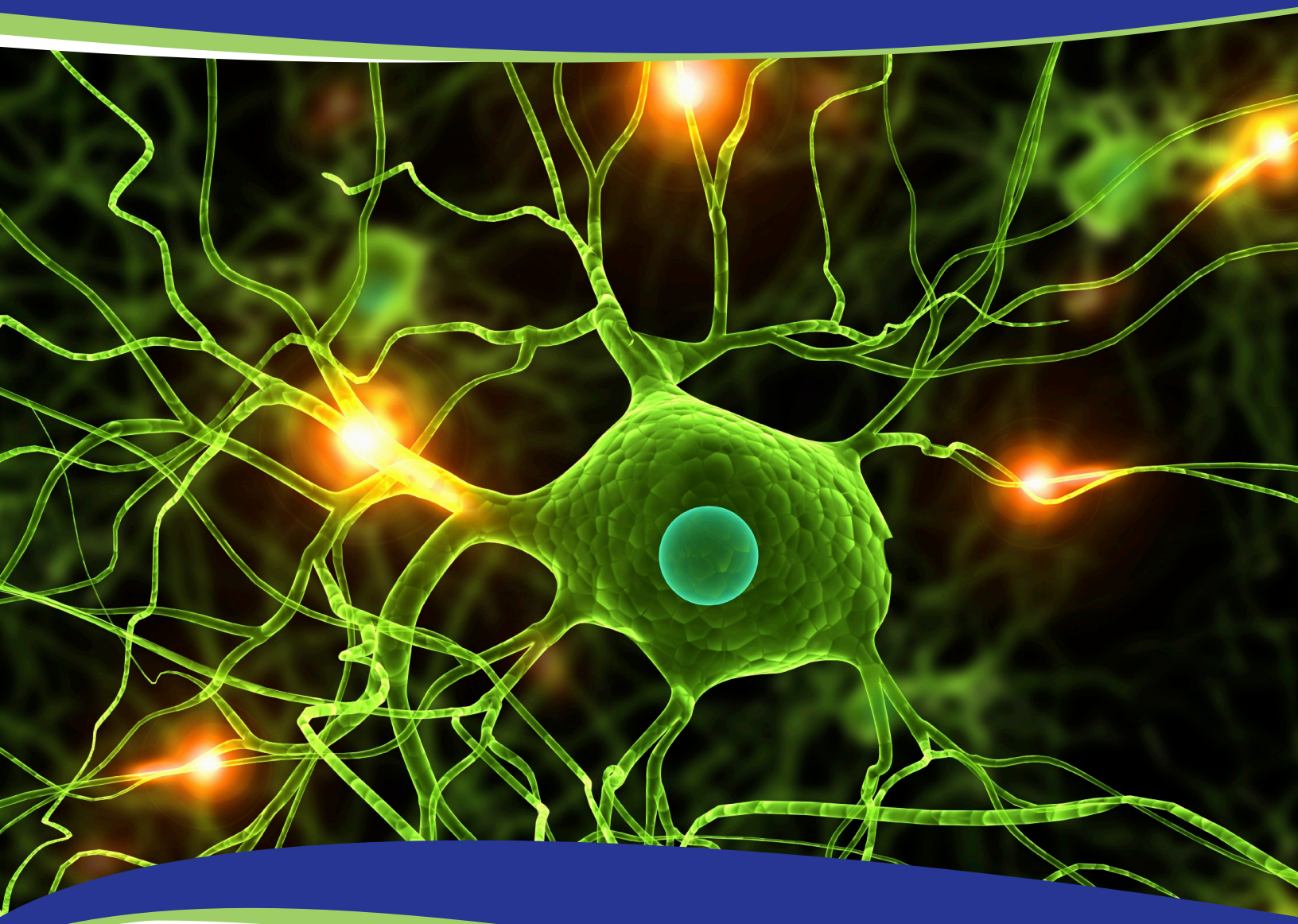

Autism & Mental Health Issues

A guidebook on mental health issues affecting individuals with Autism Spectrum Disorder

Introduction to Autism & Mental Health

Autism is a neuro-developmental disorder that is typically diagnosed by age three and is a lifelong disability. It has an impact on three main areas in a person's life: social development, communication skills and restricted interests. As a spectrum disorder, autism can affect someone in mild to severe ways in these areas. In addition, we see sensory and behavioral differences that can become barriers to fully participating in one's education.

