ECHO IDAHO

K12 School Nurses

School-Based Behavioral Health Management

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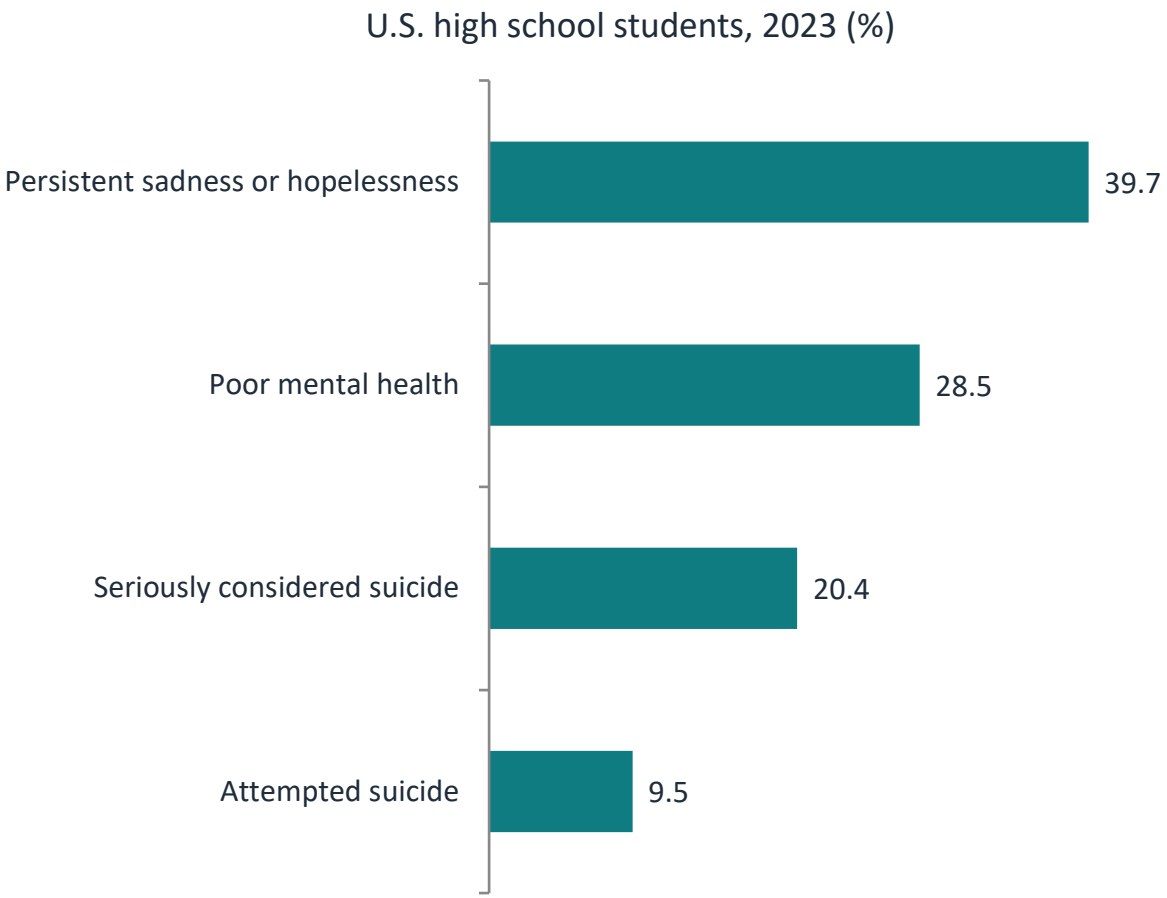
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Objectives

Setting the stage	Why the health office matters and where the nurse fits
Behavioral de-escalation	The escalation cycle, verbal tools, environment, Idaho guardrails
Psychosocial support	Trauma-informed care, connection, brief health-office tools
Children/Adolescents with Autism	Emotional stress, trauma, and adapting our approach
Warning signs and higher levels of care	Recognizing risk, Idaho pathways, hand-off, and re-entry

