DAY 1 -- AGENDA
THURSDAY, JUNE 16, 2016

8:00 – 8:45 a.m.	**Registration/Continental Breakfast** *Receive Name tags, Packets, Etc.*
8:45 – 9:00 a.m.	Welcome **Sharon Coppedge Long, Executive Director** **Oklahoma Parents Center, Inc.**
9:00 – 10:15 a.m.	Responding to Problem Behaviors in the classroom: Socially Mediated vs. Emotionally Driven, PROMPT System and Personalized De-escalation for Explosive Behavior **Diana Browning Wright, MS, LEP** *This presentation focuses on problem behavior in students with and without disabilities and examines the role of all stakeholders (parents, administrators, teachers, special staff) in achieving rule following behavior in a school setting. Learn how to support rule following behaviors whether they are occurring for social reasons or from emotional overloaded students with chronic high arousal levels sometimes associated with a history of trauma.*
10:15 – 10:35 a.m.	**Break**
10:35 – 11:50 a.m.	Presentation Continued **Diana Browning Wright, MS, LEP**
11:50 – 12:50 p.m.	**Boxed Lunch will be provided** Option #1: Classic Chef Salad with Chicken Tenders Option #2: Ham with American Cheese on a Croissant Option #3: Southwest Chicken Wrap
12:50 – 2:10 p.m.	Presentation Continued **Diana Browning Wright, MS, LEP**
2:10 – 2:30 p.m.	**Break**
2:30 – 3:30 p.m.	Presentation Continued **Diana Browning Wright, MS, LEP**
3:30 – 3:45 p.m.	**Closing/ Door Prizes/Evaluations**

Responding to Problem Behaviors: Socially Mediated vs. Emotionally Driven

Diana Browning Wright, M.S., L.E.P.

The ACEs Study Implications

- Adverse Childhood Experiences (ACE) Study
  - Calculate yourself (but keep it private)
  - Calculate 2 different students with behavior issues for whom you know their background very well

HERE WE GO!

What Are ACEs?

Adverse Childhood Experiences

- ACEs are experiences in childhood that are unhappy, unpleasant, hurtful.

- Sometimes referred to as toxic stress or childhood trauma.

strong communities raise strong kids

Adverse Childhood Experiences Survey

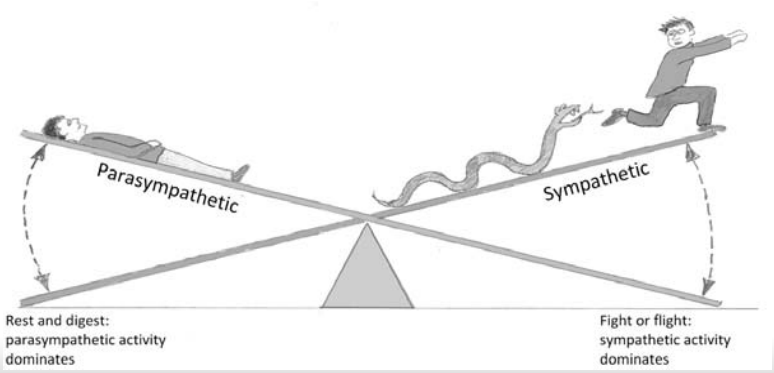
Let's Review the Implications

- An ACE Score of 4 or more results in having multiple risk factors for these diseases or the disease themselves
- An ACE score of 6 or more results in a 20 year decrease in life expectancy

strong communities raise strong kids

Stress – Wigs Kids Out (and us too)

- **Homeostatic balance** (a state of **homeostasis**): having an ideal body temperature, an ideal level of glucose in the bloodstream, an ideal everything
- **Stressor**: anything that knocks you out of homeostatic balance



Allostatic Load
When Stress Becomes Too Much

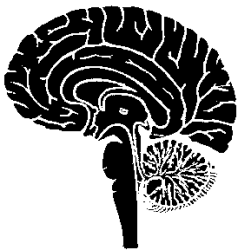
•**Allostatic load:** the wear and tear on the mind and body that results from either too much stress or inability to manage stress.

- Not turning off the stress response when it is no longer needed
- Response to perceived stressors that never even happen
- Inability to manage the intensity of stressors in the moment

Negative Impact of High Allostatic Load

On our body:

- Headache
- Muscle tension or pain
- Cardiovascular
- Fatigue
- Change in sex drive
- Stomach upset
- Sleep problems



On our mind:

- Anxiety
- Restlessness
- Lack of motivation
- Memory problems
- Irritability & anger
- Sadness or depression

On our behavior:

- Angry outbursts
- Avoidance of important activities
- Overeating or undereating
- Social withdrawal
- Drug or alcohol abuse

Adverse Childhood Experiences (ACES) Study

Of 17,000 respondents, two-thirds had at leat one adverse childhood event

- Physical, emotional or sexual abuse
- Emotional or physical neglect
- Growing up with family members with mental illness, alcoholism or drug problems
- Family violence
- Incarcerated family member
- One or no parents
- Parental divorce

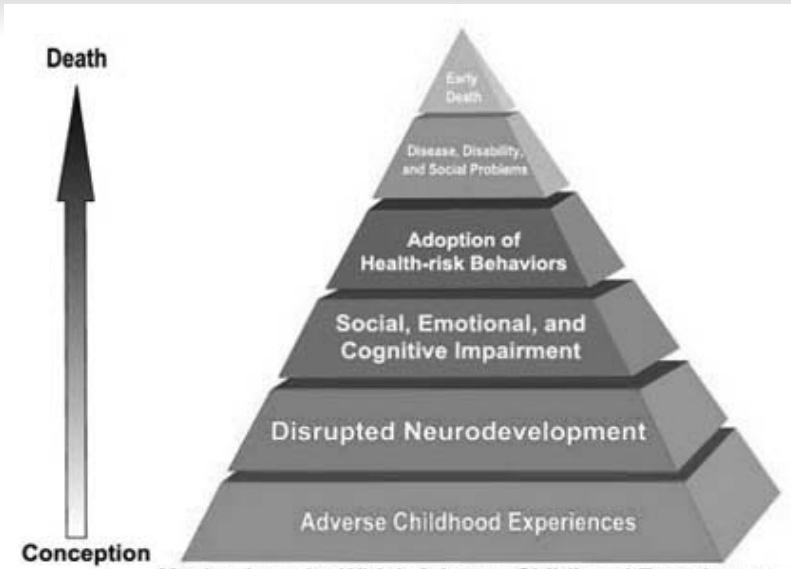
Findings

Of the 17,000+ respondents…

- Two-thirds had at-least 1 adverse childhood event
- 1 in 6 people had four or more ACES
- More than 25% grew up in a household with an alcoholic or drug user
- 25% had been beaten as children

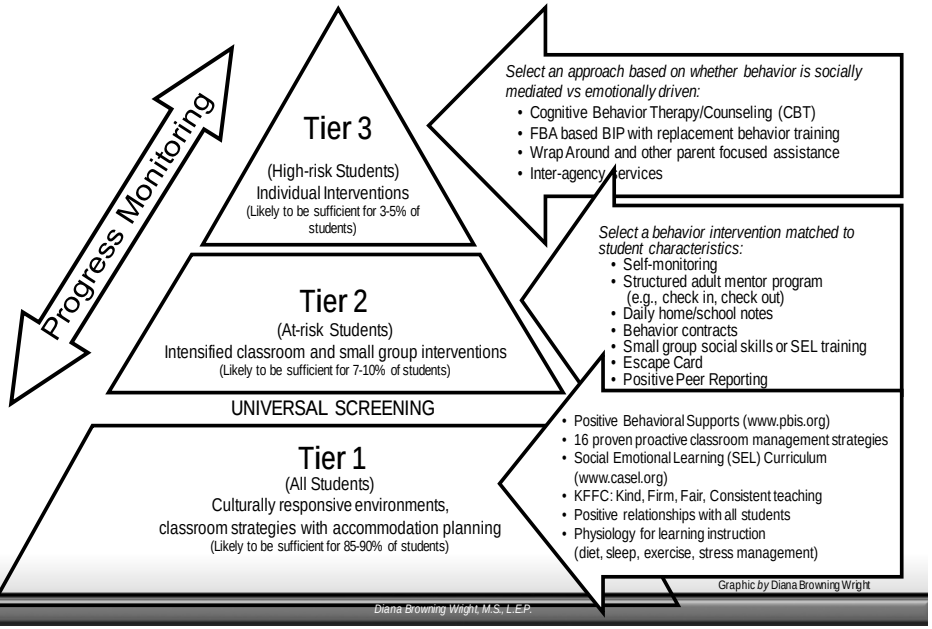
Findings Continued

- People with ACE scores of 4 or more:
  - Twice as likely to smoke
  - Seven times as likely to be alcoholics
  - Six times as likely to have had sex before age 15
  - Twice as likely to have cancer or heart disease
  - Twelve times more likely to have attempted suicide
  - Men with six or more ACEs were **46** times more likely to have injected drugs than men with no history of adverse childhood experiences



Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

Three-Tiered RtI Model for Behavior and Social/Emotional Support



Why not stop light?

Card Pulling vs. Rainbow Club

See handout "Classwide systems" On www.pent.ca.gov for Rainbow Club

Compare and Contrast

Rainbow Club	Card Pulling Stop Light
A class wide system focused on drawing attention to rule following behavior	A class wide system featuring drawing class attention to rule breaking
Maintains and Enhances Teacher/Student(s) relationships	Disrupts teacher/student(s) relationships
Consistent with behavioral theory: progressive shaping (reinforcing) of behavior with built in response cost that allows correction without rejection; basic human needs: enhances a sense of belonging	Inconsistent with behavior theory: It focuses on finding students to publically show "they aren't like you;" emphasizes punishment as the overarching control method, can disrupt sense of belonging

Compare and Contrast

Rainbow Club	Card Pulling Stop Light
Allows for private response cost: lowering to the color below the current achievement of the student in a private manner, then "catch 'em being good" to restore as soon as possible	Often the restoration is not immediate and has side effects on class climate in that some children fear the teacher may "pull their card" and humiliate them randomly
All students begin at the bottom every several days; no student stays at lowest level for more than an hour	All students are at top level (green) and the only place to go is down rather than motivating all students to go up
Allows teacher to walk around with "cues" (colored cards) to award the next layer in the rainbow Payoff daily is by achievement earned; all students earn something	Allows teacher to walk around looking for violations No payoff for achievement

Moving To Behavior Intervention Plan (BIP) Or Other Tier 3?

Socially mediated vs. emotionally driven?

- **Socially Mediated**, i.e., externally reinforced, behavior is to get something or to reject/escape something in an environment
- **Emotionally Driven**, i.e., internally reinforced, or a response to previous trauma triggered now in this environment

BIP Examples Of Behaviors

Examples of socially mediated behaviors that may not have not responded to default behavior interventions and therefore require a BIP include:

- Hitting others in protest/escape their behaviors, or hitting to get their attention
- Making sexually explicit remarks to get laughs from others
- Refusing to do work to escape the task requirement, or the class!
- Etc., etc.

Socially Mediated Behaviors In BIPs Require:

- Replacement behavior training
  - Socially mediated behaviors require instruction on skillful use of a functionally equivalent replacement behavior (FERB) when default interventions failed
- Reinforcement of overall positive behaviors as well as FERBs
- Specification of how staff should respond if and when problem behavior occurs again
- Progress Monitoring and Two-Way Communication

Cognitive Behavior Therapy (CBT) And Other Evidence Based Therapy/ Counseling

- **Anxiety** triggered by fear of failure or separation anxiety or selective mutism that is not seeking a response from the environment and does not respond to environmental changes and default behavior interventions. These require a specific protocol to address the emotions, e.g., a cognitive behavioral treatment plan.
- **Depressed** withdrawn behaviors not seeking a response from the environment that have not responded to lesser interventions that have attempted to "behaviorally activate" require a cognitive behavioral treatment plan.

Emotionally Driven Examples

- **School Phobia** and other phobias that require a specific evidence based protocol to systematically desensitize the student to stress provoking stimuli. (CBT approaches)
- **Habits**, such as tic disorders, that require an evidence based Habit Reversal Protocol (CBT approaches)
- **Repetitive genital rubbing** (pleasure seeking) that has not responded to environmental changes to enhance engagement and is not associated with child abuse (non FERB based Direct Treatment protocol)

Emotionally Driven Examples

- Separation Anxiety, Selective Mutism, etc
- Post-Traumatic Stress Disorder (PTSD)
- Other Trauma Disorders

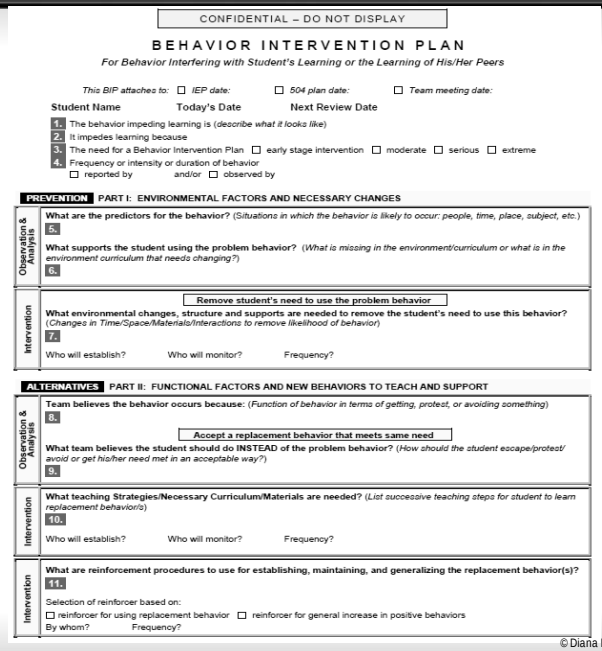
Evidence Based Treatment Required!

See: www.pent.ca.gov/forms for a Direct Treatment Protocol

Reminder: Quality BIPs

All effective plans are a movie, not a snapshot

- Change environment variables
- Teach alternative, acceptable (replacement) behaviors- FERB and General Positive Behavior Skills
- Reinforce general positive behavior AND use of Functionally Equivalent Replacement Behavior
- Safely and productively handle problem behavior when/if it occurs again
- Two-way Communicate with key stakeholders
- Includes a Progress Monitoring Schedule



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BEHAVIOR INTERVENTION PLAN

For Behavior Interfering with Student's Learning or the Learning of His/Her Peers

This BIP attaches to: ☐ *IEP date:* ☐ *504 plan date:* ☐ *Team meeting date:*

Student Name **Today's Date** **Next Review Date**

1. The behavior impeding learning is (*describe what it looks like*)
2. It impedes learning because
3. The need for a Behavior Intervention Plan ☐ early stage intervention ☐ moderate ☐ serious ☐ extreme
4. Frequency or intensity or duration of behavior ☐ reported by and/or ☐ observed by

PREVENTION PART I: ENVIRONMENTAL FACTORS AND NECESSARY CHANGES

Observation & Analysis

What are the predictors for the behavior? (*Situations in which the behavior is likely to occur: people, time, place, subject, etc.*)
5.

What supports the student using the problem behavior? (*What is missing in the environment/curriculum or what is in the environment curriculum that needs changing?*)
6.

