Setting Up for Success

Strategies to Help Young Students Engage in Learning

I am…

Melissa Holton, M.S.

School Psychologist,
Counselor (ERMHS), and
Behaviorist
for West Contra Costa USD

I am also…

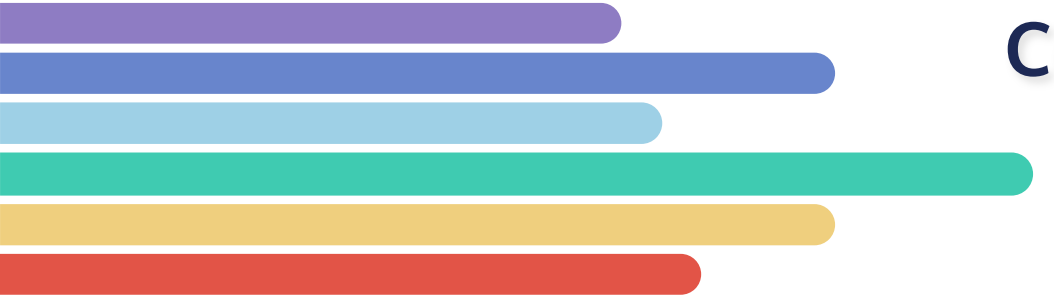
Mom to

Two boys ages 5 & 3

Pictures taken at the USS Hornet Museum in Almeda, CA

Goals for our time

Building A Foundation



Common Disabilities of Childhood

CDC data: ages 3-17 from 2016-2019:

Prevalence

- ~9.5% Attention Deficit Hyperactivity Disorder or ADHD (previously referred to as Attention Deficit Disorder or ADD <- this is an outdated term)
- ~9.4% Anxiety
- ~2.5% Autism Spectrum Disorder (the category of Asperger's no longer exists)
- ~8.9% Behavior Problems (e.g., Conduct Disorder, Oppositional Defiant Disorder, other non-diagnosed)
- ~0.2% Blindness or Visual Impairment
- ~0.3% Cerebral Palsy
- ~4.4% Depression
- ~0.6% Hearing Impairment
- ~1.2% Intellectual Disability
- ~8.0% Language Disorder
- ~7.9% Learning Disability
- ~0.8% Seizure Disorder (e.g., Epilepsy)

★ *Not every "condition" is defined as a disability.*
★ *Not every "disorder" has been recognized (e.g., sensory processing disorder, nonverbal learning disability, etc.)*

Medical vs. Educational Models

- Differences in criteria for diagnosis (medical model) and eligibility (educational model)
- Differences in terminology (even the same terms can have different meanings)
- Differences in service delivery

Medical vs. Educational Models

Medical Model = Diagnosis

Diagnostic & Statistical Manual of Mental Disorders, 5th Edition - Text Revision (DSM-V-TR)

- Used in USA, comparative to ICD-10 used internationally.
- DSM-V contains more than 70 disorders.
- Published March 2022 (previous edition published May 2013)
- Used in the healthcare field
- Provides diagnostic criteria for over 70 mental health disorders, which includes development disorders

Educational Model = Eligibility

California Education Code (Ed. Code)

- Used to determine eligibility for special education services in the public school system
- Embedded in the California Code of Regulations, Title V, Section 3030
- Last updated in 2015 (in effect July 2016)
- Derived from federal law (IDEA & ESSA)
- Provides eligibility criteria for 14 handicapping conditions

Medical vs. Educational Models

Diagnostic & Statistical Manual of Mental Disorders, 5th Edition - Text Revision (DSM-V-TR)

Neurodevelopmental Disorders:

- Intellectual Disabilities
  - Intellectual Disability
  - Global Developmental Delay
  - Unspecified Intellectual Disability
- Communication Disorders
  - Language Disorder
  - Speech Sound Disorder
  - Childhood Onset Fluency Disorder
  - Social Communication Disorder
  - Unspecified Communication Disorder
- Autism Spectrum Disorder
- Attention-Deficit/Hyperactivity Disorder
  - Attention-Deficit/Hyperactivity Disorder
    - Predominantly inattentive
    - Predominantly inattentive-hyperactive
    - Combined
  - Other Specified Attention-Deficit/hyperactivity Disorder
  - Unspecified Attention-Deficit/Hyperactivity Disorder
- Specific Learning Disorder
  - Dyslexia (mild-severe)
  - Dysgraphia (mild-severe)
  - Dyscalculia (mild-severe)
- Cont.

Anxiety Disorders:

- Separation Anxiety
- Selective Mutism
- Specific Phobia
- Social Anxiety Disorder
- Panic Disorder
- Agoraphobia
- Generalized Anxiety Disorder
- Cont.

Trauma and Stress-Related Disorders:

- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder
- Posttraumatic Stress Disorder
- Cont.

