Strategies to Support Students with Anxiety and Depression

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Learner Objectives

- Understand the importance of this topic NOW
- How to recognize internalizing (anxiety/ depression) features
- Learn evidence based methods of prevention teachers and parents can do
- Review the graduated sequence of evidence based curricula, supports and interventions
- Learn methods to keep students safe
- Learn how to communicate with parents

Learner Objectives (continued)

- Learn when to consider
  - Goals in the IEP
  - Supplementary Aids and Supports
  - Related Service: Cognitive Behavior Therapy
  - Assessment for Special Education (EBD)

Why Now: Depression and Anxiety?

- Center for Disease Control and World Health Organization: Depression becoming leading illness in students by 2017
- American Pediatrics and Psychiatry summaries
- National Institute of Mental Health prevalence summaries

Theories? : American cultural "Bleak Outlook" Shift, Learned Helplessness, Other

World Health Organization

- By the year 2017, depression is projected to reach 2nd place of the ranking of DALYs calculated for all ages, both sexes.
- Today, depression is already the 2nd cause of DALYs in the age category 15-44 years for both sexes combined.

DALYs = Disability Adjusted Life Years
The sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability.

World Health Organization

- Depression is a common mental disorder, characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy and poor concentration.
- These problems can become chronic or recurrent, substantially impairing an individual's ability to cope with daily life. At its most severe, depression can lead to suicide. Most cases of depression can be treated with medication or psychotherapy.

http://www.who.int/topics/en/

NIMH: Prevalence and Age-of-Onset 2005

Mental illness: half of all lifetime cases begin by age 14; three quarters have begun by age 24.

- Anxiety disorders often begin in late
- Childhood mood disorders in late adolescence
- Substance abuse in the early 20's.

http://www.nimh.nih.gov/science-news/2005/mental-illness-exacts-heavy-toll-beginning-in-youth.shtml

National Institute of Mental Health

http://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml

Anxiety Disorders

- Anxiety disorders include panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, generalized anxiety disorder, and phobias (social phobia, agoraphobia, and specific phobia).
- Approximately 40 million American adults ages 18 and older, or about 18.1 percent of people in this age group in a given year, have an anxiety disorder.

National Institute of Mental Health

Anxiety Disorders

- Anxiety disorders frequently co-occur with depressive disorders or substance abuse.
- Most people with one anxiety disorder also have another anxiety disorder. Nearly three-quarters of those with an anxiety disorder will have their first episode by age 21.5

National Institute Mental Health PTSD

Post-Traumatic Stress Disorder (PTSD)

- Approximately 7.7 million American adults age 18 and older, or about 3.5 percent of people in this age group in a given year, have PTSD.[1, 2]
- PTSD can develop at any age, including childhood, but research shows that the median age of onset is 23 years.[5]

National Institute of Mental Health

- **Social Phobia**
- Approximately 15 million American adults age 18 and over, or about 6.8 percent of people in this age group in a given year, have social phobia.[1]
- **Social phobia begins in childhood or adolescence, typically around 13 years of age.** [5]

National Institute Mental Health: Generalized Anxiety Disorder

Generalized Anxiety Disorder (GAD)

- Approximately 6.8 million American adults, or about 3.1 percent of people age 18 and over, have GAD in a given year.[1, 2]
- GAD can begin across the life cycle, though the median age of onset is 31 years old.[5]

National Institute of Mental Health

Panic Disorder

- Approximately 6 million American adults ages 18 and older, or about 2.7 percent exhibit PD.
- Panic disorder typically develops in early adulthood (median age of onset is 24), but the age of onset extends throughout adulthood.[5]
- About one in three people with panic disorder develops agoraphobia, a condition in which the individual becomes afraid of being in any place or situation where escape might be difficult or help unavailable in the event of a panic attack.

National Institute of Mental Health

Agoraphobia

- *Agoraphobia* involves intense fear and anxiety of any place or situation where escape might be difficult, leading to avoidance of situations such as being alone outside of the home; traveling in a car, bus, or airplane; or being in a crowded area.

National Institute of Mental Health

Agoraphobia

- Approximately 1.8 million American adults age 18 and over, or about 0.8 percent of people in this age group in a given year, have agoraphobia without a history of panic disorder.
- The median age of onset of agoraphobia is 20 years of age.

