37th ANNUAL DOOR COUNTY SUMMER INSTITUTE

"HIGH-RISK" STUDENTS: STRATEGIES FOR POSITIVELY INFLUENCING CHILDREN AND ADOLESCENT'S BEHAVIORAL, EMOTIONAL, AND SOCIAL NEEDS

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A copy of our slides can additionally be shared upon request following the workshop

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MONDAY – DAY 1

WHICH STUDENTS ARE "HIGH-RISK"?

1. **Students with Developmental Disabilities (e.g., autism)**

   - If educational plans and programs are not individualized and designed for effective learning and inclusion, we are at risk of "doing skills vs. building skills" for the students. The potential of *breeding* dependence has multiple costs.

2. **Students with Disruptive, Impulse-Control, and Conduct Disorders**

   - Many school-based discipline measures, if not designed to support the demonstration of adaptive alternative behaviors, often fall-short and contribute to persistent challenges.

3. **Students who experience Mental Health Disorders (e.g., Depression, Anxiety).**

   - If Social Emotional Learning is not effectively provided and generalization strategies not employed, students may experience increased emotional distress and be at much greater risk of academic failure and school avoidance.

4. **Students who experience Trauma and/or Bullying**

   - Research indicates that exposure to trauma and bullying has well-established detriments to the victim (and perpetrator's) social, emotional, behavioral, academic, and physical functioning, including increased risk for substance use and suicide.

5. **Students with Learning Disabilities and/or Neurodivergent Conditions**

   - Failure to adapt and modify instruction and/or address executive functioning deficits, place students with neurodivergent conditions at risk for long-term challenges.

6. **Students from Lower SES and/or begin school with little School Preparedness**

   - Research indicates students who begin school having 2000 to 3000 fewer vocabulary words than their peers are at-risk of reading comprehension difficulties and not finishing high school.

7. **Students who identify as LGBTQ+**

   - Students who are mistreated and stigmatized are at higher risk of emotional distress and suicidality.

NOTE: Many students experience multiple risk factors.

HOW SCHOOLS CAN MITIGATE CHALLENGES FOR "AT-RISK" STUDENTS
- A GENERAL OVERVIEW –

1. Establish a Positive School Culture and Climate

- Create a School Mission Statement along with policies and actions to achieve it
- Increase School-Connectedness
- Cultivate Parent/Caregiver and Community Engagement
  - See *Principal and Parent Involvement Checklists*
- Foster teacher Beliefs, Attitudes, and Practices to align with Mission Statement
- Establish a Culture of Team
  - Facilitate communication systems and avoid/overcome "Silos"
- Organize School Preparedness
  - Create an invited learning environment
  - See *Needs to Know Checklist*
  - Provide Staff Training for Crisis-Intervention
  - Set up Threat Assessment Teams and Practice Emergency Preparedness

2. Universal/School-Wide Interventions (Primary Prevention/RTI Tier 1)

- Principal Report Card on Creating a Safe and Inviting Learning Environment
  - Use of the School Climate Scale
- Establish a Trauma-Informed School
- Bully Prevention and Bystander Programs
- Character Education Programs

3. Selected Interventions for "At-Risk" Students (Secondary Prevention/RTI Tier 2)

- Establish and implement a process for identifying "High-Risk" Students (e.g., Child Study Team)
- Academic Intervention Support (AIS)/Homework Help/Peer-Tutoring
- SNAP Program (Stop Now and Plan) – Leena Augimeri
- Think First Program – James Larson
- "Lunch Bunch"/"Skill of the Week Program"
- Parent Support and Education

4. Indicated Interventions for Identified Students (Tertiary Prevention/RTI Tier 3)

- Special Education (IEP Services and 504 Plan Supports)
- Wrap-Around services involving family members and community agencies
- Behavior Intervention Plans
- Skill Building to develop *adaptive alternative behaviors*

Additional Resources:

www.melissainstitute.org www.promoteprevent.org/snapshots www.teachsafeschools.org

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EXAMPLES OF "TOP DOWN" EVIDENCE-BASED INTERVENTIONS

SCHOOL-BASED INTERVENTIONS

School Readiness Programs
Perry Point Preschool Programs
Bystander Intervention Training
Good Behavior Game
Promoting Alternative Thinking Strategies (PATHS)
Social-Emotional Learning Problem-Solving
School drop-out prevention programs
Programs/prenatal care for pregnant students
Head Start Programs
Anti-Bullying Programs
Positive Behavior Support
Peace Builders Program
Character Education Programs
After school programs
Lunch and nutritional programs
College prep programs - - One Goal

SCHOOL MENTAL HEALTH PROGRAMS

CBITS – Cognitive-behavioral Intervention for Trauma in Schools
Trauma-focused Cognitive Behavior therapy
Coping CAT for students with anxiety disorders
Courses in treating depressed students and preventing depression in high-risk students
Treatment for children whose parent suffers mental disorders, substance abuse, and violence
Student Bereavement Groups
New Beginning Program for students whose parents have recently been divorced
Students whose military parents have been deployed and/or returned injured

FAMILY-BASED INTERVENTIONS

Nurse-family home visitation program
ACT Raising Safe Kids Program
Triple P Program (Positive Parenting Practices)
Child-parent psychotherapy
Incredible Years Program
Home-school Liaison Programs
Parent Management Training (Use computer technology, see Jones et al. 2012)
Multi-dimensional Foster Care Treatment Program

COMMUNITY-BASED INTERVENTIONS

Civic engagement programs for students (Helping Others)
Reduction of the availability of guns
Medical Health Insurance for students
Income Supplement Programs
Earned Income Tax Credits (ETIC)

TECHNOLOGY-BASED INTERVENTIONS

Websites for students

www.au.reachout.com

Web-based treatments

www.melissainstitute.org/wp-content/uploads/2017/08/Dr.-Meichenbaum-The-Future-of-Psychotherapy-Using-Computer-Technology-and-Social-Media.pdf

A "BOTTOM'S UP" LIST OF BEHAVIORAL INFLUENCE "KERNELS"

ANTICEDENT-BASED INTERVENTIONS

Post reminders and signs ("Bully-free Zone").
Post school's Mission Statement.
Post Classroom Rules and refer to them often.
Post daily, weekly, and monthly schedules on a regular basis.
Post reminder signs of GOAL, PLAN, DO, CHECK.
Include displays and pictures of the school's accomplishments (Reinforce concept of being a member of the school community).
Use non-verbal cues (Teacher turn off and on classroom lights, buzzer to note transitions).
Use Advance Organizers when giving instructions (An overview of what is going to be taught and why).
Use Informed Instruction (How does the present lesson follow from previous lessons and where is the present lesson headed? State explicitly the learning objectives. *"When this lesson is completed you will be able to understand or do the following"*.) Instructions should include a beginning, middle and end statements.
Use "soft" reprimands (Be close by the student, use name and gentle reminders).
Use non-verbal reminders (hand or facial signals with students).
Use cue-cards and place them on student's desk (Behavior Chain Analysis). For example, SLANT which stands for "Sit up, Listen, Ask Questions, Nod, Track the speaker".
Reduce distractions.
Use video self-modeling film of a behavioral sequence.
Use visits to new school settings (transitions from elementary to middle, or middle to high school). Address anticipatory uncertainty.
Practice skills ahead of time (fire drill and lock down practices).

CONSEQUATING DESIRED BEHAVIORS

Use verbal praise for effort, not just for product.
Use overhead compliments.
Use peer-to-peer praise notes.
Use prize bowls ("mystery" rewards) in classroom and in afterschool settings.
Use Principal lottery (Spend special time with person of status).
Use "active" time out procedures.
Use response cost procedures.
Use overcorrection or positive practice.
Use public posting of student's work.
Use public posting of the class accomplishments.
"Catch them being good" and acknowledge using metacognitive action verbs when praising. *("I notice you were using your plan... You caught yourself. You backed off."*)

CHANGE BEHAVIORAL ROUTINES/SCRIPTS and MINDSETS

Assign students meaningful helper roles.
Have students engage in civic activities (help others).
Use team-based cooperative activities.
Use peer teaching (Put students in a consultative role).

Use bystander interventions (Change social norms - - “Golden rule”).
Use choral responding.
Elicit commitment statements (“If … then” rules and “Whenever … if” rules).
Have students fill out planful statements and behavioral scripts.
Challenge student. For example, beat the clock, buzzer
Have students self-monitor (Use a Behavioral Checklist).
Have students journal, create a playbook, keep progress notes, track changes.
Use story-telling (metaphors, analogies) to teach routines and educational content (“Turtle technique”).
Use direct instruction procedures
Use discovery-based learning (The “Art of Socratic questioning,” highlighting “What” & “How” questions)
Tap the process of student’s thinking (“*Walk me through how you chose that answer*”).
Model thinking – Use “think aloud”.
Have students use self-modeling procedures (video demos).
Use the language of “becoming” and “possibilities” (“*As yet*,” “*So far”*).
Use Motivational Interviewing Procedures – help student discuss topic that they usually
avoid in a non-challenging manner (Express empathy and develop discrepancies of the way things are and the way they want them to be. Avoid argumentation and support self-efficacy).
Use RE-verbs, (RE-do, RE-program, RE-learn, RE-connect, RE-silient, RE-bound, RE-think, RE-write).
Convey a “growth” mindset of the possibility of incremental change, as compared to an “entity”
mindset (little hope for improvement). Convey that you can teach students the “tricks” and “strategies” that successful students use to perform such tasks. (See Dweck, 2008).
Use examples that “destinies are malleable”. Stories of how students have “beaten the odds”
and overcome adversities. Use Mentors.
Bolster students’ school connectedness. Ask students the following questions:

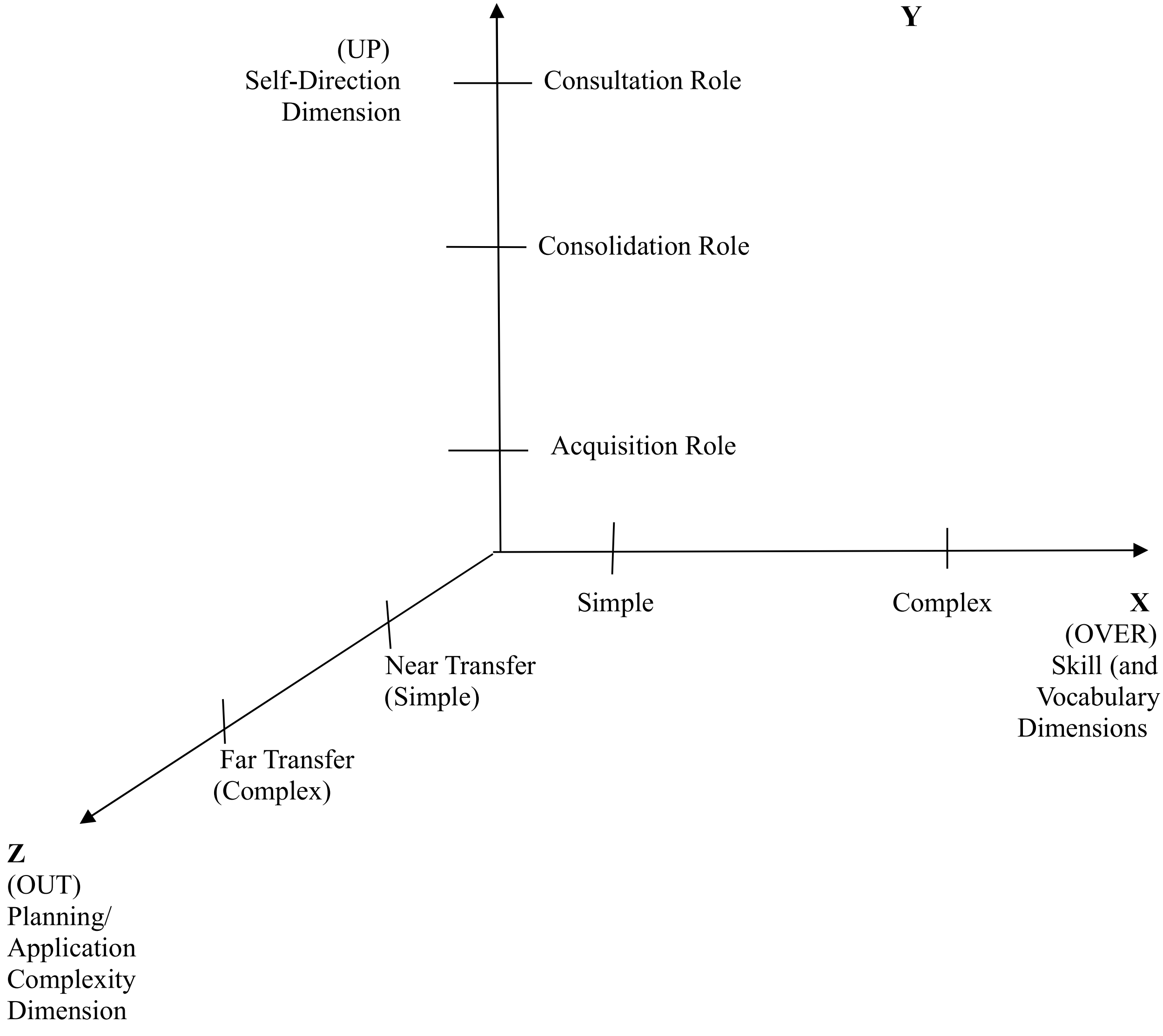
“If you were absent from school, who besides your friends would notice that you were missing, and would they miss you?”

“If you needed help from someone in school, who besides your friends would you go to for assistance?”

Encourage students to view themselves as “Peace builders”.
Provide students with Metacognitive Prosthetic Devices (MPD’s) (Memory prompts, instructional
reminders, organizational supports, time management routines, study habits). Ways to support the Prefrontal Cortex of executive skills.
Use metaphors, “Tool box”. “Traffic control center for the brain”. “How to CBT themselves in
the moment” (CBT= Cognitive behavior therapy). “Use rules for yourself”. “How to talk back to your amygdala” (part of brain in charge of emotions). “Use uh-oh response”. “Go off auto-pilot”. “Avoid mind traps”. “Play detective”.
Implement programs that encourage group support - - use of study groups.
Encourage students to hang around with the “Right” people. Discuss the concept of “Right” people.
Encourage key abilities of grit, curiosity, conscientiousness. Learn the difference between
wanting something and choosing it. Bolster self-confidence.
Have students “take credit” for improvements (Self-attributional training).
Provide resilience training. ***See Meichenbaum (2012) www.roadmaptoresilience.org***.

WAYS TO IMPROVE ACADEMIC PERFORMANCE

FIGURE 5:1 The Three Dimensions of Mastery



For a math article that discusses the application of the 3-Dimensional Model visit https://melissainstitute.org/skills-self-direction-and-applications-for-better-math-instruction/

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TUESDAY – DAY 2

KEY CONSIDERATIONS FOR EFFECTIVELY INCLUDING "HIGH-RISK" STUDENTS

The need to educate all students in the least restrictive environment (LRE) is not only law (IDEA), but also, effective placement in an LRE can be vital to a student's development. Successful inclusion, particularly for individuals with intellectual/developmental disabilities (I/DD) and/or emotional and behavioral disorders (EBD), requires more than just the provision of educational accommodations and common supplementary aides and services. There are a series of additional considerations necessary to ensure best placement, address challenging behaviors, nurture independence, and foster generalization.

A. INCLUSION OR EXCLUSION: CONSIDERATIONS FOR DETERMINING THE MOST APPROPRIATE SETTING

- I/DD and EBD exist along a broad continuum of functioning levels; thus, it is impossible to identify a one-best educational plan, setting, or accommodations based on diagnoses/educational classification. School placements can vary widely and dimensionally from:
    - General Education vs. Special Education
    - Inclusion vs. Exclusion
    - With or Without Aide Support

- Understand the unique needs and abilities of each student. Utilize measures that will help prompt necessary and relevant information. For example, Classroom Survival Checklist (Vincent et al., 1980), School Function Assessment (Pearson Education, 2008), Needs to Know Checklist (attached).

