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School-Based Anxiety Treatments for Children and Adolescents

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SUMMARY

School-based empirically supported treatments for anxiety disorders are a promising avenue for providing necessary intervention to distressed youth who would otherwise never receive treatment. Sustaining such programs in school settings should be viewed as a multiple-stage process, from integration of the program into the institution and maintenance of the intervention to responding to institutional change and ownership of the program by the school.⁵¹ Given the scarce resources available to schools, additional research on embedding programs into the school culture and maximizing existing resources is essential to enhancing the sustainability of school-based interventions for anxiety disorders and reaching youth in need.

Keywords

Anxiety; School-based treatment; Children; Adolescents; Dissemination

Anxiety disorders are common among children and adolescents; however, anxious youth are rarely identified.¹ Unlike disruptive behavior disorders, anxiety disorders often go unnoticed by teachers and parents because clinically anxious youth are generally compliant, follow rules, and do not draw attention. Therefore, it is not surprising that anxious youth are the least likely among youth with psychiatric disorders to receive treatment.² Furthermore, even when youth access services, it is unclear what type of treatment they receive. Although several empirically supported treatments for anxious youth exist,^{3–5} more than 80% of community-based treatment for anxious youth is not supported by scientific evidence.^{6,7} There are also many barriers to treatment in traditional settings (eg, community clinics and independent clinicians), including stigma, long waitlists, and high costs.⁸ Taken together, these factors underscore the importance of exploring alternative venues and methods for identifying and treating youth with anxiety disorders.

ADVANTAGES OF SCHOOL-BASED TREATMENT

Schools are viewed as a promising avenue for providing mental health services to children and adolescents. Schools are already the main point-of-entry into the mental health service system for youth,^{9–12} with one study showing that more than 70% of mental health treatment

for youth is provided by schools.¹⁰ In addition, because schools offer relatively convenient and inexpensive services, barriers to accessing specialty care, such as financial and transportation difficulties, can be eliminated.^{13,14} For example, school-based mental health clinics have been found to increase service utilization for both low-income adolescents¹⁵ as well as adolescents enrolled in a health maintenance organization.¹⁶ In light of common stigmas associated with mental health care, school-based treatment may also promote more positive attitudes toward mental health services among youth,^{17,18} especially when offered among a variety of other routine educational and counseling services. Access to treatment in schools may normalize mental health care and may therefore increase the likelihood of students in need receiving treatment.

For these reasons, school-based treatments are receiving increasing attention as a venue to address the unmet mental health needs of youth, particularly those with anxiety disorders.¹⁹ School-based treatments are particularly appropriate for anxiety disorders as schools provide unique opportunities for identification of anxious youth, treatment, and generalization of skills. For example, youth may display significant anxiety in academic and social settings at school that is not apparent or easily triggered in a more comfortable home environment with family support.²⁰ Schools are also optimal for the treatment of anxiety disorders, as there are ample opportunities to help students confront the many anxiety-provoking situations present at school. Specifically, exposure exercises at school could focus on exams and tests for youth with generalized anxiety disorder and achievement-oriented worries. Socially anxious youth may be helped to face negative evaluation fears associated with public speaking, performance in gym and music classes, and approaching unfamiliar peers and authority figures. Additionally, peers and teachers may be enlisted to assist in exposures to feared situations. In sum, these factors indicate that schools are advantageous settings for the treatment of anxiety disorders in children and adolescents.

Although schools are ideal venues for anxiety disorder treatment in youth, only in recent years has the transportability of efficacious cognitive-behavioral treatments for anxiety disorders to schools been evaluated. This article will review four school-based treatments for anxiety disorders that have shown promise in controlled trials (see Table 1 for an overview and Table 2 for links to treatment manuals). This will be followed by a discussion of issues and challenges related to delivering anxiety treatments in a school environment and important areas for future research.

COOL KIDS

Treatment Description

The Cool Kids Program: School Version²¹ is an eight-session cognitive-behavioral intervention for anxiety symptoms in children, which was adapted for the school environment from previous group treatments for anxiety disorders.²² Sessions focus on core cognitive-behavioral treatment (CBT) components, such as psychoeducation, cognitive restructuring, and graduated exposure to anxiety-provoking situations. Additionally, Cool Kids includes sessions on assertiveness, coping with bullying, and social skills. Treatment sessions last about 1 hour each and are conducted during the school day in groups of eight to ten children. Two parent information sessions address parenting strategies as well as concepts taught to the children, which parents are encouraged to use to manage their own anxiety.

