

**SECTION XIV:
MENTAL HEALTH**

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Note: The material in this section includes excerpts from *The Comprehensive School Health Manual*, Massachusetts Department of Public Health and *When Being A Good Parent Is Not Enough*, Health Education Consultants

SCHOOL'S ROLE

The school plays a role in promoting healthy emotional development for all children. Spending every day in the company of youngsters who are profoundly affected by the world in which they live, educators develop a deep awareness of the importance of the positive influence of the school. They know that healthy emotional and social development, including a sense of self-worth, is critical to the success of children in and outside the classroom.

The school can also play a role in identifying children with emotional, behavioral and mental health problems and ensuring that they get proper assessments and appropriate interventions. Mental health problems have a variety of causes and can be made worse by learning disabilities or physical health problems; some may have a physiological base, while others may be a result of trauma or of familial or social stresses and problems.

Whatever the cause, there is a compelling reason for the school to be alert to the issues. It is important that a joint effort be forged among schools, parents and community mental health providers. School professionals such as guidance counselors, school psychologists, nurses, social workers and school based health center providers are in a position to bridge the gap between these groups.

Possibly the most critical element to success with school is for the student to develop a close and nurturing relationship with at least one caring adult. Students need to feel that there is someone within school whom they know, to whom they can turn and who will act as an advocate for them. (Excerpt from a Massachusetts Department of Education report.)

DEVELOPMENTAL STAGES

An understanding of the stages of children's and adolescents' social and emotional development is helpful in distinguishing between behavior that is typical of a development phase and what may necessitate observation and treatment by professionals. Typically, the middle years of childhood are a kind of golden age, an exciting time of emotional awakening, growth and engagement that forms the foundation for a fulfilling adult life; adolescence may bring an increase in emotional turbulence. The following are some very broad guidelines regarding school-aged children and adolescents; however, they may differ based on the child's gender, cultural background and other individual characteristics. It is also important to note that social and emotional development can be disrupted and/or arrested if a child or adolescent experiences significant or prolonged trauma.

▪ AGES 0-1 YEARS

- Develop basic trust.
- Cry in rage until needs are met.
- Cuddle, make eye contact, smile.
- Cry for help (excessive crying, sleep disturbance, feeding disorder, extreme stranger anxiety, muscular rigidity).

▪ AGES 1 TO 3 YEARS

- Develop autonomy.
- Explore (running, climbing, getting into things).
- Develop comfort, pleasure, or safety seeking behaviors (clinging, thumb sucking).

- Hit/bite to get attention.
- Explore own body (potty train).
- Regress to infantile behavior occasionally.
- Develop language.
- Plays along others without much interaction or sharing play themes, toys, or activities.

AGES 4 TO 5 YEARS

- Develop initiative, becoming independent from parents.
- Explore limits.
- Create imaginary companions.
- Express aggression with siblings or peers.
- Engage in bathroom talk.
- Become curious about body parts and sexual differences; engage in masturbation.
- Works together to plan and carry out shared themes in play, shares toys or activities.

AGES 6 TO 7 YEARS

- Exhibit extremes of emotional responses (joyous delight instead of quiet joy or hysterical crying instead of simple sadness).
- Express susceptibility to hurt feelings.
- Exhibit school phobia — a fear of going to school that can lead to feigned or psychosomatic illness.
- Quarrel with parents, especially mother, as a means of discharging separation anxiety associated with starting school or testing the parent-child relationship in this new school-oriented stage of life.
- Form multiple, relatively superficial, and relatively short-term relationships with peers.
- Engage in sex play to satisfy curiosity about genitals.
- Frequently initiate sibling rivalry.
- Occasionally resort to lying or stealing as a coping mechanism or means of rebellion.
- Ability to play together with mutually agreed upon rules.

AGES 7 TO 9 YEARS

- Exhibit much more emotional equilibrium than previously, although at age 8 may go through a recurrence of extreme emotional reactions and quarrels with parents.
- Experience both fear and rational concern related to possible dangers lurking in the outside world: crime, violence, and catastrophe.
- Become interested in sex talk and sex jokes and become curious about the mechanics of reproduction.
- Develop crushes on peers.
- Handle competitive play — winning and losing — relatively well.
- Worry about failure in academic performance.
- Assume more responsibility for own acts instead of blaming others.
- Fear being wrong or being humiliated.
- Ability to follow rules during play with others.

AGES 9 TO 11 YEARS

- Generally happy and content.
- Rely more and more on peers as opposed to parents for evaluation, approval and direction.
- Form “puppy love” relationships with peers.
- Develop more mature relationships with siblings.
- Exhibit concern over issues of justness and fairness.
- Seek and develop a “best friend” relationship.
- Worry about the possibility of parents fighting, divorcing, losing their jobs, becoming ill or dying.

AGES 11 TO 13 YEARS

- Become very self-conscious and sensitive about physical development, physical health and sexuality.
- Fear losing possessions, popularity or status.
- Develop romantic attachments with peers.
- Occasionally lose patience with siblings and parents if they appear to interfere with personal, peer-related interactions and ambitions.
- Seek and develop a close circle of friends for social support.
- Exhibit moodiness and irritability.

AGES 13 TO 19 YEARS

- Crave personal freedom from parents but still want and need their love.
- Intensely concerned about understanding why things are the way they are.
- Experiment and test the limits of pleasure and pain; may be involved in a reckless act of thrill seeking.
- May spend much of time at home silent and withdrawn, treat adults in general with distrust and disrespect, defy household rules and family standards, refuse to go anywhere with the family, skip school, run away, experiment with drugs, engage in sex.

PREVENTION ACTIVITIES

The major causes of mortality and morbidity among children and adolescents (accidents, homicide, suicide, substance abuse and sexually transmitted diseases) are preventable. Other risk factors may be related to poverty or lack of adequate food, shelter and clothing. There are many useful intervention techniques that can be used for each type of prevention. Some techniques can be applied at any level; for example, all students can be taught social skills. Small groups focusing on social skills training can be useful as secondary prevention for children at risk, and social skills taught to a group of students having difficulty with peers can provide tertiary prevention for those children. Obviously, different problems may call for different interventions.

PRIMARY PREVENTION

Primary prevention consists of providing children in advance with resources and skills necessary to cope with complex life situations. Such skills can help students gain a sense of competence and self-worth, which is critical to social and emotional well-being. Teachers, in concert with other school staff, such as the principal, guidance counselor and health staff, have an important role to

play in building a positive and a safe learning environment for students. Topics and activities might include the following: improving problem-solving skills, coping skills, communication skills; teaching cooperation; anger management skills and other life skills that promote tolerance; helping students resolve conflicts with other students and with adults; and providing opportunities for positive emotional expression.

In addition to organizing and facilitating student-focused prevention activities, mental health professionals may play an important role as organizational consultants to schools. They might be involved in helping the school maintain a nurturing and a safe learning environment, providing consultation to teachers and staff about positive management of different behavioral concerns, and assisting schools to develop policies and procedures to deal with social and emotional related issues.

SECONDARY PREVENTION

Secondary prevention efforts focus on identifying and providing services for children who are at risk of developing social and emotional concerns that may disrupt their academic gains. Children at risk may include those with family issues, learning disabilities and/or those affected by a significant loss or effects from prolonged trauma. Because teachers are in daily contact with students, they may be in a position to identify these children. A typical example of secondary prevention is educational support groups with a trained professional that focuses on helping children learn positive coping strategies.

TERTIARY PREVENTION

The third level of prevention consists of providing services to children who are actively demonstrating social and emotional concerns that warrants further assessment and/or appropriate referral. Schools may provide tertiary services in-house or make the necessary referral needed to a licensed mental health professional in the community to provide the appropriate behavioral health care and/or services. Trained school staff may also provide the appropriate support and follow-up services for students in need of outpatient care or transitioning from out of home treatment facilities. Students may be seen for individual or group counseling to maintain continuum of care.

COMMON PSYCHOLOGICAL PROBLEMS

It is extremely important for helping professionals to understand the dynamics of a particular child's situation in order to help that child effectively. Physiological problems, such as chemical imbalances in the brain, neurological disorders, environmental discord, may be underlying factors in any given case, and effective intervention depends on comprehensive assessment, appropriate diagnosis and treatment planning. The parents or guardians of children who are withdrawn or overly aggressive, those having significant problems interacting with peers or adults, and those encountering serious academic problems should be contacted and the students referred for assessment.

This section reviews the prevalence and symptoms associated with some common psychological problems of school-aged children and adolescents, and it suggests some school-based interventions that may be applied.

DEPRESSION

Depression can range from transient feelings to mood disorders. Mood disorders affect thought, feelings, behavior, and overall physical health. Everyone has feelings of sadness, discouragement and moodiness that are normal responses to failure or distress, but depression is different from sadness. Depression is an illness that evolves from a normal emotional reaction to a disorder typified by feelings and behaviors that last longer than a few days and are so intense that they require treatment.

Although there is disagreement about the actual rate of illness, there is widespread agreement that children can and do suffer from clinical depression. Low self-esteem, the tendency to self-blame, feelings of powerlessness and hopelessness, and loss of pleasure in living are all common indicators of depression. It is sometimes difficult to identify depression in children by these indicators because children may not express their feelings or feel sad at all. Instead, they feel angry, irritable, aggressive, and/or hostile. Children and teens may exhibit symptoms of depression through absenteeism, various forms of acting out (aggressive and/or violent behavior) or somatic complaints (frequent stomach aches, headaches, etc.).

While mental health professionals continue to debate the exact causes of depression, onset appears to be associated with a complex mix of multiple factors including stress and emotional loss. One widely held theory suggests that there is a genetic component that may make people (including children) biologically vulnerable to depression. In reaction to stressful situations, biologically vulnerable people are thought to experience changes in their body chemistry that may result in their becoming depressed. Poverty, divorce, death, illness, family discord, abuse, confusion about sexual identity and neglect are examples of stressful traumas that may make children more vulnerable and more at risk of becoming depressed.

Some children are more resilient to these traumas than others. Two children who are vulnerable to depression may react very differently to the same experience. For example, if both experience the death of a significant person, one's reaction may be short-lived grief, while the other may develop full-blown depression.