- Every child needs to be stimulated/engaged. If they are not engaged by the environment, we will be leaving it to the student to create their own stimulation and engagement. This can result in an increase in disruptive/ problematic behaviors.

- Special area subjects (e.g., PE, Library, Music, Art, etc.) require the demonstration of *special* skill sets. Like the development of math, reading, and writing skills, there are ways to teach and encourage the skills that will allow for more success in special area classes (e.g., attending to group-based directions from 40 ft across a gymnasium; sitting quietly and attending to a story in library; standing on risers next to peers in music).

- If the purpose of inclusion is beyond the learning of the educational content, clarify the individualized goal of inclusion (e.g., increasing participation, adherence to class rules, or socialization) and develop a plan that embraces a *laddered* approach to skill building.

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B. REDEFINE CONSEQUENCES: CONSIDERATIONS & STRATEGIES FOR REDUCING CHALLENGING BEHAIVORS

6 FACTORS CONTRIBUTING TO THE PERSISTENCE OF CHALLENGING BEHAVIORS

1) MISUSE OF CONSEQUENCES

- If the purpose of school- and parent-issued consequence is to change problematic behaviors, there is need to re-consider the consequences that are repeatedly administered.

  Key Consideration: *How will these consequences not need to be administered in the future.*

- Many conventional/traditional school and parent-based responses to challenging behaviors fail for individuals with I/DD or EBDs.

  Key Consideration: *Every challenging behavior is occurring because a more appropriate behavior is not. Why is the more appropriate behavior not occurring?*

- For individuals with I/DD/EBD a more appropriate behavior is not occurring due to:
  - **Skill Acquisition Deficits:** *Can't do skill b/c it is not part of behavioral repertoire.*
  - **Skill Fluency Deficits:** *Not sure where to do the skill b/c of lack of awareness.*
  - **Skill Performance Deficits:** *Won't perform the skill b/c they do not see the relevance.*

2) AVOIDING THE DEVELOPMENT OF ADAPTIVE ALTERNATIVE BEHAVIORS

- Focus is often on the risk-reduction of maladaptive behaviors by trying to avoid triggers and minimize agitation in response to early warning signs (e.g., relinquish items, remove demands, reduce expectations, tolerate/ignore). While effective in the short-term, this can lead to adults *walking on eggshells* and passing challenges on to next year's team.

- Differentiate between Unaccommodating and Accommodating Accommodations. Unaccommodating accommodations are designed to get the student and staff through the moment, without consideration as to how that accommodation may not be needed in the future. See Assessment of Accommodations (attached).

- In working on IEP goals, do not ignore the importance of one's Individual Life Plan (ILP).

  Key Considerations: *Every prompt/accommodation is b/c the student is not demonstrating a skill. The most distinguishing difference between* ***Doing vs Building a Skill*** *is whether we have an exit strategy/plan. In other words, how will we not need to provide the same level of prompting and accommodating next week, month, or year from now?*

- When needed, establish an Individualize Independence Plan (IIP) to reduce adult support and foster independence.

3) INADEQUATE DEVELOPMENT OF ADAPTIVE ALTERNATIVE SKILLS

Key Considerations for Building Adaptive Alternative Behaviors:

i. Name the Behavior that is Not Occurring.

- The most important question to ask is ***"What behavior is not occurring?"***
- Consider why the more appropriate behavior is not occurring.

Skill Acquisition Deficits	(*Build it*)
Skill Fluency Deficits	(*Show it*)
Skill Performance Deficits	(*Encourage it*)

ii. Address Skill Acquisition Deficits

- To combat skill acquisition deficits there is need for skill building.
- Understand the advantages and limitations of providing skill-building through pull-out services. Pull-out services can be effective to address skill-acquisition deficits, but not fluency/performance deficits.
- Do not take skill demonstration for granted. Task-analyze the adaptive alternative behaviors ala Skillstreaming (Ellen McGinnis www.skillstreaming.com).
- Increase practice and rehearsal. Build skills when calm.

iii. *Address Skill Fluency Deficits*

- To combat skill fluency deficits there is need to increase student awareness and understanding of instances where skills are expected. Help student notice the contextual indicators.
- Move from 8:15 (i.e., 8 adults responding to a behavior challenge in 15 different ways) to 10:1 by naming the adaptive alternative behavior and having a consistent plan of how to respond.
- Front-load for success (think-ahead) and be a *moment seizer.*
- Clarify x 3 (expectations, criterion, and outcomes).
- Be consistent not tolerant.

iv. *Address Skill Performance Deficits*

- To combat skill performance deficits there is need to increase the relevance for an individual to demonstrate the adaptive alternative behaviors over their well-ingrained functional behaviors.
- The second most important question to ask is ***"Why should they do the more appropriate behavior?"***
- Differentiate between Reinforcement vs. Bribing. A reinforcement plan clarifies expectations and outcomes ahead of time for staff and student and includes a plan for raising expectations and fading reinforcement.
- Clarifying outcomes ahead of time, allows for strong-willed students to self-determine whether they get access to meaningful privileges/undesired outcomes.
- Teach in a manner so child cannot fail (*Tilt the balance*). Embrace behavioral shaping.
- Move towards naturalistic reinforcement by teaching Social Thinking (Michelle Garcia Winner – www.socialthinking.com) and/or using the principles of Motivational Interviewing

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4) FAILING TO ADDRESS NEGATIVE THINKING

- Individuals who become angry, irritable, anxious, or sad, tend to have negative thinking tendencies (e.g., binocular thinking, fortune telling, discounting positives, blaming self/others).
- While breaks and distraction can be helpful, these responses will be limited if they don't change how a student negatively perceives a situation or themselves.
- Thoughts and feelings play a role in all students' behaviors, not just those who can clearly communicate. Thus, there is need and ways to adapt CBT-type strategies for individuals with I/DD and/or who may be concrete thinkers.
- Utilize strategies to build more positive thinking, such as:
  - Label emotions and validate experiences to increase emotional awareness.
  - Make and 'bank' positive concluding statements.
  - Check and reflects/*Consider the facts*.
  - Create social stories and scripts to embed positive thinking.
  - Build predictable responses to unpredictable events (address intolerance of uncertainty).
  - Teach positive rethinking skills (e.g., Flip It and self-reassurance).
  - Model positive responses.

5) FAILING TO PLAN FOR GENERALIZATION

- Increase team communication and awareness of skills being developed.
- Clarify the roles and responsibilities of staff members.
- Transition from discrete trial/embedded instruction to incidental and generalized instruction.
- Increase student's awareness of their goal as student's can't change what they are not aware of or want to change (i.e., Clarify x 3).
- Highlight positive skill demonstration of others to serve as exemplars.
- Identify a generalization plan (e.g., "Skill of the Week" for student and team).
- Discuss and anticipate potential barriers before it fails.

6) FAILING TO EVALUTE EFFECTIVENESS OF ALL INTERVENTIONS

- Adopt simple evaluation methods to allow for on-going progress monitoring. Ask what do we expect to increase and decrease as a result of the *next* intervention?

  Key Consideration: *Despite our understanding of the literature and best-practice, our years of experience, our success in working with previous students, the very next thing we do for our very next students is a guess. There is need to determine if we guessed right.*

Needs To Know Checklist

A Service Preparation Checklist for Working with ASD

- ❑ Will you be working with a student who has an Autism Spectrum Disorder (ASD) during the upcoming school year?

This list highlights important areas to consider in preparing to work with a child with an ASD. Considering these items prior to meeting/working with a particular child will facilitate the child's transition into his/her new educational setting. Any items unchecked should be considered as soon as possible.

- ❑ Do you understand the nature of the child's disability (e.g., features and characteristics impacting learning)?
- ❑ Are you aware of the child's primary mode of communication? Can you communicate in that manner?
- ❑ Is the child able to convey his/her wants and needs for assistance/help?
- ❑ Do you know how well the child comprehends verbal-language?
- ❑ Are you aware of the child's social interests and interaction abilities?
- ❑ Is the student able to appropriately fulfill leisure/social time (e.g., lunch, free play, recess, before/after school)?
- ❑ Does the child have sensory sensitivities? (tactile, auditory, olfactory, visual, vestibular, other)
- ❑ Does the student have any self-stimulatory behavior? Do you know in which circumstances it is most likely to occur?
- ❑ Is the child able to respond appropriately to unexpected changes in routine?
- ❑ Are there any medical/sleep concerns? Are there any diet restrictions?
- ❑ Are you aware of the child's self-care abilities (feeding, hygiene, toileting, dressing, cleaning up)?
- ❑ Is the child able to manipulate all school objects independently (e.g., locker, book, pencil, scissors, etc.)
- ❑ Is the child able to navigate and transition themself through school without assistance?
- ❑ Do you know if the child is able to independently follow classroom/school routines?
- ❑ Is the child able to differentiate between safe and dangerous and know how to respond in an emergency?
- ❑ What factors facilitate and decrease the child's attention?
- ❑ Have you reviewed the student's IEP?
- ❑ Has last year's team shared information, materials, etc.?
- ❑ Are you familiar with all of the student's learning accommodations?
- ❑ Do you understand the gap between the child's abilities and your/family/district/state expectations?
- ❑ Have individualized learning objectives been identified?
- ❑ Have adaptive teaching methods been developed? What do they involve?
- ❑ Have means been developed to monitor progress?
- ❑ Do you know who the professional and related-service providers are?
- ❑ Does the student have an aide and has the aide been identified? Trained?
- ❑ Do all team members understand their responsibilities?
- ❑ Has a team meeting been scheduled to discuss the child?
- ❑ Are you familiar how the child conveys and responds to frustration?
- ❑ Is a behavior intervention plan necessary? Does a behavior intervention plan already exist?
- ❑ Is staff trained to implement, if necessary, crisis/physical intervention?
- ❑ What is the child's preferred mode of reinforcement? How frequent?
- ❑ What are the child's areas of interest?
- ❑ Have you consulted with his/her parents?
- ❑ Is the child engaging in any treatments/therapies outside of school?
- ❑ Has means been established to communicate btw home and school about the child's progress and challenges?

ASSESSMENT OF ACCOMMODATIONS

(1) Consider and list the various daily accommodations/supports that you provide your child/student.
(2) Each accommodation you are providing is necessary because some other skill is not occurring. Indicate what the other skill(s) is that needs to be developed.
(3) Identify whether that other skill is a necessary skill for the child to possess to be successful in their Individual Life Plan (ILP).
(4) Note whether a plan is in place or has been considered to build that skill.
(5) Indicate if you are providing an unaccommodating accommodation (UA) or an accommodating accommodation (AA)

UA* = *YES *Necessary Skill* **+ *NO*** *Plan*
AA* = *YES *Necessary Skill* **+ *YES*** *Plan*

ACCOMMODATIONS/SUPPORTS (1)	WHAT SKILL(S) IS NOT OCCURRING? (2)	Necessary Skill for ILP? (3)	Is There a Plan to Build Skill? (4)	UA or AA (5)
1.		Y N	Y N	UA AA
2.		Y N	Y N	UA AA
3.		Y N	Y N	UA AA
4.		Y N	Y N	UA AA

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RESET

1. **NOTICE** it is time to RESET because I am upset
   → My teachers/parents can let me know
   "<Child Name>, It's time to Reset."

2. **STOP** what I am doing.

3. **HANDS TOGETHER**

4. **TAKE A DEEP SLOW FLICKERING BREATH**

5. **SLOWLY COUNT TO 10**

6. **WHEN CALM LET MY PARENTS/TEACHERS KNOW "I'M SET"**

7. **PROVE MYSELF**
   → **Stay calm and follow rules for next <u>2</u> minutes**
   - *Keep calm body*
   - *Follow directions*
   - *Have quiet voice*
   - *Stay in area*

8. **CELEBRATE** because I **RESET**

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RESET

1. **NOTICE** I need to ***RESET*** because I am feeling
   - If I don't recognize I am frustrated my teachers/mom can let me know "<Child's Name>, it's time to ***RESET.***"

2. **STOP** and take a deep breath and
   THINK BEFORE I ACT

3. **THINK** about the consequences if I do not ***RESET***
   - ***Am I going to get in trouble?*** *If YES, then I better RESET*
   - ***Am I going to feel regret/embarrassment?*** *If YES, then I better RESET*

4. **CONSIDER** my choices about how to ***RESET:***
   - ***Request a short break*** from the situation

   - ***Make an appropriate complaint*** *(quietly and privately)*
   - ***Ask for help***
   - ***Distract myself*** with a RESET activity
   - ***Rethink the situation/***FLIP IT

5. **CHOOSE** my best choice(s).

6. **LET MY PARENTS/TEACHERS KNOW** that I am calm by stating
   "I am RESET"

7. **PROVE MYSELF** by staying calm and following class/house rules for the next 5 mins.

8. **CELEBRATE** for demonstrating my goal of ***RESETTING***

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Daily Report Card

Name: ________________ **Date:** ______________

Subject	**Acts Respectfully:** X or fewer instances of tantrums, talking back, or complaints.	**Friendship** X instances of being a friend	**WOW!** Demonstrates *"Let It Go"*
	Yes No	**Yes No**	
	Yes No	**Yes No**	
	Yes No	**Yes No**	
	Yes No	**Yes No**	
MORNING SUCCESS RATE: ______________			
	Yes No	**Yes No**	
	Yes No	**Yes No**	
	Yes No	**Yes No**	
	Yes No	**Yes No**	
AFTERNOON SUCCESS RATE: ______________			

PRIVILEGE CHART

LEVEL	**SUCCESS RATE**	**REWARD**
Honor Level	100%	*<Insert Reward + Bonus>*
Level 1	85%-99%	*<Insert Reward>*
Level 2	70%-84%	*<Insert Status Quo/None>*
Level 3	Below 70%	*<Insert Mild Consequence>*

NOTES/COMMENTS:

____

____

DAILY PROGRESS NOTE

Name: ______________ **Date:** _____________

SUBJECT	**FOLLOW CLASS RULES** X or fewer reminders for violating class rules (List)	**FOCUS** Correctly answer 50% of attention questions asked during the class	**WOW MOMENTS!** Student demonstrates Skill of the Week or a Prior Skill of the Week.
<List subject>	**Yes No**	**Yes No**	
<List subject>	**Yes No**	**Yes No**	
<List subject>	**Yes No**	**Yes No**	
<List subject>	**Yes No**	**Yes No**	
<List subject>	**Yes No**	**Yes No**	
<List subject>	**Yes No**	**Yes No**	
<List subject>	**Yes No**	**Yes No**	
<List subject>	**Yes No**	**Yes No**	
DAILY SUCCESS RATE: _________________			

SKILL(S) OF THE WEEK

SKILL OF THE WEEK:	**Asking for Help**
PRIOR SKILLS OF THE WEEK:	Focus, Making Contributions, Showing Interest in Others, Offering Assistance, RESET (using self-control), FLIP IT (-ve to +ve)

PRIVILEGE CHART

LEVEL	**SUCCESS RATE**	**PRIVILEGE**
Honor Level	100%	To Be Determined + BONUS
Level 1	85%-99%	To Be Determined
Level 2	70%-84%	None
Level 3	Below 70%	Consequence

NOTES/COMMENTS:

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SELF-MONITORING TRACKING FORM

After each subject, XXXXX and his teacher/aide will record whether XXXXX met each target behavior. The corresponding agreement rating should be circled to indicate whether XXXXX accurately self-monitored during the specified period.

