Chapter 6

MENTAL HEALTH IN SCHOOLS

Counseling, Psychological, And Social Services

Mental, Emotional and Behavioral Disorders in Children and Adolescents

School Violence

Counseling, Psychological and Social Services

Possibly the most critical element to success within school is the student developing a close and nurturing relationship with at least one caring adult. Students need to feel that there is someone within school whom they know, to whom they can turn, and who will act as an advocate for them.[1]

Overview

Recent scientific research confirms that brain growth and neurophysiologic development during the first years of life respond directly to the influence—positive or negative—of early emotional relationships. The neurologic pathways produced during this early period have profound effects on the behaviors of children and adolescents, and affect their interactions with both their families and extended society. Contemporary American life, however, challenges families' abilities to promote successful developmental outcomes and emotional health for their children.

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

The school can also play a role in identifying children with emotional, behavioral, and mental health problems and ensuring that they get proper assessments and appropriate interventions. Mental health problems have a variety of causes and can be exacerbated by learning disabilities or physical health problems; some may have a physiological base; others may be a result of trauma or familial or social stresses and problems. Whatever the cause, there is a compelling reason for the school to be alert to these issues. While one in 10 children and teens suffers from an emotional or behavioral problem that would benefit from treatment, fewer than one in five of these children receive treatment in any one year.[2]

Counselors and other professionals working in schools are well positioned to serve as student advocates, family advisors, and community partners in supporting the well-being of children and families.[3] Schools and districts should develop policies to actively promote the mental health of their students through primary, secondary, and tertiary interventions aimed at students, families, and the community. The following section will discuss the roles of four particular school professionals—the counselor, the psychologist, the nurse, and the teacher—in promoting and fostering the mental health and welfare of children in Texas schools. These roles will often overlap in the day to day course of caring for students. However, with appropriate communication and team building on the part of these professionals, each can come to learn the various strengths and areas of expertise of the others, thereby promoting more efficient use of their and their students' time and energy. In addition to descriptions of their basic roles and functions, this section will look at several groups of students who are at higher risk for emotional and/or mental instability, and how these school personnel can best address those risks.

The Counselor

The professional school counselor is a certified/licensed educator who addresses the needs of students comprehensively through the implementation of a developmental school counseling program. School counselors are employed in elementary, middle/junior high, senior high, and post-secondary settings. Their work is marked by attention to age-specific, developmental stages of student growth and the needs, tasks, and student interests related to those stages. School counselors work with all students, including those who are considered "at risk" and those with special needs. They are specialists in human behavior and relationships that provide assistance to students through seven primary interventions:

- **Counseling (individual and small group):** A confidential relationship in which the counselor helps students to resolve or cope constructively with their problems and developmental concerns. The counseling process facilitates both the identification of students with special needs or who are "at risk," as well as the interpretation of assessment tests and other non-test student data. Group counseling is both efficient and effective, and can make it possible for more people to achieve a healthier personal adjustment, handle the stresses of a rapidly changing technological and complex environment, and learn to work and live with others. School

counselors facilitate many groups (e.g., parent education group, peer helpers group, student support group), as well as train others as group facilitators.

- **Pupil assessment:** Includes scheduling, performing, scoring, and interpretation of school testing. Counselors are also responsible for assisting students in evaluating their aptitudes and abilities through interpreting standardized tests. In so doing, they can guide the student towards the additional information they need to make career and transition decisions. They may advise teachers who need to understand psychological evaluations and who are interested in improving their content-referenced testing skills.

- **Large group guidance:** A planned, developmental program of guidance activities designed to foster students' academic, career, and personal/social development. It is provided for all students through a collaborative effort by counselors and teachers.

- **Consultation:** A collaborative partnership in which the counselor works with parents, teachers, administrators, school psychologists, social workers, visiting teachers, medical professionals, and community health personnel in order to plan and implement strategies to help students be successful in the education system. This may include test score interpretation, and in some schools the counselor advises school committees in the selection of tests.

- **Coordination/Administration:** A leadership process in which the counselor helps to organize, manage, and evaluate the school counseling program. This might include participation in decisions about instructional curriculum. The counselor assists parents in obtaining needed services for their children through a referral and follow-up process and serves as liaison between the school and community agencies so that they may collaborate in efforts to help students.

- **Information officer:** Includes informing parents, teachers, and staff about counseling services, informing employers and colleges about

students according to school policy, and ensuring two-way communication between school and home.

- **Research:** The counselor is expected to read and interpret literature to apply research findings to everyday counselees' situations and to improve his or her skills continuously through evaluation of counseling techniques.[4,5]

Professional school counselors are responsible for developing comprehensive school counseling programs that promote and enhance student learning. By providing interventions within a comprehensive program, school counselors focus their skills, time, and energies on direct services to students, staff, and families. The American School Counselor Association (ASCA) recommends that professional school counselors spend at least 70% of their time in direct services to students. ASCA considers a realistic counselor to student ratio for effective program delivery to be a maximum of 1:250.

Above all, school counselors are student advocates who work cooperatively with other individuals and organizations to promote the development of children, youth, and families in their communities. School counselors, as members of the educational team, consult and collaborate with teachers, administrators, and families to assist students to be successful academically, vocationally, and personally. They work on behalf of students and their families to insure that all school programs facilitate the educational process and offer the opportunity for school success for each student. School counselors are an integral part of all school efforts to insure a safe learning environment for all members of the school community.[6]

The Psychologist

School psychologists are mental health professionals trained to work in schools, community clinics, and a variety of other settings to address learning, behavior, and mental health issues. They use their training and skills to team with educators, parents, and other mental health professionals to ensure that every child learns in a safe, healthy, and supportive environment. School psychologists understand the factors that help children develop positive mental health, healthy behaviors, and academic and social competence.

School psychologists tailor their services to the particular needs of each child and each situation, using many different strategies. The following mental health services are typically provided within the context of general and special education:

Consultation/Case Management: Includes assisting teachers, parents, and children to better understand the relationships between child development, academic performance, and social skills in promoting positive mental health and healthy behavior. Psychologists also identify, promote, and coordinate school and community services and resources that will enhance learning, positive student behavior, attitudes, and psychological development.

Assessment/Diagnosis: Using a wide variety of techniques (e.g., classroom observation, interviews with teachers/staff) at an individual, group, and system level, school psychologists evaluate: psychological and social competence; personality and emotional development; learning environments and school climate related to health behaviors and barriers to learning; and the need for school-based or community mental health services and/or special education services.

Intervention/Treatment: Includes the following:

- Working face to face with children and families to address life stressors and barriers that interfere with positive adjustment;
- Helping students learn to solve conflicts and problems independently;
- Providing psychological counseling for children and families;
- Providing social skills training, behavior management, and coping strategies;
- Helping families, schools, and communities deal with crises, such as separation, loss or violent acts; and
- Working with students and families to provide integrated community services focusing on psychosocial wellness and other health-related issues.

Prevention/Early Detection: Includes the following:

- Increasing student, family, school, and community awareness of mental health stressors and strategies to provide supportive school environments for all learners;
- Screening for mental health and learning problems;
- Teaching parents and teachers the skills and strategies to cope with disruptive behavior;
- Helping to foster tolerance, understanding, and appreciation of diversity in the school community;
- Working with parents, teachers, and support personnel to create a healthy and safe school environment; and
- Partnering with school and community-based personnel to provide a comprehensive model of school-based mental health services.

Mental Health Education and Research: School psychologists provide training and participate in research activities regarding: psychosocial development; substance abuse; healthy sexuality; crisis prevention and management; coping with life stressors; professional development; generating new knowledge about learning and behavior; evaluating the effectiveness of violence prevention programs, behavior management systems, and other services; and planning and evaluating school-wide programs to promote healthy outcomes for all students.

Advocacy and Public Policy Development: Includes: consulting with public policymakers and advocating for legislation promoting mental health and education programs; identifying and seeking sources of funding for mental health and educational services; identifying and promoting community resources and outreach; and linking research-based practices to mental health advocacy and policy development.

School psychologists are well qualified to provide comprehensive, cost-effective mental health services given their broad-based training and experience, as well as their understanding of mental health within the school context. Their training emphasizes preparation in general psychological and educational principles; mental health assessment and treatment; child development; school organization; learning; behavior; and motivation, and involves a minimum of 60 graduate semester hours, including a year-long internship. To work as a school psychologist, one must be certified and/or licensed

by the state in which services are provided. Many school psychologists hold doctoral degrees.

The Nurse

Nurses should work within their school system to provide health information that considers the total human being in the educational process. School nurses work to: facilitate positive student responses to normal development; promote health and safety; intervene with actual and potential health problems; and actively collaborate with others to build student and family capacity for adaptation, self-management, self-advocacy, and learning. School nurses also help students cope with developmental, situational, social, financial, and emotional problems so that they will learn better.[7] Health counseling and education provided by the nurse can provide students with knowledge and skills in decision making, personal value identification, problem-solving, and communication and contact with a caring adult, all of which strengthen the self-esteem of the student.[8] One of the most important roles for the school nurse is being an advocate for the individual needs of children.

The school nurse will encounter students' mental health needs directly or indirectly. Children and adolescents may experience psychological or emotional distress through physical symptoms. It is common for an adolescent with depression to exhibit recurrent psychosomatic symptoms such as abdominal pain, chest pain, headache, lethargy, weight loss, dizziness, syncope, or other nonspecific complaints, any or all of which may lead to visits to the nurse. Girls or boys experiencing sexual abuse may present similarly, with anxiety-related symptoms ranging from asthma or colitis exacerbations to headaches and difficulty concentrating in school. An astute school nurse will recognize the need to evaluate physical symptoms carefully while considering the possibility of anxiety or depression as an underlying cause. The school nurse should inquire about the possibility of sexual or physical abuse if there is reason to suspect this. If abuse is disclosed the school nurse is mandated by law to report the abuse to Child Protective Services (CPS). More information about child abuse and reporting is located in Chapter 10 of this manual. The school nurse can refer these students to appropriate mental health services per school or district policy.[9]

Nurses need to be familiar with the kinds of psychosocial health issues that exist in their particular school and community, as well as in the school health community at large, and

to work within those areas to fill in existing gaps in their clinical knowledge. Nurses understand the physiological bases for psychological and affective symptoms, and can work with students to help them understand the connections between their minds and their bodies. This might include counseling students about the antidepressant effects of physical activity, or about how the proper balance of foods can promote better learning and concentration abilities.

The school nurse can provide the school community with invaluable information regarding mental and emotional health and stability. Workshops, classroom appearances, "mental" health fairs, and carefully planned postings of information in the office or clinic are just a few of the ways that nurses can communicate the message about good mental health to students and staff. Topics that might be included are: violence recognition and prevention, substance abuse, sexuality/abstinence and decision-making, and anger/stress management. Nurses can also provide input into school health curriculum and offer suggestions as to appropriate guest speakers or other health activities designed to foster students' understanding of their own mental health and well-being.

As a case manager, the nurse works to provide and evaluate comprehensive, coordinated health care and related services. Case management is a service model that focuses on the assessment of needs and planning a continuum of care for students and families. Studies have shown that families depend on nurses as a means of support when dealing with a child with a disability, and rely particularly on "helpful informational support."[10]

The Teacher

The teacher's role in promoting the emotional and mental well-being of their students is somewhat less specific than those of the psychologist, counselor, or nurse. Students spend the majority of their time with teachers, however, and signs and/or symptoms of emotional distress or instability may first be revealed in the classroom. Teachers should work actively with mental health professionals in the school system to learn about behavior that should prompt a referral. As part of an overall team within the school, teachers can provide valuable information to psychologists, nurses, parents, and others involved with the students' health and well-being.

