The REACH Institute

The "Action Signs" Project

A toolkit to help parents, educators and health professionals identify children at behavioral and emotional risk

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The "Action Signs" Project

Overview

Despite well-documented levels of emotional and behavioral problems in the nation's youth, studies have repeatedly shown that 75% of youth with these problems are usually not identified and usually do not receive needed care. Stigma and lack of awareness likely contribute substantially to this problem.

To address these and other related problems, the Surgeon General issued a "call to action" in January 2001, and urged the development of **a crisp set of warning signs that when present, warrant additional professional evaluation and possible intervention.** Therefore, the **Action Signs Project (originally called the "Warning Signs Project"),** funded by the Center for Mental Health Services (CMHS) and the National Institute of Mental Health (NIMH), was first developed at the Center for the Advancement of Children's Mental Health at Columbia University/New York State Psychiatric Institute, and completed by the investigators which at the REACH Institute and at the Mayo Clinic.

The project has used rigorous research methods (epidemiological data sets), DSM diagnostic criteria, as well as the input of parents, doctors, teachers, and youth, so that these **'action signs'** are worded in common-sense non-stigmatizing terms, yet still indicate significant emotional problems that should lead one to getting further professional input and possible help. Based on the extensive review and input of parents, educators, scientists, and providers, all of these Action Sign candidates have been reviewed for clinical and community use and usefulness. A list of these signs and an overview of the scientific process that guided their development is described in this document.

Toolkit:

The attached toolkit is intended to provide dissemination tools, materials, and training guidelines for a wide variety of stakeholders including physicians, teachers, and parents as well as advocacy organizations. For example, the toolkit includes a sample poster for use in physician's offices and schools, informational handouts for parents and youth, and self-adhesive stickers for use in a medical chart to guide doctors in their asking youth and families about the presence of the action signs.

This set of 'Action Signs' and accompanying materials are intended for educational and instructional purposes alone. The action signs are a set of indicators of potentially serious emotional, mental or behavioral difficulty. **The information, resources, literature cited, and internet links are not intended as a diagnostic guide, and should not be viewed as a substitute for a mental health evaluation by a competent, licensed professional.**

The toolkit also includes information for utilizing these action signs in clinical and school settings. There are sample scripts and guidelines for introducing a discussion of the Action Signs, issues related to making a mental health referral, and a list of local referral resources.

Information is included to help educate the professional or family member who has identified a child in need of referral. These tools are:

- Glossary of terms involving child mental health diagnosis, symptoms and other information.
- Literature including reviews of professional literature in relevant areas of children's mental health
- Advocacy Organizations to provide resources for parents of children that have been identified.

The internet resources and links to professional and advocacy organizations are not intended as a general endorsement of these organizations' policies, or of the health providers or clinical services that may be listed on their web sites or printed literature. The literature and internet resources may be viewed as educational and instructional tools that help identify problems, and highlight national, regional and local organizations and other resources for particular disorders.

This toolkit may be used in part or as a whole, however the content and language of specific action signs should not be changed or altered, except by written consent of the authors.

An example of the final set of Action Signs is provided on the following page. The scientific background and context for this project follows.

Action Signs for Helping Kids in Your Setting

Your behavioral health is an important part of your physical health. If you are experiencing any of these feelings, let your doctor know. You are not alone…not 1 in a 1000, but 1 in 10, because many kids have similar problems! Getting help is what counts. Help is available, and treatments work! Don't wait. Talk with a helpful adult, such as your family, doctor, school nurse or counselor, or religious leader, if you have one.

- Feeling very sad or withdrawn for more than 2 weeks
- Seriously trying to harm or kill yourself, or making plans to do so
- Sudden overwhelming fear for no reason, sometimes with a racing heart or fast breathing
- Involvement in many fights, using a weapon, or wanting to badly hurt others
- Severe out-of-control behavior that can hurt yourself or others
- Not eating, throwing up, or using laxatives to make yourself lose weight
- Intense worries or fears that get in the way of your daily activities
- Extreme difficulty in concentrating or staying still that puts you in physical danger or causes school failure
- Repeated use of drugs or alcohol
- Severe mood swings that cause problems in relationships
- Drastic changes in your behavior or personality

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The Action Signs Project

Background

Despite the presence of well-established diagnostic criteria for children's mental disorders for over 20 years (American Psychiatric Association, 1980; 1987; 1994), substantial difficulties have remained in terms of the ability to recognize the presence of mental illness in children and adolescents by the lay public and even professionals. Estimates compiled by the Office of the Surgeon General (1999) indicate that only 30% of children with mental or emotional disorders are in fact receiving any treatment (Burns et al., 1995; Leaf et al., 1996). Even with a well-recognized condition such as ADHD, estimates indicate that only half of children within any given year receive any form of treatment (Jensen et al., 1999; Jensen, 2000).

Recognition of children's mental health needs and access to services depends upon the awareness and actions of key adults (Briggs-Gowan et al., 2000; Garland et al., 2001; Pescosolido, 1992; Wildman et al., 1999). Abundant data indicate that lack of recognition of children's mental health problems is not a problem among the lay public only, but characterizes personnel in education, welfare, juvenile justice, and healthcare sectors (Costello et al., 1988a; 1988b; Glisson and Himmelgarn, 1988; Kelleher and Long, 1994; U.S. Public Health Service, 1999; 2000; 2001a; 2001b). Under-identification is of particular concern in schools and primary care settings, where virtually all children are seen and where identification might be especially feasible.

For example, in primary care settings, generally only one in four children with a current mental disorder are identified by their pediatrician or family doctor (Wolraich, 2002). In fact, by far the best predictor of the primary care doctor identifying a child's mental health problem is governed by whether the parent raises specific concerns in this regard (Briggs-Gowan et al., 2000; Klasen and Goodman, 2000). For this reason, the Report of the Surgeon General's Conference on Children's Mental Health urged specific action steps where frontline providers such as physicians, nurses, daycare providers, teachers and others, are given the skills and tools to recognize early symptoms of emotional and behavioral problems for proactive intervention (OTSG, 2001).

Even when a problem might be recognized by the child's primary care provider, there is often a lack of communication that exists between the provider and the parent (Jensen, 2002; Klasen and Goodman, 2000), and terms used by the parent may be understood differently by the physician and vice-versa. To illustrate, in a study of nationally representative samples of 201 pediatricians and 300 parents of 3-18 year old children (Pappadopulos and Jensen, 2001), both doctors and parents were asked to rate the several aspects of doctor-parent communication frequency and difficulty vis-à-vis children's mental health problems. Seventy-seven percent of doctors noted that they <u>frequently</u> ask parents about the child's mental health, while fully 44% of parents state that their child's doctor <u>never</u> inquires. In addition, 57% of doctors indicated that parents have <u>some or a lot</u> of difficulty discussing concerns about their child's mental health, while 76% of parents say it is <u>not at all</u> difficult.

These communication problems are complicated by difficulties in distinguishing symptomatic from normative behaviors. Long symptom lists are often used to educate and help parents, physicians, teachers and others to identify children with mental health needs. However, such lists may be of relatively little assistance, if the parent, teacher, or physician reasons (correctly), "every child has some of these symptoms some of the time." Further, identification and referral of children in need often suffers due to poor communication between primary care and mental health professionals and clinics. These problems lead to incomplete and fragmentary efforts at care coordination.

In order to overcome such problems, better ways to communicate about children's mental health needs must be developed, in terms that are easily understood and readily communicated across persons of different backgrounds, training, and education. In addition, simpler ways of characterizing mental health problems are needed that better fit the limited human capacities to make complex judgments under uncertainty (for example, whether to refer or not to refer a given child for evaluation and assistance). Determining the presence or absence of multiple symptoms, weighting them, evaluating their significance, and summing them requires many complex steps, compared to more simple present/not-present determinations of a well-described criterion, such as a single "warning" or "Action sign."

Usefulness of Action Signs

The idea of creating "warning" or action signs for health problems is not a new one. In 1971, President Nixon declared a "War on Cancer" with the enactment of the National Cancer Act (Cole, 1977; Eyre, 1996; Rauscher, 1974). Seven warning signs were developed as a communication tool for early intervention (Balshem et al., 1988; Hintz, 1992; Nichols et al., 1996). These warning signs were meant to be easily understood and remembered, so that those in need would more readily realize when a checkup is required. Any single warning sign was meant to trigger an action, i.e., seeing one's doctor for an evaluation.

Conceivably, attempts to develop child mental health warning signs might adopt a similar strategy. In his 2001 "Call to Action," Surgeon General David Satcher, MD, discussed the urgent need to identify children with mental health problems, and he emphasized the need to find better ways of communicating to the public that certain behaviors warrant professional attention (Office of the Surgeon General, 1999). Although various professional and advocacy organizations have previously distributed lists of child mental health warning signs and symptoms, to our best knowledge such documents have always represented expert opinions and/or consensus statements, neither supported by scientific evidence nor tested for user friendliness, interpretability, and communication value.

Following up on the Surgeon General's challenge, Federal officials determined that brief, common sense descriptions of children's behavioral and/or emotional problems might be useful if they could: a) accurately characterize children with valid mental health disorders and whose needs were not being addressed, b) be cast in language readily understood by teachers, doctors, and the general public; and c) be readily accepted by the general public as credible signs of a child's need for mental health assistance. The ultimate application of such descriptions might then be to deploy them as communication/education tools and public messages (i.e., as 'action signs") to assist the

public in ensuring that such children are identified and obtain mental health care. The term "action signs" is preferred over "warning signs," given the existence of stigma surrounding mental health issues, and the clear mandate for adults to take action when a child or youth exhibits any one of the signs.

This effort may be especially effective in helping mental health, primary care and educational professionals coordinate referral and care. The Center for Mental Health Services (CMHS), a division of SAMHSA, has long championed better coordination and organization of care children's metal health care in a "Systems of Care". This model is intended to consider the physical, emotional, social, educational, and family needs among community agencies and services. An effective set of action signs would be an important first step in providing this coordinated care.