CHECK IF NO CLASS	SUBJECT	PREPARATION CHECKLIST	RATER	TARGET #1: Prepared for Class	TARGET #2: ≤ 3 Instance of Interrupting	TARGET #3: ≤1 Instance of Biting/Scratching
☐	**SOCIAL STUDIES**	□ Homework	**Student**	YES NO	YES NO	YES NO
		□ Pencil/Pen	**Teacher/Aide**	YES NO	YES NO	YES NO
		□ Books/Notebook	**Agreement**	**YES NO**	**YES NO**	**YES NO**
☐	**SCIENCE**	□ Homework	**Student**	YES NO	YES NO	YES NO
		□ Pencil/Pen	**Teacher/Aide**	YES NO	YES NO	YES NO
		□ Books/Notebook	**Agreement**	**YES NO**	**YES NO**	**YES NO**
☐	**MATH**	□ Homework	**Student**	YES NO	YES NO	YES NO
		□ Pencil/Pen	**Teacher/Aide**	YES NO	YES NO	YES NO
		□ Books/Notebook	**Agreement**	**YES NO**	**YES NO**	**YES NO**
☐	**ENGLISH**	□ Homework	**Student**	YES NO	YES NO	YES NO
		□ Pencil/Pen	**Teacher/Aide**	YES NO	YES NO	YES NO
		□ Books/Notebook	**Agreement**	**YES NO**	**YES NO**	**YES NO**
☐	**SPANISH**	□ Homework	**Student**	YES NO	YES NO	YES NO
		□ Pencil/Pen	**Teacher/Aide**	YES NO	YES NO	YES NO
		□ Books/Notebook	**Agreement**	**YES NO**	**YES NO**	**YES NO**
☐	**PHYS. ED.**	□ Sneakers	**Student**	YES NO	YES NO	YES NO
		□ Shorts/T-shirt	**Teacher/Aide**	YES NO	YES NO	YES NO
		□ Bathing suit	**Agreement**	**YES NO**	**YES NO**	**YES NO**
☐	**MUSIC/ ART**	□ Homework	**Student**	YES NO	YES NO	YES NO
		□ Pencil/Pen	**Teacher/Aide**	YES NO	YES NO	YES NO
		□ Books/Notebook	**Agreement**	**YES NO**	**YES NO**	**YES NO**
☐	**TECH.**	□ Goggles	**Student**	YES NO	YES NO	YES NO
		□ Pencil/Pen	**Teacher/Aide**	YES NO	YES NO	YES NO
		□ Pouch	**Agreement**	**YES NO**	**YES NO**	**YES NO**

DAILY TARGET BEHAVIOR % (# of Teacher YES / # of Teacher ratings): ___________

Circle Daily Target Behavior Level

Honor Level	**Level 1**	**Level 2**	**Level 3**
(100%)	(85%-99%)	(70%-84%)	(< 70%)

DAILY AGREEMENT % (# of Agreement YES / # of Agreement ratings): __________

Circle Daily Agreement Level

Honor Level	**Level 1**	**Level 2**	**Level 3**
(100%)	(85%-99%)	(70%-84%)	(< 70%)

****

TARGET BEHAVIOR PRIVILEGE CHART

Honor Level	100%	60 minutes of screen time
Level 1	85%-99%	30 minutes of screen time
Level 2	70%-84%	15 minutes of screen time
Level 3	Below 70%	No screen time

AGREEMENT *BONUS* PRIVILEGE CHART

Honor Level	100%	*Bonus 45* minutes of screen time
Level 1	85%-99%	*Bonus 30* minutes of screen time
Level 2	70%-84%	*Bonus* 15 minutes of screen time
Level 3	Below 70%	No screen time

****

Notes/Comments:

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___

___

SUMMARY OF KEY CONSIDERATIONS FOR ADDRESSING CHALLENGING BEHAVIORS

- **Identify the challenging behavior(s).**

- **Consider how the behavior(s) relates to its environment.**
  - What is the topography of the behavior (i.e., when, where, how often, how long)?
  - Are there any predictable antecedents/triggers/setting events?
  - Are there medical, learning, home, peer, or medication factors that impact the student?
  - Is the student stimulated and engaged in the setting?
  - How do staff currently respond to the behavior (be cautious of 10:20)?

- **Based on the understanding of setting events/antecedents, identify ways the environment can be structured, and accommodations be made, to set the student and staff up for success.**
  - What behavior(s) is not occurring that necessitates the need for reoccurring prompts?
  - Are we providing accommodating or unaccommodating accommodations?
  - Do we have an exit strategy/plan to reduce prompts/accommodations?

- **Identify what behavior(s) is not occurring.**
  - Every problematic behavior is a result of a more appropriate behavior not occurring.
  - What would be the more adaptive (preferred) alternative behavior?
  - What role does mindset play? Does the student have a negative mindset?

- **Consider why the more appropriate behavior(s) is not occurring.**
  - Is there a skill -acquisition, -fluency, and/or -performance deficit?
    - Does the student ever do the more appropriate behavior?
    - Does the student know the where and when to do the more appropriate behavior?
    - Does the student see value in doing the more appropriate behavior?
  - Is there presently effective/in effective use of consequence/discipline?
  - Is the student mindful/aware of his behavior? *Kids can't change what they do not know.*

- **Is there is a <u>plan</u> to develop, encourage, and support the acquisition and the generalization of the demonstration of the more appropriate behavior?**
  - Does the plan Clarify x 3 (expectations, criterion, outcome)?
  - Does the plan instruct the student in the adaptive alternative behavior?
    - Does the plan recognize the complexity of skill acquisition and allow for practice?
  - Do staff know their role in supporting the demonstration of the appropriate behavior?
    - Do staff know how to seize the moment and address fluency deficits?

- **Consider if there is relevance for the student to demonstrate the more appropriate behavior.**
  - Ask why should the student do the more appropriate behavior?
  - Are we *bribing or* are we *reinforcing?* Do we have a *reinforcement plan?*
  - Is the plan set up so that the student cannot fail (and we do not fail) and "tilt the balance"?

- **Consider any barriers as to why the plan may fail prior to the plan's implementation.**

- **Consider how to measure and track the student's response to the intervention.**
  - Everything we try is a guess. How will you know if we guessed right?
  - What do we expect to increase? What do we expect to decrease?
  - Have we established a doable and meaningful data-tracking plan?

WEDNESDAY – DAY 3

FACT SHEET ON ANGER AND AGGRESSIVE BEHAVIORS

1. Aggressive behaviors are relatively STABLE over the life-span and in many ways predictable.

2. Aggressive behaviors may be of an *instrumental form* (designed to achieve a set of specific goals) or an *emotionally reactive form*, or a combination of both.

3. There has been an increase in the level of violence toward others and toward oneself during the period of the pandemic.

4. Anger and aggression may be a secondary reaction to other emotions such as fear, anxiety, sadness, depression, humiliation, embarrassment, grief and the like. Anger can vary in its intensity, frequency and duration. Individuals may dwell or ruminate on OLD ANGER and not let the anger go.

5. While the emotion of anger often contributes to aggressive behaviors, other emotions such as depression and anxiety can also contribute to aggression. In fact, anger-related problems co-occur with 19 different psychiatric disorders, such as PTSD and Traumatic Head Injury. Anger interferes with patients' processing related emotions.

6. Individuals often have implicit theories about their anger. For example, once anger is experienced, it has to blow.

7. There is nothing wrong with becoming angry. It is what one does with the angry feelings that is the most critical determinant. Anger in response to perceived social injustice and discriminatory events has led to major collective actions for social change (e.g., Civil and Gay rights, Me Too Movement, Black Lives Matter, Amnesty International). Emotions like anger, fear, anxiety, sadness, grief are MESSENGERS to take some actions. What individuals do with their feelings of anger distinguishes those who are high and low in becoming aggressive.

EXAMPLES OF REACTIVE AGGRESSION

- Often an impulsive, highly emotional, quick response to perceived threat or insult
- Aggression due to escalation of interpersonal argument or disagreement
- Immediate response to provocation or name calling
- Response to saving face or reputation in front of others
- Response to the challenge to one's Code of Honor or manhood
- Belief that the aggressive response is justified (i.e., retaliation)
- Evidence little remorse for one's aggressive behavior
- Personal belief that one cannot control such emotional reactions ("Once your temper blows it blows")

EXAMPLES OF INSTRUMENTAL AGGRESSION

- Use aggression to achieve a particular set of goals, such as settling some actual or perceived *grievance*
- Often planned and rehearsed
- Personal belief that aggression will work or achieve one's goals or the group's goals

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BEHAVIORAL SEQUENCE OF SCHOOL SHOOTERS

Studies indicate that there is no specific profile, but the following behavioral sequence have been identified:

1. **Grievance**
   - actual or perceived
2. **Non-spontaneous**
   - planned and rehearsed
3. **Presence and rumination of violent behavior**
   - often read about or collect information about other mass-shooters
4. **Plan attack**
   - obtain weapons, ammunition and victims
5. **Plan escape routes**
   - familiar with school grounds, school activities or school routines
6. **Presence of emotional leakage of intent**
   - often tell or show peers of one's violent plans. This has significant Implications for PEER WARNING systems.
7. **Direct or veiled threats**
8. **Perform violent act**

REFERENCES AND RESOURCES RELATED TO SCHOOL SHOOTINGS

Augimeri. L. et al. (2021). Early Assessment Risk List (3 to 11 year olds)
https://childdevelop.ca/snap/risk-assessment-tools

Borum R., et. al. SAVRY (Adolescents ages 12 to 18) Structured assessment of violence in youth
https://www.parinc.com

de Viers, Robbe M. et al. SAPROF – Structured Assessment of Protective Factors for Violence Risk
https://www.saprof.com/

Schildkraut, J., R. G. Cowan, & T. M. Mosher. (2024). The Parkland mass shooting and the path to intended violence: A case study of missed opportunities and avenues for future prevention. Homicide Studies, 28(1), 3-26.
https://doi.org/10.1177/10887679211062518

Schildkraut, J., & L. B. Geller. (2023). Mass shootings in the United States: Prevalence, policy, and a way forward. The ANNALS of the American Academy of Political & Social Science, 704(1), 181-203.
https://doi.org/10.1177/00027162231164484

Schildkraut, J., E. A. Greene-Colozzi, A. B. Nickerson, & A. Florczykowski. (2023). Can school lockdowns save lives? An assessment of drills and use in real-world events. Journal of School Violence.
https://doi.org/10.1080/15388220.2022.2162533

Vijoen J. et al START-AV ADOLECENTS
https://protect-international.com/product/short-term-assessment-risk-treatability-adolescent-version-startav-manual/

MINDSET OF ANGRY AND AGGRESSIVE INDIVIDUALS

It is being proposed that to go from being provoked and becoming annoyed, irritated, bothered, frustrated to becoming intensely angry, enraged, furious and aggressive, the following steps are invoked:

1. **Perception of Provocations**
    - threat, injustice, interruption of one's plans and behaviors, challenge to one's Code of Honor like "Manhood", racial slurs, and the like.

2. **Attribution of Intentionality**
    - perception and appraisal that this action was done "on purpose".

3. **Have a Hostility Bias**
    - on the lookout for possible provocations and misappraise ambiguous events as intentional provocations that elicit readily accessible, pre-programmed aggressive emotionally scripted behavioral patterns or action plans.

4. **Justification**
    - view that one's angry and aggressive responses are justified
    - "An eye for an eye, a tooth for a tooth" , "I am ONLY hurting them back like they have hurt me"

5. **Engagement in Absolute Thinking**
    - thinking processes filled with "musts" and "shoulds"
    - what Albert Ellis called the tendency to "MUSTurbate" and the predilections to "SHOULD on your head ".

6. **Use of Inflammatory Stereotypical Language that Dehumanizes the Victims of Angry and Aggressive Behaviors**

7. **Payoffs or Reinforcements for Engaging in Aggression that Works, at least in the Short Run, In Achieving One's Goals.**
    - Such aggressive behaviors may be consistent with cultural or cohort norms that meet a set of expectations. For instance, to "Save face and one's reputation," "to show that one is King of one's Castle", "that there will be payoffs in Heaven, in the next life". In short, a set of meaning-making beliefs help to maintain and exacerbate the level of anger and aggression.

IF THERE IS ANY MERIT TO THIS ANALYSIS,
WHAT DO YOU THINK ARE THE TREATMENT IMPLICATIONS?

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TABLE 1

DEVELOPMENT OF AGGRESSIVE BEHAVIORS IN STUDENTS:
A DYNAMIC CASCADE MODEL OF THE DEVELOPMENT OF AGGRESSIVE BEHAVIOR

As Dodge et al. 2008 observe, each domain in the developmental sequence operates in concert to lead to violent behavior.

Genetic Vulnerability Contributions

↓

Adverse Social Context

↓

Early Developmental Risk Factors

↓

Cumulative Exposure to Victimizing Experiences

↓

Lack of School Readiness

↓

Development of Early Behavior Problems

↓

Academic and Social Failures

↓

Coercive Parenting: Lack of Supervision, Monitoring and Academic Support

↓

Deviant Peer Association

↓

School-based Policies and Involvement with Juvenile Justice System That Aggregates Deviant Youth

TABLE 2

**DEVELOPMENT OF AGGRESSIVE BEHAVIORS IN STUDENTS:
IMPLICATIONS FOR PREVENTION AND TREATMENT INTERVENTIONS**

What could you do to:

1. Help reduce teenage pregnancy.
2. Provide services to pregnant teenagers.
3. Provide home-visiting nursing programs to high-risk families.
4. Offer services to reduce the likelihood of victimization and provide treatment to victimized families.
5. Nurture school readiness, especially in the area of reading, provide empathy training early in development.
6. Provide parent-child training programs.
7. Implement school-based early screening procedures to identify high-risk students and high-risk families.
8. Create safe, inviting schools designed to reduce bullying and cyber-bullying.
9. Improve academic performance and nurture a future orientation - - offer career counselling.
10. Bolster resilience, provide mentoring programs that will build on the youth's strengths that lead to contact with prosocial peers and a bond with prosocial mentors, activities and institutions.
11. Work with parents to improve supervision, monitoring, conflict resolution, and positive affective bonds, and address family dysfunction and familial psychopathology.
12. Provide school-based interventions that are designed to reduce high-risk deviant behaviors such as dating violence
13. Offer school-based mental health programs with "high-risk" students.
14. Provide media literacy courses.
15. Provide evidence-based skills intervention around anger and impulse control, empathy training and social problem-solving.
16. Incorporate generalization guidelines to promote skills maintenance.
17. Eliminate or minimize practices that aggregate deviant youth.
18. Convince others that implementing such interventions needs to be prevention – oriented, administered early in the developmental cycle, and comprehensive addressing multiple risk factors. Moreover, there is a need to convince supporters of these intervention programs that doing so will not only be effective and have salutary consequences, but it will result in significant financial savings.
19. Build in evaluation procedures. What do we know "works" and what has been found to inadvertently increase violence (make things worse)? A number of well-intentioned intervention programs, not only do not work but they actually backfired and made things "worse" (see Table 3). What is common is that they bring together or aggregate deviant peers where these youth can mutually reinforce and model aggressive behaviors. How many of these programs are in place in your community? I have also included a list of viable alternative programs that should be tried (See Table 4).

