

Children's
Mental
Health
Matters.org
A MARYLAND PUBLIC
AWARENESS CAMPAIGN

Educators



Dear Educator:

The Children's Mental Health Matters! Campaign is proud to introduce you to our new and revised Educator Resource Kit. As a teacher, school administrator or school counselor, you are in a unique position to notice mental health problems that children may have and to help families understand these issues. This kit gives you the tools to facilitate that process.

Included in the kit are fact sheets for teachers/school personnel. It is our hope that this kit will provide valuable resource information and links for educators on a wide range of behavioral health issues, including depression, suicide, self-injury, substance use and bullying. Feel free to make photocopies of any of the enclosed fact sheets and share them with teachers, administrators, assistants, school personnel and others.

The Campaign is co-sponsored by the Mental Health Association of Maryland (MHAMD) and the Maryland Coalition of Families (MCF), with support and resources provided by the Maryland Department of Health - Behavioral Health Administration. The Campaign's goal is to raise awareness of children's mental health needs and enhance outreach efforts to families, communities and schools.

Should you need anything further, including additional Educator Resource Kits or other materials, please do not hesitate to contact info@mhamd.org.

We appreciate your support of this important campaign and all you do for Maryland's children. Please visit www.ChildrensMentalHealthMatters.org for more information.

Sincerely,



Linda Raines
Chief Executive Officer
MHAMD



Jane Plapinger
Executive Director
MCF

Acknowledgements: American Academy of Child & Adolescent Psychiatry, Robert P. Franks, PhD, Child & Health Development Institute - www.kidsmentalhealthinfo.com and Andrea Chronis-Tuscano, PhD, Director, Maryland ADHD Program and NIMH Science Advisor for



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ADHD is a disorder that affects approximately eight percent of school-age children. ADHD makes it difficult for children to pay attention or sit still. Until recently, it was believed that children outgrew ADHD in adolescence as hyperactivity often lessens during the teen years. However, it is now known that ADHD nearly always persists from childhood through adolescence and that many symptoms continue into adulthood. In fact, current research reflects rates of roughly two to four percent among adults. It is more common in males than females in childhood, but equally prevalent in males and females in adulthood.

ADHD is characterized by developmentally inappropriate levels of:

- Inattention - trouble focusing, getting distracted, trouble keeping attention, making careless mistakes, losing things, trouble following through on things, poor organization, doesn't seem to be listening
- Impulsivity - acting without thinking, interrupting, intruding, talking excessively, difficulty waiting for turns
- Hyperactivity - trouble sitting still, fidgeting, feeling restless, difficulty engaging in quiet activities

3 Types of ADHD

- ADHD Combined Type (Classic ADHD) – trouble with inattention, hyperactivity and impulsivity
- ADHD Predominantly Inattentive Type – trouble with attention, sluggish; difficult to identify
- ADHD Predominantly Hyperactive Impulsive Type – trouble with impulsivity and hyperactivity; occurs more often in younger children

Given the high prevalence of ADHD, most classrooms will have at least one child or adolescent with ADHD. Although individuals with this disorder can be very successful in life, without proper identification and treatment, ADHD may have serious consequences, including school failure, family stress and disruption, depression, problems with relationships, substance use, delinquency, risk for accidental injuries and job failure. Additionally, at least two thirds of individuals with ADHD have another co-existing condition, such as learning problems, anxiety or behavior

problems. Early identification and treatment are extremely important. Teachers are often the first to notice the symptoms of ADHD.

What can educators do about it?

What can educators do about it? When a teacher suspects ADHD, it is important to first speak with the child's parents or caregivers. It is important to work in partnership with parents and mental health experts to develop an intervention plan as quickly as possible when these warning signs occur, because a quick response has been found to increase the probability of successful outcomes. Effective ways to engage parents include:

- Encouraging them to share their view about their child
- Asking them to express their concerns about their child's academic and behavioral performance
- Asking questions to determine that you have full information
- Discussing with parents the best ways (e.g. phone calls, notes) to communicate with them on a regular basis

How is ADHD diagnosed?

A good assessment consists of:

- Parent and teacher ratings of behavior
- Behavioral observations in the classroom
- Clinical interview with parents
- IQ/achievement testing to assess for learning disabilities
- Discussing with parents the best ways (e.g. phone calls, notes) to communicate with them on a regular basis

There are several types of professionals who can diagnose ADHD including school psychologists, clinical psychologists, clinical social workers, nurse practitioners, neurologists, psychiatrists and pediatricians. Once diagnosed, ADHD in children often requires a “multi modal” comprehensive approach to treatment which includes:

- Parent and child education about diagnosis and treatment
- Behavior management techniques
- Medication
- School programming and supports

What can educators do about it?

- Setting up a school-home note system
- Being consistent
- Using praise and rewards frequently
- Using at least five times as many praises as negative comments
- Ignoring mild inappropriate behaviors that are not reinforced by peer attention

- Using commands/reprimands to cue positive comments for children who are behaving appropriately that is, find children who can be praised each time a reprimand or command is given to a child who is misbehaving
- Allowing frequent movement breaks
- Using multi modal teaching tools
- Using active tasks for learning
- Using appropriate commands and reprimands
 - Use clear, specific commands
 - Give private reprimands at the child’s desk as much as possible
 - Reprimands should be brief, clear, neutral in tone, and as immediate as possible
- Identifying a peer buddy to help with organizational tasks
- Giving the student a separate, quiet place to take tests
- Allowing inattentive students extra time on tests
- Breaking large tasks down into smaller tasks
- Mixing high-interest and low-interest task/topics

Resource Links

Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD)

National Resource Center on ADHD
A Program of CHADD, funded through a cooperative agreement with the Centers for Disease Control and Prevention.
<https://chadd.org/for-educators/overview/>

Identifying and Treating Attention Deficit Hyperactivity Disorder: A Resource for School and Home

U.S. Department of Education
<https://www2.ed.gov/rschstat/research/pubs/adhd/adhd-identifying.html>

Maryland State Department of Education

<http://marylandpublicschools.org/about/Pages/DSFSS/SSSP/ADHD/index.aspx>

Teaching Children with Attention Deficit Hyperactivity Disorder: Instructional Strategies and Practices

U.S. Department of Education
<https://www2.ed.gov/rschstat/research/pubs/adhd/adhd-teaching.html>

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www.schoolmentalhealth.org
March 2009



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Children and adolescents with anxiety disorders have extreme feelings of panic, fear, or discomfort in everyday situations. Anxiety is a normal reaction to stress. However, when the anxiety becomes excessive, irrational and/or overbearing, and an individual has difficulty functioning, it has become a disabling disorder. Anxiety disorders may develop from a complex set of risk factors, including genetics, brain chemistry, personality, and life events. Affecting people of all ages, anxiety disorders are the most common type of mental health disorder in children, affecting nearly 13 percent of young people¹ and 40 million American adults. Overall, nearly one quarter of the population will experience an anxiety disorder over the course of their lifetimes.²

Common types of anxiety disorders

Panic Disorders

Characterized by unpredictable panic attacks. Common symptoms are: heart palpitations, shortness of breath, dizziness, and anxiety. These symptoms are often confused with those of a heart attack. If you are not sure what the symptoms are attributing to, call 911.

Specific Phobias

Intense fear reaction to a specific object or situation (such as spiders, dogs, or heights) which often leads to avoidance behavior. The level of fear is usually inappropriate to the situation and is recognized by the sufferer as being irrational.

Social Phobia

Extreme anxiety about being judged by others or behaving in a way that might cause embarrassment or ridicule and may lead to avoidance behavior.

Separation Anxiety Disorder

Intense anxiety associated with being away from caregivers, results in youth clinging to parents or refusing to do daily activities such as going to school.

Obsessive-Compulsive Disorder (OCD)

Individuals are plagued by persistent, recurring thoughts (obsessions) and engage in compulsive ritualistic behaviors in order to reduce the anxiety associated with these obsessions (e.g. constant hand washing).

Post-Traumatic Stress Disorder (PTSD)

PTSD can follow an exposure to a traumatic event such as natural disasters, sexual or physical assaults, or the death of a loved one. Three main symptoms are: reliving

of the traumatic event, avoidance behaviors and emotional numbing, and physiological arousal such as difficulty sleeping, irritability, or poor concentration.

Generalized Anxiety Disorder (GAD)

Experiencing six months or more of persistent, irrational and extreme worry, causing insomnia, headaches, and irritability.

Why is this important?

Given that the prevalence of anxiety disorders is over one in ten youths, most classrooms will have at least one child or adolescent with an anxiety disorder. In order to better serve the needs of the students, teachers need to have a familiarity with these disorders, their symptoms and the effective strategies that can be used to assist in treatment. Because anxiety disorders often cause serious consequences such as school failure, absenteeism, classroom disruption, the inability to complete basic tasks, family stress, and impaired social relationships, the understanding, compassion and support of educators is essential to better accommodate students with these disorders.

What can educators do about it?

When a teacher suspects an anxiety disorder, it is important to first speak with the child's parents or caregivers. It is important to work in partnership with parents and mental health experts to develop an intervention plan as quickly as possible when these warning signs occur, because a quick response has been found to increase the probability of successful outcomes.

Effective ways of engaging parents include:

- Encouraging them to share their view about their child
- Asking them to express their concerns about their child's academic and behavioral performance
- Asking questions to determine that you have full information
- Discussing with parents the best ways (e.g. phone calls, notes) to communicate with them on a regular basis
- Become familiar with the common symptoms of anxiety disorders in children and adolescents, making the appropriate referral when the disorders are suspected.
- Inform parents of any academic or social problems a child may experience, especially if the child appears anxious, has problems completing tasks, or is isolated by their peers.

Once diagnosed, specific classroom interventions include:

- Accommodate student's late arrival and provide extra time for changing activities and locations, because transitions and separation are frequently difficult for children with anxiety disorders.

- Recognize that often it is a youth's anxiety that causes them to disregard directions, rather than an intentional desire to be oppositional.
- Develop a "safe" place where the youth can go to relieve anxiety during stressful times or provide calming activities.
- Encourage the development of relaxation techniques that can work in the school setting; often these can be adapted from those that are effective at home.
- Work with a child regarding class participation and answering questions on the board, understanding that many anxious youth fear answering incorrectly.
- Encourage small group interactions and provide assistance in increasing competency and developing peer relationships.
- Reward the child's efforts.
- Provide an organized, calming, and supportive environment.
- For maximum effectiveness, foster feedback from youth about these interventions.

Resource Links

The Anxious Child – Handout for parents created by the American Academy of Child and Adolescent Psychiatry
https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/The-Anxious-Child-047.aspx

Bright Futures - Tips for Parenting the Anxious Child
Free handout for parents.
<https://www.brightfutures.org/mentalhealth/pdf/families/mc/tips.pdf>

Massachusetts General Hospital
School Psychiatry Program and MADi Resource Center
Provides a wealth of information on anxiety disorders, with specific information on symptoms, treatments, and interventions for families, educators, and clinicians.
<https://www.massgeneral.org/condition/anxiety-disorders>

Psych Central - Anxiety Disorders
Offers anxiety screening quizzes, detailed information on the symptoms and treatment options available for anxiety disorders, and online resources such as websites, relevant book information, and support groups.
<https://psychcentral.com/quizzes/anxiety-quiz#Learn-More-About-Anxiety>

Worry Wise Kids
Lists the red flags that can alert parents to each individual anxiety disorders, details the steps parents can take if they suspect their child suffers from an anxiety disorder, and supplies parenting tips for helping anxious youth.
<http://www.worrywisekids.org>

Adapted from Resources found on:
www.schoolmentalhealth.org March 2009



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Bullying may be physical or verbal. Teasing, ignoring, or intentionally hurting another child are all types of bullying. Harassment and sexual harassment are also considered forms of bullying. Bullies may be large and aggressive, but they also could be small and cunning. Victims of bullying have poor self-confidence and typically react to threats by avoiding the bully. Both bullies and their victims make up a fringe group within schools. Those children who bully want power over others. Both bullies and their victims feel insecure in school. Boys typically bully by using physical intimidation. Girls bully in a less obvious manner by using social intimidation to exclude others from peer interactions.

Why is this important?

When compared to their developmental peers, students who bully their peers are:

- More likely to react aggressively to conflict in the classroom.
- More likely to engage in disruptive behavior.
- More likely to display signs of depression.
- Less likely to gain acceptance by classmates.
- More likely to bring a weapon with them to school.

What can educators do about it?

