Nurse’s Role in the Mental Health of Students

MICHIGAN SCHOOL NURSE GUIDELINES AND RESOURCES

Original Date of Issue: 2016
Foreword

These guidelines contain recommendations for current best practices for the health service topic addressed. They have been reviewed by the School Nurse Practice Subcommittee of the Michigan Statewide School Nurse Task Force as a means to provide consistent and safe care to the students. Specific laws and regulations that direct school nursing practice or other health services are identified in the guidelines. There is no guarantee that the use of guidance in this document will lead to any particular result or outcome. The information in this document was researched in April, 2016.

Purpose

This document will provide guidelines and resources for the school nurse’s role in the mental health of students.

Overview

The Center for Disease Control and Prevention (CDC) (CDC, 2016a) defined mental health in childhood as reaching developmental and emotional milestones, learning healthy social skills and how to cope when there are problems. Mentally healthy children have a positive quality of life and can function well at home, in school, and in their communities (CDC, 2016a). The CDC (2016a) indicated mental disorders among children are described as serious changes in the way children typically learn, behave, or handle their emotions, which can cause distress and problems getting through the day (CDC, 2016a).

In the United States, an estimated 21% of children and adolescents meet the diagnostic criteria for evidence of a mental health disorder and have evidence of at least minimal impairment (Foy, 2010). Studies have shown mental illness begins early in life. Half of the adults in the United States with a mental health disorder had symptoms by the age of 14 (Foy, 2010). Merikangus (2010) found the most common diagnosed mental illnesses in school-aged children and high school students were anxiety (including posttraumatic stress disorder), behavior disorders (attention deficit hyperactivity and conduct disorders), mood disorders (including depression and bipolar disorders), and substance use disorders. Among affected adolescents, 50% of disorders had their onset by age 6 for anxiety disorders, by age 11 for behavior disorders, by age 13 for mood disorders, and by age 15 for substance use disorders (Merikangus, 2010). The National Institute of Mental Illnesses (2005) supports the concept that mental illness begins very early in life indicating that one half of all lifetime cases begin by age 14; three quarters have begun by age 24.

The CDC (2016a) reported on the number of children in the United States who have specific mental disorders using a variety of data sources between the years 2005-2011 and found children between the ages of 3-17 had the following:

- Attention-deficit/hyperactivity disorder (ADHD) (6.8%)
- Behavioral or conduct problems (3.5%)
- Anxiety (3.0%)
- Depression (2.1%)
- Autism spectrum disorder (1.1%)
• Tourette syndrome (0.2%) (among children aged 6–17 years).

Adolescents aged 12–17 years identified as having a current diagnosis of:
• Illicit drug use disorder in the past year (4.7%)
• Alcohol use disorder in the past year (4.2%)
• Cigarette dependence in the past month (2.8%).

The United States Preventive Services Task Force (2016) reported on major depressive disorder and indicated morbidity may be demonstrated by decreased school performance, poor social functioning, early pregnancy, increased physical illness, and substance abuse. The mean age of onset of for major depressive disorder in childhood and adolescence was 14 -15 years (onset is earlier in girls than boys). Only 36% to 44% of children and adolescents with depression received treatment, suggesting that the majority of depressed youth are undiagnosed and untreated.

The CDC (2015) described suicide as a serious public health problem that is the third leading cause of death for youth between the ages of 10 and 24. The top three methods used in suicides of young people are firearm (45%), suffocation (45%) and poisoning (8%). Fried, Williams, Cabral and Hacker (2013) studied the relationship between the timing of adolescent development and risk factor for suicide using nationally representative data from the Add Health survey and found depression was a risk factor for suicide attempts in both 9th and 11th grade. At the 9th grade level, the researchers indicated illegal drug use, homosexual orientation, using public assistance, and physical development were important risk factors (Fried et al., 2013). At the 11th grade level, sexual abuse, being in counseling, and being of “other” race or ethnicity were risk factors (Fried et al., 2013). Protective factors identified for reducing the risk for suicide included the adolescent’s perception of connectedness to parents and family; emotional well-being; having high self-esteem and a school-dense network of friends for girls; and grade-point average for boys (Fried et al., 2013). Cooper, Clements and Holt (2012) completed a literature review examining adolescents involved in bullying or cyberbullying as a victim, offender, or victim/offender and found a strong correlation between childhood bullying and adolescent suicide. The risk of suicide increased with increased exposure to bullying. Cyberbullying victims were two times more likely to commit suicide. Adolescents with the greatest risk of suicidality were those with multiple roles in bullying and those who experienced high frequency and multiple types of bullying.

