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CONTENTS

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- 5** President's Message
- 7** Building Mental Health Alliances in the School and Community
BY CAROL J. KAFFENBERGER AND JUDITH O'RORKE-TRIGIANI
- 11** School-wide Depression Screenings
BY ANNE ERICKSON AND NICHOLAS R. ABEL
- 14** Using Origami in Counseling
BY ANGELA CLEVELAND
- 17** A School Counselor's Experience Using Check-in/Check-Out
BY KATIE RYAN AND KELSEY LaRUE
- 20** Supporting Traumatized Students
BY ROBIN GURWITCH AND DAVID SCHONFELD

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DREAMING BIG

SHERRI McLAUGHLIN



Greetings, Illinois school counselors! The start of my presidential year is now upon me. I began my reign by attending the ASCA Convention in Phoenix, Arizona. I learned a great deal about leadership, offerings to the state organizations from ASCA, and the movement of our great counseling profession into the next century.

Many exciting and positive things are happening to the field of counseling all across the country. I heard testimonies of states that have now passed into law the ASCA comprehensive school counseling model in their schools; the national average of student-to-school counselor ratio put into law and practice; the elimination of non-counselor duties assigned to school counselors; and mandates to have one school counselor per school in some states. These announcements not only inspired me but also empowered me to think about my personal goals and plan of action for my term as the Illinois School Counselor Association (ISCA) president.

I have always tried to reach for the stars and dream big! I would love to see more job opportunities for our current and future school counselors. I would love to increase membership in ISCA and get more school counselors involved in leadership and continuing education. One goal of mine is to encourage and increase the number of school counselors attending and presenting at our state conferences. I hope to utilize technology and partner with ASCA in the area of professional development. My plan is to create webinars and make links available to our members regarding professional development, and I hope that this service will also increase membership. I plan to work closely with our board and executive director, Dan Stasi, on a number of projects that include: the Day on the Hill; political agenda for ISCA; state conference; statewide career curriculum; enhancing our website; ISCA elections; National School Counselor Week; ISCA attire; membership drives; workshops and professional development; promoting participation in school counseling initiatives; and partnering with other state student services organizations. I would love to get the ball rolling in the area of student-to-school counselor ratios, comprehensive school counseling programs, and mandatory school counselors in every Illinois school. That is the overall big dream.

I plan to wish on that star and I hope to stand in front of the ASCA convention leadership delegate assembly one day and say that Illinois has adopted these practices and made them state laws! I know that change can come slowly but it must start somewhere and continue to persevere in order to make a dream a reality. I look forward to serving the school counselors of Illinois. It is an honor and a privilege. ■■■

Many exciting and positive things are happening to the field of counseling all across the country.

Contact Sherri McLaughlin, ISCA president, at smclaughlin@jsd117.org.

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BUILDING MENTAL HEALTH ALLIANCES IN THE SCHOOL AND COMMUNITY

BY CAROL J. KAFFENBERGER AND JUDITH O'RORKE-TRIGIANI

Approximately 14-20% of school-age children are diagnosed with mental health or behavioral disorders, yet 75% of these students will not receive needed mental health interventions. Parents, teachers, and students seek help from the school and school counselor, but the counselor's ability to respond can be limited by large caseloads, inadequate training, or lack of awareness of community resources. One way school counselors can increase their capacity to meet the mental health needs of students is by identifying resources and building alliances in their communities.

Providing direct and indirect services to address emotional and mental health issues that keep students from succeeding at school is a primary responsibility of the school counselor. The school counselor is often the first person in the school to learn of the concerns of teachers and parents, or to work directly with the student. Short-term counseling and crisis intervention services can be provided to students individually and in small groups. School counselors can assess mental health concerns and, when appropriate, recommend community mental professionals for ongoing services.

Successfully meeting the mental health needs of all students may require new service delivery models that will depend on collaboration among all of the adults in the child's life and access to mental health resources in the local community. The following case examples offer a glimpse into ways to serve students and building alliances.



CASE EXAMPLES



Chris, a white 7th-grader, is aggressive on the school bus and in the hallways. He is having difficulty adjusting to changing classes, can't seem to sit still in class, and generally is not handling the expectations and responsibilities of middle school. He has already received interim reports in three subjects and has been non-responsive to school-based efforts to help him. The school counselor has met with him on three occasions at the request of his teacher and plans to meet with his parents to discuss possible referrals. Before this meeting, she consults with the special education coordinator and the school psychologist to consider options for working with Chris.