Defining Criteria

Thus, with input from multiple agencies; officials from the National Institute of Mental Health (NIMH) and the Center for Mental Health Services (CMHS) co-supported a contract to develop a scientifically-grounded, early indicators guide based on existing longitudinal databases on children=s mental health. This effort was aimed at identifying science-based risk indicators that are malleable, developmentally and culturally sensitive, and that predict a range of outcomes including positive functioning. Further, these indicators were meant to be functional for teachers, various health care providers, parents and other primary caregivers who are the "gate-keepers" and in key positions to recognize and identify children with mental health needs. Thus, these signs were intended to assist caregivers in recognizing what kinds of behaviors to look for and help them determine what questions to ask and when to obtain assessments of their child=s emotional or behavioral functioning.

Several tasks were identified in pursuit of these goals. A CMHS-appointed steering committee reviewed recent epidemiologic surveys, and reanalyzed them to identify common, easily understood symptom profiles that might serve as indicators. Potential indicators were then tested against diagnostic, impairment, and service use criteria to ensure that they correctly identified youth with significant, severe, and unmet mental health needs. Indicators were also required to work equally well across age, gender, and ethnic groups. Finally, potential action signs were vetted by key stakeholders (parents, teachers, educators, primary care professionals and youth).

In addition, the steering committee (SC) of child mental health epidemiologists, parent/advocacy representatives, and policy experts provided initial guidance by identifying a list of possible action signs and helped determine project guidelines:

1) Focus principally on the most severely mentally ill children. The reason underlying this approach is that important questions have been raised by scientists and the general public as to whether children with milder symptoms do indeed have a mental health disorder. Focusing the project on helping others identify children with undeniable problems thus decreases the risk for "false positives.";
2) Identify symptom profiles that characterize children who have relatively common yet credible and severe mental health problems and who are not

receiving any health care for these problems. Ideally, these symptom profiles should be well distributed across major age and gender groups. All total, children with one or more of these symptom profiles should equal about 5% of the community population (Friedman et al., 1996), thus consistent with identifying those with clear-cut problems;

3) Show that the symptom profiles map onto recognized psychiatric diagnoses (with positive predictive values $\geq$ 50%);
4) Show that the symptom profiles themselves reflect unmet need, i.e., that these children with severe problems are not receiving any care for their difficulties;
5) With the input of major stakeholders (parents, primary care providers, teachers, and youth), translate the profiles into common sense language, in order to facilitate their further testing and use as "action signs".

Review of Data Sets

Review of Scientific Literature, Identification of Optimal Databases, Data Analysis, and Identification of Meaningful Symptom Profiles

To identify appropriate data sets where the necessary analyses could be done, a comprehensive review was performed, which included the existing English language research literature on epidemiologic studies of children's mental health need, services use, and unmet need, using Grateful Med and PsychInfo search engines. Also, additional consultations were held with NIMH staff to find any relevant, Federally funded epidemiologic studies funded but not yet published in the literature. All Federally funded national epidemiological studies were reviewed, as well as local community or regional studies (Bird et al., 1989; Bird et al., 1993; Briggs-Gowan et al., 2000; Costello et al., 1996; Flisher et al., 2000; Ge and Conger, 1999; Goodman et al., 1998; Kessler et al., 1994; Lahey et al., 1996; Lavigne et al., 1998; Lewinsohn et al., 1998; Loeber et al., 1999; Roberts et al., 2002). After initial review of eligible data sets, the following final criteria were established for final selection of a minimum of 4 data sets: the data set must 1) employ well-validated tests for a range of established psychiatric disorders, 2) ascertain both specific symptoms and symptom patterns as well as diagnoses; 3) determine whether the child is currently receiving services, 4) take place in North America, 5) be conducted from 1990 or later, and 6) be based on a large, representative community sample.

Four data sets were selected as most promising and available for analysis: Methods for the Epidemiology of Mental Disorders in Children and Adolescents (MECA), Iowa-Georgia Rural Minority Study (IOWA), Depression and Anxiety in Minority Youth and Primary Care (TEXAS), and Antisocial Behaviors in U.S. and Island Puerto Rican Youth (BRONX) data sets (Bird et al., 1989; Bird et al., 1993; Flisher et al., 2000; Ge and Conger, 1999; Goodman et al., 1998; Lahey et al., 1996; Roberts et al., 2002). The sample sizes ranged from nearly 1,000 to over 4,000 children, with age ranges falling between 5 and 17 years old. In addition to having the necessary characteristics described above, these data sets were also chosen because they employed the same diagnostic and symptom assessment instrument (the Diagnostic Interview for Children

and Adolescents (DISC), versions 2.3 and 4.0 (Shaffer et al., 1996)), facilitating the ease of applying the same analyses across all four data sets, and ultimately combining data sets for summary analyses.

The SC initially proposed symptom profiles based principally on face validity (i.e., problems that are frequently seen in clinical settings and are characterized by substantial impairment and need for services). The chosen symptom profiles closely paralleled the following disorders and/or problem areas: depression, suicidal plans/attempts, anxiety, aggression, and eating disorders. After input from several focus groups, four additional constructs were added: extreme difficulties with attention/hyperactivity, repeated use of illegal drugs, mood swings, and drastic personality changes. The latter two symptom profiles could not be gleaned from the DISC interviews in any of the 4 data sets, since questions pertaining to those constructs are not asked as a part of the DISC interview.

These proposed symptom profiles were operationalized into data analytic algorithms in order to test them within each of the data sets. In order to perform this task, the measures (DISC 2.3 and DISC 4) were examined to find the items (if answered positively) that would meet the criteria for the proposed symptom profile. For example, the depression symptom construct was operationalized by 3 criteria – a) depressive symptoms; b) lasting a minimum of two weeks; and c) resulting in impairment. All three of the characteristics could be gleaned from specific questions asked by the DISC, allowing the symptom profile construct to be operationally defined, "Severe depression almost every day for at least 2 weeks, and causing impairment with family, friends, or work." [1] For each symptom profile in each data set, the frequency of the profile was determined, as was whether a given child with that profile had received mental health services within the last 6 months. In addition, frequency analyses by age and gender were calculated for all symptom profiles.

In addition, the action signs were retested in two other epidemiologic data sets. One of these data sets was provided by the Duke University Caring for Children in the Community Project, which used an alternative diagnostic and assessment measure called the CAPA (Child and Adolescent Psychiatric Assessment) (Angold and Costello, 2000). A second data set was identified, specifically to identify the problems of very young children, since no comparable data set was available in the United States (National Longitudinal Study of Children and Youth, Canada, Offord & Bennett, 2003). These data sets confirmed the validity and potential usefulness of the indicators in 6-17 year old children using a different diagnostic instrument (Caring for Children in the Community, Duke University) as well as the existence, severity, and persistence of such problems in children ages 2-5 (National Longitudinal Study of Children and Youth, Canada, Offord & Bennett, 2003).

[1] Complete enumeration of the specific DISC question items that were chosen to map onto each of the symptom profiles is available from the warning signs Project Director (E. Goldman, PhD) upon request. He may be contacted by email at eliotgoldman@gmail.com.

Focus Groups

To augment the statistical analyses of the symptom profiles, focus groups were conducted to obtain further feedback and input, in order to ensure the credibility of the framework and usability of the proposed action signs (approval granted by the New York State Psychiatric Institute Institutional Review Board). The focus groups consisted of parents, teachers (elementary, middle, and high schools), pediatricians, mental health advocates, and adolescents. Groups were conducted in geographically representative areas of the country including the Northeast (New York, New Jersey) Mid-Atlantic (Washington, D.C), Southeast (Raleigh, North Carolina, Atlanta, Georgia, Orlando Florida), West (Salt Lake City, Utah, San Francisco, California) and Mid-West (Des Moines, Iowa). Participants were deliberately drawn from diverse socioeconomic, cultural, and ethnic backgrounds, with the goal of targeting those individuals and groups that were representative of potential users of the final action signs document (i.e., teachers, parents, physicians, and youth themselves). Focus groups were conducted using the following procedures:

Those who attended the focus groups were given the list of potential action signs and asked several questions in a format in which they could expand upon and elaborate their ideas:

1) Is this an important problem?
2) How would you describe this child in your own words?
3) Should this child be seen professionally?
4) What additional problems are we missing?

In addition to their input on each of the individual symptom profiles, the participants were asked to describe appropriate ways to present these mental health messages with the following questions: 1) In what formats should these symptom profile/action signs be presented?, 2) What is the best way to identify mental health problems in children without labeling or stigmatizing the child?, 3) How could these messages be made culturally appropriate and understood within each target audience?, and 4) Should they be used for very young children?

After extensive input from the focus groups, feedback that was repeated across multiple focus groups was incorporated into final language suggestions. Then, the action signs and proposed language were provided to key advocacy organizations and professional associations. Each organization was asked to review the action signs draft document and pay special attention to the specific action signs and language used to describe them. Recommendations were solicited as to how to best present them to various groups such as pediatricians, parents, teachers and other relevant target audiences. As with the focus groups, they were asked whether or not critical additional action signs were missing from our list. Finally, they were asked to provide their tentative endorsement of the action signs project as a whole (see page 39).

Throughout the 20 focus groups, various opinions were raised on the wording, usability, and presentation of the action signs. With each group, the symptom profiles were continuously sculpted until close to unanimous agreement was reached. Upon

completion of the focus groups and obtainment of input from key advocacy groups, the wording of the symptom profiles did change significantly).

Groups were conducted in two distinct phases. Initial phase groups were conducted in the Northeast (New York, New Jersey), Mid-Atlantic (Washington D.C.), and Southeast (Atlanta, Georgia); they tended to focus on the language, developmental variables and relevancy of specific action signs. In the second phase, groups were conducted in the Southeast (Raleigh, North Carolina, Atlanta, Georgia, Orlando Florida), West (Salt Lake City, Utah, San Francisco, California) and Mid-West (Des Moines, Iowa); these groups focused more on implementation issues, regional differences in terminology, and cultural variables.

