HUDSON COUNTY SCHOOLS OF TECHNOLOGY

Mental Health

&

Wellness Handbook

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Mission Statement

We are a dynamic, diverse and compassionate learning community that encourages growth and embraces change through meaningful activities in a student centered environment.

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Introduction

This handbook is a practical, accessible guide to the promotion of good mental health in Hudson County Schools of Technology. It provides staff with up-to-date information on childhood and adolescent mental health concerns commonly encountered in schools, and offers practical suggestions for identifying and supporting students with specific mental health difficulties. The handbook is an invaluable resource for the district. It includes essential information about child and adolescent mental health services and outlines a whole-school approach to the promotion of good mental health.

Mental Health In Context

Research states that on average in schools of around a thousand students at any one time there will be fifty students who are clinically depressed, a further hundred with significant emotional difficulties, ten affected by eating disorders and up to ten who will attempt suicide in the next year (Mind, 1997). The importance of mental health in children and young people is highlighted by recent concerns about increases in:

• children with disruptive behavior being excluded from schools; • violence in schools and juvenile crime;
• psychosocial disorders in young people;
• suicides and incidents of self-harm among children and adolescents; • the numbers of children affected by marital breakdown;
• the numbers of children involved in substance abuse;
• the incidence of children subjected to abuse or neglect.

Due to these factors, children's mental health is being given more attention in schools. School Staff are uniquely placed to influence the mental health of children and young people. As well as being in a position to recognize the symptoms of mental health difficulties at an early stage, they can enhance the social and emotional development of children and foster their mental well-being through their daily responses to students. According to the Mental Health Foundation (1999), schools have 'a critical role to play' in these aspects of mental health. In addition, Rutter (1991) provides evidence that school experiences are important for children's psychological, as well as their intellectual, development and asserts therefore that schools need to concern themselves with children's self-esteem and their social experiences, as well as their academic performance. The majority of children with mental health concerns never reach specialist services so their needs have to be addressed by mainstream institutions, such as schools. At the same time, current pressures on schools, such as the demands of the curriculum, make it more difficult for staff and teachers to address the emotional and social needs of students. Whilst it is desirable that children achieve academic success, personal and social development are also vital if they are to grow into well-adjusted adults.

The inclusion of children with a wide range of special needs in mainstream

schools means that today's teachers and staff must also support many troublesome and troubled children, whose needs are not easily met. Although some teachers may consider that meeting the mental health needs of children does not fall within their remit, unmet emotional needs inevitably impact on children's learning and make the task of teaching more difficult. So it is therefore important for teachers and staff to learn to identify children's mental health needs.

Many mainstream teachers and staff lack awareness of children's mental health issues. They lack the necessary knowledge, understanding and skills for addressing the needs of children with mental health problems. At times, even very experienced teachers and staff can feel out of their depth when faced with such students. They may be uncertain about the approach they should adopt or have concerns that whatever they do may exacerbate these children's difficulties. This dilemma is sometimes reinforced by the reluctance of health professionals to share information with teachers and staff and their failure to acknowledge the constraints that teachers and staff are under when working with these children in a mainstream school setting. It is important that teachers and staff have more knowledge and understanding of children's mental health problems and that they are aware of potential strategies for addressing them. With increased knowledge, training and experience, teachers can do a lot more to improve children's mental health.

Prevention and the promotion of children's emotional well-being

The term mental health encompasses physical and emotional well-being as well as the absence of mental illness. It is about the capacity to live a full and active life and the flexibility to cope with life stresses when they arise (Weare, 2000). In children, it also involves being able to make the most of their abilities and relationships. Encouraging children's emotional competence and developing their social skills can help them to build up resilience to mental health problems, as well as enhancing their learning potential. Schools have a primary role in helping children develop these skills (Mental Health Foundation, 1999) and, in this way, staff and teachers can make a major contribution to addressing both the mental health and learning needs of the children and young people with whom they come into contact. The appointment of mental health coordinators in schools, school-based mental health services, peer support schemes and out of school activities to foster

children's emotional and social skills and to combat growing concern about widespread psychological and psychiatric problems among children is vital. Whilst some children's mental health difficulties may have a distinct biological cause, in the majority of cases environmental factors and children's interactions with those around them can greatly enhance or hinder their progress. An interactive view is now widely accepted and, increasingly, greater emphasis is placed on the impact of the school environment on children with problems (DES, 1989). School influences are very often important contributing factors, for example, in students behaviour (e.g. Galloway *et al*., 1982; Rutter *et al*., 1979) and the importance of the teacher's interaction with pupils is well recognised (Greenhalgh, 1994). The school environment is of paramount importance and it is widely acknowledged that schools and teachers can have an enormous influence on shaping children's emotional development and behaviour, published in the Taylor and Francis e-Library, 2005.

This has led to greater consideration of whole-school approaches to children's mental health problems. By creating a positive ethos teachers can provide a more rather than less therapeutic environment and one which enables pupils to grow emotionally, to be themselves and to discuss their problems rather than having to resort to other ways of demonstrating that they have difficulties. By developing an ethos of trust, openness and understanding, with a focus on relationships, as well as giving students responsibility, staff and teachers can enhance the mental well-being of all students, published in the Taylor and Francis e-Library, 2005.

