

Providing Social, Emotional and Behavioral Services on a Budget

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There are two approaches

- Behavioral Approach because the behavior is used to get something or reject/escape something
- Cognitive Behavioral Approach because the behavior is due to faulty "meaning-making"
- See handouts to differentiate which interventions go with which which model

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What is the Source that drives the selected approach?

- Socially Mediated Behavior
 - Responds to reinforcement of absence of the problem if the payoff is as big or bigger than the payoff for the problem
 - Behavior is calculated to get or reject an outcome
 - Addressed in default behavioral interventions or behavior plans
- Emotionally Driven Behavior
 - Responds to adopting better coping methods and skills
 - Behavior is responsive to an internal state (fear, anxiety, faulty meaning making)
 - Addressed in direct treatment, i.e. Cognitive Behavioral Therapy

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What Is Mental Health AKA Social/Emotional Health?

- The psychological state of someone who is functioning at a satisfactory level of emotional and behavioral adjustment
 - wordnetweb.princeton.edu/perl/webwn
- **How** do we know when functioning is “satisfactory?”
- **When** does unsatisfactory functioning cross over to mental illness?

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Mental Health/Social Emotional Health Continuum

- Mental health is a continuum that fluctuates over time. No one is devoid of stress, anger, sadness, and from time to time there is difficulty shaking it
- Young children in poverty, males and African American children are suffering disproportionately
 - http://www.nccp.org/publications/pub_882.html
 - But, research suggests that up to 50 percent of the impact of income on children’s development can be mediated by interventions that target parenting

Duncan, G. J., Brooks-Gunn, J. 2000. Family Poverty, Welfare Reform, and Child Development. Child Development 71: 188-196.

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Social Emotional Health Problems

- Are expressed in a continuum of behaviors:
 - Internalizing problems through internalizing disorders
 - Externalizing problems through externalizing disorders
 - A combination of internalizing and externalizing



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Indicators Of Internalizing Problems

- Shy
- Spends time alone
- Seems nervous, fearful, or anxious
- Appears sad or unhappy
- Talks negatively about self
- Disinterested in school
- Has pessimistic view about future
- Cries at inappropriate times
- Easily frustrated and shuts down

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Non-Indicators Of Internalizing Problems

- Interacts with others
- Spends free time with peers
- Seems calm and relaxed
- Has a positive attitude
- Says nice things about self and others
- Highly motivated in school
- Has an optimistic view of future
- Exhibits normal responses
- Perseveres through difficult assignments

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Indicators Of Externalizing Problems

- Calling other students bad names
- Taking other students' belongings without asking
- Arguing or refusing to comply with adult requests or directions
- Disturbing others while they are working
- Punching or kicking others
- Blurting out answers
- Bullying others

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Non-Indicators Of Externalizing Problems

- Saying nice things to others or nothing at all
- Asking the person to borrow their belonging before using it
- Follow directions the first time
- Working quietly while others finish their work
- Keeping hands and feet to self
- Raising hand and waiting quietly
- Respecting others
- Being agreeable

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Degree Of Impairment

- Problems move to disorders with the degree of impairment the problem causes



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Parental Involvement/Support

- Can we teach students who come from homes with limited parental support how to read? **YES**
- Can we teach students who come from homes with limited parental support behavioral expectations and social-emotional skills? **YES**
- **If we can't count on parents, then what other system in society can we count on to teach students social, emotional, and academic skills?**

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Scientific Research Findings

- Emotional and behavioral problems are linked to academic performance
 - Behavior problems cause academic problems
 - In turn, academic problems cause behavior problems

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graph TD; A[ACADEMICS] <--> B[PHYSICAL HEALTH]; A --> C[MENTAL HEALTH]; B --> C;
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Scientific Research Findings

- A student's emotional and behavior problems are more stable than his IQ, if untreated
 - If untreated, students will continue to exhibit behavior problems into the secondary grades and beyond

(Moffitt, 1998; Walker, Ramsey, & Gresham, 2004)

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Scientific Research Findings

Implementing *proactive, positive, prevention-oriented school-based practices*

- Improves student behavior and the orderliness and safety of the school environment
- Improves students' academic achievement
- Prevents students from traveling down a path toward negative life course outcomes

(Kratochwill, Albers, & Shernoff, 2004; Wilson & Lipsey, 2007)

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**Center For The Study Of Social Policy
Research Findings**

Good social-emotional and mental health is a key component of children's health and healthy development

National data document children experience a significant range of mental, social, emotional and behavioral health conditions, and most of their problems are amenable to intervention

<http://www.cssp.org/policy/papers/Promote-Childrens-Social-Emotional-and-Behavioral-Health.pdf>

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Scientific Research Findings

