SALT LAKE CITY SCHOOL DISTRICT
Your Best Choice

WELL-BEING TEAM

School Year 2019-20

Aaron J. Fischer, Ph.D., BCBA-D

U-TTEC Lab
Technology in Training, Education, and Consultation
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Wellbeing Team (WBT) Program Description

Background

The University of Utah's Technology in Training, Education, and Consultation (U-TTEC) Lab currently facilitates direct service practicum and applied research experiences to Educational Psychology students in the College of Education. The U-TTEC lab currently provides behavioral support services to various school districts across Utah. We provide supports targeting the behavioral needs of a broad range of students in both general and special education classrooms. The U-TTEC lab provides professional development training, sustainable programming, and rigorous assessment data to support teachers and parents. Additionally, our services are intended to increase school district personnel's ability to effectively serve other students who are not the direct focus of the U-TTEC lab's consultative service, but who are also engaging in problem. The U-TTEC lab also provides behavioral mental health support to schools in the Salt Lake Valley. Schools that are receiving behavioral mental health support receive consultation from graduate students on school-wide and class-wide strategies to improve students' mental health and students directly receive behaviorally-focused individual and/or group therapy. The U-TTEC lab provides graduate students with high-quality supervision and training experiences commensurate with the practical responsibilities that they will perform as professionals in school and other interdisciplinary clinical settings. These trainings and supervision opportunities are critical for the graduate students and uniquely position them for success in the independent careers as school practitioners.

The U-TTEC lab is directed by Aaron J. Fischer, Ph.D., BCBA-D, Assistant Professor of School Psychology and Adjunct Assistant Professor of Psychiatry at the University of Utah. Dr. Fischer is a licensed psychologist and licensed board-certified behavior analyst in Utah. He has extensive experience working in schools and other interdisciplinary clinical settings to improve outcomes for students with academic and behavior problems. His research and clinical experiences focus on evidence-based school consultation with teachers, school staff, and parents.

Purpose of the Wellbeing Team

The goal of this project is to build capacity within Salt Lake City School District for a tiered approach to address students' mental health needs. In particular, our goal is to build sustainability within the school by implementing preventative techniques and to address the current need for mental health support by providing direct therapeutic services to students. Project activities include consultation with school staff (e.g., teachers, counselors, administrators), group therapy, individual therapy, parent training, and professional development.

Section 1: Referral Process

REFERRAL PROCESS FOR THERAPEUTIC SERVICES

By: Magenta J. Silberman, M.Ed.

Mental health concerns do not follow the traditional behavioral and academic model of school intervention implementation. Traditionally, when a student exhibits academic or behavioral difficulties, they are referred to increasingly more targeted interventions to match the intensity of the behavior. This process is not always the case for mental health concerns. The individual student has greater input into the selection of treatment, and acute mental health needs (e.g., suicidality) require immediate intensive interventions that may bypass less intensive interventions. There are many ways that students may be referred for therapy services. These include:

Tier 1 Referral

Tier 1, or universal support, is composed of mental health interventions that are provided to every student. This includes, but is not limited to, school culture, social-emotional learning (SEL) curricula, psychoeducation, and family involvement. Schools may also have school-wide screening to evaluate the mental health needs of each student in the school. If a student endorses elevated scores on a universal screener, this may be grounds for referral to the Wellbeing Team (WBT). Additionally, if a student is non-responsive to school-wide initiatives, they may be referred by their teacher, counselor, or an administrator. Upon referral to the WBT, an intake will be conducted with the student to determine the need and willingness to participate in therapy, as well as establish consent and assent when appropriate. The WBT will have a collaborative meeting to determine which treatment, if any, would be appropriate for the student. However, if it is found appropriate that Tier 1 mental health support is not in place in the classroom or could be implemented with greater fidelity, the teacher may need to consult with the WBT prior to or in addition to student therapy services.

Tier 2 Referral

Following a referral from a teacher, counselor, or an administrator, a WBT member will conduct an intake to determine the therapeutic needs of the student. There are two available therapy services at the Tier 2, or targeted, level. The most common therapeutic intervention is group therapy. Group therapy consists of approximately 3-6 students who share common symptomatology (e.g., depression, anxiety), behaviors (e.g., substance use), or experiences (e.g., parental divorce). There are common manuals used for group therapy (see “Resources for Group

Therapy"), though many group facilitators will rely on process-oriented groups within a treatment.

In addition to group therapy, there is also an opportunity for *check-ins*. A *check-in* is not a therapeutic intervention, but rather an informal opportunity to evaluate the student's wellbeing. During a *check-in*, a brief interview is conducted to determine the students' risk for acute symptomatology (e.g., suicide, homicide) and their interest in therapy. If a student is deemed to be a safety risk and they still refuse services, the student is referred to counselors and administration (e.g., principal) for supports. A WBT member will typically conduct a *check-in* with a student because they or their family has denied participation in therapy, or the student is unsure about which therapeutic intervention (e.g., group or individual) they feel comfortable with. *Check-ins* may be done on a biweekly, monthly, or bi-monthly basis, depending on the specific concern or what the student would like. If any acute need is reported by the student, and they still refuse participation in therapy, the administrator, counselors, and guardians are notified. The WBT may be involved in the development of a safety plan and meet with parents in this case. If the student indicates they would like to participate in therapy during a *check-in*, an intake interview is conducted by a WBT member and a collaborative meeting between all members determines what would be the most appropriate placement for the student.

Tier 3 Referral

Nearly all referrals will first have a check-in or intake interview. In rare circumstances, the student may require immediate support. If a student is in immediate crisis, expressed active suicidal ideation, is experiencing major depression or is in a state of psychosis, the student will be immediately referred for individual therapy. Prior to starting therapy, the WBT therapist should attempt to create a safety plan with the student and relevant school personnel. Additionally, if a student self-refers and requests to receive individual therapy instead of group therapy, then the student will receive individual therapy.

Considerations

Communication with Stakeholders. While these are the recommended paths for student referrals, it is critical to consider the needs of the individual school. You must receive input from all of the stakeholders (e.g., teachers, principals, counselors) on what the ideal referral system would look like to minimize miscommunication and maximize the ease at which students receive therapeutic services. It is also critical to consider how school staff wants to communicate regarding students' treatment. For example, administrators may wish to be alerted when a student on a *check-in* list agrees to participate in therapy. Additionally, it may be helpful for teachers to be aware of treatment goals in therapy so that they can reinforce the skills in the classroom and incorporate them into the student's education plan. When the WBT members

consider the input of important stakeholders within the school, including the guardians and students themselves, the students are put in a better position for success.

Scheduling. While mental health support is critical for student academic success, WBT therapists must be aware of the impact that removing a student from class has on the student's academic progress and on the procedures of the classroom. For example, if a student is struggling to keep up with the content in their English class, it may adversely affect their academic performance to remove the student during that class period. Conversely, if a student really enjoys their science class, they may find the therapy process aversive if they always leave their favorite class. Communication with the student and their teachers will ensure that you are able to see the student at an optimal time that minimizes adverse effects. Additionally, if the time you are seeing the student will vary from week to week, it is important that the student and relevant teachers and/or administrators are informed of the days and times you plan to see the student.

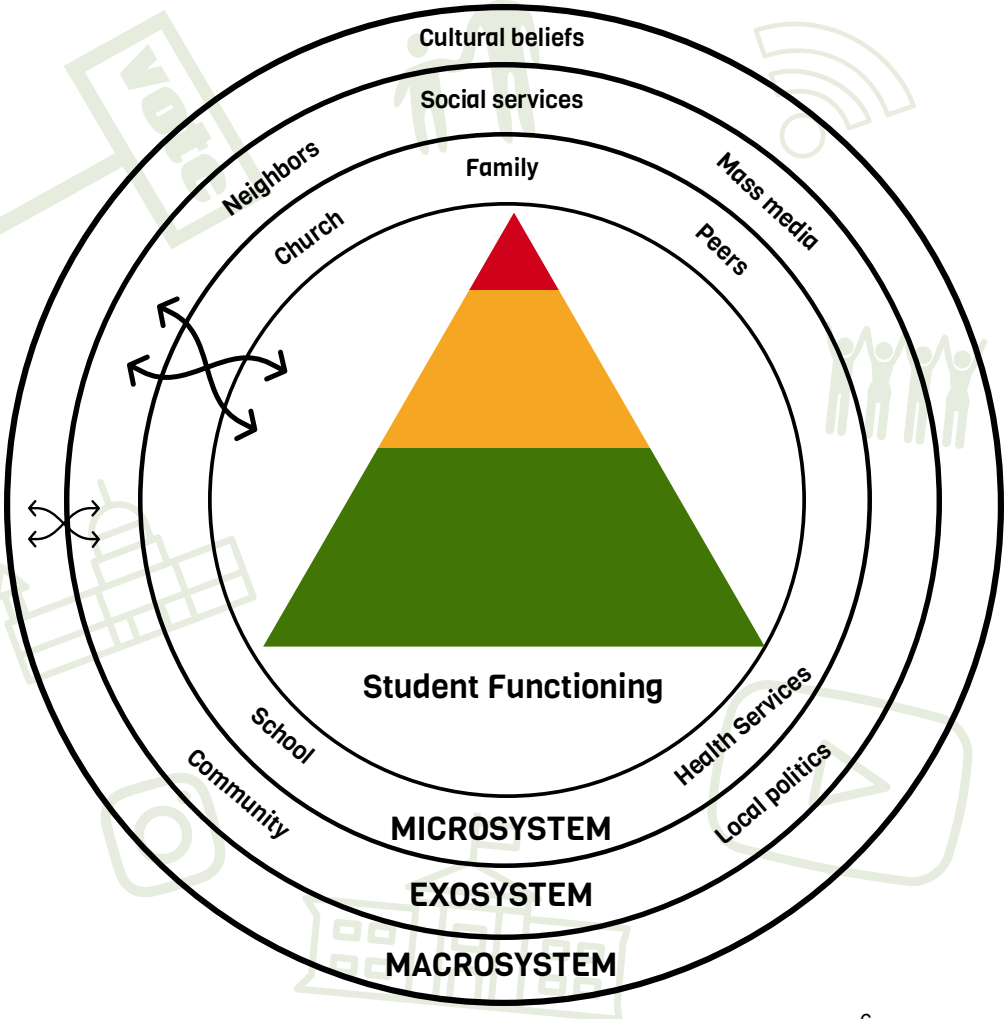
Schoolwide and Class-wide Support. Oftentimes, it appears easier to see a student for therapeutic services, rather than consider preventative approaches to the student's concerns. When considering whether or not a student needs services when referred by school staff, it is important to think about less intensive interventions as well. For example, if one teacher refers several students for anxiety, the WBT therapist may recommend anxiety-reducing techniques for the classroom. Alternatively, if a larger percentage of students are reporting gang involvement, it may be advantageous to have a schoolwide training or psychoeducation session. Even if a student is receiving therapy, they are still entitled to receive Tier 1 schoolwide and class-wide supports; WBT meetings should address this in their collaborative teaming.

MENTAL HEALTH REFERRAL PROCESS

at Bryant Middle School and Salt Lake Center for Science Education

INFLUENCE OF SYSTEMS ON STUDENT WELL-BEING

Multiple factors influence how individual students function, perceive themselves and behave. The diagram to the right displays the interchange between systems, where they are in relation to each other, and where the student functions within those systems.



REFERRAL PROCESS FOR MENTAL HEALTH SUPPORT

Tier 3: Individual Psychotherapy

- Referrals may come from: students themselves, guardians, and/or teachers
- Students at this level receive therapy for acute needs, including:
  - Major depression
  - Psychosis
  - Active suicidal ideation
- All referrals will be routed to a check-in interview, UNLESS:
  - Immediate emergency response is needed
  - Student self-referral for therapy
- If student shows lack of interest, they will be pushed for Tier 2 supports instead

Tier 2: Groups and Check-Ins

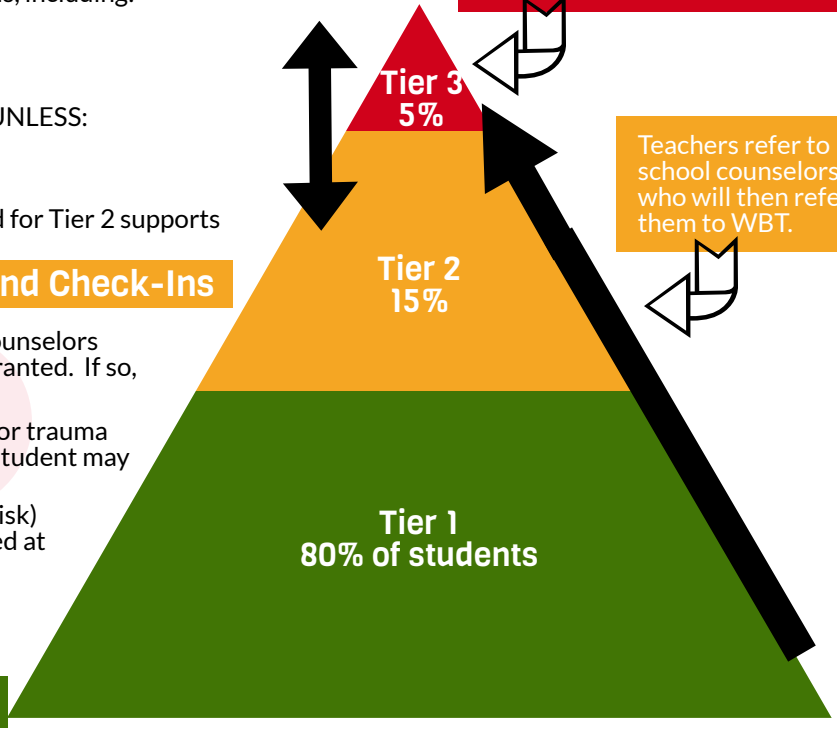
- Teachers should make student referrals to school counselors
- School Counselor will make referrals to WBT if warranted. If so, WBT will conduct 20-min check-in:
  - Interview student about any suicidal ideation or trauma
  - Based on the student's global well-being, the student may receive the following services:
    - Individual psychotherapy (Tier 3, high-risk)
    - Groups selected by information provided at check-in (Tier 2, at-risk)
- Students remaining at the Tier 2 level will have bi-monthly check-ins. Student well-being will be monitored over time.

Tier 1: Universal Supports

- Social-emotional learning through Second Step
- Schoolwide social-emotional attitudes and values (i.e., school rules, reinforcement systems, positive interactions)
- School culture
- Class-wide psychoeducation
- Teacher well-being
- Family involvement

Students can be directly referred to Tier 3 by self-referral, guardian referral, and administration referral.

Teachers refer to school counselors, who will then refer them to WBT.



Remember:
When referring students, report symptoms and behaviors rather than diagnoses.

Section 2: Tier 1

TIER 1 DATA COLLECTION SCHEDULE

By: Magenta J. Silberman, M.Ed.

Date	SSWQ	ODRs, Attendance, Suspensions	Teacher Acceptability Measures
Beginning of year	Beginning of October	Collect data from year prior at beginning of next academic year and compare to current school year at the completion of the academic year.	Beginning of October
Mid-year	January		-
End of year	Beginning of April		Beginning of April

TEACHER-STUDENT RELATIONSHIPS: ESTABLISHING POSITIVE RELATIONSHIPS AND IMPROVING RELATIONSHIPS WITH DIFFICULT STUDENTS

By: Christina C. Omlie, M.A., M.Ed. & Lauren Perez, M.Ed.

Improving students' relationships with teachers has important, positive and long-lasting implications for both students' academic and social development. Solely improving students' relationships with their teachers will not produce gains in achievement. However, those students who have close, positive and supportive relationships with their teachers will attain higher levels of achievement than those students with more conflict in their relationships.

Positive teacher-student relationships are associated with: increased likelihood of student engagement, fewer disruptive behaviors, increased cooperation, improved social functioning, increased academic achievement, and a reduced likelihood of burnout (Jennings & Greenberg, 2009; Roorda, Koomen, Spilt, & Oort, 2011). Teachers often report wanting motivated students in their classrooms. There are a variety of factors that contribute to student motivation ranging from self-efficacy, perceived abilities or competencies, and intrinsic motivation (Roorda et al., 2011; Skinner & Belmont, 1993). Although a teacher may be lucky to get a group of confident, intrinsically motivated students in their classroom, more often than not teachers are left to the task to bolster many students' self-concepts and serve as a cheerleader to keep students motivated an on-track. As a result, building and nurturing positive teacher-student relationships is a critical component to student success and teacher job satisfaction (Jennings & Greenberg, 2009).

There is a relationship between student motivation and person-centered teaching variables, namely warmth, empathy, respect, and encouragement. Overall, affective variables of empathy and warmth are the most strongly related to student outcomes over other person-centered variables (Cornelius-White, 2007) Positive teacher-student relationships — evidenced by teachers' reports of low conflict, a high degree of closeness and support, and little dependency — have been shown to support students' adjustment to school, contribute to their social skills, promote academic performance and foster students' resiliency in academic performance (Battistich, Schaps, & Wilson, 2004; Birch & Ladd, 1997; Curby, Rimm-Kaufman, & Ponitz, 2009; Rudasill, Reio, Stipanovic, & Taylor, 2010).

Teachers who experience close relationships with students reported that their students were less likely to avoid school, and appeared more self-directed, more cooperative and more engaged in learning (Birch & Ladd, 1997; Decker, Dona, & Christenson, 2007). Teachers who use more learner-centered practices (i.e., practices that show sensitivity to individual differences among students, include students in the decision-making, and acknowledge students' developmental, personal and relational needs) produced greater motivation in their students than those who used fewer of such practices (Daniels & Perry, 2003).

The quality of early teacher-student relationships has a long-lasting impact. Specifically, students who had more conflict with their teachers or showed more dependency toward their teachers in kindergarten also had lower academic achievement (as reflected in mathematics and language arts grades) and more behavioral problems (e.g., poorer work habits, more discipline problems) through the eighth grade (Hamre & Pianta, 2001). Further, kindergarten students who are close and experience less conflict with their teachers developed better social skills as they approached the middle school years than kindergarten children with more conflictual relationships' experiences in the past (Berry & O'Connor, 2009). Thus, having skills in place to foster teacher-student relationships in the classroom is a critical component to effective teaching strategy.

Establishing Relationships with Students

Know Your Students

- Knowing a student's interests can help you create examples to match those interests.
- Greet each student by name when they enter your classroom.
- If a student who loves basketball comes to you with a question about a math problem, you might respond to her with a problem involving basketball.
- If a student who speaks Spanish at home comes to you with a question about English vocabulary, you might answer his question and then ask him what the word is in Spanish and how he'd use it in a sentence. This type of specific responding shows that you care about your students as people and that you are aware of their unique strengths (i.e., fluency in another language).
- Knowing a student's temperament can help you construct appropriate learning opportunities.
- If a girl in your class is particularly distractible, you can support her efforts to concentrate by offering her a quieter area in which to work.
- If a boy in your classroom is very shy, appears engaged but never raises his hand to ask questions, you can assess his level of understanding of a concept in a one-on-one conversation at the end of class.

Give Students Meaningful Feedback

- Notice the way that you give feedback to your students. If possible, watch a video of your own teaching.
- Are you giving students meaningful feedback that says you care about them and their learning, or are you constantly telling your students to hurry?
- In your conversations, are you focusing on what your students have accomplished or are you concentrating your comments on what they have not yet mastered?
- Does your body language, facial expression and tone of voice show your students that you are interested in them as people too?
- Are you telling them to do one thing, yet you model quite different behavior? For example, are you telling your students to listen to each other, but then look bored when one of them talks to the class? Be sure that the feedback you give to your students conveys the message that you are supporting their learning and that you care about them.

Are you paying more attention to some students than to others? When you fail to recognize particular students, you can communicate a low level of confidence in their abilities. Individual students may "tune out" and believe that you don't expect they will be able to answer your questions. This message is compounded when these students see others being called on regularly.

Create A Positive Classroom Climate

- Be sure to allow time for your students to link the concepts and skills they are learning to their own experiences. Build fun into the things you do in your classroom. Plan activities that create a sense of community so that your students have an opportunity to see the connections between what they already know and the new things they are learning, as well as have the time to enjoy being with you and the other students.
- Make sure to provide social and emotional support and set high expectations for learning.
- Display student work, provide positive verbal reinforcement for student behavior, show off the class's achievements.

Be Respectful and Sensitive to Adolescents

- Supportive teacher-student relationships are just as important to middle and high school students as they are to elementary students. Positive relationships encourage students' motivation and engagement in learning. Older students need to feel that their teachers respect their opinions and interests just as much as younger students do. Even in situations where adolescents do not appear to care about what teachers do or say, teacher actions and words do matter and may even have long term positive (or negative) consequences.

Engage in Self-Care

- Frustration can have a devastating effect on teacher-student relationships, as it tends to cause educators to make irrational decisions. Usually you know when you are becoming frustrated and can quickly identify the signs and symptoms. As an educator, the question is not *if* you will become frustrated or stressed but *when* you will and *how* you will deal with it.

Improving Relationships with Difficult Students

Develop Positive Discourse with Students with Challenging Behavior

- Think about what you say to the difficult students in your classroom. Are you constantly bombarding your more challenging students with requests to do something? Do you find yourself constantly asking students to stop doing what they are doing? No one likes being badgered and pestered, and your students are no exception.
- Try to find a time or place when you can have positive discussion with the problem student.
- Notice and mention the positive behaviors they exhibit.

- Remind yourself that even if a challenging student appears unresponsive to your requests, she is hearing the messages that you are giving her. Her responses may not change her immediate behavior but may matter in the long term.

Make Extra Effort to Develop and Sustain Relationships with Difficult Students

Difficult students require more energy on your part. For example, you may need to spend time with them individually to get to know them better — to understand their interests as well as what motivates them. This will not only allow you to tailor your instruction to their interests and motivation, but the time spent will also allow them to develop trust in you. Recent research on high school students who have frequent and intense discipline problems shows that when adolescents perceive their teachers are trustworthy people, they show less defiant behavior (Gregory & Ripski, 2008). Persistent teacher-student conflict throughout the elementary years increases the likelihood that children will exhibit negative externalizing behaviors (O'Connor et al., 2012), so it is important for teachers to build close relationships at an early age with children at-risk for behavioral issues.

Be Cognizant of Risk Factors for Problematic Relationships:

- Boys typically have more conflict and less closeness in their relationships with teachers than girls (Baker, 2006; Howes et al., 2000; Hughes, Cavell, & Wilson, 2001).
- High levels of teacher-student conflict may affect girls and boys differently. For example, teacher-student conflict appears to affect math achievement more negatively for girls than for boys (McCormick & O'Connor, 2014).
- Students with more internalizing symptoms (e.g., depression, anxiety) have been found to have greater dependency on their teachers than their average counterparts (Henricsson & Rydell, 2004), whereas students with more externalizing problems (e.g., aggression, problem behaviors) may show more conflict with teachers (Murray & Murray, 2004).
- Students who exhibit more problem behaviors at home and school tend to develop more conflictual and less close relationships with their teachers (Birch & Ladd, 1998; Murray & Murray, 2004; O'Connor et al., 2012).
- Students with emotional disturbances or mild intellectual disability often have more negative relationships with teachers than students without these problems (Murray & Greenberg, 2001).
- For students at risk for problematic teacher-student relationships, teachers need to make extra efforts to offer the social and emotional support likely to help them meet the challenges they face in school.

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PROBLEM-SOLVING CONSULTATION IN SCHOOLS

By: Rovi Hidalgo, M.Ed.

School-based consultation includes a relationship between a consultant (e.g., school psychologists, the consultee (e.g., teacher, parent), and the client (e.g.., the student). The characteristics of consultation include (a) services provided at the primary, secondary, tertiary, and special education levels; (b) a consultant-consultee relationship; (c) voluntary services; (d) collaborative directiveness; (e) respect; and (f) consultee and client-driven services. Consultant and teacher desires validate the use of consultation. Consultant services impact student outcomes, even though they may not work with students directly (Frank & Kratochwill, 2014).

Frank & Kratochwill (2014) outline the five stages of Problem-Solving Consultation: Rapport Building, Problem Identification, Problem Analysis, Plan Implementation, and Program Evaluation. The **Rapport Building** stage is highly important, as it increases consultee buy-in, and therefore, cooperation and intervention effectiveness. Within this stage, consultants become familiar with the consultee's previous experiences with consultation, diversity and cultural values, interpersonal skills, and goals from consultation. Consensus between the consultant and consultee is also gained. The second stage, **Problem Identification**, involves defining the problem behavior in objective and measurable language, and tentative identification of antecedents, consequences, and settings. Further describing the problem behavior, the consultee describes the magnitude (i.e., intensity) and frequency of the problem behavior. Goals are developed, and the plan for baseline data collection and assessment is created. In the **Problem Analysis** stage, the consultant and consultee will examine baseline assessment data; data may come from direct observations, student records, and ABC charts. Barriers for intervention implementation are identified. The fourth stage, **Plan Implementation**, involves the preparation of written procedures, modeling, and teaching intervention procedures using behavioral skills training (i.e., "Tell-Show-Do"). Teacher and student data are collected, and performance feedback is given. The fifth and final stage is **Problem Evaluation**, where the consultant and consultee review intervention data and base decisions off of such. If the intervention proves to be effective, generalization and maintenance plans are discussed. The schedule for follow-up measurement is also determined.

