



SC COUNCIL FOR CHILDREN WITH BEHAVIORAL DISORDERS

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Creating a "Healing Environment" for Mr. Small Small

One of the many wonderful things I get to do as a Self-Contained ED Teacher in a public elementary school is to help kids recover from trauma. It seems that every year there is that one special kid in my class that touches my heart more than any of the others. Mr. Small Small has been that kid all year.

I got Mr. Small Small when he was six years old, victim of type 2 or complex trauma resulting from extended exposure to traumatizing situations repeatedly early in life. The doctor said he was suffering from post-traumatic stress disorder and his behavior was characterized by hyper-arousal, hyper-vigilance, problems

with concentration and focus, and exaggerated startle response. His behavior challenged our best efforts in teaching him academics for any length of time. Instead, we focused on what Howard Bath calls "The Three Pillars of Trauma-Informed Care" in *Journal of Safe Management of Disruptive and Assaultive Behavior*, Volume XVII/ Issue I, March, 2009 published by Crisis Prevention Institute, Inc.

In his article, Bath states that "The brain-based stress response systems of these children appear to become permanently changed as they focus attention on the need to ensure safety rather than

on the many growth-promoting interests and activities that secure children find attractive and stimulating.

Bruce Perry (2006) has observed that traumatized children reset their normal level of arousal. Even when no external threats exist, they are in a constant state of alarm. In particular, such children come to view adults as potential sources of threat rather than sources of comfort and support.



Tony Rothfork
SC-CCBD President

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CCBD presents position paper at a US Congressional Hearing

On Tuesday, May 19, 2009 the U.S. House Committee on Education and Labor held a hearing to examine abusive and deadly uses of seclusion and restraint in U.S. schools. Seclusion and restraint are physical interventions used by teachers and other school staff to prevent students from hurting them-

selves or others. The GAO report revealed hundreds of cases of abuse of seclusion and restraints.

The Council for Children with Behavioral Disorders (CCBD) has just released recommendations for legislation in a Position Summary on Physical Restraint & Seclusion Procedures in School Settings

as well as two longer detailed documents. **Dr. Reece Peterson, CCBD member and professor at the University of Nebraska, was a witness at this hearing.** Media coverage was extensive, including CBS and NPR. Watch the hearings which are archived at <http://edlabor.house.gov>

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VISIT OUR UPDATED WEBSITE!

& meet David Hedges, our new webmaster.

Join SC-CCBD next at...

The state **SC-CEC Conference**,
January, 2010 in Myrtle Beach

Details coming to: www.myscceec.org

Don't forget to Register for FREE courses at the summer **Research to Practice Institute** being held July 13-17, 2009 at Lugoff Middle School in Lugoff, SC.

https://ero1.eschoolsolutions.com/user/login.taf?_function=logout&orgId=49603

Check out these websites:

specialedconnection.com

educationdaily.com educationdaily.net

Newly elected members of International CCBD:

Vice President: Diana Rodgers-Adkinson

Secretary: Shelley Neilson-Gatti

Student Member: Melissa Stormont

Representative B: Mitchell Yell

Their term begins July 1, 2009.

PLAN to be there! Friday & Saturday, October 9&10, 2009

Behavioral Health for All Students: Research Based Practices

A Conference to be held October 9 – 10, 2009

Share this News-letter with a colleague, a principal, a special education coordinator.

Encourage them to join CCBD to support children with emotional behavioral challenges.

Dr. Howard Muscott will be the featured presenter at this two-day conference. Dr. Muscott directs the New Hampshire PBIS programs, and recently spoke at the National Children's Mental Health Day event in Washington, DC. **Dr. Muscott is a nationally recognized expert in the application of effective behavior practices including collaboration between schools, families, and agencies for supporting students needing secondary or tertiary supports.**

The conference will be held in Columbia at the Columbia Convention Center, in the Vista area of town. Friday will include a morning general session focusing on effective behavior support, and afternoon sessions including a train-the-trainer session for secondary/tertiary PBIS trainers, and a dozen breakout sessions on behavior support practices. Saturday will continue with keynote sessions and breakout sessions.

