Evidence-Based Practices for Children and Adolescents with Serious Emotional Disturbances

Session III:

The Evidence for School-Based Mental Health Services

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September 8, 2005
Objectives of today’s session

- Range of SBMH programs – their relative strengths
- Key elements associated with good outcomes
- Family involvement and four plans for achieving it
- Close-up of one strong program and its core elements
What does “evidence-based” mean in schools?

Review of program evaluations by Rones & Hoagwood (2000):

<table>
<thead>
<tr>
<th>SBMH programs evaluated 1985-1999</th>
<th>337</th>
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<tbody>
<tr>
<td>Those with control groups &amp; standardized measures</td>
<td>130</td>
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<tr>
<td>Those that met criteria for review (quasi-experimental, randomized, etc.)</td>
<td>47</td>
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What does “evidence-based” mean in schools?

No Child Left Behind:

... research should involve the application of “rigorous, systematic, and objective procedures to obtain reliable programs and valid knowledge relevant to educational activities and programs”

- Empirical, rigorous data analyses
- Experimental or quasi-experimental design
- Valid and reliable data across observers
What does “evidence-based” mean in schools?

New draft of *No Child Left Behind*:

- “Accepted by a peer-reviewed journal or by a panel of independent experts through a comparably rigorous, objective, and scientific review.”
Needed improvements in school implementation studies

- Full and detailed descriptions of interventions
- Explanations of training procedures
- Fidelity checklists or observation methods for key elements of the intervention
- Attention to transportability of effective mental health treatments from setting to setting.
Children’s Mental Health Problems

- 21% of school-age children & adolescents have a “diagnosable mental health problem”
- 11% have a “significant functional impairment”
- 5% have an “extreme functional impairment”
Schools—the primary providers of mental health services for children

- 75-80% get no specialized services.
- Those with diagnoses and functional impairments were 7 times more likely to get services.
- Of those who did receive services,
  70% received them from the schools; for nearly half, schools the sole provider.
Schools—the primary providers of mental health services for children

- Offering treatment in schools improves access and reduces early termination from treatment.
- IDEA and Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) dollars have made funding possible.
What about the evidence base school-based mental health services overall?

- No differences between those seen in clinics and in schools on measures of life stress, violence, family support, self-concept, and emotional behavioral disturbance. Those with high scores on measures of internalizing problems were less likely to have had services in the past. So SBMC may reach children and youth who otherwise would not receive services.

  Weist et al, 1999
What about the evidence base for offering mental health care in schools overall?

- SBMH greatly enhances mental health program use in disadvantaged areas (Catron et al, 1998);
- They are viewed positively by clients (Nabors et al, 1999);
- They are at least as effective as clinic-based services as measured on the CGAS and GAF for children and the CAFAS and Achenbach for adolescents (Armbruster & Lichtman, 1999);
- They lead to positive outcomes. (Weist et al, 1996).
Delivery Mechanisms and Formats

1. School-Financed Student Support Services

2. School-District Mental Health Units
3. Formal Connections with Community Mental Health Centers

- CMHC staff & services at schools
- Linkages to enhance access & coordination at agency or at school
- Formal community/school partnerships to provide MH services
- Contracting with community providers to provide MH services
4. **Classroom-Based Curriculum & Special “Pull-Out” Interventions**

- Integrated instruction as part of regular classroom content
- Special interventions run by specially trained personnel
- Curriculum part of a multifaceted set of interventions designed to enhance positive development and prevent problems
Primary Prevention:
School-/Classroom-Wide Systems for All Students, Staff, & Settings

Secondary Prevention:
Specialized Group Systems for Students with At-Risk Behavior

Tertiary Prevention:
Specialized Individualized Systems for Students with High-Risk Behavior:
Functional Behavioral Analysis (FBA); Behavior Intervention Plan (BIP)

~80% of Students

~15%

~5%
**Primary Prevention:**
- General Education
- 8:1 Student to teacher ratio
- School-Wide PBS
- Problem Solving Process
- AEA Support Services
- Vocational Programs
- Staff, & Settings