Lifelong Prevalence Concerns: Depression

- Depression is the leading cause of disability worldwide among persons age 5 and older.
- 7-14% experience an episode of depression before the age of 15.
- 60-80% of children and adolescents with depression are undiagnosed and untreated
- One in five adolescents in US considers suicide.
- Depression directly or indirectly results in 1700 teen suicides per year.

Lifelong Prevalence Concerns Depression

- Junior high begins episodes, if not earlier
- Some studies, 9 % of adolescents have had first bout of severe depression
- 50% of episodes of severe depression reoccur

Contrast with:

- Born 1900 or earlier, 1% have an episode by old age
- Born 1925 or earlier, 4% by old age

(Seligman, 1995, 2005)

American Academy of Child and Adolescent Psychiatry: Characteristics

- Frequent sadness, tearfulness, crying
- Decreased interest in activities; or inability to enjoy previously favorite activities
- Hopelessness
- Persistent boredom; low energy
- Social isolation, poor communication
- Low self esteem and guilt
- Extreme sensitivity to rejection or failure

http://www.aacap.org/cs/root/facts_for_families/the_depressed_child

American Academy of Child and Adolescent Psychiatry: Characteristics

- Increased irritability, anger, or hostility
- Difficulty with relationships
- Frequent complaints of physical illnesses such as headaches and stomachaches
- Frequent absences from school or poor performance in school
- Poor concentration
- A major change in eating and/or sleeping patterns

American Academy of Child and Adolescent Psychiatry: Characteristics

- Talk of or efforts to run away from home
- Thoughts or expressions of suicide or self destructive behavior
- A child who used to play often with friends may now spend most of the time alone and without interests.

American Academy of Child and Adolescent Psychiatry: Characteristics

- Things that were once fun now bring little joy to the depressed child.
- Children and adolescents who are depressed may say they want to be dead or may talk about suicide. Depressed children and adolescents are at increased risk for committing suicide.
- Depressed adolescents may abuse alcohol or other drugs as a way of trying to feel better.

Anxiety in Youth: Children's Emotional Healthlink (CEHL.ORG)

- Social Anxiety Disorder, Social Phobia, PTSD, Panic Disorder and Specific Phobia:
  - Precede onset of substance abuse disorders
  - Associated with increased probability of SUD
- High prevalence (10-20% of youth)
  - Significantly impairs social, academic, family and independent function
  - Highly comorbid with mood and substance abuse
  - Commonly persist to adulthood

See: http://www.cehl.org/art_94.shtml

Emotional and Behavioral Disorders

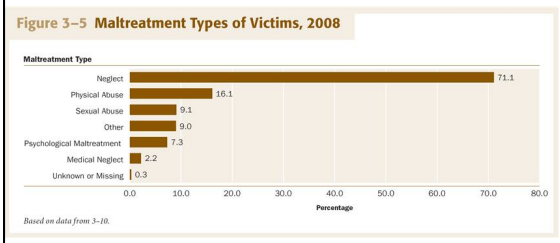
- **Anxiety-Based Disorders Disorders**
  - **Separation Anxiety Disorder (SAD)**
  - **Generalized Anxiety Disorder (GAD)**
  - **Specific Phobia**
  - **Social Phobia**
  - **Obsessive Compulsive Disorder (OCD)**
- **Depressive Disorders**
  - **Major Depression**
  - **Dysthymia**
  - **Bipolar Disorder**
- **Trauma-related Disorders**
  - **Acute Stress Disorder**
  - **Post-traumatic Stress Disorder**
- **Disruptive Disorders**
  - ADHD
  - Oppositional Defiant Disorder
  - Conduct Disorder
- **Adjustment Disorders**
  - **w/ Depressed Mood**
  - **w/ Anxiety**
  - **w/ Mixed Anxiety & Depressed Mood**
  - **w/ Disturbance of Conduct**
  - **w/ Mixed Disturbance of Emotions & Conduct**

Another View

Internalizing Disorders	Externalizing Disorders
Emotions manifest internally Behavior Deficits	Emotions manifest externally Behavior Excesses

Youth can manifest combinations within and across the categories

Some Sources of Stress Related to Anxiety and Depression



U.S. Department of Health & Human Services, Administration on Children Youth & Families. Child Maltreatment 2008. Washington, DC: U.S. Government Printing Office, 2009). Retrieved September 17, 2010 from http://www.acf.hhs.gov/programs/cb

Trauma Focused CBT

http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/

Free on line training on

✓ Trauma Focused CBT from Medical University of South Carolina

http://tfcbt.musc.edu/

Why Select Only Evidence Based?