This conference will be appropriate for those concerned with effective behavior support practices, including school staff members, families, and agencies. Registration fees are \$35 per day, or \$70 for both days, and will include lunch both Friday and Saturday.

South Carolina CCBD Members

who are on the 2008-09

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Do you REALLY know about the medications your students take?

Ever since the positive behavioral effects of stimulant medications were first discovered accidentally during the 1930's, psychotropic medications have become an increasingly popular intervention for addressing inappropriate behaviors. While it is estimated that only between 2% to 3% of all children and adolescents are prescribed psychotropic medications, prevalence rates increase dramatically (26%) when dealing with special education students.



The highest use of medications therapy however, (52% to 76%)

has historically been among students with ADHD and emotional and behavioral disorders (EBD).

While psychotropic medications do not cure mental illnesses, they often help children control their symptoms, enabling them to function better within society, their families, and school. Some of the more common psychotropic medications prescribed for students with EBD are shown below in Table 1, which was recently published in an article reviewing medication use among students with EBD (Ryan, Reid, Gallagher, & Ellis 2008). The Table provides a listing of the various categories of medications, as well as the potential benefits and potential side effects associated with each.

The efficacious use of these medications requires monitoring students for desired behavioral outcomes, as well as potential side effects. While physicians are ultimately responsible for monitoring medi-

cation effectiveness, they can not do so within the confines of the classroom and must rely upon feedback from educators. Given teachers are in close proximity of students for up to six hours per day, they are in an excellent position to monitor medication effectiveness and provide feedback to the prescribing physician.

Unfortunately, most teachers have minimal knowledge regarding many of these medications. Hopefully, this Table will be a useful resource and provide you with a better understanding of the various types of psychotropic medications your students might be taking. If you would like additional information, I strongly recommend reading the articles referenced below. Also, see Tables on pages 4 and 5 .

Joe Ryan, Ph.D.

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References

- Ryan, J. B., Reid, R. & Ellis, C. (2008). A survey of special educator knowledge regarding psychotropic interventions for students with emotional and behavioral disorders. *Remedial & Special Education*, 29(5), 269-279.
- Ryan, J. B., Reid, R., Gallagher, K. & Ellis, C. (2008). Prevalence rates of psychotropic medications for students placed in residential care. *Behavioral Disorders*, 33(2), 99-107.

Medications Commonly Prescribed for Students who have Emotional-Behavioral Disabilities

Category	Commonly Prescribed Examples Trade Name / (Generic Name)	Desired Therapeutic Outcome
Antidepressants	<p style="text-align: center;"><u>Atypical Antidepressants</u></p> <p>Desyrel (<i>trazodone</i>) Effexor (<i>venlafaxine</i>) Serzone (<i>nefazodone</i>) Wellbutrin (<i>bupropion</i>)</p> <p style="text-align: center;"><u>Tricyclic Antidepressants</u></p> <p>Anafranil (<i>clomipramine</i>) Pamelor & Aventyl (<i>nortriptyline</i>) Tofranil (<i>imipramine</i>)</p>	Used to treat depression, anxiety, panic, obsessions, compulsions, bed-wetting, night terrors, sleep walking, and symptoms of ADHD
Adrenergic Agonists (Antihypertensives)	<p>Catapres (<i>clonidine hydrochloride</i>) Inderal (<i>propranolol hydrochloride</i>) Tenex (<i>guafacine hydrochloride</i>)</p>	Primarily used to treat symptoms of Tourette's, chronic tics, and ADHD. Occasionally prescribed for aggression, post traumatic stress disorder (PTSD), anxiety and bipolar disorders.
Antipsychotics	<p>Clorzaril (<i>clozapine</i>) Haldol (<i>haloperidol</i>) Moban (<i>molindone</i>) Navane (<i>thiothixene</i>) Orap (<i>pimozide</i>) Risperdal (<i>risperidone</i>) Seroquel (<i>quetiapine</i>) Thorazine (<i>chlorpromazine</i>) Zyprexa (<i>olanzapine</i>)</p>	Atypical antipsychotics are frequently used to treat aggression in youth and reduce aggression in complex comorbid disorders. Typical antipsychotics are used as a second line of treatment for aggression in children.
Anxiolytics	<p>Ativan (<i>lorazepam</i>) Buspar (<i>buspirone</i>) Klonopin (<i>clonazepam</i>) Restoril (<i>temazepam</i>) Valium (<i>iazepam</i>) Xanax (<i>alprazolam</i>)</p>	Sometimes referred to as antianxiety medications, and are typically prescribed for short-term treatment of insomnia and anxiety.
		Continued on page 5