Substance abuse may also be a contributing factor. Some youth who are depressed begin to self-medicate with drugs or alcohol. If you notice any signs of drug or alcohol use, this is a reason to assess for co-occurrence of substance abuse and a mood disorder.

Symptoms

Depression is more than the blues or blahs; it is more than the normal everyday ups and downs. When that "down" mood, along with other symptoms, lasts for more than a couple of weeks, the condition may be clinical depression. Clinical depression is a serious health problem that affects the total person. In addition to feelings, it can change behavior, physical health and appearance, academic performance, social activity and the ability to handle everyday decisions and pressures. The most common symptom is a persistent change in mood, often characterized by sadness, helplessness and hopelessness. However, some depressed people have a persistent mood state characterized by anxiety and agitation. Most educators are aware of the more common "depressed mood" of clinical depression, but it is important to be aware that some depressed children may be identified by acting out, restlessness, and general agitation. Depression may also be cyclical in nature, characterized by *both* a depressed mood and agitation.

According to the National Institute for Mental Health, a child or adolescent diagnosed with major depression typically exhibits at least five of the following symptoms, including either the first or second symptom, for at least two weeks. Look for sudden changes in behavior that are significant, last for a long time, and are apparent in all or most areas of his or her life (pervasive).

- Depressed or irritable mood for most of the day.
- Aggression toward self and others.
- Diminished interest or pleasure in almost all activities most of the day.
- Marked decline in school performance, skipping classes and opting out of school activities
- Withdrawing from friends and social involvement.
- Significant increase or decrease in weight or appetite or failure to gain expected weight.
- Inability to sleep or excessive sleepiness.
- Slowed body movements or hyperactivity/agitation.
- Fatigue or loss of energy.
- Feelings of worthlessness or excessive or unnecessary guilt.
- Inability to concentrate or indecisiveness.
- Recurrent thoughts of death, thoughts of suicide, with or without a suicide plan.

Another type of depression is Seasonal Affective Disorder (SAD). Seasonal changes may explain some children's mood shifts. Children and teens that experience SAD typically become tired, unhappy and lethargic during the winter months.

BIPOLAR DISORDER (Previously called manic-depressive illness.)

Bipolar disorder is a serious form of mental illness that affects perceptions, thoughts, moods and behavior. In this illness moods are more affected than other functions. In bipolar disorder the person may have recurrent manic episodes or manic episodes alternating with depressive episodes or primary depressive episodes. Highs may alternate with lows, or the person may feel both extremes at close to the same time.

Although less common in young children, bipolar disorder does occur in teenagers and young adults. This illness can affect anyone. However, if one or both parents have bipolar disorder illness, the chances are greater that their children will develop the disorder.

Bipolar disorder illness may begin with either manic or depressive symptoms. Mania affects thinking, judgment and social behavior in ways that cause serious problems and embarrassment. In depressive episodes of any age group signs are similar to those that occur in depressed teens, and diagnosis can only be made with careful observation of behavior patterns over an extended period of time.

Bipolar disorder must be diagnosed by a professional using a series of psychiatric, psychological, psychosocial and other evaluations. Diagnosis should not be attempted by untrained school staff, the student or a family member; it is clinically based on patient report and observation of behavior. With proper treatment, a person with bipolar disorder can live a productive life. However, this diagnosis is associated with a high mortality rate; 10-15% of youth diagnosed with bipolar disorder who attempt suicide complete it.

Symptoms

- **Manic Episode**

- Perceptual Disturbances - may see self as having special powers or abilities and others as admiring and adoring; may have auditory and/or visual hallucinations.
- Cognitive Disturbances – has increased thinking speed; may have delusions of grandeur; has difficulty concentrating; have flight of ideas and/or rapid shifting of thoughts and ideas.
- Mood Disturbances – is usually in elevated, euphoric mood; self-esteem may be extremely inflated; has decreased need for sleep.
- Behavioral Disturbances - uses loud, rapid speech that is difficult to interrupt; talks of or acts out involvement in grandiose projects; demonstrates psychomotor agitation , (pacing, twitching, gross gesturing, inability to sit still); may change appearance and dress; exhibits sexual acting out.

- **Depressive Episode**

- Depressed or irritable mood for most of the day.
- Aggression toward self and others.
- Diminished interest or pleasure in almost all activities most of the day.
- Significant increase or decrease in weight or appetite or failure to gain expected weight.
- Inability to sleep or excessive sleepiness.
- Slowed body movements or hyperactivity/agitation.
- Fatigue or loss of energy.
- Feelings of worthlessness or excessive or unnecessary guilt.
- Inability to concentrate or indecisiveness.
- Recurrent thoughts of death, thoughts of suicide without a suicide plan.

What Schools Can Do

Children and adolescents who are at risk for depression or bipolar symptoms may be helped by consistent nurturing from trusted adults. People who survive traumatic childhood experiences often mention the crucial role a **single caring adult** played in their survival. Very often, that caring adult was an educator. The following are suggestions for school personnel to help children who are at risk.

- Someone should be identified to take time to talk with the student to explore and identify feelings. Empathic listening and validation of feelings are crucial.
- Feedback should be given in a non-judgmental fashion and should emphasize the following.
 - Unbearable pain can be survived.
 - Help is available.
 - You are not alone.
 - Talking helps.

- Triage/Psychological First Aid works best if there is a connection or relationship with the student.
 - Is there any immediate safety threat? Is the individual going to hurt him/herself or others? If “yes,” see “Suicide Ideation” topic this section.
 - How long has the individual been feeling this way? Hours, days, weeks?
 - Is there anything good going on in his/her life?
 - Does the individual have anyone else to talk to?
 - How much of the time does the individual not feel depressed?

- In consultation with the student’s parents/guardians refer any student who exhibits symptoms of bipolar disease to the school’s identified mental health professional. Ideally, these students should be assessed by a primary health provider as well as a provider with mental health expertise.

- There should be a procedure established for school personnel to obtain immediate professional help for students exhibiting symptoms of bipolar disease, especially if the student mentions suicidal thoughts.

SUICIDAL IDEATION

(Please see pages 35-41 for additional information on suicide.)

Suicide attempts can correctly be considered a symptom of depression. However, a successful suicide is such a devastating event for everyone, including the school, that it is worthwhile for educators to learn more about it specifically. There is some evidence that a successful suicide of one student may lead to suicide attempts by other students in the same school as a result of a “contagion” or copycat effect.

There is no one identifiable cause of suicidal ideation, but certain factors may put some youth at higher risk. Triggers may include fights with parents, school difficulty, trouble with the law, death or divorce, physical or sexual abuse, substance abuse, or breaking up with a girlfriend or boyfriend. Youth worried about their sexual orientation and their families and society’s response to it are most at risk for suicide. Many children and adolescents experience stresses, but some are more vulnerable to feeling extremely troubled, hopeless or anxious. They may feel that life is unbearable, that it will never get better, and that they are powerless to do anything to change the situation.

Students in this decade have a much broader knowledge of the world than in earlier times. Some mental health professionals speculate that a significantly stressed family and social environment, coupled with a graphic and detailed knowledge of the state of the world, may predictably lead to a sense of helplessness and hopelessness which are common complaints of the depressed suicidal person.

Symptoms

Generally, marked and persistent change in behavior and/or mood is the most significant sign of a student in difficulty with depression. The American Psychiatric Association (APA) lists the following 14 key behaviors that may indicate risk:

- Sudden drop in school performance
 - Reduced class participation (sometimes withdrawing completely)
 - Sudden lowering of grades in all or most subjects

Failure to meet school expectations previously met

- Loss of interest in activities
Quitting a part-time job, school activity, club or sports group
Less “hanging out” with peers at usual times and locations
Isolating self
Not responding to telephone calls as usual
- Fatigue
Sleeping too much or too little
Dramatic change in energy levels (sometimes hyperactivity)
Sleeping in class
Appearing lethargic and apathetic in class
- Inability to concentrate
Inattentiveness
Inability to respond when called upon
Frequent responses of “didn’t hear/understand the question”
Outbursts of shouting, complaining or unexplained irritability
Crying often and easily, sometimes for no apparent reason
Rebelliousness with peers and/or school personnel
Unusual displays of irritability
- Expression of fear or anxiety
Apprehension in ordinarily comfortable settings
Concerns that others are “after” him/her
- Aggression, refusal to cooperate, antisocial behavior
Breaking common, easy-to-comply-with rules
Presenting messy, unclean appearance
Using obscenities and negative responses in every-day discussions
Avowing disinterest in succeeding or completing basic assignments
Increasing absences or lateness
- Change in peer group
Apparent abandonment of usual close group or type of friends
Seeking friends in groups not connected to school and/or engaged in high risk behavior
- Somatic complaints
Frequent complaints of illness, headaches or stomachaches
Eating problems (loss of appetite or constant hunger)

Signs of injuries (self-inflicted, resulting from risky behavior)

- Alcohol and/or other drug abuse
Frequent intoxication or drugged appearance
Appearance of objects associated with alcohol or other drug use
Sudden need for more money (may be stealing, seeking another job, asking others for money)
- Recurring thoughts or statements about death or suicide
Expressing written or verbal statements reflecting helplessness and hopelessness
Acquiring a weapon, rope, pills or other potentially lethal device
Talking about or engaged in risky behaviors (drinking and driving, unprotected sex, drug use)
Fixation on a tragic theme or event (often the death of a famous person)

Note: Any of the following indicators must be viewed as serious and responded to immediately.

- Making final arrangements and/or amends
Giving away possessions, especially prized ones
Paying off old debts
Apologizing for past (often long past) behaviors
Talking about desired funeral arrangements
Exhibiting sudden dramatic improvement in mood and behavior following a period of noticeable depression
- Loss
Death of friend or relative (especially if more than one in a short time)
Violent death of friend or family member
Suicide of another student in the school
Break-up with boy/girlfriend
Break-up of family
Diagnosis of health problems in self, family member or friend
Incarceration of loved one
- Previous suicide attempt
Requires immediate mental health intervention if coupled with any of above behaviors
Precedes some 80% of completed suicides

What Schools Can Do

No one teacher or other school professional should feel responsible for or decide alone how to proceed with a potentially suicidal student. Every school professional should learn how to respond

to a student's request for help and also how to react if warning signs are noticed. In addition, every school system and every school should have a crisis protocol, a crisis team and community resources available to deal with suicidal students and other crisis situations. (See Developing a Youth Suicide Response Plan this Section.)

