



**EDS 245:
Psychology in the Schools**

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Introduction to Mental Health Interventions

**Mental Health Interventions:
A Credentialing Standard**

Standards for Graduate Preparation of School Psychologists

2.4 Interventions and Mental Health Services to Develop Social and Life Skills

- School psychologists have knowledge of biological, cultural, developmental, and social influences on behavior and mental health; behavioral and emotional impacts on learning and life skills; and evidence-based strategies to promote social-emotional functioning and mental health.
- School psychologists, in collaboration with others, demonstrate skills to use assessment and data-collection methods and to implement and evaluate services that support socialization, learning, and mental health.

NASP (2010)



**Mental Health Interventions:
A Credentialing Standard**

Standards for Graduate Preparation of School Psychologists

2.6 Preventive and Responsive Services

- School psychologists have knowledge of principles and research related to resilience and risk factors in learning and mental health, services in schools and communities to support multi-tiered prevention, and evidence-based strategies for effective crisis response.
- School psychologists, in collaboration with others, demonstrate skills to promote services that enhance learning, mental health, safety, and physical well-being through protective and adaptive factors and to implement effective crisis preparation, response, and recovery.

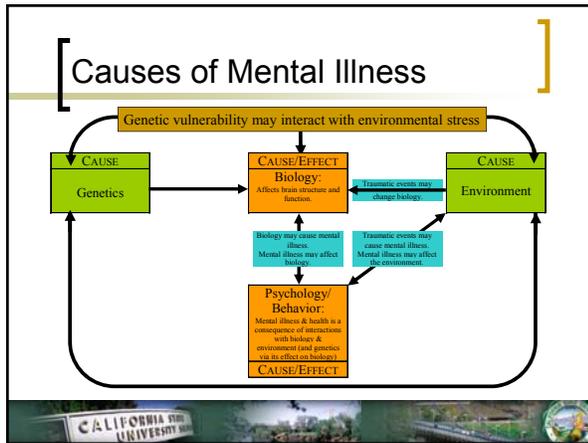
NASP (2010)

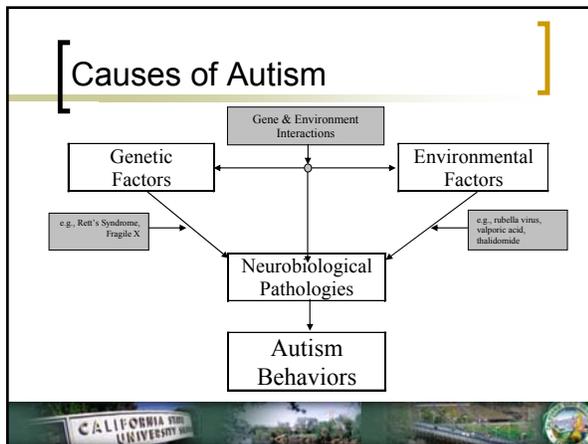


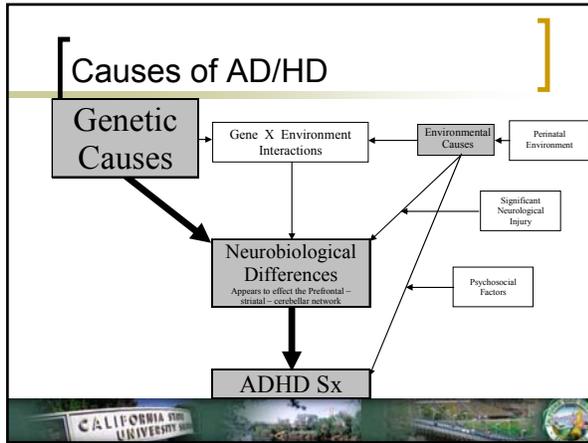
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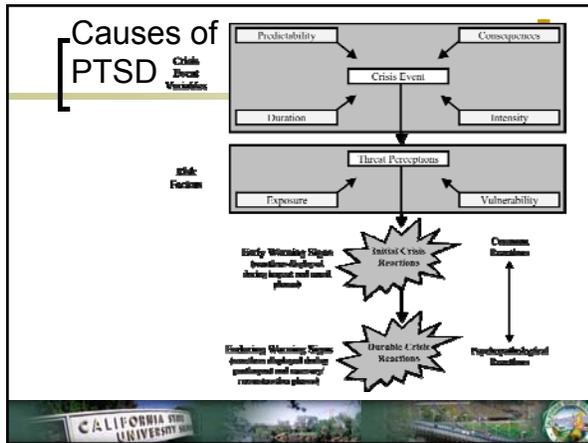
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Mental Health/Illness Theory









Causes of Mental Illness

- Genetic and Environmental Factors
 - There may be certain genes that convey to the child susceptibility to mental illness.
 - Autism, bipolar disorder, schizophrenia, and ADHD have genetic links.
 - Recent research
 - Caspi, A., Sugden, K., Moffit, T. E., Taylor, A. Craig, I. W., Harrington, H., McClay, J., Mill, J., Martin, J., Braithwaite, A., & Poulton, R. (2003, July 18). Influence of life stress on depression: Moderation by a polymorphism in the 5-HTT gene. *Science*, 301(5632), 386-389. [ABSTRACT](#)

Causes of Mental Illness

- Abstract
 - In a prospective-longitudinal study of a representative birth cohort, we tested why stressful experiences lead to depression in some people but not in others. A functional polymorphism in the promoter region of the serotonin transporter (5-HT T) gene was found to moderate the influence of stressful life events on depression. Individuals with one or two copies of the short allele of the 5-HT T promoter polymorphism exhibited more depressive symptoms, diagnosable depression, and suicidality in relation to stressful life events than individuals homozygous for the long allele. This epidemiological study thus provides evidence of a gene-by-environment interaction, in which an individual's response to environmental insults is moderated by his or her genetic makeup.



Risk Factors

- Variables that increase the chances of mental illness.
 - Internal (Genetic/Biological)
 - Prenatal damage from exposure to alcohol, illegal drugs, and tobacco
 - Low birth weight
 - Difficult temperament
 - Family history of mental illness
 - 20 to 50% of children with depression have a family history of depression.



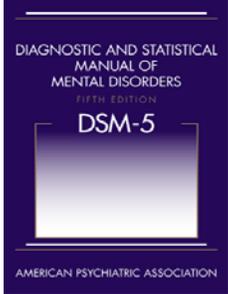
Risk Factors

- Variables that increase the chances of mental illness.
 - External (Environmental)
 - Poverty
 - Deprivation
 - Abuse and neglect
 - Unsatisfactory relationships
 - Parental mental health disorder
 - Exposure to traumatic events



Common Mental Health Challenges Among Youth

- AD/HD
- Anxiety Disorders
- Eating Disorders
- Elimination Disorders
- Mood Disorders
- Schizophrenia
- Tic Disorders

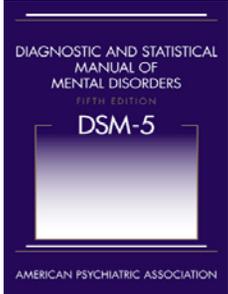


Common Mental Health Challenges Among Youth

- Comorbidity
 - It is not unusual for students to have two or more challenges.

DSM ordering information:
<http://www.psych.org/>

Information about DSM 5
<http://www.dsm5.org/Pages/Default.aspx>



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Mental Health/Illness Assessment

Diagnosis and Assessment

- EDS 244: Social, Emotional, & Behavioral Assessment
- EDS 247: Assessment of Special Needs
 - As young people are often unable to verbalize thoughts and feelings, assessment typically relies on parents, teachers, and other professionals (e.g., school psychologists).
 - Checklists and questionnaires often supplement these interviews.
 - Behavioral observations.
 - Projective techniques.



Diagnosis and Assessment

- Behavior Rating Scales
 - Omnibus survey
 - [Behavioral Assessment System for Children \(BASC\)](#)
 - [Child Behavior Checklist \(CBCL\)](#)
 - Symptom specific
 - [The Children's Depression Inventory](#)
 - [Revised Children's Manifest Anxiety Scale \(2nd ed.\)](#)
 - Adaptive Behavior
 - [Vineland Adaptive Behavior Scales](#)



Diagnosis and Assessment

- Interviews (EDS 248 and 240)
 - Clarification of behavioral concerns and identification of symptoms.
 - Developmental history.
 - Behavior history.
 - Family history.
 - Health history.
 - [Student](#).



Diagnosis and Assessment

- Behavioral observations (EDS 240)
 - Anecdotal
 - Systematic/objective
 - Time sampling
 - Duration



Diagnosis and Assessment

- Projective techniques (EDS 244 and 243)
 - Sentence completion test #1
 - Sentence completion test #2
 - Guess Why Game
 - Three Wishes



Diagnosis and Assessment

- Template for the Psycho-educational report for use with the child who has and emotional disturbance (ED).