**Michigan and National Data**

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months.</td>
<td>27%</td>
<td>29%</td>
</tr>
<tr>
<td>Seriously considered attempting suicide during the past 12 months</td>
<td>16%</td>
<td>17%</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
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<tr>
<td>Actually attempted suicide one or more times during the past 12 months.</td>
<td>8.9%</td>
<td>8%</td>
</tr>
</tbody>
</table>

**Legal Framework for Managing the Mental Health of Students**

**Federal Law**

An Act to restore the intent and protections of the Americans with Disabilities Act of 1990. |
|----------------------------------------|--------------------------------------------------------------------------------|

Family Educational Rights and Privacy Act (FERPA) allows for the disclosure of personally identifiable information in connection with a health or safety emergency to public health authorities without individual or parent authorization if knowledge of the information is necessary to protect the health or safety of the student or other individuals under § 99.31(a) (10) and § 99.36 of the FERPA regulations.

<table>
<thead>
<tr>
<th>Protection of Pupil Rights Amendment <a href="http://familypolicy.ed.gov/ppra">http://familypolicy.ed.gov/ppra</a></th>
<th>Surveys may be subject to the Protection of Pupil Rights Amendment.</th>
</tr>
</thead>
</table>

**Michigan Law**

| Bullying [PA 241 of 2011](http://familypolicy.ed.gov/ppra) | The board of a school district or intermediate school district or board of directors of a public school academy shall adopt and implement a policy prohibiting bullying at school, as defined in this section. |
MICHIGAN ASSOCIATION OF SCHOOL NURSES - NURSE’S ROLE IN THE MENTAL HEALTH OF STUDENTS

<table>
<thead>
<tr>
<th>Bullying</th>
<th>Bullying policy must comply with 2014 amendments but not limited to the inclusion of cyberbullying as form of bullying.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PA 478 of 2014</strong></td>
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<tr>
<td>Mental Health Code Rights of Minor</td>
<td>A minor of 14 years of age or older up to 12 visits or four months whichever comes first may request and receive mental health services on an outpatient basis without the consent or knowledge of a parent or guardian. Consent to inform the parent or guardian must be obtained from the minor unless there is a compelling need for disclosure and the minor is informed of the health professional’s intent to notify the party.</td>
</tr>
<tr>
<td>§ 330.1707(1)</td>
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</table>

**School Nurse’s Role**

Public health provides the foundation for the specialty practice of school nursing and is one of the five principles of the *Framework for 21st Century School Nursing Practice*. Key tenets and responsibilities of public health practiced by school nurses include surveillance, outreach, population-based care, levels of prevention, social determinants of health and health equity (Maughan, Bobo, Butler, Schantz, & Schoessler, 2015; NASN, 2016). The National Association of School Nurses (NASN) framework provides guidance for the school nurse’s role in the mental health of students.

NASN (2013) believes school nurses serve a vital role in the school community by promoting positive mental health outcomes in students through school/community evidence-based programs and curricula. School nurses collaborate with school personnel, community health care professionals, students and families, in the assessment, identification, intervention, referral, and follow-up of children in need of mental health services (NASN, 2013). Ravenna & Cleaver (2016) reviewed the literature to determine school nurses’ experience of managing young people with mental health problems and found that school nurses recognized they played a key role in promoting young people’s mental health but also found school nurses faced time and resource barriers.

**Recommendations for Practice**

**Surveillance**

**Population Surveillance**

The MDE (2015) offers the Michigan Profile for Healthy Youth (MiPHY) on-line survey ([https://mdoe.state.mi.us/schoolhealthsurveys/Home/Login.aspx](https://mdoe.state.mi.us/schoolhealthsurveys/Home/Login.aspx)) to support local and regional needs assessment. The MiPHY provides student results on health risk behaviors including substance use, violence, physical activity, nutrition, sexual behavior, and emotional health in grades 7, 9, and 11. The survey also measures risk and protective factors most predictive of alcohol, tobacco, and other drug use and violence. MiPHY results, along with other school-reported data, can help schools make data-driven

When any surveys or assessments are completed at school it is essential to protect student privacy. Many surveys are subject to the Protection of Pupil Rights Amendment (PPRA) and the Family Educational Rights and Privacy Act (FERPA). Students need to be assured that their responses will be kept confidential and that their answers can’t be tracked back to them (U.S. Department of Health and Human Services [USDHHS], 2016). School administrators need to be consulted and involved in all decisions regarding screening tools and the need for parental consent (Platt, 2014).

