Live captioning by Ai-Media

SPEAKER:
Yeah, I do not know if they are –

JORDAN KERR:
Welcome everybody! This is the Children's Mental Health Champion Program Pathways to Inclusion: Addressing the Mental Health Needs of Students Across the Age Span. We ask you that when you join, if you could mute. And...

SPEAKER:
(Laughs)

JORDAN KERR:
This webinar will be recorded and archived on AUCD's website. We have closed captions available and the transcript will be available as well following the archive. I will go ahead and pass this over to Judy Reaven who is one of our children's mental health champions and she will take us away for today.

JUDY REAVEN:
Thank you so much, Jordan, for the introduction. Welcome, everybody! We are excited to do this presentation today. I think we all know and you are on here so you are very well aware of the ongoing public health concern of children's mental health.

Certainly in recent times, we have been hearing all kinds of press really about the crisis. At the end of last year, the Surgeon General issued a warning about the crisis in youth mental health. It was just a couple weeks ago, I was reading the New York Times and in the Sunday Times they had this article on the front page about mental health in US teens.

The reality is that even though we have been hearing this present last few months or year or so, the crisis has been building for more than 10 years. We are seeing increases in anxiety, depression, ADHD – other kinds of mental health symptoms across our youth.

It is certainly reaching the threshold of a crisis. Negative life experiences and stress can certainly contribute to people's experience of mental health conditions. We know that access to quality education, healthcare, where you live, how much money you have – those are social determinants of health and also social determinants of mental health.

Jordan said that I am one of the mental health champions. The four of us are. This is a project that

 

started four years ago and there were six champions when we first started, now we have grown to 12. There are three main goals of this project and you can see them here.

One is to connect and create family/community partnerships. The second is to promote early identification and evidence-based treatment of mental health needs. The third is preventing mental health disorders through sharing information and working in context.

The four of us are working very hard to promote mental health in these areas. The link below will give you more information about the Children's Mental Health program which is a connection between us and AUCD.

So the four of us talked together as we were planning this webinar. We realize we had a lot of shared interests in terms of working with schools. Some of the things we landed on as we put together our presentations were the importance of bringing research, especially evidence-based research and practice, into community and schools.

The recognition that mental health is a barrier for all kinds of things. When you are a student, it is a barrier for participation in school and making friendships. Really truly being included. A big focus of this presentation webinar is for the four of us to try to address how mental health is interfering with students.

And what kinds of suggestions and recommendations we can make to support our students. So we have four wonderful presentations lined up for you. You can see the titles here. We have arranged them in order of age.

Tova is going to start with our youngest learners and Joanne will speak about adolescents and adults. Each of us will speak for about 18 minutes or so. There may be time for one brief question at the end of each presentation and then we will go right into the next one.

The hope is to have a good 10 minutes or so at the end to open it up to discussion. With that, I'll actually go ahead and just turn it over to Tova to start her presentation.

TOVA HARTLE:
Okay, well hello, good afternoon and welcome everyone! Thank you so much for joining us today. I am going to begin today by talking a bit about the topic of addressing the mental health needs of our youngest learners. How Early Experiences Impact School Success.

For this presentation, I will focus on the lasting impacts of early adversity, how childhood trauma affects our growth and development from a very young age, what exactly is infant and early childhood

 

mental health, what does it look like and how do we respond as educators and caregivers to mental health concerns?

First, I will take a quick moment to introduce myself. My name is Tova Hartle and I'm a licensed board certified school counselor out of the state of South Dakota. I work primarily with early childhood and young elementary students.

As mentioned earlier, as we go through the slides for today's presentation, feel free to ask questions through the chat feature. We will leave sometime at the end as Judy mentioned.

On this next slide here, as we all know, children's brains are like sponges. They process information acquired from everything and everyone around them. Which is why trauma and adversity during the first years of life can have a significant and lasting impact on overall health and wellness throughout the lifespan.

When we look at early life stressors, we find that ACES were early adverse experiences are related to aggressiveness, impulsivity, deficiencies in language development and socialization skills. I am not sure if you are all familiar with ACES but I have the pyramid shown here on the side.

This represents the conceptual framework for the ACES study which shows us how ACES are related to developmental, physical and mental well-being throughout the life course. As you see here – generational, historical trauma, environmental and social conditions all add to the context of how our early and inherited experiences contribute to a lifelong growth and development.

With all the research behind ACES is telling us is that when a child is exposed to that frequent, unrelenting stress without the buffer of adult support – that is the key phrase there. The buffer and protection. Those experiences can profoundly impact the body stress system which will present in the disruption of healthy brain development.

What we really want to do is serve as a buffer. We want to serve as protection for the child. And to do whatever we can to build up those protective factors in the child's life so we can ultimately outweigh the whisk factors. -- Risk factors.

We have seen the impact of adverse childhood experiences for years. But it is in more recent years that we have that brain research to back that up to support the theory that our early experiences significantly impact the development and basic architecture of the brain.

When we think of that early timeframe for -- brain development in the first few years of life, more than 1 million neural connections are formed every second. Which is super hard to even imagine. 1 million

 

new neural connections every second.

So this is when the sensory pathways for things like basic vision and hearing are the first to develop. Then it is kind of followed by language skills and those higher cognitive functions. When we talk about that crucial timeframe, a whole lot hinges on the first 1000 days.

So this is the time. That is really crucial as it affects the areas and not only that physical growth but also social and emotional growth as well. On this next slide here, I put this quote that I took from Donna Jackson (Unknown Name).

This shows how distracted your biology or biography comes and how you can heal. What she says and I have it here on the slide, (Reads) "What kills you doesn't -- what does not kill you does not often make you stronger. Earlier, the opposite is true. Stressors, losses and adversities that we face as children shape our biology in ways that shape our adult health."

That is what we are finding. With this research into brain development, we know that in the early years of life it really does provide a foundation for growth and development across the lifespan. Okay, on the next slide I did include the definition here. I will be honest with you that when I first started hearing the term "infant mental health" or even "early childhood mental health", I did not know what to think or even what it meant.

