

Chapter 7

Behavioral Health in Schools

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Promoting Children's Behavioral Health

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[mentalhealthamerica.net/conditions/childrens-mental-health](https://www.mentalhealthamerica.net/conditions/childrens-mental-health)

Children's Mental Health Matters

Just as you can help prevent a child from catching a cold or breaking a bone, you can help prevent a child from having mental health problems. We know what it takes to keep a child physically healthy—nutritious food, exercise, immunizations—but the basics for good mental health aren't always as clear. The first "basic" is to know that children's mental health matters. We need to treat children's mental health just like we do their physical health, by giving it thought and attention and, when needed, professional help.

Consequences of Mental Illness May Be Prevented

Although there can be a genetic or biological component to mental illness, and many children live in unsafe environments that put them "at-risk" of developing mental health problems, the consequences of mental illness may often be prevented through early intervention. At the very least, it is possible to delay mental illness and/or lessen symptoms. The best way to promote children's mental health is to build up their strengths, help to "protect" them from risks and give them tools to succeed in life.

Mental Health Promotion

Promoting a child's mental health means helping children feel secure and relate well with others, as well as fostering their growth at home and at school. We do this by helping to build a child's confidence and competence—the foundation of strong self-esteem. This can be achieved by providing a child with a safe and secure home; warmth and love; respect; caring and trusting relationships with family, friends, and adults in the community; opportunities to talk about experiences and feelings; time to play, learn, and succeed; encouragement and praise; and consistent and fair expectations with clear consequences for misbehavior.

Know the signs

If there is concern that a child may be experiencing a mental health problem, it is important for adults to seek help from a doctor or mental health professional. Just like with physical illness, treating mental health problems early may help to prevent a more serious illness from developing in the future. Consider consulting a professional if a child you know:

- Feels very sad, hopeless or irritable.
- Feels overly anxious or worried.
- Is scared and fearful; has frequent nightmares.
- Is excessively angry.
- Uses alcohol or drugs.
- Avoids people; wants to be alone all of the time.
- Hears voices or sees things that aren't there.
- Can't concentrate, sit still or focus attention.
- Needs to wash, clean things or perform certain rituals many times a day.
- Talks about suicide or death.
- Hurts other people or animals; or damages property.
- Has major changes in eating or sleeping habits.
- Loses interest in friends or things usually enjoyed.
- Falls behind in school or earns lower grades.

What Parents Can Do

- Care for your children's mental health just as you do for their physical health.
- Pay attention to warning signs, and if you're concerned there might be a problem, seek professional help.
- Let your children know that everyone experiences pain, fear, sadness, worry and anger and that these emotions are a normal part of life; encourage them to talk about their concerns and to express their emotions.
- Be a role model—talk about your own feelings, apologize, don't express anger with violence, and use active problem-solving skills.
- Encourage your children's talents and skills, while also accepting their limitations. Celebrate your children's accomplishments.
- Give your children opportunities to learn and grow, including being involved in their school and community and with other caring adults and friends.
- Think of "discipline" as a form of teaching, rather than as physical punishment; set clear expectations and be consistent and fair with consequences for misbehavior; make sure to acknowledge both positive and negative behaviors.

What Teachers Can Do

- Think about mental health as an important component of a child being "ready to learn;" if a child is experiencing mental health problems, he or she will likely have trouble focusing in school.
- Know the warning signs of mental illness and take note of these in your students and seek consultation from the school mental health professional when you have concerns; psychological and/or educational testing may be necessary.
- Use the mental health professional(s) at your school as resources for: preventive interventions with students, including social skills training; education for teachers and students on mental health, crisis counseling for teachers and students following a traumatic event, and classroom management skills training for teachers.
- Allow your students to discuss troubling events at school or in the community; encourage students to verbally describe their emotions.

What Doctors Can Do

- Recognize that mental health is part of a child's overall health.
- Be informed about mental health issues in children and know the warning signs of mental illness.
- Become familiar with mental health screening tools. Use these when a "red flag" is raised or routinely screen for illness, asking both children and parents about a child's emotions and behaviors—especially substance use, depression symptoms, school performance and talk of suicide.
- Be familiar with the most effective pharmacologic and non-pharmacologic treatment options.
- Make referrals for mental health care when appropriate and follow-up with parents after a referral is made.

Learn more about specific behavioral health conditions and children

- ADHD - attentional problems
- Autism - developmental delay
- Bipolar Disorder - depression and high energy
- Conduct Disorder - behavioral problems
- Depression - sadness
- Grief - coping with loss
- Suicide - thoughts of death/dying
- Substance use - drinking and using drugs

Help is Available

Mental disorders in children are treatable. Early identification, diagnosis and treatment help children reach their full potential and improve the family dynamic. Children's mental health matters! To learn more, talk to a doctor or mental health professional, or visit one of the websites below.

Resources

Mental Health America

800-969-6MHA

mentalhealthamerica.net

American Academy of Child and Adolescent Psychiatry

aacap.org

American Psychiatric Association

psych.org

American Psychological Association

apa.org

Center for Parents and Information Resources

parentcenterhub.org

Federation of Families for Children's Mental Health

ffcmh.org

Kids Mental Health Information Portal

kidsmentalhealth.org

National Alliance On Mental Health

www.nami.org, 800-950-NAMI Helpline

NAMI Georgia

770-234-0855

www.namiga.org

Georgia Collaborative ASO

CA Crisis & Access Line, 1-800-715-4225

mygcal.com

Crisis Text Line, Reach a trained counselor by text.

GA 741741

Role of the School Nurse

While the school nurse is not expected to be an expert in mental health, the reality is that he/she is often one of the few professionals seeing these high-risk children. The school nurse may be responsible for administering the children's psychiatric medication and can often be the first healthcare professional to see the symptoms linked with disorders like anxiety, depression, anorexia and substance abuse.

Making sure school nurses have the proper information related to pediatric mental illness will help move children in the schools toward getting the treatment they need. Having an awareness of mental illness and the symptoms also helps to decrease the stigma attached to mental illness. The reality is that mental illness exists in the pediatric population, but research supports that early detection and treatment is of great importance in the possibility of health restoration.

As a school nurse, the reality of the workload includes covering the entire student population, plus daily medical and medication needs. Managing mental health needs are an important additional responsibility. Keeping the following in mind will help you prioritize your role in mental health as a school nurse:

- Understand the basics of mental health in kids.
- Identify mental health risk factors.
- Decrease stigma.
- Refer for treatment.
- Collaborate with the school counselor/school social worker.
- Talk of suicide should be taken seriously. Intervention should be quickly taken. Please visit the following Web site for a comprehensive tool, "Preventing Suicide – A Toolkit for High Schools."

store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-High-Schools/SMA12-4669?WT.ac=AD20120820HP_4669

On July 1, 2015, HB 198, Jason Flatt Act-Georgia went into effect. This relates to student mental health in elementary and secondary education and requires annual suicide prevention education training for certificated school system personnel.
legis.ga.gov/Legislation/en-US/display/20152016/HB/198

Resources

The Jason Foundation – Provides information about youth suicide and provides free educational material for teachers/youth workers.

jasonfoundation.com/get-involved/educator-youth-worker-coach

Mental Health in Schools, Module 6 – Texas Guide to School Health Programs

dshs.state.tx.us/schoolhealth/pgtoc.shtm

Mental Health in Schools: New Roles for School Nurses – Center for Mental Health in Schools at UCLA

smhp.psych.ucla.edu/pdfdocs/nurses/unit1.pdf

National Strategy for Suicide Prevention 2012: Goals and Objectives for Action

store.samhsa.gov/product/National-Strategy-for-Suicide-Prevention-2012-Goals-and-Objectives-for-Action/PEP12-NSSPGOALS

National Association of School Nurses - The School Nurses Role in Behavioral/Mental Health of Students

<https://www.nasn.org/nasn/advocacy/professional-practice-documents/position-statements/ps-behavioral-health>

Mood Disorders

A mood disorder is a disorder that affects a person's emotional state. The most common mood disorders that affect children are **bipolar disorder and major depression**. According to the National Institutes of Mental Health (NIMH) statistics (nimh.nih.gov/health/statistics/prevalence/any-mood-disorder-in-children.shtml), the prevalence of mood disorders in adolescents ages 13-18 is 14 percent, affecting more girls than boys.

The information below is being reprinted with permission from Mental Health America.

Bipolar Disorder

Many children and especially adolescents experience mood swings as a normal part of growing up, but when these feelings persist and begin to interfere with a child's ability to function in daily life, bipolar disorder could be the cause. Bipolar disorder, also known as manic-depression, is a type of mood disorder marked by extreme changes in mood, energy levels and behavior.

Symptoms can begin in early childhood but more typically emerge in adolescence or adulthood. Until recently, young people were rarely diagnosed with this disorder. Yet up to one-third of the 3.4 million children and adolescents with depression in the United States may actually be experiencing the early onset of bipolar disorder, according to the American Academy of Child and Adolescent Psychiatry. Doctors now recognize and treat the disorder in both children and adolescents, but it is still an under-recognized illness.

Children with bipolar disorder usually alternate rapidly between extremely **high moods (mania) and low moods (depression)**. These rapid mood shifts can produce irritability with periods of wellness between episodes, or the young person may feel both extremes at the same time. Parents who have children with the disorder often describe them as unpredictable, alternating between aggressive or silly and withdrawn. Children with bipolar disorder are at a greater risk for anxiety disorders and attention-deficit hyperactivity disorder (ADHD) and substance abuse. These "co-occurring" disorders complicate diagnosis of bipolar disorder and contribute to the lack of recognition of the illness in children. 1

Signs and Symptoms

Bipolar disorder begins with either **manic or depressive symptoms**. The lists below provide possible signs and symptoms. Not all children with bipolar disorder have all symptoms. Like children with depression, children with bipolar disorder are likely to have a family history of the illness. If a child you know is struggling with any combination of these symptoms for more than two weeks, talk with a doctor or mental health professional.

MANIC SYMPTOMS

- Severe changes in mood—from unusually happy or silly to irritable, angry or aggressive
- Unrealistic highs in self-esteem; may feel indestructible or believe he or she can fly
- Great increase in energy level; sleeps little without being tired
- Excessive involvement in multiple projects and activities; may move from one thing to the next and become easily distracted
- Increase in talking; talks too much, too fast, changes topics too quickly, and cannot be interrupted; may be accompanied by racing thoughts or feeling pressure to keep talking
- Risk-taking behavior such as abusing drugs and alcohol, attempting daredevil stunts, or being sexually active or having unprotected sex.