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School Mental Health Interventions

Community Mental Health Interventions

- Psycho-social
 - Licensed Psychologists, Licensed Clinical Social Workers (LCSW), Marriage Family Therapists (MFT), Licensed Professional Clinical Counselors (LPCC).
- Psychopharmacological
 - Physicians (e.g., Psychiatrists)



Combined Interventions

- Combined treatments are most effective
 - Treatment of Adolescents With Depression Study (TADS) Team. (2004). [Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression: Treatment for adolescents with depression \(TADS\) randomized controlled trial.](#) *JAMA*, 292(7), 807-820.



Combined Interventions

- **Context** Initial treatment of major depressive disorder in adolescents may include cognitive-behavioral therapy (CBT) or a selective serotonin reuptake inhibitor (SSRI). However, little is known about their relative or combined effectiveness.
- **Objective** To evaluate the effectiveness of 4 treatments among adolescents with major depressive disorder.
- **Design, Setting, and Participants** Randomized controlled trial of a volunteer sample of 439 patients between the ages of 12 to 17 years with a primary *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, diagnosis of major depressive disorder. The trial was conducted at 13 US academic and community clinics between spring 2000 and summer 2003.



Combined Interventions

- **Interventions** Twelve weeks of (1) fluoxetine alone (10 to 40 mg/d), (2) CBT alone, (3) CBT with fluoxetine (10 to 40 mg/d), or (4) placebo (equivalent to 10 to 40 mg/d). Placebo and fluoxetine alone were administered double-blind; CBT alone and CBT with fluoxetine were administered unblinded.
- **Main Outcome Measures** Children's Depression Rating Scale-Revised total score and, for responder analysis, a (dichotomized) Clinical Global Impressions improvement score.



Combined Interventions

- **Results** Compared with placebo, the combination of fluoxetine with CBT was statistically significant ($P = .001$) on the Children's Depression Rating Scale-Revised. Compared with fluoxetine alone ($P = .02$) and CBT alone ($P = .01$), treatment of fluoxetine with CBT was superior. Fluoxetine alone is a superior treatment to CBT alone ($P = .01$). Rates of response for fluoxetine with CBT were 71.0% (95% confidence interval [CI], 62%-80%); fluoxetine alone, 60.6% (95% CI, 51%-70%); CBT alone, 43.2% (95% CI, 34%-52%); and placebo, 34.8% (95% CI, 26%-44%). On the Clinical Global Impressions improvement responder analysis, the 2 fluoxetine-containing conditions were statistically superior to CBT and to placebo. Clinically significant suicidal thinking, which was present in 29% of the sample at baseline, improved significantly in all 4 treatment groups. Fluoxetine with CBT showed the greatest reduction ($P = .02$). Seven (1.6%) of 439 patients attempted suicide; there were no completed suicides.



[Combined Interventions]

- Conclusion?



[School Psychology Mental Health Interventions]

- Consultation
 - Working with parents, teachers, and administrators to develop plans to address the challenges to learning presented by mental illness.
 - Finding ways to meet the learning challenges in the general education environment.



[School Psychology Mental Health Interventions]

- Identification of Mental Health Issues and Making Appropriate Referrals
 - Requires basic knowledge of mental illness and knowledge of local mental health resources (e.g., MFTs, LCSWs, LPCC, licensed psychologists, psychiatrists).
 - Knowing when to make appropriate referrals requires awareness of the limits of your training.
 - What do you think are your **current** "limits?"
 - What do you think are the limits of the **typical** credentialed school psychologists?



**School Psychology
Mental Health Interventions**

- Group Counseling (EDS 231)
 - A first choice school mental health intervention.
 - Facilitate social-emotional growth.
 - Typically address affective and social goals
 - Group process skills and an understanding of group dynamics are important in a number of different contexts (e.g., SSTs and IEPs).



**School Psychology
Mental Health Interventions**

- Individual Counseling (EDS 241 Counseling and Psychotherapy for the School Psychologists and EDS 440)
 - Different programs will offer different orientations. At CSUS we will train you in a Solution Focused approach
 - Builds on strengths and focuses on resiliency.
 - Collaborates on finding solutions instead of focusing on problems.
 - Cognitive behavioral approaches are also examined
- NOTE: Although it may appear that counseling is a self contained phenomenon, these skills are important to many different school psychology activities. What are some of these activities?



**School Psychology
Mental Health Interventions**

- Crisis Intervention (EDS 246b, Preventive Psychological Interventions)
 - How to help student, parents, and staff cope with traumatic events.
 - How to address the student who is experiencing a personal crisis.
 - Acute distress generated by an apparently unsolvable problem.
 - Homicidal and Suicidal ideation.



**School Psychology
Mental Health Interventions**

- **Suicide Risk Assessment**
 - Current Plan
 - The greater planning = greater risk
 - Pain
 - The more unbearable pain = greater risk
 - Lack of resources/Reasons for living
 - The more alone = greater risk
 - Prior Suicidal Behavior
 - Prior behavior = 40X greater risk
 - Mental Health Status
 - Mental illness (esp. mood disorders) = greater risk

Current Factors

Historical Factors



**School Psychology
Mental Health Interventions**

- Special education eligibility decisions
 - Determining if a students needs require special education assistance.
 - May involve other mental health professionals.
 - Requires documentation that less restrictive educational interventions are not sufficient.



**Special Education Eligibility:
“Emotional Disturbance”**

1. An emotional condition.
2. Has existed ...
 - a) for a long period of time,
 - b) to a marked degree,
 - c) and significantly adversely affects educational performance.
3. Is the primary handicap.



Special Education Eligibility: "Emotional Disturbance"

4. Results in an/a ...

- a) inability to learn, which cannot be explained by intellectual, sensory, or other health factors.
- b) inability to build or maintain satisfactory relationships with peers and teachers.
- c) inappropriate types of behaviors or feelings under normal circumstances.
- d) general pervasive mood of unhappiness or depression.
- e) tendency to develop physical symptoms or fears associated with personal or school problems.



Mental Health Matters: Key Points

1. Mental illness places a significant burden on the individual, schools, and society
2. School psychologists are perfectly positioned to promote mental wellness and qualified to address the challenges of mental illness
3. There are well established and effective school-based approaches to addressing mental health



The Burden of Mental Illness

Individual

1. 13 to 20% of children
2. 1994-2011 surveillance suggests increasing prevalence
3. 24% increase in inpatient admissions 2007-2010
 - o Mood disorders a common primary diagnosis
 - o 80% increase in rate of rate of hospitalizations of children with depression

Merikangas et al. (2010); Health Care Cost Institute (2012); Perou et al. (2013); Pfunter et al. (2013)



[The Burden of Mental Illness]

Individual

- 65% of boys and 75% of girls in juvenile detention facilities have at least one mental illness
 - *We are incarcerating youth living with mental illness, some as young as eight years old, rather than identifying their conditions early and intervening with appropriate treatment* (NAMI, 2010, ¶ 9).

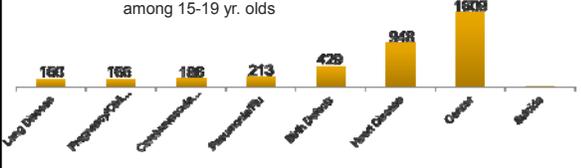
Teplin et al. (2002)



[The Burden of Mental Illness]

Individual

- 90% of all suicides are associated with mental illness
- Suicide is the second leading cause of death among 15-19 yr. olds



Cause of Death	Count
Long Disease	166
Pregnancy/Child	166
Complications	186
Parasitosis	213
Self-Denial	429
Heart Disease	948
Cancer	1909
Suicide	1909

Hoyert & Xu (2012); Shaffer & Craft (1999)



[The Burden of Mental Illness]

Individual

- Apparently alleviation of the pain of the mentally ill student is insufficient for some
- Not everyone thinks that school psychologists matter when it comes to success in school



Richmond (2014)



[The Burden of Mental Illness]

School

1. Mental illness is associated with poor academic achievement, academic decline, and poor attendance
2. Mental wellness (e.g., healthy self-regulation, emotional competence, and positive relationships) is associated with school success and achievement

Boyce et al. (2002); Roderick et al. (1997); DeSocio & Hootman, (2004); U.S. Department of Health and Human Services (1999)



[The Burden of Mental Illness]

School

- Over 10% of high school dropouts are attributed to mental illness
- Approximately half of students 14 years and older with a mental illness dropout of high school
 - The highest dropout rate of any disability group

Breslau et al. (2008); U.S. Department of Education (2001)



[The Burden of Mental Illness]