So I looked up the definition and I always include this in the presentations because I want to make sure you have this. What we know now is that Infants Childhood Mental Health or ICMH is the – Mike early years and their ability to exploit the environment that they learn.

What we learn is that young children show characteristics at a very early age of things like anxiety disorders or the heightened stress response system. Depression or even posttraumatic stress disorder. With that said, young children respond to and process emotional experiences and traumatic events in ways that could be a little different than even adults or older children.

It is kind of important for us to remember that words, especially for our younger learners, they may not always come easily because there is still that language development there. It is not so easy for them to form sentences, explanations, or descriptions of feelings.

Really things like play therapy, drawing, or even bibliotherapy which I personally think is really helpful. You know, reading or looking at picture books. Even while the child is off doing something else in my office, I will still be reading to them and asking questions.

They are retaining up. You know? They are listening and retaining. So I do think that bibliotherapy at

 

least with the younger kids is a really great tool. But in any case, these are all ways to really learn from younger or preschool aged children and understand their experiences and thought processes without having them to use so many words.

When words do not come easily, we want to teach them the words. When we say things like "can you use your words?" That is good and all but we want to give them options or a list. You know, "are you feeling frustrated? Upset? Confused? Are you hurt? If so, where? Are you embarrassed?"

That way they can choose from a list that helps us better understand them and helps them not resort to behaviors in order to explain or show how they are feeling. Because, when we talk about preschool expulsion numbers and in the side I have here, a lot of the times these are children who are acting out their feelings which would come across to us as a misbehavior.

So which child is more likely to be suspended? The child that can voice how they feel and say "I am really disappointed" or "I am really hurt because such and such happened." For the child who doesn't have the words they going to hurt another child or physically act out their feelings?

So emotional vocabulary and this teaching the skills is really important. We know expulsion rates are high for preschoolers. They are about 10 times more likely to drop out of high school, experience academic failure or grade attention and face incarceration as adults. More so than those who are not expelled or suspended at a young age. What the data tells us is that when a child experiences expulsion early in their education it predicts it in later grades.

I did want to provide you with a few case examples so I have some pictures here on the next slide of what early childhood mental health can possibly look like in our youngest learners. Here I have a few pictures of the sand tray and this is something I have available in my office. When working with a child who has experienced trauma and adversities, they may not have a lot of control or power in their lives so giving them freedom of choice and control while in a safe environment is super important to the therapeutic process. This is something the child has chosen to do and with children who have not experienced significant trauma, when they take the sand tray they might create more playful, typical everyday scenarios. I've seen kids create a beach or hide toys in the sand or play with boats or pretending the sand is water. I have seen some kids create car races or families going to the zoo or even sometimes they pair up the animals so they all have a friend. Lots of different nonviolent and non-fearful imaginary situations. But with those children who have experience more stressful or traumatic early years I have seen this where they tend to create a scenario where the family or individual are backed into a corner and there are more threatening characters like dangerous animals or soldiers and they are on the attack. These pictures on the side are of two different children and what they each independently created but they are very similar. Again this is something I see kind of often with those children who are really experiencing or working through some early childhood adversities.

 

When we talk about anxiety, the causes are when a child feels unsafe or there is low social connectedness or feeling alone or feelings of high environmental threat, like the world around them is not safe. I would say for this situation there may be a higher likelihood of maybe a child developing and anxiety disorder because we see through Theraplay that they perceive the world around them as threatening or scary or not safe. But we do see also a positive protective factor in these pictures as there is a family unit that are close together. That is a good thing, a positive. An example anyways.

On the next slide, working with a younger child who may not have the verbal skills to express themselves I often have them draw pictures of their family or their home. Here is an example of a drawing of a home and what is interesting about this is it is actually really quite detailed. We see here a picture of grandma clearly upset with an older grandson who is in the bed and when I asked the child what grandma was holding she said that this was something to throw at the grandson and so we see quite a number of alcohol bottles and pill bottles as described by the child so this is what the child sees and experiences and this is what they consider their home. With a young child to isn't experiencing significant trauma or adversities you can imagine when you say draw your home, it might be more like the outside of a house or there is a sun in the sky or flowers or grass or Windows any door but here in this picture we see something that is a bit more concerning for a young child. For me, red flags are going off all over the place, there are many risk factors here. This to me really shows signs of early childhood mental health concerns in that young children who experience things like saying or experiencing abuse or neglect or domestic violence or parental incarceration as in this case, or substance abuse, the family member as in this case as well, these are kids that are especially vulnerable to developing things like anxiety disorders or depression or post traumatic stress disorders and such. There is a saying that it is most potential mental health problems will not become mental health problems if we respond to them early. I think that is the ultimate goal to be able to identify and recognize the precursors so we can provide support and early intervention from a young age so we can prevent more significant concerns from developing later down the road.

Then one final example on the next slide here, this is an activity with a slightly older child, I think this girl was about six or seven years old. But this is where we talk about what is within our control. Our circle of control, and what is outside that circle. This is helpful for a child who has experienced trauma or adversities and maybe has very little control over outside occurrences or actions of others. Sometimes this is in a good activity, for some children who really aren't quite there. As far as recognizing what they can control. They might not have the ability to control much in their lives. You would want to be careful with this. Make sure the child is receptive and for this child in particular, this really is something that she takes to. She enjoys talking about this. It helps to refocus because her mind is just all over the place. And so there is so much going on for her that we need to focus on a couple of things. It is something she does enjoy it seems to want to talk about. In any case we have a circle and inside the circle is a list of things that are within the child's control and on the outside we list

 

things that are not necessarily within her control. Those are the things that we can let go of. We can't control those things so we let go and we try not to think too much about that stuff or let it bother us too much. Together we brainstorm some things that we can't control like we can't control how others act. Or how the fighting, there is fighting that goes on among adults, we can't control what adults say. I think she wrote down what adults do to kids and what grown-ups do like lock them in the car. So we can talk through that and process through that. I let her write down things wherever she feels they belong. So she wrote on the line parents getting arrested and dog fights. She wrote them on the line so I talked to her about how that can be fully outside the circle, it doesn't need to be on circle because it's stuff that she really can't control. She may be feel she bear some of the responsibility so it's something we process through. On the inside of the circle we talk about the positives. The things within our control and these are the things we want to focus on. Instead of those outside factors that we can't do much about. On the inside here we listed "what I say" showing kindness for others, looking out for brothers and sisters, she loves to read to them. She wrote down going to the park and then she thought of gymnastics and volleyball and fishing. They are all within her control and we talked about keeping ourselves safe to the best of our ability, making safe choices. Knowing who to talk to and who is a safe adult and where to go to keep ourselves safe. The goal of the activity is to relieve some of the stressors, focus on the positive detective factors and reframe our thoughts, reduce some of the self blame and increase feelings of power and control over our lives which can be really helpful for some students but can also be a little overwhelming for others.