- **Social skills are the best predictor of later academic performance:**
 - Caprara, Barbaranelli, Pastorelli, Bandura, & Zimbardo (2000) & Malecki & Elliott (2002) have found that prosocial skills (cooperating, helping, sharing, and consoling) are a better predictor later academic achievement than is earlier academic achievement
 - School-based emotional and behavioral supports produce significant gains in end-of-the year academic state testing results

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Scientific Research Findings

- **All people, including students, are motivated intrinsically and extrinsically**
 - Depending on the activity, a person may rely more on intrinsic or extrinsic motivation
 - Schools that employ a combo of intrinsic & extrinsic strategies are most successful

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Scientific Research Findings

- Emotional and behavioral problems are responsive to school-based supports, ***even during the adolescent years & without parental support***
 - Teachers can play a vital role in the prevention and remediation of emotional and behavioral disorders

(Cook et al., 2008)
(Wagner et al., 2006)

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NREPP (SAMHSA)'s Beliefs Based On Research Findings

- Behavioral Health is Essential to Health Prevention Works
- People recover
- Treatment is Effective

Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence based Programs and Practices (NREPP)

See: <http://store.samhsa.gov/product/Helping-Children-and-Youth-With-Serious-Mental-Health-Needs-Systems-of-Care/SMA06-4125> and <http://www.nrepp.samhsa.gov/index.aspx>

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IDEA Hierarchy For Observed Problems

- If the student with an IEP has behavior impeding learning, consider strategies, including positive behavioral interventions, strategies and supports (behavioral interventions)
 - Supplementary aids and supports: to maintain least restrictive environments
- If the student with an IEP needs a related service, provide that service
 - Related service: to benefit from special education (specialized provider for behavioral or emotional interventions)

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IDEA Hierarchy For Problems Observed

- If the student is found to meet criteria for emotional or emotional/behavior disorder(Ed, E/BD) provide special education, defined as specialized instruction to address the unique needs of the student:
 - Content
 - Methodology
 - Instructional strategies
- We will discuss this later!

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Conundrums Mental Health And The IEP – Law

- Problems we have had (or are having) in Special Education
 - Differentiating related services vs. supplementary aids and supports, when, how, who, how much, when to start and when to discontinue
- Problems we have had (or are having) in Special Education
 - Eligibility of African American youth as ED-avoiding disproportionality
 - Yet, Structures of RTI/MTSS have been shown to address these issues

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Disproportionality Prevention

- Donovan, M. S., & Cross, C. T. (2002). Minority students in special and gifted education. Washington, DC: National Academy Press.
- **“ There is substantial evidence with regard to both behavior and achievement that early identification and intervention is more effective than later identification and intervention.”**

Executive Summary, p. 5
(Reschly)

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Three-Prong Solution

- RtI procedures as a way of delivering a continuum of supports, so all students receive what they need to be successful and proactively and objectively identifying students who may need extra assistance to address lack of school readiness that may result from low income environments
- Awareness training of susceptibility of errors in judgment
- Training on multicultural awareness and a culturally responsive lens to improve cultural competency

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RtI As A Solution.....

- Proactive, prevention-focused service delivery model
 - Not wait-to-fail
- Providing students with a continuum of evidence-based supports prior to special education consideration
- Implementation of positive behavior supports as alternatives to punitive disciplinary practices
 - See: www.pent.ca.gov/forms, "office support process"

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The Solution? Multi-Tiered Systems Of Behavior AND Emotional Supports And Services

- Yet, 85% of American teachers have not received two or more courses in running effective classrooms, supporting desired behavior and skillfully handling problem behavior that promote social emotional well being.
(Browers A. & Tomic, W. (2002); Cook, C.R. (2009) Mock, D.R. & Kaufman, J.M. (2002)
- 20% of school age children suffer social emotional and mental health problems at some point K-12

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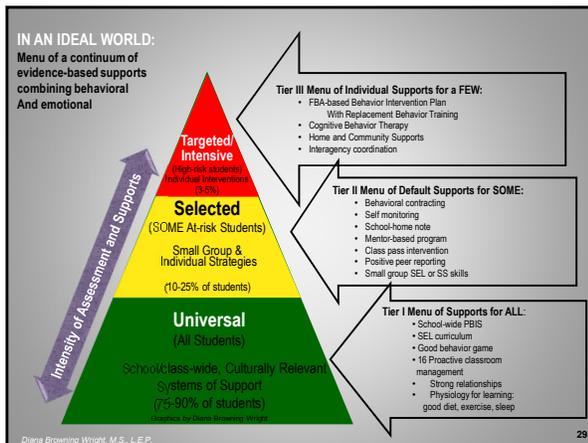
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The Solution? Multi-Tiered Systems Of Behavior AND Emotional Supports And Services

Problems we encounter:

- We can't serve all in special education,
- Some of us believe we can't ethically, morally deny students interventions just because they don't meet the criteria for special education
- Not every school is finding tiers of solutions
- Not every school has found a universal screening tool to find customers

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What Works?