Intervention

Remove student's need to use the problem behavior

What environmental changes, structure and supports are needed to remove the student's need to use this behavior? (*Changes in Time/Space/Materials/Interactions to remove likelihood of behavior*)
7.

Who will establish? Who will monitor? Frequency?

ALTERNATIVES PART II: FUNCTIONAL FACTORS AND NEW BEHAVIORS TO TEACH AND SUPPORT

Observation & Analysis

Team believes the behavior occurs because: (*Function of behavior in terms of getting, protest, or avoiding something*)
8.

Accept a replacement behavior that meets same need

What team believes the student should do INSTEAD of the problem behavior? (*How should the student escape/protest/avoid or get his/her need met in an acceptable way?*)
9.

Intervention

What teaching Strategies/Necessary Curriculum/Materials are needed? (*List successive teaching steps for student to learn replacement behavior/s*)
10.

Who will establish? Who will monitor? Frequency?

Intervention

What are reinforcement procedures to use for establishing, maintaining, and generalizing the replacement behavior(s)?
11.

Selection of reinforcer based on:
☐ reinforcer for using replacement behavior ☐ reinforcer for general increase in positive behaviors
By whom? Frequency?

EFFECTIVE REACTION PART III: REACTIVE STRATEGIES

What strategies will be employed if the problem behavior occurs again?

12.

1. Prompt student to switch to the replacement behavior
2. Describe how staff should handle the problem behavior if it occurs again
3. Positive discussion with student after behavior ends

Optional:

4. Any necessary further classroom or school consequences

Personnel?

OUTCOME PART IV: BEHAVIORAL GOALS

Behavioral Goal(s)

13.

Required: Functionally Equivalent Replacement Behavior (FERB) Goal

By when	Who	Will do X behavior (line 9)	For the purpose of y (line 8)	Instead of Z behavior (line 1)	For the purpose of y (line 8)	Under what contingent conditions	At what level of proficiency	As measured by whom and how

Option 1: Increase General Positive or Decrease Problem Behavior

By when	Who	Will do what, or will NOT do what	At what level of proficiency	Under what conditions	Measured by whom and how

Option 2: Increase General Positive or Decrease Problem Behavior

By when	Who	Will do what, or will NOT do what	At what level of proficiency	Under what conditions	Measured by whom and how

The above behavioral goal(s) are to: ☐ Increase use of replacement behavior and may also include:
☐ Reduce frequency of problem behavior ☐ Develop new general skills that remove student's need to use the problem behavior

Observation and Analysis Conclusion:

Are curriculum accommodations or modifications also necessary? Where described: ☐ yes ☐ no
Are environmental supports/changes necessary? ☐ yes ☐ no
Is reinforcement of replacement behavior alone enough (no new teaching is necessary)? ☐ yes ☐ no
Are both teaching of new replacement behavior AND reinforcement needed? ☐ yes ☐ no
This BIP to be coordinated with other agency's service plans? ☐ yes ☐ no
Person responsible for contact between agencies ☐ yes ☐ no

COMMUNICATION PART V: COMMUNICATION PROVISIONS

Manner and content of communication

14.

1. Who?	2. Under what condition(s) (Contingent? Continuous?)	3. Delivery Manner	4. Expected Frequency?	5. Content?	6. How will this be two-way communication

1. Who?	2. Under what condition(s) (Contingent? Continuous?)	3. Delivery Manner	4. Expected Frequency?	5. Content?	6. How will this be two-way communication

1. Who?	2. Under what condition(s) (Contingent? Continuous?)	3. Delivery Manner	4. Expected Frequency?	5. Content?	6. How will this be two-way communication

PARTICIPATION PART VI: PARTICIPANTS IN PLAN DEVELOPMENT

☐ Student
☐ Parent/Guardian
☐ Parent/Guardian
☐ Educator and Title
☐ Educator and Title
☐ Educator and Title
☐ Administrator
☐ Other
☐ Other

Evaluating Your Functional Behavior Assessment (FBA) Report

- Were all elements that document process and conclusions included?
- Did you specify that a BIP is appropriate for the problem?

See: Checklist for Complete FBA Reports and a model FBA report at www.pent.ca.gov/forms

FUNCTIONAL BEHAVIOR ASSESSMENT REPORT

An FBA is an evidence-based, analytical process based on observations, review of records, interviews, and data analysis to determine the function the behavior serves for the student, how that function can be met more appropriately and how the environment can be altered to better support positive behaviors.

Date of Report: _____

Date(s) of FBA Data Collection: _____

SECTION 1: Student Information

Student Name: ____ (Last (legal)) ____ (First (no nicknames)) __ (M.I.) ☐ Male ☐ Female

Birthdate: ____ **Grade:** Drop down menu

Resident District: ____ **Building:** ____

Attending District: ____ **Building:** ____

Attending Area Education Agency: ____ **Attending Building Phone:** (___) ___-____

SECTION 2: Parent/Guardian Information

☐ Parent ☐ Foster Parent ☐ Guardian ☐ Surrogate ☐ Student

Name: ____ **Address:** ____ **City/State:** ____ **Zip:** ____

Home Phone: (___) ___-____ **Work Phone:** (___) ___-____ **Cell Phone:** (___) ___-____ **E-mail:** ____@____

SECTION 3: Behavior Analysis

1. **Behavior(s) of concern** *(State a clear, measurable, and observable description of the behavior or behaviors of concern)*

2. **Frequency, Intensity, and/or Duration of current behavior:**

3. **Analysis of this behavior was based on:**
   ☐ Interviews with ____
   ☐ Student observation(s) on ____ at ____
   ☐ Review of records, consisting of: ☐ health ☐ discipline ☐ other: ____
   ☐ Environmental analysis for supportive and unsupportive variables on ____
   Summary of Interview, Observation, Record Review, and Environmental Analysis:

4. **Is the behavior impeding learning of the student or peers?** ☐ Yes ☐ No
   If yes, please describe:

5. **Have Tier II Strategies and Interventions been tried?** *(e.g., school/home notes, behavior contracts, self-monitoring)*
☐ Yes ☐ No
Describe selected intervention:

6. **Result of selected Tier II Positive Behavior Interventions and Strategies:**

7. **Is a Behavior Support Plan recommended?** ☐ Yes ☐ No

8. **Environmental Factors:**
   - **What are the predictors for the current behavior(s)?** *(Antecedent events that trigger problem behavior)*
   - **What supports the student using the current problem behavior(s):** *(e.g., what is in the environment that should be eliminated or reduced? What is not in the environment that should be added?)*

9. **Functional Factors:**
   - **Hypothesis of function (purpose) of this behavior for this student:**
   - **Suggested functionally equivalent replacement behavior:**

SECTION 4: Conclusion/Recommendation

1. **Conclusions:** *(Recommendations for IEP, 504, or school team consideration)*

2. **Estimate of need for behavior support:**
☐ Extreme
☐ Serious
☐ Moderate
☐ Needs attention, early stage intervention
☐ Monitor behavior only; no formal behavior support plan is necessary at this time

3. **If a Behavior Support Plan is NOT to be developed, consider:**
☐ Behavior goals to be developed by: _____ and contained in: _____
☐ Consider Tier II interventions, such as _____
☐ Consider other Tier III interventions, such as referral to outside agencies or district provided Cognitive Behavioral Therapy
☐ Consider involvement of Challenging Behavior Team (CBT), due to the severity or treatment resistance of problem behavior
Rationale for selection of other approach:

4. **This team has determined that if a behavior plan is NOT to be developed as a result of this assessment, a formal behavior support plan will be developed if the problem behavior:**
☐ continues or ☐ escalates
Describe:

5. **This student has:** ☐ a current IEP ☐ a current 504 Plan ☐ neither

6. **Goals to monitor future behavior will be added to:**
☐ a new or amended IEP
☐ a new or amended 504 Plan
☐ a school team's plan (no IEP or 504 Plan)

7. **Date of Implementation:** ____

SECTION 5: Evaluation Personnel

Individuals contributing to this evaluation:

Name	Position	Name	Position

Contact person for this report: ____
Phone: (____)____-____
E-mail: ____@____

BIP Desk Reference And BIP-QE II

- Use to train staff on the key concepts of applied behavioral analysis and behavior intervention plans

Download the 345 page manual for free:
www.pent.ca.gov

Multiple Purposes For BIP-QE II

- Use to keep proper focus balance between positive behavioral interventions and potential future disciplinary considerations
- Use when a BIP has not been successful
- Use to improve your ability to legally defend the team's Behavior Plan

What The BIP-QE II Does NOT Measure

- Whether the new behaviors, interventions, environmental changes, and reinforcers fit the student
- Whether the behavior was socially mediated or internally driven
- Whether this plan is developmentally appropriate for this student

See: http://www.pent.ca.gov/beh/dev/dev.html

BIP-QE II Does NOT Measure Fidelity

- Whether the plan was or will be implemented consistently and skillfully
- This takes observation, data analysis and review systems

Peer Reviewed Journal Publications

www.pent.ca.gov/hom/research.html

- Cook, C.R., Mayer, G.R., Browning-Wright, D., Kraemer, B., Gale, B. & Wallace, M.D. (2012). Exploring the link between evidence-based quality of behavior intervention plans, treatment integrity and student outcomes under natural educational conditions. The Journal of Special Education, 46, 3-16.
- Kraemer, B. R., Cook, C. R., Browning-Wright, D., Mayer, G. R., & Wallace, M. D. (2008). Effects of training on the use of the Behavior Support Plan Quality Evaluation Guide with autism educators: A preliminary investigation examining positive behavior support plans. Journal of Positive Behavior Interventions, 179-189.

Peer Reviewed Journal Publications

www.pent.ca.gov/hom/research.html

- Cook, C. R., Crews, D., Browning-Wright, D., Mayer, R., Gale, B., & Kraemer, B. (2007). Establishing and evaluating the substantive adequacy of positive behavior support plans. Journal of Behavioral Education, 16, 191-206.
- Browning-Wright, D., Mayer, G. R., Cook, C. R., Crews, D., Kraemer, B. R., & Gale, B. (2007) A preliminary study on the effects of training using behavior support plan quality evaluation guide (BSP-QE) to improve positive behavioral support plans. Education and Treatment of Children, 30, 89-106.

Implications Of Research For Practitioners

- Research on the BIP has demonstrated that the better the evaluated plan, the more likely the plan will be implemented with fidelity
  - "Failure to properly or consistently implement the behavioral interventions identified in an appropriately developed BIP can amount to a denial of FAPE." (Norlin, John W. (2012) FBAs and BIPS: Meeting IDEA Compliance Obligation. Palm Beach Gardens, Florida: LRP publication, p.28.]

Implications Of Research For Practitioners

- The BIP-QE II is a valid and reliable instrument for evaluating behavior plans
- Use the BIP-QE II as a training tool when teaching staff how to develop a complete and adequate BIP. Research has shown that this tool increased staff performance
- Periodically evaluate your plans to maintain skill mastery

What IS The Positive Behavior Intervention Process for Socially Mediated Behaviors?

- **A data-driven team approach with built-in accountability for a supplementary aid & support**
  - Follows a carefully look at the context of the problem behavior
  - Hypothesizes why the behavior is occurring
  - Develops a plan to teach the student a replacement behavior and new skills
  - Changes environments to match student needs
  - Involves people who really care about the student
  - Develops a written plan capturing the team's decisions and methods

What IS The Positive Behavior Intervention Process for Emotionally Driven Behaviors?

- **A data-driven team approach with built-in accountability for related services to benefit from Special Education**
  - Follows a carefully look at the context of the problem behavior and the history of trauma and triggers
  - Hypothesizes why the behavior is occurring
  - Develops a plan to teach the student coping behaviors and new skills
  - Involves people who really care about the student
  - Develops a plan capturing the team's decisions and methods

This form describes a treatment protocol for emotionally-driven behavior.
This is NOT a BEHAVIOR INTERVENTION PLAN.

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DIRECT TREATMENT PROTOCOL

This plan attaches to: ☐ *IEP, date:* ☐ *504 plan, date:* ☐ *School Team, meeting date:*

Student Name **Today's Date** **Next Review Date**

1. The behavior is (*describe what it looks like*)
2. What is the impact of this behavior on the student's educational performance (i.e., academic and social-emotional functioning)?
3. Describe other interventions that have been used (e.g., BIP implementation, medication management, parent counseling, etc.)
4. Why does this behavior require treatment by a related service provider?
5. Baseline for the behavior: Frequency or intensity or duration of behavior
   ☐ reported by and/or ☐ observed by
6. Does this treatment protocol also require positive behavior supports and a behavior intervention plan? ☐ yes ☐ no
   If yes, describe rationale for both a treatment protocol and a behavior intervention plan to address this behavior

Environment **PART I: Environmental Situations in which this behavior occurs and suggested environmental changes**

Observation & Analysis

7. **What are the situations in which this behavior is likely to occur?**
   Who collected this data? Dates

Environmental Changes

8. **What environmental changes will remove opportunity or reduce likelihood of the behavior occurring?**
   Who will establish? Who will monitor? Frequency?

Treatment **PART II: Direct evidence-based treatment to be provided**

Observation & Analysis

Team believes the student's identified problem should be addressed by the following evidence-based treatment protocol

9.

Intervention/ Treatment Protocol

What specific materials and approaches will be used to treat the emotional dysregulation and unhelpful thinking patterns that are resulting in the student's problem behavior?

10.

Who will implement? Who will monitor? Frequency? Expected duration of treatment?

Reinforcement Methods

What reinforcement procedures will be used in this treatment protocol to support development and generalization of learned skills?

11.

Reinforcement for: ☐ less frequent behavior ☐ lower intensity ☐ skill practice during session or homework ☐ using skills in natural situations

Selection of reinforcer based on:

By whom? Frequency of reinforcement?

EFFECTIVE REACTION **PART III: FUTURE RESPONSES TO PROBLEM BEHAVIOR**

How will staff respond to future episodes of this problem behavior?

12.

Is there a need to develop a personalized crisis prevention and response plan due to the intensity of the problem? ☐ yes ☐ no

Who will need training on desired responses if the behavior occurs again?

What personnel will train teachers and staff on effective responses? When?

OUTCOME **PART IV: BEHAVIORAL GOALS**

Behavioral Goal(s)

13. **A decrease or elimination of the problem behavior through this treatment protocol will be monitored by achievement of these goals during treatment sessions and in observations of the student in natural settings**

Three categories of goals

Reductions or elimination of problem behaviors

By when	Who	Will do what, or will NOT do what	At what level of proficiency	Under what conditions	Measured by whom and how

Increase in the use of learned skills or coping techniques

By when	Who	Will do what, or will NOT do what	At what level of proficiency	Under what conditions	Measured by whom and how

Improvements in student ratings of subjective units of discomfort/distress

By when	Who	Will do what, or will NOT do what	At what level of proficiency	Under what conditions	Measured by whom and how

Coordination of Treatment Protocol with Other Services and Supports:

Are curriculum accommodations or modifications also necessary? ☐ yes ☐ no
- If yes, where described:

Does this behavior also require a behavior intervention plan? ☐ yes ☐ no

Does this treatment protocol require coordination with behavior intervention plan implementers? ☐ yes ☐ no
- If yes, person responsible for coordinating treatment protocol and behavior intervention plan implementers:

Does this treatment protocol need to be coordinated with other agency's service plans? ☐ yes ☐ no
- If yes, persons responsible for contact between agencies

Is this treatment protocol necessary to benefit from the student's special education? ☐ yes ☐ no
- If yes, this treatment protocol is a "related service." Person responsible for providing the related service:

COMMUNICATION **PART V: COMMUNICATION PROVISIONS**

Manner and content of communication

14.