Action Signs Language Issues: Important caveats were raised in the focus groups about how to best characterize problems in very young (less than 5 years old) children. Thus, many of the symptom profiles were not applicable to that age group (such as suicide or illicit drug use) and other key profiles were missing for this age group, such as an inability to relate to others, cooperate in group settings or being hurtful to other children but showing no remorse. Further, most focus group participants felt uncomfortable with the prospect of "labeling" very young children and possibly thereby doing harm, since behavior and development are so much in flux at young ages, and because so many problem behaviors seem to be time-limited. Based on these concerns, focus group participants felt (and Steering Committee members concluded) that it might be more effective to discuss the idea of "school readiness" for these children, rather than mental health action signs.

One of the most interesting findings from the focus groups involved the language itself. For instance, most parents seemed to dislike the word "depression." They felt that this word was for adults, that children did not experience depression, and that a word like "sadness" was more appropriate. In contrast, teachers felt that "sadness" was not overtly seen in school in children, instead noting that children suffering from depression showed emotional "withdrawal" from school activities, peers, and teachers. The word "suicide" was also controversial, with many parents feeling that "suicide" was a term that most persons thought that principally characterized an adult behavior and that would not readily be understood as applicable to children. Instead, most participants preferred terms such as "trying to kill" oneself or "seriously wanting to die." Also problematic was the profile for panic attacks, which caused confusion among various focus groups. Informants easily misinterpreted the word "panic", since it is often used in everyday life as a milder term than in its professional usage. Final language of the symptom profiles/action signs is included in this packet.

Action Signs Implementation Issues: Key implementation issues received critical attention by teacher and physician focus groups. Suggestions to make the action signs feasible included use of posters, videos, information packets and checklists. Teachers and physicians alike must struggle with the need to identify problematic children in the face of time constraints, institutional resistance and scarcity of resources in dealing with the child and family if a child with mental health needs is identified.

Physicians, nurses and teachers also suggested that an item be included for their use for children with frequent medical complaints. These included complaints about

symptoms such as headaches and stomach aches as well as those children who miss significant school time due to illness. Chronic sleep disturbances were also noted as a potential Action Sign reflecting the need for a referral.

Focus groups were also helpful in identifying regional and cultural differences that might affect action signs usefulness and implementation. Many teachers and parents noted the importance of simplified language for children and parents when English in not their first language. Further, regional differences were noted for phrases describing aggression (in North Carolina "fussing" as a substitute for fighting or arguing). However the most striking regional/cultural discussion in relation to the action signs took place with Native American youth leaders, teachers and mental health professionals. Their comments addressed several important issues, including the intense alienation many families and youth feel from the "white man's" school and health care system. When their children were identified as needing help, they often felt relegated to a resource-poor special education system or possibly were over-medicated in an attempt to quell what outsiders saw as the youth's "rebellious" behavior. They were particularly concerned of an initiative that might result in more of their youth being labeled as problematic, when they felt that there had already been rampant over-identification in their community. This group's powerful and pointed feedback highlighted the need for sensitivity to the cultural, historical and systemic issues embedded within the action signs initiative, and how action signs should be carefully tested (and amended to individualize it to specific communities, as necessary) before large-scale deployment.

Overall, the focus group feedback was invaluable in providing information regarding the design and implementation of this toolkit. Participants' comments highlighted the need for simple yet clear language, awareness of cultural and regional issues, and the complexity of trying to describe behavioral and emotional problems that resist easy description. In addition, participants often raised concerns about implementation issues, such as how one can best secure services if a child with unmet mental health needs is identified, further underscoring the need to test and deploy action signs in the context of the services available to that community.

Current Applications

The findings from the focus groups revealed the central importance of and need for accurate communication and well-understood language terms among the various stakeholders who must converse with each other, if children with mental health needs are to be identified and treated. There is a need for simple messages that have been tested (Fishbein et al., 2002) and "cross-translated" among all of the interested parties, if "action signs" are to be used and useful. Involving all of the key stakeholder groups is essential, because parents, teachers, physicians, and youth themselves may have different language terms that communicate the necessary constructs, as well as different settings and opportunities for observation and identification of those with significant emotional and behavioral disorders.

We are exploring the utility of these action signs in a variety of settings. When taught to physicians, teachers, or parents, the hope is that the action signs will result in these key adults taking actions that increase the likelihood of an appropriate evaluation and, if the evaluation suggests the need, that appropriate services are sought and

delivered. Different "tools" and aids (an initial set is included in this document) should be developed for different stakeholders. For example, some teachers noted that posters depicting each of the action signs might be useful for school settings. Physicians might find pocket-sized cards with the essential details, coupled with wording for questions to facilitate their asking parents or youth about the action signs might be useful. Media messages might be used to reach the general public, possibly increasing public awareness and decreasing stigma. The same format or tool may not work for all stakeholders, and specific tools will have to be developed with their input and then formally tested in their settings. Concerns over even the terms "warning sign" or "indicator' were vetted; and some stakeholders suggested a less stigmatizing, more proactive term, "action sign," meaning, make sure this child is evaluated by his or her doctor.

The importance of this project lies not nearly so much in language and meaning, but the quality of life and health of children everywhere. Given that 2/3rd of all suicidal children do not use services, we cannot afford to wait to address these issues. Depression appears to be on the rise in youth (Kessler et al., 1994; World Health Organization, 2001), and there are too many unnecessary fatalities. Behavioral problems are the so-called new and most common type of significant morbidity in children and youth, and as a society we need to rise to the challenge of addressing these problems. New, effective treatments are increasingly available, but it will take an informed populace and physician cadre to see that these treatments get to the children that need them.

Identification and referral by a physician, nurse or teacher cannot take place in isolation. The identified child must be evaluated, treated and understood within a larger community context. In this sense the action signs project dovetails with efforts by the Federal government (Center for Mental Health Services) in the development of a 'systems of care' model. This model is based on the premise that the mental health needs of children, adolescents, and their families must be met within their home, school, and community environments, and that the systems serving these needs must be child-centered, family-driven, strengths-based, culturally competent and involving interagency collaboration.

Accordingly, the Action Signs project seeks not only to provide earlier, more efficient identification of children in need of services, but recognizes the complexity of our educational, health, and mental health care systems, and the diversity and differing needs of the children and families that these systems must serve. To address these challenges, the action signs themselves, as well as their associated tools include supporting materials and information for families, youth, and professional staff. Working together, and with such tools, better and earlier identification of our children who need mental health services should become more than just a hoped-for goal, but a national accomplishment.

For training and/or guidance in the use of this toolkit, contact Lisa Hunter Romanelli, PhD, Executive Director, the REACH Institute, info@TheReachInstitute.org

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THE ACTION SIGNS PROJECT
GLOSSARY OF TERMS

ANXIETY DISORDERS:

Generalized Anxiety Disorder:
Children with generalized anxiety disorder (GAD) have recurring fears and worries that they find difficult to control. They worry about almost everything—school, sports, being on time, even natural disasters. Children with GAD are usually eager to please others and may be "perfectionists," dissatisfied with their own less-than-perfect performance. They may be:

- Restless
- Irritable
- Tense
- Easily tired
- Having trouble concentrating or sleeping

Obsessive-Compulsive Disorder:
Obsessive-compulsive disorder (OCD) typically begins in early childhood or adolescence. Children with OCD have frequent and uncontrollable thoughts (called "obsessions") and may perform routines or rituals (called "compulsions") in an attempt to eliminate the thoughts. In the case of OCD, these obsessions and compulsions take up so much time that they interfere with daily living and can cause a young person a great deal of anxiety. Those with the disorder often repeat behaviors to avoid some imagined consequence. Some common compulsions for people with OCD include:

- Excessive hand washing due to a fear of germs
- Counting
- Repeating words silently
- Rechecking completed tasks

Panic Disorder:
Panic disorder is a common and treatable disorder. Children and adolescents with panic disorder have unexpected and repeated periods of intense fear or discomfort, along with other symptoms such as a racing heartbeat or shortness of breath. These periods are called "panic attacks" and last minutes to hours. Panic attacks frequently develop without warning. Symptoms of a panic attack include:

- Intense fearfulness (a sense that something terrible is happening)
- Racing or pounding heartbeat
- Dizziness or lightheadedness
- Shortness of breath or a feeling of being smothered
- Trembling or shaking
- Fear of dying, losing control, or losing your mind

Post-Traumatic Stress Disorder:
Children who experience a physical or emotional trauma such as witnessing a shooting or disaster, surviving physical or sexual abuse, or being in a car accident may develop post-traumatic stress disorder (PTSD). Children are more easily traumatized than adults. An event that may not be traumatic to an adult—such as a bumpy plane ride—might be traumatic to a child. A child may "re-experience" the trauma through nightmares, constant thoughts about what happened, or reenacting the event while playing. A child with PTSD will experience symptoms of general anxiety, which include:

- Irritability
- Trouble sleeping
- Trouble eating
- Being easily startled

Separation Anxiety Disorder:
Children with separation anxiety disorder have intense anxiety about being away from home or caregivers that affects their ability to function socially and in school. These children have a great need to stay at home or be close to their parents. Children with this disorder may worry excessively about their parents when they are apart from them. When they are together, the child may cling to parents, refuse to go to school, or be afraid to sleep alone. Other common symptoms include:

- Repeated nightmares about separation
- Physical symptoms, such as stomachaches and headaches

Social Phobia:
Social phobia usually emerges in the mid-teens and typically does not affect young children. Young people with this disorder have a constant fear of social situations such as speaking in class or eating in public. This fear is often accompanied by physical symptoms such as sweating, blushing, heart palpitations, shortness of breath, or muscle tenseness. Young people with this disorder typically respond to these feelings by avoiding the feared situation. Young people with social phobia are often:

- Overly sensitive to criticism
- Have trouble being assertive
- Suffer from low self-esteem

Social phobia can be limited to specific situations, so the adolescent may fear dating and recreational events but be confident in academic and work situations.

ATTENTION DEFICIT/HYPERACTIVITY DISORDER:

There are three main types of ADHD. One type is characterized by inattentiveness, one type is characterized by hyperactive or impulsive behavior, and the third type is combined—when children exhibit signs of both types. Symptoms are often unnoticed until a child enters school. To be diagnosed with ADHD, a child must show symptoms in at least two settings, such as home and school, and the symptoms must interfere with the child's ability to function at home or school for at least six months. Specialists have agreed that at least six symptoms from the following lists must be present for an accurate diagnosis, and symptoms must begin by age 7.