Students are struggling, and the school nurse often sees it first

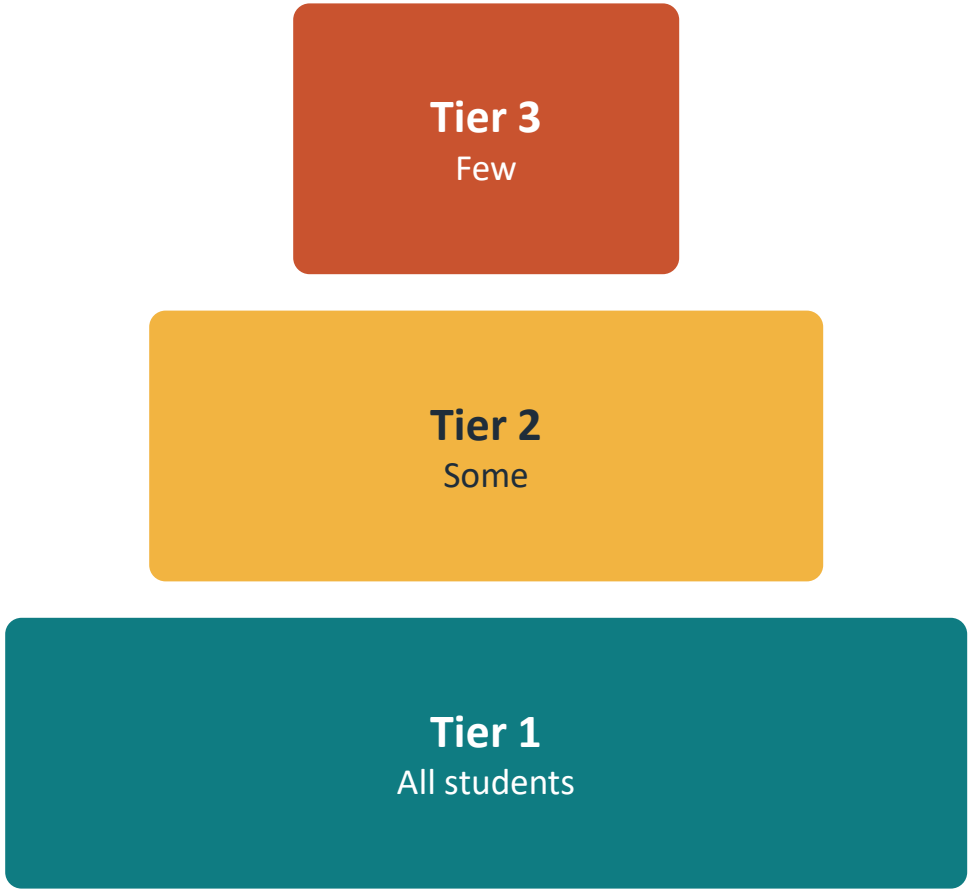


The school health office is often the “front door”

- Headaches, stomachaches, and fatigue often mask anxiety, depression, or trauma
- Frequent visits are a signal worth tracking, not a nuisance
- The nurse is a trusted adult outside the discipline system
- Early recognition shortens the path to care

Sources: Verlenden et al., MMWR Suppl 2024 (CDC YRBS 2023); AAP Council on School Health, Pediatrics 2016

The school health system: a tiered model



Intensive

Crisis response, safety planning with the team, community referral, re-entry coordination

Targeted

Scheduled check-ins, coping skills, visit tracking, 504 and IEP input, counselor referral

Universal

A calm office space, health promotion, staff education, screening per district policy

Sources: NASN, Framework for 21st Century School Nursing Practice, 2016; AAP Council on School Health, Pediatrics 2016

01

Behavioral de-escalation

Staying safe, lowering the temperature, and protecting the relationship

Behavior is communication: regulate first

1 Regulate

Calm the body first. Lower your voice, slow your pace, reduce demands. Offer space, water, or movement.

2 Relate

Connect before you correct. Name the feeling, show you are on their side, and listen.

