

CHAPTER FOURTEEN – MENTAL HEALTH

School's Role

Every school staff member has a crucial role in promoting healthy emotional development for all children. Students who have a healthy emotional and social development, including a sense of self-worth, contributes to their success in and outside the classroom. School staff spend every day in the company of students, who are profoundly affected by their world in which they live, develop a deep awareness of the importance of the positive influence they have on those students at school.

Since school staff spend their days with students, staff can observe student's behaviors and actions throughout the day. This gives staff the distinct advantage of detecting children who display emotional, behavioral, or mental health problems and are charged with ensuring that students are referred for the proper assessments and appropriate interventions. Mental health problems have a variety of causes, and can be made worse if the student has a learning disability or physical health problem, some may have a physiological base, others may be a result from trauma, familial dysfunction, social stresses, or other problems. Whatever the cause, there is a compelling reason for the school to be alert to the issues and respond accordingly. It is important for schools to encourage, support and participate in community of care that includes parents, mental health providers, law enforcement, and any other vested community partner to ensure proper care and action is taken when needed. School professionals such as guidance counselors, school psychologists, nurses, social workers, and school based health center providers can educate and bridge the gap between these groups to obtain a successful working relationship in integrated care for every student in need.

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

Developmental Stages

Developmental stages are a set of functional skills "bench marks" or age-specific tasks that most children develop by a certain age range. Understanding these stages of a child or adolescent's social emotional development is helpful in distinguishing between behavior that is typical of the development phase and what behaviors may need observation and treatment by professionals. The following are general milestones children reach within each stage of development based on Piaget's cognitive development, Erikson's psychological

development, Freud's psychosexual development and Kohlberg's moral development. These stages are broad with the primary focus on achieving general developmental milestones, however, they may differ based on the child's gender, cultural background, and other individual characteristics. It is important to note that social emotional development can be disrupted and/or halted if a child or adolescent experiences significant or prolonged trauma.

Birth to 2 Years of Age

- Develop basic trust
- Oral stage, the mouth, tongue, and gums are the focus of sensations
- Most action is reflexive, like sucking and grasping
- Objects are extensions of self
- Cry to have needs met
- Self-comforts

2 to 3 Years of Age

- Develops autonomy (toileting, feeding, walking, & talking)
- Associates words with objects (language development)
- Explores and asks many questions
- Self-centered, requires sharing/cooperation to help move beyond self-centeredness
- Parallel without much interaction or sharing play themes, toys, or activities

4 to 6 Years of Age

- Explores limits
- Very active, enjoys things that involve movement
- Speech becomes more social
- Following rules of a game not developed
- Plan and engages in symbolic play/activities with others
- Curious about body parts and genitalia differences

7 to 12 Years of Age

- Learn to be competent and productive in mastering new skills
- Learn to make good choices and exercise self-discipline
- Solves concrete problems
- Form relationships with peers
- Engage in activities/play with mutually agreed upon rules
- Becomes aware of wider rules of society/viewpoints

13 to 18 Years of Age

- Develop crushes on peers
- Explores self-identity
- Uses rational thinking
- Develops moral reasoning
- Handle competitive play-winning and losing relatively well
- Rely more on peer's evaluation, approval & direction opposed to parents
- Self-conscious and sensitive to physical development
- Exercises independency from parents

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 nutrition, 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. 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. It is important to match different problems with the appropriate interventions.

Primary Prevention (Skill Building)

Primary prevention consists of providing children 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 all 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 (Resource Building)

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. Teachers are in daily contact with students, and they may be able 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 (Linking to Appropriate Service)

The third level of prevention consists of providing services to children who are actively demonstrating social and emotional concerns that warrant 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 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 Mental Health Concerns

It is extremely important for helping professionals to understand the dynamics of each individual child's situation to help that child effectively. Physiological problems, such as chemical imbalances in the brain, neurological disorders, or environmental discord, may be underlying factors in any given case. 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 student referred for an assessment.

Depression

Feelings of sadness, discouragement, and moodiness are normal responses to failure or distress; however, 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. Mood disorders affect thought, feelings, behavior, and overall physical health. Depression can range from transient (short-term) feelings to mood disorders.

According to the National Institute for Mental Health (NIMH), an estimated 3 million adolescents aged 12 to 17 in the United States had at least one major depressive episode in the past year. This number represented 12.5% of the U.S. population aged 12 to 17. Indicators for depression could include low self-esteem, the tendency to self-blame, feelings of powerlessness and hopelessness, and loss of pleasure in living. Although, these indicators may be difficult to identify depression in children 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, sexual identity, and neglect are examples of stressful events that may make children more vulnerable and at risk for depression. Some children are more resilient to these traumas than others. Two children who are vulnerable to depression may react 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 a major depressive episode. Another contributing factor is substance abuse. Some youth who are depressed may begin to self-medicate with drugs or alcohol. Any signs of drug or alcohol use could warrant a co-occurrence disorder assessment.

Symptoms

According to the National Alliance on Mental Illness (NAMI), 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.

Depression is more than the blues or the normal everyday ups and downs. When that “down” mood, along with other symptoms that lasts for more than a couple of weeks, then it may be clinical depression. Clinical depression is a serious health problem that affects all aspects of the person. It can change the way a person feels, behaves, their 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 individuals have a persistent mood state characterized by anxiety and agitation. 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.

What Schools Can Do

Educator can support the mental health of all students in the classroom and school, not just individual students who may exhibit behavioral issues, including signs of depression. Here are recommendations from the U.S. Department of Health and Human Services:

- Educate staff, parents, and students on symptoms of and help for mental health problems
- Promote social and emotional competency and build resilience
- Help ensure a positive, safe school environment
- Teach and reinforce positive behaviors and decision-making
- Encourage helping others
- Encourage good physical health
- Help ensure access to school-based mental health supports
- Promote the healthy social and emotional development of all children and youth
- Recognize when young people are at risk for or are experiencing mental health problems
- Identify how to intervene early and appropriately when there are problems

Bipolar Disorder (Previously called manic-depressive illness)

Bipolar disorder is a serious form of mental illness that affects perceptions, thoughts, moods, and behavior. Bipolar Disorder affects mood more than other functions. 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, the chances are greater that their children will develop the disorder.

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

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. Diagnosis 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; the risk for suicide is increased for an adolescent with bipolar disorder.

