AUTISM SPECTRUM DISORDERS AND THE ROLES OF THE SCHOOL SOCIAL WORKER

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With countless books, news stories, and the public’s musing on the topic of autism spectrum disorders (ASD), it is clear that this mental health issue has gained more attention in the past few years than ever before. ASDs represent a group of developmental brain disorders that affect one’s ability to interact with the world around him. The Centers for Disease Control (CDC) estimates that an average of one in 150 children has an ASD (CDC, 2009). As awareness of the disorder grows, the mysteries surrounding ASDs have yet to be unraveled and continue to puzzle medical professionals, teachers, service providers, and affected individuals. However, individual’s affected by ASD and the professionals who interact with them have an immediate need for support and information.

Social workers take on many roles, including that of clinician, consultant, educator, and advocate. Because of these various roles, it is important that school social workers (SSWs) be knowledgeable about all facets of ASD, including the diagnostic process, the assessment process, and the range of evidence-based intervention efforts. Further, it is necessary for SSWs to understand the policies affecting children experiencing ASD at the school, state, and federal levels.

Clinical Intervention and Collaborative Consultation

Currently, a few successful evidence-based practice interventions have been identified, including discrete trial instruction and pivotal response training; however, behavioral therapy interventions have been particularly and significantly successful in addressing the needs of an individual with Pervasive Developmental Disorder (PDD) and ASD.

Applied behavioral analysis (ABA) has been used to systematically improve a child’s behaviors through a reward system (Rutherford, Quinn, & Mathur, 2004). A baseline analysis of the child’s behaviors is documented prior to introducing an intervention. The child’s behaviors are then documented again after the intervention takes place to determine if there has been a change. If additional support is needed for the child to be successful in the classroom, the SSW advocates for placing an ABA professional in the classroom, along with the teacher, to provide these services.

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Recently, there have been several high-profile, completed suicides by children under the age of 14. In April 2009, an 11-year-old boy from Springfield, Massachusetts, hung himself in his home while his mother was in the kitchen preparing supper. Several days later, another 11-year-old boy from Atlanta, Georgia, hung himself in his home. The families of both boys claimed that the suicides were the result of bullying that occurred in their schools. In February 2009, a 10-year-old boy who lived near Chicago hung himself in the school bathroom after being disciplined by a teacher. All three cases emphasize the need for action by school social workers in elementary and middle schools.

Public health statistics on suicide are showing an alarming increase in suicide among children under the age of 14. The specific meaning of these statistics is not immediately clear, but the numbers infer that suicide is a leading cause of death among children in this age group. The American Association of Suicidology (AAS) reports that the suicide rate for this age group increased by 50 percent from 1981 to 2005 and that 216 children completed suicide in the United States in 2006 (2009). The statistics appear to be affected by underreporting, a belief that young children do not kill themselves, or that death was accidental (Barrio, 2007).

Since there is limited information about the nature of childhood suicide, the role of school teachers and school social workers is crucial. For many, it is inconceivable to imagine a young child mentally arriving at a place where he or she wishes to die. School social workers are typically trained with developmental theories that state early-age children do not cognitively understand the finality of death. It is easy to infer from these theories that children cannot really intend to kill themselves if they do not understand the meaning of death. The statistics and the specific accounts of children who kill themselves, however, point to the importance of understanding the nature of suicide in this age group and the significance of the school’s role. If armed with knowledge about suicidal behavior in children 14 and under, school social workers and teachers, in collaboration with parents, can take the appropriate actions that may possibly save the lives of suicidal children.
Since ASDs are such complex disorders and characteristics of the disorders vary among individuals, practitioners need to be trained and knowledgeable about various interventions to achieve possible success with each client. Each individual must be acknowledged as a unique person who has specific needs—not just a disorder. Serving children with ASD will also require SSWs to collaborate with other professionals involved in the client’s care, and they should be familiar with and knowledgeable of the interventions used by each clinician. For example, interventions that include sensory integration therapy; the recommendation of certain medications, including homeopathic medications and supplements; as well as recommended dietary changes are common treatments used in caring for children with ASD.