Hierarchy of children's needs

An important perspective on children's development and behaviour is provided by Maslow (1970), who suggested that children have certain basic needs which must be met if they are to reach their potential in all areas of development. If lower-level needs are not met children will be unable to meet higher-order needs and progress towards self actualisation. Each level of Maslow's hierarchy is described briefly below.

Physiological needs

The lowest level of the hierarchy comprises physiological needs, such as for

food and shelter. If children do not get enough to eat they will be unable to concentrate their attention on the various tasks they must address, including their schoolwork. There is also some evidence to suggest that a poor diet is linked with long-term problems, such as hyperactivity and mental illness in adolescence.

Safety needs

This includes physical and psychological safety. Children living in war zones clearly need to focus on their own safety to the extent that attention cannot be given to higher level needs. However, children can also be afraid for their physical safety in their own homes due to abusing parents, or in their neighbourhoods due to high crime levels. Children in homes where parents are going through a separation or divorce may have their need for psychological safety threatened and therefore may be distracted from addressing the developmental tasks associated with their stages of development.

Love and belonging

The third level is the need for love and belonging, and to feel accepted as part of a group. Children who are withdrawn, isolated or rejected by their peers are therefore unable to move on to address higher-order needs which are critical to the development of sound mental health. They may hide their feelings of rejection or react with antisocial behaviour in order to cover them up.

Self-esteem

The fourth level is the need to feel good about oneself. This crucial need is denied to children who are focused too much on earlier needs and threatened when they are subjected to excessive criticism or are ignored by the important people in their lives. The importance of self-esteem in children's development cannot be overemphasised and is discussed in a separate section below.

Self-actualisation

The fifth level of the hierarchy is the fulfilment of one's potential to the maximum extent possible. This is only possible if lower-level needs are being met.

Self-esteem

It is clear from the theories previously discussed that the acquisition of self-worth or self esteem is one of the most fundamental developmental tasks of childhood. It is therefore not surprising that in children exhibiting signs of behavioural or mental health problems low self-esteem tends to be a common feature.

Self-esteem is the individual's assessment or unconditional appreciation of him- or herself. The term self-esteem is often confused with the self-concept, the sum total of an individual's mental and physical characteristics and his or her evaluation of them (Lawrence, 1987). It has three aspects: thinking (cognitive), feeling (affective) and action (behavioural). Lawrence explains that for teachers it is useful to consider the self-concept as developing in three areas: self-image, ideal self and self-esteem. The self-image is how the individual sees him- or herself whereas the ideal self is what he or she would like to be. Self-esteem is the individual's perception of the discrepancy between the two. How we feel about ourselves is a consequence of how we interpret our experiences and, in many respects, our self-esteem is a cumulative record of how we have been treated and how we treat ourselves throughout life.

Shavelson and Bolus (1982), cited in Lawrence (1987), have proposed a hierarchy of self-esteem which is useful for teachers since it illustrates how the global self-esteem of an individual can be influenced by both academic and non-academic (e.g. social) ability. Children may feel inadequate in some situations more than others. If children who have difficulty learning mathematics, for example, are frequently forced to participate in these activities eventually their overall self-esteem might fall. In addition, if an individual continues to fail in areas of life which are valued by significant others then his or her self esteem will be affected. It is obvious, therefore, that failure at school can easily lead to low global self-esteem, particularly when children have learning difficulties.

The development of self-esteem

The development of self-esteem depends on parental attitudes, opinions and behaviour, combined with children's experience of mastery of the environment. Over the years children's feelings about their worth and capabilities become increasingly internalised and are less dependent upon the immediate responses of those around them. Self-esteem comes from being loved and wanted, as well as having a sense of belonging. Thus, self esteem develops from a reference to other groups, such as family and friends. From early childhood onwards children are trying to find their place in groups, through friends, clubs and religious affiliations. As toddlers learn to walk, explore their environment, play, talk and engage in all kinds of social interactions they look to their parents and other adults for their reactions. This is all part of the development of self-esteem. In healthy families parents' reactions are affirming and supportive, even when limits have to be set on children's behaviour. Parents also need to set realistic expectations for their children. Self-esteem therefore initially develops as a result of interpersonal relationships within the family, which gradually give precedence to school influences and those within the larger society. For children of school age, however, self-esteem continues to be affected mainly by the significant people in their lives, usually parents, teachers and peers.

The development of self-esteem takes place throughout childhood, adolescence and adulthood. It is considered to begin in infancy with the development of basic trust and from relationships with empathic others as well as children's emerging capacity to accomplish tasks successfully. If a child is to flourish emotionally and socially parents have to be very attentive to the noises and expressions of babies. It is this sensitivity from familiar figures that gives children the sense of security required for social and emotional competence. A secure attachment is the basis for the capacity to be curious, to learn and to be sympathetic to the concerns of others. In the first year, the development of the sense of oneself as separate from the surroundings is the first step in the development of self concept and is one of the most important achievements of this period. In the second year of life the infant's ability for self-recognition is usually acquired, with the first categories being age and sex. The realisation of object permanence and intentional behaviour enables the infant to explore and investigate the environment with considerably more confidence. School-age children extend their self-definition to include their likes and dislikes and comparisons with other children. In middle childhood

children's social circles widen so that their self-esteem comes to be influenced by a wider range of people. The influence of the attitudes and opinions of others depends upon how highly such people are valued by children.
Important too are children's successes and failures. Children with disabilities may compare themselves unfavourably with others so it may be more difficult for them to maintain a sense of mastery over their environment, which is an important ingredient of self-esteem. By adolescence the self-image has become part of the personality structure, and, though it is still subject to modification, this becomes harder as the years go by. During adolescence there is an extended period of re-evaluation of one's self.