Students on the autism spectrum often have a co-existing mental health disorder that may be undiagnosed. Professionals have little information on this topic and frequently miss the signs and symptoms of a co-existing mental health disorder. Teachers are left unequipped in their classrooms to determine what is motivating their students with autism to behave in ways that challenge their education. The assumption of most people is that all behaviors are related to a student's autism diagnosis. This assumption will leave mental health issues that exist untreated and may, in fact, exacerbate symptoms.

The research indicates that mental health issues have a negative impact on academic performance and sustainability. For example, studies have looked at students diagnosed with ADHD, pediatric bipolar disorder, depression and anxiety, and have found similar outcomes. Van Ameringen, Mancinia, and Farvoldenb (2003)[1] found that anxiety disorders are associated with a higher rate of early school withdrawal. Pavuluri, O'Connor, Harral, Moss and Sweeney (2006)[2] studied pediatric bipolar disorder and ADHD and noted that no difference between these two groups of students existed when looking at academic performance. Both groups experienced difficulties with attention, memory, and problem solving. All of these issues served to contribute to poor academic performance. Similarly, students diagnosed with depressive mood disorders have been related to lower academic achievement[3]. There is a high percentage of students diagnosed with Pervasive Developmental Disorder Not Otherwise Specified who have been determined to have a co-existing mental health issue.

The information contained in this document is to provide the reader with signs and symptoms of autism and mental health concerns, what educators need to know, managing a crisis, and resources that are available to support students, their families and educators.

Screening for Comorbid Psychiatric Conditions in Students with Autism Spectrum Disorders

About Mental Health Screening

Mental health screening tools

A mental health screening tool is a brief, culturally sensitive questionnaire for identifying individuals who may have mental health challenges that merit further attention, intervention, or evaluation[4,5]

- **Screening tools can serve three primary purposes:**
  1. Assess an individual's symptoms.
  2. Measure progress after intervention has begun.
  3. Provide a framework for discussing an individual's challenges.
- A screening tool is **not a diagnostic tool** but rather a "triage" process. A positive screen does not necessarily mean a student meets criteria for a diagnosis. Only a trained clinician is qualified to interpret screening results.

First steps in implementing the screening process[6]

- **Develop a planning committee** comprised of parents, educators, mental health experts, primary care providers, and other representatives from the community. The planning team will:
  - » **Develop policy** ensuring confidentiality safeguards are in place.
  - » **Draft agreements** between schools and collaborating community providers clarifying responsibilities in order to facilitate the collaborative process and address liability issues.
  - » **Ensure policies are approved** by appropriate education and mental health boards.
  - » **Determine when to administer** the screen (e.g., transitional grades: 6th–7th, and 9th–10th) and **what** tools to use.
  - » **Ensure adequate staff training** and supervision on **how to** administer, score, interpret the data, and refer to community providers, etc.
  - » **Identify a "Screening Coordinator"** (e.g., guidance counselor, nurse) who assumes responsibility for the screening process.
- **A list of recommended screening tools** can be found at http://www2.massgeneral.org/schoolpsychiatry. The majority of these screening tools have not been studied in individuals with ASD, and results should be interpreted cautiously. In addition, the Autism Spectrum Disorder-Comorbid for Children (ASD-CC) is a 49-item informant based rating scale designed to identify emotional difficulties that commonly occur with ASD.

Important steps to remember when implementing and interpreting the screen

1. **Obtain parental consent and student assent** before administering screening.
2. **Administer screening** in a confidential area, and prioritize privacy of results.
3. **Remember clinical judgment can override results** from a screening assessment. A student who does not meet a particular cut-off score on a screening tool may still need further evaluation.
4. **Notify and offer assistance** in connecting parents of any student found to be in need of further evaluation with a local mental health professional.
5. **Immediately refer to a trained professional** any student who screens positive for suicidal or homicidal ideation.

