

**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 and adjustment counselors 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' emotional and psychological 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.

### **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 thing).
- Develop negativity (clinging, thumb sucking).
- Hit/bite to get attention.
- Explore own body (potty train).

- Regress to infantile behavior occasionally.
- Develop language.

### **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.

### **AGES 6 TO 7 YEARS**

- Exhibit extremes of emotional responses (joyous delight instead of quiet joy or hysterical crying instead of simple sadness).
- Express susceptible 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.

### **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, 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.

### **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 emotional well-being. Teachers, in concert with other school staff, such as principal, guidance counselor and health staff, have an important role to play in building a positive classroom atmosphere for students. Topics and activities might include the following: problem-solving class meetings; improving communication skills; teaching cooperation; helping students handle anger, frustration and aggression; teaching 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 environment, providing consultation to teachers and staff about management of different problem behaviors, and assisting schools to develop policies and procedures to deal with mental health and related issues.

## **SECONDARY PREVENTION**

Secondary prevention efforts focus on identifying and providing services for children who are at risk of developing emotional, behavioral or school-related problems. Children at risk may include those with family or learning problems or those experiencing the loss of a significant person. 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 group counseling with a trained mental health specialist which focuses on helping children learn to cope with problems in their lives.

## **TERTIARY PREVENTION**

The third level of prevention consists of providing services to children who are actively demonstrating emotional, behavioral or school-related problems. In these cases, trained school staff may provide concentrated support and follow-up for students who are apathetic, acting out or showing poor self-esteem, as well as for students returning to school after residential treatment. Students may be seen for counseling in small groups or in individual sessions. Schools may provide tertiary services in-house or develop links with community mental health programs to provide them with the necessary expertise or services.

## **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 or neurological disorders, may be underlying factors in any given case, and effective intervention depends on 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. Everyone has feelings of sadness, discouragement and moodiness that are normal responses to failure or distress. 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. Instead, children 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.

### **Symptoms**

It is believed that a child's internal experience of depression is similar to that of an adult. 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 Philip Kendall, 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.

- 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 plan or a suicide plan.

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

### **What Schools Can Do**

Children and adolescents who are at risk for depression may be helped by consistent nurturing from trusting 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 students who might be 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 it 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 "Suicidal Tendencies" topic in 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 depression 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 depression, especially if the student mentions suicidal thoughts.

### **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 manic-depressive illness, the chances are greater that their children will develop the disorder.

Manic-depressive 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 youngsters 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; has 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 may be helped by consistent nurturing from trusting 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.

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  - 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 Tendencies” 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 TENDENCIES**

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 tendencies, 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.

### **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**

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 experience by school-aged children is the death of a significant other. Some students lose grandparents during their years at school; and some may lose parents, siblings, friends or other emotionally significant individuals. In addition, the death of a pet may be a traumatic event. Sometimes students and school personnel are forced to deal with the death of a classmate or staff member. Few teachers, school nurses, and other school personnel go through their careers without knowing a student who is grieving.

### **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. Some of the emotions that grieving children and adolescents experience are denial, anger, acting out, withdrawal, guilt and depression.

## **What Schools Can Do**

No one can prevent, nor should they try to prevent, the natural course of grieving. These are normal reactions that take time to resolve. Talking with a trusted adult can help a child understand some of the feelings and thoughts that accompany grief. The following are some suggestions for school personnel who are dealing with a grieving student.

- When talking with a student use words that the student can understand.
- Younger children may regress to outgrown behavior, such as thumb sucking, soiling themselves, hair twisting or other self-comforting behaviors. Educators should remember that these regressions are temporary, and they should continue to support the student during this phase. It is also important to discourage any teasing from other students about these behaviors.
- Some students may fear that they, too, will die or that someone else close to them may die soon. They need the opportunity to express these fears and be reassured.
- Children may need to ask the same questions about death many times. Adults should encourage these questions and be patient while supplying the same honest, simple answers over and over.
- Use every day events in student's own lives to help them understand and talk about death and dying, i.e. pets' deaths, newspaper or television reports of death, and the birth and death of the changing seasons.

## **DISRUPTIVE BEHAVIORAL DISORDERS**

These disorders are characterized by actions that are socially disruptive and distressing to 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.