Occupational therapy, physical therapy, and speech therapy have proven effective in addressing the sensory integration needs. An SSW needs to advocate for the child to be assessed by one or all of these professionals, either by those in the school system or by those in a private practice or public health clinic/agency setting. An occupational therapist will often work with the individual’s five senses of sight, touch, sound, taste, and smell. He or she will also incorporate balance, sense of movement, and sense of knowing one’s position in space (boundaries) into the therapy intervention plan. Physical therapists can help children with ASD who often suffer from acute motor delays and weak muscle tone to build up strength, coordination, and basic motor skills. Because most ASD children are either non-verbal (at the lower end of the speech spectrum) or extremely verbal (at the upper end of the speech spectrum), speech therapists are normally brought in to help improve and/or develop a wide range of communication skills, including non-verbal communication (e.g., gestural communication, use of picture/flash cards), speech pragmatics (i.e., appropriately knowing how, when, and why to say things), conversation skills (e.g., back-and-forth exchange), and concept skills (e.g., use of “story scripts” to help convey abstract ideas such as “truth” and “justice”).

Medical doctors often prescribe a wide variety of medications to address different behavioral concerns and other related symptoms. The SSW should be knowledgeable of the child’s medication and be aware of its possible medical implications and side effects. Homeopathic intervention treatments are utilized to invoke alterations in the child’s physiological process based on touch, movement, manipulation, and other sensory manipulations (Levy & Hyman, 2005). Homeopathic practitioners often focus on nutritional supplements, special diets, avoidance of allergenic foods, treatment of intestinal bacterial/yeast over-growth, and detoxification of heavy metals (Levy & Hyman, 2005).

Another intervention commonly utilized is recommended change in diet. The gluten-free/casein-free diet is currently the most commonly used dietary treatment. The rationale

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for the gluten-free/casein-free diet is based on the assumption that children with ASD have an inability to break down proteins from products such as wheat and dairy, thus causing developmental delays and/or impairments (Levy & Hyman, 2005). Gluten- and casein-free food products can be found at natural food stores, but with the increase of popularity in the diet, more products are becoming available at general grocery stores, as well.

**Educator and Advocate**

SSWs can educate those in the school system who interact with children with ASD, so they should be aware of the various organizations and range of resources available that specialize in ASD. *The School Community Tool Kit*—developed by Autism Speaks, the nation’s largest autism science and advocacy organization—can be an invaluable resource for developing trainings for school personnel. Autism Speaks also provides a state-by-state database of resources for family members and parents in need of support. Informing parents of local support groups is crucial.

In addition to the need for information and support, families are also struggling with the high costs of treatment interventions. In most states, health insurance companies are not covering needed costs of interventions, and often families must pay these costs out of their pockets or be forced to go without services. Autism treatment can cost families up to $50,000 a year (Johnson, 2009), and according to Autism Speaks (2009) who applauded the New Jersey Senate for joining 12 other states in passing autism insurance reform legislation, now “thirteen states – Arizona, Colorado, Connecticut, Florida, Louisiana, Illinois, Indiana, Montana, New Mexico, Pennsylvania, South Carolina and Texas – have enacted autism insurance reform legislation. Some two dozen other state legislatures introduced similar legislation during the 2009 session.” SSWs need to be informed of what legislative activities have occurred in their state and what treatment is covered. In addition, SSWs can initiate such legislation and advocate for the passage of a particular bill. Given the current health care reform debates, SSWs can also encourage families dealing with ASDs and their communities to contact their state representatives and voice their concerns on how health care reform will affect families dealing with autism.

There have been great strides made within the past several years in addressing service needs associated with ASD. Even though services are currently limited or inaccessible for those living in low-income families or in poverty, there are great grounds for optimism. As awareness grows, more people are seeing the need to support individuals. It is the SSW’s responsibility to acknowledge, learn from, and develop new intervention strategies that best fit the diverse needs of individuals and families. In order to provide the best services possible, social workers must stay up-to-date on current research and consult with other professionals regarding evidence-based interventions. Social workers and other service care providers need to work collaboratively in an effort to provide low-cost, effective intervention strategies. Social workers, medical professionals, school professionals, and other service providers must reach out to those in need of services.

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A literature review on suicidal behavior in children under the age of 12 states that “the essential quality of suicidality is the intent to cause self-injury or death, regardless of cognitive ability to understand finality, lethality, or outcomes” (Tishler, Reiss, & Rhodes, 2007). For children under the age of 14, suicidal gestures may be exhibited more in school than at home. It is not uncommon for children to make the threats to kill themselves after negative interactions with teachers or other children. Without an understanding of childhood suicide, it is possible to view suicidal gestures as attention-seeking and/or high risk behaviors. (Barrio, 2007).