The National Education Association has explicitly recognized the importance of education in the maintenance and promotion of stable, functional, healthy families and

the emotional, physical, and mental health of people within these families.[11] They also believe that programs should be established for both students and parents/guardians within the school system that promote:

- The development of self-esteem and positive self-concept in individuals of all ages in various family roles;
- The learning and practicing of positive interpersonal communication skills and conflict resolution;
- Education in human growth and development;
- Positive parenting techniques that include strategies to deal effectively with violent behavior; and
- An understanding of societal issues and problems related to children, spouses, parents/guardians, older generation family members, and other family members.[12]

Teachers have a very important role to play in building a positive classroom atmosphere for students. Topics and activities that can enhance the standard curriculum include: holding problem-solving class meetings; improving communication skills; teaching cooperation; helping students handle anger, frustration, and aggression; teaching tolerance of diversity; helping students to resolve conflicts with other students (and with adults); and providing opportunities for positive emotional expression.[13] The importance of teacher attitude has also been discussed by researchers.[14] It is suggested that teachers' expectations should be open and encouraging at all times in order to facilitate the development of self-esteem in their students. Suggestions for encouraging students include:

- Help students to work towards improvement, not perfection. Commend effort.
- Build on strengths and demonstrate faith in students.
- Stimulate and lead students without pushing them ahead of their own pace.
- Integrate all students into the group.
- Help students develop the courage to be imperfect. Help them to learn from their mistakes.

In addition, teachers can develop skills to foster the emotional growth of their students. These skills may be developed through workshops, in-service presentations provided by

the school psychology or counseling staff, or courses offered in the community.
Teachers can develop skills in crisis management, counseling methods, group discussion
and leadership, role-playing, stress/anger management, and recognition of students "at-
risk" for emotional problems (e.g., substance abuse, homosexuality, violence). In
general, there are six concepts that teachers can use to guide themselves towards
developing these skills:

- Understanding the special needs and psychological development of
  children and adolescents;
- Having knowledge of the typical emotional problems of normal
  development;
- Having knowledge of the development and self-esteem in children and
  adolescents;
- Understanding the interactions among school experiences, scholastic
  progress, and self-esteem;
- Understanding the positive and negative effects of praise on emotional
  growth; and
- Understanding emotional, academic, and intellectual readiness factors.

Mental Health In Schools[15]

Each day school nurses are confronted with many students who are doing poorly in
school as a result of health and psychosocial problems. Increasingly, school nurses find it
necessary to do something more than their original training prepared them to do.
There is enhanced emphasis on coordination and collaboration within a school and with
community agencies to provide the "network of care" necessary to deal with complex
problems over time. Thus, services in schools are expanding and changing rapidly.
Schools' efforts to address health and psychosocial problems encompass:

- Prevention and pre-referral interventions for mild problems;
- High visibility programs for high-frequency problems; and
- Strategies to address severe and pervasive problems.

New Roles for School Nurses

With continuing education, school nurses can join other mental health professionals in bringing specialized understanding of cause (e.g., psychosocial factors and pathology) and intervention (e.g., approaching problem amelioration through attitude and motivation change and system strategies). This knowledge can have many benefits. For instance, mental health perspectives of "best fit" and "least intervention needed" strategies can contribute to reduced referrals and increased efficacy of mainstream and special education programs. With respect to pre and in-service staff development, such perspectives can expand educators' views of how to help students with everyday issues as well as with crises and other serious problems -- in ways that contribute to positive growth. Specialized mental health understanding also can be translated into programs for targeted problems (e.g., depression, dropout prevention, drug abuse, gang activity, teen pregnancy).

Because they are inundated with students who need assistance for mental health and psychosocial concerns, a key service many school nurses find themselves providing is the identification and processing of such students. Major tasks in carrying out this service are

- Initial Problem Identification;
- Screening/Assessment;
- Client Consultation And Referral Triage; and
- Initial Case Monitoring.

Nurses also must be prepared to respond to students' psychological crises. And with respect to primary prevention and treatment, they often find themselves providing:

- Mental Health Education;
- Psychosocial Guidance And Support (Classroom/Individual); and
- Psychosocial Counseling.

They also are a valuable resource for ongoing case monitoring. This leads to the view that the range of functions nurses and other pupil service specialists should perform for schools are:

- Direct service activity (e.g., crisis intervention in emergency situations; short-term assessment and treatment, including facilitating referral and case management; prevention through promotion of physical and mental health and enhancing resources through supervising professionals-in-training and volunteers);

- Resource coordination and development (e.g., organizing existing programs; integrating with instruction through in-service mentoring and consultation; interfacing with community agencies to create formal linkages; preparing proposals and developing new programs; acting as an agent of change to create readiness for systemic reform and facilitating development of mechanisms for collaboration and integration; providing support for maintenance of reforms; participation on school governance and planning bodies);

- Enhancing access to community resources (e.g., identifying community resources; assisting families to connect with services; working with community resources to be more responsive to the needs of a district's students; community coalition building).

Initial Problem Identification

School nurses can play an active role in screening, identification, and referral of children with emotional, behavioral, and/or mental health problems. Many children will visit the school nurse's office during the day. Some children visit the nurse several times a day; these children are often known as "frequent fliers." Children who visit the nurse during the day with a variety of non-specific complaints are trying to communicate a concern they may not be able to express verbally. Some children may be having difficulty in the classroom and need a break from the tension of trying to succeed. Some children may be trying to work out a problem with their friends, or a problem at home, while other children may just be feeling sad and need comforting words from a familiar person.

It is important for the nurse to realize that "frequent fliers" are not just trying to waste time in the nurse's office but have a real need for which they are seeking help. The school nurse should be astute and realize that the child who is always trying to skip math class may be failing and may need help asking for additional tutoring or may even need an evaluation for a learning disorder. The nurse should consult with the child's teacher, counselor, and/or parent when a "frequent flier" is coming repeatedly to the office. This is a very sensitive area of practice, and frequently parents will respond by telling their

child not to "bother the nurse anymore." It is imperative that the nurse communicate clearly with the teacher and/or parent the need to work together to help the child feel more comfortable at school by helping the child understand what is upsetting him or her. School nurses should compile a list of mental health professionals in their area who are trained to care for children and their families.

The Pediatric Symptom Checklist (PSC) is a screening tool used frequently in pediatric practices to determine if a child's mood or behavior is enough to warrant a referral for mental health services.

> Several states (e.g., Arizona, Massachusetts) now recommend the PSC or other brief questionnaires for psychosocial screening during EPSDT, and a number of HMO's (Kaiser of Northern California, Neighborhood Health Plan of Massachusetts) are piloting the use of the PSC as a routine part of well-child visits. The PSC is also being used as a part of annual screenings in a variety of non-health care settings like Ventura County, California Head Start. A positive score reflects a high likelihood that a child is having significant psychosocial dysfunction. Although certain responses may suggest a diagnosis, the PSC is a screening tool and not diagnostic. If positive, the clinician should pursue a brief interview reviewing the child's major areas of functioning (school, family, activities, friends and mood). If this brief interview supports the PSC findings, the clinician then decides whether a follow-up appointment, further evaluation or referral is indicated.[16]

The PSC was developed by Dr. Jellinek from the Massachussets General Hospital. If a child has a positive screen the parent and/or school counselor should be notified (the PSC and scoring information are included as Exhibit 3, at the end of this chapter).

Connecting a Student with the Right Help
The process of connecting the student with appropriate help can be viewed as encompassing four facets:

> (1) Screening/assessment
> (2) Client consultation- and referral
> (3) Triage
> (4) Initial case monitoring

Screening; A Note of Caution

Formal screening to identify students who have problems or who are "at risk" is accomplished through individual or group procedures. Most such procedures are *first-level* screens and are expected to *over identify* problems. That is, they identify many students who do not really have significant problems (false positive errors). This certainly is the case for screens used with infants and primary grade children, but false positives are not uncommon when adolescents are screened. Errors are supposed to be detected by follow-up assessments.

Because of the frequency of false positive errors, **serious concerns arise when screening data are used to diagnose students and prescribe remediation and special treatment.** Screening data primarily are meant to sensitize responsible professionals. No one wants to ignore indicators of significant problems. At the same time, **there is a need to guard against tendencies to see *normal variations* in student's development and behavior as problems.**

Screens do not allow for definitive statements about a student's problems and need. **At best, most screening procedures provide a preliminary indication that something may be wrong**. In considering formal diagnosis and prescriptions for how to correct the problem, one needs data from assessment procedures that have greater validity.

It is essential to remember that many factors that are symptoms of problems also are common characteristics of young people, especially in adolescence. Cultural differences also can be misinterpreted as symptoms. To avoid misidentification that can inappropriately stigmatize a youngster, all screeners must take care not to overestimate the significance of a few indicators and must be sensitive to developmental, cultural, and other common individual differences.

Comments on Screening/Assessment and Diagnosis

When someone raises concerns about a student, one of the best tools a nurse can have is a structured referral form. This encourages the referrer to provide detailed information about the nature and scope of the problem. An example of such a form is provided at the end of this section.

Gather other available information about the student. It is good practice to gather information from several sources, including the student. Useful sources are teachers, administrators, parents, sometimes peers, etc. If feasible and appropriate, a classroom observation and a home visit also may be of use.

A nurse can perform a screening interview. The nature of this interview will vary depending on a age of the student and whether the concerns raised are general, about misbehavior and poor school performance, or specific, about lack of attention, overactivity, major learning problems, significant emotional problems such as appearing depressed and possibly suicidal, or about physical, sexual, or substance abuse. It is important to look for assets as well as weaknesses. Clarify the role of environmental factors in contributing to the student's problems.

Remember:

- Students often somatize stress (complain of physical pain when they are emotionally stressed); but remember that some behavioral and emotional symptoms stem from physical problems.

- The student may be exhibiting behavior that is fairly common at a particular development stage. Moreover, age, severity, pervasiveness, and chronicity are important considerations in diagnosis of mental health and psychosocial problems.

Client Consultation and Referral

When someone becomes concerned about a student's problems, one of the most important roles to play is assisting the individual in connecting directly with someone who can help. This involves more than referring the student or parents to a resource. The process is one of turning referral procedures into an effective intervention in and of itself. Minimally,

such an intervention encompasses consultation with the concerned parties, assisting them by detailing the steps involved in connecting with potential referral resources, and following-up to be certain of follow-through. It may also include cultivating referral resources to maximize their responsiveness to referrals.

Using all the information gathered, sit down with those concerned (student, family, other school staff) and explore what seems to be wrong and what to do about it. Such consultation sessions are part of a shared problem solving process during which the nurse can provide support by assisting the involved parties in:

- Analyzing the problem (Are environmental factors a concern? Are there concerns about underlying disorders?)
- Laying out alternatives (clarifying options/what's available)
- Deciding on a course of action (evaluating costs vs. benefits of various alternatives for meeting needs)

Finally, it is essential to work out a sound plan for ensuring there is follow-through on decisions. Thinking in terms of intervention steps, a good consultation and referral process helps you do the following:

(1) Provide ways for students/families and school personnel to learn about existing resources.

This entails widespread circulation of general information about on- and off-campus programs and services and ways to readily access such resources.

(2) Establish whether a referral is necessary.

This requires an analysis of whether current resources can be modified to address the need.

(3) Identify potential referral options with the student/family.

Review with the student/family how referral options can assist. A resource file and handouts can be developed to aid in identifying and providing information about appropriate services and programs, and off-campus, for specific types of concerns (e.g.,

individual/group/family/professional or peer counseling for psychological, drug and alcohol problems, hospitalization for suicide prevention). Remember that many students benefit from group counseling. And, if a student's problems are based mainly in the home, one or both parents may need counseling -- with or without the student's involvement as appropriate. Of course, if the parents won't pursue counseling for themselves, the student may need help to cope with and minimize the impact of the negative home situation.

(4) Analyze options with student/family and help with decision-making as to which are the most appropriate resources.

This involves evaluating the pros and cons of potential options (including location, fees, least restrictive and intrusive intervention needed) and, if more than one option emerges as promising, rank ordering them. For example, because students often are reluctant to follow-through with off-campus referrals, first consideration may be given to those on-campus, then to off-campus district programs, and finally to those offered by community agencies. Off-campus referrals are made with due recognition of school district policies.

(5) Identify and explore with the student/family potential barriers to pursuing the most appropriate option.

Is there a financial problem? A transportation problem? A problem about parental consent? Too much anxiety/fear/apathy? At this point, it is wise to be certain that the student (and where appropriate the family) truly feels an intervention will be a good way to meet her or his needs.

(6) Work on strategies to reduce barriers to follow-through.

