DOCUMENT RESUME

ED 426 529	EC 306 962
TITLE	School-based Services. Chapter 4.
PUB DATE	1996-00-00
NOTE	41p.; In: A System of Care of Children's Mental Health: Expanding the Research Base. Proceedings of the Annual Research Conference (8th, Tampa, FL, 1996); see EC 306 958.
AVAILABLE FROM	Web site: http://lumpy.fmhi.usf.edu/CFSroot/rtc/pubs/pubs.html
PUB TYPE	Speeches/Meeting Papers (150)
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	Adolescents; Agency Cooperation; Ancillary School Services; *Behavior Disorders; Children; Counseling; Delivery Systems; Disability Identification; Elementary Secondary Education; Emotional Development; *Emotional Disturbances; *Integrated Services; Mental Disorders; *Mental Health; Models; Outcomes of Treatment; Pupil Personnel Services; Severity (of Disability); Social Development; Substance Abuse

ABSTRACT

This collection of papers presented at a 1996 conference on children's mental health focuses on school-based services. The eight papers have the following titles and authors: (1) "Facilitating the Social/Emotional Development of Middle School Students: A Model for Improving School-Based Curriculum" (Craig Barringer and Doug Cheney); (2) "School-Based Wraparound: How Implementation and Evaluation Can Lead to System Change" (Lucille Eber and others); (3) "Identification of Students with SED: Correlates of State Child-Count Data" (Donald Oswald and Martha Coutinho); (4) "Comparison of Children and Adolescents with Serious Emotional Disturbance Served in Hospital and School" (Suzanne Markel-Fox and others); (5) "One Year Outcome Findings of the Vanderbilt School-Based Counseling Evaluation Project" (Vicki S. Harris and others); (6) "Interagency Collaboration Efforts with Families with Severe School Refusal Problems" (Fiona Thomson and Mary E. Evans); (7) "Day Treatment for Children with Emotional and Behavioral Disorders: A Program Evaluation" (Jerry Oestmann); and (8) "Designing, Implementing, and Evaluating a School-Based Psychoeducational Group for Children with Behavioral Problems from Families with Substance Abuse Issues" (Martha Morrison Dore and others). (Individual papers contain references.) (DB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ERIC

ED 426 529

8th Annual Children's Mental Health Research Conference Proceedings. Chapter 4. School-based Services.

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☑ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

C 306962

BEST COPY AVAILABLE

ERIC

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Facilitating the Social/Emotional Development of Middle School Students: A Model for Improving School-Based Collaboration

Authors

Introduction Method Results Discussion References

Return to Table of Contents

Introduction

Project Destiny (Designing Educational Support Teams through Interagency Networks for Youth with Emotional or Behavioral Disorders) is a three year training and research project funded by the US Office of Education and Rehabilitative Services. It is part of an initiative to improve school-based services for students with emotional or behavioral disorders (EBD), which was established under the Individuals with Disabilities Education Act of 1990 (IDEA). The project assesses the impact of staff development and school-wide intervention programs on the performance of students with EBD who are included in general education classrooms. We have discussed the entire project elsewhere (Cheney & Barringer, 1995 : Cheney, Barringer, Upham & Manning, 1995). The present discussion focuses on baseline assessments of (a) existing service models, (b) teacher competencies, and (c) student characteristics.
Return to top

Method

Subjects/Sites. Subjects were 113 middle school students (grades 5-8); and 25 teachers, with an average of 18 years experience. Subjects were selected from two New Hampshire communities, one suburban (pop. < 75,000) and one rural (pop. = 10,000). Using a multiple gating procedure (Walker, Severenson, Stiller, Williams, Haring, Shinn & Todis, 1988; Walker & Severnson, 1992), teachers identified 67 students with EBD, 6 of whom had been classified as Seriously Emotionally Disturbed (SED) under special education law; teachers also identified 46 students whom they considered typical for age and grade level.

Intervention Program. During three consecutive school years, a research team comprised of a special educator, a psychologist and a family counselor will provide: (a) monthly didactic presentations to staff, (b) bi-monthly case studies , (c) parent support groups, and (d) consultation concerning school-wide interventions (e.g., problem solving approaches, social skills curricula, and crisis prevention techniques).