Generally, disruptive behavior disorders result when a child has not formed healthy relationships with significant others, especially family members. Referred to as reactive attachment disorder, this inability to form healthy relationships results from various forms of environmental childhood disruptions. The two major disruptive behavioral disorders discussed here are conduct disorders and oppositional defiant disorder.

### **Symptoms**

#### **Conduct disorders**

- Running away
- Stealing, lying
- School truancy
- Fire setting
- Cruelty to animals and people
- Destruction of property

#### **Oppositional defiant disorders**

- Argumentativeness
- Frequent loss of temper
- Constant anger/resentfulness
- Easily annoyed by others

- Swearing
- Blames others for own mistakes or difficulties

### **What Schools Can Do**

Disruptive behavioral disorders are manifestations of serious attachment problems. Because educators may see such disorders in the classroom and have to defuse a related situation, the most useful thing they can do is to be aware of the disorders and their symptoms and resolve to bring such problems to the attention of school health professionals as soon as possible. Special education evaluation is one possible intervention to initiate. Teachers, parents and mental health professionals need to work together to teach the student healthy relationship skills and pro-social behaviors. Clearly stated, consistent, enforceable limits are essential in 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.

#### ▪ **Psychosocial Interventions**

Facilitate training in social skills to encourage successful peer contacts and positive experiences, increase knowledge about appropriate behavior, and improve the child's popularity with the peer group.

Praise child's efforts to demonstrate the use of positive social skills, such as empathy, assertiveness, problem solving, etc.

Encourage family and individual counseling.

Encourage behavior modification program at home and in school.

### **ATTENTION DEFICIT DISORDERS**

Even though attention deficit disorders are classified as one type of disruptive behavioral disorder, they are being considered separately here because they are a common problem in American schools. Attention deficit hyperactivity disorder (ADHD) is the leading psychiatric diagnosis in American children, according to some researchers. These disorders were at one time all lumped together under the term hyperactivity. However, research shows that attention deficit can also occur without hyperactivity and is diagnosed separately as attention deficit disorder (ADD).

No one knows exactly what causes ADD/ADHD, although most experts believe there is a physiological explanation—perhaps a single gene that predisposes individuals to a variety of

disorders. Family members of children with these disorders may have ADD/ADHD as well as other problems such as depression, anxiety, anti-social behavior and substance abuse. Other experts think that ADD/ADHD is caused by a deficiency in some of the neurotransmitters in the brain (norepinephrine or dopamine) that are thought to regulate attention and the ability to focus and control oneself; this deficiency in neurotransmitters is thought to result from fetal mal-development or genetic transmission. Yet other experts believe that diet, nutrition and other environmental factors can be both causative and curative.

### **Symptoms**

#### ▪ **ADD Inattention Symptom List**

Often has difficulty following through on instructions and sustaining attention.

Frequently appears not to listen.

Often loses things necessary for tasks.

Fails to give close attention to details.

Is often disorganized.

Frequently makes careless mistakes in schoolwork.

Is often forgetful.

Daydreams when should be paying attention.

Unmotivated to complete schoolwork or task.

Youngsters with ADD may be perceived as stupid, lazy, stubborn and defiant if they are unable to produce in a classroom setting. They tend to be overlooked in school because although they are not producing, they are not disruptive. They may be isolated and withdrawn, slowly losing self-esteem as they fail repeatedly at school tasks. These students are at risk of drifting away from school when they are old enough to do so.

#### ▪ **ADHD Hyperactive-Impulsive Symptom List**

Often has difficulty waiting turn in group situations.

Frequently interrupts or intrudes on others.

Blurts out answers to questions.

Has difficulty playing quietly.

Often leaves seat.

Frequently runs around or climbs excessively.

Often fidgets or squirms.

Talks excessively.

Acts as if driven by a motor and cannot remain still.

Youngsters with ADHD are likely to live with rejection from teachers, parents and peers because they have trouble controlling their behavior. A typical development profile includes irritability, colic and sleep disturbances in infancy. As a toddler the child is active in a troublesome way, may disrupt the environment more than the average child, and may be unable to listen or

respond to parental discipline. During the preschool years, the child has social adjustment problems, difficulty making and keeping friends, and temper tantrums; he/she can be domineering and is teased frequently. By first grade, teachers typically have noticed that the child cannot sit still and is easily distracted. Academic problems appear early but are commonly attributed to immaturity or academic readiness. These children are at increased risk for emotional and physical abuse as a result of their behavior.