This often overlooked step is essential to follow-through. It entails taking the time to clarify specific ways to deal with apparent barriers.

(7) Give the student/family a written summary of what was decided including follow-through strategies.

A referral decision form can summarize (a) specific directions about enrolling in the first choice resource, (b) how to deal with problems that might interfere with successful enrollment, and (c) what to do if the first choice doesn't work out. A copy of such a form can be kept on file for purposes of case monitoring.

(8) Give the family a follow-through status report form.

This form is intended to let the school know whether the referral was successful and if not, whether additional help is needed to connect the student/family to needed resources. Remember that teachers and other school staff will want to know that something was done. Without violating any confidentiality considerations, the nurse can and should send them a quick response reassuring them that the process is proceeding.

(9) Follow-through with student/family and other concerned parties to determine current status of needs and whether previous decisions were appropriate.

This requires establishing a reminder (tickler) system so that a follow-up is made after an appropriate period of time.

Obviously, the above steps may require more than one session with a student/family and may have to be repeated if there is a problem with follow-through. In many cases, one must take specific steps to help with follow through, such as making direct connections (e.g., by phone) to the intake coordinator for a program. Extreme cases may require extreme measures such as arranging for transportation or for someone to actually go along to facilitate enrollment.

Consent and Due Process

There was a time not so long ago when assessing students with problems and assigning them to special programs was done matter-of-factly. Most professionals believed they knew who needed help and what help was needed. It was a relatively simple matter to inform those involved that a problem existed and what was to be done. Growing awareness of rights and of the potentially harmful effects of treatment led to safeguards. Currently, consent is not taken for granted.

Parent organizations and child advocates have insisted that parents be involved in any decision that might have a profound effect on the course of a child's life. This fact is reflected in the "procedural safeguards" enacted into federal law. These safeguards are rooted in the legal concept of due process as established in the Fourteenth Amendment to the federal constitution.

Due process protects people's rights; procedural safeguards are meant to help guarantee that everyone is treated fairly. They are meant to ensure that parents are involved in decisions regarding testing and placement of their child. Interventions are not supposed to take place without parental consent.

Interviewing: Exploring the Problem with the Student/Family

The following general guide is meant to provide an overview of the types of information the school nurse might pursue in order to learn a bit more about a student's problem.

In general, you will want to explore:

> What's going well?

> What's not going so well and how pervasive and serious are the problems?

> What seems to be the cause, or causes, of the problems?

> What's already been tried to correct the problems?

> What should be done to make things better?

> (What does the student/family think should be done? Do the causes shed any light on what needs to be done? Does what's already been tried shed any light? What are the student/family willing to try? How much do they truly think that things can be made better?)

Remember, a formal interview with a student about psychosocial/mental health concerns, requires a signed informed consent from a parent or legal guardian. It is good practice to get the student's assent as well.

Understand the Nature and Scope of Problems

To explore what's going well and what's not, ask about current status related to various aspects of a student's daily life. To this end, Henry Berman, MD, proposes an approach to interviewing that he calls HEADS (**H**ome, **E**ducation, **A**ctivities, **D**rugs, and **S**exuality). This acronym is meant to guide the interviewer in exploring key facets of a young person's life, especially those that may be a source of trouble.

Borrowing and adding to this framework, the following areas and topics might be explored with respect to current status. Where problems are identified, past circumstances related to the area and topic can be further discussed to help clarify duration, possible causes, and past or current efforts to deal with them.

Home & Health

Place of residence
Where does the student live and with whom?

Physical conditions and arrangements in the residence?

Family status relationships, and problems? (separation, loss, conflict, abuse, lack of supervision and care, neglect, victimization, alienation)

Physical health
Developmental problems?

Somatic complaints?

Accident proneness?

Indications of physical or sexual abuse? Indications of eating problems?

Recent physical injury/trauma?

Emotional health?
Anxieties?

Fears?

Frustration?

Anger? Frequent and extreme mood swings?

Self-image? (degree of perceived sense of competence/efficacy; sense of worth; feelings of personal control over daily events feelings of

dependency on others; gender concern; self-acceptance; defensiveness)

Isolation or recent loss?

Hopes and expectations for the future?

If unhappy, is s/he depressed?

If depressed, is s/he suicidal?

Psychic trauma?

Symptoms of mental illness? (hallucinations, delusions)

Education

School functioning

School attended, grade, special placement?

Learning? (level of skills)

Performance? (daily effort and functioning, grades)

Motivation? (interests, attendance)

Relationships at school

Behavior? (cooperation and responsiveness to demands and limits)

Special relationships with any school staff? (anyone really liked or hated)

Plans for future education and vocation?

Activities

Types of interests (music, art, sports, religion, culture, gang membership)

Responsibilities (caring for siblings, chores, job)

Relationships with peers

Any close friends? Separation/loss? Conflict? Abuse? Neglect? Victimization? Alienation?

Relationships with other adults

Involvement with the law

How individual usually spends time

Drugs

     Substance use, abuse

Sexuality

     Active sexually (informed about pregnancy and STD prevention?)

     Considering becoming active sexually

     Is, has been, or currently wants to be pregnant

     Sexual orientation

You will also want to use the contact to **observe** aspects of the student/family that can shed additional light on these matters. These include

        Appearance: dress, grooming, unusual physical characteristics

        Behavior: activity level, mannerisms, eye contact, manner of relating to parent/therapist, motor behavior, aggression, impulsivity

        Expressive Speech: fluency, pressure, impediment, volume

        Thought Content: fears, worries preoccupations, obsessions, delusions, hallucinations

        Thought Process: attention, concentration, distractibility, magical thinking, coherency of associations, flight of ideas, rumination, defenses (e.g., planning)

        Cognition: orientation, vocabulary, abstraction, intelligence

        Mood/Affect: depression, agitation, anxiety, hostility absent or unvarying; irritability

        Suicidality/Homicidality: thoughts, behavior, stated intent, risks to self or others

Attitude/Insight/Strengths: adaptive capacity, strengths and assets, cooperation, insight, judgment, motivation for treatment

In assessing possibilities and motivation for addressing problems, you will want to explore:

- Desirable and desired, long-terms outcomes
- Barriers that may interfere with reaching such outcomes
- Immediate needs and objectives for intervention.

And you will want to clarify the student's, parents', and school's role in the process, and any other assistance that is needed, feasible, and desired.

Psychosocial Guidance and Support

Each day many students require a small dose of personalized guidance and support to enhance their motivation and capability for coping with stressors. Others who are involved in therapeutic treatment (e.g., personal counseling, psychotherapy, psychotropic medication) need someone who understands the treatment and can deal with related concerns that arise at school.

Personalized guidance and support is best provided on a regular basis in the classroom and at home. There are great benefits to be gained from any role the nurse may play in helping teachers function in ways where they directly provide such support or do so through use of various activities and peer support strategies. Nurses also can play a role in mobilizing and enhancing support from those in the home.

The school nurse also is a logical person for a student to contact if something is amiss between what is happening at school and the student's therapeutic regimen. And s/he is a good person to interface with a student's personal counselor or therapist and to act as a school-site case manager so that there is coordination between the school's efforts to teach and treatment practices.

Guidance and support involve a range of potential activities:

- Advising; advocacy and protection;

- Providing support for transitions (e.g., orienting new students and connecting them with social support networks, facilitating students with special needs as they transition to and from programs and services);
- Mediation and conflict resolution;
- Promoting and fostering opportunities for social and emotional development;
- Being a liaison between school and home;
- Being a liaison between school and other professionals serving a student;

Note: Special considerations and concerns arise related to students taking psychotropic medications. As a follow-up aid for school staff a resource packet on this topic entitled *Students and Psychotropic Medication: The School's Role* -- prepared by the Center for Mental Health in Schools at UCLA is available at: http://smhp.psych.ucla.edu/. Psychotropic medications are also addressed in Chapter 5, *Medication Administration,* of this manual

Psychosocial Counseling

Some student's problems will be more than you should try to handle. In this situation, you should make the best effort you can to connect them with the right help. There are many, however, who could benefit from your counseling, once you have equipped yourself for the task and if you can create the time.

Good counseling builds on the type of caring which is fundamental to all nursing. It also encompasses the basics of any good working relationship, and a bit more. Basics are highlighted here. You will want to learn more and a good next step is to read some of the works referenced at the end of this unit.

In general, counseling requires the ability to carry on a *productive dialogue,* that is, to talk with, not at, others. This begins with the ability to be an active (good) listener and to avoid prying and being judgmental. It also involves knowing when to share information and relate one's own experiences as appropriate and needed. Some thoughts about engaging students in a productive dialogue are outlined on the following pages.

Counseling also requires the ability to create a working relationship that quickly conveys to the student

- **Positive value and expectation** (that something of value can and will be gained from the experience);

- **Personal credibility** (that the counselor is someone who can help and can be trusted to be keep his or her word, be fair, and be consistent, yet flexible);

- **Permission and protection to engage in exploration and change** (that the situation is one where there are clear guidelines saying it is okay and safe to say what's on one's mind).

The process requires the ability to respond with:

- **Empathy, warmth, and nurturance** (e.g., the ability to understand and appreciate what others are thinking and feeling, transmit a sense of liking, express appropriate reassurance and praise, minimize criticism and confrontation);

- **Genuine regard and respect** (e.g., the ability to transmit real interest, acceptance, and validation of the other's feelings and to interact in a way that enables others to maintain a feeling of integrity and personal control).

In general, the focus is on enhancing motivational readiness to dialogue by creating a sense of positive value and expectation for counseling, personal credibility for the counselor, and permission and protection for engaging in exploration for change.

Some specific things to do are:

- Create a private space and a climate where the student can feel it is safe to talk;
- Clarify the role and value of keeping things confidential;
- Avoid interruptions;
- Start slowly, avoid asking questions, and minimize pressure to talk (the emphasis should be more on conversation and less on questioning, and on

non-sensitive topics related to the student's main areas of personal interest);

- Encourage the student to take the lead;
- Humor can open a dialogue; sarcasm usually has the opposite effect;
- Listen with interest;
- Respond with empathy, warmth, nurturance, and genuine regard and respect;
- Use indirect leading statement such as "Please tell me more about…" or direct leading statements such as "You said that you were angry at your parents?"
- If needed, use structured tools (surveys, sentence completion) to guide a student;
- (Examples of tools that may be useful are included in the accompanying materials resource packet entitled Screening/Assessing Students: Indicators and Tools.);
- Sometimes a list of items (e.g., things that students generally like and dislike at school or after school) can help elicit a student's views and open-up a dialogue;
- When questions are asked, use open-ended, rather than yes/no questions;
- Appropriate self-disclosure by a counselor may disinhibit a reluctant student;

In addition, for groups:

- Facilitate sharing through various activities (pairing a reluctant student with a supportive peer, having the group share backgrounds);
- Clarify that trust, respect, confidentiality, etc. are a function of commitment to the group -- not a matter of stating rules;

Mental, Emotional, and Behavior Disorders in Children and Adolescents

The Center for Mental Health Services extends appreciation to the National Institute of Mental Health, which is part of the National Institutes of Health, for contributing to the preparation of this fact sheet. Any questions or comments about its contents may be

directed to the CMHS National Mental Health Services Knowledge Exchange Network
(KEN) http://smhp.psych.ucla.edu/.

Mental, Emotional, and Behavior Problems

Young people can have mental, emotional, and behavior problems that are real, painful,
and costly. These problems, often called "disorders," are a source of stress for the child as
well as the family, school, community, and larger society. The number of families who
are affected by mental, emotional, and behavior disorders in young people is staggering.
It is estimated that as many as one in five children or adolescents may have a mental
health problem that can be identified and treated. At least 1 in 20--or as many as 3 million
young people - may have "serious emotional disturbance." This term refers to a mental
health problem that severely disrupts a person's ability to function socially, academically,
and emotionally.

Mental health disorders in children and adolescents are caused by biology, environment,
or a mix of both. Examples of biological factors are genetics, chemic imbalances in the
body, and damage to the central nervous system, such as a head injury. Many factors in a
young person's environment can affect his or her mental health, such as exposure to
violence, extreme stress, and loss of an important person.