<p>Internalizing</p> <ul style="list-style-type: none"> • PBS alone, no change • SEL alone, moderate change • SEL combined with PBS substantive change 	<p>Externalizing</p> <ul style="list-style-type: none"> • SEL alone, small change • PBS alone, moderate change • SEL combined with PBS substantive change
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Cook, C.R., Frye, M., Jewell, K., & Slemrod. (under review). Preliminary evaluation of combining Positive Behavior Support and Social Emotional Learning as an integrated approach to school-based universal prevention. *School Psychology Review*.

#1
SCHOOL-WIDE PBS:
Teaching, Modeling and Reinforcing
Common Behavioral Expectations and
Creating a Positive School Culture

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The Components Of School-wide PBS

1. Establish 3-5 common behavioral expectations;
 - e.g., Safe, respectful, responsible
2. Clear definitions of problem behaviors and the consequences associated with each one;
3. Regularly scheduled instruction and assistance in desired positive social behaviors is provided;

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The Components Of School-wide PBS

4. Effective incentives and motivational systems are provided to encourage students to behave differently;
 - Keep ratio of positive to negative statements in mind
5. Staff receives training, feedback and coaching about effective implementation of the systems; and
6. Systems for measuring and monitoring the intervention's effectiveness are established and carried out

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#2
SOCIAL SKILLS & SEL CURRICULA:
Adopting a curriculum to teach students how to recognize and manage their emotions, demonstrate care and concern for others, and make

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Social Emotional Learning

- "the process through which children develop the skills necessary to recognize and manage emotions, develop care and concern for others, make responsible decisions, form positive relationships, and successfully handle the demands of growing up in today's complex society" (CASEL, 2002, p.1)
- These skills include the ability to:
 - Recognize and manage emotions
 - Care about and respect others
 - Develop positive relationships
 - Make good decisions
 - Behave responsibly and ethically

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www.casel.org/about/index.php

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Top 10 School Social Skills!*

1. Listens to Others
2. Follows Directions
3. Follows Classroom Rules
4. Ignores Peer Distractions
5. Ask for Help
6. Take Turns in Conversations
7. Cooperates with Others
8. Controls Temper in Conflict situations
9. Acts Responsibly with Others
10. Shows Kindness to Others

*Based on surveys of over 800 teachers rating importance of social skills.

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6-Step Instructional Sequence

1. **Tell** (Coaching)
2. **Show** (Modeling)
3. **Do** (Role Play & Behavioral Rehearsal)
4. **Feedback** (how did it go?)
5. **Monitor Progress** (Performance Feedback)
6. **Generalize**

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#3 PROACTIVE CLASSROOM MANAGEMENT:
A host of proactive strategies that teachers can implement to prevent the occurrence of problem behaviors and create a classroom environment that is conducive to learning

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Two Critical Variables For Learning

- Time devoted to instruction (TDI)
 - How much time throughout the day is devoted to learning activities
 - Direct instruction, small group activities, independent seatwork
- Academic engaged time (AET)
 - Learning does not occur if the student is not paying attention (NO DUH!)

If students are on-task, they aren't off task!

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16 Proactive Classroom Management Strategies

1. Organizing a productive classroom	9. Teacher proximity
2. Establishing positive relationships with all students in the class	10. Motivation system to reward desirable behavior
3. Positive greetings at the door to pre-correct and establish positive climate	11. Goal setting and performance feedback
4. Classroom rules/expectations and procedures are visible and known by every student	12. Visual schedule of classroom activities
5. Transitions are managed well	13. Effective cuing systems to release and regain attention
6. Independent seatwork is managed and used when needed	14. 5 to 1 ratio of positive:negative interactions
7. Communicating competently w/ students	15. Smiling and positive affect
8. Teach, model, and reinforce prosocial skills	16. Frequent opportunities to respond

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#4 GOOD BEHAVIOR GAME:
Group management procedures that increases academic engagement and reduce disruptive behavior at times when students are likely to misbehave

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Good Behavior Game (GBG)
Barrish, Saunders, & Wolf (1969)

- Classwide behavior management strategy
- 20 independent replications across different grade levels, types of students, and settings
- Prevents substance abuse and antisocial behavior
- Interdependent group contingency
- Capitalizes on human nature
 - Social influence and competition

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**Good Behavior Game(s)
 Using Group Contingencies**

www.interventioncentral.org/htmldocs/interventions/classroom/gbg.php

www.evidencebasedprograms.org/Default.aspx?tabid=154

www.pent.ca.gov/for/f7/bspdeskreference07.pdf

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Tier 1: Mindfulness Training