Evidence for Cool Kids

Mifsud and Rapee²¹ evaluated Cool Kids in a sample of 91 children (ages 9–10) by randomizing nine schools in low-income communities in Australia to either Cool Kids or a waitlist control.²¹ Students scoring in the clinical range of the Revised Manifest Anxiety

Scale,²³ a self-report measure of anxiety, were selected to participate. Groups were co-led by a school counselor and an experienced community mental health worker. Compared to the control, children in the Cool Kids condition showed significantly greater decreases in self- and teacher-reported anxiety both at post-treatment and 4-month follow-up. This study suggests that Cool Kids is a promising school-based intervention; however, since delivery by experienced community mental health workers is not a sustainable model, further research is needed to evaluate its effectiveness when delivered only by school-based providers.

BALTIMORE CHILD ANXIETY TREATMENT STUDY IN THE SCHOOLS

Treatment Description

Baltimore Child Anxiety Treatment Study in the Schools (BCATSS)²⁴⁻²⁶ is designed to provide mental health treatment for inner-city adolescents with anxiety disorders as an integrated part of established school-based mental health clinics. The treatment was adapted from a previously supported group CBT program.^{5,27} The BCATSS program was tailored for the school environment and an urban, lower socioeconomic status, predominantly African American population (eg, examples were changed to be culturally relevant). Based on feedback from school mental health professionals, BCATSS was implemented individually during 12 weekly sessions (35 minutes each).²⁵ This CBT program is comprised of psychoeducation, relaxation skills, problem solving, cognitive restructuring, relapse prevention and graduated in-vivo exposures to feared situations reinforced by self-reward and contingency contracts. The *BCATSS* intervention has a modular approach, allowing the clinician flexibility in choosing which core CBT skills (“modules”) to deliver in a particular session based on the needs of the student.²⁵ Optional parent sessions (one to three) were also added to increase involvement.²⁶

Evidence for BCATSS

The BCATSS treatment has been evaluated in two small randomized controlled trials. Preliminary support for Ginsburg and Drake’s²⁴ adaptation of group CBT for a predominantly inner-city African American population was demonstrated in a small randomized controlled study ($N=12$) comparing BCATSS to an attention-support control in 14- to 17-year-old adolescents diagnosed with generalized anxiety disorder, social phobia, specific phobia, and/or agoraphobia. Two advanced psychology graduate students with training in CBT implemented the program. Results showed that self- and clinician-rated anxiety symptoms were significantly lower after treatment in the CBT group compared to the control group. In addition, 80% of the control group continued to meet criteria for an anxiety disorder after treatment, versus only 25% of the CBT group.

The second randomized controlled trial^{25,26} compared the BCATSS CBT program to usual care (UC) in a small study of 7- to 17-year-old ($M=10.28$) inner-city African American youth with anxiety disorders ($N=32$). Therapists were school-based master’s and doctoral level clinicians, trained primarily in social work, counseling, or psychology. Because there was only one clinician per school, the same clinician implemented both conditions.²⁵ Clinicians were explicitly instructed to exclude CBT techniques in the usual care condition and instead implement nonspecific strategies, such as art and supportive therapy.²⁶ Results showed no differences across conditions at post-treatment, with 50% of CBT participants and 46% of UC participants no longer meeting criteria for an anxiety disorder. Similar results were found at 1-month follow-up: 42% of participants in the CBT group and 57% in the UC group no longer met criteria for an anxiety disorder. A central methodologic limitation was that CBT-trained clinicians also delivered usual care, resulting in poor treatment differentiation across conditions. Per review of 25% of UC therapy sessions, 56%

contained CBT techniques, despite ongoing coaching to exclude these components. In addition, although the authors rated how much of the module content (eg, psychoeducation, exposure) was delivered (adherence), they did not report how skillfully these specific techniques were conducted (competence). Therefore, it is possible that the implementation quality impacted treatment outcome. Another possibility is that novice therapists may be more effective with structured rather than flexible treatments, as the latter may require more expertise to determine the appropriate module to deliver. Clearly, several questions remain unanswered, and thus additional research examining the value of modular treatments may be necessary.