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/or 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/kill him/herself or others? If “yes”, see “Suicide Ideation”.
 - 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 disorder 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 disorder, especially if the student exhibits suicidal ideation.

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 the 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.

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 DSM-5 lists the behaviors that are associated with conduct disorders:

A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of at least 3 of the following criteria in the past 12 months from any of the categories below, with at least one criterion present in the last 6 months.

Symptoms

- Aggression to People and Animals
 - Often bullies, threatens, or intimidates others.

- Often initiates physical fights.
- Has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun).
- Has been physically cruel to people.
- Has been physically cruel to animals.
- Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery).
- Has forced someone into sexual activity.
- Destruction of Property
 - Has deliberately engaged in fire setting with the intention of causing serious damage.
 - Has deliberately destroyed others' property (other than by fire setting).
- Deceitfulness or Theft
 - Has broken into someone else's house, building, or car.
 - Often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others).
 - Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery).
- Serious Violations of Rules
 - Often stays out at night despite parental prohibitions, beginning before age 13 years.
 - Has run away from home overnight at least twice while living in the parental or parental surrogate home, or once without returning for a lengthy period.
 - Is often truant from school, beginning before age 13 years.
 - The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.
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Oppositional Defiant Disorder (ODD)

Children with oppositional defiant disorder 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.

Symptoms

According to the DSM-5 the symptoms of oppositional defiant disorder include:

- Angry/Irritability Mood
- Often loses temper
- Is often touchy or easily annoyed
- Is often angry and resentful
- Argumentative/Defiant Behavior
- Often argues with authority figures or, for children and adolescents, with adults.
- Often actively defies or refuses to comply with requests from authority figures or with rules.
- Often deliberately annoys others.
- Often blames others for his or her mistakes or misbehavior.
- Vindictiveness
- Has been spiteful or vindictive at least twice within the past 6 months.

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 to work together to accurately identify whether a child has conduct disorder or oppositional defiant disorder. The following are guidelines for diagnosis to be made by a mental health professional.

The DSM-5 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 symptoms exhibited at least once per week for individuals who are 5 years or older. For those younger than 5 years, the behavior should occur on most days for a period of at least 6 months.
- The symptoms cause distress or impair work, school or social functioning.
- Symptoms do not occur during psychotic, substance abuse, depressive, or bipolar disorder. Also, criteria are not met for disruptive mood dysregulation disorder.
- Symptoms do not fulfill criteria for Conduct Disorder.
- If over age 18, ensure the individual does not meet the criteria for Antisocial Personality Disorder.

When a behavioral health professional diagnoses 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.

What Schools Can Do

Educational Interventions

- Provide an environment that is structured, predictable, and conducive to learning. Seat the student where there is minimal 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 instructions.
- 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.
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Mental Health Interventions (licensed mental health professionals only)

- A licensed mental health professional, a psychologist, social worker or family therapist, works 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.

- 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 symptoms.

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.

Attention-Deficit / Hyperactivity Disorder

Attention-Deficit Disorder (ADD) was renamed Attention-Deficit/Hyperactivity Disorder (ADHD) in 1994. 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 ADHD is a biologically based disorder with a strong genetic connection, and 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 although it is not understood why this is the case.

The Centers for Disease Control and Prevention (CDC) claim that recent surveys show approximately 11% of children 4-17 years of age (6.4 million) have been diagnosed with ADHD as of 2011. 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.

Symptoms

There are three different types of ADHD - predominantly inattentive, predominantly hyperactive/impulsive, and combined, each with their own set of symptoms. According to the DSM-5 the symptoms for the types of ADHD are as follows:

The predominantly inattentive type (formerly ADD):

- Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate).

- Often has difficulties sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading).
- Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).
- Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked) (not due to oppositional behavior or failure to understand instructions).
- Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines).
- Often avoids, dislikes or is reluctant to engage in tasks that require sustained mental efforts (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).
- Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, keys)
- Is often easily distracted by extraneous stimuli (for older adolescents and **adults this may include unrelated thoughts**).
- Is often forgetful in daily activities (e.g., doing chores, running errands, for older adolescents and adults).

The predominantly hyperactive/impulsive type:

- Often fidgets with or taps hands or feet or squirms in seat.
- Often leaves seat in classroom or in other situations in which remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place).
- Often runs about or climbs in situations in which it is inappropriate (Note: in adolescents or adults it may be limited to subjective feelings of restlessness).
- Often unable to play or engage in leisure activities quietly.
- Is often "on the go" or acts as if "driven by a motor" (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with).
- Often talks excessively.
- Often blurts out an answer before a question has been completed (e.g., completes people's sentences; cannot wait for turn in conversation).
- Often has difficulty waiting his or her turn (e.g., while waiting in line).
- Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people's things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).

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.

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 to work together to accurately identify whether a child has ADHD. The following are guidelines for diagnosis.

The DSM-5 has identified that to be diagnosed with ADHD an individual must display:

Inattention:

Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities.

Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.

Hyperactivity and impulsivity:

Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and negatively impacts directly on social and academic/occupational activities.

Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or a failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.

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 who 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.
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Mental Health Interventions (licensed mental health professionals ONLY):

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.

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

1. Medical/Psychiatric Interventions

The main ADHD medications include stimulants, non-stimulants 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

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 to compensate for feelings and emotions that may otherwise seem overwhelming.

According to the DSM-5 here are the diagnostic criteria/symptoms that are used to identify an eating disorder:

Pica

- Persistent eating of nonnutritive, nonfood substances over a period of at least 1 month.
- The eating of nonnutritive, nonfood substances is inappropriate to the developmental **level of the individual.**
- The eating behavior is not part of a culturally supported or socially normative practice.
- If the eating behavior occurs in the context of another mental disorder (e.g., intellectual disability [intellectual developmental disorder], autism spectrum disorder, schizophrenia) or medical condition (including pregnancy), it is sufficiently severe to warrant additional clinical attention.

Rumination Disorder

- Repeated regurgitation of food over a period of at least 1 month. Regurgitated food **may be re-chewed, re-swallowed, or spit out.**
- The repeated regurgitation is not attributable to an associated gastrointestinal or other medical condition (e.g., gastro-esophageal reflux, pyloric stenosis).
- The eating disturbance does not occur exclusively during the course of anorexia nervosa, bulimia nervosa, binge-eating disorder, or avoidant/restrictive food intake disorder.