School

- May play a role in the so called "achievement gap"
 - While the overall PTSD rate among high school aged youth is 5%, the prevalence of PTSD among some urban populations can be as high as 30%

Berton & Stabb (1996); Buka et al. (2001); Saigh et al. (1997); Seedat et al. (2004); Lipschitz et al. (2000)



[The Burden of Mental Illness]

Society

- Mental disorders are among the most costly conditions to treat in children
 1. In the US, the annual cost of mental disorders among persons under age 24 years was estimated at almost \$2.5 billion
 2. Mental disorders in childhood is associated with mental disorders in adulthood, which is in turn associated with decreased productivity, and increased substance use and injury

Soni (2009); Eisenberg & Neighbors (2007); National Research Council (2007); Perou et al. (2013); Reeves et al. (2011); Smit et al. (2006)



[Mental Health Matters: Key Points]

1. **Mental illness places a significant burden on the individual, schools, and society**
2. **School psychologists are perfectly positioned to promote mental wellness and qualified to address the challenges of mental illness**
3. **There are well established and effective school-based approaches to addressing mental health**



[School Psychologists: Well Positioned to Address Mental Health]

1. Only 20 percent of children with mental disorders receive mental health services
2. However, of those who do receive care 70 to 80% receive this care in a school setting
3. Not surprisingly, given these statistics, the most common entry point to mental health services is the school

J.S. Public Health Service (2000); Rones & Hoagwood (2000)



**School Psychologists:
Well Positioned to Address Mental Health**

Mental Health Service Entry Point	N	%
Education	531	60.1
Specialty mental health	258	27.3
General medicine	141	12.9
Child welfare	52	6.5
Juvenile justice	30	2.5

Farmer et al. (2003)



**School Psychologists:
Well Positioned to Address Mental Health**

Further supporting this assertion, are the facts that

1. 88.7% of our nation's youth attend a public school.
2. Youth are 21 times more likely to visit a school-based health clinic for their mental health care than they are a community based clinic
3. Half of all life time cases of mental illness have their onset by age 14 years

Kessler et al. (2005); Juszczak, Melinkovich, & Kaplan (2003); U.S. Department of Education (2009)



**School Psychologists:
Well Positioned to Address Mental Health**

Disorder	Age of Onset
Any mental disorder	50% by age 14
Any anxiety disorder	50% by age 11
Any mood disorder	25% by age 18
Any impulse control disorder	90% by age 18
Any substance use disorder	25% by age 18

Kessler et al. (2005)



**School Psychologists:
Qualified to Address Mental Health**

NASP's Standards for the Graduate Preparation of School Psychologists

- Address both promotion of wellness and response to illness
 - 2.4: Interventions and Mental Health Services to Develop Social and Life Skills
 - 2.6: Preventive and Responsive Services

NASP (2010)



**School Psychologists:
Qualified to Address Mental Health**

- While 90% of school psychologists report having counseling training, over 40% report not providing counseling services
- Common reasons
 - Services provided by other personnel
 - Lack of time during school day
 - No expectation in district to provide services
 - *School psychologists cannot afford to relinquish a role that they have been trained to undertake, or to refrain from providing a vital service to students as a response to the perceptions or lack of expectations of others. (p. 667)*

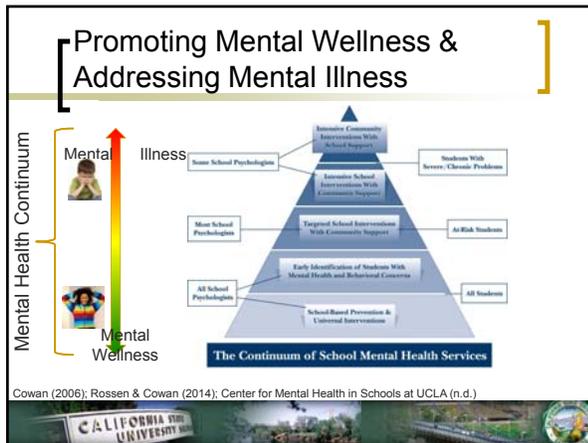
Hanchon & Fernald (2013)



**Mental Health Matters:
Key Points**

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Promoting Mental Wellness

Universal Wellness promotion

- Positive Behavioral Supports
- Social and Emotional Learning
 - Improves social relationships
 - Increases attachment to school and motivation to learn
 - Reduces anti-social, violent, and drug-using behaviors

Horner et al. (2002); CASEL (n.d.); CASEL (2012)

Addressing Mental Illness

Universal Screening

- School-based mental health screening needs to be as institutionalized as is school-based vision and hearing screening.
 - *The key step in reform is to move school-based psychological services from the back of the service delivery system, in which only students at the highest level of risk receive services, to the front of service delivery through the use of universal, proactive screening.* (p. 174)

Dowdy (2010)

Addressing Mental Illness

Targeted Prevention and Intervention

- Screening results suggesting mental health problems in 1st grade predict poor academic achievement 3 years later.
- Students with mental health risk have lower achievement when compared to students without such risk.
 - Unlike poverty, parental education and preexisting academic ability—the other major predictors of academic success in this study—mental health is a risk factor that may yield to intervention (p. 409).

See Kamphaus et al. (2014) for a current discussion of behavioral and emotional risk screening
Guzman et al. (2011)



Addressing Mental Illness

Individual Intervention

- ED identification and special education eligibility determinations, but ...
 - 13 to 20% of youth experience a mental disorder
 - 0.56 to 0.73% of students are identified ED (1994-2010)
 - 4,000,000 youth suffer from a serious mental disorder
 - 700,000 students are identified ED under IDEA (2013)

Perou et al. (2013); U.S. Department of Education (2013); U.S. Department of Health and Human Services (1999)



Case Study

- Shane is a 12-year-old 7th grader.
- Good grades until 4th grade. Currently failing 5/6 classes.
- Teachers report that Shane does not pay attention.
- He “frequently appears preoccupied.”
- No contact with his dad. There are reports that Shane’s father has “mental problems” before he abandoned his family two years ago.
- May have witnessed frequent violent domestic battles.
- Both Shane and John have frequent arguments with their mother, each other, and with their siblings.



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Special Issues

Mental Health and Culture

- The same behavior in one setting or culture might be acceptable and even typical. While it might be seen as pathological in another.
- Idioms of distress and “Culture-Bound Syndromes.”



Mental Health and Culture

- Idioms of distress and “Culture-Bound Syndromes” (APA, 2000).

Amok	Koro	Shenjing shuairuo
Ataque de nervios	Latha	Sken-k'uei
Billis	Locura	Shin-byung
Boufee delirante	Mal de ojo	Spell
Brain fog	Nervios	Susto
Dhat	Pibloktoq	Taijin kyofusho
Falling out	Qi-gong psychotic	zar
Ghost sickness	Rootwork	
Hwa-byung	Sangue dormido	



Legal & Ethical Issues

- Consent
- Privilege
- Confidentiality
 - Age 12 and above?
 - 51-50
 - Responding to suicidal ideation
- School referrals to mental health
 - ~~AB 26.5~~ → (school psychologists)



Lecture Outline

- Risk Factors
 - Variables that signal the need to look for warning signs of suicidal thinking.
- Warning Signs
 - Variables that signal the possible presence of suicidal thinking.
- General Staff Procedures
 - The actions all school staff members are responsible for knowing and taking whenever suicide warning signs are displayed.
- Risk Assessment and Referral
 - The actions taken school staff members trained in suicide intervention.



Myths and Facts Quiz (True or False)

1. If you talk to someone about their suicidal feelings you will cause them to commit suicide.
2. When a person talks about killing himself, he's just looking for attention. Ignoring him is the best thing to do.
3. People who talk about killing themselves rarely commit suicide.
4. All suicidal people want to die and there is nothing that can be done about it.
5. If someone attempts suicide he will always entertain thoughts of suicide.
6. Once a person tries to kill himself and fails, the pain and humiliation will keep him from trying again.

Sources:
Giffen, Mary, M.D. and Carol Felsenthal. *A cry for help*. Doubleday and Col, 1983.
Giffen, Mary, M.D. and Carol Felsenthal. *Handbook for suicide prevention*. The Center for Information on Suicide Prevention, 1980.



Recognizing the Need for a Suicide Risk Assessment

- Risk Factors
 - Variables that signal the need to look for warning signs of suicidal thinking.
- Warning Signs
 - Variables that signal the possible presence of suicidal thinking.



