana Anonymous 415-419-3555</p> <p>Narcotics Anonymous 877-612-7837</p> <p>Opiate Detox 415-457-3755</p> <p>Transition-Age Programs 415-870-9298</p>
Suicide Prevention	<p>Buckelew</p> <p>Crisis Counselor - 415-499-1100</p> <p>Grief Support - 415-499-1195</p>

Appendix D

Suspected Child Abuse Report Form

Figure 1 Suspected Child Abuse Report <https://marincasa.org/wp-content/uploads/2017/09/Suspected-Child-Abuse-Report.pdf>

<div style="display: flex; justify-content: space-between; align-items: center;"> Print <div style="text-align: center;"> <h2 style="margin: 0;">SUSPECTED CHILD ABUSE REPORT</h2> <p style="margin: 0;">To Be Completed by Mandated Child Abuse Reporters Pursuant to Penal Code Section 11166</p> </div> Reset Form </div>						
CASE NAME: _____ CASE NUMBER: _____						
PLEASE PRINT OR TYPE						
A. REPORTING PARTY	NAME OF MANDATED REPORTER	TITLE	MANDATED REPORTER CATEGORY			
	REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS	Street	City	Zip	DID MANDATED REPORTER WITNESS THE INCIDENT? ☐ YES ☐ NO	
	REPORTER'S TELEPHONE (DAYTIME) ()	SIGNATURE		TODAY'S DATE		
B. REPORT NOTIFICATION	☐ LAW ENFORCEMENT ☐ COUNTY PROBATION		AGENCY			
	☐ COUNTY WELFARE / CPS (Child Protective Services)		DATE/TIME OF PHONE CALL			
	ADDRESS Street City Zip		TELEPHONE ()			
C. VICTIM One report per victim	NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE		SEX	ETHNICITY
	ADDRESS Street City Zip		TELEPHONE ()			
	PRESENT LOCATION OF VICTIM		SCHOOL		CLASS GRADE	
	PHYSICALLY DISABLED? ☐ YES ☐ NO	DEVELOPMENTALLY DISABLED? ☐ YES ☐ NO	OTHER DISABILITY (SPECIFY)		PRIMARY LANGUAGE SPOKEN IN HOME	
	IN FOSTER CARE? ☐ YES ☐ NO	IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE: ☐ DAY CARE ☐ CHILD CARE CENTER ☐ FOSTER FAMILY HOME ☐ FAMILY FRIEND			TYPE OF ABUSE (CHECK ONE OR MORE) ☐ PHYSICAL ☐ MENTAL ☐ SEXUAL ☐ NEGLECT ☐ OTHER (SPECIFY)	
	RELATIONSHIP TO SUSPECT		PHOTOS TAKEN? ☐ YES ☐ NO		DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? ☐ YES ☐ NO ☐ UNK	
	1. NAME BIRTHDATE SEX ETHNICITY		3. NAME BIRTHDATE SEX ETHNICITY			
	2. NAME BIRTHDATE SEX ETHNICITY		4. NAME BIRTHDATE SEX ETHNICITY			
D. INVOLVED PARTIES	NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE		SEX	ETHNICITY
	ADDRESS Street City Zip		HOME PHONE ()		BUSINESS PHONE ()	
	NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE		SEX	ETHNICITY
	ADDRESS Street City Zip		HOME PHONE ()		BUSINESS PHONE ()	
	SUSPECT'S NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE		SEX	ETHNICITY
	ADDRESS Street City Zip		TELEPHONE ()			
	OTHER RELEVANT INFORMATION					
E. INCIDENT INFORMATION	IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX ☐ IF MULTIPLE VICTIMS, INDICATE NUMBER: _____					
	DATE / TIME OF INCIDENT		PLACE OF INCIDENT			
	NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incidents involving the victim(s) or suspect)					

SS 8572 (Rev. 12/02)

DEFINITIONS AND INSTRUCTIONS ON REVERSE

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS 8583 if (1) an active investigation was conducted and (2) the incident was determined not to be unfounded.