Diagnosis of abnormal behaviour

In the following explanations of the normal sequence of and conditions for children's development have been presented. Implicit in much of the discussion is the assumption that deviation from the normal sequence of events leads to abnormal development, which results in children having mental health problems. However, the point was made in that children's behaviour needs to be seen as spanning a continuum from naughtiness that is within the normal range of behaviour, through emotional or behavioural difficulties, to mental health problems and disorders. The difficulty then is agreeing criteria for deciding whether behaviour is within the normal range or whether it really is abnormal and therefore warrants attention. There is no one agreed system for child and adolescent mental health disorders, but the most widely used guide for making such decisions is what is commonly referred to as DSM-IV. This is the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994). Within DSM-IV, disorders are grouped together with their own criteria and children who exhibit a sufficient number of symptoms receive the diagnosis. Another system, the ICD-10, the tenth edition of the *International Classification of Diseases* (World Health Organization, 1992), is used more widely in Europe and takes a similar approach.

The classification of mental disorder often seems to have negative connotations, whatever terms are used, but having a classification system creates order and allows broad treatment approaches to be considered for similar cases, as well as providing an agreed system that can be used by different professionals. Being able to classify the problem helps draw on

existing research to understand the child and his or her family and to select effective treatment approaches. It should be recognised, however, that many childhood disorders do not fit neatly into categories and there is often an overlap of symptoms between one disorder and another, despite the fact that, over the last few decades, criteria have become more and more refined.

DSM-IV uses what is called multiaxial assessment because rather than put a problem into a single category, it summarises information in five areas or axes in order to provide a more complete picture. These are outlined below.

Axis I: clinical disorders

These include problems such as schizophrenia, school phobia, mood disorders, anxiety disorders, adjustment disorders and identity disorders.

Axis II: personality disorders and cognitive impairment

These include factors which are not the main concern but which may make the problem worse, such as paranoid thoughts or limited intellectual ability.

Axis III: general medical conditions

These include conditions that may influence behaviour, such as a heart condition or a high level of stress.

Axis IV: psychosocial and environmental problems

These include factors that can add to stress and thereby make problems worse, such as bereavement and marriage breakdown.

Axis V: global functioning

This focuses on how children are functioning in their day-to-day lives. It considers psychological, social and vocational domains. It involves an overall rating on a scale from one to a hundred of how an individual is functioning, with one representing persistent danger of serious harm to self or others and a hundred representing superior functioning in a wide range

of activities.

For diagnosis, the number and severity of symptoms are vital, as is also the requirement for symptoms to lead to significant impairment in a variety of aspects of the child's life. To some extent, however, the cut-off point is arbitrary and if it is too high there may be some children who need help that do not receive it, whilst if it is too low those that might otherwise be considered normal will be diagnosed with the disorder.

DSM-IV has been criticised for taking the view that mental disorder is inherent within the individual and for not taking into account the contextual factors involved. Such a view can lead to children and families abdicating responsibility for behaviour and to limited treatment interventions. More recently, mental health professionals have taken the view that contextual factors are important and this is reflected in their treatment methods. Despite diagnosis, each individual has a unique personality, background and factors that pertain to their particular situation that need to be taken into account when considering treatment approaches. They will have their own strengths, weaknesses and coping strategies and it is important therefore not to rely solely on diagnosis. The giving of a diagnosis in itself has both positive and negative aspects. On the one hand, the negative effects of labelling at this early stage may not be helpful. Once labelled, children may be perceived and responded to differently by their parents, their peer group, teachers and others. The majority of mental health professionals are aware of these issues and guard against unnecessary and negative labelling, as well as encouraging other professionals to do the same. On the other hand, diagnosis makes it easier for the family to cope as the problem becomes more understandable and acceptable and indirectly this is then likely to have a positive effect on the child. Improved access to services and a more positive attitude from others are additional benefits. The benefits of diagnosis therefore have to be weighed against the negative consequences.

Within the following we address ADHD and Conduct Disorder types of mental health problems and disorders likely to be encountered by teachers, the DSM-IV criteria are used to define the mental health problems discussed.

ADHD Features

The symptoms of ADHD can adversely affect children's overall development and can indirectly result in academic failure, low self-esteem, delinquent

behaviour, family conflict and social isolation. The features can vary widely, although the major behaviours, as stated earlier, are hyperactivity, inattention and impulsivity. These are discussed in more depth here.

Hyperactivity

Hyperactivity is concerned with excessive movement. It can involve an increase in the rate of normal activities, an increase in purposeless, minor movements that are irrelevant to the task in hand, fidgeting or restlessness. Observations have shown that excessive movement commonly occurs in children with ADHD and that it may be evident even when they are asleep (Taylor *et al*., 1991). This type of behaviour can be very disruptive and irritating to others and the distinction between what is excessive and what is appropriate in a given situation can be difficult.

Inattention

Inattention can involve attending only briefly to tasks, changing rapidly from one task to another and being distracted by irrelevancies in the environment, as well as concentrating only for brief periods of time. Observations and accounts by parents and teachers show that these types of behaviours are more common in children with ADHD. Whether they are distracted, however, varies considerably with the situation and the task in hand. Such behaviours can have a major adverse effect on children's performance at school and their relationships with teachers, as well as their peers.