**Individual Assessment and Screening**

1. School nurses can refer students to a behavioral specialist for mental health screening. Selekman, Diefenbeck, and Guthrie (2013) provided the following cautions for implementing mental health screening in the school setting:
   - Ensure there are adequate onsite and community resources to handle positive screens for routine follow-up and emergency interventions.
   - Ensure school policies are being followed and school administrators approved the screening process.
   - Obtain active parent consent.

2. Assess and refer as indicated students for suicide risk factors which may include being teased/bullied, experiencing the loss of a loved one, serious relationship conflict, having a serious medical condition, or being exposed to suicide (Strunk, Sorter, Ossegge, and King, 2014). Somatic symptoms associated with anxiety and depression include stomachaches, recurrent abdominal pain, headaches and musculoskeletal pain (Humensky, Kuwabara, Fogel, Wells, Goodwin, Van Voorhees, 2010). Children who are victims of bullying visit the school nurse 4.7 times per school year (Cooper et al, 2012).


**Outreach**

The CDC (2016b) provides the Whole School, Whole Community, Whole Child (WSCC) model that expands beyond the Coordinated School Health Components and emphasizes a unified and collaborative approach to learning and health. Schools could consider developing a WSCC team that would include parents, students, staff and community members to address mental health issues as well as other student health issues. For example, the WSCC team could develop a suicide risk assessment strategy for the school/school district (Nolta, 2014). The WSCC approach offers important opportunities that may improve healthy development and educational attainment for students: [http://www.cdc.gov/healthyyouth/wscC/](http://www.cdc.gov/healthyyouth/wscC/)
Population-based Care

1. The MDE (2016b) provides an integrating mental health in schools’ toolkit that helps school districts assess their approach to mental health that can be retrieved from: [www.michigan.gov/schoolmentalhealthtoolkit](http://www.michigan.gov/schoolmentalhealthtoolkit). Other resources identified by the MDE (2016c) can be retrieved at: [www.michigan.gov/schoolmentalhealth](http://www.michigan.gov/schoolmentalhealth).

2. Consider advocating for utilizing the School Health Index (SHI) as an assessment tool to identify the strengths and weaknesses of school health and safety policies and programs as well as developing an action plan for improving student health and safety. The process involves teachers, parents, students, and the community in improving school services (CDC, 2015). Retrieved from [http://www.cdc.gov/ViolencePrevention/suicide/youth_suicide.html](http://www.cdc.gov/ViolencePrevention/suicide/youth_suicide.html). The Healthy School Action Tools, or HSAT, are a suite of online tools designed to help Michigan schools and districts assess the health of their school environments and take action to improve those environments. There is a social & emotional topic area in the HSAT along with resources. Information about the HSAT can be retrieved from [http://www.mihealthtools.org/hsat/default.asp](http://www.mihealthtools.org/hsat/default.asp).

3. Advocate for school-wide prevention models such as, the tiered Positive Behavioral Interventions and Support (PBIS) that provides the infrastructure for the delivery of more intensive services and programs for children with greater needs (AAP Council on School Health, 2013; Bradshaw, Waasdorp & Leaf, 2012). The U.S. Department of Education’s (USDOE) Office of Special Education can provide technical assistance to help with the Positive Behavioral Interventions and Support (PBIS) framework ([http://www.pbis.org/](http://www.pbis.org/)) that builds support and respect within a school (USDOE, 2016).

4. Build strong partnerships with key stakeholders from the community to provide needed student support and an infrastructure to implement services as school (Montanez, Berger-Jenkins, Rodriguez, McCord, & Meyer, 2015; AAP Council on Community Pediatrics, 2016; Bains & Diallo, 2016).


Levels of Prevention

Primary Prevention

1. Promote a positive school climate by participating in interdisciplinary teams to create safe school environments (NASN, 2013).

2. Serve as a liaison between community mental health providers, the family and school personnel. Advocate for easy access to mental health services (NASN, 2013).