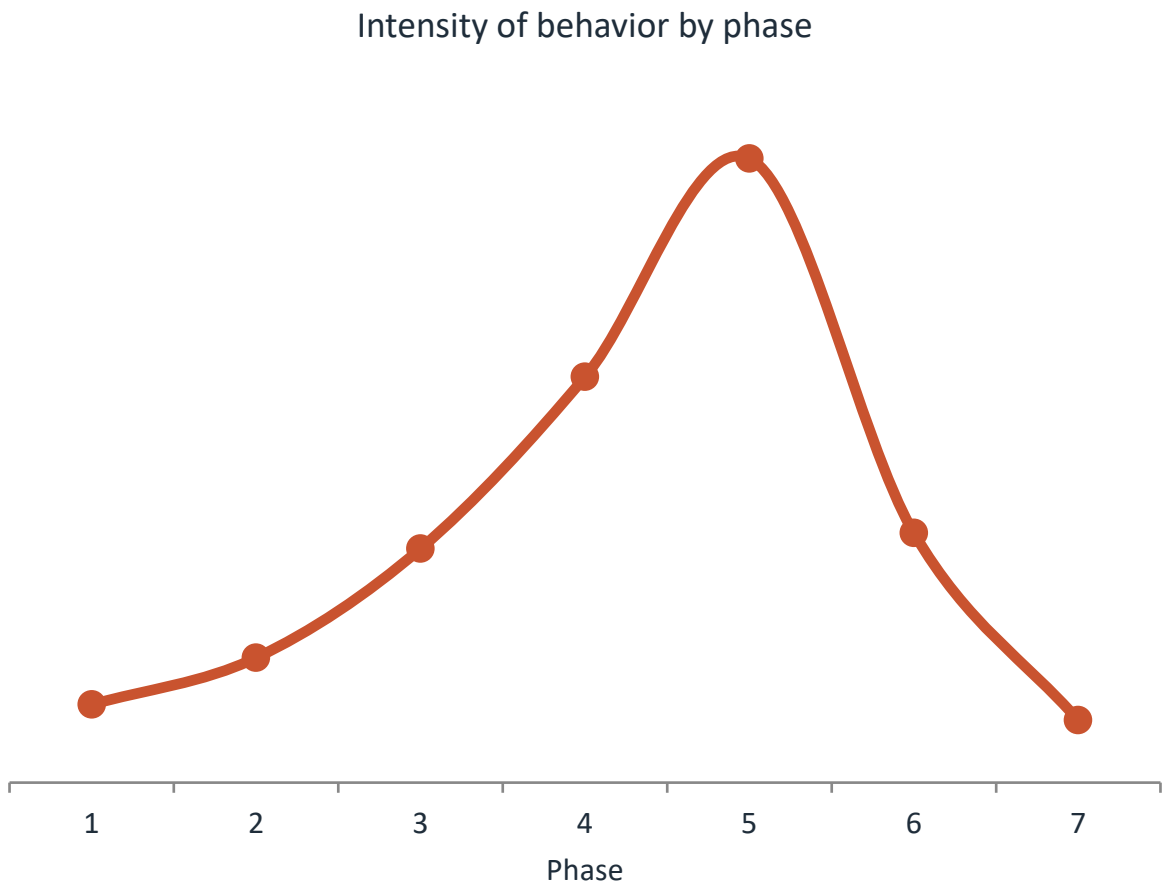
3 Reason

Only now problem-solve. Talk through what happened, the choices, and the next step.

A dysregulated student cannot take in reasoning, consequences, or long sentences. Your calm is the intervention.

Sources: Perry & Winfrey, What Happened to You?, 2021; Richmond et al., West J Emerg Med 2012

The escalation cycle: match the response to the phase



1 **Calm** Build rapport and teach coping skills

2 **Trigger** Notice early; remove or reduce the stressor

3 **Agitation** Offer space, movement, or a quiet task

4 **Acceleration** Brief, neutral limits; no power struggles

5 **Peak** Safety only; few words; clear the area

6 **De-escalation** Quiet and low demand; no lecture

7 **Recovery** Reconnect, then debrief and plan

Sources: Colvin & Scott, Managing the Cycle of Acting-Out Behavior in the Classroom, 2nd ed., 2015

Ten domains of verbal de-escalation

1

Respect personal space

Two arm-lengths; exits open

2

Do not be provocative

Calm face, open hands

3

Establish verbal contact

One person does the talking

4

Be concise

Short phrases; repeat calmly

5

Identify wants and feelings

“What do you need right now?”