- Implement a primary suicide prevention program, teaching staff, parents and children to be aware of the seriousness of suicidal comments and how to ask for help promptly if they have such thoughts or know of someone else who is having such thoughts.
- Avoid displaying shock, judgment or disapproval if someone discloses suicidal thoughts.
- Show any identified individual true concern that his/her disclosure is taken seriously.
- Tell the individual that suicidal intent or thoughts cannot be kept confidential and that it is necessary to seek help from others. Remind the individual that this is because he/she is cared for and that needed help is being accessed.
- If someone has talked about suicide, discuss it with a school psychologist, counselor, school nurse, principal or other designated person so that an assessment of completion potential can occur immediately.
- Do not leave an individual alone, particularly if the risk of suicide is high. Take him/her along to get help or call/send someone else for help.
- Prepare yourself! Once a suicide crisis presents it becomes the priority and other tasks will have to be delegated or set aside to maintain student safety.
- Include the following in a crisis response manual.
 - A checklist of procedures to follow in the event of a crisis including responses to clear-cut or suspected suicidal thoughts or intent.
 - A list of crisis intervention team members with telephone numbers.
 - A list of community resources that includes addresses and telephone numbers, such as Department of Social Services, the local mental health agency, Suicide Hotline, AIDS Hotline, National Runaway Switchboard, police and fire departments, and local or regional addiction and psychiatric resources.

A comprehensive School Based Suicide Prevention, Intervention and Postvention Model can also be found at: <http://store.samhsa.gov/shin/content/SMA12-4669/SMA12-4669.pdf>

NON SUICIDIAL SELF INJURY

Many people believe that self mutilation or self injury is considered a suicidal behavior however, that is a myth. According to the American Academy of Child and Adolescent Psychiatry or AACAP, self injury is the act of destroying body tissues without suicidal intent. The HSE South Regional Suicide Resource Office explains NSSI as an attempt for the adolescent to "preserve themselves." Meaning that their self injury releases emotions that may become strong enough to indicate a suicide attempt. However, it is suggested that the risk of suicide for those who engage in NSSI is between 50 and 100 times greater than the general population. Non Suicidal Self Injury (NSSI) is called many things including: self mutilation, self harm, parasuicide, self inflicted violence, cutting, or carving. While cutting is the most commonly seen type of self injury it can be any of the following:

- Carving

- Scratching
- Branding
- Marking
- Picking/pulling skin and hair
- Burning/abrasions
- Biting
- Head banging
- Bruising
- Hitting
- Ingestion of harmful objects (razor blades, staples, etc.)

The AACAP states that adolescents may self-injure in an attempt to rebel or take risks, however for some adolescents the self-injuring behavior may be the expression of a more serious mental illness such as major depressive disorder, psychosis, posttraumatic stress disorder (PTSD), bipolar disorder or borderline personality disorder. NSSI is so common in borderline personality disorder it is the only diagnosis within the DSM 5 that has NSSI listed in the Diagnostic Criteria. At times it may be that NSSI is a fad or the result of peer pressure and has little to no bearing on the adolescent's mental health although it may endanger their physical health. NSSI should be distinguished from other similar behaviors that may fall under the following categories:

- Self-destructive behaviors: eating disorders, substance misuse, or sexual risk taking
- Self-harm: overdosing, suicide, or para-suicide.
- Body enhancement: cosmetic surgery, body piercing, or tattooing
- Factitious disorder: when someone causes injury to themselves with the express purpose of gaining attention or to achieve a desired end. This is classified as separate than NSSI due to the person wanting the injury to be made public.
- Somatic expressions of feeling: illness or paralysis which has no apparent cause.
- Self-injury due to psychosis: where the individual may be harming themselves due to their psychosis, example: Voices telling them to cut themselves or feeling as though they need to cut bugs out of their skin.

NSSI can serve several different functions for adolescents. Affect regulation may be the most common; however a change in cognitions such as a distraction or an attempt to stop suicidal thoughts may be present. Or the NSSI may be a form of self-punishment or to stop dissociation according to Peterson, Freedenthal, Sheldon and Andersen (2008).

Symptoms

Although the most telling symptoms of NSSI are the injuries themselves there are several symptoms that are associated with the injuries. According to Peterson, et al, the adolescent may have intense emotions or hyper arousal, avoidant behavior, and decreased expression of emotions. NSSI in its essence is a disorder of hiding behaviors so many parents or school health personnel may notice that the adolescent becomes increasingly secretive or may begin wearing clothing that is out of season, such as wearing a long sleeve shirt throughout the summer.

What Schools Can Do

When school health personnel are responding to a NSSI in an adolescent they should remember that their actions in response to the revelation are just as important as the actual treatment.

According to the HSE South Regional Suicide Resource Office, responses that may be seen as condemnatory or dismissive are not helpful. These responses might involve labeling the adolescent as “attention seeking”, not seeing the behaviors as potentially harmful and not making the appropriate referrals for treatment.

School health personnel can help the student by responding in a sympathetic and supportive manner. Adolescents engaging in NSSI should be referred to either the school mental health counselor/social worker or to an outside treatment agency immediately.* The student should not be scolded for their behavior as that may be the only way they knew of releasing their emotions and it may have prevented them from engaging in a more serious behavior. A positive and nonjudgmental attitude by the staff member who was confided in may be the one thing that helps the adolescent engage in treatment. The adolescent should also be given the time to talk and to be heard by the staff member, even if for just a few minutes. The staff member should express clearly to the adolescent that the behavior is okay to talk about and that they understand. Another recommendation is that the adolescent should be involved in their treatment and choosing how or where they will be treated, within normal boundaries. The staff member should inform the student of the next steps in the reporting process if the adolescent is under the age of 14 and does not fall under the confidential services legislation within New Mexico.

*If the adolescent has an open injury they should be referred to the school nurses as soon as possible to have medical care.

Resources

American Academy of Child and Adolescent Psychiatry (2009) *Facts for Families: Self Injury in Adolescents*. Washington, DC

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed). Arlington, VA. American Psychiatric Association

HSE South Regional Suicide Resource Office (2007). *Understanding Self Harm: Handbook*. Jones Hill, Waterford.

Meuhlenkamp, Jennifer J. (n.d) *Capturing the Essence of Self-Injury in Adolescents*. Retrieved from <http://www.mentalhealthscreening.org/enews/adolescentsi.aspx>

Peterson, J., Fredenthal, S., Sheldon, C., & Andersen, R. (2008). Nonsuicidal Self Injury in Adolescents. *Psychiatry* 2008, 5(11), 20-26.

DIVORCE

It is estimated that about half of all children in the United States will spend part of their lives in a single-parent family. Given this statistic, it is likely that every school will have at least some students of divorced or divorcing families in every class. Indeed, it is not uncommon for a high proportion of students in a classroom to have divorced parents.

The divorce process is a time during which all family members must learn to achieve a new balance. It is a time of loss, growth and change. Children may experience a wide range of emotions — anger, grief, guilt and sadness among them — following a divorce. Separation or divorce may be experienced as a relief for some, particularly if there has been constant conflict or abuse. Predictably, it is a time of stress. Divorce can affect children from the same family in very different ways; it is important not to presume to know how any given child will react to the situation.

There is considerable variability in how children cope with divorce and separation. In addition to causing varying degrees of disruption and stress for the entire family, divorce may also result in a change in financial status. This may necessitate relocation and/or restricted ability to participate in school programs. Students may experience behavioral or academic performance problems in school and an overall dip in self-esteem or a sense of helplessness and lack of control over life situations. There may be continuing tensions between parents over arrangements for any children. Parental work patterns may change, and children may have less contact with one or both parents.

Symptoms

All of the following behaviors may be indicative of normal reactions to divorce as long as they are not extremely severe, protracted or numerous. If these symptoms persist or become increasingly severe, then the student may need additional help from a mental health professional.

- Inability to concentrate.
- Either a drop in or perfectionist obsession with school performance and grades, often to the extreme.
- Crying for no apparent or immediate reason.
- Displays of anger or being sullen, acting-out or rebelliousness.
- Loss of enthusiasm, sense of humor or joy.
- Regression to outgrown self-comforting behaviors such as thumb sucking.
- Development of tics or nervous behaviors such as nail biting or hair pulling.
- Withdrawal or isolation of self.
- Loss of memory or inability to follow directions.
- An intense need to please.
- Pervasive sadness.
- Rejection of one parent.

What Schools Can Do

The school represents a safe environment for any child of divorcing parents. Educators can help by being supportive of all students, being alert to signs of failure to cope and by having a plan to help students experiencing difficulty. Schools should set the tone that both parents are important partners in the family-school relationship. Educators can respond in the following ways to try to help students cope.

- Offer teachers consultation on various reactions children may have to divorce.
- Keep in touch with parents about the student's school experience.
- If the parents or student self-disclose, explain that during divorce children may feel strong emotions that sometimes make it hard to pay attention in school or do school work as usual. Encourage the student to talk to a trusted adult about his/her feelings. Continue to monitor the student and offer support.
- Encourage participation in family counseling and/or a divorce support group if available. This is an optimal opportunity for prevention.

- When there is concern in any way about the severity of a child’s reaction, lack of signs of recovery, (recovery may take months) or any other aspects of behavior contact the parents/guardians for referral of the child to a mental health professional immediately.
- Encourage participation in a divorce support group if appropriate and available.
- Arrange for all parents/guardians to receive information from the school and for all parents to attend conferences and other school events.
- Do not presume that there are two biological parents in the home. Sensitivity to children living in single parent families, with guardians, or in households with other relations or responsible adults is key to validating a child’s sense of well-being.
- If appropriate, become familiar with the child’s schedule for seeing parents. The change in routine may be confusing for the child and it may help the child to know that someone is aware of the changes.
- Never take sides or bad mouth a parent.