The framework for these interventions is the Project Destiny Transdisciplinary Model (see Table 1), which is based on research in the fields of child and adolescent development (Bowlby, 1988, Kholberg, 1984), developmental psychopathology (Cicchetti, 1993; Cicchetti & Toth, 1992), and special education (Walker, Colvin & Ramsey, 1994). This model program provides guidelines for creating a school context that facilitates the social-emotional development of all students, and provides extra support for students with EBD. A fundamental assumption of the model is that social/emotional development, a primary determinant of school performance, is influenced by four developmental factors, (1) biological factors, (2) affective factors, (3) interpersonal/familial factors and (4) cognitive factors

Measurement Instruments. The research design for the project calls for 15 instruments to be

ERIC

administered at the beginning and end of each school year. This report, however, concerns only the following subset of instruments:

1. Assessment of School Context Survey (see Table 1),
2. Teacher Competency Survey (Bratten, 1993),
3. Social Skills Rating Scale (Gresham & Elliot, 1990),
4. Teacher Report Form (Achenbach, 1991),
5. Inventory of Parent & Peer Attachment (Armsden & Greenberg, 1987),
6. Youth Self Report (Achenbach, 1991), and
7. Reynolds Adolescent Depression Scale (Reynolds, 1986).

Using these instruments, informants indicated their agreement/disagreement with the specific aspects of the proposed model program; and compared existing service delivery systems to the model. Informants also rated the competence of teachers, as well as the behavior, academic performance, social skills and emotional functioning of students. Other data (e.g., achievement test scores and teacher's comments) were collected using archives, direct observations, and interviews.
Return to top

Results

Service Delivery Systems. Teachers who completed the Assessment of School Context Survey agreed with 23 of the 26 components of the proposed model. Teachers further indicated that the service delivery systems in their schools lacked most of the components specified in the model (e.g., family support groups, an adequate number of consulting specialists, and adequate planning time for teachers and students). All schools used IDEA (1990) as their service delivery model, under which less than 12% of students with EBD received services; often these were not the students of greatest concern to teachers.

Teacher Competence. As reported elsewhere (Cheney & Barringer, 1995), classroom teachers rated themselves as having little or no knowledge concerning (a) the course of normal social/emotional development, (b) federal and state definitions and regulations pertaining to EBD, (c) the functions of community agencies providing services to this population, (d) characteristics of students and their families, (e) individual differences among students with EBD, and (f) relevant constructs from the fields of mental health and education. As expected, teachers reported greater expertise with respect to managing group behavior in the classroom and using appropriate instructional techniques. In general, teachers did not feel competent, and reported high levels of frustration, with respect to integrating students with EBD into their general education classrooms.

Student Characteristics. Using a multiple-gating procedure, teachers accurately differ- entiated youth with EBD from typical students; in the sample of 113 students, there were 7 false positives and 0 false negatives. Students with EBD differed from the typical group on virtually all measures.

Teachers' reports were also valid indicators of students scores along the internalizing/externalizing dimension (Achenbach & Edelbrock, 1983). Finally, students who had been classified SED under special education law differed significantly from unclassified students with EBD on only three variables: the classified group's behavior was rated as more internalizing, and they showed a greater degree of idiosyncratic thinking; the unclass-ified students with EBD showed greater elevations on the externalizing and aggression subscales.

A subsequent K-Means Cluster Analysis (see Table 2) yielded three groups of students: The Typical group (n = 46) showed well developed social skills and no serious emotional, behavioral or academic

problems; these students' self-ratings in all of these areas were generally consistent with those obtained from teachers and parents.

In contrast, the Aggressive/Academic Problem group (n = 34) scored below average with respect to social skills and in all academic subjects. Their TRF scores also showed significant problems with aggressive behavior, delinquency, inattention and idiosyncratic thinking. These social-emotional difficulties were reported by teachers, but not by the students, who ranked themselves within the average range on all YSR subscales.

Students in the Aggressive/Depressed group (n = 33) were similar to those in the Aggressive/Academic Problem group: their TRF scores indicated significant problems in the areas of aggressive behavior, delinquency, idiosyncratic thinking and social skill development; unlike the Aggressive/Academic Problems group, however, their academic achievement was within normal limits despite indications that they were socially withdrawn and well above the clinical cut-off on the depression measure. In addition, compared to their teachers' ratings, students in the Aggressive/Depressed group rated themselves as having more, and more severe emotional problems.

There were also significant differences between groups with respect to their attachments to their mothers and fathers: as expected, the Typical group demonstrated the strongest attachment to parents and showed equivalent attachment to their mothers and fathers; average attachment scores were lower for both the Aggressive/Academic Problems group and the Aggressive/Depressed groups. These two groups showed similar scores, and both groups appeared to have a stronger attachment to mother than to father.
Return to top

Discussion

At baseline, all schools relied exclusively on the administrative guidelines in IDEA (1990) as a model for service allocation. The majority of students with EBD have not been well-served by this model (Carson, Sitlington & Frank, 1995; Chesapeake Institute, 1994; Cheney & Harvey, 1994; Wagner, Newman, D'Amico, Jay, Butler-Nalin, Marder & Cox, 1991); our results are consistent with previous findings concerning this issue.

Our baseline data indicated that a small percentage (< 12%) of students with EBD were involved with special education programs; in addition, classroom teachers were not prepared to deliver educational services to students with EBD. Teachers were aware of students who needed additional support; however, they hesitated to make referrals for special education services due to social stigma, parental reaction, or problems obtaining timely evaluations and follow-up services.