3. Identify and intervene early with students struggling with mental, psychosocial or emotional issues (AAP Council on School Health, 2013; Merikangus et al., 2010; NASN, 2013).
4. Educate students, family members, school staff and community about behavioral, instructional, social and emotional problems seen in school-age children and adolescents (NASN, 2013; Selekman et al., 2013; Taliaferro & Resha, 2016). Youth Mental Health First Aid (National Council for Behavioral Health, 2013) is an educational program designed to teach parents, family members, caregivers, teachers, school staff, peers, neighbors, health and human services workers, and other caring citizens how to help an adolescent (age 12-18) who is experiencing a mental health or addictions challenge or is in crisis. Youth Mental Health First Aid is primarily designed for adults who regularly interact with young people. The course was developed by the National Council for Behavioral Health. More information about Youth Mental Health First Aid can be found at http://www.mentalhealthfirstaid.org/cs/take-a-course/course-types/youth/.

5. Identify at-risk youth and link them to suicide prevention services (Fried et al., 2013; Johnson & Parsons, 2012; Strunk et al., 2014; Nolta, 2013). Systematic early detection of adolescent suicide is key to prevention. Utilize evidence-based suicide prevention programs in the school setting. Examples of two evidence-based programs on the National Registry for Evidence-based Programs and Practices include Sources of Strength (http://legacy.nreppadmin.net/ViewIntervention.aspx?id=248) and Signs of Suicide (http://legacy.nreppadmin.net/ViewIntervention.aspx?id=53). Information about these programs can be found at the Suicide Prevention Resource Center (http://www.sprc.org/bpr/section-i-evidence-based-programs).

Note: SAMHSA (n.d.) provides a free toolkit on preventing suicide in the high school. The tool kit can be retrieved at http://store.samhsa.gov/product/SMA12-4669


Secondary Prevention
   - School-based Health Centers were found to eliminate barriers and provide access to mental health services in a study completed by Bains and Diallo (2016). Lofink, et al., (2011) described the mental health services School-based Health Centers provide: crisis intervention, comprehensive individual evaluation and treatment, case management, classroom behavior and learning support, substance abuse counseling, assessment and treatment of learning problems, peer mediation and prescription, and management of behavioral health medications. The MDHHS funds 100 Child and Adolescent Health Centers. For more information, see www.michigan.gov/cahc.
   - Michigan’s mental health services are coordinated through local Community Mental Health Services Programs (CMHSPs) for children who qualify (severe emotional disturbance). MDHHS (2016a) provides an alphabetical list of CMHSPs retrieved at http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4868_7145-14792--,00.html. There are other mental health resources in communities as well (i.e. private practice or other agencies who serve youth that aren’t severely emotionally disturbed.
   - The MDHHS (2016b) provides contact information for the National Suicide Prevention Lifeline NOW at http://www.michigan.gov/mdhhs/0,5885,7-339-71548_54879-358892--,00.html 1-800-273-TALK (8255) as well as information about gatekeeper training programs.

2. Provide supportive counseling (Selekman et al., 2013). Positive comfort measures such as talking to supportive adults, engaging in calming activities, physical exercise should be encouraged (Platt, 2014).
3. Monitor for adverse effects of pharmacotherapy (Selekman et al., 2013; Taliaferro & Resha, 2016).

4. Provide medication education (Taliaferro & Resha, 2016).

5. Develop a care plan to respond constructively to somatic complaints (Taliaferro & Resha, 2016).

6. For students with a mental health diagnosis, school nurses can develop and implement 504 plans, the health portion of the Special Education Individual Education Plan (IEP), Emergency Action Plans and the Individualized Health Care Plan (AAP Council on School Health, 2013; NASN, 2013; Selekan et al., 2013).

7. Document the nursing process using a structured documentation model (Clausson, E.K., Berg, A., Janlov, A.C., 2015; Selekan et al., 2013). Document mental/emotional health office visits just as physical visits are documented (Selekan et al., 2013).

8. Case management to support students to ensure compliance with treatment as long as necessary (NASN, 2013). Classroom teacher can be a good source of information about social behavior (bullying, fighting, withdrawal, threats, oddness) and changes in academic performance (Platt, 2014).