Medications Commonly Prescribed for Students who have Emotional-Behavioral Disabilities

continued from p. 4

Category	Commonly Prescribed Examples Trade Name / (<i>Generic Name</i>)	Desired Therapeutic Outcome
Mood Stabilizers	Depakene or Depakote (<i>valproate or valproic acid</i>) Eskalith CR & Lithonate (<i>lithium</i>) Klonopin (<i>clonazepam</i>) Lithobid (<i>lithium carbonate</i>) Tegretol (<i>carbamazepine</i>)	Prescribed to control mania that accompanies Bipolar Disorder and Anxiety Disorders such as Panic. Sometimes used in combination with antidepressants for depression that proves resistant to. Some anticonvulsants have demonstrated effectiveness for aggressive behavior, bipolar disorders, and attention deficits with Tourette syndrome.
Selective Norepinephrine Reuptake Inhibitors (SNRIs)	Edronax (<i>reboxetine</i>) Strattera (<i>atomoxetine</i>)	Proven effective for ADHD and sometimes used to help treat depression and the associated symptoms of anxiety.
Selective Serotonin Reuptake Inhibitors (SSRIs)	Celexa (<i>citalopram</i>) Luvox (<i>fluvoxamine</i>) Prozac (<i>fluoxetine</i>) Zoloft (<i>sertraline</i>)	Used to treat depression, panic disorder, obsessive compulsive disorder (OCD), bulimia, and post traumatic stress disorder (PTSD).
Stimulants	Adderall (<i>Mixture of amphetamines</i>) Concerta, Daytrana & Ritalin (<i>Methylphenidate</i>) Cylert (<i>pemoline</i>) Desoxyn Gradumet tablets (<i>Methamphetamine</i>) Dexedrine & Dextrostat (<i>Dextroamphetamine</i>)	Prescribed for ADHD to improve attention span, ability to complete tasks, and follow directions, while decreasing distractibility, hyperactivity, and impulsivity.

Becoming a Transition Specialist

Recently a friend asked me if I still do transition work. You see, a couple of years ago I took a little trip outside my comfort zone and worked a year as a Transition Specialist. I learned volumes that year before returning to a setting that more closely matches my first love, behavior. When I say I learned volumes, I literally mean that. Google 'special education transition' and you'll get almost 6 MILLION hits.

No wonder that most of us give little attention to those three spaces on the IEP that are allocated to transition. If you're like me, the thought of sifting through those six million hits gives you an instant case of information overload. And who has time for transition when there are FBA's to complete, BIP's to write, progress reports to finish, grading, faculty meetings, phone calls, parent conferences, and let's not forget instruction!

So let's talk about THE biggest lesson that I learned during my year as a Transition Specialist: **Transition is the single most important thing that any of us do as educators, and we are all transition specialists!** Mind you, I like having designated transition folks in the district to make community contacts and sift through those six million hits for me. But Transition Specialists who spend most of their time outside the classroom are going to be limited by the very nature of their job. Your school and district level transition specialists will not have the in-depth knowledge of your students' interests and abilities that you have working with them day in and day out. **No one is going to know your students the way you do as the classroom teacher and no one is going to be able to provide the level of transition preparation that you can provide.**

If you're thinking that providing transition services in addition to managing behavior, that is a pretty tall order. But there's good news.

Instruction for Transition is **NOT** an additional subject to teach, a stand-alone unit of instruction, or a pull-out program.

Instruction for Transition **IS** making academics meaningful and relevant, connecting school to the real world, and relating work to something that happens every day.