You want to be careful with this and make sure the child is receptive and an active participant as well.

To finish up, circling back to the question of this portion of the session today, how do our early experiences impact school success? Ideally we want to see every child get a strong start and if we keep -- think of this as a race, we wouldn't want to see a child not being able to start at the same time as their peers but it is in essence what happens to some of our children, they don't get a strong start so it may be more difficult for them to have a strong finish. Not impossible and just more difficult so for those children that have less than a strong start in means they will need a lot more support from the adults in their lives and they will need to experience more protective factors to outweigh the risk factors and help them along the way. That is where we come in. Again, we know this stuff but what do we do? There is power and strength in connection. Kids will learn and grow only if they feel connected and love.

There is so much research out there that is telling us the single most protective factor in the context of potential traumatic stress is the strong child/caregiver relationship. We can be that buffer. When we looked up the word buffer in the dictionary it says it is to lessen or moderate the impact. We can serve as a buffer to lessen or moderate the impact of trauma. I always say that every teacher is a teacher for well-being. We all have the capacity to promote mental health, it doesn't fall on any one person. I also always say one in five children have mental health concerns but five of five have mental health. We

 

can play a role in the healthy child development and can serve as a

Role model, mentor and source of support for a child that needs up. Seeing our children through the trauma informed lens, when we have that understanding we have the deeper insight into what is causing the behaviors. Through this lens we can view these less than desirable behaviors, through the lens. The behavioral manifestations are a protective mechanism that the child has developed over time. The child has adapted their behavior as a means for survival.

On the last slide as I finished, I have to quote one of my favorite authors, Pam (Unknown name) the author of parenting through connection, through love instead of fear. She says for a child to overcome adversity and drive the need at least one person in their life who thinks that the sun rises and sets on them. Someone who delights in their existence and loves them unconditionally. To finish, when I talk about how early experiences impact school success, it is true that our early experiences impact school success but how? That is hard to know. Again, when a child is held back from the starting line in a race, it doesn't mean they won't finish the race and it doesn't mean they won't win the race, but it may mean that they may have some catching up to do. Our support can make all the difference. This is what we know and this is what we can do, we can be there for our kids, support them, connect with them and bring to the table strong, supportive and caring relationships. So I will leave you with that today and thank you for your attendance and I will now transfer it over to our next presenter Doctor Micah Orliss who will speak to us on the topic of the incredible years program addressing social and emotional needs of early elementary students.

MICAH ORLISS:
Thank you, that was great to hear that put so eloquently about early childhood mental health. I am a psychologist at Children's Hospital of Los Angeles. I'm a clinical assistant professor of pediatrics at (Indiscernible) school of medicine and USC. I will speak to you about the incredible years program. I an agency mentor in the child program, small group program and do trainings for that. I will talk about that as an example of how evidence-based practice can be used to address some of the mental health crisis going on.

If we look at the next slide here, what we are talking about again is an overall mental health crisis as Judy showed us the beginning, as the Surgeon General has identified, exacerbated significantly by the pandemic. The impacts of this were profound on kids. In addition to that existential angst and tension that was all around that everybody felt including children, kids had to watch their parents go through a lot of stress. There were things like financial stress, loss of jobs and income. Family illnesses or deaths, significant and dramatic changes in routine. Things like all of a sudden not going to school, doing school from home or on Zoom. Not being able to see her friends and learning from that social milieu that kids live in. Trauma in the home. It is believed and we are still starting to see this that rates of abuse increased during the pandemic because of the family stress and parental stress going on.

 

And a lot of those age-appropriate things that kids might otherwise be learning in early childhood like separating and going to school every day, coming home at the end of the day wasn't happening, kids were staying in their little bubble which was saved but didn't give them the opportunities to separate. They didn't get the opportunities to socialize on the playground and things like that were absent. This affected all children differently, certainly depending on how long they were doing remote schooling, and I think different kids had different resources available. Some could pod up with other kids and others didn't have that. What I think happened was that kid was fewer resources were impacted disproportionately and if we look at the next light, we are as we emerge from this, we are still seeing this mental health crisis.

Those of you who work with kids can see what it was like before and what it is like now. It is interesting as a parent to hear what their days are like after school compared to how they were before. I am here in California and California is perpetually at risk for earthquakes.

We always have to be on guard for them, we never know when they are coming but we do know they will come. We have trails and earthquakes kids at home and at work. I think a similar approach is beneficial to thinking about the pandemic. Although we can see things now, we do not know how much is yet to come and what the longer-term impacts of this are.

That does not mean you need to passively sit and wait for a problem to emerge. We can be really active in terms of what we do to prepare, prevent and mitigate the risk of things getting worse. That is really what I am thematically going to be talking about today.

What we are seeing already is things like behavioral challenges in school. We are seeing children who, you miss six months of school and playing with friends, there will be social skills that you need to catch up on. We are seeing more emotional dysregulation.

Kids who get more easily upset and lack the coping skills to manage that. We are starting to see the longer-term impacts of that sort of trauma and exposure. The ripple effects of an initial trauma are starting to be seen in terms of how kids respond to being away from their families. To being at school.

What we are also seeing is that schools have fewer staffing. They have less staff than they did before. That also limits the amount of supervision and support that can be provided no matter what the intentions may be. It is sometimes difficult to get the people in place to do a job that we need to deal and to provide the extra support these kids need.

I think we can all agree that we need to do something. What we do is my next slide. So what we are looking for are effective and efficient solutions. This is not something where we will be thinking about it on a case-by-case basis but really, what are the resources and the tools that we have that can be

 

deployed to reach and impact the maximum number of kids.