In adolescence, the symptoms are the same but are manifested in different ways. Peer rejection is common for ADD/ADHD adolescents, resulting in increasingly lowered self-esteem. Due to lack of acceptance as a result of social and conduct difficulties, many adolescents either are forced to associate with any group that accepts them or they spend more and more time alone. Academic work may continue to be affected by the inability to concentrate, and opportunities for risk-taking may be sought to gratify their need for self-esteem.

### **What Schools Can Do**

In-service training for teachers and other staff on the issues of ADD and ADHD are helpful. While there is as yet no known way to prevent ADD, there are many interventions that have proven to be helpful. Identification of the problem is the first step and requires the cooperation of teachers, parents, school nurses, mental health professionals and pediatricians. Proper screening typically includes an extensive interview with the parent, an interview with the child, completion of rating scales, and direct observation of the child in the classroom.

A combination of educational, psychological, nutritional and medical interventions are typically developed. Treatment requires the full cooperation of teachers and parents working closely with other professionals. Research has consistently shown that medication is most effective when coordinated with academic and psychosocial measures. Regardless of whether or not medication is prescribed, the other interventions can greatly assist the student, family and school.

#### **▪ 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.

#### **▪ Psychosocial Interventions**

Facilitate training in social skills to encourage successful peer contacts and positive experiences, increase knowledge about appropriate behavior, and improve the student's popularity with the peer group.

Praise student's efforts to demonstrate the use of positive social skills, such as empathy, assertiveness, problem solving, etc.

Encourage family and individual counseling.

Encourage behavior modification program at home and in school.

- **Medical/Psychiatric Interventions**

Assure administration of medication as prescribed by the student's health care provider. Side effects of sleeplessness, weight loss or allergic reaction can usually be prevented if dosages are carefully monitored and adjusted as necessary. It is important to consider a variety of strategies prior to using medication because of potential side effects. Nutritional and dietary assessment with follow up intervention are often recommended.

## **EATING DISORDERS**

Eating disorders present complex clinical problems that involve physical changes. They include the following behaviors; incessant dieting, compulsive overeating, repetitive bingeing and purging and/or compulsive exercising. The majority of individuals who experience eating disorders are adolescent females. Adolescence is characterized by intense preoccupation with appearance, especially body weight. Societal and cultural emphasis on thinness effects how adolescent females feel about their weight and body image.

There are marked psychological difficulties that lead to the development of an eating disorder and reinforce its continuance. Adolescent females who have a strong sense of not being in control of their lives are more likely to develop eating disorders (including those experiencing physical and sexual abuse). The ability to control food intake and lose weight is experienced as taking control.

### **Symptoms**

Low self-esteem, frustration and rigidity are often exhibited in eating-disordered children and teens. In addition, a lack of ability or opportunity to recognize and directly express feelings (especially anger), depressive symptoms, irritability as well as a sense of shame, guilt and not feeling safe have been associated with 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.

## **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, stomachache, 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, stomachache 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.

## PSYCHOTROPIC MEDICATIONS (Use in Children and Adolescents)

### ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

#### Stimulants

This group of psychotropic medications is used as part of a total treatment regimen that at best includes psychological, educational and social remedial measures to address a behavioral syndrome characterized by symptoms that include moderate-to-severe distractibility, short attention span, hyperactivity, emotional adaptability and impulsivity. Stimulants are used to improve attention span and to decrease hyperactivity and impulsivity.

Drug: Generic (Brand) Name	Side Effects & Related Considerations
Dextroamphetamine sulphate [Dexadrine, Ferndex, Dexampex]	<ul style="list-style-type: none"> <li>▪ SE: Restlessness, nervousness, hyperactivity, dizziness, insomnia, unusual fatigue, headache, palpitations, loss of appetite, weight loss, nausea, dry mouth, mood changes, hypersensitivity.</li> <li>▪ Administer medication after meals if loss of appetite is a problem. Numerous drug interactions occur.</li> <li>▪ Dosage evaluation is recommended if no improvement occurs in one month; periodic drug-free periods are recommended to assess efficacy.</li> <li>▪ Gradual discontinuation is recommended if used for a long period.</li> </ul>
Dextroamphetamine[s] & Amphetamine[s] complex [Adderal]	(Same as above)
Magnesium pemoline [Cylert]	<ul style="list-style-type: none"> <li>▪ Dizziness, irritability, insomnia, fatigue, tics, loss of appetite, nausea, weight loss, mild depression, seizures, headache, abdominal discomfort.</li> <li>▪ Long-term use may affect the liver and can produce physical and psychological dependence. Periodic reductions or drug-free periods are recommended to assess efficacy.</li> <li>▪ Liver function studies are recommended for long-term users.</li> </ul>
Methelphenidate hydrochloride [Ritalin]	<ul style="list-style-type: none"> <li>▪ Agitation, depression, insomnia or drowsiness, mood changes, weight loss, irritability, nervousness, dizziness, tics, palpitations, anorexia, loss of appetite, nausea, dermatitis, growth suppression.</li> <li>▪ Administer medication after meals if loss of appetite is a problem.</li> <li>▪ Dosage evaluation is recommended if no improvement in one month; periodic drug-free periods are recommended to assess efficacy.</li> </ul>