Suicide Intervention Risk Factors

- Psychopathology
 - Associated with 90% of suicides
 - Prior suicidal behavior the best predictor
 - Substance abuse increases vulnerability and can also act as a trigger
- Familial
 - History
 - Stressor
 - Functioning



Suicide Intervention Risk Factors

- Biological
 - Reduced serotonergic activity
- Situational
 - 40% have identifiable precipitants
 - A firearm in the home
 - By themselves are insufficient
 - Disciplinary crisis most common



Variables That Enhance Risk

- Adolescence and late life
- Bisexual or homosexual gender identity
- Criminal behavior
- Cultural sanctions for suicide
- Delusions
- Disposition of personal property
- Divorced, separated, or single marital status
- Early loss or separation from parents
- Family history of suicide
- Hallucinations
- Homicide
- Hopelessness
- Hypochondriasis



Suicide Intervention Warning Signs

- Verbal
 - Most individuals give verbal clues that they have suicidal thoughts.
 - Clues include direct ("I have a plan to kill myself") and indirect suicide threats ("I wish I could fall asleep and never wake up").
- Behavioral



Suicide Intervention Warning Signs

- Verbal Clues
 1. "Everybody would be better off if I just weren't around."
 2. "I'm not going to bug you much longer."
 3. "I hate my life. I hate everyone and everything."
 4. "I'm the cause of all of my family's/friend's troubles."
 5. "I wish I would just go to sleep and never wake up."
 6. "I've tried everything but nothing seems to help."
 7. "Nobody can help me."
 8. "I want to kill myself but I don't have the guts."
 9. "I'm no good to anyone."
 10. "If my (father, mother, teacher) doesn't leave me alone I'm going to kill myself."
 11. "Don't buy me anything. I won't be needing any (clothes, books)."



Suicide Intervention Warning Signs

- Behavioral Clues
 1. Writing of suicidal notes
 2. Making final arrangements
 3. Giving away prized possessions
 4. Talking about death
 5. Reading, writing, and/or art about death
 6. Hopelessness or helplessness
 7. Social Withdrawal and isolation
 8. Lost involvement in interests & activities
 9. Increased risk-taking
 10. Heavy use of alcohol or drugs



Suicide Intervention Warning Signs

- Behavioral Clues (continued)
 11. Abrupt changes in appearance
 12. Sudden weight or appetite change
 13. Sudden changes in personality or attitude
 14. Inability to concentrate/think rationally
 15. Sudden unexpected happiness
 16. Sleeplessness or sleepiness
 17. Increased irritability or crying easily
 18. Low self esteem



Suicide Intervention Warning Signs

- Behavioral Clues (continued)
 19. Dwindling academic performance
 20. Abrupt changes in attendance
 21. Failure to complete assignments
 22. Lack of interest and withdrawal
 23. Changed relationships
 24. Despairing attitude



Asking the “S” Question

- The presence of suicide warning signs, especially when combined with suicide risk factors generates the need to conduct a suicide risk assessment.
- A risk assessment begins with asking if the student is having thoughts of suicide.



Identification of Suicidal Intent

- Be direct when asking the “S” question.
 - **BAD**
 - *You're not thinking of hurting yourself, are you?*
 - **Better**
 - *Are you thinking of harming yourself?*
 - **BEST**
 - *Sometimes when people have had your experiences and feelings they have thoughts of suicide. Is this something that you're thinking about?*



Predicting Suicidal Behavior (CPR++)
(Ramsay, Tanney, Lang, & Kinzel, 2004;)

- **C**urrent plan (greater planning = greater risk).
 - How (method of attempt)?
 - How soon (timing of attempt)?
 - How prepared (access to means of attempt)?
- **P**ain (unbearable pain = greater risk)
 - How desperate to ease the pain?
 - Person-at-risk's perceptions are key
- **R**esources (more alone = greater risk)
 - Reasons for living/dying?
 - Can be very idiosyncratic
 - Person-at-risk's perceptions are key



Predicting Suicidal Behavior

(CPR++)
(Ramsay, Tanney, Lang, & Kinzel, 2004)

- (+) Prior Suicidal Behavior?
 - of self (40 times greater risk)
 - of significant others
 - An estimated 26-33% of adolescent suicide victims have made a previous attempt (American Foundation of Suicide Prevention, 1996).
- (+) Mental Health Status?
 - history mental illness (especially mood disorders)
 - linkage to mental health care provider



RISK ASSESSMENT

Suicide Risk Assessment Summary Sheet

Instructions: When a student acknowledges having suicidal thoughts, use as a checklist to assess suicide risk. Items are listed in order of importance to the risk assessment.

	<i>Risk present, but lower</i>	<i>Medium Risk</i>	<i>Higher Risk</i>
1. Current Suicide Plan A. Details B. How prepared C. How soon D. How (Lethality of method) E. Chance of intervention	Vague Means not available No specific time Plan, check written Others present most of the time Plan is bearable Wants pain to stop, but not desperate Identifies ways to stop the pain	Some specifics Plan carries close by Within a few days or hours Drugs, alcohol, car, vessel Others available if called upon Plan is almost unbearable Deciding desperate for relief	Well thought out Plan carries in hand Immediately Over, hanging, jumping Not one easily isolated Plan is unbearable Desperate for relief from pain
2. Pain	Deep available, student acknowledges that significant others are concerned and available to help	Limited ways to cope with pain	Will do anything to stop the pain
3. Resources	Family and friends available, but are not perceived by the student to be willing to help	Family and friends are not available and/or are hostile, judgmental, exhausted	Family and friends are not available and/or are hostile, judgmental, exhausted
4. Prior Suicidal Behavior of A. Self B. Significant Others	No prior suicidal behavior No significant others have engaged in suicidal behavior	One previous low lethality attempt; history of threats Significant others have recently attempted suicidal behavior	One of high lethality, or multiple attempts of moderate lethality Significant others have recently committed suicide
5. Mental Health A. Coping behaviors B. Depression C. Medical status D. Other Psychology	History of mental illness, but not currently considered mentally ill Daily activities continue as usual with little change Mild, feels slightly down No significant medical problems Stable relationships, personality, and school performance	Steadily ill, but currently receiving treatment Some daily activities disrupted, disturbance as eating, sleeping, and schoolwork Moderate, some moodiness, sadness, irritability, loneliness, and decrease of energy Anxiety, but clear, some, or psychosomatic illness Recent change in behavior and substance abuse, acute suicidal behavior in stable personality Moderate reaction to loss and environmental changes	Steadily ill and not currently receiving treatment Gross disturbances in daily functioning Overwhelmed with hopelessness, sadness, and feelings of helplessness Chronic debilitating, or acute catastrophic, illness Suicidal behavior in unstable personality, emotional disturbance, repeated difficulty with peers, family, and teachers Severe reaction to loss or environmental changes
6. Stress	No significant stress		
Total Checks			

Interviewing the Suicidal Child

- Questions to ask in the evaluation of suicidal risk in children
 1. *Suicidal fantasies or actions:*
Have you ever thought of hurting yourself?
Have you ever threatened or attempted to hurt yourself?
Have you ever wished or tried to kill yourself?
Have you ever wanted to or threatened to commit suicide?
 2. *Concepts of what would happen:*
What did you think would happen if you tried to hurt or kill yourself?
What did you want to have happen?
Did you think you would die?
Did you think you would have severe injuries?



Standardized Risk Screening Tools

- Beck Scale for Suicidal Ideation (BSI)
 - 21 item self-report for adolescents
 - Best to detect and measure severity of ideation
 - One of only scales to assess between active and passive ideation
- Suicidal Ideation Questionnaire (SIQ)
 - Severity or seriousness of ideation (Reynolds)
 - Two version for 7-9th and 10-12th grades
 - Draw-back: No item regarding past or current suicide attempts



Interviewing the Suicidal Student

- **Ask about:**
 - Background information/prior attempts
 - Be aware of the “underground of information
 - This may be best chance to find out accurate info
 - Contagion
 - Who has influenced this situation
 - Who is this situation influencing



Interviewing the Suicidal Student

- Be direct
- Explore current stresses (school, home, community)
 - Look for evidence of tunnel vision, hopeless/despair, free-floating rage
 - Look for impulsiveness, drug/alcohol use, behavior problems in school
 - Look for all risk factors
 - Look for evidence of a plan, practice behavior




Interviewing the Suicidal Student

- Explore current resources, strengths, contraindications
- Contraindications can include...
 - Support system (even if unrecognized)
 - Ability to see options and problem-solve
 - Can do cognitive rehearsal, some flexibility
 - Level of self-esteem, future thinking
 - Can connect with intervener
 - Urge situation specific



Interviewing the Suicidal Student

- "Who else do you know that's done/thought about this?"
- "Who else have you told?"
 - May need immediate interviews
- Check status of siblings, best friends, relatives
- Look for suicide pacts



Interviewing the Suicidal Student

- Initial 3/4 of intervention is active listening
- Final 1/4 is being active in taking control, being the "expert"
- Try to change at least one thing for student
 - Pick one current stress that is easy and quick to change
 - This can give student hope
- Direct emotional traffic