Signs of inattentive behavior:

- Difficulty following instructions
- Difficulty focusing on tasks
- Losing things at school and at home
- Forgetting things often
- Becoming easily distracted or having difficulty listening
- Lacking attention to detail, making careless mistakes or being disorganized
- Failing to complete homework or tasks

Signs of hyperactive behavior:

- Fidgeting excessively
- Difficulty staying seated
- Running or climbing inappropriately
- Talking excessively
- Difficulty playing quietly
- Always seeming to be "on the go"
- Blurting out answers or frequently interrupting
- Having trouble waiting his or her turn
- Interrupting or intruding on others

BIPOLAR DISORDER:

Bipolar disorder begins with either manic or depressive symptoms. The lists below provide possible signs and symptoms. Not all children with bipolar disorder have all symptoms. Like children with depression, children with bipolar disorder are likely to have a family history of the illness. If a child you know is struggling with any combination of these symptoms for more than two weeks, talk with a doctor or mental health professional.

Manic Symptoms:

- Elevated, expansive or irritable mood
- Decreased need for sleep
- Racing speech and pressure to keep talking
- Grandiose delusions
- Excessive involvement in pleasurable but risky activities

- Increased physical and mental activity
- Poor judgment
- In severe cases, hallucinations

Depressive Symptoms:

- Pervasive sadness and crying spells
- Sleeping too much or inability to sleep
- Agitation and irritability
- Withdrawal from activities formerly enjoyed
- Drop in grades and inability to concentrate
- Thoughts of death and suicide
- Low energy
- Significant change in appetite

CONDUCT DISORDER:

Conduct disorder is a repetitive and persistent pattern of behavior in children and adolescents in which the rights of others or basic social rules are violated. The child or adolescent usually exhibits these behavior patterns in a variety of settings—at home, at school, and in social situations—and they cause significant impairment in his or her social, academic, and family functioning.

Behaviors characteristic of conduct disorder include:

- Aggressive behavior that causes or threatens harm to other people or animals, such as bullying or intimidating others, often initiating physical fights, or being physically cruel to animals.
- Non-aggressive conduct that causes property loss or damage, such as fire-setting or the deliberate destruction of others' property.
- Deceitfulness or theft, such as breaking into someone's house or car, or lying or "conning" others.
- Serious rule violations, such as staying out at night when prohibited, running away from home overnight, or often being truant from school.

Many youth with conduct disorder may have trouble feeling and expressing empathy or remorse and reading social cues. These youth often misinterpret the actions of others as being hostile or aggressive and respond by escalating the situation into conflict. Conduct disorder may also be associated with other difficulties such as substance use, risk-taking behavior, school problems, and physical injury from accidents or fights.

DEPRESSION:

The list below outlines possible signs of depression. If a child is struggling with any combination of these symptoms for more than two weeks, a mental health professional should be contacted.

- Frequent sadness, tearfulness, or crying.
- Feelings of hopelessness.
- Withdrawal from friends and activities.
- Lack of enthusiasm or motivation.
- Decreased energy level.
- Major changes in eating or sleeping habits.
- Increased irritability, agitation, anger or hostility.
- Frequent physical complaints such as headaches and stomachaches.
- Indecision or inability to concentrate.
- Feelings of worthlessness or excessive guilt.
- Extreme sensitivity to rejection or failure.
- Pattern of dark images in drawings or paintings.
- Play that involves excessive aggression directed toward oneself or others, or involves persistently sad themes.
- Recurring thoughts or talk of death, suicide, or self-destructive behavior.

EATING DISORDERS:

ANOREXIA NERVOSA:

Anorexia nervosa is a serious, often chronic, and life-threatening eating disorder defined by a refusal to maintain minimal body weight within 15 percent of an individual's normal weight. Other essential features of this disorder include:

- An intense fear of gaining weight
- A distorted body image
- Amenorrhea (absence of at least three consecutive menstrual cycles when they are otherwise expected to occur)

In addition to the classic pattern of restrictive eating, some people will also engage in recurrent binge eating and purging episodes. Starvation, weight loss, and related medical complications are quite serious and can result in death. People who have an ongoing preoccupation with food and weight even when they are thin would benefit from exploring their thoughts and relationships with a therapist. The term *anorexia* literally means loss of appetite, but this is a misnomer. In fact, people with anorexia nervosa ignore hunger and thus control their desire to eat. This desire is frequently sublimated through cooking for others or hiding food that they will not eat in their personal space. Obsessive exercise may accompany the starving behavior and cause others to assume the person must be healthy.

BULIMIA NERVOSA:
Bulimia nervosa is a serious eating disorder marked by a destructive pattern of binge-eating and recurrent inappropriate behavior to control one's weight. It can occur together with other psychiatric disorders such as depression, obsessive-compulsive disorder, substance dependence, or self-injurious behavior. Binge eating is defined as the consumption of excessively large amounts of food within a short period of time. The food is often sweet, high in calories, and has a texture that makes it easy to eat fast. For those who binge, sometimes any amount of food, even a salad or half an apple, is perceived as a binge and is vomited.

Inappropriate compensatory behavior to control one's weight may include:

- Purging behaviors
    - Self-induced vomiting
    - Abuse of laxatives, diuretics, or enemas
- Non-purging behaviors
    - Fasting
    - Excessive exercise

People with bulimia nervosa often feel a lack of control during their eating binges. Their food is usually eaten secretly and gobbled down rapidly with little chewing. A binge is usually ended by abdominal discomfort. When the binge is over, the person with bulimia feels guilty and purges to rid his or her body of the excess calories. To be diagnosed with bulimia, a person must have had, on average, a minimum of two binge-eating episodes a week for at least three months. The first problem with any eating disorder is constant concern with food and weight to the exclusion of almost all other personal concerns.

SUICIDE:

Suicide is the result of many complex factors. More than 90% of youth suicide victims have at least one major psychiatric disorder, although younger adolescent suicide victims have lower rates of psychopathology (Gould et al., 2003). It is important to note that while the majority of suicide victims have a history of psychiatric disorder, especially mood disorders, very few adolescents with psychiatric disorder will go on to complete suicide.
Other important risk factors for suicide and suicidal behavior include:

- Prior suicide attempt
- Co-occurring mental and alcohol or substance abuse disorders
- Family history of suicide
- Parental psychopathology
- Hopelessness
- Impulsive and/or aggressive tendencies
- Easy access to lethal methods, especially guns
- Exposure to the suicide of a family member, friend, or other significant person
- History of physical or sexual abuse

- Same-sex sexual orientation (only been shown for suicidal behavior, not suicide)
- Impaired parent-child relationships
- Life stressors, especially interpersonal losses and legal or disciplinary problems
- Lack of involvement in school and/or work ("drifting")

SUBSTANCE ABUSE:

Teens use alcohol and other drugs for many reasons, including curiosity, because it feels good, to reduce stress, to feel grown up or to fit in. It is difficult to know which teens will experiment and stop and which will develop serious problems. Teenagers at risk for developing serious alcohol and drug problems include those:

- with a family history of substance abuse
- who are depressed
- who have low self-esteem, and
- who feel like they don't fit in or are out of the mainstream

This information was partially based on a number of governmental, professional and patient advocacy resources that are available on the internet: These include:

1) SAMHSA National Mental Health Information Center at the Center for Mental Health Services, http://www.mentalhealth.samhsa.gov/publications/browse.asp

2) Mental Health America
http://www.mentalhealthamerica.org

3) The National Alliance on Mental Illness
http://www.nami.org

4) The American Academy of Child and Adolescent Psychiatry
http://www.aacap.org

For training and/or guidance in the use of this toolkit, contact Lisa Hunter Romanelli, PhD, Executive Director, the REACH Institute, info@TheReachInstitute.org

The Action Signs Project
Literature on Mental Health Disorders

ANXIETY:

Books

1. Vasey MW, Dadds MR (Eds) (2001), **The developmental psychopathology of anxiety.** London, Oxford University Press

This book brings together some of the foremost experts to review and integrate the current research and theory on the major factors that shape anxiety disorders in childhood and throughout the life span.

2. Ollendick TH, March JS (Eds) (2004), **Phobic and anxiety disorders in children and adolescents: A clinician's guide to effective psychosocial and pharmacological interventions**. London, Oxford University Press

This comprehensive, interdisciplinary guidebook is designed for the mental health practitioner seeking to utilize proven and effective interventions with children and adolescents suffering from significant anxiety and phobic disorders. Each chapter is co-authored by a clinical child psychologist and a child psychiatrist, framing the volume's unique and balanced perspective. This guide will help bridge the chasm between clinical research and clinical practice, uniting the forces intrinsic to child psychiatry and clinical child psychology.

3. Eisen AR, Kearney CA, Schaefer CE (Eds) (1995), **Clinical handbook of anxiety disorders in children and adolescents.** Northvale, NJ, Jason Aronson, Inc.

This book addresses the major clinical features of anxiety and anxiety-related disorders as they are specifically manifested in [children and adolescents]. Written by experienced clinicians concurrently involved in research, it combines . . . treatment methods based on sound, systematic studies.

Web Sites

1. **Anxiety Disorders (2003).** Retrieved November 22, 2005, from SAMHSA’s National Mental Health Training Center, Center for Mental Health Services Web site: http://www.mentalhealth.samhsa.gov/publications/allpubs/ken98-0045/default.asp

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD):

Books

1. Jacobs EH (2000), **ADHD: Helping parents help their children**. Northvale, NJ, Jason Aronson, Inc.

In this book, the author demonstrates how he helps parents work effectively to acquire skills that will help their children. Addressing both the necessity and the complexity of developing a therapeutic relationship with the child's parents, he guides clinicians through the process of offering information about ADHD, coping with the parents' emotional reactions, identifying differences in mothering and fathering, and engaging the parents in an examination of the effectiveness of their parenting skills and disciplinary methods.

2. Lensch CR (2000), **Making sense of attention deficit/hyperactivity disorder.** Westport, CT, Bergin & Garvey

The primary purpose of this book is to bridge the gap between research knowledge and the knowledge in use by educators on attention deficit hyperactivity disorder (ADHD). The book is a review and interpretation of selected studies on the causes, co-occurrence with other disorders, diagnosis, and treatments of ADHD. It provides the reader with the opportunity to gain an understanding of ADHD for making mindful, informed decisions on approaches best suited to meet the challenges presented by this disorder.