Brian is an African American 5th-grader who has been diagnosed with anxiety disorder. He

sees a psychiatrist who manages his medications and oversees his treatment plan, and is working in coordination with the school counselor and Brian's mom and teacher to put a plan in place to help Brian function at school. Brian will participate in eight weeks of small group counseling aimed at teaching cognitive behavioral strategies such as coping and self-regulation. Working with peers dealing with similar issues may help Brian realize he is not the only child dealing with anxiety and may provide opportunities to help others. Brian's teacher works with the school counselor to learn strategies that can support Brian in the classroom.



Susan is a Chinese American 2nd-grader who has been diagnosed with Autism Spectrum Disorder (ASD). She receives special

CONTINUED ON PAGE 8

education services at school but spends most of her day in a regular classroom. Susan's teacher needed help from the special education teacher and the school counselor to support Susan in the classroom. Susan's parents emigrated from China and are struggling to understand Susan's diagnosis and how to help her in school. The school counselor has reached out to the local Multicultural Counseling Center for resources for the parents and Susan.



David, a Hispanic male and high school junior, is returning to school after receiving inpatient treatment for depression and substance abuse following the suicide of his sibling. The school counselor collaborates with the mental health care providers at his inpatient treatment facility and develops a transition plan for returning to school. After talking with David and his parents throughout his treatment, she secures permission to brief the staff directly involved with David to plan for his return to school. The school counselor consults with David's outpatient counselor who works on coping skills. The school counselor also invites David to a substance abuse group that she co-leads with the counselor from the local community mental health center. Together, they monitor David for signs of substance use and any potential suicidal ideation. The school counselor monitors David's attendance daily and frequently meets with him individually to problem solve and monitor his progress. The school counselor also meets with David's mother and provides referrals for groups for her and other family members. Permission was also given for the school counselor to brief the elementary school counselor where David's younger siblings attend so that their needs can be addressed.



Anna is a freshman of Arab descent who just immigrated to the U.S. to escape the war in her country. She panicked during a recent fire drill due to the noise and the students fleeing the building. Anna shared with the school counselor that she has frequent flashbacks, acts as if she is on edge, and is unable to form relationships with others. The school counselor reaches out to the family and provides referrals for counseling. She explains signs and symptoms of PTSD and the treatment process, develops a plan for managing fire drills, and reassures Anna's family that counseling will not impact her academic record. She works with Anna on coping and social skills to help Anna adjust to her new environment. She consults frequently with the Arabic-speaking therapist who specializes in PTSD whom she met at a session on helping children from the Arab world transition to the school system. The school counselor also coordinates a student ambassador program where model students help new students adjust to the school. Anna and her carefully chosen student ambassador become friends and resources are secured for Anna to participate in afterschool activities.

STRATEGIES FOR BUILDING ALLIANCES

- 1 Review school data** to understand the needs of the students in the school. Follow up by exploring the resources that available within the school, district, and community.
- 2 Become knowledgeable about the types of resources within the school and in the community.** There is no substitute for networking, interviewing, and researching the types of mental health services and support avail-

able in the community. Counseling Collaborative Learning Teams (CLTs) allow school counselors to meet to discuss community-level data, common issues, and plan programmatic responses. Build your resource list by sharing resources with other school counselors in your community. School counseling associations may be resources for materials and programs at the local and state levels.

3 Provide direct services to students, including crisis counseling and short-term individual and group counseling. You can conduct the initial phases of assessment, then work with parents and teachers to facilitate appropriate referrals when additional help is needed. School counselors reduce barriers to learning by teaching coping, social, and problem-solving skills.

4 Build strong relationships with parents. Parent consultation and education is an essential part of the school counseling program. Your role is often to educate parents about behavioral and mental health issues and to coordinate treatment plans at school and home. Invite mental health providers as guest speakers to educate parents about mental health issues and ease parents' concerns about the counseling process and encourage them to seek help.

5 Seek additional training. By collaborating with other professionals, school counselors can learn new strategies and improve their services to students. As part of your professional development, school counselors can continue to learn about effective evidence-based skills and strategies, such as social skills training for the school setting. Access training in person or online via state and national

counseling organizations and through the school-based collaborative learning team.

6 Build alliances within the school. Alliances with classroom teachers, special education staff, parent liaison, school psychologist, social worker, and administrators, as in the case examples, involve sharing responsibility for the success of all students. Helping education professionals in the school understand the importance of reducing mental health barriers so that students can learn is an important responsibility of the school counselor. The most effective interventions are integrated into the learning environment and encourage the adults in the school

community to support and reinforce mental health goals through parent and teacher consultation. Mental health services, including follow-up and monitoring, are most effectively provided in the child's school and home and require collaboration among all the adults in the child's life.

7 Build alliances with building-level administrators. Principals are crucial in recognizing school counselors' role in addressing students' social/emotional needs so that barriers to learning can be removed. Sharing data that demonstrates the effectiveness of interventions aimed at mental health issues provides you with opportunities to advocate not only

for students, but for the school counseling program.