It is easy to get bogged down with the myriad of tasks it takes to serve a group of students with behavior disorders, **but ultimately, all our behavioral objectives and data collection and research based instruction have the goal of producing tax-paying citizens.** So how do we do that when we can't get little Zachary to stay in his seat or little Mia to stop screaming long enough to take them to a job site? Consider trying some of the following:

Invite a guest speaker to your classroom. The first time I tried this I was on pins and needles worrying about how the kids would behave, but they were just amazing when the guests arrived. Just be sure you practice, practice, practice beforehand. It also helps to give every student some kind of job for the day: someone can greet, someone can be the photographer or videographer, someone else the paper passer-outer (you get the idea). Do some group research about a career that is a common interest for your students (bet they all like food and music). This can work particularly well if you have access to a Smart Board.

Start a classroom business. Recycle crayons, grow heirloom tomatoes, manufacture greeting cards. You'll be astounded at the insight you'll gain into your students and the teachable moments that arise from doing real work with a group of students.

Contact your Transition Specialist to talk about how you can become partners in transition. Ask which of those six million hits might provide the best information for you to use with your students. Become a Transition Specialist yourself, right in your own classroom, and watch as behavior problems decrease and your students blossom.

Log on to www.scccbd.com and start or join a blog discussion about what transition might look like in your classroom!

Sandy Simpson, Teacher, Givhans Alternative Program, Dorchester School District 2

Creating a "Healing Environment" for Mr. Small Small

-continued from page 1

In school settings such children are often described as hyper-vigilant because they constantly scan the environment for potential sources of danger.

Clearly Mr. Small Small's brain had become re-tuned to the possibility of harm as we learned how to best support his efforts to recover from the life-altering trauma that occurred to him. **Howard Bath goes on to explain that at the core of traumatic stress is a breakdown in the capacity to regulate internal states including fear, anger and sexual impulses. He says that one does not need to be a therapist to help address three crucial elements of healing: the development of safety, the promotion of healing relationships, and the teaching of self-management and coping skills.** That is exactly what I and my two aides did every day all year long with Mr. Small Small.

We constantly worked on creating that primary survival need of safety characterized by consistency, reliability, predictability, availability, honesty, and transparency to create a safe environment. We consciously developed a comfortable connection with Mr. Small Small and he gradually learned that it was ok to drop his guard around us and allow us to positively interact with him for gradually increasing periods of time among several school environments. Lastly, we continue to work with him in helping him learn how to regulate his emotions and impulses. **Bath says that "These children may need adults who are willing to "co-regulate" with them when their emotions run wild . . ." and that's exactly what we did on a daily basis.** We sat with him, talked with him and were always there to comfort and reassure him that he was safe and that it wasn't necessary to try to run away or hit others reacting to that urge to fight or flight.

Mr. Small Small has calmed down and matured immensely in a year's time in our "Healing Environment" and continues to make remarkable improvements to self-regulate. Today, a year later, he rarely wets himself, or throws chairs or lashes out and hits an adult or another student acting out his feelings of anger and frustration. Today Mr. Small Small can sit calmly with another adult while learning the sounds of syllables and listening to a story being read about "Paint it Purple".

Today Mr. Small Small told us that he doesn't want to be called Mr. Small Small any more. Today he wants to be called Mr. Big Big.

Perry, B. (2006). Applying principles of neurodevelopment to clinical work with maltreated and traumatized children. In N. Webb (Ed.), Working with traumatized youth in child welfare (pp. 27-52). New York: The Guilford Press.

And how did Mr. Small Small get his name?