## Hypertensives

Hypertensive medications are centrally acting drug and as nervous system inhibitors they slow the heartbeat. They should not be used if depression is present, but are approved for treatment of ADHD with impulsive/aggressive behaviors. (See Depression for ADHD with depression.)

Drug: Generic (Brand) Name	Side Effects and Related Considerations
Clonidine hyperchloride [Catapres]	<ul style="list-style-type: none"> <li>▪ Sedation, dizziness, headache, nausea, anxiety, restlessness, nightmares, dry mouth, constipation, weight gain, dizziness due to low blood pressure.</li> <li>▪ Sudden discontinuation may cause blood pressure to increase. May take 2-4 weeks to be effective. Taper on and off.</li> </ul>
Guanfacine [Tenex]	<ul style="list-style-type: none"> <li>▪ May lead to tiredness, headaches, stomachaches, and decreased appetite.</li> <li>▪ Not recommended for under age 12 as safety and efficacy have not been proven.</li> </ul>

## DEPRESSION

### Anti-depressants

Anti-depressants are used to treat serious depression, school phobias and other serious anxiety disorders, bedwetting, some bulimic-type eating disorders and attention deficit-hyperactivity disorder.

Drug: Generic (Brand) Name	Side Effects and Related Considerations
Fluoxetine hydrochloride [Prozac] sertraline hydr.ochloride[Zoloft]paroxetine hydrochloride [Paxil]	<ul style="list-style-type: none"> <li>▪ Prozac: nausea, agitation, anxiety, increased activity, and insomnia. Zoloft: chest pain, hypertonia, increased appetite, tinnitus, rhinitis. Paxil: nervousness, dizziness, tremor, nausea &amp; decreased appetite, sweating.</li> <li>▪ All: do not use MAO's concurrently.</li> <li>▪ Not as beneficial in treating hyperactivity as tricyclic anti-depressants.</li> </ul>

### Tricyclic Anti-depressants

Drug: Generic (Brand) Name	Side Effects and Related Considerations
Imipramine hydrochloride [Tofranil], Nortriptyline hydrochloride [Pamelor], desipramine hydrochloride [Norpramin]	<ul style="list-style-type: none"> <li>▪ Dry mouth, sedation, constipation, urinary retention, blurred vision, dizziness, rash, and EKG changes.</li> <li>▪ Baseline EKG required; EKG and blood level monitoring required with dosage change.</li> <li>▪ Works synergistically with stimulants. Taper on and off. Lethal in overdose.</li> </ul>

## AGGRESSIVE/IMPULSIVE BEHAVIORS

### Anti-convulsants

Drug: Generic (Brand) Name	Side Effects and Related Considerations
Carbamazepine [Tegretol, Mazepine, Eptol]	<ul style="list-style-type: none"> <li>▪ Drowsiness, dizziness, fatigue, coordination problems, respiratory depression, edema, nausea, vomiting, rashes, blood disorders, agitation and/or sedation, hepatitis, nystagmus.</li> <li>▪ Withhold and notify provider immediately with toxicity (fever, anorexia, unusual fatigue, bruising, bleeding).</li> <li>▪ Reliability of oral contraceptives may be reduced.</li> <li>▪ Requires close monitoring of blood cell counts, platelets.</li> </ul>
Valproic acid [Depakene]	<ul style="list-style-type: none"> <li>▪ Nausea, vomiting, indigestion may occur early in treatment - usually transient; sedation, mood changes depression, psychosis, aggression, hyperactivity, and behavioral deterioration have been reported.</li> <li>▪ Monitor liver function especially during first six months, as hepatic failure can be fatal.</li> </ul>

### Anti-psychotics – (See Psychotic Disorders)

Occasionally anti-psychotics are given in low doses as an adjunct to treat aggressive behavior, impulsiveness, difficulty sustaining attention, and poor frustration tolerance.