8 Build mental health alliances in the community. These important alliances begin with getting to know what resources exist. Communities usually have a variety of private and community-based mental health service providers. Build a resource list of agencies, names, contact information, fee schedules, and specialties. Ideally, visit or meet the various service providers. Networking with other school counselors in the district will also help build the available resource list.

CONTINUED ON PAGE 10

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9 Build other alliances in the community. Community social services agencies may be able to assist with financial support or referrals to agencies that provide services for free or on a sliding scale. Often, agencies publish a handbook of community resources. Religious and cultural organizations may be a source of information about the culture or attitudes toward receiving mental health, or may offer resources such as a counseling center, or financial or social support. Paraprofessionals who share demographic characteristics or have conquered similar challenges can also be an appropriate resource for the student and family. Local and national

advocacy groups such as Autism Speaks (www.autismspeaks.org) and Autism Now (autismnow.org) and online resources such as Support for Families of Children with Disabilities (www.supportforfamilies.org) can provide information, support, and referral sources. Other alliances worth exploring are with local colleges and universities with a research interest in a particular mental disorder, or volunteer programs aimed at supporting community members.

10 Stay informed about the latest research and provide resources to parents and staff by using the National Institutes of Health website at www.nih.gov, or The

Children's Mental Health Network at www.cmhnetwork.com.

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This article is based on an article published in Professional School Counseling:

Kaffenberger, C, & O'Rourke-Trigiani, J. (2014). Addressing student mental health needs by providing direct and indirect services and building alliances in the community. Professional School Counseling, 16, 323-332.

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SCHOOL-WIDE DEPRESSION SCREENINGS

BY ANNE ERICKSON AND NICHOLAS R. ABEL

You may be familiar with the sobering statistic that a school of about 1000 students can expect to deal with the death of a student from suicide at least every two to three years. This is according to CDC data on the nationwide prevalence of suicide attempts and completions among adolescents.

In 2001, the school psychologist at Mahtomedi High School and I (Anne) began noticing an increase in the number of students who were chronically absent or frequently visited the nurse's office with what we believed were psychosomatic symptoms of depression—headaches, stomachaches, nausea, and fatigue. At the same time, we also noticed an increase in the number of students being hospitalized for depression and suicide attempts. Often, we knew nothing about their condition until we received a phone call from the hospital or the student's parent with a request for homework. Mahtomedi High School (MHS) serves about 1200 students from several suburbs of St. Paul, Minnesota. The student body is predominantly Caucasian, high-achieving, and financially stable.

Our perceptions were confirmed by our school's results on the Minnesota Student Survey (MSS), which is given every three years to ninth- and 12th-graders across the state. It was clear that we needed to take proactive steps on behalf of our students with mental health issues, and we began planning our depression screening and suicide awareness program.

First, we researched depression screening instruments. We ultimately decided on the Reynolds Adolescent Depression Scale - Second Edition (RADS-2) due to its length of only 30 questions, high reliability and validity with adolescents, eighth-grade reading level,



and absence of questions that could be controversial. Next, we created a short classroom guidance lesson about the signs and symptoms of depression and suicide, including suggestions about what students could do if they were concerned about themselves or someone they knew. We then reached out to a community-based agency called SAVE (Suicide Awareness Voices of Education) to arrange for classroom speakers who could talk about their struggles with depression and deliver a message of hope, including treatment options for students. Last, we applied for and were awarded a grant through a local foundation and our county public health office to implement the program in the ninth and 10th grades through our school's required Health class.

We decided to use a passive parent permission process. Parents were informed that we would administer the RADS-2 in the required Health class to all ninth- and 10th-grade students, but that parents could call or return an enclosed form if they had questions or did not want their student to participate. After having the language in this form approved by our school district's attorney, we gave it to the Health teacher to send home to parents. The Health teacher asked each student to address his or her

own envelope to ensure that parents received the information. Very few parents pulled their student from the screening or presentation, and those who did generally reported that the student was already being treated for depression.

Today, our screenings and classroom presentations look much like they did in 2001. A school counselor or school psychologist is always present in the classroom. We begin by administering the RADS-2, which takes about 10 minutes. Next, we deliver a presentation that covers the warning signs and symptoms of depression and suicide and stresses the importance of students seeking help and referring friends about whom they are worried. Frequently, these lessons include the chance to role play such situations. We then ask students to rate the session on a survey, and the counselors and counseling interns quickly go to work scoring the RADS-2 instruments.