Interviewing the Suicidal Student

- Be aware of personal space, usually close physically to student
- Don't use rapid-fire style of questioning
- Ask "How do you survive, take care of yourself?"
- Goals: find out information, establish therapeutic relationship, clarify their thinking



Interviewing the Suicidal Student

- Is self-injurious behavior a possibility?
 - Communication of intent
 - Lack of impulse control
 - Mismatch of youth and environment
 - Dramatic change of affect
- Might the urge to injure self be acted upon?
 - Is there a plan, what is goal of plan
 - Degree of impulsivity
 - Previous history/attempts



Interviewing the Suicidal Student

- How imminent is the possibility of action?
 - Sense of urgency-lack of control
 - Accessibility to a method
 - Is the method in character
 - A note written
- Are there contra-indications to the action
 - Support system, self-esteem
 - Seeing options, cognitive rehearsal, flexibility



Interviewing the Suicidal Student

- Tell student you will need to contact parent
 - At end of interview
 - If student asks earlier, don't lie
 - "My job is to keep you safe"
- Judge student reaction
 - Get student input on *how* to do this (not *whether*)
 - This leaves some control for student



School-Based Suicide Intervention

- General Staff Procedures
 - The actions all school staff members are responsible for knowing and taking whenever suicide warning signs are displayed.
- Risk Assessment and Referral
 - The actions taken by school staff members trained in suicide risk assessment and intervention.



Suicide Intervention General Staff Procedures

- Responding to a Suicide Threat.
 - **A student who has threatened suicide must be carefully observed at all times** until a qualified staff member can conduct a risk assessment. The following procedures are to be followed whenever a student threatens to commit suicide.



Suicide Intervention General Staff Procedures

1. Stay with the student or designate another staff member to supervise the youth constantly and without exception until help arrives.
2. Under no circumstances should you allow the student to leave the school.
3. Do not agree to keep a student's suicidal intentions a secret.
4. If the student has the means to carry out the threatened suicide on his or her person, determine if he or she will voluntarily relinquish it. **Do not force the student to do so. Do not place yourself in danger.**



Suicide Intervention General Staff Procedures

5. Take the suicidal student to the prearranged room.
6. Notify the Crisis Intervention Coordinator immediately.
7. Notify the Crisis Response Coordinator immediately.
8. Inform the suicidal youth that outside help has been called and describe what the next steps will be.



Risk Assessment and Referral

1. Identify Suicidal Thinking
2. From Risk Assessment Data, Make Appropriate Referrals
3. Risk Assessment Protocol
 - a) Conduct a Risk Assessment.
 - b) Consult with fellow school staff members regarding the Risk Assessment.
 - c) Consult with County Mental Health.



Risk Assessment and Referral

4. Use risk assessment information and consultation guidance to develop an action plan. Action plan options are as follows:

- A. **Extreme Risk**
 - If the student has the means of his or her threatened suicide at hand, and refuses to relinquish such then follow the Extreme Risk Procedures.
- B. **Crisis Intervention Referral**
 - If the student's risk of harming him or herself is judged to be moderate to high then follow the Crisis Intervention Referral Procedures.
- C. **Mental Health Referral**
 - If the student's risk of harming him or herself is judged to be low then follow the Mental Health Referral Procedures.



Risk Assessment and Referral

A. **Extreme Risk**

- i. Call the police.
- ii. Calm the student by talking and reassuring until the police arrive.
- iii. Continue to request that the student relinquish the means of the threatened suicide and try to prevent the student from harming him-or herself.
- iv. Call the parents and inform them of the actions taken.



Risk Assessment and Referral

B. **Crisis Intervention Referral**

- i. Determine if the student's distress is the result of parent or caretaker abuse, neglect, or exploitation.
- ii. Meet with the student's parents.
- iii. Determine what to do if the parents are unable or unwilling to assist with the suicidal crisis.
- iv. Make appropriate referrals.



Risk Assessment and Referral

C. Mental Health Referral

- i. Determine if the student's distress is the result of parent or caretaker abuse, neglect, or exploitation.
- ii. Meet with the student's parents.
- iii. Make appropriate referrals.

- Protect the privacy of the student and family.
- Follow up with the hospital or clinic.



What is ADHD

- One of the most common childhood behavior disorders.
- Affects 3 to 7 percent of the general population.
- Primary symptoms are
 - Inattention
 - Hyperactivity/Impulsivity



General Behavior Interventions

- Behavioral intervention for the student with ADHD should employ functional assessment.
- Should not be focused on ADHD symptoms per se, but rather on the student's specific behavior problems
- There are, however, a set of empirically validated interventions for this group of students.

However, not all of these interventions will work for all ADHD students.



Behavior Interventions: Environmental Adjustments & Accommodations

- Setting the ADHD Child Up for Success
 - Task Duration
 - Direct Instruction
 - Peer Tutoring
 - Scheduling
 - Novelty
 - Structure and Organization
 - Rule Reminders
 - Auditory Cues
 - Pacing of Work
 - Instructions
 - Productive Physical Movement
 - Active vs. Passive Involvement



Behavior Interventions: Setting the ADHD Child Up for Success

- Task Duration
 - Assignments should be brief
 - Break longer projects up into manageable parts. For example,

2+3 =	4+5 =	6+7 =	Stop Here! Have work checked
7+5 =	8+9 =	4+3 =	Stop Here! Have work checked
8+8 =	2+4 =	9+9 =	Stop Here! Have work checked
3+3 =	2+9 =	1+7 =	Stop Here! Have work checked



Behavior Interventions: Setting the ADHD Child Up for Success

- Direct Instruction
 - ADHD students tend to do better in teacher directed vs. independent seatwork activities.
- Is this relevant to any of your BIPs?



**Behavior Interventions:
Setting the ADHD Child Up for Success**

- Structure and Organization
 - Doing so increases the benefits of direct instruction.
 - For example, provide lecture outlines.

Topic: The Discovery of America

Main Idea 1: Native Americans
Main Idea 2: Vikings
Main Idea 3: Columbus

- For example, provide a concept map.

```
graph TD; Topic[Topic] --- M1[Main idea]; Topic --- M2[Main idea]; Topic --- M3[Main idea]; Topic --- M4[Main idea];
```

**Behavior Interventions:
Setting the ADHD Child Up for Success**

- Structure and Organization
- Other examples:
- Is this relevant to any of your BIPs?

**Behavior Interventions:
Setting the ADHD Child Up for Success**

- Receiving Peer Tutoring
 - Facilitates both academic and behavioral gains among ADHD students.
 - Especially helpful when combined with teacher feedback.
 - As little as 20 minutes per day may increase time on-task
- Providing Peer Tutoring
 - Cross age tutoring
- Is receiving and/or providing tutoring relevant to any of your BIPs?

**Behavior Interventions:
Setting the ADHD Child Up for Success**

- Scheduling
 - Provide academic instruction in areas of greatest concern early in the school day.
 - Reserve afternoon sessions for nonacademic, more active activities.
- Is this relevant to any of your BIPs?



**Behavior Interventions:
Setting the ADHD Child Up for Success**

- Novelty
 - Increase stimulation of instructional materials
 - For example, use brightly colored paper.
 - Increase novelty of instruction.
 - For example, alter teaching style.
- Other examples?
- Is this relevant to any of your BIPs?



**Behavior Interventions:
Setting the ADHD Child Up for Success**

- Rule Reminders and Visual Cues
 - Rules must be well defined and understood.
 - Clear consequences.
 - Do not rely on the student's memory of the rules.
 - Rules must be frequently reinforced.
 - Review rules after extended breaks/weekends.
 - Use visual cues as reminders (use icons for pre-readers).
 - For example,

Begin work immediately	Work quietly	Remain seated	Follow directions	Complete assignments
✓	✓		✓	
	✓	✓		
✓	✓	✓	✓	✓



Behavior Interventions:
Setting the ADHD Child Up for Success

- Pacing of Work
 - Allow students to set their own pace.
- Is this relevant to any of your BIPs?
- Other examples?



Behavior Interventions:
Setting the ADHD Child Up for Success

- Instructions
 - Should be short and direct.
 - Ask students to rephrase directions.
 - Be prepared to repeat directions.
- Other examples?
- Is this relevant to any of your BIPs?



Behavior Interventions:
Setting the ADHD Child Up for Success

- Choice
 - Allow students to chose the activity to be completed.
 - For example, give students a "to do" list and let them decide which to do first, second, etc. Students are require to switch activities every 15 minutes.
 - Effective when combined with other behavioral interventions



**Behavior Interventions:
Setting the ADHD Child Up for Success**

- Productive Physical Movement
 - Structure lessons to include movement.
 - For example,
 - Provide stretch breaks.
 - Ask the student to run errands.
 - Ask the student to perform classroom chores
 - Include out of seat activities (e.g., math worksheets that have the student get up and have work checked).
 - Create an "office" and allow movement within it.