- Model prosocial behavior that asserts the self-worth of each individual student. Explain to students the balance between appearing too passive and acting too aggressive towards others.
- Actively observe student behavior in the classroom. Do certain people always sit on the fringes of the classroom? What students almost never participate in class discussion?
- Speak with parents to see if additional stressors at home contribute to the bullying dynamic. Is the child the victim of abuse or neglect? If you think this could be a possibility, follow your school procedures.
- Include discussions of conflict-resolution in your lesson plan. Find creative ways to engage all students in group work during class time.
- Ask school clinicians to present on consequences of bullying. Explain to students the negative cycle of bullying and how it can have fatal consequences.
- Become familiar with the bullying prevention curriculum in your school. In Maryland, state law requires that all public schools include a bullying prevention component within their curriculum.

Resource Links

American Academy of Child & Adolescent Psychiatry - Facts for Families: Bullying

https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Bullying-080.aspx

Bullies & Victims: A Primer for Parents

<https://www.nasponline.org/resources-and-publications/resources-and-podcasts/school-climate-safety-and-crisis/school-violence-resources/bullying-prevention>

Bullying and Cyberbullying

Advice for parents and carers to help keep children safe from bullying, wherever it happens

<https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/bullying-and-cyberbullying/>

Netsafe's Cyberbullying

<https://www.netsafe.org.nz/advice/harmfuldigitalcommunications/>

National Association of School Psychologists

Bullying Prevention & Intervention: Information for Educators

<https://www.nasponline.org/resources-and-publications/resources-and-podcasts/school-climate-safety-and-crisis/school-violence-resources/bullying-prevention>

Stop Bullying - Prevention at School

<https://www.stopbullying.gov/prevention/at-school>

Technical Assistance Bulletin for Implementing Maryland's Model Policy to Address Bullying, Harassment, or Intimidation

Division of Student, Family, and School Support Division of Special Education/Early Intervention Services. November 2013

<http://www.marylandpublicschools.org/about/Documents/DSFSS/SSSP/BullyingPreventionTAB.pdf>

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A crisis can happen at any time. Crises such as a school shooting, student suicide, or death of a teacher can emotionally debilitate teachers and students. If a friend or family member has been seriously injured or killed, a home damaged, or school environment changed, there is a greater chance that the child will experience difficulties coping. Whatever the circumstance, the emotional effects on children can be tremendous. These external factors have a direct impact on the child's mental and emotional feelings. This could result in the need for crisis management and intervention.

Why is crisis information important?

When compared to their developmental peers, children in crisis

- Have lower levels of academic performance
- Are more likely to exhibit changes in behavior
- Are more likely to feel more anxious or worried than usual
- Are more likely to have anger or conduct problems
- Are more likely to isolate themselves from friends or family, or have a sudden, new group of friends
- Might have the inability to concentrate
- Are more likely to hurt other people, destroy property, or harm themselves
- May resort to drugs and/or alcohol to ameliorate the pain
- Are at risk for suicide

Age appropriate reactions and related symptoms associated with crisis

- Sadness and crying
- School avoidance
- Physical complaints (headache or stomach ache)
- Poor concentration
- Irritability
- Regressive behavior
- Aggressive behavior
- Anxiety
- Confusion
- Withdrawal/social isolation
- Attention seeking behavior

Early Adolescence

- Withdrawal/isolation from peers
- Loss of interest in activities

- Rebelliousness
- Generalized anxiety
- School difficulty, including fighting
- Fear of personal harm
- Poor school performance
- Depression
- Concentration difficulties

Adolescence

- Anxiety and feelings of guilt
- Poor concentration and distractibility
- Psychosomatic symptoms (e.g., headaches)
- Antisocial behavior
- Agitation or decrease in energy level
- Poor school performance
- Peer problems
- Withdrawal
- Loss of interest in activities once enjoyed

When is help needed?

Help from a physician or mental health professional will be needed if the child or adolescent:

- Threatens or attempts suicide
- Has reactions that interfere with daily functioning over a prolonged period of time
- Re-experiences the trauma through flashbacks, hallucinations, or constant reenactment through play with other children
- Exhibits aggressive, violent, or intensely irrational behavior
- Excessively uses alcohol and/or drugs

What can educators do about it?

- Become a more active observer of student behavior in and around the classroom.
- Consult with school personnel who are trained in crisis response and crisis intervention.
- Inform caregivers and school clinicians about your observations of the student.
- Educate students regarding likely responses to the crisis.
- Give students an opportunity to discuss their feelings and reactions to the crisis.
- Create a feedback loop with caregivers and school clinicians to reassess student symptoms.

- Ask school clinicians to present on different treatment approaches for crisis intervention and management.
- Use empathy and listen in a non-critical and non-judgemental manner when students are discussing their feelings.
- Allow students to express themselves through other modes of communication, especially those students who are hesitant to verbalize their feelings.
- Develop classroom activities and assignments, and homework assignments that address students' feelings regarding crisis.

Crisis intervention is ongoing. Further discussions may need to ensue and address residual feelings regarding the crisis.

Resource Links

National Association of School Psychologists

When It Hurts to Be a Teenager

<https://www.nasponline.org/resources-and-publications/resources-and-podcasts/mental-health/mental-health-disorders>

National Association of School Psychologists

Depression: Supporting Students at School Vol. 35(3) by Huberty, T. (2010).

<https://www.nasponline.org/about-school-psychology/families-and-educators>

National Center for PTSD

PTSD in Children and Adolescents

https://www.ptsd.va.gov/professional/treat/specific/ptsd_child_teens.asp

National Alliance on Mental Illness

A Family Guide: What Families Should Know about Adolescent Depression and Treatment Options

<http://cpancf.com/pdf/namifamilyguidedepressionadolescentsandchildren.pdf>

Mental Health First Aid Maryland

<http://www.mhfamaryland.org/>

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Maryland is a culturally, ethnically, and racially diverse state. Culture shapes people's attitudes, beliefs, and behaviors. Everyone is a member of multiple cultural groups based on race, ethnicity, faith, region of country, type of work, level of education, physical ability or disability status, sexual identity and so forth. If you are working with youth that have different cultural backgrounds from your own, there can be additional communication challenges. Many communities have agencies that provide services for specific cultural and ethnic populations.

Why is this important?

In today's classroom, the cultural differences that exist between teachers and their students are numerous. Diversity may exist with regard to race, culture, religion, language, sexual orientation, and socioeconomic status. In addition, many students in the classroom are faced with stressors such as homelessness, unavailability of caretakers, abuse, teen parenting, trauma, and community violence, which can negatively impact their academic performance. Unfortunately, within schools, many students are also faced with discrimination from other students as well as school staff, due to a lack of understanding or empathy with regard to the variations in beliefs, practices, and values of different cultural groups. Since ethnic minority children have higher rates of suspension/expulsion, special education placement, and school dropout, it is evident that numerous disparities exist within the education system. Culture has a significant impact on beliefs and attitudes about child development, identification of problems, and judgment about the best way to intervene when problems do occur. Furthermore, each of us operates within an individual culture, which espouses specific beliefs that determine how we interact with others and interpret their actions. Cultural variations in expressions of behavior may contribute to misunderstandings and conflict, which can be decreased through enhancing multicultural awareness.

What can educators do about it?

- Recognize the cultural diversity and uniqueness of students and learn as much as you can about your students' cultural background.
- Recognize that socioeconomic and political factors have a significant impact on the psychosocial functioning of culturally and ethnically diverse groups.
- Recognize the diversity that exists within minority groups.
- Develop an awareness of your own cultural and ethnic background and acknowledge differences in the culture between you and your students.
- Identify your biases and prejudices and determine how they affect your expectations of students and your relationships with them and their families.
- Use instructional strategies and curriculum that are sensitive to cultural differences.
- Continuously request and accept feedback from students and their families.
- If you are present when bullying, harassment and/or discrimination takes place, follow school procedures and work with colleagues, families, partnerships, and students to stop the bullying, harassment, and/or discrimination.
- Promote tolerance and understanding of cultural differences.

Resource Links

Culturally Responsive Teaching

The Education Alliance at Brown University
<https://www.brown.edu/academics/education-alliance/teaching-diverse-learners/strategies-0/culturally-responsive-teaching-0>

National Education Association - Cultural Competence

<https://www.nea.org/professional-excellence/professional-learning/just-equitable-schools/cultural-competence>

Mental Health: Culture, Race, and Ethnicity

A Supplement to Mental Health: A Report of the Surgeon General Documents the disparities in access, quality and availability of mental health services for ethnic minorities and proposes recommendations for improvement.
<http://www.ncbi.nlm.nih.gov/books/NBK44243/>

Improving Cultural Competence: A Treatment Improvement Protocol, SAMHSA

<https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4849.pdf>

Infant Mental Health and Cultural Competence, Zero to Three

<https://www.zerotothree.org/resources/1599-infant-mental-health-and-cultural-competence>

Multicultural Pavilion

A multitude of resources about multicultural education including a multicultural quiz, trainings, workshops, curriculum, and links to other websites.
<http://www.edchange.org/multicultural/>

President's New Freedom Commission on Mental Health Subcommittee on Cultural Competence

Report addressing the disparities in health care, the role of culture in service delivery, and making several policy recommendations for improving the health care system.
http://govinfo.library.unt.edu/mentalhealthcommission/subcommittee/Sub_Chairs.htm

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Students with symptoms of depression exhibit many behaviors that cause significant impairment in social or academic functioning. These symptoms include irritability, diminished interest in daily activities, social withdrawal, physical complaints, and declining school performance. The diagnostic criteria for major depression reflect the developmental differences between adults and children who suffer from the disorder. Educators may notice changes in the students appearance including clothing and hygiene, as well as interaction with other students.

Why is this important?

When compared to their developmental peers, students with depression:

- Are less likely to participate in school activities.
- Are more likely to disrupt classroom activities.
- Are more likely to skip class and miss time away from school.
- Are more likely to engage in risky behavior, such as substance use.
- Are more likely die by suicide.

What can educators do about it?

When a teacher sees any of these signs, it is important to first speak with the child's parents or caregivers. It is important to work in partnership with parents and mental health experts to develop an intervention plan as quickly as possible. When these warning signs occur, a quick response has been found to increase the probability of successful outcomes.

Effective ways of engaging parents include:

- Encouraging them to share their view about their child
- Asking them to express their concerns about their child's academic and behavioral performance
- Asking questions to determine that you have full information
- Discussing with parents the best ways (e.g. phone calls, notes) to communicate with them on a regular basis

Classroom strategies include

- Become a more active observer of student behavior in and around the classroom.
- Consider different factors that may contribute to symptoms of depression. Look at each student on an individual, case-by-case basis.
- Inform caregivers and school clinicians about your observations of the student.
- Help other school staff members learn how to identify the symptoms of depression.
- Teach school staff how to respond to "cries for help" from students with depression.
- Create a feedback loop with caregivers and school clinicians to reassess student symptoms.
- Ask school clinicians to present on different treatment approaches for childhood depression.

Resource Links

National Association of School Psychologists Depression: A Quiet Crisis

<https://www.nasponline.org/about-school-psychology/families-and-educators/information-for-principals-and-administrators>

Preventing Youth Suicide: Brief Facts and Tips

<https://www.nasponline.org/resources-and-publications/resources-and-podcasts/school-climate-safety-and-crisis/mental-health-resources/preventing-youth-suicide>

Preventing Youth Suicide: Tips for Parents and Educators

<https://www.nasponline.org/resources-and-publications/resources-and-podcasts/school-climate-safety-and-crisis/mental-health-resources/preventing-youth-suicide/preventing-youth-suicide-tips-for-parents-and-educators>

Depression: Supporting Students at School

<https://www.nasponline.org/about-school-psychology/families-and-educators>

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Aggressive, negative, defiant, destructive, or hostile behavior may be symptoms of ADHD co-occurring with disruptive behavior disorders, such as oppositional defiant disorder or conduct disorder. Aggression has different components: verbal (e.g. insults or threats), behavioral (e.g. pounding, throwing things, or violating personal space), and emotional (e.g. raised voice or looks angry). What is seen as aggression can vary between individuals and across cultures. If you are concerned that a young person is becoming aggressive, you need to take steps to protect yourself and others. A child may not be able to explain that the aggressive behavior is related to a mental health challenge, disorder, or severe emotional distress. Sometimes, aggression takes the form of instigating a fight, sometimes the child simply provokes others to fight, or antagonizes and threatens other children. These children, often referred to as “bullies,” usually have few true friends, poor social skills, and little self-confidence.