9. Gregory and Vessey (2004) offered the strategy of bibliotherapy that uses children’s books to serve as a unique conduit of exchange between parents, teachers, and children to help solve problems. Determining which book to use with a student is critical in ensuring the child can identify with the main character and events in the story. There is a resource list of books based upon the child’s age.

**Tertiary**


2. Encourage school policies that provide guidance on how to respond to the aftermath of a suicide (Strunk et al., 2014).

**Social Determinants of Health and Health Equity**

1. Education, literacy, social support networks, neighborhood safety, access to health services and culture impact health (NASN, 2016). School nurses can participate in their school district’s interdisciplinary team to promote initiatives and curricula that teach and role model positive self-esteem, tolerance, diversity, anti-bullying programs, anti-violence programs, and suicide prevention programs (NASN, 2013).

2. School nurses need to be aware that cultural variations in suicide rates exist, with Native American/Alaskan Native youth having the highest rates of suicide-related fatalities (CDC, 2015). Native Americans have suffered, and continue to suffer, with three major types of trauma: 1) cultural trauma, 2) historical trauma, 3) intergenerational trauma (Hummingbird, L.M., 2011). A nationwide survey of youth grades 9-12 in public and private schools in the United States found Hispanic youth were more likely to report attempting suicide than their black and white, non-Hispanic peers (CDC, 2015).

3. Parental perception of the school environment was found to be important to the well-being of children of immigrant children (Hamilton, Marshall, Rumens, & Simich, 2011). Initiatives for the newest immigrant parents with children in schools need to include open lines of communication.
4. Collaboration with school district cultural liaisons and/or language interpreters for translation of letters and forms being sent to parents can facilitate communication with parents that have language barriers (Silkworth & Hoxie, 2012).


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**Red Flags for Managing Mental Health in the School Setting**

1. Platt (2014) indicated there are groups of children who may be especially vulnerable due to environmental factors. The bullied child can experience an extreme level of stress which can make the genetically vulnerable student develop mental illnesses such as depression. Abused and neglected children and children experiencing a significant loss either through divorce or death may also be at risk. Students who present with chronic physical complaints for which there is no organic basis should be evaluated for an emotional component for the symptom.

2. The American Foundation for the Prevention of Suicide (2011) provides the following warning signs for suicide and risk factors for suicide:

**Suicide Warning Signs**

<table>
<thead>
<tr>
<th>If a person talks about:</th>
<th>Specific things to look for in a person’s behavior</th>
<th>People who are considering suicide often display one or more of the following moods:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being a burden to others</td>
<td>Increased use of alcohol or drugs</td>
<td>Depression</td>
</tr>
<tr>
<td>Feeling trapped</td>
<td>Looking for a way to kill themselves, such as searching online for materials or means</td>
<td>Loss of interest</td>
</tr>
<tr>
<td>Experiencing unbearable pain</td>
<td>Acting recklessly</td>
<td>Rage</td>
</tr>
<tr>
<td>Having no reason to live</td>
<td>Withdrawing from activities</td>
<td>Irritability</td>
</tr>
<tr>
<td>Killing themselves</td>
<td>Isolating from family and friends</td>
<td>Humiliation</td>
</tr>
<tr>
<td></td>
<td>Sleeping too much or too little</td>
<td>Anxiety</td>
</tr>
</tbody>
</table>
Visiting or calling people to say goodbye

Giving away prized possessions

Aggression

## Suicide Risk Factors

<table>
<thead>
<tr>
<th>Health Factors</th>
<th>Environmental Factors</th>
<th>Historical Factors</th>
</tr>
</thead>
</table>
| Mental health conditions:  
  - Depression  
  - Bipolar (manic-depressive)  
  - Schizophrenia  
  - Borderline or antisocial personality disorder  
  - Conduct disorder  
  - Psychotic disorders, or psychotic symptoms in the context of any disorder  
  - Anxiety disorders | Stressful life events which may include a death, divorce, or job loss | Previous suicide attempts |
| Serious or chronic health condition and/or pain | Prolonged stress factors which may include harassment, bullying, relationship problems, and unemployment | Family history of suicide attempts |
| | Substance abuse disorders | |
| | Access to lethal means including firearms and drugs | |
| | Exposure to another person’s suicide, or to graphic or sensationalized accounts of suicide | |
References


*Signs of Suicide*. Retrieved from [https://mentalhealthscreening.org/gatekeeper](https://mentalhealthscreening.org/gatekeeper)