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TABLE 3

PROGRAMS AND POLICIES THAT AGGREGATE DEVIANT PEERS AND THAT SHOULD BE AVOIDED, IF POSSIBLE

(*From Dodge et al. 2006 and www.teachsafeschools.org*)

Education

1. Tracking of low-performing students
2. Forced grade retention for disruptive youth
3. Self-contained classrooms for unruly students in special education
4. Group counselling of homogeneously deviant youth
5. Zero tolerance policies for deviant behavior
6. Aggregation of deviant youth through in-school suspension
7. Expulsion practices
8. Alternative schools that aggregate deviant youth
9. Individuals with Disabilities Education Act (IDEA) reforms that allow disruptive special education students to be excluded from mainstream classrooms
10. School-choice policies that leave low-performing students in homogeneous low-performing schools

Juvenile Justice and Child Welfare

1. Group incarceration
2. Military-style boot camps and wilderness challenges ("brat camps")
3. Incarceration placement with other offenders who committed the same crime
4. Custodial residential placement in training schools
5. Three strikes-mandated long prison terms
6. Scared Straight
7. Group counselling by probation officer
8. Institutional or group foster care
9. Bringing younger delinquents together in groups
10. Vocational training

Mental Health

1. Any group therapy in which the ratio of deviant to non-deviant youth is high
2. Group therapies with poorly trained leaders and lack of supervision
3. Group therapies offering opportunities for unstructured time with deviant peers
4. Group homes or residential facilities that provide inadequate staff training and supervision

Community Programming

1. Midnight basketball
2. Unstructured settings that are unsupervised by authority figures (e.g., youth recreation centers designed as places for teens to "hang out")
3. Group programs at community and recreation centers that are restricted to deviant youth
4. After-school programs that serve only or primarily high-risk youth

TABLE 4

EFFECTIVE PROGRAMS THAT REPRESENT
VIABLE ALTERNATIVES TO AGGREGATING DEVIANT PEERS
(*From Dodge et al. 2006 and www.teachsafeschools.org*)

Education

1. Universal, environment-centered programs that focus on school-wide reform, including:
   a. clearly explicated expectations for student and staff behavior
   b. consistent use of proactive school discipline strategies
   c. active monitoring of "hot spots" for behavior problems
   d. improved systems to monitor student achievement and behavior
2. Universal classroom programs to build social competence (e.g., Responding in Peaceful and Positive Ways, PATHS, school-wide bullying prevention programs)
3. School-wide positive behavior support
4. Individual behavior support plan for each student
5. Improved training in behavior management practices for classroom teachers, especially:
   a. group contingencies
   b. self-management techniques
   c. differential reinforcement
6. Incredible Years Teacher Training
7. Good Behavior Game
8. Consultation and support for classroom teachers
9. Family-based Adolescent Transitions Program
10. Matching deviant youth with well-adjusted peers (e.g., Coaching, Brain Power, Peer Coping Skills Training, the Montreal Longitudinal Project)
11. Multimodal programs (e.g., LIFT-Linking Interest of Families and Teachers, Fast Track, Seattle Social Development Project)
12. Proactive prevention programs that shape student "morals" and encourage responsible decision-making
13. Cognitive-behavioral Intervention for Trauma in Schools (CBITS)

Juvenile Justice and Child Welfare

1. Functional family therapy
2. Intensive protective supervision
3. Teaching Family Home Model
4. Sending delinquent youth to programs that serve the general population of youth in their neighborhoods (e.g., Boys and Girls Clubs)
5. Community rather than custodial settings
6. Interpersonal skills training
7. Individual counselling
8. Treatment administered by mental health professionals
9. Early diversion programs
10. Victim-offender mediation
11. Teen court programs

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12. Therapeutic jurisprudence programs
13. Community commitment orders
14. Psychiatric consultation

Mental Health

1. Individually administered treatment
2. Family-based interventions
3. Triple P Program (Positive Parenting Program)
4. Adolescent Transitions Program
5. Linking the Interests of Families and Teachers (LIFT)
6. Iowa Strengthening Families Program
7. Family Unidas Program
8. Mentoring Program
9. Programs such as Big Brothers/Big Sisters

Community Programming

1. Public or private organizations that are open to all youth, regardless of risk status, and that provide structure and adult involvement (e.g., religious groups, service clubs, Scouts, Boys and Girls Clubs)
2. School-based extracurricular activities that include pro-social peers
3. Encouragement of commitments outside of gangs (e.g., to jobs, family roles, military service, mentors)
4. Early childhood interventions such as the Perry Preschool Program, school readiness programs like Head Start, and programs that highlight reading comprehension skills
5. Job Corps
6. Policing programs that target high-crime neighborhoods where high-risk youth congregate
7. Community efforts to reduce marginalization of specific groups of youth

What are the lessons to be learned from previous attempts to replace aggressive and delinquent behaviors?

Attempts to treat aggressive children and youth and their families has been going on for some time. It is worth taking stock and asking what has the field of prevention and treatment learned? Consider the following summaries for work with children and youth who evidence **Disruptive Behavior Disorders (DBD**) and those who have adjudicated as **juvenile delinquents**.

We should develop an evaluative critically-minded stance and require those who conduct intervention programs to demonstrate how they have considered these lessons in their treatment planning.

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ILLUSTRATIVE INTERVENTION PROGRAMS FOR EMOTIONAL DYSREGULATION

SNAP (STOP NOW AND PLAN) PROGRAM

Here are helpful resource links pertaining to SNAP:

- Why SNAP? YouTube link https://youtu.be/rSl4IoEQrLc
    - 6-minute video with animations and video clips of SNAP graduates and caregiver
    - Nice overview of the issue and need
    - Includes video interview clips of SNAP graduates and caregivers
- Navigating the Middle Years with Self-Control/CDI-SNAP-Resource Guide
    - https://childdevelop.ca/snap/sites/default/files/CDI-SNAP-ResourceGuide-DIGITAL-FINAL_02.pdf
    - www.childdevelop.ca
- YouTube Page with a series of additional SNAP Videos
    - https://www.youtube.com/@StopNowAndPlan/videos
- Video that highlights the SNAP strategy – How Johnny uses SNAP Strategy
    - https://www.youtube.com/watch?v=XR85Coi4bBQ&t=9s
- Video highlighting what to expect when calling informational phone number
    - https://www.youtube.com/watch?v=iDedvmxIXgk
    - Provides an overview on what SNAP is and what to expect when a caregiver/family comes to a SNAP door for services
    - Identifies the various SNAP service components
- Orlando News 9 video: https://youtu.be/gX_l9LnuV88
    - Investigates Dept. of Juvenile Justice program (SNAP) scaling across Florida

THINK FIRST PROGRAM

- Larson, J., & Lochman, J. E. (2010). *Helping schoolchildren cope with anger: A cognitive-behavioral intervention* (2nd. Ed.). New York: Guilford Press
- Larson, J. (2005). *Think First: Addressing aggressive behavior in secondary schools.* New York: Guilford Press.

Problem Solving Discourse - Donald Meichenbaum, Ph.D.

www.youtube.com/watch?v=Lkz2CgwOwic

The video is a scripted depiction of the three phases of Meichenbaum's Problem Solving Discourse.

The treatment manual is available for free at: www.teachsafeschools.org/problemsolving.html

CBT WITH ANGRY AND AGGRESSIVE STUDENTS

1. Work to establish, maintain and monitor the therapeutic alliance with both the student and the referring person (educator, parent)

2. Conduct a functional, situational and developmental assessment. Assess for evidence of any co-occurring disorders.

3. Establish collaborative intervention goals.

4. Have the student perform some sort of self-monitoring as in the case of Hassle Logs.

5. Teach emotional skills like emotion regulation like SNAP, distress tolerance, self soothing (relaxation) and self-talk and problem-solving GOAL- PLAN - DO - CHECK (negotiation skills)

6. Use role playing and in vivo practice.

7. Follow Generalization Guidelines.

8. Obtain follow-up assessments. Check with the referral persons.

HOW EFFECTIVE ARE COGNITIVE-BEHAVIORAL INTERVENTIONS FOR ANGRY AND AGGRESSIVE INDIVIDUALS?

There are 7 meta-analyses (Beck & Fernandez, 1998; Del Vecchio & O'Leary, 2004; Di Giuseppe & Tafrate, 2003; Edmonson & Conger, 1996; Gansle, 2005; Sukhodolsky et at.,2003; Tafrate, 1995). These meta-analyses yield medium to strong effect sizes, indicating that 75% of those individuals receiving anger treatment improved compared to controls. Populations treated include angry-involved medical patients; angry community volunteers; angry aggressive drivers; vets with PTSD and comorbid disorders; generally angry college students; angry aggressive offenders with comorbid substance abuse disorders; batterers; young mothers at risk for child abuse; individuals with intellectual disabilities; individuals with traumatic brain injuries.

Treating School-Based Reactive Anger and Aggression: The Chicago Model

James Larson, Ph.D.
University of Wisconsin-Milwaukee

Treating School-Based Reactive Anger and Aggression

The Chicago Model

Presenter:
Jim Larson, Ph.D.
The Melissa Institute for Violence Prevention and Treatment
Department of Psychology, UW-Whitewater

1

"He who opens a school door closes a prison" – Victor Hugo

- About 75 percent of America's state prison inmates, almost 59 percent of federal inmates, and 69 percent of jail inmates did not complete high school
- Dropouts are more than eight times as likely to be in jail or prison as high school graduates
- Ninth grade retention is a powerful risk factor for dropping out of high school
- The U. S. spends more than $50 billion in incarceration costs per year

Stanford Graduate School of Education. May 2014; Moretti, 2007

2

A Working Hypothesis

- Treating child and adolescent aggressive behavior in the school setting may increase the likelihood of earning a diploma. Earning a diploma may decrease the likelihood of community crime and eventual incarceration.

3

Multi-Tiered Systems of Support in Chicago Public Schools

INDICATED	FEW	Individual Clinical Support
SELECTED	SOME	Anger Coping & Think First and C-BITS
UNIVERSAL	ALL	Second Step SEL

4

4

Who to Focus On?

- On the road to dropout but still hanging on
- Has the academic potential
- Makes many bad decisions
- Demonstrates impulsive anger and aggression primarily toward peers
- Behavior not sufficiently managed at Tier 1
- Behavior is not typically proactive

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Proactive Aggression

- **goal-oriented aggressive behaviors; <u>want</u> something**
- **Initiated by the aggressor for a purpose; often planned**
- **cool-headed, mean, <u>bully-type</u>**
- **often see little reason to change; high self-concept**
- **tend to do poorly in counseling therapy**

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Reactive Aggression

- Unplanned, impulsive, *reactive* anger often leading to aggression
- Frequently an angry emotional reaction to someone else's real or presumed behavior
- Often chronic and serious discipline problems
- More likely to participate in skills training
- Numerous social-cognitive deficits and distortions

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Treating Reactive Aggression as a School Problem

- The exclusive focus of treatment is school behavior
  - Relationships with teachers, administrators, and other adults
  - Relationship with other students in the school building or environs
  - Relationship with academic demands

Knowledge and influence of the clinician: "When you come through that door. . ."

8

Why School-Based Treatment?

- Abundance of socially challenging peers and adults
- Abundance of rules
- Numerous skilled adults for collaboration
- Capacity to manipulate both reinforcers and challenges in the environment
- Consent issues may be in place already

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Challenges

- Administrator/Teacher resistance
- Adequate treatment room space
- Privacy issues
- Parental involvement in the daytime
- Numerous vacations and school cancellations

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Overarching Goals of School-Based Intervention

- Interrupt the downward spiral of academic and behavioral engagement
- Work to return locus of control to student
- Train cognitive strategies for anger regulation
- Increase repertoire of behavioral coping strategies
- Begin the formation of adjusted school-based schemata to foster increased confidence and competence

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"Think First" Intervention for Middle and High School

- Adapted from seminal work of Donald Meichenbaum along with the applied group process work of Eva Feindler and others
- Origins in Milwaukee Public Schools
  - Reaction to upswing in school violence associated in part with advent of crack cocaine
- Introduced 2009 in Chicago's *Culture of Calm*

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Chicago Public Schools

- Training in ***Anger Coping*** **(elementary)** and ***Think First*** **(secondary)** are organized out of the Center for Childhood Resilience at Lurie Children's Hospital in Chicago
- Trainees include **school counselors, school social workers, and school psychologists,** along with licensed community-based practitioners
- First Think First training in CPS: 2009

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Chicago Public Schools

- Trainees receive two full days of participatory learning in either intervention
- Additional support is provided via small group problem-solving during the first year
- Group leaders are required to collect from the students pre- and post data from selected instruments for CPS use

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Young People Arriving at High School with . . .

- Academic difficulties, previous retention, and/or special education
- Poss. co-occurring ADHD, trauma react. and depression (esp. girls)
- Elevated levels of peer rejection
- Bully victimization (and poss. perpetration)
- Likely community and family problems
- **. . . and problematic cognitive deficits and distortions**

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Social Information Processing
(Dodge, 1991; Crick & Dodge, 1994)

Deciding what to do moment to moment:

1. Attend to available social cues
2. Give meaning to the cues
3. Select desired outcomes
4. Generate possible responses
5. Identify potential consequences
6. Act out selected responses

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Social Information Processing Deficits in Reactive Aggressive Youth
(Dodge, 1991; Crick & Dodge, 1994)

1. attend to available social cues
2. give meaning to the cues
3. select desired outcomes
4. Generate possible responses
5. Identify potential consequences of a response
6. Act out selected responses

1. Hypervigilant for aggressive cues
2. Hostile attributional biases
3. Higher value on retaliation than affiliation
4. Narrow solution generation abilities
5. Tendency to evaluate aggression positively
6. Difficulty enacting prosocial skills

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Bust him up! Make him re-build it

He's too big to fight.

I need respect

Hey! Fix it back, Bitch!!

On purpose!!

He's destroying it!!

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Treating School-Based Reactive Anger and Aggression: The Chicago Model

James Larson, Ph.D.
University of Wisconsin-Milwaukee

Social Information Processing Deficits in Reactive Aggressive Youth
(Dodge, 1991; Crick & Dodge, 1994)

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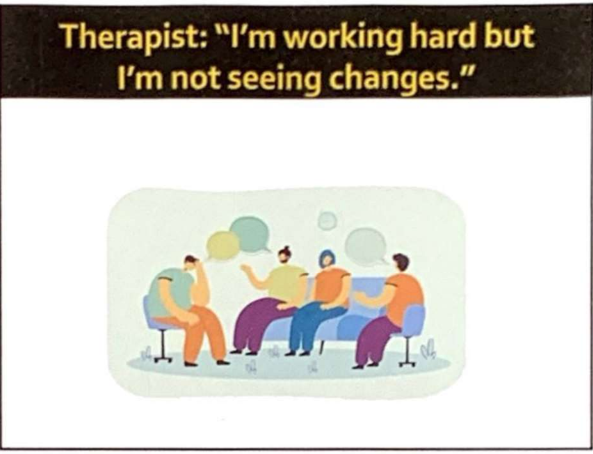
Therapist: "I'm working hard but I'm not seeing changes."



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Knowing THAT vs. Knowing HOW

- Knowing about a new behavior is NOT the same as being able to enact that behavior under rapidly moving conditions of ambiguity and emotion

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Reactive Aggressive Youth Selected Treatment Interventions

Social-Cognitive Deficit	Training Focus
1. Hypervigilant for aggressive cues	Train verbal & nonverbal cue recognition
2. Hostile attributional biases	Attribution re-training
3. Higher value on retaliation than affiliation	Consequential thinking
4. Narrow solution generation abilities	Solution generation skills
5. Tendency to evaluate aggression positively	Perspective-taking development
6. Difficulty enacting prosocial skills	Behavioral skills training

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Classroom Progress Monitoring Report

Student's Name ______ Teacher ______
For the time period ______ to ______

PLEASE CONSIDER THE TIME PERIOD AS A WHOLE

1. Adherence to classroom rules and routines

Above the class average	At the class average	Below the class average	Well below the class average
4	3	2	1

Optional Comment:

2. Self-control of vocal disruptive behavior

Above the class average	At the class average	Below the class average	Well below the class average
4	3	2	1

Optional Comment:

3. Self-control of anger

Above the class average	At the class average	Below the class average	Well below the class average
4	3	2	1

Optional Comment:

4. Homework returned

Above the class average	At the class average	Below the class average	Well below the class average
4	3	2	1

Optional Comment:

5. In-class assignment effort

Above the class average	At the class average	Below the class average	Well below the class average
4	3	2	1

Optional Comment:

6. (Optional other: ______

Above the class average	At the class average	Below the class average	Well below the class average
4	3	2	1

Optional Comment:

Teacher signature ______

Please return to ______

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Think First Targeted Students

- Have history of anger-influenced aggressive behavior in school *(Intervention Record Review)*
  - *Pattern of* vs. late-starter or situational
  - Lack of response to school discipline structure
- Have evidence of protective factors
  - **Connected** positively to school in some manner
  - Lacking co-occurring serious mental health issues

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Treating School-Based Reactive Anger and Aggression: The Chicago Model

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School Connectedness and Personal Protective Factors

Student has evidenced connectedness to this or previous school (Two or more)

- Regular attendance (80% or higher)
- Primarily passing grades
- Extracurricular activity
- Positive ongoing relationship with adult in school
- Other ___________

Student has two or more protective factors

- Successful older sibling or close relative
- Positive involvement of parent or home care adult
- Evidence of interscholastic-level athletic potential
- Evidence of average or better intelligence
- Evidence of competent interpersonal skills (can be likeable and appropriate around adults)
- Proficient-level group testing in reading
- Positive peer group
- No co-occurring AODA or documented mental health concerns.