GRIEF AND LOSS

It is difficult to estimate the proportion of students in a school who are grieving as the result of experiencing significant loss. Perhaps the most common type of loss experienced by school-aged children is the death of a significant other. Some students lose grandparents; some may lose parents, siblings, friends or other emotionally significant individuals. Sometimes students and school personnel are forced to deal with the death of a classmate or staff member. In addition, the death of a pet may be a traumatic event or a best friend moving away. Children whose parents divorce, who are in foster care or who have been adopted at older ages can experience multiple losses. Few teachers, school nurses and other school personnel go through their careers without knowing a student who is grieving. It is important that school personnel take the time to become aware of a child’s history of loss so they know how best to support that student. (See “About Grief” in the Resource Section of this manual.)

Symptoms

It is important to recognize that grief is a normal and necessary reaction to any type of loss. Students who are grieving need to be given as much time and opportunity as they need to grieve. It is crucial that school staff not try to fix, deny or overlook student’s grief. Children’s grief behavior may differ from that of adults; they may or may not openly mourn. There are two types of grief that children may experience – normal grief (also called uncomplicated bereavement) and childhood traumatic grief. In both normal and traumatic grief some of the emotions that children and adolescents experience are denial, anger, acting out, withdrawal, guilt and depression.

Other reactions to both normal and traumatic grief may include temporary physical complaints or they may regress returning to behaviors they had previously outgrown, like bed wetting, thumb sucking or clinging to parents. Both groups may have sleep problems, loss of appetite and decreased interest in family and friends.

Childhood Traumatic Grief (Information below is summarized from the “In Depth General Information Guide to Childhood Traumatic Grief for School Personnel” available at the link [www. NCTSN.org](http://www.NCTSN.org)).

Children who develop childhood traumatic grief reactions experience the cause of that death as horrifying or terrifying, whether the death was unexpected or due to natural causes. Even if the manner of death is not objectively sudden, shocking or frightening to others, children who perceive the death this way may develop childhood traumatic grief.

For some children and adolescents, responses to traumatic events can have a profound effect on the way they see themselves and their world. They may experience important and long lasting changes in their ability to trust others, their sense of personal safety, their effectiveness in navigating life challenges and their belief that there is justice or fairness in life.

It is important to keep in mind that many children who encounter a shocking or horrific death of another person will recover naturally and not develop ongoing difficulties; while other children may experience such difficulties. Every child is different in their reactions to traumatic loss. (See “Ten Things Adults can do to Help Grieving Children and Teenagers” in the Resource section of this manual.)

HOW GRIEF MANIFESTS FOR CHILDREN AND TEENAGERS

Although everyone grieves differently when a family member or close friend dies, here are some common grief experiences for children and teenagers:

Feeling different from other kids or teenagers: Often, this feeling of alienation just comes over the child. He or she may not even associate it with the death or the grief, but just feels different. Other times a child or teenager is very clear that the death was a turning point that separated her from friends, peers or family members. She may say that no one understands how she feels, or that people don't know how to talk to her anymore. While some kids grow closer to surviving family members after the death, other children and teens feel alone with what they're going through.

A rollercoaster of emotions: Numbness, anger, fear, confusion, sadness, loneliness, happiness, fatigue, agitation, resentment, manic excitement, guilt, disappointment, worry, and so on. The feelings can come in quick succession, and be unpredictable, adding to the instability the child may already be feeling. The child may feel like a different person than he was before the death. Parents and caregivers often comment, “I don't know him anymore. He's not the same person he used to be.”

Adjusting to secondary losses: Besides the death itself, there are usually other changes in a child's life caused by the death, some of which will feel like losses. Family dynamics among surviving family members may shift—sometimes quite dramatically. In many cases the family feels unstable to the child. If the surviving parent(s) or caregivers are grieving, the child may feel that she has temporarily lost those people, too, or at least that they've changed. Routines and schedules, so important to children, are often disrupted. Family finances may change. The child's identity and self-esteem undergo a significant shift when a key person is suddenly missing from her life. These are just a few examples of secondary losses.

Anger, irritability, lashing out and getting in trouble: *Many grieving children and teens have sudden bursts of anger or a “short fuse.” Parents, caregivers and teachers may be startled by the child or teen lashing out, defying adults or becoming more sullen and withdrawn. Some kids start*

to have trouble at school, or start to get in trouble at school or at home as a reaction to the death and to the death-related changes in their lives.

Trying to be perfect: Many grieving children and teens try to suppress their grief or hide it from other family members. They may also try to be “perfect” (get straight A’s, overachieve), both as a way to feel in control and to compensate for the pain and turmoil the family is experiencing. Kids with this pattern of response are typically emotional caretakers for their parents or for other grieving family members. Often these behaviors are subconscious, but sometimes the child is aware of doing these things.

Can’t think straight, preoccupied: *Periods of not being able to pay attention, focus or complete tasks often go on for a long time after the death, and may come in waves, just as grief does. This can affect grades and also relationships with teachers and adults.*

Shock and delayed reaction, or grief intensifying as time goes on: *Most children and teenagers look back on the time right after the death and say that they were in shock, and that it really hit them several months later. Many times, grieving children and teenagers are hitting the deepest part of their grief right when other people are expecting them to be “getting over it” or “moving on.”*

Guilt and regrets: Some kids have regret and guilt about any times when they were mad at the person who died, or having argued with the person. Also, they may blame themselves for the death in ways that seem to make no logical sense to others, or feel that if only they had done something different, they might have prevented it.

Processing grief through play, art, sports, tears and other non-verbal ways: Children often have a hard time putting their feelings about the death into words. If they do not say much about their grief, they may be able to process it through play, art, sports or other physical activity, crying, or through nurturing and reassurance (being held by a person they love or snuggling with pets or stuffed animals). While this is normal, it can be challenging for parents and caregivers who wish their children would talk about it to let them know how their grief process is going.

Crying and not crying: Some children cry a lot, and others very little or not at all. It’s all normal. Children often need to be told that it’s okay to cry. On the other hand, judging a child for not crying or pressuring him to cry is not helpful. Some children are very upset but may have a hard time expressing through tears.

Cyclical grieving: Many children and teenagers are still strongly affected by the death many, many years later. Their grief may come up unexpectedly sometimes and take them by surprise. Some people say that grief is a life-long process for them.

Other Common Manifestations of Grief

- Re-grieving at life milestones
- Re-grieving at new developmental stages
- Physical symptoms like headaches, chest pains, stomachaches, dizziness, etc.
- Fear that other people will die and they will be left alone, sometimes manifesting as clinging to parents and caregivers or anxious behavior
- Anxiety and worry, sometimes panic attacks
- Nightmares
- Changes in eating and sleeping patterns; not wanting to sleep alone

- Regressing to younger behaviors
- Having unanswered questions if they were not told the whole story of the death
- If very young, unable to comprehend the finality of death
- Mixed feelings about the death, including relief, sometimes causing guilt
- Questioning beliefs
- Lower self-esteem; identity loss
- Social changes: isolating and/or not wanting to be alone
- Keeping pictures or special things that remind them of the person
- Transformation

By Katrina Koehler, Executive Director at Gerard's House, a grief support center for children, teenagers and their families in Santa Fe, New Mexico. Feel free to make copies of this handout with an acknowledgment of the source. For more information, please contact us at (505) 424-1800 or go to gerardshouse.org

Grief and Loss Resources

National

National Child Traumatic Stress Network www.NCTSN.org

Local

Santa Fe - Gerard's House Phone (505) 424-1800 www.gerardshouse.org

Albuquerque

Children's Grief Center

Phone: 505-323-0478

Email: info@childrensgrief.org

Address: 3020 Morris NE

Albuquerque, NM 87111

Website: <http://www.childrensgrief.org/>

EFFECTS OF TRAUMA

Research has shown that today's school communities have the potential to face many more crisis situations than ever before. In addition, the nature and severity of the types of crisis and trauma that can develop today were almost nonexistent 30 years ago. Examples include; hostage taking, sniper attacks, adolescent suicide, high teenage rates of motor vehicle-related deaths, bomb scares, war, natural disasters and terrorist activities. Along with the above mentioned crisis situations children are often victim/witnesses to domestic violence, experience child abuse and neglect which may include physical, emotional or sexual abuse; experience family substance abuse issues and the loss of family members due to homicide, suicide or drug overdose or are part of the immigrant community. Trauma can happen to anyone, regardless of gender, age, socioeconomic status or ethnicity.

Traumatic response results from exposure to drastic and tragic change in an individual's environment which has become common and familiar to them. Trauma response can also result from exposure to long term conditions that continually break down an individual's ability to cope day to day; such as poverty or neglect and abuse.

Trauma is not a new concept. However, until recently, it has largely been viewed to be applicable to only a select group of individuals, under extraordinary circumstances – for example, survivors of the above mentioned catastrophic events. There have been some notable exceptions; but for the most part, trauma has not been recognized as a part of the daily, regular, experience of many individuals, including children and adolescents. Nor has the profound linkage between trauma and child development and the disruption of physical and emotional health been fully recognized.

Implementing a Trauma Informed System

Many of the children who will arrive at school with behavioral health or substance abuse problems have experienced one or more traumas in their lives. Therefore, it is very important that school health personnel, educators and administrators are aware of how trauma impacts the lives of their students; their behavior; their ability to form meaningful relationships and their ability to learn.