Constructing responsive school contexts requires an understanding of differences in students' social-emotional development. In the Project Destiny middle schools, students with EBD showed important differences with respect to, (a) signs of clinical depression, (b) attachment to father, (c) social withdrawal, (d) academic achievement, and (e) self-awareness concerning the types of emotional and behavioral problems of concern to their parents and teachers. Such fundamental, developmental differences may account for some of the variance in the effectiveness of behavioral techniques commonly used with this population (e.g., contracting, contingency management, social skills training); we will collect additional data during the next two years of the project, and attempt to further study this issue.

Collaborating with students to facilitate social/emotional development involves structuring their interactions with people and materials in the environment according to mutually agreed upon goals.

In the ideal case, the differential impact of developmental variables on the performance of students will determine the kinds of school-based services each student receives; students' needs also will determine both the nature of staff development and the types of interactions that will facilitate social/emotional development. Determining the concordance of data concerning students' needs collected from families, teachers, community specialists and, most importantly, the students themselves, can provide a basis for

collaboration; for example, compared to students in the Aggressive/Academic Problems group, students in our Aggressive/Depressed group seemed to be more aware of the problems identified by their teachers, and therefore may be relatively more amenable to collaborating on solutions.

Focusing on how an individual interacts with people and materials in the environment is a common practice in clinical settings; however, this notion may be new, and seem impractical to middle-school teachers and administrators, who have been mainly concerned with large groups of students, rather than individuals within the group. Meaningful inclusion of young teens with EBD in general education requires that teachers, administrators, parents and students share an understanding of how to best facilitate the individual student's social emotional development. Presently, the absence of a shared developmental model is an obstacle to this sort of collaboration , and thus blocks the full inclusion of students with EBD in the educational process. Over the next two years, Project Destiny will assess the utility of an empirically based developmental model for inclusion of students with EBD in general education.

Return to top

References

Achenbach, T. (1991a). Manual for the Teacher's Report Form. Burlington, VT: University of Vermont Department of Psychiatry.

Achenbach, T. (1991b). Manual for the Youth Self Report and 1991 Profile. Burlington, VT: University of Vermont Department of Psychiatry.

Achenbach, T. and Edelbrock, C. (1983). Manual for the Child Behavior Checklist and Revised Child Behavior Profile. Burlington, VT: University of Vermont Department of Psychiatry.

Armsden, G. C. and Greenberg, M. T. (1987). The inventory of parent and peer attachment: Individual differences and their relationship to psychological well-being in adolescence. Journal of Youth and Adolescence, 16 (5), 411-419.

Bowlby, J. (1988). A secure base: Parent-child attachment and healthy human development. New York: Basic Books.

Braaten, S. (1993). Emotional and Behavioral Disorders Teacher Competency Survey. Minneapolis: Institute for Adolescents with Behavior Disorders.

Carson, R. R., Sitlington, P. L. & Frank, A. R. (1995). Young adulthood for individuals with behavioral disorders: What does it hold? Behavioral Disorders, 20 (2), 127-135.

Cheney, D. & Barringer, C. (1995). Teacher competence, student diversity, and staff training for the inclusion of middle school students with emotional and behavioral disorders. Journal of Emotional and Behavioral Disorders, 3 (3), 174-182.

Cheney, D., Barringer, C., Upham, D., & Manning, B. (In review). Designing educational support teams through interagency networks of youth with emotional and behavioral disorders: Project DESTINY. Services in the School.

Cheney, D. A. & Harvey, V. S. (1994). From segregation to inclusion: One district's program changes for students with emotional and behavioral disorders. Education and Treatment of Children, 17 (3), 332-346.

Chesapeake Institute. (September, 1994). National agenda for achieving better results for children and youth with serious emotional disturbance. Washington, DC.

Cicchetti, D. (1993). Developmental psychopathology: Reactions, reflections, projections.

ERIC

Developmental Review, 13, 471-502.

Cicchetti, D. & Toth, S. L. (1992). The role of developmental theory in prevention and intervention. Development and Psychopathology, 4, 489-493.

Gresham, F. & Elliot, J. (1990). Social Skills Rating System. Circle Pines, MN: American Guidance Service.

Individuals with Disabilities Education Act of 1990, 20 USC. (1400 et. seq.)
Kohlberg, L. (1984). Essays on moral development. Volume 2: The psychology of moral development. San Francisco: Harper & Row.

Reynolds, W. M. (1986). Reynolds Adolescent Depression Scale. Odessa, FL: PAR, Inc.

Wagner, M., Newman, L., D'Amico, R., Jay, E. D., Butler-Nalin, P., Marder, C. & Cox, R. (1991). Youth with Disabilities: How Are They Doing? The First Comprehensive Report from the National Longitudinal Transition Study of Special Education Students. Menlo Park, CA: SRI International.