Evidence-based practices, which most of you will know, mental health practices, school interventions that have met rigorous requirements to demonstrate their effectiveness. This typically means that there has been at least two studies that show that they are effective relative to either a control group or another evidence-based practice. And independent of at least one independent replication as well.

There are lots and lots of tools that are out there that have met this criteria. They depend on sort of the age of the kids you are working with, the nature of the problem, the setting you will use it with, specific diagnoses or symptoms that you are trying to do. It is an incredible program that I will be speaking out about in a moment.

This is an evidence-based practice where you can use it with a number of kids. You know, sort of maximally increasing the details of that. This is a program that can be developed in a variety of settings.

I worked in a certain mental health clinic setting where we use it but it is also something that can be used in a school setting or a head start setting or a regional center setting. These are available in a variety of places.

What I love about doing things in the school setting is that you have already decreased to barriers to access. 100% of kids have mental health needs as Tova talked about. Of those who need the mental health treatment, maybe only 25 actually get it.

Part of that is because of stigma, part of that is the challenge of getting your child to a clinic. If you can do these things in the school setting, you reduce logistical challenges and the stigma around going to a specialized mental health agency.

So schools are an excellent opportunity to reach that number of kids and get more of that 75% who would not otherwise get those services. The other thing that is great about evidence-based practices is that it can be prevention focused.

You can treat kids who are at risk but not necessarily effectively showing significant symptoms at this time, it is just suspected that those will reemerge later. So the idea again is that as great as it is to have innovations and we want to do that, we have existing programs that are ready to go and ready to be deployed right now.

We do not need to reinvent the wheel, so to speak. We can start now and really prevent problems from occurring down the road. In the next slide, I will talk more about the incredible years program. This is

 

an example of programs that would be ideally situated -- suited for the situation we find ourselves in now. Evidence-based practices, this is one of the earliest.

There is a lot of rigorous research behind it that shows that it is effective. Again, although it was developed through the University of Washington, it has shown its effectiveness in all regions of the US and internationally as well.

It has a big international footprint and is used across Europe, and is emerging into Asian – some of the Asian countries. Southeast Asia and China as well as Australia and New Zealand. So lots of effectiveness with different cultures, languages, settings and the program itself is adaptable to those. It is proven to be effective in those settings.

Why this works in a school setting is the child group that I am going to be talking about. It is called small group Dina Ward dinosaur school as we refer to it with the kids. It is effectively imitating a school setting. Using it in school, it is a natural fit.

It is the classroom dina that is not just brought into a classroom for students who are at risk or needing treatment. There are other components that can be added in length than teaching management program and a school aged parenting program or preschool-aged parenting program that can be brought into the school as well.

On the next slide, we will see the goals of Incredible Years are to decrease early onset conduct problems. As well as increase social, emotional, and academic competencies. For those of you working in a school, I am sure this resonates right now with what you are seeing in kids you work with and what they need. We are seeing more behavior problems, social and emotional challenges.

Academic delays because of the lack of school access that kids had during the pandemic. Especially for those who may have needed, you know, more specialized academic curriculums. Long-term ideas and we note these issues early on 10 to play out in a fairly predictable way.

In adolescence, they lead to delinquency and substance abuse. We are looking to change that trajectory through programs like the Incredible Years. Incredible Year as well play a role in these key principles with theoretical underpinnings. First of all, we look at behavioral.

Behavior that gets attention tends to be repeated. So behaviors, even negative attention tend to be repeated. Behaviors that are ignored tend to decrease over time. We are utilizing that as a tool as well as things like praise, positive attention, token economy for behaviors we want. We are really attending to the behaviors we want.

The other theoretical underpinning is social learning. Kids learn from the people around them. Other kids, parents, teachers, peers – things like that. We are using that to teach kids what to do not just by telling them that by showing them what to do. We have videos and weekly practices.

This is learned by seeing and doing as opposed to being spoken to or being told what to do. We also have puppets, I will introduce my colleague here. This is Wally, Wally is making his debut. I do not have a full bio for him but "hi everybody! I am Wally, I am seven years old!"

She is one of the kids in the dinosaur group and participates with the other kids to model and lead particular examples so that kids can learn from him. We have a tiny turtle as well that helps to teach about anger management, things like that.

So we have these tools that really make the program engaging. Because the kids, as we see, the kids that we are working with are the youngest ones. We are working with 4-8 years old. After that age, the puppets are less effective.

But I will show this pyramid of what we are trying to teach with this. This is the parenting pyramid and the teaching pyramid. We are trying to spend some time with the pyramid and avoiding consequences as much as possible. Really bringing out behavior change through a lot of positive things. Praising, rewarding, and encouraging.

Playing with kids, practicing problem-solving, talking and listening to your feelings. All of the things at the base of this pyramid are where we are spending probably 95% of our time during these groups.

Really utilizing not to decrease the need for consequences. There is still needed and incorporated by the program but that is the principle behind us. We are trying to help every class or every family or every... every child to get that attention at the bottom of the pyramid through positive attention.

If you go to the next slide, you will see again that this is a program for kids who are 4-8 years old. We are looking for the small group Dino which is a treatment program. We are looking for kids with clinically significant behavior problems.

7 kids may not seem like a lot but when you have that many kids bouncing off the walls, it is a busy room. So we keep it small. This is 18 weeks or longer. We encourage it to be done over two hours per week which can be 12 hours setting or two one-hour settings.

In the classroom is actually a prevention model that can be applied to an entire classroom. It is used in much smaller chunks throughout the course of an entire academic year. Maybe 15 or 20 increments. -- Minute increments.

 

Incredible Years as I mentioned, it has a lot of research behind it. You can go to their website to see this. This is not published research. Incredible Years has been encouraged as one of the evidence-based practices here through the Department of mental health in Los Angeles County for probably about 10 years now.

They have been used in a variety of clinics, not just from Children's Hospital. These are all of the clinics that have been using it throughout the county. We are seeing clinically and clinically significant changes.