"Early in the year we told him big boys don't cry. Big boys don't pee in their pants. Big boys don't pick their nose. He responded with, 'I'm not a big boy; I'm a small boy. Small boys eat baby food, and wear diapers, and suck their thumb.' I think he never had a chance to be a baby when he was baby, so earlier this year he wanted to be one. His infant days were miserable for him and he remembers. He used to say, 'I don't want to be Nick; nobody loves Nick; Nick is bad; Nick gets thrown against the wall; people are mean to Nick. I'm Mr. Rothfork or I'm Mr. Crooks; I'm Mr. Small Small.' — **Tony Rothfork, Mr. Small Smalls' teacher**

Implementation of an Explicit Reading Program with Youth Attending Alternative Schools in South Carolina

Most alternative schools serve as last-chance opportunities for students who, because of their behavior, low academic achievement, or both, are at extremely high risk for dropping out of school. Moreover, dropping out has profound negative consequences for students, their families, communities, and society (Christle, Jolivette, & Nelson, 2005). Students who drop out of school have limited options for employment, usually working in low-skilled, low-paying positions with fewer advancement possibilities. **With one-third of students failing to graduate from high school, the costs to society are devastating, including forgone national income, forgone tax revenues for the support of government services, increased demand for and cost of social services, and increased crime and associated costs.** Students who drop out are more likely than students who graduate to become involved in the juvenile justice system. In fact, dropouts comprise 85% of juvenile justice cases (Stanard 2003).

Many students in alternative schools, who are at high risk for dropping out of school and subsequent incarceration, struggle academically. Comparison of the 2006 South Carolina PACT scores for eighth-graders in English/Language Arts (E/LA) showed that 62% of students in alternative schools scored Below Basic, opposed to only 27.3% of those in regular public schools (<http://ed.sc.gov>). Since it costs tax payers 6 X more on average to incarcerate a youth than to educate her/him in a public school, our tax dollars would be more wisely spent by helping students to successfully graduate from high school.

Given the fact that academic failure and read-

ing difficulties are strong predictors for dropping out of school and subsequent incarceration, there is a need for wide-spread use of intensive remedial reading programs for struggling students. Unfortunately, there is limited research on strategies for teaching reading to older students who are at risk for dropping out of school and subsequent incarceration. Researchers who have targeted this group have suggested that explicit instruction of reading skills is an effective strategy.

I conducted a pilot study to determine the feasibility and significance of an explicit reading intervention with struggling readers in alternative schools in South Carolina. The objective was to determine if substantial literacy gains could be made with students in alternative schools using an evidenced-based reading program—the *Corrective Reading Program* (CRP) (Engelmann, Hanner, & Johnson, 1999), and whether these literacy gains would have positive effects on other academic & behavioral outcomes. Unfortunately I experienced many difficulties in conducting this research project which leave the research questions unanswered. Five teachers in three alternative schools were trained to implement the CRP and we began with 57 students who were identified for the program (i.e., test results showed them reading 2 or more years below grade level). Only 11 students completed the program. Those students who did not complete the program were either sent back to public school or expelled for the remainder of the year. This was indeed unfortunate since the 11 students who completed one CRP level made gains in oral reading fluency—an indicator of overall reading

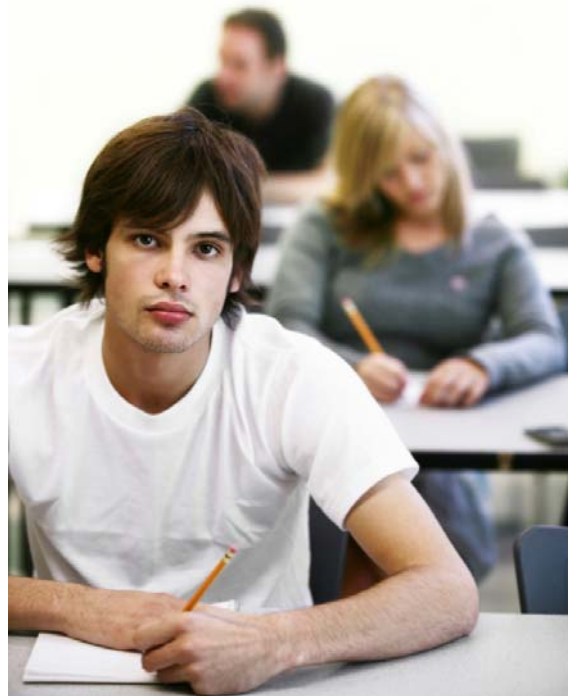
competence. In six months they increased their words correct per minute (WCPM) a mean of 20 with a range from 6 – 46. Seven of the 11 students made gains on the Wide Range Achievement Test – Word Recognition with a mean Standard Score gain of 6 points and a range from -3 to 13 points. Other indicators did not yield clear data (MAP Scores, Attitude Surveys, Teacher Questionnaires, Woodcock Johnson Reading Mastery Scores). Teachers who implemented the program also expressed frustration with the fact that students were sent back to their schools after nine weeks and that students were often suspended and missed lessons.