Evidence based means researchers who do not make a profit on the program evaluate multiple well designed studies and determine the extent to which the "effect size" of using the intervention is large enough to justify using the intervention

✓ .50 and above is the magic number

Resources to Find Evidence-Based Interventions

- ABCT: http://www.abct.org/sccap/?m=sPro&fa=sPro
- NREPP: http://www.nrepp.samhsa.gov/
- Promising Practices Network http://www.promisingpractices.net
- What Works Clearinghouse: http://ies.ed.gov/ncee/wwc/

What you see: Commonalities Across Different Emotional Disabilities

1. **Cognitive responses**
   - Irrational beliefs
   - Faulty automatic thoughts
   - Poor perspective taking
2. **Emotional responses**
   - Fear/anxiety, depression, anger, emotional dysregulation

(Cook, C.R., PPT training on CBT, 2012)

What you see, continued

3. **Behavioral responses**
   - Avoidance behaviors
   - Oppositional behaviors
   - Aggressive behaviors
   - Poor coping strategies
4. **Somatic responses**
   - Accelerated heart rate
   - Flushed face
   - Shortness of breath
   - Physical complaints without a medical explanation

(Cook, C.R., PPT training on CBT, 2012)

What is Felt: Reactions to Provocative Stimuli

- **Physical sensations:** e.g., rapid heart rate, short of breath, cold sweaty hands, blushed face, butterflies
- **Thoughts/Beliefs:** interpretation and meaning making of situation
- **Feelings:** sad, angry, upset, depressed, worried

Results in:

- **Escape/Avoidance Behaviors:** attempt to remove contact with provocative stimulus
- **Oppositional Behaviors:** when forced to have contact with provocative stimulus

(Cook, C.R., PPT training on CBT, 2012)

Environmental Triggers that Provoke Negative Reactions

- **Methods to Determine Triggers:**
  - Interview the child
    - List a time when you have….
  - Observation
  - Self-monitoring
  - Informant reports (e.g., parent or teacher)

Physiological Symptoms Experienced in Response to Environmental Triggers

- **Somatic complaints**: headaches, stomachaches, muscle tension
- **Physiological arousal**: racing heart, sweating palms, teeth chattering, dizziness, flushed face, trembling hands

(Cook, C.R., PPT training on CBT, 2012)

Thinking Errors: Anxiety/Depression

- AKA: Cognitive distortions or faulty automatic negative thoughts
- Thoughts that do not appropriately match the context in which they occur
  - Anxious student thinking "If I leave the house, something bad will happen to my family."
  - Depressed student thinking "Nobody ever wants to sit with me."

(Cook, C.R., PPT training on CBT, 2012)

Cognitive Distortions

- **All-Or-None Thinking:** see things in only two categories (extremes) and there is no middle ground (e.g., good or bad, safe or dangerous, clean or dirty)
- **Labeling:** attach a global negative label to yourself (e.g., I'm a failure.)
- **Overgeneralization:** interpret one isolated current situation as a sequence of bad events by using words like "always" or "never" when you describe it or think about it; make far-reaching, global conclusions based on a single event

(Cook, C.R., PPT training on CBT, 2012)

Cognitive Distortions

- **Negative Filter:** focus on an isolated negative detail and selectively attend to it, so that ultimately your interpretation of everything that's happening becomes distorted; focus on the negatives and ignore the positives and bigger picture
- **Discounting the Positive:** disqualify positive events and assume that they don't count. If you accomplish something you could be proud of, you tell yourself that it wasn't that important, or that anyone could have done it.