OUR PROGRAM'S IMPACT

Since the program was implemented, approximately 4,650 MHS students have been screened for depression and received the lesson on mental health and suicide awareness. We consistently find about 10% of the students screened to be at risk for depression. We contact the parents of these students and offer them a copy of the screening results and contact information for an area mental health agency. This first contact typically comes from a school counselor because many parents and students have an established relationship with the counselor and perceive this information to be less intimidating from a person they know and trust. Parents typically appreciate the help, the connection with school support staff, and the insight into

CONTINUED ON PAGE 12

their students' personality and academic achievement. In more than 10 years of providing this service, only one parent has been resistant to acting on the information we provided following the screening, and this person was convinced to seek outside services after meeting face to face with two of our school counselors.

We are fortunate that families in our community have access to a wide array of mental health providers, many of whom charge on a sliding scale. Our town also has a free medical clinic that can provide mental health services should all other options fail. Due to the availability of affordable services, most of the families we refer are able to arrange for the help their students need. Many of the referred students enter therapy and some also start on medication. Although school personnel are not typically involved in treatment, we follow the ASCA Ethical Standards for School Counselors as it relates to seeking out a signed release of information in order to coordinate services and support the student at school.

From 2001 to 2010, according to the MSS, our school experienced a decrease in the percentage of students reporting depression in ninth grade (14% down to 12%) and 12th grade (11% to 5%), and in the percentage of students making a suicide attempt in ninth grade (4% to 1%) and 12th grade (3% to 2%). The feedback from school counselors, support staff, students, and parents has contributed to our belief that the screening and awareness program has been a success. More students seek help or refer friends for issues related to mental health. Student comments regarding the presentation have been overwhelmingly positive, and students have openly told us in front of their peers that we may have saved their life. Mirroring the results of the MSS, we have seen a noticeable decrease in suicide

attempts and hospitalizations, and our school has not experienced a completed suicide since this program was implemented in 2001. Unfortunately, this has not been the case at neighboring school districts, a few of which have implemented similar screening programs after experiencing multiple suicides among their student bodies.

Although we cannot attribute the absence of a suicide at MHS directly to our prevention and screening program, we are confident that, at the very least, we are making a difference in the lives of students with mental health issues.

BEFORE YOU START A PROGRAM

School counselors should proceed with caution in implementing a depression screening program. Possible negative consequences include the risk of false positives or false negatives, possible stigmatization, the overall cost-effectiveness of such programs, and the risk that a school may not have the resources to deal effectively with every student found to be at risk. Counselors must carefully consider the availability of time, resources, and response personnel in their particular school communities. We encourage reading suggestions and recommendations from those who have studied the issue (see "For further reading") and we recommend that counselors carry liability insurance (such as that offered through ASCA membership) in case of a difficult situation.

Explore a variety of programs and screening tools, paying particular attention to the types of parent permission (i.e., active vs. passive) allowed under the rules of the program or instrument. Many formalized programs exist for screening students for suicide risk and mental health disorders, including Signs of Suicide (<https://mentalhealthscreening.org/programs/youth>) and the Lifelines

program (<https://www.hazelden.org/web/public/lifelines.page>).

We encourage school counselors to collect, track, and report data related to any screening or prevention program they implement. Data such as attendance, referrals to school support staff for mental health concerns, suicide attempts, hospitalizations for mental health issues, and student feedback given on post-intervention evaluations can all be useful in demonstrating the effectiveness of a school's program.

Explore options for funding such a program, including grants offered by state and local education agencies or businesses, partnerships with community mental health agencies, and reallocation of funds through the local school board. At MHS, we are fortunate to have received financial support from several sources, the largest of which is our local Mahtomedi Area Education Foundation (MAEF). This organization works to raise money for our screening program every year, and they also coordinate the distribution of Oliver's Fund, which was started by the parents of a 2002 graduate of MHS who was being treated for depression while in high school but tragically took his life while attending college.

MAKING A DIFFERENCE

Since the project began at MHS in 2001, we have never skipped a year of screening or presentations in the Health classes, and we still find this to be some of the most meaningful work we do all year. We feel lucky to have administrators who understand these issues and support our staff in continuing this work. Our community cares about their young people and allows them to receive education on this difficult topic. As a result of the screening, education, and student reports of problematic behavior that come out of these lessons, referrals to our school

counseling office have increased and we feel we have positively impacted school safety and climate.

Our hope is that all secondary schools will provide screenings for depression, similar to screenings for vision and hearing in elementary schools. As trained mental health professionals, school counselors are uniquely positioned to help the well-being of students who are struggling with mental health issues. Although ASCA does not recommend that counselors provide long-term therapy for students, counselors can impact student mental health through crisis interventions, referrals, advocacy, outreach, classroom guidance, and screening. Depression is treatable and suicide is preventable, but early recognition and intervention are vital. ■■■

FOR FURTHER READING

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*This article is based on an article published in Professional School Counseling: Erickson, A., & Able, N. (2014). A high school counselor’s leadership in providing school-wide screenings for depression and enhancing suicide awareness. *Professional School Counseling*, 16, 283-289.*



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USING ORIGAMI IN COUNSELING

As students' folding fingers transform paper, the shapes—and the shaping—work some therapeutic magic.