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PARTICIPATION **PART VI: PARTICIPANTS IN PLAN DEVELOPMENT**

- ☐ Student
- ☐ Parent/Guardian
- ☐ Parent/Guardian
- ☐ Educator and Title
- ☐ Educator and Title
- ☐ Educator and Title
- ☐ Administrator
- ☐ Agency Representative
- ☐ Psychologist
- ☐ Related service providers
- ☐ Other

Streamlined 10 Steps

After the decision is made to conduct the assessment and permission is received

1. Meet with teacher(s) and outline the follow-up steps to plan development

   Typically 30 minutes
2. Review Records and Interview Stakeholders (e.g., teachers, parents, administrators, paraeducators, therapists peers, etc.)

   Typically 1-2 hours
3. Classroom observation (see section 3 in BIP Manual on line) for environmental assessment and functional observation

   Typically 30 minutes to one hour

Streamlined 10 Steps

4. Set up data collection for baseline and explain to classroom staff (use FAOB, see section 3 on line)
   Typically 30 minutes
5. Collect and Analyze data
   Typically one hour
6. Meet with implementer(s) and discuss the 3 pathways on the pathway chart, using "consultant script for pathways" (see section 3)
   Typically 45 minutes to one hour
7. Write FBA or Social/Emotional/Mental Health report or other summary of data collected
   Typically 30 to 45 minutes

Streamlined 10 Steps

8. Transfer report data to appropriate places on a behavior plan or a direct treatment plan and prepare notes for IEP or other meeting
   Typically 30 to 45 minutes
9. Meet as a IEP or school team. Get three agreements again from all elements of pathway chart with all members and discuss the FBA findings
   Typically 30 minutes
10. Develop interventions as a team to match analysis, with parent giving "meaningful input and participation" OR describe treatment approach for emotionally driven behavior
    Typically one hour

Remove Need By Teaching Alternative Skills (Socially Mediated)

- **Replacement Skills**: One-to-one replacement skills that serve the exact function as the problem behavior
- **General Skills**: Broad skills that alter problem situations and prevent the need for problem behaviors
- **Coping and Tolerance**: Skills that teach students to cope with or tolerate difficult situations

Problem Behavior Decreases When These Skills Are In The Repertoire Of The Student (Socially Mediated)

Get/Obtain: Attention, Activity, Objects

- Express choice or preferences
- Follow schedule & participate in routines
- Request help
- Initiate interaction or gain attention
- Self-manage within activities
- Work toward delay of reinforcement

Problem Behavior Decreases When These Skills Are In The Repertoire Of The Student (Socially Mediated)

Avoid/Escape: Activity, Attention, Demands

- Use schedule or checklist to self-manage
- Set own work goals
- Express preferences or choice
- Request and take break
- Participate in steps or portion of routine
- Request or seek help

Communication Skills Prevent Problem Behaviors (Socially Mediated)

TEACH – How to *ask for* or *signal for*:

help	a break
interaction	attention
time alone	reduced demands
more time	alternative assignment
choice	opportunity to move around

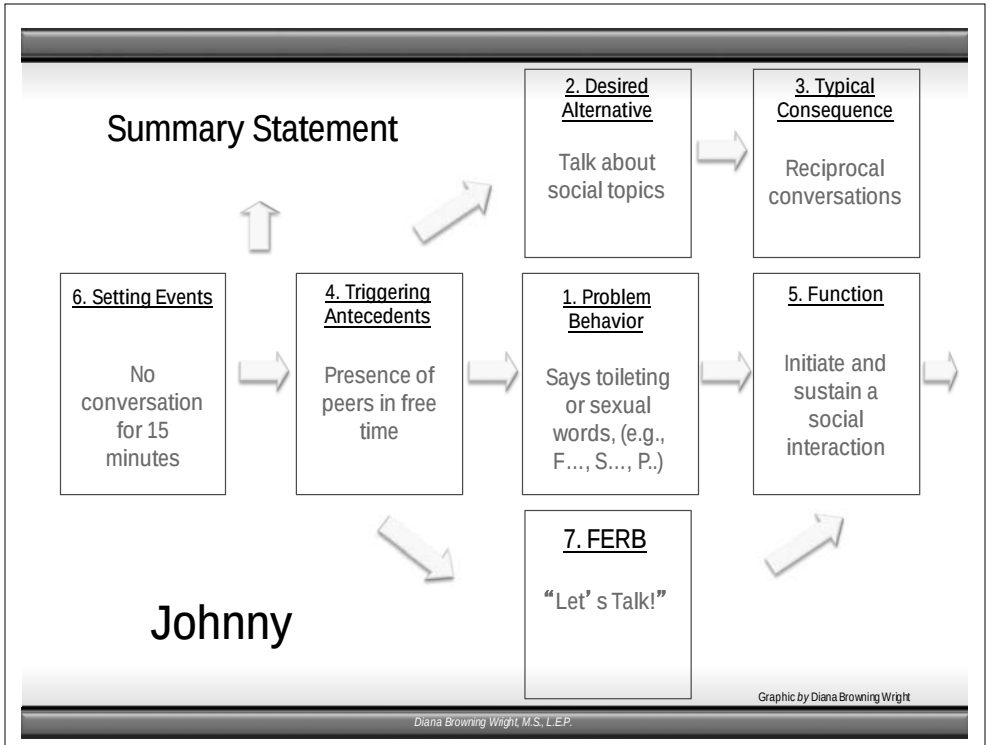
Problem Behavior Decreases When General Skills Increase (Socially Mediated)

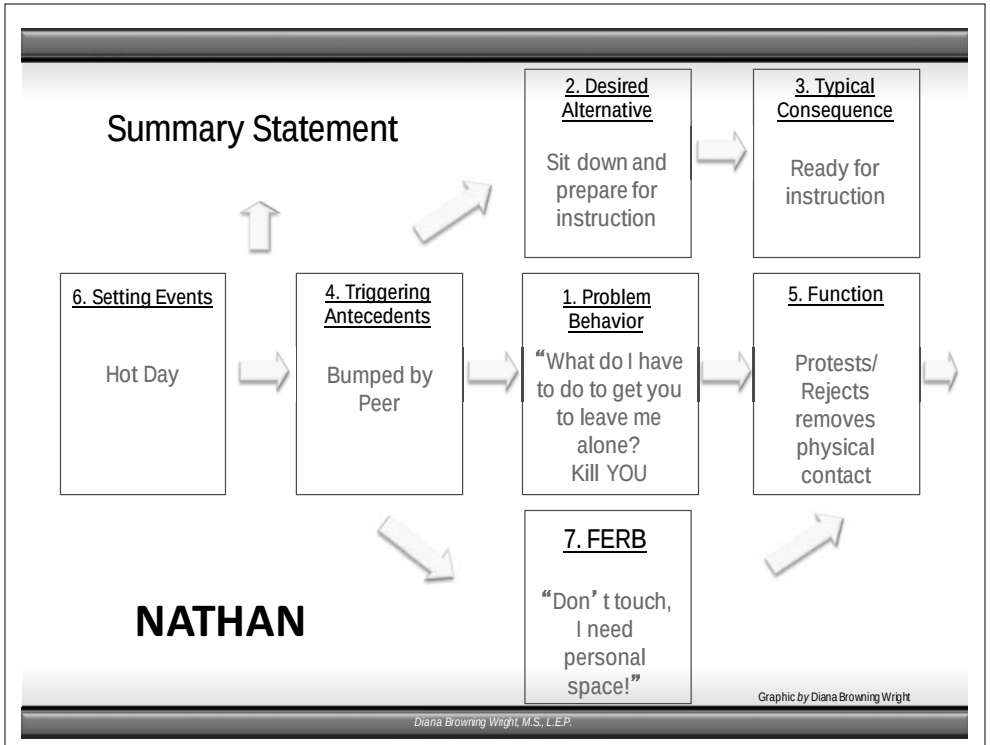
- Academic Skills
- Use of Technology – Hi & Lo Tech
- Organization Skills
- Leisure Skills
- Social Interaction Skills
  - Initiate and respond to interactions
  - Make friends
  - Problem solve
  - Deal with stress

Problem Behavior Decreases When Self-Management Or Coping Skills Increase (Socially Mediated and Emotionally Driven)

TEACH* *Relaxation Techniques

- Positive Self – Talk
- Guided Imagery
- Deep Breathing
- Muscle Relaxation
- Physical Stress Relievers
- Mindfulness (See Mind Up)





Socially Mediated Behavior Problems

- **Type 1**: One problem behavior for one function
  - Hits to engage others
- **Type 2**: Two or more problem behaviors for one function
  - Hits, spits, bites to avoid doing work
- **Type 3**: One behavior for two or more functions
  - Hits to engage others and to escape work

Behavior Problems

- **Type 4**: Multiple behaviors in sequence for one function
  - Rocks, mutters, throws chairs, then runs to escape work
- **Type 5**: Multiple discrete behaviors for multiple functions
  - To engage others, student hits
  - To escape, student runs away
  - To get attention from teacher, student spits on desk
  - To get to front of line, knocks over peers

Behavior Problems

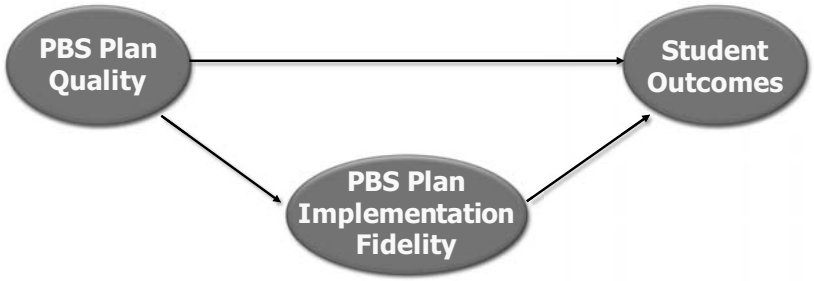
- Requires one pathway for each behavior unless Type 4, which can list problems in sequence in the problem behavior box
- Do NOT write a Behavior Plan for more than 2 or 3 multiple behaviors with different functions
  - Choose pivotal behaviors and write behavior plan for one or two behaviors
  - Often environmental changes will alter multiple behaviors

Research On Training And Scoring Behavior Plans

- A method of learning behavior analysis and improving quality of plans
- A method of evaluation of the extent to which your plan is in alignment with the field of behavior analysis
- A method of improving likely fidelity once the plan is approved
- A method of improving outcomes for students

Most Recent Published Research

- Exploring the connection between Positive Behavior Support (PBS) plan quality, plan implementation fidelity, and student outcomes



Graphic by Diana Browning Wright

Relationship Between Plan Quality And Plan Fidelity

- Results: the better the plan, the more likely the plan is to be implemented with integrity (i.e., implemented as written [r = .56])
- Analysis results: We examined the sequence to determine whether fidelity significantly predicts student outcomes
  - Step 1: Developed a high quality plan
  - Step 2: Implemented the plan with high fidelity (as written)
  - Step 3: Improved student outcomes

Follow-up Analysis Needed

Research Needs: Staff characteristics that relate to behavior plan quality, implementation fidelity, and student outcomes

- Preliminary results suggest that "number of ABA courses" is positively correlated with PBS plan quality (the more courses, the better the plan) and
- "Years in education" is negatively correlated with BIP quality (i.e., the more years in education the poorer the BIP plan)

Where To Get Free Self-Training On-line

- *www.pent.ca.gov*

  "Behavior Intervention Plan Desk Reference"
  - A Comprehensive Manual that includes how to score behavior plans (section 15) write effective behavior goals (section 8) that are measureable, how to develop effective communication between all stakeholders, how to link pathways to the plan (section 3), how to consult using the pathway tool (section 3) and many other embedded "how to" guides

www.pent.ca.gov

Emotionally Driven Behaviors?

Related Service to Benefit from Special Education vs. Supplementary Aids and Services to Maintain the LRE

Earlier Onset Of Internalizing Disorders

- First episode of anxiety, depression is occurring earlier and earlier in American culture
- Warnings on increasing internalizing disorders in children are increasing
- Cultural shift from "the American Dream" to "Bleak Outlook" see: Optimistic Child by Martin Seligman

School-Based Problems And Disorders

- Internalizing problems:
  - **Anxiety, Fears, Phobias**
  - **Depression**
  - **Trauma Responses**
- Children and youth vary from normal to disordered functioning in each of these areas

Anxiety Disorders

- Prevalence of Anxiety, Fears, Phobias
  - 6-15% for children and adolescents
    - 2.0-12.9% Separation anxiety (normal between 7 mo. And 6 years)
    - 5.0-10.0% Generalized Anxiety Disorders (GAD)
    - 3.0-10.0% Specific phobia
    - 0.5-2.8% Social phobia
    - 1.0-2.0% Obsessive Compulsive Disorders (OCD)

Depressive Disorders

- Prevalence of Major Depression:
  - 3% in preadolescents
  - 15-20% in adolescents
  - Girls > Boys in adolescence
- Prevalence of Dysthymic Disorder:
  - ~3% of children and adolescents
  - Equal in males & females during childhood/adolescence

Trauma-Related Emotional Disorders

- Prevalence of Post-Traumatic Stress Disorder (PTSD)
  - 2-5% of children and adolescents
  - Fewer than 20% of children with a history of exposure to a traumatic event have had a psychiatric disorder, mainly anxiety disorders, including post-traumatic stress disorder (PTSD)

(Costello, Erkanli, Fairbank, & Angold, in press)

- Sex differences
  - Girls 2-3 times more likely than boys

What Is Trauma?

- Sudden or unexpected events
- Shocking nature of events
- Actual or threatened death/threat to life/bodily integrity
- Subjective feelings of intense terror, horror, or helplessness

Which Experiences Are Traumatic?

- Child physical or sexual abuse
- Witnessing or victimization of domestic, community, or school violence
- Severe accidents
- Potentially life-threatening illnesses
- Natural/human-made disasters
- Sudden death of family member/peer
- Exposure to war, terrorism, or refugee conditions

Maltreatment Data

- U.S. Department of Health & Human Services, Administration on Children Youth & Families. Child Maltreatment
  - Data on severe inflicted child abuse, trauma, which in 2011 resulted nationally in the death of 1570 per 100,000 children
    - 76.7 million children 0-17 in USA projected for 2013, data not yet available

http://www.acf.hhs.gov/sites/default/files/cb/cm11.pdf#page=28

What Teachers And Staff Observe In Emotional/Internalizing Patterns Of Behavior

- A shrinking of the student's repertoire of approach behaviors and skills to nothing (poor use of social skills)
- Students develop a repertoire of avoidance behaviors in attempt to alleviate anxiety out of their life.
- Students that fear separation from their caregivers attempt to cling to their caregivers to avoid being separated.