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Reactive Aggression in Girls

- Girls tend to exhibit reactive aggressive cognitive deficits and distortions similar to those of boys
- Both boys and girls engage in relational aggression, but girls seem to feel greater victimization and persevere longer
- Stronger tendency to hold prolonged grudges

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Training Objectives

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TF Global Training Objectives

- Increase student's capacity for **personal self-control** over own behavior (PCB/ Loc. of control)
- Increase student's capacity for **regulating** personal **feelings of anger**
- Increase student's capacity for understanding the **perspective of others** (Leads to empathy?)
- Increase student's commitment to **academic progress** (Classroom Progress Monitoring)
- Provide student with a useful step-wise **problem-solving** methodology, and . . .
- Train critical **new behavioral skills**

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Projected Treatment Outcomes Student will:

- Articulate insight into the features of their own anger and aggression – The **KNOWLEDGE** component
- Show new behavioral responses to high-risk situations – The **SKILLS ACQUISITION** component
- Demonstrate the capacity to engage new skills in multiple contexts – the **GENERALIZATION** component

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KNOWLEDGE Goals with Reactive Aggressive Youth

- One can learn substantial control of anger
- Anger is dimensional
- Thinking can be used to regulate anger
- Breathing and exercise can be used to regulate anger

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KNOWLEDGE Goals with Reactive Aggressive Youth

- Progress in school comes only if one does what is necessary to progress
- Conflicts can be framed as problems
- Most problems have more than one solution
- Most school behavior is choice behavior

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KNOWLEDGE Component: Insight + *Model*

- Trainer models or demonstrates the application of the new knowledge. For example:
  - Uses CHOICE language
  - Frames students' concerns as "problems"
  - Uses dimensional anger terms
- **Each TF module articulates Knowledge Level and Skill Level outcomes relative to that module**

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SKILLS ACQUISITION Goals with Reactive Aggressive Youth

- Palliative anger regulation procedures
- Use of self-instruction for anger control
- Use of consequential thinking
- Use of assertiveness skills
- Use of problem-solving to address current issues ⟶
- Techniques for managing relapse (*"A setback is a setup for a comeback!"*)
  - *ALL In vitro* and then *in vivo*

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Once again. . .

- Knowing about a new behavior is NOT the same as being able to enact that behavior under rapidly moving conditions of ambiguity and emotion

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SKILLS ACQUISITION Component: Insight + Model + *Rehearse*

- This is the active practice part
- Critical to make it as genuine as possible
- Can be in group and as a mini-experiment in the authentic setting
- Multiple settings/multiple situations help enhance generalization

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GENERALIZATION Goals with Reactive Aggressive Youth

- The contexts of concern are identified, and support energized
  - Parents, school personnel, prosocial peers
  - *"Guidelines for Generalization Support Persons"*
- Bridges between training and authentic environment are created
  - Homework tasks are essential
- Possible barriers are identified and procedures to address the identified

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Treating School-Based Reactive Anger and Aggression: The Chicago Model

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GENERALIZATION Component: Insight + Model + Rehearse + Feedback

- Feedback from trainer and from other group members – Not criticism
  - Wastebasket Exercise
- Provide feedback during practice and after
- What worked? Why did it work?
- Reinforce COPING rather than just mastery
  - Managing set-backs and avoiding perfection
- **Convey an expectation for transfer!**

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GENERALIZATION Component: Insight + Model + Rehearse + Feedback

- *Reject "Train and Hope" models (D.M.) Let them know your expectations.*
- *Practice! Practice! Nothing of practical use with reactive aggressive youth is learned after a single trial or two!*
- Systematically increase the stress and authenticity
- Use "Academic Self-Monitoring Form"

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GENERALIZATION Component: Post Group

- Build in post-group booster sessions
- Enlist those who have completed the training as consultants and advisors to newest group
- Bring TF grads in to participate in roll-plays

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Larson's Wishlist to Reduce the Prison Population

- Child behavioral training and family supports starting with (or before) pre-K
- Family support for "red-shirting"
- Comprehensive bullying prevention informed by social-ecological principles
- Social and Emotional Learning (SEL) thru M.S.
- Skilled Tier 2 counseling for anger and aggression management K-12

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Training in Your Schools

To enquire about training for school-based mental health practitioners in the greater Chicago Area in either *Think First* or *Anger Coping*:

Contact Colleen Cicchetti, Ph.D. at the Center for Childhood Resilience, Lurie Children's Hospital in Chicago -- Colleencicchetti2014@gmail.com

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THURSDAY – DAY 4

INCIDENCE AND NEUROLOGICAL AND PSYCHO-SOCIAL IMPACT OF EXPERIENCING MULTIPLE ADVERSE CHILDHOOD EXPERIENCES (ACEs)

- Adverse Childhood Experiences (ACEs) are common
  - 2/3 experience 1 ACEs
  - 1/5 experience 3+ ACEs
  - 1/10th experience 5+ ACE life events

- Lifetime consequences of 4+ include an increased chance of Substance Abuse disorder, depression and suicidality, victimization.

- ACEs impact stress hormones that modulate neural structures in the brain and can impact long-term synaptic potentiation in the corticolimbic (HPA Axis) associated with the Prefrontal Cortex (PFC), as well as cortical differences.

- As a consequence, such "high-risk" students evidence a variety of self-regulatory and meta-cognitive deficits. These are exacerbated by poverty.

- Consider the following impact of exposure to violence authored by a 10-year-old boy living in Chicago.

CONFINED BY VIOLENCE

~ Author Name Unknown, 10 year old, Chicago ~

I want to go outside to play, but I can't
Not because it is a rainy day
It is to avoid the gunshots that may come my way

I want to go outside to play, but I can't
Not because I have no bike to ride
It's because my mom fears
I'll be another victim of a senseless homicide

I want to go outside to play but I can't
Not because it is after hours, or even that it is way too dark
It's because of the gunshots that occur in the neighborhood park

I want to go outside to play. but I can't
Not because I have no friends
It is because of the violence that never ends

I want to go outside to play, but I can't
Not because I don't deserve it
There this thing called life and I am trying to preserve it

NEUROLOGICAL IMPLICATIONS OF ADVERSE CHILDHOOD EXPERIENCES AND TRAUMA

- Exposure to multiple diverse traumatic victimizing experiences can alter brain architecture and function, derail developmental "wear and tear" on the body. (Allostatic Load)

- Neurobiological changes resulting from exposure to ACEs include alterations to the amygdala, hippocampus, anterior cingulate prefrontal cortex, nucleus accumbent, and at the neurochemical level alterations including dopamine, norepinephrine, epinephrine, cortisol, serotonin brain-derived neurotrophic factor, endocannabinoids, glutamate and neuropeptides.

- When a child experiences adversity early in life, their monocytes and macrophages (types of white blood cells) become calibrated to respond to future threats with a heightened pain inflammatory response, and by influencing the hormonal system and dysregulation of cortisol levels.

- Traumatic stress may alter the organization and "tuning" of multiple stress response systems, including the immune system, the autonomic system and the hypothalamic-pituitary-adrenal (HPA) axis and alter gene expression. For example, childhood maltreatment sensitizes the amygdala to over respond to threat.

- Childhood adversity has been associated with shorter telomeres. Telomeres are receptive DNA sequences that cap and protect the ends of chromosomes from DNA damage and premature aging.

- In terms of the developing brain, exposure to cumulative adverse events contributed to:

  a) Reduction in the volume and activity levels of major structures including the corpus callosum (connective fibers between the left and right side of the brain), limbic system (amygdala and hippocampus) that is involved in emotional regulation.

  b) Cerebral lateralization differences or asynchrony. Abused children are seven times more likely to show evidence of left hemisphere deficits.

  c) Impact the communication between the Prefrontal Cortex (PFC) (upper portion of the brain) and the Amygdala (lower portion of the brain). The "top-down" regulation of executive skills can be compromised by perceived threats and stressors.

  d) The bottom-up emotional processes (amygdala) can "hijack" the PFC.

- The earlier and the longer the exposure to cumulative ACE, the greater the neurological impact.

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DEVELOPMENTAL CHANGES IN CHILDREN'S AND ADOLESCENT'S BRAIN DEVELOPMENT - TREATMENT IMPLICATIONS -

"The teenage brain is a work in progress"
"Go to your room until your cerebral cortex matures"

A major concern of any treatment approach with adolescents is the need to tailor the interventions in a developmentally sensitive fashion, given the recent findings about neurological changes in the teenage years. Consider the following findings and the treatment implications.

Laurence Steinberg (2008, 2009 a,b) and Dahl and Spear (2004) have summarized the anatomical changes in the brain during adolescence.

1. There is a decrease in gray matter in prefrontal regions of the brain during adolescence, reflecting a synaptic pruning (namely, the process by which unused neuronal connections are eliminated), resulting in improved information processing and logical reasoning.

2. Changes in the dopaminergic activity involving a proliferation, reduction and redistribution of dopamine receptors in paralimbic or prefrontal cortical regions. Dopamine plays a critical role in the brain's reward system. This remoulding of dopaminergic activity can contribute to sensation seeking behaviors, given the youth's heightened salience to rewards.

3. Increase in white matter in prefrontal regions, reflective of myelination improving the efficiency of neural signalling. Whereas synaptic pruning occurs during early adolescence, the myelination process takes place toward the latter phases of adolescence and into early adulthood. This contributes to the development of executive functions, such as response inhibition, planning ahead, weighing risk and rewards and the consideration of multiple sources of information.

4. There is also an increase in brain connections among cortical areas and between cortical and subcortical regions. Such increased connectivity facilitates the development of emotional regulation and facilitates social information processing.
   These structural changes and the accompanying changing patterns in brain activities contribute to the gradual development of self-management skills. As Steinberg concludes:

   > "Brain systems implicated in basic information processing reach adult levels of maturity by mid-adolescence. Whereas those that are active in higher order executive functions, self-regulation and the coordination of affect and cognition do not mature until late adolescence or even early adulthood" (2009, p. 744).

Or described more poetically,

"The combination in middle adolescence of an early arousal reward system and a still immature self-regulatory system has been likened to 'starting an engine without yet having a skilled driver.'"

From 14 to 16 (pre to mid-adolescence) impulse control, reward sensitivity, sensation seeking, risk taking, and reckless behaviors, and having an easily arousal reward system are all prevalent. From 16 to early adulthood, such behaviors as impulse control, anticipation of future consequences, strategic planning and resistance to peer influences increase.

Steinberg's research demonstrates that the brains of teens lack the maturity to enable them to consistently control their impulses, resist peer pressure and appreciate the risk of their actions. They require "**metacognitive prosthetic devices or tools" to develop self-regulatory and peer-resistant behaviors.** Teens, especially in early adolescence, have reward-seeking arousal systems, but the ability to put the brakes on is still maturing.

Therapists need to adapt their interventions accordingly to meet these growing capacities. "Teenagers are less mature than we might have thought, especially, in the early stages of adolescence" (Steinberg, 2009).

TREATMENT OF CHLDREN WHO HAVE EXPERIENCED TRAUMATIC AND VICTIMIZING EXPERIENCES

~ Visit https://tfcbt2.musc.edu/ for a discussion of Trauma Focused Cognitive Behavior Therapy

1. **Assessment procedures of children and family members**

2. **Trauma-Focused Cognitive Behavior Therapy Practice (TF-CBT)**
   A mnemonic summarizes the procedures:

   P -- PSYCHO-EDUCATION AND PARENTING SKILLS
   R -- RELAXATION
   A -- AFFECT EXPRESSION AND REGULATION
   C -- COGNITVIE COPING
   T -- TRAUMA NARRATIVE AND PROCESSING
   I -- IN VIVO GRADUAL EXPOSURE
   C -- CONJOINT PARENT-CHILD SESSIONS
   E -- ENHANCING SAFETY AND FUTURE DEVELOPMENT

   TF-CBT is a phase-oriented intervention:

   - Sessions 1-4 focuses on P-R-A-C
   - Sessions 5-8 focuses on T-I
   - Sessions 9-12 focuses on C-E

   TF-CBT has been applied for children as young as 3 to youth of 18. Conducted weekly over several weeks. Treatment usually entails individual sessions with the child and parallel sessions with the caregiver. The same therapist sees both the child and the caregiver and later conducts joint sessions when sharing and processing the trauma narrative. There is a direct discussion and processing of traumatic experiences.

   A number of children's story books and play therapy procedures may be used. A variety of emotion regulation skills training procedures and parent training procedures are often included.

3. **Alternative Treatment Approaches**
   Use of cognitive behavior play therapy and art expressive procedures

4. **Build Upon the Child's Strengths and Bolster Resilience in a Culturally Sensitive Manner**

5. **Build in Protective Factors: How to Involve the School in the Treatment Process**

6. **How to Engage Parents in Processes Designed to Nurture a Resilient Mindset in Their Children**

EPIDEMIOLOGICAL STUDIES OF ADOLESCENT DEPRESSION

- 12-month prevalence rate exceeds 6% for major depressive disorder (MDD) and 10% for dysthymic disorder in youth.

- The point prevalence for MDD alone has been estimated at 3-8%.

- By age 18, nearly 25% of all youth in the U.S. will have experienced depressive disorder (Zalsman wet al. 2006)

- Prevalence of Dysphoric Disorder (DD) begins earlier and lasts longer than Major Depressive Disorder (MDD) (0.6-1.7% school children, 1.6%-8% adolescents). DD increases the risk of developing MDD.

- The average age of onset of MDD is around 13 years. One third of those youth with MDD which occur around age 16 have had previous episodes of depression.

- MDD in childhood tends to have an acute onset that lasts an average of 7 to 11 months. 80%-90% of youth will recover from this index episode. Recovery usually takes 11 months. The remaining 10%-20% will have persistent depression that can last longer than 18 months.

- 40% of youth with MDD will have a remission within 2 years; 70% within 5 years. Each recurrence increases the likelihood of future depressive episodes.

- Some 6% to 10% will have protracted depression that will persist into adulthood. The earlier the onset of depression, the more likely it is to persist into adulthood and more likely to recur and be associated with social handicaps.

- MDD increases the risk of developing bipolar depressive disorder (BPD). 20% - 40% of MDD adolescents develop BPD within 5 years.

- MDD precedes the onset of Substance Abuse Disorders (SUDs) by 4 to 5 years. 15% of those with MDD will go on to develop SUDs, while 20% with MDD will go on to develop a secondary anxiety disorder.

- Youth with DD & MDD are most at risk of having longer and more severe depressive episodes, with a higher incidence of suicidality and poor responsiveness to treatment.

- Half of children with MDD meet criteria for at least one other psychiatric diagnosis. For example, the overall rate of comorbidity for anxiety and depressive disorders is 30% - 40%. Anxiety disorders tend to precede the onset of depressive disorders. For example, social phobia and being shy is often a forerunner of MDD, with an onset of 11.3 years. They are also at higher risk for suicidal ideation and behaviors. Disruptive Behavior Disorders are also often comorbid with adolescent MDD. Other comorbid disorders with adolescent MDD

include PTSD, Eating Disorders, Substance Abuse Disorders, Learning Disabilities and chronic physical illnesses like irritable bowel syndrome. (Szigethy et al. 2007). **There are multiple pathways to depressive disorders.**

- An example of the comorbidity of substance abuse, depression and suicidal behavior was examined by Bagge and Sher, (2008). They noted that alcohol use can increase psychological distress, depressed mood due to neuropharmacological changes, alcoholic "myopia" which narrows alternative thinking and constricts cognitions, and results in interpersonal academic and legal problems which are reasons adolescents attempt suicide. It has been estimated that 25% of youth who attempt suicide use alcohol or drugs at the time of the attempt. Subsequent substance abuse predicts reattempts.

- Epidemiological studies (Brown et al. 2007) have documented higher rates of internalizing disorders among Native Americans, Latino Americans, Asian Americans and African American adolescents compared to European American adolescents. Latino Americans reported the highest level of depressive symptoms of all ethnic groups. Symptom expression varies across ethnoracial groups. For example, the highest rate of somatic symptoms are reported by Latino and Asian American youth. (Anderson & Mayers, 201).