BY ANGELA CLEVELAND

Like all school counselors, I am always looking for fun, creative, and therapeutic ways to address student needs. However, I am not the craftiest of people; I struggle to make my stick figure drawings look remotely like people. For working with children, whether independently or in small groups, I seek engaging strategies that are fun yet focused on the topic at hand. My quest has led me to Origami, the traditional Japanese art of paper folding.

I love that it is simple paper folding. Mistakes, or “creative accidents,” are not a catastrophe, as my students with perfectionist tendencies learn. It’s just paper, and making mistakes is proof you are trying. Origami also teaches kids who give up easily that if they keep at it, they can achieve their goals. Rather than rushing through their work, I find that students tend to slow down to attend to the small details, the minute folds that make their work look its best.

I have used Origami as a calming-down strategy for students who have been removed from a classroom for disruptive behaviors. The withdrawn student who refuses to talk will open up and engage with me while I sit quietly and turn a square piece of paper into a cute little animal. The use of Origami seems to magically tear down the walls and open a child to engage when he or she is suddenly curious rather than filled with anger.

I have also found that Origami can be an effective, inexpensive, and fun tool to address some of the most serious topics we face as school counselors. Origami baskets can be used to balance stressors and coping skills. My students and I create two baskets and fill one with tiny slips of paper that identify the things that cause us stress and the

I have used Origami as a calming down strategy for students who have been removed from a classroom for disruptive behaviors.

other with effective and creative coping skills. Yes, making Origami is one of the coping skills!

Origami is a great stress reliever. I put on relaxing music, and a peaceful silence or relaxed conversation comes over us as we work on our favorite projects. This activity is a great way for kids who are learning social skills to work together on project. Sometimes sharing about themselves or learning the nuances of a back-and-forth conversation can be hard for children. It’s easy to use Origami to engage in conversation. For example, I have had students create Origami houses and decorate them with aspects of their lives. They include who they live with at home, pets, and even sports they enjoy. Creating these tiny works of art and sharing them

is a safe and fun way for students to interact and open up.

For students who are struggling with loss, we have filled little Origami heart boxes with the names of loved ones, cherished memories, and things we want our departed loved ones to know about our lives now. You can tie a string to the origami heart to turn it into a holiday ornament or decorative reminder of a loved one. On the anniversary of a loss or the birthday of the loved one, students often have a special ceremony, such as releasing a balloon with a note attached. Sometimes children have struggled to write a note or letter, and a special origami heart can feel like an impactful gesture without writing a lengthy letter.

For students who may need some encouragement to practice leadership skills, I provide the opportunity to lead the group in teaching us a new Origami piece. It’s so exciting to see students circle around a peer who is teaching them how to make something fun!

How can you get started using Origami in your counseling setting? My favorite resource is absolutely free, available to you and your

students—*YouTube!* A quick search provides many helpful tutorials, I also recommend checking out www.origami-instructions.com to get some great ideas and written instructions. ■■■

Angela Cleveland is a school counselor at Hillsborough Township Public Schools in Hillsborough, NJ. She is a Google Certified Educator who advocates for using technology to enhance students' learning experiences and online professional collaboration opportunities, yet she recognizes that sometimes hands-on activities with students can be more meaningful than any digital tool. For more information, contact her at acleveland@htps.us.

- House: Instructions and *Video*
- Secret Heart Box: *Instructions* and *Video*
- Basket: *Instructions* and *Video*
- Another house style: https://www.youtube.com/watch?v=rbyV_wgjhEc

See page 16 for instruction sheet on how to make the house.



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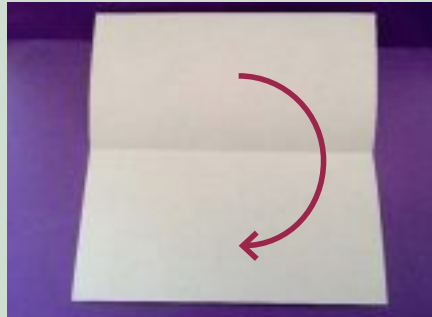
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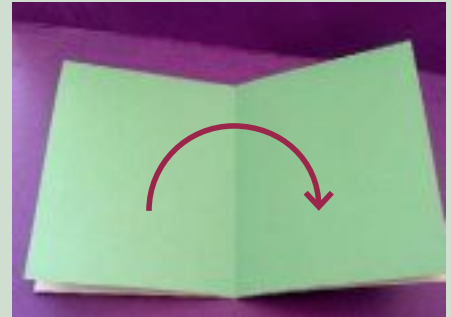
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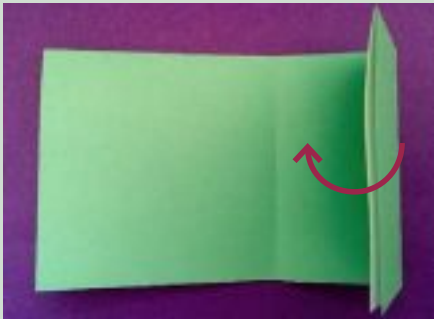
Make a Simple Origami House