Next Steps

1. **Formulate a "Planning Team"** comprised of relevant individuals from school and community to develop confidentiality policy, formalize community liaisons, and make critical decisions about the screening process (e.g., when to screen and what tools to use).
2. **Ensure adequate staff training** on screening tool implementation, scoring, and interpretation.
3. **Designate contact person** within the school to oversee the screening process.
4. **Obtain parent consent and student assent** before administering screen.
5. **Make appropriate referrals** based on screening results, including immediate referral for positive screen for suicidal or homicidal ideation.

Signs of Possible Mental Health Conditions in Persons with Autism Spectrum Disorders

While the core deficits of autism have been well-studied, a less investigated cause of impairment in individuals with ASD is the occurrence of comorbid psychiatric disorders. Recent epidemiological studies have suggested that nearly three out of every four individuals with ASD meet criteria for another (comorbid) mental health disorder[7]. Unfortunately, comorbidities are often overlooked in the ASD population, with serious negative consequences on quality of life, school and family functioning, and access to appropriate treatment.

Prevalence of Mental Health Issues in ASD

Research has consistently indicated that persons with ASD exhibit an **increased risk of developing psychiatric disorders**, when compared to the general population.

- Studies within the last decade reveal rates between 67% and 70.8%[7,8] of individuals with ASD who would meet criteria for an additional mental health disorder described within the Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM-IV)[9,10].
- Having a comorbid psychiatric condition significantly increases the risk of multiple diagnoses.
  - » 41% of the entire sample had 2 or more co-occurring disorders in addition to ASD, with 17% having 2 disorders and 24% having 3 or more[7].
- Evidence also suggests that individuals with ASD may be twice as likely to exhibit comorbid disorders when compared to those with non-ASD intellectual or developmental disabilities[11,12].

Prevalence rates for the most common co-occurring psychiatric disorders:

One of the challenges to diagnosing comorbid psychiatric conditions in ASD is the result of specific exclusionary criteria within the DSM-IV diagnostic system[9,10].

- In the DSM-IV, a diagnosis of autism precludes making a formal diagnosis of a number of other psychiatric disorders, including Attention Deficit Hyperactivity Disorder (ADHD), Obsessive Compulsive Disorder (OCD) and Social Anxiety Disorder, thus making it impossible to receive a comorbid clinical diagnosis of these mental health conditions.
- This policy warrants reconsideration due to the large number of individuals with clinical symptoms in these areas and the implications for treatment that this presents.

ADHD

ADHD may be the **most common co-occurring psychiatric disorder** among children with ASD, occurring in approximately 50% of one sample[8].

- Other studies have estimated rates as falling between 28.2% and 31%[7,13].
- The rate increased to nearly 55% when sub-threshold cases were included[13].
- ADHD in combination with ASD may confer significantly increased risk for a more complicated symptom presentation; nearly 85% of individuals with comorbid ASD/ADHD met criteria for an additional disorder[13].

Anxiety

Anxiety symptoms seem to be "part and parcel" of the everyday experience of many individuals with ASD, with a large number (over 40%) meeting DSM-IV criteria for specific anxiety conditions[7]. The most common anxiety diagnoses appear to be:

- **Specific Phobias or fears (44%)**—fear of specific objects, activities, or situations (e.g., heights, insects, the dark, storms, etc.).
- **Social Anxiety (29.2%)**—fear of being negatively evaluated in social situations.
- **Generalized Anxiety (13.4%)**—persistent, excessive, uncontrollable anxiety/worrying.
- **Panic Disorder (10.1%)**—recurrent panic attacks that are not associated with any specific stimuli.
- **Obsessive Compulsive Disorder (OCD)** is also very common, although rates in individuals with ASD have varied across studies from approximately 8% to more than 33%[7,13].
  - » However, some level of compulsive behavior may be observed in the majority (>85%) of individuals with ASD[14] indicated that the vast majority (86%) of their sample exhibited some level of compulsive behavior.
- **Disorders which commonly co-occur with anxiety disorders** in the general population, including Tourette syndrome and other tic disorders, have also been observed in ASD.