- The role of biological factors (5-HTT transporter gene) that has been linked to mood disorders, family processes, environmental/social risk factors and differential protective factors such as social support vary across diverse adolescent groups. See work by Caspi et al. (2003), Kaufman et al. (2004) and Kendler et al. (2005) for examples of the ways stressful life events and social supports impact on serotonin transporter system in predicting episodes of major depression.

- The role of acculturation, cultural identity as risk or protective factors varies across ethnic, gender and SES. There is a need to adjust therapeutic interventions with depressed youth based in ethnic/cultural needs. (Cardemil et al., 2010) (*see* www.melissainstitute.org *13th Annual Conference on culturally sensitive interventions).*

- The gender ratio of diagnosable depression is roughly equal before puberty, but by early adolescence girls are two to three times more likely to be depressed than boys.

- One of the potential causal factors for this gender difference may be increased cognitive vulnerability among females (namely, the tendency to ruminate (brood about problems) and a negative inferential style (tend to choose more passive and less effective strategies for solving problems). Girls also possess a more negative orientation to problems relative to boys and a more negative view of self. They tend to focus on the fact that one is depressed, one's symptoms of depression, and the causes, meaning and consequences of one's depressive symptoms. Stark et al. (2010) have developed a treatment for depressed girls.

- There are developmental changes in the expression of depression. Prepubertal children evidence more somatic complaints and psychomotor agitation, as well as comorbid

separation anxiety and phobias. Adolescents evidence more anhedonia hopelessness, helplessness and hypersomnia.

- 30% of depressed adolescents will experience a relapse. Long-term follow up indicates that 50% of youth will have another depressive episode.

- Youth depression predicts low academic achievement and school failure, substance abuse and dependence, and later in life, unemployment and early parenthood. It is associated with psychiatric comorbidity and increased risk of attempted and completed suicide (Fergusson & Woodward, 2002).

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SOME FACTS ABOUT ADOLESCENT SUICIDE

(Research gleaned from Berman et al., 2005; King, 1997; McIntosh, 2000; NIMH, 2008 and Nock et al. 2008)

- ***From 2001 to 2019 the suicide rate of adolescents, ages 10 to 19, increased by some 90% and Emergency visits related to self-injury raised by 88%.***

- Adolescent suicide is a major health problem and accounts for at least 100,000 deaths in young people worldwide, according to the World Health Organization.

- Suicide is the third leading cause of death among 10- to 19-year-olds in the U.S.

- Among young adults (15-24), there is one suicide for every 100 to 200 attempts. Nearly 20% of adolescents in middle school and high school report having seriously considered attempting suicide during the past year.

- The Youth Risk Behavior Surveillance Survey (YRBS) found that nearly 15% of adolescents had made a specific plan to attempt suicide. 700,000 received medical attention for their attempts.

- Boys who identify as being gay or bisexual are up to 7X more likely to attempt suicide than other boys in their high school.

- 10% of adolescents, who attempt suicide, reattempt within 3 months, up to 20% reattempt within 1 year, and 20% to 50% reattempt within 2 to 3 years. Prior suicide attempts is one of the most important predictors of completed suicide, with a 30-fold increase risk for boys and a 3-fold increase for girls. With each repeated attempt, the risk of lethality increases as attempters use more severe methods.

- The presence of a co-morbid psychiatric disorder significantly increases the risk of suicide attempts, particularly conduct disorders and substance abuse. 90% of adolescents and 60% of preadolescents who complete suicide had a mental disorder.

- The rate of suicide among adolescents has quadrupled since the 1950's.

- In the U.S., youth suicide is alarmingly high with a rate 3X the National Average. White youth have higher rates than African American youth, with Asian Pacific Islanders having the lowest rate. Hispanics have a relatively low suicide completion rate, but they are significantly more likely than either white or African American adolescents to report suicidal ideation. Suicide rates among Native American groups vary, but some groups have been found to be as high as 13 times the rate for all races.

- Surveys of youth in grades 9-12 indicate that:
    - 15% of students reported seriously considering suicide.
    - 11% reported creating a suicide plan.

- 7% reported trying to take their own life in the past 12 months.

- In a typical high school class of 30 students, one student will seriously consider suicide, 2 or 3 (one boy and 2 girls) will attempt suicide, and one student will make an attempt sufficiently harmful to require medical attention.

- One half of those who are clinically depressed do not receive any treatment.

- Only 1 in 3 youth who attempt suicide receive help following the attempt. 45% of adolescents who attempt suicide do NOT attend one psychotherapy session after an emergency visit for their suicide attempt.

- Each suicide intimately affects at least 8 people.

- Recent years have witnessed major advances in the treatment of depressed and suicidal youth, including the use of Social Internet Media. However, it is critical to note that the Internet can also lead at-risk youth to material that increases their risk such as information regarding methods of suicide which can lead to increased lethality of attempts.

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ASSESSMENT AND TREATMENT: A CHECKLIST OF CLINICAL ACTIVITIES

1. **Take a complete patient history.**

2. **Use a Case Conceptualization Model that assesses for both proximal and distal risk and protective factors, potential barriers and strengths**. For example:

   Distal Risk Factors that include prior suicidal behaviors; history of mental disorders such as depression, anxiety and personality disorders, disturbed family context and parental loss before age 12; sexual orientation.

   Proximal Risk Factors that include stressful life events, sexual and physical abuse; academic difficulties; functional impairment due to physical illness and injury; suicide in social milieu; and a cultural belief that suicide is "noble" and accessible means of suicide.

   Proximal risk factors in combination with one or more distal risk factors heightens suicide risk.

   This combination of proximal and distal risk factors was highlighted in Joiner's (2005, 2010) Interpersonal-Psychological Theory of Suicide. He highlighted the role of:

   a) Thwarted belongingness is an unmet need to belong that involves a lack of frequent, positive social interactions and feelings of not being cared about by others

   b) Perceived burdensomeness is a belief that one is a burden and liability to others

   c) Acquired capability to enact lethal self-injury and withstand the fear of death. This acquired capacity is developed over time through repeated exposure to painful and provocative events (habituation to fear and pain in self-injury).

   The clinician should assess for each of these psychological areas.

   > Thwarted belongingness: "***Do you feel connected to other people?"***
   > ***"Do you have someone you can call when you are feeling badly?"***

   The clinician should consider the client's social support network, interpersonal losses and the level of social involvement, lack of family cohesion).

   > Perceived Burdensomeness ***"Sometimes people think that the people in my life would be better off if I was gone. Have you been thinking like that?"***

   The clinician should assess for feelings of "expendability"; significant others would be better off without them.

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Assess Acquired Capability ***Consider history of self-injuries and high-risk behaviors and Resolve Plans and Preparations.***

A history of non-suicidal self-injury (NSSI) is a risk factor for suicidal behavior. Such NSSI may be intended to relieve tension, produce a feeling of aliveness, alter consciousness, gain attention, reflect a "cry for help".

Messer and Fremouw (2008) have discussed various explanatory models of NSSI in adolescents. They highlight that up to 28% of individuals who self-mutilate have had suicidal ideation at some point. There is a need to determine if the self-mutilation was deliberate, repetitive, was normative for peer group, provided a sense of relief from the sense of tension, anxiety and anger that existed prior to the act and whether the adolescent had intent to die from self-injury.

The rate of NSSI varies across adolescent populations (15% in community population to 60% in institutional and residential youth). They are often categorized as "lonely", "sad" and "alone" and have a history of sexual abuse with difficulties in regulating and coping with negative emotions.

The significance of NSSI as a risk marker for suicidal behavior is underscored by the following findings. The risk of suicide increases 50-100 times within the first 12 months after an episode of self-injury compared to the general population. Approximately one-half of persons who die by suicide have a history of self-injury and this proportion increases to two-thirds in younger age groups (Appleby et al. 1999; Cooper et al. 2005).

In summary, Joiner's interpersonal psychological theory of suicidal behavior states that the desire for suicide arises when an individual feels that he or she is a burden on other people and simultaneously feels disconnected from others. In addition, an individual with a desire to commit suicide will not make a serious attempt or die by suicide unless he or she has acquired the capability for lethal injury.

3. **Directly assess for suicidality** (suicidal thoughts, intentions, plans, accessibility and potential lethality). As Berman (2010) observes:

> *"Suicidal patients quite often conceal their thoughts and/or simply deny having suicide ideation, particularly when they are intent on dying by suicide and wish not to be stopped. Verbalized suicidal ideation, while a cardinal indicator of heightened risk for potential, overt suicidal behavior is neither a necessary, nor a sufficient condition for the assessment of risk for that behavior. A formulation of a patient's risk instead rests on an assessment of a number of acute risk factors reflecting a patient's intense suffering (despair, anguish). (See mnemonic below IS PATH WARM?)."*

4. **Assess for the presence of both depression and comorbid disorders using a life-span perspective.**

   Depression is a risk factor in approximately 60% of those who die by suicide or who make a non-fatal attempt. But 40% have no evidence of depression. Only about 1% of Americans who have clinical depression will die by suicide within the next year. (Berman, 2010). Since only 10%-40% of those adolescents who attempt suicide have made a previous attempt, it is necessary to assess for other risk factors such as other mental disorders. See Miller et al. (2007) for a discussion of possible assessment instruments.

5. **Obtain releases to connect with past therapists and secure the patient's medical and mental health records.**

6. **Formulate a diagnosis using DSM.**

7. **Document, document, document... "Thinking out loud for the record" (See Below).**

8. **Obtain Informed Consent (See Rudd et al. 2009).**

9. **Use supervisors, colleagues to discuss patient's suicidal risk and therapeutic steps taken.** Document these contacts.

10. **Build in a safety plan.** A caveat has been offered by Berman (2010) who observed:

    > *"There is <u>no evidence</u> that Suicide Contracts are effective in preventing suicide. Safety planning is considered a best practice, but it's empirical effectiveness has <u>not</u> been tested".*

    The primary focus of a Safety Plan should be on reducing acute risk factors and then treat the underlying vulnerability that predisposes the patient to be suicidal. The Safety Plan Model reduces the patient's capability and desire to act by removing access to means, counteracts substance abuse, helps calm anxiety and aggression, engages significant others, improves sleep and helps stabilize the environment.

11. **Assess for the family dynamics and involve them if indicated.**

12. **Provide hope by assessing for strengths and signs of resilience** (**"In spite of" behaviors**) **and engage clients in <u>collaborative goal-setting</u>.**

    For a discussion of how goals and accompanying beliefs lead people in and out of depression, see Rothbaum et al. (2009). They highlight how the cognitive vulnerability of adopting the goal of avoiding proof of worthlessness combined with self-handicapping behaviors (effort withdrawal and rumination) predispose individuals to bouts of depression. They view rumination as an "excuse generating machine" that contributes to

self-blame and self-denigration in the desire to avoid feelings of worthlessness (Nolen-Hoeksema et al., 2008).

Treatment should help depressed individuals shift from such performance-focused goals and face-saving self-handicapping behaviors to learning-focused goals which are designed to improve and grow, cultivate existing abilities, develop new skills and strategies and master new tasks.

The presence of social supports, the engagement and enjoyment of prosocial activities, religiosity, plans for the future, a history of coping skills, generally suggests lowered suicidal risk (Ramey et al. 2010). However, as Berman (2010) observes, “The presence of acute risk factors will trump the presence of protective factors every time”.

13. **Continually assess for ongoing risk for suicide and the possible need for increased supervision** (e.g., psychiatric hospitalization).

    The days and weeks immediately subsequent to psychiatric hospitalization are a period of significant risk for suicide. Given this increased risk, Berman (2010) recommends that the first outpatient appointment following discharge occur within 48 hours of discharge; or less, if at all possible.

14. ***“Throughout the therapy process continually communicate that you care and convey your commitment to doing whatever needs to be done to keep the patient alive- that every effort will be made to help the patient to decrease his/her pain, hopelessness and lethality”*** *(Bongar and Stolberg, 2009, p. 16).*

TREATMENT OF DEPRESSED ADOLESCENTS

1. **Incidence and Impact of Depression**

2. **Need to be Person-Centered: Track the Development and the Multiple Factors that Can Contribute to the Adolescents Depression**

    a. Consider the role of co-occurring disorders
    b. Consider the role of cultural and gender identity issues
    c. Use the Case Conceptualization Mode and Timelines
    d. Customize treatment to meet the Youth's clinical needs and preferences
    e. Employ a life-span assessment approach
    f. Assess for the Youth's implicit theories of their presenting problems and what is needed to change

3. **Assessment Approaches: Use the Art of Questioning to Conduct Both Situational and Functional Analyses.**

    a. Use scales that assess the level of depression, hopelessness, and reasons for living.
    b. Consider presence of risk and protective factors.
    c. Be goal-oriented and strength-based; Use Motivational Interviewing Procedures.

4. **Alternative Treatment Approaches**

Cognitive Behavior Therapy/Dialectical Behavior Therapy/
Acceptance Therapy that incorporates Mindfulness Training/
Behavioral Activation/Interpersonal Therapy/Family-Based Therapy/
Use of Antidepressants.

5. **Core Tasks of Psychotherapy**

    a. Safety First
    b. Establish, maintain, and monitor the quality of the therapeutic alliance. Use session by session Patient Informed Feedback Procedures.
    c. Employ Psycho-Education: Use the Clock Metaphor.
    d. Use Collaborative Goal-Setting (establish "SMART" Goals)
    e. Teach Emotion Regulation and Cognitive Rethinking Skills
        - Use Evidence-Based, Alternative and Implications Type Questioning Skills
    f. Teach Interpersonal Skills (Goal – Plan – Do – Check)

6. **Build In Generalization Guidelines Before, During, and at the Conclusion of Treatment**

7. **Engage in Relapse Prevention and Active Aftercare Planning**

8. **Put the Client in a Consultative Role**

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NURTURING A THERAPEUTIC ALLIANCE: QUESTIONS THAT ARE DESIGNED TO NURTURE A COLLABORATIVE THERAPEUTIC RELATIONSHIP WITH ADOLESCENTS

See B. Bertolino, 2003, Change-oriented therapy with adolescents and young adults. New York: Norton.
See D. Meichenbaum, 2004, Treating individuals with anger-central problems and aggressive behavior.

The following questions and considerations are designed to help engage adolescents and their parents in therapy. As Bertolino (2003) has highlighted, small changes in the language and "story-telling" can open new possibilities for future change. The "art of questioning" is one of the most valuable tools clinicians can use.

1. **Conduct a Situational Analysis**
   How often does the problem typically happen?
   Where does it happen?
   When does it usually occur and how long does it last?
   When does it end?
   Who is present?
   How do they respond?
   What have you tried to do to help address this problem?

   Assume future solutions through future talk
   Use expression such as *yet* and *so far*
   So far things have not gone right for you
   You haven't found a way to stay out of trouble yet

   I would like to invite you to consider noticing any differences in the problems that brought you here and telling me about them when we meet again. For example,

   Are there any changes when you get depressed?
   How depressed do you become?
   How long does the depression lasts?
   What do you do with your depression?
   Ask one question at a time.

2. **Turn problem statements into goals and future actions**
   So you would like to see...
   So one of the things we would focus on is to find a way to change...
   So when you get the sense that..., what will be different for you?
   So when you put the trouble behind you, I wonder (I'm curious) how will your life be different?

3. **Translate the client's absolutistic statements that use "all", "nothing" or that reflect "black-white" thinking into partial statements.**
   Much of the time...
   In the last while...
   Always?
   Never?
   Any exceptions?

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4. **Solicit feedback on sessions.**
   How was today's session?
   What was helpful or unhelpful?
   Did we talk about what you wanted to talk about?
   Did we work on what you wanted to work on?
   How was the pace of our session? Did we go too fast or too slow, or was the pace just right?
   Was there anything missing from our session that you would like to see us include in the next session?
   Is there anything I should have asked that I did not ask?
   Is the way we are proceeding to address your concerns fitting with the way you expect change to occur?
   What ideas do you have about how I can help you with this?
   I want to take the time to make sure I understand where you (or each person) are coming from. Is that okay with you?
   I would like to hear your ideas about what you think should happen next in our sessions.
   There are many possibilities. We could...or you could decide to...
   What might make the next session a little better for you?
   Are you okay with that?
   I have to tell you that I am a bit confused about...
   I'm still wondering if...
   Correct me if I am wrong.
   Are there any changes you would recommend for our future sessions?
   Did you feel heard and understood?
   Is there anything you would like me to do differently in future sessions?
   How would you explain your experience in therapy today to others who might be curious?
   What might make coming here again a little better for you?