1 Start with square origami paper. Fold in half.



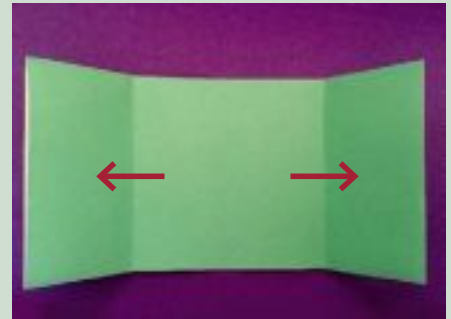
2 Fold in half, then open again to show center fold line.



3 Fold in right edge to center fold.



4 Fold in left edge to center fold.



5 Then unfold left and right folds.



6 Open right fold, and (using finger as guide), squash it down to make a triangle.



7 Press the fold flat to make a triangle.



8 Fold left fold back to make house stand on its own.

A SCHOOL COUNSELOR'S EXPERIENCE USING CHECK-IN/CHECK-OUT

BY KATIE RYAN AND KELSEY LaRUE

The Check-in/Check-out (CICO) intervention establishes a structured daily routine to reduce and prevent the escalation of students' problem behaviors. With CICO, adults prompt students to engage in positive behavior, provide behavioral feedback to the student at predictable times of day, develop a meaningful adult-student relationship through positive interaction, and communicate behavioral challenges and successes with families daily.

FOUNDATION

As the solo school counselor at Jefferson Elementary in New Ulm, MN, I (Katie) had the benefit of working with a wonderful group of people

and cannot take sole credit for our success using CICO. Although I served as the CICO coordinator, the success of the program reflects how well the *system* works together. This article begins by describing the School-wide Positive Behavior Support foundation that made CICO effective. Co-author Kelsey LaRue was a school counseling intern at Jefferson Elementary when the CICO program was implemented.

CICO is considered a tier two intervention within the School-wide Positive Behavior Support system; therefore, a functioning tier one and tier three team were essential. Knowledgeable teachers were invaluable in identifying students for the intervention, so a significant

amount of staff development was crucial to making the system work. Staff buy-in is probably the most important factor in any school-wide program. At Jefferson Elementary, we were lucky (given time and hard work) to have all of the above.

IDENTIFYING THE CORRECT STUDENTS

As counselors, we know that every student is unique and requires an interaction that fits him or her. Educational interventions are no exception. CICO is not designed for every student; it is designed to be a good fit for a specific population of students.

CONTINUED ON PAGE 18

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Referrals to CICO happen several ways at Jefferson Elementary: teacher, data-driven, or parent/guardian referrals. Teachers make a referral for any behavior or academic issue by completing a Teacher Request for Assistance form; once the form is complete, it triggers a conversation at our weekly grade-level team meetings known as Teachers Assisting Teachers (TAT) meetings. When a student gets four or more office discipline referrals, it also prompts a conversation at the TAT meeting. Depending on the concern discussed at TAT, CICO may or may not be suggested as a good intervention for the student. Parents/guardians can also refer their student by having a conversation with any adult in the building (classroom teacher, administrator, school counselor, etc.).

Not all students who are referred for CICO are a good fit for the approach. What we found through trial and error and is documented in the literature is that students with attention-maintained problem behaviors are the best fit for CICO (see references). We conduct a functional behavior assessment for all students we are considering for CICO to make sure that we set the student up for a successful intervention as much as possible.

CICO: THE INTERVENTION

After identifying a student for CICO, the classroom teacher assists the team in making a daily point sheet based on the student's daily schedule; this sheet is sometimes referred to as a daily behavior report card. The point sheet allows the teacher to give immediate feedback after a predetermined amount of time (such as at the end of each subject).

As the CICO coordinator, I begin my day by reviewing point sheets and students' goals, which are identified through the functional behavioral assessment. During this check-in process, I make my best effort to connect and build

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The student receives immediate feedback from teachers in the form of points on their sheet.

a personal relationship with the student; my goal is for each CICO student to begin their day with a positive adult interaction at school. Once their goal is set (for example, earn 80% of the total points for the day), they bring their point sheet to their classroom to begin their day. This process takes me about 5 minutes per student.