Impulsivity

Impulsiveness means acting without reflecting. This might include, for example, thought less rule breaking, impetuously acting out of turn and getting into dangerous situations because of recklessness, all of which can be irritating to both peers and adults. Some children, however, can act in these ways for reasons other than thoughtlessness and these behaviours are often seen in children who are defiant or aggressive, as well as those with ADHD (Taylor *et al*., 1991).

Incidence

The true incidence of ADHD cannot accurately be determined because it

cannot be strictly defined or accurately measured (Barkley, 1990). Incidence rates will depend on the definition used, the population studied and the location, as well as the degree of agreement amongst parents, teachers and professionals. The vast apparent differences in the incidence rates of ADHD between the USA and the UK reflect the confusion over diagnosis. Figures in the UK are given as approximately one in a thousand or 0.1 per cent (Rutter *et al.*, 1970) and in the USA as 5 per cent (Miller *et al.*, 1973). ADHD is more common in boys than girls by a ratio of about seven to one. Girls often show attention deficits and impulsivity problems without hyperactivity or conduct disorder problems and because they are easy to manage they may go unrecognised and their needs unmet. Boys, on the other hand, are more likely to show physical hyperactivity and conduct disorder problems. Some British studies estimate that between 1 and 2 percent of boys in the child population have ADHD (Taylor *et al*., 1991).

Causes

There is no agreed single cause of ADHD. A wide and complex array of influential factors, which are biological, psychological and social in nature, and which can interact in different ways, are likely to be responsible. The pattern of causes and associations is not the same in all cases (Johnston, 1991). Research findings have been inconsistent mainly because of the frequency of associated disorders. The causes implicated have included genetic factors, brain differences, family and social factors, diet and levels of lead in the bloodstream. These are outlined briefly below.

Genetic factors

ADHD may be principally an inherited condition or there may be a biological predisposition to the disorder. Goodman and Stevenson (1989), for example, estimated that heredity accounted for between 30 to 50 per cent of the disorder, whilst common environmental factors, such as poverty, family lifestyle, pollution or diet, accounted for up to 30 per cent. There is little evidence that ADHD can arise purely out of social or environmental factors, although it may be exacerbated by such factors.

Brain differences

Neurological studies suggest that the irregular metabolism of brain chemicals contributes directly to the behaviour patterns seen in children with ADHD. A deficiency in neurotransmitters in the areas of the brain involved in response inhibition, attention and sensitivity to rewards and punishments may characterise some individuals with the disorder (Zametkin *et al*., 1990). Less than 5 percent of children with ADHD have evidence of brain damage caused, for example, by head trauma or brain infection, and more subtle brain injuries, such as birth-related brain injury, have only shown a weak association with ADHD (Barkley, 1990; Wodrich, 1994).

Conduct Disorder Features

Conduct disorder is the most frequently occurring of mental disorders affecting children and adolescents. Its incidence ranges from 6 to 16 per cent in boys and from 2 to 9 per cent in girls (American Psychiatric Association, 1994). However, early, persistent and severe patterns of antisocial conduct only occur in about 5 percent of children (Hinshaw and Anderson, 1996; Kazdin, 1995). Conduct disorder is more prevalent during adolescence than childhood. The incidence of oppositional defiant disorder has consistently been found to be higher than conduct disorder and ranges from 10 to 22 percent of children (Nottleman and Jensen, 1995). The number of referrals for children with conduct disorders to all agencies is considered to be increasing. In childhood, conduct disorder is three or four times more common in boys, although by adolescence this difference decreases (Earls, 1994). In most boys onset occurs before the age of 10, whilst in most girls onset occurs between 13 and 16. There is greater persistence in boys than in girls, although many girls (between 1 and 6 per cent) still display severe conduct problems as young adults. Conduct disorder is universal in that it occurs in every culture and level of society, although different cultures and societies may play different roles in its development and expression. It does, however, tend to be more prevalent in children and adolescents from socially deprived backgrounds.

Causes

There is a diverse range of potential influences on children’s behaviour and this is likely to involve a complex interplay of child, family, community and

cultural factors (Hester and Kaiser, 1998; Holmes *et al*., 2001). Numerous factors have been associated with conduct disorder, but it is often unclear whether they increase the risk or are the result of the disorder. Individual child characteristics, parenting practices and family organisation are probably the key factors that influence the likelihood of problems escalating into later life, although genetics and neurobiological factors may play some part, as do also peer relationships and cultural and media influences, in the development of the disorder. These are each outlined below.

Child characteristics

Certain personal characteristics, including a difficult temperament, impulsivity and educational difficulties, place children at risk for long-term conduct problems. Some

children have a temperament that makes them harder to bring up than others. Academic and intellectual difficulties often precede conduct disorder, although there is little evidence that school failure is a primary cause. Deficits in language, in problem-solving skills and in how these children process information in social situations may provide a common underlying cause (Hinshaw and Anderson, 1996). Children's characteristics interact with family factors in complex ways.

Family factors

Family difficulties, such as parental conflict, violence, stress and psychological problems, have a strong association with conduct disorder. Typically, these children come from families in which divorce or separation, lack of affection, lack of stable and secure family relationships, and inconsistent management are common. Poor parenting skills, including the reinforcement of negative behaviours and the ignoring of positive ones, promote antisocial behaviour (Patterson *et al*., 1982). Harsh or inconsistent discipline, physical abuse and inadequate supervision have also been noted (Dodge *et al*., 1997). A combination of children's individual characteristics and poor parenting skills is often associated with more persistent and severe problems. Additional stresses on families, such as poor housing, poverty

and unemployment, create instability that may further contribute to conduct problems.