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

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

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Positive Psychology: Evidence-Based Resources

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

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Tier 1: Teaching Optimism

- The Optimistic Child by Martin Seligman
 - Teachers
 - Parents
- Good PLC or grade level meetings activity
- Pessimism is the breeding ground of internalizing disorders

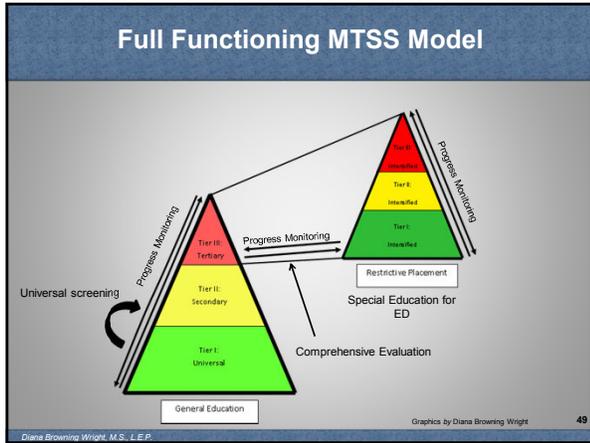
<http://www.authentichappiness.sas.upenn.edu/books.aspx?id=187>

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Interventions NOW!

- Choose evidence-based interventions for two categories:
1) socially mediated behaviors 2) behaviors that are emotionally driven
- Determine who needs what from which category (universal screening for social emotional problems followed by student matching to interventions)
- Provide interventions of increasing intensity based on student response data from the interventions
- Assess for special education (ED) if 3 Tiers of interventions delivered with fidelity are exhausted
- See handouts for differentiation of approaches

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- ### Emotional And Behavioral Disorders
- **Anxiety-Based Disorders**
 - Separation Anxiety Disorder (SAD)
 - Generalized Anxiety Disorder (GAD)
 - Specific Phobia
 - Social Phobia
 - Obsessive Compulsive Disorder (OCD)
 - **Depressive Disorders**
 - Major Depression
 - Dysthymia
 - Bipolar Disorder
 - **Trauma-related Disorders**
 - Acute Stress Disorder
 - Post-traumatic Stress Disorder
 - **Disruptive Disorders**
 - ADHD
 - Oppositional Defiant Disorder
 - Conduct Disorder
 - **Adjustment Disorders**
 - w/ Depressed Mood
 - w/ Anxiety
 - w/ Mixed Anxiety & Depressed Mood
 - w/ Disturbance of Conduct
 - w/ Mixed Disturbance of Emotions & Conduct
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- ### What Is Anxiety?
- Anxiety = fear and produces worry
 - Anxiety is unavoidable in life—all people experience it
 - It can serve many positive functions such as motivating the person to take action to solve a problem, escape dangerous situations, or resolve a crisis
 - It is considered normal when it is appropriate to the situation and goes away when the situation has been resolved
 - e.g.,
 - Appropriate worry = worrying when a person holds a gun to your head
 - Dysfunctional worry = afraid to go to school because you might get shot there
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What Is Anxiety?

- **A response to perceived, actual, or anticipated event that creates a sense of fear, worry, and/or dread**
symptoms of anxiety
 - Somatic
 - Perspiration, abdominal tensing, trembling, flushed face, increased heart rate, light headedness
 - Cognitive
 - Rumination, excessive worry, and anxious thinking (expecting the worst will happen)
 - Emotional
 - Fear, sad, nervous
 - Behavioral
 - Crying, nail biting, shaky voice, rigid posture, avoidance

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Anxiety Disorders

- **Prevalence**
 - 6-15% for children and adolescents
 - 2.0-12.9% Separation anxiety
 - 5.0-10.0% GAD
 - 3.0-10.0% Specific phobia
 - 0.5-2.8% Social phobia
 - 1.0-2.0% OCD

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Depressive Disorders

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

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Beck's Cognitive Triad Of Depression

- **Negative view of the self** (e.g., I'm unlovable, ineffective, nothing I do is right)
- **Negative view of the future** (e.g., nothing will work out, the future looks bleak)
- **Negative view of the world** (e.g., world is hostile, others are out to get me)

Beck, 1978

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Trauma-Related Disorders

- Prevalence of PTSD
 - 2-5% of children and adolescents
 - Fewer than 20% of children with a history of exposure to a traumatic event have had a psychiatric disorder, mainly anxiety disorders, including posttraumatic stress disorder (PTSD) (Costello, Erkanli, Fairbank, & Angold, in press)
- Sex differences
 - Girls 2-3 times more likely than boys

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What Is Trauma?