Throughout the day, the student receives immediate feedback from teachers in the form of points on their sheet. Who will be responsible for the point sheet is decided between the teacher and the student, depending on the student's maturity level.

At the end of the day, CICO students check out with me, and I assist them in looking at their day with a positive mindset. At this time, the student is able to reflect on the day and look to see where areas need improvement. The student and I fill out a Home Report that will make a caregiver aware of how the student's day went. Before they go home, students set a goal for the next day. Like the morning check-in, the check-out takes about 5 minutes per student.

DATA COLLECTION

As you know, data collection is essential for staying accountable to our stakeholders; in the case of CICO, sharing data with caregivers, teachers, and students is necessary. Throughout the years of implementation, I have learned that the most effective use of my time that produces accurate, usable data is to plot average weekly point totals compared to average weekly goal points. I have found that using weekly totals as opposed to daily totals made reviewing data more manageable. Data entry takes about 10 minutes per student per week, plus additional time to analyze the data with the TAT team each month. After reviewing the data, the team can decide to continue the intervention, move to a different intervention, or discontinue interventions all together.

WHEN IT WORKS

When we see improvement in the student's behaviors and they continuously meet their goal, then the team starts discussing a "graduation" for the student. Keep in mind is that some students benefit from the structure of CICO and are more successful continuing the intervention despite the fact that they could graduate from the program. Other students find success in working their way out of the program. Overall, the data and your knowledge of the student as

an individual will guide the team in making the best decision regarding the intervention.

WHEN IT'S NOT WORKING

As stated earlier, CICO intervention is not the best fit for every student. As a team, we pay careful attention to the student's goals and their ability to achieve success on the program. Best practice with intervention fidelity suggests four to six weeks of intervention before discontinuing. Student success may not begin immediately upon implementation of the intervention. Students need some time to understand their role in working toward meeting their goals. After about six weeks, the team can look to the data for a thorough understanding of the student's success with

the program and make appropriate adjustments.

FINAL THOUGHTS

Building a successful system of interventions for students that addresses their behavioral needs in the classroom takes time, patience, and buy-in. A solid School-wide Positive Behavior Support foundation is essential in building a CICO program that will effectively assist positive behavior change. There are several keys to implementing a successful program: a supportive staff, an effective, data-driven problem solving team, and patience. Ultimately, students recognize that there are several adults in the school that care about them and their education. Students begin to address their problem behaviors

that interfere with learning and adults are present to support their success. ■

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This article is based on an article published in Professional School Counseling:

Martens, K., & Andreen, K. (2014). School counselors' involvement with a school-wide positive behavior support system: Addressing student behavior issues in a proactive and positive manner. *Professional School Counseling, 16*, 313-321.

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SUPPORTING TRAUMATIZED STUDENTS

Learn the vital steps school counselors can take to aid students' recovery from trauma or loss.

BY ROBIN GURWITCH AND DAVID SCHONFELD

Students' lives are all too often touched by trauma and loss. About 90% of students experience the death of a family member, relative, or someone they cared about by the time they graduate from high school. Children also face traumatic events such as parents' divorce, domestic violence, child maltreatment, parental substance abuse, and accidents.

These experiences affect children's thoughts, feelings, behaviors, and physical well-being, and can impact their learning potential and school performance. Students, parents, and school staff may turn to school counselors for help in the

aftermath of such events. Understanding how trauma and loss can affect students is the first step in knowing how to support them. Although there are common reactions, each student will react in his or her own way and in his or her own time.

Students feel the effects not only of the trauma or loss itself but also of many additional (secondary) losses. After a natural disaster, students and their families may be forced to move, change schools, and leave friends and the security of the familiar school. After the death of a parent, the family may face financial challenges. Without

the deceased parent's income, extracurricular activities may no longer be an option and the student loses important supports such as peers and trusted adults. Trauma and loss can also affect the student's plans for the future. Without a parent, who will help with college applications? Secondary losses include an overall decreased sense of security and safety.

School counselors can take many supportive actions to help students after a trauma or loss.

Initiate conversation: After a trauma or loss, students may be hesitant to approach school personnel, including school counselors,

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especially if they have not interacted with the school counseling staff in the past. Students may not want to feel different or may sense that the adults are not comfortable discussing the event. Let the student know you are aware of the recent experience and are thinking of him or her. Let the student know you are available to talk and to listen. Provide options for a time to talk. Remember, listen more than you talk. Be aware of verbal and nonverbal behaviors in the student.

Validate feelings and experiences: Students need to know you really hear what they are sharing. Through open-ended questions

and reflective listening, let students know you not only empathize but understand the difficulties and concerns expressed.