COGNITIVE-BEHAVIORAL INTERVENTION FOR TRAUMA IN SCHOOLS

Treatment Description

Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)²⁸ is a school-based group treatment developed for youth ages 10 to 15 with clinically significant symptoms of posttraumatic stress disorder (PTSD) and depression secondary to trauma exposure (excluding sexual abuse). CBITS was designed to be implemented by mental health clinicians in an urban multicultural environment. CBITS is generally comprised of ten one-hour weekly group treatment sessions (five to eight students per group), one to three individual sessions, two optional parent education meetings, and one teacher education meeting.^{28,29} The treatment elements of CBITS include psychoeducation, relaxation, adaptive coping skills, cognitive restructuring techniques, graduated imaginal exposure to traumatic memories, processing of traumatic memories, and social problem solving skills. Imaginal exposure through writing and drawing is initially conducted in individual sessions and subsequently in the group. CBITS sessions present skills using a combination of didactic presentation, developmentally appropriate examples, worksheets, and games. The focus of treatment is the generalization of concepts learned in treatment sessions to real-life situations by applying them to a given child's specific difficulties.²⁸

Evidence for CBITS

Two randomized controlled trials have shown support for CBITS compared to a waitlist control in youth with clinically significant PTSD symptoms secondary to exposure to community violence.^{28,30} In both studies, CBITS was implemented by psychiatric social workers based in the school districts' mental health clinic. The first study ($N = 199$) found that third through eighth graders (mean age = 11.4 years; $SD = 1.7$) with clinically elevated PTSD symptoms participating in CBITS had significantly lower PTSD symptoms post-treatment compared to waitlist control.³⁰ Small adaptations for this study included reducing group sessions from ten to eight and increasing parent sessions from two to four, which focused on themes of loss and separation common to immigration. Similarly, Stein and colleagues²⁸ found that sixth graders ($N = 126$) participating in CBITS reported significantly greater reductions in PTSD and depressive symptoms compared to those in the waitlist control group three months and six months post-treatment. These two studies provide evidence for the effectiveness of CBITS for PTSD symptoms when implemented in urban multicultural schools.

The feasibility of school-based group CBITS compared to clinic-based individual Trauma Focused-Cognitive-Behavioral Therapy (TF-CBT) was supported by an investigation of fourth to eighth graders ($N = 118$) with elevated PTSD symptoms 15-months post-Hurricane Katrina in New Orleans.³¹ Three components of CBITS were not delivered in this study due to resource and time limitations: the individual session prior to the start of group, teacher informational meetings and in two of the three schools, parent meetings. The CBITS treatment was implemented by school-based mental health professionals, while TF-CBT was

conducted by social workers and psychologists employed at a community mental health center.³² Although youth in both treatment groups showed clinically significant improvements in PTSD symptoms at 10-month follow-up, CBITS was far more accessible to participants as 98% of youth randomized to CBITS were enrolled in treatment compared to only 23% of youth assigned to TF-CBT. This highlights the greater ability of school-based treatments to reach and retain distressed youth compared to treatments delivered in traditional community mental health settings.

Support for Students Exposed to Trauma

Support for Students Exposed to Trauma (SSET),³³ an adaptation of CBITS, was designed to be implemented by school counselors and teachers to increase accessibility. SSET delivers the components of CBITS in 10 weekly group sessions utilizing a lesson plan format and omits the individual and parent meetings included in CBITS. SSET showed superiority to a waitlist control in 76 sixth to eighth graders scoring at least 11 on the Child PTSD Symptom Scale³⁴ (ie, moderate to high PTSD symptoms) subsequent to exposure to violence within the last year. Students in the SSET group showed small improvements in PTSD and depressive symptoms at 3-month follow-up. While these decreases appeared to be more substantial than those of the waitlist control, the small sample size limited the statistical power to detect effects. Although additional studies are needed, these preliminary findings suggest that SSET is a feasible intervention for PTSD symptoms that can be delivered by school personnel.