Keys to Success

Relationship quality, acceptability, and implementation integrity have been identified to have direct influences on consultation outcomes (Frank & Kratochwill, 2014). First, relationship quality between the consultant and consultee predicts intervention adoption, implementation quality, and student outcomes (as mentioned by Gutkin & Curtis, 2009; Erchul & Raven, 1997; in Frank & Kratochwill, 2014). Several researchers have sought modification to increase intervention acceptability for teachers, with findings suggesting: (a) positive interventions; (b) simple implementation, rather than complex; (c) interventions that responds to severe, rather than mild, behavior; (d) implemented with high integrity; and (e) using interventions considered

effective. Third, considering implementation integrity as a component within treatment acceptability and intervention effectiveness, consultants should seek to fulfill this factor. Multiple researchers have found the use of treatment scripts, consultee goal-setting and feedback procedures, and performance feedback interviews to be helpful (Frank & Kratochwill, 2014). Additionally, teachers should be directly trained on treatment integrity and utilize interventions that have already been accepted by teachers. Other factors that improve behavior consultation outcomes include interpersonal skills (e.g., the use of jargon rather than approachable language, conflict resolution skills, social influence and likability), and consultant management skills (e.g., maintaining a consultation schedule, and documentation).

In conclusion, consultants should consider the following to increase outcomes:

1. Take active steps to build rapport
2. Practice within areas of competency
3. Seek collaboration in schools
4. Provide ongoing professional development (e.g., conferences, articles)
5. Self-assess performance

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SECOND STEP®: A SOCIAL-EMOTIONAL LEARNING CURRICULUM

By: Rovi Hidalgo, M.Ed.

Social-emotional learning (SEL) curricula help establish physically and emotionally safe school environments that allow academic and social success ("Schools are reducing bullying and improving academics with social-emotional learning," 2013). Specifically, SEL programs improve students' attitudes, behavior, and skills to resist bullying (District Administration, 2013). A meta-analysis of 213 studies revealed that students who underwent socio-emotional learning curricula demonstrated enhanced SEL skills (i.e., identifying emotions through social cues, goal-setting, perspective taking, and conflict resolution), attitudes toward self and others (e.g., self-esteem, self-concept and self-efficacy), and positive social behaviors, as well as a reduced level of emotional distress (Durlak, Weissberg, Dymnicki, Taylor & Schellinger, 2011). Following the implementation of SEL programs, students also demonstrated a reduction in conduct problems, namely, disruptive class behavior, noncompliance, and aggression (Durlak et al., 2011).

The *Second Step*® program is a SEL program developed by the Committee for Children (CfC), an American non-profit organization. *Second Step*® curricula is available for students in grades K-8. Within grade-level material are weekly lessons for teachers to implement within their classrooms. The program is skills-focused and emphasizes direct instruction of skills in the areas of learning, empathy, emotion regulation, and problem-solving (Low, Cook, Smolkowski & Buntain-Ricklefs, 2015). The logic model for *Second Step*® asserts that students who receive direct instruction of skills, are given opportunities to practice and receive reinforcement for using skills, are likely to experience a range of improved immediate (e.g., increased self-regulation, social-emotional competence and attendance, on-task behavior and task completion) and long-term outcomes (e.g., school success, feelings of school belonging, improved peer relationships and a reduction in externalizing and internalizing behavior patterns; Low et al., 2015).

Second Step® has been found to improve social skills (Holsen, Iversen & Smith, 2009; Holsen, Smith & Frey, 2008; as cited in Low et al., 2015). Additionally, in a study seeking to determine the effects of Second Step® on social behavior, classroom management, and other outcomes in elementary students, it was determined that students who needed the most support (e.g., students with a higher-than-average number of problematic behaviors) experience the most pronounced benefits as a result of *Second Step*® (Low et al., 2015). Positive effects were also found for student conduct problems, hyperactivity, peer problems, and social skills (Low et al., 2015). In a study evaluating the effectiveness of *Second Step*® for English Language Learners, implementation of the program was associated with an increase in social and emotional skills (Brown, Jimerson, Dowdy, Gonzales & Stewart, 2012). Middle school students who underwent *Second Step*® were also less likely to be targets of homophobic name-calling and report sexual harassment (Espelage, Low, Polanin & Brown, 2015).

Generally, teachers support the *Second Step*® program. Teachers reported an increased use of the problem-solving method when talking and listening to students, as well as an awareness in how

to interpret social situations, following implementation of the program (Larsen & Samdal, 2011). Additionally, teachers favored the program's stance on allowing students to solve their own problems; overall, they felt that *Second Step*® served as an effective tool for addressing and solving conflicts, both for themselves and their students (Larsen & Samdal, 2011).

For more information, please see the *Second Step*® website at http://www.secondstep.org/

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MOTIVATIONAL INTERVIEWING

By: Stephanie J. Pirsig M.A., M.Ed.

Motivational Interviewing (MI) is a systematic process to help clients develop the intrinsic motivation to change. It was conceptualized in 1983 by as a short-term intervention for substance use in addiction counseling but has since been generalized for use with other health and mental health behaviors (Miller & Rollnick, 2013). So far, it has been utilized in couples counseling, healthcare, the criminal justice system, groups, adolescents and young adults for issues like substance use, smoking, risky sexual behaviors, eating disorders, and disruptive behavior. Additionally, MI can be used as a comprehensive therapeutic intervention or as a jumping-off point before switching to another therapeutic modality.

MI may be a particularly useful therapy when working with young people. While setting goals may be a new concept for young people, autonomy is an essential developmental consideration, and rolling with resistance, a strength of MI, make it a good match for this population.

MI is rated 3.9/4.0 on the Substance Abuse and Mental Health Services Administration (SAMHSA's) National Registry of Evidence-based Programs (U.S. Department of Health and Human Services, 2019). It is best applied in situations when specific behavior changes are desired and measurable. In school settings, MI is effective in reducing risky adolescent behavior, improving academic achievement, improving attendance, and high school dropout rate. In medical settings, it has been useful in cardiovascular disease, improving blood pressure, weight, BMI, and cholesterol. MI has also been shown effective as a telephone-based treatment for physical activity in client with MS and major depressive disorder and increasing help-seeking behaviors.

MI Spirit and Fundamentals

The three key components within a client-therapist relationship in MI are collaboration, evocation, and autonomy. In collaboration, therapists and clients work together to explore client motivation. Evocation involves the therapist drawing out the client's motivation, yet the client owning responsibility for change. Lastly, autonomy refers to the therapist respecting the client's free will.

Four general principles for the therapist to include in the approach to working with clients are expressing empathy, developing discrepancies, rolling with resistance, and supporting self-efficacy. The four processes a therapist uses in MI are Engaging, Focusing, Evoking, and Planning.

Foundational therapy skills utilized in MI are: Open-ended questions, Affirmations, Reflecting skills, and Summarizing (OARS). They encourage Change Talk to increase behavior change. Open-ended questions are questions that cannot be answered with a brief "yes' or "no." Good

practice in MI is to aim for more open questions than closed ones. Affirmations are statements that show we notice something about our clients (i.e., what they are going through, witnessing a strength) and understand something about the client. Although affirmations convey empathy, they are not praise statements. Reflecting skills are a response in statement form that conveys understanding and collaboration and keeps the conversation going, all while guessing the meaning. A reflection may be simple, complex, effective, or a purposeful over or understatement of the clients affect. Reflections allow the client to direct the conversation more than direct questioning, therefore, a ratio of 2:1 is a good rule of thumb. Effective reflections take practice. Summary statements are a type of refection that links or pulls ideas together and allow the client to hear various aspects of their situation simultaneously in a reasonably concise manner. A good summary statement conveys that the listener is listening, understands the situation and the client's emotions, is affirming and allows the client to clarify and add details.

Rolling with Resistance

When "rolling with resistance," the therapist acknowledges that resistance is an important and part of the change process. Therapists can use the following tools to roll with resistance: reflection, providing feedback, reframing questions from varying perspectives, recalling previous client statements about change, exploring pros and cons of changing, and adding thoughts or reframing in ways the client may not have thought of previously.

Further, it is essential to keep the client responsible for the problem and any resistance to addressing the issue (efficacy). The therapist supports self-efficacy by reinforcing the client's beliefs, promoting change to improve one's life, asking the client to share stories about how they overcame past obstacles and achieved success, and encouraging clients to use "change talk." Change Talk indicates increasing levels of self-efficacy, commitment to change, and shows clients are ready to set goals and pursue an action plan. The therapist can support making commitment permanent through bringing awareness of the need for change, providing space in the therapeutic relationship to accept the change, strategies on how to change, and giving constructive feedback when observing behavior changes.

Change Talk

MI is distinct in its focus on language; at the heart of MI is "Change Talk". Change Talk includes statements about why an individual should change, and consists of phrases such as, "I need to do this" or "It's important that I improve…"

The therapist is responsible for creating an atmosphere that allows the client to explore reasons for and against change, all while listening for and effectively responding. Therapists need to help the client identify their reasons for changing because people are much more likely to believe their own opinions than others (Miller & Rollnick, 2013). It is important for the therapist to be able to recognize categories of change and differentiate Change Talk from preparation talk. Therapists are most helpful when they can identify which factors are motivating the client and match their reflections on the client's readiness for change.

How to Recognize Change Talk & Categorize It

Natural, spontaneous talk about change typically falls under distinct, identifiable categories: preparatory (DARN) or activating (CAT). It is essential for the therapist to recognize when the client's language transitions from preparation to activation to identify if the client is ready to plan for change, or still if he/she is still in the contemplation stage of change.

DARN/CAT: Identifying Preparatory and Activation Language

"DARN" and "CAT" are acronyms for identifying preparatory and activation language and is helpful to understand the client and his/her readiness for change. Knowing where the client is in the process can assist in identifying motivations for change and forming reflections that match their readiness. However, therapist engagement is the priority, rather than categorizing change statements during sessions.

The first acronym, "DARN," includes preparatory language about change. Knowing the DARN categories can help you form questions that elicit change talk. The letters in "DARN" stand for:

- **D**esire statements, including language about wanting a change. Examples include, "I would like to lose some weight," "I hope to get a better job," "I wish I could quit smoking," and/or "I want to get a divorce."
- **A**bility statements are those that reflect one's perception that they can make a change. These statements reflect that change seems possible – however, these statements do not indicate commitment. Example statements include, "I could start walking 20 minutes a day", "I can turn off my email at work to focus more," or "I'm able to. . ."
- **R**eason statements are those that convey a specific reason for the change, and do not reflect desire or ability. Individuals can have a good reason for the change and still not want to do or not feel capable of making a change. Example may include "to improve my health."
- **N**eed statements stress importance or urgency of change, do not imply desire or ability, but may overlap with reason (why). Examples of need statements include, "I need to get my blood sugar under control", "I have to stop drinking", "I must . . ..", "I've got to . . .", or "Something has to change."

Alternatively, the acronym "CAT" describes activating language about change. The client will often express Action and Talking Steps before Commitment language. The acronym stands for:

- **C**ommitment language indicates the intention to change and is the strongest predictor that change will occur; however, it's strength can vary according to where the client is at in the process. Clients may verbalize Change Talk that reflects movement from contemplation to action. The stronger the commitment language, the more likely the person is to follow through, and therapy sessions can serve as a public promise. To evaluate the strength of the client's commitment language, the therapist can consider, "would it hold up in court or be a satisfactory response to a marriage vow?" Weak commitment language likely indicates low commitment to change while strong

commitment language reflects a stronger commitment to change. Weak commitment language may sound like “I’m considering. . .” or “I could do it . . ..” while strong commitment language is like a promise "I will," "I intend to," or “I am going to.”

- **A**ctivation language is weaker than commitment language. Activation language indicates the individual is "almost there" in terms of committing. This type of language suggests that a client is leaning in a particular direction. Examples of activation language are, “I’m willing to walk twice a week”or “I am prepared to talk with my boss.” When activation statements are made, the therapist can move the client toward stronger commitment by prompting for specifics, such as: “What exactly will you do?”, “What could you imagine yourself doing?” "When will you do this?" or “Would it be helpful to make this a between-session goal”? Once activation language is present, the client is likely ready to create a plan for change, and the therapist can stop eliciting Change Talk.
- **T**aking steps describes language that indicates that an individual has already done something in the direction of change. Example statements include, "I made a doctor's appointment," "This week I called about a job," or “I found a gym to join.”

While it is easy to get excited about CAT, it is essential to remain with the client’s level of readiness. Pushing for change when the client is not ready will lower their commitment. Some potential CAT hazards are: underestimating client ambivalence, therapist over-prescribing solutions, and insufficient client direction. People may talk about plans for change while still being ambivalent about change. If the therapist suspects client ambivalence to change, they can try understating reflections for change.

In “over-prescription of solutions”, sometimes referred to as the “Righting Reflex,” the therapist may eagerly provide problem-solutions rather than allowing the client to direct the change. To minimize over-prescribing solutions, if the client appears stuck, the therapist can ask permission to give a suggestion “other people I’ve worked with have told me. . .” Clients may have insufficient direction about change. The therapist should listen for whether they have specific ideas about change or ask if they want particular ideas about change.

Other signs the client is ready to create a plan for change include a decrease in resistance or Sustain Talk, the client appears to have reached a resolution, and may seem more peaceful and settled, reports envisioning change, or they talk about experimenting with change.

Evoking and Responding to Change Talk

To elicit Change Talk, the therapist first must ensure the foundations of accurate empathy and OARS to create an atmosphere where the client is comfortable vocalizing reasons for and against change. When beginning to evoke Change Talk, the therapist should aim to match their reflections and to elicit questions to assess the client’s readiness. Evoking Change Talk should not be construed as an investment in the client changing in any particular way; simply exploring the possibility of change may result in the client deciding not to change. If the therapist moves too fast, it will likely promote Sustain Talk from the client. Clients often verbalize Change Talk and sustain talk in the same conversation, which may reflect ambivalence; this is a normal part of the change process.

Two tools to help evoke Change Talk are using the acronym DARN to structure Change Talk evoking questions, and the Readiness Ruler to gage importance and capability. Examples of each are as follows:

Evoking Change Talk Using DARN:

- Desire: ask questions using ‘want,' ‘wish,' or ‘like':
  - How would you like things to change?
  - What do you wish was different in your marriage?
- Ability: ask about what a person can do, can do, or could do:
  - What change could you make to reduce alcohol use?
  - How could you restructure your morning to get more work done?
- Reason: ask what reasons they have for changing:
  - Why do you want to stop drinking?
  - What will change when your diabetes is under control?
- Need: ask why they have to, why it’s important
  - What makes this important?
  - What makes this change necessary?

Evoking Change Talk Using the Readiness Ruler

“On a scale of 0-10, with ‘0’ being not at all, and ‘10’ being more than anything, how important/capable (is it to you to save more money/ do you feel of making this change)?”

Whatever number the client chooses, ask them “Why did you pick ___ and not (a number 2 digits less)?

If the client picks 1, ask, "What makes it a ‘1' and not a ‘0'? If the client picks a 0, talk about why they chose that number.

If the client selects a ‘10', you can say "It's clear that this is very important to you it couldn't be any more important!! What makes it so important?"

Then ask, “What would it take for you to go from ____ to ____ (2 digits higher)?” The answers given here are Change Talk answers.

Sustain Talk

Sustain Talk, sometimes referred to as "resistance," describes statements one makes for why they should stay the same. Change and Sustain Talk are often both present in sessions. Ambivalence or moving back and forth between Change Talk and Sustain Talk is a normal part of the change process, yet the proportion between the two is essential. While the dominance of Sustain Talk and an equal mix with Change Talk predicts the status quo, a predominance of Change Talk predicts behavior change (Moyers, Martin, Houck, Christopher, and Tonigan, 2009). Being able

to respond effectively to sustain Talk allows the therapist to gauge the client's readiness for change and identify treatment targets (i.e., ability or need).

Recognizing Sustain Talk

While Change Talk consists of utterances for change, Sustain Talk is utterances for maintaining the status quo. For example, Change Talk sounds like "I'm ready to quit smoking," while Sustain Talk may look like "I know I need to quit smoking, but this isn't the right time." Sustain talk can also be broken down into DARN CAT categories.

- **Desire** – "I just want to eat what I like."
- **Ability** – "I've tried, and I can't quit smoking."
- **Reason** – "There's no cancer in my family, Doc."
- **Need** – "I can't manage my stress without smoking."
- **Commitment** - "I'm not going to exercise, and that's that."
- **Activation** – "I'm not willing to put myself out there."
- **Taking Steps** – "I discontinued my membership at the gym."

If the client is mainly providing Sustain Talk, take a step back. First, determine whether or not the client is actually engaging in Sustain Talk. For example, the therapist may ask, "Getting to work on time isn't a concern for you?" Then, allow the client to respond and shift the conversation (best outcome). If the client doesn't shift, focus can be shifted with a reflection (possibly a guess) on something the client previously said, such as, "Your real concern is impressing your boss with the quality of your work." If Sustain Talk is paired with high emotion, reflect the emotion.

Revert to the "12 Roadblocks to Listening" in the WBT manual appendix when responding to Sustain Talk. Therapeutic responses to Sustain Talk include amplified reflection and double-sided reflections. An amplified reflection is reflecting what the person has said using more extreme language, which may cause the person to back away from Sustain Talk. Double-sided reflections are revealing both the Sustain Talk and Change Talk in juxtaposition. In double sided-reflections, make sure to use the word "and" and not "but," – "but" is the great eraser of statements! Examples of reflection types are as follows:

- *Client*: "Well, I overdo it sometimes, but I don't have a problem with drinking."
- *Simple reflection:* "You don't think of yourself as a problem drinker."
- *Amplified reflection:* "Your drinking has never really caused any problems or unpleasant effects in your life."
- *Double-sided reflection:* "You think you drink too much at times, and also you don't think of yourself as a problem drinker."

<u>When Change and Sustain Talk Co-Occur</u>

Reflect the Change Talk and see if the client goes with it (readiness for change) or backs off of it (ambivalence/precontemplation phase). When a therapist responds effectively to Sustain or

Change Talk, clients will give you immediate feedback on how you're doing. Feedback might take the form of agreeing or correcting.

Avoid questions that elicit Sustain Talk or where the language or tone of question could convey shaming.

Developing a Change Plan

Use OARS to create a change plan. The therapist should listen for mobilizing Change Talk. While some ambivalence may remain, the client will indicate when they are ready. To test the water on one's readiness for planning, listen for mobilizing Change Talk (CAT), then provide the client with a comprehensive summary which may outline the DARN/CAT statements. For example, a client may say:

- **Desire:** "I want to quit smoking."
- **Ability:** "I can start by delaying my first cigarette to one hour after I wake up."
- **Need:** "I need to do this for my health."
- **Reason:** "I want to be a good example for my kids."
- **Commitment:** "This is what I'm going to do: delay my first cigarette by one hour."
- **Activation:** "I'm ready to do this."
- **Taking Steps:** "I delayed for 40 minutes yesterday by taking a shower, brushing my teeth, and getting dressed first thing."

Once a comprehensive summary of the client's plan is provided, follow up with a question about their next steps, such as "I wonder what you'll do next," "So, where does all this leave you?," or "So what are you thinking about [area of concern] at this point"? Using open-ended questions avoids pressuring the client to come up with a plan before they are ready. The client may not be ready to engage in the plan if they respond to questions with Sustain Talk. In this case, clarify the client's objective – do they want to make a change? Do they want to process?

If the client responds to "what next" questions by providing a decision or giving more Change Talk, this is an excellent time to transition negotiating a change plan. When the client is ready to create a change plan, identify which of the three scenarios your client falls. Three scenarios include (1) they have a good idea of how they want to change (2) have several good options for changing and need to decide which to pursue or (3) need to develop a plan from scratch. If the client is in the third scenario, the therapist can work with them by eliciting mobilizing Change Talk.

<u>Troubleshooting</u>

It is imperative to troubleshoot the client's plan to prepare them for potential challenges. The therapist can ask, "What challenges do you foresee?" or "What might get in the way of this plan." If the client cannot foresee any challenges, the therapist can ask to share some obstacles that have come up for other people they have worked with who have faced a similar situation. However, it is not ideal for the therapist is consistently providing solutions for client-presented problems. Be specific when troubleshooting and making plans.

People are more likely to believe what they hear themselves say – the plan must be their own. While commitments to change typically fluctuate over time, people are more likely to follow through with a plan if it is specific and expressed to someone else. The therapist's role in strengthening the commitment to change is (a) to be a witness to their plan and (b) provide more guidance when and if desired by the client. Using MI, we can increase the likelihood that the client is satisfied with the change plan and implements it. It is often easier to ask for activation language than a bold commitment. This is accomplished by asking questions similar to "What steps are you willing to take this week?", "What part of this plan do you think you're ready to do?", or "You're excited to get started-what will you do first?" it may be helpful to break big goals into small chunks.

Therapist Next Steps for Learning: Practice & Feedback

Learning Through Practice

- Watch Won't You Be My Neighbor? (Neville, 2018) to see the "MI spirit"
- Look up MI videos on YouTube
    - https://www.youtube.com/watch?v=s3MCJZ7OGRk
    - https://www.youtube.com/watch?v=EvLquWI8aqc
    - https://www.youtube.com/watch?v=bTRRNWrwRCo
- Consider focusing on one aspect at a time, such as a 1-month focus on asking more open-ended questions than closed ones, 1-month focus on 2:1 reflection/question ratio, 1-month focus on eliciting Change Talk, and 1-month concentrate on responding to Change Talk
- Do role-plays with colleagues or loved ones, such as: Taste of MI Exercise, 15-minute reflective listening, eliciting Change Talk exercise, in the WBT manual appendix.
- Additionally, record the role plays, listen to, and rate yourself on OARS sheet. You can "score" yourself on several variables: % of closed questions, % of open-ended questions, summary statements, 2:1 ratio, etc. etc.). Do this again in a month and see if there are any changes.

Learning Through Research Articles & Books

- Miller, W. R. & Moyers, T. B. (2006). Eight stages in learning motivational interviewing. *Journal of Teaching in the Addictions*. Retrieved from: https://www.tandfonline.com/doi/abs/10.1300/J188v05n01_02
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- Miller, W. R., & Rollnick, S. (2013). *Applications of motivational interviewing. Motivational interviewing: Helping people change (3rd edition).* New York, NY, US: Guilford Press.
  Rollnick, S., Miller, W.R., & Butler C.C. (2008). *Motivational Interviewing in Health Care***:** *Helping Patents Change Behavior.* The Guilford Press, New York, New York.

Levels of Reflections

Simple: the listener either repeats an element of what the speaker has said or may say something close to what the speaker has said. This can be a useful prompt to keep one talking. However, if the listener feels like the conversation is going nowhere, then the therapist may be relying too much on simple reflections.

Complex: A significant restatement in which the listener *infers the meaning/makes a guess* of what is said and reflects this back in new words. This type of reflections adds to and extends what was said. When done skillfully, the complex reflection continues the paragraph, *saying the next sentence* rather than repeating the last one (a simple reflection).
Affective: Often regarded as the sincerest form of reflection, this is a complex reflection that emphasis the emotional dimensions through feeling statements, metaphor, etc.

10 Things That MI Is Not

1. Based on the transtheoretical model of change (Prochaska & DiClemente,1982)
2. A way of tricking people into doing what you want them to do
3. A specific technique (MI is a counseling *method*; no specific technique is required)
4. Decisional balance, equally exploring pros and cons of change
5. Assessment feedback
6. A form of cognitive-behavior therapy
7. Just client-centered therapy
8. Easy to learn
9. What you were already doing
10. A panacea for every clinical challenge

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BUILDING RAPPORT WITHIN THE SCHOOL

By: Pamela A. Cornejo, M.Ed.

Teachers

Building rapport with teachers is critical for creating connection and valuing of the mental health services provided by the WBT. Their support can dramatically impact their participation and assistance with the WBT's initiatives and services. Their frequent interactions with students highlight them as a helpful resource for student referrals and gaining a picture of student engagement and behavior in the classroom. Pulling students out of class for therapy services may be stressful for the teacher to facilitate make-up work or endure classroom disruptions. A strong rapport can assist with this.

- Ideas for Rapport Building:
    - Attend faculty meetings
    - Promptly respond to emails from teachers
    - Take advantage of moments to greet or have brief conversations
    - Eat lunch in the faculty lounge during their lunch times
    - Ask permission to attend one of their classes
    - Positively reinforce their efforts and interests in gaining resources, consultation or identifying students for therapy services
    - Consistently thank teachers for their patience and assistance in facilitating therapy services

School Staff

School staff may not directly impact therapy outcomes but they are just as important to build a rapport with to promote a positive school environment. They also can potentially be great sources for student referrals if they have established relationships with students. These include school personnel such as front desk staff, school nurse, janitors, meal staff, afterschool providers, technology assistance staff, and registrar staff. Building strong connections to school staff will result in smoother therapy services through assistance with pulling students from classes, finding supplies, utilization of additional therapy spaces (i.e. the conference rooms, borrowing keys) and pulling contact information for parents.

- Ideas for rapport building:
    - Greet every staff member you see
    - Have brief conservations if they seem to have time for it
    - Thank them for their role in the school

Students

Visibility and familiarity with students are important to build connection and increase likelihood for self-referral to WBT services. Students will associate you with positive regard if they can experience WBT therapists in casual settings and interactions. This means that a proactive approach to engaging with students outside of therapy or referral circumstances will need to be facilitated throughout the school year. Positive interactions with students can be as brief as a greeting or a simple question. Although these interactions are brief and seemingly insignificant, they will contribute to the reputation of WBT overall.