6

Listen closely

Reflect back what you heard

7

Agree or agree to disagree

Find something true to affirm

8

Set clear limits

State facts, not threats

9

Offer choices and optimism

Two acceptable options

10

Debrief student and staff

Restore the relationship

Sources: Richmond et al., West J Emerg Med 2012 (Project BETA); Gerson et al., West J Emerg Med 2019

What to say, and what to avoid

Try

- “I can see this is really hard. I’m here.”
- “You’re not in trouble. I want to help.”
- “Would you rather sit here or by the window?”
- “Take your time. I’ll wait with you.”

Avoid

- “Calm down.” “You’re overreacting.”
- “Why did you do that?”
- “If you don’t stop, I’m calling the principal.”
- Arguing the facts, raising your voice, cornering

How you say it matters more than what you say: low volume, slow pace, even tone.

Sources: Richmond et al., West J Emerg Med 2012; Gerson et al., West J Emerg Med 2019

Set the stage: environment and body language

Reduce the audience

Move peers out rather than moving the student

Lower stimulation

Dim lights, cut noise, limit the number of adults

Position for safety

Stand at an angle; you both keep a path to the door

One voice

A single staff member leads; others stay quiet

Slow everything down

Pace, speech, and movement; silence is fine

Meet basic needs

Water, a snack, rest, bathroom, pain relief

Think medical first. Hypoglycemia, pain, seizure or post-ictal state, head injury, medication effects, intoxication, and infection can all present as “behavior.”

Sources: Gerson et al., West J Emerg Med 2019; Richmond et al., West J Emerg Med 2012

When safety is at risk: guardrails

Idaho Code § 33-1224

- Restraint and seclusion are never discipline or punishment
- Corporal punishment and chemical restraint are prohibited
- Every district and charter must have a policy covering all students, including reporting
- Staff assigned to students receive annual training

The school nurse's role

- Know your district policy and crisis team in advance
- Assess student and staff for injury after any physical intervention
- Watch for medical distress during and after
- Document objectively: times, observations, actions
- Flag repeat incidents for team review

Physical intervention is a last-resort safety measure, and it can itself be traumatic.

Sources: Idaho Code § 33-1224 (H.B. 281, 2023); Idaho Department of Education implementation summary. Not legal advice; follow district policy.

After the incident: repair and learn



Restore

Once calm, reconnect without a lecture. The relationship comes first.



Debrief

Ask the student: What happened? What helped? What would help next time?



Document

Objective facts, times, and actions. Notify the family per district policy.



Plan

Update known triggers and the coping plan. Schedule team follow-up.

A student can look calm before they are calm. Hold new demands until recovery is complete.

Sources: Colvin & Scott, 2015; Richmond et al., West J Emerg Med 2012

02

Psychosocial support

Everyday practices that keep students regulated, connected, and in class

A trauma-informed lens

Realize

how common trauma is, and that recovery is possible

Recognize

the signs in students, families, and staff

Respond

by building this knowledge into daily practice

Resist

re-traumatizing through how we intervene

Six principles

1. Safety
2. Trustworthiness and transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice, and choice
6. Cultural, historical, and gender responsiveness

From "What's wrong with you?" to "What happened to you, and what do you need?"

Sources: SAMHSA, Concept of Trauma and Guidance for a Trauma-Informed Approach, 2014

Connection is protective

48–66%

lower odds of health-risk outcomes in adulthood for teens with high school and family connectedness, compared with low on both

Outcomes included emotional distress, violence, and substance misuse

- Know names, and one thing each frequent visitor cares about
- Be a consistent, non-judgmental adult
- Help each student name one trusted adult at school
- Partner with families early, not only in crisis
- Link students to clubs, mentors, and peers

Sources: Steiner et al., Pediatrics 2019; Verlenden et al., MMWR Suppl 2024

Brief tools for the health office

Validate

“That sounds really hard.” Name the feeling before fixing anything.

Ground

5-4-3-2-1 senses, cold water on the hands, feet flat on the floor.