## PSYCHOTIC DISORDERS

Anti-psychotic drugs are used to treat severe behavioral problems in children marked by extreme combativeness and/or explosive hyper-excitability behavior, out of touch with reality, hallucinations and/or delusions.

### Neuroleptics

Drug: Generic (Brand) Name	Side Effects and Related Considerations
Thioridazine hydrochloride [Mellaril] Chlorpromazine hydrochloride [Thorazine] Haloperidol [Haldol]	<ul style="list-style-type: none"> <li>▪ Dyskinesia, dystonic reactions, tremor, rigidity, drooling, akathisia, cognitive dulling, sedation.</li> </ul>

### Atypical Neuroleptics

Drug: Generic (Brand) Name	Side Effects and Related Considerations
Risperidone [Risperdal]	<ul style="list-style-type: none"> <li>▪ Dizziness, EKG changes, weight change, constipation (decreased SE compared to typical anti-psychotics).</li> </ul>

\*Reference: Green, W.H. (1995). *Child and Adolescent Clinical Psychopharmacology*. Baltimore, MD: Williams & Wilkins.

# 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><b>Low or Moderate Risk Criteria</b></p> <ul style="list-style-type: none"> <li>• Staff member observes behavior or warning signs that indicate student may be at risk.</li> <li>• Student may have verbalized suicidal thoughts. However,             <ul style="list-style-type: none"> <li>- he/she does not have a plan.</li> <li>- he/she does not have access to a potentially lethal weapon or other means of harming him/herself.</li> <li>- he/she may mention a means, but verbalizes no depth of planning or commitment.</li> </ul> </li> </ul>	<p><b>Low or Moderate Risk Response</b></p> <ul style="list-style-type: none"> <li>• School personnel will contact available crisis responder (e.g. school counselor, school nurse, SBHC staff, etc.)</li> <li>• 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.”</li> <li>• If harm is not imminent, seek consent from student to contact parent.</li> <li>• Crisis responder will refer student and family to resources appropriate to level of risk.</li> <li>• Crisis responder will notify designated school personnel (e.g. counselor) about student crisis.</li> <li>• Crisis responder will follow up with student and family as appropriate and as agreed upon.</li> </ul>
<p><b>High Risk Criteria</b></p> <ul style="list-style-type: none"> <li>• Student has overtly voiced intent to engage in a suicidal act.</li> <li>• Student has gone beyond mere thoughts and has thought of actual actions.</li> <li>• Student has a suicide plan, but does not have means to carry it out.</li> </ul>	<p><b>High Risk Response</b></p> <ul style="list-style-type: none"> <li>• School personnel will contact SBHC or other crisis responder available (e.g. school counselor, school RN).</li> <li>• Crisis responder will meet with student to determine extent of crisis. A suicide assessment checklist should be administered.</li> <li>• <b>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.</b></li> <li>• Crisis responder will counsel student through crisis, help mitigate stress and develop a “safe plan” with student input.</li> <li>• Crisis responder will notify designated school personnel about student’s intent and suicidal behavior.</li> <li>• Crisis responder will refer student and family to outside resources appropriate to level of risk.</li> <li>• <b>Parents should be notified of students behavior and expressed intent.</b> <ul style="list-style-type: none"> <li>- Student may only be released to parents or someone equipped to provide help.</li> <li>- Before student release, next steps should be determined in an intervention meeting with crisis responder, student and parent/guardian.</li> <li>- 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.</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>• Crisis responder will follow up with student and family periodically. <i>(Add agreed upon follow up procedures.)</i></li> </ul>
<p><b>Severe Risk Criteria</b></p> <ul style="list-style-type: none"> <li>• Student has concrete plan with means readily available and accessible.</li> <li>• Student has access to lethal means needed to carry out act.</li> <li>• Student is in process of carrying out suicidal act.</li> </ul>	<p><b>Severe Risk Response</b></p> <ul style="list-style-type: none"> <li>• School personnel should contact first available crisis responder (i.e. school counselor, school nurse, SBHC).</li> <li>• Crisis responder will determine extent of crisis after meeting with student and administering a suicide assessment checklist.</li> <li>• <b>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.</b></li> <li>• <b>Parents should be notified immediately.</b> <ul style="list-style-type: none"> <li>- Student should only be released to parents or someone equipped to provide necessary supervision until student safety is secured (e.g. hospitalization).</li> <li>- Before student release, next steps should be determined in an intervention meeting with crisis responder, student and parent/guardian.</li> <li>- 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.</li> <li>- Student should be entrusted to someone able to provide safe environment and accompany student to a treatment agency or hospital.</li> </ul> </li> <li>• Crisis responder should counsel student through crisis and help mitigate stress until parent/guardian arrives.</li> <li>• 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.</li> <li>• 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.</li> <li>• Crisis responder will notify designated school personnel about student's intent and suicidal behavior or suicide attempt.</li> </ul>