Implementing a trauma-informed system within the school setting can be challenging but can have a major impact on the school environment and has been shown to decrease many of the disruptive behavioral issues a school community deals with on a regular basis. By integrating trauma sensitivity into school policies and teaching strategies, school climates and academic achievement can greatly improve, especially in districts serving fiscally depressed communities

Below is a **Trauma Fact Sheet for Educators** from the **National Child Traumatic Stress Network (NCTSN)**. The NCTSN serves as a valuable resource for developing and disseminating evidence-based intervention, trauma-informed services and public and professional education. By combining knowledge of child development, expertise in the full range of child traumatic experiences and attention to cultural perspectives, NCTSN offers specific information on how trauma impacts children of varying ages, important information for teachers, administrators and parents. The link to NCTSN is: www.NCTSN.org (See Resource Section of this manual for *Trauma Facts for Educators*)

POST TRAUMATIC STRESS DISORDER

Post-traumatic stress disorder or PTSD is a disorder that can happen in response to a traumatic event that exceeds the individuals coping resources. All of the following information is for PTSD in children older than age six. According to the American Psychological Association (APA) as many as two thirds of adolescents report experiencing a traumatic event by age 16. A traumatic event that can cause PTSD is defined as "exposure to actual or threatened death, serious injury or sexual violence," according to the DSM 5. Examples of these events could include: sexual

abuse or violence, physical abuse, disasters such as fires, hurricanes or floods, violent crimes or motor vehicle accidents. PTSD may also occur after witnessing violence such as domestic violence, community violence and war. It is important to note that nearly all individuals, especially children, will display some type of distress or behavioral changes immediately following a traumatic event, however children are incredibly resilient and many will return to their prior level of functioning. It is when the symptoms last longer than one month or when the symptoms cause significant impairment in functioning that a PTSD diagnosis is warranted. Risk factors for having an increased chance of symptoms of PTSD are: exposure to multiple traumas, history of anxiety problems, or having experienced familial adversity according to the APA (2008).

Symptoms

Diagnosis of PTSD should be based off of the Diagnostic and Statistical Manual of Mental Disorders (fifth edition). PTSD is coded as 309.81 by the DSM or as F43.10 by the ICD-9-CM. The following should serve as a summary of the criterion but is not exhaustive.

- A. Exposure to actual or threatened death, serious injury, or sexual violence
 - a. The exposure can be directly experiencing or witnessing the event, learning that the event occurred to a close family member or friend, or by experiencing repeated or extreme exposure to aversive details of the event
- B. Presence of Intrusion Symptoms
 - a. Can be expressed through distressing memories of the event, distressing dreams, or dissociative reactions in which the adolescent feels as though the event is recurring.
 - i. In children older than 6 years, repetitive play may occur that includes aspects of the traumatic event, the dreams may not have recognizable content and trauma specific reenactment may occur in play.
- C. Avoidance of stimuli associated with the traumatic event
- D. Negative alterations in cognitions or moods associated with the traumatic event
 - a. Could be expressed by negative beliefs of expectations about oneself, others or the world, distorted cognitions about the cause of the event, diminished interest in significant activities, inability to experience positive emotions, and many other expressions.
- E. Alterations in arousal associated with the event
 - a. Expressed through: irritable behavior, self-destructive behaviors, hypervigilance, exaggerated startle response, problems with concentration or sleep disturbances.
- F. The symptoms should have lasted longer than 1 month
- G. The symptoms should be causing significant impairment in an area of functioning such as social, or school.
- H. The symptoms are not attributable to the effects of a substance.

In children and adolescents symptoms may appear as the development of new fears related to the event, separation anxiety, nightmares, sadness, reduced concentration, decline in performance at school, anger, somatic complaints or irritability. According to the American Academy of Child and Adolescent Psychiatry (AACAP) children who experience repeated trauma may experience dissociation, or an emotional numbing that helps to block the pain and trauma. They may also become depressed, withdrawn and detached from their feelings. In many adolescents, symptoms of a trauma may present themselves as somatic complaints such as a headache or a chronic stomachache. They may also revert to earlier behaviors such as thumb sucking or having separation anxiety (AACAP, 2011). In addition, children may experience what is called “time skew,” in which the adolescent may mis-sequence the events of the trauma or not remember exact details. They may also have “omen formation” which is a belief that there was warning signs preceding the trauma. These symptoms can often take the place of visual flashbacks or amnesia which is present for adults experiencing PTSD, according to the National Center for PTSD.

What Schools Can Do

Early intervention following a trauma is critical, with an emphasis of creating a feeling of safety (AACAP, 2011). However, according to the DSM 5, symptoms can begin within the first 3 months following a trauma but can also be delayed by months or years. Therefore, continued support of an adolescent who has experienced a trauma is beneficial.

If the trauma is a widespread trauma that may affect multiple students, bringing in a crisis team or additional mental health resources may be warranted. Having a plan in place for crisis is required by New Mexico Administrative Code 2.12.6.8:

a plan addressing the behavioral health needs of all students in the educational process by focusing on students’ social and emotional wellbeing;

(8) school safety plans at each school building focused on supporting healthy and safe environments and including but not necessarily limited to:

- (a) prevention,
- (b) policies and procedures, and
- (c) tactical emergency response plan;

If a nurse is the first professional to hear of the trauma, the protocols set in place by the school district should be followed regarding mandatory reporting. The nurse should then help the child feel safe and secure and refer to the school mental health counselor or the outside treatment provider.

For school mental health counselors the recommended treatment for adolescents suffering from PTSD are cognitive-behavioral therapies and more specifically trauma-focused CBT, play therapy has also been empirically validated but only for younger children. Psychological first aid is also a resource for school mental health personnel as it details how to help the adolescents with less severe symptoms and gives information on how to refer out the adolescents with more severe symptoms. Psychological first aid was created by the National Child Traumatic Stress Network and the National Center for PTSD. It can be found at: <http://www.nctsn.org/content/psychological-first-aid>.

Resources

American Academy of Child and Adolescent Psychiatry. (2011). *Facts for Families: Posttraumatic Stress Disorder (PTSD)*. Washington, DC. American Academy of Child and Adolescent Psychiatry.

American Psychological Association (2008). *Children and Trauma: Update for Mental Health Professionals*. Washington, DC. American Psychological Association.

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed). Arlington, VA. American Psychiatric Association

Hamblen, J., Barnett, E. (2012). *PTSD in Children and Adolescents*. Retrieved from: <http://www.nctsn.org/content/psychological-first-aid>

DISRUPTIVE BEHAVIORAL DISORDERS

These are serious behavioral and emotional disorders characterized by being socially disruptive and displaying annoying behavior towards others. The essential feature has been identified as a persistent pattern of conduct in which the basic rights of others and major age appropriate societal norms or rules are violated.

Disruptive behavior disorders occur in 2%-16% of children in United States. There is no clear cause identified but it is believed that a combination of biological, genetic, and environmental factors may contribute to disruptive behavior disorders.

- **Biological:** Defects or injuries to specific areas in the brain can lead to behavioral problems as indicated in the results of some studies. It is also linked to abnormal levels of chemicals called neurotransmitters in the brain. The neurotransmitters assist nerve cells in the brain to communicate with one another and when this is disrupted or not working properly the messages are not delivered correctly in the brain resulting in disruptive behavior disorders or other mental illnesses. Many children and teens with disruptive behavior disorders may also suffer from other mental illnesses, such as, ADHD, learning disorders, depression, substance abuse or an anxiety disorder which may also be contributing factors to their behavior problems.
- **Genetics:** These children tend to have close family members that have mental illness such as mood disorders, anxiety disorders, and personality disorders. This may create a genetic predisposition for disruptive behavior disorders.
- **Environmental:** A dysfunctional family, a family history of mental illness and/or substance abuse, a traumatic experience and inconsistent discipline by parents can contribute to the development of behavior disorders.¹

The two major disruptive behavioral disorders are Conduct Disorder and Oppositional Defiant Disorders (ODD).

Symptoms

CONDUCT DISORDERS

Children with conduct disorders tend to be irritable, have low self-esteem and throw frequent temper tantrums. They do not realize the negative impact of their behavior on others and have little guilt or remorse in hurting others. This disorder is more common in boys than girls. The symptoms of conduct disorders are separated into **four** general categories:

- **Aggression towards people or animals:** These behaviors threaten or cause physical harm and may include intimidation, physical fights, bullying, using weapons, physically cruel to people or animals, stealing and forcing someone into sexual activity.

- **Destructive behavior:** The deliberate destruction of property such as arson (intentionally setting a fire) and vandalism (destroying another person's property).
- **Deceitful behavior:** This may include theft, lying/conning to avoid obligations, shoplifting, and forgery or breaking into someone's home or cars to steal.
- **Serious violation of rules:** Staying out before age 13, despite parental prohibition. This also includes running away, skipping school, or being sexually active at a young age. ^{1,2}

OPPOSITIONAL DEFIANT DISORDER

Children with oppositional defiant disorders exhibit a pattern of uncooperative, defiant, hostile, and annoying behavior for those in authority. These behaviors disrupt normal daily activities at home, with the family and at school. The symptoms of oppositional defiant disorder include:

- Throwing temper tantrums
- Argumentative with adults
- Actively defying or refusing to obey rules (of adults) at home or school
- Deliberately annoying others
- Blaming others for one's own mistakes and misbehavior
- Being touchy or easily annoyed by others
- Angry and resentful
- Spiteful and vindictive

What Schools Can Do

Identification of the problem is the first step in providing the child with the most appropriate support and interventions. This requires that administration supports the needs of the school staff and that teachers, parents, school nurses, mental health professionals and Physicians work together to accurately identify whether a child has conduct disorder or oppositional defiant disorder. The following are guidelines for diagnosis.

The DSM-IV-TR has identified that to be diagnosed with **conduct disorder** an individual must:

- Exhibit a pattern of repetitive behavior where the rights of others or social norms are violated.
- The presence of three (or more) of the above symptoms have to be present in the previous 12 months, with at least one symptom present the previous 6 months.

The DSM-IV-TR has identified that to be diagnosed with **oppositional defiant disorder** an individual must:

- Exhibit defiant, hostile, negativistic behavior for at least 6 months with 4 or more of the above symptoms exhibited.
- The symptoms cause distress or impair work, school or social functioning.
- Symptoms **do not** occur in the course of Mood or Psychotic Disorder.
- Symptoms **do not** fulfill criteria for Conduct Disorder.
- If over age 18, the patient does not meet the criteria for Antisocial Personality Disorder.

When diagnosing a child with disruptive behavioral disorders it is important to gather information from multiple sources to make an accurate diagnosis. A pediatrician, trained psychologist, neurologist, psychiatrist or trained clinical social worker can make the diagnosis in conjunction with

input from parents, other caregivers, teachers and other school staff that know the child. The psychiatrist or clinician must determine whether other psychiatric disorders are present using a specially designed interview and assessment tools to evaluate the child before finalizing a diagnosis of conduct disorder or oppositional defiant disorder. It is important to complete a comprehensive assessment with the parents and child on the child's overall functioning and family situation.