Depression and Mood Disorders

Depression and Mood Disorders have produced the **most variable comorbidity rates of all the mental health conditions**, ranging from very rare (less than 1%) to upwards of 30%. More is known about prevalence rates of depression in ASD than is known about comorbidity with bipolar disorder.

- **Depression**
  - » In one study, 10% of the children with autism had at least 1 episode of major depression meeting DSM-IV criteria[13].
  - » Rates for sub-threshold symptoms (a period of depression or irritability which did not meet DSM-IV depression/dysthymic disorder criteria) range from 11% to nearly 25%[7,13].
  - » As in the general population, rates of mood/depressive disorders seem to increase in adolescence and adulthood, occurring in 25% and 30-37% of individuals, respectively[8,15].
- **Bipolar Disorder**
  - » One study indicated that the prevalence of bipolar disorder was 3 times that of major depressive disorder, accounting for 75% of their sample of individuals with ASD and comorbid mood disorders[15].
  - » Family history of mood disorders in first- and second-degree relatives may exacerbate risk for developing bipolar disorder. Only 10.7% of individuals with ASD without a comorbid mood disorder had a family history of mood disorder, compared with 37.5% of those with comorbid ASD/mood disorder[15].

Identification and treatment of mood disorders in ASD is critical, as research indicates that the presence of clinically significant depressive symptoms is linked to less optimal long term outcomes[16].

Factors which may increase risk for comorbidity

Certain factors may play a role in increasing the likelihood of developing a comorbid disorder and may underlie the high prevalence rates of psychiatric conditions among individuals with ASD:

Associated medical conditions & syndromes

Individuals with ASD have additional comorbid medical conditions that are associated with psychiatric comorbidity.

- Examples include Fragile X syndrome (associated with hyperactivity and social anxiety), Prader-Willi syndrome (associated with compulsive behavior) and seizure disorders (which can be associated with aggression and/or anxiety).

Familial genetic factors

There is increasing evidence that the incidence of autism and mood disorders seem to cluster in families.

- Bipolar disorder might be more common in first- and second-degree relatives families with Asperger syndrome.
- An association between symptoms of OCD in parents of children with autism and repetitive and restricted behaviors in their children has also been observed[17].

Psychosocial factors

These may also contribute to the development of comorbid psychiatric conditions, both in the general population and in individuals with ASD (e.g., peer rejection, low levels of social support, academic difficulties, etc.).

- **Individuals may be at increased risk** for encountering these psychosocial factors due to their social and communication deficits and behavioral patterns.
- **Cognitive and processing limitations** (such as problem-solving/coping skills) are often less well-developed in persons with ASD, which further increases their risk of adverse psychosocial experiences.
- **Many individuals with ASD are aware of their difficulties** and this awareness often increases during puberty. Awareness of one's "differentness" may underlie the development of anxiety and depression.

Factors Which may Hinder Identification and Diagnosis

Individuals with ASD often are under-diagnosed and therefore go untreated. Community professionals may face specific challenges in making an accurate diagnosis of psychiatric conditions among individuals with ASD. Some of the more common roadblocks to accurate diagnosis include:

- **Diagnostic Overshadowing:** this term refers to the tendency to attribute the development of new problems/behaviors to the ASD condition itself (e.g., all challenging behaviors are attributed to the known disorder), effectively ruling out the possibility of the presence of another disorder.
- **Baseline exaggeration** is a related concept in which behaviors signaling the development of a psychiatric condition simply reflect an increase, or exacerbation of, long-standing behavioral difficulties. This increase in severity of challenging behaviors may be a communication of internal distress (agitation, depression, hypomania, anxiety) and is especially likely to occur for symptoms that commonly occur in autism, such as hyperactivity or obsessiveness.
- **Applicability of current diagnostic criteria to individuals with ASD is questionable**, particularly for those with intellectual disabilities and/or significant communication challenges. Symptoms may "look" different in individuals with ASD than they do in typically-developing individuals, while others cannot be evaluated as accurately in non-verbal or minimally-verbal persons with ASD.
  - » Since many diagnoses, such as depression and anxiety, rely in part on subjective complaints (feelings of sadness, restlessness, loss of pleasure, worries or intrusive thoughts), less-verbal individuals will often not meet diagnostic criteria.