What Teachers See And Hear As Student Reacts To Provocative Stimuli

- **Physical sensations**: (e.g., rapid heart rate, short of breath, cold sweaty hands, blushed face, butterflies)
- **Thoughts/Beliefs**: faulty interpretation and meaning making of situation
- **Escape/Avoidance Behaviors**: attempt to remove contact with provocative stimulus
- **Oppositional Behaviors**: when forced to have contact with provocative stimulus
- **Feelings**: sad, angry, upset, depressed, worried

What Teachers See And Students Report

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

Early Intervention By Teachers *Through Physiology For Learning*

- Use Strategies and Procedures to Monitor and Support Physiology for Learning
  - Diet: teach and support families in healthy eating/healthy minds
  - Sleep hygiene: log activities 30 minutes before bedtime activities, time in bed , times up in the night, time out of bed, fatigue level at waking and daily mood

Early Intervention By Teachers *Through Physiology For Learning*

- Use Strategies and Procedures to Monitor and Support Physiology for Learning
  - Exercise: endorphins – move it or lose it
  - Stress management e.g., relaxation techniques, "belly breathing," mindfulness practices, etc.
  - Stress Management: Evidence based mindfulness-see www.learning2breathe.org (HS) and www.mindup.org (pre k-8)

Early Intervention By Teachers *Prevention Through Mindfulness Training*

- Existing in the present moment
  - Preventing the thoughts about the past and future from invading and capturing your mind
- What's happening now?
  - Going through the senses
    - What am I seeing?
    - What am I smelling?
    - What am I feeling?
    - What am I hearing?
    - What am I tasting?

See: http://mindfulnessforchildren.org/research/

Resources for Schools

- **Mind Up**: http://thehawnfoundation.org/mindup/mindup-curriculum/
- **Mindfulness In Education**: www.mindfuleducation.org
- **Mindful Schools**: http://www.mindfulschools.org
- **Positive Psychology:**
  www.greatergood.**berkeley**.edu
  www.ggia.berkeley.edu
  www.authentichappiness.org

Positive Psychology: Evidence-Based Resources

- https://sites.google.com/site/psychospiritualtools/Home/psychological-practices/three-good-things *(Listen to Martin Seligman explain the 3 good things technique)*
- Ben's Top 11 positive psychology websites at: http://www.authentichappiness.sas.upenn.edu/newsletter.aspx?id=76
- http://www.authentichappiness.sas.upenn.edu/books.aspx *(Look for THE OPTIMISTIC CHILD)*
- http://www.authentichappiness.sas.upenn.edu/testcenter.aspx *(Look for adult and children tools)*

Depression Specific Strategies

- Tracking of Mood/Activity Level
- Behavioral Activation Planning
  - Identify baseline level of pleasant events
  - Identify "high impact" activities
  - Promote participation in pleasant activities
    - Join a club (to increase social experiences)
    - Set a goal to learn to do something better (to increase success experiences)
    - Invite others to join your activities
  - Reward completion of goal doing something that is:
    - Very enjoyable
    - Under self-control
    - Powerful – equal to effort made to accomplish goal
    - Immediately available

Social Emotional Learning (SEL)

- These Social Emotional skills include the ability to:
  - Recognize and manage emotions
  - Care about and respect others
  - Develop positive relationships
  - Make good decisions
  - Behave responsibly and ethically

Two Components To SEL

- SEL involves:
  1. Teaching students a set of skills to help support their social and emotional well-being and,
  2. Creating a safe, caring learning environment conducive to learning where students are encouraged and reinforced for applying those skills.

What Works?

Internalizing

- PBS alone, no change
- SEL alone, moderate change
- SEL combined with PBS substantive change

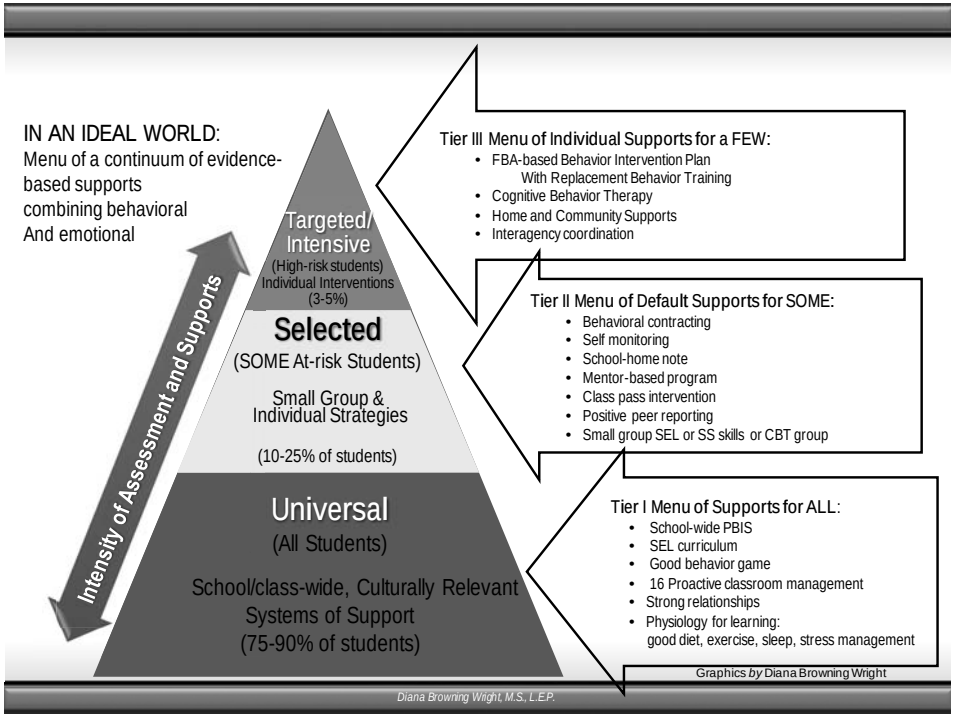
Externalizing

- SEL alone, small change
- PBS alone, moderate change
- SEL combined with PBS substantive change

Cook, C.R., Frye, M., Jewell, K., & Slemrod, (under review). Preliminary evaluation of combining Positive Behavior Support and Social Emotional Learning as an integrated approach to school-based universal prevention. *School Psychology Review.*

Signs Of Need For Second Tier Of Supports And Recommendations

- In Behavioral RTI/MTSS schools: High scores on the internalizing half of Universal Screening Measures for behavior
- In non-RTI/MTSS schools: high intensity, duration and/or frequency of presenting problems described above, after prevention measures have been used both in class and school-wide



Sample Tier 2: School Protocol And Contract For School Avoidance

- Address morning routine to reduce anxiety
  - Review anxiety management strategies
- Develop school drop-plan
  - Identify parent who will take the child to school, what time parent will bring child to school, what child will do upon arrival
  - School personnel's role in Jenny's arrival
- Modifications during school day
  - Identify "point person" and plan for Jane if anxiety is high
  - Provide that person with anxiety management tools developed during sessions
  - Determine whether Jane can call parents (and how many times) during school day

School Contract

- Incentives for attending school
  - Appropriate incentives: special time with mom or dad, play date with friend, extra story at bedtime, special snack
- If child does not attend school or leaves school early:
  - Child should not engage in pleasurable activities during the time he is supposed to be in school
  - Parents should respond in a neutral manner
  - Child should complete class work during school hours
  - No screen time: TV, video games, iPod, computer, etc.

Strategy Use In School Contract

- Parents and student track strategy use together
- When the student feels anxious, the students keeps a record of which anxiety management strategy was used and the outcome
  - Strategies: read note cards, review sheets made in session, belly breathing, role play

Other Tier 2 For Internalizers

- Small Group SEL, Cognitive Behavior Therapy (CBT), Social Skills
- Check-in/Check-out Mentoring [*The Behavior Education Program (BEP)]*
- Positive Peer Reporting
  - Use in Self Governance Meeting (see www.pent.ca.gov)
  - Use in a Protocol, e.g. Pit Crews (see www.pent.ca.gov)
- Self Monitoring System
- Escape Card

The Cognitive Behavioral Model

Situation
↓
Thoughts &
Meaning Making
↓
Reaction
(Emotional, Behavioral and
Physiological)
↓
Consequences
(Perceived and actual)

What Should We Be Doing For: DEPRESSION

Best Support	Good Support
• Cognitive Behavior Therapy • Interpersonal Therapy • Cognitive Behavior Therapy and Medication	• Behavioral Activation • Client Centered Therapy • Cognitive Behavior Therapy with Parents • Play Therapy • Relaxation

David-Ferndon & Kaslow, 2008

What Should We Be Doing For: ANXIETY (fears and phobias too)

Best Support	Good Support
• Cognitive Behavior Therapy – Education – Exposure – Response Prevention – Modeling	• Assertiveness Training • Cognitive Behavior Therapy and Medication • Cognitive Behavior Therapy with Parents • Hypnosis • Play Therapy • Relaxation

Silverman, Pina, & Viswesvaran, 2008

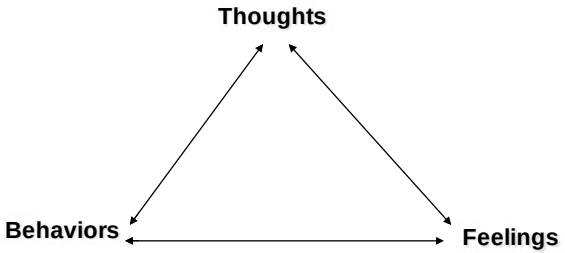
What Should We Be Doing For: TRAUMA

Best Support	Good Support
• Cognitive Behavior Therapy	• Cognitive Behavior Therapy with Parents • Play Therapy

Cohen, Deblinger, Mannarino & Steer (2004); DeArrellano, Waldrop, Deblinger, Cohen, & Danielson (2005)

Cognitive Behavioral Therapy

- Thoughts, emotions, and behaviors are reciprocally linked and that changing one these will necessarily result in changes in the other



Graphics *by* Diana Browning Wright

Cognitive Behavioral Therapy

CBT is a combination of cognitive techniques (how we think) and behavioral techniques (how we act)

Premise: The way an individual feels and behaves in influenced by the way s/he processes and perceives her/his experiences

Premise: Dysfunctional behavior is the result of dysfunctional thinking

Dialectical Behavior Therapy (DBT) Individual And Group

- Linehan, M. M. (1993). Cognitive-behavioral treatment of borderline personality disorder. The Guilford Press: New York. Lihenan, M. M. (1993). Skills training manual for treating borderline personality disorder. The Guilford Press: New York. http://dbtcentermi.org/Overview_of_DBT_.php
- Borderline personality disorder, OCD, emotion regulation disorders, eating disorders, cutting, etc

Who Is Qualified To Deliver CBT School Services?

- **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

Who Is Qualified To Deliver CBT School Services?

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

How Does Someone With A Scope Of Practice Move In To Scope Of Competence?

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

Key Concept: CBT Is About Helping The Student Draw The Connection Between Thoughts, Feelings, And Behaviors

- E.G., Thoughts, Feelings, & Behaviors Associated with Anxiety
  - **Thought**: this is scary
  - **Feeling**: anxiety
  - **Behavior**: Escape
  - Teach the student to attend to attend to body signals, thought signals, action signals

Coping Cat Tier 2 Group/Tier 3 Individual

- Kendall (1994)
  - 16 session CBT (Coping Cat) superior at posttreatment to waiting list control
  - Gains maintained at 1 yr (n=47, age 9-13)
- Kendall et al (1997)
  - 16 session CBT (Coping Cat) superior to waiting list posttreatment
  - Maintained at 12 mos (n=94, age 9-13)

Coping Cat

- Kendall, P.C., & Hedtke, K.A. (2006). Cognitive-behavioral therapy for anxious children: therapist manual, (3rd edition). Ardmore, PA :Workbook Publishing.
- Kendall, P.C., Choudhury, M.A., Hudson, J., & Webb, A. (2002). The C.A.T. project manual. Ardmore, PA :Workbook Publishing.
  - For children 14-17
- Kendall, P.C., & Hedtke, K.A. (2006). The Coping cat workbook, (2nd edition). Ardmore, PA :Workbook Publishing.
  - For children 7-13

http://www.workbookpublishing.com/

Coping With Depression Tier 2 Class Design

- Clarke (1990)
  - 16 session group (4-8 participants with active depression or depressed mood)
    - Two 2-hour sessions per week for 8 weeks
  - Psychoeducational & cognitive behavioral intervention
  - Targeting youth 14-18 years old
  - Adapted from Adult Coping with Depression Course (Lewinsohn et al., 1984)

Coping With Depression (CWD-A)

- Lewinsohn et al. (1990)
  - 16 session CBT (CWD-A) **superior at post treatment** to waiting list control
  - Gains **maintained** at 24 mos (n=59, age 14-18)
- Clarke et al. (1999)
  - 16 session CBT (CWD-A) **superior to waiting list post treatment**
  - **Maintained** at 12 & 24 mos (n=123, age 14-18)

Coping With Depression (CWD-A)

- Rohde et al. (2004)
  - 16 session CBT (CWD-A) **superior at post treatment** to control non-therapeutic intervention for symptom reduction & improved social functioning
  - (n=93, age 13-17, comorbid MDD & CD)
  - No change in symptoms of CD
  - Significant differences **not maintained** at 6 & 12 mos follow-up

CWD-A

- Clarke, G., Lewinsohn, P., & Hops, H. (1990). Leader's manual for adolescent groups: Adolescents coping with depression course. Portland, OR: Kaiser Permanente.
- Clarke, G., Lewinsohn, P., & Hops, H. (1990). Student workbook: Adolescents coping with depression course. Portland, OR: Kaiser Permanente.
- Center for Health Research http://www.kpchr.org/public/acwd/acwd.html

CWD-A Skill Areas

- Mood Monitoring
- Social Skills
  - Opportunities to learn/practice social skills are interspersed throughout the program
- Pleasant Activities
  - To increase positive/social activities and decrease negative/punishing events
- Relaxation
  - To reduce stress associated with social & other situations & promote enjoyment

CWD-A Skill Areas

- Constructive Thinking
  - To address negative/irrational thoughts
- Communication
  - Feedback, modeling, & behavioral rehearsal to correct negative behaviors
- Negotiation & Problem-Solving
  - Define problem, brainstorm solutions, pick mutually agreeable solution, & plan for implementing agreement
- Maintaining Gains
  - Integrating skills, anticipation of future problems, maintain gains, create Life Plan, & prevent relapse

Trauma-Focused CBT

- Trauma-focused cognitive behavioral therapy (TF-CBT)
  - Child-focused
  - Parents included in therapy
    - Involving parents in therapy leads to significantly greater improvements in child's depressive & externalizing behaviors
    - Helps parents resolve emotional distress about child's trauma & optimizes ability to be supportive of child
  - Culturally sensitive
- Treating Trauma & Traumatic Grief in Children & Adolescents

Cohen, Mannarino, & Deblinger (2006)

Free online training at http://tfcbt.musc.edu/

Trauma-Focused CBT

- Cohen, Deblinger, Mannarino, & Steer (2004)
  - 12 session TFCBT for children with symptoms of PTSD who experienced sexual abuse superior at posttreatment to child-centered therapy treatment
  - Greater reductions in symptoms of PTSD & depression in children & symptoms of depression in parents (n=229, age 8-14)

Trauma-Focused CBT

- Cohen, Mannarino, & Staron (2006)
  - 12 session TFCBT for children with symptoms of PTSD who experienced traumatic grief
  - Compared to pretreatment, children reported significant improvements in symptoms of traumatic grief, PTSD, depression & anxiety at posttreatment; Parents reported significant reductions in symptoms of PTSD, internalizing, & behavior problems & their own PTSD (n=39, age 6-17)

Cognitive Behavior Intervention (CBI) For Trauma In Schools Tier 2 or 3

- Free programming and resources at : http://cbitsprogram.org
- School-based, group, and individual intervention
- 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

Cognitive Behavior Intervention For Trauma In Schools Tier 2 or 3

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

Cognitive Behavior Intervention For Trauma In Schools

- 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 for students from 5th to 12th grade 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

Trauma-Focused Components Of TF-CBT

- **P**sychoeducation & Parenting Skills
- **R**elaxation
- **A**ffective modulation
- **C**ognitive coping & processing
- **T**rauma narrative
- **I**n vivo mastery of trauma reminders
- **C**onjoint parent-child sessions
- **E**nhancing future safety & development

Grief-Focused Components Of TF-CBT

- Grief psychoeducation
- Grieving the loss & resolving ambivalent feelings
- Preserving positive memories
- Redefining the relationship & committing to present relationships

Related Service Needed?