In these situations, children’s self-injurious behaviors, like running out in traffic, perching on high window sills, or stabbing themselves with pencils, can be misinterpreted as non-suicidal gestures.

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References


Resources
Autism Society of Minnesota (AuSM)
www.ausm.org
An organization of families, educators, care givers, and professionals committed to supporting individuals with autism spectrum disorders (ASD). Established in 1971, AuSM has members throughout the state of Minnesota and the upper Midwest.

Autism Speaks
www.autismspeaks.org
The nation’s largest autism science and advocacy organization, dedicated to funding research into the causes, prevention, treatments and a cure for autism; increasing awareness of autism spectrum disorders; and advocating for the needs of individuals with autism and their families.

The School Community Tool Kit
www.autismspeaks.org/docs/family_services_docs/sk/School_Community_Tool_Kit.pdf
A comprehensive tool kit, designed by Autism Speaks, to assist members of the school community in understanding and supporting students with autism.
The Role of the School Social Worker

At some point in their careers, most school social workers and teachers will likely know a student who dies by the act of suicide. All school professionals, inevitably, will face the reality of losing a child and the need to help other students cope with death. The death of a child by suicide can shake the very core beliefs of any helping professional. The after-effects resound throughout schools, affecting other students, staff members, parents, and, indeed, the entire community. When this happens, the school social worker is expected to soothe, explain, and assist students and school personnel to cope with the aftermath.

There are many ways for school social workers to address the issue of childhood suicide and to be involved in prevention efforts. These might include establishing a school crisis team aimed at helping any student identified as depressed or expressing suicidal thoughts, educating all school personnel about the nature of suicidal thinking and behavior, developing peer assistance programs, and developing school curricula aimed at prevention.

Suicide is preventable. Children who are contemplating suicide frequently display warning signs of their distress. Parents, teachers, friends, and school social workers are in key positions to pick up on these signs and offer help. School social workers should be aware of the risk and protective factors associated with youth suicide. According to Dr. Vincent Iannelli (2009), a board certified pediatrician and Fellow of the American Academy of Pediatrics, several risk factors have been identified that include the following:

- Mood disorders
- Chronic anxiety
- Previous suicide attempts
- Genetics/family history of suicide or psychiatric conditions
- Stressful events, including relationship breakups/family problems, etc.
- Drug and alcohol abuse
- Eating disorders
- Being bullied
- Dropping out of school

An example of a protective factor is the presence of a strong, supportive, involved parent (Barrio, 2007). According to the Centers for Disease Control (2009), a 1999 report by the U.S. Public Health Service identified several protective factors:

- Effective clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Family and community support (connectedness)
- Support from ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent ways of handling disputes
- Cultural and religious beliefs that discourage suicide and support instincts for self-preservation

By being aware of the risk and protective factors, the school social worker knows how to accurately intervene. Suicide is also prevented by educating children and parents. This is accomplished by incorporating specific content into the school curriculum about suicide awareness through staff development programs for teachers, parents, administrators, and students.

At the secondary level, the Signs of Suicide (SOS) program has been identified by social work researchers (Joe & Bryant, 2007) and the U.S. Department of Health and Human Services-Substance Abuse and Mental Health Services...
Administration (SAMHSA, 2008) for its National Registry of Evidence-based Programs and Practices as an effective suicide prevention program. The SOS program is designed as a two-day, secondary school-based intervention that includes screening and education. Students are screened for depression and suicide risk and referred for professional help as needed. The SOS program uses an educational approach to increase the knowledge of depressive symptoms and to teach students how to recognize these symptoms in oneself or others.

The SOS curriculum has been designed for use with secondary school students. It does not appear that an evidenced-based suicide prevention curriculum has been developed for elementary children. Although there are several effective and character education programs for use with elementary school children, these do not specifically target suicidal thinking or behavior for this age group.

The school environment can be a key to preventing child suicide. School personnel must be willing to intervene when a life is at stake. School social workers can be influential in assisting schools by providing leadership, staff development, and prevention and intervention programs for children at risk for suicide. School social workers can also advocate for new elementary curricula being adopted and aid in the elimination of misconceptions surrounding suicide in children.