DEPRESSIVE SYMPTOMS

- Frequent sadness or crying
- Withdrawal from friends and activities
- Decreased energy level, lack of enthusiasm or motivation
- Feelings of worthlessness or excessive guilt
- Extreme sensitivity to rejection or failure
- Major changes in habits such as oversleeping or overeating
- Frequent physical complaints such as headaches and stomachaches
- Recurring thoughts of death, suicide or self-destructive behavior

Many teens with bipolar disorder abuse alcohol and drugs as a way to feel better and escape. Any child or adolescent who abuses substances should be evaluated for a mental health disorder. If an addiction develops, it is essential to treat both the mental health disorder and the substance abuse problem at the same time.

What Can Parents and Caregivers Do?

Bipolar disorder is treatable. Early identification, diagnosis and treatment will help children reach their full potential. Children who exhibit signs of bipolar disorder should be evaluated by a mental health professional that specializes in treating children. The evaluation may include consultation with a child psychiatrist, psychological testing and medical tests to rule out an underlying physical condition that might explain the child's symptoms. A comprehensive treatment plan should include psychotherapy and, in most cases, medication. This plan should be developed with the family, and, whenever possible, the child.

1 Papolos, Demetri F., M.D., "Childhood-onset Bipolar Disorder: Under-diagnosed, Under-treated and Under Discussion," *NARSAD Research Newsletter*, 12(4) Winter 2000/2001: 11-13. Published by the National Alliance for Research on Schizophrenia and Depression, bbrfoundation.org.

Bipolar Resources

The Balanced Mind Foundation

thebalancedmind.org

Bipolar Disorder – Mental Health America

mentalhealthamerica.net/go/information/get-info/bipolar-disorder

Bipolar Disorder - National Institute of Mental health

nimh.nih.gov/health/topics/bipolar-disorder/index.shtml

Depression and Bipolar Support Alliance

ndmda.org

Depression

The information provided below is reprinted with minor modifications from the National Institutes of Mental Health (NIMH) at www.nimh.nih.gov/health/statistics/major-depression.shtml.

In 2016, an estimated 3.1 million adolescents aged 12 to 17 in the United States had at least one major depressive episode. This number represented 12.8 percent of the U.S. population aged 12 to 17. The prevalence of major depressive episode was higher among adolescent females (19.4%) compared to males (6.4%).

Because normal behaviors vary from one childhood stage to another, it can be difficult to tell whether a child who shows changes in behavior is just going through a temporary “phase” or is suffering from depression.

In The Past

- People believed that children could not get depression. Teens with depression were often dismissed as being moody or difficult.
- It wasn't known that having depression could increase a person's risk for heart disease, diabetes and other diseases.
- Today's most commonly used type of antidepressant medications did not exist. Selective serotonin reuptake inhibitors (SSRIs) resulted from the work of the late Nobel Laureate and NIH researcher Julius Axelrod, who defined the action of brain chemicals (neurotransmitters) in mood disorders.

Today

- We now know that youth who have depression may show signs that are slightly different from the typical adult symptoms of depression. Children who are depressed may complain of feeling sick, refuse to go to school, cling to a parent or caregiver, or worry excessively that a parent may die. Older children and teens may sulk, get into trouble at school, be negative or grouchy, or feel misunderstood.
- Findings from NIMH-funded, large-scale effectiveness trials are helping doctors and their patients make better individual treatment decisions. For example, the Treatment for Adolescents with Depression Study (TADS) found that combination treatment of medication and psychotherapy works best for most teens with depression.
nimh.nih.gov/funding/clinical-research/practical/tads/index.shtml
- The Treatment of SSRI-resistant Depression in Adolescents (TORDIA) study found that teens who did not respond to a first antidepressant medication are more likely to get better if they switch to a treatment that includes both medication and psychotherapy.
nimh.nih.gov/funding/clinical-research/practical/tordia/treatment-of-ssri-resistant-depression-in-adolescents-tordia.shtml
- The Treatment of Adolescent Suicide Attempters (TASA) study found that a new treatment approach that includes medication plus a specialized psychotherapy designed specifically to reduce suicidal thinking and behavior may decrease suicide attempts in severely depressed teens.
Journal of the American Academy of Child & Adolescent Psychiatry, 2009-10-01, Volume 48, Issue 10, Pages 987-996.
- Depressed teens with coexisting disorders such as substance abuse problems are less likely to respond to treatment for depression. Studies focusing on conditions that frequently co-occur and how they affect one another may lead to more targeted screening tools and interventions.
- With medication, psychotherapy or combined treatment, most youth with depression can be effectively treated. Youth are more likely to respond to treatment if they receive it early in the course of their illness.
- Although antidepressants are generally safe, the U.S. Food and Drug Administration has placed a “black box” warning label—the most serious type of warning—on all antidepressant medications. The warning says there is an increased risk of suicidal thinking or attempts in youth taking antidepressants. Youth and young adults should be closely monitored especially during initial weeks of treatment.

- Studies focusing on depression in teens and children are pinpointing factors that appear to influence risk, treatment response and recovery. Given the chronic nature of depression, effective intervention early in life may help reduce future burden and disability.
- Multigenerational studies have revealed a link between family history of depression and changes in brain structure and function, some of which may precede the onset of depression. This research is helping to identify biomarkers and other early indicators that may lead to better treatment or prevention.
- Advanced brain imaging techniques are helping scientists identify specific brain circuits that are involved in depression and yielding new ways to study the effectiveness of treatments.

Tomorrow

- Years of research are now showing promise for the first new generation of antidepressant medications in two decades, with a goal of relieving depression in hours, rather than weeks. Such a potential breakthrough could reduce the rate of suicide, which is consistently one of the leading causes of death for young people. In 2015, the CDC listed suicide as the second leading cause of death for youth ages 15-19 and the third leading cause of death for youth ages 10-14.
- Research on novel treatment delivery approaches, such as telemedicine (providing services over satellite, Internet, phone or other remote connections) and collaborative or team-based care in medical care settings will improve the quality of mental health care for youth.
- Sophisticated gene studies have suggested common roots between depression and possibly other mental disorders. In addition to identifying how and where in the brain illnesses start before symptoms develop, these findings have also encouraged a new way of thinking about and categorizing mental illnesses. In this light, NIMH has embarked on a long-term project—called the Research Domain Criteria (RDoC) project—aimed at ultimately improving the treatment and prevention of depression by studying the classification of mental illnesses, based on genetics and neuroscience, in addition to clinical observation.

nimh.nih.gov/research-priorities/rdoc/index.shtml

Signs and Symptoms of Depression

Know the warning signs for depression. Note the duration, frequency and severity of troubling behavior. The following symptoms often persist more days than not for at least two weeks*:

- Persistent sad, anxious or “empty” feelings
- Feelings of hopelessness or pessimism
- Feelings of guilt, worthlessness or helplessness
- Irritability, restlessness
- Loss of interest in previously pleasurable activities or hobbies, including sex
- Fatigue and decreased energy
- Difficulty concentrating, remembering details and making decisions
- Insomnia, early-morning wakefulness or excessive sleeping
- Overeating or appetite loss
- Thoughts of suicide, suicide attempts
- Aches or pains, headaches, cramps or digestive problems that do not ease even with treatment

*National Institutes of Mental Health

nimh.nih.gov/health/publications/depression/what-are-the-signs-and-symptoms-of-depression.shtml

What Can Parents and Other Caregivers Do?

- Get accurate information from health care providers, libraries, hotlines, the Internet and other sources.
- Take the child to see a mental health professional or doctor for evaluation and diagnosis if he or she is exhibiting several of the warning signs noted above. The evaluation may include psychological testing, laboratory tests and consultation with other specialists.
- Ask questions about treatments and services. A comprehensive treatment plan may include psychotherapy, ongoing evaluation and, in some cases, medication. Optimally, the treatment plan is developed with the family and, whenever possible, the child.
- Talk to other families in your community or find a family network organization.

Early Childhood Depression (0-5)

Although rare and the studies are limited, clinical depression can begin as early as preschool.

Signs and Symptoms:

- The depressed preschooler may:
- Appear less joyful
- Feelings of guilt
- Have difficulty enjoying activities and play
- Decreased in activity level
- Difficulty with sleep
- Have problems with appetite
- Have feelings of sadness or irritability
- Anger outbursts or acting out behaviors

Treatment of Preschool Depression:

- Different types of therapy can be helpful, such as cognitive behavioral therapy (CBT), Parent-Child Interactive Therapy and Play Therapy

Depression Resources

Depression – Mental Health America

[mentalhealthamerica.net/index.cfm?objectid=C7DF94A1-1372-4D20-C81EDE3D3BB4474C](https://www.mentalhealthamerica.net/index.cfm?objectid=C7DF94A1-1372-4D20-C81EDE3D3BB4474C)

Depression – National Institute of Mental Health

[nimh.nih.gov/health/topics/depression/index.shtml](https://www.nimh.nih.gov/health/topics/depression/index.shtml)

Depression and Bipolar Support Alliance

[dbsalliance.org](https://www.dbsalliance.org)

Depression in Teens – Mental Health America

[mentalhealthamerica.net/index.cfm?objectid=C7DF950F-1372-4D20-C8B5BD8DFDD94CF1](https://www.mentalhealthamerica.net/index.cfm?objectid=C7DF950F-1372-4D20-C8B5BD8DFDD94CF1)

Anxiety Disorders

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An anxiety disorder is a mental health problem that can affect people of all ages, including children. In fact, anxiety disorders are the most common type of mental health disorder in children. According to the NIMH, the lifetime prevalence is 32 percent of children ages 13-18, affecting girls more than boys.

[nimh.nih.gov/health/statistics/prevalence/any-anxiety-disorder-among-children.shtml](https://www.nimh.nih.gov/health/statistics/prevalence/any-anxiety-disorder-among-children.shtml)

All children experience some anxiety; this is normal and expected. For example, when left alone at preschool for the first time, many children will show distress; or a young child within his or her own room may develop a fear of the dark. Such anxiety becomes a problem when it interrupts a child's normal activities, like attending school and making friends or sleeping. Persistent and intense anxiety that disrupts daily routine is a mental health problem that requires help.