In-service training for school staff on symptoms of disruptive behavioral disorders, specifically conduct disorder and oppositional defiant disorder, with appropriate behavioral interventions and the importance of communicating and working with the family will support the academic success of the child. Teachers, parents and mental health professionals coordinating and communicating with one another to teach the child healthy relationship skills and pro-social behaviors, with appropriate consequences, in a consistent manner is essential to classroom management.

- **Educational Interventions**

Provide an environment that is structured, predictable and conducive to learning. Seat the student where there is a minimum of distraction, encourage peer tutoring, and provide a quiet study area.

Provide specialized instruction with frequent eye contact. Be clear and concise; simplify, break down and repeat instruction.

Provide supervision and consistent consequences. Have established clearly stated consequences for misbehavior, administer consequences immediately and calmly, enforce rules consistently, and avoid ridicule and criticism.

Be specific in naming and describing the behavior that has resulted in the consequence.

Enhance self-esteem through frequent encouragement and praise.

- **Psychotherapy**

A licensed mental health professional, a psychologist, social worker or family therapist, work with the child to develop more effective ways to express and control their anger. Utilizing cognitive-behavior therapy assists the child in reshaping the way they think to improve behavior.

Family therapy is used to improve family interactions and communication among family members.

A specialized therapy technique called parent management training (PMT) teaches parents enhanced parenting skills. This technique trains parents in:

- Observing and identifying the child's behavior and the situations in which it occurs.
- Identifying the behavior that needs to be changed in a specific and concise manner.
- Focus on enhancing parenting skills.

- Behavior modification and demonstration of interventions that will be utilized (coaching the parents).
- Utilize strategies to reward positive behavior and respond to negative behaviors with taking away privileges (rewards).
- Consistency is the key to any intervention.
- Medical/Psychiatric Interventions.

Medications are not approved for specifically treating conduct disorder or oppositional defiant disorder but medications may be used to treat some of the distressing symptoms¹.

ATTENTION DEFICIT/HYPERACTIVITY DISORDER

Attention Deficit Disorder or ADD was renamed Attention Deficit/Hyperactivity Disorder or ADHD in 1994. Attention deficit disorder (ADD) is a general term frequently used to describe individuals that have attention deficit hyperactivity disorder without the hyperactive and impulsive behaviors. The terms ADD and ADHD are often used interchangeably for both those who *do* and those who *do not* have symptoms of hyperactivity and impulsiveness.

Scientific research supports the conclusion that attention deficit/hyperactivity disorder (ADHD) is a biologically based disorder and has a strong genetic connection - it tends to run in families. The biological research shows that children with ADHD have lower levels of the neurotransmitter dopamine in critical areas of the brain. The National Institute of Health (NIH) research observed, in PET scans, that those with ADHD had significantly lower metabolic activity in regions of the brain controlling attention, social judgment, and movement than those individuals without an ADHD diagnosis. ADHD is 3 to 4 times more common in boys than girls but it is not understood as to why this is the case.⁴

The American Psychiatric Association defines Attention Deficit/ Hyperactivity Disorder (ADHD) as “one of the most common health disorders, affecting approximately 5 to 10% of children in the United States. The hallmarks of the syndrome of ADHD are inattention, hyperactivity and impulsivity. Symptoms of this condition are expressed in multiple settings and across numerous functional domains, thus demonstrating the pervasiveness of this condition.”⁵

Symptoms

There are three different types of ADHD - predominantly inattentive, predominantly hyperactive/impulsive, and combined, each with their own set of symptoms.

1) The predominantly inattentive type (formerly ADD) often:

- fails to give close attention to details or makes careless mistakes in homework, work, or other activities
- has difficulties sustaining attention in tasks or play activities
- does not seem to listen when spoken to directly
- does not follow through instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)

- has difficulties organizing tasks and activities
- avoids, dislikes or is reluctant to engage in tasks that require sustained mental efforts
- loses things necessary for tasks or activities (e.g. toys, school assignments, pencils, books)
- is easily distracted by extraneous stimuli
- is forgetful in daily activities

2) The predominantly hyperactive/impulsive type:

The hyperactive often:

- fidgets with hands or feet or squirms in seat
- leaves seat in classroom or in other situations in which remaining seated is expected
- runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
- has difficulty playing or engaging in leisure activities quietly
- is "on the go" or acts as if "driven by a motor"
- talks excessively

The impulsive often:

- blurts out answers before questions have been completed
- has difficulty awaiting turn
- interrupt or intrudes on others (e.g. conversations or games)

3) The combined type (inattentive/hyperactive/impulsive): Those with combined type have a combination of inattentive and hyperactive/impulsive symptoms; this is the most common type of ADHD.

The combined type of ADHD is more prevalent in elementary school-aged boys and the predominantly inattentive type is diagnosed more often in adolescent girls.^{4,6}

What Schools can do

Identification of the problem is the first step in providing the child with the most appropriate support and interventions. This requires that administration supports the needs of the school staff and that teachers, parents, school nurses, mental health professionals and physician work together to accurately identify whether a child has ADHD. The following are guidelines for diagnosis.

The DSM-IV-TR has identified that to be diagnosed with ADHD an individual must:

- Exhibit at least six of the symptoms from either of the above lists, some of these symptoms must have been displayed before the age of 7.
- These behaviors must occur in and negatively impact at least two settings, such as home, school, day-care or friendships, with clear evidence that it impairs functioning in two of these settings.
- The symptoms must last for at least 6 months.

When diagnosing a child with ADHD it is important to gather information from multiple sources to make an accurate diagnosis. A pediatrician, trained psychologist, neurologist, psychiatrist or trained clinical social worker can make the diagnosis in conjunction with input from parents, other caregivers, teachers and other school staff that know the child. The psychiatrist or clinician must determine whether other psychiatric disorders are present before finalizing a diagnosis of ADHD. It is important to complete a comprehensive assessment with the parents and child on the child's overall functioning and family situation. This will rule out other situations that can trigger behavior that may resemble ADHD but are symptoms in reaction to:

- A death or divorce in the family, a parent's job loss, or other sudden change.
- Undetected seizures.
- An ear infection that causes temporary hearing problems.
- Problems with schoolwork caused by a learning disability.
- Anxiety or depression.

Parents, other caregivers, teachers and other school staff that know the child are in the best position to observe the child's behavior in various settings, i.e. home, community and school. The parents, caregivers, teachers and other appropriate school staff can complete a standardized rating scale to provide an accurate picture of the child's behavior in various settings. The physician can also do a complete medical examination to rule out medical problems (i.e. hearing and vision) as well as other medical issues. This information from multiple sources is pertinent to making an accurate ADHD diagnosis.

In-service training for school staff on symptoms of ADHD, appropriate behavioral interventions and the importance of communicating and working with the family will support the academic success of the child with ADHD.

- **Educational Interventions**

Provide an environment that is structured, predictable and conducive to learning. Seat the student where there is a minimum of distraction, encourage peer tutoring, and provide a quiet study area.

Provide specialized instruction with frequent eye contact. Be clear and concise; simplify, break down and repeat instruction.

Provide supervision and consistent consequences. Have established clearly stated consequences for misbehavior, administer consequences immediately and calmly, enforce rules consistently, and avoid ridicule and criticism.

Be specific in naming and describing the behavior that has resulted in the consequence.

Enhance self-esteem through frequent encouragement and praise.

- **Behavioral Management Therapy**

A licensed mental health professional, a psychologist, social worker or family therapist, works with the parents and teacher to provide training in child behavior management.

The training consists of viewing the child's behavior as a function of ADHD rather than as a negative behavior and focusing on appropriate behavior. Training includes ignoring minor inappropriate behavior.

This therapy consists of providing clear and concise directions to the child and establishing an effective incentive program such as tokens, tickets or reward points. The management of the child's behavior is through the application of immediate and consistent consequences in the form of rewards or removal of privileges.

The main elements of behavioral management therapy are:

- **Goal-setting:** The parent and teacher assist the child in learning to set and accomplish specific goals, such as completing a chore, finishing a classroom assignment, able to play with a peer on the playground, and being able to sit at his/her desk for an hour or more.
- **Rewards and consequences:** The child receives rewards for good behavior and/or achieving identified goals. The child's negative behavior will get a time out or a loss of privileges.
- **Consistent therapy for a long period of time:** Utilization of goal-setting, rewards and consequences with the child until the child internalizes these behavioral changes on their own.⁶

Treatment does need to be tailored to the individual needs and personal history of the child.

- Medical/Psychiatric Interventions

The main ADHD medications include stimulants, nonstimulants and antidepressants. Some of these drugs have side effects. The most common side effects are:

- Decreased appetite/weight loss
- Sleep problems
- Headaches
- Jitteriness
- Social withdrawal
- Stomach aches
- Acne

The side effects can be managed through careful monitoring of the dosages. It is important to communicate and work closely with the child's doctor to ensure accurate administration of the medication as prescribed.

A multidisciplinary approach to treating ADHD is the most effective. Utilizing a multidisciplinary approach to treating ADHD includes:

- Educating parents and the child on their diagnosis and treatment options
- ADHD medication
- Behavior management therapy
- Involvement of teacher
- Involvement of counselor

References:

<http://www.webmd.com/metnal-health/metnal-health-conduct-disorder>

http://www.psychnet-uk.com/x_new_site/DSM_IV/a_index_dsm.html

<http://www.mayoclinic.com/health/oppositional-defiant-disorder/DS00630>

http://namimi.org/adhd?gclid=CLCcv_6bsqMCFQVGnQodcGFK3Q

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 4th ed. Washington, DC: American Psychiatric Press; 2000.

<http://www.webmd.com/add-adhd/guide/adhd-symptoms>

<http://school.familyeducation.com/learning-disabilities/treatments/30083.html>

EATING DISORDERS

Eating disorders are complex clinical conditions that arise from a combination of long-standing behavioral, biological, emotional, psychological, interpersonal, and social factors. They can include, but are not limited to, the following behaviors; incessant dieting, compulsive overeating, repetitive bingeing and purging and/or compulsive exercising. Scientists and researchers are still learning about the underlying causes of these emotionally and physically damaging conditions. We do know however, about some of the general issues that can contribute to the development of eating disorders.