3. Jensen PS (2004), **Making the System Work for Your Child with ADHD.** New York, NY, Guilford Press

Even for parents who "do everything right," the road to successful management of ADHD is seldom smooth. Now leading child psychiatrist Dr. Peter Jensen guides parents over the rough patches and around the hairpin curves in this empowering, highly informative book. Readers learn the "whats," "whys," and "how-tos" of making the system work--getting their money's worth from the healthcare system, cutting through red tape at school, and making the most of fleeting time with doctors and therapists.

BIPOLAR/MANIA:

Books

1. Birmaher B (2004), **New Hope for Children and Teens With Bipolar Disorder**. New York, NY, Three Rivers Press

This book is an essential resource for the parents of bipolar-diagnosed children and teens. Readers will discover how they can help their bipolar child not only manage the diagnosis, but also enjoy a happy childhood and develop the natural strengths and gifts that every child has to offer. Written by a top expert in the field, this book dispels the myths about bipolar disorder while offering real solutions.

2. Geller B, DelBello MP (Eds) (2003), **Bipolar disorder in childhood and early adolescence.** New York, NY, Guilford Press

This book addresses epidemiology, diagnosis and assessment, comorbidity, and the life course of the disorder, examining how bipolar illness presents differently in children than in adults and how it can be identified and studied.

3. Lederman J, Fink C (2003), **The ups and downs of raising a bipolar child: A survival guide for parents.** New York, NY, Fireside Books

This book gives parents the sound advice and expert information they need to cope with this challenging diagnosis, and shows how to provide essential care and support for a bipolar child as well as for the rest of the family.

Articles

1. Coyle, JT, Pine DS, Charney DS, Lewis L, et al. (2003), **Depression and Bipolar Support Alliance Consensus Statement on the Unmet Needs in Diagnosis and Treatment of Mood Disorders in Children and Adolescents.** *J Am Acad Child Adolesc Psychiatry.* 42:1494-1503

The 36-member Consensus Development Panel met to focus attention on the critical unmet needs of children and adolescents with mood disorders and to make recommendations for future research and allocation of healthcare resources. Patients experience limited exposure to clinicians adequately trained to address their problems and little information to guide care decisions, particularly concerning bipolar disorder. National efforts are required to restructure healthcare delivery and provider training and to develop more advanced research.

Web Sites

1. **Mood Disorders (2003).** Retrieved November 22, 2005, from SAMHSA's National Mental Health Training Center, Center for Mental Health Services Web site: http://www.mentalhealth.samhsa.gov/publications/allpubs/ken98-0049/default.asp

CONDUCT DISORDER/OPPOSITIONAL DEFIANT DISORDER:

Books

1. Bloomquist ML, Schnell SV (2002), **Helping children with aggression and conduct problems: Best practices for intervention.** New York, NY, Guilford Press

This book reviews and integrates the findings of numerous program developers to present best-practice guidelines for clinical, school, and community settings. The book reflects the authors' combined 30 years of applied and research experience in the field. It provides a virtual blueprint for practice for anyone working with this challenging population of age 3-12 and their families.

2. Hill J, Maughan B (Eds) (2001), **Conduct disorders in childhood and adolescence.** New York, NY, Cambridge University Press

Conduct disorders are very common in the population and the most frequent reason for clinical referrals to child and adolescent mental health facilities. Aggression and oppositional behaviour in young children often becomes persistent, and substantially increases the likelihood of adult problems of criminality, unstable relationships, psychiatric disorder and harsh parenting. This comprehensive book reviews established and emerging aspects of conduct disorder, with contributions from leading clinicians and researchers in the field. Integrating findings from a wide range of research perspectives, this book is intended for mental health practitioners and others with clinical, sociological or medicolegal interests in child health and behavior.

3. Quay HC, Hogan AE (Eds) (1999), **Handbook of disruptive behavior disorders.** Dordrecht, Netherlands, Kluwer Academic Publishers

This book provides the researcher, clinician, teacher, and student in mental health fields with information about what have come to be called the Disruptive Behavior Disorders of children and adolescents.

4. Essau CA (Ed) (2003), **Conduct and oppositional defiant disorders: Epidemiology, risk factors, and treatment.** Mahwah, NJ, Lawrence Erlbaum Associates, Publishers

Written by an eminent group of international experts, this book offers a comprehensive cutting-edge overview of all the major aspects of conduct disorder (CD) and oppositional defiant disorder (ODD) in children and adolescents.

5. Greene RW (1998), **The explosive child: A new approach for understanding and parenting easily frustrated, "chronically inflexible" children**. New York, NY, HarperCollins Publishers

This book is about explosive, inflexible, easily frustrated children who often exhibit severe behaviors and who can make life extraordinarily challenging and frustrating for themselves and those who interact with them. Though they have been described in many ways and may carry any or many of various psychiatric diagnosis (ODD, ADHD, Tourette's disorder, depression, bipolar disorder, and obsessive compulsive disorder), the author believes their behavior is still poorly understood and therefore difficult to change.

DEPRESSION:

Books

1. Sameroff AJ, Lewis M, Miller SM (Eds) (2000), **Handbook of developmental psychopathology** (2nd ed.). Dordrecht, Netherlands, Kluwer Academic Publishers

Developmental psychopathology involves the study and prediction of maladaptive behaviors and processes across time. This new edition of the Handbook furthers the goal of integrating developmental processes into the search for adequate categorical systems for understanding child mental health problems and the trajectories that lead to adult psychopathology.

2. Essau C, Petermann F (Eds) (1999), **Depressive disorders in children and adolescents: Epidemiology, risk factors, and treatment.** Northvale, NJ, Jason Aronson, Inc.

The aim of this book is to provide a comprehensive summary of the state-of-the-art information in depressive disorders in children and adolescents, information that is scientifically and clinically relevant for mental health professionals.

3. Shaffer D, Waslick BD (Eds) (2002), **The many faces of depression in children and adolescents.** Washington, DC, American Psychiatric Publishing, Inc.

Although research on the diagnosis and treatment of depression in children and adolescents has lagged far behind that in adults, recent large-scale studies--armed with operationalized criteria and validated assessment instruments--have done much to close this gap. In this book the authors lead a group of contributors in presenting an overview of the key findings and concepts emerging from recent empirical efforts to understand the cause of depressive illness in youth.

Web Sites

1. **Mood Disorders (2003).** Retrieved November 22, 2005, from SAMHSA's National Mental Health Training Center, Center for Mental Health Services Web site: http://www.mentalhealth.samhsa.gov/publications/allpubs/ken98-0049/default.asp

EATING DISORDERS:

Books

1. Thompson JK, Smolak L (Eds) (2001), **Body image, eating disorders, and obesity in youth: Assessment, prevention, and treatment.** Washington, DC, American Psychological Association

This book examines the relationship between body image disturbances and eating disorders in our most vulnerable population: children and adolescents. Chapters review current research, assessment techniques, and suggestions for treatment and prevention. This volume delivers direction for researchers in the field as well as guidance for practitioners and clinicians working with young clients suffering from these disorders.

2. Robert-McComb JJ (Ed) (2001), **Eating disorders in women and children: Prevention, stress management, and treatment.** Boca Raton, FL, CRC Press

This book describes an approach that combines specifically designed stress management techniques with treatments for symptoms of eating disorders. This comprehensive approach examines and evaluates the signs and symptoms of the various stages of anorexia, bulimia, and compulsive overeating.

3. Natenshon AH (1999), **When your child has an eating disorder: A step-by-step workbook for parents and other caregivers.** San Francisco, CA, Jossey-Bass

A step-by-step approach to understanding eating disorders for parents. It starts by defining eating disorders and addressing common misconceptions surrounding them. The author helps parents determine if their child actually has a problem by clearly outlining signs of the disease. Next, she discusses the action steps for getting children on the road to recovery. Finally, she walks parents through the long recovery process.

Articles

1. Gowers S, Bryant-Waugh R (2004), **Management of child and adolescent eating disorders: the current evidence base and future directions.** *J Child Psychol Psychiatry Allied Discip* 45:63-83

This review summaries the recent research literature covering management in three areas, namely physical management, psychological therapies, and service issues, and identifies prognostic variables.

2. Littleton HL, Ollendick T (2003), **Negative body image and disordered eating behavior in children and adolescents: What places youth at risk and how can these problems be prevented?** *Clin Child Family Psychol Review* 6:51-66

In this review, the authors examine the prevalence of negative body image and disordered eating behaviors (i.e., excessive dieting, binge eating, and inappropriate weight loss techniques) in children and adolescents. The article also explores correlates and predictors of the development of these problems, including individual, familial, and social factors, as well as discusses factors that may serve a protective function.

Web Sites

1. **Eating Disorders (2003).** Retrieved November 22, 2005, from SAMHSA's National Mental Health Training Center, Center for Mental Health Services Web site: http://www.mentalhealth.samhsa.gov/publications/allpubs/ken98-0047/default.asp

SUBSTANCE USE:

Books

1. Stevens SJ, Morral AR (Eds) (2003), **Adolescent substance abuse treatment in the United States: Exemplary models from a national evaluation study.** New York, NY, Haworth Press, Inc.

This edited book examines trends in ten adolescent substance use and treatment approaches along with the need for developing and evaluating adolescent substance abuse treatment programs. Adolescents enrolled in these programs participated in a baseline assessment and follow-up assessments at some of all the 3, 6, 9, and 12-month postbaseline follow-up points. Each program also participated in a cost analysis so that treatment outcomes can be compared against the cost of treatment.

2. Monti PM, Colby SM, O'Leary TA (Eds) (2001), **Adolescents, alcohol, and substance abuse: Reaching teens through brief interventions.** New York, NY, Guilford Press

This volume reviews a range of empirically supported approaches to dealing with alcohol and other drug problems in this large and diverse clinical population. The focus is on motivationally based brief interventions that can be delivered in a variety of contexts that address key developmental considerations, and that draw on the latest knowledge about the processes of addictive behavior change. Bringing together a multidisciplinary group of expert contributors, this is an essential resource for anyone working with or studying adolescents a risk.