What causes aggression in children?

The aggressor will rarely have self-confidence and gains it through aggressive behavior. Aggressors are attention seekers and they enjoy the attention they gain from being aggressive. Power brings attention and the aggressor has learned this. Due to the child's weaker self-image and the fact that they don't fit in, they try aggressive behavior and soon become leaders, even though they usually know that they are behaving inappropriately.

What can educators do about it?

- Never ignore inappropriate aggressions and do not get drawn into a power struggle with the aggressor
- Be firm but gentle in your approach. Remember, the aggressor can handle the tough side of you, but they will succumb to gentleness and it's really what they want - the right kind of attention.
- Deal one-to-one with the aggressor and devise a plan for them to take control of their behavior. See behavior contracts in below resources included.
- Successful teachers know that when they establish a one-to-one relationship with the aggressor, success soon follows. Remember, the aggressor can usually tell

if you genuinely like them. Be genuine, this child merely needs attention.

- Provide opportunities for this child to act appropriately and get some badly needed attention. Give them responsibilities and provide praise.
- Catch the aggressor behaving well and provide immediate, positive feedback. In time, you will see that the aggressive behaviors will start to diminish.
- Provide them with activities that bring forth leadership in a positive way. Always let them know that you care, trust, and respect them. Remind them that it's the inappropriate behaviors that you don't like.
- Provide as many methods as you can for this child to take ownership for their inappropriate behavior.
- Probe them with how an issue should have been handled and how will it be handled next time.

Never forget that ALL children need to know you care about them and that they can contribute in a positive way. It took the child a long time to become a master of aggressive behavior. Be consistent, patient, and understand that change will take time.

(Copied from: <https://www.thoughtco.com/the-aggressive-child-3110252>)

Resource Links

Behavior Contracts

<https://www.thoughtco.com/behavior-contract-and-behavior-monitoring-tools-3110696>

American Academy of Adolescent and Child Psychiatry, Understanding Violent Behavior in Children

https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Understanding-Violent-Behavior-In-Children-and-Adolescents-055.aspx

Aggressive Behavior – Encyclopedia of Children's Health Provides definitions, prevention strategies, and parent concerns

<http://www.healthofchildren.com/A/Aggressive-Behavior.html>

Addressing Classroom Disruption and Threatening Behavior

<https://tltc.umd.edu/disruptive-demanding-or-threatening-student-behavior>

Breaking the Behavior Code – How teachers can read and respond more effectively to disruptive students

<https://childmind.org/article/breaking-behavior-code/>

Adapted from Resources found on:
www.schoolmentalhealth.org
March 2009



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Learning doesn't begin when children start school, it begins at birth. By the time children turn three, they have already begun to lay the foundation for the skills and abilities that will help them succeed in school. Problem solving, toleration frustration, language, negotiating with peers, understanding routines, and self-control are all skills that are developed early in life. The pace of brain development in this stage of life far exceeds growth in subsequent life stages. Research tells us that early experiences can, and often do, impact brain development. Supporting a child's social and emotional development is a critical component of school-readiness. Parents and caregivers can help children to identify and express emotions, foster secure relationships, encourage exploration, and provide a secure base for the child.

What are social-emotional skills?

Broadly, social-emotional skills encompass a wide variety of skills children need to develop in order to build and maintain healthy social relationships and to understand how to effectively manage emotions.

Why are social-emotional skills important?

Children's mental health or the social and emotional domain is an important domain of development. A child must have social and personal skills to get along with other people, to have self-respect, and to believe they can learn in school. Developing strong social and emotional skills are critical to a child's success in school and at home. Research suggests that children with strong social and emotional skills in kindergarten are more successful than children who do not have strong skills in this area of development.

How do we teach social and emotional skills?

Children begin building these skills from birth largely from observing and interacting with others.

We can teach social and emotional skills by

- Remodeling pro-social behavioral
- labeling children's and adults feelings
- Fostering friendships
- Teaching the steps for problem solving
- Reading books about social and emotional topics (like feelings and friendship)

- Doing activities that foster empathy, kindness, and compassion
- Re-framing our view of behavior - think of all behavior from children as a communication of what they may need or want or be unable to say
- Using positive discipline strategies
- Using and modeling self-calming techniques
- Giving children lots of praise and reinforcement

Behaviors that warrant concern Infants and Toddlers (birth to age 3)

- Chronic feeding or sleeping difficulties
- Inconsolable "fussiness" or irritability
- Incessant crying with little ability to be consoled
- Extremely upset when left with another adult
- Inability to adapt to new situations
- Easily startled or alarmed by routine events
- Inability to establish relationships with other children or adults
- Excessive hitting, biting, and pushing of other children or very withdrawn behavior

Preschoolers (ages 3 to 5)

- Compulsive activities (e.g., head banging)
- Wild, despairing tantrums
- Withdrawn; shows little interest in social interaction
- Repeated aggressive or impulsive behavior
- Difficulty playing with others
- Little or no communication; lack of language
- Loss of earlier developmental achievements

Childhood Traumas

What is Traumatic Stress?

Research has shown that exposure to traumatic events early in life can have many negative effects throughout childhood and adolescence, and into adulthood. Children who suffer from child traumatic stress are those who have been exposed to one or more traumas over the course of their lives and develop reactions that persist and affect their daily lives after the traumatic events have ended.

What Is Resilience?

Resilience is the ability to adapt well over time to life-changing situations and stressful conditions. While many things contribute to resilience, studies show that caring and supportive relationships can help enhance resilience. Factors associated with resilience include, but are not limited to:

- The ability to make and implement realistic plans;
- A positive and confident outlook; and
- The ability to communicate and solve problems.

Factors that contribute to childhood trauma

- Caregiver's competencies
- Neglect
- Witnessing domestic violence
- Witnessing community violence

- Emotional, physical, or sexual abuse
- Loss of caregiver

Symptoms of Traumatic Stress:

- Re-experiencing the event, reenactments
- Avoidance and general numbing of responsiveness
- Increased arousal

What does it look like?

- Changes in play
- New fears
- Separation Anxiety
- Sleep disturbances
- Physical complaints
- Distress at reminders
- Withdrawal, sadness, or depression
- Easily startled
- Difficulties with attention, concentration, and memory
- Acting out, irritability, and aggression

Programs that Support Early Childhood Mental Health

- Home Visiting programs
- Early Head Start
- Head Start
- Judy Centers

Resource Links

Maryland SEFEL Pyramid Model

<https://earlychildhood.marylandpublicschools.org/sefel>

Early Childhood Mental Health Consultation Project

<https://earlychildhood.marylandpublicschools.org/infant-and-early-childhood-mental-health-iecmmh-consultation-project>

The Promise Resource Center

<http://thepromisecenter.org/>

National Child Traumatic Stress Network Resources for School Personnel

<https://www.nctsn.org/audiences/school-personnel>

The Backpack Series

<https://challengingbehavior.cbcs.usf.edu/Implementation/family.html#collapse2>



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An Eating Disorder is a psychological condition that manifests itself in unhealthy eating habits. There are four diagnoses which are characterized by specific behaviors exhibited by the individual. Two primary behaviors are bingeing, the consumption of a large amount of food in a short period of time, and purging or self-induced vomiting. Misuse of laxative, diet pills, or water pills are also considered purging.

Types of eating disorders

Bulimia Nervosa is the most common of the four diagnoses. It is characterized by a preoccupation with food and weight, bingeing and a compensation for bingeing by purging, excessive exercise, or fasting. This pattern is accompanied by shame and secrecy.

Anorexia Nervosa is characterized by a refusal to maintain a normal weight for one's height, body type, age, and activity level; intense fear of becoming "fat" or gaining weight (extreme concern over one's weight); body image misconception; and loss of menstrual periods in females.

Binge Eating Disorder is characterized by bingeing, feelings of shame, and self-hatred associated with bingeing, but no compensatory behavior such as purging.

Eating Disorders Not Otherwise Specified covers all maladaptive eating behaviors that do not fit into the above diagnoses. Examples include: restricting food intake, meeting some but not all of the requirements for the above diagnoses, chewing food and spitting it out, or bingeing and purging irregularly.

Why is this important?

- Of the currently more than 10 million Americans afflicted with eating disorders, 90 percent are children and adolescents.
- The average age of eating disorders onset has dropped from 13-17 to 9-12.
- The number of males with eating disorders has doubled during the past decade.

Students with an eating disorder may:

- Exhibit low self-esteem and a poor body image.
- Be prone to mood swings, perfectionism, and depression.
- Suffer from many physical problems such as:
 - Excessive weight loss
 - Irregularity or absence of menstruation in females
 - Hair loss
 - Severe digestive system problems x Damaged vital organs
 - Tooth and gum problems
 - Swollen salivary glands due to induced vomiting
 - General malnutrition
 - Dehydration
 - Thinning of the bones resulting in osteoporosis or osteopenia
- Struggle in their relationships with their family and friends.
- Perform poorly in their academic performance.
- Jeopardize their overall health, including both physical and psychological health, with their unhealthy eating habits.
- Suffer from other psychiatric disorders such as depression, anxiety, obsessive compulsive disorder, and alcohol and drug dependencies.

What can educators do about it?

- Discuss your concerns with the child's parents. Make sure to consult with the family.
- To assist with diagnosis of an eating disorder, always look for other psychiatric disorders. Eating disorders are mostly associated with other mental disturbances such as depression, mood disorders, and anxiety disorders.
- Schedule eating disorder information sessions for parents and caregivers. Discuss the symptoms and diagnoses of eating disorders and place emphasis on preventive measures.
- Correlate your efforts with teachers and school officials

to add healthy lifestyle courses into the school's educational programs. Since treating eating disorders can be both lengthy and expensive, it is beneficial to use preventive measures before the problem arises.

- Research the best location and the most effective option for treatment in your area. Always be prepared to make a referral to parents and caregivers of the affected children with eating disorders.

A treatment plan should consist of cognitive behavioral, interpersonal, and family therapy. A complete course of treatment should consider all of the contributing factors such as the person's own personality, environment, relationships, and family.

Resource Links

American Academy of Child & Adolescent Psychiatry Facts for Families: Teenagers with Eating Disorders

https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Teenagers-With-Eating-Disorders-002.aspx

Academy for Eating Disorders (AED)

About eating disorders/diagnoses and more specifically, eating disorder diagnoses

<http://www.aedweb.org/>

National Institute of Mental Health Eating Disorders

<http://www.nimh.nih.gov/publicat/eatingdisorders.cfm>

National Association of Anorexia Nervosa and Associated Disorders (ANAD)

<http://www.anad.org/>

National Eating Disorders Association (NEDA)

<https://www.nationaleatingdisorders.org/>

PBS Learning Media: Body Needs

<https://cet.pbslearningmedia.org/resource/midlit11.sci.spffood/nutrition-what-your-body-needs/>

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Educators who understand that families generally are the ones most knowledgeable about their own children will be more likely to find a returned respect and spirit of collaboration with families. Educators who consult with families regarding concerns they may have about a child's mental health will benefit from family input and mutual collaboration. Teachers and other school personnel who are more informed about both family involvement in schools and children's mental health will be more likely to have success in teaching children with mental health needs. It has been established that children have greater academic success when families are involved in schools. Children with mental health disabilities certainly have the same, if not a greater need for their families and educators to work together. Educators who can approach families in a non-judgmental and cooperative spirit are more likely to have success in working with the child with mental health needs.

Why is this important?

- Children have more school success when families are involved in their education
- Positive family and staff interaction help to achieve overall positive school climate
- Schools with strong family involvement see greater student achievement
- School staff and families who work collaboratively for a student will be more likely to have student cooperation

What can educators do about it?

- Educate yourself about mental health diagnoses in children and adolescents
- Work in a spirit of mutual respect and cooperation with families to ensure success for every child in school
- Adopt positive and effective communication strategies with all families
- Refer children to a mental health professional in your school if you have concerns
- Contact families with concerns about their child
- Refer families to support and advocacy groups if the family requests that you do so

Resource Links

American Academy of Child and Adolescent Psychiatry

Facts for Families provides concise and up-to-date information on issues that affect children, teenagers, and their families.

https://www.aacap.org/AACAP/Families_and_Youth/Family_Resources/Home.aspx

National Center for School Mental Health

The National Center for School Mental Health (NCSMH) at the University of Maryland School of Medicine is a technical assistance and training center with a focus on advancing research, training, policy, and practice in school mental health.