These are the two outcome measures that the county has used. We see kids beginning the group with almost cut off intensity score by the end of the group, the average has decreased pretty meaningfully. In the next slide we can see again.kids begin the group above the cutoff score for problem behaviors.

And then they are below the line significantly. We are seeing these changes over time and...

SPEAKER:
(Indiscernible)

MICAH ORLISS:
We see the youth outcome questionnaire scores with getting kids who are beginning above the cutoff and ending below the cutoff. I brought these scores here because these are real world scores. These are not done in a highly controlled research setting.

This is really just kind of fieldwork and filled results. The kind of results that are really achievable. That is the website if you'd like to check it out yourself. If you go to the
you can see that this is one of the many programs that are out there. I just think it is one that I know and one I have seen effective and a great way to treat a number of kids. With the kinds of issues that we are seeing a rise because of the pandemic. I know that learning a new program and implementing it effectively in a school setting may seem like a lot with everything else going on and all the staffing shortages but this is a long-term view. This will pay dividends down the road. Once you can get a program like this up and running, your kids will benefit, the schools will benefit, the families will benefit and the communities will benefit. This is the time to implement it so our mental health needs of kids and families are addressed in the long term. Thank you and I'm going to pass the baton now to my colleague Judy Reaven who will talk about fears and schools and her program.

JUDY REAVEN:
I don't know if there are any quick questions before I go.

 

SPEAKER:
So far no questions in the chat so go ahead.

JUDY REAVEN:
That was really interesting to hear you talk about it and it lays the groundwork nicely for some work that we have been doing as well as Tova's work. I will talk about facing your fears and talk about anxiety and we will talk about neuro- diverse learners.

I just needed to disclose that I do receive royalties from the facing your fears program which I will talk about the school-based program and not the clinic but we will share some information about our work.

I have heard both talk about anxiety and other kinds of mental health issues. This program and how I think about it as we specifically do target anxiety symptoms, we know that anxiety is super common and autistic students and kids with other neuro- differences. If you or someone you know experiences anxiety you know the impact it has on your life. If you are an adult it might affect you at work, in your community and if you are a student or child it will affect you at school.

That is why we want to try to address it. The other reason we want to study this and do something about anxiety and narrow diverse learners is because it is treatable. The research in the neuro- typical population indicates very significant improvements using cognitive behavior therapy approaches which I will review briefly. We know when we modify CBT for our learners, they respond very well and there are a handful of school-based studies, not many but a handful of school-based programs that have tried to tackle delivering CBT to know diverse learners in school settings and again with really nice results.

So what is the impact of anxiety? Separate from whether there is a diagnosis or not, this is how anxiety can affect students. Many have trouble using the bathroom for all kinds of reasons. Sometimes it is because they are loud, or Germany or toilets are flushing, there are other kids in there. Many of the kids are afraid of being late at the beginning of the school day to a particular class if they are a middle school are and they are trying to pass between classes. Talking in class and asking for help, that, I see that across all ages. You can think how talents that would be if you don't know how to ask for help. Many of our kids are then quiet and don't do well in school but fear doing poorly in school but don't know how to ask for help.

Some of our kids have trouble going to school, separating from their parents. And making mistakes, the fear of making mistakes and the fear that your teacher will get mad at you or yell at you. I have seen this so many times in the kids I work with.

We have also seen a whole bunch of fear some that are overlapping with what I said but some that are

 

related to virtual delivery. I don't know that there are still some hybrid models out there and kids who have exclusively online learning. And some of those difficulties are trouble logging on, trouble staying connected. Keeping your video on and being in front of a camera. It has been quite challenging for some of the folks I work with and again some of the ones that I mentioned earlier, asking for help, making mistakes, you can have the same mistakes whether it is virtual or in person.

Mica talked about the lost opportunities with COVID-19 so I won't belabor the point other than to say that in terms of disproportionately affected populations, definitely it has disproportionately affected the folks I work with which are neural diverse learners. Folks in our community have had trouble accessing care, having trouble with misdiagnosis so there may be two years that folks have been waiting to get an accurate assessment to be able to understand the strengths and challenges. Who knows the impact of social isolation on all of us really but on our community, folks with autism and other NDD it can be pretty profound.

Then the burden on her parents trying to juggle jobs in school and their own challenges and stress and it has been pretty significant.

That is a focus on students and families but I am assuming some of you are also school folks. We hope there are school folks on the call and it has affected our teachers and educators and everyone in the school setting. This is a headline from a Colorado newspaper about the staffing shortages that were alluded to earlier. Then the crisis in our own state, I am in Colorado and our Children's Hospital is also declared a state of emergency in the numbers of kids that are presenting with mental health. And to highlight this even more, access to care, it is even more difficult for students of color and students from low income communities.

So good news, we know I think a little bit about what to do about it at least the anxious symptoms that many of our people present with. The treatment of choice is CBT and if we were live and in person I would ask you to raise your hand if you know what it is. It is hard for me to know who knows what it is and who doesn't. I will briefly tell you what the core components are.

They are really listed here on the left inside so psychoeducation means explaining the anxious symptoms going on in any one of us when we feel anxious about something. We pay attention to how to calm our bodies down, we pay attention to what thoughts we might be telling ourselves, we pay attention to making an informed choice about pros and cons in terms of what are the best choices to make. We are responding to our anxiety. Most importantly through exposure we face fears. That means do the thing you are afraid of a little bit at a time. You can see on the right-hand side, there is the diagram that has the connection between thoughts feelings and behavior and that is at the core of CBT. Here is another way to look at it. We have what is going on in our bodies, a sense of dread and all kinds of physical feelings and what we might say about that experience. "This is never going to go

 

away, I can't do it, it is too scary...". Our job in an intervention is try to do something about it so they don't get stuck here.

I will present on some of the recent the completed research that we have done in our own program. I've been studying now for near 20 years and I will talk about the school-based program.

Mica did a beautiful job talking about why we want to deliver interventions in school in terms of access and in a group delivered way which this is, it can be delivered in a small group as well. The purpose of the project, my research project was to adapt our clinic-based program through a lot of stakeholder input to say how can we make it work in schools. Then we did it, implemented it in public school settings in three districts in Colorado. We trained interdisciplinary school providers, this is a key here, we trained mental health and non-mental health folks to do the intervention and then we used a train the trainer approach during our randomized trial to compare facing your fears to traditional care.