Articles

1. Redmond C, Spoth R, Shin C, Hill GJ (2004), **Engaging Rural Parents in Family-Focused Programs to Prevent Youth Substance Abuse**. *J Primary Prevention* 24:223-242

This article collected data during telephone interviews with 1,156 parents of sixth graders from 36 rural schools to examine the relationships of family sociodemographic factors, parents' perceptions of their child's susceptibility to future substance use involvement, parents' perceptions of their ability to prevent such problems, and the perceived benefits of family-skills programs designed to prevent adolescent problems. Findings supported the hypotheses that parental efficacy perceptions inversely affect perceptions of child susceptibility and that perceptions of child susceptibility positively affect perceived program benefits.

2. Kendall PC, Kessler RC (2002), **The impact of childhood psychopathology interventions on subsequent substance abuse: Policy implications, comments, and recommendations.** *J Consult Clin Psychology* 70:1303-1306

This article makes observations about policy implications and offers a combination of commentary and recommendation regarding the special issue on the impact of childhood psychopathology interventions on subsequent substance abuse.

SUICIDE:

Books

1. Goldston DB (2003), **Measuring suicidal behavior and risk in children and adolescents.** Washington, DC, American Psychological Association

This book offers practitioners and researchers practical, up-to-date information on a wide range of instruments used to evaluate suicidal behavior in children and adolescents. In this critical and comprehensive reference book, the author describes conceptual, definitional, and psychometric issues important in evaluating and comparing various assessment instruments and then focuses on available instruments that can be used for screening purposes or as adjuncts in detecting, describing, or estimating the risk of suicidal behavior.

2. Shaffer D, Waslick BD (Eds) (2002), **The many faces of depression in children and adolescents.** Washington, DC, US: American Psychiatric Publishing, Inc.

In this book the authors lead a group of contributors in presenting an overview of the key findings and concepts emerging from recent empirical efforts to understand the cause of depressive illness in youth. Topics include developments in the emerging field of youth suicide prevention. Throughout, the contributors also offer strategies for optimizing interventions and outcomes in this population.

Articles

1. **Adolescent Depression and Suicide: A Comprehensive Empirical Intervention for Prevention and Treatment** (2003)**.** *Family Therapy* 30:61

This article presents an empirically based interventive approach to helping adolescents and families deal with adolescent depression and suicide. In a unique approach, the text combines theory, intervention, and empirically based techniques for practitioners working with the adolescent and his or her family.

2. Gould, MS, Kramer RA (2001), **Youth suicide prevention**. *Suic Life-Threatening Beh* 31:6-31

This article reviews the literature on the prevalence of youth suicide in the US, the risk factors for child and adolescent suicide, and the application of this knowledge to designing prevention strategies. The article concludes with a benefits assessment of each of the suicide prevention strategies presented in the review.

GENERAL CHILD PSYCHOPATHOLOGY AND SERVICES RESEARCH:

Books

1. Burns B, Hoagwood K (Eds) (2002), **Community treatment for youth.** New York, New York, Oxford Press

This book presents a collection of articles which reviews current thinking and practice in community treatment. Issues such as systems of care, case management, Multi-systemic therapy are reviewed. The role of family, school and other community resources are considered as well.

2. Epstein MH, Kutash K, Duchnowski A (Eds) (1998), **Outcomes for children and youth with emotional and behavioral disorders and their families: Programs and evaluation best practices**. Austin, Texas, Pro-Ed

While there has been an upsurge in interest and investment in the field of services for children and youth with emotional and behavioral disorders and their families, progress and application of research findings has not always been smooth, or guided by a comprehensive strategic plan. This book addresses these challenges and contributes to the growing knowledge base in the field. Some of the current best practices in services for children and their families, as well as in the research and evaluation of these services, are presented

3. Lerner RM, Steinberg L (Eds) (2004), **Handbook of adolescent psychology**, **2nd ed.** Hoboken, NJ, John Wiley & Sons

This edition of the book is concerned with all aspects of development during the second decade of life, with all the contexts in which this development takes place and with a wide array of social implications and applications of the scientific knowledge gained through empirical research.

4. Kazdin AE, Weisz JR (Eds) (2003), **Evidence-based psychotherapies for children and adolescents.** New York, NY, Guilford Press

This book provides an overview of evidence-based treatments for social, emotional, and behavioral problems in children and youth. Pioneering psychotherapy researchers offer accessible, hands-on presentations of their respective approaches: how each treatment was developed; its conceptual and empirical bases; what it looks like in practice, and how, why, and for whom the therapy works.

5. Vance HB, Pumariega A (Eds) (2001), **Clinical assessment of child and adolescent behavior.** New York, NY, John Wiley & Sons, Inc.

This book presents a description of the assessment process and intervention/treatment approaches for disorders found in infancy, childhood, and adolescence. Each chapter provides detailed, procedural guidelines for the assessment of these disorders, current descriptions of assessment instruments used in the identification process, detailed case studies, and an integrated treatment approach, including the use of psychopharmacology agents in the management of these challenging behaviors.

Web Sites

1. **Teen mental health problems: What are the Action signs (2002).** Retrieved November 22, 2005, from SAMHSA's National Mental Health Training Center, Center for Mental Health Services Web site: http://www.mentalhealth.samhsa.gov/publications/allpubs/Ca-0023/default.asp

2. **Choosing the right mental health therapist (2003).** Retrieved November 22, 2005, from SAMHSA's National Mental Health Training Center, Center for Mental Health Services Web site: http://www.mentalhealth.samhsa.gov/publications/allpubs/KEN98-0046/default.asp

3. **Girl power! Is good mental health (1999).** Retrieved November 22, 2005, from SAMHSA's National Mental Health Training Center, Center for Mental Health Services Web site: http://www.mentalhealth.samhsa.gov/publications/allpubs/CA-0038/Default.asp

For training and/or guidance in the use of this toolkit, contact Lisa Hunter Romanelli, PhD, Executive Director, the REACH Institute, info@TheReachInstitute.org

The Action Signs Project

Advocacy and Professional Organizations (Listed Alphabetically)

ORGANIZATIONS PROVIDING AN OFFICIAL ENDORSEMENT OF THE TOOLKIT

American Academy of Child and Adolescent Psychiatry
3615 Wisconsin Avenue, N.W.
Washington, DC 20016
(202) 966-7300 (tel)
www.aacap.org

American Academy of Pediatrics
141 Northwest Point Boulevard
Elk Grove Village, IL 60007-1098
(847) 434-4000 (tel)
(847) 434-8000 (fax)
www.aap.org

American School Counselors Association (ASCA)
1101 King Street, Suite 625
Alexandria, VA 22314
(800) 306-4722 (tel)
(703) 683-ASCA (2722) (tel)
(703) 683-1619 (fax)
http://www.schoolcounselor.org

American School Health Association (ASHA)
7263 State Route 43
P.O. Box 708
Kent, OH 44240
(330) 678-1601 (tel)
http://www.ashaweb.org

Anxiety Disorders Association of America (ADAA)
8730 Georgia Avenue, Suite 600
Silver Spring, MD 20910
(240) 485-1001 (tel)
(240) 485-1035 (fax)
AnxDis@adaa.org
www.adaa.org

Center for Mental Health Services (CMHS)
Division of Knowledge Development and
Systems Change/Administration
Room 11C-16/Parklawn Building
5600 Fishers Lane
Rockville, MD 20857
(301) 443-1333 (tel)
(301) 443-3639 (fax)
www.mentalhealth.org

Centers for Disease Control and Prevention (CDC)
Department of Health and Human Services
1600 Clifton Road
Atlanta, GA 30333
(404) 639-3311 (tel)
(404) 639-3534 / (800) 311-3435 (public inquiries)
http://www.cdc.gov/

Child and Adolescent Bipolar Foundation (CABF)
1000 Skokie Boulevard
Wilmette, IL 60091
(847) 256-8525 (tel)
(847) 920-9498 (fax)
www.bpkids.org

Children and Adults with
Attention Deficit Disorder (CHADD)
8181 Professional Place, Suite 105
Landover, MD 20785
(301) 306-7070 or (800) 233-4050 (tel)
(301) 306-7090 (fax)
www.chadd.org

Depression and Bipolar Support Alliance
730 N. Franklin Street, Suite 501,
Chicago, Illinois 60610-7224 USA
(800) 826-3632; (312) 642-0049 fax (312) 642-7243
www.dbsalliance.org

Federation of Families for Children's
Mental Health (FFCMH)
1101 King Street
Suite 420
Alexandria, VA 22314
(703) 684-7710 (tel)
(703) 836-1040 (fax)
www.ffcmh.org

National Alliance for the Mentally Ill (NAMI)
2107 Wilson Boulevard
Suite 300
Arlington, VA 22201
(703) 524-7600 (tel)
(703) 950-6264 (NAMI helpline)
www.NAMI.org

National Association of School Psychologists
4340 East West Highway, Suite 402
Bethesda, MD 20814
(866) 331-6277
http://www.nasponline.org

Mental Health America
1021 Prince Street
Alexandria, VA 22314
(703) 684-7722 (tel)
(703) 684-5968 (fax)
www.mentalhealthamerica.org

School Social Work Association of America
University of Pennsylvania
3701 Locust Walk
Philadelphia, PA 19104
(847) 289-4527 (tel)
http://www.sswaa.org

Society for Adolescent Medicine (SAM)
1916 Copper Oaks Circle
Blue Springs, MO 64015
(816) 224-8010 (tel)
(816) 224-8009 (fax)
sam@adolescenthealth.org
http://www.adolescenthealth.org/

World Psychiatric Association
Dept. of Psychiatry & Behavioral Sciences
Metropolitan Hospital Center
New York Medical College
1901 First Avenue, Suite 4M-3
New York, NY 10029
(212) 423-7001 (tel)
(212) 876-3793 (fax)
wpasecretariat@wpanet.org
wpa@dti.net
www.wpanet.org/

TENTATIVE ENDORSEMENT (Pending Final Review)