These roadblocks to making comorbid diagnoses are especially dangerous because they limit access to psychiatric condition-specific treatment and may prevent the diagnosis and treatment of other serious psychological impairments. **Identification and treatment of comorbid disorders is associated with better long term outcomes than treating core symptoms of autism alone**[13].

Potential Indicators of an Underlying Mental Health Issue in Individuals with ASD

This section describes common symptoms of specific psychiatric disorders in the general population, along with behaviors that may be noticed in an individual with ASD. It is important to note that symptoms of anxiety and mood disorders (depression/bipolar) often can only be recognized as deviations from previously exhibited behavior, especially when the individual's level of cognitive and/or language ability is limited and/or there is

no well-developed augmentative communication strategies.

ADHD

Symptoms of ADHD in the general population include the following main symptom "clusters": hyperactivity, impulsivity, and inattention. Individuals can be diagnosed with 3 different "subtypes" of ADHD, based on which symptom cluster their behavior reflects.

1. **The predominantly hyperactive/ impulsive subtype**, consists of symptoms such as interrupting others, blurting out answers, being "on the go," difficulty sitting still and talking excessively.
2. **The predominantly inattentive subtype** is characterized by distractibility, forgetfulness, difficulty with sustaining focus on tasks or activities, organizational problems, and making careless errors.
3. **The combined subtype** includes symptoms from both hyperactivity/impulsivity and inattention.

Behaviors which may be observed in individuals with ASD:

- **All of the symptoms of ADHD** may be observed in a similar manner in individuals with ASD.
- However, children with ASD are significantly **more likely to exhibit the inattentive subtype** (rates of 65% in a recent ASD sample) and children without developmental disorder typically exhibit the combined subtype[13].

Anxiety

- Our current diagnostic system contains a variety of specific anxiety disorders, which differ primarily in the object or source of the anxiety, as opposed to the specific symptoms displayed.
- All anxiety disorders result in avoidance of the source of anxiety, or experiences of extreme distress when the source is encountered.
- Symptoms can be physiological, behavioral and/or cognitive:
  - **Physical reactions** include sleep difficulties (e.g., problems falling or staying asleep), muscle tension, being easily fatigued, headaches, stomachaches, shortness of breath, rapid heartbeat, and sweaty palms.
  - **Cognitive symptoms** include difficulty concentrating (inattention) or having one's mind go "blank," worry which is difficult to control and which occurs in a wide range of situations, activities and subjective feelings of restlessness or being "keyed-up" or "on edge" and/or irritability.
  - **Behavioral symptoms** include agitation (fidgeting, playing with objects, difficulty sitting still, pacing), difficulty separating from caregivers, avoidance of certain objects and/or activities or distress (freezing, crying, trembling) when these objects/activities are encountered.

Behaviors which may indicate an anxiety disorder in individuals with ASD:

- **Avoidance** of new people, tasks, environments and/or materials.
- Increases in **performance of rituals** and/ or rigid and inflexible behavior.
- Increases in reliance to **rules or scripts.**
- Increases in **resistance to transitions** or changes to routine.
- Narrowing of **focus of attention** on special interest.
- **Withdraws from social situations** or begins to avoid social situations.
- **Low frustration tolerance** and/or tantrums when things don't go "as expected."
- **Perfectionistic behavior** (may be related to anxiety over performance).
- **Seeks constant reassurance** through repetitive questioning and/or checking behaviors.

In addition, the following may also differentiate the symptoms seen in individuals with ASD from those in the general population.

- **Specific phobias[13]:**
  - Common phobias in typically developing children (such as fear of flying, stores, standing in lines, bridges, and tunnels) seem to occur at much lower rates in children with autism.
  - The most common phobias in children with ASD (found in 32% of one sample) were fear of needles and/or shots and crowds.
  - Over 10% of the children with autism also had a phobia of loud noises, which is not common in typically developing children.
- **Obsessive-compulsive disorder (OCD)[13]:**
  - The most common type of compulsion in children with ASD was a ritual involving other individuals; nearly half of the children diagnosed with OCD had compulsions that involved others having to do things a certain way.
  - Another frequent compulsive behavior for children with ASD was the "need to tell/ask", which typically involves having to ask the same question in extensive question-asking rituals or having to say the same statement over and over.