**Secondary Prevention:**
- Level II Services
- 5:1 Student to teacher ratio
- Limited integration into general education classes
- Targeted Interventions

**Tertiary Prevention:**
- Level III Services
- 3:1 Student to teacher ratio
- Functional Behavior Assessments
- Highest level of supervision and security

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Iowa Juvenile Home—Toledo
Iowa Behavioral Alliance

Drake University
Iowa State University
Federation of Families for Children’s Mental Health

Iowa Department of Education
Delivery Mechanisms and Formats (cont.)

5. Comprehensive, Multifaceted, and Integrated Approaches

• Community schools
• Coordinate school and community services
• Restructure student support programs and services and integrate them into school reform agendas
Iowa Instructional Supports

Developing Our Youth:
Fulfilling a Promise, Investing in Iowa’s Future

Enhancing Iowa’s Systems of Supports for Development and Learning
Iowa Department of Education
Iowa Collaboration for Youth Development
Fall 2004
Iowa Instructional Supports

- Education
  - Health
    - Child Welfare
      - Substance Abuse
        - Workforce Development
          - Economic Development

- All children &
  - successful in school;
  - healthy and socially competent;
  - prepared for productive adulthood;
  - in safe, supportive families, schools, and communities.
Key elements associated with good outcomes

- Consistent program implementation
  - School culture and climate
  - Cooperation of school leadership
  - Program fidelity
- Multi-component programs that target the ecology of the child
Key elements associated with good outcomes

- Multi-component programs that target the ecology of the child
  - e.g., Parents, teachers, and peers involved in Fast Track intervention program, all receiving training

- Multiple behavior change techniques
  - focus on specific behaviors and skills targeted in the intervention; tutoring, home visits, information, cognitive and behavioral skills training
Key elements associated with good outcomes — Rones and Hoagwood—

- Multi-component programs that target the ecology of the child
  - e.g., Parents, teachers, and peers involved in Fast Track intervention program, all receive training to mitigate CD factors

- Multiple behavior change techniques
  - focus on specific behaviors and skills targeted in the intervention; tutoring, home visits, information, cognitive and behavioral skills training
2004 Program Resource

Safe, Supportive, and Successful Schools

Step by Step

David Osher, Kevin Gwyer, Stephanie Jackson

American Institutes for Research

Funded by SAMHSA
Published by Sopris West, 2004
Purpose
ART is a response to antisocial behavioral excesses and prosocial behavioral deficits. ART consists of three interventions: Skillstreaming, Anger Control Training, and Moral Reasoning Training, which seek to enhance interpersonal skill competence, enhance self-mediated ability to control anger, and enhance the young person’s moral reasoning ability and social problem-solving skills, respectively.

Program Background
Aggression Replacement Training was designed to serve a diverse group of males and females aged 11 to 19. Since its inception in 1986, the program has been implemented at 700 sites, including schools and various delinquency and mental health settings.

Scope of Program
Aggression Replacement Training subjects have been a diverse population, including students of various ethnic, cultural, and class backgrounds. The majority of ART interventions have been implemented in urban areas, but many also have occurred in suburban and rural settings.

Specific Problems/Risk Factors Targeted by ART
Chronic aggressive behavior; inability to control anger when provoked; a deficit in expressing one’s feelings; poor response to failure; ineffective coping skills with group pressure; and refusal to follow reasonable requests all are targeted.

Program Operations
Aggression Replacement Training has three basic components: Skillstreaming, Anger Control Training, and Moral Reasoning Training. The training is integrated into the school day—from homeroom to classes to after-school detention. Teachers, counselors, psychologists, behavior specialists, correctional officers, and other school or center personnel (trainers) offer youth training
Key elements associated with good outcomes

- Integration of program content into general classroom
  - WYTIWYG & WhereYTIIWhereYGI
- Developmentally appropriate program components
What works for whom?