- If the symptoms occur in the context of another mental disorder (e.g., intellectual disability [Intellectual developmental disorder] or another neurodevelopmental disorder), they are sufficiently severe to warrant additional clinical attention.

Specify if: In remission- After full criteria for rumination disorder were previously met, the criteria have not been met for a sustained period of time.

Avoidant/Restrictive Food Intake Disorder

According to the DSM-5, this is an eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:

- Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
- Significant nutritional deficiency.
- Dependence on enteral feeding or oral nutritional supplements.
- Marked interference with psychosocial functioning.
- The disturbance is not better explained by lack of available food or by an associated

culturally sanctioned practice.

- The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced.
- The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.

Anorexia Nervosa

- Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.
- Intense fear of gaining weight or of becoming fat or persistent behavior that interferes with weight gain, even though at a significantly low weight.
- Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Specify whether:

Restricting type: During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.

Binge-eating/purging type: During the last 3 months, the individual has engaged

in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Bulimia Nervosa

• Recurrent episodes of binge eating. An episode of binge eating is characterized by **both of the following:**

- Eating, in a discrete period (e.g., within any 2-hour period), an amount of food that is larger than what most individuals would eat in a similar period of time under similar circumstances.
 - A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
- Recurrent inappropriate compensatory behaviors to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.
- The binge eating and inappropriate compensatory behaviors both occur, on average,

at least once a week for 3 months.

- Self-evaluation is unduly influenced by body shape and weight.
- The disturbance does not occur exclusively during episodes of anorexia nervosa.

Binge-Eating Disorder

• Recurrent episodes of binge eating. An episode of binge eating is characterized **by both of the following:**

- Eating, in a discrete period (e.g., within any 2-hour period), an amount of food that is definitely larger than what most people would eat in a similar period of time under similar circumstances.
 - A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
- The binge-eating episodes are associated with three (or more) of the following:
- Eating much more rapidly than normal.
 - Eating until feeling uncomfortably full.
 - Eating large amounts of food when not feeling physically hungry.
 - Eating alone because of feeling embarrassed by how much one is eating.
 - Feeling disgusted with oneself, depressed, or very guilty afterward.
- Marked distress regarding binge eating is present.
- The binge eating occurs, on average, at least once a week for 3 months.
- The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

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 based on 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 are 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 danger from eating disorders to physical health, it is important to share concerns with 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.

Post-Traumatic Stress Disorder (PTSD)

Post-traumatic stress disorder (PTSD) is an individual’s response to a traumatic event that exceeds one’s coping resources. All the following information is for PTSD in children over the age of six. According to the American Psychological Association (APA) as many as two thirds of adolescents’ report experiencing a traumatic event by age 16. PTSD is described in the DSM-5 as caused by the “exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

- Directly experiencing the traumatic event(s).
- Witnessing, in person, the event(s) as it occurred to others.
- Learning that the traumatic event(s) occurred to a close family member or friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
- Experiencing repeated or extreme exposure to aversive details of the traumatic event(s).”

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, or 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.

Diagnosis of PTSD should be based on the DSM-5. The following should serve as a summary of the criterion but is not exhaustive.

- Exposure to actual or threatened death, serious injury, or sexual violence (the exposure can be directly experienced or witnessed traumatic event(s), or learned of the traumatic event(s) that occurred to a close family member or friend, or by experiencing repeated or extreme exposure to aversive details of the event(s)).
- Presence of Intrusion Symptoms can be expressed through recurrent, involuntary, and intrusive distressing memories of the event(s), distressing dreams, dissociative reactions, or intense or prolonged psychological distress at the exposure to cues or symbols in which the adolescent feels as though the event(s) is recurring.
- In children older than 6 years, repetitive play may occur that includes themes or aspects of the traumatic event(s), frightening dreams may not have recognizable content and trauma-specific reenactment may occur in play.
- Persistent avoidance of stimuli associated with the traumatic event(s) beginning after the traumatic event(s) occurred. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or associated with the traumatic event(s), i.e.: any event(s) or avoiding external reminders (people, places, conversations, activities, objects, situations).
- Negative alterations in cognitions and mood associated with the traumatic event. Inability to remember an important aspect of the traumatic event(s), expressed by exaggerated negative beliefs or expectations about oneself, others or the world, distorted cognitions about the cause of the event(s) that lead to the individual blaming himself/herself or others, persistent negative emotional state, diminished interest in significant activities, feelings of detachment or estrangement from others, and inability to experience positive emotions.
- Alterations in arousal reactivity associated with the traumatic event(s) expressed through: irritable behavior and anger outbursts, reckless or self-destructive behaviors, hypervigilance, exaggerated startle response, problems with concentration or sleep disturbances.

Symptoms

In children and adolescent's 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
- Avoidance.

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. 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 were 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. The symptoms should have lasted longer than 1 month, causing significant impairment in an area of functioning such as social, or school. The symptoms are not attributable to the effects of a substance.

What Schools Can Do

Early intervention following a trauma is critical, with an emphasis on 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 response is required by [New Mexico Administrative Code 6.12.6.8](#): “a plan addressing the behavioral health needs of all students in the educational process by focusing on students’ social and emotional wellbeing” with school safety plans at each school building.

For school mental health counselors, the recommended treatment for adolescents suffering from PTSD are cognitive-behavioral therapies and more specifically trauma-focused Cognitive Behavioral Therapy (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-schoolspfa>

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 crisis situations mentioned above children are often victims/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.

Trauma Fact Sheet for Educators

One out of every four children attending school has been exposed to a traumatic event that can affect learning and/ or behavior.

FACT: Trauma can impact school performance.

- Lower GPA
- Higher rate of school absences
- Increased drop-out
- More suspensions and expulsions
- Decreased reading ability

Single exposure to traumatic events may cause jumpiness, intrusive thoughts, interrupted sleep and nightmares, anger and moodiness and /or social withdrawal – any of which can interfere with concentration and memory.

FACT: Trauma can impair learning.

- Adversely affect attention, memory, cognition
- Reduce a child’s ability to focus, organize and process information
- Interfere with effective problem solving and /or planning
- Result in overwhelming feelings of frustration and anxiety

Chronic exposure to traumatic events, especially during a child’s early years, can result in the following

FACT: Traumatized children may experience physical and emotional distress.