**Behavior Interventions:
Setting the ADHD Child Up for Success**

- Active vs. Passive Involvement
 - Create active learning conditions.
 - For example,
 - Allow the student to hold instructional materials.
 - Allow the student to help with audio-visual aids.
 - Ask the student to write important points on the chalk board.
 - Other examples?
 - Is this relevant to any of your BIPs?



**Behavior Interventions:
Setting the ADHD Child Up for Success**

- Distractions
 - Complete elimination of distraction stimuli is not effective.
 - Remove attractive competing alternatives
- Is this relevant to any of your BIPs?



**Behavior Interventions:
Setting the ADHD Child Up for Success**

- Anticipation
 - Recognize those situation that require sustained attention and/or remaining seating for long periods.
 - These may be especially challenging.
 - Make adjustments accordingly.
- Other examples?
- Is this relevant to any of your BIPs?



**Behavior Interventions:
Contingency Management for the Student with ADHD**

- Powerful external reinforcement
- Self Monitoring
- Token Economy Systems
- Response-Cost Programs
- Time-out



**Behavior Interventions:
Contingency Management for the Student with ADHD**

- Powerful external reinforcement (and punishment?)
 - Need to be of a higher magnitude
 - Punishment may be needed
 - Is this issue relevant to any of your BIPs?



Behavior Interventions:
Contingency Management for the Student with ADHD

- Self-Monitoring
 - Provide auditory cues to prompt behavior.
 - For example, "When the tone plays place a check (✓) if you are on-task."

	Tone 1	Tone 2	Tone 3	Tone 4	Tone 5
My Rating					
Teacher Rating					
Teacher on-task rating	=				
My on-task rating	=				
Agreement	=				

Other examples? Might this be used in any of your BIPs?



Behavior Interventions:
Contingency Management for the Student with ADHD

- Token Economy Systems
- Response Cost Systems
 - Keep in mind ADHD students are easily frustrated.
 - If "cost" occurs too often it may be counterproductive
 - Must include an opportunity to earn points back.
- Might this be used in any of your BIPs?



Behavior Interventions:
Contingency Management for the Student with ADHD

- Time Out
 - Use least restrictive form
 - Time out from attention



Introduction:
Reasons for Increased Vigilance

- Autism is more common than once thought
 - 70:10,000 in the general population
 - 1:50 6- to 17-year-olds per parent report in 2011/2012
 - vs. 1 in 86 in 2007
 - 7% of special education population in 2012
 - vs. 1% of special education population in 1991
 - But... only 0.6% of total student population meet IDEA criteria (vs. the estimate 2% in the general student population)



Introduction:
Reasons for Increased Vigilance

- Autism can be identified early in development,

and...
- Early intervention is an important determinant of the course of autism.



Introduction:
Reasons for Increased Vigilance

- Not all cases of autism will be identified before school entry
 - Mean age at identification
 - Autistic Disorder (24 studies) mean range
 - 32 to 89 months
 - Asperger's Disorder (16 studies) mean range
 - 45 to 134 months
 - PDD-NOS (13 studies) mean range
 - 40 to 111 months

source: Daniel & Messinger (2014)



Introduction:
Reasons for Increased Vigilance

source: Finkbeiner, Zimmerman et al.

Introduction: 1952 1968 1980 1987 1994 2000 2013

Diagnostic vs. Special Education Classifications

History of Diagnostic Classification

1. *DSM (1952) & DSM-II (1968)*
 - Schizophrenic Reaction (Childhood Type)
2. *DSM-III (1980)*
 - Pervasive Developmental Disorder
 - Childhood Onset PDD, Infantile Autism, Atypical Autism
3. *DSM-III-R (1987)*
 - Pervasive Developmental Disorder
 - PDD-NOS, Autistic Disorder
4. *DSM-IV (1994) & DSM-IV-TR (2000)*
 - Pervasive Developmental Disorder
 - PDD-NOS, Autistic Disorder, Childhood Disintegrative Disorder, Rett's Disorder

Introduction:
Reasons for Increased Vigilance

APA (2013)

Diagnostic Classification: *DSM-5*

- Section II: Diagnostic Criteria and Codes
 - Placed within the subclass of *Neurodevelopmental Disorder*.
 - *Autism Spectrum Disorder*

DSM-IV-TR	DSM-5
Autistic Disorder	Autism Spectrum Disorder
Asperger's Disorder	
Rett's Disorder	
Childhood Disintegrative Disorder	
PDD Not Otherwise Specified	Social Communication Disorder

Introduction:
Diagnostic vs. Special Education Classifications

- **DSM-5 Revision Goals**
 - Better recognize “essential shared features” of ASDs
 - Provide a clearer and simpler diagnosis
 - **DSM-IV-TR**
 - PDD Dx = 2,027 symptom combinations
 - **DSM-5**
 - ASD Dx = only 11 different ways to meet diagnosis (if all three of Criterion A’s social communication and social interaction symptoms are required).

Introduction:
Diagnostic vs. Special Education Classifications

DSM-5 Diagnostic Criteria

- Autism Spectrum Disorder (ASD; pp. 50-59)
 - Persistent impairment in reciprocal social communication and social interaction; and restricted, repetitive patterns of behavior, interests, or activities.
- Social (Pragmatic) Communication Disorder (SCD; pp. 47-49)
 - Problems with pragmatics, as manifested by deficits in understanding and following social rules of verbal and nonverbal communication.

Introduction:
Diagnostic vs. Special Education Classifications

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative not exhaustive; see text): p. 50

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships, ranging for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

Introduction:
Diagnostic vs. Special Education Classifications

DSM-5

p. 50

- B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text)
 1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
 2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).
 3. Highly restricted, fixated interests that are abnormal in intensity of focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
 4. Hyper- or Hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

source: APA (2013)

Diagnostic Evaluation:
DSM-5 Diagnostic Criteria

DSM-5

pp. 50-51

- C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).
- D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.
- E. These disturbances are not better explained by intellectual disability (intellectual development disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder an intellectual disability, social communication should be below that expected for general developmental level.

source: APA (2013)

Introduction:
Diagnostic vs. Special Education Classifications

DSM-5

pp. 50-51

- Specifiers
 - Social communication severity level AND Restricted, repetitive behaviors severity level
 - Level 1, Level 2, Level 3.
 - With or without accompanying intellectual impairment
 - Separate estimates of verbal and nonverbal skill are necessary
 - With or without accompanying language impairment
 - With impairment = "No intelligible speech (nonverbal)," "single words only," or "phrase speech"
 - Without impairment = "Speaks in full sentences" or "has fluent speech."
 - Receptive and expressive language skills should be considered separately

source: APA (2013)

Introduction:
Diagnostic vs. Special Education Classifications

■ Specifiers (continued) pp. 50-51

- Associated with a known medical or genetic condition or environmental factors
 - Genetic condition (e.g., Rett syndrome, Fragile X syndrome, Down syndrome)
 - Medical condition (e.g., epilepsy).
 - Environmental factor (e.g., valproate, fetal alcohol syndrome, very low birth weight).
- Associated with another neurodevelopmental, mental, or behavior disorder
 - e.g., attention-deficit/hyperactivity disorder; developmental coordination disorder; disruptive behavior, impulse-control, or conduct disorders; anxiety, depressive, or bipolar disorders; tics or Tourette's disorder; self-injury; feeding, elimination, or sleep disorders.
- With catatonia



Introduction:
Diagnostic vs. Special Education Classifications

■ Social (Pragmatic) Communication Disorder (SCD) pp. 47-48

- A. Persistent difficulties in the social use of verbal and nonverbal communication.
- B. Deficits result in functional limitations in effective communication, social participation, social relationships, academic achievement, or occupational performance, individually or in combination.
- C. Onset of symptoms is in the early developmental period.
- D. Symptoms not attributable to another medical or neurological condition or to low abilities in the domains of word structure and grammar, and are not better explained by autism spectrum disorder, intellectual disability, global developmental delay, or another mental disorder



Introduction:
Diagnostic vs. Special Education Classifications

■ Will DSM-5 change the prevalence of Autism? pp. 47-48

- **Yes**, a 17% decrease has been noted in an epidemiologic sample
 - 2.64% *DSM-IV* PDD
 - 2.20% *DSM-5* ASD
- *DSM-IV* to *DSM-5*
 - Autistic Disorder, 99% of sample ASD; 1% SCD
 - Asperger Disorder, 92% of sample ASD; 8% SCD
 - PDD-NOS, 63% of sample ASD; 32% SCD
- **But**, most individuals with a prior *DSM-IV* PDD Dx meet *DSM-5* criteria for ASD or SCD