Anxiety Disorders Most Common to Children

Generalized Anxiety Disorder

Children with generalized anxiety disorder (GAD) have recurring fears and worries that they find difficult to control. They worry about almost everything—school, sports, being on time, even natural disasters. They may be restless, irritable, tense or easily tired, and they may have trouble concentrating or sleeping. Children with GAD are usually eager to please others and may be “perfectionists,” dissatisfied with their own less-than-perfect performance.

Separation Anxiety Disorder

Children with separation anxiety disorder have intense anxiety about being away from home or caregivers that affects their ability to function socially and in school. These children have a great need to stay at home or be close to their parents. Children with this disorder may worry excessively about their parents when they are apart from them. When they are together, the child may cling to parents, refuse to go to school, or be afraid to sleep alone. Repeated nightmares about separation and physical symptoms such as stomachaches and headaches are also common in children with separation anxiety disorder.

Social Phobia

Social phobia usually emerges in the mid-teens and typically does not affect young children. Young people with this disorder have a constant fear of social or performance situations such as speaking in class or eating in public. This fear is often accompanied by physical symptoms such as sweating, blushing, heart palpitations, shortness of breath or muscle tenseness. Young people with this disorder typically respond to these feelings by avoiding the feared situation. For example, they may stay home from school or avoid parties. Young people with social phobia are often overly sensitive to criticism, have trouble being assertive and suffer from low self-esteem. Social phobia can be limited to specific situations, so the adolescent may fear dating and recreational events but be confident in academic and work situations.

Obsessive-Compulsive Disorder

Obsessive-compulsive disorder (OCD) typically begins in early childhood or adolescence. Children with OCD have frequent and uncontrollable thoughts (called “obsessions”) and may perform routines or rituals (called “compulsions”) in an attempt to eliminate the thoughts. Those with the disorder often repeat behaviors to avoid some imagined consequence. For example, a compulsion common to people with OCD is excessive handwashing due to a fear of germs. Other common compulsions include counting, repeating words silently and rechecking completed tasks. In the case of OCD, these obsessions and compulsions take up so much time that they interfere with daily living and cause a young person a great deal of anxiety. People with OCD realize their thoughts are irrational but are unable to stop the thoughts or behaviors.

Post-Traumatic Stress Disorder

Children who experience a physical or emotional trauma such as witnessing a shooting or disaster, surviving physical or sexual abuse, or being in a car accident may develop post-traumatic stress disorder (PTSD). Children are more easily traumatized than adults. An event that may not be traumatic to an adult—such as a bumpy plane ride—might be traumatic to a child. A child may “re-experience” the trauma through nightmares, constant thoughts about what happened, or reenacting the event while playing. A child with PTSD will experience symptoms of general anxiety, including irritability or trouble sleeping and eating. Children may exhibit other symptoms such as being easily startled.

What Can Parents and Other Caregivers Do?

By identifying, diagnosing and treating anxiety disorders early, parents and others can help children reach their full potential. Anxiety disorders are treatable. Effective treatment for anxiety disorders may include some form of psychotherapy, behavioral therapy or medications. Children who exhibit persistent symptoms of an anxiety disorder should be referred to and evaluated by a mental health professional that specializes in treating children. The diagnostic evaluation may include psychological testing and consultation with other specialists. A comprehensive treatment plan should be developed with the family, and, whenever possible, the child should be involved in making treatment decisions.

Early Childhood Anxiety

It is common for children to experience anxiety. However, when the child’s worries and/or fear seem to be getting in the way of their functioning, then they could be suffering from anxiety disorder.

Common symptoms:

- Worrying more days than not (for at least 6 months)
- Trouble controlling the worry
- Feeling restless, keyed up, or on edge
- Irritability
- Muscle tension
- Problems falling and/ or staying asleep
- Fears of specific objects (i.e., shots, dogs), performance, or social situations
- Frequently upset when being away from parents/ caregivers and/or worried that something bad will happen to them
- Frequent complaints of physical symptoms (i.e., headaches, stomachaches)
- Refusing to go to school

Implications for Untreated Anxiety:

- Problems with school and friends
- School refusal
- Family problems
- The anxiety worsens and/ or frequently returns

Common Dilemmas for Those Caring for the Child

- The child’s anxiety takes up a lot of time of those caring for them
- Those caring for the child can get “drawn in” to the anxiety such as giving excessive reassurance
- Those caring for the child may succumb to “giving in”
- Those caring for the child may be unsure whether the behavior is “attention-seeking” or not
- Family may get concerned about what to tell the school, friends, and others

Common Misconceptions:

- The child should be protected from being anxious
- The child's anxiety should be kept a secret
- We should not acknowledge the fear
- The child's anxiety and fear is misunderstood for being defiant

How Those Caring for the Child Can Help:

- Acknowledge and accept the anxiety as legitimate
- Provide confidence in the child's ability to cope (and expect them to work on coping with their anxiety gradually)
- Acknowledge all the ways in which those caring for the child are accommodating the anxiety
- Collaboration among those caring for the child is important

Treatment for anxiety disorders:

- Cognitive Behavioral Therapy (CBT) – can help the child work on skills to cope with the anxiety and fears they have been avoiding
- Medication – Antidepressants are not approved until the age of 6 in children. In certain severe cases, antidepressants, such as Selective Serotonin Reuptake Inhibitors (SSRIs) are used to treat anxiety in children before the age of 6 and are most helpful when combined with cognitive behavioral therapy
- Parent, child and family interventions – In therapy, the parent and caregiver are taught by the therapists on interventions and skills to use with their child to address their fears and anxiety.

Anxiety Disorder Resources

Anxiety and Depression Association of America

adaa.org

Anxiety Disorders and Kids – Mental Health America

mentalhealthamerica.net/go/information/get-info/anxiety-disorders

“Stress Can Really Get On Your Nerves.” Romain, Trevor,
Free Spirit Publishing; (Revised & Updated Edition) edition (April 26, 2018)

amazon.com/Stress-Really-Nerves-Laugh-Learn%C2%AE/dp/1631982451

Obsessive-Compulsive Foundation

ocfoundation.org

Self-Harm

In the United States, youth have the highest burden of nonfatal self-inflicted injury (i.e., deliberate physical harm against oneself, inclusive of suicidal and nonsuicidal intent) requiring medical attention. One study found that emergency department (ED) visits for these injuries during the 1993 to 2008 period varied by age group, ranging from 1.1 to 9.6 per 1000 ED visits, with adolescents aged 15 to 19 years exhibiting the highest rates.

<https://jamanetwork.com/journals/jama/article-abstract/2664031>

Symptoms

Signs and symptoms of self-injury may include:

- Scars
- Fresh cuts, scratches, bruises or other wounds
- Excessive rubbing of an area to create a burn
- Keeping sharp objects on hand
- Wearing long sleeves or long pants, even in hot weather
- Difficulties in interpersonal relationships
- Persistent questions about personal identity, such as “Who am I?” “What am I doing here?”
- Behavioral and emotional instability, impulsivity and unpredictability
- Statements of helplessness, hopelessness or worthlessness

NIMH definitions of common terms

- **Suicide** is defined as death caused by self-directed injurious behavior with intent to die as a result of the behavior.
- A **suicide attempt** is a non-fatal, self-directed, potentially injurious behavior with intent to die as a result of the behavior. A suicide attempt might not result in injury.
- **Suicidal ideation** refers to thinking about, considering, or planning suicide.

Suicide is the second leading cause of death in youth ages 15-19, and the third leading cause of death ages 10-14. (CDC, 2015)

A 2015 nationwide study of youths in 9-12th grade found that 17.7% of students reported seriously considering suicide, 14.6% reported creating a plan and 8.6% reported trying to take their own lives in the 12 months preceding the survey. (CDC Youth Risk Survey)

Suicide admissions to Children’s Hospitals doubled over the last decade.

Risk Factors:

- Previous suicide attempt
- Close family member who has died by suicide
- Past psychiatric hospitalization
- Recent losses
- Social isolation and or hopelessness
- Co-occurring mental and alcohol or substance abuse disorders
- Impulsive and/or aggressive tendencies
- Exposure to violence in the home or social environment
- Handguns in the home, especially if loaded
- Parental psychopathology
- Chronic physical illness

Suicide is a complex human behavior, with no single determining cause. The following groups have demonstrated a higher risk for suicide or suicide attempts than the general population:

- American Indians and Alaska Natives
- People bereaved by suicide
- People in justice and child welfare settings
- People who intentionally hurt themselves
- People who have previously attempted suicide
- People with medical conditions
- People with mental/substance use disorders
- People who are LGBT

Reference

<https://www.cdc.gov/vitalsigns/suicide/index.html>

Suicide Resources

American Academy of Child & Adolescent Psychiatry

aacap.org/Default.aspx

American Association of Suicidology

suicidology.org

Georgia Crisis and Access Line

1-800-715-4224

Jason Foundation, Inc. (JFI) at Focus by the Sea

jasonfoundation.com/resources

Kristin Brooks Hope Center – Hopeline

800-SUICIDE (800-784-2433)

hopeline.com

National Suicide Prevention Lifeline

800-273-TALK (8255)

suicidepreventionlifeline.org

S.A.F.E. Alternatives (Self-Abuse Finally Ends)

800-DON'T CUT (800-366-8288)

selfinjury.com

Self Injury – Mental Health America

mentalhealthamerica.net/go/information/get-info/self-injury

The Jed Foundation

jedfoundation.org

Young People and Suicide: Safeguarding Your Students against Suicide – Mental Health America

mentalhealthamerica.net/young-people-and-suicide-safeguarding-your-students-against-suicide

Suicide Prevention Lifeline

1-800-273-TALK or 1-800-SUICIDE

Crisis Text Line, Reach a trained counselor by text.