- Physical symptoms like headaches and stomachaches
- Poor control of emotions
- Inconsistent academic performance
- Unpredictable and/or impulsive behavior
- Over or under-reacting to bells, physical contact, doors slamming, sirens, lighting, sudden movements
- Intense reactions to reminders of their traumatic event:
 - Thinking others are violating their personal space, i.e., “What are you looking at?”
 - Blowing up when being corrected or told what to do by an authority figure
 - Fighting when criticized or teased by others
 - Resisting transition and/or change

FACT: The child who has been traumatized can be helped.

- Follow the school’s reporting procedures if abuse is suspected.
- Work with the child’s caregiver(s) to share and address school problems.
- Refer to community resources when a child show signs of being unable to cope with traumatic stress.
- Share Trauma Facts for Educators with other teachers and school personnel.

Please visit www.NCTSN.org for specific information on Psychological & Behavioral Impact of Trauma: High School Student examples and many other trauma related links.

Suicidal Ideation

Suicide attempts can be considered a symptom of depression. A suicide death is a devastating event for everyone, including the school. Therefore, it is worthwhile for educators to learn more about suicide specifically. There is some evidence that a suicide death of one student may lead to suicide attempts and/or completions by other students in the same school because of a “contagion” or copycat effect.

According to the Substance Abuse and Mental Health Services Administration’s (SAMHSA) *Preventing Suicide: A Toolkit for High Schools* guidebook “risk factors for suicide refer to personal or environmental characteristics that are associated with suicide. The environment includes the social and cultural environment as well as the physical environment. People affected by one or more of these risk factors may have a greater probability of suicidal behavior. Some risk factors cannot be changed—such as a previous suicide attempt—but they can be used to help identify someone who may be vulnerable to suicide.”

SAMHSA notes that there is no “agreed-upon” list regarding risk factors of youth suicide. However, SAMHSA does provide a list of risk factors identified by the most recent research:

Behavioral Health Issues/Disorders

- Depressive disorders
- Substance abuse or dependence (alcohol and other drugs)
- Conduct/disruptive behavior disorders
- Other disorders (e.g., anxiety disorders, personality disorders)
- Previous suicide attempts
- Self-injury (without intent to die)
- Genetic/biological vulnerability (mainly abnormalities in serotonin functioning, which can lead to some of the behavioral health problems listed above).

Note: The presence of multiple behavioral health disorders (especially the combination of mood and disruptive behavior problems or substance use) increases suicide risk.

Personal Characteristics

- Hopelessness,
- Low self-esteem,
- Loneliness,
- Social alienation and isolation, lack of belonging,
- Low stress and frustration tolerance,
- Impulsivity,
- Risk taking, recklessness,
- Poor problem-solving or coping skills,
- Perception of self as very underweight or very overweight,
- Capacity to self-injure,
- Perception of being a burden (e.g., to family and friends).

Adverse/Stressful Life Circumstances

- Interpersonal difficulties or losses (e.g., breaking up with a girlfriend or boyfriend),
- Disciplinary or legal problems,
- Bullying, either as victim or perpetrator,
- School or work problems (e.g., actual, or perceived difficulties in school or work, not attending school or work, not going to college),
- Physical, sexual, and/or psychological abuse,
- Chronic physical illness or disability,
- Exposure to suicide of peer.

Risky Behaviors

- Alcohol or drug use,
- Delinquency,
- Aggressive/violent behavior,
- Risky sexual behavior.

Family Characteristics

- Family history of suicide or suicidal behavior,
- Parental mental health problems,
- Parental divorce,
- Death of parent or other relative,
- Problems in parent-child relationship (e.g., feelings of detachment from parents, inability to talk with family members, interpersonal conflicts, family financial problems, family violence or abuse, parenting style either under protective or overprotective and highly critical).

Environmental Factors

- Negative social and emotional environment at school, including negative attitudes, beliefs, feelings, and interactions of staff and students,
- Lack of acceptance of differences,
- Expression and acts of hostility,
- Lack of respect and fair treatment,
- Lack of respect for the cultures of all students,
- Limitations in school physical environment, including lack of safety and security,
- Weapons on campus,
- Poorly lit areas conducive to bullying and violence,
- Limited access to mental health care,
- Access to lethal means, particularly in the home,
- Exposure to other suicides, leading to suicide contagion,
- Exposure to stigma and discrimination against students based on sexual orientation; gender identity; race and ethnicity; disability; or physical characteristics, such as overweight. Stigma and discrimination lead to:
 - Victimization and bullying by others, lack of support from and rejection by family and peers, dropping out of school, lack of access to work opportunities and health care,
 - Internalized homophobia, stress from being different and not accepted, and stress around disclosure of being gay, which can lead to low self-esteem, social isolation, and decreased help-seeking,
 - Stress due to the need to adapt to a different culture, especially reconciling differences between one's family and the majority culture, which can lead to family conflict and rejection.

Symptoms/Warning Signs for Suicide and Corresponding Actions

Seek immediate help from a mental health provider, 9-1-1 or the local emergency provider,

New Mexico Crisis and Access Line 1-855-662-7474 or

National Suicide Prevention Lifeline at 1-800-273-TALK (8255)

When you hear, or see any one of these behaviors:

- Someone threatening to hurt or kill themselves.
- Someone looking for ways to kill themselves: seeking access to pills, weapons, or other means.
- Someone talking or writing about death, dying, or suicide, when these actions are out of the ordinary for the person.

OR:

If you witness, hear, or see anyone exhibiting one or more of these behaviors:

- Hopelessness—expresses no reason for living, no sense of purpose in life,
- Rage, anger, seeking revenge,
- Recklessness or risky behavior, seemingly without thinking,
- Expressions of feeling trapped—like there's no way out,
- Increased alcohol or drug use,
- Withdrawal from friends, family, or society,
- Anxiety, agitation, inability to sleep, or constant sleep,
- Dramatic mood changes,
- No reason for living, no sense of purpose in life.

What Schools Can Do

No individual 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 notice signs of mental distress and how to respond to a student's request for help. In addition, every school system and every school should have a crisis protocol (policy & procedures), a crisis team, and have knowledge of community resources that are available to appropriately handle students who exhibit suicidal behavior and any other crisis situations.

Every school should have a crisis protocol, a crisis team, and community resources available to deal with suicidal students and other crisis situations.