Caring families and communities working together can help children and adolescents
with mental disorders. A broad range of services is often necessary to meet the needs of
these young people and families.

The Disorders

Following are descriptions of some of the mental, emotional, and behavior problems that
can occur during childhood and adolescence. All of these disorders can have a serious
impact on a child's overall health.

Some disorders are more common than others, and conditions can range from mild to
severe. Often, a child has more than one disorder.

Anxiety disorders are among the most common of childhood disorders. They affect an
estimated 8 to 10 of every 100 children and adolescents. These young people experience

excessive fear, worry, or uneasiness that interferes with their daily lives. Anxiety disorders include:

- **Phobia** - an unrealistic and overwhelming fear of some object or situation;
- **Generalized anxiety disorder** - a pattern of excessive, unrealistic worry not attributable to any recent experience;
- **Panic disorder** - terrifying panic attacks that include physical symptoms such as rapid heartbeat and dizziness;
- **Obsessive-compulsive disorder** - being trapped in a pattern of repeated thoughts and behaviors such as counting or handwashing; and
- **Post-traumatic stress disorder** - a pattern of-flashbacks and other symptoms that occurs in children who have experienced a psychologically distressing event such as physical or sexual abuse, being a victim or witness of violence, or exposure to some other traumatic event such as a bombing or hurricane.

Major depression is recognized more and more in young people. Years ago, many people believed that major depression did not occur in childhood. But we now know that the disorder can occur at any age. Studies show that up to 6 out of every 100 children may have depression. The disorder is marked by changes in:

- Emotion - the child often feels sad, cries, looks tearful, feels worthless;
- Motivation - schoolwork declines, the child shows no interest in play;
- Physical well-being - there may be changes in appetite or sleep patterns and vague physical complaints;
- Thoughts - the child believes that he or she is ugly, that he or she is unable to do anything right, or that the world or life is hopeless.

Some adolescents or even elementary school children with depression may not place any value on their own lives, which may lead to suicide.

Bipolar disorder (manic-depressive illness) in children and adolescents is marked by exaggerated mood swings between extreme lows (depression) and highs (excitedness or manic phases). Periods of moderate mood occur in between. During a manic phase, the child or adolescent may talk nonstop, need very little sleep, and show unusually poor judgment. Bipolar mood swings can recur throughout life. Adults with bipolar disorder,

as common as 1 in 100 adults, often experienced their first symptoms during teenage years.

Attention-deficit/hyperactivity disorder (ADHD) occurs in up to 5 of every 100 children. A young person with attention-deficit/hyperactivity disorder is unable to focus attention and is often impulsive and easily distracted. Most children with this disorder have great difficulty remaining still, taking turns, and keeping quiet. Symptoms must be evident in at least two settings (for instance, at home and at school) for attention-deficit/hyperactivity disorder to be diagnosed.

Learning disorders affect the ability of children and adolescents to receive or express information. These problems can show up as difficulties with spoken and written language, coordination, attention, or self-control. Such difficulties can make it harder for a child to learn to read, write, or do math. Approximately 5 of every 100 children in public schools are identified as having a learning disorder. Both ADHD and other learning disabilities are covered more extensively in Chapter 7 of this manual.

Conduct disorder causes children and adolescents to act out their feelings or impulses toward others in destructive ways. Young people with conduct disorder repeatedly violate the basic rights of others and the rules of society. The offenses that these children and adolescents commit often get more serious over time. Examples include lying, theft, aggression, truancy, fire-setting, and vandalism. Children and adolescents with conduct disorder usually have little care or concern for others. Current research has yielded varying estimates of the number of young people with this disorder; most estimates range from 4 to 10 of every 100 children and adolescents.

Eating disorders can be life threatening. A young person with **anorexia nervosa**, for example, cannot be persuaded to maintain a minimally normal body weight. This child or adolescent is intensely afraid of gaining weight and doesn't believe that he or she is underweight. Anorexia affects 1 in every 100 to 200 adolescent girls and a much smaller number of boys.

Youngsters with **bulimia nervosa** feel compelled to binge (eat huge amounts of food at a time). Afterward, to prevent weight gain, they rid their bodies of the food by vomiting, abusing laxatives, taking enemas, or exercising obsessively. Reported rates vary from 1 to 3 out of 100 young people. Eating disorders is discussed in greater detail below.

Autism spectrum disorder or autism appears before a child's third birthday. Children with autism have problems interacting and communicating with others. They behave inappropriately, often repeating behaviors over long periods. For example, some children bang their heads, rock, or spin objects. The impairments range from mild to severe. Children with autistic disorder may have a very limited awareness of others and are at increased risk for other mental disorders. Studies suggest that autism spectrum disorder affects 7 to 14 of every 10,000 children.

Schizophrenia can be a devastating mental disorder. Young people with schizophrenia have psychotic periods when they may have hallucinations (sense things that do not exist, such as hearing voices), withdraw from others, and lose contact with reality. Other symptoms include delusional or disordered thoughts and an inability to experience pleasure. Schizophrenia is even more rare than autism in children under 12, but occurs in about 3 out of every 1000 adolescents.

Counseling, Psychological and Social Services: Special Populations

This section will outline several of the populations to which school personnel will most likely provide the bulk of their mental and emotional health care services.

Children with Special Health care Needs

Children and adolescents with chronic health conditions have an increased prevalence of psychological symptoms when compared to healthy children. Parents' self-esteem, mental health, social support network, and beliefs about health care all have an impact on the success of children's adaptation to chronic illness, as do the cohesiveness, flexibility, and effectiveness of shared communication within the family.[17] The counselor and psychologist can work with both the children and families, in groups and individually, to address these important influences on the student's overall health. The counselor can also provide these students with social skills training in the classroom setting or in small groups, and can provide guidance and counseling for career planning and a smooth transition from school to career.[18] Nurses can also assist by case managing these students and families and ensuring that appropriate community resources are being utilized. Counselors and nurses especially can consistently act as advocates for these students in

the community. Teachers can ensure that these students are appropriately integrated into classroom activities, and can work with the nurse in helping the student to obtain necessary medications and/or treatments with the least possible academic and social disruption.

"At risk" Youth/Suicide

There are many definitions of the "at risk" student; any student may be at risk with respect to dropping out of school, becoming truant, performing below academic potential, or exhibiting behaviors that may be harmful to self and/or others. The underlying reasons for these behaviors often deal with personal and social concerns such as poor self-esteem, family problems, unresolved grief, neglect, or abuse.[19]

Suicide is the third leading cause of death for adolescents 15 to 19 years old.[20] Adolescents at higher risk commonly have a history of depression, a previous suicide attempt, a family history of psychiatric disorders, family disruption, and certain chronic or debilitating physical disorders or psychiatric illness. Alcohol use and alcoholism also can indicate a higher risk for suicide, as alcohol has been associated with 50% of suicides.[21] High levels of community violence may contribute to emotional and conduct problems and add to the risk of suicide for exposed youth.

There is no one identifiable cause of suicidal tendencies, but certain factors may put some youth more at risk. Triggers may include fights with parents, school difficulty, trouble with the law, death or divorce, physical or sexual abuse, or breaking up with a girlfriend or boyfriend. Many children and adolescents experience stressors, but some are more vulnerable to feeling extremely troubled, hopeless, or anxious; they may feel that life is unbearable, that it will never get better, and that they are powerless to do anything to change the situation. Some mental health professionals speculate that a significantly stressed family and social environment, coupled with a graphic and detailed knowledge of the state of the world, may predictably lead to a sense of helplessness and hopelessness, common complaints of the depressed suicidal person.[22]

All adolescents with symptoms of depression should be asked about suicidal ideation with a question such as "Have you had thoughts about death, or about killing yourself?"[23] Depressed or suicidal adolescents are often relieved that someone has heard their cry for help. For most adolescents, this cry represents an attempt to resolve a difficult conflict,

escape an intolerable living situation, make someone understand their desperate feelings, or make someone feel sorry or guilty. Suicidal thoughts or comments should never be underestimated or dismissed as unimportant, nor should they be ignored due to a lack of knowledge about how to respond. Adolescents must be told by caring and knowledgeable school staff that their plea for assistance has been heard and that they will be helped.[24]

School counselors can work towards primary prevention with this group of students by running groups and programs about depression, family stress, or even coping with world events. Individualized and large group academic guidance can provide focus and support to students who might not otherwise receive much hope for success in their relationships outside of school. Psychologists can educate staff about the above-described issues, and provide information to all staff about when and how to refer a student for further assessment and evaluation of risk. Psychologists can also work with counselors to implement a primary suicide prevention program throughout the school. Nurses need to remain aware of the varying ways that students can present with depression and severe mood alteration, which can include somatic complaints as well as an abrupt return to cheerfulness after an obvious period of a depressed mood. Nurses can routinely ask students who receive health services about their mood, as well as about how things are going outside of school. Teachers will spend the majority of time with all students, and therefore are often the most informed staff about mood alteration, behavior changes, and/or family difficulties. Teachers can use guest speakers in the classroom to educate students about the kinds of options they have in their community if they experience periods of depression or hopelessness. A suicidal risk assessment guide is included as Exhibit 1 of this section, and a screening checklist is included as Exhibit 2 at the end of this chapter.

All staff need to approach these students with caution and with respect and care. Students need to be told that confidentiality will be maintained unless the student expresses a desire to harm themselves or someone else, or discloses abuse. Other school/community professionals and parents must be informed immediately if a student describes a plan of action (e.g., when and how they will harm themselves, has procured a weapon) and/or if any staff is aware that the student has begun to say goodbye to friends or peers (this is often done by giving away prized possessions, or making obvious amends or apologies). Every school clinic/health office and principal's office (at minimum) should also have on hand:

- 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 and their telephone numbers; and
- A list of community resources (including address and telephone numbers) such as the Department of Human 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.

Eating Disorders[25]

Eating is controlled by many factors, including appetite, food availability, peer and cultural practices, and attempts at voluntary control. Dieting to a body weight leaner than needed for health is highly promoted by current fashion trends, sales campaigns for special foods, and in some activities and professions. Eating disorders involve serious disturbances in eating behavior, such as extreme and unhealthy reduction of food intake or severe overeating, as well as feelings of distress or extreme concern about body shape or weight. Researchers are investigating how and why initially voluntary behaviors, such as eating smaller or larger amounts of food than usual, at some point move beyond control in some people and develop into an eating disorder. Studies on the basic biology of appetite control and its alteration by prolonged overeating or starvation have uncovered enormously complex issues, but in the long run have the potential to lead to new pharmacologic treatments for eating disorders.

Eating disorders are not due to a failure of will or behavior; rather, they are real, treatable medical illnesses in which certain maladaptive patterns of eating take on a life of their own. The main types of eating disorders are anorexia nervosa and bulimia nervosa. A third type, binge-eating disorder, has been suggested but has not yet been approved as a formal psychiatric diagnosis. Eating disorders frequently develop during adolescence or early adulthood, but some reports indicate their onset can occur during childhood or later in adulthood. For this reason, it is important that school nurses be familiar with the risk factors for eating disorders as well as the signs and symptoms. They must also be aware of community resources that can be of assistance in treating children and adolescents with eating disorders.

Eating disorders frequently co-occur with other psychiatric disorders such as depression, substance abuse, and anxiety disorders. In addition, people who suffer from eating disorders can experience a wide range of physical health complications related to maladaptive nourishment, including serious heart conditions and kidney failure, which may lead to death. Recognition of eating disorders as real and treatable diseases, therefore, is critically important.

Females are much more likely than males to develop an eating disorder. Only an estimated 5 to 15 percent of people with anorexia or bulimia and an estimated 35 percent of those with binge-eating disorder are male.

Anorexia Nervosa

An estimated 0.5 to 3.7 percent of females suffer from anorexia nervosa in their lifetime. Symptoms of anorexia nervosa include:

- Resistance to maintaining body weight at or above a minimally normal weight for age and height;
- Intense fear of gaining weight or becoming fat, even though underweight;
- 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 denial of the seriousness of the current low body weight;
- Infrequent or absent menstrual periods (in females who have reached puberty).