Peer relationships

Difficult peer relationships are a risk factor for early-onset conduct disorder and involvement with deviant peers is a powerful predictor of the disorder. In this way, a vicious circle can develop which reinforces negative behaviours. Children with conduct problems are often rejected by non-deviant peers.

Cultural and media influences

Cultural differences in the expression of conduct disorder can be dramatic. One group of children with conduct problems, for example, comes from families who live in communities where delinquent behaviour is accepted and culturally ingrained. These children may live an antisocial life, but they are reasonably well adjusted both socially and emotionally. In addition, a correlation between violence on television and aggressive behaviour has been demonstrated and this can provide a negative model for children to follow.

Genetics

As described above, a number of traits may predispose children to conduct disorder and it has been suggested that half of these may be due to heredity, but the role of genetics needs further study. Temperament and aggression, for example, may be largely inherited. It is thought that a biological backcloth of antisocial behaviour, coupled with an adverse home environment, may interact to produce aggression and conduct disorder.

Neurobiological factors

The need for stimulation in these children may have a neurobiological basis. There are consistent findings that there are neurological deficits in antisocial children compared with others (Moffitt, 1993). Neurobiological factors,

such as low arousal and reactivity, however, are thought to play a greater role in early-onset conduct disorder.

This handbook spans the boundaries of mental health. In doing so, it is hoped that it will provide the information and guidance for teachers and staff needed to help students with mental health concerns. They must also be able to recognize, however, the limits of what they can achieve alone, as well as the indications that children should be referred for more specialist help. When working with students with diagnosed mental health disorders, a teachers and staff role should be complementary to that of mental health workers, with whom they will need to liaise closely.

School Based Mental Health Staff

County Prep High School

School Nurse
*Eileen Garrett Ext.6309
Role:
The school nurse assesses and evaluates the health and developmental status of students. Communicating with students, families and health care providers. Interpreting medical information to school staff working with the student.

School Counselors/Case Manager
*Patricia Villareal Ext.6327
*Tim Brennan Ext. 6329
*Caroline Ulivella Ext. 8468
*Jennifer Constantine Ext.6326
*Eileen Scibette Ext. 6313
*Ann Gherardi Ext. 6316

Role:
School counselors in HCST work to maximize student success, promoting access and equity for all students. As vital members of the school leadership team, school counselors create a school culture of success for all. School

counselors design and deliver school counseling programs that improve student outcomes.

School Social Workers
*Steven Finn Ext. 6315
*Sharon O'Reilly Ext. 6320
Role:
Social workers working in HCST provide services to students to enhance their emotional well-being and improve their academic performance. School social workers can also address issues such as substance abuse and sexuality issues in the higher grade levels.

District Wide School Psychologists
*Marisol Lopez Ext. 6331
*Maria DeMarzo Ext. 6823

Role:
The School psychologists in HCST are uniquely qualified members of school teams that support students' ability to learn and teachers' ability to teach. They apply expertise in mental health, learning, and behavior, to help children and youth succeed academically, socially, behaviorally, and emotionally.

High Tech High School

School Nurse:
Karen Fargo Ext. 6817
The school nurse assesses and evaluates the health and developmental status of students. Communicating with students, families and health care providers. Interpreting medical information to school staff working with the student.

School Counselors/Case Manager
*Neermen Hanna-Avegno Ext. 6822
*Michael Buscio Ext. 6809
*Catherine Alvarez Ext. 6810

*Craig Morrison Ext. 6836
*Danijela Belovarac Ext. 6829
*Maria Mullahey Ext. 6813

Role:
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School Social Workers
*Valeria Arias Ext.6824
*Erica White Ext. 6831
Role:
Social workers working in HCST within school systems provide services to students to enhance their emotional well-being and improve their academic performance. School social workers can also address issues such as substance abuse and sexuality issues in the higher grade levels.

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Explore Middle School

School Nurse
Anthony Fontaine Ext.
Role:
The school nurse assesses and evaluates the health and developmental status of students. Communicating with students, families and health care providers. Interpreting medical information to school staff working with the student.

School Counselors
*Mariel Teschlog Ext. 8358

Role:
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School Social Workers
*Martha Rand Ext. 8580, 3306

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<u>How to refer to the Department of Children & Families (DCPP)</u>

Please Note: All staff are mandated reporters.
You are responsible for making the report once you are aware.

Must contact DCPP immediately
Call: 1800-982-7397
Fax - 201-217-7010
Online - https://www.nj.gov/dcf/about/divisions/dcpp/

*DCPP is able to look at timestamps of when calls are made.
*Call as early as possible.
*Staff- can ask someone to cover class to make a call.
*Staff certificates are at risk if no action is taken. Person who receives the information is the one that makes the call.
*Law Enforcement notification does not replace the phone call.
*Decide as a school how you are going to distribute the "call cards".

What to do when a student threatens harm

Threats: All staff must report any potential threats to the Principal or designee
School based mental health professionals will help determine the type of threat, provide mental health support and refer to the threat assessment team as needed
Threat Assessment Team: (may vary) Meets at least monthly to review threats made
Members include: Administration, school social worker, school psychologist, school counselor, & Director of Special Services.