(Cook, C.R., PPT training on CBT, 2012)

Cognitive Distortions: Anxiety/Depression

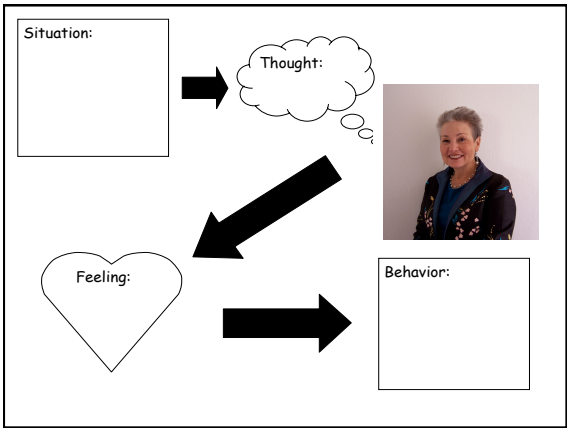
- **Mind Reading:** automatically assume that others are having negative thoughts about you without having any evidence for it (believe you know what other people are thinking)
- **Fortune-Telling:** predict that things will turn out terribly before they even start and without having any evidence for this prediction
- **Emotional Reasoning:** assume that your feelings reflect the way things really are; think something must be true because you feel it so strongly and you ignore evidence to the contrary.

(Cook, C.R., PPT training on CBT, 2012)

Cognitive Distortions: Anxiety/Depression

- **"Should" and "Must" Statements:** expect that things should be the way you want them to be. If they are not, you feel guilty. "I shouldn't have made so many mistakes."
- **Personalization:** believe that others are reacting to you, without considering more likely explanations for their behavior
- **Unfair Comparisons:** hold unrealistically high standards and focus primarily on the few people who meet those standards; always finding yourself inferior in comparison

(Cook, C.R., PPT training on CBT, 2012)



Internalizing vs. Externalizing

Internalizers, turn emotion inward

Externalizers, turn emotion outward

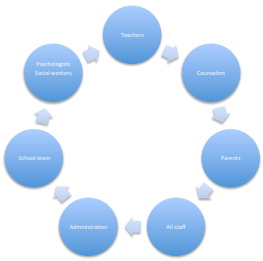
Don't be fooled!:
Some students have both internalizing and externalizing problems

Do We Know This?

For every complex **problem** there is an answer that is clear, simple, and wrong.

-H. L. Mencken.

How Should We Respond?



Understanding Diagnosis:Highlights

- **Anxiety Disorders Interview Schedule (ADIS-IV) Child and Parent Interview Schedules**

Wendy K. Silverman, Ph.D. and Anne Marie Albano, Ph.D.

Oxford University Press: http://www.oup.com/

Understanding Diagnosis:Highlights

- **Children's Depression Inventory 2**

Maria Kovacs, Ph.D. at http://www.mhs.com

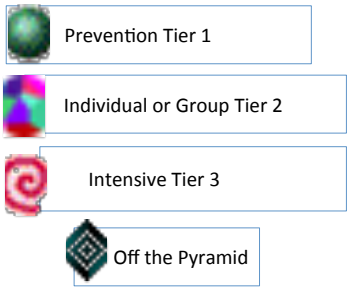
- **Reynolds Adolescent Depression Scale-2**

William M. Reynolds, Ph.D. at http://www.sigmaassessmentsystems.com/assessments/rads.asp

- **Beck Depression Inventory®–II**

Aaron T. Beck, Ph.D. & Robert A. Steer, Gregory K. Brown http://www.pearsonassessments.com

Match Supports with Behaviors



Tier 1 prevention

Exemplary: Penn Prevention Program (PPP)

More than 17 controlled trials with almost 2,500 children from a variety of geographic, socio-economic, and cultural backgrounds.

Positive long lasting results, building on Martin Seligman's lifelong work in resilience.

See: The Optimistic Child and other scholarly studies and books by Martin Seligman

Tier 1 prevention

Penn Prevention Program (PPP)

Curriculum designed to promote resilience and prevent symptoms of depression: ages 10-14.

- Cognitive component- teaches identifying self-talk, thinking more flexibly and accurately about encountered problems
- Problem-solving component- teaches skills (e.g., assertiveness, relaxation, creative brainstorming, decision making) that can help youth cope with day-to-day stressors they encounter

http://www.pennproject.org/

Tier 1 prevention

The Penn Prevention Project: 4 skills in school to generate Optimism, which has been proven to prevent and ameliorate depression

1. Thought catching
2. Evaluating automatic thoughts
3. Generating more accurate explanations
4. Decatastrosphizing

Adversity-Beliefs-Consequences

Tier 1 prevention

Teachers play a critical role in helping children develop Optimism:

- Give high rates of reinforcement (5 to 1)
- Implement both SEL and PBIS
- Remember Mirror Neurons and SMILE as much as possible
- Use class wide systematic positive techniques to get to know all students
- Use techniques for "behavior activation"

Tier 1 prevention

Teachers play a critical role:

- Use Positive Peer Reporting techniques
- Use classwide Good Behavior Games
- Use Direct Teaching strategies with high rates of responding:
  - ✓ choral responding,
  - ✓ every pupil response techniques
- Consider class wide Optimism Training
- Watch for bullying and exclusions and involve administration

Tier 1 prevention

SEL Curriculum: see www.casel.org, see safe and sound pdf and http://nrepp.samhsa.gov/

- **FRIENDS** curriculum (Australia)

http://www.friendsinfo.net/
Endorced by WHO, world wide program

- **Strong Kids/Strong Teens**, developed by Ken Merrell

http://strongkids.uoregon.edu/
http://www.brookespublishing.com/store/books/merrell-69322/index.htm

Tier 1 prevention

SEL Curriculum: see www.casel.org, see safe and sound pdf and http://nrepp.samhsa.gov/
For example:

- **Second Step, Revised** (but new data has not yet been completed, was previously primarily targetted aggression, now will include internalizing as well)
- **Lions Quest**, primarily community building, but some emotional regulation

Tier 2 individual & group

- Positive peer reporting group
- Small group social skills practice
- Small group SEL curricula
- Structured Mentoring, such as BEP
- Self Monitoring
- Home School Notes

http://www.shoplrp.com/product/p-300280.html

RTI and Behavior: A Guide to Integrating Behavioral and Academic Supports
Jeffrey Sprague, Clayton R. Cook, Diana Browning Wright, Carol Sadler

Tier Three Intense

Behavior Plan?

✓ An action plan for what staff will do

Cognitive Behavior Therapy?

✓ Direct school based mental health service

School-Based Mental Health Services

- Not for all students
- For the few students who have clinically significant problems and require therapeutic services in addition to or instead of prevention efforts and behavioral supports at Tier 1 and Tier 2

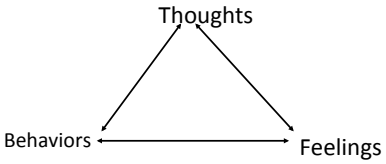
BEYOND BEHAVIORAL SUPPORTS:

- ✓ **Cognitive Behavior Therapy**
- ✓ **Behavior Activation Therapy**
- ✓ **Acceptance and Commitment Therapy**

- **Can be a related service**
- **Can be delivered by support staff**

Cognitive Behavioral Therapy?

- Based on the premise that thoughts, emotions, and behaviors are reciprocally linked and that changing one these will necessarily result in changes in the other



(Cook, C.R., PPT training on CBT, 2012)

What is Cognitive Behavioral Therapy?

- CBT is a combination of cognitive techniques (how we think) and behavioral techniques (how we act)
- The way an individual feels and behaves in influenced by the way s/he processes and perceives her/his experiences
- Dysfunctional behavior is the result of dysfunctional thinking

The Cognitive Behavioral Model

Situation

↓

Thoughts & Meaning Making

↓

Reaction (Emotional, Behavioral and Physiological)

↓

Consequences (Perceived and actual)

Contrast with: The General Behavioral Model

ANTECEDENTS

↓

BEHAVIORS

↓

Maintaining CONSEQUENCES (The function of the behavior)

Who is qualified to deliver CBT?

- **Scope of practice** is defined for the profession as a whole
  - It is within the scope of practice for the following professions to deliver CBT:
    - School psychologist
    - Social worker
    - Clinical psychologist
    - Counseling psychologist
    - School counselor
    - Marriage and family therapist

(Cook, C.R., PPT training on CBT, 2012)

Who is qualified to deliver CBT?

- **Scope of competence**, however, is individually defined/determined for each practitioner
  - This is determined based on the individual's previous training, experience, and supervision

(Cook, C.R., PPT training on CBT, 2012)

How to include CBT within your scope of competence?

- Continuing education
- Take additional coursework
- Read relevant literature
- Watch relevant videos
- Read relevant information online
- Get consultation
- Get supervised experience

Necessary for CBT Success

- The individual's willingness to practice the skills when they are not anxious, angry, or in pain.
- Success often depends on the parent's willingness to encourage their child to practice, including practicing with him or her, and using positive reinforcement for cooperation and successful outcomes.