- 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 potential risk assessment can occur immediately.
- Do not leave a suicidal individual alone. 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 should 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 updated 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.

Developing a Youth Suicide Response Plan

Collaboration and coordination between the school district, its various schools, the School Based Health Center (if applicable), community agencies, and regional hospitals 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 i.e. reintegration plan for student upon returning to school
- On-going training and practice of the suicide prevention plan for entire staff

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 assessments of ideation, 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 any student

General Guidelines for Assessing Suicide Risk	
<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 lethal 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/guardian. • 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 “safety 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 student’s behavior and expressed intent. <ul style="list-style-type: none"> - Student may only be released to parents or someone equipped to provide help. - 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.

that they believe may be at risk for suicide to designated faculty crisis responder (usually school nurse or social worker).

<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. 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, 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 collaborative safety plan based on student's strengths, resources, and coping skills.
- Move to the safety planning process, using the information learned during the initial intervention to create an individualized safety plan.
- 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 in suicide crisis. It should include the way the 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.
- In collaboration with the student both 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 to the student.
- The student should be helped to identify coping resources and personal strengths.
- The safety plan should include removing potentially lethal means of pursuing suicide and plans for formal follow up (e.g. next appointment with clinician or another provider). Lack of willingness to adhere to a safety plan 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 in suicide crisis. It should include the way the 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 needs 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.
- Communication with School Health Officer (See Adverse Event Reporting Form Section II Resources)
- 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.

Non-Suicidal Self-Injury (NSSI)

Non-suicidal self-injury (NSSI) can also be known as self-mutilation, self-harm, or self-abuse, but it is most commonly known as cutting. NSSI is any deliberate, non-suicidal behavior or physical harm that a person self-inflicts on their body and is primarily aimed at relieving emotional distress. NSSI is a maladaptive coping mechanism used to deal with extreme stress or painful emotions. There are many different reasons for NSSI, some reasons might be to avoid feeling numb, lonely, to stay alive, or sometimes clusters of cutting behaviors form in social groups. The behavior of NSSI may be an expression of a more serious mental illness such as borderline personality disorder or dissociative disorder. NSSI is listed as one of the criteria for borderline personality disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

Signs

Most often any type of sharp object is used for self-injurious behavior, such as (but not exclusively) a razor from a pencil sharpener, thumb tacks, knife, paper clip, scissors, disassembled shavers, or a pencil eraser. The most common NSSI behaviors are:

- Cutting
- Burning the skin
- Hitting
- Poking
- Picking
- Scratching
- Biting oneself
- Punching oneself.

Other indications to consider could be:

- Frequent or unexplained scars, cuts, bruises, or burns
- Social emotional isolation
- Disconnectedness
- Substance misuse
- Possession of sharp objects.

In addition, general signs of depression and extreme risky behaviors are other indicators to consider.

If cutting behaviors are present, the injury could be anywhere on the arms, wrists, hands, stomach, legs or in between the toes. It is not uncommon for someone to cover up their wounds by wearing long sleeved shirts or jackets when it is not appropriate for the weather. However, others might display their wounds openly. If any NSSI behaviors are observed, regardless of the severity, knowledge of the behavior requires staff to step into action by following up with the proper intervention and care to prevent further self-injury or potential wound infection due to the self-injurious behavior.

Is It a Suicide Attempt?

Non-suicidal self-injury is not always an attempt to suicide. When youth self-injure or cut themselves, they are expressing their inner pain which might be keeping them from suicide. Nevertheless, there is an increased risk for suicidal behavior for those who self-injure. It is recommended as best practice to assess and make the necessary referrals for suicide risk assessment when youth self-injure or cut themselves.

What Schools Can Do

If any signs of NSSI are visible on a student, staff should:

- Approach the student in a calm and caring matter-remember it could be easy to be shocked or in disbelief, and staff should keep their emotions under control.
- Never leave the student alone.
- Listen and be available to the student.
- Inform the student that you are required to report this.

- Emphasize to the student that they are not in trouble nor will they be punished.
- Ensure a safe transfer of the student to a school counselor, social worker, and/or nurse.
- Notify a school administrator.

Schools can appropriately manage NSSI behavior by providing annual and routine mock training to every staff member of the school. This training should include:

- Policy and procedures on NSSI.
- Identification and response to NSSI.
- Referral and follow-up to NSSI.
- Required/not required notification process (parents, staff members, CYFD, etc.)
- Linkages and coordination with community mental health resources.

It is important to incorporate best practice into your school policy and procedures when implementing NSSI interventions. Whether individual schools or entire school districts, it is recommended to identify and fully implement a crisis team. The crisis team should receive comprehensive training on how to address and manage NSSI behavior on campus and develop student safety procedures.

Preventing Social Contagion

Social contagion is the manner of behavior (i.e. self-harming) that can spread among members of a group after finding out their peer has engaged in that same behavior. To prevent social contagion in schools, school staff must:

- Reduce communication around self-injury by advising students not to explicitly talk with other students.
- Do not convene a school-wide assembly on the topic.
- Do not discuss with the students how or why the youth hurt themselves.
- Do not conduct a group setting intervention.
- Assist in the management of scars and wounds of those students who self-injure. Visible scars, wounds, and cuts should be discouraged.

Social media is another form of communication that is a perfect venue for the spread of self-injurious behavior among social groups. School staff should encourage parent(s) or guardian(s) to monitor their children’s social media accounts, and encourage them to talk with their children when self-injurious behaviors are mentioned or displayed, as well as immediately informing a responsible adult to help others stay safe.

What Schools Can Do

Best practices indicate that school staff should:

- Educate students about the signs of distress in themselves and others.
- Teach the use of positive coping skills and provide access to mental health resources.
- Keep conversations regarding self-injury amongst those who “need to know” and in a private setting.
- Focus on preventing imitative behaviors.
- Provide ongoing monitoring of students by all staff and parents.
- When self-injury is identified, provide immediate and appropriate services and referrals for the student.

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 experience 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 or seek help for an underlying problem – in this case, fear of tests or in more serious situations the fear of parental reactions, abuse/neglect.