The above situations require immediate attention and must be communicated in person. DO NOT notify via email or voicemail and DO NOT wait until the end of the day to share your concerns.
Reference communication flow chart to staff (protocols to reporting threats). The Threat Assessment Team utilizes a mandated research based model (CSTAG). It is not staff's responsibility to determine if a threat took place, the team will make that determination. If staff suspects a threat, notify one of the members of the team.

What to do when a student threatens harm

Suicidal Ideations:
All staff must inform administration immediately of any concerns.
School based mental health staff will assess the risk, take appropriate action and consult as needed with the school principal.

The above situations require immediate attention and must be communicated in person. DO NOT notify via email or voicemail and DO NOT wait until the end of the day to share your concerns.

Provide example of how bad it could be if a student threatens self harm and there was no proper protocol follow up by staff
"If not communicated appropriately what could go wrong…"

Reasons for referral to mental health staff

*Student Concerns

*Behaviors, academics, trauma,
significant home life changes, etc.

*Mental health concerns

*Economic hardship

*Early warning system indicators - EDIS

*Substance use concerns

*Pregnant or parenting

*Identify your specific school resources (ie. school supplies, food pantry, closet, etc.)

*Making a referral to mental health staff

Handle with care initiative

Local Police Department will notify the school administrator regarding student concerns in the community.
Staff will then be notified as appropriate with a "Handle with care" email.
No details will be shared regarding the incident.
Intent is for staff to be supportive & understanding towards students.

Please, do NOT ask questions of the student or parent.

Adverse childhood experiences-ACES

Toxic stressors in childhood that lead to changes in learning and behavior.

How can we support students?
Caring Relationships
Positive learning environment
Consistency within the classroom
Clear expectations

-**Examples of ACES**: abuse, neglect, witnessing domestic violence, caregiver depression or addiction

-Possible behavior indications you might see in your students due to trauma include excessive anger, difficulty concentrating, clinginess, alienation from peers, hoarding, etc.

-Adverse Childhood Experiences

Covid-19's Potential Impact on Students

Social/emotional (trouble making friends, clinginess)

Behavioral (physical or verbal aggression, perfectionistic, controlling or anxious behaviors)

Health (increase in risky behaviors such as drug/alcohol abuse or sexual acting out)

* Everyone reacts differently to stressful situations *

How we can support

Utilize SEL (Social Emotional Learning) curriculum

Emphasize routines and traditions

Prioritize relationships

Refer to school-based mental health staff as needed

Long Term Impact of Trauma in Children & Teens

Learning problems, including lower grades and more suspensions and expulsions

Increased use of health and mental health services

Increased involvement with the child welfare and juvenile justice systems

Long-term health problems (diabetes and heart disease)

Unaddressed trauma can lead to more serious outcomes. Important to identify and refer for outside mental health services.

Please Note:

These are just a few examples of ways that students could be impacted. It's important to note that one's response to the outbreak depends on their background, the things that make them different from other people, and the community they live in. We may have students who are just now enrolling after being out of school for a year and/or who have had little contact with peers their age. There will be long term impacts on our students from the pandemic that we will see in the school system.

Mental Health NJ Legislation

N.J. STAT. ANN. § 30:4-27.2(r). "Mental illness" means a current, substantial disturbance of thought, mood, perception or orientation which significantly impairs judgment, capacity to control behavior or capacity to recognize reality, but does not include simple alcohol intoxication, transitory reaction to drug ingestion, organic brain syndrome or developmental disability unless it results in the severity of impairment described herein. The term mental illness is not limited to "psychosis" or "active psychosis," but shall include all conditions that result in the severity of impairment described herein.

N.J. STAT. ANN. § 30:4-27.2(h). "Dangerous to self" means that by reason of mental illness the person has threatened or attempted suicide or serious bodily harm, or has behaved in such a manner as to indicate that the person is unable to satisfy his need for nourishment, essential medical care or shelter, so that it is probable that substantial bodily injury, serious physical debilitation or death will result within the reasonably foreseeable future; however, no person shall be deemed to be unable to satisfy his need for nourishment, essential medical care or shelter if he is able to satisfy such needs with the supervision and assistance of others who are willing and available.

N.J. STAT. ANN. § 30:4-27.2(i) "Dangerous to others or property" means that by reason of mental illness there is a substantial likelihood that the person will inflict serious bodily harm upon another person or cause serious property damage within the reasonably foreseeable future. This determination shall take into account a person's history, recent behavior and any recent act or threat.

Student Wellness: Resources

SEL Curriculums

Class meetings

Schoolwide and classroom routines

Parent-teacher relationships

Parent-student relationships

Student-student relationships

Trauma-informed teachers

Student Mental Health Curriculum

Small group counseling

Individualized behavior plans

Individual Counseling
FBA/BIP

RTI Model (Progression of Services)

Tier 3 - Top - 3-5%
Tier 2 - Middle - 15-20%
Tier 1 - Bottom - 80%

Self Care

Produces positive feelings

Boost your confidence and self-esteem

Remind yourself and others that your needs are important too

Stay sharp motivated and healthy

Mindful of your own needs to better support others

Maintain your physical and emotional health to handle stressors

Mental health website (Links Provided Appendix)

Crisis response

MTSS (Multi-Tiered System of Support)

School based mental health teams

Social Emotional Learning (SEL)

Substance use

Suicide prevention

Risk assessment/Baker Act

Threat assessment

Mental health training

Mental health resources

Activities

Calm Techniques

More than ever students and parents are in need to learn social emotional tools. The following represents mindfulness activities that were utilized with students, parents and teachers during virtual and in person learning to help lessen stress. The activities consisted of breathing exercises, meditation, relaxation and mindful exploration lessons. This was a Flyer give out to students and families.