CA Education Code

1. Autism
2. Deaf-blindness*
3. Deafness*
4. Emotional Disturbance*
5. Hearing Impairment*
6. Intellectual Disability
7. Multiple Disabilities*
8. Orthopedic Impairment*
9. Other Health Impairment*
10. Specific Learning Disability
11. Speech and Language Disorder
12. Traumatic Brain Injury*
13. Visual Impairment*

* *Medical diagnoses*

DSM-V-TR Diagnostic Criteria for ASD

Diagnostic & Statistical Manual of Mental Disorders, 5th Edition - Text Revision (DSM-V-TR)

Autism Spectrum Disorder:
To meet diagnostic criteria for ASD according to DSM-5, a child must have persistent deficits in each of three areas of social communication and interaction (see A.1. through A.3. below) plus at least two of four types of restricted, repetitive behaviors (see B.1. through B.4. below).

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive; see text):
   1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
   2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
   3. Deficits in developing, maintaining, and understand relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

Specify current severity:
Severity is based on social communication impairments and restricted, repetitive patterns of behavior.

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):
   1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
   2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).
   3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
   4. Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g. apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

Specify current severity:
Severity is based on social communication impairments and restricted, repetitive patterns of behavior.

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).
D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.
E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

Note: Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder.
Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder.
Specify if:
With or without accompanying intellectual impairment.
With or without accompanying language impairment
Associated with a known medical or genetic condition or environmental factor
(Coding note: Use additional code to identify the associated medical or genetic condition.)
Associated with another neurodevelopmental, mental, or behavioral disorder
(Coding note: Use additional code[s] to identify the associated neurodevelopmental, mental, or behavioral disorder[s].
With catatonia (refer to the criteria for catatonia associated with another mental disorder)
(Coding note: Use additional code 293.89 catatonia associated with autism spectrum disorder to indicate the presence of the comorbid catatonia.)

CA Education Code Criteria for Autism

California Education Code

California Code of Regulations [CCR], Title V, Section 3030 (b)(1)

Autism:

(1) Autism means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three, and adversely affecting a child's educational performance. Other characteristics often associated with autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences.

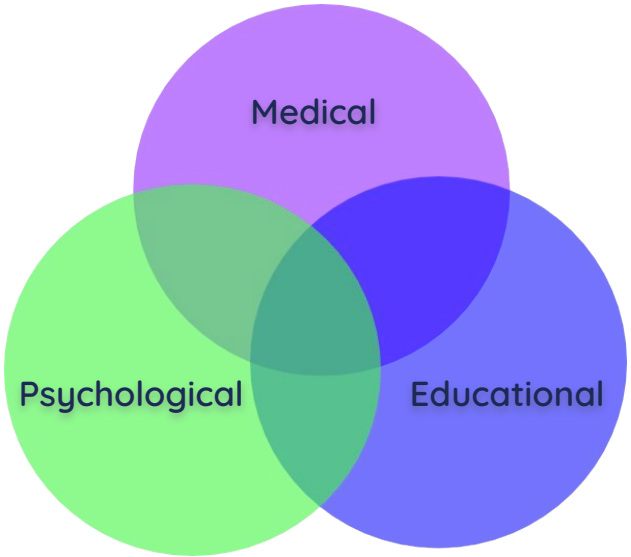
(A) Autism does not apply if a child's educational performance is adversely affected primarily because the child has an emotional disturbance, as defined in subdivision (b)(4) of this section.

(B) A child who manifests the characteristics of autism after age three could be identified as having autism if the criteria in subdivision (b)(1) of this section are satisfied.

Difficulties with Diagnoses

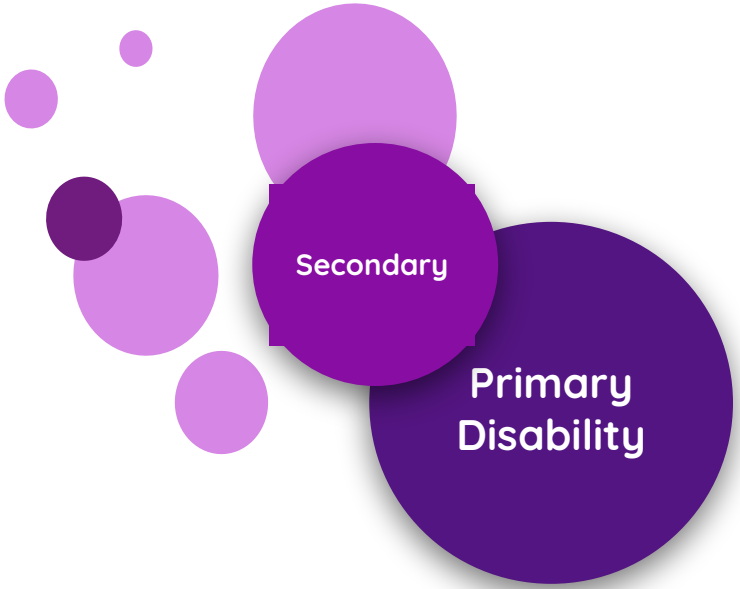
Categorizing Disorders

Disorders are often diagnosed and treated isolation, but many disorders overlap.