(Cook, C.R., PPT training on CBT, 2012)

How to Describe in IEPs

- If the internalizing behavior is now determined to be a "need" for support, describe the team's "need discussion", and develop a measurable 6 part goal: By when, who, will do what, at what level of proficiency, under what conditions, as measured by whom and how
- If behavior is impacting learning of the student or peers, supplementary aids and supports to maintain LRE are necessary. This can be a tier 2 intervention, or tier 3 behavior plan if tier 2 is unsuccessful
- If behavior is not responding to tier 2, consider a Related Service, Cognitive Behavioral Therapy by staff with scope of practice and scope of competence is a related service

Tier Three Intense

To address Selective Mutism

✓ Treatment protocol developed by Christopher Kearney, University of Nevada

Author of: Helping Children with Selective Mutism and Their Parents: A Guide for School-Based Professionals

Tier Three Intense

A resource for parents of children with excessive shyness or selective mutism is:
Kearney, C.A. (2011). *Silence is not golden: Strategies for helping the shy child*. New York: Oxford University Press.

http://www.oup.com/us/catalog/general/subject/Psychology/Clinical/?view=usa&ci=9780195326628).

Tier Three Intense

A resource for school officials who address children with selective mutism:
Kearney, C.A. (2010). *Helping youths with selective mutism and their parents: A guide for school-based professionals*. New York: Oxford University Press.
http://www.oup.com/us/catalog/general/subject/Psychology/PractitionerClientGuides/?view=usa&ci=9780195394542.

Tier Three Intense

Intensive School Refusal, Social Anxiety, Depression age 8-17

Coping Cat Program
to Address Anxious
and Depressive Symptoms
http://www.promisingpractices.net/program.asp?programid=153

Tier Three Intense

Coping with Stress Curriculum for at risk youth

- ✓ targets adolescents at risk for depression who are experiencing elevated depressive symptoms, or "demoralization."

Tier Three Intense

Coping with Stress Curriculum for at risk youth 13-18

- ✓ Involves cognitive-restructuring techniques in which participants learn to identify and challenge negative or irrational thoughts that may contribute to the development of future mood disorders, such as depression

Tier Three Intense

Coping with Stress Curriculum for at risk youth 13-18, deliver individually or small group

- ✓ Download for free:

http://www.kpchr.org/research/public/acwd/acwd.html

Coping with Stress

- ✓ .CWS is an adaptation of the Adolescent Coping with Depression Course (Clarke, Lewinsohn, and Hops, 1990), which targets adolescents already experiencing major depression or dysthymia.

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CBITS: grades 5th-12th

- ✓ The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program is a school-based, group and individual intervention designed to reduce symptoms of post-traumatic stress disorder (PTSD), depression, and behavioral problems, and to improve functioning, grades and attendance, peer and parent support, and coping skills.

CBITS: grades 5th-12th

- ✓ CBITS is for students who have witnessed or experienced traumatic life events such as community and school violence, accidents and injuries, physical abuse and domestic violence, and natural and man-made disasters.

CBITS: grades 5th-12th

- ✓ CBITS uses cognitive-behavioral techniques (e.g., psychoeducation, relaxation, social problem solving, cognitive restructuring, and exposure).

CBITS: grades 5th-12th

http://cbitsprogram.org/

Access free coursework for professionals and free materials, everything you need to implement CBITS at your school.

Program Commonalities?

Gives students the skills to manage The "false fire alarm", their autonomic arousal system which is out of control
Takes 6-10 weeks learning new skills before confronting the stimuli that set off the fight or flight response

Somatic Management Techniques

- **Somatic management techniques -** because the body is conditioned to respond in a heightened state of avoidance or escape (fight or flight) to external stimuli that is *perceived* as threatening or fearful, student are taught relaxation techniques to calm this response.
  - Deep breathing, positive self-talk, cognitive distraction technique

(Cook, C.R., PPT training on CBT, 2012)

Cognitive Restructuring

- **Cognitive restructuring –** The student learns new ways to deal with feared situations by investigating, uncovering and challenging anxiety-provoking thoughts. The following techniques are incorporated into this component: identification of automatic thoughts (AT), gathering evidence to dispute negative AT's and keeping a diary to monitor daily thoughts.