SKILLS FOR ACADEMIC AND SOCIAL SUCCESS

Treatment Description

Skills for Academic and Social Success (SASS)³⁵ is a school-based group CBT program for adolescents with social anxiety disorder adapted from Social Effectiveness Therapy for Children (SET-C), an efficacious group treatment for children with social anxiety disorder.^{3,36} Like SET-C, SASS focuses on gradual exposure, social skills, and peer generalization. However, SASS includes adaptations for adolescents (eg, addition of realistic thinking) and the school environment (eg, shorter sessions, involvement of teachers). SASS consists of 12 weekly 40-minute (ie, one class period) group sessions, two individual meetings, two parent meetings, two teacher meetings, four social events with outgoing peers, and two booster sessions. Social skills training includes initiating and maintaining conversations, nonverbal behaviors (eg, maintaining good eye contact), and assertiveness. Graduated in vivo exposures to feared social situations are often integrated into the school environment, for example, volunteering to answer a question in class, talking with a teacher, or giving an oral presentation. Individual meetings focus on setting goals and problem solving any obstacles to treatment. To increase generalization of skills and exposure to real-world settings, the four social events are conducted with group members and outgoing peers together in settings adolescents often spend time in, such as bowling or laser tag. Parent meetings include psychoeducation, parenting strategies including preventing their child's avoidance, and rewarding nonanxious behavior. Teacher meetings focus on the goals of SASS, education regarding social anxiety, and enlisting teachers' help with classroom exposures.

Evidence for SASS

Support for SASS has been provided by two randomized controlled trials. The first investigation compared SASS to a waitlist control in urban parochial high school students with social anxiety disorder ($N = 35$).³⁷ Groups were co-led by a clinical psychologist and a psychology graduate student. Results found that 94% of SASS participants were classified as responders based on their improved functioning at post-treatment, versus only 12% of the

control group. In addition, 67% of SASS participants, compared to only 6% of controls, no longer met criteria for social anxiety disorder post-treatment. Lower clinician-rated diagnostic severity and self-reported social anxiety and social avoidance were found for the SASS group at post-treatment and 9-month follow-up.

The second trial examined the specific efficacy of SASS compared to a credible attention control in adolescents aged 14 to 16 ($N = 36$) with a primary diagnosis of social anxiety disorder.¹ The attention control group, equal in time and adult attention, included relaxation training and four social events without outgoing peers. Results demonstrated superiority of SASS, with more than 82% of SASS participants classified as responders, compared to 7% of those in the attention control. Importantly, only 41% of SASS participants continued to meet criteria for social anxiety disorder post-treatment, while all control participants still qualified for the disorder. Students receiving SASS also exhibited greater overall improvement and lower clinician-rated social anxiety severity at post-treatment and 6-month follow-up.

Currently, Masia Warner and colleagues are conducting a large, federally funded, randomized controlled trial of SASS implemented by school guidance counselors to investigate its transportability to school settings.³⁸ This study will examine whether school personnel without specialized training in CBT can effectively deliver a cognitive-behavioral intervention. Positive findings would highlight the potential effectiveness of a more sustainable model of evidence-based care delivered by school personnel to reach underserved youth with social anxiety disorder.

Summary of School-Based Anxiety Treatments

Studies of school-based treatment programs for anxiety disorders in youth suggest promise for effectively delivering these evidence-based programs in schools. However, several gaps in our current knowledge exist. One shortcoming has been the reliance on specialized mental health clinicians to deliver interventions, which is costly and resource intensive. Researchers have called for training school-based personnel (eg, school counselors and teachers) to deliver these evidence-based interventions, but it remains unknown whether they can do so effectively. In addition, surprisingly few investigations of school-based anxiety treatments have investigated the impact of intervention on academic and other school-related variables upon which schools are evaluated (eg, grades, standardized test scores, attendance). Overall, many questions remain regarding methods to facilitate successful implementation and sustainability of school-based mental health programs. The following section focuses on several areas requiring additional exploration, such as the integration of treatments into school culture, improving identification of anxious youth, and the utilization of school-based personnel as treatment providers.