<http://www.schoolmentalhealth.org/About/>

CHADD

Children and Adults with ADHD Maryland Chapters is the nation's leading non-profit organization serving individuals with ADHD and their families. Local chapters are in Baltimore City and Anne Arundel, Baltimore, Harford, Howard, and Montgomery Counties.

<http://www.chadd-mc.org/>

Learning Disabilities Association of Maryland

Promotes awareness and provides support to maximize the quality of life for individuals and families affected by learning and other disabilities.

www.ldamd.org

Maryland Coalition of Families

A grassroots coalition of family and advocacy organizations dedicated to: Improving services for children with mental health needs and their families and building a network of information and support for families across Maryland.

www.mdcoalition.org

(410) 730-8267 - Toll Free (888) 607-3637

Mental Health Association of Maryland

Since 1915, the Mental Health Association of Maryland (MHAMD) has been a leader in progressive programs resulting in more effective treatment, improved outcomes for individuals, increased research and greater public understanding of the needs of children and adults living with mental illness.

<http://www.mhamd.org/>

(443) 901-1550 - Toll Free (800) 572-6426

Mental Health First Aid Maryland

Is an 8 hour course targeted to the general public. Mental Health First Aid is the initial help given to someone developing a mental health problem or in a mental health crisis before appropriate professional or other assistance, including peer and family support, can be engaged.

<https://www.mhamd.org/what-we-do/training/mental-health-first-aid-maryland/>

(443) 901-1550 - Toll Free (800) 572-6426

NAMI Maryland

An advocacy organization for family and friends of people with serious mental illness, and people who have a mental illness.

<http://md.nami.org/>

(410) 863-0470 - Toll Free (800) 467-0075

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Handbook of School Mental Health: Advancing Practice and Research. Evans, N. A. Lever (Eds.) pp. 135-147.

Kluwer Academic/Plenum Publishers: New York, NY.

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Grief is the normal process when there is a death or a loss such as a divorce. Grief may produce physical, mental, social, or emotional reactions. Physical reactions can include changes in appetite, physical problems such as headaches or stomachaches, sleeping problems, and illness. Mental reactions can include anger, guilt, sadness, worry, and despair. Social reactions can include withdrawal from normal activities and the need to be near others or to be apart from others. Grief processes also depend on the situation surrounding the death or loss, the relationship with the person who was lost, and the person's attachment to that person. Bereavement is the period after a loss during which grief is experienced. The time of bereavement depends on several factors including a person's attachment to the person or thing that was lost and the amount of time spent anticipating the loss.

Why is this important?

- As educators, we are responsible for helping children mourn their losses and feel safe in their school environment.
- The way in which children are communicated with and managed at the time of a loss will affect how they are able to grieve at the time and how they manage loss in the future.
- Grieving youth are prone to depression, anxiety, and many other problems.
- Often, grieving youth have problems in school. Whether it be lower grades or aggressive behavior, children often manifest their pain in the school setting.

What can educators do about it?

- It is important to keep children informed about the death of a loved one or peer. They should be told the truth as soon as possible in a way that is tailored to their level of understanding. Be sure to address their fears and answer their questions, so they may fully understand what is happening and how they are feeling. Be aware that children may ask the same questions over and over.
- Do not avoid the topic if the child wants to talk. Although death can be an uncomfortable topic, children should feel comfortable talking about their feelings. If an adult is closed to these discussions, it can send the message that grieving is shameful or not valued.

- Create a safe place outside the classroom for the child to go if they need to be alone, set this up so no explanation is needed in front of classmates. Ensure that either you or another adult is available to talk at these times.
- Keep in close contact with parents. Ensure that you are monitoring and noting any behavior that may seem different. Meet with parents regularly. It is important to remember that teachers often spend more time with children than anyone. It is necessary to know your students well in order to watch for any signs of serious problems.
- Make sure to use developmentally appropriate terms when explaining death to children. It is important to be clear and not dance around the issue with euphemisms.
- Be patient. Grieving children often show signs of poor concentration and may act out. It is important to help kids stay on task. Often having a routine is comforting. If they are being disruptive it may be more beneficial to refer them to the guidance counselor or school psychologist rather than reprimanding.
- Be involved in planning a memorial service which can help a child receive closure and focus on fond memories of the person. Involvement should be strictly on a volunteer basis and children should not be forced to participate. Children who do not wish to participate in planning should be invited to the memorial services provided in or outside of school.

Resource Links

The Dougy Center for Grieving Children and Families

This website offers a variety of resources including an excellent publication called Helping the Grieving Student: A Guide for Teachers — a great book that provides teachers with practical advice when dealing with grieving students.
<http://www.dougy.org>

National Association of School Psychologists

Addressing Grief: Tips for Teachers and Administrators
<https://www.nasponline.org/resources-and-publications/resources-and-podcasts/school-climate-safety-and-crisis/mental-health-resources/addressing-grief/addressing-grief-tips-for-teachers-and-administrators>

UCLA School Mental Health Project Grief and Loss Practice Notes

<http://smhp.psych.ucla.edu/pdfdocs/practicenotes/grief.pdf>

Linda Goldman Helping Children with Grief and Trauma

A great resource for teachers, provides general information on what to expect from a grieving child.
http://www.grievingchildren.net/Helping_the_grieving_child_in_school.htm

With Eyes Open-Resources for Teachers and Parents

http://www.pbs.org/witheyeyesopen/resources_youth.html

The Child's Loss: Death, Grief, and Mourning

By Dr. Bruce Perry

Gives a great overview of what grieving children go through as well as common asked questions.

<http://www.scholastic.com/browse/article.jsp?id=4039>

Helping Children Deal With Grief

Child Mind Institute

<https://childmind.org/article/helping-children-deal-grief/>

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Human Trafficking in its most basic form is fraudulently, forcibly, or coercively using another for purposes of exploitation. There are two main types of human trafficking: sex trafficking and labor trafficking. Victims can come from all backgrounds and become trapped in different locations and situations. The majority of victims are women and girls, though men and boys are also impacted; they include all races, ethnicities, sexual orientations, gender identities, citizens, non-citizens, and income levels; they are trapped and controlled through assault, threats, false promises, perceived sense of protection, isolation, shaming, and debt; and they do not have to be physically transported between locations to be victimized. In general, human trafficking involves exploitation and the exchange of money. In 2012, the definition of sexual abuse in Maryland was changed to include human trafficking. No community—urban, rural, or suburban—school, socioeconomic group, or student demographic is immune.

Why is this important?

Many child victims of human trafficking are students in our school systems. School administrators and staff need to be aware that cases of child trafficking are being reported in communities across the nation and Maryland is not immune.

What can educators do about it?

If you work in a school in any capacity, the law states that you are a mandated reporter. Schools can and should be safe havens for students and even more so for students whose lives are otherwise characterized by instability and lack of safety or security. In these cases, school personnel are uniquely well-positioned to identify and report suspected abuse and connect students to services—actions that can prevent trafficking and even save lives. Everyone who is part of the school community has the potential to be an advocate for child victims of human trafficking. In order to build healthy learning environments, educators and school personnel must be knowledgeable about the signs and symptoms of trafficking, ways to support disclosure, and the steps to take if there is a strong suspicion of trafficking.

Learn about your school's policies and protocols. If the school does not have clear policies and protocols, talk to the principal about instituting them. Share this information with school staff, administrators, school boards, and members of the community. The first rule is to always "pay attention."

Maryland State Department of Education recommends schools have an effective anti-trafficking protocol. Schools should, at a minimum develop, adopt, enforce, and implement a policy to address child abuse in general and trafficking in particular:

- make sure all school personnel are properly trained on the school's human trafficking policy;
- make certain campus security is in place so that all visitors are screened;
- provide programs and guidelines for parents and guardians;
- assess the child's environment and take every possible step to help make it safe;
- partner with local law enforcement experts and agencies to provide a parent awareness program on the dangers and warning signs of child sex trafficking.

Who is at risk?

Though there is no standard profile of a child trafficking victim, several risk factors make certain children more susceptible. Reports indicate that traffickers often target children and youths with a history of sexual abuse, dating violence, low self-esteem, and minimal social support. Runaway and homeless youths are at particularly high risk for becoming victims. There is also a strong correlation between sexually exploited youths and childhood sexual abuse, chronic maltreatment, and neglect and otherwise unstable home environments. Research findings estimate

that between 33 and 90 percent of victims of commercial child sexual exploitation have experienced these types of abuses. Evidence also suggests that lesbian, gay, bisexual, or transgender (LGBTQ) youths can be up to five times more likely than heterosexual youths to be victims of trafficking due to the increased susceptibility that comes with the feelings of rejection and alienation that are often experienced by LGBTQ youth.

Risk Factors

- Lack of personal safety
- Isolation

- Emotional distress
- Homelessness
- Poverty
- Family dysfunction
- Substance use
- Mental illness
- Learning disabilities
- Developmental delay
- Childhood sexual assault
- Promotion of sexual exploitation by family members or peers.
- Lack of social support

Resource Links

Maryland State Department of Education – Child Abuse, Neglect & Human Trafficking

<http://marylandpublicschools.org/about/Pages/DSFSS/SSSP/CAN-HT/index.aspx>

Maryland’s Resource for Mandated Reporters

<https://www.reportabusemd.com/>

Baltimore Child Abuse Center

<http://www.bcaci.org>

MSDE Child Abuse, Neglect, and Mental Injury

<http://earlychildhood.marylandpublicschools.org/system/files/filedepot/3/childabuseneglectandmentalinjury2015.pdf>

Maryland Child Protective Services

<http://dhr.maryland.gov/child-protective-services/>

U.S. Department of Health and Human Services, Administration for Children and Families

<https://www.acf.hhs.gov/otip>

National Center for Missing and Exploited Children

<https://www.missingkids.org/>

1-800-843-5678 (1-800-THE-LOST)

National Human Trafficking Resource Center

<http://www.polarisproject.org/what-we-do/national-human-trafficking-hotline/the-nhtrc/overview>

Hotline: 1-888-373-7888

Code of Maryland Regulations

COMAR 13A.15.07.02

<http://www.dsd.state.md.us/comar/comarhtml/13a/13a.15.07.02.htm>

Trainings

U.S. Department of Homeland Security, Blue Campaign, Human Trafficking Awareness Training

<http://www.dhs.gov/blue-campaign/awareness-training>

Adapted from Resources found on:

www.marylandpublicschools.org and

<https://safesupportivelearning.ed.gov/sites/default/files/HumanTraffickinginAmericasSchools.pdf>



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GLBTQ/LGBTQ is a collective term to refer to Lesbian, Gay, Bisexual, Transgender and/or Questioning people. The term gay is used to refer to same-sex sexual orientation (both male and female). A lesbian is a female who is exclusively emotionally, sexually, romantically, and/or aesthetically attracted to other females. The term bisexual is the human sexual orientation that refers to the aesthetic, romantic, or sexual desire for people of either gender or of either sex. Transgender is an umbrella term for people whose gender identity and/or gender expression differs from what is typically associated with the sex they were assigned at birth. If an individual is said to be “questioning,” it most often means that they are going through a phase of exploration and possible transition regarding their sexual orientation. Another definition is that the “questioning” period is the initial phase prior to “coming out.”

Coming Out

The process of “coming out” describes the voluntary public announcement of one’s (often homosexual or bisexual) sexual orientation, sexual attractions, or gender identity.

- “Being out” is when an individual does not try to hide these characteristics.
- “Being outed” occurs when these characteristics are made public against one’s wishes or against one’s consent.

Homophobia is the fear of, aversion to, or discrimination against homosexuality or homosexuals. It can also mean hatred or disapproval of homosexual people, their lifestyles, sexual behaviors or cultures, and is generally used to assert bigotry.

Why is this important?

GLBTQ students:

- Are far more likely to skip classes and drop out of school.
- Are at a higher risk for substance abuse.
- Are subjected to harassment, violent threats, physical/sexual assault, slurs, insults, and jokes (the average high school student hears 25 anti-gay slurs daily).
- Are more prone to depression and loneliness.
- Attempt suicide 2 to 3 times more frequently than their heterosexual peers.

What can educators do about it?