Depression

- The most essential features of major depression in DSM-IV are change of mood and loss of interest. Depressed mood is typically indicated by either subjective report (e.g., feels sadness or emptiness) or observation made by others (e.g., appears tearful or irritable).
- Additional symptoms include: feelings of lethargy, fatigue, or loss of energy, changes in sleep and/or eating habits (either too much or too little), reported feelings of worthlessness or excessive or inappropriate guilt, difficulty concentrating or indecisiveness, and recurrent thoughts of death, suicidal thoughts, suicide attempts or plans for committing suicide.
- In individuals with autism, the most common presenting symptoms of depression may be significantly increased agitation, self-injury, and/or temper outbursts[18].

Behaviors which may indicate depression in individuals with ASD:

- **Increase in tearfulness or irritability** and/or absence of "happiness" or smiling in individuals who frequently did so in the past.
- **Loss of interest** in activities or friends.
- **Resistance to participating** in activities that were once engaged in willingly.
- **Agitation or restlessness**, pacing, hyperactivity, or wandering.
- Development of, or an increase in **tantrums, meltdowns, or aggression.**
- Development of, or an increase in **stereotyped behaviors**.
- **Decreased or increased sleep**, resists bedtime and/or wakes up frequently at night.
- **Difficulty staying awake** during the day.
- **Decrease in attention** to tasks.
- **Decrease in productivity** and/or apathy.
- **Self-deprecating** comments.
- Deliberate, **potentially lethal acts**.

Bipolar Disorder

- In the general population, bipolar disorder is defined by distinct periods where

mood is persistently and abnormally elevated, expansive, or irritable.

- Individuals with bipolar disorder may have a decreased need for sleep (often going for days without sleeping) and an inflated sense of self-esteem or importance (feels one is "special" and/or "invincible").
- Additional symptoms include distractibility, racing thoughts, a pressure to keep talking, and/or excessive risk-taking behaviors or involvement in pleasurable activities with high potential for harmful consequences (such as sexual activity, drug use, compulsive gambling, shopping, etc.).

Behaviors which may indicate bipolar disorder in individuals with ASD:

- **Mood is inflated**, elated, irritable, angry or fluctuates between happy and irritable throughout the day regardless of circumstances.
- **Decreased frustration tolerance**, overactivity/hyperactivity.
- **Aware at night and active** about the house or awakens early and appears energetic despite their lack of sleep.
- In relationship to developmental level, an **individual feels they can do or achieve more** than is typical for them.
- **May create new tasks** or take on new jobs or work that are not realistic.
- **Increase in the frequency and/or intensity of vocal stereotypes**, perseverative questioning and/or repetitive speech.
- **Increase in preoccupation** with hobbies or recreational activities.
- **Increase in the frequency or intensity of ritualistic or compulsive activities**, rituals may become rapid or disorganized.
- **Increase in the intrusiveness** of interactions with others; less inhibited (disinhibition).
- Increase in obvious **sexual interests**.
- **Inability to follow** previously understood rules and limits.
- **Hallucinations**, delusions, and paranoid thoughts.

Next Steps

- **Provide training** to families and school/community personnel working with students with ASD with information about mental health disorders and behaviors which should serve as "red flags" for the consideration of a comorbid psychiatric disorder.
- **Identify professionals** with expertise in psychiatric/psychological disorders who can participate in the assessment and treatment/educational decision-making teams when a comorbid disorder is suspected.
- **Consider the possibility of a comorbid mental health condition** for individuals with ASD exhibiting any of the following:
  - » Changes in behavioral patterns that cannot be explained by medical conditions or recent environmental changes.
  - » Change in behavioral patterns that persist longer than expected after an environmental change.
  - » Sudden development of new behaviors.
  - » Any time a functional behavior assessment is being conducted or a change of placement (due to challenging behaviors) is being considered for a student.
- **Refer student for screening/evaluation** of mental health concerns.
- **Provide teachers and family members with information** and strategies to assist student while they await screening and diagnosis