WHITE COPY-Police or Sheriff's Department; BLUE COPY-County Welfare or Probation Department; GREEN COPY- District Attorney's Office; YELLOW COPY-Reporting Party

Appendix E

Marin County System of Support Flowchart

Figure 2 Marin County System of Support Flowchart and Checklist Marin County Office of Education;
www.jade.marinschools.org

Appendix F

Defining Family Rules

Defining Family Rules

Use this worksheet to organize your rules and expectations in the home. Try to avoid using words like “stop” and “don’t.” Instead, put a positive spin on what *is* allowed. Example: “Always knock on closed doors before entering a room” vs. “Don’t just barge in.”

Set rules for:

Household Responsibility and Participation:	Chores:
Mealtime/Snacking:	Allowance:
Privacy:	Earnings/Savings:
Language:	Guests:
TV/Video Games:	Car:
Homework/School:	Substances:
Computer/Internet:	Dating:

Curfew:	Sibling/Family Behavior:
Forbidden Activities:	Phone Usage:
Other:	

Appendix G

Parent Teen Collaborative Discipline Worksheet

Parent Teen Collaborative Discipline Worksheet

1. List of responsibilities teenager feels they can handle (ex. Weekday curfew is 8:30 pm, weekend curfew is 11:00 pm):

-
-
-
-

2. Agreed upon responsibilities with conditions (ex. Curfew is allowable as long as you know where they are, they call/text if late, and if homework is completed beforehand):

-
-
-
-

3. Reasonable disciplinary actions if conditions are not met (ex. If curfew is broken without call or text, curfew will be set back to an earlier time).

-
-
-

4. Reasonable rewards if conditions are met (ex. Three months of meeting curfew with all conditions met results in the opportunity for privileges to expand):

-
-
-

5. Non-negotiables (ex. Driving under the influence, drug use, ditching school, etc.):

-
-
-

6. Action steps to take when in danger (ex. Call dad if I do not have a sober ride home).

-
-
-

7. Goals for parent to notice (ex. I want you to have complete trust in me, I want to make more of my own choices, etc.):

-
-
-

8. Ways we can communicate effectively when something goes wrong (ex. Parent should focus on my acceptable behaviors just as much as my acceptable ones, all conversations need to be approached without accusing each other of anything, etc.):

-
-
-

Signature of Parent:

Signature of Teenager:

Appendix H

Safety Plan Template

Safety Plan Template

Step 1. Warning Signs/Triggers:	
<ul style="list-style-type: none"> • • • • 	
Step 2. Things I can do/say to calm myself:	
<ul style="list-style-type: none"> • • • • 	
Step 3. People and social settings you can visit when you need a distraction:	
Name:	Phone:
Name:	Phone:
Name:	Phone:
Place:	Place:
Step 4. People you can call to ask for help:	
Name: <ul style="list-style-type: none"> • • • 	Phone: <ul style="list-style-type: none"> • • •

Step 5. Professionals/Agencies you can contact when you feel out of control:	
Clinicians/Agencies: <ul style="list-style-type: none"> • • 	Phone: <ul style="list-style-type: none"> • •
Local emergency department address: <ul style="list-style-type: none"> • • 	Phone: <ul style="list-style-type: none"> • •
Prevention hotlines: <ul style="list-style-type: none"> • Suicide Prevention Hotline • 	Phone: <ul style="list-style-type: none"> • 1 (800) 273-TALK •
Other: <ul style="list-style-type: none"> • 	Phone: <ul style="list-style-type: none"> •
Step 6. List the ways you can make the environment safe:	
<ul style="list-style-type: none"> • • • 	
Step 7. These are your reasons for living:	
<ul style="list-style-type: none"> • • • • • 	

Appendix I

Preparing for Mental Health Care Worksheet

Preparing for Mental Health Care Worksheet

1. Primary Concern: •
2. When Did You First Start Noticing Changes in Your Teen's Behavior? •
3. Has Your Teenager Ever Thought About or Attempted Suicide? •
4. New/Problematic Behaviors or Symptoms Observed: • • •
5. Strengths of Adolescent: • • •
6. Medications Adolescent is Currently Prescribed/Taking: • • •
7. Previous Counseling/Treatment: • •

8. Family History of Mental Health Concerns/Illness

-
-
-

9. Insurance Information:

-

10. Questions You Have:

-
-
-

Questions to consider:

- *What is your particular approach, expertise, or training in treating these mental health concerns?*
- *What will treatment cost/do you accept my insurance?*
- *Will I be involved in my adolescent's treatment plan?*
- *What is your policy about confidentiality?*