Breathe

Slow breaths with a longer exhale for two to three minutes.

Check the basics

Sleep, food, water, missed medication, pain.

One next step

Pick a single small, solvable problem together.

Plan the return

Time-limited rest, a pass, and a set check-back time.

Track the pattern: visit frequency, time of day, and the class being missed often tell the story.

Sources: Brymer et al., Psychological First Aid for Schools, NCTSN 2012; NASN 2016

03

Children/Adolescents with Autism

Emotional stress, trauma, and adapting our approach

Autistic teens carry a heavier load

1 in 4

report suicidal thoughts; about 8% have attempted

O'Halloran 2022

3×

the odds of suicidality and of self-injury vs. non-autistic peers

Blanchard 2021

44%

are bullied at school (pooled victimization estimate)

Maïano 2016

2×

as likely to have four or more adverse childhood experiences

Berg 2016

Co-occurring conditions are common: ADHD 28%, anxiety disorders 20%, depressive disorders 11% (Lai 2019). Distress is often missed because it presents differently.

Sources: O'Halloran 2022; Blanchard 2021; Maïano 2016; Berg 2016; Lai 2019 (full citations on reference slides)

Where the stress comes from

What we see Meltdown · shutdown · refusal · bolting · aggression · self-injury

What is often underneath

Sensory overload

Noise, lights, smells, crowded halls and cafeterias

Masking

Exhausting effort to hide autistic traits; tied to suicide risk

Bullying and exclusion

Often unreported; ask directly and specifically

Unpredictability

Schedule changes, substitutes, transitions, drills

Being misunderstood

Literal speech read as rude; distress read as defiance

Past frightening events

Restraint, seclusion, or painful medical care

Sources: Kerns et al., J Autism Dev Disord 2015; Cassidy et al., Mol Autism 2018; Maïano et al., Autism Res 2016

Meltdown, shutdown, burnout: not misbehavior



Meltdown

An involuntary response to overload, not a choice. Crying, shouting, bolting, hitting self or objects.

What helps: Safety, space, quiet, and time



Shutdown

The same overload turned inward. Goes silent or still, cannot answer, may seem “fine” or defiant.

What helps: Low demand, no questions, a quiet place



Burnout

Long-term exhaustion, loss of skills, and lower tolerance for stimulation after chronic stress without support.

What helps: Fewer demands, rest, acceptance, a team plan

A tantrum has a goal and stops when the goal is met. A meltdown ends when the nervous system recovers.

Sources: Raymaker et al., Autism in Adulthood 2020; National Autistic Society, Meltdowns: a guide for all audiences

Distress can look different



Watch for change from baseline

- New or increased self-injury or repetitive behavior
- Loss of skills, speech, or interest in a favorite topic
- School refusal, more nurse visits, physical complaints
- Changes in sleep, eating, or toileting
- Flat or mismatched affect, even when describing suicidal thoughts



Adapt how you ask

- Concrete, literal questions, one at a time
- Extra processing time; offer writing, typing, or visuals
- Do not rely on eye contact or facial expression
- Ask caregivers what distress looks like for this student
- Take every statement seriously; do not attribute it all to autism

Sources: O'Halloran et al., Clin Psychol Rev 2022; Kerns et al., J Autism Dev Disord 2015; Lai et al., Lancet Psychiatry 2019

De-escalation, adapted for autistic students

Do

- Cut language to a few calm words
- Lower sensory input: lights, noise, people
- Give time and space; waiting is doing something
- Allow stimming and movement
- Offer visual choices or a known calming item
- Use the student's own plan and communication system

Avoid

- Touching or blocking without a safety need
- Demanding eye contact or "use your words"
- Several adults talking at once
- Rapid questions or repeated prompts
- Removing comfort objects
- Debriefing too soon; recovery may take hours

Sources: Gerson et al., West J Emerg Med 2019; National Autistic Society; Raymaker et al., Autism in Adulthood 2020

04

Warning signs and higher levels of care

Recognizing risk and navigating Idaho’s system from the school setting

Warning signs: how urgent is it?