- Times to Socially Engage Students:
    - In the hallway between classes
        - Could be in any hallway or close to a teacher's classroom door
    - Before the first period - grab a breakfast item and greet students
    - Lunch - attempt to sit at every lunch table and greet as many students as possible
    - In the front office when students are seated and waiting
    - Parent-teacher conferences
    - Open houses
    - As they walk into the auditorium for assemblies

Parents

Increasing visibility and positive contact with parents greatly impacts the likelihood of parent's decision to consent to therapy services. WBT therapists will benefit from attending as many school events as possible to provide information regarding the therapy services available and so they may personally meet the person responsible for individual therapy provision and referral to the community.

- Ideas for Building Rapport:
    - Attend all school events
        - Prepare for the school event by having therapy consent form packets readily available in both Spanish and English, an informational sheet about the Wellbeing Team, and an engaging activity or candy.
        - Events: Parent teacher conferences, open house, registration days, concerts, and plays.
        - Talk with as many parents as possible while they wait in line during the parent-teacher conferences. The more relaxed and sociable you are, the more comfortable parents will feel to engage with you.
    - Attend parent committee meetings to introduce yourself.
        - Regularly engage with parents who are leads of the committee so that they may promote Wellbeing Team activities and informational sheets
    - Send brief emails and text messages to the parent listservs
        - Front desk can facilitate the message by providing them with the information
    - Brief headlines on the school marquee

        - The librarian at Bryant Middle School can include brief headlines on the marquee to promote any WBT activities
    - Greet parents when they enter the front desk area
        - Although this is not an introduction, a positive brief encounter may be helpful if their student seeks therapy services

Section 3: Tier 2

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GROUP RECRUITMENT AND SELECTION

By: Christina C. Omlie, M.A., M.Ed.

Creating and launching a therapy group may be perceived as a challenge to a new facilitator. Without prior experience, it may be difficult to figure out where to begin to ensure that the proposed group will fill to capacity. As with any other product, to "sell" a therapy group to recruit participants that are a good fit with the treatment goals and objectives.

First, it is important when developing recruitment materials and discussing the group with potential referral stakeholders that you have a clear vision of what the group focus is. The more specific the purpose and objectives for your group are, the better. For example, instead of "Relationship Building," niche that down to: "Building Healthy Adolescent Relationships in the Technological Age." Having a specific vision will help you hone in on where to market to your ideal group participants.

Second, create a name for your group that adds hope**.** For example, when in the process of developing a group in response to a potential cyber-bullying situation or unwanted sexual advances made over social media, instead of using words related to perpetrators of victims, using different language in the group acronym is useful. For example, T.A.R.A., which is an acronym for "Technology and Relationships for Adolescents," would be a more positive name for a group. When the students share with a friend or family member that they are going to their "TARA Group" meeting, it adds confidentiality to the work as well.

Third, group facilitators should decide of whether you want your group to be open or closed. When using manualized group therapies, keeping a closed group is ideal to help manage the volume of progress monitoring data collected throughout the group session trajectory. If the facilitator(s) are choosing to offer a processing group, it may be useful to open the group up to all students as a form of Tier 1 services. Ultimately, deciding on whether a group will be open or closed will be reliant on the facilitator(s) preference and the group objectives.

Advertising for Group Recruitment

Create an informational flyer or email for promoting information regarding the group. This document should include the W's (i.e. who, what, where, when and why) so that students, teachers, parents and staff clearly understand the purpose, member eligibility, where and when group will be held and the treatment goals and objectives. After an informational flyer is created, email it to all school stakeholders, print out copies for administrative personnel to have on hand for guardians and to post around the school facility. Each informational sheet should include the following information:

- Group Name
- Group Objectives (i.e., what is it?)

- Time and Day (i.e., when is it?)
- Description of Target Population (i.e., who would benefit?)
- Description of Referral Process (i.e., how can people be referred?)

The purpose of group therapeutic services is to provide targeted services to groups of students identified as presenting with at-risk concerns. There are a variety of ways students may be referred to received group services. Students may be identified for services by:

- Teacher, parent, peer, or self- referrals
- Office detention referrals (ODRs)
- Screening measures
- Informal, "homegrown" measures
- Validated, formal measures

Although the number of students participating in a therapy group may range from 4 to 10, referral and/or recruitment data collection is up to the discretion of the group facilitator(s).

Selection

After recruitment, selection of group participants is an important process. Not only will it help the facilitator(s) get to know students better prior to the beginning of group, but also determine how good of a fit the participant is in terms of needs. It is during the intake when students have an opportunity to learn more about the group being offered and make an informed decision about their participation. When selecting group therapy members, facilitators should use the group therapy intake for all referred students.

It is important for facilitators to conduct an intake for each group therapy participant for several reasons. There will be situations where a student's needs are greater than what group therapy can offer. In these situations, it is important for the individual conducting the group intake to refer that student for an individual intake to potentially receive individual therapy services. Other times, there will be students who do not meet criteria for the group but may wish to receive occasional check-ins by the WBT to assess whether a different group may be a better fit for their presenting concerns.

Keeping presenting concerns in mind, there may also be students referred to a group who may negatively affect the group dynamic. In these situations, it is important to deliver clear expectations for group behavior. Relatedly, meeting students in person allows for the student to have autonomy and make a decision related to their own treatment. If assent is denied, be sure to document the student's lack of interest and keep their information secure in case they change their mind and wish to receive services in the future.

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DEVELOPING A SCHOOL-BASED THERAPY GROUP

By: Christina C. Omlie, M.A., M.Ed.

The Wellbeing Team (WBT), which is comprised of graduate clinicians from the University of Utah, will be accountable for providing group therapy services as a facilitator or co-facilitator as part of targeted, Tier 2 services offered at designated schools in Salt Lake City School District. Group therapy will serve as a selected service for students who have been identified as being at-risk for a variety of common mental health concerns including: depression, anxiety, and substance use. Other therapy groups will focus on building specific skills such as but not limited to: social skills, problem-solving and decision-making, relationship building, and processing skills.

This procedural guide serves as an outline on how WBT should recruit, conduct intakes, collect required forms (e.g., consent forms), plan for group implementation, and collect therapy progress data. Examples of different group therapy interventions are included in the procedural guides for: ROAM, ADAPT, and PEERs. Regardless of the focus of a proposed therapy group, members of the WBT who are designated as being responsible for conducting group therapy will be required to complete the following for each group:

- Systematically collect/compile referral data
- Group Intake Guide (for each group member)
- Consent Forms (for each group member)
- Group Therapy Rubric
- Appropriate pre- and post- data collection

Design and Programming

When designing and developing programming for a therapy group, there are several components that must be considered first:

- Objectives and Treatment Goals
    - Consider the treatment group's objectives and treatment goals will help dictate the type of work conducted in group and the focus of discussion topics.
    - Treatment goals may align with a developed, research-based manual or it may be a better fit for the facilitator(s) to develop a group from scratch.
        - Manualized (i.e. using a specific evidence-based model via a clinical manual) versus not manualized
        - Didactic (e.g. providing information to the group that increase skills in identified deficits) versus process based (e.g. allowing space for students to share and discuss their experiences concerning specific discussion prompts)?
- Group Members

    - Decide which students are your target audience for the group (e.g. qualifying behaviors or concerns).
- Group Logistics
    - Where and when will group be held? It may be helpful to hold group during a time in which the student doesn't miss an entire class period (e.g. lunch or across half marks of two class periods).

Group Therapy Recruitment

The purpose of group therapeutic services is to provide targeted services to groups of students identified as presenting with at-risk concerns. There are a variety of ways students may be referred to received group services. Students may be identified for services by:

- Teacher, parent, peer, or self- referrals
- Office detention referrals (ODRs)
- Screening measures
- Informal, "homegrown" measures
- Validated, formal measure

Although the number of students participating in a therapy group may range from 4 to 10, referral and/or recruitment data collection is up to the discretion of the group facilitator(s). For more information related to group recruitment and selection, see the section on *Group Recruitment and Selection*.

Group Intake Guide

Facilitator(s) are required to conduct an intake interview for each potential group participant and are responsible for scheduling a time in which students may meet for 30 minutes to complete the intake. The purpose of the intake is to determine the student's fit for group. If the presenting behaviors/concerns, functioning and communication styles are within the therapy objectives, then the student will likely be a fit for the group. If a student expresses ongoing concerns with suicidal ideation or homicidal ideation, eating disorders, addiction, or trauma (abuse), then they would be a better fit for individual therapy.

WBT members may choose to follow the "Group Therapy Intake Guide" provided in the manual, tailoring specific questions to match the need of the proposed group. WBT members may choose to create their own intake rubric, however, they are required to include the following information:

- Description of the proposed group
- Overview of confidentiality and consent
- Student demographic information
- Current and past suicidal ideation
- Current and past homicidal ideation
- Presenting concerns

- Previous therapy experience
- Coping strategies
- Clinical impressions
- Obtain assent

Information collected during group intakes should serve to inform therapy and should be applied in planning for group sessions in the *Group Therapy Rubric*.

Consent Forms

Students planning on attending group therapy are required to obtain signed consent forms from a legal guardian. All WBT clinicians are required to check with the respective school's administrative team to ensure that all necessary signatures are obtained in instances where legal guardianship may include individuals different from individuals the student is currently living with.

Group Therapy Rubric

A *Group Therapy Rubric* must be completed for each therapy group offered through the WBT. Completing a rubric prior to beginning therapy implementation will help facilitator(s) remain on-schedule. It should be noted, however, that there will be situations where the facilitator(s) may find that repeating a lesson is necessary. In those situations, it is important to update the rubric for documentation purposes. Information in each rubric should include:

- Session number
- Session objective
- Opening activity (e.g., ice breaker, discussion prompt, short activity)
- Outline of session agenda (i.e., specific lesson components)
- Closing Activity (e.g., discussion prompt, short activity)

Pre- and Post- Data Collection

Group therapy data collection is up to the discretion of the WBT facilitator(s). When planning for groups, it is useful to refer to either the manual being referenced in your group therapy rubric. Oftentimes, there will be measures recommending for progress monitoring or in some cases there will be a manual-specific measure developed by its author(s). When choosing your measure, consider the goals of your group participants. There may be more than one treatment goal depending on the students who are present. For example, when leading a therapy group related to depression, it may be useful to incorporate a measure related to substance use in tandem with a mood questionnaire if there are several group members who indicate substance use as a potential coping mechanism during group intakes. In contrast, if no group members indicate substance use but several indicate problems with self-esteem, a different questionnaire aimed at subject wellbeing may be appropriate for use instead.

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LIST OF USEFUL MANUALIZED GROUP THERAPY INTERVENTIONS

By: Christina C. Omlie, M.A., M.Ed.

The Tier 2 services provided by the Wellbeing Team (WBT) are intended to provide supports to a selective group of students identified as exhibiting at-risk behaviors. Group therapy is an integral part of the WBT Tier 2 student services and is intended to target specific groups of students who present with similar treatment concerns. Although there will be didactic therapy groups conducted through the WBT, the use of manualized therapy programs provides group facilitators with a research-based treatment for specific concerns.

Below is a list of a variety of group therapy treatment manuals designated by different presenting concerns. Although the list is not comprehensive of every manualized treatment available on the market, each has received substantial research support for their specific use with adolescents and are have been implemented by current WBT members. WBT group therapy facilitators should consider implementing manualized therapies in their entirety but may also choose to use specific components from different manuals to provide a best fit therapy for their student participants.

Manual Name	Presenting Concerns	Theoretical Orientation	Number of Sessions
Advancing Problem-solving and Decision-making for Teens (ADAPT)	Decision-making Problem-solving Substance use	CBT	12 Total
Adolescent Coping with Depression (ACWD)	Low mood Anhedonia Withdrawal	CBT	16 Total
DBT® Skills Manual for Adolescents	Depressed or irritable mood Interpersonal relationship difficulties Inappropriate anger Impulsivity	DBT	6 Training Modules
Program for the Education and Enrichment of Relational Skills (PEERS®)	Social skills Communication skills Making and keeping friends	CBT	16 Total
Social Sills Improvement System (SSiS)	Social skills Problem behaviors Academic competencies	CBT	7 Target Categories
The Thriving Adolescent: Using Acceptance and Commitment Therapy and Positive Psychology to Help Teens Manage Emotions, Achieve Goals, and Build Communication	Anxiety Coping skills Emotion management Building healthy relationships	ACT	-

        - Draw the first row of a blank Decision-Making Chain on the whiteboard
        - Use examples – work backward through the Decision-Making chain
        - Draw second row of the chain
            - Summarize
        - Practice session skills - students will create their own chain
        - Review lesson – clarify what was covered
    - **Closing Activity:** Snowstorm
- **Session 4:**
    - **Objective**: Why Do I Do That? Part I
    - **Opening Icebreaker**: reflective prompt or very short activity
    - **Session Agenda:**
        - Review with students problem-solving and different ways of preventing problems by understanding how they develop
        - Provide overview on white board on Mapping Problem Behaviors and introduce basic steps in mapping problem behavior
        - Complete map using example
        - Summarize
        - Map other problem behaviors depending on time available
    - **Closing Activity:** Ask students how they might use mapping to understand problem behaviors
- **Session 5:**
    - **Objective:** Why Do I Do That? Part II
    - **Opening Icebreaker**: reflective prompt or very short activity
    - **Session Agenda:**
        - Review the relationship between triggers, behaviors, and positive and negative consequences
        - Students increase their understanding of why problem behaviors occur.
        - Students learn how to use positive alternative behaviors in place of problem behaviors to serve the same needs but with better outcomes.
        - Use Mapping Alternative Behaviors handout to list out five positive alternative behaviors to use for themselves.
    - **Closing Activity**: reflective prompt or very short activity
- **Session 6:**
    - **Objective**: What Are Drugs and What Do They Do?
    - **Opening Icebreaker**: reflective prompt or very short activity
    - **Session Agenda:**
        - Psychoeducation on the physical, psychological, and social effects of drug use and how to get accurate information that will help them make informed decisions when offered drugs.
            - Take time to solicit and answer common questions about drugs. Use the "Common Questions About Drugs" rubric on page 121 of the ADAPT manual for reference.
            - Choose Activity 1 (drug information chart) or Activity 2 (true/false quiz) from the ADAPT manual
    - Students will learn the importance of having accurate information in order to make good decisions.

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PEERS GROUP THERAPY

By: Christina C. Omlie, M.A., M.Ed.

The Program for the Education and Enrichment of Relational Skills (PEERS®) was designed as an intervention focusing on adolescents in middle and high school who demonstrate difficulty making and keeping friends. The program has been implemented with teens and young adults with Autism Spectrum Disorder (ASD) and related patient populations with deficits in social skills or demonstrate other social challenges.

The PEERS curriculum is intended for higher functioning adolescents without significant intellectual deficits. The sessions focus on skills related to making and keeping friends and managing peer conflict and rejection. Examples of lessons include having two-way conversations, entering and exiting conversations, electronic forms of communication, choosing appropriate friends, using humor appropriately, being a "good sport", having successful get-togethers, managing arguments with friends and handling teasing, physical bullying, and other forms of social rejection.

The PEERs curriculum is meant to be used as a complete program in its entirety, however, presenting each lesson in the order presented in the manual may prove difficult in school settings. The WBT facilitator(s) of the PEERS group are encourage to follow the lessons as designed. It should be noted, however, that there may be situations that arise that going out-of-order may prove to be an appropriate choice if there is an immediate need or personal connection to group members at that time. Lessons are didactic in nature and involve role-play demonstrations, behavioral rehearsal exercises, and homework assignments designed to improve social skills generalization in school settings.

Below is an example of a completed Group Plan Rubric for the PEERS curriculum. This is to be used as a supplement to guide planning outside of the material presented within the manual. WBT facilitators have access to the PEERS manual at both Bryant Middle School and SLCSE in the WBT office. The group facilitator(s) may plan beginning and closing activities at their own discretion. Planning for what lesson content to include in group sessions is up to the discretion of the facilitator(s).

PEERS Group Plan Rubric:

- **Statement of Purpose:** PEERS is a free therapy group for students to build social skills to make and keep friends.

- **Setting**: Salt Lake Center for Science Education; 7th and 8th grade; age (range = 13-14); urban - Salt Lake City

- **Target Population**: Individuals with deficits in social skills.

- **How members will be selected**: teacher, counselor, and admin referral. Group intake following referral to determine fit for grouping.

- **Logistics**: Bi-weekly, Thursday 8:30-9:15am. 14 weeks of treatment at SLCSE.

- **Facilitators:** Christina Omlie

- **Theoretical Orientation**: Consistent with the theoretical orientation of the program, PEERs will be delivered from a cognitive-behavioral perspective.

- **Group Norms/Rules**:
    - Review confidentiality:
    - Give example of appropriate sharing and non-examples
    - Speak from your heart and know that it does not need to be said perfect
    - It's ok to pass, your presence is enough
    - Feelings are truths
    - Ask for any additional
    - Appropriate behavior during sharing (KYHFOOTY)

- **Troubleshooting:**
    - Monopolizers: will introduce a "talking stick" to ensure one voice at a time. Will encourage round robin sharing.
    - Problem behavior: reference back to the rules, reward appropriate behavior (e.g., provide snack items when following rules), positive praise when acting appropriately.
    - If students are not engaged, we will plan for more interactive activities for the same content next time. We will ensure to use a didactic approach that maximizes their participation and minimizes "lecture" style.

- **Plan for Each Session**: Include the following:
    - **Session 1:**
        - **Objective:** Introduction and Trading Information
        - **Opening Icebreaker:** Opening discussion prompt: What's your name? Why do you think you're in the group? What is one positive thing about yourself that you'd like to share with everyone?
        - **Session Agenda**:
            - Respective activity outlined in the PEERS manual.
        - **Closing Activity:** Debrief: What are you excited about for group? What are you nervous about?
    - **Session 2:**
        - **Objective:** Two-Way Conversations
        - **Opening Icebreaker:** Discussion prompt or short activity.
        - **Session Agenda:**
            - Homework review
            - Respective activity outlined in the PEERS manual.
        - **Closing Activity:** Discussion prompt or short activity.
    - **Session 3:**

        - **Objective:** Electronic Communication
        - **Opening Icebreaker:** Discussion prompt or short activity.
        - **Session Agenda:**
            - Homework review
            - Respective activity outlined in the PEERS manual.
        - **Closing Activity:** Discussion prompt or short activity.
    - **Session 4:**
        - **Objective:** Choosing Appropriate Friends
        - **Opening Icebreaker:** Discussion prompt or short activity.
        - **Session Agenda:**
            - Homework review
            - Respective activity outlined in the PEERS manual.
        - **Closing Activity:** Discussion prompt or short activity.
    - **Session 5:**
        - **Objective:** Appropriate Use of Humor
        - **Opening Icebreaker:** Discussion prompt or short activity.
        - **Session Agenda:**
            - Homework review
            - Respective activity outlined in the PEERS manual.
        - **Closing Activity:** Discussion prompt or short activity.
    - **Session 6:**
        - **Objective:** Starting and Joining Conversations
        - **Opening Icebreaker:** Discussion prompt or short activity.
        - **Session Agenda:**
            - Homework review
            - Respective activity outlined in the PEERS manual.
        - **Closing Activity:** Discussion prompt or short activity.
    - **Session 7:**
        - **Objective:** Exiting Conversations
        - **Opening Icebreaker:** Discussion prompt or short activity.
        - **Session Agenda:**
            - Homework review
            - Respective activity outlined in the PEERS manual.
        - **Closing Activity:** Discussion prompt or short activity.
    - **Session 8:**
        - **Objective:** Good Sportsmanship
        - **Opening Icebreaker:** Discussion prompt or short activity.
        - **Session Agenda:**
            - Homework review
            - Respective activity outlined in the PEERS manual.
        - **Closing Activity:** Discussion prompt or short activity.
    - **Session 9:**
        - **Objective:** Get-Togethers
        - **Opening Icebreaker:** Discussion prompt or short activity.
        - **Session Agenda:**
            - Homework review

        - Respective activity outlined in the PEERS manual.
    - **Closing Activity:** Discussion prompt or short activity.
- **Session 10:**
    - **Objective:** Two-Way Conversations
    - **Opening Icebreaker:** Discussion prompt or short activity.
    - **Session Agenda:**
        - Homework review
        - Respective activity outlined in the PEERS manual.
    - **Closing Activity:** Discussion prompt or short activity.
- **Session 11:**
    - **Objective:** Handling Arguments
    - **Opening Icebreaker:** Discussion prompt or short activity.
    - **Session Agenda:**
        - Homework review
        - Respective activity outlined in the PEERS manual.
    - **Closing Activity:** Discussion prompt or short activity.
- **Session 12:**
    - **Objective:** Handling Teasing and Embarrassing Feedback
    - **Opening Icebreaker:** Discussion prompt or short activity.
    - **Session Agenda:**
        - Homework review
        - Respective activity outlined in the PEERS manual.
    - **Closing Activity:** Discussion prompt or short activity.
- **Session 13:**
    - **Objective:** Handing Physical Bullying
    - **Opening Icebreaker:** Discussion prompt or short activity.
    - **Session Agenda:**
        - Homework review
        - Respective activity outlined in the PEERS manual.
    - **Closing Activity:** Discussion prompt or short activity.
- **Session 14:**
    - **Objective:** Handling Cyber Bullying
    - **Opening Icebreaker:** Discussion prompt or short activity.
    - **Session Agenda:**
        - Homework review
        - Respective activity outlined in the PEERS manual.
    - **Closing Activity:** Discussion prompt or short activity.
- **Session 15:**
    - **Objective:** Minimizing Rumors and Gossip
    - **Opening Icebreaker:** Discussion prompt or short activity.
    - **Session Agenda:**
        - Homework review
        - Respective activity outlined in the PEERS manual.
    - **Closing Activity:** Discussion prompt or short activity.
- **Session 16:**
    - **Objective:** Final Review, Post-test Assessment, and Graduation

        - **Opening Icebreaker:** Discussion prompt or short activity.
        - **Session Agenda:**
            - Homework review
            - Respective activity outlined in the PEERS manual.
        - **Closing Activity:** Discussion prompt or short activity.

- **Evaluation tool** (i.e. – pre- and post-tests, grades, etc.):
    - SUDS ratings

- **Forms**
    - ❑ Informed consent (be sure to include info about limits to confidentiality, what clients can expect, any fees, info about attendance, group rules), may also want to consider a permission to tape form
    - ❑ Letters to teachers, passes, needs assessment, etc. (if relevant)

II. Plan for Publicizing or Generating Interest in the Group:

- ❑ Post group therapy infographic across school.
- ❑ Send email outlining purpose of group and target students to teacher and school staff for referrals.
- ❑ Provide infographic information to school for administrators to use during parent/teacher conferences.

References

Laugeson, Elizabeth A. (2014). *The PEERS curriculum for school-based professionals: social skills training for adolescents with autism spectrum disorder.* New York, NY: Routledge.

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ADAPT GROUP THERAPY

By: Christina C. Omlie, M.A., M.Ed.

Advancing Decision-making and Problem-solving for Teens (ADAPT) is a cognitive-behavioral therapy (CBT) intervention that incorporates components of social learning theory. The program is designed to teach, reinforce, and support the development of problem-solving and decision-making skills to help adolescents use strategies to handle common adolescent problems such as: aggression, depressive moods, and substance use.

ADAPT is designed to be implemented over a 12-week period and can be facilitated by school professionals such as school counselors, school psychologists, social works, and other qualified school mental health personnel. Sessions are delivered in a small group format and last a duration of approximately 45 to 60 minutes.

The rationale behind the development of ADAPT relies on the idea that adolescents who demonstrate effective problem solving and decision-making skills tend to experience fewer problem behaviors. Through the systematic development of and improvement of problem-solving and decision-making skills, this program promotes the positive behavior and good mental health for participants to cope in many different situations.

Target Students

This program is designed as a secondary or preventative intervention for middle and high school students who have been identified as being at risk for developing more serious problem behaviors.

Example of ADAPT Rubric

Statement of Purpose: Advancing Decision Making and Problem-Solving for Teens

Setting: Bryant Middle School; 7th and 8th grade; age (range = 13-14); urban - Salt Lake City

Target Population: individuals with concerns regarding anger management, problem solving, and/or substance use.

How members will be selected: teacher, counselor, and admin referral. Group intake following referral to determine fit for grouping.

Logistics: 1x per week, Friday 8:30am-9:15am. 12 weeks of treatment at Bryant Middle School.

Facilitators: Christina Omlie, Magenta Silberman; Main point contact person: Christina Omlie

Theoretical Orientation: Consistent with the theoretical orientation of the program, ADAPT will be delivered from a cognitive-behavioral perspective.