Comorbid Conditions

Often disabilities and disorders occur together.



What A Diagnosis Doesn't Tell You

Individual:

- It doesn't tell you how the disability is manifested or experienced by the individual
- It doesn't tell you the specific skills deficits or processing issues a child has, at the moment

Comorbidity:

- It doesn't (necessarily) tell you what comorbid disorders, conditions, or traits the child might have

Intensity:

- It doesn't tell you how much the disability is impacting the child's day-to-day functioning

Mitigation:

- It doesn't tell you what strengths the child has.
- It doesn't tell you the resources (i.e., family, community, agencies) the child has access to

Needs:

- It doesn't tell you what the child needs, in order for them to function best

Treatment:

- It doesn't tell you what treatments or strategies would be best for the child
- It doesn't tell you what accomodations the child needs
- It doesn't tell you what progress has already been made

What A Diagnosis Does Tell You

A diagnosis tells you that an individual exhibits significant enough impairments to justify treatment and/or services.

A diagnosis some of the common characteristics of the disability and what conditions might be associated with

A diagnosis gives you a starting point for asking

Diagnostic Summaries

Anxiety Disorder:

- Feelings of (different combinations): restlessness or being keyed up, easily fatigued, difficulty concentrating or mind going blank, irritability, muscle tension, sleep disturbances (unsatisfactory sleep or excessive sleep) for more than 6 months
- Can be situation specific or generalized
- Comorbid conditions: inattention or restlessness, attendance problems, disruptive behavior, depression, difficulty answering questions, frequent complaints of illness, learning problems or learning disorder, not completing academic tasks, panic attacks, avoiding participating in social groups, ASD

Attention-Deficit Hyperactivity Disorder (ADHD):

- Characterized by inattention and/or hyperactive behaviors that interfere with functioning or development
- Different subtypes: Inattentive, Hyperactive, Combined
- Inattention = unable to appropriately regulate attention, ignore distraction, complete tasks, appears disorganized
- Hyperactivity = fidgety, needs to move, impulsive, talks fast, “blurts out”
- Comorbid conditions: depression, anxiety, Tic disorders, behavior disorders, learning disabilities, language disabilities, motor skill difficulties, executive function deficits, social skill deficits, substance use disorders, obesity, prematurity, ASD

Diagnostic Summaries

Autism or Autism Spectrum Disorder (ASD):

- Characterized by deficits in verbal and nonverbal communication along with impaired social skills
  - Often accompanied by resistance to change (routines and environment), sensory sensitivities, repetitive actions/speech, and/or restricted interests
- Comorbid conditions: speech and language impairments, ADHD, learning disabilities, intellectual disability, sleep disorders, inadequate nutrition, GI disorders, prematurity, epilepsy, OCD, schizophrenia, bipolar, anxiety disorders, and depression

Behavior Problems:

- In DSM-V-TR diagnoses are Oppositional Defiant Disorder and Conduct Disorder
- Sometimes referred to as maladaptive behaviors
- Examples: eloping, aggressive behaviors (hitting, kicking, pinching, etc.), using inappropriate language, noncompliance, etc.
- Important to operationally define what is observed
- Comorbid conditions: ASD, ADHD, PTSD, prematurity, mood disturbances, learning disorder

Diagnostic Summaries

Intellectual Disability:

- Characterized by a significant cognitive impairment along with deficits in adaptive behaviors
- Adaptive behaviors are the behaviors people need to function on a daily basis: communication, care for oneself (dressing, feeding, caring for hygiene), perform simple/routine tasks, safety awareness, money & time skills, etc.
- Comorbid conditions: chronic health conditions, cerebral palsy, genetic abnormalities, ASD, epilepsy, anxiety disorders, sleep disorders, psychiatric disturbances, prematurity

Major Depressive Disorder or Depression:

- Depressed mood (irritablilty more likely in children) and loss of interest in pleasurable activities for most of the day for 2 weeks and combination of: weight loss or gain, slow thoughts and movement, fatigue/loss of energy most of the day, feelings of worthlessness or excessive guilt, decreased ability to think and make decisions, suicidal ideation
- Associated with medical conditions such as epilepsy, concussion, diabetes, thyroid issues, long-term illness, vitamin D deficiency
- Comorbid conditions: behavior problems, suicidal ideation/behavior, self-injury or self destructive behavior, substance use, prematurity, inattention

Diagnostic Summaries

Language Disorders:

- Many subgroups & sub-subgroups:
  - Speech = the way we say words & sounds
    - Articulation = pronunciation
    - Fluency = Stuttering
    - Voice = coordination of vocal folds and breath (volume and pitch)
  - Language = how we use words to share information and make requests
    - Receptive = understanding what people say
    - Expressive = sharing thoughts, feelings, needs/wants
      - Pragmatic = social language
- Can have combinations of deficits
- Comorbid conditions: ASD, ADHD, behavior problems, learning disorder, mood disorders, neurological disorders, developmental disorders, musculoskeletal disorders, prematurity, etc.