Additional Readings

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Journals and Websites

- **National Association for the Dually Diagnosed (NADD)**— www.thenadd.org
- **Journal of Autism and Developmental Disorders**
- **Mental Health Aspects of Developmental Disabilities**
- **Diagnostic Manual—Intellectual Disability (DM-ID): A Textbook of Diagnosis of Mental Disorders**
  - » An adaptation of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition—Text Revision (DSM-IV-TR).
  - » The goal of this text is to facilitate a more accurate psychiatric diagnosis of people with ID. Chapters cover individual DSM-IV categories and special issues (i.e., assessment and diagnostic procedures and presentations of behavioral phenotypes of genetic disorders). For each disorder, descriptive text and details of how to apply diagnostic criteria, as well as tables of adapted diagnostic criteria are included.

Awaiting Diagnosis: Supporting Individuals with Autism Spectrum Disorders & Mental Health Concerns

Proactive Measures to Support Mental Health Issues

Take A Public Health Approach[19]

- **Know the students.**
  - » Take data on the mental health of students
    - » Are mental health needs being met?
    - » Are there gaps in mental health services?
  - » Use data to identify risk factors and protective factors for students.
- **Identify risk and protective factors.**
  - » **Risk factors:** conditions that increase the likelihood of problem behavior.
  - » **Protective factors:** conditions that interact with risk factors to reduce the likelihood of problem behavior.
  - » Balance a deficit approach to reduce risk factors with a strengths-based approach to promote protective factors.

Promote Physical Health

- Provide information regarding healthy eating, exercise, sleep, etc.
- Provide information regarding stress management.

Teach Coping Skills

- **Support the development of self-awareness**, particularly of one's emotional experiences (i.e. Anger Scale or Anger-mometer).
- **Teach self-regulation** techniques (i.e. deep breathing, progressive muscle relaxation, sensory breaks, etc.).

Teach a Student to Relax[20]

- Remember that **relaxation is a skill**.
  - » Teach explicitly, practice regularly, and monitor progress (data collection).
- Pick the **right time**.
  - » Without distractions to promote concentration.
- Make the **time**.
  - » Set aside a regular time to teach and practice relaxation skills.
- Create a **habit**.
  - » Practice consistently until relaxation skills become a ritual or habit.
- Create a **relaxing environment**.
  - » Provide a quiet, comfortable area for the student to learn and practice.
- Use **praise** and make it fun!
  - » Encourage the student with praise for success as well as attempts.
  - » Make it meaningful to the student.
- **Keep it simple** and short.
  - » Practice often for short periods of time.
- Teach by **example**.
  - » Demonstrate relaxation skills; model what the student should do to relax.
- Focus on the **goal**.
  - » Focus on a student using these skills when situations arise.

Be Prepared[21]

- **Know community resources** and contact information.
- **Establish relationships** with related community professionals.
  - » Psychologists, psychiatrists, physicians, law enforcement officials, crisis teams, etc.
- **Educate law enforcement** officials about potential crises.
- **Teach student with ASD how to communicate** with law enforcement officers, firefighters, emergency medical technicians, and other community helpers.
- **Teach the student with ASD whom to call** in different situations.

Establish a Crisis Plan with the Student and their Family

- Provide the student with ASD a **laminated information card** including: name, diagnosis, symptoms/behaviors, medications, allergies, and guardian's name and contact information.
- **Establish primary contact** (physician et al) as well as back-up contact in the event of an emergency.
- Enter the student in a **community identification system**, if possible.
- Consider a **MedicAlert bracelet**.

Methods to Calm an Escalating Situation

Responding Constructively to Emotional Outbursts[21]

- Recognize that **"meltdowns"** do not "come out of nowhere."
- Recognize that **you can make a difference**; avoid the assumption that there is "nothing" you can do.