- Serve as a model for other students. Be sensitive to the language you use and put an end to any discriminatory jokes or language that you hear.
- Be an ally. Educate yourself as to the needs and experiences of GLBTQ youth and their families. Make yourself available to listen to problems that GLBTQ kids may be having both in school and at home. Indicate that you are an ally by placing a rainbow sticker or something similar on your classroom door.
- Help make schools safer. Urge your school to develop anti-discrimination policies protecting GLBTQ students from bullying, harassment, violence, and discrimination. The American Psychological Association has created their own policies related to GLBTQ youth in the schools which can be found at <https://www.apa.org/about/policy/resolution-supporting-gender-diverse-children.pdf>

- Speak with colleagues about the importance of protecting GLBTQ youth.
- Start a Gay/Straight Alliance (GSA).
- Recruit other allies from the faculty and student body to begin a student run club that serves as a safe place for anyone to come and discuss GLBTQ issues.

If resistance is encountered by parents:

- Create a broad support network. Ensure that each person knows that the real issue is safety for students.
- Explain to parents that a GSA is not about “sex” or promoting homosexuality. Use evidence-based facts that support what you hope to accomplish.
- Some may feel that it is not part of the school’s role. However, protecting students is part of a school’s role.

Resource Links

Genders & Sexualities Alliance Network (GSA)

Originally Gay-Straight Alliance. For information on starting a GSA at your school visit <https://gsanetwork.org>

It’s Elementary: Talking about Gay Issues in School

A documentary that focuses on teachers challenging common stereotypes and mistreatment of gays within their own schools. The film shows children (some as young as first grade) reacting to information about the gay community and questions that are discussed in the classroom.

<https://groundspark.org/our-films-and-campaigns/elementary>

Creating Safe Schools for Lesbian and Gay Students: A resource guide for school staff

A resource guide for different strategies to keep schools safe for GLBT students.

<http://twood.tripod.com/guide.html>

Gay, Lesbian & Straight Education Network (GLSEN)

Includes many resources from current research to education on putting policies into action. <http://www.glsen.org/>

Providing Safe Spaces for Transgender and Gender Non-Conforming Youth: Guidelines for Gender Identity Non-Discrimination

A guide to laws, regulations, and best practices for use in schools. Maryland State Department of Education - October 2015

<https://pflagmd.files.wordpress.com/2011/12/providing-safe-spaces-for-transgender-and-gender-non-conforming-youth.pdf>

**Adapted from Resources found on:
www.schoolmentalhealth.org
March 2009**



Coordinated by



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An increasing number of students with behavioral health disorders are in the classroom. As a result, teachers need to implement strategies to effectively manage their classrooms. Though the majority of children respond positively to approaches that emphasize positive, clearly-defined, school-wide expectations, a significant subgroup of students need more targeted interventions to prevent problem behavior patterns and to succeed in school. These children and adolescents typically need a modified classroom environment along with practice learning behavioral expectations that may differ from those they have learned outside the classroom.

What can educators do about it?

There are specific things you can do in the classroom to prevent and manage problem behavior:

- Post four to five classroom rules that are simple, positively-framed (tell your kids what to do instead of what not to do), and easily seen. Include consequences for following or not following the rules.
- Be consistent in observing and following the rules.
- Make sure that your students understand what behavior is and is not acceptable.
- Try to move around the classroom often (teacher proximity helps), and try different seating arrangements to maximize positive interactions between groups of students.
- Use consistent routines for all classroom activities, from how to ask a question to what to do when requesting to use the restroom.

Carefully observe and measure what is really going on.

- Rather than defining what a student is doing wrong (hitting, getting out of their seat, yelling), ask yourself what the function of the behavior may be (i.e. are they trying to get something, like attention, or avoid something, like school work that is too difficult, by acting out?).
- Notice what is happening in your classroom both before and after a student misbehaves.
- Use one of the many tools available to keep track of antecedents and consequences, which chart a student's behavior based on what is happening in the immediate environment. If, for example, they mostly act

out in math, then perhaps the material is too challenging, or the time of day is difficult (could they be hungry?), or they have trouble with a specific student or teacher. What happens after they act out? Are they rewarded for their negative behavior by receiving attention from you or their peers? Have they been able to avoid doing the work?

Develop a plan to address the underlying motivation.

- Use your observations to develop a theory about why a student is misbehaving and address the underlying motivation. If they are acting out to get attention from peers, for example, then help them learn other ways of getting attention from peers, such as joining an activity or sharing something.
- Teach the student an alternate behavior and reinforce that behavior in a way that will give the student the same response (attention, feeling of competence, etc.).
- Help the student use the more appropriate behaviors by providing frequent feedback (verbal and non-verbal cues).
- Focus on the student's motivation and relate the material to their life.
- If the function of the behavior is to avoid doing work, try a different teaching technique, review directions, consider peer tutoring, or help the student with specific aspects of the work.
- Praise students frequently for replacement (good) behaviors.

Stigma and discrimination are associated with mental health challenges and disorders. Stigma involves negative attitudes (prejudice) and discrimination refers to negative

attitudes and behaviors may hinder youth and young adults with problems from seeking help. They may be ashamed to discuss mental health problems with family, friends, or school staff. They may also be reluctant to seek professional help out of concern about what others will

think of them. People with mental health challenges can begin to believe the negative things that others say about them. Better understanding of the experiences of young people with mental health challenges and disorders can reduce prejudice and discrimination.

Resource Links

Center for Effective Collaboration and Practice

<https://www.air.org/project/center-effective-collaboration-and-practice-cecp>

National Association of School Psychologists

<https://apps.nasponline.org/search-results.aspx?q=observing+classroom+behavior>

Intervention Central

Offers free tools and resources to help school staff and parents to promote positive classroom behaviors and foster effective learning for all children and youth.
www.interventioncentral.org

Minnesota Association for Children's Mental Health

Classroom activities
<https://macmh.org/classroom-activities/>

Mental Health America

The country's leading nonprofit dedicated to helping ALL people live mentally healthier lives.
<https://screening.mhanational.org/>

Be Proactive in Managing Classroom Behavior

Babkie, A. M. (2006). 41(3), 184-187.
<https://journals.sagepub.com/doi/abs/10.1177/10534512060410031001>

Classroom Behavior Management: A Dozen Common

Mistakes and What to Do Instead; Barbetta, P. M., Norona, K. L., and Bicard, D. F. (2005). 49(3), 11-19.
<http://web.cortland.edu/andersmd/psy501/12.htm>

Classroom Factors Linked with Academic Gains Among Students with Emotional and Behavioral Problems

Gunter, P. L., Coutinho, M. J., and Cade, T. (2002). Preventing School Failure, 46(3), 126-132.
<https://www.tandfonline.com/doi/abs/10.1080/10459880209603357>

Evaluation of a Targeted Intervention Within a Schoolwide System of Behavior Support - Journal of Behavioral Education;

Hawken, L. S., and Horner, R. H. (2003). 12(3), 225-240.
<https://psycnet.apa.org/record/2003-07831-005>

Where to seek help for a mental disorder? National survey of the beliefs of Australian youth and their parents.

Jorm, A.F., Wright, A., & Morgan, A.J. (2007) Medical Journal of Australia, 187: 556-60
<https://www.ncbi.nlm.nih.gov/pubmed/18021042>

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The Children's Mental Health Matters! Campaign recognizes the stress our educators are under in both Maryland and across the country. We want the teachers within our schools to be safe, supported and healthy. With that in mind, we have developed this fact sheet for teachers.

Main Sources of Teacher Stress

- Increased school threats - schools are often thought of and have been targets for violence.
- Challenging relationships - with school leadership, colleagues, parents, and students
- Job demands - high stakes testing and managing students with behavior problems
- Disempowerment - feeling lack of inclusion in school decision making
- Discussion & training of school safety

Consequences of Teacher Stress

- Mental health - High levels of stress can lead to symptoms of depression, anxiety, post-traumatic stress disorder and other diagnoses
- Physical health - psychological stress also affects physical health. Managing physical health by seeing a primary care physician regularly, eating a balanced diet, exercising, and getting enough rest can decrease health complications and improve overall quality of life and wellbeing.
- Teacher performance - teachers with high levels of stress show more symptoms of depression, which can negatively affect teacher performance.
- Student outcomes - teachers who report high feelings of burnout or depressive symptoms have classrooms with more behavior problems
- High turnover - It is estimated that between 23-42% of teachers stop teaching within their first five years. Reasons for leaving the field include: poor working conditions, low salary, student behavior problems, lack of classroom resources, lack of input with school decision making and unsupportive leadership.

Tips for Educators

Be aware of the signs of stress, burnout or mental health problems.

- Emotional - feeling detached, overwhelmed, or hopeless
- Physical - having low energy, decreased concentration, sleeping poorly
- Behavioral - feeling increasingly irritable with students, colleagues, family or friends, excessive alcohol or substance use
- Professional - performing job-related tasks poorly, feeling low job-morale
- Cognitive - experiencing confusion, trouble with decision making, or trauma imagery
- Spiritual - questioning the purpose of life, feeling hollow
- Interpersonal - withdrawing from colleagues, friends, or family, feeling extreme worry about family members can diagnose ADHD, including school psychologists, clinical psychologists, clinical social workers, nurse practitioners, neurologists, psychiatrists and pediatricians.

Use a team approach

Work alongside colleagues from your school district to advocate for policies that promote teacher well-being, eg. shared decision-making, mental health breaks, and increased classroom support.

Reach out for help

Get support from your colleagues, school counselor/psychologist, trusted administrator, family, friends, primary care physician, and/or a mental health professional. Contact your school's employee assistance program (EAP) that provides assistance, support and referrals for professional mental health services.

Practice self-care

Take care of yourself by eating well, exercising, participating in activities that bring joy, or taking a break during the work day.

Practice mindfulness

Mindfulness can improve concentration and emotional self-regulation, decrease burnout symptoms and increase social and emotional competence. Implementing mindfulness practices in the classroom can improve the overall classroom environment. There are many websites, phone/device apps, and books available with helpful suggestions on how to integrate mindfulness into your life to reduce stress.

Resource Links

American Federation of Teachers - 2017 Educator Quality of Work Life Survey

https://www.aft.org/sites/default/files/2017_eqwl_survey_web.pdf

Teacher Stress and Health Issue Brief, Pennsylvania State University, Greenberg MT, Brown JL, and Abenavoli RM. September 1, 2016

<https://www.rwjf.org/en/library/research/2016/07/teacher-stress-and-health.html>

Kaiser Permanente Thriving Schools School Employee Well Being Website

<https://thrivingschools.kaiserpermanente.org/school-employees/>

The National Child Traumatic Stress Network Self Care Tips for Educators

<http://traumaawareschools.org/resources-materials/3162/Self-CareNCTSN.pdf?1385564566>

When Students Are Traumatized, Teachers Are Too

<https://www.edutopia.org/article/when-students-are-traumatized-teachers-are-too>

Cultivating Mindfulness for Educators

<https://www.nytimes.com/2017/09/07/learning/lesson-plans/cultivating-mindfulness-for-educators-using-resources-from-the-new-york-times.html>

Mindful Schools Educator Course

<https://www.mindfulschools.org/about-mindfulness/our-programs/>

Apps and Tools to Help Manage Stress for Teachers, Teach for America January 28, 2019 edition

<https://www.teachforamerica.org/stories/apps-and-tools-to-help-manage-stress-for-teachers>



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Psychiatric medications are any medications used to treat a mental health disorder (i.e., ADHD, Depression). Medications prescribed by a medical professional (when taken as prescribed), along with other non-medication interventions, can be important elements in the successful treatment of psychiatric disorders. Medications can help to control symptoms, make other kinds of treatment more effective, and most importantly, may help to reduce the barriers to learning and enhance school and life success.

Some facts to know

- Medications do not cure psychiatric disorders.
- Medications may not cure psychiatric disorders, but in many cases, along with other non-medication interventions (therapy, parent and teacher support), they can help a child or adolescent function despite continuing mental distress and difficulty coping effectively.
- Length of treatment depends on the individual and the disorder. Some children may only need to take medication for a set time period and then never need it again, while others may have to take medication for longer periods of time.
- Medications may not produce the same effect in everyone. Some children may respond better to one medication than another, often due to factors such as age, sex, body size, body chemistry, physical illnesses, diets, and other treatments. Some may need larger doses versus smaller doses and some may have side effects, while others may have no side effects. Some may experience minimal symptom relief as opposed to having complete symptom relief.
- Families and teachers often report that a combination of medication and therapy have allowed their child to participate in school much like other children, along with improved functioning at home.
- Medications should be used only when the anticipated benefits outweigh the risks.
- It is not unusual for children/adolescents to require changes in dosages and/or medications over time. It is important to regularly monitor the impact of medications

Why is this important?