(Cook, C.R., PPT training on CBT, 2012)

Problem-Solving

Problem solving – A student is taught to identify real life problems, then to list and evaluate possible solutions to overcome the problem, assess the (dis)advantages of each solution, and select the best action for resolving the problem.

(Cook, C.R., PPT training on CBT, 2012)

Exposure

- **Exposure** - Involves gradual and systematic exposure to a feared situation. It can take the form of **guided imagery** (the therapist guides the student through step-by-step visual imagery of confronting the feared situation); **symbolism** (the use of pictures or props); **simulation** (role-playing a feared situation); or **in vivo** (contact with the real situation).
  - **Graduated exposure** - For instance, a student that is afraid of dogs. He can become used to dogs through a series of graduated exposure to a dog. He may first be confronted by using pictures of dogs in friendly situations (symbolism) and later encouraged to stand near a dog, next to a dog and then to touch a dog (in vivo).

(Cook, C.R., PPT training on CBT, 2012)

Differences, Anxiety/Depression?

Depression Focus: Activate behaviors for engagement and attaining reinforcement to prevent pulling away and ruminating on negative "takes" on experience

Anxiety Focus: Activate tolerance for small manageable doses of the stressor(s) and gradually increase

Off the Pyramid

Some students require intensive special education services in terms of

- ✓ Content,
- ✓ Methodology
- ✓ instructional strategies

Delivered in restrictive settings, including related services and supplementary aids in that setting

Off the Pyramid

Some students are receiving independent psychological support services off campus by therapists parents have employed

- ✓ Require communication on progress, but not content of treatment
- ✓ Arrange two way communication

See communicating progress form, attached

If student does not have an IEP

- Consider whether failure to respond to 3 tiers of internvention has triggered a "child find" obligation for assessment
- If student is non responsive to three tiers, consider whether EBD is present and conduct a comprehensive assessment with norm referenced tools and response data

Keeping Students Safe

- Evaluate for bullying, especially cyber bullying

http://www.pent.ca.gov/thr/bullyflowchart.pdf and http://youthviolence.edschool.virginia.edu/

- Employ a research validated threat assessment protocol consistent with The Safe School Initiative
- See: **Guidelines for Responding to Student Threats of Violence (k-12)**

Dewey G. Cornell, Ph.D. Peter L. Sheras, Ph.D.

Keeping Students Safe

- Establish a Check In, Check Out monitoring system 2x daily with a caring mentor
  - See: http://www.amazon.com/Behavior-Education-Program-Check-Intervention/dp/1593854161
- Evaluate for presence of suicidal thinking if depression is present
  - http://www.suicidology.org/c/document_library/get_file?folderId=235&name=DLFE-141.pdf

Keeping Students Safe

- Develop communication logs from staff on behaviors in classroom and on the yard
- Establish 2 way communication with physicians and therapists in the community
- Establish a case manager and be aware of increasing and decreasing levels of medication if anti depressants are prescribed

Keeping Students Safe

- Be sure absenteeism is followed up with more than automated calls!
- Use Subjective Units of Discomfort (SUD) or Feeling Thermometers to monitor student's change as a result of both in-school Tier 3 services, (or get reports from others on SUD)

Subjective Units of Distress (SUD)

Design the units, take multiple measures over time

0 1 2 3 4 5 6 7 8 9 10

completely calm moderate distress high distress

Assistance in designing?

https://www.msu.edu/course/sw/850/stocks/pack/slfanch.pdf

Or use Feeling Thermometers

http://www.schoolbehavior.com/Files/FeelingThermometer.pdf

Communicating with Parents

- Share specific, observed behavioral excesses and behavioral deficits logs
- Share content: skills taught and efforts to address the specific behaviors
- Share SUDs and Feeling Thermometer results during interventions
- For TIER 3, parents may require assistance to respond more adaptively to their child's distress

Take Home Message for Educators

- All researchers from multiple government agencies consistently report a rise in internalizing disorders in children and youth
- Social Emotional Development problems impacts academics and require school based structures of support
- There are known evidence based curricula, supports and interventions that can be provided to all, some, and a few students to prevent, address and manage these disorders

Thank You For Attending!

If I can be of further assistance,

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