   I will be checking in with you regularly to find out what's been helpful to you, what's not helpful, what's working and what's not working. Is that okay with you? I want to find out what we have done together that has been of benefit to you. This way I will be able to learn from you if our working together has helped or if anything needs to change in terms of the services we provide or whether a referral to another service would be of more help.

5. **Relapse Prevention Questions: Learning from setbacks (slips)**
   What signs were present that things were beginning to slip?
   What have you learned from this setback?
   What will you do differently in the future as a result of this knowledge/experience?
   What can you do differently in the future if things begin to slip?
   Is there anything that might come up between now and next time we meet that might pose a threat (hurdle, barrier) to the changes you have made?
   Can you think of anything that might come up that would present a challenge (barrier) for you staying on track?

6. **Taking Credit For Change**
   What have you noticed that has changed?
   What specifically seems to be getting better?

Who first noticed that things had changed?
When did you first notice that things had changed?
What did you notice happening?
What did you do that resulted in...?
How did you get yourself to do that?
How did you get that to happen?
How was that different than before?
How did that help you?
Where did you get the idea to do it that way?
What did you tell yourself?
What do you think made the difference?
If X were here, what would they say has contributed to the change you brought about?
What does it say about you that you have been able to...?
What kind of person are you that you have been able to ...?
Where did this X (courage, will-power) come from?
What kind of inner strengths do you draw on in such moments of difficulty/adversity?
What kind of inner qualities do you possess that allow you to...?
What would others say are qualities that you possess that help you when you need them?
Consider how change comes about with your parents. How can we work together so these changes continue into the future?
What have you already learned about how to make it through a day at school?
How have you managed to go so many days in a row at school without having a X?
How will you let people know when you become angry without hurting anyone else or yourself?
Who will you want to be sure to talk to this week at school?
Until we meet again next week, who can you depend upon (or call upon) when you begin to notice bad feelings (or trouble) coming on?

7. Fostering Generalization

Can you tell me a little about how things are since the last time we met?
How can we use what we learned last week to help you deal with the problem you are having with...?
Pretty tough situation. Is there anything you could do...?
I am wondering if you could...
What might happen if you...?
I am not certain you are ready for that yet.
That sounds pretty hard. Maybe, we should think of something else to do...
Why is it important to correctly guess what someone's intentions are or what they want?
What, if anything, has been different since the last time we met?
The last time we met, you mentioned that on a scale of one to ten, things were at a five.
Where would you say things are today?
Were you surprised by how you were able to...?
What did you do differently?
What did you do when you found out that...?
Do you ever find yourself out there in your day-to-day experiences asking yourself the questions that we ask each other, here in our meetings?

TIMELINE ONE

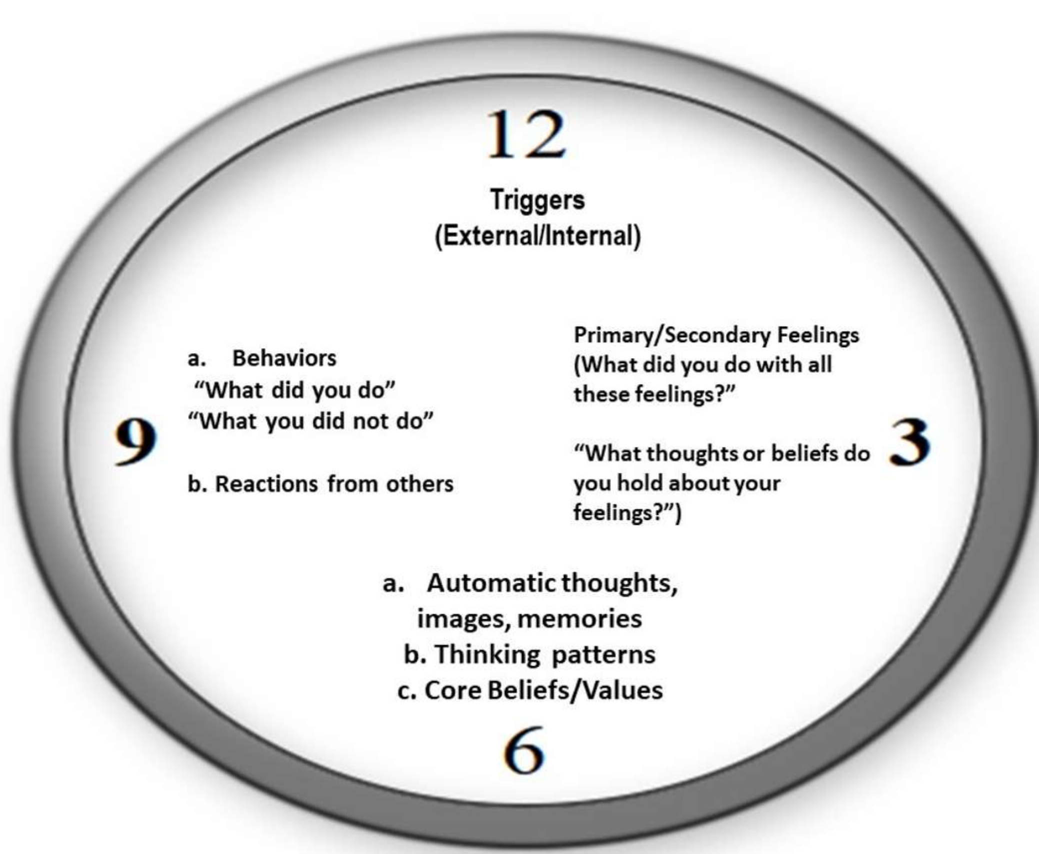
Trace with the patient the series of major stressful events and losses that they or their family experienced since the patient's birth to the present. Also, note what professional or non-professional interventions were provided? Query whether these interventions were judged to be helpful?

TIMELINE TWO

Trace with the patient any evidence of patient resilience, strengths, or "in spite of behaviors". These may include some patient's accomplishments, interpersonal relations or major transitions. Follow up with questions of "What" and "How" the patient accomplished these activities despite the stressful events enumerated in TIMELINE ONE?

TIMELINE THREE

Trace with the patient from the present to the future what are treatment goals that they want to work on achieving. Ask how would we know that treatment was effective? TIMELINE THREE will lead to collaborative goal-setting that nurtures HOPE.



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FRIDAY – DAY 5

CHARACTERISTICS OF RESILIENT CHILDREN

Behavioral Self-regulation Skills
Control impulses and slow down
Stay focused and avoid distractions
Delay gratification
Abilities or talents that are valued by others
Do well at school (multiple sources of "strengths")

Emotional Self-regulation skills
Have an easy temperament
Manage emotions-calm self-down when provoked
Persistent, show grit, and evidence a "passion" for a given area
Optimistic, future orientation and positive outlook
Hopeful
Self-control and self-discipline
Have a sense of humor

Cognitive and Metacognitive Skills
Cognitively flexible
Evidence "executive"/metacognitive skills (planful, self-monitoring, self-interrogative, reflective).
Aware of thought processes and choices

Prosocial Skills
Committed to a relationship within and outside family
School connectedness, participate in school activities and extracurricular activities
Has "Social Capital"- - Access prosocial networks, "Guardian Angel",
Advocate for self - - willing to seek help and access Kin
Hang around with the "right" people (prosocial mentors and peers)
Believe in the need "to give to get."
Mindful of thoughts and feelings of others
Willing to help others - - share in family responsibilities
Hold a part time job
Respect others and rules
Part of group who evidences cohesion or a collective sense of togetherness (e.g., church attendance, kinship gatherings)
Part of a group that has family rituals and routines and evidences a "collective efficacy"

WAYS TO BOLSTER RESILIENCE IN "HIGH-RISK" CHILDREN AND THEIR PARENTS

See the following items on the Melissa Institute Website https://melissainstitute.org/

Meichenbaum, D. Understanding resilience in children and adults.
Meichenbaum, D. Ways to implement interventions in schools.
Meichenbaum, D. The emerging neurobiology of resilience.

Also see Conference Handouts by Ann Masten, Esther Deblinger, Marlene Wong, Joan Asarnow

COMMUNITY INTERVENTIONS FOR HIGH-RISK STUDENTS

Research indicates that approximately 20% or 16 million students live in poverty and in terms of school preparedness they lag significantly behind. This lag is exacerbated if the student is a minority member. Moreover, this is further enhanced if the student has experienced a number of Adverse Childhood Experiences. Students who have 8 or more such ACEs will evidence as much as a 30 IQ deficit. By the Senior High school year level, such a student of 17-year-old minority status who has been victimized will function at the same level as a 13-year-old (up to four grades behind.)

They also have a greater likelihood of being placed in a Special education class, have school suspension, expulsion and school dropout. High school dropouts will earn $250,000 less over their lifetime and pay $100,000 less in taxes. It has been estimated that a 5% increase in high school graduation would result in a societal savings of one billion dollars.

HERE IS THE GOOD NEWS, Research also indicates that one-half to two- thirds of such "high-risk" students "beat the odds" and evidence resilience. What are the characteristics of such resilient students and what can the Community of Schools, Parents , Clinicians and Community leaders do.

ILLUSTRATIVE SCHOOL-COMMUNITY INTERVENTIONS

1. Provide early school preparedness skills where indicated, about social and academic skills.
2. Employ a Principal Checklist (See below).
3. Employ a Parent Involvement Checklist (See below).
4. Conduct trauma-informed interventions on an individual basis (TF-CBT) or on a group basis (CBITS).
5. Provide interventions following natural disasters, and such stressors for children who are experiencing divorce.
6. Implement an anti-bullying and cyber-bullying programs. Train teachers how to intervene and provide supports and also classroom management. (See www.teachsafeschools.org).
7. Provide school-wide SEL (Social, emotional learning instruction).
8. Create an Inviting Learning Environment, especially for LGSTQ+ students, (See how to bolster resilience in LGBTQ students on the Melissa Institute Website)
9. Implement a Peer Warning System and work on relationship between students and the SRO.
10. Conduct student assessment procedures such as Pronto Boxes. Class play measures and Map assessment of student perception of "School Hot Spots", "Dead Zones".
11. Address issues of presence of gangs (dress, insignia, language). Query all students on how safe they feel getting to school and getting home.
12. Do NOT implement school policies that exacerbate the challenges that high-risk students face. Do NOT employ grade retention policies, suspensions, expulsions. One year retention, results in a 40% high school dropout; two-year retention has a 90% high school dropout rate.
13. Do NOT aggregate "High-risk" students in one class or in one school.
14. Implement an After-school program like school sports, music, or study program to teach executive skills, where indicated.
15. Implement a community civic altruism program.
16. Implement a prevention school dropout program.
17. Ensure school safety procedures such as practice Lockdown skills.
18. Implement an Active absentee program.
19. Have an Active Summer Program
20. Bolster resilience of students and teachers. Convey a resilient mindset. (See work by Dweck and Tough).
21. Evaluate these interventions and report the results.

PRINCIPAL'S CHECKLIST

In a column (March 13, 2018), the New York Times columnist David Brooks noted that "Good leaders make good schools." He observed:

> *"When you learn about successful principals, you keep coming back to the character traits they embody and spread: energy, trustworthiness, honesty, optimism, determination. We went through a period when we believed you could change institutions without first changing the character of the people in them. But we were wrong. Social transformation follows personal transformation."*

The **PRINCIPAL'S CHECKLIST** enumerates the variety of Principal initiatives that can be conducted at the school-wide level (Primary Prevention), or with identified "high risk" students and their families (Secondary Prevention), and with students who have evidenced persistent behavioral problems and require more intensive wrap-around services and crisis management interventions (Tertiary prevention). This Checklist can be viewed as a type of **PRINCIPAL REPORT CARD**. It highlights the need "to pay attention to small things".

PRIMARY PREVENTION

1. Principals should be a visible presence in greeting all students and parents visiting the school.

2. Conduct a formal review of all safety policies and school emergency plans and practices. For example, establish a regular schedule for safety drills.

3. Conduct a school safety assessment and identify any safety weaknesses and strengths and correct deficiencies.

4. Provide staff training on school safety, emergency management and bullying.

5. There are staff members trained in emergency first aid and CPR, and their identities and hourly locations are posted.

6. Connect with community law enforcement personnel, first responders to a crisis.

7. Establish a reporting system for bullying and safety concerns.

8. School exterior grounds have been assessed for security concerns by law enforcement personnel or by individuals trained in Crime Prevention through Environmental Design (CPTED).

9. All areas of the building and grounds are supervised and there are no obvious "dead zones" where problems can occur, including parking lots, loading docks, and interior stairwells.

10. The interior of the school buildings is well-lit, clean and reflects pride in school identity and the accomplishments of its student body.

11. Assess for not only the safety of the school and school grounds, but also assess for the safety of the routes students take to school. (Ask students to draw a map of how they get to and from school and/or their perceived school bus safety) Interview school bus drivers and implement intervention strategies, as required.

12. There are effective access control policies and procedures for keeping intruders out of the school.

13. There are effective policies and procedures for keeping weapons out of the building.

14. A rigidly enforced key control policy is in effect and sensitive locks are replaced every three to four years.

15. There are effective policies and procedures for keeping gang-related "identifiers" and behaviors out of the building and off school grounds.

16. Check to see if staff members feel safe at all times during the school day. Work to improve the emotional climate of the school.

17. The school has a well-formulated Mission Statement that is posted and shared with all parties, and underlies improvement efforts. Work to change norms and expectations about aggression and violence.

18. The school has a collaboratively written Code of Conduct that has been examined for currency. It is educational more than punitive, and defines desirable, as well as undesirable behaviors and resultant consequences.

19. Administration and teachers have established an Inviting Learning Environment that encourages school bonding and ownership from all groups of students, staff and parents. Set up a School Website, telephone hotline, Home-school Link. Be sure to have teachers contact parents when students are doing well in school. Involve students in establishing and implementing rules and activities.

20. Academic standards are high, and pride in achievement is emphasized and publicly expressed through multiple outlets.

21. Cultural, ethnic and other minority groups are valued and diversity is respected and honored. Bolster strengths of students and their families.

22. Parents are welcomed into the building and provided with opportunities and information to be full partners in their child's education. Work with parents to improve parenting skills such as monitoring, supervising and academic support.

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23. All teachers have received training in classroom behavior management, and 95% of disciplinary consequences are administered at the classroom level.

24. All students receive evidence-based classroom instruction in anger management, social problem-solving, and/or conflict resolution across multiple grade levels.

25. The school has a comprehensive school-wide anti-bullying program in place and systematically evaluates its effectiveness.

26. The school has implemented a student peer mediation training program.

27. The school has implemented a peer warning system that allows for confidential student communication to identified adults.

28. The school has a broadly represented Crisis Intervention Team that has been trained in crisis response and management. The school has a Threat Assessment Team who are familiar with the behavioral pattern, ("red flags") of mass school shooters.

29. Administration and school personnel have undertaken initiatives to foster community-based supports and partnerships. Increase the availability of youth development opportunities and civic activities.

SECONDARY PREVENTION

30. All teachers have received training on methods to tailor academic instruction to meet diverse student needs. Convey high, clear expectations, but be realistic and collaborative.

31. The school has undertaken a special initiative to improve students' reading achievement and monitor its effectiveness. (See the Melissa Institute Reading Initiative Program ***www.readingteacher.net***).

32. Have a commitment to systematically collect data to evaluate intervention programs designed to reduce bullying, improve academic performance, improve parental involvement reduce absenteeism, suspensions, expulsions, and drop outs. Share this data with staff and provide Professional Development days for staff training on a needs basis.

33. Work to bolster student "connectedness" to school and encourage teachers to be supportive, look for the good in students and point it out to them and share it with others. Celebrate student contributions, not give up on students who made mistakes, and talk to them about their futures. (See the video by James Larson on how to turn an aggressive youth into social problem solvers).