Learning Disorders:

- Difficulties learning (specific academic skills), manifested during school-age, underperforming what is typically expected (over 6 months)
- In DSM-5-TR called Dyslexia, Dyscalculia, Dysgraphia, and Learning Disorder - Not Otherwise Specified
- In Ed Code called Specific Learning Disability
- Can affect multiple areas
- Comorbid conditions: ASD, ADHD, behavior problems, language disorders, mood disorders, prematurity

Language Matters

- Person-first vs. Identity-first language
  - PFL = “Person with autism”
  - IFL = “Autistic person”
- Neurodivergent vs. neurotypical
- No more Asperger’s -> all forms of autism now referred to as Autism Spectrum Disorder (ASD)
- Function vs. Needs
  - High or low functioning
  - Mild, moderate, extensive support needs

Processing Moment

Characteristics of ASD

Reminder!

All people are different.

While people with similar disorders may share some common characteristics, no two people are alike in how their disorders manifest or respond to treatment.

ASD - Key Characteristics

All people diagnosed with ASD demonstrate impairments in social communication.

Common social difficulties:

- Poor play skills - poor cooperative play, lack of interest in peers, etc.
- Rejecting or ignoring social overtures
- Responding to or initiating joint attention (for purposes beyond requesting item/activity)
- Using and interpreting nonverbal signals - body language, facial expressions, tone of voice, etc.
- Maintaining conversations - conversational turn-taking, staying on-topic, asking follow-up questions
- Perspective taking - checking for understanding, making predictions based on previous knowledge, understanding others' thought processes, etc.

ASD - Key Characteristics

Autistic individuals may have specific difficulties in receptive and expressive language

Receptive language difficulties may include:

- Delayed vocabulary development
- Difficulty following directions
- Difficulty understanding abstract concepts
- Difficulty interpreting social language, such as sarcasm and jokes

Expressive language difficulties for:

Persons who are ***nonverbal*** may include:

- Delayed development or lack of spoken language (20-30% of individuals with ASD)
- May require augmentative and assistive communication (PECS, voice output device, high tech device, etc.).

Persons who are ***verbal*** may include:

- Delayed or immediate echolalia (with or without communicative intent)
- Stereotyped or repetitive use of non-echolalic language routines
- Use of idiosyncratic speech (e.g., inappropriate word use)
- Grammatical structure which may appear immature or pedantic
- Abnormal use of pitch, intonation, rhythm or stress

ASD - Key Characteristics

Autistic individuals may demonstrate restricted/repetitive and stereotyped patterns of behavior, interests, and activities.

- Stereotyped behaviors or repetitive motor movements
  - Examples: hand flapping or finger flicking, spinning objects, lining up toys, or use of speech such as - echolalia, stereotyped use of words or phrases, etc.
- Excessive adherence to routines and sameness
  - Examples: distressed by changes in the schedule, insisting on adherence to rules, or having inflexible thinking
- Ritualized patterns of behavior such as repetitive questioning or pacing.
- Highly restricted, fixated interests that are abnormal in intensity or focus.

ASD - Key Characteristics

Autistic individuals may have differences in sensory processing i.e., hyper or hypo sensitive to sensory input.

- **Visual input sensitivities**
  - Examples: staring at spinning objects, being bothered by fluorescent lights, or having trouble with keeping their place when reading
- **Auditory input sensitivities**
  - Examples: covering ears during loud noises, preferring loud music or none at all in the car, or not being able to respond to verbal prompts when in a noisy area.
- **Tactile input sensitivities**
  - Examples: disliking getting hands or feet messy, avoiding/preferring certain surfaces, textures, or fabrics, or finding specific types of touch aversive (light touch on the shoulder vs. deep pressure hug).
- **Taste/Smell sensitivities**
  - Examples: not eating certain foods, licking or tasting non-food items, or finding strong perfume or cologne aversive.
- **Proprioceptive input sensitivities** are difficulties interpreting sensations from muscles, joints, ligaments, and tendons e.g., putting too much pressure on pencil when writing or falling/crashing into things
- **Vestibular input sensitivities** are over or under sensitivities to balance and movement sensations e.g., having trouble staying seated, constantly leaning head on hands and arms, or easily losing balance.