What are we looking at in terms of the core components of this intervention? While we start with the psycho Ed which I referenced which means we want to help kids identify a variety of words to describe their anxious symptoms. We help them identify what situations make them feel anxious and what is going on in their body. We do a comparison about how much time we spend worrying and how much is left for fun and I will show you a graphic on that. And we spent a lot of time thinking about emotion regulation.

Many kids and kids with anxiety experience emotion regulation. Our help is to calm your body, calm your mind and get them into the zone you want to be in. The other big component of this is facing your fears. Doing the thing you are afraid of a little at a time.

This is what the program looks like. Like session by session, to give you an overview so it is 12 sessions, 40 minutes each time and I just went through all the core components and I think you can see it through the lesson titles. In the first couple of sessions we are focusing on what happens to your body and we are focusing on what situations are anxiety provoking. Then we spent some time measuring anxiety and doing some deep breathing and other strategies to calm your body. Then we pay attention to our mind, then we face fears in schools.

This is just a couple of graphics that I think really illustrate how we convey a somewhat complex concept to a group of narrow diverse learners. This is the first example, we say Tyrone words and gets upset (Reads) but these are medium worries. He still has some time for fun but it is really a shame that he spent all this time worrying. Then we ask the kids how much time do you think he might spend worrying. We contrast that to Sophia who only worries about a couple of things and her worries are not that intense and she has plenty of time for fun. Then we again ask the kids how much the things she spent worrying. Then we asked them to fill it in for themselves. We don't care about the precision of

 

their responses as much as the spirit of what we are trying to convey. This is worrying is wasting time. It just is, it doesn't get us anywhere and it doesn't have much problem solve anything. It really gets in the way of us doing the things we want to do. Not just having fun but participating in school or the things we need to do as students.

That is all the psychoeducation and then the final piece is as I have said several times you have to face your fears. This is a quick example of a list of something students might actually have to do if they were afraid of toilets flushing and we absolutely have students who are afraid of toilets flushing. If we were going to do small steps they might begin by standing outside the bathroom and then having a toilet flush. They might gradually move closer to the stall and have the toilet flush and then eventually flush the toilet themselves or be able to go to the bathroom with their class and have all the toilets flush and wash their hands and have all the noise but be able to do it.

There may be many more steps that it takes but we try to help them help the sense of being brave and they can do things they think that they can do. Because this was a research project I will share little data.

That is that over the course of this study which was a three year research program, we trained 101 interdisciplinary school providers and what we said was we preferred that you had to have at least one mental health person consulting with the group or on the team because we are talking about mental health symptoms. However we wanted and encouraged speech language pathologist, nursing, OT, special ed teachers to be able to do the intervention. All the folks at the front lines of working with diverse students so we wanted to equip them to know what to do.

They attended 12 hour training and that was pretty interactive and they worked with us twice per month for 20 or 30 minute phone calls in between the delivering of the sessions. To answer questions they might have.

As Mica said when you're learning a new program, you are learning something new and it is hard to do that sometimes. We wanted to support them on the front end of that. The kids who participated, inclusion criteria over the couple of years we had 81 students in our randomized trial and between that and our pilot we had over 100. We said you had to have a known educational identification or medical diagnosis or suspected autism because we were interested in narrow diverse learners. Especially learners on the autism spectrum but not exclusively.

They had to have anxiety they got in the way. To give you a feel for the diversity of our school providers, you can see the bulk of them were identified as special educators or psychologists. But we had almost 4 that were SLPs. We had mental health folks and a small percentage of therapists.

The other part that is interesting and why I keep saying neurodivergence learners and not just autism is because when we looked at their IEP's, we wanted to see what their primary eligibility status was. You can see that this was a study that was being provided – Mark Pro voted -- promoted as being for students with autism.

Language disorders, emotional disabilities and so on and so forth. The truth is that we feel like this kind of program is not unique to kids on the spectrum. The whole idea is to make these concepts accessible to all kinds of burgers. -- learners.

Here are some of the outcomes to quickly share with you. Most of the schools that we had in our randomized trial were able to deliver the problem as intended. Did they do all of the parts of it that we wanted them to do? The answer is yes. The second question we wanted to ask ourselves is did their anxiety scores improve?

In other words, did they have reductions in anxiety symptoms? We looked at both parent report and student report, at least for this initial analysis. We saw that in many ways, parents reported significant reductions in anxiety. Which is important to indicate because parents are not in school.

They are noticing something at home, not just hearing a teacher report. They are noticing things themselves. Certainly, it was not across the board. There were things that we did not see significant improvement on. But again, according to student report, we saw my significant reports. We were encouraged.

Another metric was to look at a specific diagnostic category. I will say many of our students met an intense fear of something which could be something like toilet flushing. You can see if you look at the blue line, this was at baseline. We actually had some differences even at baseline where our active treatment group had somewhat higher ratings. But you can really see the differences in terms of pre- and post intervention or active treatment.

That is a significant difference whereas the control group really has no change. Again, there is a lot of work to be done in terms of how meaningful this is and how robust some of our findings are. But we were actually quite encouraged to see that we can deliver this inner mental health intervention and school settings. Here's the real world success. We wanted students to feel like they can use a bathroom at school, common weights to a class and ask for help, make mistakes, keep their video on, do all of these things that were challenging where anxiety can interfere.

That is what real successes. I hope we will remember from this is that mental health symptoms are super common. Especially anxiety in neurodivergence letters. Non-mental health providers can deliver a CBT and intervention and we believe students can benefit from it.

To really just highlight and punctuate this point is that school partnerships may hold the key to access. So many problems in access for healthcare in the community, school partnerships are the key. We appreciate you all being here and listening to this. I think – oh, this is my team and this was funded by HIRSA so I wanted to give a shout out to them.

With that, I will end my presentation and turn this over to Joanne. I do not know if there were any brief questions?

JOANNE MALLOY:
There was, somebody said is the similarly focus to trauma CBT? What are the differences?