Symptoms

According to the DSM-5 a Somatic Symptom Disorder diagnosis must meet the following criteria:

- One or more somatic symptoms that are distressing or result in significant disruption of daily life.
- Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:
 - Disproportionate and persistent thoughts about the seriousness of one’s symptoms
 - Persistently high level of anxiety about health or symptoms
 - Excessive time and energy devoted to these symptoms or health concerns.
 - Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months)

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 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, most 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 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 Medication: Use with Children and Adolescents

Ensuring Quality Care

School nurses play an integral role in promoting quality student care. When a student requires a 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). The CDC claims that Data from the National Health and Nutrition Examination Survey shows approximately 6.0% of U.S. adolescents aged 12–19 reported psychotropic drug use in the past month.

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 several 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:

- 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.
- 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:

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

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 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.

Signs of stress after a divorce

All the following behaviors may be indicative of normal reactions to divorce if 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 having trouble. 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.

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 **DO 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, 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.

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.

How Grief Manifests for Children and Teenagers

Although everyone grieves differently when a family member, loved one, or close friend dies, there 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 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 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 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

Child Abuse and Neglect

Report suspected child abuse or neglect by calling #SAFE (#7233) from a cell phone or 1-855-333-SAFE. Child Protective Services (CPS) strives to enhance the safety, permanency, and well-being of children and families in New Mexico. We believe that a concern for children extends to all children in New Mexico, not just our own.

CPS receives reports of alleged child maltreatment 24 hours a day, seven days a week, through Statewide Central Intake at 1-855-333-SAFE (7233) or #SAFE from cell phones. CPS investigate reports of child maltreatment and intervene to keep New Mexico's children safe. CPS provides foster care to approximately 2,500 children each day and works with families to enable parents to safely and appropriately care for their children. When that cannot be accomplished, CPS workers find safe, permanent families for children through adoption or permanent guardianship.

What Schools Can Do

Child abuse and neglect are serious and widespread problems, but it can be interrupted and prevented. School personnel can play a key role in the identification and reporting of suspected child abuse.

The New Mexico Children's Code (32A-4-1 NMSA through 32A-4-34 NMSA) sometimes cited as the Abuse and Neglect Act, states that physicians, law enforcement officers, nurses, school personnel and others acting in official capacities who SUSPECT abuse must report it immediately to the local offices of the Children, Youth, and Family Department (CYFD), Social Services Division in their respective communities or appropriate tribal social services offices. All certified school personnel, including school nurses, are required to complete training in the detection and reporting of child abuse and neglect during the person's first year of employment by a school district in New Mexico (22A-10-32 NMSA).

When a child discloses indicators discussed in the following pages, it does not prove conclusively that a child is abused or neglected. He/she may tell a story that seems difficult to believe, but the story should be taken seriously and the child's concerns explored.

The presence of more than one indicator combined with other information warrants further assessment by CYFD. School employees do not need to substantiate abuse before reporting it to CYFD. They only need to SUSPECT it. In New Mexico, the CYFD or appropriate tribal social service office investigates all reports of suspected child abuse or neglect.

Reporting Child Abuse/Neglect

- CYFD maintains the NM Statewide Central Intake (SCI) system which is housed in Albuquerque for reporting suspected or known child abuse/neglect. It can be accessed state-wide through a hotline 1-855-333-SAFE (7233) or #SAFE from cell phones. Detailed information on reporting suspect abuse/neglect is available at: <https://cyfd.org/child-abuse-neglect/reporting-abuse-or-neglect>.
- Reports are more likely to result in appropriate action and/or investigation if the following information is available at the time the report is being made.
- Name of child, parent and legal guardian, address where child resides
- Age, sex, SS# of child
- Family composition, language spoken in home
- Location of the child at time of reporting
- Location where suspected abuse occurred
- Name and address of person alleged to be responsible for abuse/neglect
- Nature and extent of suspected abuse or neglect
- Names of other professionals in contact with child
- Past history of child/family
- Child's affect
- Any disability the victim may have
- History of domestic violence, substance abuse/mental illness, or criminal activity

Physical Indicators of Abuse

The following information is presented for reference for school health providers when concerns arise of child abuse (physical and sexual) and neglect. Keep in mind that some of the indicators and behaviors presented here are seen in children who are experiencing stress within their families. Family problems such as domestic violence, alcoholism, or parental absence may affect a child's physical and mental health. A key element in assessing the possibility of child abuse is checking to see if the child can offer a reasonable explanation for his/her behavior and/or physical findings. A history that is not consistent with injuries or observed behaviors is a key factor in deciding whether abuse has occurred.

Physical Abuse

When physical abuse occurs, the signs are often visually evident but may go unnoticed and/or be considered normal for an active child. Here are some signs that may trigger suspected abuse for a health care provider.

Bruises in various stages of healing

- on the face, lips, mouth, torso, back, buttocks, or thighs
- forming a pattern/imprint reflecting the shape of the article that was used to inflict the mark on the body
- on different skin surfaces of the body inconsistent with the history of the injury
- regularly appearing bruises after absence, weekend, or vacation

Burns for which the child has no explanation

- classic cigar or cigarette burns on the soles, palms, back or buttocks
- sock-like or glove-like intentional immersion burns on the extremities that may be doughnut shaped on buttocks or genitalia and spare creases of the body
- intentional burns leaving a characteristic imprint pattern on the skin surface such as curling iron, electric burner, iron, or heated objects
- infected burns as result of delay in seeking treatment

Deformities with accompanying swelling/pain suspicious of fractures/dislocations

- commonly of extremities, skull, nose, or facial structure
- multiple fractures in various stages of healing revealed on medical evaluation

Lacerations, abrasions, injuries, or hair loss/bald patches on a child with no reasonable or consistent explanation offered

- seen most often on the child's face, eyes, internal and external oral area, genitalia, buttocks, and anus
- injuries in various stages of healing
- circumferential ligature marks may be the result of "rope burns" around the ankles, wrists, and neck
- hair loss usually in patches and potentially the result of forceful pulling

Sexual Abuse

Indicators of sexual abuse are more likely to be subtle and behavioral in nature; however, physical indicators of sexual abuse may include the following signs.

- New onset of difficulty walking or sitting
- Bloody, stained, or inappropriately soiled underwear (leaves and dirt inside present on outer clothing) underwear but not
- Swelling, bruising, lacerations, or bleeding in genital or anal area
- Pregnancy
- Pain or bleeding on urination
- Vaginal/penile discharge and/or odor
- Sexually transmitted infections (STIs)
- Poor sphincter tone (poor bowel or bladder control).