GA 741741

Substance Abuse

Every year, the Monitoring the Future (MTF) survey measures drug, alcohol and tobacco use and related attitudes among eighth, 10th and 12th graders. The following are facts and statistics about youth substance use from the 2017 MTF report.

drugabuse.gov/publications/drugfacts/high-school-youth-trends

Illicit Drug Use

- Illicit drug use among teenagers was increasing as of 2011 but has remained steady or decreased somewhat in more recent years.
- Substances at historic low levels of use include alcohol and cigarettes, heroin, prescription opioids, MDMA (Ecstasy or Molly), methamphetamine, amphetamines, and sedatives.
- Other illicit drugs showed five-year declines, such as synthetic marijuana, hallucinogens other than LSD, and over-the-counter cough and cold medications.
- Five-year trends, however, did reveal an increase in LSD use among high school seniors, although use still remains lower compared to its peak in 1996.
- Despite the continued rise in opioid and overdose deaths and high levels of opioid misuse among adults, lifetime, past-year, and past-month misuse of prescription opioids (narcotics other than heroin) dropped significantly over the last five years in 12th graders.
- Past-year marijuana use declined among 10th graders and remains unchanged among 8th and 12th graders compared to five years ago, despite the changing state marijuana laws.

Alcohol

- Alcohol use among teens has dropped to historically low levels, as has binge drinking.

Tobacco

- Use of traditional cigarettes has continued to decline to the lowest levels in the survey's history.
- Use of other tobacco products including hookah and smokeless tobacco declined among high school seniors.

Prescription Drug Abuse

The following information has been adapted from "Smart Moves, Smart Choices – Get Smart, Take Action, Teen Prescription (Rx), Drug Abuse Awareness School Tool Kit" (pages 10, 11, 15 - August 2011).

smartmovessmartchoices.org/pdfs/SmartMoves_SchoolToolKit_Web.pdf

Teen prescription drug abuse is a serious and growing problem in the United States.

- One in four teens has taken a prescription drug that was not prescribed for them by a doctor, for the purpose of getting high or for any other reason. ¹
- Every day, 2,500 young people use a prescription pain reliever for a nonmedical use for the first time. ²
- Prescription medications are the drug of choice for 12 to 13-year-olds. ³

Where do teens get prescription medications?

Most teens say they get their hands on prescription drugs from the homes of friends and relatives. In fact, access to medications can be as easy as opening a medicine cabinet, drawer or kitchen cupboard in a teen's own home or a relative's house.

However, research shows that teens who learn a lot about the risks of drugs from their parents are up to 50 percent less likely to use drugs. ⁴

For a comprehensive list of the signs and symptoms of prescription medication abuse, visit smartmovessmartchoices.org/educators.

Educators Can Make a Difference

Because students attend school every day, teachers, principals and school nurses may be able to notice changes or problems in teens even before parents do. Educators are in a perfect position to educate students about the dangers of prescription drug abuse and address any problem situations that they notice.

BE AWARE OF CHANGES IN STUDENTS

Look for the signs and symptoms of prescription drug abuse in your students, including physical, behavioral and academic changes.

IMPLEMENT AWARENESS PROGRAMS

Let students know that the school takes prescription drug abuse seriously and implement awareness programs aimed at students, teachers and parents. Help students understand the risks and consequences of prescription drug abuse by holding school assemblies and implementing lesson plans.

GET PARENTS INVOLVED

Educate parents about teen prescription drug abuse and encourage them to:

- Safeguard teens by restricting access to prescription medications in the home. Take all prescription medications out of accessible areas and put them in a safe, locked location.
- Stress that prescription medications should NEVER be shared.
- Inform grandparents, other relatives and neighbors about this issue and encourage them to lock up all medications in their homes.
- Begin a dialogue with teenagers about prescription drug abuse and encourage open, honest and nonjudgmental communication.
- Properly dispose of all unused or expired prescription medications.
- Learn to recognize the signs of abuse.
- Be good role models.

- 1 The Partnership at DrugFree.org and MetLife Foundation. 2010 Partnership Attitude Tracking Study (PATS) Key Findings, 2011: 2.
- 2 U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) Office of Applied Studies. *A Day in the Life of American Adolescents: Substance Use Facts*. The OAS 2007: Report, 2007:2.
- 3 U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) Office of Applied Studies. *Results from the 2009 National Survey on Drug Use and Health: Volume I*. National Findings: 18.
- 4 The Partnership at DrugFree.org and MetLife Foundation. *2008 Parents Attitude Tracking Study (PATS)*, 2009:11.

Additional resources from this material can be viewed at smartmovessmartchoices.org.

Substance Abuse Resources

American Council for Drug Education

acde.org

"Best practices in ATOD Prevention Handbook." Markwood, Alan., 1997.

chestnut.org/Portals/14/PDF_Documents/Lighthouse/Downloads/97bestp4.pdf

DrugFacts: High School and Youth Trends – National Institute on Drug Abuse, The Science of Drug Abuse and Addiction

drugabuse.gov/publications/drugfacts/high-school-youth-trends

Preventing Drug Abuse among Children and Adolescents (In Brief) – The National Institute on Drug Abuse

drugabuse.gov/pdf/prevention/InBrief.pdf

Preventing Drug Abuse: The Best Strategy

drugabuse.gov/publications/science-addiction/preventing-drug-abuse-best-strategy

Smart Moves – Smart Choices School Toolkit

smartmovessmartchoices.org/pdfs/SmartMoves_SchoolToolKit_Web.pdf

SAMHSA'S National Helpline 24/7, 365 day a year treatment referral and information in English and Spanish for individuals and family members facing mental illness and or substance use disorders

1-800-662-help (4357)

Attention Deficit Hyperactivity Disorder (ADHD)

The following information was adapted from the National Institutes of Mental Health at [nimh.nih.gov/health/publications/attention-deficit-hyperactivity-disorder/index.shtml](https://www.nimh.nih.gov/health/publications/attention-deficit-hyperactivity-disorder/index.shtml).

Attention deficit hyperactivity disorder (ADHD) is one of the most common childhood disorders and can continue through adolescence and adulthood. Symptoms include difficulty staying focused and paying attention, difficulty controlling behavior and hyperactivity (over-activity).

ADHD has three subtypes:

1. Predominantly hyperactive-impulsive

- Most symptoms (six or more) are in the hyperactivity-impulsivity categories.
- Fewer than six symptoms of inattention are present, although inattention may still be present to some degree.

2. Predominantly inattentive

- The majority of symptoms (six or more) are in the inattention category and fewer than six symptoms of hyperactivity-impulsivity are present, although hyperactivity-impulsivity may still be present to some degree.
- Children with this subtype are less likely to act out or have difficulties getting along with other children. They may sit quietly, but they are not paying attention to what they are doing. Therefore, the child may be overlooked, and parents and teachers may not notice that he or she has ADHD.

3. Combined hyperactive-impulsive and inattentive

- Six or more symptoms of inattention and six or more symptoms of hyperactivity-impulsivity are present.
- Most children have the combined type of ADHD.

Treatments can relieve many of the disorder's symptoms, but there is no cure. With treatment, most people with ADHD can be successful in school and lead productive lives. Researchers are developing more effective treatments and interventions, and using new tools, such as brain imaging, to better understand ADHD and to find more effective ways to treat and prevent it.

Symptoms of ADHD in Children

Inattention, hyperactivity and impulsivity are the key behaviors of ADHD. It is normal for all children to be inattentive, hyperactive or impulsive sometimes, but for children with ADHD, these behaviors are more severe and occur more often. To be diagnosed with the disorder, a child must have symptoms for six or more months and to a degree that is greater than other children of the same age.

Children who have symptoms of **inattention** may:

- Be easily distracted, miss details, forget things and frequently switch from one activity to another
- Have difficulty focusing on one thing
- Become bored with a task after only a few minutes, unless they are doing something enjoyable
- Have difficulty focusing attention on organizing and completing a task or learning something new
- Have trouble completing or turning in homework assignments, often losing things (e.g., pencils, toys, assignments) needed to complete tasks or activities
- Not seem to listen when spoken to
- Daydream, become easily confused and move slowly
- Have difficulty processing information as quickly and accurately as others
- Struggle to follow instructions.

Children who have symptoms of **hyperactivity** may:

- Fidget and squirm in their seats
- Talk nonstop
- Dash around, touching or playing with anything and everything in sight
- Have trouble sitting still during dinner, school and story time
- Be constantly in motion
- Have difficulty doing quiet tasks or activities.

Children who have symptoms of **impulsivity** may:

- Be very impatient
- Blur out inappropriate comments, show their emotions without restraint, and act without regard for consequences
- Have difficulty waiting for things they want or waiting their turns in games
- Often interrupt conversations or others' activities.

ADHD Can Be Mistaken for Other Problems

Parents and teachers can miss the fact that children with symptoms of inattention have the disorder because they are often quiet and less likely to act out. They may sit quietly, seeming to work, but they often are not paying attention to what they are doing. They may get along well with other children, compared with those with the other subtypes who tend to have social problems. But children with the inattentive kind of ADHD are not the only ones whose disorders can be missed. For example, adults may think that children with the hyperactive and impulsive subtypes just have emotional or disciplinary problems.

Causes

Scientists are not sure what causes ADHD, although many studies suggest that genes play a large role. Like many other illnesses, ADHD probably results from a combination of factors. In addition to genetics, researchers are looking at possible environmental factors and are studying how brain injuries, nutrition and the social environment might contribute to ADHD.

Genes

Inherited from our parents, genes are the "blueprints" for who we are. Results from several international studies of twins show that ADHD often runs in families. Researchers are looking at several genes that may make people more likely to develop the disorder. Knowing the genes involved may one day help researchers prevent the disorder before symptoms develop. Learning about specific genes could also lead to better treatments.

Children with ADHD who carry a particular version of a certain gene have thinner brain tissue in the areas of the brain associated with attention. This NIMH research showed that the difference was not permanent, however, and as children with this gene grew up, the brain developed to a normal level of thickness. Their ADHD symptoms also improved.

Environmental factors

Studies suggest a potential link between cigarette smoking and alcohol use during pregnancy and ADHD in children. In addition, preschoolers who are exposed to high levels of lead, which can sometimes be found in plumbing fixtures or paint in old buildings, may have a higher risk of developing ADHD.

Brain injuries

Children who have suffered a brain injury may show some behaviors similar to those of ADHD. However, only a small percentage of children with ADHD have suffered a traumatic brain injury.

Sugar

The idea that refined sugar causes ADHD or makes symptoms worse is popular, but more research discounts this theory than supports it. In one study, researchers gave children foods containing either sugar or a sugar substitute every other day. The children who received sugar showed no different behavior or learning capabilities than those who received the sugar substitute. Another study in which children were given higher than average amounts of sugar or sugar substitutes showed similar results.