Group Norms/Rules:

- Review confidentiality:
- Give example of appropriate sharing and non-examples
- Speak from your heart and know that it does not need to be said perfect
- It's ok to pass, your presence is enough
- Feelings are truths
- Ask for any additional rules to be defined by group members
- Appropriate behavior during sharing (KYHFOOTY)

Plan for Each Session: Include the following:

- **Session 1:**
  - **Objective for session:** orient to group and get to know group members
  - **Opening Icebreaker:** Discussion hot potato
  - **Agenda for session:** introduce the purpose of group, group norms, and "get to know you" activity
  - **Closing Activity:** Debrief: What are you excited about for group? What are you nervous about?
- **Session 2:**
  - **Objective:** How do I Solve Problems?
  - **Opening Icebreaker**: Connection web
  - **Session Agenda:**
    - Introduce problem solving
    - Discuss differences between small and large problems
      - Provide examples and group discussion
    - Discuss three mistakes that can make it difficult to solve a problem
      - Failing to examine the problem, failing to identify solutions, trying to solve a problem with a poor or impulsive choice
      - Have students identify people who are good and bad problem solvers and then describe characteristics of each
      - Good problem solvers: 1. recognize problems when they are small, 2. solve small problems before they become larger problems, 3. Follow through on a good solution to a problem.
      - Draw/write about a person who you believe is a good problem solver. Tell us about that person and what they have done that makes them a good problem solver.
  - **Closing Activity:** Share out on your person and related back to good problem-solving skills
- **Session 3:**
  - **Objective**: Why Do Things Happen to Me?
  - **Opening Icebreaker**: Check-in - what are you going to do/what did you do for Thanksgiving break?
  - **Session Agenda:**
    - Display and discuss the 4-Ws to Solve Problems

        - Use the "Drug Facts Versus Myths" rubric on page 124 of the ADAPT manual for reference.
    - Students will learn and practice how to check the accuracy of what they hear and read.
    - Solicit feedback from students on their opinion on their progress in group.
    - **Closing Activity**: reflective prompt or very short activity
        - If short on time, the closing activity could be used as a tool to solicit group therapy feedback.
- **Session 7:**
    - **Objective**: How Do I Refuse Drugs? – Triggers, Communication, Reasons
    - **Opening Icebreaker**: reflective prompt or very short activity
    - **Session Agenda:**
        - Student learn and practice effective drug refusal skills.
            - Use the Triggers, Communication, Reasons handout from the ADAPT manual or use whiteboard to guide discussion.
        - Teach students how peer pressure influences their decisions about drug use.
        - Students will learn that having personal reasons for not using drugs makes it easier to refuse drugs.
    - **Closing Activity**: reflective prompt or very short activity
- **Session 8:**
    - **Objective**: How Do I Communicate Better with Others? – Assertive Communication Skills
    - **Opening Icebreaker**: reflective prompt or very short activity
    - **Session Agenda:**
    - Learn and practice effective communication skills to develop appropriate assertiveness in difficult situations.
    - Students will learn about the benefits and drawbacks of the four communication styles – Aggressive, Passive, Indirect, and Assertive.
    - Students learn how to use I-messages.
    - Students learn the listening skills of Listen, Clarify, and Recap.
    - **Closing Activity**: reflective prompt or very short activity
- **Session 9:**
    - **Objective**: How Do I Manage My Anger?
    - **Opening Icebreaker**: reflective prompt or very short activity
    - **Session Agenda:**
        - Students learn that it is normal to experience anger occasionally.
        - Students learn that managing anger involves recognizing their body cues, thoughts, and feelings in response to external triggers.
        - Students learn how to manage anger by Recognizing their anger, Reviewing options, and Responding effectively (R^3).
        - Students learn that a calm response to anger can pave the way for effective problem solving.
    - **Closing Activity**: reflective prompt or very short activity
- **Session 10:**
    - **Objective**: How Do I Manage My Negative Mood?

    - **Opening Icebreaker**: reflective prompt or very short activity
    - **Session Agenda:**
        - Students learn that negative moods are normal from time to time.
            - Introduce the topic of mood management.
        - Students learn that managing negative moods involves recognizing their internal reactions – thoughts and feelings – to external situations.
            - Use the Negative Thoughts Chart from the ADAPT manual.
        - Students learn effective mood management skills.
            - Engage in mood related role-play.
    - **Closing Activity**: reflective prompt or very short activity
- **Session 11:**
    - **Objective**: How Do I Get the Support I Need from Others?
    - **Opening Icebreaker**: reflective prompt or very short activity
    - **Session Agenda:**
        - Students learn that getting support from others is normal and helps people better handle stressful situations.
            - Option to use the Social Support Circle worksheet from the ADAPT manual to facilitate discussion.
        - Students learn effective skills for obtaining social support for themselves.
        - Students review listening skills and problem-solving skills for providing social support to others.
    - **Closing Activity**: reflective prompt or very short activity
- **Session 12:**
    - **Objective**: **Generalization**
        - Review the skills learned over the course of the program
        - Discuss strategies for obtaining post-group support
        - Empower students to share their experiences with the program
    - **Opening Icebreaker**: Check-ins, shout-outs
    - **Session Agenda**:
        - Discuss feelings associated with termination of group services
        - Review the skills learned during the program – hand out ADAPT Skills Review
        - Problem-solve how they will obtain support they need once ADAPT ends
        - Ask students to share their feedback about ADAPT
        - Conclude with handing out certificate of participation
    - **Closing Activity:** Honey Roast – similar to a comedy roast but group members say kind things about each other for a portion of time (3 min)

- **Strategies for Dealing with Challenges:**
    - Monopolizers: will introduce a "talking stick" to ensure one voice at a time. Will encourage round robin sharing.
    - Problem behavior: reference back to the rules, reward appropriate behavior (e.g., provide snack items when following rules), positive praise when acting appropriately.

- If students are not engaged, we will plan for more interactive activities for the same content next time. We will ensure to use a didactic approach that maximizes their participation and minimizes "lecture" style.

- **Final closing activity**:
  - Group reflection: every group member will share what they learned and valued about the group experience.
  - Party: bring snacks, listen to music, hang out

- **Evaluation tool** (i.e. – pre- and post-tests, grades, etc.)
  - Use the pre-made risk questionnaire in the ADAPT Manual.

- **Forms**
  - Informed consent (be sure to include info about limits to confidentiality, what clients can expect, any fees, info about attendance, group rules), may also want to consider a permission to tape form
  - Letters to teachers, passes, needs assessment, etc. (if relevant)

- **Plan for Publicizing or Generating Interest in the Group:**
  - Email letter to teachers explaining purpose of group to solicit referrals
  - Post ADAPT infographic throughout the school to encourage student self-referrals.

References

Burrow-Sanchez, J. (2013). *ADAPT: Advancing decision making and problem solving for teens.* Eugene, OR: Pacific Northwest Publishing.

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ADOLESCENT COPING WITH DEPRESSION GROUP THERAPY

By: Christina C. Omlie, M.A., M.Ed.

Adolescent Coping with Depression (ACWD) is cognitive-behavioral therapy group designed for adolescents with active depressive symptoms. Although the course is designed for use with groups of four to eight adolescents, this therapy can easily be modified to be used on an individual basis, in conjunction with other types of treatment, or with at-risk (or non-depressed) teenagers as a preventative program.

ACWD combines aspects of several theories of depression: cognitive, self-control, and interpersonal interaction. Different sessions focus on re-framing negative thoughts that are driven by dysfunctional beliefs that lead to depressive symptoms and disrupting the feedback loop that leads to deficits in self-control processes (e.g., self-monitoring, self-evaluation, and self-reinforcement). ACWD also relies on behavioral formulations to assist participants to notice that maladaptive depressive symptoms have been acquired over time and thus can be unlearned. The model of ACWD entails that symptoms should be viewed to be important in and of themselves rather than be considered as underlying manifestations of conflicts; treatment is focused on modifying specific behaviors and cognitions instead of attempting to reorganize an individual's personality.

An important component of the therapy is the structure of the session. The premise behind the structure of ACWD is that effective therapy begins with a well-planned rationale that provides structure to initially guide patients towards the belief that they can control their own behavior and thus their own depression. The therapy provides a structured process of training in skills for individuals to feel more effective in handling their daily life. Of importance, these skills should be of significance to the patient and fit the rationale to produce optimal outcomes for participants. This program emphasizes assigning "homework" to encourage independent use of skills outside of therapy and the course provides structure to ensure that the skills are attainable for the patient. Participants are also encouraged to attribute improvements in their mood to their own skillfulness versus the skill of the group facilitator(s).

Below is an example of an initial and final session modeled using the Group Therapy Rubric to help guide the group facilitator(s) through ACWD. The rubric is to be used as a supplement to the ACWD manual that is accessible through the WBT folder on BOX. The ACWD facilitator(s) may adapt lessons from the ACWD to tailor to their individual group members' needs to fit the CBT model the therapy is based.

ACWD Group Therapy Rubric:

- **Statement of Purpose:** ACWD is a free cognitive-behavioral therapy group for students to build coping skills to better handle negative emotions and depressive symptoms.

- **Setting**: Salt Lake Center for Science Education; 7th and 8th grade; age (range = 13-14); urban - Salt Lake City

- **Target Population**: Students who have been identified as being at-risk for more serious depressive symptoms.

- **How members will be selected**: teacher, counselor, and admin referral. Group intake following referral to determine fit for grouping.

- **Logistics**: Weekly, Thursday 8:30-9:15am. 14 weeks of treatment at SLCSE.

- **Facilitators:** Christina Omlie

- **Theoretical Orientation**: Consistent with the theoretical orientation of the program, CWD will be delivered from a cognitive-behavioral perspective.

- **Group Norms/Rules**:
    - Avoid depressive talk
    - Allow for all to have equal time
    - Confidentiality -- personal things shared are not to be shared outside of group
    - Offer support
        - Be constructive in feedback
        - Caring
    - Non-pressuring -- it is ok to pass

- **Troubleshooting:**
    - Monopolizers: will introduce a "talking stick" to ensure one voice at a time. Will encourage round robin sharing.
    - Problem behavior: reference back to the rules, reward appropriate behavior (e.g., provide snack items when following rules), positive praise when acting appropriately.
    - If students are not engaged, we will plan for more interactive activities for the same content next time. We will ensure to use a didactic approach that maximizes their participation and minimizes "lecture" style.

- **Plan for Each Session**: Include the following:
    - **Initial Session:**
        - **Objective:** Depression and Social Learning
        - **Opening Icebreaker:** Opening discussion prompt: What's your name? Why do you think you're in the group? What is one positive thing about yourself that you'd like to share with everyone?
        - **Session Agenda**:

- Complete mood questionnaire or other pre-data
- How to Change Your Life Activity
  - Making positive interactions with new people
  - Interview activity – taking turns talking about self
- Personality as a three-part system
  - Feelings and emotions
  - Actions
  - Thoughts
- Emotional Spirals
  - Differences between downward and upward spirals
- Mood diary
  - Monitoring your own mood
- Homework assignment

▪ **Closing Activity:** Debrief: What are you excited about for group? What are you nervous about?

o **Final Session:**

▪ **Objective:** Prevention, Planning, and Ending

▪ **Opening Icebreaker:** Perform a mini "Honey Roast" – each member has an opportunity for the other group members to say something kind/something they appreciate about the individual member.

▪ **Session Agenda:**

- Review homework – review long- and short-term goals
- Mood questionnaire
  - Compare outcome of mood questionnaire for each member of the group from the first session to the last session.
- Discussion of maintaining treatment gains.
- Create an emergency plan to better handle major life events that may trigger depression symptoms.
- Group Activity:
  - Pair students together to create their teammate different suggestions about how to deal with stressful events they are anticipating and apply learned skills that may be useful.
- Review of covered Topics:
  - Relaxation techniques
  - Increasing pleasant activities
  - Changing negative thinking
  - Friendly skills, improving relationships.
  - Active listening and self-disclosure (communication)
  - Negotiation and problem-solving
  - Making a life plan

▪ **Closing Activity:**

- Facilitators may close with remarks related to enjoying group, being proud of progress, and allow times for other to make remarks if they choose to and come to a sense of closure.

- Remaining time can be used for socializing. During this time, the facilitator(s) should make brief personal contacts with each member and provide them with a certificate of graduation.

- **Evaluation tool** (i.e. – pre- and post-tests, grades, etc.):
  - Beck Depression Inventory
  - Children's Depression Inventory
  - SUDS Ratings

- **Forms** –
  - Informed consent (be sure to include info about limits to confidentiality, what clients can expect, any fees, info about attendance, group rules), may also want to consider a permission to tape form
  - Letters to teachers, passes, needs assessment, etc. (if relevant)

- **Plan for Publicizing or Generating Interest in the Group:**
  - Post group therapy infographic across school.
  - Send email outlining purpose of group and target students to teacher and school staff for referrals.
  - Provide infographic information to school for administrators to use during parent/teacher conferences.

References

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Weersing, V. R., Jeffreys, M., Do, M. T., Schwartz, K. T., & Bolano, C. (2017). Evidence base update of psychosocial treatments for child and adolescent depression. *Journal of clinical child and adolescent psychology: the official journal for the Society of Clinical Child and Adolescent Psychology, American Psychological Association, Division 53*, *46*(1), 11-43.

RELAXATION, OBSERVATION, ACCEPTANCE, AND MINDFULNESS (ROAM)

By: Emily Davis, M.A., M.Ed., Stephanie Pirsig, M.Ed., & Pamela Cornejo, M.Ed.

- **Statement of Purpose:** ROAM is a free therapy group for students experiencing feelings of stress and anxiety. Techniques from Acceptance and Commitment Therapy and Mindfulness will be utilized to help students learn to observe their thoughts and feelings, identify emotions and unhelpful thought patterns, and learn strategies to manage them effectively.
- **Setting**: Salt Lake Center for Science Education and Bryant Middle School
- **Target Population**: Individuals experiencing stress and sub-clinical levels of anxiety
- **How members will be selected**: teacher, counselor, and admin referral. Group intake following referral to determine fit for grouping.
- **Logistics**: Weekly, Day & Time TBD. 8 weeks of treatment at SLCSE and Bryant
- **Facilitators:** Emily Davis, Stephanie Pirsig
- **Theoretical Orientation**: Acceptance and Commitment Therapy and Mindfulness

Introduction

Adolescence is a crucial period for emotional, behavioral, and social development. Aversive and stressful events (e.g., specific events, negative emotion, cognitive processing) in childhood are prevalent, profoundly impact lifetime outcomes, (Gilbert et al., 2015) and increase the likelihood for internalizing and externalizing problems (Merikangas, He, Burstein, et al., 2010). Half of all mental health disorders begin by age 14, and three-quarters begin by age 20 (World Health Organization, 2018). Within the school setting, internalizing concerns, such as anxiety, are associated with school refusal (Kearney & Albano, 2004), poor academic performance (Ma, 1999), low school functioning (Mychailyszyn, Mendez, & Kendall, 2010), social isolation (Scharfstein, Alfano, Beidel, & Wong, 2011), and increased dropout rates (VanAmeringen, Mancini, & Farvolden, 2003).

Acceptance and Commitment Therapy

Based on behavioral principles and Relational Frame Theory (RFT), the goal of Acceptance and Commitment Therapy (ACT) is to ease human suffering and decrease maladaptive behavior by changing the relationship one has with distressing private events (i.e., thoughts and feelings), while clarifying values and initiating values-driven behavior change (Hayes, Strosahl, & Wilson, 1999). ACT targets both psychological and behavioral expressions of stress and anxiety through

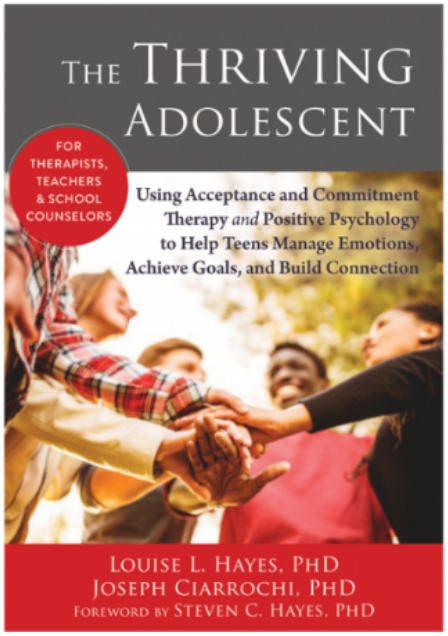
six core processes- acceptance, values, self-as-context, committed action, cognitive defusion, and present moment awareness (Hayes, Luoma, Bond, Masuda, & Lillis, 2006).

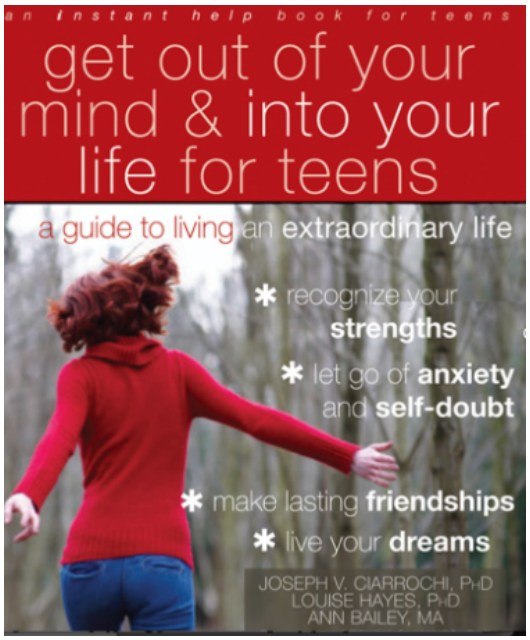
ACT's focus on behavioral change through psychological flexibility and mindfulness highlights its value as an evidence-based modality for a variety of mental health concerns, including stress and anxiety. ACT-based therapies for anxiety among adults are well documented, and when compared with other manualized treatments (i.e., CBT) the results indicated equivalent impacts on primary outcomes and targeted process measures (Bluett, Homan, Morrison, Levin, & Twohig, 2014). Among adolescents, mindfulness and psychological flexibility are positively correlated with quality of life and academic competence but negatively correlated with internalizing symptoms and externalizing behaviors (Greco, Baer & Smith, 2011).

Relaxation, Observation, Acceptance and Mindfulness (ROAM)

ROAM is a school-based group therapy that draws from ACT, mindfulness and positive psychology. Each session includes mindfulness exercises, a review of the previous session and home practice, weekly topic psychoeducation, a variety of experiential activities, and brief home practice activities. The most current iteration utilizes an 8-session protocol modified from Learning DNA-V: The Basic Skills outlined in part one of The Thriving Adolescent (Hayes & Ciarrochi, 2015). As of manual publication in summer 2019, a final protocol is still being modified to fit the needs of the school environment. If you are interested in ACT, the DNA-V model, and mindfulness, explore the following resources that contribute to the development of the ROAM group:

- *The Thriving Adolescent* (Hayes & Ciarrochi, 2015)
- *Get Out of Your Mind and Into Your Life for Teens* (Ciarrochi, Hayes, Bailey, & Hayes, 2012)





- The Thriving Adolescent website

    - https://thrivingadolescent.com
- Online training for the DNA-V Model
    - https://www.praxiscet.com/events/dna-v/
- Acceptance and Commitment training through Praxis
    - https://www.praxiscet.com
- Various workshops are offered at USU throughout the year that are helpful

Outcome Measures

The following outcome measures are used as pre/post measures for all ROAM groups.

- Child and Adolescent Mindfulness Measure (CAMM-10; Greco, Baer & Smith, 2011)
- Avoidance and Fusion Questionnaire (AFQ-Y; Greco, Lambert, & Baer, 2008)
- Student Subjective Well-Being Questionnaire (SSWQ; Renshaw et al., 2014)
- ROAM Acceptability Questionnaire
    - Post-measure only

General Session Outline

Plan for Each Session: Include the following:

*Refer to ROAM Protocol for specific session-by-session guidelines

- **Session (45-minutes)**
    - **Icebreaker/Opener:** game, thought question, unstructured process time, etc.
    - **Objective for session:** Orient group to the purpose of today's session
    - **Review of Previous Session:** Briefly discuss the previous week's session content and bridge to this week's content
    - **Session Content:** Psychoeducation and introduction to new concepts
    - **Activity:** Experiential, written, or process focused
    - **Closing Activity:** Mindfulness exercise

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Bluett, Homan, Morrison, Levin, and Twohig. "Acceptance and Commitment Therapy for Anxiety and OCD Spectrum Disorders: An Empirical Review." *Journal of Anxiety Disorders*28.6 (2014): 612-24. Web.

Ciarrochi, Joseph V., Hayes, Louise L, Bailey, Ann, and Hayes, Steven C. *Get Out of Your Mind and Into Your Life for Teens: A Guide to Living an Extraordinary Life.* 2012. Web.

Gilbert, L. K., Breiding, M. J., Merrick, M. T., Thompson, W. W., Ford, D. C., Dhingra, S. S., & Parks, S. E. (2015). Childhood adversity and adult chronic disease: an update from ten states and the District of Columbia, 2010.*American journal of preventive medicine*, *48*(3), 345-349. Web.

Halliburton, and Cooper. "Applications and Adaptations of Acceptance and Commitment Therapy (ACT) for Adolescents." *Journal of Contextual Behavioral Science* 4.1 (2015): 1-11. Web.

Hayes, Louise L., and Ciarrochi, Joseph. *The Thriving Adolescent: Using Acceptance and Commitment Therapy and Positive Psychology to Help Teens Manage Emotions, Achieve Goals, and Build Connection*. 2015. Print

Hayes, Luoma, Bond, Masuda, and Lillis. "Acceptance and Commitment Therapy: Model, Processes and Outcomes." *Behaviour Research and Therapy* 44.1 (2006): 1-25. Web

Hayes, S. C., Strosahl, K., & Wilson, K. G. (1999). Acceptance and commitment therapy. New York, NY: Guilford Press.

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ROLLING WITH RESISTANCE AND INCREASING GROUP COHESIVENESS

By: Christina C. Omlie, M.A., M.Ed.

Tier 2 services provided by the Wellbeing Team (WBT) are intended to provide therapy to a selective group of students identified as exhibiting at-risk behaviors. Although students who select to participate in group therapy have similar presenting concerns, they are still individuals who have unique personal and learning histories. In many instances, differing backgrounds can work to enhance group cohesiveness and encourage individuals to share their own experiences during sessions. In other cases, however, heterogeneity between group members creates a potential for friction and counterproductive interactions.

WBT members who facilitate group therapy will likely experience difficulties encouraging all group members to participate appropriately. Relatedly, it may take time for all group members to feel comfortable sharing during sessions. There are a variety of ways facilitators can help facilitate group cohesiveness and decrease resistance. Strategies outlined below are designed to be positive, reinforce appropriate group behavior, and honor the students' autonomy and preferences.

Handling Resistance

Resistance to therapy is a common difficulty faced by therapy facilitators. Occasionally, there will be group participants who refuse to participate, participate inappropriately, or in rare instances actively sabotage sessions. Most often, students who engage in resistant behaviors respond well to high quality adult and peer attention. Beyond maintaining unconditional positive regard to students during sessions, it is important to find different strategies for the group therapy to be a reinforcing, positive experience for students attending. Options for handling resistance include:

- Review of group expectations
- Behavioral contingencies
- Differential attention
- Replacing negative talk with positive talk
- Incorporation of games

Other therapeutic techniques to help build rapport and reduce resistance include:

- Mirroring non-verbal behaviors
- Honor and respect silence – provide the option to "pass" during discussions in lieu of forcing participation
- Use of a "talking stick" for discussion monopolizers
- Identify a student with resistant behavior to serve as an "expert consultant"

Solicitation of Feedback

Individuals receiving therapy are more likely to view their experience in a more positive light when facilitator(s) solicit feedback after every therapy session (Esmiol-Wilson, Partridge, Brandon, Kollar, & Benning-Cho, 2017). WBT group therapy facilitators should frequently elicit feedback from group members related to their preferences for opening and closing activities and perceptions of lesson structure. Although facilitators may not be able to deliver on requests made by students, they should always do their best to respond to and follow up with students regarding their provided feedback.

When transitioning groups from therapy, it is important for students to reflect on their learning experiences during the course of the group. Data derived from elicited feedback from group participants has shown that feedback directly informs the therapeutic process (Esmiol-Wilson et al., 2017). Further, students who attended a specific group who perceived the facilitator(s) as response to their needs will likely remember their experience in group positively and encourage other peers to participate.

Rapport Building Activities

Building a sense of community between group members helps students feel comfortable to share and be vulnerable during sessions. Facilitators may use their discretion in deciding whether to build rapport with individual students or bring in activities to build cohesiveness for the whole group with different activities. Below are several ideas for short activities to encourage students to connect positively with each other and to the group facilitator(s):

- Simple ice breakers: have students share about personal interests, highs and lows of the week, what they likes/dislike, hobbies, etc.
- Music: have students share a piece of music they currently relate to and have a group discussion.
- Many students find shared interests and other commonalities over listening to music.
- Games: have students work together on a problem to open up discussion that is less vulnerable than the therapy content
- “Honey Roast”
- Snowball: have all students write something negative occurring in their life, have them crumple their piece of paper and throw it in the middle for a “snowball fight”

References

Dub, F. S. (1997). The pivotal group member: A study of treatment-destructive resistance in group therapy. *International Journal of Group Psychotherapy*, *47*(3), 333–353. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1997-06704-004&site=ehost-live

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Hornsey, M. J., Olsen, S., Barlow, F. K., & Oei, T. P. S. (2012). Testing a single-item visual analogue scale as a proxy for cohesiveness in group psychotherapy. *Group Dynamics: Theory, Research, and Practice*, *16*(1), 80–90. https://doi.org/10.1037/a0024545

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Section 4: Tier 3

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TIER 3 LEAD WEEKLY TASKLIST

By: Pamela A. Cornejo, M.Ed.

The following task list includes items that help to facilitate the individual therapy services.