People with this disorder see themselves as overweight even though they are dangerously thin. The process of eating becomes an obsession. Unusual eating habits develop, such as avoiding food and meals, picking out a few foods and eating these in small quantities, or carefully weighing and portioning food. People with anorexia may repeatedly check their body weight, and many engage in other techniques to control their weight, such as intense and compulsive exercise, or purging by means of vomiting and abuse of laxatives, enemas, and diuretics. Girls with anorexia often experience a delayed onset of their first menstrual period.

The course and outcome of anorexia nervosa varies across individuals: some fully recover after a single episode; some have a fluctuating pattern of weight gain and relapse; and others experience a chronically deteriorating course of illness over many years. The

mortality rate among people with anorexia nervosa has been estimated at 0.56 percent per year, or approximately 5.6 percent per decade, which is about 12 times higher than the annual death rate due to all causes of death among females ages 15-24 in the general population. The most common causes of death are complications of the disorder, such as cardiac arrest or electrolyte imbalance, and suicide.

Bulimia Nervosa

An estimated 1.1 percent to 4.2 percent of females have bulimia nervosa in their lifetime. Symptoms of bulimia nervosa include:

- Recurrent episodes of binge eating, characterized by eating an excessive amount of food within a discrete period of time, and by a sense of lack of control over eating during the episode;
- Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting or misuse of laxatives, diuretics, enemas, or other medications (purging); fasting; or excessive exercise**;**
- The binge-eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months;
- Self-evaluation is unduly influenced by body shape and weight.

Because purging or other compensatory behavior follows binge-eating episodes, people with bulimia usually weigh within the normal range for their age and height. However, like individuals with anorexia, they may fear gaining weight, and feel intensely dissatisfied with their bodies. People with bulimia often perform the behaviors in secrecy, feeling disgusted and ashamed when they binge, yet relieved once they purge.

Treatment Strategies

Eating disorders can be treated and a healthy weight restored. The sooner these disorders are diagnosed and treated, the better the outcomes are likely to be. Because of their complexity, eating disorders require a comprehensive treatment plan involving medical care and monitoring, psychosocial interventions, nutritional counseling and, when appropriate, medication management. At the time of diagnosis, the clinician must determine whether the person is in immediate danger and requires hospitalization.

Treatment of anorexia nervosa calls for a specific program that involves three main phases:

(1) Restoring any weight lost to severe dieting and purging;

(2) Treating psychological disturbances such as distortion of body image, low self-esteem, and interpersonal conflicts; and

(3) Achieving long-term remission and rehabilitation, or full recovery.

Early diagnosis and treatment increases the treatment success rate. Use of psychotropic medication in people with anorexia should be considered only after weight gain has been established. Certain selective serotonin reuptake inhibitors (SSRIs) have been shown to be helpful for weight maintenance and for resolving anxiety and other mood disorders.

People with eating disorders often do not recognize or admit that they are ill. As a result, they may strongly resist getting and staying in treatment. Family members or other trusted individuals, can be helpful in ensuring that the person with an eating disorder receives needed care and rehabilitation. For some people, treatment may be long term.[26]

School nurses can play an integral role in the prevention and recognition of eating disorders. Some things that school personnel can do include:

- Classroom education as part of the comprehensive health education curriculum should contain opportunities for learning and discussion about societal attitudes about weight and appearance.
- Coaches, school nurses, and teachers should observe students' body appearance and discuss the impact of eating disorders with students who appear to be at risk.
- Because of the serious danger of eating disorders to physical health, concerns should be shared with the school health or mental health professiona,l who should then consult with the student and parent for a referral to the student's primary health care provider.[27]

For more information about eating disorders, the following resources may be contacted:

National Institute of Mental Health (NIMH)
Office of Communications and Public Liaison
Public Inquiries: (301) 443-4513
E-mail: **nimhinfo@nih.gov**
http://www.nimh.nih.gov

American Anorexia Bulimia Association, Inc.
Phone: (212) 575-6200
http://www.aabainc.org

Eating Disorders Awareness and Prevention, Inc.
Phone: (800) 931-2237
http://www.edap.org

Harvard Eating Disorders Center
Phone: (888) 236-1188 ext. 100
http://www.hedc.org

National Association of Anorexia Nervosa and Associated Disorders
Phone: (847) 831-3438
http://www.anad.org

Substance Abuse

Substance abuse is recognized as a health problem and a symptom of physical, social, and/or emotional problems among children and adolescents. Surveys suggest that nearly one-third of high school seniors continue to experiment with illegal drugs, despite the fact that 90% of them express disapproval of such use.[28] This apparent contradiction highlights the enormous complexity of this issue, and an expanded discussion can be found in Chapter 12 of this manual. Substance abuse can cause problems with memory, discipline, motivation, sexual experimentation or acting out, risk-taking, and/or antisocial and/or violent behaviors, and therefore all school staff have a role to play in addressing this increasingly prevalent problem. The U.S. Department of Health and Human Services' Healthy People 2000 recommendation is that a quality school health program should:

> Provide factual information about the harmful effects of drugs, support and strengthen students' resistance to using drugs, carry out collaborative drug abuse prevention efforts with parents and other community members, and be supported by strong school policies as well as services for confidential identification,

assessment, and referral to treatment and support groups (often provided through a student assistance program) for drug users.[29]

Counselors may be the key persons to implement and coordinate student assistance programs, which serve as a systematic effort to help students understand themselves as self-respecting human beings while helping them to accept responsibility for their own actions.[30] These programs should provide proactive approaches to existing substance abuse, and involve early identification of problem behavior, as well as thorough assessment and follow-up. It is the counselor's responsibility to refer the student to the appropriate agencies or consultants if the student's problems are beyond the counselor's level of expertise. The counselor may also help to facilitate confidential recovery/sobriety meetings in the school, and will be integral to transitioning students back to school who are returning from extended treatment programs.[31]

Psychologists can provide valuable information to counselors, teachers, and nurses about screening for substance abuse, and how to approach an individual student in whom the problem is suspected. Psychologists can provide counseling to families of these students and can also offer screening tools that can be used by the nurse. Structured and thorough interviews, carried out confidentially, can be extremely useful in assessing risk and/or identifying existing problems. (See Exhibit 4 for information on ordering one of these tools, the West Virginia University Adolescent Risk Survey - WVUARS.)

Nurses should be involved in initiating, participating in, and/or cooperating with school and community activities designed to prevent and/or treat the problem of substance abuse.[32] Nurses must also learn to screen and be alert for possible substance abuse in their office or clinic. Substance abusers may present to the nurse indirectly, either with somatic complaints related to the abuse or the stress of their problem, or with vague questions or problems that are a way of asking for help from a trusted professional. Nurses can also play a significant role in supporting students returning from treatment, by making their office or clinic a type of "safe haven" for a student struggling with sobriety or peer pressure issues.

Teachers can incorporate drug awareness curricula into their classrooms and can arrange for guest speakers—such as local celebrities or other respected community figures—to do the same. Teachers can also be aware of the subtle and often indirect ways that students reveal substance abuse problems. A high index of suspicion is often needed to spot an

early problem—school absences, falling grades, or disciplinary problems invariably surface at some point. Physical signs can also be subtle: papillary changes or odors on the clothes or breath.[33] Teachers will also play a large role in transitioning any student who has returned from a treatment program back into the classroom and everyday life of the school.

Family Crisis/Divorce

Difficulties in a student's home may be chronic or temporary. The structure of families and patterns of family life in the U.S. have changed profoundly in the past quarter century. The number of births to unmarried women has increased from 5% to 32%, and the divorce rate has doubled. It is estimated that 25% of children growing up in this decade will experience their parents' divorce. As a consequence, approximately 8% fewer children are living with 2 parents, and only 61% live with both biological parents. These social changes have strained the ability of families to provide for their children's needs, and, as a result, the health, development, and well-being of children have been jeopardized.[34]

Parents and/or caregivers that do not live with their children can still provide the fundamentals of love and esteem to their children. In fact, many of the problems associated with low self-esteem are just as likely to occur in children whose families are apparently stable. Teachers and nurses may pick up on new problems or symptoms and refer the students to the mental health professionals in the school system.

Homosexuality/Alternative Sexual Orientation

Societal attitudes toward homosexuality have had a decisive impact on the extent to which individuals have hidden or made known their sexual orientation. Many gay and lesbian youth first become aware of and experience their sexuality during adolescence. The etiology of homosexuality remains unclear, but in 1973 the American Psychiatric Association reclassified homosexuality as a sexual orientation/expression rather than as a mental disorder. Many adolescents and adults engage in homosexual activity and experimentation but still characterize themselves as primarily heterosexual.[35] This can be confusing in adolescence, however, as it is a time when the formation of an identity is an extremely important developmental task. Sexual identity formation involves deciding on both the kinds of sexual behaviors in which one wants to engage, and deciding whether or

not to engage in sexual intercourse. Confronting the possibility of a homosexual identity can compound these already difficult decisions and tasks.

The psychosocial problems of gay and lesbian adolescents are primarily the result of societal stigma, hostility, hatred, and isolation. The gravity of these stresses is underscored by data that document gay youths account for up to 30% of all completed adolescent suicides. Approximately 30% of a surveyed group of gay and bisexual males have attempted suicide at least once. A tolerant school environment can play a powerful role in supporting these teens. It is extremely important that school staff members are aware of this risk, and provide anticipatory guidance for those students for whom a painful struggle is apparent. It is also crucial that staff members understand their own attitudes towards homosexuality, and if necessary, refer a student in need to a more tolerant staff member.

Counselors can facilitate groups within the school that focus on tolerance, diversity, and the identity formation tasks that adolescents face. Psychologists can provide information to school staff about the kinds of mental and emotional instability for which gay and lesbian youth are at risk, through presentations, distribution of literature, or interactive workshops that allow staff to explore their own feelings about homosexuality and tolerance. Nurses can use their clinical expertise to educate students about the health-related issues surrounding their sexuality, including the risks of sexually transmitted disease associated with homosexual activity and high-risk behaviors. Nurses can also use their assessment skills to screen for students having difficulty coping with sexual adjustment and make appropriate referrals either within or outside of the school system. Teachers can promote and maintain tolerant classrooms, observe and assess for harassment of openly or perceived to be homosexual students, or for students whose behavior or emotional affect appears changed or withdrawn in any way. Teachers should work with mental health professionals to learn the most effective ways to approach these situations and to refer the students to the appropriate counseling or support group.

Violent Relationships

Students in schools are a reflection of the larger society around them. Some will routinely face interpersonal violence in their lives—either directly in relationships, or indirectly through violent relationships between others in their lives. This violence may or may not be known to school personnel. Some studies have shown that child abuse occurs in 30-

60% of family violence cases in families with children, and that a child's exposure to a father abusing his or her mother is the strongest risk factor for transmitting violent behavior from one generation to the next. Girls, in particular, are at risk for relationship violence—40% of teenage girls ages 14 to 17 report knowing someone their age who has been hit or beaten by a boyfriend, and one in two rape victims is under the age of 18 (one in six is under 12).[36] The causes of these types of interpersonal violence are many and complex: substance abuse, lack of self-esteem or sense of community, low or lack of income, and/or childhood experiences. Exposure to interpersonal violence seriously undermines a child's ability to realize their full developmental and affective potential.

Counselors in schools can run groups and offer individual counseling to students who have acknowledged the presence of violence in their lives. Larger groups that may include students who have not disclosed their violent situations can address the topics of dating and domestic and interpersonal violence, and introduce the concepts of limit-setting and personal safety and integrity. Counselors can screen for the existence of interpersonal violence by choosing and administering questionnaires to students that include questions such as "Do you feel safe at home and in your friendships and other relationships with your peers?" Anonymous surveys can also be conducted within the school system to assess for the prevalence of violent relationships, and workshops and educational efforts can be tailored to students' reported problems. Nurses can also screen for violence by asking one or two simple questions like the one suggested above. Teachers can include violence prevention and personal integrity/safety instruction in their regular curriculum, and can also learn about what kinds of behaviors victims of interpersonal violence might demonstrate. All staff should understand how to make a referral to a counselor or psychologist, and hotline numbers should be posted in places like the nurse's office or clinic, as well as more private places like bathrooms and locker rooms.