Introduction:
Diagnostic vs. Special Education Classifications

- Adjudicative decision makers have NEVER even suggested the *DSM* is a “controlling authority.”
- Eligibility is (and always has been) driven by state and federal regulations.
- In others words, a *DSM-5* diagnosis of ASD or SCD will not automatically result in special education services (or even 504 accommodations).

sources: Brock & Warren, 2013; in press; Brock et al. (2003); Shinn et al. (1999)



Introduction:
Diagnostic vs. Special Education Classifications

- However, adjudicative decision makers sometimes consider a *DSM* diagnosis as relevant.
- If a *DSM-5* diagnosis is available, it MUST be considered
- Furthermore, *DSM-5* may prove helpful to IEP teams.
 - *DSM-5* may result in the ASD population being more homogeneous.
 - The addition of hyper- or hyporeactivity criteria may help identify the need for behavior support.
 - Severity levels and specifiers (e.g., with or without ID) may assist in program planning

source: Brock & Warren, 2013; in press; Brock et al. (2003); Shinn et al. (1999)



Introduction:
Diagnostic vs. Special Education Classifications

Autism Eligibility Criteria
IDEA 34 Code of Federal Regulations §300.7(c)(1)

Autism means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three, that adversely affects a child's education performance. Other characteristics often associated with autism are engagement in repetitive activities and stereotypical movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences.

- (i) Autism does not apply if a child's educational performance is adversely affected primarily because the child has an emotional disturbance, as defined in paragraph (c)(4) of this section.
- (ii) A child who manifest the characteristics of autism after age three could be identified as having autism if the criteria in paragraph (c)(1)(i) of this section are satisfied.

source: Brock & Warren, 2013; in press; Brock et al. (2003); Shinn et al. (1999)



Introduction:
Diagnostic vs. Special Education Classifications

- Special Education Practice recommendations
 1. Ensure a thorough evaluation from professionals who have knowledge of autism.
 2. Design IEPs for students with autism to meet their unique needs.
 3. Provide appropriate interventions to address any impeding behaviors.
 4. Work collaboratively with family members and consider parents' needs for training and practical help.

Source: University of Washington (2005); <http://wea.u.washington.edu/Wecore/Bulletins/Bulletin2.doc>

Introduction:
Diagnostic vs. Special Education Classifications

- Practice recommendations
 5. Design IEPs that meet the standards of FAPE and reassess when a student makes little or no progress..
 6. Be sure that the professionals evaluating students are qualified.
 7. *Under Section 504, it is required that educators working with students with disabilities must be trained in the area of the student's disability..*

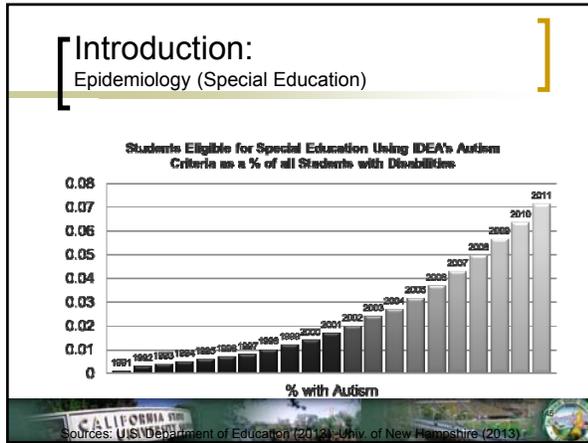
Source: University of Washington (2005); <http://wea.u.washington.edu/Wecore/Bulletins/Bulletin2.doc>

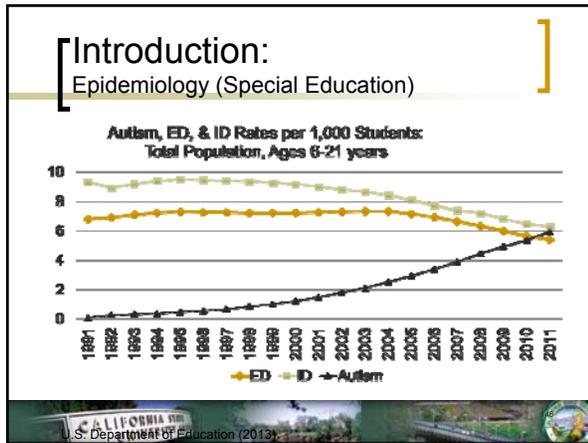
Introduction:
Epidemiology (Special Education)

Total Number of Students Eligible for Special Education Using IDEA's Autism Criteria

Year	years 11 - 6	years 17 - 12	years 21 - 18
1993	~10,000	~5,000	~2,000
1994	~12,000	~6,000	~2,500
1995	~15,000	~7,000	~3,000
1996	~18,000	~8,000	~3,500
1997	~22,000	~9,000	~4,000
1998	~28,000	~11,000	~5,000
1999	~35,000	~13,000	~6,000
2000	~45,000	~16,000	~7,500
2001	~55,000	~19,000	~9,000
2002	~68,000	~23,000	~11,000
2003	~82,000	~28,000	~13,000
2004	~98,000	~34,000	~16,000
2005	~115,000	~41,000	~19,000
2006	~135,000	~49,000	~23,000
2007	~155,000	~58,000	~27,000
2008	~175,000	~68,000	~32,000
2009	~195,000	~79,000	~37,000
2010	~215,000	~91,000	~43,000
2011	~235,000	~103,000	~50,000

Source: U.S. Department of Education (2013)





- Introduction:**
Epidemiology (Special Education)
- Explanations for Changing Rates in Special Education
 - IEP teams have become better able to identify students with autism.
 - Autism is more acceptable in today's schools than is the diagnosis of intellectual disability (or what was previously referred to as mental retardation).
 - The intensive early intervention services often made available to students with autism are not always offered to the child whose primary eligibility classification is intellectual disability.
- Source: Education.com

Special Education Eligibility Evaluation: Report Recommendations

- From a review of the literature we have identified interventions often recommended when addressing some of the specific challenges associated with these disorders.
- The slides that follow offer some of these recommendations (along with the accompanying background information) that we feel you might find useful when writing a psycho-educational report.
- It is important to acknowledge that without a careful assessment of specific student needs this information will not be relevant.
- However, following a comprehensive psycho-educational evaluation, and the identification of specific student needs, this information will be helpful in stimulating thinking about appropriate psycho-educational report recommendations for the student with autism.



Special Education Eligibility Evaluation: Report Recommendations

- If the student is challenged by social situations, then the following intervention and support recommendations might be appropriate:***



Special Education Eligibility Evaluation: Report Recommendations

- Provide interpretation of social situations as indicated. Specifically, the following are suggested:
 - Make use of social stories.™
 - A social story is a short story that explains a specific challenging social situation. The goal is to find out what is happening in a situation and why.



**Special Education Eligibility Evaluation:
Report Recommendations**

- The following is an example of a social story:

When Other Students Get Upset
Sometimes other students get upset and cry. When this happens their teacher might try to help them. The teacher might try to help them by talking to them or holding them. This is okay. Sometimes when other students get upset and cry, it makes me upset and angry. I can use words to tell my teacher that I am upset. I can say, "That makes me mad!" or "I'm upset!" It is okay to use words about how I feel. When I get upset I will try to use words about how I feel.



**Special Education Eligibility Evaluation:
Report Recommendations**

- For more information about social stories go to
 - <http://www.thegravcenter.org/>



**Special Education Eligibility Evaluation:
Report Recommendations**

- Use cartooning to illustrate the rules of challenging social situations.
- For example, ...



**Special Education Eligibility Evaluation:
Report Recommendations**

Explain problematic social situations and in doing so let _____ know that there are specific choices to be made and that each choice has a specific consequence. Specific steps in this process are as follows:

- Help the _____ understand the problematic social situation (i.e., who was involved, what happened, etc.)
- Facilitate _____'s brainstorming of options for responding to the situation.
- Help _____ explore the consequences for each option identified.
- Help _____ identify the response that has the most desirable consequences.
- Develop an action plan.
- Practice the response to the problematic social situation by role playing, visualizing, writing a plan or talking it out with a peer.



**Special Education Eligibility Evaluation:
Report Recommendations**

- To address _____'s difficulty making friends, the following interventions are recommended:
 - Establish structured activities with peers. These activities should have pre-assigned roles that can be practiced.
 - Provide direct instruction on how to approach an individual or group.
 - Provide direct instruction on the skills needed to interact with peers.
 - Structure social opportunities around _____'s special interests



**Special Education Eligibility Evaluation:
Report Recommendations**

- After a challenging social situation conduct a "social autopsy." Such a conversation involves an examination and inspection of _____'s social errors to discover their causes, better understand the consequences of such errors, and to decide what can be done to prevent it from happening again.