34. Since school alienation has been found to be a key factor in the development of juvenile delinquency, work to bolster student "connectedness" to school.

35. Check on the health of your students. (Make sure they have basic health needs met like vision and hearing problems, nutritional and safety issues like homelessness).

ASK THE STUDENT THE FOLLOWING QUESTIONS:

"If you were absent from school, who besides your friends would notice your absence and would miss you?"

"If you had a problem in school who could you go to for help?"

36. Supportive services staff are provided adequate time and relief from other duties to implement interventions for identified students at risk.

37. Existing interventions for at-risk students have undergone recent program evaluations to assess their effectiveness.

38. Administrators treat office referrals as teaching opportunities to augment disciplinary procedures.

39. Out-of-school suspension is exceedingly rare and used only for clear issues of student safety and when home supervision can be assured.

40. In-school suspension is used sparingly, only for the most serious offences, and it contains an academic support component.

41. School personnel have assessed the drop-out problem and implemented evidence-based dropout prevention programs.

42. The school has implemented a mentoring program for at-risk students.

43. Ongoing needs assessment and program planning are driven by authentic data from disciplinary referrals and academic progress monitoring, and interventions are linked to the data.

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TERTIARY PREVENTION

44. Students with chronic and persistent behavior problems are routinely provided with assessment-driven behavior intervention plans.

45. Students with chronic anger management and aggression problems are provided with evidence-based skills training by support services staff.

46. All school personnel have been taught and have practiced ways to defuse and redirect students who evidence aggressive and violent behaviors.

47. There are staff members professionally trained in student restraint and safe transport, and their identities are known by everyone.

48. Effective partnerships or wraparound arrangements with families, community mental health, law enforcement and social service agencies are maintained to support the highest risk students.

49. School personnel have been trained to identify and help students who live with neglect and violence.

50. Actively lobby for aides and funds to meet the needs of all " high-risk "special education students in your school.

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PARENT INVOLVEMENT QUESTIONNAIRE

Donald Meichenbaum, Univ. Waterloo, & Andrew Biemiller, Univ. of Toronto

This questionnaire is designed to determine how you and your school involve parents in the education of their children. It provides a list of possible ways to involve parents in terms of:

(a) communication (both written and oral) about school activities and about specific topics such as homework;
(b) possible collaborative activities with parents and
(c) administrative support for parent involvement.

There are no right or wrong answers to these questions. The intent of this questionnaire is to have educators consider and reflect upon the many ways to involve parents in the education of their children. Certainly, the feasibility of some of these suggestions will vary depending upon the grade level, subject area, and school setting. We have provided space for you to indicate other ways you and your school have involved parents. Please feel free to send these suggestions to us so that we can revise the questionnaire.

COMMUNICATION WITH PARENTS

Please answer the following questions by circling YES or NO.

A. Written communication with parents

YES NO 1. At the beginning of the school year, I send a letter home to each parent.

2. In my written correspondence with parents. I:

YES NO (a) mention how much I look forward to working with their son/daughter and with them.

YES NO (b) comment on the need for parents and teachers to act as collaborators and partners and have a continuing exchange, and I encourage them to be an advocate for their child.

YES NO (c) indicate that I will call them when I need their help, as well as when their son/daughter does well.

YES NO (d) extend an invitation to parents to call me to arrange a visit to meet (highlight the importance of two-way communication).

YES NO 3. I provide parents with a written general description of what we will be working on during the term and why these activities are important.

YES NO 4. Later in the school year, I provide parents with an ongoing assignment calendar of the work we will be covering in class over the next few weeks and why this work is important (e.g., description of unit objectives, types of problems and assignments, and ways in which students will be assessed; lists of books to be used, recommended children's books, and upcoming school events).

YES NO 5. I provide parents with ongoing written communication in the form of a class newsletter about what the class has been doing and learning, and some of the things students will be learning in the near future. (Students can participate in the production of this newsletter.)

YES NO 6. I indicate to parents that over the course of the school year, their son/daughter will be asked to interview them (or other family members, relatives, neighbors) about learning and helping strategies, and about when they use math and written language in their day-to-day activities.

YES NO 7. I indicate that students will be bringing home a folder of their school-work labeled TAKE HOME/BRING BACK. There will be space for parents to initial and comment on this week.

YES NO 8. I provide parents with a survey/questionnaire to provide information about their child's reading behavior (e.g., average amount of reading time per week, leisure reading habits, favorite books, reading strengths and weaknesses).

YES NO 9. I occasionally send parents a Teacher-Gram and invite them to send back a Parent-Gram about their child's progress.

B. Oral communication (phone calls/meetings) with parents

YES NO 10. I call each parent (at least once per year, preferably once per term) to give positive feedback (i.e., convey something their child did well).

YES NO 11. The ratio of positive to negative phone calls that I make to parents per month is 3 or 4 to 1.

YES NO 12. I keep track (in a running log) of each parent telephone call, recording the date, the name of the student, whom I spoke to, the topic, the parent's reactions, and any follow-up plan.

YES NO 13. I schedule meetings with parents to review their children's progress.

YES NO 14. At these meetings, I usually indicate what their child has studied in class, and discuss their child's study habits (finishing assignments, studying, helping others), academic achievement, and classroom behavior.

YES NO 15. At parent-teacher conferences, I have students attend so they can actively participate (e.g., show work from their portfolios, become self-advocates). Students are advised beforehand on how to contribute to these sessions.

YES NO 16. I encourage students to share with their parents what they do in class, in their homework, and in their other school activities.

C. Communication with parents about homework

YES NO 17. I inform parents about my expectations concerning homework (e.g., amount, time schedule) and comment on the benefits of students' doing homework.

YES NO 18. I provide parents with a list of suggestions on how they can help their son/ daughter with homework (e.g., ways parents and students can work out rules related to the setting, times, and routine, ways to motivate students to do homework

ways to provide help contingent on their child's request and need, ways to monitor homework loosely, ways to balance homework with other activities).

YES NO 19. I ask parents for their observations on their child's homework activities (e.g., difficulties, limitations, what went well). I ask parents to initial the homework assignments.

YES NO 20. I provide parents with specific suggestions for working with their children (e.g., read for 15 minutes with their children most nights; ask their children about their school activities and what they have learned each day in school).

YES NO 21. I provide parents with books and other learning materials to use at home with their children.

YES NO 22. I encourage parents to give their children home roles and responsibilities, especially those that involve serving others and that occur on a routine basis (setting the table, doing shopping, etc.).

D. Involvement of parents

YES NO 23. I invite parents into my classroom to observe teacher-led and student-led activities (e.g., how I read stories aloud to students, how students do cross-age tutoring, etc.)

YES NO 24. I review with parents how they can make their home more literacy-friendly (encourage their children's leisure reading behavior).

YES NO 25. I invite parents to assist in my class.

YES NO 26. I make parents feel welcome when they visit my class (e.g., have students give tours, have a display center with sample work available, have a list of things parents can do to help).

YES NO 27. I encourage parents to keep a running diary or journal of their children's progress and difficulties and to share this with me.

YES NO 28. I review with parents biographical information about their son/daughter and journal entries they have provided.

YES NO 29. I welcome parent evaluation of my teaching practices, students' progress, and class and school programs.

YES NO 30. I solicit information from parents about their interests, talents, and hobbies so I can request their involvement and help.

YES NO 31. I provide students with tasks or games in which they can involve their parents.

YES NO 32. I provide parents with a list of choices of how they might become involved at school and/or home with their child's education.

E. Administrative support for parent involvement

YES NO 33. My school views parents as partners in the students' education.

YES NO 34. My principal and/or department head encourages parental involvement and the maintenance of ongoing parental contact (in writing, phone calls, meetings).

YES NO 35. My school holds workshops for teachers on how to work collaboratively with parents.

YES NO 36. My school has created an environment that is inviting to parents (e.g., signs welcome parents into the school; office staff welcome them; teachers greet parents when they pass them in the hall; there is a parent reception area with relevant written material and newsletters).

YES NO 37. My school has a parent-teacher association that meets regularly.

YES NO 38. My school solicits parent input on important decisions concerning their children (parents are members of the governing council of the school).

YES NO 39. My school has a parent's night (or family night, or grandparent's gala) when parents can participate in tours and activities and discuss their child's progress with the teacher (e.g., a portfolio night when students can show their work).

YES NO 40. My school invites parents to participate in school activities (e.g., staff the library, chaperone school trips, share ethnic activities, help with fund-raising).

YES NO 41. My school has special events for parents to discuss particular topics (e.g., parent involvement, report cards, transitions to new grades such as middle to high school, selection of courses, drug abuse, etc.).

YES NO 42. My school holds special evening sessions for parents on learning-related activities (e.g., how to help with homework, how to read to students, how to bolster students' self-esteem, why some students succeed in school).

YES NO 43. My school has a parents' night on a specific subject (e.g., math night) so parents can understand what and how the students are being taught.

YES NO 44. My school has a back-to-school night during which parents are invited to experience the kinds of activities/tasks their children are asked to perform in class.

YES NO 45. My school involves students, teachers, and parents in cooperative learning activities in which they assist each other in achieving learning tasks and goals.

YES NO 46. Parents attend an "open house" where students have opportunities to showcase their work. Students rehearse for this event.

YES NO 47. My school has encouraged parents to identify with its mission statement

YES NO 48. My school provides both before-school and after-school programs for students to help accommodate parents' work schedules.

YES NO 49. My school is located in a high-poverty area, and we have undertaken such activities as having parent night in a local church or laundromat (e.g., offering free use of the laundromat with a parent visit).

YES NO 50. My school provides or helps to coordinate with other agencies a home-visiting outreach program.

YES NO 51. My school provides specific skill programs for parents (e.g., helping parents improve their literacy skills) or referrals to other services.

YES NO 52. My school provides support to parents in obtaining their GED.

YES NO 53. My school is involved in a parent literacy program (i.e., after-school educational assistance to children in the presence of their parents).

YES NO 54. My school provides transportation and day-care services when parents are visiting the school.

YES NO 55. Parents are notified immediately about any unexplained student absences.

YES NO 56. My school has an active truancy prevention program that involves parents.

YES NO 57. My school has established involvement and activities with local business and community leaders (e.g., an apprenticeship program).

YES NO 58. Parents in my school view their involvement as a responsibility to their children.

YES NO 59. Parents are asked to sign a contract indicating their responsibilities to the education of their children.

YES NO 60. We monitor parent involvement and try to understand the factors that contribute to their noninvolvement (e.g., failure to attend meetings, volunteer, call or meet with the teacher, review student's homework, portfolio, etc.).

Please indicate any additional activities and procedures you use to involve parents, or ideas about what you would like to see your school employ.

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EXAMPLE COMMUNITY-BASED INTERVENTIONS TO ADDRESS THE NEEDS OF "HIGH-RISK" STUDENTS

A. WORK WITH THE COMMUNITIES TO REDUCE VIOLENCE

1. Identify hot spots
2. Use of Crime Stoppers
3. Create a re-entry program
4. Relocation program
5. “Fix” the community
6. Involve community members and agencies

B. WORK WITH INDIGENOUS POPULATIONS IN THE U.S. AND CANADA

1. Role of Elders
2. Role of families
3. Maintain cultural beliefs, customs, rituals (e.g., Concepts of harmony)
4. Use journey metaphor (e.g., Canoe trip)

C. WORK WITHIN A FOREIGN COUNTRY

Another community-based intervention has been offered by the country of Iceland. Some 14 European countries have adopted this modeled intervention. The intervention includes the following features.

1. Iceland has designated a National Prevention Day
2. They provide funds for after school youth recreational activities
3. They conduct an annual youth anonymous survey to all 10- to 16-year-old students in order to assess the presence of risk and protective factors.
4. This survey also ask questions about family life, peer association and after school activities.
5. They provide youth with adult mentors.
6. They bolster parent involvement with the school system.
7. They work to bolster the students' self-efficacy and social competence. They focus on the students developing a resilient mindset.
8. They require all students to engage in some form of altruistic civic activity.

WAYS TO ACHIEVE GENERALIZTION AND LONG-TERM MAINTAINENCE OF BEHAVIOR CHANGES
- SUMMARY OF GENERALIZATION GUIDELINES -

At the Outset of Training Activities

1. Establish a therapeutic alliance
2. Collaborative goal-setting
3. Nurture a generalization attitude
4. Raise concerns about generalization from the outset
5. Use discovery-based learning (Socratic questioning)
6. Label and refer to generalization strategies
7. Use direct instruction to generalize
8. Solicit public comments
9. Individualize instruction
10. Anticipate potential barriers
11. Select training tasks carefully
12. Create "Community of Learners" (Alumni)

During The Training Activities

13. Scaffold instruction in "teachable window"
14. Use Acronyms-Simplify training
15. Provide graduated prolonged training to the point of mastery
16. Train at the meta-cognitive problem-solving level
17. Provide "big picture" (Advance organizers, informed instruction, access tutee's knowledge)
18. Explicitly instruct on how to transfer
19. Train across settings and response domains
20. Use cognitive modeling
21. Nurture "possible self"
22. Have tutee generate reasons
23. Conduct Relapse Prevention Training

At The Conclusion of Training Activities

24. Put tutee in a consultative role
25. Build in "pay offs" reinforcers
26. Label and reinforce transfer activities. (Use metacognitive discourse—"plan, notice, catch, in spite of")
27. Provide between session coaching
28. Trouble shoot and engage in problem-solving following failures ("learning opportunities")
29. Provide Aftercare case management (Ensure continuity of care)
30. Review progress and ensure self-attribution ("Take credit")
31. Design personal transfer activities
32. Involve significant others
33. Space out training sessions
34. Provide booster sessions
35. Use graduation ceremony

WEBSITES

Adverse Childhood Experiences Study
www.acestudy.org

American Psychological Association Adults and Children Together (ACT) Against Violence
www.actagainstviolence.org

Assistance to Teenagers
www.reachout.com

Bullying
www.eyesonbulling.org

California Evidence-based Clearinghouse
http://www4cw.org

Cangleska Inc.: Serve Oglala Lakota Nation
www.cangleska.org

Center for Early Adolescence
http://www.earlyadolescence.org

Couples Communication Program
http://www.couplecommunications.com

Dropout From School
http://www.abcsc.org

Gay, Lesbian and Straight Education Network
http://www.glsen.org/educator

Healthy People
http://www.healthypeople.gov

Melissa Institute for Violence Prevention
www.melissainstitute.org

Mental Health Net Self-Help Resources
http://www.mentalhealth.net/selfhelp/

National Center for Injury Prevention and Control (NCIPC/CDC)
http://www.cdc.gov/ncipc *Email: cdcinfo@cdc.gov*

National Child Traumatic Stress Network
www.nctsn.org (Phone 919-682-1552)

National Coalition of Anti-violence Programs
http://www.avp.org/dv/NCACVPDVReport2000.pdf
National Registry of Effective Programs and Practices

http://modelprograms.samhsa.gov/template.cfm?page=nrepbutton

Neighborhood Check-up Interventions
http://Promiseneighborhoods.org

Positive Behavior School Program
https://www.pbis.org/

Positive Parenting Programs
www.tripleP.net

Preventive Education
http://www.loveyourrelationship.com
http://www.okmarriage.org

Prevention of Depression
http://preventionofdepression.org

Psych Central
http://www.psychcentral.com

Reading Instruction
http://www.readingteacher.net

Social And Emotional Learning
http://casel.org
https://www.edutopia.org/
https://www.commonsense.org/education/lists/great-social-and-emotional-learning-curricula-and-programs
https://www.panoramaed.com/blog/social-emotional-learning-curriculum
https://everydayspeech.com/
https://www.secondstep.org/

Student Civic Engagement
http://www.myle.org

UCLA Center for Mental Health
http://smhp.psych.ucla.edu/rebuild/Rebuilding.htm
http://smhp.psych.ucla.edu/pdfdocs/enhancingtheblueprint.pdf

Web-based training in Trauma-focused Cognitive Behavior Therapy
www.musc.edu/tfcbt