All staff can model and consistently reinforce respectful human interactions and deliver the message that violence is not a normal part of human relationships. For children experiencing or witnessing violence this may be the most important role the school can play. See Exhibit 5 for a violent relationship self-assessment tool.

School Violence

School violence is a prominent public health issue, which has devastating effects on our country's youth. The three leading causes of death for children and adolescents are direct outcomes of violence: traumatic accidents, homicide and suicide.[37] According to the American Academy of Pediatrics, the United States has the highest youth homicide and suicide rate among the 26 wealthiest nations in the world.[38]

School-related violent crime has become a national problem. Most schools in the United States are safe, however, and children are much more likely to experience violence outside the school or in transit to or from school. Fewer than one percent of youth homicides take place in schools. The total number of school-associated violent deaths has decreased, but the number of multiple-victim events appears to have increased[39]. In 1998, 9 out of every 1000 students were victims of a serious violent crime while at school or while in transit to or from school[40]. Other, less serious violent school activities include assaults without weapons, bullying, hostile or threatening speech, and gang violence. The rate of non-fatal violent crimes on school campuses has decreased from 48 per 1000 students in 1992 to 43 per 1000 in 1998.[41]

The number of students who report carrying weapons to school has decreased, from 12% in 1993 to 7% in 1999. The number of students who report being threatened by another student with a weapon has not decreased. Seven to eight percent of children report being threatened or injured with a weapon at school annually.[42]

Physical fighting without weapons has declined from 16% to 14% between 1993 and 1999, but bullying continues, especially in the middle schools and junior high schools. In 1999, 10% of students in 6th and 7th grade reported being bullied in school.

Despite these frightening statistics, in the last decade, children are apparently feeling safer in schools. In 1995 the percentage of students ages 12 to 18 who avoided one or more places within or around the school out of fear for their safety was 9%. In 1999 only 5% of children and adolescents reported avoiding particular places.

Children and adolescents are not the only ones affected by school violence. Faculty and staff are now working in an increasingly dangerous environment. According to the 1997

Youth Risk Behaviors Report, 8.3% of high school students carried a weapon such as a gun, a knife, or a club to school.[43] Between the years of 1992 and 1996, an average of 4 teachers out of 1000 annually were victims of serious violent crime on the job. During the 1993-1994 school year, 12 percent of teachers were threatened with violence by a student and four percent of teachers were actually physically attacked by a student.[44]

It is essential that students, faculty and staff feel safe and secure in school in order to facilitate learning. Schools are responsible for providing a safe and health-promoting environment for children.[45] Schools can be made safer if faculty, staff, and the community identify factors that cause youth violence and take steps to reduce the incidence of violence in their communities. Many agencies are collaborating to address this problem and to build a nationwide support system for schools and communities.

National Association of School Nurses
POSITION STATEMENT: Role of the School Nurse in Violence Prevention

…Escalating incidents of threats and acts of violence in society are putting communities at risk. Exposure to violence has significant emotional, behavioral and cognitive effects on children. Children who are exposed to violence are likely to exhibit fear, behavioral, cognitive and concentration problems and resultant difficulty achieving optimal academic success. Children who are not successful in schools are more likely to be violent than those who are successful.

Although schools are some of the safest places in America, it has become necessary for school districts to be proactive in preventing and/or addressing these situations. Societal influences, which have contributed to the increased incidence of violence, include:

- Changing family structure
- Changing societal roles
- Easy access to dangerous weapons
- Media influence, which has sensationalized and desensitized individuals to the impact of violence
- Lack of acceptance of diversity
- Increasing demands on young people that negatively affect coping abilities
- Increasing incidence of all forms of domestic abuse

- Increased incidence of hopelessness and helplessness and
- Perceived need for instant gratification

Rationale:

The dramatic escalation in incidents of violence has created a sense of urgency in our society. Schools should be "safe zones" and adopt positions of no tolerance for weapons, crime and violence. Schools and communities must thoughtfully plan to proactively change behaviors in their quest to create a positive, healthy, and safe environment. School nurses have the unique ability to address problems holistically, including physical, emotional, and social perspectives. School nurses are prepared to deal with the physical and emotional results of violence, to contribute to positive youth development and academic success and to collaborate with school and community teams toward violence prevention and intervention.

Conclusion:

It is the position of the National Association of School Nurses that school nurses have expertise to assist students to develop problem solving and conflict resolution techniques, coping and anger management skills, and a positive self-image. Furthermore, it is the position of the National Association of School Nurses that school nurses should be active members of crisis intervention teams and curriculum committees, and be involved in the development and planning of intervention and prevention programs.[46]

Legislation

Gun Free Schools Act

The Gun Free Schools Act requires that all states receiving federal funds under the *Elementary and Secondary Education Act* (EESA) must have a state law (put into effect by October, 1995) requiring that any student who has brought a firearm into school be suspended or expelled for no less than one year.

Texas School Safety Center

Section 37.202 of the Texas Education Code (TEC),[47] discusses the definition and purpose of the Texas School Safety Center. "The purpose of the center is to serve as: (1) a central location for school safety information, including research, training, and technical assistance related to successful school safety programs; and (2) a resource for

the prevention of youth violence and the promotion of safety in the state." Section 37.205 of the TEC[48] states that:

> The center shall conduct for school districts a safety training program that includes:
>
>   (1) development of a positive school environment and proactive safety measures designed to address local concerns;
>   (2) school safety courses for law enforcement officials, with a focus on school district police officers and school resource officers;
>   (3) discussion of school safety issues with parents and community members; and
>   (4) specialized training for the staff of alternative education programs and juvenile justice alternative education programs.

The center must also, according to Section 37.207 of the TEC,[49] instruct each district in the development of a safety and security audit procedure and compile the data from all school districts. This data must be made available to the public. The center must also develop a website that provides information and data related to school safety in Texas.

The Texas School Safety Center is located in San Marcos, Texas. It is currently developing a model crisis management plan for use by Texas schools. The center may be contacted at the following address:

> Texas School Safety Center
> Southwest Texas State University
> San Marcos, TX 78666
> Phone: (512) 245-3696
> Fax: (512) 245-9033
> http://cie.ci.swt.edu/safety

Primary Prevention: Principles of Prevention and Early Warning Signs

The Department of Education, the Department of Justice, and the American Institutes for Research developed a report entitled, "Safeguarding Our Children: An Action Guide."

According to the report an effective policy for school violence prevention must include three tiers:

1. **Schools must build a school-wide foundation for all children.** This involves:
   a. Supporting positive discipline, academic success, and mental and emotional wellness through a caring school environment;
   b. Teaching students appropriate behaviors and problem solving skills;
   c. Positive behavioral support; and appropriate academic instruction with engaging curricula and effective teaching practices.

2. **Schools must identify students at risk for severe academic or behavioral difficulties early on and create services and supports that address risk factors and build protective factors for them.** Approximately 10-15% of students exhibit problem behaviors indicating a need for such early intervention. It is important that staff be trained to recognize early warning signs and make appropriate referrals. Once students are identified, they must receive coordinated services that meet their individual needs. A number of approaches have been developed for interventions at this stage, including anger management training, structured after-school programs, mentoring, group and family counseling, changing instructional practices, and tutoring.

3. **Schools must identify and provide intensive interventions for the few children who are experiencing significant emotional and behavioral problems.** This involves providing coordinated, comprehensive, intensive, sustained, culturally appropriate, child-and family-focused services and supports. Such interventions might include day treatment programs which provide students and families with intensive mental health and special education services; multi-systemic therapy, focusing on the individual youth and his or her family, the peer context, school/vocational performance, and neighborhood/community supports; or treatment foster care, an intensive, family-focused intervention for youth whose delinquency or emotional problems are so serious and so chronic that they are no longer permitted to live at home. To be effective, these approaches generally require the collaboration of schools, social services, mental health providers, and law enforcement and juvenile justice authorities.[50]

Research has documented that the most important factor in the prevention of youth violence in schools is the early identification of warning signs in children and adolescents at risk. Early recognition allows for children to get the support that they need before violent behavior is manifested. It is crucial for the entire educational community to be involved in prevention efforts, including teachers, administrators, nurses, counselors, and community members.[51]

In most cases of violence against self or others, early behavioral or emotional warning signs are present. Warning signs are signals that a child may need help. Stigmatization of individual students and jumping to conclusions because they fit a particular profile should be avoided, but genuine concern about students based on the presence of warning signs is not only okay, it is necessary.

The identification of early warning signs by school personnel and community members can be facilitated by the establishment of close, caring, and trusting relationships with students. Getting to know their needs, feelings, attitudes, behaviors and values will allow educators and parents to recognize subtle changes.

Following is a list of early warning signs. None of the following signs alone are predictive of aggression or violent behavior. Many times, violent behavior has a multifactorial etiology, and appears as a response to a particular set of circumstances. When seen in combination, these warning signs are indicative of a need for further assessment of a child and possible intervention.[52]

- Social withdrawal
- Excessive feelings of isolation and being alone
- Excessive feelings of rejection
- Being a victim of violence
- Feelings of being picked on and persecuted
- Low school interest and poor academic performance
- Expression of violence in writings and drawings
- Uncontrolled anger
- Patterns of impulsive and chronic hitting, intimidating, and bullying behaviors
- History of discipline problems

- Past history of violent and aggressive behavior
- Intolerance for differences and prejudicial attitudes
- Drug use and alcohol use
- Affiliation with gangs
- Inappropriate access to, possession of, and use of firearms
- Serious threats of violence

According to Early Warning, Timely Response: A Guide to Safe Schools (U.S. Department of Education, 1998), interventions may include:

- Providing training and support to staff, students, and families in understanding factors that can set off and/or exacerbate aggressive outbursts.
- Teaching the child alternative, socially appropriate replacement responses—such as problem solving and anger control skills.
- Providing skill training, therapeutic assistance, and other support to the family through community-based services.
- Encouraging the family to make sure that firearms are out of the child's immediate reach. Law enforcement officers can provide families with information about safe firearm storage as well as guidelines for addressing children's access to and possession of firearms.

Other intervention tactics may include teaching positive interaction skills, providing comprehensive services, and referring the child for special education evaluation.[53]

The Role of the School Nurse
The school nurse should play an active role in screening students for early warning signs. S/he can do this by making an effort to get to know her or his students, establishing trusting relationships with them, and collaborating with teachers, counselors and other staff members. S/he can also initiate referrals and follow-up on interventions with students that have been identified as being at risk of violent behavior. In addition, s/he can develop educational materials promoting a safe and healthy environment for the school community.

Conflict Resolution[54]

Conflict resolution skills provide youths with a valuable tool to use when confronted with a situation that may otherwise lead to violent or self-destructive behavior. The process of conflict resolution may assist youths involved in interpersonal or intergroup conflicts to lessen the intensity of such situations and avoid violence and injury. All schools should implement a conflict resolution education program. The following discussion outlines basic causes and types of conflict, possible responses to conflict, and steps in the problem-solving process. In addition, some suggestions for conflict resolution education are presented.

Situations in which conflict is likely to arise include situations involving limited resources, differing values, and interference with satisfaction of psychological needs. The root cause of the majority of conflicts involves basic human psychological needs. The four needs that motivate behavior are belonging, power, freedom and fun. Conflicts may occur between two people who disagree about how these needs should be met or when meeting one need for one person causes fulfillment of another's need to be denied. For example, during an elementary school recess, one student's need for belonging may be fulfilled by making fun of another student while others look on. The student being picked on, in turn, is denied the right to have fun at recess or may be denied the right of freedom by feeling the need to play on another part of the playground to avoid the student harassing him. He may become angry and act out, because he is unable to satisfy his basic psychological needs.

There are three tiers of responses to conflict: soft, hard, and principled. Soft responses include withdrawing, ignoring, denying or giving-in. Hard responses include threatening, pushing, hitting, and yelling. Principled responses include listening, understanding, respecting and resolving. Both soft and hard responses can lead to lose-win or lose-lose situations, in which one side benefits at the expense of the other or both sides lose. Principled responses lead only to win-win situations. Conflict resolution education teaches students, teachers and other school staff members methods for engaging in principled responses to conflict, thus eliminating situations where one or both sides lose. In effect, the situations that often provoke people to act out in violence (e.g. lose-lose or lose-win situations) are completely avoided.