Neglect and Emotional Abuse

The effects on children of neglect and emotional abuse are long term and are more likely to manifest by chronic physical and mental ill health. The health care provider may observe any or all the following neglect and emotional abuse signs and symptoms.

- Unattended physical problems and unmet medical needs of the child
- Underweight child or small stature for age with no known medical diagnosis to explain condition (failure to thrive)
- Normal intelligence but showing deficiencies in areas of intellectual and motor development
- Inappropriate care consistent with hunger, poor hygiene, and unsuitable clothes for climate

Behavioral Indicators of Abuse

Behavioral indicators of abuse are nonspecific; the child who is experiencing sexual abuse may demonstrate the same behavior as a child who is experiencing emotional abuse. For example, sexual or emotional abuse of a five-year-old child may result in a behavior change such as “wetting his/her pants”.

The observer should keep in mind that a sudden change in behavior is more concerning than observation of a behavior which has always been present in that child. The observer should be aware that many factors can influence a child’s behavior. Family difficulties such as domestic violence, drug addiction, parental loss will also result in behavioral changes in a child.

Behavior indicators seen in children who may be abused or neglected might include emotional changes, school problems, inappropriate sexual behavior, signs of neglect.

Emotional Changes

- Withdrawal, depression, or expression of suicidal thoughts (e.g., I want to die, I should just go away, I feel like killing myself)
- Child demonstrates anger by violent or self-abuse acts
- Child demonstrates unreasonable fearful reactions to normal circumstances (e.g., a child who is afraid to be alone in a room)
- Younger child demonstrates new clingy or irritable behavior (e.g., always wants to sit in the teacher’s lap or cries, becomes angry, lashes out with little provocation).

School Problems

- New onset of poor concentration or decreased attention span
- Consistently demonstrates fatigue or listlessness (e.g., falling asleep in class)
- Delinquent or anti-social behaviors (e.g., stealing, violence or threatened violence towards classmates)
- Truancy or frequent absences from class
- Dramatic change in academic achievement
- Unwillingness to change for or participate in physical education class
- Poor peer relationships/friendless (e.g., a child no one wants to play with)
- Demonstration of low self-esteem by behavior or statements
- Demonstration of regressive behavior (e.g., a 6-year-old who now sucks her thumb, refuses to eat unless fed, and talks “baby talk”)
- Demonstration of fear of a specific person or situation or new onset of withdrawal (e.g. a child who previously went gladly with a caretaker now resists vigorously)

- Extension of stay at school with early arrival and late departure (e.g. abuse occurs at home and child is fearful to return).

Inappropriate Sexual Behavior

- Inappropriate displays or seeking of “affection” (e.g., attempts French kissing with teacher, sexually provocative dress or manner for developmental level)
- Demonstration of sophisticated, precocious knowledge of sex acts by engaging others in sexual acts (e.g. attempts oral sex on other children or inserts objects in another child’s anus or vagina)
- Inappropriate compulsive masturbation to the exclusion of other enjoyable activities
- Masturbation in a manner that could cause injury (e.g. inserts objects in vagina or anus).

Evidence of Neglect

- Begging for or stealing food at school
- Lack of appropriate supervision outside of school
- Child is alone for extended periods of time inappropriate to developmental level
- Child makes statements indicating no caretaker in the home
- Untreated medical condition (e.g. untreated seizures, asthma, ADD, ADHD, or diabetes).

Follow-up on Reporting

Any verbal statement from a child that he/she has been sexually or physically assaulted in any way constitutes suspicion of abuse and must be reported.

Collaboration between the schools and social services is strongly encouraged to maintain reliability and continuity of care. The school nurse can establish a working relationship with the local social service agency by contact and follow up with the assigned social worker/case manager. Consideration should be given to regular meetings with school nurses, other school staff and social services staff to establish and maintain an ongoing rapport.

Human and Sex Trafficking Awareness

According to the National Human Trafficking Resource Center, human trafficking is a form of modern-day slavery in which traffickers use force, fraud, or coercion to control victims for engaging in commercial sex acts or labor services against his/her will. Sex trafficking has been found in a wide variety of venues within the sex industry, including residential brothels, escort services, fake massage businesses, strip clubs, and street prostitution. Labor trafficking has been found in diverse labor settings including domestic work, small businesses, large farms, and factories.

Signs a child may be involved in human trafficking/sex trafficking may be considered normal or familiar adolescent behavior. Here are some signs that may trigger suspected human/sex trafficking for a health care provider.

Behavioral Indicators of a child sex trafficking victim:

- Inability to attend school on a regular basis and/or unexplained absences
- Frequently running away from home
- References made to frequent travel to other cities
- Bruises or other signs of physical trauma, withdrawn behavior, depression, anxiety, or fear
- Lack of control over a personal schedule and/or identification or travel documents
- Hunger, malnourishment, or inappropriate dress (based on weather conditions or surroundings)
- Signs of drug addiction
- Coached or rehearsed responses to questions
- Sudden change in attire, behavior, relationships, or material possessions (e.g., expensive items)
- Uncharacteristic promiscuity and/or references to sexual situations or terminology beyond age-specific norms
- A “boyfriend” or “girlfriend” who is noticeably older and/or controlling
- Attempt to conceal scars, tattoos, or bruises
- Sudden change in attention to personal hygiene
- Tattoos (a form of branding) displaying the name or moniker of a trafficker, such as “daddy”
- Hyperarousal or symptoms of anger, panic, phobia, irritability, hyperactivity, frequent crying, temper tantrums, regressive behavior, and/or clinging behavior
- Hypoarousal or symptoms of daydreaming, inability to bond with others, inattention, forgetfulness, and/or shyness.

Behavioral indicators for labor trafficking victim:

- Being unpaid, paid very little, or paid only through tips
- Being employed but not having a school-authorized work permit
- Being employed and having a work permit but clearly working outside the permitted hours for students
- Owning a large debt and being unable to pay it off
- Not being allowed breaks at work or being subjected to excessively long work hours
- Being overly concerned with pleasing an employer and/or deferring personal or educational decisions to a boss
- Not being in control of his or her own money
- Living with an employer or having an employer listed as a student’s caregiver
- Desire to quit a job but not being allowed to do so

What Schools Can Do

To build healthy learning environments, school personnel must be knowledgeable about the signs and symptoms of child trafficking, ways to support disclosure, and the steps to take if there is a strong suspicion of trafficking. If a school staff member notices a student who shows signs of potential trafficking, the first rule is to always pay attention. Learn about the school’s policies and protocols. If the school does not have clear policies and protocols, talk to the principal about instituting them. Share this information with school staff, administrators, school boards, and members of the community.