References


“Why aren’t you in school?”
“I don’t go to school.”
“Why not?”
“They don’t want me there.”
(Steinbeck, 1943)

Alternative education means many different things to many different people. Alternative education can refer to schools or programs that provide non-traditional, new, or non-standard educational options for students who are not presently academically successful in comprehensive educational environments, “paying particular attention to the student’s individual social needs and academic requirements for a high school diploma” (Smink & Reimer, 2005). Alternative education options include continuation schools—an alternative to comprehensive high school, primarily for students who are considered at-risk of not graduating at the normal pace due to disciplinary reasons, teen pregnancy, drug use, etc., or alternatively because they are mentally gifted and the regular high school pace is below their level—opportunity programs, Regional Occupational Programs (ROP), and adult education options. Martens (2004) states that alternative education settings are designed to accommodate educational, behavioral, and/or medical needs of children and adolescents that cannot be adequately addressed in a traditional school environment. Usually these students are offered the possibility of shorter school days and open-entry/open-exit formats through “participating in a variable credit” schema.

Jimerson (2001) reminds us that children “do not haphazardly fail to meet academic standards; rather their lack of academic success often reflects the failure of adults to provide appropriate support and scaffolding to facilitate their early developmental and academic trajectories.” Occasionally, according to Martens (2004), students themselves “may not function or feel comfortable on a comprehensive [school] campus, so these students may opt for the alternative program as well.” Some schools and programs have strong political, scholarly, or philosophical orientations, while others are more of an assembly of administrators, teachers, and students dissatisfied with some aspect of mainstream or traditional K-12 education.

Last year, California enrolled more than six million children in its K-12 schools (California Department of Education, 2008). Of that group “more than 10% of…public high school students attend some kind of ‘alternative’ program” (California Alternative Education Research Project [CAERP], 2008). This research also highlighted these students’ “difficult circumstances and challenges.”

One Recent Study
CAERP (2008) examined California’s 519 continuation schools and found several significant facts about the students:

• Continuation school students are more likely to be Hispanic, African-American, and English learners.
• Continuation school students appear to be more likely to drop out.
• Between 11% and 14% of continuation students report that they have either engaged in or been a victim of violence.
• Continuation students are almost three times more likely than comprehensive high school students to be in foster care or living with a relative other than a parent.

Programs were generalized into three general categories: strong youth development programs, programs that operate in a midrange, and dumping grounds. The categorization was based on the variance of program design and function, which is heavily influenced by local county and district context. Programs identified as being most effective shared several similar characteristics:

• Partnerships with community colleges
• Relationships with local businesses

• Relationships with mental health and substance abuse program providers
• Relationships with probation departments

The authors of the CAERP report concluded, “Many vulnerable youth are caught in the middle, wanting a different course for themselves, but not finding the support or ‘hand holds’ that would enable them to change direction.” Dropping out becomes a series of decisions and experiences, not a particular point-in-time event (Bridgeland, Dilulio, & Morison, 2006).

What Can Be Done?

One significant conclusion seems evident: “In the absence of clear signals about expectations,
systematic support, and incentives for performance, the quality of instruction in schools depends largely on the beliefs, effort, and motivation of individual teachers and administrators” (CAERP, 2008). However, as some have argued, ‘remediation’ is rarely a fair alternative to skilled instruction the first time. Denied diplomas will not make up for denied opportunities” (Rogers, 2005).

Consequently, there are at least three apparent and understandable lessons gained from working with these high-risk students, according to Landsberg (2006). First, to achieve success in reclamation, they must be reclaimed individually, one at a time, with lots of special attention. Second, teachers, counselors, and administrators must perform their duties with extraordinary passion, grace, humility, and dedication in order to produce significant results. Third, school personnel usually cannot change each student’s negative personal environment—but neither can they forget, ignore, or discount it. Specifically, school social workers can continue to help students in alternative education settings by remaining knowledgeable and skilled in their practice and advocating for students in the school and community at large.

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References


Resource

NASW Credentialing Center
SocialWorkers.org/credentials
Certified School Social Work Specialist (C-SSWS)
NASW has partnered with the Give an Hour Program. Your support is needed. Please help by volunteering. For more information about the program and how you can register please visit www.giveanhour.org.
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