Answer questions and correct misinformation and misattributions: Students may have many questions after a trauma or loss. Answer them simply and directly at an age-appropriate level; this will increase communication. As you talk with students, listen for misinformation and misattributions, which often lead to feelings of guilt and shame. Gently correct these, supplying accurate information.

Educate students and caregivers about common reactions: Stu-

dents' reactions to trauma or loss may frighten them or leave them feeling different from their peers. Learning from you about common reactions can help normalize their reactions and encourage them to talk more openly about them. You can also help parents and caregivers learn about these reactions, which they may be experiencing themselves. Discussing how distress can lead to stress or conflict in the home can help family members recognize distress, and this can lead to increased support and patience with their children. For ex-

CONTINUED ON PAGE 22



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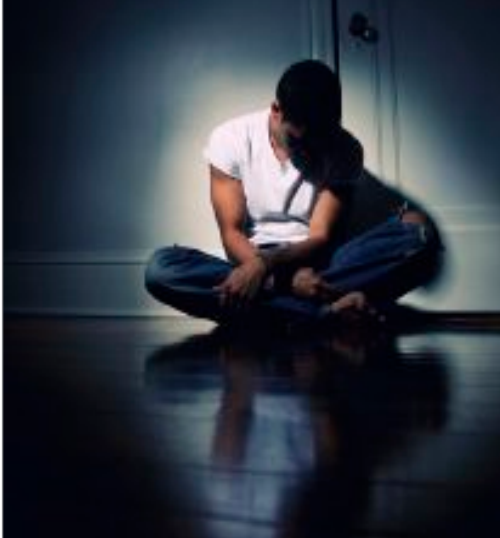
ample, knowing that school performance may be adversely affected is important to students, parents, and teachers. This knowledge can be paired with modified assignments and tests, as well as patience and support with homework.

Help students identify positive coping strategies: Talk to the students about how they coped with past challenges. Reinforce positive strategies they may have used to help them through these difficulties and teach new strategies if needed, including anxiety management or addressing intrusive thoughts. Some examples of positive coping include: relaxation exercises, talking to and spending time with friends and family, thought-stopping strategies for intrusive thoughts, maintaining a sense of routine, getting rest, and having a healthy diet. With the student, generate a menu of coping strategies they have used or could use with this event.

Identify triggers or reminders: Students' reactions may intensify when they experience a reminder of the trauma or loss. Reminders may be obvious, such as sirens or debris associated with a disaster or accident. Other triggers might be reading a story in class where a similar event occurs, hearing a song that reminds the student of the loss, or attending an event the deceased loved one used to enjoy. Holidays, birthdays, special occasions, and anniversaries all can be triggers for increased reactions. Triggers can occur soon after the trauma or loss, and in the short- and long-term aftermath of the event. Help students identify potential triggers and coping strategies to use when reactions occur. Work out with teachers a mechanism by which the student can leave class to speak with you or go to a safe location if feeling overwhelmed by a trigger.

Encourage return to extracurricular activities they enjoyed before the trauma: Participating in activi-

Students can augment their coping and healing when they reach out and help others who may also be distressed.



ties can help students begin to feel their world can have some semblance of normalcy again. Students may need "permission" to have fun again. They may not have the same level of enjoyment they once had, but with continued involvement, the enjoyment is likely to increase. Through these activities, students can reconnect with supportive friends and adults. The activities also provide a respite from the trauma and loss, another important piece of the healing process.

Encourage activities that promote help and healing: Students can augment their coping and healing when they reach out and help others who may also be distressed. Talk to students about ideas they may have for helping others in similar or even unrelated situations. Listen and incorporate their ideas into a helping and healing activity.

Maintain regular communication with the student's teachers

and caregivers: Continue to check in with adults important in the student's life. Teachers can give you insight about how the student is coping in class, and parents can give you similar information about how things are going at home. With permission, consider connecting with the student's pediatrician. This, coupled with your interactions, may be the best way of knowing if students are coping effectively or if more intensive mental health interventions may be needed. You can then help facilitate a referral as needed.

Be available for the immediate, short, and long term: Once you connect with students who have experienced a trauma or loss, you become someone they may turn to when they are having difficulties. It only takes a moment to say, "Tell me how things are going." This lets students know you care and you remember about their trauma or loss. They will likely turn to you when other challenges arise in the future. Your concern and support have can make a significant positive impact on students' lives immediately after a difficult event and well into their future.

As a school counselor, you are also in an ideal position to provide training and information to school personnel around issues of trauma and loss. Your background and knowledge of typical child development and behavior and recognition of mental health concerns makes you a trusted resource for your school community. ■

This article previously appeared in ASCA School Counselor, Vol. 50, No 1.

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