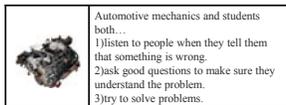
Special Education Eligibility Evaluation: Report Recommendations

- Identify specific social conventions that need to be taught and then provide direct instruction. Examples, of social conventions that _____ may need to be taught include the following (LIST SPECIFIC SOCIAL RULES THAT ASSESSMENT DATA SUGGESTS TO BE PROBLEMATIC. EXAMPLES FOLLOWS):
 - "Do not ask to be invited to someone's party
 - Do not correct someone's grammar when he or she is angry.
 - Never break laws – no matter what your reason.
 - Do not touch someone's hair even if you think it is pretty.
 - Do not ask friends to do things that will get them in trouble.
 - Do not draw violent scenes.
 - Do not sit in a chair that someone else is sitting in – even if it is 'your' chair.
 - Do not tell someone you want to get to know better that he or she has bad breath."



Special Education Eligibility Evaluation: Report Recommendations

- Make use of _____'s special interests to develop "power cards" that facilitate understanding of social rules. (TRY TO LINK THE STUDENTS SPECIAL INTERESTS TO PROBLEMATIC SOCIAL SITUATIONS.) For example, make use of _____'s interest in automotive mechanics and provide him/her with the following card that can be placed on his/her desk and/or placed in his/her pocket.



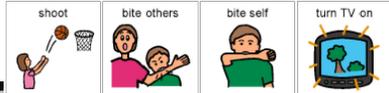
Special Education Eligibility Evaluation: Report Recommendations

- ***If the student has difficulties with expressive language, then the following might be appropriate:***



Special Education Eligibility Evaluation:
Report Recommendations

- Consider making use of a Picture Exchange Communication System (PECS).
- PECS is a picture based communication system where the student gives a picture or symbol of a desired item in exchange for the item itself.
- The intent of PECS is to assist the student in developing spontaneous communication. The following are examples of PECS symbols:



Special Education Eligibility Evaluation:
Report Recommendations

- Sample PECS IEP objectives can be found at <http://www.pecsaustralia.com/downloads.php>
- PECS pictures and photos can be found at www.childrenwithspecialneeds.com/downloads/pecs.html
- Blank PECS image grids, and daily and weekly picture card schedule forms
- www.do2learn.com/picturecards/forms/index.htm



Special Education Eligibility Evaluation:
Report Recommendations

- For more information about PECS go to
 - http://www.bbbautism.com/pecs_contents.htm



**Special Education Eligibility Evaluation:
Report Recommendations**

- Specific PECS cards should include the following (AS INDICATED BY ASSESSMENT DATA):
 - "Break" Cards that assist _____ in communicating when he/she needs to escape a task or situation.
 - "Choice" cards that provide _____ some control by indicating a choice from a prearranged set of possibilities
 - "All done" cards that assist _____ in communicating when he/she is finished with an activity or task.
 - "Turn-taking" cards that can be used to visually represent and mark whose turn it is.
 - "Wait" cards that can be used to visually teach the concept of waiting.
 - "Help" cards that assist in teaching _____ to raise his/her hand to indicate the need for assistance.



**Special Education Eligibility Evaluation:
Report Recommendations**

- ***If disruptive behavior problems are present, then following might be appropriate:***



**Special Education Eligibility Evaluation:
Report Recommendations**

- Functional behavioral assessment is recommended.



Special Education Eligibility Evaluation:
Report Recommendations

- Students with autism frequently engage in disruptive behaviors to escape demands and gain or maintain access to perseverative items and activities. Thus, the focus of any functional assessment should include special attention to perseverative behaviors that might serve to obtain desirable sensory stimuli.



Special Education Eligibility Evaluation:
Report Recommendations

- Students with autism also frequently engage in disruptive behaviors to escape aversive sensory stimuli. Thus, the focus of any functional assessment should also direct attention to perseverative behaviors that might serve to escape from aversive sensory stimuli.



Special Education Eligibility Evaluation:
Report Recommendations

- If disruptive behavior problems are present and known to be related to perseverative activities, then following might be appropriate:***
 - Identify and decrease environmental and/or physiological conditions that are related to perseverative behavior.
 - Determine if the behavior is an attempt to avoid aversive sensory stimulation or a strategy to obtain desirable sensory stimulation.



Special Education Eligibility Evaluation:
Report Recommendations

- ***If a student needs predictability (e.g., becomes anxious when new materials/activities are introduced), then the following might be appropriate:***
 - Employ "priming." This involves showing the actual instructional materials that will be used in a lesson the day, evening, or morning before the given classroom activity is going to take place. Priming should be brief (10 to 15 minutes) and built into _____'s daily schedule and should take place in a relaxing environment.



Special Education Eligibility Evaluation:
Report Recommendations

- ***If disruptive behaviors appear to be related to anxiety and/or a desire to avoid aversive sensory stimulation, then the following might be appropriate:***
 - The problem (perseverative) behaviors appear to have a calming or organizing effect and might be related to anxiety. Thus, the following strategies are recommended as they appear to reduce anxiety (and in doing so may decrease the need for the perseverative behaviors):
 - Establish predictable routines
 - Use visual schedules to facilitate coping with change
 - Practice alternative coping behaviors such as relaxation



Special Education Eligibility Evaluation:
Report Recommendations

- ***If disruptive behaviors appear to be related to obtaining desirable sensory stimulation, then the following might be appropriate:***
 - The problem (perseverative) behaviors appear to be positively reinforcing. Thus, the following strategies are recommended:
 - Provide appropriate access to the desired sensory stimulation on a regular basis. Provide instruction on how to appropriately obtain the desired stimuli. This will decrease the need to engage in behaviors that have as their function obtaining the stimuli.
 - Providing contingent access to the desired sensory stimulation may be used as a positive reinforcer for the completion of instructional tasks.



**Special Education Eligibility Evaluation:
Report Recommendations**

- ***If the student has weaknesses in social, language, attention, organizational, transitioning, and auditory processing, then the following might be appropriate:***
 - The instructional program should centers on an _____'s strengths (TYPICALLY ROTE MEMORY AND VISUAL PROCESSING), special interests, and needs. It may include the following:
 - Visual schedules that depict the student's daily routine
 - Work systems
 - Calendars to help the student understand when regularly scheduled events may occur
 - To facilitate transitions, make use of visual cues that forewarn the student when something is going to end, stop or be all done. This assists in transitions.
 - Place classroom rules in a visual form on the student's desk.



**Special Education Eligibility Evaluation:
Report Recommendations**

- ***If a student has reading fluency and/or comprehension difficulties, then the following might be appropriate:***
 - Highlighted text
 - Study guides



**Special Education Eligibility Evaluation:
Report Recommendations**

- ***If a student has written expression (e.g., handwriting) difficulties, then the following might be appropriate:***
 - When assessing _____'s content knowledge allow for verbal, instead of written responses.
 - When completing written assignments allow _____ to use the computer instead of pen or pencil.
 - Multiple-choice tests can be used instead of short answer to assess subject matter knowledge
 - Allow _____ to create projects, rather than producing written reports.



**Special Education Eligibility Evaluation:
Report Recommendations**

- ***If a student has difficulty with note taking, then the following might be appropriate:***
 - Provide _____ with a complete outline including the main idea and supporting details.
 - Provide _____ with a skeletal outline that he/she can use to fill in details.



Treatments

- **Behavior and Communication Approaches**
 - **Applied Behavior Analysis (ABA):**
 - Discrete Trial Training (DTT)
 - Early Intensive Behavioral Intervention (EIBI)
 - Pivotal Response Training (PRT)
 - Verbal Behavior Intervention (VBI)



Treatments

- **Behavior and Communication Approaches**
 - **Other therapies that can be part of an autism treatment program include:**
 - Developmental, Individual Differences, Relationship-Based Approach (DIR; also called "Floortime")
 - Treatment and Education of Autistic and related Communication-handicapped Children (TEACCH)



Treatments

- Dietary Approaches?
- Medication?
- Complementary and Alternative Treatments?



Additional Resources

- Free materials from the CDC (great for parents)
 - <http://www.cdc.gov/ncbddd/autism/freematerials.html>
 - [Growth Chart](#)
 - [Milestones Card](#)
 - [Resources Fact Sheet](#)
 - [Developmental Screening Fact Sheet](#)
 - [Autism Spectrum Disorders Fact Sheet](#)



Questions?



Next Topic (10/28/15): Hot Sheet Presentations
No assigned reading or papers due