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

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Which Experiences Are Traumatic?

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

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Maltreatment Data

- U.S. Department of Health & Human Services, Administration on Children Youth & Families. Child Maltreatment
 - Data on severe inflicted child abuse, trauma, which in 2011 resulted nationally in the death of 1570 per 100,000 children
 - 76.7 million children 0-17 in USA projected for 2013

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

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Disruptive Disorders

- Prevalence of Conduct Disorder
 - 1 – 10%
 - Gender differences
 - Few differences in rate of conduct problems during infancy/toddlerhood
 - Males exhibit more conduct problems than females between the ages of 4 & 13 and post-puberty
 - Smaller differences between males & females around puberty
 - Males more likely to be on life-course persistent trajectory; similar prevalence for adolescence-limited trajectory

Lahey et al., 2006

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Disruptive Disorders

- Prevalence of Oppositional Defiant Disorder (ODD)
 - 2 – 16 %
 - Gender differences
 - Before puberty more prevalent in males than females
 - After puberty, equal prevalence for males and females

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Who Has ODD And CD?

- Children of delinquent parents
- Children of substance abusing parents
- Low SES associated with increased risk for DBD
- Racial/ethnic differences are not observed when SES controlled
- More prevalent in boys than girls; boys age 14-17 have steeper increase in delinquent behavior than girls
- Girls may manifest in different ways (e.g., relational aggression)

Note: These statements are summarized from data presented across many studies (e.g., Patterson, Capaldi & Dishion, 1992; Shaw et al., 1994).

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Life Outcomes Of Disruptive Behavior Disorders

- Higher rates of violence, arrest/conviction, substance abuse/dependence, unemployment
- Poor school performance, low educational attainment, problems with peers, social isolation
- Mental health & health problems
- Violent, coercive parenting
- Children with problem behaviors

De Genna et al., 2007; Farrington, 1991; Jaffee et al., 2006; Offord & Bennett, 1994; Offord, Boyle, & Racine, 1991; Temcheff et al., 2008

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Commonalities Across Different Emotional Disabilities

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

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Commonalities Across Different Emotional Disabilities

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

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What Should We Be Doing For: DEPRESSION

Best Support	Good Support
<ul style="list-style-type: none">• CBT• Interpersonal Therapy• CBT and Medication	<ul style="list-style-type: none">• Behavioral Activation• Client Centered Therapy• Cognitive Behavior Therapy with Parents• Play Therapy• Relaxation

David-Ferridon & Kaslow, 2008

What Should We Be Doing For: ANXIETY

Best Support	Good Support
<ul style="list-style-type: none">• CBT<ul style="list-style-type: none">– Education– Exposure– Response Prevention– Modeling	<ul style="list-style-type: none">• Assertiveness Training• Cognitive Behavior Therapy and Medication• Cognitive Behavior Therapy with Parents• Hypnosis• Play Therapy• Relaxation

Silverman, Pina, & Viswesvaran, 2008

What Should We Be Doing For: TRAUMA

Best Support	Good Support
<ul style="list-style-type: none">• Cognitive Behavior Therapy	<ul style="list-style-type: none">• Cognitive Behavior Therapy with Parents• Play Therapy

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

What Should We Be Doing For: ATTENTION

Best Support	Good Support
<ul style="list-style-type: none">• Contingency Management• Parent Management Training• Self Verbalization• Behavior Therapy and Medication	<ul style="list-style-type: none">• Biofeedback• Contingency Management• Education• Management Training and Problem Solving• Physical Exercise• Relaxation and Physical Exercise• Social Skills and Medication

Jensen et al., (2001); Pelham & Fabiano, (2008)

What Should We Be Doing For: CONDUCT

Best Support	Good Support
<ul style="list-style-type: none">• CBT-Anger Control• Parent Management Training• Parent Child Interaction Therapy PCIT• Group Assertiveness Training• Contingency Management• Multi-systemic Therapy• Multidimensional Treatment Foster Care	<ul style="list-style-type: none">• Client Centered Therapy• Communication Skills• Functional Family Therapy• Parent Management Training and Problem Solving• Physical Exercise• Problem Solving• Rational Emotive Therapy• Relaxation• Social Skills• Transactional Analysis

Eyberg, Nelson, & Boggs, 2008

Resources To Find Evidence-Based Interventions

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

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School based Behavior intervention Plans

- Only when default behavior interventions and solid Tier 1 have not addressed the problem
- Only for socially mediated behavior, with reinforcement coming from the environment, NOT for internally driven behaviors of an emotional nature
- Are supplementary aids and supports to maintain an LRE if the student has an IEP
- See: www.pent.ca.gov for the Behavior Desk Reference, how to develop effective behavior plans

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School-Based Mental Health Services At Tier 3