I continue to wonder about those 46 students who didn't get to finish our reading intervention. The implications for the future are dismal for the overwhelming number of secondary students who struggle in reading, particularly those attending alternative programs. **One teacher in our study said, "Reading is the gatekeeper for other subjects. I think we need to focus more on reading in our daily curriculum and in all other subject areas."** While improved literacy is not the only preventive factor for dropping out and incarceration, it is definitely a critical component that may provide more positive outcomes for many at-risk youth.

References

Christle, C. A. & Yell, M. L. (2008). Preventing youth incarceration through reading remediation: Issues and solutions related to reading deficits for at-risk students. *Reading and Writing Quarterly*, 24(2) 148-176.

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Engelmann, S., Hanner, S., & Johnson, G. (1999). *Corrective Reading Series Guide*. Columbus, OH: SRA McGraw-Hill.

Stanard, R. P. (2003). High school graduation rates in the United States: Implications for the counseling profession. *Journal of Counseling & Development*, 81 (2), 217-222.

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DID YOU KNOW THAT THERE ARE 245 SCHOOLS IN SOUTH CAROLINA WHO ARE IMPLEMENTING PBIS? MORE WILL BE TRAINED THIS SUMMER.

Ning stands for **NetworkING**.

Try it at <http://pbisning.ning.com/>

Thanks, Daniel!

**At CCBD, Advocacy is
"our thing"!**

For more details, visit www.scccbd.com

PLAN TO ATTEND!

The 8th Biennial International Conference on Children and Youth with Behavioral Disorders,
Sheraton 4 Points in Denver, CO
September 23-26, 2009

RFPs due by June 15, 2009

*For more information, go to www.scccbd.com
or behavioralinstitute.org/CCBD.htm*

From: Dr. Joseph Ryan, Treasurer Council for Children with Behavioral Disorders, who spoke at a meeting on seclusion and restraints

Subject: AFTER ACTION REPORT WHITE HOUSE STAFF MEETING (26 May 09)

Read the complete report Joe made to the CCBD EC on the SC website.

Dr. Howard Muscott, chairman of the CCBD Foundation, was honored to give a briefing to the US Congress on the work they are doing with PBIS and Children's Mental Health in NH. He spoke on Children's MH Awareness Day, May 7, 2009.

One Good Idea.... Leads to Another... THANKS for Sharing!

The Lemonade Cart

Have you ever had to clear your classroom quickly when a student is acting aggressively? Have you ever sent the other students out of the room to remove the audience? If you have, then you'll agree that **the rest of the class deserves the opportunity to focus on meaningful work while the situation back in the classroom is handled.** That's where the *Lemonade Cart* can save the day!

The Lemonade Cart is simply a supply of emergency plans that are stored on a portable cart. It gets its

name from the old saying, "When life hands you lemons.... Make lemonade." The cart is fully stocked with motivating activities, sharpened pencils, educational games, and anything else that will ensure that the students make the most of their time away from the classroom. And of course, it is restocked after each use.

Students benefit from practicing how to leave the classroom quickly when a classmate becomes aggressive. Just like a fire drill, have a signal that tells the students that it's time to leave. Have a destination in mind and a back-up location or

two. This will limit confusion and save instructional time. But above all things, praise the students for leaving the room appropriately. This practice will help things go smoothly when a real emergency occurs.

The Lemonade Cart even benefits the aggressive child back in the classroom. Its use allows the teacher to focus solely on de-escalation techniques instead of worrying about the rest of the class.

**Jill T. Chapman
Saxe Gotha Elem School, SC
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