## **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.

# Depression Checklist for Youth

The following checklist can help to assess and document a youth's feelings and behavior. This information can provide a medical or mental health provider with a picture of the youth's emotional state.

<b>SIGNS OF POSSIBLE DEPRESSION</b> (circle all that apply)	<b>DESCRIPTION</b> (how long, how often, give examples)
<b>Feelings:</b> <i>Does the youth express the following?</i>	
<ul style="list-style-type: none"> <li>• Sadness</li> <li>• Emptiness</li> <li>• Hopelessness</li> <li>• Guilt</li> <li>• Worthlessness</li> <li>• Not enjoying everyday pleasures</li> </ul>	
<b>Thinking:</b> <i>Is the youth having difficulty with the following?</i>	
<ul style="list-style-type: none"> <li>• Concentrating</li> <li>• Making decisions</li> <li>• Completing school work</li> <li>• Maintaining grades</li> </ul>	
<b>Physical Problems:</b> <i>Does the youth complain of the following?</i>	
<ul style="list-style-type: none"> <li>• Headaches</li> <li>• Stomachaches</li> <li>• Joint or backaches</li> <li>• Lack of energy</li> <li>• Sleeping problems</li> <li>• Weight or appetite changes (gain or loss)</li> </ul>	
<b>Behavioral Problems:</b> <i>Does the youth exhibit the following?</i>	
<ul style="list-style-type: none"> <li>• Restlessness</li> <li>• Irritability</li> <li>• Unwillingness to go to school</li> <li>• Wanting to be alone</li> <li>• Cutting classes or skipping school</li> <li>• Dropping out of sports, hobbies or activities</li> <li>• Drinking or using drugs</li> </ul>	
<b>Suicide Risk:</b> <i>Does the youth think or talk about the following?</i>	
<ul style="list-style-type: none"> <li>• Suicide</li> <li>• Death</li> <li>• Other morbid subjects</li> </ul>	

*Adapted from the National Mental Health Association.*

# CONFIDENTIAL SERVICES FOR MINORS IN NEW MEXICO

As addressed in the New Mexico Statutory Authority

[Last revised 1/16/02]

## § 24-1-9 NMSA 1978 ... Sexually transmitted disease

Any person regardless of age has the capacity to consent to an examination and treatment by a licensed physician for any sexually transmitted disease.

## § 24-1-13.1 NMSA 1978 ... Pregnancy

A health care provider shall have the authority, within the limits of his license, to provide prenatal, delivery and postnatal care to a female minor. A female minor shall have the capacity to consent to prenatal, delivery and postnatal care by a licensed health care provider.

## § 24-8-5 NMSA 1978 ... Contraception

Neither the state... nor any health facility furnishing family planning services shall subject any person to any standard or requirement as a prerequisite for receipt of any requested family planning service...[exceptions do not address age of client].

## §24-10-2 NMSA 1978 ... Emergency Conditions

... in cases of emergency in which a minor is in need of immediate hospitalization, medical attention or surgery and the parents of the minor cannot be located for the purpose of consenting...after reasonable efforts have been made..., consent can be given by any person standing in locus parentis to the minor.

## §32A-6-14 NMSA 1978 ... Mental Health (including substance abuse)

Any child shall have the right, with or without parental consent, to consent to and receive individual psychotherapy, group psychotherapy, guidance, counseling or other forms of verbal therapy that does not include aversive stimuli or substantial deprivations. ...{does not include electroconvulsive therapy or psychotropic medications}