- Behaviors that produce automatic reinforcement, i.e., are not socially mediated, require a treatment plan that may be a related service if there is an IEP

Examples: Non responsiveness to behavior supports may suggest the behavior requires another approach, history of trauma, general anxiety, social anxiety, depression, selective mutism, habit reversal needs (OCD, Tourettes,etc.) and so forth

Differentiating socially mediated from behaviors producing automatic reinforcement:
http://www.pent.ca.gov/mh/differentiatingbehavior.pdf

What About Services For Internalized Behavior?

- Tutorial on differentiating socially mediated from behaviors producing automatic reinforcement
  http://www.pent.ca.gov/mh/differentiatingbehavior.pdf
- Forms for a Protocol for Addressing Problem Behavior Resulting from Internal States
  http://www.pent.ca.gov/mh/protocolinternalstates.pdf
- Need to coordinate a combination of approaches? Behavior support, academic accommodations and mental health/counseling services?
  http://www.pent.ca.gov/mh/coordinationofplansMH.pdf

Disproportionality Prevention

- Donovan, M. S., & Cross, C. T. (2002). Minority students in special and gifted education. Washington, DC: National Academy Press.

"There is substantial evidence with regard to both behavior and achievement that early identification and intervention is more effective than later identification and intervention."

Executive Summary, p. 5
(Reschly)

What do we DO when explosions happen?

- PROMPT system (next ppt show) for socially mediated behaviors
- Personalized deescalation system (next ppt show) for emotionally driven behaviors

NOTE: Restrictive settings are appropriate for non-responders to Tier 1 and Tier 2 delivered with fidelity in order to deliver specialized instruction (see handouts)

THANK YOU!

Please visit PENT website for further assistance.

Diana Browning Wright, M.S., L.E.P.

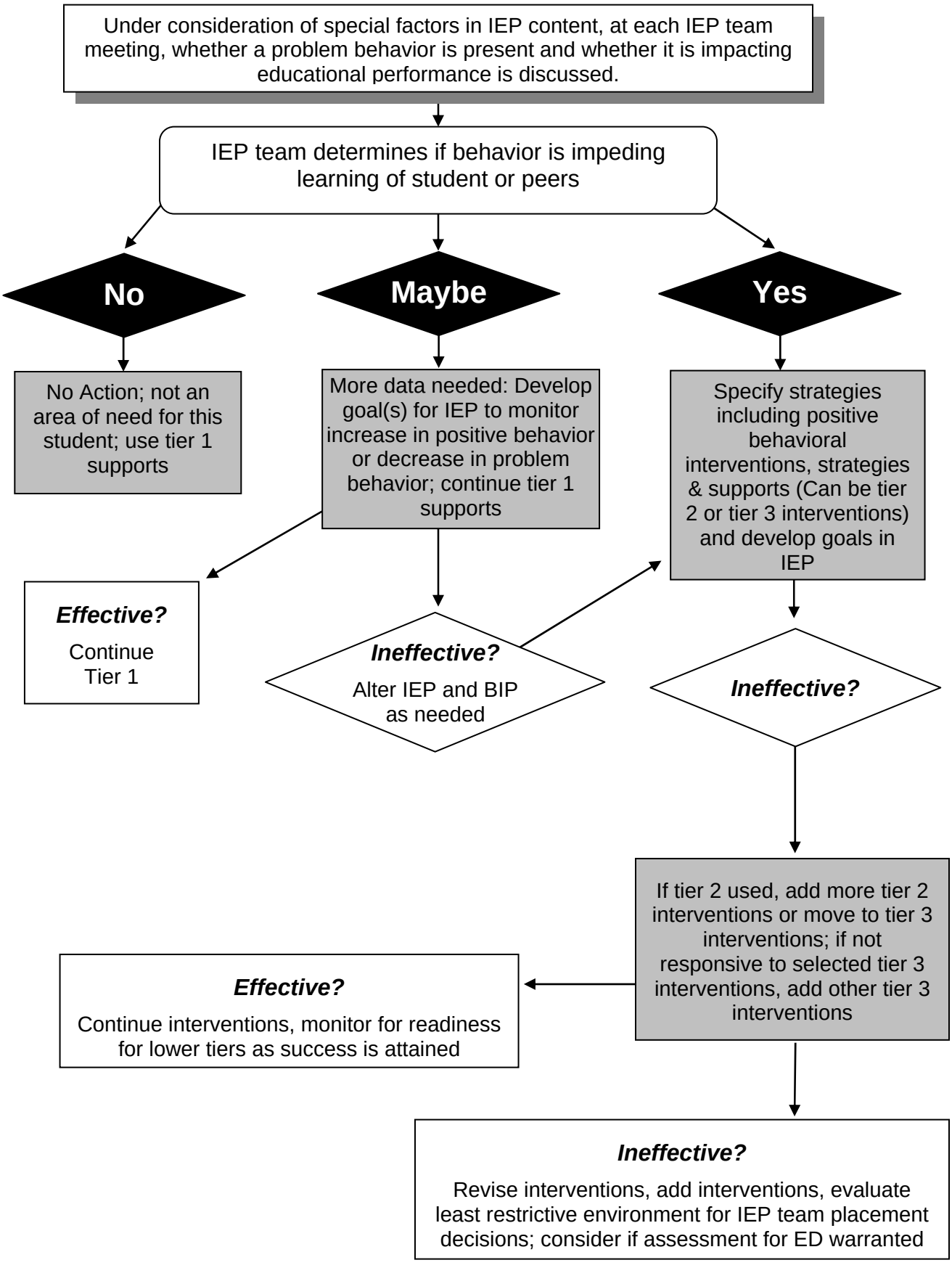
www.pent.ca.gov

www.dianabrowningwright.com

(626) 487-9455

Thank you for ALL that you do for students with poorly understood behaviors!

Behavioral RtI for Students with IEPs



Specially Designed Instruction and Related Services for Students with Emotional/Behavioral Disorders

Diana Browning Wright

Specially Designed Instruction

Legally specially designed instruction (SDI) is the content, methodology and instructional strategies unique to the individual with emotional/behavioral disability. If the student does not need SDI, then eligibility criteria for the disability has not been met.

In general these students have difficulty following adult directives, getting along with peers, modulating mood, managing real and perceived stressful events in their lives in order to thrive in school. This includes coping with heightened arousal from stress response, anxiety and fears due to self defeating thoughts and in general the interpretation of the world through a negative, defeatist lens rather than an optimistic, growth mindset.

The TIERS model classroom assures that all students receive the specific SDI that will allow the student to recover to the extent possible, from the symptoms that created the eligibility.

Content Components in TIERS programs include:

1. **Social Skills curriculum** that teaches acceptable ways to accept feedback, and other teachable skills that may not be in the students' skill repertoire.
    a. Skillstreaming, Boy's Town Social Skills Curriculum, Social Skills Improvement System are sample evidence based curricula.
2. **Social Emotional Learning curriculum** that teaches students how to cope with stress, and manage thoughts and feelings
    a. See: www.casel.org for evidence based SEL curriculum such as Second Step k-8, School Connect 9-12, The Ruler, Strong Teens, Strong Kids, Lions' Quest and others
3. **Physiology for Learning** that includes mood scaling, diet, sleep hygiene and stress management through mindfulness training
    a. Mood: See Subjective Units of Distress/Discomfort Scaling, (SUDS)
    b. Mindfulness: See **Mind-Up** for prek-8 and **Learning2 Breathe** for 9-12
    c. Sleep hygiene and diet: See sleep hygiene record keeping logs and health curricula for diet
4. **Self-Governance Circles** to provide the format for learning the social skills of complementing others, accepting complements, accepting and giving apologies

Methodologies and Instructional Strategies in TIERS programs include:

1. **An interval delivered point system** that gives feedback on full, partial and no success in general areas of safe, respect and responsible behavior as well as targeted individual goals.
2. **A daily contingent access to a honor's room/social laboratory** when 80% or better points are earned in order to practice social skills taught in class in the social laboratory, less structured environment.
3. **A three level system of motivation** based on increased success in meeting daily goals that includes honors outings in the community with continued success.
4. **A bonus point system** delivered within the interval to provide continuous positive feedback to motivate the student to continue with good behaviors up to the interval feedback session. This pays off in student store and can be used to gradually teach delaying of gratification through a banking system.
5. **Rigorous academics** tailored to specific skill deficits as well as common core instruction for grade placement delivered with high student engagement to prevent escape motivated behaviors.
6. **A systematic response to problem behavior, P.R.O.M.P.T.** that is linked to the point system based on solid relationships and a step-wise system of response for willful behavior.
7. **A personalized de-escalation protocol** for out of control emotionally driven explosions that uses collaborative problem solving to maintain safety.
8. **A 4 step reboot system** that does not include seclusion. This is as an alternative to suspension for most of the dangerous behaviors that would result in suspension of non-disabled students.

Related Services

Students with Emotional/Behavioral Disability may require related service(s) to benefit from their special education services. Related service providers may often be counselors, school or clinical service providers, behavior specialists, Marriage/Family Therapists, Licensed Clinical Social Workers and so forth.

When the student has not responded to the specially designed instruction, and an additional combination of behavioral contract, school home notes, and mentoring, the IEP team will meet to determine that next layer of intervention that will be delivered through providers. An IEP meeting can be called at any time to evaluate need for related services.

1. **For willful purposeful behavior** designed to get something or escape something, a FBA Functional Behavioral Assessment may be conducted by designated personnel to develop a Behavior Intervention Plan to examine replacement behavior instruction needs and other individualized positive behavioral supports. Often a behavior specialist will become involved in delivering supporting and supervising record keeping on replacement behavior training and consultation.

2. **For emotionally driven behavior**, a cognitive behavioral approach may be undertaken to provide measurable skill instruction delivered by one of the related service providers identified above.
3. **For storm and stress in the home** affecting social emotional wellbeing and academic engagement, related service providers may include parent supports, instruction and wrap around services in addition or instead of cognitive behavior intervention/therapy.

Three Approaches for Altering Behavior: *Socially Mediated vs. Emotionally Driven Behavior*

by Diana Browning Wright, M.S., L.E.P.

All approaches to address behavior strive to change how the student behaves by three methods:

1) altering what the individual does;

2) altering the "meaning-making" errors the student makes of environmental and social events, i.e., faulty thoughts; or;

3) altering how the person feels in response to environmental, internal, remembrance of trauma or current social events. The IDEA has emphasized the behavioral approach, whereas those providing related services have emphasized the thinking and feeling interventions for disturbed social emotional functioning.

DO: Functional assessment is used to determine how to change the behavior when "default behavioral interventions" (such as behavior contracts, mentoring programs, self monitoring, etc.) have not been successful.

Behavior analysis interventions alter what the student does, by manipulating antecedents and consequences so an acceptable behavior is used by the student to get his/her desired outcome and the competing undesired behavior is eliminated or reduced. Functional behavioral assessment begins the process of analysis, and behavior intervention and support plans outline the necessary changes. This approach is mandated for use in schools when students with IEPs have behavior that is a "manifestation of disability" following a manifestation determination meeting, as well as when a behavior "impedes the learning of the student or peers," and a determination of positive behavioral interventions and strategies must be considered to address the problem.

Functional assessment is used to determine how to change the behavior when "default behavioral interventions" have not been successful.

THINK: Cognitive behavior therapy addresses faulty processing. For example, students with emotional disturbance sometimes attribute "negative intention to neutral stimuli," e.g., "You hate me and want to put me down!" attributed to a staff member attempting to help the student correct a math problem, or "See how he's looking at me! He wants to fight with me!" attributed to a casual glance from a peer without the intent to fight. This approach is typically used when default behavior interventions and function-based behavioral interventions have not successfully changed the behavior. It is often considered a "related service" provided by trained implementers

FEEL: Medication, systematic desensitization and other direct treatments directly addressing feeling states are sometimes used with students whose anxieties or affectual disregulation impact their behavior. These direct treatments are provided by skilled implementers with specialized training, following evidence based treatment protocols. Medication is not provided by school districts, however systematic desensitization and other treatments can be provided as part of the education program for a student with an IEP if the team has identified an individual goal that needs to be met through this service.

Systematic Desensitization Procedures may mean different things to different people. It is NOT forcing a person to confront a stimulus. Systematic desensitization is a specific behavior therapy technique that breaks the link between the anxiety- provoking stimulus and the anxiety response. This treatment systematically exposes a feared or anxiety provoking stimuli in very small doses, allowing the person to cope with the internal state produced by the stimuli *slowly.* This technique is used in behavior therapy to treat phobias and other behavior problems involving anxiety. The client is exposed to the threatening situation under relaxed conditions until the anxiety reaction is extinguished *If you move too fast, or do not have adequate training or attempt this procedure not under relaxed conditions, the behavior can become much worse.* This treatment requires the patient to gradually confront the aversive or uncomfortable or fearful situation or object of fear. There are three main elements to the process. Do not use these procedures if you have not been well trained.

Examples of systematic desensitization gone wrong: A student with autism ran every time the school bell rang. The plan called for blocking him and holding "so he could get over the fear." (Non-systematic, non-relaxed condition, not in small doses or under his control to terminate). This resulted in hitting to escape, and school staff containing him near the bell, "so he could get over it." Staff holding a student in circle to "desensitize him to aversion to singing," and forcing a student to taste undesired foods "to expand the diet" are other examples of non-skilled erroneous intervention.

A hypothesized "self esteem deficit" is not a periodically occurring internal state fluctuation. Behavior therapy does not address "self esteem" directly. Through provision of a Tier 1 reinforcing environment and/or success in learning activities "self esteem" may be altered because mastery has been achieved.

"Self Esteem" is an abstract term not addressed in behavior analysis nor in behavior plans because it attempts to very indirectly affect behavior rather than focusing on direct behaviors to be taught and reinforced. There currently is no evidence based specific intervention to address self esteem for the purpose of altering behavior.