In one more study, children who were considered sugar-sensitive by their mothers were given the sugar substitute aspartame, also known as Nutrasweet. Although all the children got aspartame, half their mothers were told their children were given sugar, and the other half were told their children were given aspartame. The mothers who thought their children had gotten sugar rated them as more hyperactive than the other children and were more critical of their behavior, compared to mothers who thought their children received aspartame.

Food additives

Recent British research indicates a possible link between consumption of certain food additives like artificial colors or preservatives and an increase in activity. Research is underway to confirm the findings and to learn more about how food additives may affect hyperactivity.

Diagnosing ADHD

Children mature at different rates and have different personalities, temperaments and energy levels. Most children get distracted, act impulsively and struggle to concentrate at one time or another. Sometimes, these normal factors may be mistaken for ADHD. ADHD symptoms usually appear early in life, often between the ages of 3 and 6, and because symptoms vary from person to person, the disorder can be hard to diagnose. Parents may first notice that their child loses interest in things sooner than other children, or seems constantly "out of control." Often, teachers notice the symptoms first, when a child has trouble following rules, or frequently "spaces out" in the classroom or on the playground.

No single test can diagnose a child as having ADHD. Instead, a licensed health professional needs to gather information about the child and his or her behavior and environment. A family may want to talk first with the child's pediatrician. Some pediatricians can assess the child themselves, but many will refer the family to a mental health specialist with experience in childhood mental disorders such as ADHD. The pediatrician or mental health specialist will first try to rule out other possibilities for the symptoms. For example, certain situations, events or health conditions may cause temporary behaviors in a child that seem like ADHD.

The referring pediatrician and specialist will determine if a child:

- Is experiencing undetected seizures that could be associated with other medical conditions
- Has a middle ear infection that is causing hearing problems
- Has any undetected hearing or vision problems
- Has any medical problems that affect thinking and behavior
- Has any learning disabilities
- Has anxiety or depression, or other psychiatric problems that might cause ADHD-like symptoms
- Has been affected by a significant and sudden change, such as the death of a family member, a divorce or parent's job loss

A specialist will also check school and medical records for clues, to see if the child's home or school settings appear unusually stressful or disrupted, as well as gather information from the child's parents and teachers. Coaches, babysitters and other adults who know the child well also may be consulted.

The specialist also will ask:

- Are the behaviors excessive and long-term, and do they affect all aspects of the child's life?
- Do they happen more often in this child compared with the child's peers?
- Are the behaviors a continuous problem or a response to a temporary situation?
- Do the behaviors occur in several settings or only in one place, such as the playground, classroom or home?

The specialist pays close attention to the child's behavior during different situations. Some situations are highly structured, but some have less structure. Others would require the child to keep paying attention. Most children with ADHD are better able to control their behaviors in situations where they are getting individual attention and when they are free to focus on enjoyable activities. These types of situations are less important in the assessment. A child also may be evaluated to see how he or she acts in social situations, and may be given tests of intellectual ability and academic achievement to see if he or she has a learning disability.

Finally, if after gathering all this information the child meets the criteria for ADHD, he or she will be diagnosed with the disorder.

Treating ADHD

Currently available treatments focus on reducing the symptoms of ADHD and improving functioning. Treatments include medication, various types of psychotherapy, education or training, or a combination of these treatments.

Medications

The most common type of medication used for treating ADHD is called a "stimulant." Although it may seem unusual to treat ADHD with a medication considered a stimulant, it actually has a calming effect on children with ADHD. Many types of stimulant medications are available. A few other ADHD medications are non-stimulants and work differently than stimulants. For many children, ADHD medications reduce hyperactivity and impulsivity and improve their ability to focus, work and learn. Medication also may improve physical coordination.

However, a one-size-fits-all approach does not apply for all children with ADHD. What works for one child might not work for another. One child might have side effects with a certain medication, while another child may not. Sometimes several different medications or dosages must be tried before finding one that works for a particular child. Any child taking medications must be monitored closely and carefully by caregivers and doctors.

Stimulant medications come in different forms, such as a pill, capsule, liquid or skin patch. Some medications also come in short-acting, long-acting or extended release varieties. In each of these varieties, the active ingredient is the same, but it is released differently in the body. Long-acting or extended release forms often allow a child to take the medication just once a day before school, so they don't have to make a daily trip to the school nurse for another dose. Parents and doctors should decide together which medication is best for the child and whether the child needs medication only for school hours or for evenings and weekends, too.

A list of medications and the approved age for use follows. ADHD can be diagnosed and medications prescribed by M.D.s (usually a psychiatrist) and in some states also by clinical psychologists, psychiatric nurse practitioners and advanced psychiatric nurse specialists. Check with your state's licensing agency for specifics.

Trade Name	Generic Name	Approved Age
Adderall	amphetamine	3 and older
Adderall XR	amphetamine (extended release)	6 and older
Concerta	methylphenidate (long acting)	6 and older
Daytrana	methylphenidate patch	6 and older
Desoxyn	methamphetamine hydrochloride	6 and older
Dexedrine	dextroamphetamine	3 and older
Dextrostat	dextroamphetamine	3 and older
Focalin	dexmethylphenidate	6 and older
Focalin XR	dexmethylphenidate (extended release)	6 and older
Intuniv	guanfacine	6 and older
Kapvay	clonidine	6 and older
Metadate ER	methylphenidate (extended release)	6 and older
Metadate CD	methylphenidate (extended release)	6 and older
Methylin	methylphenidate (oral solution and chewable tablets)	6 and older
Ritalin	methylphenidate	6 and older
Ritalin SR	methylphenidate (extended release)	6 and older
Ritalin LA	methylphenidate (long acting)	6 and older
Strattera	atomoxetine	6 and older
Vyvanse	lisdexamfetamine dimesylate	6 and older

*Not all ADHD medications are approved for use in adults.

NOTE: "Extended Release" means the medication is released gradually so that a controlled amount enters the body over a period of time. "Long Acting" means the medication stays in the body for a long time.

SIDE EFFECTS OF STIMULANT MEDICATIONS

The most commonly reported side effects are decreased appetite, sleep problems, anxiety and irritability. Some children also report mild stomachaches or headaches. Most side effects are minor and disappear over time or if the dosage level is lowered.

- **Decreased appetite.** Be sure the child eats healthy meals. If this side effect does not go away, suggest to the parent to talk to the child's doctor. Also talk to the doctor if there are concerns about the child's growth or weight gain while he or she is taking this medication.
- **Sleep problems.** If a child cannot fall asleep, the doctor may prescribe a lower dose of the medication or a shorter-acting form. The doctor might also suggest giving the medication earlier in the day, or stopping the afternoon or evening dose. Adding a prescription for a low dose of an antidepressant or a blood pressure medication called clonidine sometimes helps with sleep problems. A consistent sleep routine that includes relaxing elements like warm milk, soft music or quiet activities in dim light may also help.
- **Less common side effects.** A few children develop sudden, repetitive movements or sounds called tics. These tics may or may not be noticeable. Changing the medication dosage may make tics go away. Some children also may have a personality change, such as appearing "flat" or without emotion. **The child's doctor should be contacted if you see any of these side effects.**

ARE STIMULANT MEDICATIONS SAFE?

Under medical supervision, stimulant medications are considered safe. Stimulants do not make children with ADHD feel high, although some kids report feeling slightly different or “funny.” While some parents worry that stimulant medications may lead to substance abuse or dependence, there is little evidence of this.

FDA WARNING ON POSSIBLE RARE SIDE EFFECTS

In 2007, the FDA required that all makers of ADHD medications develop Patient Medication Guides that contain information about the risks associated with the medications. The guides must alert patients that the medications may lead to possible cardiovascular (heart and blood) or psychiatric problems. The agency undertook this precaution when a review of data found that ADHD patients with existing heart conditions had a slightly higher risk of strokes, heart attacks and/or sudden death when taking the medications.

The review also found a slight increased risk, about 1 in 1,000, for medication-related psychiatric problems, such as hearing voices, having hallucinations, becoming suspicious for no reason or becoming manic (an overly high mood), even in patients without a history of psychiatric problems. The FDA recommends that any treatment plan for ADHD incorporate an initial health history, including family history, and examination for existing cardiovascular and psychiatric problems.

One ADHD medication, the non-stimulant atomoxetine (Strattera), carries another warning. Studies show that children and teenagers who take atomoxetine are more likely to have suicidal thoughts than children and teenagers with ADHD who do not take it. **If a child is taking atomoxetine, watch his or her behavior carefully. A child may develop serious symptoms suddenly, so it is important to pay attention to the child’s behavior every day.** Ask parents and other people who spend a lot of time with the child to tell you if they notice changes in the child’s behavior. Call a doctor right away if the child shows any unusual behavior. While taking atomoxetine, your child should see a doctor often, especially at the beginning of treatment, and be sure that your child keeps all appointments with his or her doctor.

DO MEDICATIONS CURE ADHD?

Current medications do not cure ADHD. Rather, they control the symptoms for as long as they are taken. Medications can help a child pay attention and complete schoolwork. It is not clear, however, whether medications can help children learn or improve their academic skills. Adding behavioral therapy, counseling and practical support can help children with ADHD and their families to better cope with everyday problems. Research funded by the National Institute of Mental Health (NIMH) has shown that medication works best when treatment is regularly monitored by the prescribing doctor and the dose is adjusted based on the child’s needs.

Psychotherapy

Different types of psychotherapy are used for ADHD. Behavioral therapy aims to help a child change his or her behavior. It might involve practical assistance, such as help organizing tasks or completing schoolwork, or working through emotionally difficult events. Behavioral therapy also teaches a child how to monitor his or her own behavior. Learning to give oneself praise or rewards for acting in a desired way, such as controlling anger or thinking before acting, is another goal of behavioral therapy. Parents and teachers also can give positive or negative feedback for certain behaviors. In addition, clear rules, chore lists and other structured routines can help a child control his or her behavior.

Therapists may teach children social skills, such as how to wait their turn, share toys, ask for help or respond to teasing. Learning to read facial expressions and the tone of voice in others and how to respond appropriately can also be part of social skills training.

How can parents help?

Children with ADHD need guidance and understanding from their parents and teachers to reach their full potential and to succeed in school. Before a child is diagnosed, frustration, blame and anger may have built up within a family. Parents and children may need special help to overcome bad feelings. Mental health professionals can educate parents about ADHD and how it impacts a family. They also will help the child and his or her parents develop new skills, attitudes and ways of relating to each other.