- Not for all students
- For the few students who have clinically significant problems and require therapeutic services in addition to or instead of behavioral supports
- Requires one on one for approximately 16 weeks, not forever

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BEYOND BEHAVIORAL SUPPORTS

Cognitive Behavior Therapy

Cognitive Behavioral Therapy

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

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graph TD; Thoughts --> Behaviors; Behaviors --> Feelings; Feelings --> Thoughts;
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Cognitive Behavioral Therapy

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

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The General Behavioral Model

ANTECEDENTS
↓
BEHAVIORS
↓
CONSEQUENCES

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The Cognitive Behavioral Model

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

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Observable And Reported Reactions To Provocative Stimuli

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

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Dialectical Behavior Therapy (DBT) Individual And Group

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

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Who Is Qualified To Deliver CBT?

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

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Who Is Qualified To Deliver CBT?

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

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

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

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

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

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Physiological Symptoms Experienced In Response To Environmental Triggers

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

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Vicious Cycle Of Avoidance

Each time this cycle completes itself, the underlying anxiety is reinforced....stimuli will continue to be anxiety-provoking.

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Sadness Moving To Disorder Early Recognition: Symptoms Of Depression

1. Depressed or irritable mood most/all of day
2. Decreased interest in previously enjoyed activities most/all of day
3. Significant change in weight (eating more/less than normal)
4. Significant change in sleep (insomnia/hypersomnia)
5. Psychomotor agitation or retardation nearly every day
6. Fatigue/loss of energy nearly every day
7. Worthlessness or inappropriate guilt
8. Decreased ability to think/concentrate
9. Recurrent thoughts of death/suicidal ideation

— > 5 symptoms in 2 weeks means you are clinically depressed
— 1-2 symptoms may mean temporary unhappiness

Caution: DSM 5 is to be released in May 2013
<http://www.mental-health-today.com/dep/dsm.htm>

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Coping Cat

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

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Coping Cat

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

<http://www.workbookpublishing.com/>

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Coping With Depression

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

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Coping With Depression (CWD-A)

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

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Coping With Depression (CWD-A)

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

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CWD-A

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

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Trauma-Focused CBT

- Trauma-focused cognitive behavioral therapy (TF-CBT)
 - Child-focused
 - Parents included in therapy
 - Involving parents in therapy leads to significantly greater improvements in child's depressive & externalizing behaviors
 - Helps parents resolve emotional distress about child's trauma & optimizes ability to be supportive of child
 - Culturally sensitive
- Treating Trauma & Traumatic Grief in Children & Adolescents
Cohen, Mannarino, & Deblinger (2006)

[Free online training at http://tfcbt.musc.edu/](http://tfcbt.musc.edu/)

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Trauma-Focused CBT

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

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Trauma-Focused CBT

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

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Cognitive Behavior Intervention For Trauma In Schools

- Free programming and resources at : <http://cbitsprogram.org>

School-based, group, and individual intervention

- Reduce symptoms of post-traumatic stress disorder (PTSD), depression, and behavioral problems, and to improve functioning, grades and attendance, peer and parent support, and coping skills

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Cognitive Behavior Intervention For Trauma In Schools

- Reduce symptoms of post-traumatic stress disorder (PTSD), depression, and behavioral problems, and to improve functioning, grades and attendance, peer and parent support, and coping skills

For students from 5th to 12th grade who have witnessed or experienced traumatic life events such as community and school violence, accidents and injuries, physical abuse and domestic violence, and natural and man-made disasters. CBITS uses cognitive-behavioral techniques (e.g., psychoeducation, relaxation, social problem solving, cognitive restructuring, and exposure).

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Coping Power Program: A School-Based Violence Prevention Program

- Manualized cognitive behavioral intervention program based on anger arousal and social-cognitive models
- For late elementary and middle school students
- Can be readily implemented by school counselors and mental health professionals
- Demonstrated preventive effects on delinquency & substance use among at-risk youth

(Lochman & Wells, 2002a,b; 2003; 2004)

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Coping Power

- Lochman & Wells (2002a, 2004)
 - 34 session CBT (Coping Power) [superior at 1 year posttreatment](#) to untreated control for child-component only & child + parent components
 - Lower rates of self-reported delinquent behavior, parent-reported substance use, & improved teacher-rated functioning (n=183, males in grades 4-6)
- Lochman, Boxmeyer, Powell, Roth, & Windle (2006)
 - 24 session CBT (Coping Power) & 10 parent sessions, [superior](#) to control group at post-treatment
 - Lower rates of teacher-rated problem behaviors (n=240, 5th graders)

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Coping Power

- Lochman et al. (2001)
 - Adapted for deaf children in residential school screened for aggressive behavior
 - Significant improvements in teacher-rated behavior, social problem solving skills, & communication for students receiving treatment in comparison to control group (n=49)

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Coping Power

- Lochman, J.E., Wells, K.C., & Lenhart, L.A. (2008). Coping power child group program: Facilitator guide. New York: Oxford University Press.
- Lochman, J.E., Wells, K.C., & Lenhart, L.A. (2008). Coping power child group program workbook. New York: Oxford University Press.