ASD - Key Characteristics

Autistic individuals may have difficulties with executive functioning (i.e., attention, working memory, planning, reasoning, sequencing, and flexible thinking).

- Attention - ability to focus our mental and physical resources on a stimuli, while ignoring the rest. Attention is a limited resource
- Working Memory - capacity to take-in, store, and manipulate information (tied to attention)
- Planning - mental process that allows us to choose the necessary actions to reach a goal, decide the right order, assign each task to the proper cognitive resources, and establish a plan of action
    - This involves: goal-setting, sequencing steps, understanding cause and effect, sense of time, attention, memory, etc.
    - Example: getting dressed -> socks before shoes
- Flexible thinking - allows for problem-solving through the generation of alternative solutions
    - Rigid thinkers - thrive on routine and consistency, often have strong work ethic, goal-oriented, trouble understanding social rules (too much variability), “black and white” thinking, anxiety when something is perceived to be “wrong”, prone to catastrophizing

ASD - Key Characteristics

No two people with ASD are alike, but many demonstrate common learning characteristics.

- Often demonstrate strong rote memory skills. May need more time to process information and/or may have smaller working memory capacity. It may be especially difficulty to process several pieces of information at one time.
  - May need additional time and more supports (visual reminders, prompts, etc.)
- Many individuals with ASD are able to better process information when presented visually.
  - May benefit from pictures, modeling the behaviors of others, hands-on activities, and concrete examples.
- Unstructured time or extensive waiting can be difficult for many.
  - Schedules or checklists can help ease the anxiety or confusion surrounding unstructured time. Consider having a box of wait time activities, such as books, toys, or sensory items.
- ASD individuals often have difficulty generalizing learned skills from one setting to another.
  - May need to teach skills across different settings, people, and activities.
- Organization of materials and activities can be problematic.
  - May need to teach individuals with ASD how to organize their materials for different classes, keep their lockers tidy, how to use an agenda, and gather materials for homework.
- Some individuals with ASD are high-achieving in all areas, some have high word recognition skills, but poor comprehension, others have high calculation skills, but poor applied math problem skills, and a proportion are low in all areas.

Processing Moment

Strategies for Success

Evidence Based Practices for ASD

- Focused intervention practices that have substantial evidence for effectiveness in promoting positive outcomes for learners, especially those with ASD.
- As of 2022 there are 28 Evidence Based Practices for ASD
- Matrix of EBPS
- Definition of EBPs
- AFIRM learning modules

Reinforcement

Reinforcement is an event or activity that occurs after an individual exhibits a desired behavior; which helps to increase the occurrence of that behavior

Positive Reinforcement:

an event or activity that occurs/is added after an individual exhibits a desired behavior, which helps to increase the occurrence of that behavior

Examples:

- Verbal Praise
- Food
- Access to toy/ highly preferred item
- Token Boards
- Stickers & Star Charts
- Access to highly preferred activity/ person

Negative Reinforcement:

an event or activity that is taken away/stopped after an individual exhibits a desired behavior, which helps to increase the occurrence of that behavior

Examples:

- Break from non-preferred task
- End of non-preferred task
- Removal of aversive stimulus
- Decrease of intensity of aversive stimulus (e.g. turning music down)

Reinforcement: Key Components

- Provided/Eliminated immediately following the target behavior
- Match the target behavior in value (ex: washing hands = sticker or a gummy)
- Are meaningful to the individual
- Access is minimized outside of the targeted/intervention setting
- Rotated to avoid satiation