IMPLICATIONS FOR RESEARCH AND PRACTICE

School Culture and Context

Efforts to increase the accessibility of evidence-based treatments to youth with anxiety disorders may be bolstered by a better understanding of factors affecting the ability of schools to adopt and sustain mental health programs. Consideration of school context, such as school climate, resources, and the impact of educational accountability, will likely influence whether schools will accept and prioritize these treatments.³⁹ Because schools' main focus is education, future studies providing evidence that school-based treatments positively affect academics and other variables aligning with school values are essential to increasing uptake and sustainability of school-based treatments. Further research on methods to better integrate mental health programs into the school culture may also improve the acceptability of programs to important stakeholders, such as school administrators. For

example, incorporating treatment components into the general classroom curriculum has been found to increase program sustainability for universal intervention programs.⁴⁰ Applying this concept to targeted students with anxiety disorders, such as evaluating integration of school-based programs into existing student services (eg, guidance counseling) or extracurricular activities (eg, club format), may also increase feasibility. Finally, future research should examine optimal methods to maximize schools' existing resources to manage students' mental health needs. For instance, Ringeisen and colleagues³⁹ suggest replacing the current individualized case management approach to school-based mental health care with a model combining classroom-based intervention and as-needed group treatment or consultation from specialized clinicians. This innovative model, along with other methods to improve integration of mental health services into the existing school culture, is critical to increasing long-term sustainability of school-based mental health programs.

Identification of Clinically Anxious Students

Another essential area for future study will be testing methods for enhancing recognition or detection of youth with anxiety disorders. Research on the ability of school personnel to identify youth with internalizing disorders has focused mostly on teachers rather than more specialized personnel such as counselors, and findings have been inconclusive. Not surprisingly, teachers are generally more likely to recognize externalizing behaviors than internalizing problems such as anxiety and depression.^{41,42} There is some evidence to suggest that youth are more likely to access services when school personnel (eg, teachers, school counselors) are made aware of their anxiety rather than parents or other adults.⁴³ This indicates that research on educating and training school personnel in the identification of anxiety, through observation or school-wide screenings, is critical to increasing early detection and treatment.^{44,45} Studies examining the accuracy and sensitivity of self-report measures in predicting anxiety disorders would clarify the effectiveness and efficiency of utilizing these measures in school-wide screenings to identify anxious youth. Of course, a challenge of improving methods for identifying anxious youth is the resulting increase in referrals for mental health care, which schools may not be equipped to handle. This highlights the importance of increasing the availability of mental health care providers through school-based treatments.

School-Based Treatment Providers

To date, the majority of investigations of school-based interventions have been implemented by mental health clinicians employed by research teams. Because the costs and feasibility of hiring mental health clinicians are prohibitive for most schools, there is a significant need to establish the effectiveness of school-based interventions for anxiety disorders when delivered by school personnel. With specialized training, supervision, and support, school guidance counselors may be ideal candidates to be trained in the implementation of mental health interventions. School counselors are present in all high schools, typically comprise a large team, and enter their profession to assist and guide youth.⁴⁶ Furthermore, a recent national survey revealed that 90% of guidance counselors wanted reductions in administrative tasks and caseloads to increase time for assisting students and receiving training.⁴⁷ This indicates that guidance counselors may be open to opportunities to receive training in school-based treatments, especially because guidance counselors are routinely asked to manage their students' emotional needs.

However, the literature has shown that efficacious treatments delivered in research settings often show reduced effectiveness in clinical settings.⁴⁸ It has been theorized that treatment fidelity, defined as adequate adherence to a treatment manual and competence in delivery,⁴⁹ is related to treatment outcome.⁵⁰ Further research is needed to document this relationship

and to identify what levels of fidelity are sufficient for treatment response, which has the potential to inform training approaches and supervision. The ongoing study by Masia Warner and colleagues examining whether school counselors can effectively implement a group CBT program for adolescents with social anxiety disorder will contribute to this gap in the literature.

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KEY POINTS

- School-based empirically supported treatments for anxiety disorders are a promising avenue for providing necessary intervention to distressed youth who would otherwise never receive treatment.
- Sustaining such programs in school settings should be viewed as a multiple-stage process, from integration of the program into the institution and maintenance of the intervention to responding to institutional change and ownership of the program by the school.
- Given the scarce resources available to schools, additional research on embedding programs into the school culture and maximizing existing resources is essential to enhancing the sustainability of school-based interventions for anxiety disorders and reaching youth in need.