Disseminate the School District Wifi Password	The staff who can provide the password varies by campus. In general, the password can be provided by the principal and assistant principal. After obtaining the password, an image of the password will be sent to all the Wellbeing therapists via email or text.
Maintain the Referral List	Update the individual therapy referral and treatment list with any changes to status, therapist assignment and outcomes. Email the relevant Wellbeing team member with updates if needed.
Manage Therapist Folders	After completing the intake, create a folder, grant access to the assigned therapist, upload consent forms and email the therapist with the case assignment and treatment measures instructions.
Allocate Time for Social Opportunities	Decide when you are available to interact with students/teachers/staff during non-therapy activities.
Manage and Monitor the WBT Google Calendar	Ensure that therapists are updating their therapy session schedule.
Conduct Individual Therapy Intakes	Schedule a consistent time for conducting intakes. Prioritize students who have been identified as in high need or at high risk, then students who have been on the list the longest.
Prepare Consent Form Packets	Print the consent form packets in both English and Spanish and ensure that they are readily available for staff in the same place or provide the staff with packets to keep in their offices.
Manage the Individual Spaces	Ensure that the iPads are charged and have available memory space for recording of therapy sessions. Print treatment measures and have them readily available in therapy offices.
Check in with WBT Therapists	Check that all therapists have the information related to scheduling, pulling students from class, therapy spaces, treatment measures, and electronic use. Be available when therapists have consultative needs via email, in person or phone call.

Monitor schedule for meetings between staff and students	Ensure time for any specific meetings related to specific students with staff/teachers/administration. Maintain notes on outcomes of meetings.
Maintain therapy office open between sessions in case of walk-ins	Leaving the door open allows for students to walk into the therapy space and introduce themselves or assist a friend in building the courage to talk to the Tier 3 Lead. This is also a helpful opportunity for teachers to have brief conservations about a student.

PSYCHOTHERAPY ORIENTATIONS

By: Pamela A. Cornejo, M.Ed.

Psychotherapy orientations are frameworks that inform a therapist's theory, conceptualization, treatment planning and progress monitoring in their clinical work. The following provides a brief overview of the Common Factors Theory and common psychotherapy orientations.

Common Factors

A growing body of literature has examined the factors that contribute to the efficacy of psychotherapy. The common factors theory, based on meta-analyses of treatment outcome research, suggests that treatments will work if the following elements are present: therapeutic bond, belief in the treatment's efficacy, agreement in therapy goals, an explanation for the client's distress that is rooted in the client's cultural worldview, and a treatment rationale that fits psychological principles (Wampold & Imel, 2015). In addition, several different psychotherapy orientations show relative efficacy for treatment (Wampold & Imel, 2015), meaning specific ingredients (e.g. interventions) do not significantly account for a client's progress. Research suggests the therapeutic bond is one of the greatest predictors of treatment outcomes and therefore serves as an important component of the therapeutic process (Wampold & Imel, 2015). Therapists should consider their own beliefs and cultural values in selecting a psychotherapy orientation and treatment interventions while building a therapeutic bond with their clients.
If a therapist is interested in examining treatment outcome research, then the American Psychological Association, Division 12's website is a helpful resource. It outlines research evidence for efficacy of treatment by diagnosis and psychotherapy orientation (https://www.div12.org/psychological-treatments/).

Suggested Reading:

- The Great Psychotherapy Debate, 2nd Edition by Bruce Wampold, Ph.D.
- Developing Your Theoretical Orientation in Counseling and Psychotherapy, 4th Edition by Duane A. Halbur and Kimberly Vess Halbur
- Laska, K. M., Gurman, A. S., & Wampold, B. E. (2014). Expanding the lens of evidence-based practice in psychotherapy: A common factors perspective. *Psychotherapy, 51*(4), 467-481. http://doi.org/10.1037/a0034332
- Lambert, M. J. (2013). Ch. 6, The Efficacy and Effectiveness of Psychotherapy. In Lambert, M.J. (Ed). Bergin and Garfield's Handbook of Psychotherapy and Behavior Change (5th Ed.). Wiley & Sons
- Theories of Counseling and Psychotherapy: Systems, Strategies, and Skills (4th Edition) by Linda W. Seligman and Lourie W. Reichenberg

Common Psychotherapy Orientations

Acceptance and Commitment Therapy (ACT)

ACT is an approach to psychotherapy within the larger umbrella of Cognitive Behavioral Therapy that focuses on a client's values and beliefs. Instead of symptom reduction and diagnosis, ACT works under a transdiagnostic framework that uses acceptance and mindfulness strategies to promote psychological flexibility in clients.

- Suggested Readings/Texts
  - Acceptance and Commitment Therapy, 2nd Ed.: The Process and Practice of Mindful Change by Steven C. Hayes, Kirk D Strosahl & Kelly G. Wilson
  - The Thriving Adolescent: Using Acceptance and Commitment Therapy and Positive Psychology to Help Teens Manage Emotions, Achieve Goals, and Build Connection by Louisa L. Hayes, Joseph V. Ciarrochi, & Steven C. Hayes Ph.D.
  - ACT Made Simple: An Easy-To-Read Primer on Acceptance and Commitment Therapy (The New Harbinger Made Simple Series) by Russ Harris and Steven C. Hayes Ph.D.

Cognitive Behavioral Therapy (CBT)

CBT is a therapy approach that emphasizes symptom reduction by addressing cognitive distortions and behaviors. Therapists provide psychoeducation based on the cognitive triad (i.e. affect, behavior and cognition). Supporting positive change in affect, behavior, and cognition works to interact and impact the client's worldview and symptomology.

- Suggested Readings/Texts
  - Cognitive Behavior Therapy, Second Edition: Basics and Beyond by Judith S. Beck and Aaron T. Beck
  - The CBT Toolbox: A Workbook for Clients and Clinicians by Jeff Riggenbach
  - Treating Trauma and Traumatic Grief in Children and Adolescents. Judith A. Cohen, Anthony P. Mannerino , and Esther Deblinger . Guilford Press: New York, NY, 2006

Relational-Cultural Therapy (RCT)

RCT's theory for treatment is in alignment with ideology of multiculturalism and feminist principles. In essence, RCT focuses on developing a therapeutic bond within a culturally sensitive framework to address the feeling of isolation and disconnection and experiences of social injustice that contributes to symptoms.

- Suggested Readings/Texts:
  - Relational-Cultural Therapy, 2nd Edition (Theories of Psychotherapy Series) by Judith V. Jordan, Ph.D.
  - The Power of Connection by Judith Jordan

Dialectical Behavioral Therapy (DBT)

DBT is a psychotherapy approach that falls under the broader category of CBT through its use of boosting skills in managing stress, emotional regulation, and relational connection. It was developed for clients with disordered personality tendencies and long histories of relational difficulties.

- Suggested Readings/Texts
  - The Dialectical Behavior Therapy Skills Workbook: Practical DBT Exercises for Learning Mindfulness, Interpersonal Effectiveness, Emotion Regulation & Distress Tolerance by Matthew McKay, Jeffrey C. Wood, and Jeffrey Brantley
  - DBT Skills Training Handouts and Worksheets, 2nd Ed. By Marsha M. Linehan
  - DBT Therapeutic Activity Ideas for Working with Teens by Carol Lozier
  - Linehan, M. M. (2015). DBT® skills training manual (2nd ed.). New York, NY, US: Guilford Press.

Feminist Multicultural Therapy (FMT)

FMT is an integrated psychotherapy approach that considers societal and cultural influences, client empowerment and therapeutic collaboration for addressing distress symptomology. Therapists working within this approach seek to help the client gain empowerment through the therapeutic relationship and gain an understanding of how their distress is defined and shaped by societal factors.

- Suggested Readings/Texts
  - Multicultural Feminist Therapy: Helping Adolescent Girls of Color to Thrive by Thelma Bryant-Davis
  - Wolf, J., Williams, E. N., Darby, M., Herald, J., & Schultz, C. (2017). Just for women? Feminist multicultural therapy with male clients. *Sex Roles: A Journal of Research.* https://doi.org/10.1007/s11199-017-0819-y

Person Centered Therapy/Humanism

Person-Centered therapy is an approach that is grounded in the belief that client distress stems from a lack of self-fulfillment. Theoretically, people experience distress when the person they believe they are is not reflected in their daily experience. This framework also proposes that people are innately good and that therapists should hold unconditional positive regard for their clients. During therapy, a person-centered therapist will follow the client's lead on what to discuss in therapy sessions.

- Suggested Readings/Texts
  - Man's Search for Meaning by Viktor E. Frankl
  - On Becoming a Person: A Therapist's View of Psychotherapy by CarlRogers, Kramer M.D., Perter D.

- Person-Centered Psychotherapies (Theories of Psychotherapy Series) by Cain PhD, David J.

Interpersonal Process Approach (IPA)

IPA is an integrative approach that is informed by CBT, Family Systems Approach and Object Relations Theory. This approach seeks to provide the client with corrective emotional experience through a supportive therapeutic bond that will boost skills and connection and carry over into the client's social relationships across settings. IPA believes that client distress stems from issues in a client's relational tendencies.

- Suggested Readings/Texts
  - Interpersonal Process Approach in Therapy: An Integrative Model, 7th Ed. By Edward Teyber and Faith Teyber
  - Reese, R. J., Slone, N. C., & Miserocchi, K. M. (2013). Using client feedback in psychotherapy from an interpersonal process perspective. *Psychotherapy, 50*(3), 288-291. https://doi.org/10.1037/a0032522

Motivational Interviewing (MI)

MI seeks to boost a client's motivation and commitment for change. In therapy, MI emphasizes collaboration and focusing on self-identified reasons for change. This orientation has been primarily examined for treatment of substance use disorders and medication adherence, though a growing body of literature is examining other applications.

- Suggested Readings/Texts
  - Motivational Interviewing: Helping People Change, 3rd Ed. By William R. Miller
  - Motivational Interviewing with Adolescents and Young Adults by Sylvie Naar-King and Mariann Suarez
  - Motivational Interviewing in Schools: Conversations to Improve Behavior and Learning (applications of Motivational Interviewing) by Stephen Rollnick, Sebastian G. Kaplan, and Richard Rutschman

References

Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate* (2nd ed.). New York, NY: Routledge.

SUICIDE AND HOMICIDE RISK ASSESSMENT

By: Pamela A. Cornejo, M.Ed.

Suicide and homicide are among the leading causes of death for adolescents (Centers for Disease Control and Prevention, 2017). For Utah specifically, suicide is the leading cause of death (Utah Death Certificate Database, 2015). Although suicidal and homicidal ideation is discussed during the intake, some students wait until they are assigned their therapist to discuss either of these topics. The following includes tools and suggestions for discussing suicide and homicide with adolescents.

Discussing a student's thoughts about suicide/homicide will provide an opportunity to assess for risk and understanding of the severity of distress in their daily experience. Remaining calm, empathetic, and open to discussing suicide/homicide will help the adolescent feel relaxed and supported. If a therapist is nervous, hesitant, or overly concerned to ask about the student's experience, or if the student perceives the therapist as so, the assessment of symptoms and risk may be inaccurate. It is also helpful to explain to the student why discussing these topics is important in supporting their wellbeing. Beginning any risk assessment with the confidentiality responsibility of the therapist may not be helpful in encouraging the student to share their emotional experiences. Doing so too early in the discussion may discourage a student from fully describing the intensity or frequency. It may be more helpful to first provide space for the student to share their experience and assess the intensity. If the student describes experiences that suggest they are at-risk for suicide then the therapist should (1) provide validation and support to the student's expressed emotional difficulties and normalize those feelings, (2) remind the student about confidentiality and that suicidal/homicidal ideation is one of the exceptions to confidentiality, and (3) explain what the next steps are to support the student (e.g. informing family, creating a safety plan, referral to a community provider).

Definitions

Morbid Ideation: existential thoughts or contemplations about death. This type of ideation may have less immediate risk than active suicidal ideation.

Suicidal Ideation: thoughts or contemplation about the act of suicide.

Homicidal Ideation: thoughts or contemplations about killing another person. Thoughts about harming someone else (e.g. hitting, kicking, general injury or accident) is not equivalent to thoughts of homicide.

Risk Assessment

Assessing for suicidal and homicidal ideation should include discussions about ideation, plan, behaviors, and intent. The content and details of these conversations should be well documented as soon as possible. If phone calls are required, with regard to confidentiality, they should be

completed that same day. Before doing so, inform the student that the phone call will be made. Some students may be nervous about informing their parents about the ideation, so walking them through the next steps will help them understand how you plan to support them while fulfilling your clinical duty.

1. Ideation: thoughts and contemplations, frequency, intensity, reasons for emotional experience, perceptions of current circumstances. Level of risk increases with higher rates of frequency, intensity and greater amounts of perceived reasons for suicide/homicide.
    a. Example questions: Have you ever thought about being dead? Have you ever thought about killing yourself? How often have you had these thoughts? When was the last time you had thought about this? When do you think about death/suicide?
2. Plan: specific steps identified for contemplating suicide/homicide (i.e. means, access to the specific manner of harm, timing, location, access). Level of risk increases with the number of details described. It is important to assess how realistic their plan is because the greater the specificity and access to their plan, the greater the likelihood that the student may successfully complete it.
    a. Example questions: Have you thought about how you would kill yourself/hurt someone else? Do you know where you could access that object? When would you do it? Would you write a letter or let anyone know?
3. Behaviors: Past attempts, rehearsal behaviors (engaging in behaviors that approximates or prepares for committing suicide), self-harm.
    a. Ask questions that assess whether the student has gotten close to attempting suicide/homicide.
    b. Example questions: Have you ever tried to commit suicide/homicide? Do you ever engage in self-harm, like cutting, scratching, burning?
4. Intent: Seriousness/extent to which the adolescent intends to complete suicide
    a. From a scale of 1 to 5, 1 being not at all and 5 being absolutely yes, how likely are you to try to kill yourself/hurt someone else?

Suicide Risk Assessment Tools

- 6-Item Kutcher Adolescent Depression Scale: KADS-6
    - This is a measure that assesses the degree of severity in an adolescent's experience of depression. See Appendix D.# for scoring and interpretation information.
- Tool for Assessment of Suicide Risk for Adolescents (TASR-A)
    - See Appendix D.# for scoring and interpretation information.

Crisis Intervention

The Wellbeing Team does not provide crisis intervention. This is conducted by the school counselors in collaboration with administration and families. If a student does an immediate risk for suicide/homicide, then the student should be connected to the school counselors to enact

school policy for crisis intervention. Inform the student that looping in school counselors and family will allow for the best support possible.

References

Centers for Disease Control and Prevention. (2017). Web-based injury statistics query and reporting system (WISQARS). National Center for Injury Prevention and Control. https://www.cdc.gov/injury/wisqars/LeadingCauses.html

Utah Death Certificate Database, Office of Vital Records and Statistics, Utah Department of Health, 2015-2017 data queried via Utah's Indicator Based Information System for Public Health (IBIS-PH) [cited 2019 June]. IBIS Version 2015.

SAFETY PLANNING

By: Pamela A. Cornejo, M.Ed.

Safety planning is a helpful approach to address moments in which students express frequent ideation that puts them at risk for engaging in risky and harmful behavior. The following are some ideas for discussion topics to develop and assess a student's safety when they are emotionally elevated. These topics will likely not be covered within one specific session. Over time, the student has to collaboratively identify their warning signs, coping skills/strategies, and social supports.

Warning Signs: Increasing awareness of triggers (e.g. location, people, timing, situations) will assist the student in addressing their emotions before it elevates to risk. Exploring the student's experience is important to do before examining coping skills.

Coping Skills/Strategies: Discussing ideas for things that students can do when they are aware of their emotional dysregulation. This may include internal (e.g. mindfulness) or external (e.g. journaling, physical activity, listening to music) strategies. These should be based on what the student believes will be effective and helpful. Sometimes encouragement to try different strategies can broaden their pool of options. This also includes hearing about how the student typically responds when emotionally elevated and assessing the success of these strategies. Validating and empathizing with the student's strategies helps to open responsiveness to contemplating new strategies.

Social Supports: Perceptions of isolation, support and connection greatly influence the student's experience and risk for harm. In safety planning, assessing relationships and who a student identifies as someone comfortable to reach out to when distressed is key. Therapists may be the one person that validates and supports a student. In essence, therapists should discuss social supports with the intent of understanding a student's social experience, increasing social connection and boosting skill in accessing social support. For some students, the risk for harm comes from unchangeable social circumstances (e.g. home relationships). In those circumstances, it is helpful to discuss how to assess for risk at home and safe ways to enact boundaries.

Supplemental Elements:

- Many students have access to cellphones. See Tier 3 Appendix for a list of helpful smartphone applications for students to utilize.
- Provide the student with relevant hotline numbers just in case they may be experiencing a crisis or emergency while not on the school campus.
- Depending on the social circumstances, it may be helpful to incorporate the family in engaging with discussion about safety planning.

COMMUNITY REFERRALS FOR TREATMENT

By: Pamela A. Cornejo, M.Ed.

Cases for Community Referral

Although school-based therapy may be a great fit for some students to receive services, there are specific circumstances during which it may be a better fit to refer the student to a community provider. The fit for school-based treatment should be based upon the experience and expertise within the Wellbeing Team, the school campus and the clinical judgment of the supervising licensed psychologist. When the presenting concerns exceed the Wellbeing Team's therapeutic capacity for monitoring symptomology, then the student should be referred to the community and placed under case management with the Tier 3 Lead. The following are presenting concerns that would be appropriate for community referral, based on a Wellbeing Team composed of graduate students: Eating Disorders, Substance Use Disorders, disordered personality tendencies, intensive depression and active suicidal risk and intensive sexual aggression towards peers or adults.

Case Management

If a student or family does not have any financial capacity for access to a community provider, then the Tier 3 Lead can place the student on their caseload as a case management client. This means meeting with the student and speaking with the intention of assisting them in finding therapeutic services. Case management differs from the Tier 2 Check-In in that the timeline for oversight is supposed to be as brief as possible. It may differ greatly across cases in that some families may just want the community provider list, a phone call or an in-person meeting to discuss the referral to a community provider. Maintain and update a list of potential community providers for easy access to therapists and the school campus (i.e. school counselors and administration). See Tier 3 Appendix for a current community provider list.

TERMINATION OF INDIVIDUAL THERAPY

By: Pamela A. Cornejo, M.Ed.

Individual Therapy Termination- Procedures for Individual Therapists

The process of termination of individual therapy is a therapeutic opportunity for clients to experience an ending of a positive relationship, review of the therapy experience and gains, and facilitation of empowering and constructive conversations about the therapeutic journey and feedback for the therapist. In preparation for termination of therapy, therapists have many options for activities and discussions. Each therapist will likely have different ideas about the best course for each of their clients. Termination between clients may likely look and feel very different because of the different relationships that therapists develop with their clients. Many clients respond in a variety of ways to the ending of the therapeutic relationship. Some may experience any combination of sadness, anger, worry, or relief. All of the possible responses from clients are within the norm and each therapist will decide how they will respond to their client's termination process.

Common Termination Themes

Many therapists have ideas and expectations about how they might experience termination with a specific client. In addition to the documentation and general procedural components, therapists often need to contemplate how to respond to clients who they do not have the opportunity to terminate with, gifts during termination, and last session discussion topics.

- Reflection about Termination with Each Client
  - Each relationship with clients brings out emotions and ideas for closure. It is helpful to contemplate several questions:
    - What values may inform the expectations of the termination process?
    - How do you feel about ending of relationships in your personal life?
    - What are your boundaries about hugs with each client? Would you be comfortable with hugging a client that requests one? If you are not comfortable, how will you gently address a hug request?

- Conversation Topics
  - Treatment Review
    - Treatment process, goals, progress, treatment transfer. It may be helpful to highlight treatment measure endorsement or what the student believes has changed.
    - "What parts did you like about therapy?"
    - "What could have been different or better in therapy?"

    - Ending of the Relationship
        - Overview of the therapeutic bond, therapist and client perceptions
        - "What has been your experience of therapy?"
        - "How does it feel for it to be our last session?"
        - "Would it be ok if I shared my experience of working with you?"
- Gifts
    - Gifts come up in the therapy process for a variety of reasons. Some cultures believe in gift giving as a sign of appreciation. Additionally, some therapists like to provide small, nonmonetary value gifts as a supplement for closure.
        - How would you like to address gift giving from a student?
        - What types of termination gifts would be acceptable or appropriate to give to students?

Schoolwide Termination- Timeline and Procedures for the Tier 3 Lead

Ongoing:

- All therapists will email the Tier 3 Lead when they terminate individual therapy so that the Tier 3 Lead may schedule a time to meet with the client for completion of the Individual Therapy Feedback Survey.

April:

- Preparing for termination of individual therapy
    - Individual therapists: via email, send a reminder to therapists to terminate the first week of May and to actively discuss the timeline for termination with clients in session. In addition to reminding about the termination of therapy, ask therapists to discuss the opportunity of transitioning to group therapy with their clients. If the client states interest in group therapy then these students will be added to the group therapy treatment list.
    - Staff, counselors and administration: via email, send a reminder of the conclusion of individual therapy during the first week of May and that all referrals made will be a wellbeing check to assist facilitation for finding community providers, and provide a list of low-cost community referrals to administration if parents request individual therapy.
    - Print copies of the Individual Therapy Feedback Survey and schedule times for any remaining clients to complete them in the Wellbeing Office.

May:

- All individual therapy concludes during the first week.
    - Individual therapists: (1) check in with therapists about their termination dates so that the Tier 3 Lead may ask the client to complete the Individual Therapy Feedback Survey within one week of termination. (2) Confirm referrals to group therapy.
    - Staff, counselors and administration: via email, send a reminder that all individual therapy has concluded and any referrals to the Tier 3 Lead will be to assist in community referral for therapy.
- Scan and upload all Individual Therapy Feedback Surveys to UBox.
- Create and transfer all of the Survey data to an excel spreadsheet.

- Update therapy folders by removing therapist access to therapy folders and transferring completed treatment cases to the “Previous Clients” folder.
- Update treatment list so that outcomes for each client case is noted (e.g. completed, student transferred schools).

DESCRIPTION OF TREATMENT MEASURES

By: Pamela A. Cornejo, M.Ed.

The following is a brief description of measures that may be utilized for monitoring treatment progress and outcomes.

Avoidance and Fusion Questionnaire for Youth (AFQ-Y)

- 8-item self-report questionnaire that assesses a youth's psychological inflexibility and experiential avoidance. Higher scores suggest higher endorsement of psychological inflexibility and experiential avoidance.
  Further Reading:
  Greco, L. A., Lambert, W., & Baer, R. A. (2008). Psychological inflexibility in childhood and adolescence: Development and evaluation of the Avoidance and Fusion Questionnaire for Youth. *Psychological Assessment, 20*(2), 93-102. https://doi.org/10.1037/1040.3590.20.2.93.sup(Supplemental)

Student Subjective Wellbeing Questionnaire (SSWQ)

- 16-item self-report questionnaire that assesses school-specific wellbeing in four subscales: Joy of Learning, School Connectedness, Educational Purpose and Academic Efficacy. It also yields an Overall Student Wellbeing composite score. Higher scores suggest a higher endorsement of positives on the subscale and composite.
  Further Reading:
  Greco, L. A., Lambert, W., & Baer, R. A. (2008). Psychological inflexibility in childhood and adolescence: Development and evaluation of the Avoidance and Fusion Questionnaire for Youth. *Psychological Assessment, 20*(2), 93-102. https://doi.org/10.1037/1040.3590.20.2.93.sup(Supplemental)

Youth Externalizing Problems Screener (YEPS)

- 10-item self-report questionnaire that measures a youth's experience of behavioral/mental health problems in the externalizing domain. Higher scores suggest higher endorsement of externalizing problems. A score equal to or higher than 21 suggests a clinical level of internalizing problems.
  Further Reading:
  Renshaw, T. L., & Cook, C. (2018, November 27). Preliminary Psychometrics of Responses to the Youth Externalizing Problems Screener. Retrieved from osf.io/dznx7
  Renshaw, T. L. (2019, January 29). Development and Validation of the Youth Internalizing and Externalizing Problems Screeners (YIPS and YEPS). Retrieved from osf.io/63nzf

Youth Internalizing Problems Screener (YIPS)

- 10-item self-report questionnaire that measures a youth's experience of behavioral/mental health problems in the internalizing domain. Higher scores suggest higher endorsement of internalizing problems. A score equal to or higher than 21 suggests a concerning level of internalizing problems.

  Further Reading:

  Renshaw, T. L. (2019, January 29). Development and Validation of the Youth Internalizing and Externalizing Problems Screeners (YIPS and YEPS). Retrieved from osf.io/63nzf

Working Alliance Inventory- Client (WAI-C)

- 12-item self-report questionnaire for the client to assess their perception of therapeutic alliance between therapist and client. It yields three subscales: bond, task and goal. Higher scores suggest a higher endorsement of a good therapeutic alliance.

  Further Reading:

  Hatcher, R. L., & Gillaspy, J. A. (2006). Development and validation of a revised short version of the Working Alliance Inventory. *Psychotherapy Research, 16*(1), 12-25. https:..doi.org/10.1080/10503300500352500

Working Alliance Inventory- Therapist (WAI-T)

- 12-item self-report questionnaire for the therapist to assess their perception of therapeutic alliance between therapist and client. It yields three subscales: bond, task and goal. Higher scores suggest a higher endorsement of a good therapeutic alliance.