While eating disorders may begin with preoccupations with food and weight, they are most often about much more than food. People with eating disorders often use food and the control of food in an attempt to compensate for feelings and emotions that may otherwise seem over-whelming. For some, dieting, bingeing, and purging may begin as a way to cope with painful emotions and to feel in control of one's life, but ultimately, these behaviors will damage a person's physical and emotional health, self-esteem, and sense of competence and control.

Psychological Factors that can contribute to Eating Disorders:

- Low self-esteem
- Feelings of inadequacy or lack of control in life
- Depression, anxiety, anger, or loneliness

Interpersonal Factors that can contribute to Eating Disorders:

- Troubled personal relationships
- Difficulty expressing emotions and feelings
- History of being teased or ridiculed based on size or weight
- History of physical or sexual abuse

Social Factors that can contribute to Eating Disorders:

- Cultural pressures that glorify "thinness" and place value on obtaining the "perfect body"

- Narrow definitions of beauty that include only women and men of specific body weights and shapes
- Cultural norms that value people on the basis of physical appearance and not inner qualities and strengths

Biological Factors that can contribute to Eating Disorders:

- Scientists are still researching possible biochemical or biological causes of eating disorders. In some individuals with eating disorders, certain chemicals in the brain that control hunger, appetite, and digestion have been found to be unbalanced. The exact meaning and implications of these imbalances remains under investigation.
- Eating disorders often run in families. Current research indicates that there is some genetic contributions to eating disorders

A person with eating disorders may have a general mistrust of health care providers, due to her/his own secrecy and embarrassment about the problem. A teenager approached about an apparent eating disorder may react with denial of difficulties or a refusal to participate in rehabilitation. These responses reflect an overwhelming fear of letting go of the coping strategy and, thus, a return to a state of perceived weakness and helplessness.

What Schools Can Do

- Classroom education as part of the comprehensive health education curriculum should contain opportunities for learning and discussion about societal attitudes and media messages regarding weight and appearance.
- Because of the serious danger from eating disorders to physical health, it is important to share concerns with the school health professionals including any mental health providers, who should consult with the student and parent for a referral to the student's primary health care provider.
- Eating disorders are complex conditions that can arise from a variety of potential causes. Once started, however, they can create a self-perpetuating cycle of physical and emotional destructions. All eating disorders require professional help.
- The National Eating Disorder Association provides toolkits and more detailed information. The Toolkits available were created specifically for school personnel that include teachers, coaches, and administrators. Please go to <http://nationaleatingdisorders.org/> for more information or to access those Toolkits.

SOMATIC COMPLAINTS

These complaints are known to occur among children and adolescents and are caused by a combination of organic and psychological factors. Persistent or frequently recurring symptoms such as headache, stomach ache, nausea, diarrhea and palpitation are often difficult to diagnose. Some children may be predisposed to psychosomatic illness because of specific physiological and psychological vulnerabilities. It is common for an individual to experience somatic symptoms in a stressful situation.

Somatic illnesses result when an individual experiences a patterned persistent exaggeration of somatic complaints. Most adults recognize that a headache is a result of being stressed and take steps to reduce or withdraw from the stress. Others, especially children, may not recognize the

connection between the symptom (headache) and the cause (worry about the big test tomorrow). The headaches may persist because the student does not recognize and deal with an underlying problem -- in this case, fear of tests or in more serious situations the fear of parental reactions, abuse/neglect.

Symptoms

In primary disorders a physiological problem (such as diabetes or asthma) is already present. The psychosomatic element is the aggravation of already existing symptoms. Thus, a child with diabetes may actually develop recurrent bouts of metabolic imbalance triggered by emotions. A child with asthma may have severe attacks at times of extreme emotional stress. In both cases there is a physiological illness present.

In secondary disorders no preexisting medical problem can be found. Thus the child with headaches due to test anxiety may undergo a battery of tests that produce no physiological evidence to explain the headaches. It should be noted, however, that it is likely that headaches and other physical symptoms are as real and painful as are those of someone with a medical diagnosis.

Following is a list of some of the most commonly seen psychosomatic complaints in children:

- Asthma - Bronchial asthma is typically caused by allergic reactions, but in some cases emotions and stress can trigger an attack.
- Stomach Problems - Emotions have a marked effect on the gastrointestinal system. When a child is upset, the appetite may diminish or nausea and cramping may occur. Vomiting may be induced by anxiety provoking experiences. A large proportion of complaints such as upset stomach, heartburn, stomach ache and diarrhea can be caused by reactions to emotional stress.
- Headaches - Simple headaches (not migraine) may be the result of tension or stress. They can also result from hunger or lack of sleep, which is why a thorough assessment/interview is needed. Migraine headaches are uncommon in children under age 12, but they may begin during adolescence and must be monitored by a health care provider.
- Urinary Incontinence (Enuresis) - Enuresis is common in childhood. When there are no abnormalities found in the physical examination it is likely that enuresis is caused by emotional factors. It may be a sign of anxiousness or insecurity. Unexpressed anger may manifest itself in this way, particularly in cases of abuse and neglect. Even without treatment, the majority of children outgrow their enuresis by puberty or early adolescence.
- Encopresis - Encopresis may be defined as fecal holding with constipation and fecal soiling. The constipation results in overflow incontinence. Children are often unaware of their accidents and unable to control them. While the origin of encopresis is frequently physical, some factors which can lead to withholding behavior resulting in constipation and/or leaking of stool include the school environment, the school bus environment, the busy routine of the school day, lack of privacy in school bathrooms as well as abuse and neglect.
- Cardiovascular Symptoms - Anxious children may experience a prolonged rapid heart rate (tachycardia). The child may describe it as a "pounding heart" or "racing pulse" and may fear that a heart attack is impending. This fear of heart attack increases the anxiety that aggravates the tachycardia which can set up a vicious cycle.
- Psychosomatic Skin Disorders - Most cases of skin rash (urticaria) are due to disease or allergic reactions; other cases may be caused by emotional stress. Urticaria due to emotional

stress usually occurs on the neck, face and arms; although, it may appear over the entire body. It is more common in girls than boys and occurs more frequently in adolescents than younger children.

- Diabetes - The emotional state of a diabetic child may have a marked effect on the course of the illness. Deviations from the prescribed medication or diet may result in serious medical emergencies.

What Schools Can Do

Determine whether or not an ailment is a physical disorder or caused by emotional factors. If treated early, many psychosomatic complaints will not become chronic problems. It is important for school personnel to pay close attention to illnesses in children. Children who have frequently recurring episodes of the same symptoms should be referred to a primary care provider or mental health provider.

SUBSTANCE ABUSE

Substance or alcohol use by an adolescent should be considered abuse because the adolescent cannot legally obtain or use the substance (unless taking as prescribed by a physician).

Prescription drug abuse occurs when the adolescent is either taking the substance in excess of the prescription, using another person's prescription or using the prescription for a reason other than prescribed; for example, an adolescent sharing their Ritalin prescription with other students.

Teachers and other school personnel may suspect a student of being on a substance and send them to the school health personnel per the school district policy. However, it is not the role of the school health personnel to confirm or disapprove that a student is under the influence of a substance. Each school district should have a policy in place for referring students out to an independent testing location for such tests. Counseling for substance abuse should also be referred out as only a Licensed Alcohol and Drug Abuse Counselor (LADAC) can provide the service.

PSYCHOTROPIC MEDICATIONS: Use with Children and Adolescents

Ensuring Quality Care

School nurses play an integral role in promoting quality student care. When a student requires psychopharmacological intervention, school nurses may refer to an appropriately licensed provider who can prescribe psychotropic medication. Though psychotropic medication is sometimes prescribed without behavioral health support services, it is recommended that the student be offered behavioral health resource information. If the student refuses counseling, it is important to know that the prescribing provider is responsible for monitoring the student's medication reactions per guidance set forth by the American Academy of Child and Adolescent Psychiatry (AACAP).

School nurses can also promote integrated and coordinated services for students who are prescribed psychotropic medication. Integrated care can best be achieved through close coordination among the prescribing provider, the student's Primary Care Physician, the treating Behavioral Health Provider, and school health and behavioral health resources.

Also, it is important to know that a number of policies and state statutes guide provider prescribing practices for psychotropic medications. Among these are the guidance set forth by the Food and Drug Administration (FDA) and American Academy of Child and Adolescent Psychiatry (AACAP). Providers must also adhere to New Mexico Statutory Authority (NMSA) regarding consent for psychotropic medications, as follows:

- 1) In accordance with NMSA 32A-6A-14, for students age 13 and younger, the informed consent of a student's legal custodian is required before providing treatment, including psychotropic medication. Custodial written consent must be included in student's medical record.
- 2) In accordance with NMSA 32A-6A-15, for students age 14 and older, psychotropic medications may be prescribed with the informed consent of the student. When psychotropic medications are prescribed, the provider must notify the child's legal custodian of medications the student is taking and possible side effects or medication interactions. Student written consent and custodial notification must be documented in the student's medical record.

Finally, because of complex drug interactions and effects of certain medications on children and adolescents, it is highly recommended that providers consult with a child and adolescent psychiatrist for assistance with evaluation and medical management under the following circumstances:

- 1) Student presents with complex behavioral health needs or the co-occurrence of medical and behavioral health conditions.
- 2) Greater than three psychotropic medications are being prescribed.
- 3) Two or more antipsychotic medications are being prescribed.
- 4) Prescribing psychotropic medication to children 5 years of age or younger.