References Resources

U.S. Department of Health and Human Services resource guide

<https://www.mentalhealth.gov/talk/educators/index.html>.

ADHD Resources

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

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

CDC (2011) ADD/ADHD prevalence: <https://www.cdc.gov/ncbddd/adhd/data.html>

Child Abuse & Neglect Resources

Statewide Central Intake - #SAFE (#7233) from a cell phone or 1-855-333-SAFE

<https://cyfd.org/child-abuse-neglect/reporting-abuse-or-neglect>

<https://pulltogether.org/>

<https://pulltogether.org/resources-by-county>

Child Abuse & Neglect

<https://pulltogether.org/support/keep-my-children-safe/child-abuse-neglect>

Children's Code – Chapter 32A

<http://public.nmcompcomm.us/nmpublic/gateway.dll/?f=templates&fn=default.htm>

Developmental Stages Resources

Child Development Institute: Erickson Stages of Social-Emotional Development

<https://childdevelopmentinfo.com/child-development/erickson/>

Freud's Psychosocial Developmental Stages: <https://www.verywell.com/freuds-stages-of-psychosexual-development-2795962>

Kohlberg's Moral Development: <http://www.simplypsychology.org/kohlberg.html>

New Mexico Pediatric Society: <http://www.nmaap.org/#!resources/cxwa>

WebMD: Piaget's Developmental Stages: <http://www.webmd.com/children/piaget-stages-of-development>

Eating Disorder Resources

National Institute of Mental Health (2010) Eating disorder prevalence

<https://www.nimh.nih.gov/health/statistics/prevalence/eating-disorders-among-children.shtml>

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

National Eating Disorder Association. Educator Toolkit

<http://www.nationaleatingdisorders.org/educator-toolkit>

Grief and Loss Resources

National Child Traumatic Stress Network: <http://nctsnet.org/>

Santa Fe - Gerard's House Phone (505) 424-1800: <http://gerardshouse.org/>

Albuquerque -Children's Grief Center

Phone: 505-323-0478

Address: 3001 Trellis Dr. NW

Albuquerque, NM 87107

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

“In Depth General Information Guide to Childhood Traumatic Grief for School Personnel”
available at the link www.NCTSN.org.

Human & Sex Trafficking Awareness Resources
Pull Together.org <https://pulltogether.org/support/keep-my-children-safe/child-abuse-neglect>

National Human Trafficking Resource Center

505 Get Free Human Trafficking Safety and Support Services – The Life Link
<http://www.505getfree.org/>

505-470-0163 (office)
505-GET-FREE (text or voice hotline)<https://humantraffickinghotline.org/>

National Human Trafficking Hotline 1-888-373-7888

<https://humantraffickinghotline.org/what-human-trafficking/recognizing-signs>

Human Trafficking in American Schools Manual

<https://humantraffickinghotline.org/sites/default/files/Human%20Trafficking%20in%20Americas%20Schools%20-%20DoEd.pdf>

Video - Recognizing and Responding to Human Trafficking in a Healthcare Context

<https://humantraffickinghotline.org/resources/recognizing-and-responding-human-trafficking-healthcare-context>

Mental Health Concerns Resources

National Institute of Mental Health (2015) Major Depression among Adolescents.

<https://www.nimh.nih.gov/health/statistics/prevalence/major-depression-among-adolescents.shtml>

[U.S. Department of Health and Human Services, Mental Health.gov](http://www.mentalhealth.gov)

<https://www.mentalhealth.gov/talk/educators/index.html>

Non-Suicidal Self-Injury (NSSI) Resources

Cornell Research Program on Self-Injury and Recovery:

<http://www.selfinjury.bctr.cornell.edu/>

Self-Injury in Schools: <http://www.scar-tissue.net/schoolsipolicy.pdf>

Signs of Suicide: Middle School Program Self-Injury Packet:

http://educatorsandselfinjury.com/wp-content/uploads/2009/11/SOS-Self-injury-packet_2009.pdf

PTSD Resources

American Academy of Child and Adolescent Psychiatry. (2011). *Facts for Families:*

Posttraumatic Stress Disorder (PTSD). Washington, DC:

http://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/Facts_for_Families_Pages/Posttraumatic_Stress_Disorder_70.aspx

American Psychological Association (2008). Children and Trauma: Update for Mental Health

Professionals. Washington, DC: <http://www.apa.org/pi/families/resources/children-trauma-update.aspx>

American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental

Disorders (5th ed). Arlington, VA.

Hamblen, J., Barnett, E. (2012). *PTSD in Children and Adolescents*. Retrieved from:

<http://www.nctsn.org/content/psychological-first-aid>

National Child Traumatic Stress Network (NCTSN) is: <http://www.nctsn.org/>

New Mexico Administrative Code, Title 6 Chapter 12 Part 6

<http://ped.state.nm.us/nutrition/2014/final%20wellness%20rule%20revision%20for%208-15-14.pdf>

Psychotropic Medications Resources

Bostic, J. (2010). Evaluation of Medication Side Effects.

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.

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).

Centers for Disease Control and Prevention (CDC) (2013) Psychotropic Medication Use

Among Adolescents. <https://www.cdc.gov/nchs/products/databriefs/db135.htm>

New Mexico Law (Statutes)

<http://public.nmcompcomm.us/nmpublic/gateway.dll/?f=templates&fn=default.htm>

Somatic Complaints Resources

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

Suicide Crisis Response Resources

New Mexico Crisis and Access Line <http://www.nmcrisisline.com/> 1-855-662-7474

National Suicide Prevention Lifeline 1-800-273-8255

Substance Abuse and Mental Health Services Administration's (SAMHSA) *Preventing*

Suicide: A Toolkit for High Schools guidebook on suicide prevention

<http://store.samhsa.gov/shin/content//SMA12-4669/SMA12-4669.pdf>

<http://store.samhsa.gov/product/SMA12-4669>.

The Comprehensive School Health Manual, Massachusetts Department of Public Health

(<http://massclearinghouse.ehs.state.ma.us/SCH/SH3001R.html>)