  Further Reading:

  Hatcher, R. L., & Gillaspy, J. A. (2006). Development and validation of a revised short version of the Working Alliance Inventory. *Psychotherapy Research, 16*(1), 12-25. https:..doi.org/10.1080/10503300500352500

Section 5: Appendices

Appendix A: Consent Forms

WELLBEING TEAM (WBT)

Notice of PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT THE STUDENT MAY BE USED AND DISCLOSED AND HOW LEGAL GUARDIANS CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment to both the student and legal guardians' privacy:
The Wellbeing Team is dedicated to maintaining the privacy of the legal guardian's and child's personal health information as part of providing professional care. We are also required by law to keep you/your child's information private. These laws are complicated, but we must give you this important information. Please ask the counselor if you would like a copy of NPP for your records.

We will use the information about your child's health which we get from the legal guardian or from others mainly to provide your child's treatment. After the legal guardian has read this NPP, we will ask you to sign a Treatment Consent Form and Video Recording Form to let us use and share information. The signature of the legal guardian is necessary for us to serve the student.

If the legal guardian or the Wellbeing Team want to use or disclose (send, share, release) your child's information for any other purposes for any other purposes the counselor will discuss this with the legal guardian and ask them to sign an Authorization form to allow this.

We will keep your child's health information private but there are some times when the laws require us to use to share it. For example:

1. When there is a serious threat to the student's health and safety or the health and safety of another individual or the public. We will only share information with a person or organization that is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a court requires us to do so.
4. For Workers Compensation and similar benefit programs.
5. Additional situations, which are less common, are describe in the longer versions of NPP.

Legal guardian rights regarding the student's health information:

1. Legal guardians can ask the counselor to communicate with them about health and related issues in a particular way or at a certain place which is more private for you. For example, you can ask the counselor to call you at home, and not at work to schedule or cancel an appointment. The counselor will try their best to accommodate your request.
2. Legal guardians have the right to ask the counselor to limit what they tell people involved in your child's care, such as family members and friends. While they don't have to agree to your request, if they do agree, they keep this agreement except if it is against the law, or in an emergency, or when the information is necessary to treat the student.
3. You have the right to a copy of this notice. If we change this NPP we will provide the new version.

4. You have the right to file a complaint with the licensed psychologist, Aaron J. Fischer, PhD, BCBA, LP, LBA and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care your counselor provides to you/your child in any way.

If you have any questions regarding this notice or the health information privacy policies, please contact:
Aaron J. Fischer, PhD, BCBA, LP, LBA

The effective date of this notice is July 25, 2018.
The counselor has provided the health information privacy policies with me.

Signature Date

WELLBEING TEAM INFORMATION and TREATMENT CONSENT FORM

Who We Are: The Wellbeing Team (WBT) provides counseling opportunities to students who attend Bryant Middle School and Salt Lake City Center for Science and Education. University of Utah graduate students working towards a degree in school psychology or counseling psychology provide the counseling services on school campus. These students are supervised by Aaron J. Fischer, Ph.D, BCBA-D, LP, LBA, a licensed psychologist, and are hereafter referred to as "counselors." Because this is a school-based treatment model with limited resources, we reserve the right to deny treatment to any person who is not deemed appropriate to be seen in this setting. Therefore, students are not considered a client of the WBT until the intake process is complete, the intake information has been reviewed by a licensed professional, an offer to provide services has been made by the WBT, and both students and parents have agreed to receive the type of services being offered.

Confidentiality: Contact between parents and students with the WBT will remain confidential. Students are the clients for services; therefore, all conversations between the counselor and the student will remain confidential. However, counselors are required by law to report certain information to other persons/agencies without your permission. Examples of such situations include: if they are ordered to do so by a court of law, if the information must be reported in accordance with the Child Abuse or Elder and Dependent Adult Abuse Reporting Laws or if you threaten to harm yourself or another person.

Consent: All clients may be observed by the licensed psychologist and graduate students engaged in the study of School & Counseling Psychology. All sessions may be digitally recorded for supervision and training purposes in order to monitor quality of therapy services. If recorded, sessions will be stored on a password protected HIPAA and FERPA compliant cloud storage platform. All sessions, if recorded, may be stored as long as the materials are needed for program management, research and training purposes. By signing this Consent Form, students and parents are consenting to the digital recording of all therapy sessions with counselors. The video recording consent form explains in further detail the recording purposes and stipulations and is also required to be signed by both students and parents to receive therapy services.

All clinical materials such as digital recordings, documents, and information obtained by observation and therapy services may be used for program management, research, and training purposes. Restricting access to these materials protects confidentiality. Case records are securely stored and may be accessed only by individuals involved in specific training, research, or treatment activities approved by the School & Counseling Psychology Programs. Names and identifying information will be removed from all clinical materials prior to their use in training, research, and/or scientific publication.

All case records are securely stored and may be accessed only by the Wellbeing Team, which includes counselors and the licensed psychologist and any other clinical personnel deemed appropriate by the licensed psychologist. If any individual on the WBT knows the student or parents on a personal basis, that individual will not have access to the materials. Bryant Middle School, Salt Lake City Center for Science and Education and the Salt Lake City School District do not have access and will not be given access to these materials.

Self-Report Assessments: In order to monitor and enhance the effectiveness of the services the WBT provide, all clients will complete self-report assessments when the counselor or licensed psychologist deems it appropriate. By signing this Consent Form, students and parents are agreeing to the completion of these assessments as part of treatment.

Client Rights: The WBT are dedicated to establishing a safe environment that fosters open and honest communication. Students, as clients, are encouraged to discuss their progress in counseling and may end services at any time. Students, as clients, are invited to discuss any concerns they may have about their treatment or the services provided with their counselor and/or their counselor's supervisor.

Client Responsibilities: Once accepted as a client, students have an obligation to disclose significant information about their mental and medical status to their counselor. Students are expected to attend the sessions at the agreed upon dates and times, unless rescheduling efforts are made with their counselor or student has ended therapy services. If these conditions are not met, the WBT reserves the right to terminate treatment. If students miss sessions, their counselor will collaborate with students to identify any barriers or issues to therapy and check in on the student's interesting in counseling. If the missing of sessions continue, then counselors will discuss the possibility of termination with the student.

In order to provide a safe environment for our clients and counselors, we ask that students follow any and all school district standards for conduct, including refraining from any violent or aggressive behavior to self, others, or property while in session. Should a client bring a weapon to a counseling session, or in any other way make a counselor feel unsafe, threatened, or in danger, the counselor has the authority to immediately terminate the session and cancel all future sessions with the client until the matter has been resolved to the satisfaction of WBT and the individual counselor.

Contacting the Clinic: WBT counselors cannot be reached directly, nor are they available for consultation after hours or for emergency crisis services. If an emergency arises in which parents or students need the police, fire department or an ambulance, call **9-1-1**. If parents or students require consultation during regular business hours, please call the University Neuropsychiatric Institute Warm Line at **801-587-1055**. If you need emergency consultation outside regular working hours, contact the University Neuropsychiatric Institute at **801-581-3000** and ask to speak to a crisis worker.

Records Requests: Laws and standards of the mental health & psychology professions require that the Wellbeing Team keep written counseling records. Because the records contain information that can be misunderstood by someone who is not a mental health professional, it is our general policy that students and parents may not review them; however, at the parents' request, the WBT will provide parents with a treatment summary. Bryant Middle School, Salt Lake City Center for Science and Education and the Salt Lake City School District do not have access and will not be given access to records.

Benefits & Risks: Although there are many potential benefits to mental health services (e.g., better relationships, improved self-esteem, reduction of specific symptoms), it can also be difficult at times. Part of the work during counseling is to talk about things that are difficult to discuss and may bring up unpleasant feelings. It is important for students to let their counselor know when they are experiencing these feelings so that they can be helpful. Sometimes a student may stop coming to treatment when it gets hard because they don't realize that discomfort is a natural part of the process. The more consistently students come to treatment, the more value they will get from it. Students and parents have a right to receive a copy of the consent form, video consent form and privacy practices form that they sign and of any written consent documentation that is used in obtaining your consent.

Student and parent signatures below indicate that both students and parents have read this agreement and agree to its terms. These matters have been explained to students and parents and they fully and freely give consent for the child to receive counseling services.

_____

Name of Client(s) (Please Print)

_____ _____

Signature of Client(s) and/or Minor Child Date

_____ _____

Signature of Legal Representative of Minor Child Date

_____ _____

Counselor Name (please print) Date

WELLBEING TEAM VIDEOTAPE AGREEMENT FORM

Name of Child/Adolescent_____

Name(s) of Parent/Guardian_____

I, _____, as guardian of _____ authorize permission to the Wellbeing Team to videotape my child for the purpose of professional education, supervision, treatment and research as part of the service agreement.

The video agreement states:

1. Both student and guardian consents to the use of videotape to be taken in the therapy offices of the Wellbeing Team during the course of individual and group counseling.
2. The videotape will be used solely in the interest of the advancement of mental health programs and services for the purpose of professional education, supervision, treatment and research. The videotape will not be used for any other purpose.
3. The Wellbeing Team agrees not to use, or permit the use of the name of the child/adolescent named above in connection with any direct or indirect use of exhibition of the videotape for any use other than set forth in the service agreement.
4. The Wellbeing Team is the sole owner of all rights in and to the videotape. Bryant Middle School, Salt Lake City Center for Science and Education and the Salt Lake City School District do not have any rights to the videotape.
5. There shall be no financial compensation for the use of such videotape.

_____ _____

Student Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Counselor Signature Date

Parental Permission Document

BACKGROUND

The Wellbeing Team (WBT) provides counseling opportunities to students in Salt Lake City School District. University of Utah graduate students working towards a degree in school psychology or counseling psychology provide the counseling services on school campus. These students are supervised by Aaron J. Fischer, PhD, BCBA-D, LP, LBA, a licensed psychologist, and are hereafter referred to as "counselors." Your child is being asked to participate in a research study looking at the effectiveness of these counseling services on improving prosocial skills (such as resilience) and reducing internalizing symptoms (such as anxiety). Should you or your child deny participation in the research study this will not affect your child's clinical treatment.

STUDY PROCEDURE

The goal of this research study is to learn more about school-based therapeutic practices for adolescents. Your child is being asked to participate because they have already been referred or asked to receive counseling services at school. The research portion of this study is a questionnaire given to your child prior to the already-scheduled counseling services.

The questionnaires will ask several questions about how your child has been feeling in the past month, opinions of themselves or school, or about relationships with friends and family. The questions will vary depending on why your child was referred for counseling services.

Then, once your child starts their counseling program (either individual or group therapy for the predetermined amount of time agreed upon with the WBT counselor), your child will be asked to fill out the same questionnaire as they filled out prior to starting therapy.

Details regarding the referred therapy services have been, or will be discussed separate from this parental permission form. This form discusses the research portion (two questionnaires) only.

RISKS

The risks of the research portion of your child's counseling services are expected to be minimal. There is a potential for a loss of confidentiality if your child's responses to the questionnaires were to be released on accident, but we have taken precautions to make this risk very small.

BENEFITS

Your child may not directly benefit from the study, but the study may provide valuable information for school-based multi-tiered mental health supports. We hope that the information we get from this study may serve to provide greater information about the effectiveness of school-based therapeutic interventions. Hopefully this understanding can lead to the adoption of such models for additions schools and/or school districts.

ALTERNATIVE PROCEDURES

If you do not want your child to participate in a research study, they may receive services from the WBT through the normal course of clinical treatment. They may also wish to receive therapeutic services through community therapists.

CONFIDENTIALITY

Contact between you and your child with the WBT will remain confidential. Your child is the client for services; therefore, all conversations between the counselor and your child will remain confidential. However, counselors are required by law to report certain information to other persons/agencies without your permission. Examples of such situations include: if they are ordered to do so by a court of law, if the information must be reported in accordance with the Child Abuse or Elder and Dependent Adult Abuse Reporting Laws or if your child threatens to harm themselves or another person as well as serious threats to public health or safety.

Any recordings or images made during the study will be used for supervision purposes and scientific meetings. All media data will be stored in an encrypted online storage database that requires two-factor authentication (use of two passwords) that is in compliance with HIPPA and FERPA law to ensure maintained confidentiality of student information. Consent forms will be maintained in a locked filing cabinet in which only WBT members have access. In publications, your child's name will be removed and replaced with an anonymous indicator (such as "student 1").

PERSON TO CONTACT

If you have any questions, complaints, or concerns about this study, or if you feel your child has been harmed a result of participation, you can contact Aaron J. Fischer, PhD, BCBA-D, LP, LBA at 801-587-1842. Dr. Fischer may be reached during typical business hours Monday-Friday 9:00am-5:00pm.

Institutional Review Board: Contact the Institutional Review Board (IRB) if you have questions regarding your rights as a research participant. Also, contact the IRB if you have questions, complaints or concerns which you do not feel you can discuss with the investigator. The University of Utah IRB may be reached by phone at (801) 581-3655 or by e-mail at irb@hsc.utah.edu.

Research Participant Advocate: You may also contact the Research Participant Advocate (RPA) by phone at (801) 581-3803 or by email at participant.advocate@hsc.utah.edu.

VOLUNTARY PARTICIPATION

Participation in research is voluntary. You can tell us that you do not want your child to participate in this research study. Choosing not to participate will not affect your students ability to receive school-based counseling services. Your child can start the study and then choose to stop the study later. This will not affect your relationship with the investigator.

COSTS AND COMPENSATION TO PARTICIPANTS

There are no costs and compensations to participants.

CONSENT

By signing this consent form, I confirm I have read the information in this parental permission form and have had the opportunity to ask questions. I will be given a signed copy of this parental permission form. I voluntarily agree to allow my child to take part in this study.

_____
Child's Name

_____
Parent/Guardian's Name

_____ _____
Parent/Guardian's Signature Date

_____
Relationship to Child

_____
Name of Person Obtaining Consent

_____ _____
Signature of Person Obtaining Consent Date

University of Utah
Institutional Review Board
Exemption 5/3/2019

IRB_00114730

Assent to Participate in a Research Study

Who are we and what are we doing?
We are The Wellbeing Team (WBT), a group of University of Utah graduate students working towards degrees in school psychology or counseling psychology. The WBT provides counseling opportunities to students in Salt Lake City School District. These students are supervised by Aaron J. Fischer, PhD, BCBA-D, LP, LBA, a licensed psychologist. You are being asked to participate in a research study looking at the effectiveness of counseling services provided by the WBT on improving prosocial skills (such as resiliency) and reducing internalizing symptoms (such as anxiety and depression). If you do not wish to participate in the research study will not affect any counseling services you are already or will be receiving.

Why are we asking you to be in this research study?
We are asking you to be in this research study because we want to learn more about effective school-based therapeutic practices for adolescents. We want you to be in this study because you have already been referred or asked to receive counseling services at school.

What happens in the research study?
If you decide to participate in this research study, along with the permission of your parent or guardian, you will complete a questionnaire that asks you several questions about yourself. These questions might ask things about how you've been feeling in the past month, your opinions of yourself or school, or about your relationships with friends and family. Which questions you will be asked to answer depends on why you were referred for counseling services. You will then begin receiving individual or group therapy for a predetermined amount of time that you agree to with your counselor from the WBT. Therapy is different for many people, but you can expect to meet with one counselor (or two if you are participating in a group) to talk about details of your life, emotions, and/or thoughts. At the end of therapy, you will be asked to answer the same questions you filled out before you started therapy.

Will any part of the research study hurt you?
While there are likely no risks for participating, it may be difficult for you at times to participate in therapy. Part of the work during counseling is to discuss difficult topics, which may make you feel uncomfortable or other unpleasant feelings. The risks are similar to when you discuss personal information with others. Your therapist will try to help you if you begin to feel unpleasant feelings, such as sad or uncomfortable. You can stop therapy at any time if you want to.

Will the research study help you or anyone else?
People benefit from therapy in different ways. You may notice that you have improved relationships with others, improved self-esteem, and/or a reduction of certain feelings (like sadness or anxiety). You may develop more ways to help yourself when you are feeling unpleasant feelings or more strategies to help you talk with others. Participating in this research study may also provide information to help other people who may want to receive therapy in school as well. Although participation may benefit other students, you might not directly benefit from participating in the study.

Who will see the information about you?
Contact between you and the WBT, including your counselor, will remain confidential. That means that we do not share what you discuss in therapy with anyone else. However, counselors sometimes are required by law to share some information to help keep you and others safe. Some examples of information your counselor is required to share is: if your counselor is ordered to by the court of law, if you report any information of a child (including yourself) or elderly person being harmed, or if you say you are going to hurt yourself or another person. Any recordings of therapy will be kept in a safe online storage database. These recordings will only be used to show to the supervisor of the WBT. The information and contact between you and the WBT and counselors will remain confidential. There is a risk for loss of confidentiality or privacy of your participation. However, we have procedural guidelines to train administration and staff on maintaining confidentiality.

What if you have any questions about the research study?
You can ask questions at any time. If you have a question later that you didn't think of now, you can call Aaron Fischer at 801-587-1842, or ask a member of the WBT the next time we see you.

Do you have to be in the research study?
You do not have to participate in this study if you do not want to. Being in the study if up to you. If you would still like to receive counseling services and not be in this study, that is okay. Saying no to being in the study will not affect your future therapy. Even if you say yes now, you can change your mind later and tell us you want to stop. We will also ask your parent or guardian to give permission for your to be in this study. But even if you parent or guardian says yes, you can still decide not to be in the research study.

Agreeing to be in the study
I was able to ask questions about this study. Signing my name at the bottom means that I agree to be in this study. My parent or guardian and I will be given a copy of this form after I have signed it.

Printed Name

Sign your name on this line

Date

Printed Name of Person Obtaining Assent

Signature of Person Obtaining Assent

Date

The following should be completed by the study member conducting the assent process if the participant agrees to be in the study. Initial the appropriate selection:

_____ The participant is capable of reading the assent form and has signed above as documentation of assent to take part in this study.

_____ The participant is not capable of reading the assent form, but the information was verbally explained to him/her. The participant signed above as documentation of assent to take part in this study.

Appendix B: Tier 1

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SALT LAKE CITY
SCHOOL DISTRICT
Your Best Choice

LIST OF RELEVANT MENTAL HEALTH DATES

By: Magenta J. Silberman, M.Ed.

Often times the specific week or day may vary, be sure to check with relevant organizations to determine the specific week or date for a particular school year. Links are provided for reference when applicable on where to confirm the specific week or day and provide more information on the topic.

January

- Mental wellness month
- National Drug and Alcohol Facts Week - check with the National Institute on Alcohol Abuse and Alcoholism website: https://www.niaaa.nih.gov

February

- Eating Disorders Awareness Month
- Random Acts of Kindness Week - 2nd full week of February

March

- National Youth Violence Prevention Week - 3rd full week of March or sometimes in April. Check the Students Against Violence Everywhere website: nationalsave.org
- Self-injury Awareness Day - March 1

April

- Autism Awareness Month
- Stress Awareness Month
- Alcohol Awareness Month
- Sexual Assault Awareness and Prevention Month
- World Health Day - April 7th

May

- Mental Health Month
- Borderline Personality Disorder Awareness Month
- National Women's Health Week - check the NWHW website: https://www.womenshealth.gov/nwhw
- National Children's Mental Health Awareness Day - specific day varies, check www.samhsa.gov/children/awareness-day

June

- LGBTQ+ Pride Month
- National Men's Health Week/Month - check Men's Health website at http://www.menshealthmonth.org/
- PTSD Awareness Day - June 27th

August

- Friendship Day - 1st Sunday of August

September

- National Recovery Month
- Suicide Prevention Month
- National Suicide Prevention Week - specific week varies, check the American Foundation for Suicide Prevention website at https://afsp.org
- World Suicide Prevention Day - September 10th

October

- Bullying Prevention Month
- Mental Illness Awareness Week - 2nd week of October
- OCD awareness week - 2nd week of October
- World Mental Health Day and National Depression Screening Day - October 10th
- ADHD Awareness Month

November

- World Kindness Day - November 13th
- International Survivors of Suicide Day - 3rd Saturday of November
- International Stress Awareness Day - November 6th

December

- International Day of Persons with Disabilities - December 3

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RESOURCES FOR SCHOOL-WIDE AND CLASS-WIDE MENTAL HEALTH

By: Magenta J. Silberman, M.Ed.

Social-emotional Learning Curriculums and Integration into the School

- CASEL provides detailed information about SEL at their website: https://schoolguide.casel.org/
- List of programs, elementary and secondary, available on Box. Download them from the website here: https://casel.org/guide/
- Studies on implementation in schools:
    - Mellin, E.A., Ball, A., Iachini, A., Togno, N., & Rodriguez, A.M. (2017). Teachers' experience collaborating in expanded school mental health: implications for practice, policy and research. *Advances in School Mental Health Promotion, 10*(1), 85-98.
    - Oberle, E., Domitrovich, C.E., Meyers, D.C., & Weissberg, R.P. (2016). Establishing systemic social and emotional learning approaches in schools: a framework for schoolwide implementation. *Cambridge Journal of Education, 46*(3), 277-297.
    - Stephan, S.H., Sugai, G., Lever, N., & Connors, E. (2015). Strategies for integrating mental health into schools via a multitiered system of support. *Child and Adolescent Psychiatric Clinic of North America,* 211-231.

Trauma-Informed Schools

- Factsheet on trauma treatment in schools: https://www.elc-pa.org/wp-content/uploads/2015/06/Trauma-Informed-in-Schools-Classrooms-FINAL-December2014-2.pdf
- The National Child Traumatic Stress Network (NCTSN) has extensive information about how trauma affects children and various interventions. Find schoolwide resources here: https://www.nctsn.org/trauma-informed-care/trauma-informed-systems/schools/nctsn-resources
    - Included in the link above, but of particular importance, is the Child Trauma Toolkit for Educators, found here: https://www.nctsn.org/resources/child-trauma-toolkit-educators

Studies on School/Classroom Culture

- Greene, R.W. (2014). Lost at school: why our kids with behavioral challenges are falling through the cracks and how we can help them. Amazon link to the book here:

https://www.amazon.com/Lost-School-Behavioral-Challenges-Falling/dp/1501101498/ref=sr_1_6?keywords=trauma+informed+schools&qid=1559146802&s=gateway&sr=8-6
- Milkie, M.A., & Warner, C.H. (2011). Classroom learning environments and the mental health of first grade children. *Journal of Health and Social Behaviors, 52*(1), 3-21.
- Modin, B. & Ostberg, V. (2009). School climate and psychosomatic health: a multilevel analysis. *School Effectiveness and School Improvement, 20*(4), 433-455.
- Yang, C., & Bear, G.G. (2018). Multilevel associations between school-wide social-emotional learning approach and student engagement across elementary, middle, and high schools. *School Psychology Review, 47*, 45-61.

Embedding Mental Health in School Systems

- PBIS Recommendation on integrating tiered mental health with PBIS https://www.pbis.org/Common/Cms/files/Forum16_Presentations/RDQ%206%20Brief%20-%20Mental%20Health.pdf

Cultural Competence

- Website for recommendations on improving cultural competence https://www.gssaweb.org/wp-content/uploads/2015/04/Strategies-for-Building-Cultural-Competency-1.pdf
- National Education Association information and recommendations http://hin.nea.org/tools/30402.htm
- Guidelines for secondary school personnel on practicing cultural competence https://safesupportivelearning.ed.gov/resources/culturally-competent-schools-guidelines-secondary-school-principals
- NASP position statement for culturally responsive schools https://www.nassp.org/policy-advocacy-center/nassp-position-statements/culturally-responsive-schools/
- NASP has a variety of resources available for promoting cultural competency for school staff at nasponline.org

Studies on Supporting Teacher Wellbeing:

- Collie, R.J., Shapka, J.D., Perry, N.E., & Martin, A.J. (2015). Teachers' beliefs about social-emotional learning: identifying teacher profiles and their relations with job stress and satisfaction. *Learning and Instruction*, *39*, 148-157.
- Dolev, N. & Leshem, S. (2016). Teachers' emotional intelligence: the impact of training. *The International Journal of Emotional Education, 8*(1), 75-94.
- Hen, M. & Sharabi-Nov, A. (2014). Teaching the teachers: emotional intelligence training for teachers. *Teaching Education*, *25*(4), 375-390.

- Vesely, A.K., Saklofske, D.H., & Leschied, A.D.W. (2013). Teachers- the vital resource the contribution of emotional intelligence to teacher efficacy and well-being. *Canadian Journal of School Psychology, 28*, 71-89.

Student/Teacher Interactions

- American Psychological Association recommendations for improving student/teacher interactions and the importance of that relationship: https://www.apa.org/education/k12/relationships
- School-wide PBIS behavioral approaches to improving relationships: https://www.pbis.org/Common/Cms/files/Forum18_Presentations/RDQ7%20Brief%20-%20Student-Teacher%20Relationships.pdf
- Related study: Twemlow, S.W., Fonagy, P., Sacco, F.C., & Brethour, J.R. (2006). Teachers who bully students: a hidden trauma. *International Journal of Social Psychiatry, 52*(3), 187-198.

TEACHER-STUDENT RELATIONSHIPS

By: Christina Omlie, M.A., M.Ed., and Lauren Perez, M.Ed., BCBA

OVERVIEW & OBJECTIVE

Improving students' relationships with teachers has important, positive and long-lasting implications for both students' academic and social development.

Positive Teacher-Student Relationships are Related to:

- Increased likelihood of student engagement
- Fewer disruptive behaviors
- Increased cooperation
- Improved social functioning
- Increased academic achievement
- Reduced likelihood of teacher burnout

Quality Instruction Comes First!