- Although many children and adolescents with mental health disorders can be very successful in life by utilizing non-medication interventions only (individual, group, or family therapy, parent and teacher support), medications may also be a factor that may help in the treatment of a mental health disorder or it may help to make these other forms of treatments more effective.
- Without proper identification and treatment, mental health disorders in childhood may have serious consequences such as school failure, family conflicts, problems with relationships, problems developing social skills, substance abuse, delinquency, and even risk for accidental injuries and death.
- As with any intervention, a case-by-case decision making process is necessary depending on a child's diagnosis and individual needs. The decision to medicate should be made solely by the child's parents or caregivers and a medical professional experienced in diagnosing and treating childhood disorders.

What can educators do about it?

If you are wondering if medication can help a child in your class, express your concerns to the child's parent/caregiver and suggest referral to a medical professional. There are several types of professionals who can diagnose and treat mental health disorders including school psychologists, clinical psychologists, clinical social workers, nurse practitioners, neurologists, psychiatrists, and pediatricians.

What happens next

The medical professional will meet with the child and family and a decision will be made concerning medication management. The child may then begin a trial of taking the medication while being monitored closely by the parent and the medical professional. It is recommended that parents/guardians notify all caretakers (other family members, teachers, the school nurse/nurse practitioner, and others who are in charge of this child) when a child is taking medication; however, it is up to the parent/ guardian and the child as to whether they want to notify others. It is often helpful if others are aware so that they can also report favorable results and side effects and to also monitor the administration of the medication.

Your role if you are aware that a child is taking medication

- Become educated on the medication if possible (see

medical professional for verbal and written information that is available about the medication).

- Monitor the child in your class. Look for side effects and favorable results.
- If the child is taking medication in school, help to make sure the child takes the medication on the correct schedule.
- Ask parents or medical professionals if there are any foods or drinks that the child should avoid while taking the prescribed medications.
- Some families do not want others to know that their child is on medication for fear of rejection/teasing or labeling. Please be discreet if you are aware that a child is on medication. If the school nurse is involved with the medication management, maintain a working relationship with them so that the child can receive the best care possible.

Resource Links

American Academy of Child and Adolescent Psychiatry Psychiatric Medication For Children And Adolescents Part I - How Medications Are Used

https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Psychiatric-Medication-For-Children-And-Adolescents-Part-I-How-Medications-Are-Used-021.aspx

Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD)

This website offers information detailed information regarding ADHD.
<http://www.chadd.org/>

National Institute of Mental Health (NIH)

Mental Health Medications webpage helps consumers and families understand how and why medications can be used in treating mental health problems.

<https://www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml>

U.S. National Library of Medicine and the National Institute of Health (Medline Plus)

Offers an alphabetical list of drugs, supplements, and herbal information. Provides an explanation of why this medication is prescribed, how this medicine should be used, precautions, side effects, storage conditions for the medicine, brand names, and other important information.
<https://druginfo.nlm.nih.gov/drugportal/>

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All children are oppositional or aggressive from time to time, especially if they are tired, upset, or stressed. They may argue and talk back to teachers, parents, and other adults. Oppositional behavior is a normal part of development for toddlers and early adolescents. However, oppositional behavior becomes a serious concern when it is so frequent that it stands out when compared with other children of the same age. Students with Oppositional Defiant Disorder (ODD) show a pattern of negative, hostile, and defiant behavior that lasts at least six months and impairs their ability to interact with caregivers, teachers, and classmates. During this time period, the child or adolescent may often lose their temper, actively defy adults, and appear spiteful. Other symptoms may include frequent temper tantrums, blaming others for their mistakes or misbehavior, and being easily annoyed by others.

Why is this important?

5 to 15 percent of school-age children have ODD. When compared to their peers, children with ODD are more likely to have difficulties with academic performance and may engage in risky behaviors including criminal activities and substance use. Without intervention, children with ODD are more likely to develop other problems including a conduct disorder, which involves a range of behaviors that include destruction of property, aggression towards people and animals, lying, stealing, and serious violation of rules. Teachers are often the first to notice signs of ODD.

What can educators do about it?

When a teacher suspects ODD, it is important to first speak with the child's parents or caregivers. It is important to work in partnership with parents and mental health experts to develop an intervention plan as quickly as possible when these warning signs occur. A quick response has been found to increase the probability of successful outcomes.

Effective ways of engaging parents include

- Encouraging them to share their view about their child
- Asking them to express their concerns about their child's academic and behavioral performance
- Asking questions to determine that you have full information
- Discussing with parents the best ways (e.g. phone calls, notes) to communicate with them on a regular basis

Refer the child or adolescent for an evaluation if ODD is suspected.

- There are several types of professionals who can diagnose ODD including school psychologists, clinical psychologists, clinical social workers, nurse practitioners, psychiatrists, and pediatricians.

Specific classroom strategies include:

- Set up a school-home note system
- Be consistent
- Use praise and rewards frequently
- Use at least five times as many praises as negative comments
- Ignore mild inappropriate behaviors that are not reinforced by peer attention
- Use commands/reprimands to cue positive comments for children who are behaving appropriately — that is, find children who can be praised each time a reprimand or command is given to a child who is misbehaving

- Use appropriate commands and reprimands
- Use clear, specific commands
- Give private reprimands at the child's desk as much as possible
- Reprimands should be brief, clear, neutral in tone, and as immediate as possible
- Clarify the consequences of misbehavior. When a student misbehaves, remember to follow through with the appropriate consequences.
- Remember to make eye contact when requesting something of the student. This conveys the seriousness of the demand and the sincerity of your relationship with the student.
- Do not ask too much of a student at one time. Keep your requests short and simple. Avoid issuing ambiguous commands such as, "It would be nice if you stopped annoying the class." This statement does not tell the student what to do and embarrasses the student in front of classmates.
- Work with parents and school clinicians to create a reward system that is meaningful for the student and useful in the classroom.
- Provide feedback to caregivers and school clinicians by using daily report cards.

Resource Links

Mental Health America

Is the country's leading nonprofit dedicated to helping ALL people live mentally healthier lives.
<https://screening.mhanational.org/>

Oppositional Defiant Disorder - A Guide for Families American Academy of Child and Adolescent Psychiatry

https://www.aacap.org/App_Themes/AACAP/docs/resource_centers/odd/odd_resource_center_odd_guide.pdf

Oppositional Defiant Disorder - Facts for Families American Academy of Child and Adolescent Psychiatry

Reviewed January 2019
https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Children-With-Oppositional-Defiant-Disorder-072.aspx

Conduct Disorder - Facts for Families

American Academy of Child and Adolescent Psychiatry
 Updated June 2018
https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Conduct-Disorder-033.aspx

Violent Behavior in Children and Adolescents

Facts for Families - AACAP December 2015
https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Understanding-Violent-Behavior-In-Children-and-Adolescents-055.aspx

Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) in Children and Adolescents: Diagnosis and Treatment

by Dr. Jim Chandler
https://jamesdauntchandler.tripod.com/ODD_CD/oddcdpamphlet.pdf

Oppositional Defiant Disorder (ODD)

Mayo Clinic
<https://www.mayoclinic.org/diseases-conditions/oppositional-defiant-disorder/symptoms-causes/syc-20375831?p=1>

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Psychosis occurs when an individual loses contact with reality, resulting in severe disruptions in thinking, emotion, and behavior. Psychosis can have a serious impact on a person's life. Relationships, work, school, other usual activities, and self-care can be difficult to initiate or maintain. Psychosis can be present with many disorders including post-traumatic stress disorder, schizophrenia, psychotic depression, bipolar disorder, schizoaffective disorder, and drug-induced psychosis. Symptoms for psychosis usually begin in late adolescence or early adulthood.

Psychosis affects the way a person thinks, feels and acts

Symptoms include:

- Hallucinations (hearing, seeing, tasting, smelling, or feeling things that are not there)
- Delusions (fixed beliefs that are false, such as that one is being watched or followed)
- Disordered/confused thinking and difficulty concentrating
- Rapid changes in mood/feelings
- Behavior changes including not taking care of or grooming oneself as usual or laughing at inappropriate times

One of the problems in psychosis is that the condition causes the brain to take in too much information all at once, which can leave a person feeling very overwhelmed. Also, the brain has a hard time seeing the differences between what is "real," what is a "dream", and what is a "fantasy." Individuals can believe that the information that their brains are giving them is real and occurring even when it is clear to others that it is not.

Why is this important?

Experiencing symptoms of psychosis may disrupt a child's life. When psychosis is detected early, many problems can be prevented and the greater the chances are of a successful recovery. Mental illnesses with psychosis often develop between ages 15 to 25. This is a critical stage of life when teens and young adults are developing their identities, forming relationships, and planning for their future.

At school, a young person may

- Appear unmotivated
- Distance themselves from peers
- Show a decline in completing work, not do as good a job as they used to, or miss school
- Have inappropriate or no reactions to others
- Do things to drown out auditory hallucinations (e.g. listening to music on headphones in class)

These behaviors can all have an impact on school achievement, and some may result in disciplinary responses.

What can educators do about it?

Treatment for psychosis often involves the following:

- Learning treatment options and working with professionals
- Working with a mental health professional to learn coping skills
- Working with a physician to determine how medications can help
- Working with professionals that specialize in helping youth and young adults to manage relationships and jobs

Resource Links

Maryland Early Intervention Program (EIP)

Offers specialized programs with expertise in early identification, evaluation, and comprehensive psychiatric treatment of adolescents and young adults at risk for, or in the early states of mental illness with psychosis.
www.marylandeip.com

For Teachers: How to identify and refer students with psychosis, a medical condition of the brain

ReachOut Psychosis Tour - February 2009
<http://www.reachoutpsychosis.com/psychosis-a-medical-illness-of-the-brain-how-to-spot-and-stop-psychosis-early/>

National Association of Special Education Teachers

<https://www.naset.org/>

Early Psychosis Intervention Clinic

Johns Hopkins Bayview Medical Center

Treats adolescents and young adults ages 14 to 24.

For information call (410) 955-5212 or contact Krista Baker, LCPC at kbaker1@jhmi.edu

https://www.hopkinsmedicine.org/psychiatry/specialty_areas/schizophrenia/patient_information/treatment_services/early_psychosis.html



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The Behavioral Health Administration, Child and Adolescent Resilience, Wellness and Prevention Committee has defined resilience as: “an innate capacity to rebound from adversity and change through a process of positive adaptation. For youth, resilience is a fluid, dynamic process that is influenced over time by life events, temperament, insight, skill sets and the primary ability of caregivers and the social environment to nurture and provide them a sense of safety, competency and secure attachments.” Resilience is the ability to successfully navigate the inevitable stress, change, uncertainty, and sorrows in life in a way that reinforces a sense of competency and gratitude for others that have helped out along the way.

Everyday ways to promote resilience in schools

- Encourage alternative ways for parents to be actively engaged in their child's education
- Support the belief that all students are resilient and have emerging skills to be nurtured
- Promote strategies that recognize the importance of social emotional learning
- Promote achievement in a broad array of settings to help foster intrinsic motivation
- Expand on successful efforts that continue to improve overall school climate

Further points to consider about resilience

Resilience is not a static concept, rather it can fluctuate over time, and across developmental stages and life domains and circumstances. This is true for individuals, families, communities, systems, and organizations. People need to be resilient throughout their lives, and the ability of children to be competent and connected is often enhanced by how that is modeled and promoted by the adults in their lives.

Resilience is not only an ability to bounce back from trauma and adversity. It also includes everyday resilience. It is the capacity to be empathetic, grateful, and able to put things in perspective, which allows people to deal with the stress, challenges, and disappointments of everyday life. It is that cumulative resilience that helps support an overall sense of wellbeing and self-efficacy, and allows people to weather more severe adversities when they occur.

Resilience in people takes different pathways and involves adapting to an ongoing change process. This includes reflecting on the benefits of one's belief system, while interacting and successfully negotiating with external societal, career, and familial demands and expectations. There is also the interplay between trauma and resilience that needs to be based on the understanding and promotion of protective factors in mitigating risk.

Family, cultural, and gender differences in functioning and worldview need to be understood and valued in how resilience is viewed, while also understanding what role societal norms and individual differences have in evaluating assumed outcomes for any member of a given group. An example of this is the belief that girls are not good in math and science and the unfortunate consequences that belief has for the world, and for individual girls who might end up doubting and/or not pursuing their own gifts.

There is much in the field of neuroscience that shows that the brain/mind is capable of lifelong growth, resilience, adaptation, and plasticity. For all adults who work with and/or raise children this is providing the scientific evidence that can support resilience-based approaches that assumes a fundamental posit and belief that all children can flourish.