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Anger Awareness: Anger Thermometer

The diagram shows a vertical thermometer with four levels. The top level is black and labeled 'Enraged, Furious'. The second level is dark grey and labeled 'Steaming Mad'. The third level is light grey and labeled 'Irritated, Annoyed'. The bottom level is blue and labeled 'Frustrated'.

- Enraged, Furious**
 - Using thermometers, children label own levels of anger, and of their *triggers* at each level
- Steaming Mad**
 - Can better problem solve at low to moderate levels of anger
- Irritated, Annoyed**
 - Use large version of thermometer on the floor to show anger changes during role-play activities
- Frustrated**
 - Aggressive children tend to report their anger in "on-off" terms as "angry" or "not-angry"

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Reactions To Provocative Stimuli

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

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Thinking Errors

- AKA: Cognitive distortions or faulty automatic negative thoughts
- Thoughts that do not appropriately match the context in which they occur
 - Anxious child thinking "If I don't get an A on the test, my mom won't love me."
 - Aggressive kid thinking "If I show him who the tough guy is, they won't get in my way again."
 - Depressed kid thinking "No one ever wants to sit with me."

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What About Behavior Support Services?

- Continue providing a continuum of care for behavior support, from class-wide to individual for socially mediated behavior issues
- Socially Mediated Behavior occurs to produce an outcome in the environment:
 - Get something desired in the environment
 - Get rid of something undesired in the environment

Free manual: <http://www.pent.ca.gov/dsk/bspmanual.html>

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What About Behavior Support Services?

- Behavior plans require establishment of a functionally equivalent replacement behavior to allow the student to produce the same outcome with a more acceptable behavior
 - E.g., escape work not by screaming and running, but by using a break card

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What About Behavior Support Services?

- Individual behavior plans that are legally sound, produce student outcomes and teacher fidelity
 - <http://www.pent.ca.gov/hom/research.html>
 - Differentiating socially mediated from behaviors producing automatic reinforcement:
<http://www.pent.ca.gov/mh/differentiatingbehavior.pdf>
- Protocol for Addressing Problem Behavior Resulting from Internal States



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What About Mental Health Services?

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

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What About Emotionally Driven Behaviors?

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

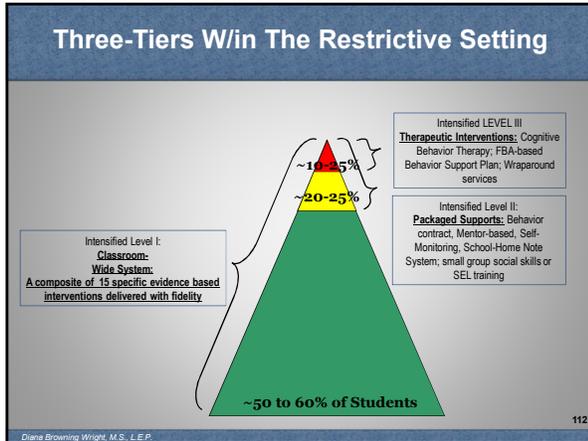
Examples: Non responsiveness to behavior supports may suggest the behavior requires another approach, history of trauma, general anxiety, social anxiety, depression, selective mutism, habit reversal needs (OCD, Tourettes, etc.) and so forth

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“Off The Pyramid”

- When the student is “off the pyramid” in behavioral RTI, what are the effective components?
 - What is the combination of services in restrictive settings to address the most intense needs that produce change;
 - When should the student move to specialized residential care, or back to a comprehensive campus?

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- ### RTI In Restrictive Settings For EBD
- Available at www.shoplrp.com
 - Composed of three tiers of interventions
 - Includes specialized instruction in terms of content, methodology and instructional strategies
 - All elements are evidence-based
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- ### Resources For School Practice
- Helping the Noncompliant Child, Second Edition: Family-Based Treatment for Oppositional Behavior
 - [Robert J. McMahon PhD \(Author\)](#), [Rex Forehand PhD \(Author\)](#)
 - Family Check up Model
 - Parenting assistance
 - <http://pages.uoregon.edu/cfc/intervention.htm>
 - First steps to success
 - Evidence based interventions for kindergarten
 - See: <http://ies.ed.gov/ncee/wwc/interventionreport.aspx?sid=179>
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More Resource For School Practice