Parenting skills training helps parents learn how to use a system of rewards and consequences to change a child's behavior. Parents are taught to give immediate and positive feedback for behaviors they want to encourage, and to ignore or redirect behaviors they want to discourage. In some cases, the use of "time-outs" may be used when the child's behavior gets out of control. In a time-out, the child is removed from the upsetting situation and sits alone for a short time to calm down.

Parents are also encouraged to share a pleasant or relaxing activity with the child, to notice and point out what the child does well, and to praise the child's strengths and abilities. They may also learn to structure situations in more positive ways. For example, they may restrict the number of playmates to one or two, so that their child does not become overstimulated. Or, if the child has trouble completing tasks, parents can help their child divide large tasks into smaller, more manageable steps. Also, parents may benefit from learning stress-management techniques to increase their own ability to deal with frustration, so that they can respond calmly to their child's behavior.

Sometimes, the whole family may need therapy. Therapists can help family members find better ways to handle disruptive behaviors and to encourage behavior changes. Finally, support groups help parents and families connect with others who have similar problems and concerns. Groups often meet regularly to share frustrations and successes, to exchange information about recommended specialists and strategies, and to talk with experts.

Tips for Parents to Help Kids Stay Organized and Follow Directions

- **Schedule.** Keep the same routine every day, from wake-up time to bedtime. Include time for homework, outdoor play and indoor activities. Keep the schedule on the refrigerator or on a bulletin board in the kitchen. Write changes on the schedule as far in advance as possible.
- **Organize everyday items.** Have a place for everything, and keep everything in its place. This includes clothing, backpacks, and toys.
- **Use homework and notebook organizers.** Use organizers for school material and supplies. Stress to your child the importance of writing down assignments and bringing home the necessary books.
- **Be clear and consistent.** Children with ADHD need consistent rules they can understand and follow.
- **Give praise or rewards when rules are followed.** Children with ADHD often receive and expect criticism. Look for good behavior, and praise it.

What conditions can coexist with ADHD?

Some children with ADHD also have other illnesses or conditions. For example, they may have one or more of the following:

- **A learning disability** – A child in preschool with a learning disability may have difficulty understanding certain sounds or words or have problems expressing himself or herself in words. A school-aged child may struggle with reading, spelling, writing and math.
- **Oppositional defiant disorder** – Kids with this condition, in which a child is overly stubborn or rebellious, often argue with adults and refuse to obey rules.
- **Conduct disorder** – This condition includes behaviors in which the child may lie, steal, fight or bully others. He or she may destroy property, break into homes or carry or use weapons. These children or teens are also at a higher risk of using illegal substances. Kids with conduct disorder are at risk of getting into trouble at school or with the police.
- **Anxiety and depression** – Treating ADHD may help to decrease anxiety or some forms of depression.
- **Bipolar disorder** – Some children with ADHD may also have this condition in which extreme mood swings go from mania (an extremely high elevated mood) to depression in short periods of time.

- **Tourette syndrome** – Very few children have this brain disorder, but among those who do, many also have ADHD. Some people with Tourette syndrome have nervous tics and repetitive mannerisms, such as eye blinks, facial twitches or grimacing. Others clear their throats, snort or sniff frequently, or bark out words inappropriately. These behaviors can be controlled with medication.

ADHD also may coexist with a sleep disorder, bed-wetting, substance abuse or other disorders or illnesses.

ADHD Resources

Children and Adults with Attention Deficit/Hyperactivity Disorder
chadd.org

National Center for Learning Disabilities
www.NCLD.org

All Kinds of Minds
www.allkindsofminds.org

Great Schools - Learning Disabilities
<http://www.greatschools.org/special-education.topic?content=1541>

Impact ADHD: Helping Parents Help Kids
<http://impactadd.com/>

Understood - For Learning & Attention Issues
<https://www.understood.org/en/about/our-founding-partners/learning-disabilities-association-of-america>

Books

All Dogs have ADHD by Kathy Hoopman

101 ADHD - ADD Tips by Brenda Murphy

ADHD and Teens by Colleen Alexander-Roberts

Driven to Distraction: Recognizing & Coping with ADD from Childhood to Adulthood.
Author: Edward Hallowell

Eating Disorders

According to the NIMH, lifetime prevalence of eating disorders in adolescents ages 13-18 is 2.7 percent, affecting more girls than boys. However, it is important to note that eating disorders do exist in boys and are often missed because they present differently. For example, they may occur when boys appear to be eating healthy and working out in an effort to fit in for sports. For additional information about the prevalence of Eating Disorders among Children, please visit [nimh.nih.gov/health/statistics/prevalence/eating-disorders-among-children.shtml](https://www.nimh.nih.gov/health/statistics/prevalence/eating-disorders-among-children.shtml).

The content below is adapted from Mental Health America.

People with eating disorders experience serious disturbances in their eating patterns, such as a severe and unhealthy reduction in their food intake or overeating, as well as extreme concern about body shape or weight. Eating disorders usually develop during adolescence or early adulthood.¹ Eating disorders are not due to weak willpower or bad behavior; rather, they are real, treatable illnesses. The two main types of eating disorders are anorexia nervosa and bulimia nervosa.

Anorexia Nervosa

Extreme weight loss and believing that one is fat despite excessive thinness are key features of anorexia.

The following behaviors are signs that a person may have anorexia:

- Skips meals, takes tiny portions, will not eat in front of others or eats in ritualistic ways
- Always has an excuse not to eat
- Will only eat a few "safe," low-calorie, low-fat foods
- Loses hair, looks pale or malnourished, and wears baggy clothes to hide thinness
- Grows more body hair called "lanugo"; this is the body's attempt to insulate the skin because of low body fat
- Loses weight, yet fears obesity and complains of being fat despite excessive thinness
- Detests all or specific parts of the body, insists she or he cannot feel good about self unless thin
- Exercises excessively and compulsively
- Holds to rigid, perfectionist standards for self and others
- Withdraws into self and feelings, becoming socially isolated
- Has trouble talking about feelings, especially anger

Bulimia Nervosa

People who have bulimia regularly binge-eat and then attempt to prevent gaining weight from their binge through purging (e.g., vomiting, abusing laxatives, exercising excessively).

The following are signs that a person may have bulimia:

- Binges, usually in secret, and empties cupboards and refrigerator
- Buys "binge food" (usually junk food or food high in calories, carbohydrates and sugar)
- Leaves clues that suggest discovery is desired: empty food packages; foul-smelling bathrooms; running water to cover sounds of vomiting; use of breath fresheners; poorly hidden containers of vomit
- Uses laxatives, diet pills, water pills or "natural" products to promote weight loss
- Abuses alcohol or street drugs to deaden appetite or escape emotional pain
- Displays a lack of impulse control that can lead to rash and regrettable decisions about sex, money, commitments, careers, etc.

Causes of Eating Disorders

As with most mental illnesses, eating disorders are not caused by just one factor but by a combination of sociocultural, psychological and biological factors.

Sociocultural and psychological factors

- Low self-esteem⁴
- Pressures to be thin (i.e., pressure to lose weight from family and friends)³
- Cultural norms of attractiveness as promoted by magazines and popular culture³
- Use of food as way of coping with negative emotions³
- Rigid, “black or white” thinking (e.g., “being fat is bad” and “being thin is good”)³
- Over-controlling parents who do not allow expression of emotion³
- History of sexual abuse³

Biological factors

- Genetic predisposition to eating disorders, depression and anxiety³
- Certain personality styles, for example obsessive-compulsive personality type²
- Deficiency or excess of certain brain chemicals, or neurotransmitters, especially serotonin⁴

What Other Mental Illnesses Commonly “Co-occur” with Eating Disorders?

Mental illnesses such as depression, anxiety and alcohol/drug addiction are sometimes found in people with eating disorders. Some of these disorders may influence the development of an eating disorder, and some are consequences of it. Many times, eating and co-occurring disorders reinforce each other, creating a vicious cycle.

What are the Long-term Effects of Eating Disorders?

Left untreated, eating disorders may lead to malnutrition; muscle atrophy; dry skin, hair, and nails; dental problems; insomnia or chronic fatigue; ulcers; low blood pressure; diabetes; anemia; kidney, liver and pancreas failure; osteoporosis and arthritis; infertility; seizures; heart attack; and death:

- The most common causes of death are complications of the disorders, including suicide.¹
- The mortality rate among people with anorexia is 12 times higher than the death rate among females ages 15 to 24 from all other causes.¹

What Treatments are Available?

Eating disorders are treatable. The sooner they are diagnosed and treated, the better the outcomes are likely to be. Eating disorders require a comprehensive, long-term treatment plan that usually involves individual or family therapy and may include medication and immediate hospitalization. Unfortunately, many people with eating disorders will not admit they are ill and refuse treatment. Support from family and friends is vital to successful treatment and recovery.¹

2016 American Academy of Pediatrics Message Regarding preventing Obesity and Eating Disorders in Adolescence

<http://pediatrics.aappublications.org/content/138/3/e20161649>

- Discourage dieting – encourage healthy eating and physical activity behaviors
- Promote positive body image – do not encourage body dissatisfaction
- Encourage more frequent family meals
- Encourage families not to talk about weight – encourage talk about healthy eating and being active to stay healthy
- Inquire about a history of mistreatment or bullying in overweight and obese teenagers – address this issue if present
- Carefully monitor weight loss in an adolescent who needs to lose weight – ensure the patient does not develop the medical complications of starvation

References

1. The National Institute of Mental Health, "Eating Disorders: Facts about Eating Disorders and the Search for Solutions," Pub No. 01-4901, Feb. 2002, omh.ny.gov/omhweb/booklets/EatingDisorder.pdf.
2. Anorexia Nervosa and Related Eating Disorders, Inc. Website. Feb. 2002, anred.com.
3. Nolen-Hoeksema, Susan, *Abnormal Psychology, 2nd Ed.* Boston: McGraw Hill, 2001.