Three types of problem-solving processes include:

- Negotiation;
- Mediation; and
- Consensus decision-making.

The six steps in each of these problem-solving processes are:

- Set the stage;
- Gather perspectives;
- Identify interests;
- Create opinions;
- Evaluate options; and
- Generate agreement.

In order for any of these processes to be successful, four principles of the process of conflict resolution should be adhered to. These include:

- Separate the people from the problem;
- Focus on interests, not positions;
- Invent options for mutual gain; and
- Use objective criteria.

There are four approaches to conflict resolution curriculum in use in schools around the country today.

- **Process Curriculum:** In these schools, specific classroom time is devoted to educating students about the principles and process of conflict resolution. The classroom time may consist of a "unit" on conflict resolution in a particular class or as part of a daily lesson.
- **Mediation Program:** These schools have a specific group of adults or peers who have been specially trained in conflict resolution and/or mediation and serve as mediators or third-party facilitators to help students in conflict reach solutions.

- **Peaceable Classroom:** Conflict resolution skills are built into all subjects in the curriculum. This holistic approach is the foundation for Peaceable School.
- **Peaceable School:** In this comprehensive program, conflict resolution skills, principles and processes are practiced by all in the school community, including staff, administrators, and parents.

Exhibit 1: Suicidal Risk Assessment Guide [1]

Examples of Adolescents at Low, Moderate, and High Risk for Suicide

Low Risk

- Took 5 ibuprofen tablets after argument with girlfriend
- Impulsive; told mother 15 minutes after taking pills
- No serious problems at home or school
- Occasionally feels "down," but has no history of depression or serious emotional problems
- Has a number of good friends
- Wants help resolving problems and is no longer considering suicide after interview

Moderate Risk

- Suicidal ideation precipitated by recurrent fighting with parents and failing grades in school
- Wants to "get back" at parents
- Cut both wrists while at home alone; called friend 30 minutes later
- Parents separated, changed school this semester, history of attention-deficit hyperactivity disorder
- Symptoms of depression for the last 2 months; difficulty controlling temper
- Binge drinking on the weekends
- Answers all the questions during the interview, agrees to see a therapist if parents get counseling, will contact the interviewer if suicidal thoughts return

High Risk

- Thrown out of house by parents for smoking marijuana at school, girlfriend broke up with him last night, best friend killed in auto crash last month
- Wants to be dead; sees no purpose in living
- Took father's gun; is going to shoot himself where "no one can find me."
- Gets drunk every weekend and uses marijuana daily
- Hates parents and school; has run away from home twice and has not gone to school for 6 weeks
- Hospitalized in the past because he "lost it"
- Does not want to answer many of the questions during the interview and hates "shrinks."

---

[1] American Academy of Pediatrics (AAP). (2000). *Policy Statement: Suicide and Suicide Attempts in Adolescence (RE9928).* http://www.AAP.org/policy/re9928.html

Exhibit 2: Suicidal Assessment – Checklist 1

Unfortunately, suicide is a major cause of death in adolescents, and school staff must be
vigilant about the possibility of suicide risk in the students they care for. When a child
appears to be seriously depressed it is critical to notify parents. Resources within and
outside of the school should be consulted to help the student. The following assessment
checklist can be used when students appear seriously depressed or suicidal. The checklist
is recommended to help school health personnel focus a discussion with the child about
their feelings and to help assess the level of risk for suicide. Follow-through steps are
provided to help school health staff know what to do after completing the assessment
checklist.

Suicidal Assessment – Checklist [55]

Student's Name: Date: Interviewer:

(Suggested points to cover with student/parent)

1) PAST ATTEMPTS, CURRENT PLANS, AND VIEW OF DEATH

Does the individual have frequent suicidal thoughts?   Y   N

Have there been suicide attempts by the student or significant   Y   N
others in his or her life?

Has she or he mad special arrangements to leaver this world,   Y   N
such as giving away prized possessions?

Does the student fantasize about suicide as a way to make others   Y   N
feel guilty or as a way to get a happier afterlife?

2) REACTIONS TO PRECIPITATING EVENTS

Is the student experiencing extreme psychological distress?   Y   N

Have there been major changes in recent behavior along with   Y   N
negative feelings and thoughts?

> (Such changes often are related to recent loss or threat of loss of significant others
> or of positive status and opportunity. They also may stem from sexual, physical,
> or substance abuse. Negative feelings and thoughts often are expressions of a
> sense of extreme loss, abandonment, failure, sadness, hopelessness, guilt, and
> sometimes inwardly directed anger).

3) PSYCHOSOCIAL SUPPORT

Is there a lack of a significant other – to help the student survive?   Y   N

Does the student feel alienated?   Y   N

4) HISTORY OF RISK-TAKING BEHAVIOR

Does the student take life-threatening risks or display poor   Y   N
impulse control?

Use this checklist as an exploratory guide with students about whom you are concerned. Because of the informal nature of this type of assessment, it should not be filed as a part of a student's regular school records.

FOLLOW-THROUGH STEPS AFTER ASSESSING SUICIDAL RISK CHECKLIST

____(1) As part of the process of assessment, efforts will have been made to discuss the problem openly and nonjudgementally with the student (keep in mind how seriously devalued a suicidal student feels. Thus, avoid saying anything demeaning or devaluing, while conveying empathy warmth, and respect). If the student has resisted talking about the matter, it is worth a further effort because the more the student shares the better off one is in trying to engage the student in problem solving.

___(2) Explain to the student the importance of and your responsibility for breaking confidentiality in the case of suicidal risk. Explore whether the student would prefer taking the lead or at lest be present during the process of informing parents and other concerned parties.

___(3) If not, be certain the student is in a supportive and understanding environment (not left alone/isolated) while you start informing others and arranging for help.

___(4) Try to contact parents by phone to

        a) inform about concern
        b) gather additional information to assess risk
        c) provide information about problem and available resources
        d) offer help in connecting with appropriate resources

___(5) If a student is considered to be in danger, only release her/him to the parent or someone who is equipped to provide help. In high-risk cases, if parents are unavailable (or uncooperative) and no one else is available to help, it becomes necessary to contact local, public agencies (e.g., children's services, services for emergency hospitalization, local law enforcement). Agencies will want the following information:
- student's name/address/birth date/social security number
- data indicating student is a danger to self (see Suicide Risk—Checklist)
- stage of parent notification
- language spoken by parent/student
- health coverage plan if there is one
- where student is to be found

___(6) For non-high risk students, if phone contacts with parents are a problem, information gathering and sharing can be done by mail.

___(7) Follow-up with student and parents to determine what steps have been taken to minimize risk.

___(8) Document all steps taken and outcomes.

___(9) Report child endangerment if necessary.

Exhibit 3:

Pediatric Symptom Checklist

Please mark under the heading that best fits your child:

	Never	Sometimes	Often
1. Complains of aches and pains			
2. Spends more time alone			
3. Tires easily, with little energy			
4. Fidgety, unable to sit still			
5. Has trouble with a teacher			
6. Less interested in school			
7. Acts as if driven by a motor			
8. Daydreams too much			
9. Distracted easily			
10. Is afraid of new situations			
11. Feels sad, unhappy			
12. Is irritable, angry			
13. Feels hopeless			
14. Has trouble concentrating			
15. Less interest in friends			
16. Fights with other children			
17. Absent from school			
18. School grades dropping			
19. Is down on himself/herself			
20. Visits doctor with doctor finding nothing wrong			
21. Has trouble with sleeping			
22. Worries a lot			
23. Wants to be with you more than before			
24. Feels he/she is bad			
25. Takes unnecessary risks			
26. Gets hurt frequently			
27. Seems to be having less fun			
28. Acts younger than children his/her age			
29. Does not listen to rules			
30. Does not show feelings			

	Never	Sometimes	Often
31. Does not understand other people's feelings			
32. Teases others			
33. Blames others for his/her troubles			
34. Takes things that do not belong to him/her			
35. Refuses to share			

The Pediatric Symptom Checklist obtains reports of children's behavioral/emotional problems on 35 items that describe specific behaviors and emotions. Parents rate their child for how true each item is using the following scale: 0= never (as far as you know); 1= sometimes true; 2= often true. For school-aged children 6-16 years, a total score of 28 or higher is taken as an indication of significant psychosocial impairment. For children ages 2-5, the scores on items 6, 7, 14 and 15 are ignored and a total score based on the 31 remaining items is completed. The cutoff score for younger children is 24 or greater. Although parents have been shown to be the most reliable reporters of their children's psychosocial and behavioral problems, some mood disorders especially in adolescents are more reliably identified by the patients themselves. When problems like these are suspected, interviewing the child or adolescent, using the youth self-report of the PSC or a specific disorder screen like the Children's Depression Inventory may be more valid."[56]

Exhibit 4: Helpful Resources

Center for School Mental Health Assistance
http://csmha.umaryland.edu/csmha2001/mission.php3

Center for Mental Health in Schools
http://smhp.psych.ucla.edu
(See especially the section "Special Material Developed by Our Center," and click on
Resource Aid Packets for several clearinghouses of information about mental health in
schools, including a catalogue of internet sites relevant to school mental health).

The West Virginia University Adolescent Risk Survey (WVUARS)
Assessment, planning and intervention tool useful for the school nurse or other healthcare
professional. Includes questions for teens about: nutritional status, exercise,
drugs/alcohol/tobacco, sexual activity, school performance, depression, abuse, safety,
violence, friends and family, good qualities, and future plans. Can be administered in
approximately 10 minutes in the office or clinic.
Can be ordered from:
        Dr. K. Perkins
        P.O. Box 9214
        Morgantown, West Virginia 26506-9214

Davis, BJ, Voegtle, KH. *Culturally Competent Healthcare for Adolescents: A Guide for
Primary Healthcare Providers.* (1994). Chicago: American Medical Association Press.

American Academy of Pediatrics (AAP), Division of Public Education.   (1998). "Media
History Form."   In *Media Matters Campaign Kit.* Elk Grove Village, IL: American
Academy of Pediatrics Press.

Violence/Violent Relationships
National Domestic Violence Hotline
1-800-799-SAFE (1 800 7997233)
http://www.ndvh.org/

RAINN: Rape, Abuse & Incest National Network
1-800-656-HOPE (1 800 6564673)
http://www.rainn.org/

Violence Against Women Online Resources
http://www.vaw.umn.edu/

San Antonio Rape Crisis Hotline
(210)349-RAPE
http://www.rapecrisis.com

(*Note – The services from the above resources are not limited to addressing violence and violent relationships. Schools and nurses should use them for any concerns about sexual abuse, incest, child abuse or sexual violence. In addition, help is not limited to recent survivors; the abuse or violence may have occurred long ago).

Homosexuality/Gay Issues
PFLAG: Parents and Friends of Gays and Lesbians
A group organized to promote the health and well-being of gay, lesbian, bisexual and transgendered persons through support, education and advocacy.

1762 M Street, NW
Suite 400
Washington, DC 20036
(202) 467-8180
http://www.pflag.org

Exhibit 5: Violent Relationship Self-Assessment Tool

Quiz: How is your relationship?

Does your partner:

- Embarrass you with bad names and put-downs?
- Look at you or act in ways that scare you?
- Control what you do, who you see or talk to, or where you go?
- Stop you from seeing or talking to friends or family?
- Take your money, make you ask for money or refuse to give you money?
- Make all of the decisions?
- Tell you that you are a bad parent or threaten to take away or hurt your children?
- Act like the abuse is no big deal, it's your fault or even deny doing it?
- Destroy your things or threaten to kill or hurt your pets?
- Intimidate you with guns, knives or other weapons?
- Shove you, slap you or hit you?
- Force you to drop charges?
- Threaten to commit suicide?
- Threaten to kill you?

If you answered yes to even one of these questions, you may be in an abusive relationship. If you need to talk, call us.

1-800-799-7233 or 1-800-787-3224 (TTY for the Deaf)

If you or a friend is experiencing domestic violence, PLEASE CALL our confidential toll-free number.

Call the National Domestic Violence Hotline at 1-800-799-SAFE or from a TTY at 1-800-787-3224.

Te has preguntando: Como esta la relacion con mi pareja?