JUDY REAVEN:
There are some subtle differences between CBT for trauma and CPD -- CBT for anxiety. I will say there are more similarities than differences. They do tend to be trauma focused lenses when we do CBT. The other thing I will say is that in terms of eligibility, if the students came to us with clear trauma histories that were not even history but like a recent -- traumatic event, our program may not be the best first pass.

We recommend a different approach or at least a trauma focused approach which is something we said we don't do even though I think you can hear the similarities across CBT. Happy to take other questions and I can also monitor the child a little bit. But I will turn it over to JoAnn to make sure we have time before we hand. Go for it!

JOANNE MALLOY:
Thank you, Judy. Great presentations and it is a real pleasure and honor to be a part of this. I am JoAnne Malloy from the New Hampshire Institute on disability. I have been working with adolescents in planning the transition from school to career space for 24 years.

I have really honed in on working with youth with emotional and behavioral concerns. Judy, are you? Thank you. So before the pandemic and for many of you if you work in schools and work in high schools, youth with mental health disorders have been traditionally doing worse than any other disability group for 20 years.

The data is there. They are suspended from school at 2 1/2 times the rate of students without disabilities. They drop out of school at rates that are four times that of a typical student. That data really has not changed much in the last 20 years, unfortunately.

We do not even know during the pandemic what is happening too many of these high schoolers.

 

Because we have seen the data that 25% of them have not come back to in person learning after having been learning remotely.

So, there were high rates of school dropout and difficult social behavior. Of course, trauma. Now we are having more and more understanding that trauma leads to behavioral issues as Tova talked about. In adolescents and lifelong.

We also know that because these youth are not in school or not doing well in school, perhaps not finishing, many of the doors are closed to them. There are low rates of income and employment. Mobilization of mental health services and low rates of community and social supports.

I have worked with these youth for a long time. Because of their behaviors, they are cut off from the social networks that so many adolescents rely on to be successful. Judy, you can go on. Thank you so much.

The problem is that because they may be connected to school, the school does not impact with their mental health providers. They don't want to go to mental health clinics or be connected. We know that at least 70% of youth in our criminal justice systems have a mental health disorder or concern. Many of them are not having their needs met in those settings.

So they are not really identified as having perhaps a mental health issue but they are more seen as having a behavior issue. This leads to being incarcerated in the justice system. Not enough identified by schools is having an emotional disability or disturbance in special education language.

A gross under identification of those youth. So they do not get special education services. Suicide is the third leading cause of death among youth across our country. So we know that many youth are really struggling no matter what.

But if they have a mental health concern or other kinds of social determinants, the disadvantages and they are not doing well. Many are dying by suicide. They are reporting having depression and feeling sad. What are we going to do about this? Go ahead.

Mary Wegner and Marianne Davis, who are pillars in the field of transitions with mental health disorders, they talked about relationships as very, very important. As Tova talked about, many of these transition aged youth have cut off from their social systems. Rebuilding their relationships is important.

We know that man touring has a really strong impact on adolescents who have experienced trauma. The rigor, we should not lower our standards. We should have high expectations of the students. Even though many of them have learning issues.

Use need relevant instruction and relevant activities. Relevance to what they want to do and inspired to do is really important. What is the adolescent interested in? They are not just determined by their disorder. They are going through all kinds of changes that typical adolescents are going through. On top of it all, they are at a big disadvantage because of their histories.

Involving them and their families in transitions. So about 25 years ago, we developed an approach in New Hampshire that was based on person centered clinics. I will show you this now, RENEW stands for resilience, education, (Indiscernible).

All of our staff here are very engaged in graphics facilitation as a tool for any age group. We are very, very interested in promoting self-determination and raising individuals voices.

So the context for this renewal logic model, if you will, we are looking at youth who are engaged in home school or community. They may be involved in multiple systems. They are experiencing failure in school and in the community. They may not necessarily have a diagnosis because many of our youth would not qualify for special education services.

Or they are not going to diagnostic systems. We are just looking for youth who are not doing well, particularly in school. What are facilitators provide is what we call personal features planning. Some of you may know (Unknown Name) from Connecticut.

They really coined that phrase and it includes choice making and problem solving. They elevate the youth's voice. There are also individualized teams around each use. This is to increase their social supports and social connections as well as social capital.

Then we talk about personally relevant schools and career activities. How use monitor their progress along the way using data and their own descriptions of how they are doing. What we are looking for a short-term is greater self-determination.

In other words, the youth is beginning to stand up for themselves and really show more self-advocacy if you will. We look for better engagement and more effective and natural and paid supports for the youth. Longer-term, we are looking for consumption, better education outcomes and employment outcomes. Go ahead, Judy.

We can skip this, this is just the development of our RENEW model over time. This is important no, a lot of people when we go to training they say "we do self-determination and empowerment." But we do -- what we do with this model is trained very carefully about elevating the students way.

We are talking about putting the student in the driver's seat. Even if others around them think they can't do it because of their behaviors or the way they have been before, we really look at canceling (unknown term) the youth so they can have little successes and take on more as they go.

We are focused on strengths, not focused on dysfunction or their diagnosis. We are not trying to fix them. We are really elevating their strengths and focusing on building resilient skills, social connections, self-advocacy, problem-solving, having specific positive goals. We talk about unconditional care and we are focused on equity and inclusion. Community-based inclusion. Because as we saw earlier with the data, many use with emotional behavioral disorders are not included in typical classrooms or even typical schools.

The renew implementation or intervention process has four phases. There is engagement and futures planning usually with just the facilitator and the use. There might be one other person there. And I will show you an example in a few minutes. Phase 2 is about bringing the team on board and the initial plan is developed. Phase 3 is about implementation and monitoring with data and the final phase is when they use after about nine months to a year is ready to be transitioned to less intensive supports.

So this is the graphic facilitation process that we use and again I have cited (Unknown name) and Marsha Forrest real (Indiscernible) of inclusion and person centered planning. Some of you may be familiar with them. We go through these maps in order, we talked with the use and say tell us your story, your history. Tell us who you are today, tell us about your strengths and accomplishments. Who are the people in your life? What works and what doesn't work for you? And then between five and six we moved to jump ahead and say tell us about your dreams, if everything was perfect what would it look like? Talk about your fears and your concerns. Tell us about what your deep underlying needs are and let's go to your goals and next steps. These are facilitated by a trained individual who graphically displays this on chart paper.