Treatment Protocols for Internal Functions may include:

- Medical Treatment (may include medications or titration of current medications) - Although medication or medical interventions do not significantly affect most behaviors, at times they do, and should be considered.
- Direct Mental Health Assessment and Services - Cognitive Behavior Therapy
  i. Externalizing: Aggression, such as "Coping Power" protocol (see references)
  ii. Internalizing: Anxiety, such as "Coping Cat"
- Family Therapy - Other direct treatment (see below)
- Direct Treatment: Systematic Desensitization Procedures - This treatment can be used for school and other phobias, school refusal, anxiety, heightened arousal due to touch sound or visual input, and for selective mutism.
- Altering or controlling antecedents to reduce occasions that trigger internal states (may be included in an accommodation plan) - Stimulus satiation - Environmental engineering - Altering stimulus control
- Altering consequences - Stimulus change following the behavior
- Direct Treatment: Teaching behavior modulation (reducing intensity and duration) - Feedback Systems - Relaxation, breath control - Anger Management
- Coping Strategies - Mindfulness Treatment

Does the behavior really need to be addressed?

Behavior plans in school need to be developed when behavior impedes learning of the student or his or her peers and other Tier 1 or Tier 2 interventions have not been successful. These are appropriate for behaviors which are externally motivated, and for which a functionally equivalent replacement behavior can be identified, taught and reinforced.

For behavior that serves an internal function, affecting quality of life or for medical reasons, treatment may be provided (see above) to reduce the negative impact, if any, of the behavior. If this behavior is to be addressed in school, the following guidelines may be helpful.

- Is addressing this behavior necessary for the student to benefit from the provision of special education? If so, the IEP team must consider "related services" to address the behavior. This may include medical services (for diagnosis only), mental health, occupational and physical therapy, speech and language services, etc.
- If the student does not have an IEP, and the school has determined that no disability is present, provision of treatment, if necessary, can be given as a general education service, if resources permit, e.g., school counseling. Alternatively, the school can refer the parents, at their request, to outside agencies or providers.
- For psychiatric conditions, e.g., selective mutism, separation anxiety, bipolar disorder, psychosis, etc., the primary treatment is mental health services. The school may, however, develop a treatment protocol to reduce the impact of behaviors associated with the disorder, and/or an accommodation plan that describes how the staff will respond to exhibited behaviors. These conditions require good home/school/medical management team communication to assure information flows smoothly between all parties. A case manager is required.

- For medical conditions, such as Tourette's Syndrome, repetitive behaviors such as tongue clicking, swearing, facial grimacing, touching others, etc. may occur. With Diabetes, disorientation may occur when blood sugar is low. With allergies, repetitive throat clearing or eye rubbing may occur. In Obsessive Compulsive Disorder, a strong drive to engage in a repetitive behavior such as pencil sharpening, using the bathroom, touching, etc. may be observed as the student attempts to address the underlying anxiety of a non completed ritual. These students may require accommodations outlined in either a 504 plan, or another accommodation plan to address negative impact of the condition on educational performance. See accommodation planning at www.pent.ca.gov. They will also likely require good home/school/medical team communication. Often a case manager is identified to facilitate this process. It is important to remember, however, that students with these conditions may be using behavior to achieve an external function as well and also will benefit from behavior plans with functionally equivalent replacement behaviors!
- For students with seizure disorders and migraine patterns, sometimes the approaching internal state results in a strong behavioral response, such as running around the room, hitting people, moaning, screaming and other behaviors not associated with environmental conditions or social interactions. The student knows the internal state currently being experienced will intensify as the condition advances. These students require staff to be able to "read" the purpose or function of their behavior. Under the condition of an approaching internal undesired event, the student may be unresponsive to supports that work under other conditions and require an accommodation plan.
- For medical conditions, such as encopresis (bowel movements, including persistent leakage/diarrhea in underwear after toilet training has been attained) and enuresis (bladder "accidents" after toilet training has been achieved) careful assessment is required. These conditions often have a purely medical basis (e.g., sequelae of an impacted bowel/constipation or parasites or of urinary tract or bladder infection). However, on occasion these conditions can also be indicative of a life trauma, or life transition or a more enduring problem, such as emotional disturbance. Determining the school based intervention will require careful assessment and rule out of medical reasons before other interventions are developed or assessment is conducted.
- For students with behaviors associated with attention deficit/hyperactivity disorder it is important to remember that not all of these students will require either an IEP or a 504 plan. Accommodations may be specified to address problems associated with the condition, if necessary, either as part of Tier 1/Tier 2 school interventions or as part of an IEP/504 plan. To require an IEP not associated with a learning disability, the student must need "specialized instruction in terms of content or methodology due to the nature of the disability" (i.e., special education for OHI, Other Health Impairment). PENT Forum 2009 Section 3 Page 10 of 28

For example, students with AD/HD often blurt out answers during a class discussion. Sometimes these behaviors are externally motivated, e.g., to get attention from peers and/or teacher. Sometimes, however, these behaviors are internally motivated, due to a heightened arousal and a short auditory memory span. The student blurts out because the thought will not be available when his or her turn finally comes. The motivation to speak under heightened arousal is great, and although the teacher may attempt to punish blurting out, it may not be effective in suppressing the behavior. This behavior is often seen when the student is engaged in social interactions as well. She may not wait her turn to speak, and may blurt out the comment, talking over her peers in response to an internal state. An accommodation plan as well as using more active responding techniques during class discussions, e.g. turn to your partner, etc., may not only reduce blurting, it may increase all students' active engagement!

Multi-Tiered System of Support for Behavior/Social Emotional Development

by Diana Browning Wright, M.S., L.E.P.

Tier I Behavioral RTI: Prevention
Expected Prevention Rate: 75-95% of students

Behaviorally Oriented Components	Emotionally Oriented Components
Positive Behavioral Supports, including 3 to 5 core rule continuous instruction, class-wide and school-wide reinforcement systems	Social Emotional Learning Curriculum (see: www.casel.org)
16 proactive classroom management components: (see below)	16 proactive classroom management components (see below)
Addressing physiology for learning: Sleep, exercise and diet	Addressing physiology for learning: Sleep, exercise and diet
Good Behavior Game (addresses deviant peer affiliation)	Mindfulness, Relaxation Training (Positive Psychology research)
	Optimism Training (Seligman)

The 16 Proactive Classroom Management Components

Each component has been independently validated as preventing problem behaviors and results in greater time devoted to instruction (TDI) and greater academic engagement time (AET)

BOC = *Primarily a behavior oriented component*
EOC = *Primarily an emotionally oriented component, increasing teacher/student bonding and creating a positive feeling about school*
BOC/EOC = *Both behavioral and emotionally oriented component*

BOC 1. **Classroom behavioral expectations are posted, taught, reviewed and known by every student.** *Students become clear on what desired behaviors are, and pre-correction prevents occurrences of problems*

BOC 2. **Transitions are taught and managed well.** *Problem behaviors occur in unstructured and lengthy transitions. When transitions are structured and short, problems are avoided.*

BOC 3. **Independent seatwork is limited for skill fluency practice and managed effectively when used.** *High rates of meaningless, boring and lengthy independent worksheet format skill practice produces an environment where protests are common.*

BOC 4. **Organizing a productive classroom (minimal effort to pay attention, easy flow in/out of room, optimal seating arrangement, limit distractions, etc.).** *Environmental structure has long been associated with greater on-task behavior.*

BOC 5. **Teacher mobility and proximity control is used (teacher does not stand in one spot. Keeps students alert by tracking the teacher and teacher uses proximity control as a method to redirect problem behavior).** *Students act out less when adults are more visibly monitoring their behavior.*

BOC 6. **A motivation system to reward desirable behavior is in place.** *Students come with a range of intrinsic motivation for a range of subject areas and activities. Reinforcement increases motivation to engage in less desired activities.*

BOC 7. **Goal setting and performance feedback is routine.** *Students are more motivated to stay on task and complete work skillfully if they have collaboratively set goals and received feedback.*

BOC 8. **Cuing systems to release and regain student attention and foster high student engagement are used** *when the teacher uses routines and gestures to gain and release attention, the students respond rapidly, decreasing lost instruction time.*

BOC/EOC 9. **Visual schedule of classroom activities is used.** *Knowing the schedule helps students understand what can be expected and helps with deficits in delaying gratification. For students with emotional issues, structures and routines help anxiety bind.*

BOC/EOC 10.**Teaching, modeling, and reinforcing desired prosocial classroom skills** (following directions the first time, actively listening, waiting patiently, sharing with others, accepting feedback, etc.) *Social skills instruction helps all students understand what produces payoff and thus alters problem behavior that occurs when the student tries to get payoff through maladaptive methods. For students with emotional issues, their self referencing, internal orientation can interfere with learning expectations, so specific instruction for the skill deficit is warranted.*

EOC/BOC 11. **Strategic establishment of positive relationships with all students in the class (teacher intentionally reaches out to each and every student to get to know them and learn about them)** *Students with emotional issues attribute teacher dislike, even when it is not true, and respond with either internalizing or externalizing behaviors. When a student is known by the teacher, that student is less likely to be impacted by negative peer affiliations, and individual behavioral compliance is easier to achieve.*

EOC/BOC 12. **Positive greetings at the door to pre-correct and establish positive climate occurs** *as with 11. Above, relationship building prevents problems and counters maladaptive faulty meaning-making about the teacher's approval of the student.*

BOC/EOC 13. **Competent communication with all students is observed (reprimands/corrective statements are delivered in a non-threatening way and reinforcement is specific and genuine***) Behavior problems escalate when unskillful correction occurs, and reinforcement has little effect when not genuine and specific. Students with emotional problems over respond to correction, and under respond to reinforcement when not competently delivered.*

BOC/EOC 14. **Providing students with numerous opportunities to respond to teacher questions (choral responding, random asking of students, etc.) and interact with classmates over learning content (pair-share).** *High student engagement results in less opportunity for behavior problems. High student engagement (behavior activation) for students with emotional issues prevents rumination and negative meaning-making and is a key for addressing anxious and depressed youth.*

EOC/BOC 15. **Five positive comments, gestures, and interactions to every one correction, reprimand, or negative interaction (5 to 1 ratio).** *This ratio has been extensively researched and proven to result in "behavior contrast" for rapid learning of expectations. Negative intention to neutral stimuli is a thinking component for emotionally driven problems; negative intention is harder to form in the face of unremitting unconditional positive regard.*

EOC/BOC 16**. Smiling and being nice Researchers have demonstrated that when someone smiles, "mirror neurons" are activated in the observer.** *Anger, fear and other emotions have difficulty when confronted with neuronal pathways from smiling. Rather than frowning back at problem behavior, adopting a more positive facial affect results in greater change than responding negatively. Negative behaviors are harder to maintain under the onslaught of positives!*

Tier II Behavioral RTI: At Risk Children and Youth

Expected Response Rate: 15-20% of students who are non-responders to Level One who have been identified by universal screening techniques

Behaviorally Oriented Components	Emotionally Oriented Components
Social Skills Small Group instruction (e.g., Skill Streaming, SSRS, Boys Town)	Social Emotional Learning small group instruction , e.g., Second Step, Lion's Quest (see: www.casel.org safe and sound doc)
Negotiated Behavior Contract	Negotiated Behavior Contract
Escape Card	Escape Card
Home School Note System with Task Based Grounding and Celebration of success	Positive Peer Reporting (nternalizers) See: www.pent.ca.gov pit crews)
Specific twice daily mentoring (check in/check out, BEP,	Specific twice daily mentoring (check in/check out, BEP,

check and connect, check and expect)	check and connect, check and expect)
Self Monitoring protocol	Self Monitoring protocol
First Step to Success (FSS) Kindergarten only	

Tier II Interventions can be either a related service or a school based intervention depending on whether the student has an IEP, and whether the provider is a related service provider. The critical difference between Tier II Interventions and the older models of service is the ongoing problem solving, daily and weekly aggregation of outcome data, and decisions made to continue, modify, bump up to tier three or fade back to tier one made on an every four week basis when the intervention has been consistently and accurately provided (i.e., fidelity is present.)

Tier III Behavioral RTI: Intense Needs

Expected Response Rate: All but the few students who need restrictive "off the pyramid" supports and structure will respond. Tier III is for students who did not profit from Tier II Interventions, or for whom individual specific disorders (e.g., separation anxiety, selective mutism, borderline personality disorder, etc. require direct specific protocols and individualized treatment plans)

Behaviorally Oriented Components	Emotionally Oriented Components
Functional Analysis Assessment/Functional Behavioral Assessment and Behavior Plan development with replacement behavior training	Cognitive Behavioral Therapy
Family Wrap Around and Parent Training	Dialectical Behavioral Therapy
	Other evidence based protocols for anxiety, depression and habit reversal needs

Observable Emotionally Driven Behavior in Children and Youth That Requires a Continuum of Care

by Diana Browning Wright, M.S., L.E.P.

Students' behavior that is suggestive of either mental health or social/emotional development problems requiring attention in school fall in two categories: externalizing and internalizing behaviors. Modern thinking suggests that these problems need to be addressed through a multi-tiered system or continuum of both behavioral and emotional supports, from what every teacher can do in the classroom to prevent problems from moving to disorders (Tier I), through what schools can do in default interventions (Tier II) through what can be provided on an individual basis in schools when problems have been treatment resistant and disorder is present (Tier III). At Tier III for emotionally driven behaviors, either existing district staff (counselors, nurses, school psychologists, social workers, clinical psychologists, MFTs) or inclusion of outside therapists privately hired by families, or outsourced with school district funding can be used to address the student's needs. Evidence based interventions that are 70-90% successful when implemented with fidelity exist, and are composed of specific small group and individual Cognitive Behavioral Therapy, Family Wrap Around Services, Dialectical Behavior Therapy and other evidence based treatment for emotionally driven behavior. Even for students with what had been viewed as intractable problems can in fact improve or eliminated their problems.

When a student is treatment resistant to behavioral approaches that reinforce desirable behavior, ranging from school wide and class wide Positive Behaviors Supports (Tier I), to individual contracts, mentoring and other evidence based default interventions (Tier II) to Behavior Intervention Plans (Tier III), the behavior can be viewed as not "socially mediated," in other words, behavior that occurs to achieve a desired result in the environment. Behavior Analysis is an important tool, but not the sole tool, to address problems. Automatic reinforcement coming from within can be the root cause of emotion-based problems and when behavioral approaches fail the school team will wish to consider this. Evidence based, emotional supports, interventions and direct treatment from specialized staff may need to be provided to address the problem. Even externalizing behaviors, most commonly treated with behavioral approaches, may need emotional treatment when trauma, depression, anxiety and other challenges to development have occurred in the past, or are currently occurring. Our more complex students will require a specialized content, methodology and instructional strategies in restrictive settings that emphasize stringent behavioral and emotional learning curriculum, as well as specialized emotional supports.

EXTERNALIZING BEHAVIORS

Externalizing behaviors are overt behaviors that are disruptive, distracting, and/or harmful to others. Students who exhibit externalizing behaviors are often well known by educators because they are most often 1) disruptive to the classroom learning environment, 2) verbally and/or physically aggressive toward others, 3) defiant towards adult authority, and/or 4) frequent and intense rule violators.