Content material MUST BE engaging, age-appropriate and well matched to the student's skills for the effects of positive teacher-student relationships to "work its magic"

How to Develop Positive Relationships with Students:

- Know and demonstrate knowledge about individual students' backgrounds, interests, emotional strengths and academic levels
- Greet students when they walk into the classroom
- Show your pleasure and enjoyment of students
- Interact with students in a responsive and respectful manner
- Call on all students to answer in class
- Acknowledge the importance of peers in schools by encouraging students to be caring and respectful to one another

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IMPROVING TEACHER-STUDENT RELATIONSHIPS

Things to DO

- Always call students by their names, find out information about their interests and strive to understand what they need to succeed in school
- Make an effort to spend individual time with each student, especially students who are difficult or shy
- Be careful to show your students that you want them to do well in school through both actions and words
- Model a warm and respectful interaction style towards other students and adults in the schools
- Employ healthy coping strategies to manage frustration such as taking a deep breath or talking about your feelings

Things to AVOID

- Displaying negativity through snide and sarcastic comments toward the student
- Describing to others that you are always struggling or in conflict with a particular student
- Giving up too quickly on efforts to develop positive relationships with difficult students
- Ignoring or avoiding interactions with a particular student
- Resorting to yelling, harsh punitive control, or "single-ing out" - student victimization or bullying may be common occurrences in such negative classrooms
- Waiting for negative behaviors and interactions to occur in the classroom

How to Help Improve Relationships with Students with Challenging Behavior

Think about what you say to the difficult students in your classroom. Are you constantly bombarding your more challenging students with requests to do something? Do you find yourself constantly asking students to stop doing what they are doing? No one likes being badgered and pestered, and your students are no exception.

- Try to find a time or place when you can have positive discussion with the problem student
- Notice and mention the positive behaviors they exhibit
- Remind yourself that even if a challenging student appears unresponsive to your requests, she is hearing the messages that you are giving her. Her responses may not change her immediate behavior but may matter in the long term

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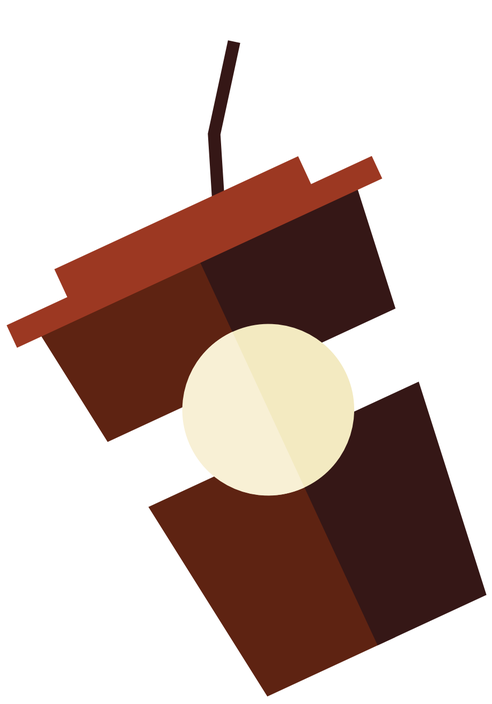
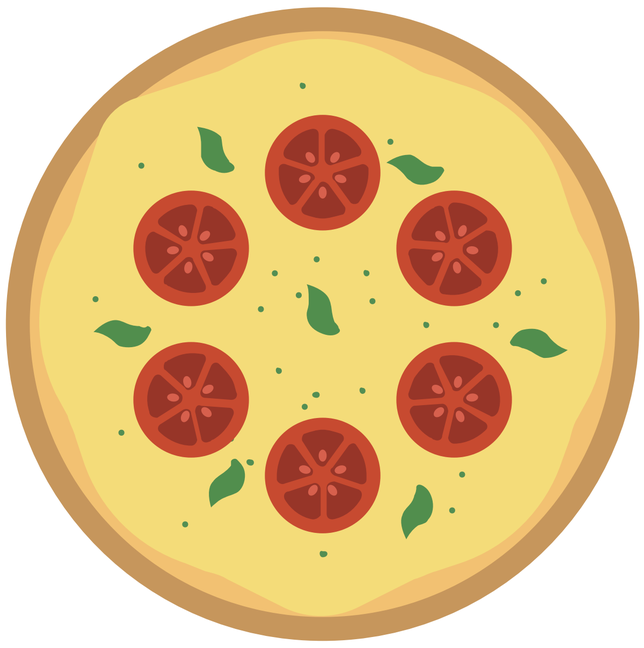
REINFORCING ADULTS

By: Rovi Hidalgo, M.Ed., and Anna Purkey, M.Ed.

OVERVIEW & OBJECTIVE

Teachers and school personnel serve an integral and impactful role in the lives of their students by providing academic, emotional, and behavioral support. Evidence indicates teachers are less likely to experience burnout if they feel supported and respected by members of school leadership. How do we create a positive and supportive atmosphere within a school? Providing frequent rewards and recognition of teachers and school personnel is an effective way to show how much the school leadership values their contributions to the students and the school.





DATES TO CONSIDER

Teachers and school personnel serve an integral and impactful role in the lives of their students by providing academic, emotional, and behavioral support. Evidence indicates teachers are less likely to experience burnout if they feel supported and respected by members of school leadership. How do we create a positive and supportive atmosphere within a school? Providing frequent rewards and recognition of teachers and school personnel is an effective way to show how much the school leadership values their contributions to the students and the school.

FEBRUARY

National School Counseling Week: First Week of Febrary

APRIL

Administrative Professionals Day: Last week of April

MAY

Teacher Appreciation Week: First Week of May

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STRATEGIES FOR REWARDS

There are multiple strategies and systems that schools can implement to increase the morale and positive climate within schools. While the following list is not exhaustive, there are various resources online for more ideas.

Treat School Staff and Faculty as Individuals

Get to know the teachers, learn about their hobbies and interests

Greet each other in the hallways

Be respectful of each other's time, arrive to meetings on time and end meetings on time

Help teachers find connections between personal values and school values

Create a questionnaire for faculty and staff to share their birthdays and other information

Select a faculty/staff member of the week and designate a bulletin board to share fun facts the person would like to share

Learn what snacks faculty and staff prefer and ensure those snacks are available in the break room and at meetings

Rewarding Faculty and Staff

Include faculty and staff in the Principal's 200 Club. When the winning students are selected, enter the adult who gave the ticket into a drawing for a prize.

Have an MVP trophy for faculty and staff to give to a colleague to recognize them. The trophy can be given to the next MVP at an assembly.

Give faculty break tickets to be redeemed for a short break from teaching. School leadership can substitute for the teacher.

Have faculty and staff participate in creating goals and when goals are met a reward can be provided.

Decorate faculty and staff doors with a positive message.

Host catered luncheons or provide a coffee cart for faculty and staff.

BUILD TRUST

- To provide clear outlines of each individual's role within the school to ensure everyone understands what is expected of them.
- Keep faculty and staff updated about issues within the school to ensure everyone has accurate information.

RECOGNIZE SUCCESSES

- Take time to celebrate successes by faculty and staff and provide shoutouts.
- Encourage faculty and staff to send positive notes to their colleagues.
- Ask faculty and staff to keep a diary and record when things go well and encourage them to share these times during meetings.

REPORTING TO DCFS

By: Magenta Silberman, M.Ed.

What Do I Report?

What you are required to report:

- Physical abuse
- Emotional abuse
- Sexual abuse
- Domestic violence
- Neglect
- Homelessness or students without proper care

For more information on what is required to be reported, please visit:

https://www.powerdms.com/public/UTAHDHS/documents/275074

How Do I Report?

1. Inform your principal of your intention to call. Then, call the Department of Child and Family Services (DCFS) Intake Line at 1-855-323-3237. It may be helpful to have another person (e.g., counselor or administration) with you while making this call. You may also wish to have your counselor or administrator make the call on your behalf while you are present.

2. While they may not need all of the information, if possible be prepared to share with DCFS the following:
   - Student's name, age, gender, and address
   - Parents' name, address, and work schedule
   - Nature of the concern, such as a description of the injury (e.g., bruises) conditions observed (e.g., student was distressed), or a description of what the student shared
   - What was done after the student shared this information
   - Where and when the act of abuse occurred
   - What, if any, harm the actions had on the student
   - Your name, location, and contact information

3. You may be required to write a report of what you observed or what the student told you. Include a brief report of what information you have on the act of abuse and work with your principal to submit to DCFS if necessary.

4. Document the following:
   - What you observed or were told by the student
   - That you reported the information (including day and time)
   - The student's case number for your records. It is helpful to have another person with you who can also document that you reported the information.

PROBLEM-SOLVING CONSULTATION

By: Rovi Hidalgo, M.Ed.

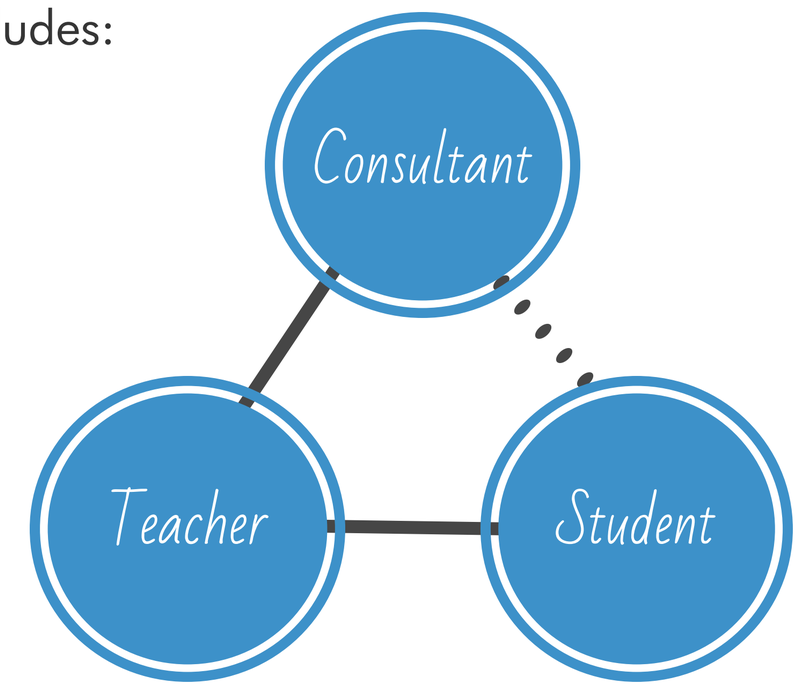
OVERVIEW & OBJECTIVE

Problem-Solving Consultation (PSC) includes:

Interventions that are based on operationally defined student behavior

Establishment of systematic methods of data collection with clear objectives for client behavior change

Requirement of teacher behavior change for implementation and data collection



STAGES OF PSC

1 Problem Identification

Describe the problem in objective and operational terms. Discuss why the problem is a problem that warrants intervention. Identity desired outcomes.

2 Problem Analysis

Utilize interviews, observations, standardized measures, etc. to analyze problem. Determine problem frequency, topography, and identify changeable variables contributing to the problem. Commit to change (Teacher buy-in is critical!)

3 Plan Development & Intervention

Discuss evidence-based and functionally-relevant interventions. Choose an intervention and determine intervention timelines, staff training procedures, methods to measure fidelity, and methods to measure effectiveness.

4 Plan Evaluation

Assess intervention plan's effectiveness. Was the desired outcome achieved? If not: Was the plan implemented with fidelity? If yes: Celebrate success & develop maintenance plans.

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PROCEDURES FOR SUICIDE

By: Magenta Silberman, M.Ed.

STEPS FOR TEACHERS

Suicidal Ideation

- Active suicidal ideation: a wish to die and a plan for how to take one's life.
- Passive suicidal ideation: a wish to die but without any plan to do so.

Self-Harm

Hurting yourself on purpose. Self-harming does not mean that the student is suicidal, but the risk of suicidal ideation is greater for these students.

Suicidal Ideation

If a student expresses active suicidal ideation you should:

1. Validate the student for sharing information and express your support for the student. You might say:

   "I really appreciate you sharing that information with me. It sounds like things are really difficult right now, and I want to support you to help manage some of those feelings. I know that the counselors, principal, and well-being team do too. I'm going to take you to the office so that you can talk with one those people one-on-one and be able to talk more about what you're feeling. Again, I really appreciate you talking with me today."

2. Remind them of their supports at the school
3. Immediately inform the principal, vice principal, or counselors of the name of the student and the concern. They will contact the students parent or guardian.
4. Take the student to the counselor's or admin's office. If you are unable to walk the student to the office, keep the student in your classroom until your next transition time or call for help. Do not leave the student alone.

If a student expresses passive suicidal ideation you should:

1. Validate the student for sharing information and encourage that they talk more about it. You might say:

   "I really appreciate you sharing that information with me. It sounds like things are really difficult right now, and I want to support you to help manage some of those feelings. If it's okay with you, I'd like to give your name to the counselors and the well-being team so that you can talk with them more about these feelings. Again, I really appreciate you talking with me today."

2. Remind the students of their supports at the school and ask if they need some time to talk to someone right now. If so, take the student to a counselor. If not, proceed to step 3.
3. Inform the principal and counselors of the student and their presenting concerns. They will make a referral so the student can see someone on the Well-being Team if they wish.

Suicide Attempts

Is there is a suicide attempt on school grounds, follow the procedures outlined in your emergency response booklet under "suicide attempt in school."

If a student tells you they are self-harming:

1. Validate the student for sharing information and express your support for the student.
2. Tell the student about their supports at their school.
3. Inform the principal and/or counselors of the name of the student and the concern. They will refer the student for services from the Well-being Team.

Caution

It can be difficult to see or hear of self-harm. You may experience feelings or fear or worry yourself. It is important not to project those feeling on the student.

If you suspect self-harm:

Inform the principal and/or vice principal of the name of the student and the concern. Administration will contact the Well-being Team to refer this student for services. You may also contact the Well-being Team directly.

If you would like to refer a student for mental health support, please contact the Well Being Team:

christina.omlie@utah.edu
magenta.silberman@utah.edu
pamela.cornejo@utah.edu

PROCEDURES FOR SUICIDE

By: Magenta Silberman, M.Ed.

STEPS FOR ADMINISTRATORS AND COUNSELORS

Here are steps to follow after a student indicates active suicidal ideation.

1 Evaluate the risk for suicide. You will want to ask the student some questions on the following:

1. What is the student currently feeling?
2. What is the student's current and past level of depression?
3. What is the student's current and past level of hopelessness?
4. Does the student have a current suicide plan or plan to harm themselves?
5. What method, if any, does the student plan to use?
6. Do they have access to that method?
7. Have they attempted suicide in the past?
8. If so, what method did the student use in their previous attempt?

2 To determine the student's overall risk, consider the answers to the previous questions, as well as:

1. What were the warning signs that initiated the referral?
2. What are the student's perceptions of burdensomeness and belongingness?
3. Is there a history of or current use of drugs or alcohol?
4. Has the student demonstrated any abrupt behavior changes?
5. What are the student's current problems and stressors at home?
6. What is the history of bullying, victimization, loss, or trauma?
7. Have they recently experienced a negative life event, such as a breakup?
8. What are the student's reasons to live?

3 If a student verbalizes a high or moderate risk for suicide (current plan and access to method, current ideation and previous behaviors):

1. Notify the parent/guardian. Do NOT contact via e-mail or leave a voicemail - talk to someone directly. If no response from parents, contact listed emergency contacts.
2. Do not leave the student alone.
3. When the parent/guardian arrives, inform them:
   - That the student expressed a wish to end their life.
   - Do not inform the parent/guardian of risk. Rather, state facts, such as: "I've called you in today because your child told us that they wanted to end their life. This may be a difficult thing to hear and talk about, but I am here to support you and your child in developing a plan to keep them safe."
   - Have them agree to seek mental health support.
   - That they should suicide proof their home, including locking up guns, medications or sharp objects.
   - Provide them with the numbers for UNI:
     1. CrisisLine: 1-800-273-8255
     2. Crisis Text Line: Text START to 741-741
     3. WarmLine (if not in crisis but need support): 801-587-1055
   - Develop a plan for reentry to the school
4. If a guardian refuses to pick the student up or the student expresses that they will take their life if they go home, you must:
   - Have the student and/or guardian stay with you at the school and
   - Call the mobile crisis outreach team (MCOT) at UNI. Call their CrisisLine at 1-800-273-8255 and explain that you have a student who is actively suicidal

4 If the student verbalizes a low risk (ideation):

1. Reassure the student.
2. Monitor the student throughout the school day.
3. Notify parent/guardian DIRECTLY. Do NOT leave a voicemail or e-mail.
4. Inform parent/guardian of what happened and their resources within the school and community.
   - Do not inform the parent/guardian of risk. Rather, state facts, such as: "I've called you in today because your child told us that they sometimes felt so sad they wanted to end their life. This may be a difficult thing to hear and talk about, but we have many school staff that are here to support you and your child."
5. Create a support plan that utilizes support systems within the school, coping skills, and resources (UNI, Safe UT).
6. Refer to the Well-being Team.

5 Document what procedures you used to determine risk, the student's risk, and your follow-up actions.

If you would like to refer a student for mental health support, please contact the Well Being Team:

christina.omlie@utah.edu
magenta.silberman@utah.edu
pamela.cornejo@utah.edu

SECOND STEP

By: Rovi Hidalgo, M.Ed.

OVERVIEW & OBJECTIVE

The Second Step program is a socio-emotional learning (SEL) curriculum for students grades K-8. Programs are available in packages particularly for Pre-K, grades K-5, and grades 6-8. Currently, Second Step sells the following programs: Social-Emotional Learning, Bullying Prevention, and Child Protection. In particular, students are taught skills on empathy, calming down, and problem-solving.

Within Second Step are evidence-based content and procedures to be implemented both schoolwide and in classrooms. Within programs are weekly lessons and activities for teachers to apply.

LESSONS

Units within Second Step, across grades, include:

- **Skills for Learning:** learning to listen, focusing attention, following directions, and self-talk for learning
- **Empathy:** identifying feelings within themselves and others, showing care, respecting differences, confidence, and making friends
- **Emotion Management:** managing embarrassment, anxiety and anger
- **Problem-Solving:** making plans, responsibility, & dealing with gossip and peer pressure
- **Mindsets & Goals:** mistakes, if-then plans, and goal-setting
- **Values & Friendships:** values, decisions, and friend-making
- **Thoughts, Emotions & Decisions:** handling emotions & unhelpful thoughts
- **Serious Peer Conflict:** avoiding and resolving conflict

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STUDENT SEXUAL HARASSMENT

By: Magenta Silberman, M.Ed.

DEFINITION OF SEXUAL HARASSMENT:

When someone bothers someone else with words, actions, or pictures of a sexual nature.

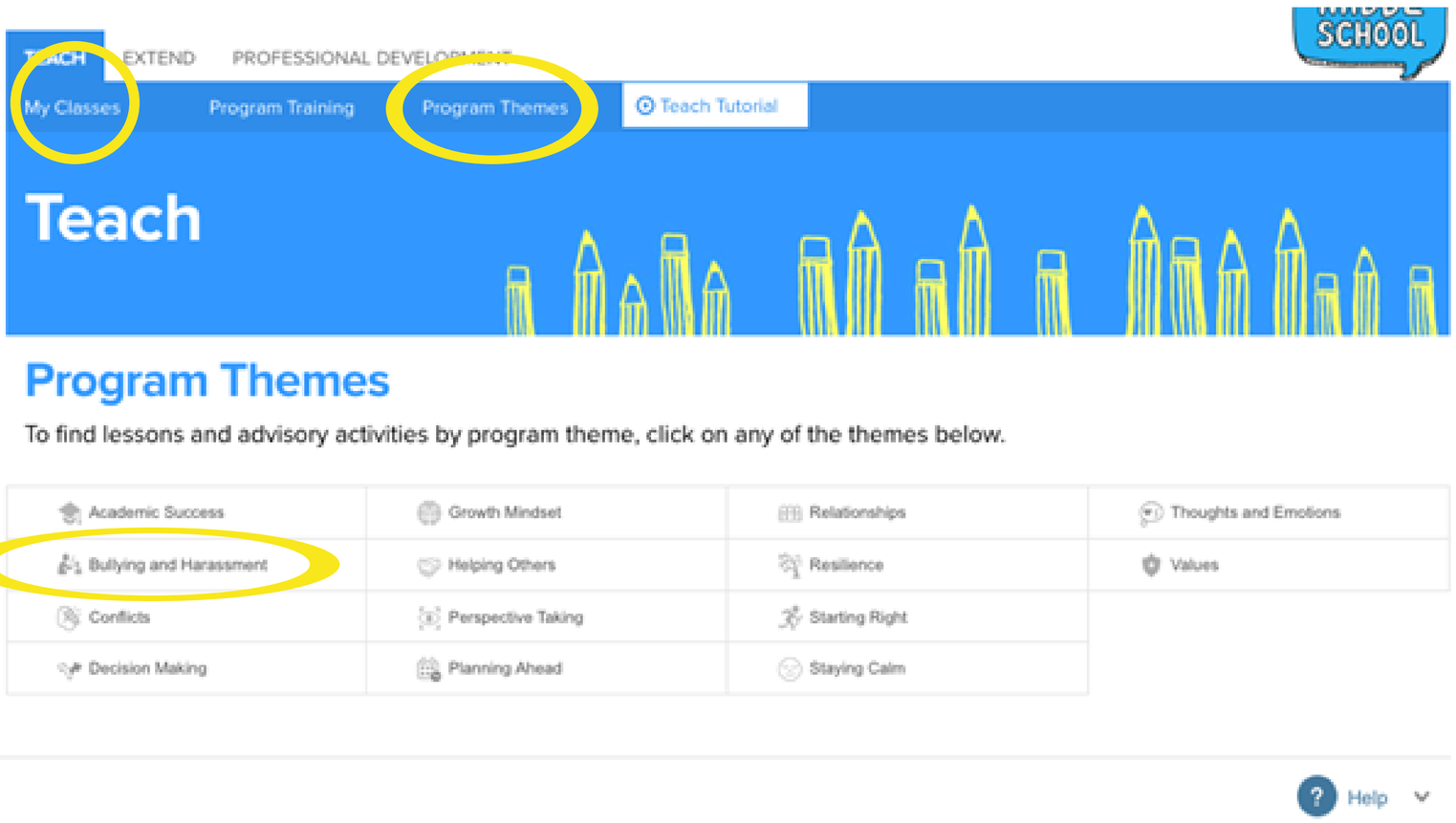
What are the differences between flirting and sexual harassment?

Flirting is when you don't mind the attention and can make it stop. Sexual harassment is when you don't like the attention and feel powerless to stop it.

What to Do:

1. Stop any ongoing harassment immediately, which may include separating the victim and perpetrator
2. Ensure you report any instances of harassment that you are aware of
3. Strategize with students about improving the classroom environment
4. Enlist the support of parents
5. Make certain the classroom is welcoming for all students
6. Post and review what the definition of sexual harassment is and what the consequences are
7. Stay calm and do not shame either student. Refer and report to administration.

For more information, see the Second Step lesson and activities on Sexual Harassment! You can find this under "teach" -> "program themes" -> "Bullying and Harassment"



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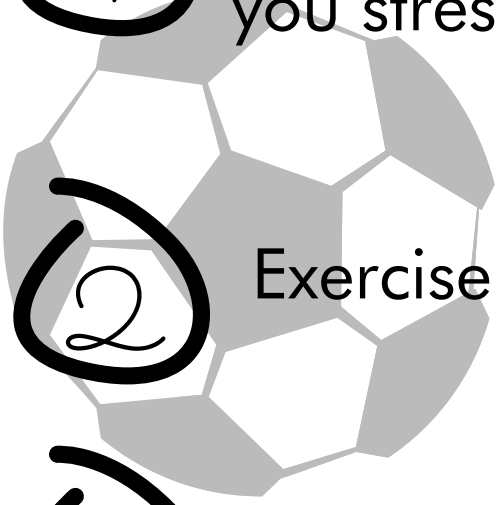
5 Tips to Manage Stress



1. Take a break - from work, people, or anything causing you stress
2. Exercise
3. Smile and laugh
4. Reach out to someone
5. Meditate and practice mindfulness

RESPONDING TO:

Homophobia, Transphobia, Policing of Gender Identity and/or Gender Norms, & Heterosexism

By: Magenta Silberman, M.Ed.

BROAD CONSIDERATIONS

- Merely telling the students to stop is not enough and does not send a clear message to the students. The students need to understand why we do not use those words and the impact is has on other people.
- Keep your voice and body calm when you speak with the students, avoid shaming and punishing them and focus on educating them. If there are instances of bullying, calmly explain what they said, how it is bullying, the consequences for bullying, and deliver that consequence.
- This may be a hard topic for your personally. Regardless of your opinions and perceptions of the LGBTQI+ community, everyone has the right to feel safe and no one deserves to experience bullying. You are still required as an educator to act when you see instances of discrimination.

TERMS AND DEFINITIONS

Cisgender: denoting or relating to a person whose sense of personal identity and gender corresponds with their birth sex.

Transgender: denoting or relating to a person whose sense of personal identity and gender does not correspond with their birth sex.

Gender: socially constructed characteristics of women and men.

Sex: division of living things based on their reproductive functions.

Gender policing: enforcing normative gender expectations.

Homophobia: dislike of or prejudice against homosexual people.

Transphobia: intense dislike of or prejudice against transsexual or transgender people.

SITUATIONS & HOW TO RESPOND

Disrespectful Use of Words like "Gay" and "Lesbian"

Education on how they used the word and provide an alternative ("if you mean to say you do not like something, then use those words")

Telling the student that those terms are not insults and politely tell them not to use those words in that way.