OK so this is a young woman T who was on probation when we first met her. Very articulate and animated young woman. She came on board with Renu because she wasn't happy where she was at. Next slide please. This is her people map, and the way we facilitate this is "tell me you are the real close people to you, who would you go to if you were in trouble on Saturday night, who would you call? Here she mentioned her mom and some friends and we talked about who else is in your circle that you find is a positive impact but maybe not your closest friends and she identified her dad and then, who are your professional contacts, your groups, the people you really do use at various times and she identified those folks and then outside the circle who is not helpful. This map really helps me as a facilitator to understand T's social network. In all the different things she's involved in. When we form a team we know who would might be asking to help.

This is her dreams. This isn't a teacher telling her you need to graduate from high school, this is her

 

actually saying I want to graduate from high school. And 99% of the use we work with say that. But it is not people telling them they need to it is them saying I would really like to but I can't even imagine how I am going to. You see on the upper right-hand caller, graduating high school is one of the goals, she would like to be a job as an author or a teacher or vocational specialist things that she might be into there. She wants to be close with her family and her mental health counselor was a member of her team so that alerts the counselor to things she can work on with her. She wanted to be married to the right guy, wants a big house, a big boat and a Porsche. What we say is facilitators I'd like a big red Porsche as well but let's hone in on what is more immediate. So we go to the next slide and we see the goals that she identified for that year. So we begin to drill it down to be more concrete. This all came from her, she wanted to look into nursing. She wanted to get her driver's license. She wanted to get off probation and in the upper left-hand corner there, she wanted to have a job so she could have money. She wanted to get good grades and stay out of trouble. So with the next step that comes next, is her plan. Then the members of the support network were brought in to help with brainstorming on how she could accomplish different parts of her plan. What happened with this particular young woman which is the next slide, she got off probation within 30 days and the reason why is because the probation officer saw she had a network of helpers and saw that she was animated and dedicated to doing better and they really saw a way, a pathway for how she could be OK without being on probation. Otherwise the probation officer might be saying you've got to finish school, you gotta go to all your classes, you have to pass all your classes which is unhelpful. For a lot of use they just tune it out. She got off probation, made the honor roll, followed curfew and got the support she needed to be drug and alcohol free and got a job at Dunkin' Donuts. She made a lot of strides based on this.

I will only take a couple more minutes, we can skip some of these other slides but I do believe they will be shared with all of you. We have a very robust implementation model for training people and we have had some studies where we talked about different outcomes and evaluated different outcomes. Usually with comparison groups, or pre-and post and what we found was that there was improved functioning, behavioral health functioning among youth who engaged in Renew. Better high school completion rates, better grades, increase number of classes past and satisfaction by using Renew. In terms of the school experience, we really need to pay attention to those with mental health challenges who are in high school. It is a very Pat -- fast moving train, and if you work in high school you know what I'm talking about. You have to get your credits every year to stay on track to graduate and for many use they get discouraged especially if they are learning issues or behavioral issues and certainly the disruption of being suspended frequently. They just give up. So they really need a concentrated intervention that helps them get all excited about their post high school opportunities and potential. But they need to learn how to plan and problem solve because many of them have not been given control and have not been taught how to plan or how to follow through on their objectives.

I'm going to leave it at that Judy and Micah and Tova and give people a chance to ask questions if they would like. There is data in my slides and eye contact is there and we can skip those.

JUDY REAVEN:
I can stop the share but I wanted to include the last slide because as we said at the top of all of this, we are all part of the children's mental health Champions and there is more information to read about all of our work if people are interested. Thank you Joanne, we don't actually get to hear each other go into depth on some of our projects and things we work on so that was really cool for us.

I think right now we just have a few minutes and we can open it to the group and I don't know. Some of you may have already been monitoring the chat so I don't know if there are specific questions we want to talk through.

JOANNE MALLOY:
I don't see questions in the chat.

JUDY REAVEN:
There was a question about data. We have a (Indiscernible) on the website... Have you go to the iMac the Colorado (Indiscernible) and that would be (Indiscernible) and I would also say there was a recent paper that we published on the pilot work of the facing your fears school-based program which was in the Journal Evidence-Based Practice (Indiscernible). The other thing I am wondering about and maybe for all of us, if we want to put our email addresses, I think you can track us down in other places but I am certainly happy to send you a publication that are probably the easiest way to go and maybe others are as well. So I am just throwing my email into the chat and others can feel free to connect with me.

JOANNE MALLOY:
I'm really excited that the UCEDD is doing (Indiscernible) there are so many (Indiscernible) referring and as Tova said children they have disabilities and then they may have adverse childhood experiences on top of it and experience all kinds of developmental issues as a result and every child is unique. So we should have approaches that take into account the unique needs of the child. Looks like (Unknown name) put their email on the chat and it sounds like that would be helpful to send out right? So I am just copying that down.

SPEAKER:
Thank you very much.

 

JUDY REAVEN:
Looks like someone else would like some information, I think when you are putting your email and the chat it means you like us to send information? We certainly can, but when this goes away, keeping track of it might be tricky. If you can copy hours down at all that is probably the best way to go in case we lose you once all of this goes away.

SPEAKER:
I can save the chat and share with you all.

JUDY REAVEN:
Perfect that will help. Any other quick questions? Comments?

SPEAKER:
I just want to thank you because we need to dedicate efforts to understand what mental health interventions even the ones that work for the typically developing population, which of those ones work for the narrow diverse population. I into that so at the (Indiscernible) center for Child development so thank you.

JUDY REAVEN:
So it sort of looks like folks are signing off I am guessing and we certainly appreciate everybody's time and attention, we know it is a big issue and that you have so many other competing things to do right now that it is tricky to fit all of this into our calendars and so we really appreciate your time and attention and certainly you can reach out to anyone of us if you have additional questions.

JOANNE MALLOY:
Thank you (Indiscernible)

(Multiple speakers)
Thank you everyone. Goodbye.

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