Eating Disorders Resources

Anorexia Nervosa and Related Eating Disorders, Inc. (ANRED)

anred.com

Eating Disorder Information and Referral Center

EDreferral.com

Eating Disorder Referral and Information Center

edreferral.com/findingatherapist.htm#Finding/Evaluating%20a%20Therapist

Eating Disorders – Mental Health America

mentalhealthamerica.net/conditions/eating-disorders

National Association of Anorexia Nervosa and Associated Disorders (ANAD)

anad.org

National Eating Disorders Association (NEDA)

nationaleatingdisorders.org

Screening for Mental Health – National Eating Disorder Awareness

mentalhealthscreening.org/media/national-eating-disorder-awareness-week-february-22-28

National Eating Disorders Screening Program (NEDSP)

mentalhealthscreening.org/events/national-eating-disorder-screening-program.aspx

Overeaters Anonymous (OA)

overeatersanonymous.org

SmartGirl

smartgirl.org/about/library.html#healthb

The Harris Center for Education and Advocacy in Eating Disorders (formerly the Harvard Eating Disorders Center)

harriscentermgh.org

The Renfrew Center Foundation

renfrew.org

Bullying

The information below is adapted from stopbullying.gov.

Definition

Bullying is unwanted, aggressive behavior among school-aged children that involves a real or perceived power imbalance. The behavior is repeated, or has the potential to be repeated, over time. Both kids who are bullied and who bully others may have serious, lasting problems.

In order to be considered bullying, the behavior must be aggressive and include:

An Imbalance of Power

Kids who bully use their power—such as physical strength, access to embarrassing information or popularity—to control or harm others. Power imbalances can change over time and in different situations, even if they involve the same people.

Repetition

Bullying behaviors happen more than once or have the potential to happen more than once. Bullying includes actions such as making threats, spreading rumors, attacking someone physically or verbally, and excluding someone from a group on purpose.

There are three types of bullying:

VERBAL BULLYING

Saying or writing mean things and includes:

- Teasing
- Name-calling
- Inappropriate sexual comments
- Taunting
- Threatening to cause harm

SOCIAL BULLYING

Sometimes referred to as relational bullying, involves hurting someone's reputation or relationships. Social bullying includes:

- Leaving someone out on purpose
- Telling other children not to be friends with someone
- Spreading rumors about someone
- Embarrassing someone in public

PHYSICAL BULLYING

Involves hurting a person's body or possessions. Physical bullying includes:

- Hitting/kicking/pinching
- Spitting
- Tripping/pushing
- Taking or breaking someone's things
- Making mean or rude hand gestures

Where and When Bullying Happens

Bullying can occur during or after school hours. While most reported bullying happens in the school building, a significant percentage also happens in places like on the playground or the bus. It can also happen travelling to or from school, in the youth's neighborhood, or on the Internet.

Cyberbullying

Cyberbullying is bullying that takes place using electronic technology. Electronic technology includes devices and equipment such as cell phones, computers and tablets, as well as communication tools including social media sites, text messages, chat and websites. Examples of cyberbullying include mean text messages or emails, rumors sent by email or posted on social networking sites, and embarrassing pictures, videos, websites or fake profiles.

Why Cyberbullying Is Different

Kids who are being cyberbullied are often bullied in person as well. Additionally, kids who are cyberbullied have a harder time getting away from the behavior.

- Cyberbullying can happen 24 hours a day, 7 days a week, and reach a kid even when he or she is alone. It can happen any time of the day or night.
- Cyberbullying messages and images can be posted anonymously and distributed quickly to a very wide audience. It can be difficult and sometimes impossible to trace the source.
- Deleting inappropriate or harassing messages, texts and pictures is extremely difficult after they have been posted or sent.

Effects of Cyberbullying

Cell phones and computers themselves are not to blame for cyberbullying. Social media sites can be used for positive activities, like connecting kids with friends and family, helping students with school, and for entertainment. But these tools can also be used to hurt other people. Whether done in person or through technology, the effects of bullying are similar.

Kids who are cyberbullied are more likely to:

- Use alcohol and drugs
- Skip school
- Experience in-person bullying
- Be unwilling to attend school
- Receive poor grades
- Have lower self-esteem
- Have more health problems

Frequency of Cyberbullying

The 2014 Indicators of School Crime and Safety (National Center for Education Statistics and Bureau of Justice Statistics) indicates that 7 percent of students in grades 6–12 experienced cyberbullying. The 2013 Youth Risk Behavior Surveillance Survey finds that 14.8 percent of high school students (grades 9-12) were electronically bullied in the past year. Research on cyberbullying is growing. However, because kids' technology use changes rapidly, it is difficult to design surveys that accurately capture trends.

Risk Factors for Bullying

No single factor puts a child at risk of being bullied or bullying others. Bullying can happen anywhere—cities, suburbs or rural towns. Depending on the environment, some groups—such as lesbian, gay, bisexual or transgendered (LGBT) youth, youth with disabilities and socially isolated youth—may be at an increased risk of being bullied.

Children at Risk of Being Bullied

Generally, children who are bullied have one or more of the following risk factors:

- Are perceived as different from their peers, such as being overweight or underweight, wearing glasses or different clothing, being new to a school, or being unable to afford what kids consider “cool”
- Are perceived as weak or unable to defend themselves
- Are depressed and anxious, or have low self esteem
- Are less popular than others and have few friends
- Do not get along well with others, seen as annoying or provoking, or antagonize others for attention

However, even if a child has these risk factors, it doesn't mean that they will be bullied.

Weight-Based Bullying

Research has shown that obese children are more likely to be bullied compared to non-obese children, regardless of sex, race, social skills, academic performance or socioeconomic status. Overweight or obese kids are not only more likely to be bullied, but they may also perpetuate bullying against other kids.

Weight-based bullying may continue even after overweight youth have experienced weight loss. One study published in the Journal of the American Academy of Pediatrics (<http://pediatrics.aappublications.org/content/early/2012/12/19/peds.2012-1106>) assessed a group of adolescents who had achieved a healthy Body Mass Index (BMI), after having a history of being overweight. Researchers found that 64 percent of these adolescents reported weight-based teasing by their:

- Peers (92 percent)
- Friends (70 percent)
- PE teachers/sport coaches (42 percent)
- Parents (37 percent)
- Teachers (27 percent)

When assessing or addressing bullying in schools, it is important not to exclude anyone as a victim or perpetrator. Evidence shows that weight-based bullying can affect children of different body shapes and sizes and can come from multiple sources including:

- Cyberbullying
- Peers, friends, family-members
- Adults in authoritative positions
 - Even well-intentioned adults may unintentionally criticize or tease children about their weight in ways that are emotionally damaging.

Weight-based bullying negatively affects the health and well-being of students; and as a school nurse, you can have a substantial role in addressing it and preventing student-targets from suffering alone, in silence. Please refer to anti-bullying strategies discussed later in this section. In addition to interacting with at-risk children and promoting coping strategies, it is important that the school nurse interact with parents in order to:

- Equip them with the tools necessary to help improve the health of their child and entire family.
- Educate them about weight-based bullying and provide appropriate strategies to help reduce the child's distress due to bullying. At a later time, if indicated by family as a need or desire, help the family to address their child's weight (if indicated) with sensitivity and adequate support (see Chapter 5 and view the Weight Management section for additional information).

Children More Likely to Bully Others

There are two types of kids who are more likely to bully others:

1. Some are well-connected to their peers, have social power, are overly concerned about their popularity, and like to dominate or be in charge of others.
2. Others are more isolated from their peers and may be depressed or anxious, have low self esteem, be less involved in school, be easily pressured by peers, or not identify with the emotions or feelings of others.

Children who have these factors are also more likely to bully others:

- Are aggressive or easily frustrated
- Have less parental involvement or having issues at home
- Think badly of others
- Have difficulty following rules
- View violence in a positive way
- Have friends who bully others

Remember, those who bully others do not need to be stronger or bigger than those they bully. The power imbalance can come from a number of sources—popularity, strength, cognitive ability—and children who bully may have more than one of these characteristics.

Signs a Child Is Being Bullied

There are many warning signs that may indicate that someone is affected by bullying—either being bullied or bullying others. Recognizing the warning signs is an important first step in taking action against bullying. Not all children who are bullied or are bullying others ask for help. It is important to talk with children who show signs of being bullied or bullying others. These warning signs can also point to other issues or problems, such as depression or substance abuse. Talking to the child can help identify the root of the problem.

Look for changes in the child. However, be aware that not all children who are bullied exhibit warning signs. Some signs that may point to a bullying problem are:

- Unexplainable injuries
- Lost or destroyed clothing, books, electronics, or jewelry
- Frequent headaches or stomach aches, feeling sick or faking illness
- Changes in eating habits, like suddenly skipping meals or binge eating. Kids may come home from school hungry because they did not eat lunch.
- Difficulty sleeping or frequent nightmares
- Declining grades, loss of interest in schoolwork, or not wanting to go to school
- Sudden loss of friends or avoidance of social situations
- Feelings of helplessness or decreased self esteem
- Self-destructive behaviors such as running away from home, harming themselves, or talking about suicide

If you know someone in serious distress or danger, don't ignore the problem. Get help right away.

Signs that a Child is Bullying Others

Kids may be bullying others if they:

- Get into physical or verbal fights
- Have friends who bully others
- Are increasingly aggressive
- Get sent to the principal's office or to detention frequently
- Have unexplained extra money or new belongings
- Blame others for their problems
- Don't accept responsibility for their actions
- Are competitive and worry about their reputation or popularity

Why don't kids ask for help?

Statistics from the 2008–2009 School Crime Supplement show that an adult was notified in only about a third of bullying cases.

Kids don't tell adults for many reasons:

- Bullying can make a child feel helpless. Kids may want to handle it on their own to feel in control again. They may fear being seen as weak or a tattletale.
- Kids may fear backlash from the kid who bullied them.
- Bullying can be a humiliating experience. Kids may not want adults to know what is being said about them, whether true or false. They may also fear that adults will judge them or punish them for being weak.
- Kids who are bullied may already feel socially isolated. They may feel like no one cares or could understand.
- Kids may fear being rejected by their peers. Friends can help protect kids from bullying, and kids can fear losing this support.

Effects of Bullying

Bullying can affect everyone—those who are bullied, those who bully and those who witness bullying. Bullying is linked to many negative outcomes including impacts on mental health, substance use and suicide. It is important to talk to kids to determine whether bullying—or something else—is a concern.