Table 1

School-based treatments for anxiety

Treatment	Number and Length of Sessions	Format	Treatment Components	Parent/Teacher Components	Overview of Effectiveness in Schools	Implementation Strengths and Limitations
Cool Kids ²¹	Eight 1-hour sessions	Group	Psychoeducation, cognitive restructuring, graduated exposure, coping with bullying, social skills, assertiveness	Two parent information sessions on parenting strategies and ways for parents to manage their own anxiety	Significantly greater decreases in self- and teacher-reported anxiety when compared to waitlist control	<p>Strengths:</p> <ul style="list-style-type: none"> • Group format • Includes dealing with bullying, social skills, and assertiveness components. <p>Limitations:</p> <ul style="list-style-type: none"> • Unknown if superior to attention control or other treatments. • Use of community mental health workers is unsustainable.
Baltimore Child Anxiety Treatment Study in the Schools (BCATSS) ²⁴⁻²⁶	Ten 45-minute sessions ²⁴ or twelve 35-minute sessions ²⁵	Group ²⁴ and individual ^{25,26}	Psychoeducation, cognitive restructuring, graduated exposure, self-reward, contingency management, relaxation skills, problem solving, relapse prevention	Up to three sessions include parents to provide parenting strategies and psychoeducation.	Significantly greater decreases in self- and clinician-rated anxiety compared to attention-support control in one small study. Another small study found no difference compared to usual care.	<p>Strengths:</p> <ul style="list-style-type: none"> • Includes self-reward, contingency management, and problem solving. • Shown to be effective with urban African American youth. <p>Limitations:</p> <ul style="list-style-type: none"> • No teacher components • Individual format^{25,26}
Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) ²⁸	Ten 1-hour sessions	Group	Psychoeducation, cognitive restructuring, graduated exposure, processing of traumatic memories, relaxation skills, social problem-solving skills, adaptive coping skills	Two parent education meetings, one teacher education meeting	Two studies found significantly greater reductions in PTSD symptoms compared to waitlist control. One study found significantly greater reductions in depressive symptoms compared to waitlist control.	<p>Strengths:</p> <ul style="list-style-type: none"> • Includes social problem-solving skills, processing traumatic memories, and adaptive coping skills. • Shown to be effective with minor adaptations for urban multicultural populations. <p>Limitations:</p> <ul style="list-style-type: none"> • Unknown whether it is more effective than attention control. • Use of school-based psychiatric social workers is not a

Treatment	Number and Length of Sessions	Format	Treatment Components	Parent/Teacher Components	Overview of Effectiveness in Schools	Implementation Strengths and Limitations
Support for Students Exposed to Trauma (SSET ³³ ; an adaptation of CBITS)	Ten 45-minute sessions (one class period)	Group	Psychoeducation, cognitive restructuring, graduated exposure, processing traumatic memories, relaxation skills, adaptive coping, problem solving	Parent phone calls. Can be implemented by teachers.	Small improvements found in PTSD and depressive symptoms at 3-month follow-up in one study.	<p>model most schools have the resources to replicate.</p> <p>Strengths:</p> <ul style="list-style-type: none"> Designed to be implemented by teachers and school counselors. <p>Limitations:</p> <ul style="list-style-type: none"> Only one study without enough power to determine if modest results are significant No significant parent component
Skills for Academic and Social Success (SASS) ³⁵	Twelve 40-minute sessions	Group	Psychoeducation, cognitive restructuring, graduated exposure, social skills, peer generalization (through social events)	Two parent meetings including psychoeducation and parenting strategies, two teacher meetings	Significantly greater number of students were classified as responders to treatment compared to waitlist and attention control.	<p>Strengths:</p> <ul style="list-style-type: none"> Inclusion of social skills and peer generalization social events <p>Limitations:</p> <ul style="list-style-type: none"> To date, shown to be effective only when implemented by clinical psychologists, although study examining SASS in school counselors is underway.

Table 2
Webpages for available treatment manuals

Treatment	Availability	Webpage
Cool Kids ²¹	For purchase	http://www.centreforemotionalehealth.com.au/pages/resources-products.aspx
Baltimore Child Anxiety Treatment Study in the Schools (BCATSS) ²⁴⁻²⁶	Not available	—
Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) ²⁸	Free	http://cbitsprogram.org/
Support for Students Exposed to Trauma (SSET ³³ ; an adaptation of CBITS)	Free	http://www.rand.org/pubs/technical_reports/TR675.html
Skills for Academic and Social Success (SASS) ³⁵	Not available	—