Emergency
Act now; do not leave alone

- Suicidal intent, a plan, or an attempt
- Access to means with stated intent
- Threat to harm others with intent or means
- Psychosis, severe confusion, or intoxication
- Self-injury needing medical care

Urgent
Evaluation the same day

- Suicidal thoughts without plan or intent
- New or escalating self-harm
- Giving away belongings, saying goodbye
- Not eating or sleeping; rapid decline
- Disclosure of abuse (also a mandated report)

Prompt referral
Within days, with follow-up

- Sadness, withdrawal, or irritability for 2+ weeks
- Falling grades or attendance
- Frequent physical complaints
- Substance use
- Marked change in weight or appetite

Sources: AAP & AFSP, Blueprint for Youth Suicide Prevention, 2022; NIMH ASQ Toolkit; AAP-AACAP-CHA Declaration, 2021

Screen, don’t guess: brief validated tools

ASQ Ask Suicide-Screening Questions

- Four yes/no questions, about 20 seconds
- 96.9% sensitivity, 87.6% specificity in pediatric ED validation
- Any “yes” needs a brief safety assessment
- Free from NIMH, with scripts and pathways

C-SSRS Columbia Suicide Severity Rating Scale

- Graded questions on ideation and recent behavior
- Intent or a plan signals the highest risk
- Shared language with EDs and crisis teams
- Free screener versions for schools

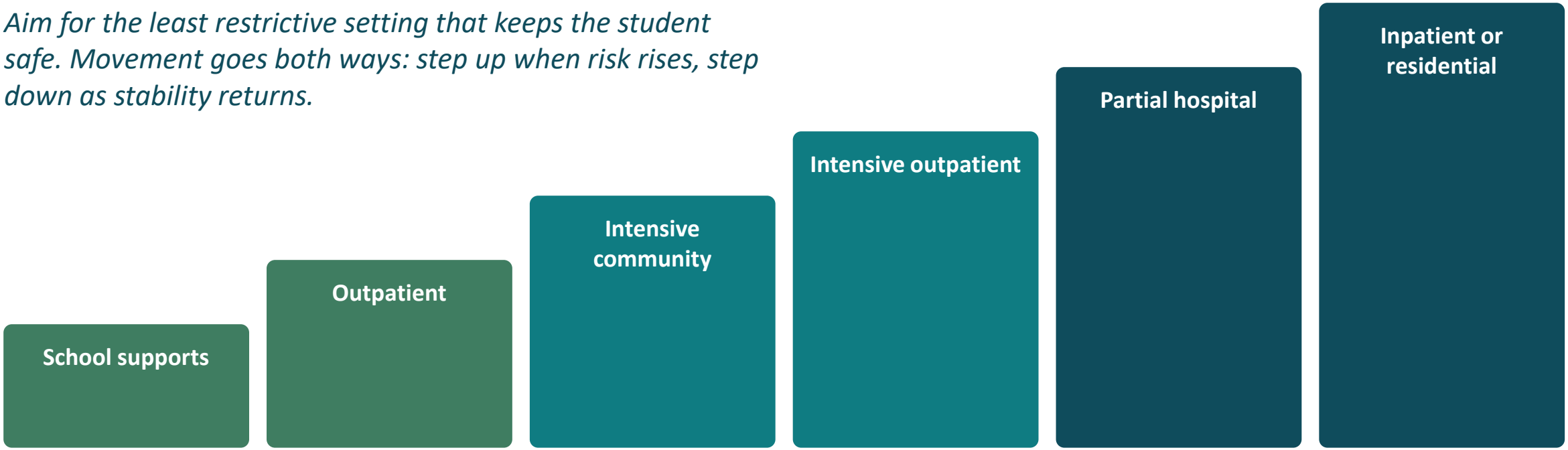


Idaho note. Screening is a health care service under Idaho Code § 32-1015 (amended March 31, 2026). Follow your district’s parental consent process. The law includes exceptions for medical emergencies and for 988 crisis services.

Sources: Horowitz et al., Arch Pediatr Adolesc Med 2012; Posner et al., Am J Psychiatry 2011; Idaho Code § 32-1015; Stanger 2026. Not legal advice.

The continuum of care

Aim for the least restrictive setting that keeps the student safe. Movement goes both ways: step up when risk rises, step down as stability returns.