“A robust group of SBMH programs were identified for a variety of emotional and behavioral problems of children..
“However, a lack of treatment studies, even among the most prevalent disorders of childhood (i.e. anxiety, ADHD, depression) was also identified. Despite the growing evidence of the significance of these disorders and their impact on child functioning, no studies that targeted particular clinical syndromes were identified.”
Lisa Hunter, PhD

School-Based Interventions for Attention-Deficit and Disruptive Behavior Disorders: A Critical Review

Draft III 4/22/02 (Draft II, 4/2/02 on the web)

26 programs: targeted one or more of the 3 severity levels, involved teachers; reported evaluation results; addressed needs of children with AD/DBD
Rated Promising, Potential, or Poor by these criteria

1. Randomized, quasi-experimental or multiple baseline research design
2. Control group
3. Use of multi-method outcome measure
4. Pre- and post findings
5. At least six-month follow-up
6. Manual detailing program components
Family Involvement

Barriers for SBMH: distance, non-availability during school/work hours, transportation problems, some students’ preference for parental non-involvement, parents’ mental illness or incapacity, parents who hate school.

But recognize that without parental involvement, limited progress with student. Need for history, analysis of change potential and means, problem-solving, partnership.
Family Involvement: four ways to achieve it

1. **Build relationships with students’ families**— follow-up calls, availability times to families for contact. Model and apply social learning theory principles—4:1 positive to negative interaction ratio to change behavior; intervening early in the behavior chain, etc.

2. **Encourage families’ positive involvement in their children’s schools**— from homework help, volunteering, PTA/PTO, to policy decision-making. Use parents as guides and advocates—PEC, FFCMH, NAMI, ASK Resource
Family Involvement: four ways to achieve it

3. Consider mental health programs with strong family components

4. Wraparound — collaborative family-provider teams that create individualized service plans for children and families with complex needs.
~80% of Students

~15%
Wraparound is a tool used to implement interagency systems of care in achieving better outcomes for youth and their families.

Wraparound involves family-centered teams and plans that are strength and needs based (not deficit based) across multiple settings and life domains.
Wraparound

...plans include natural supports, are culturally relevant, practical, and realistic.

...process creates a context for effective implementation of research-based behavioral, academic, and clinical interventions.
10 Principles of Wraparound

- Family voice and choice
- Team Based
- Natural Supports
- Collaboration
- Community based
- Culturally competent
- Individualized
- Strengths based
- Persistence
- Outcomes based

NWI – National Wraparound Initiative, Portland State University. www rtc.pdx.edu
Is Wraparound Evidence-Based?

- High levels of fidelity to MST found to be *negatively* associated with outcomes in the absence of full engagement of the family. “Therapist attempted to try to change how family members interact with others. . .”

Bruns, E.J. (2004)
Vanderbilt University School Counseling project

- Nine inner-city Nashville elementary schools run as satellites to university center. Schools randomly assigned to one of two interventions:
  - SBC Treatment group—school-based, non-behavioral counseling to students, consultation to teachers. 96% began TX. Q: service utilization.
  - AT Alternative Treatment group — students in same classrooms but received tutoring with no counseling content. Q: mental health outcomes.
  - CBC Control group — students taken to center; family given incentives, including transportation. 13% began TX.
Results

- Too few children went to clinic to continue the comparisons.

- After two years, overall SBC change ratings by parents, teachers, peers, and the children themselves were twice as high as at baseline.

- Ratings for AT students were as high.

- Behavior referrals throughout the school for all students were significantly reduced.

- At six-month follow-up, the SBC students appeared to have retained counseling content.
Empirically validated evidence-based approaches for use in schools:

- Cognitive-behavioral
- Social skills training
- Teacher consultation

References


Policy Leadership Cadre for Mental Health in Schools (2001). Mental health in schools: Guidelines, models, resources, & policy considerations. Los Angeles: Center for Mental Health in Schools at UCLA.
References