What is Mindfulness?

Mindfulness is the practice of paying attention to the present moment on purpose with kindness and curiosity. Rooted in Eastern contemplative traditions, mindfulness is non-religious and non-dogmatic and is practiced by people from all walks of life around the world with diverse cultures and spiritual beliefs. Mindfulness should be intentional with all aspects including practices which include breathing meditation, body scan, mindful movement, mindful walking, and mindful eating. Being intentional with our movements one can build the muscle of focused attention and compassionate insight. The length of formal practice can range from 5 min – 1 hour with the potential to go on for much longer periods of uninterrupted silence.

These are three ways to take a deep breath and counter the effects of stress on your mind and body:

Breathe Bubble: A simple breathing exercise to calm and recharge. It only takes a minute and acts like a reset button.

Panic SOS • A 4-minute grounding meditation that works with the breath to ease panic and anxiety.

Afternoon Reset • A seated movement practice to rejuvenate the mind and relieve stiffness in the neck, shoulders, and back.

CALM TIP

Bringing a hint of a smile to the lips during breathing exercises helps to relax the jaw and soften tension in the facial muscles.

Sample Crisis Events - Students or Staff

Medical emergency at school

Accidental death or serious injury

Bus accident

Suicide

Drug Overdose

Homicide

Team Purpose

To respond to a traumatic event and provide immediate support and assistance to those in need…

While re-establishing normalcy in the school as quickly as possible

Team Size
Big enough to provide needed services

With minimal disruption to all schools…

Services include:

Assessment & coordination of crisis intervention services needed

Classroom diffusion for students & staff

Individual crisis intervention

Group crisis intervention

Referrals to community resources

Ongoing support counseling services for days following event

Follow-up consultation

CRISIS TEAM COMMUNICATION

Mental Health Incident

Staff Members
School Nurse
Principal
Interview Student
Contact Parent/Caregiver
Contact Appropriate Personnel (Guidance/CST Team/Mental Health Professional

High Risk
Immediate Intervention
Mobile Crisis Response
Hospital /ER
Screening Tools (Optional)
Hospital clearance to return to school

Moderate Risk
Intervention
Outside Evaluation
Outside clearance to return to school

Low Risk
Intervention
Outside Resources (As appropriate)
School Counseling

Follow Up/Monitor
Or Assigned Designee

Mental Health Incident Descriptors

Risk Present, but lower
Incident Description:
-Vague
-Not Specific
-Resources: Help is available, student acknowledges that help is available.
-Stress: No significant stress
-Other Psychopathology: stable relationships, school performance, personality
-Medical Status: No significant medical problems
-Depression: mild, feels slightly down
-Mental Health: Does not have a mental illness or displaying any symptomatology
-Coping Behaviors: Continues daily activities as usual with little change

Moderate Risk
Incident Description:
-Somewhat specific
-Resources: Family & friends available, but are not perceived by the student to be willing to help or trusts them
-Stress: Moderate reaction to loss and environmental changes
-Other Psychopathology: Recent acting out behavior, possible substance abuse,
-Medical Status: short term or psychosomatic illness
-Depression: moderate, some moodiness, sadness, irritable, loneliness, and decreased energy
-Mental Health: is receiving treatment from school or outside resources
-Coping Behaviors: Some daily activities disrupted, disturbance in schoolwork, eating, sleeping

Higher Risk
Incident Description:
-Very Specific
-Resources: Family and friends are not available and/or hostile, seems exhausted
-Stress: Severe reaction to loss or environmental changes
-Other Psychopathology: Suicidal behavior in unstable personality, emotional disturbance, repeated difficulty with peers, family, teachers
-Medical Status: Chronic, debilitating, acute
-Depression: Overwhelmed with hopelessness, sadness and feelings of helplessness

-Mental Health: Not receiving any treatment and has a diagnosis, presenting with symptoms
-Coping Behaviors: Gross disturbances in daily functioning
Incident Objectives
To ensure the safety and welfare of all students and staff.
To help students and staff begin to recover from the specific incident.
Tactical Objectives
Provide mental health crisis intervention for students and staff when needed.
Make suggestions to outside mental health agencies as needed/community based mental health agencies.
Provide mental health to students assessing the risk level. (E.g) provide psychoeducation, counseling, referrals interventions as needed)

Objectives

Tactical Objectives

Provide mental health crisis intervention for students and staff when needed.
Make suggestions to outside mental health agencies as needed/community based mental health agencies.
Provide mental health to students assessing the risk level. (E.g) provide psychoeducation, counseling, referrals interventions as needed)

Ensure Psychological Safety

Provide school-wide positive behavior supports
Provide universal, targeted, and or academic & social emotional intervention and supports when needed
Develop school safety and crisis response plans
Provide safety education
Provide student guidance and counseling services