- Recognize that **you may experience emotions** during the process as well.
  - » Remain calm; avoid a power struggle with the student.
- **Recognize the warning signs** or triggers for a "meltdown."
- Reduce the **stressors** in the environment.
  - » Remove distractions from the environment or remove the student from the stressful environment.
- **Respond to the student** RATHER than the behavior.
- **Focus on the present** moment and issue at hand.
- **Be concise**; less is more with verbal directions.
  - » Avoid teaching, preaching, or explaining until the student recovers from distress.
  - » Focus directions on what you want the person to do rather than what you don't want them to do.
- **Use simple, direct language.**
  - » Avoid rhetorical questions, ultimatums, generalizations, sarcasm, or gentle teasing.
  - » Speak to the student one-on-one, if possible.
- Try to **encourage the student to re-phrase,** in his/her own words, important points you want them to retain to make sure they've understood.
- **Mean what you say and say what you mean**; follow-up words with actions.
- **Maintain realistic expectations** for the student.
  - » Recognize that the student may struggle to understand you, particularly via non-verbal communication (i.e. facial expression, gestures, etc.).
- **Focus on emotional equilibrium** then provide support for recovery after equilibrium is regained.
  - » Allow quiet downtime with a relaxing activity.
  - » Praise student for positive aspects of situation, explicitly and generously.
  - » After recovery, teach the student how to respond appropriately in future similar situations.

Tips on Communicating During an Escalating Situation[22]

- **Be gentle**; Use a soft but firm tone.
- **Be tactful.**
- Start with an open and **positive attitude.**
- **Keep it short.**
- **Wait patiently**; don't rush.
- **Provide appropriate distance** for the individual student (be close or allow space).
- **Reverse** some yes/no, short list or either/or questions for clarity.
- **Keep your facial expressions to a minimum**. Facial expressions are often difficult to interpret for many individuals with ASD and may be distracting.

Interventions to Manage a Crisis Situation

1. **Remain Calm**, to the extent possible.
2. **Assess** the severity of the situation.
3. Follow the **Crisis Plan**.
4. Determine whom to **contact**.
   - » Visit http://www.211atyourfingertips.org to locate appropriate services.
   - » Dial 211: Free, Confidential Crisis Counseling.
   - » Dial 911: Emergency mental health and basic life support ambulance services.
5. **Dial 9-1-1** only for an emergency (www.tampagov.net).
   - **An Emergency is:**
     - » Any serious medical problem (chest pain, seizure, bleeding, serious wounds).
     - » Any type of fire.
     - » Any life threatening situation (fights, person w/ weapons, gas leaks, etc.).
     - » Any crime in progress (whether or not a life is threatened).
6. **Dial 813-231-6130** (Hillsborough County) for non-emergencies.
   - **Non-emergencies include:**
     - » Delayed or "not in progress" offenses.
     - » Intoxicated persons who are not disorderly.
     - » Cars blocking the street or driveway.
     - » Non-injury auto accidents.
     - » Minor complaints.

Next Steps

Proactive Measures

- **Taking data** on mental health of all students.
- **Identifying risk factors** and protective factors from data.
- **Promoting** protective factors and reducing risk factors.
- **Teaching** self-awareness, self-regulation, and relaxation skills.
- **Providing opportunities** to practice skills prior to distress.
- **Learning community resources** and contact information (including school security).
- **Establishing relationships** with community resources and shared necessary information.
- **Teaching student with ASD appropriate contacts** for different situations.
- **Teaching student with ASD how to communicate** with community contacts.
- **Establishing Crisis Plan** with student, family of student, and related professionals.

Calming an Escalating Situation

- Carefully **review and learn the methods** to calm an escalating situation.
- **Discuss methods** to calm an escalating situation with related staff/team.
- **Create materials** to support the student during escalating situations or distress.
- **Practice self-regulation** techniques as a responsible adult during times of distress.
- **Minimize stressors** in environment.
- **Create materials** or developed area for downtime following recovery from distress.
- **Implement methods** to calm an escalating situation, as needed.
- **Debrief escalated situation** with student as well as related staff/team **AFTER** situation occurs.

Manage a Crisis

- **Remain calm** by using self-regulation techniques.
- **Assess the severity** of the situation.
- **Determine** the appropriate contact.
- **Contact** the appropriate resources.

Related Websites

- **The National Association for the Dually Diagnosed**
  http://www.thenadd.org
- **The City of Tampa**
  www.tampagov.net

End Notes/ References

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