Explaining how using those words in that way can hurt other people.

Educate the student on what those words mean and how they are not appropriate to the situation.

Homophobic Language (e.g., "fag" and "dyke")

Informing them on what those words mean and how they are hurtful to others.

Explain to the student that using homophobic language when they know it is inappropriate is bullying.

Explain how homophobic language can make people feel unsafe, and everyone should feel safe at school.

Gender Policing and Sexism

Quickly correct any instances of gender policing. For example, if a student says "We're playing football, it's not really a girls sport." You can respond to the student by saying that there are not "boy" and "girl" sports and that a persons interest is based on their personality and not their gender/sex.

Teach student the impact that phrases can have, such as calling another student "girly" or telling them to "man up." Some ways to respond include: being a girl is not an insult, people are allowed to express themselves as they choose, it is hurtful to use those phrases because it implies that there is something wrong with being a girl, and there is not.

Appendix C: Tier 2

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Granite SCHOOL DISTRICT

GROUP PLAN RUBRIC

By: Christina C. Omlie, M.A., M.Ed.

Statement of Purpose: a short statement (2-4 sentences) that reflects the purpose of the group

Setting: school level/grade level, age range, location (rural/urban, etc.)

Target Population: including why this population was selected, needs of the group, age, grade (if applicable), gender, homogenous/heterogeneous group

How members will be selected: teacher, counselor/parent referral, details of the screening/needs assessment (what questions would be important to be asked?)

Logistics: time, length of the sessions, place/location of sessions, group ground rules

Facilitators: who at which site; key person of contact for parents and teachers

Theoretical Orientation: discuss the theoretical format for the group and how the theory will influence the group process/your interaction with the group

Group Norms/Rules: each group should have 3-5 group rules that each member must abide by – one of the rules must address confidentiality

Plan for Each Session: Include the following:

- **Objective**: purpose of the session lesson
- **Opening Icebreaker**: reflective prompt or short activity
- **Agenda**: explanation of how the group session will be facilitated
- **Closing Activity**: reflective prompt or short activity

Copies of All Activities: print out copies of all activities that require a worksheet to complete in session; provide copies related to skills practiced for teachers and guardians to reinforce at school and home

Strategies for Dealing with Challenges – information related to how you will deal with challenging group members (e.g., silent members, resisters, monopolizers, manipulators, clowns, sarcastic masks, redirectors, coalescing, colluding, etc.)

Final closing activity: define/outline a plan for the final day to commemorate the entire group process

Evaluation tool(s): (i.e. – pre- and post-tests, grades, etc.)

Forms:

- Informed consent (be sure to include info about limits to confidentiality, what clients can expect, any fees, info about attendance, group rules), may also want to consider a permission to tape form
- Letters to teachers, passes, needs assessment, etc. (if relevant)

Reference Page: cite all activities/ice breakers and reference page

Plan for Publicizing or Generating Interest in the Group: Include an eye-catching/engaging/memorable poster, flyer, or brochure for the group that would appeal to the target population. Include pertinent information (e.g., who, what, where, when, why, how, etc.)

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GROUP INTAKE TEMPLATE

By: Christina C. Omlie, M.A., M.Ed.

1. Provide introduction to self and Wellbeing Team (WBT)
    - "I'm a graduate student at the U and am a member of the WBT. At this school I help provide therapy services to students. You have been referred for a group focused on _____"

2. Provide information about the GROUP
    - Name of group
    - Number of weeks long
    - How many sessions per week
    - Day of week and time
    - Description of group format and number of attending members
        i. i.e. "Students will talk about experiences and building coping skills"

3. Confidentiality
    - Define it: "Everything said during session is held confidential (i.e., will not be shared with others). There are three exceptions to this rule in which I would need to contact a responsible adult in your life: …"
    - Provide 3 exceptions:
        - Harm to self
        - Harm to others
        - Child, elder, or other vulnerable persons abuses

4. Student:
    a. <u>Demographics:</u>
    - DOB:
    - Grade:
    - Gender:
    - Race/Ethnicity:
    - Activities/Hobbies (What do you enjoy doing?)
    - "Is there anything else about you that I haven't asked that you think I should know?"

    b. <u>Suicidal Ideation:</u>
    - "Have you had any thoughts about hurting yourself?"
    - "Have you ever had any thoughts of death or not being around?"

- If so, ask re: frequency, severity, plans, attempts, rehearsals (behaviors that approximate)

c. Homicidal Ideation:
- "Have you had any thoughts of hurting others?"
- If so: towards whom, frequency, severity, plans, attempts, rehearsal (behaviors that approximate)

d. Drugs:
- Alcohol
- Tobacco
- Illicit drug use

e. Previous therapy history:
- Presenting concerns
- Focus of therapy
- Reason for termination of services

f. Coping Strategies
- "What do you typically do to make yourself feel better when you're feeling sad, angry, or upset?"
- "Do you have people in your life you feel talk to when you feel this way?"

g. AREA OF CONCERN (Change to fit purpose of group)
- Symptoms
- Frequency of symptoms
- Settings: (Have you noticed experiencing in any particular place or more often than others?
- Current management strategies

h. Clinical impressions
- Provide narrative of the student's general temperament, communication style and skill, other pertinent information

i. Assent
- Student signs assent portion of consent form

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TREATMENT INTEGRITY CHECKLIST

By: Christina C. Omlie, M.A., M.Ed.

Facilitator(s): _____ Date: _____

Session Number: _____

Instructions: Put a ✓ next to each completed component.

Component		Observations and Comments
Open with mindful breathing practice or icebreaker		
Check-in with Group/Review		
Teach lesson		
Practice lesson		
Discussion		
Journal		
Close with mindful breathing or activity		
Encouraged group discussion		
Total Number of Checks	/8	
Session Integrity %		

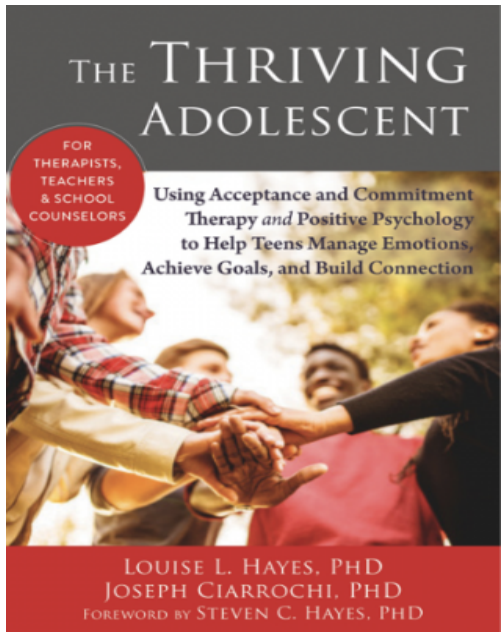
Adapted from Haygeman, E. (2015). *An adaptation of the Mindful Schools curriculum for adolescents: Feasibility and preliminary effectiveness on stress and mindfulness of adolescents in a public school setting* (Doctoral dissertation proposal)

ROAM

By: Emily S. Davis, M.A., M.Ed. & Stephanie J. Pirsig, M.A., M.Ed.

Relaxation, Observation, Acceptance, & Mindfulness (ROAM)

ROAM is an Acceptance and Commitment Therapy (ACT) based intervention group. ACT is considered transdiagnostic, meaning it is useful with a variety of problem concerns and is particularly effective in treating anxiety.
Currently ROAM is available for students dealing with stress and low to moderate anxiety levels. Groups meet for eight weekly, for 45 minute sessions.



Protocol is adapted from
The Thriving Adolescent
(Hayes & Ciarrochi, 2015)

Students Will

- Explore acceptance and mindfulness-based strategies.
- Learn to manage stress in the service of values
- Practice within a supportive group environment
- Complete home-based activities and share with group
- Share their experience

Weekly Group Sessions

Mindfulness strategies

Experiential exercises

Psychoeducation

Written exercises

Home practice

Group processing

For more information contact
emily.s.davis@utah.edu or stephanie.pirsig@utah.edu

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Appendix D: Tier 3

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ADMINISTRATION SCHEDULE OF TREATMENT MEASURES

By: Pamela A. Cornejo, M.Ed.

The following is a table of when each treatment measure should be administered during the therapy timeline. The measures may be helpful for assessing treatment outcomes in individual or group therapy. At baseline and progress monitoring timepoints, the therapist will administer the treatment measures. For follow-up, the Tier 3 Lead will administer the Individual Therapy Feedback Questionnaire and treatment outcome measures.

Therapist Administered

	AFQ-Y	**SSWQ**	**YEPS**	**YIPS**	**WAI-C**	**WAI-T**
Baseline	1st session	1st session	1st session	1st session	1st session	1st session
Progress Monitoring	Last session	Last session	Every session	Every session	Every other session	Every other session

Tier 3 Lead Administered

	Therapy Feedback	**AFQ-Y**	**SSWQ**	**YEPS**	**YIPS**
Follow-Up	Within one week of termination	One month after termination	One month after termination	One month after termination	One month after termination

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COMMUNITY PROVIDER REFERRAL LIST

By: Pamela A. Cornejo, M.Ed.

The following are a list of community therapy providers that provide therapy from a sliding scale fee. Maintaining and updating an accurate list will help families access mental healthcare outside of the WBT.

University of Phoenix Counseling Skills Center
801-506-4142
Pro Bono services *Strict no show policy
Masters Students

Polizzi Clinic
801-590-9557
polizziclinic.org

*Must meet eligibility requirements of verified low income/uninsured/no primary substance abuse diagnosis or personality disorder Tx.

Midtown Community Health
801-486-0911
Sliding scale for primary care and mental health services.

Family Counseling Center
801-261-3500
No spanish speaking therapists.
Sliding scale starting at $5. Medication management available via Medicaid.

The Family Support Center
801-955-9110
$15-$100
Accepts Medicaid. No Spanish speaking staff.
Individual therapy, family therapy, and classes offered in Spanish and English
Interns and licensed providers

Jewish Family Services
801-746-4334
Spanish speaking therapists available. Medicaid accepted.
Sliding fee: $25 *sometimes lower *insurance accepted
Interns and licensed providers

Health Clinics of Utah
801-715-3500
*Must be a client of the clinic (Initial appointment with Primary Care ~$80, and can then be referred to Mental Health services). PCN and non-insured only.
Psychiatric APRN and LCSW $5 per session.

Valley Behavioral Health
888-949-4VMH
Unfunded Clinic -Sliding scale for uninsured, limited sessions. *must complete intake assessment to qualify

Simple Modern Therapy
435-730-2973
$75-$100 (limited slots)
Licensed Clinician

Chelsy Bundy LMFT
435-731-7963
$30-$40
Intern

Silverado Counseling
801-98305540
Accepts Medicaid. No Spanish speaking therapists. No sliding fee.

Child and Family Empowerment Services
801-972-2711
CSW $85. LCSW L $125.
Spanish speaking. No sliding fee. Accepts Medicaid.

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HELPFUL SMARTPHONE APPS

By: Pamela A. Cornejo, M.Ed.

Meditation/Relaxation

- Breathe2Relax
  - Free, iOS only compatible
  - Breathing exercises with a body scanner and graphs results. Visually helps the user maintain breathing.

- Headspace
  - Fee/Cost, iPhone/android compatible
  - Breathing, mindfulness reminders and thought activities

- Colorfy: Coloring Art Game
  - Free, iPhone/android compatible
  - Drawing and painting

Depression

- Virtual Hope Box
  - Free, iOS only compatible
  - Allows users to access 4 options during depressive symptoms: “distract me”- games, “inspire me”-quotes, “relax me”- meditation activities, “coping tools”- personalized items that help to reconnect.

Wellness Management

- BoosterBuddy
  - Free, iOS only compatible
  - Mood tracker, medication management, mindfulness activities, grounding exercises

- Mindshift CBT- Anxiety Canada
  - Free, iOS only compatible
  - Based on Cognitive Behavioral Therapy (CBT) for anxiety and stress. Can test for perfectionism, anxiety, social or performance anxiety.

- What’s Up?- A Mental Health App
  - Free, iOS only compatible
  - Based on Cognitive Behavioral Therapy (CBT) and Acceptance and Commitment therapy (ACT)

Nutrition/Digestive Health

- Cara: Food, Mood, Poop Tracker
  - Free, iPhone compatible
  - Helps to monitor digestive health, build connections between stress, foods and physical symptoms and provides tips to prevent digestive distress.

Appendix E: Data Collection Measures

Student Subjective Wellbeing Questionnaire

Name:	Age:	Gender:
Date:	Grade:	Race/ethnicity:

Here are some questions about what you think, feel, and do at school.
Read each sentence and choose the one best answer.

		Almost Never	*Some-times*	*Often*	*Almost Always*
1.	I get excited about learning new things in class.	1	2	3	4
2.	I feel like I belong at my school.	1	2	3	4
3.	I feel like the things I do at school are important.	1	2	3	4
4.	I am a successful student.	1	2	3	4
5.	I am really interested in the things I am doing at school.	1	2	3	4
6.	I can really be myself at school.	1	2	3	4
7.	I think school matters and should be taken seriously.	1	2	3	4
8.	I do good work at school.	1	2	3	4
9.	I enjoy working on class projects and assignments.	1	2	3	4
10.	I feel like people at my school care about me.	1	2	3	4
11.	I feel it is important to do well in my classes.	1	2	3	4
12.	I do well on my class assignments.	1	2	3	4
13.	I feel happy when I am working and learning at school.	1	2	3	4
14.	I am treated with respect at my school.	1	2	3	4
15.	I believe the things I learn at school will help me in my life.	1	2	3	4
16.	I get good grades in my classes.	1	2	3	4

SSWQ User Guide

/ SCORING

- Scale scores are created by summing item responses as follows:
  - Joy of Learning subscale: items 1, 5, 9, 13
  - School Connectedness subscale: items 2, 6, 10, 14
  - Educational Purpose subscale: items 3, 7, 11, 15
  - Academic Efficacy subscale: items 4, 8, 12, 16
  - Overall Student Subjective Wellbeing composite scale: all items
- No reverse-scoring is necessary
- Higher scale scores are interpreted as greater levels of student subjective wellbeing
- No normative data are available for interpreting scale scores in comparison to national, regional, or local populations
- Local-norming logic might be a useful approach for interpreting scale scores

/ SUPPORT

- The project hub for the SSWQ, which has links to papers on the development and validation of the measure, is available on the Open Science Framework at https://osf.io/d54zs/
- Queries regarding the SSWQ can be addressed to Tyler Renshaw (the lead developer) at tyler.renshaw@usu.edu
- Other free, brief rating scales that might be used with the SSWQ are available at https://tyrenshaw.org/measures

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Youth Internalizing Problems Screener

Name:	Age:	Gender:
Date:	Grade:	Race/ethnicity:

Here are some questions about what you think, feel, and do.
Read each sentence and choose the one best answer.

		Almost Never	*Some-times*	*Often*	*Almost Always*
1.	I feel nervous or afraid.	1	2	3	4
2.	I feel very tired and drained of energy.	1	2	3	4
3.	I find it hard to relax and settle down.	1	2	3	4
4.	I get bothered by things that didn't bother me before.	1	2	3	4
5.	I have uncomfortable and tense feelings in my body.	1	2	3	4
6.	I feel moody or grumpy.	1	2	3	4
7.	I feel like I'm going to panic or think I might lose control.	1	2	3	4
8.	I do not really enjoy doing anything anymore.	1	2	3	4
9.	I feel worthless or lonely when I'm around other people.	1	2	3	4
10.	I have headaches, stomachaches, or other pains.	1	2	3	4

YIPS User Guide

/ SCORING

- Create the total scale score by summing all items
- No reverse-scoring is necessary
- Higher total scale scores are interpreted as greater levels of internalizing problems
- Research suggests a cutoff score of 21 might be useful for identifying concerning levels of internalizing problems
- No normative data are available for interpreting total scale scores in comparison to national, regional, or local populations
- Local-norming logic might be a useful approach for interpreting scale scores

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- The project hub for the YIPS, which has links to papers on the development and validation of the measure, is available on the Open Science Framework at https://osf.io/63nzf/
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Youth Externalizing Problems Screener

Name:	Age:	Gender:
Date:	Grade:	Race/ethnicity:

Here are some questions about what you think, feel, and do.
Read each sentence and choose the one best answer.

		Almost Never	*Some-times*	*Often*	*Almost Always*
1.	I lose my temper and get angry with other people.	1	2	3	4
2.	I have a hard time sitting still when other people want me to.	1	2	3	4
3.	I fight and argue with other people.	1	2	3	4
4.	I break rules whenever I feel like it.	1	2	3	4
5.	I talk a lot and interrupt others when they are talking.	1	2	3	4
6.	I say or do mean things to hurt other people.	1	2	3	4
7.	I have a hard time focusing on things that are important.	1	2	3	4
8.	I like to annoy people or make them upset.	1	2	3	4
9.	I get distracted by the little things happening around me.	1	2	3	4
10.	I choose not to follow directions and don't listen to adults.	1	2	3	4

YEPS User Guide

/ SCORING

- Create the total scale score by summing all items
- No reverse-scoring is necessary
- Higher total scale scores are interpreted as greater levels of externalizing problems
- No cutoff scores have yet been established for identifying concerning levels of externalizing problems
- No normative data are available for interpreting total scale scores in comparison to national, regional, or local populations
- Local-norming logic might be a useful approach for interpreting scale scores

/ SUPPORT

- The project hub for the YEPS, which has links to papers on the development and validation of the measure, is available on the Open Science Framework at https://osf.io/63nzf/
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The Tool for Assessment of Suicide Risk for Adolescents (TASR-A): How to use the TASR - A

The TASR-A was developed to assist in the clinical evaluation of young people at imminent risk for suicide. It was created by clinicians with expertise in the area of adolescent suicide assessment and the development and application of various scales and tools in clinical, research and institutional settings. The TASR-A was derived from the Tool for Assessment of Suicide Risk (TASR) that was developed for clinical use in emergency room, hospital and outpatient settings in the assessment of imminent suicide risk in adults. The adult TASR is found in the book: Suicide Risk Management: A Manual for Health Professionals (Kutcher and Chehil; Wiley-Blackwell, 2007).

The TASR is intended for use as part of a comprehensive mental health assessment of a young person considered to be at risk for suicide. The clinician should conduct the assessment in her/his usual manner and then score the TASR–A. If sections of the TASR-A have not been addressed in the interview, then the clinician should then go back and address them with the patient. A notation of the presence or absence of each risk factor identified on the TASR-A should be made in the appropriate space provided. Once the TASR-A has been completed, the clinician comes to a clinical decision as to the level of risk for imminent suicide and notes that in the space provided on the TASR–A.

The TASR-A is not a diagnostic tool since suicide is a behaviour rather than a medical diagnosis. The TASR-A is also not a predictive tool since there is no tool that can be demonstrated to predict suicide. Rather, the TASR-A is a semi-structured instrument that the clinician can follow to ensure that the most common risk factors known to be associated with suicide in young people have been assessed. The tool also provides the clinician with a convenient overview of the entire risk factor assessment, thus allowing the clinician to make a best judgment call as to the level of risk for imminent suicide. Furthermore, the TASR-A provides an excellent documentation of the comprehensiveness of the suicide risk assessment conducted by the clinician and thus may be useful for both clinical record keeping and in medico-legal cases.

The TASR-A also includes a section in which the 6 item KADS score for depression can be recorded. This is important for a number of reasons. 1) Suicide, like behaviours, can often be the entry point for clinical assessment, and depression is a common risk factor for youth suicide. 2) The presence of a depressive disorder increases the probability of suicide in young people. 3) Treatment of depression has been demonstrated to decrease suicide attempts. The 6-item KADS can be accessed on the **professionals section of our website.**

The 6-item KADS is designed for use in institutional settings (such as schools or primary care settings) where it can be used as a screening tool to identify young people at risk for depression or by trained health care providers (such as public health nurses, primary care physicians) or educators (such as guidance counselors) to help evaluate young people who are in distress or who have been identified as possibly having a mental health problem.

Permission and Training

The TASR-A can be used by expert clinicians (such as child and adolescent mental health staff working in sub-specialty or academic settings) without additional training. Training in the use of the TASR-A for other health providers is advised and can be arranged for groups of 10 or more by contacting the office of the Chair. Depending on the group, the duration of TASR-A training ranges from one to three hours.

The TASR-A is available freely for use but may not be sold, copied or otherwise distributed without the express written consent of Dr. Stan Kutcher.

We appreciate any feedback on the use, outcome or suitability of the TASR-A from any individual or group who is using it. Feedback can be directed to Dr. Stan Kutcher by email at **skutcher@dal.ca.**

Clinicians, educators, youth workers and others interested in other training programs pertaining to youth depression and suicide offered by the Chair can find further information by visiting the **training programs section of our website.**

Tool for Assessment of Suicide Risk: Adolescent Version (TASR-A)

Name: _____ Chart #: _____

Individual Risk Profile	**Yes**	**No**
Male		
Family History of Suicide		
Psychiatric Illness		
Substance Abuse		
Poor Social Supports/Problematic Environment		

Symptom Risk Profile	**Yes**	**No**
Depressive Symptoms		
Psychotic Symptoms		
Hoplessness/Worthlessness		
Anhedonia		
Anger/Impulsivity		

Interview Risk Profile	**Yes**	**No**
Suicidal Ideation		
Suicidal Intent		
Suicide Plan		
Access to Lethal Means		
Past Suicidal Behavior		
Current Problems Seem Unsolvable		
Command Hallucinations (Suicidal/ Homicidal)		
Recent Substance Use		

6 item KADS Score: _____

Level of Immediate Suicide Risk

High _____
Moderate _____
Low _____

Disposition: _____

Assessment Completed by: _____ Date: _____

6-ITEM Kutcher Adolescent Depression Scale: KADS-6

NAME: _____ CHART NUMBER: _____

DATE: _____ ASSESSMENT COMPLETED BY: _____

OVER THE LAST WEEK, HOW HAVE YOU BEEN "ON AVERAGE" OR "USUALLY" REGARDING THE FOLLOWING ITEMS:

1. **Low mood, sadness, feeling blah or down, depressed, just can't be bothered.**

☐ 0 - Hardly Ever ☐ 1 - Much of The Time ☐ 2 - Most of The Time ☐ 3 - All of The Time

2. **Feelings of worthlessness, hopelessness, letting people down, not being a good person.**

☐ 0 - Hardly Ever ☐ 1 - Much of The Time ☐ 2 - Most of The Time ☐ 3 - All of The Time

3. **Feeling tired, feeling fatigued, low in energy, hard to get motivated, have to push to get things done, want to rest or lie down a lot.**

☐ 0 - Hardly Ever ☐ 1 - Much of The Time ☐ 2 - Most of The Time ☐ 3 - All of The Time

4. **Feeling that life is not very much fun, not feeling good when usually (before getting sick) would feel good, not getting as much pleasure from fun things as usual (before getting sick).**

☐ 0 - Hardly Ever ☐ 1 - Much of The Time ☐ 2 - Most of The Time ☐ 3 - All of The Time

5. **Feeling worried, nervous, panicky, tense, keyed up, anxious.**

☐ 0 - Hardly Ever ☐ 1 - Much of The Time ☐ 2 - Most of The Time ☐ 3 - All of The Time

6. **Thoughts, plans or actions about suicide or self-harm.**

☐ 0 - Hardly Ever ☐ 1 - Much of The Time ☐ 2 - Most of The Time ☐ 3 - All of The Time

TOTAL SCORE: ☐

6-ITEM Kutcher Adolescent Depression Scale: KADS-6

OVERVIEW

The Kutcher Adolescent Depression Scale (KADS) is a **self-report** scale specifically designed to diagnosis and assess the severity of adolescent depression, and versions include a 16-item, an 11 item and an abbreviated 6-item scale.

SCORING INSTRUCTIONS

TOTAL SCORE	SCORE INTERPRETATION
0 – 5	Probably not depressed
6 and ABOVE	Possible depression; more thorough assessment needed

REFERENCE

LeBlanc JC, Almudevar A, Brooks SJ, Kutcher S: Screening for Adolescent Depression: Comparison of the Kutcher Adolescent Depression Scale with the Beck Depression Inventory, Journal of Child and Adolescent Psychopharmacology, 2002 Summer; 12(2):113-26.

Self-report instruments commonly used to assess depression in adolescents have limited or unknown reliability and validity in this age group. We describe a new self-report scale, the Kutcher Adolescent Depression Scale (KADS), designed specifically to diagnose and assess the severity of adolescent depression. This report compares the diagnostic validity of the full 16-item instrument, brief versions of it, and the Beck Depression Inventory (BDI) against the criteria for major depressive episode (MDE) from the Mini International Neuropsychiatric Interview (MINI). Some 309 of 1,712 grade 7 to grade 12 students who completed the BDI had scores that exceeded 15. All were invited for further assessment, of whom 161 agreed to assessment by the KADS, the BDI again, and a MINI diagnostic interview for MDE. Receiver operating characteristic (ROC) curve analysis was used to determine which KADS items best identified subjects experiencing an MDE. *Further ROC curve analyses established that the overall diagnostic ability of a six-item subscale of the KADS was at least as good as that of the BDI and was better than that of the full-length KADS. Used with a cutoff score of 6, the six-item KADS achieved sensitivity and specificity rates of 92% and 71%, respectively—a combination not achieved by other self-report instruments. The six-item KADS may prove to be an efficient and effective means of ruling out MDE in adolescents.*