Assistant Superintendent for School Support

Contacts board members

Contacts Superintendent

Responds to the media

Establishing a crisis team

Works closely with Principal

Assigns team leader

Ensures protocols are followed

Assists leader with protocols

Give regular updates to the building principal

School Psychologists
Contacts available school psychologists to serve on team

Supervisor of School Health

Notifies school nurse of incident and of the need to refer students as appropriate

Provides additional support to school nurse if necessary

School Principals

Contact the family for condolences and facts

Alter schedules, call staff meetings

Participate in planning meetings

Assign space for crisis team

Update & disseminate information to staff

Discuss & make decisions regarding funeral attendance, student memorials and moment of silence

Address media

Team Leader

Team leader communicates with Director of Interv/DOP Services about the event and the needs of the team

Works with Principal to coordinate all activities including planning & follow-ups

Coordinates letters &/or calls to parents

Coordinates evaluation surveys and completes the activities summary

School Social Workers

Are members of the crisis team when assigned and serve as team leader for the school

Will make crisis response their PRIORITY

Are trained to provide crisis intervention services

Complete required forms and follow protocols

School Psychologists

Are members of the team when available

Provide appropriate services

Complete all required forms & follow protocols

School Counselors

Are members of the team when available OR assist the team by:

Finding and pulling students

Finding private space for counseling

Distributing information to teachers & parents

Providing follow-up services

Teachers

Need to determine if they can teach or need help to "cover" their class(es)

Need to decide if they want to address the class or if they want a crisis team member to do it

Need to identify students in need of assistance and refer to team members

Need to be flexible with instruction and classroom & homework assignments

ALL Team members…

Meet ASAP to develop a plan of action

Provide support and guidance to students and staff

Communicate with identified team leader

Meet at end of day to debrief and plan for subsequent days

Team members SHOULD:

Have crisis team protocol training

Have some training in crisis intervention and response to traumatic events

Have experience and practice responding to crisis

Be able to put aside other work

Not be emotionally tied to the situation

Planning Meeting

Facts of the situation are reviewed (discuss rumor control)

Review of who may be impacted (students and staff)

Decisions are made about announcements and communication with staff, families, and students (outside agencies and the media)

Team members are assigned roles and locations

A debriefing meeting is scheduled

Marsy's Law

Marsy's Law became law in 2018. Amended the state constitution and various state laws to (1) expand the legal rights of crime victims. This includes "the right to prevent the disclosure of information or records that could be used to locate or harass the victim or the victim's family, or which could disclose confidential or privileged information of the victim".

Crisis Counseling Techniques

I'm sorry…….

Introduce yourself

Give some ground rules

Give the FACTS as reported by the family

Discuss what is reported by the media

Discuss rumor control & respect to family

Initiating the Conversation

Express concern

Be genuine

Invite the conversation

Listen and observe

Limit personal sharing

Offer practical advice

Offer reassurance

Maintain contact

Don't Say this
"I lost both my parents when I was your age."
Say this instead
"Tell me more about what this has been like for you."
"**You'll need to be strong now for your family. It's important to get a grip on your feelings."**
Say this instead
"How is your family doing? What kinds of concerns do you have about them?"
"My dog died last week. I know how you must be feeling."
Say this instead
"I know how I've felt when someone I loved died, but I don't really know how you're feeling. Can you tell me something about what this has been like for you?"

Don't Say This
"I know just what you're going through."
Say this instead
"Can you tell me more about what this has been like for you?"
"You must be incredibly angry."
Say this instead

“Most people have strong feelings when something like this happens to them. What has this been like for you?”
“This is hard. But it’s important to remember the good things in life, too.”
Say this instead
“What kinds of memories do you have about the person who died?”
“At least he’s no longer in pain.”
Say this instead
“What sorts of things have you been thinking about since your loved one died?”

Questions to Ask

How did you know the person(s)?

Can you tell me about other losses you have experienced?

What type of coping strategies have you used?

Who would you go to for help if needed?

Have you talked with your parents about this?

Guidelines

Educate about normal crisis reactions

Acknowledge emotions & discuss the “loss” experience

Discuss coping strategies

Discuss options for getting help

Explain importance of sharing with parents

Give handouts as appropriate

Give guidelines for attending funerals

Some Group Activities

Write letters or cards

Do drawings

Create poster

Design T-shirts

Create a sympathy book

Read a book or story about loss

What to look out for

Kids who have very strong reactions

Parent contact & send home

Referral to crisis stabilization unit

Provide follow-up services

Notify other school staff

Meet individually

Parent Communication

Letters go home for students who received individual or group counseling

Calls home (general or individual)

Calls to victim's family

Debriefing

How the day went

Plans for follow up with students

Additional follow up concerns (funerals, media, family, fundraisers, etc.)
Emotional support for team members
Team Leader Summary Forms

Activities Summary

School Evaluation Survey

Team Evaluation Survey

Appendix

Incorporating Positive Psychology Practices Document
https://drive.google.com/file/d/117KL3vPIVGvQmeZu_yTjYjDRu1B_EH62/view?usp=gmail

Self Care Toolkit Document

https://doc-08-3k-docs.googleusercontent.com/docs/securesc/qk1q0ho2f1uteco0qqep0i0ib3hnf1k2/er7koccd5gjufopcbsjoce70706u19vt/1628606625000/17696759157089505893/09464247738921764405/1VbkZ0Mc2cKjf-p8L6wSdPbhcfbZfGhkf?e=download&authuser=0

NJ Legislation

https://www.nj.gov/mhstigmacouncil/community/legislation/

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