Kids Who are Bullied

Kids who are bullied can experience negative physical, school, and mental health issues. Kids who are bullied are more likely to experience:

- Depression and anxiety, increased feelings of sadness and loneliness, changes in sleep and eating patterns, and loss of interest in activities they used to enjoy. These issues may persist into adulthood.
- Health complaints.
- Decreased academic achievement—GPA and standardized test scores—and school participation. They are more likely to miss, skip or drop out of school.

A very small number of bullied children might retaliate through extremely violent measures. In 12 of 15 school shooting cases in the 1990s, the shooters had a history of being bullied.

Kids Who Bully Others

Kids who bully others can also engage in violent and other risky behaviors into adulthood. Kids who bully are more likely to:

- Abuse alcohol and other drugs in adolescence and as adults
- Get into fights, vandalize property, and drop out of school
- Engage in early sexual activity
- Have criminal convictions and traffic citations as adults
- Be abusive toward their romantic partners, spouses or children as adults

Bystanders

Kids who witness bullying are more likely to:

- Have increased use of tobacco, alcohol or other drugs
- Have increased mental health problems, including depression and anxiety
- Miss or skip school

Bullying and Suicide

Media reports often link bullying with suicide. However, most youth who are bullied do not have thoughts of suicide or engage in suicidal behaviors. Although kids who are bullied are at risk of suicide, bullying alone is not the cause. Many issues contribute to suicide risk, including depression, problems at home and trauma history. Additionally, specific groups have an increased risk of suicide, including American Indian and Alaskan Native; Asian American; and lesbian, gay, bisexual and transgender youth. This risk can be increased further when these kids are not supported by parents, peers and schools. Bullying can make an unsupportive situation worse.

How to Talk About Bullying

Parents, school staff and other caring adults have a role to play in preventing bullying. They can:

- Keep the lines of communication open.
- Encourage kids to do what they love. Special activities, interests, and hobbies can boost confidence, help kids make friends, and protect them from bullying behavior.
- Model how to treat others with kindness and respect.

Help Kids Understand Bullying

Talk about what bullying is and how to stand up to it safely. Tell kids bullying is unacceptable. Make sure kids know how to get help. Kids who know what bullying is can better identify it. They can talk about bullying if it happens to them or others. Kids need to know ways to safely stand up to bullying and how to get help.

- Encourage kids to speak to a trusted adult if they are bullied or see others being bullied. The adult can give comfort, support and advice, even if they can't solve the problem directly. Encourage the child to report bullying if it happens.
- Talk about how to stand up to kids who bully. Give tips, like using humor and saying "stop" directly and confidently. Talk about what to do if those actions don't work, like walking away.
- Talk about strategies for staying safe, such as staying near adults or groups of other kids.
- Urge them to help kids who are bullied by showing kindness or getting help.
- Watch the short webisodes and discuss them with kids. stopbullying.gov/kids/webisodes/index.html

Keep the Lines of Communication Open

Research tells us that children really do look to parents and caregivers for advice and help on tough decisions. Check in with kids often. Listen to them. Know their friends, ask about school and understand their concerns. Sometimes spending 15 minutes a day talking can reassure kids that they can talk to their parents if they have a problem. Start conversations about daily life and feelings with questions like these:

- What was one good thing that happened today? Any bad things?
- What is lunch time like at your school? Who do you sit with? What do you talk about?
- What is it like to ride the school bus?
- What are you good at? What would do you like best about yourself?

Talking about bullying directly is an important step in understanding how the issue might be affecting kids. There are no right or wrong answers to these questions, but it is important to encourage kids to answer them honestly. Assure kids that they are not alone in addressing any problems that arise.

Start conversations about bullying with questions like these:

- What does “bullying” mean to you?
- Describe what kids who bully are like. Why do you think people bully?
- Who are the adults you trust most when it comes to things like bullying?
- Have you ever felt scared to go to school because you were afraid of bullying?
- What ways have you tried to change it?
- What do you think parents can do to help stop bullying?
- Have you or your friends left other kids out on purpose?
- Do you think that was bullying? Why or why not?
- What do you usually do when you see bullying going on?
- Do you ever see kids at your school being bullied by other kids? How does it make you feel?
- Have you ever tried to help someone who is being bullied? What happened? What would you do if it happens again?

There are simple ways that parents and caregivers can keep up-to-date with kids’ lives:

- Read class newsletters and school flyers. Talk about them at home.
- Check the school website.
- Go to school events.
- Greet the bus driver.
- Meet teachers and counselors at “Back to School” night or reach out by email.
- Share phone numbers with other kids’ parents.
- Remind and educate teachers and school staff that they also have a role to play.

Encourage Kids to Do What They Love

Help kids take part in activities, interests, and hobbies they like. Kids can volunteer, play sports, sing in a chorus, or join a youth group or school club. These activities give kids a chance to have fun and meet others with the same interests. They can build confidence and friendships that help protect kids from bullying.

Model How to Treat Others with Kindness and Respect

Kids learn from adults' actions. By treating others with kindness and respect, adults show the kids in their lives that there is no place for bullying. Even if it seems like they are not paying attention, kids are watching how adults manage stress and conflict, as well as how they treat their friends, colleagues and families.

Prevention at School

Bullying can threaten students' physical and emotional safety at school and can negatively impact their ability to learn. The best way to address bullying is to stop it before it starts. There are a number of things school staff can do to make schools safer and prevent bullying.

Getting Started

Assess school prevention and intervention efforts around student behavior, including substance use and violence. You may be able to build upon them or integrate bullying prevention strategies. Many programs help address the same protective and risk factors that bullying programs do.

Assess Bullying in Your School

Conduct assessments in your school to determine how often bullying occurs, where it happens, how students and adults intervene, and whether your prevention efforts are working.

Engage Parents and Youth

It is important for everyone in the community to work together to send a unified message against bullying. Launch an awareness campaign to make the objectives known to the school, parents and community members. Establish a school safety committee or task force to plan, implement and evaluate your school's bullying prevention program.

Create Policies and Rules

Create a mission statement, code of conduct, school-wide rules and a bullying reporting system. These establish a climate in which bullying is not acceptable. Disseminate and communicate widely.

Build a Safe Environment

Establish a school culture of acceptance, tolerance and respect. Use staff meetings, assemblies, class and parent meetings, newsletters to families, the school website and the student handbook to establish a positive climate at school. Reinforce positive social interactions and inclusiveness.

Educate Students and School Staff

Build bullying prevention material into the curriculum and school activities. Train teachers and staff on the school's rules and policies. Give them the skills to intervene consistently and appropriately.

Anti-Bullying Programs

Bully-Proofing Your School

schoolengagement.org/school-engagement-services/bully-proofing-your-school

Olweus Bullying Prevention Program

violencepreventionworks.org/public/index.page

Second Step

cfchildren.org

Stand 4 Change Against Bullying 2012

stand4change.org

Stop Bullying

stopbullying.gov

stopbullying.gov/laws/georgia.html

The Bully Project

thebullyproject.com

Bullying Resources

Bulletins for Teens: Bullying and Harrassment – National Center for Victims of Crime

victimsofcrime.org/help-for-crime-victims/get-help-bulletins-for-crime-victims/bulletins-for-teens/bullying-and-harassment

Bully Beware Productions

bullybeware.com

Bullying and Anti-bullying Legislation – National School Safety and Security Services

schoolsecurity.org/trends/bullying-and-anti-bullying-legislation

Bullying.org – Where you are NOT alone

bullying.org

Bullying: Information for Parents and Teachers – Centre for Children and Families in the Justice System

fcc.on.ca/bully.htm

“Combating fear and restoring safety in schools” – Office of Juvenile Justice and Delinquency Prevention

ncjrs.gov/pdffiles/167888.pdf

Create an Anti-Bullying Program with Resources You Have

schoolsecurity.org/trends/Managing_Bullying_Without_New_Costs.pdf

Cyber Bullying – Love Our Children USA

loveourchildrenusa.org/parent_cyberbullying.php

McGruff – The Crime Dog

mcgruff.org/#/Main

National School Safety and Security Services

schoolsecurity.org

Parents Helping to Stop Bullying and School Violence – Love Our Children USA

loveourchildrenusa.org/stopschoolviolence.php

The Safe Schools Coalition

safeschoolscoalition.org/RG-bullying_harassment_schoolbasedviolence.html

Georgia Dept of Education – Policy for Prohibiting Bullying, Cyberbullying, Harassment & Intimidation

www.gadoe.org

General Behavioral Health Resources

American Academy of Child and Adolescent Psychiatry

aacap.org

American Psychiatric Association

psych.org

American Psychological Association

apa.org

Center for Mental Health in Schools – School Mental Health Project

smhp.psych.ucla.edu

Child and Family WebGuide

<https://ase.tufts.edu/cfw/>

Children’s Mental Health Matters!

childrensmentalhealthmatters.org

Georgia DOE School Climate

<http://www.gadoe.org/External-Affairs-and-Policy/Policy/Pages/School-Climate.aspx>

Facts for Families – American Academy of Child Adolescent Psychiatry

aacap.org/AACAP/Families_and_Youth/Facts_for_Families/Facts_for_Families_Keyword.aspx

Federation of Families for Children’s Mental Health

ffcmh.org

Medications – Massachusetts General Hospital

massgeneral.org/schoolpsychiatry/schoolpsychiatry_medications.asp

National Alliance on Mental Illness (NAMI)

nami.org

National Association of School Psychologists

nasponline.org

National Institute of Mental Health

nimh.nih.gov/index.shtml

National Mental Health Association

nmha.org

National Mental Health Consumer Self-Help Clearinghouse

mhselfhelp.org

School of Psychiatry Program and MADI (Mood and Anxiety Disorder Institute) Resource Center - Massachusetts General Hospital

massgeneral.org/schoolpsychiatry

Screening for Mental Health, Inc. (SMH)

mentalhealthscreening.org

Substance Abuse & Mental Health Services Administration (SAMHSA) National Mental Health Information Center

mentalhealth.org

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Jansen P.W., et al., "Teacher and peer reports of overweight and bullying among young primary school children." *Pediatrics*, 134 (2014): 473-480, doi: 10.1542/peds.2013-3274.

Puhl R.M., Peterson J.L., and Luedicke J. "Weight-based victimization: Bullying experienced of weight loss treatment-seeking youth." *Pediatrics*, 131 (2013): e-1-9, doi: 10.1542/peds.2012-1106.