What Schools Can Do To Promote Resilience in Students, Staff, and Policies

- Promote fairness and consistency in ways students and staff can understand and respect
- Engage students to feel competent and valued before they become disconnected

- Recognize how trauma or life events can affect the ability of a student to learn and focus
- Encourage and support organizational and professional resilience
- Promote efforts to achieve academic excellence and a lifelong love of learning
- Support universal, selected, and indicated prevention activities
- Expand on approaches that enhance the self-efficacy of both staff and students
- Increase activities that foster student and family engagement and partnerships
- Advocate for more behavioral health supports for classrooms
- Encourage ways to engage students through alternative and adaptive learning styles
- Seek to find a balance between standardized testing and the essentials of learning
- Promote a sense of coherence and shared purpose that values all school staff input
- Make community service hours meaningful for the student's sense of civic responsibility
- Have goals that link increased student engagement to reducing discipline referrals
- Find ways to have community promote the value of a good education
- Help students embrace learning as something that is fun, engaging, and creative
- Show appreciation of the value teachers have in the wellbeing of future generations

Resource Links

Positive Behavioral Interventions & Supports (PBIS)

<https://www.pbis.org>

Children's Mental Health Matters!

Facts for Families - School Services

www.ChildrensMentalHealthMatters.org

National Resilience Resource Center

<http://www.nationalresilienceresource.com>

Resiliency Institute, School Workshops

<http://www.resiliencyinstitute.com/schoolWorkshops/resilientSchools.php>

The Science of Resilience

Why some children can thrive despite adversity Harvard Graduate School of Education

<https://www.gse.harvard.edu/news/uk/15/03/science-resilience>

Resilience, School Connectedness and Achievement California Department of Education

<https://www.cde.ca.gov/ls/yd/tr/schoolconnectach.asp>

Center for Mental Health in Schools University of California, Los Angeles (UCLA)

<http://smhp.psych.ucla.edu>

Education Resources Information Center (ERIC)

Review of Research on Educational Resilience

<https://eric.ed.gov/?>

WestEd

www.wested.org

Scientific Research Academic Publisher

<https://www.scirp.org>

This Fact Sheet was adapted from a longer set of documents, including a resilience poster, developed by the Maryland Behavioral Health Administration Child and Adolescent Resilience, Wellness and Prevention Committee. To download these or to learn more, please visit www.ChildrensMentalHealthMatters.org or www.mindresilience.org/about/



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School is a major part of a child's life. A child with mental health needs can experience challenges that make it difficult to be successful in school. You may need to collaborate with other school personnel to best support your students. Your school does provide a range of services that can help each child succeed.

Individualized Education Program (IEP)

Children with more intensive mental health needs may qualify for special education services under the federal law called Individuals with Disabilities Education Act (IDEA). IDEA requires that children with a disability receive additional services (IEP) to help them in school. A child with mental health needs must show certain characteristics to qualify for special education as a child with an "emotional disability."

"(i) Emotional Disability is a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's education performance:

1. an inability to learn that cannot be explained by intellectual, sensory, or health factors
2. an inability to build or maintain satisfactory interpersonal relationships with peers or teachers
3. inappropriate types of behavior or feelings under normal circumstances
4. a general pervasive mood of unhappiness or depression
5. a tendency to develop physical symptoms or fears associated with personal or school problems

(ii) Emotional Disability includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance."

In addition, in order to be eligible for services under IDEA, the student, by reason of their disability, must require special education and related services."

Note that the definition of Emotional Disability is not a diagnosis or medical term, but rather a term used in the federal education law to designate eligibility for special education. Under IDEA, if a child is found eligible, the student is entitled to an Individualized Educational Program (IEP) that is designed to meet their unique needs.

It is important to know your rights. A Parents Guide to

Understanding Your IEP: Rights and Responsibilities can be found at <http://marylandpublicschools.org/programs/Documents/Special-Ed/IEP/IEPParentsGuide2016.pdf>

504 Plans

Children with mental health needs who do not qualify for special education may qualify for services under another federal law. Section 504 of the Rehabilitation Act's definition of disability is broader than the IDEA's definition. To be protected under Section 504, a student must be determined to: have physical or mental impairment that substantially limits one or more major life activities; or have a record of such an impairment; or be regarded as having such an impairment.

Examples of what might be included:

- Adjustment to test taking (more time, questions given orally)
- Seating near the blackboard or near the teacher
- Excused from class to take medications
- Allowed to eat in class because of diabetes

Who is responsible for a 504 Plan?

- The student (if appropriate)
- Parent or Legal Guardian
- Teacher
- Administrator
- School 504 Coordinator (may be a staff person on the Student Support and/or Child Study Teams)

Others who may be included, as appropriate

- School Counselor, Social Worker, and/or Psychologist
- Physician, Psychiatrist, or other health professional
- Mental Health Clinician
- Speech/Language Pathologists
- Occupational Therapist/Physical Therapist

Center on the Social and Emotional Foundations for Early Learning (CSEFEL)

In Maryland, CSEFEL is focused on promoting the social and emotional development and school readiness of young children between birth and five years of age. CSEFEL's Pyramid model is being integrated into the effective practices to enhance young children's social and emotional competence and to prevent challenging behaviors.

<https://theinstitute.umaryland.edu/our-work/maryland-center/piec/> or

<http://csefel.vanderbilt.edu/>

Positive Behavioral Interventions and Supports

PBIS Maryland has been implemented in more than 900 schools across all 24 local school systems. The goals of PBIS are to promote a positive school climate, reduce

disruptive behaviors, and create safer, more effective schools for all students. The emphasis of PBIS is on rewarding positive behaviors rather than focusing on reactive, punitive practices. <http://pbismaryland.org/>

Medication at School

Sometimes it is necessary for children to take medication during school hours. Schools have very strict regulations governing medications at school. A form completed by a child's doctor is required and can be downloaded from the Maryland State Department of Education website:

<http://marylandpublicschools.org/about/Documents/DSFSS/SSSP/SHS/medforms/medicationform404.pdf>

All medication must be in containers labeled by the pharmacist or doctor and an adult must bring the medication to school. Non-prescription medication must be in the original container with the label intact.

Resources on Special Education

Maryland State Department of Education

<http://MarylandLearningLinks.org>

<http://marylandpublicschools.org/programs/Documents/Special-Ed/IEP/BuildingIEPsMDFamilies.pdf>

Maryland Association of Nonpublic Special Education Facilities (MANSEF)

<http://www.mansef.org>

Disability Rights Maryland

<https://disabilityrightsmd.org/>

Resources on 504 Plans

Office of Civil Rights, Protecting Students with Disabilities: Frequently Asked Questions About Section 504 and the Education of Children with Disabilities

<http://www2.ed.gov/about/offices/list/ocr/504faq.html>

Resources on IEPs

Resources related to IDEA and its implementing regulations, released on August 3, 2006.

<https://sites.ed.gov/idea/>

Understanding the Evaluation, Eligibility, and Individualized Education Program (IEP) Process in Maryland. Maryland State Department of Education, 2008.

https://www.hcpss.org/ff/special/understanding_iep.pdf

The Technical Assistance Center on Positive Behavioral Interventions and Supports.

<https://www.pbis.org/>

National School Climate Center

Promotes positive and sustained school climate: a safe, supportive environment that nurtures social and emotional, ethical, and academic skills.

www.schoolclimate.org

Maryland Learning Links Family & Community Support Services

<https://marylandlearninglinks.org/>



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Students who exhibit self-injurious behavior perform deliberate and repetitive acts of injuring their own body as a way to cope with overwhelming feelings and thoughts. Some forms of self-injurious behavior include cutting, carving, scratching, burning, branding, biting, bruising, hitting, and picking and pulling skin and hair. Studies of high school students indicated prevalence rates of self-harm in this population ranged from 13% to 24%. Onset can occur in children as young as seven years old, but the age of onset is usually between the ages of 12 and 15 years.

Self injury is serious and often co-occur with other mental health problems like depression, obsessive-compulsive disorder, or anorexia nervosa.

Why is this important?

- Students who exhibit self-injurious behavior have difficulty verbally communicating their feelings with others.
- Students who exhibit self-injurious behavior are more likely to engage in other types of risky behavior such as substance or alcohol abuse.
- Students who exhibit self-injurious behavior are more likely to isolate themselves from classmates.
- Students may inadvertently seriously harm themselves.

What can educators do about it?

Do not ignore suspicious injuries you have noticed on a young person's body. If you suspect that a student is deliberately injuring themselves:

- Discuss the situation with the child's parents or caregiver. It is important to let the child's family know of your suspicions. Ask the family to help the student seek available resources.
- Offer support and reassurance to the student. It is important not to alienate a self-injuring student but rather to build trust.
- Students should be under supervision at all times, until they have been assessed as safe or given over to the care of their parents.
- Be aware that the student's behavior is usually a symptom of a more serious underlying problem. Talk to the student about what's going on in their life that could be triggering this behavior.
- Notify the school clinicians about the student's behavior, and ask them to provide additional information and resources to the students and caregivers.

Resource Links

American Academy of Child and Adolescent Psychiatry.

Facts for Families No. 73: Self-Injury in Adolescents.
https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Self-Injury-In-Adolescents-073.aspx

ASCD: Professional Learning & Community for Educators

http://www.ascd.org/publications/educational_leadership/dec09/vol67/num04/Helping_Self-Harming_Students.aspx

Cornell Research Program on Self-Injury and Recovery: Non-Suicidal Self-Injury in Schools

<http://www.selfinjury.bctr.cornell.edu/perch/resources/non-suicidal-self-injury-in-schools.pdf>

Mental Health America

Fact Sheet on Self-Injury
<https://www.mhanational.org/conditions/self-injury-cutting-self-harm-or-self-mutilation>

National Association of School Psychologists

<https://apps.nasponline.org/search-results.aspx?q=self+injury>

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

<http://www.selfinjury.com>

Adapted from Resources found on:

www.schoolmentalhealth.org

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In 2018, the National Institute on Drug Abuse found that approximately 6.1 percent of all 8th graders, 9.6 percent of all 10th graders, and 12.4 percent of all 12th graders have used an illegal drug in the last year. Drug use may be higher among kids who have dropped out of school. One in four 12th graders report that regular marijuana use poses a great risk (26.7 percent). And, daily marijuana use continues to outpace daily cigarette use across grades, reflecting a steep decline in daily cigarette use and fairly stable daily marijuana use. After marijuana, prescription and over-the-counter medications account for most of the top drugs abused by 12th graders in the past year. Studies show that 30.2 percent of high school seniors have used alcohol in the past month. Alcohol use and binge drinking continued to show a significant five-year decline among all grades.

Other psychiatric disorders often coexist with substance use problems and need assessment and treatment. Adolescents who use drugs often act out, do poorly academically, and drop out of school. They are at risk for unplanned pregnancies, violence, and infectious diseases. As a teacher who spends a lot of time with kids, you can play a critical role in helping to identify and get help for those students at risk for or engaged in alcohol or drug use.

Why is this important?

Drugs and alcohol contribute to a host of problems for our children including:

- Poor academic performance
- Memory and learning problems
- Truancy and absenteeism
- Problems with family and peer relationships and a lack of empathy for others
- A tendency to engage in other risky activities and to feel invulnerable • An increased risk for moving on to more dangerous drugs and developing dependency, or addiction

While all children are at risk of using drugs and alcohol, the following risk factors significantly increase the chance that a child will develop a serious alcohol or drug problem:

- Having a family history of substance use, dependency or addiction
- Experiencing emotional or psychological problems
- Low self-esteem
- Not feeling connected to family, school, or community

What can educators do about it?

Research has documented that family involvement and classroom-based prevention programs are the most effective means of addressing substance use among youth.

- Watch for signs of substance use:
 - Moodiness or irritability
 - Argumentative, disruptive, rule-breaking behavior
 - Sudden mood or personality changes
 - Low self-esteem or depression
 - Poor judgment; irresponsible behavior
 - Social withdrawal; pulling away from family
 - Change in former activities or friends
 - General lack of interest
- Discuss the situation with the child's parents or caregiver.
- Notify the appropriate school staff (e.g., school counselor or mental health provider, school principal) if you suspect a student is using drugs or alcohol.
- Let your students know that you do not approve of drug or alcohol use. Develop a personal relationship with your students, and share your concerns about their safety and well-being.