Observable Behaviors: Externalizing	Observable Behaviors: Not Externalizing
• Calling other students bad names	• Saying nice things to others or nothing at all
• Taking other students' belongings without asking	• Asking the person to borrow their belonging before using it
• Arguing or refusing to comply with adult requests or directions	• Follow directions the first time
• Disturbing others while they are working	• Working quietly while others finish their work
• Punching or kicking others	• Keeping hands and feet to self
• Blurting out answers	• Raising hand and waiting quietly
• Bullying others	• Respecting others
• Arguing	• Being agreeable

INTERNALIZING BEHAVIORS

Internalizing behaviors represent inner-directed emotional problems that result in behavioral problems because internal distress or discomfort to the individual manifests as problem behaviors following faulty thinking and feeling culminating in a maladaptive behavioral response. Unlike students with externalizing behaviors, students with internalizing behaviors often go unnoticed by educators because they can be docile, quiet, and not as overtly challenging to authority. The visible signs of a student with internalizing behaviors fall in five core categories: 1) withdrawal from social interactions, 2) seems tense or nervous when at school, 3) complains about being sick or hurt yet no medical reason supporting the complaint, 4) seems sad or unhappy, and 5) negative self-talk.

Observable Behaviors: Internalizing	Observable Behaviors: Not Internalizing
• Shy	• Interacts with others
• Spends time alone	• Spends free time with peers
• Seems nervous, fearful, or anxious	• Seems calm and relaxed
• Appears sad or unhappy	• Has a positive attitude
• Talks negatively about self	• Says nice things about self and others
• Disinterested in school	• Highly motivated in school
• Has pessimistic view about future	• Has an optimistic view of future
• Cries at inappropriate times	• Exhibits normal responses
• Easily frustrated and shuts down	• Perseveres through difficult assignment

Commonalities Across Emotional Disabilities or Problems, both Internalizing and Externalizing

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

What is Felt When Externalizing and Internalizing Problems Are Present:

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

Behaviors That Result From What s Felt:

- Escape/Avoidance Behaviors: attempt to remove contact with provocative stimulus
- Oppositional Behaviors: when forced to have contact with provocative stimulus
- Somatic complaints: headaches, stomachaches, muscle tension
- Physiological arousal: racing heart, sweating palms, teeth chattering, dizziness, flushed face, trembling hands

What is Thought by Anxious or Depressed Youth:

- Thinking Errors, faulty automatic negative thoughts
- Thoughts that do not appropriately match the context
- Anxious student - "If I leave the house, something bad will happen to my family."
- Depressed student - "Nobody ever wants to be with me."

Warning: The World Health Organization has reported that four of the ten leading causes of disability in the US and other developed countries are mental disorders. They also predict that by 2020, Major Depressive illness will be the leading cause of disability in the world for women and children.

Thoughts and verbalizations of depressed youth:

- General Pessimism: focusing on negative detail and selectively attend to it, so that ultimately the student's interpretation of everything that's happening becomes distorted; focusing on the negatives and ignore the positives and bigger picture
- Black and white thinking: Viewing things in polar opposites with no shades of grey (e.g., good or bad, safe or dangerous, clean or dirty)
- Negative self labeling: a global negative thought about oneself (e.g., I'm a failure.)
- Overgeneralization: Making global conclusions based on a single event: using words like "always" or "never" when the student describes it or thinks about it
- 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
- Believing you know others have a negative view of you: automatically assume that others are having negative thoughts about you without having any evidence for it
- Negative Predicting: 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
- "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

Goals for Internalizing Behaviors

by Diana Browning Wright, M.S., L.E.P.

Goals and Progress Monitoring

- Staff have difficulty writing measurable goals
- Goals for Socially Mediated behaviors are better understood than those for Emotionally Driven

Goal Writing: External vs. Internal

- Writing goals for socially mediated behavior
  - By when, who, will do what, under what condition, at what level of proficiency, as measured by whom and how
  - See Goal Manual on PENT website: www.pent.ca.gov in BSP Desk Reference, chapter 9

Goal Writing Internal Motivation

- Writing goals for emotionally driven behavior
  - Based on baseline data
  - Uses a variety of measures
  - Does not reveal confidential information
  - Must not be just what student does in therapy session; how does this reflect on behavior in the real world?

Writing Goals and Measuring Progress

- IDEA requires a statement of annual goals, including functional goals, designed to…
  - Enable the child to be involved in and make progress in the general education curriculum

  AND (this is a two part requirement)
  - Meet the child's other educational needs the result from the disability

  (34 CFR 300.320(a)(2)(j))

Draft per Need, Not per Service *(Commentary to the Federal Register)*

"The Act does not require goals to be written for each specific discipline (e.g., physical therapy goals, occupational therapy goals) or to have outcomes and measures on a specific assessment tool."

Functional Goals

"For some children, goals may be needed for activities that are not closely related to a State's academic content and academic achievement standards."

Required

- Measurable
- Annual
- Academic AND Functional
- Address Student's educational needs
- Enable participation and progress in general curriculum

(20 USC§ 1414(d)(1)(A)(I)(II))

Measurable Goal Elements

- By when?
- Who?
- Will do what?
- Under what condition?
- At what level of proficiency?

- As measured by whom and how

Steps

1. Identify the social/emotional need
2. Determine the baseline (present level of performance)
3. Determine acquisition rate (time) of what skill

If you have an RTI system, you are progress monitoring all interventions/services

Goals 101

Sample:

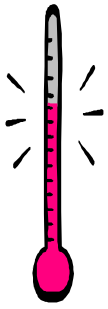
By June 6, 2013, Diana will obtain an average score of 5 or less across the last four data points, as measured by the Brief Behavior Rating Scale for anxiety symptoms completed by her classroom teacher on a weekly basis.

Choosing Three Methods for Evaluating Results

Must be capable of daily to weekly assessment of impact in the educational environment, and be composed of change sensitive items.

1. **Self Anchored Scales**
   - How to construct a self anchored scale (https://www.msu.edu/course/sw/850/stocks/pack/slfanch.pdf)
   - Google: Subjective Units of Distress Scale for a wealth of how-to's and research supporting use
   - Also See: The incredible 5 point scale
     - www.5pointscale.com
     - Google list following "incredible 5 point scale" for graphics

Building a Response Thermometer



10 - I need to escape NOW!

9 - I can't do this!

7 - Very hard, I think I can't do it

5 - Maybe I'm OK, maybe not

3 - A little worry

1 - Calm, cool, collected!

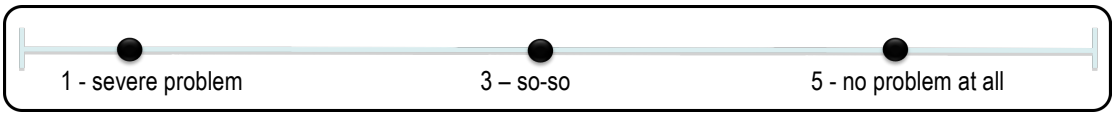
Subjective Units of Distress (SUDS)

SUDS	Description
0	You feel absolutely no distress. You are calm and relaxed. e.g., laying in the bath, having massage, watching a funny movie
25-49	You feel a *mild* level of anxiety but you can still cope with the situation. You might feel like you are more alert or a little nervous. e.g., athletes before a competition, speakers before a presentation
50-64	You feel a *moderate* level of distress that is becoming difficult to cope with. You might be distracted by the anxiety, or behaving in ways to avoid anxiety. e.g., avoiding eye contact, sitting quietly, but still attending to what's happening
65-84	You feel a *high* level of distress that is really difficult to cope with. You are more concerned with your anxiety and how to escape and less able to concentrate on what is happening around you.
85-100	You feel a *severe to extreme* level of distress and you think you cannot cope. Your body response is so overwhelming that you think you cannot possibly stay in the situation any longer.

Items from BASC Assessment for Self- Anchored Scale Progress Monitoring

- Look at "almost always" results from assessment, e.g.,
  - I get nervous
  - I worry but I don't know why
  - Etc.

  Make scales for frequency of worry, duration of worry, intensity of worry
- Create a self anchored "worry" (or other cluster) scale



2. **Selecting Progress Monitoring Tools: Brief Behavior Rating Scales**
   - Abbreviated rating scales that contain change sensitive items and assess particular domains of a student's emotional and behavioral functioning
   - Can be completed by observers (teachers, aides, specialists, etc.) daily, bi-weekly and weekly without compromising validity

   (Gresham, F. M., Cook, C. R., Collins, T., Dart, E., Rasetshwane, K., Truelson, E., & Grant, S. (2010). School Psychology Review, 39(3): 364-379.)
   - Select the brief behavior rating scale(s) that represent the main areas of concern for the student
     - Social skills
     - Depressive behaviors
     - Anxious behaviors
     - Disruptive/inattentive behaviors
     - Aggressive behaviors

3. **Global Measures of Functioning or Impairment**
   - Children's Global Assessment Scale (CGAS)
   - Child Adolescent Functioning Assessment Scale (CAFAS)

     FREE Student Life Satisfaction Scale (middle/high)
     FREE Center for Epidemiological Studies Depression Scale for Children (CES-DC)
     FREE Screen for Child Anxiety Related Disorders (SCARED)

Scales Your Staff May Already Have

- BASC II Progress Monitoring
- ASBA Brief Problem Monitor (BPM)
- Extract "almost always" items for scaling

Generate PM Graph

- Generate PM graph for each student to facilitate team-based decision making
- Construct an Excel Graph that computes trend line and effect size

Team Evaluates Graph

A. Increase fidelity of implementation
   - Data indicate poor fidelity of implementation' no decision can be made

B. Maintain existing supports
   - Data indicate student is responding well (likely to meet goal), but has not demonstrated sustained progress

C. Modify existing supports
   - Data indicate that student is making insufficient progress, but may respond well to a modification of the supports

D. Bump up a tier
   - Data indicate that student has failed to respond to the intervention (flat-liner) and is unlikely to respond to modifications of the existing tier of supports

E. Lower down a tier
   - Data indicate that student has responded well and sustained progress (minimum of 3 data points at or above goal)

CLASS-WIDE SYSTEMS TO CUE, SHAPE AND MODEL BEHAVIOR: STRATEGIES FOR TEACHERS

by Diana Browning Wright

The goal of the following classwide systems is to provide the teacher opportunities to ***shape, model and cue*** behavior, ultimately achieving rapid classroom behavior change. These behavior support systems for whole groups of students rely on three principles: drawing attention to rule-following behavior, enlisting students as providers of reinforcement for their peers, and utilizing naturally occurring classroom activities and/or privileges contingently. These methods rapidly help teachers achieve a positive classroom environment because they facilitate meeting the common needs of students of all ages: A***power, freedom, fun***, and a sense of ***belonging.***@ When these four needs are amply met, difficult behaviors become much less prevalent and individual behavior support plans much less likely to be needed.

Rainbow Club[1]

Each student in the class starts a time period (typically one week) with the first color of a six to eight color rainbow. This can be graphically presented in a wall chart or on a strip of paper posted on each student=s desk. As the week progresses, students earn additional colors. Teachers can hold up colors of the rainbow as they walk around the room as Acues@ for rule following and task completion behaviors. During brief free time activities either at the end of the day or interspersed throughout the day, students may engage in activities for which they have earned eligibility. Having a special payoff at the end of the week can also be useful. Students themselves can suggest the highest status activities for each step in the rainbow and can participate in classroom meetings to establish where new activities fit in the hierarchy. Be ready to alter the system if it is found that the most highly desirable activities are listed below level 3.

Sample:
Free Time Eligibility

1.	**Red**	free reading, notebook organizing, drawing at your seat, head start on homework
2.	**Orange**	all of **Red,** PLUS: board games, flashcard reviews in pairs, work on art project
3.	**Yellow**	all of **Red and Orange**, PLUS: checkers, mosaic work, feed animals, make a bulletin board design proposal
4.	**Green**	all of **Red, Orange, Yellow,** PLUS: chess, computer games
5.	**Blue**	all of **Red, Orange, Yellow, Green**, PLUS: office aide time, run errands for teacher, permission to eat food
6.	**Violet**	all of **Red, Orange, Yellow, Green**, PLUS: small group CD listening with headsets, dyad basketball (indoor trash can hoops), small group talking lying on the floor

Special Friday: Blue or Violet may use materials or watch a movie in the back of the classroom

Establish the Operating Rules

Tell the students: **"*If you ask for a card, or ask me to look at your behavior,*** (i.e., nagging) ***you can not earn a color. Think about what good students do.@*** The behaviors you are looking for should be prominently displayed in icons or words, or even on the students= desks on small reminder cards. (See attached samples.) Use statements such as, *I will be watching with different behaviors in mind for each of you, because each of us has different behaviors we need to work on.*

[1]The author has created this method as a positive alternative to a widely used punitive system in schools. In the punitive version, color cards are used as a response cost system whereby violations result in progressive consequences symbolized by movement from green to yellow to red.

Coaching the Student with Difficulties

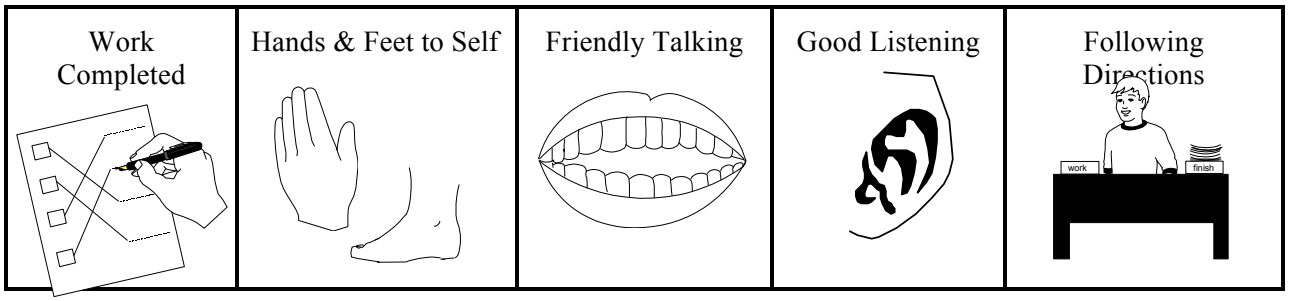
The most problematic students are the ones most in need of cuing with color cards, which become visual reminders of the need to follow rules. For example, take the student aside, confidentially inform him/her of the behavior(s) you will be looking for in the next 50 minute period, encouraging the student to show these behaviors. Walk around holding the array of color cards, looking questioningly toward the targeted student periodically.

Effective Use for Students with Difficulties

Remember: The program emphasis is on coaching a particular student on the specific behaviors he/she may want to perfect in order to advance a level in the next observation period, not on revoking status earned. One can, however, occasionally lower the student=s status as a result of misbehavior, but continual threats and demotions will not likely achieve desired results. Consider warning the student privately that he/she is at risk if improvement is not shown in the next work period. Then, if necessary, non-emotionally change the card to a lower status, and provide encouragement about the prospect of re-earning the level in the next one or two work periods. Your goal is to be able to use the color cards as non-verbal cues that signify a whole range of expected behaviors you are looking for, and to have all or nearly all students at Blue or Violet by the last free-time session of the week. Even your best behaving, most rule following students should be striving to attain Violet. As a general rule, no student should arrive at Violet before mid-point in your eligibility period. Also, if at the end of the eligibility period (e.g., the week) the most difficult students have not advanced to at least level 4 or 5, your system is not motivating the most needy. Consider appointing coaches to help these students advance during designated classwork periods. Alternatively, focus your efforts on actively coaching the student with difficulties on which specific behavior he/she should aim to exhibit in the next work period, then be sure to catch the student doing the desired behavior and advance him/her a level for that behavior. Be sure that the taste of success@ happens frequently for all students or you will have students who believe they can not be successful and therefore will sabotage the system.