Tu pareja:

- Te causa miedo la manera en que te mira o su forma de actuar ?
- Controla lo que haces, con quien hablas, a quieves o a donde vas ?
- No te permite conseguir o tener un trabajo ?
- Te quita tu dinero, hace qu le pidas dinero o rehusa darte dinero ?
- Hace todas las decisiones ?
- Te dice que eres mal padre o mala madre y te amenaza con quitarte a tus hijos?
- Actua como que no hay abuso, que la culpa es tuya o niega que lo hizo ?
- Te destruy tus pertenencias o te amenaza con lastimar a tus mascotas ?
- Te intimida con pistolas, cuchillos u otras armas ?
- Te trata con empujones, cachetadas o te golpea ?
- Te obliga a retirar cargos criminales en su contra ?
- Te amenaza con suicidarse si le abandonas ?
- Te amenaza con matarte ?

Si contestaste « Si » a tan solo una pregunta, puedes estar en una relacion abusiva. Llama gratis a nuestra linea de telefono confidencial :

1-800-799-7233 o 1-800-787-3224 (TTY Para los Sordos)

Linea   Nacional   sobre   la   Violencia   Domestica

References

[1] Massachusetts Comprehensive School Health Manual. (1995). In I. F. Goodman, & A. H. Sheetz (Eds.) Mental Health: Developmental Stages (Section 11-1). Boston, Massachusetts: Massachusetts Department of Health.

[2] Children's Defense Organization (1999).Safe Start - Child Welfare and Mental Health Division, Child Abuse. [On-line] Available: http://www.childrensdefense.org/hs_genhlth_faqs.htm

[3] American Academy of Pediatrics. (2001). The Pediatrician's Role in Family Support Programs (RE0022) [On-line]. Available: http://www.AAP.org/policy/re0022.html

[4] The American School Counselor Association. (1999). The Role of the Professional School Counselor [On-line]. Available: http://www.schoolcounselor.org/role.htm

[5] Schafer, W.D./Educational Resources Information Center. (1995). Assessment Skills for School Counselors [On-line]. Available: http://www.ed.gov/databases/ERIC_Digests/ed387709.html

[6] American School Counselor Association. (1999). The Role of the Professional School Counselor [On-line]. Available: http://www.schoolcounselor.org/role.htm

[7] Answers4Families. (2001). Important Facts about School Nurses [On-line]. Available: http://www.answers4families.org/nurses/temp/snfacts.html

[8] National Association of School Nurses. (1996). Position Statement: Substance Use and Abuse [On-line]. Available: http://www.nasn.org/positions/substance.htm

[9] SchoolNurse.com. (2001). Recognizing Sexual Abuse [On-line]. Available: http://www.schoolnurse.com/med_info/Recognizing_sexual_abuse.html

[10] SchoolNurse.com. (2001). Parents Perception of Unhelpful Support [On-line]. Available: http://www.schoolnurse.com/med_info/parentsper.html

[11] National Education Association. (2001). NEA 2000-2001 Resolutions: B-38 Family Life Education [On-line]. Available: http://www.nea.org/resolutions/00/00b-38.html

[12] National Education Association. (2001). NEA 2000-2001 Resolutions: B-38 Family Life Education [On-line]. Available: http://www.nea.org/resolutions/00/00b-38.html

[13] Massachusetts Comprehensive School Health Manual. (1995). In I. F. Goodman, & A. H. Sheetz (Eds.) Mental Health: Common Psychological Problems (Section 11-4). Boston, Massachusetts: Massachusetts Department of Health.

[14] Thompson, R.A. and Brown, N.W. (1999). Fourteen Attitudes. In "School-counselors on the Web." [On-line]. Available: http://www.school-counselors.com/teachers_inspire.html

[15] This section was adapted and reprinted with permission from the UCLA School Mental Health Project, Center for Mental Health in Schools, Department of Psychology. Resource Page, Screening Assessing Students, Indicators and Tools ,(2001). [On-line] Available: http://smhp.psych.ucla.edu/

[16] Jellinek, M., & Murphy, M. (1999). Pediatric Symptom Checklist. Pediatric Developmental and Behavior Homepage sponsored by the American Academy of Pediatrics, Section on Developmental and Behavioral Pediatrics. [On-line] Available: http://www.dbpeds.org/articles/article.cfm?name=psc

[17] Thompson, R.A. and Brown, N.W. (1999). Fourteen Attitudes. In "School-counselors on the Web." [On-line]. Available: http://www.school-counselors.com/teachers_inspire.html

[18] American School Counselors Association. (1999). The Professional School Counselor and the Special Needs Student [On-line]. Available: http://www.schoolcounselor.org

[19] American School Counselors Association. (1999). The Professional School Counselor and Students-at-Risk [On-line]. Available: http://www.schoolcounselor.org/

[20] American Academy of Pediatrics. (2000). Policy Statement: Suicide and Suicide Attempts in Adolescents (RE9928) [On-line]. Available: http://www.AAP.org/policy/re9928.html

[21] American Academy of Pediatrics. (2000). Policy Statement: Suicide and Suicide Attempts in Adolescents (RE9928) [On-line]. Available: http://www.AAP.org/policy/re9928.html

[22] Massachusetts Comprehensive School Health Manual. (1995). In I. F. Goodman, & A. H. Sheetz (Eds.) Mental Health: Suicidal Tendencies (Section 11-7). Boston, Massachusetts: Massachusetts Department of Health.

[23] SchoolNurse.com. (2001). Suicidal Threats in Teens: What would you do? [On-line]. Available: http://www.schoolnurse.com/med_info_/Suicidal_threats.html

[24] American Academy of Pediatrics. (2000). Policy Statement: Suicide and Suicide Attempts in Adolescents (RE9928) [On-line]. Available: http://www.AAP.org/policy/re9928.html

[25] Spring, M. (2001). Eating disorders: facts about eating disorders and the search for solutions National Institute of Mental Health Publication No. 01-4901 [On-line]. Available: http://www.nimh.nih.gov/publicat/eatingdisorder.cfm

[26] Spring, M. (2001). Eating disorders: facts about eating disorders and the search for solutions. National Institute of Mental Health Publication No. 01-4901 [Online]. Available: http://www.nimh.nih.gov/publicat/eatingdisorder.cfm

[27] Massachusetts Comprehensive School Health Manual. (1995). In I. F. Goodman, & A. H. Sheetz (Eds.) Mental Health (section. 11-18). Boston, Massachusetts: Massachusetts Department of Health.

[28] American Academy of Pediatrics. (1995). Policy Statement: The Role of Schools in Combating Substance Abuse (RE9522) [On-line]. Available: http://www.AAP.org/policy/00784.html

[29] American Academy of Pediatrics. (1995). Policy Statement: The Role of Schools in Combating Substance Abuse (RE9522) [On-line]. Available: http://www.AAP.org/policy/00784.html

[30] American School Counselors Association. (2000). Position Statement: The Professional School Counselor and Student Assistance Programs [On-line]. Available: http://www.schoolcounselor.org/

[31] American School Counselors Association. (2000). Position Statement: The Professional School Counselor and Student Assistance Programs [On-line]. Available: http://www.schoolcounselor.org/

[32] National Association of School Nurses. (1996). Position Statement: Substance Use and Abuse [On-line]. Available: http://www.nasn.org/positions/substance.htm

[33] SchoolNurse.com. (2001). Reclaiming Substance Abusers [On-line]. Available: http://www.schoolnurse.com/med_info/Reclaiming_substance.html

[34] American Academy of Pediatrics. (2001). Policy Statement: The Pediatrician's Role in Family Support Programs (RE0022) [On-line]. Available: http://www.AAP.org/policy/re0022.html

[35] American Academy of Pediatrics. (1993). Policy Statement: Homosexuality and Adolescence (RE9332) [On-line]. Available: http://www.AAP.org/policy/05072.html

[36] National Domestic Violence Hotline. (2001). National Domestic Violence Fact Sheet and Statistics [On-line]. Available: http://www.ndvh.org/ndvh2.html

[37] American Academy of Pediatrics. (1999). American Academy of Pediatrics: Policy Statement: The Role of the Pediatrician in Youth Violence Prevention in Clinical Practice and at the Community Level (RE9832) [On-line]. Available: www.aap.org/policy/re9832/html

[38] American Academy of Pediatrics. (1999). American Academy of Pediatrics: Policy Statement: The Role of the Pediatrician in Youth Violence Prevention in Clinical Practice and at the Community Level (RE9832) [On-line]. Available: www.aap.org/policy/re9832/html

[39] Centers for Disease Control and Prevention. (1999). Facts About Violence Among Youth and Violence in Schools [On-line]. Available: www.cdc.gov/od/oc/media/fact/violence/htm

[40] National Mental Health Association. (July 6, 2001). Facts on Violence and Youth [On-line]. Available: www.nmha.org/children/prevent/youthvio.cfm

[41] The National Youth Violence Prevention Resource Center. (July 6, 2001). School Violence [On-line]. Available: www.safeyouth.org

[42] The National Youth Violence Prevention Resource Center. (July 6, 2001). School Violence [On-line]. Available: www.safeyouth.org

[43] Centers for Disease Control and Prevention, (1999). Facts About Violence Among Youth and Violence in Schools [On-line]. Available: www.cdc.gov/od/oc/media/fact/violence/htm

[44] The National Youth Violence Prevention Resource Center. (July 6, 2001). School Violence [On-line]. Available: www.safeyouth.org

[45] The National Youth Violence Prevention Resource Center. (July 6, 2001). School Violence [On-line]. Available: www.safeyouth.org

[46] National Association of School Nurses, (2000). National Association of School Nurses Position Statement: Role of the School Nurse in Violence Prevention [On-line]. Available: www.nasn.org/positions/violenceprev.htm

[47] Texas Statutes (2001). Education Code, Chapter 37 Section 37.202 [On-line]. Available: www.capitol.state.tx.us/statutes/statutes.html

[48] Texas Statutes (2001). Education Code, Chapter 37 Section 37.205 [On-line]. Available: www.capitol.state.tx.us/statutes/statutes.html

[49] Texas Statutes (2001). Education Code, Chapter 37 Section 37.207 [On-line]. Available: www.capitol.state.tx.us/statutes/statutes.html

[50] The U.S. Department of Education & The U.S. Department of Justice. (2000). Safeguarding our Children: An Action Plan [On-line]. Available: www.ed.gov/offices/OSERS/OSEP/ActionGuide/

[51] U.S. Department of Education. (1998). <u>Early Warning, Timely Response: A Guide to Safe School</u> [On-line]. Available: www.ed.gov/offices/OSERS/OSEP/Actionguide/ (p.6)

[52] U.S. Department of Education. (1998). <u>Early Warning, Timely Response: A Guide to Safe School</u> [On-line]. Available: www.ed.gov/offices/OSERS/OSEP/Actionguide/ (pp. 8-11)

[53] U.S. Department of Education. (1998). <u>Early Warning, Timely Response: A Guide to Safe School</u> [On-line]. Available: www.ed.gov/offices/OSERS/OSEP/Actionguide/ (p. 18)

[54] Crawford, D. & Bodine, R. The Office of Juvenile Justice and Delinquency Prevention of the U.S. Department of Justice, Safe and Drug Free Schools Program, and the U.S. Department of Education. (1996). <u>Conflict Resolution Education: A Guide to Implementing Programs in Schools, Youth-Serving Organizations, and Community and Juvenile Justice Settings. Program Report</u> [On-line]. Available: www.ojjdp.ncjrs.org/about/96juvjust/confres.htm

[55] School Mental Health Project: Department of Psychology, University of California, Los Angeles. (2001). <u>Suicidal Assessment Checklist. Screening Assessing Students/Indicators and Tools, Assessment Strategies</u>. [On-line]. Available: http://smhp.psych.ucla.edu/pdfdocs/assessment/assessment.pdf

[56] Jellinek, M., & Murphy, M. (1999). Pediatric Symptom Checklist. Pediatric Developmental and Behavior Homepage sponsored by the American Academy of Pediatrics, Section on Developmental and Behavioral Pediatrics. [On-line] Available: http://www.dbpeds.org/articles/article.cfm?name=psc