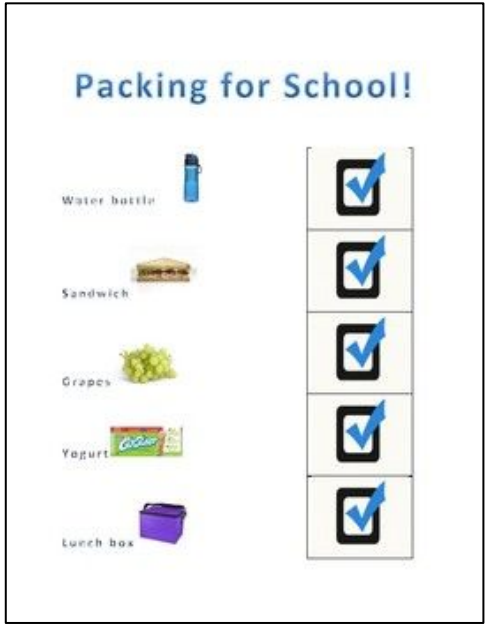
Visual Supports

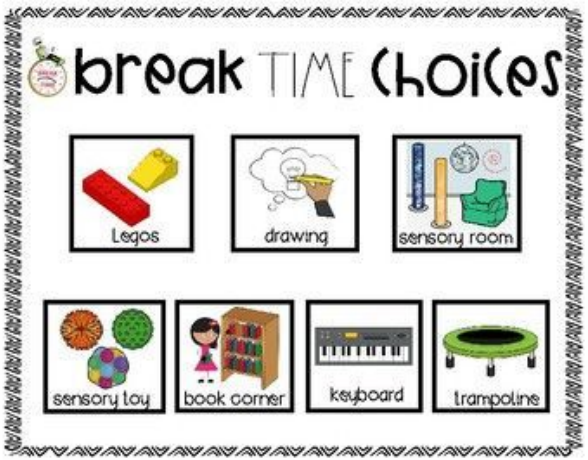
Visual supports help a child acquire a new skill without the assistance of verbal or gestural prompts. They use pictures or symbols to represent actions and objects. They are helpful for all learners, especially young children, non-readers, and visual learners. They help support independence because they do not require the presence or direct input from another person.

Examples include:

- Visual schedule (icons of daily activities)
- Pictures (e.g. pictures of handwashing in the restroom)
- Choice boards (activities, reinforcers)
- Checklists

Visual Supports: Examples





Visual Supports: Examples

Social Narratives

Visually represented stories that describe social situations and socially appropriate responses or behaviors to help individuals acquire and use appropriate social skills. Can be produced in a variety of formats. Includes information about how others feel, why the situation occurs, how others may react to the situation and where and why the situation occurs.

- Social Stories ™
- Social Articles ™
- Social Scripts
- Cartooning
- Comic Strip Conversations ™
- Power Cards
- Social Autopsies

Created by Carol Gray- Carol Gray Video

Social Narrative: Examples

Social Narrative: Examples

I Can
Control My Voice

I like making humming sounds with my voice. When I hum it tickles my throat, nose, and lips. I like the sound of my humming.

Humming helps me when I have too much energy. It helps when I'm feeling bored. It helps me when it's too quiet or when there are too many other sounds around me.

Humming is not always the best choice. Sometimes my humming bothers other people. It might make to hard for them to focus or hear what other people are saying.

There are times when it's **okay** to hum;

- at home
- at grandpa's house
- at nana and papa's house
- when I'm outside playing

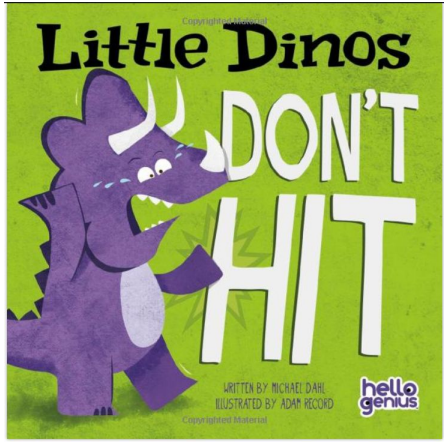
There are some times when it's **not okay** to hum;

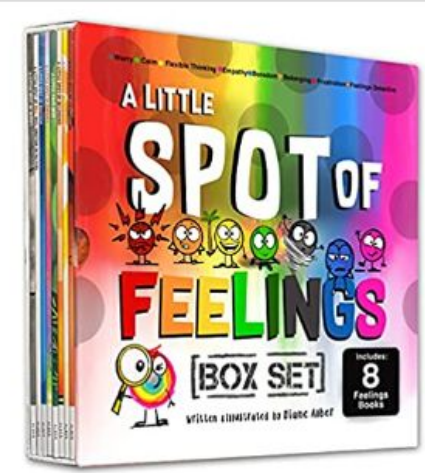
- at school
- in the store
- in small spaces with other people
- when other people are talking

I can practice controlling my voice, so I only hum when it's okay. If I need help, here's some things I can try:

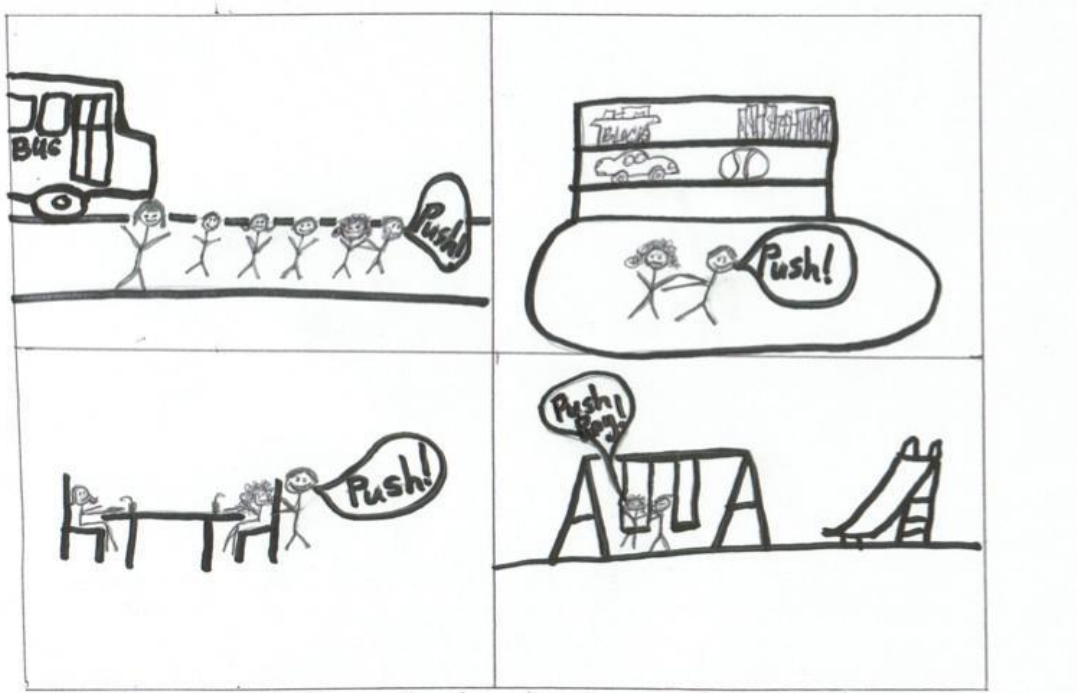
- I can ask for a break outside,
- I can use headphones to listen to music (classical works best),
- I can do an interesting activity (like puzzles or working with numbers).

If I try my best to control my voice my family, my teachers, and my friends will be happy and proud!
I should be proud of me too!!





Social Narrative: Examples



Teacher asked Roy why he kept pushing LaVerne — at the bus, at playtime, at lunch time? He pointed to the last block and said, "swing." Then "LaVerne," and then "Push!" He was trying to play!

Practical Tips

- **Communication is key!!!**
  - Casual conversations at drop-off and pick-up with the teacher
  - Sharing common terms/phrases your child is familiar with
  - Sharing what your child's interests are
  - Informing the teacher if there's anything new or different
    - Illness, sleep disturbances, family/caregiver changes
    - New interests, upcoming events, new skills
  - Parents are the information hub (school, medical, therapies, etc.)

Tips for Working with CHILD

Setting Expectations

CHILD wants to do well. He's better able to manage expectations when he understands what is required of him. Here's how we set expectations with him:

- **Make 1-5 simple, clearly stated expectations for each activity**. Presented as; "These are the expectations for circle time: #1 Sit criss-cross on the carpet. #2 Keep your body still (while he's still learning the expectations, explain that he shouldn't bump into other people). #3 Control your voice (teach – no humming), etc.
- **Ask him to repeat them back to you**. (You may have to help him remember the first few times).
- **Have him repeat them and/or review them before each activity.**
- Use visual reminders, if needed
- Use timers, tell him/show him how much time he has left

Giving Directions

CHILD has receptive and expressive language delays. So, sometimes it's hard to tell how much he understands. Here are some things we do to help him:

- **Make sure you have his attention** and direct him to look at you (paired with the gesture for pointing to your eyes).
- **Use simple, direct language** (ex: "Go sit on your chair please", "Please clean up your puzzle", etc.)
- **Repeat directions**
- **Have him repeat the direction(s) back to you**.
  - When he's having a really hard time you may need to go one word at a time for him to repeat it.
- **Pair verbal directions with visual prompt** (i.e., written directions, pictures, or an object prompt- like handing him an object and telling him to put it somewhere).
- If he's been told "no" or to leave something alone, and he seems to understand, but tries to engage with the object/activity again, you can **remind him of the "rule" by using a negative sound** like "uh-uh" or calling his name in a warning tone.

Compliance with Directions

Again, CHILD wants to do well. Usually, if he's not following directions it's because he didn't hear/understand the direction(s) or he's gotten distracted. We try to give him several chances to comply:

- **Use a hierarchy of request**:
  - The **first time** a direction is given, he gets a **"please" and praise** for compliance.
  - **Wait a 1 minute** (to give him a chance to process) before issuing directions a second time. The **second time involves a firmer tone** and "please" is not necessarily included. Also, **check for understanding of the direction(s)** by having him repeat it.
  - **Wait 1 minute**. If he has still not complied: **call his name, then slowly start counting 1-2-3**. Usually, by "2" he's looking around, trying to figure out what he's supposed to be doing.
    - *If he has not complied by "3", you will need to approach him and physically prompt him to complete the direction (ex: take his hand and lead him to his chair). You can also follow up with a mild reprimand about him not making good choices and what he should next time.*
- To **finish-up** with an object/activity; **first state that it's time to be done, then if he doesn't comply then say "Alright CHILD, 3-2-1 all done".**
- Use visual supports, as needed (ex: schedules, checklist, etc.)
- Negotiate/compromise – if he's struggling to complete an activity, offer a compromise about how many items to complete or how much time to spend on a task
- Use "First, Then" (chart or verbal) to reinforce his compliance with a preferred activity/object as an incentive.
- If he is very distracted by some other object/activity, we try to remove the distraction (this may trigger him to become upset and cry).
- If he continues to have low compliance, you may want to remove him from the classroom and give him a chance to reset. During the break you can talk to him about the importance of listening, following directions, and asking for help if he needs it.