National Association of School Nurses
1416 Park Street, Suite A
Castle Rock, CO 80109
(866) 627-6767 (toll-free tel)
(303) 663-2329 (tel)
(303) 663-0403 (fax)
nasn@nasn.org
http://www.nasn.org/

ADDITIONAL ORGANIZATIONAL RESOURCES
(These organizations have not yet reviewed the toolkit or prefer to be listed as an additional resource)

American Academy of Family Physicians (AAFP)
P.O. Box 11210
Shawnee Mission, KS 66207-1210
(800) 274-2237 (tel)
fp@aafp.org
http://www.aafp.org/

American Psychiatric Association
1000 Wilson Boulevard, Suite 1825
Arlington, VA 22209
(703) 907-7300 (tel)
http://www.psych.org

American Psychological Association
750 First Street, NE
Washington, DC 20002
(800) 374-2721 (tel)
http://www.apa.org

American Psychological Society (APS)
1010 Vermont Avenue, NW
Suite 1100
Washington, DC 20005
(202) 783-2077 (tel)
http://www.psychologicalscience.org

National Alliance for Hispanic Health
1501 Sixteenth Street, NW
Washington, DC 20036
(202) 387-5000 (tel)
alliance@hispanichealth.org
http://www.hispanichealth.org/

National Association of Social Workers
750 First Street, NE
Suite 700
Washington, DC 20002
http://www.naswdc.org

Society for Developmental and Behavioral Pediatrics
15000 Commerce Parkway, Suite C
Mt. Laurel, NJ 08054
(856) 439-0500 (tel)
(856) 439-0525 (fax)
sdbp@ahint.com
http://www.sdbp.org/

For training and/or guidance in the use of this toolkit, contact Lisa Hunter Romanelli, PhD, Executive Director, the REACH Institute, info@TheReachInstitute.org

If you think you may have Action Sign #1…

Feeling very sad or withdrawn
For more than 2 weeks

It is important because it could mean that you have depression.

Depression is serious. Many kids have this problem. The good news is it can be treated!

Kids who have depression may feel very sad. They may lose interest in things they usually like to do. They can have sleeping problems or low energy. Kids may also think a lot about death or dying. They may feel bad about themselves. Some have problems focusing or making decisions.

Your doctor can tell you that kids who have depression are not 1 in 1000 – they are 1 in 10! Your feelings are an important part of your health. If you have depression, it is time to take action! Talking with your doctor or family, will help you feel better.

To learn more, talk to an adult. You can talk to a family member, or a doctor. At school, you can talk to a nurse or a counselor. You can even talk with a religious leader like a minister, rabbi, priest, or a cleric. You may also contact one of these groups:

List Organization Names Here, Including Your Local Organizations:

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If you think you may have Action Sign #2…

Seriously trying to harm or kill yourself, or making plans to do so

It is important because it could mean that you are having suicidal thoughts.

Suicidal thoughts often start from feelings of depression. Depression is serious, and is one of kids' most common problems. The good news is that it is treatable!

Sometimes kids have thoughts about suicide when they are depressed (extremely sad). They may have made a suicide attempt in the past. They may also think about suicide if they have other behavior or substance abuse problems. Kids with suicidal thoughts may feel hopeless or do dangerous things without thinking. They may not be involved in school or may stay away from friends or family.

Your doctor can tell you that kids who have depression are not 1 in 1000 – they are 1 in 10! Your feelings are an important part of your health. If you have depression, it is time to take action! Talking with your doctor or family will help you feel better.

To learn more, talk to an adult. You can talk to a family member, or a doctor. At school, you can talk to a nurse or a counselor. You can even talk with a religious leader like a minister, rabbi, priest, or a cleric. You may also contact one of these groups:

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If you think you may have Action Sign #3…

Sudden overwhelming fear for no apparent reason, sometimes with racing heart or fast breathing

It is important because it could mean that you are suffering from panic disorder.

Panic disorder is one type of anxiety problem. It often includes feeling intense fears on many occasions. The fear may strike often and without warning. Kids with panic disorder may feel chest pain, have a racing heart, or shortness of breath. Kids having panic attacks may also feel dizzy, or have stomach pain. They may have fears of dying or "going crazy."

Your doctor can tell you that kids with panic problems are not 1 in 1000 – they are 1 in 10! Your feelings are an important part of your health. If you have panic disorder, it is time to take action! Talking with your doctor or family will help you feel better.

To learn more, talk to an adult. You can talk to a family member, or a doctor. At school, you can talk to a nurse or a counselor. You can even talk with a religious leader like a minister, rabbi, priest, or a cleric. You may also contact one of these groups:

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If you think you may have Action Sign #4…

Involved in many fights, using a weapon, or wanting to badly hurt others

It is important because it could mean that you have conduct disorder or another serious condition.

Kids with conduct disorder may be aggressive and have angry feelings that are hard to stop. It just gets out of control, and they feel badly afterwards! Kids with conduct disorder may show this problem in different places, such as home, school, or with friends. Conduct disorder is more common among boys than girls, but both boys and girls can have it. The good news is that you can get help for this problem. Getting treatment for conduct problems gives you a good chance to get better and have a bright future!

Your doctor can tell you that kids with conduct problems are not 1 in 1000 – they are 1 in 10! Remember that your emotional health is an important part of overall health. Now that you know it, it's time to take action! By talking further with your doctor or family, you will already be on the road to feeling better.

To learn more, talk to an adult. You can talk to a family member, or a doctor. At school, you can talk to a nurse or a counselor. You can even talk with a religious leader like a minister, rabbi, priest, or a cleric. You may also contact one of these groups:

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If you think you may have Action Sign #5…

Severe out-of-control behavior that can hurt yourself or others

It is important because it could mean that you have conduct disorder or another serious but treatable condition

Kids with conduct disorder may be aggressive and have angry feelings that are hard to stop. It just gets out of control, and they feel badly afterwards! Kids with conduct disorder may have this problem in different places, such as home, school, or with friends. Conduct disorder is more common among boys than girls, but both boys and girls can have it. The good news is that it's treatable! Getting treatment for conduct problems gives you a good chance to get better and have a bright future!

Your doctor can tell you that kids who have conduct problems are not 1 in 1000 – they are 1 in 10! Your feelings are an important part of your health. Now that you know it, it's time to take action! By talking further with your doctor or family, you will already be on the road to feeling better.

To learn more, talk to an adult. You can talk to a family member, or a doctor. At school, you can talk to a nurse or a counselor. You can even talk with a religious leader like a minister, rabbi, priest, or a cleric. You may also contact one of these groups:

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If you think you may have Action Sign #6…

Not eating, throwing up, or using laxatives to make yourself lose weight

It is important because it could mean that you are suffering from an eating disorder.

Teenagers with an eating disorder may eat huge quantities of high calorie food. They may make themselves vomit, or use laxatives to lose weight. These types of eating problems can cause serious problems to your health and damage your body. You may become dehydrated or have a hormonal imbalance. But the good news is that it is treatable!

Your doctor can tell you that kids who have eating disorders are not 1 in 1000 – they are 1 in 10! Your feelings are an important part of your health. If you have an eating problem , it is time to take action! Talking with your doctor or family will help you feel better.

To learn more, talk to an adult. You can talk to a family member, or a doctor. At school, you can talk to a nurse or a counselor. You can even talk with a religious leader like a minister, rabbi, priest, or a cleric. You may also contact one of these groups:

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If you think you may have Action Sign #7…

Intense worries or fears that get in the way of your daily activities

It is important because it could mean that you are suffering from an anxiety disorder

Anxiety disorders can affect people of all ages, including kids. In fact, anxiety is one of the most common emotional problems that kids have. The good news is that it is treatable!

Most kids can get nervous, worried, or anxious. It can be a problem when it stops them from doing normal activities, like going to school, making friends, or sleeping. Kids can also get anxious in different ways. Fears and worries can keep coming back and may be hard to control. These kids may have trouble concentrating or sleeping. They may also be fearful when around others, or have fears of being away from home.

Your doctor can tell you that kids who have anxiety disorders are not 1 in 1000 – they are 1 in 10! Your feelings are an important part of your health. If you have an anxiety disorder, it is time to take action! Talking with your doctor or family will help you feel better.

To learn more, talk to an adult. You can talk to a family member, or a doctor. At school, you can talk to a nurse or a counselor. You can even talk with a religious leader like a minister, rabbi, priest, or a cleric. You may also contact one of these groups:

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If you think you may have Action Sign #8…

Extreme difficulty in concentrating or staying still that puts you in physical danger or causes school failure

It is important because it could mean that you are suffering attention deficit/hyperactivity disorder.

Attention-deficit hyperactivity disorder (ADHD) is one of the most common reasons children see a doctor or counselor. Boys are more likely than girls to have ADHD, but ADHD affects both boys and girls. The good news is that it is treatable!

There are three main types of ADHD. Kids may have severe problems with paying attention. They may be overly active or they may act without thinking. These problems of sitting still, paying attention, and listening can make school difficult.

Your doctor can tell you that kids with ADHD problems are not 1 in 1000 – they are 1 in 10! Your feelings are an important part of your health. If you have ADHD, it is time to take action! Talking with your doctor or family, will help you feel better.

To learn more, talk to an adult. You can talk to a family member, or a doctor. At school, you can talk to a nurse or a counselor. You can even talk with a religious leader like a minister, rabbi, priest, or a cleric. You may also contact one of these groups:

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If you think you may have Action Sign #9…

Repeated use of drugs or alcohol

It is important because it could mean that
you are suffering from a substance use disorder.

Substance abuse means using drugs or alcohol without a medical need. It can be a serious problem for many kids. Substances may include alcohol, nicotine (tobacco, snuff), marijuana, cocaine, and inhalants. Substance use can lead to problems with school, friends and family. These problems may also lead to trouble with the police. It can also cause fighting, unplanned sex, and driving accidents.

Kids use alcohol and other drugs because they are curious. Sometimes they use substances because it feels good. Some kids may be trying to find a way to relax, feel grown up, or fit in. Kids at risk for alcohol and drug problems may have family members who abuse drugs or alcohol. These kids may also be depressed. They may have low self-esteem. They also may feel like they do not fit in.