Variation

If some student or group of students requires more frequent attention and reinforcement, consider an additional pacing/closure system. Place a small index card with lines that form five divisions on the student=s desk. Using a marking pen, place a mark in each division progressively as you circulate around the room observing desired behaviors. When the student has five clearly visible marks, the card is completed and can be exchanged for the next color he/she is working towards attaining.



"Slot Machine" Game[2]

Older students are often very responsive to opportunities for "taking a chance or taking a risk" as a reinforcer. This element is emphasized in a classroom-wide game.

Tickets are given frequently to students, paired with the appropriate social praise that specifically states which desired behavior earned the ticket and why. (e.g., "You raised your hand to say that, Josh, and waited until I could break to call on you. That really helps me keep the class focused.") One half of a two segment ticket is given to the student and the other half is kept for the up-coming drawing. These tickets can be easily made, or are available inexpensively through many theater supply stores, teacher supply outlets and catalog companies. When the selected time comes for a drawing (e.g., last 7 minutes of class), 4-5 different ticket numbers are pulled in turn. Each student with a winning ticket comes individually up to the front of the class for his/her moment of glory, choosing one of 4 to 6 upside down numbered cups on a table. Inside each of the numbered cups the teacher has placed a small strip of paper with a written description of the earned reinforcer. Potential reinforcers can be identified by students, then Xeroxed in list form. The list is then cut into strips with one reinforcer described on each coupon. Students must stay focused on the drawing because if their number is called and they need to come up to select a cup, they will not want to select one that has been already drawn. Initially the drawing should be held frequently, such as once per period. Potential reinforcers are only limited by the creativity of the teachers and students. A variety of privileges and contingent access to desired activities is suggested, as well as inexpensive tangibles. It is the opportunity to take a risk by selecting the cup that is most often the truly reinforcing element, not the quality of the earned privilege. Some commonly used reinforcers might include:

* free hamburger at McDonald's or other fast food restaurants (usually available at no cost to educators if the educator requests certificates for academic incentives)
* no penalty for one forgotten homework assignment
* a pencil, or no-cost pencil borrowing privileges
* right to be the first out the door for recess
* permission to leave class briefly for a drink of water
* do only odd-numbered math problems for homework
* 5 minutes free time with a friend of your choice
* 5 extra bonus points on a test of your choice
* no penalty for leaving class to retrieve forgotten items
* exchange seats with anyone for a particular work period
* drink of water anytime
* opportunity to be first out the door when bell rings

The class does not know which potential reinforcer from the longer menu will be placed under the cups. As each student is called to choose a cup, fewer and fewer cups with a reinforcer under them will remain. One cup can include a "gong" such as "Sorry, try again another day". This option would not typically be included for children under junior high age however. Older students usually find the opportunity to succeed at drawing a cup that does not contain the gong especially reinforcing, while younger children often find the "gong" a punisher. Students with fragile coping systems or low frustration tolerance or emotional disturbance may also not find the gong reinforcing.

[2] The author is indebted to G. Roy Mayer, Ph.D., Project Director of Constructive Discipline, an E.S.E.A. Innovative-Developmental Grant 1983, for initial descriptions of this system.

Ground rules are established so that students understand that tickets are not given to students who request them. The teacher silently holds up a ticket as a cue for rule following behaviors. The students come to understand that tickets will be given intermittently and that no one can predict when they will be given. Students then realize they should increase their appropriate behaviors to increase the likelihood of being "caught" doing the appropriate behavior. Frequently the class enjoys the activity as a whole and there is the laughter and social recognition for the person engaged in choosing the cup that might otherwise occur in a more negative manner. This activity gives students a sense of belonging to a group, having some ***fun***, gaining some ***power***, e.g., a privilege, and gaining some degree of ***freedom***, e.g., to use the reinforcer when desired. It is important for teachers to assure all students periodically receive tickets or negative results can occur. Once the class has developed a strong interest in the game, often drawings can be held as infrequently as weekly and still maintain the desired positive behaviors. Be sure to fade down to less frequent drawings slowly, however, in order to keep student motivation high.

The teacher can selectively reinforce each student for the particular behaviors that the specific student most needs to develop. For one student it might be arriving on time, for another very shy student speaking out in class might be the behavior most desired. It is important for many students to gain tickets prior to each drawing. To facilitate this process, some teachers have used a student or adult aide who has been trained to distribute the tickets with teacher cues. The teacher might signal, "Ticket," then verbally announce AJohn is following directions@ which provides the cue for the aide to walk over to give the ticket. Alternatively, the teacher might ask the aide to give 15 tickets or so throughout the lesson for "good listening during group instruction" or whatever a particular goal might be for the day.

Variations and Expansions

A rule can be instituted that further enhances the reinforcing quality of this system: The "winner" must retain the paper "coupon" to be cashed in when desired. Some students use their coupons at the first available time, while other students find simply storing up reinforcers satisfying. Having the student write his/her name on the back of the slip to avoid difficulties if it is either a lost or stolen is suggested for some groups of students with problem behaviors. Occasionally, a few students may even be observed giving their winning slips to others as a gift. This suggests that the coupon now is allowing the student to gain social recognition for his/her generosity. If the student enjoys the recognition, he/she will likely strive to earn more coupons in the future.

Frequency of giving tickets for appropriate behaviors can be varied independently of how frequent the drawings are held. Each student may have anywhere from one to ten or more tickets as he or she waits to hear the lucky numbers. Also, by watching students' reactions to the game and then asking them which reinforcers are enjoyed the most, it will be possible to identify the most potentially powerful reinforcers. It is possible to have students save their tickets from session to session, thereby increasing the students= perceptions that they may be a winner, or the teacher may elect to start with new tickets each session.

Some teachers find adding a class-wide consequence to be very effective. This can be done by having the slip of paper state the consequence such as: "Congratulations. You have won a Friday popcorn party for your class to be redeemed in the week of your choice." In this way social recognition/empowerment is earned for the student holding this coupon who must decide when to use it. Alternatively, some teachers have found that having a cumulative reward is helpful. For example, as soon as 400 tickets are earned by the class as a whole, the whole class will have a "good behavior" group surprise.

As with all effective classwide behavior programs, on-going modifications will be necessary to assure that the existing program meets the needs of the individual students and that the reinforcement needs of each student is identified.

Examples

This program has been successfully implemented in a variety of settings for a variety of purposes.

- ***Junior high "basic skills" math class:*** to increase homework completion and volunteering in class

- ***High school remedial history class:*** to increase homework completion and class attendance

- ***After -school tutoring program***: to increase both tutor and tutee coming on time, and for successful use of both listening skills (tutee) and reinforcing skills (tutor)

- ***A 6th grade class during sustained silent reading period****:* to increase reading a book continuously to completion, maintaining silence, quickly beginning to read, and other desired individual behaviors

Golden Nugget Club

The teacher spray-paints a large quantity of small rocks with gold paint. During Golden Nugget Time, the teacher walks around, holding small rocks in her/his hand, which are the cue for rule following behavior. The teacher silently hands a rock to students who are following some rule he/she observes. At the end of the golden nugget time, each student with a nugget stands up. The student then attempts to guess the rule he/she was following when the nugget was given. If the teacher decides that the guess was correct, the student gains another nugget. (Note: It is not necessary to keep track of why the nugget was given; the teacher can decide on the spur of the moment whether the behavior the student names is the one the teacher had targeted.) If the other students make validating comments such as, Way to go, Steve!, the student is authorized to place the nugget(s) in a small box at the front of the room. Some teachers encourage the other students to give the nugget-earner high-fives on his/her way to and from the box. If the student is earning praise from the group, a sense of belonging is enhanced and social prestige, ***power*** is earned, often powerful reinforcement for many students. When the box is full, the class as a whole earns something special, which the teacher has frequently advertised as the payoff.

Consider whole class pay-off activities, some of which the teacher would have done non-contingently anyway, such as : an art lesson, extended library time, extra in-class free-time, a craft activity, use of school carnival game materials typically stored away on campus, a field trip, extra recess, longer recess time, a popcorn party, video access, and so forth.

Variations

Any cumulative, visually observable item could be used by creative teachers for this system, such as: colored fall leaves to completely cover a tree; Styrofoam popcorn to fill a large box made in the shape of a movie popcorn bag, pretend money to fill a bank; small balls to fill an enclosed basketball hoop, a tagboard pizza with places to adhere the sticker pepperoni and so forth.

Keys to Success

Be sure that praise is given from students, not just from the teacher. Use the item as a non-verbal cue, i.e., hold it up and look around expectantly. Frequently give the item to a student with difficult behaviors at the moment he/she is doing something correctly; you are shaping behavior. Not only are you recognizing the student for his/her success, the student will also be getting social recognition from peers for rule-following behaviors when, later, he/she attempts to name the behavior that was being followed. Have a short list of rules prominently displayed in the room or at the students= desks from which the student can guess.

Team Basketball Competition

Announce that basketball quarter is beginning. Announce that as coach, there are certain behaviors you hope to see in the quarter: List 3-5 rules, desired behaviors, outcomes, etc. Walk around the room, stopping at work groups of 4-8 students. Quietly whisper which student at the table is following a rule. If the other students whisper back a group validation, "Way to go, Steve", "Thanks, John" or an equivalent statement likely to enhance a sense of ***belonging,*** then the teacher quietly places the small ball he/she is carrying in the bucket or small box on the table. Be sure that each table is continually earning balls, i.e., keep up the competitive element. Hold up the ball (**cue**) as you look around for the table group and student you wish to reinforce. This can be accomplished while the teacher is correcting work or assisting students as long as movement around the room is occurring frequently. Alternatively, an adult or student aide who has been coached on the procedure can distribute the balls while the teacher is busy helping students with seatwork. At the end of the basketball quarter, have each team count their balls. The top two teams then select one team member to represent the team. He/she then comes to the front of the room for a free throw play-off competition@. Standing behind a line, both students attempt in turn to make baskets in the trash can basket. Have the remainder of the students in the room count each shot out loud, A11111, 222222, 333333, etc. This keeps the focus of the whole group for this brief process. Typically, it is not necessary to provide any further reinforcer. Some teachers of elementary age students, at the end of the free-throws, have each of the winning team members give a high five to the losing team members, then return to their seat. High school teachers do not find this necessary or desirable. Teachers can choose to keep score of which team has the most points from day to day, if desired. It is important to assure that different students have opportunities to represent their group for free throws over time, and that the teacher makes sure the winning teams are varied from day to day. Also, be sure to have enough balls so that teams have at least 6 and up to 12 balls each.

Variations

Teachers have used small balls (nerf-ball soft 1" diameter are ideal), as well as crunched up pieces of paper. A small net laundry bag can be used to contain the balls by the dispensing party as he/she moves around the room, eliminating the need to continually return to a desk to get more balls.

Recommended Special Circumstances Resources

by Diana Browning Wright, M.S., L.E.P.

Need More Resources?
Bonus Intervention Leads

Check evidence based websites (see handouts) and
Check the following key materials:

Resources for School Practice

- Intervening in children's lives: an ecological, family-centered approach to mental health care
  - Thomas J. Dishion, Elizabeth A. Stormshak 0 Reviews
- American Psychological Association, 2007 - 319 pages
  Thomas J. Dishion and Elizabeth A. Stormshak family-centered, ecological approach, which engages children, adolescents, and their families.
- POSITIVE PARENTING PROGRAM (Triple P Parenting)
  - http://www.triplep-america.com
  - Psychologists, psychiatrists, and social workers working intensively with families presenting with multiple problems, are best suited to train in the Standard and Enhanced Triple P courses.
- LIVING WITH CHILDREN - *Gerald Patterson*
  - Shows how children learn behavior and how they actually train adults to behave. Written in a programmed format that makes learning quick and easy. Published by Research Press.

Screen for Child Anxiety Related Disorders (SCARED)

- FREE at: http://www.cebc4cw.org/assessment-tool/screen-for-childhood-anxiety-related-emotional-disorders-scared/
- The SCARED is a child and parent self-report instrument used to screen for childhood anxiety disorders including general anxiety disorder, separation anxiety disorder, panic disorder, and social phobia. In addition, it assesses symptoms related to school phobias. The SCARED consists of 41 items and 5 factors.
- Availability: Free for download on website:
  http://www.wpic.pitt.edu/research/AssessmentTools/default.htm A

CAFAS Child/Adolescent Functioning Assessment Scale

Caregiver Scale:

- **Material Needs** - Extent to which the youth's need for resources such as food, clothing, housing, medical attention and neighborhood safety are provided for
- **Social Support** - The extent to which the youth's psychosocial needs are met by the family

Youth Scale:

- **Moods** - Modulation of the youth's emotional life
- **Self-Harm** - Ability to cope without resorting to self-harmful behavior or verbalizations
- **Substance Use** - Substance use and the whether it is inappropriate or disruptive
- **Thinking** - Ability of the youth to use rational thought processes
- **School** - Ability to function satisfactorily in a group educational environment
- **Home** - Willingness to observe reasonable rules and perform age appropriate tasks
- **Community** - Respect for the rights and property of others and conformity to laws
- **Behavior Towards Others** - Appropriateness of youth's daily behavior

Special Circumstances Treatment: *Habit Reversal*

- John Piacentini
  Professor of Psychiatry and Biobehavioral Sciences at the UCLA School of Medicine and Director of the Child OCD, Anxiety, and Tic Disorders Program at the UCLA Semel Institute.
  http://www.semel.ucla.edu/caap
  http://tsa-usa.org/aProfessionals/ClinicalCouns/ images/Piacentin_4thIntl.pdf

Special Circumstances Treatment: *School Refusal and Selective Mutism*

- Christopher Kearney, PhD
  Professor of Psychology and Director of Clinical Training at the University of Nevada, Las Vegas. He is also Director of the UNLV Child School Refusal and Anxiety Disorders Clinic.
- See books, manuals, articles on internalizing protocols:
  http://faculty.unlv.edu/wpmu/ckearney/books-and-ordering-information/

Special Circumstances Treatment: *Suicidal Thinking and Self Injury*

- Matthew K. Nock
  Harvard University Director of Laboratory for Clinical and Developmental Research. A highly respected and prolific scholar in the area of self injury, suicide, and other topics; follow his work!
  http://www.wjh.harvard.edu/%7Enock/nocklab/publications.html
- Schools and Suicide Prevention Resources
  http://csmh.umaryland.edu/Resources/ClinicianTools/suicidepreventionresources7.pdf

Signs of Suicide (SOS) and Signs of Self Injury

- The SOS High School program is the only school-based suicide prevention program listed on the SAMHSA's NREPP (National Registry of Evidence-based Programs and Practices) that addresses suicide risk and depression, while reducing suicide attempts.
  http://www.mentalhealthscreening.org/programs/youth-prevention-programs/sos/

Other Training, Forms, Suicide Interviewing and Planning

- http://csmh.umaryland.edu/Resources/ClinicianTools/suicidepreventionresources7.pdf
- http://www.suicidology.org/c/document_library/get_file?folderId=235&name=DLFE-141.pdf
- http://www.livingworks.net/