Coping Strategies

CHILD is pretty tolerant of most things. When he gets upset it's usually because he's been denied an object or activity he wants. When this happens, he may start to cry. He will also struggle to explain what's wrong. Here's somethings that help him calm down:

- Ask him to take a **deep breath** (repeat 1-2 times).
- Have him **count** (ex: count to 20 by 2's, count backwards from 20, count to 30 by 3's), if he's struggling to get through this encourage him by asking what comes next and giving praise.
- Ask him if he would like a drink of **water.**
- Ask him if he would like **squeezes** (at home we give him a hug and squeeze him gently, at school you could give him light-moderate pressure on his shoulders or use a weighted lap pad).
- Ask if he would like to **take a break outside.**

Practical Tips

Linking Home and School

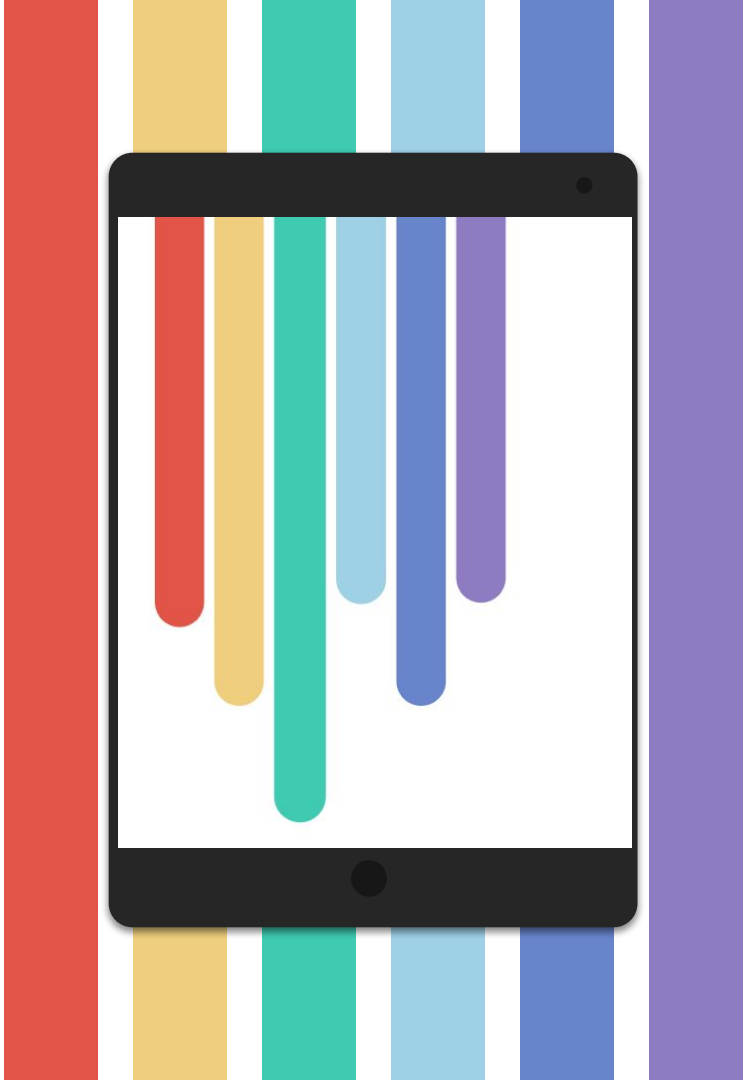
- Incorporate schedules and routines from school at home and visa versa
- Practise new skills and routines at home
- Understand that children may act very differently at home and at school
  - Videos can be helpful to show child demonstrating a behavior/skill not observed at school
- Release of information forms need to be signed before the school team can communicate with other agencies

Practical Tips

Understand that this will be a journey:

- Emotional journey
- Developmental journey
- Ups and Downs
- Destination is unknown

Q & A



Evidence-Based Practices for ASD:

- Matrix of EBPS
- Definition of EBPs
- AFIRM learning modules

Teachers Pay Teachers - for pre-made visual supports, learning activities, social stories, etc.; free and paid content

Canva - for customizing social stories and visual supports; premade templates, images; free and pro versions

Iris Center - instructional modules and other resources about wide range of behavior intervention and disability-related topics

Thank you!

Email: mholton@wccusd.net