Crisis services at any step: 988 · Mobile Response Teams · youth crisis centers · emergency department

Sources: AACAP, CALOCUS-CASII; Magellan Healthcare, Idaho Behavioral Health Plan; McEnany et al., Pediatrics 2020

From school to care: a decision guide

Imminent danger Intent, plan, means, or cannot stay safe	Urgent, not imminent Thoughts without plan or intent; rapid decline	Concerning, not urgent Lasting change in mood, behavior, or function
1 Stay with the student; move others and any means away	1 Keep the student supervised; screen per district policy	1 Share observations with the family and school counselor
2 Call 911 or your SRO; activate the school crisis team	2 Reach the parent or guardian today, in person if possible	2 Refer to the PCP or current therapist for evaluation
3 Notify the parent or guardian; send information with EMS	3 Call or text 988; a Mobile Response Team can respond	3 Medicaid: Magellan links to a CANS assessment and YES
4 ED evaluation; officers may transport under § 16-2411	4 Or the family walks in to a youth crisis center	4 Check back in 1–2 weeks: did the visit happen?

Sources: Idaho Code § 16-2411; Idaho DHW crisis services; Idaho YES; Magellan of Idaho. Adapt to your district crisis protocol.

Idaho resources to keep at your desk

988

Call or text, 24/7, free

Idaho Crisis & Suicide Hotline

Chat at idahocrisis.org

Dispatches Mobile Response Teams statewide, around the clock

Youth crisis centers

Boise	Clarvida Youth Community Support Center	**833-527-4747**
Nampa	Western Idaho Youth Support Center	**208-899-4727**
Twin Falls	ProActive Youth and Family Support Center	**208-969-9841**
Idaho Falls	Rise Up Teen and Child Crisis Center	**208-826-0994**
Coeur d'Alene	Northern Idaho Crisis Center	**208-625-4884**

Ages 5–17 · voluntary · free · walk-ins, no referral · open 24/7 · up to 23 h 59 min

Ongoing care

Magellan of Idaho
Runs the Idaho Behavioral Health Plan. magellanofidaho.com

YES
For under-18s with serious emotional disturbance; starts with a CANS assessment. yes.idaho.gov

Intensive options
Intensive Care Coordination and Idaho WInS wraparound

Sources: Idaho YES, Crisis Resources (yes.idaho.gov, updated April 2026); Idaho Crisis & Suicide Hotline; Magellan of Idaho. Verify numbers before distributing.

Making the hand-off work

1 Stay with the student

Never send a student in crisis alone to the office, the bus, or home.

2 Activate your protocol

Administrator, counselor or psychologist, and crisis team per district plan.

3 Contact the family

Suspected abuse or neglect: report within 24 hours (Idaho Code § 16-1605).

4 Give a clear hand-off

What you saw, the student's own words, screening result, medications.

5 Talk about means safety

Ask the family to lock up firearms and medications before going home.

6 Document and connect

Record facts, times, and contacts. Get a release of information.

Sources: AAP & AFSP, Blueprint for Youth Suicide Prevention, 2022; Stanley et al., JAMA Psychiatry 2018; Idaho Code § 16-1605

Coming back: re-entry after a higher level of care



Before return

Signed release of information. Discharge summary, medication changes, and safety plan in hand.

Re-entry meeting

Student, family, counselor, nurse, administrator. Agree on supports and who knows what.

First weeks

Brief daily check-ins, a lighter workload, a quiet-space pass. Watch for medication side effects.

Ongoing

Review the 504 or IEP. Stay in touch with the treating clinician. Re-screen if warning signs return.

The weeks after discharge are a high-risk period. A planned return is a safety intervention.

Sources: SAMHSA, Preventing Suicide: A Toolkit for High Schools, 2012; Stanley et al., JAMA Psychiatry 2018

Key takeaways

- Regulate first. Your calm is the intervention.
- Match your response to the phase of escalation.
- Connection and predictability are everyday prevention.
- For autistic students: fewer words, less input, more time.
- Know the warning signs and your Idaho pathway before you need them: 988, crisis centers, ED.

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