- Intervening in children's lives: an ecological, family-centered approach to mental health care
 - [Thomas J. Dishion, Elizabeth A. Stormshak 0 Reviews](#)
- American Psychological Association, 2007 - 319 pages

Thomas J. Dishion and Elizabeth A. Stormshak family-centered, ecological approach, which engages children, adolescents, and their families

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More Resources For School Practice

- POSITIVE PARENTING PROGRAM (Triple P Parenting)
 - <http://www.triplep-america.com>
 - Psychologists, psychiatrists, and social workers working intensively with families presenting with multiple problems, are best suited to train in the Standard and Enhanced Triple P courses.
- LIVING WITH CHILDREN Gerald Patterson
 - Shows how children learn behavior and how they actually train

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Life Satisfaction Scales

- Dr. Scott Huebner

See: <http://artsandsciences.sc.edu/PSYC/facdocs/hueblifesat.html>

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Screen For Child Anxiety Related Disorders (SCARED)

- FREE at: <http://www.cebc4cw.org/assessment-tool/screen-for-childhood-anxiety-related-emotional-disorders-scared/>
- The SCARED is a child and parent self-report instrument used to screen for childhood anxiety disorders including general anxiety disorder, separation anxiety disorder, panic disorder, and social phobia. In addition, it assesses symptoms related to school phobias. The SCARED consists of 41 items and 5 factors.

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SCARED

- Availability: Free for download on website: <http://www.wpic.pitt.edu/research/AssessmentTools/default.htm>

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CAFAS Child/Adolescent Functioning Assessment Scale

Youth Scale:

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

Caregiver Scale:

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

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Take Home Messages

- Social Emotional/Mental Health interventions are a continuum of services and interventions from prevention to intensive combinations of services
- FBA and BIPs are for socially mediated behaviors
- SEL, CBT and other interventions are for emotionally driven behaviors
- Interventions work when delivered with skill and fidelity by people who care and are not required to continue for endless amounts of time

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Take Home Messages

- Special Education is not required for the vast majority of children with behavioral/emotional problems
- There is a plethora of free materials and training available for Tier 3
- Restrictive Settings for EBD can result in recovery of the vast majority of students
- Restrictive Settings are needed, in addition to inclusion to provide necessary content, methodology and instructional strategies

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Final Take Home Message

If you need assistance for next-steps or a jump start, call, text, email...

Diana Browning Wright
(626)487-9455
www.dianabrowningwright.com
dbrowningw@gmail.com

We can do this!
None of us is as skilled as all of us!
If you need to speak with sites in implementation, contact me for exemplars

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Bonus Materials

- The following slides lead staff to evidence based treatment of problems observed in schools

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Special Circumstances Treatment: Habit Reversal

- Doug Woods – University of Wisconsin, Milwaukee
<https://pantherfile.uwm.edu/dwoods/www/index.htm>
- John Piacentini Professor of Psychiatry and Biobehavioral Sciences at the UCLA School of Medicine and Director of the Child OCD, Anxiety, and Tic Disorders Program at the UCLA Semel Institute.
<http://www.semel.ucla.edu/caap>

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Special Circumstances Treatment: School Refusal And Selective Mutism

Christopher Kearney, PhD. Professor of Psychology and Director of Clinical Training at the University of Nevada, Las Vegas. He is also the Director of the UNLV Child School Refusal and Anxiety Disorders Clinic.

- Google for a variety of books and manuals

See: <http://faculty.unlv.edu/wpmu/ckearney/books-and-ordering-information/>

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**Special Circumstances Treatment:
Suicidal Thinking And Self Injury**

<http://www.wjh.harvard.edu/%7Enock/nocklab/>

- Matthew K. Nock , Harvard University Director of Laboratory for Clinical and Developmental Research
Most respected scholar; follow this website!

<http://education.washington.edu/areas/ep/profiles/faculty/mazza.html>

- James J. Mazza, University of Washington

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**Signs Of Suicide (SOS)
And Signs Of Self Injury**

- The SOS High School program is the only school-based suicide prevention program listed on the SAMHSA's NREPP (National Registry of Evidence-based Programs and Practices) that addresses suicide risk and depression, while reducing suicide attempts

<http://www.mentalhealthscreening.org/programs/youth-prevention-programs/sos/>

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**Other Training, Forms, Suicide
Interviewing And Planning**

<http://csmh.umaryland.edu/Resources/ClinicianTools/suicidepreventionresources7.pdf>

http://www.suicidology.org/c/document_library/get_file?folderId=235&name=DLFE-141.pdf

[http://www.livingworks.net/page/Applied%20Suicide%20Intervention%20Skills%20Training%20\(ASIST\)](http://www.livingworks.net/page/Applied%20Suicide%20Intervention%20Skills%20Training%20(ASIST))

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