Your doctor can tell you many kids have substance use problems. The number of kids who have this problem is not 1 in 1000 – it is 1 in 10! Your feelings are an important part of your health. If you have a substance use problem, it is time to take action! Talking with your doctor or family will help you feel better.

To learn more, talk to an adult. You can talk to a family member, or a doctor. At school, you can talk to a nurse or a counselor. You can even talk with a religious leader like a minister, rabbi, priest, or a cleric. You may also contact one of these groups:

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If you think you may have Action Sign #10…

Severe mood swings that cause problems in relationships

It is important because it could mean that you are suffering from bipolar disorder or another serious problem

Severe mood swings can be a sign of more significant problems such as bipolar disorder. The good news is that these problems are treatable!

Bipolar disorder is a condition where a person switches between extreme highs and lows. Kids may quickly switch moods or are full of energy. They may think very highly of themselves or take unnecessary risks. Kids may also have signs of depression such as crying a lot, withdrawing from friends, and low energy. Not all children with bipolar disorder have all symptoms. If you are struggling with any of these symptoms for more than two weeks, talk with a doctor or parent.

Your doctor can tell you that kids who have severe mood swings are not 1 in 1000 – they are 1 in 10! Your feelings are an important part of your health. If you have severe mood swings, it is time to take action! Talking with your doctor or family will help you feel better.

To learn more, talk to an adult. You can talk to a family member, or a doctor. At school, you can talk to a nurse or a counselor. You can even talk with a religious leader like a minister, rabbi, priest, or a cleric. You may also contact one of these groups:

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If you think you may have Action Sign #11…

Drastic changes in your behavior or personality

It is important because it could mean that you are suffering from a serious condition.

Drastic changes in your behavior or personality could mean you have a serious problem. You might be struggling with feeling very sad, or moody. You may quickly switch between feeling extremely high and low. If you have a major change in personality or behavior, it is important to get help. These changes can be treated.

Your doctor can tell you that kids who have personality change problems are not 1 in 1000 – they are 1 in 10! Your feelings are an important part of your health. If you have depression, it is time to take action! Talking with your doctor or family, will help you feel better.

To learn more, talk to an adult. You can talk to a family member, or a doctor. At school, you can talk to a nurse or a counselor. You can even talk with a religious leader like a minister, rabbi, priest, or a cleric. You may also contact one of these groups:

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Combined Fact Sheet Containing All Action signs

Action Sign #1 - Feeling very sad or withdrawn for more than 2 weeks:
Depression is a serious condition and one of the most common mental health concerns in kids. The primary characteristics of depression are excessive sadness, loss of interest in activities, sleeping problems (either sleeping to much or not enough), lack of energy, preoccupation with death or dying, feelings of worthlessness or excessive guilt and difficulty in thinking, concentrating, or making decisions.

Action Sign #2 - Seriously trying to harm or kill yourself, or making plans to do so:
Suicide is the result of many complex factors. Important risk factors for suicide and suicidal behavior include prior suicide attempt, other mental and alcohol or substance abuse disorders, feelings of hopelessness, impulsive and/or aggressive behaviors, easy access to lethal methods, especially guns, or lack of involvement in school and/or work ("drifting").

Action Sign #3 - Sudden overwhelming fear for no reason, sometimes with a racing heart or fast breathing:
Panic disorder is a common and treatable disorder. Kids with panic disorder have unexpected and repeated periods of intense fear or discomfort, along with other symptoms such as a racing heartbeat or feeling short of breath. These periods are called "panic attacks" and can last minutes or go on for hours. Panic attacks frequently develop without warning. Symptoms of a panic attack include intense fearfulness, racing heartbeat, dizziness or lightheadedness, shortness of breath, a feeling of being smothered, fear of dying, losing control, or losing your mind.

Action signs #4 and #5 - Involved in many fights, using a weapon, or wanting to badly hurt others, OR severe out-of-control behavior that can hurt yourself or others:
Conduct disorder (CD) is a persistent pattern of behavior in children and adolescents in which the youth is physically aggressive to others…he or she just looses control, but often feels bad afterwards. The child or adolescent usually exhibits these behavior patterns in a variety of settings—at home, at school, and in social situations—and they cause impairment. Behaviors characteristic of conduct disorder include aggressive behavior that causes or threatens harm to other people or animals, non-aggressive conduct that causes property loss or damage, stealing, lying, or serious rule violations. In children with Oppositional Defiant Disorder (ODD), there is an ongoing pattern of uncooperative, defiant, and hostile behavior toward authority figures that seriously interferes with the youth's day to day functioning. Symptoms of ODD may include frequent or extreme rages and temper tantrums, excessive arguing with adults, refusal to listen to adult requests and rules, deliberate attempts to annoy or upset people, blaming others for his or her mistakes, being easily annoyed by others, frequent anger and resentment, mean and hateful talking when upset, or seeking revenge.

Action signs #6 – Not eating, throwing up, or using laxatives to make yourself lose weight:
Bulimia nervosa is a serious eating disorder with a destructive pattern of binge-eating and recurrent inappropriate behavior to control one's weight. Binge eating is defined as the consumption of excessively large amounts of food within a short period of time. The food is often sweet, high in calories, and has a texture that makes it easy to eat quickly. To control one's weight, someone suffering from this condition may use self-induced vomiting, abuse laxatives, starve oneself, or use non-purging behaviors, such as fasting or excessive exercise.

Action Sign #7 - Intense worries or fears that get in the way of his/her daily activities:
Children with generalized anxiety disorder (GAD) have recurring fears and worries that they find difficult to control. They worry about almost everything—school, sports, being on time, even natural disasters. They may be restless, irritable, tense, or easily tired, and they may have trouble concentrating or sleeping. Children with GAD are usually eager to please others and may be "perfectionists," dissatisfied with their own less-than-perfect performance.

Action Sign #8 - Extreme difficulty in concentrating or staying still that puts him/her in physical danger or causes school failure:
There are three main types of ADHD. One type is characterized by inattentiveness, one type is characterized by hyperactive or impulsive behavior, and the third type is combined—when children and adolescents show signs of both types. Symptoms may not be noticed until a child enters school. Some inattentive symptoms include difficulty following instructions, difficulty focusing on tasks, losing things at school and at home, lacking attention to detail, or failing to complete homework or tasks. Some hyperactive symptoms include fidgeting excessively, difficulty staying seated, running or climbing inappropriately, talking excessively, blurting out answers or frequently interrupting, or having trouble waiting his or her turn.

Action Sign #9 - Repeated use of drugs or alcohol:
Teens use alcohol and other drugs for many reasons, including curiosity, because it feels good, to reduce stress, to feel grown up or to fit in. It is difficult to know which teens will experiment and stop and which will develop serious problems. Teenagers at risk for developing serious alcohol and drug problems include those with a family history of substance abuse, who are depressed or anxious, who have low self-esteem, and who feel like they don't fit in

Action Sign #10 - Severe mood swings that cause problems in relationships:
Bipolar disorder begins with either manic or depressive symptoms. Some possible signs and symptoms include mania symptoms of severe changes in mood, usually excessively high self-esteem, increase in energy level, risk-taking behavior, or the other hand, depressive symptoms of frequent crying, withdrawal from friends, or decreased energy level. Not all children with bipolar disorder have all symptoms. Like children with depression, children with bipolar disorder sometimes have a family history of the illness.

Action Sign #11 – Drastic changes in your behavior or personality:
A drastic change in personality or behavior could be a sign of a more serious emotional problem. There is a possibility that it could be a sign of a mental health disorder, including but not limited to depression, bipolar disorder, or a personality disorder. For example, people with personality disorders may show signs of impulsivity and instability in mood, self-image, and personal relationships.

For training and/or guidance in the use of this toolkit, contact Lisa Hunter Romanelli, PhD, Executive Director, the REACH Institute, info@TheReachInstitute.org

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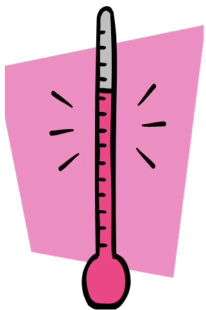
ACTION Signs: Your Youngster's Behavioral Health Thermometers

Wouldn't it be great if a thermometer could tell you
if your child was not feeling well emotionally?

Just as a thermometer measures if your child has a temperature, these action signs will tell you if your child has an emotional problem. The signs indicate when your child may be in need of professional evaluation.

If you think that your child may have any of the following action signs, tell your family physician. Take action and help your child feel better!



- **Feeling very sad or withdrawn for more than 2 weeks**
- **Seriously trying to harm or kill him/herself, or making plans to do so**
- **Sudden overwhelming fear for no reason, sometimes with a racing heart or fast breathing**
- **Involved in many fights, using a weapon, or wanting to badly hurt others**
- **Severe out-of-control behavior that can hurt him/her or others**
- **Not eating, throwing up, or using laxatives to make him/herself lose weight**
- **Intense worries or fears that get in the way of his/her daily activities**
- **Extreme difficulty in concentrating or staying still that puts him/her in physical danger or causes school failure**
- **Repeated use of drugs or alcohol**
- **Severe mood swings that cause problems in relationships**
- **Drastic changes in his/her behavior or personality**

This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is being provided with the understanding that the authors are not engaged in rendering medical or other professional services. If medical advice or other expert assistance is required, the services of a competent professional should be sought.

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Sticker Example:

Action signs for Mental Health

Instructions: Use this sticker as a reminder to ask the child about the following behaviors; follow-up on positive responses. Refer to the expanded information sheet.

- □ Feeling very sad or withdrawn; 2 weeks or more
- □ Seriously trying to harm or kill yourself, or making plans to do so
- □ Sudden overwhelming fear for no reason, sometimes with racing heart or fast breathing
- □ Involved in many fights, using a weapon, or wanting to badly hurt others
- □ Severe out-of-control behavior that can hurt yourself or others
- □ Not eating, throwing up, or using laxatives to make yourself lose weight
- □ Intense worries or fears that get in the way of your daily activities
- □ Extreme difficulty in concentrating or staying still that puts you in danger or causes school failure
- □ Repeated use of drugs and alcohol
- □ Severe mood swings that cause problems in relationships
- □ Drastic changes in your behavior or personality

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