- Create a positive classroom environment where students feel comfortable talking with you and sharing feelings. Listen carefully to what they are telling you, and let them know that you are a resource of support if they should need it.
- Encourage students to develop different ways to refuse substance use. Examples include:
 - Switching topic (“Hey, did you hear about the game last night?”)
 - Using an excuse (“I can’t, I’m meeting a friend in 10 minutes”)
 - Put the “blame” on others/parents (“My mom would kill me if she found out”)
 - Walk away
 - State the facts (“No thanks, I’ve read about what drugs can do to your body”)
- Educate yourself. Seek out resources that give current information regarding what drugs are out there and specific signs of use. Children are beginning to use at younger ages and teachers often spend more time with students than their parents. It is important to be up to date to ensure the safety of your students.
- Educate your students. Give them factual information about drugs and alcohol. It is important to challenge myths and to give them accurate information about the dangers of substance use.
- Remind your students that they will be reported if they come to school in possession of drugs or alcohol, or under the influence.
- Let your students know that you will contact their parents if you suspect drug or alcohol use. Follow through on parent contact should the need arise, but let students know that you will be contacting their parents so as not to violate their trust.
- Discuss your concerns and possible responses with your principal or other school administrators.

Resource Links

National Institute on Drug Abuse (NIDA)

Provides links to facts on specific drugs.
<https://www.drugabuse.gov/drugs-abuse>

National Institute on Drug Abuse (NIDA)

Provides links to facts on specific drugs for parents and teachers as well as age appropriate curriculum regarding drug education.
<https://www.drugabuse.gov/parents-educators>

Monitoring the Future

An annual survey, under a grant from the National Institute on Drug Abuse, of 8th, 10th, and 12th graders measuring drug, alcohol, and cigarette used and related attitudes nationwide.
<https://archives.drugabuse.gov/monitoring-future-survey-overview-findings-2013>

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Suicide is the act of taking one's own life. Suicide is the second leading cause of death among youth ages 15-24 and it accounts for 18 percent of all deaths among 15-24 year olds. Every day in the United States, over 5,240 students in grades 7 – 12 attempt suicide. In Maryland, one in six high school students has seriously considered suicide. However, building strong family relationships, having the knowledge of the risks and warning signs of suicide/depression, and having access to prevention and intervention resources will often decrease the likelihood of suicide.

Warning signs may include:

- Depressed mood
- Frequent episodes of running away or being incarcerated
- Family loss or instability; significant problems with parent
- Expressions of suicidal thoughts or talk of death or the afterlife during moments of sadness or boredom
- Withdrawal from friends and family
- Difficulties in dealing with sexual orientation
- Disinterest in or enjoying activities that once were pleasurable
- Unplanned pregnancy
- Impulsive, aggressive behavior; frequent expressions of rage
- Alcohol and/or drug abuse
- Engaging in high risk behaviors (e.g., fire-setting, involvement in cults/gangs, cruelty to animals)
- Social isolation and poor self-esteem
- Witnessing or being exposed to family violence or abuse
- Having a relative who committed or attempted suicide
- Being preoccupied with themes and acts of violence in TV shows, movies, music, magazines, comics, books, video games, and internet sites
- Giving away meaningful belongings

Research has shown that gay, lesbian, bisexual, transgender and/or questioning (GLBTQ) youth are more than twice as likely to attempt suicide than straight peers. However, sexual orientation is not noted on death certificates in the U.S. so exact completion rates are difficult to report. Studies have also confirmed that GLBTQ youth have higher rates of suicidal ideation than their straight peers and often have more severe risk factors. It is important to note that being GLBTQ is not a risk factor

in and of itself; however, minority stressors that GLBTQ youth encounter – such as discrimination and harassment – are directly associated with suicidal behavior as well as indirectly with risk factors for suicide.

Warning signs specific to GLBTQ youth may include:

- A high rate of victimization/bullying
- Difficulties in dealing with sexual orientation
- Lack of family acceptance

IMPORTANT

Some children may exhibit many warning signs yet appear to be coping with their situation and others may show no signs and yet still feel suicidal. The only way to know for sure is to ask your student and to consult a mental health professional.

What can educators do about it?

- Ask the student directly if they are considering suicide. Ask "are you thinking of hurting yourself?" or whether they have made a specific plan and have done anything to carry it out. Explain the reasons for your concerns. Listen openly to the student, tell the student that you care deeply and that no matter how overwhelming his or her problems seem, help is available.
- Immediately contact the student's parents or guardians and get the student professional help from a doctor, community health center, counselor, psychologist, social worker, youth worker, or minister. You can also call 1-800-273-8255 or the local crisis team. In Maryland, call 2-1-1, press 1.

- If the student is in immediate danger, call 911 or the local crisis team and then contact their parents. If the student has a detailed plan or appears acutely suicidal and will not talk, they could be in immediate danger and it is important to get help right away. Do not leave the student alone and seek help immediately.
- Learn the warning signs, risks and other factors associated with suicide especially if the student has made suicidal attempts or threats in the past. Ensure the student knows that you are there for them, encourage them to seek you out in times of need, and if you are not there at the time when your child feels depressed or suicidal, have another support person to go to for help.

Resource Links

American Association of Suicidology

<http://www.suicidology.org/ncpys/resources>

American Foundation for Suicide Prevention

<http://www.afsp.org>

Centre for Suicide Prevention

<http://www.suicideinfo.ca/>

Suicide Awareness Voices of Education (SAVE)

<http://www.save.org/>

Suicide Prevention Resource Center

<https://www.sprc.org/settings/schools>

National Association of School Psychologists: Preventing Youth Suicide: Tips for Parents & Educators

<https://www.nasponline.org/resources-and-publications/resources-and-podcasts/school-climate-safety-and-crisis/mental-health-resources/preventing-youth-suicide/preventing-youth-suicide-tips-for-parents-and-educators>

Yellow Ribbon Suicide Prevention Program

<https://yellowribbon.org/>

Adapted from Resources found on:

www.schoolmentalhealth.org

Behavioral Health Authorities/Core Service Agencies by Maryland County

Statewide Maryland Helpline: Call 2-1-1, press 1

County	Mental Health	Substance Use
Allegany	301-759-5070	301-759-5050
Anne Arundel	410-222-7858	410-222-7164
Baltimore City	410-433-5175	410-433-5175
Baltimore County	410-887-3828	410-887-3828
Calvert	410-535-5400 x318	410-535-3079 x14
Carroll	410-876-4449	410-876-4449
Cecil	410-996-5112	410-996-5112
Charles	410-996-5112	301-609-5757
Frederick	301-682-6017	301-600-1755
Garrett	301-334-7440	301-334-7670
Harford	410-803-8726	410-877-2341
Howard	410-313-7350	410-313-6202
Mid-Shore (CAROLINE, DORCHESTER, KENT, QUEEN ANNE'S, TALBOT)	410-770-4801	
Caroline	410-479-1882	
Dorchester		410-228-7714 x106
Kent	410-778-5783	410-778-6404
Queen Anne's		410-758-1306 x4534
Talbot		410-819-5600
Montgomery	240-777-1400	240-777-1400
Prince George's	301-856-9500	301-856-9500
Somerset	410-523-1815	443-523-1787
St. Mary's	301-475-4330	301-475-4330
Washington	301-739-2490	240-313-3310
Wicomico	410-543-6981	410-742-3784
Worcester	410-632-3366	410-632-3366



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Trauma is caused by an unforeseen event that causes extreme fear and possible harm to a child. It is also referred to as emotional harm and it is the relatively normal reaction that occurs in response to an extreme event. A student's age, level of development, and availability of support will factor into how well they deal with the trauma. With psychiatric trauma, emotional and distressful memories are stored in the brain and can lead to other emotional and social problems. Trauma does not typically appear during the traumatic event, but rather once it is over. The trauma can appear within days, weeks, months, or years.

Trauma-causing events can include but are not limited to

- Violence (e.g. school shootings, witness/victim of abuse)
- War
- Terrorism
- Sexual abuse
- Natural disaster (e.g., fire, hurricane, earthquake, flood)
- Accidents
- Medical procedures
- Serious threats (e.g. bomb threats)

Why is this important?

About 50% of children are exposed to a traumatic event. As many as 67% of trauma survivors experience lasting psychosocial impairment. Trauma can affect a child's brain and delay certain abilities, which can make it harder for the child to concentrate and study. A traumatic event can also hinder a child's emotional maturity. The child may also experience many negative emotions in which they may feel extreme betrayal and a lack of faith in their life and the world. Trauma can have serious effects on a student's well-being physically, emotionally, and academically. According to the American Psychiatric Association, educators can play an important role in the way they respond to trauma.

Some children will experience difficulty coping with the traumatic events and may develop **Post-Traumatic Stress Disorder (PTSD)**, **Child Traumatic Stress (CTS)**, depression, or overwhelming, prolonged grief.

PTSD is an anxiety disorder that occurs following exposure to an extreme stressor (i.e., when a person sees or is a part of a highly traumatic event). The event

will usually be a life-threatening or extremely distressing situation that causes a person to feel intense fear, horror or a sense of helplessness. The risk of developing PTSD is related to the seriousness of the event, the child's proximity to the event, whether or not the event was repeated and the child's relationship to those affected.

CTS occurs when children and adolescents are exposed to traumatic events or traumatic situations. This exposure can overwhelm their ability to cope with what they have experienced. Depending on their age, children respond to traumatic stress in different ways.

Signs & Symptoms

People respond in different ways to extreme trauma.

Some people may:

- Relive the event
- Avoid reminders and experience frequent flashbacks
- Have ongoing fears related to the disaster (involving loss or separation from parents)
- Have sleep disturbances or nightmares • Look on guard, uneasy, or jumpy
- Seem disconnected or have relationship problems
- Have psychiatric problems such as depression, suicidal thoughts, dissociation (losing conscious awareness of the "here and now"), or anxiety
- Engage in aggressive and/or self-destructive behavior (i.e., alcohol or drug abuse, high-risk sexual behaviors)
- Have physical complaints (i.e., stress-related conditions, eating disorders, headaches)
- Have more absences from school/refusal to go to school
- Experience concentration difficulties or irritability)

What can educators do about it?

- Early intervention is critical
- Remember that you are a role model for the student. Students will immediately pick up on how you respond to traumatic events.
- Refer the child to the school's counselor or a medical professional.
- Alert the student's parents.
- Answer the student's questions. Be as honest as

possible, listen intently, and use simple words. Be prepared to repeat answers and conversations. Offer plenty of class time for discussion if appropriate and avoid rumors and misconceptions. Make sure the students know that their feelings are perfectly normal.

- Implement activities aside from just open discussion (e.g. art projects) that may allow the students to express what they are feeling.
- Stick to as normal a classroom routine as possible.

Resource Links

American Academy of Child & Adolescent Psychiatry Talking to Children about Terrorism and War -

Tips on how to talk to children after a traumatic event occurs, not limited to terrorism/war.

https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Talking-To-Children-About-Terrorism-And-War-087.aspx

Post-traumatic Stress Disorder (PTSD)

Defines PTSD, and gives symptoms of PTSD.

https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Posttraumatic-Stress-Disorder-PTSD-070.aspx

National Center for PTSD/ PTSD in Children and Adolescents

Offers a fact sheet for PTSD in children and adolescents including diagnosis of PTSD, causes, risk factors, symptoms, and treatment.

https://www.ptsd.va.gov/professional/treat/specific/ptsd_child_teens.asp

The National Child Traumatic Stress Network Understanding Child Traumatic Stress Brochure

Defines Child Traumatic Stress, symptoms, PTSD, responses to stress and traumatic stress recovery.

<https://www.nctsn.org/resources/nctsn-resources-related-to-understanding-child-traumatic-stress>

National Child Traumatic Stress Network Resources for School Personnel

<https://www.nctsn.org/audiences/school-personnel>

National Institute of Mental Health (NIH)

Helping Children and Adolescents Cope with Disasters and Other Traumatic Events: What Parents, Rescue Workers, and the Community Can Do

<https://www.nimh.nih.gov/health/publications/helping-children-and-adolescents-cope-with-disasters-and-other-traumatic-events/index.shtml#pub7>

PBS America Responds

Classroom Resources

<http://www.pbs.org/americaresponds/educators.html>

Thirteen Online Education: Dealing With Tragedy Tips and Resources for Teachers and Parents

Lesson plans to use in response to traumatic events.

<http://www.thirteen.org/edonline/tips.html#lessonplans>

Dealing With Tragedy: Tips for teachers

<https://www.thirteen.org/edonline/tips.html#teachers>

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