Learning More About Psychotropic Medications

Psychiatric medication classes include anticonvulsants, atypical and conventional antipsychotics, SSRIs, MAOs, SNRIs, Tricyclics, other antidepressants (Bupropion, Mirtazipine, Nefazodone, Trazodone, Maprotiline, Buspirone, Benzodiazepines, Clonidine, Guanfacine), stimulants, and Strattera. Resources for understanding psychotropic medication and their use with children and adolescents can be found at:

- Bostic, J. (2010). *Evaluation of Medication Side Effects*. This evaluation, derived from the Safety Monitoring Uniform Report Form (SMURF), assists parents in identifying common symptoms their children or adolescents are experiencing that may indicate medication side effects. The evaluation can be found at: http://www2.massgeneral.org/schoolpsychiatry/pdfs/medications_EvalSideEffects.pdf.
- Los Angeles County Department of Mental Health, Children and Family Services Bureau (2009). *Psychotropic Medication for Children and Adolescents Quick Guide*. This quick guide provides information by medication class on clinical indications for use, complications and side effects, cautions and contraindications and medical follow up, please see: http://dmh.lacounty.gov/ToolsForClinicians/Reports/documents/PSYCHOTROPIC_GUIDELINES_07_01_09.pdf.
- Wilens, T. (2009) Straight Talk About Psychiatric Medications for Kids. (3rd ed).

DEVELOPING A YOUTH SUICIDE RESPONSE PLAN

INTRODUCTION

Collaboration and coordination between the school district, its various schools, the School-Based Health Center (if applicable) and community agencies are critical and essential for a youth suicide response plan to be effective. Considering access to care issues for the plan means identifying both primary care and behavioral health care service providers in close proximity if these services are not provided by the school district staff or contract staff.

When developing a youth suicide response plan the following considerations should be explored by the school district.

- What resources are available within the school?
- What resources are available within the community?
- What is the existing school district's policy on intervening with a potentially suicidal student?
- How is confidentiality of the student protected within the school district?
- Who needs to know what is going on and when?
- How do the members (school nurse, counselors, social workers, SBHC staff etc.) of the school health team(s) interface with one another?

SUICIDE RESPONSE PLAN COMPONENTS

- Communication
- Access to care
- Levels of health care provided within the school district
- Parental involvement
- Confidentiality
- Referral and assessment
- Therapeutic intervention versus disciplinary action
- Transportation policy
- Staff education/training
- Continuity of care

INDICATORS FOR ASSESSING SUICIDE RISK

Under no circumstance should an untrained person attempt to assess the severity of the suicide risk of an individual student; all assessment of threats, attempts, or other risk factors must be left to the appropriate professionals. In the assessment risk tables provided below the user should keep in mind that *crisis responder* refers to a medical or mental health provider trained in suicide prevention; *school personnel* refers to any school faculty or employee that believes a student may be at risk for suicide.

ASSESSING SUICIDE RISK GUIDELINES

<p>Low or Moderate Risk Criteria</p> <ul style="list-style-type: none"> • Staff member observes behavior or warning signs that indicate student may be at risk. • Student may have verbalized suicidal thoughts. However, <ul style="list-style-type: none"> - he/she does not have a plan. - he/she does not have access to a potentially lethal weapon or other means of harming him/herself. - he/she may mention a means, but verbalizes no depth of planning or commitment. 	<p>Low or Moderate Risk Response</p> <ul style="list-style-type: none"> • School personnel will contact available crisis responder (e.g. school counselor, school nurse, SBHC staff, etc.) • Crisis responder will meet with student to determine extent of crisis (suicide assessment checklist should be administered. If harm is imminent, use guidelines under topics “Severe Risk.” • If harm is not imminent, seek consent from student to contact parent. • Crisis responder will refer student and family to resources appropriate to level of risk. • Crisis responder will notify designated school personnel (e.g. counselor) about student crisis. • Crisis responder will follow up with student and family as appropriate and as agreed upon.
<p>High Risk Criteria</p> <ul style="list-style-type: none"> • Student has overtly voiced intent to engage in a suicidal act. • Student has gone beyond mere thoughts and has thought of actual actions. • Student has a suicide plan, but does not have means to carry it out. 	<p>High Risk Response</p> <ul style="list-style-type: none"> • School personnel will contact SBHC or other crisis responder available (e.g. school counselor, school RN). • Crisis responder will meet with student to determine extent of crisis. A suicide assessment checklist should be administered. • If harm is imminent, student will be kept under close supervision and never left alone. If at any time the situation escalates, (e.g. student has a weapon, refuses cooperation, walks out) call 911. • Crisis responder will counsel student through crisis, help mitigate stress and develop a “safe plan” with student input. • Crisis responder will notify designated school personnel about student’s intent and suicidal behavior. • Crisis responder will refer student and family to outside resources appropriate to level of risk. • Parents should be notified of students behavior and expressed intent. <ul style="list-style-type: none"> - Student may only be released to parents or someone equipped to provide help.

	<ul style="list-style-type: none"> - Before student release, next steps should be determined in an intervention meeting with crisis responder, student and parent/guardian. - If parents do not appear willing to take next steps, crisis responder or designated school personnel will call Children, Youth and Family Department (CYFD) to ensure student safety. • Crisis responder will follow up with student and family periodically. <i>(Add agreed upon follow up procedures.)</i>
<p>Severe Risk Criteria</p> <ul style="list-style-type: none"> • Student has concrete plan with means readily available and accessible. • Student has access to lethal means needed to carry out act. • Student is in process of carrying out suicidal act. 	<p>Severe Risk Response</p> <ul style="list-style-type: none"> • School personnel should contact first available crisis responder (i.e. school counselor, school nurse, SBHC). • Crisis responder will determine extent of crisis after meeting with student and administering a suicide assessment checklist. • Student should be kept under constant observation and within reach of a responsible adult at all times. If unsuccessful at interrupting student’s suicide plan call 911. Access to any lethal means for pursuing suicide should be removed/alleviated immediately. • Parents should be notified immediately. <ul style="list-style-type: none"> - Student should only be released to parents or someone equipped to provide necessary supervision until student safety is secured (e.g. hospitalization). - Before student release, next steps should be determined in an intervention meeting with crisis responder, student and parent/guardian. - If parents do not appear willing to take next steps, crisis responder or designated school personnel will call Children, Youth and Family Department (CYFD) to ensure student safety. - Student should be entrusted to someone able to provide safe environment and accompany student to a treatment agency or hospital. • Crisis responder should counsel student through crisis and help mitigate stress until parent/guardian arrives. • Crisis responder should refer student and family to outside resources appropriate to the level of risk. Contracts and release documents for facilitating referral linkage to treatment agencies should be in place at all times. • Crisis responder should follow up with student and family periodically. <i>(Add agreed upon follow up procedures.)</i> Responder should confirm that treatment was initiated, is on-going and is adequately meeting the need. • Crisis responder will notify designated school personnel about student’s intent and suicidal behavior or suicide attempt.

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SUICIDE CRISIS RESPONSE

When intervening with a student who has been determined to be at risk for suicide utilizing the risk criteria listed in the Assessing Suicide Risk table, the following guidelines are intended for use by a mental health clinician on the school staff or attached to a School-Based Health Center (SBHC).

Best Practice/Recommended Intervention

When intervention in an individual suicidal crisis is indicated the clinician should follow these guidelines.

- Immediately intervene one-on-one to address directly and empathetically the student's self-report of stressors.
- Provide positive reinforcement to the student for seeking assistance and/or accepting assistance.
- Continue to assess the lethality of the suicide risk and assess the concreteness of plan and means of implementation of the plan.
- Inform and educate student of the need to develop a safety plan.
- Move to the safety planning process, using the information learned during the initial intervention.
- Do not hesitate to seek additional consultation services during or after the crisis.

Safety Plan for Low and Moderate Risk Levels

- The safety plan should follow administrative procedures regarding communication and protocols established for an individual suicide crisis. It should include the manner in which parent/guardian will be notified, unless the clinician determines this would increase danger to the student. The student should be informed of the need for the clinician to act on identified information and to follow school district protocol, and the clinician should assist the student in understanding this process. If the clinician determines the suicide risk is low and referral to emergency services is not indicated, he/she should begin the next intervention with the anticipation of parent/guardian arrival.
- With the student informal (family, friends, clergy, etc.) and formal (doctor, other treatment providers, 24-hour crisis lines, nearest emergency room, etc.) resources should be identified as safety contacts should the risk for suicide persist or increase. Contact information for these supports should be provided the student.
- The student should be helped to identify coping resources and personal strengths.
- The student should be encouraged to contract for safety which should include a timeframe regarding willingness to involve parent/guardian in the plan, removing potentially lethal means of pursuing suicide and plans for formal follow up (e.g. next appointment with clinician or other provider). Lack of willingness to contract for safety would place the student at a higher risk level.
- The safety plan should be formalized into a written document ensuring 24-hour, 7-day week supervision until follow up assessment occurs.
- The safety plan should be reviewed with parent/guardian and contact information verified. Obtaining signatures from parent/guardian and student as well as clinician indicates agreement and formalizes the plan.

- If parent/guardian is unavailable or refuses to participate the clinician should attempt to verbally review the plan with an adult designated by the parent/guardian. If this proves unsuccessful child protective services channels should be initiated.

Safety Plan for High to Severe Risk Levels

- The safety plan should follow administrative procedures regarding communication and protocols established for an individual suicide crisis. It should include the manner in which parent/guardian will be notified, unless the clinician determines this would increase danger to the student. The student should be informed of the need for the clinician to act on identified information and to follow school district protocol, and the clinician should assist the student in understanding this process.
- If the clinician has determined that the student is in need of immediate medical or psychiatric evaluation and/or hospitalization, steps to facilitate this process should be outlined in formal agreements with acute crisis service providers for referral services.
- Transportation arrangements for the student should be guided by the school district's established and approved policies covering emergency transportation.
- A qualified adult should be identified to accompany the student to a safe environment or until care is transferred to another caregiver that is another professional or a parent/guardian.

Documentation of Intervention Events

Crisis intervention should always be documented; such documentation should include (but is not limited to):

- Risk assessment information
- Clinician's decision making process
- Student's response to intervention
- Communication with school, parents and other providers, etc.
- Record of any consultation received
- Instructions given to student and caregivers of student
- Plans for follow up.

A copy of the safety plan in its entirety should be kept in the student's chart along with all other documentation.

(See Resource Section of this manual for *Depression Checklist for Teens* and *Confidential Services for Minors*.)

Adapted from the National Mental Health Association.