Walker, H. M., Colvin, G. & Ramsey, E. (1994). Antisocial Behavior in School: Strategies and Best Practices. Pacific Grove, CA: Brooks/Cole.
Walker, H. & Severson, H. (1992). Systematic Screening for Behavior Disorders. Longmont, CO: Sopris West.

Walker, H. M., Severson, H. H., Stiller, B., Williams, G., Haring, N., Shinn, M., & Todis, B. (1988). Systematic screening of pupils in the elementary age range at risk for behavior disorders: Development and trial testing of a multiple gating model. Remedial and Special Education, 9 (3), 8-14.
Return to top

Craig Barringer, Ph.D.
Mental Health Coordinator
Project Destiny
603/358-2599 Fax: 603/358-2257
Doug Cheney, Ph.D.
Director, Institute on Emotional Disabilities
Institute on Emotional Disabilities
Keene State College
229 Main Street, Joslin Hall
Keene, NH 03435-2903
Return to top

Table 1

Return to Article

Table 1

Project Destiny Transdisciplinary Model

Project Destiny Transdisciplinary Model: Assessment of School Context		
Question	Yes	No
1. Mission statement with explicit goals for social/emotional development of students and staff		
2. Social/emotional development valued as highly as academic development		
3. Sufficient space, staff, and time relative to needs of students, parents and staff		
4. Programs and decisions follow an explicit, empirically - based model of social/emotional development		
5. Small classes or "houses": students and staff know each other		
6. Statement of rights and responsibilities (e.g., right to disagree, right to safety).		
7. Open and honest communication.		
8. All decisions concerning a student's program made collaboratively (student, parent and staff).		
9. Each student has an advisor or mentor who coordinates all aspects of the student's program.		
10. Support groups available to families and staff		
11. An interpersonal problem - solving approach to conflict resolution.		
12. Clearly stated discipline program designed to maximize students time in instruction.		
13. All students and staff familiar with crisis prevention and intervention techniques.		
14. Mental Health services available.		
15. Annual group screenings to identify students with special social/emotional needs.		
16. Timely implementation of supports for student and family.		
17. Systematic and timely evaluations of students' support programs.		
18. Staff makes families aware of community resources and supports their involvement		
19. Individualized instruction, modified curriculum and learning labs available.		
20. Tolerance for diversity		
21. Flexible time periods.		
22. Predictable schedule.		
23. Academic and social expectations based on student's competencies (not age or grade).		
24. Hierarchy of in-class intervention techniques available to teachers.		
25. Explicit entry, exit, and re-entry criteria, including procedure for processing incidents.		
26. Awareness of interaction of academic expectations and emotional functioning		
27. Medication as indicated based on students' needs.		
28. Personal assistant as indicated.		

BEST COPY AVAILABLE

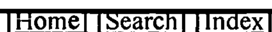

Table 2
Return to Article

Table 2
Means Scores for Student Groups from K-Means Analysis

	Student Groups				
	Typical	Agressive Academic Problem	Aggressive Depressed		
Measure	M	M	M	F	p*
IRF					
Total score	50.80	65.12	62.03	3293	
Internalising	5291	58.07	5897	512	<.05
Externalising	4850	64.44	59.40	2667	
Withdrawn	2.61	375	4.80	307	<.05
Anxious/depressed	393	673	6.67	2153	
Social problems	190	395	1.87	1470	
Thought disorder	030	152	1.83	719	<.05
Attention problems	6.45	1830	1500	2153	
Delinquent behavior	1.09	438	340	1133	
Aggressive behavior	3.43	19.61	12.83	2223	
Somatic	0.68	097	1.10	094	n.s.
YSR					
Total score	5100	5430	6756	1893	
Internalising	5030	5390	65.69		
Externalising	49.65	54.10	63.88	1178	
Withdrawn	3.19	425	531	527	<.05
Anxious/depressed	5.49	6.15	13.81	1953	
Social problems	292	3.15	600	1280	
Thought disorder	259	330	475	390	<.05
Attention problems	459	5.15	9.81	2499	
Delinquent behavior	4.45	4.45	5.81	490	<.05
Aggressive behavior	770	10.40	1694	1592	
Somatic	293	530	7.18	094	n.s.
SSRS					
Social skills	4337	17.35	14.19	1470	
Academic achievement					
Math	80.00	3035	63.06	3707	
Reading	74.65	2523	7676	3781	
Spelling	68.17	21.48	40.88	2429	
Total	7922	2339	6694	8368	
RADS					
Total	2695	4627	8895	6217	
IPPA					
Mother	98.63	84.16	81.00	973	
Father	99.10	6571	6700	1413	

p < .001 unless otherwise specified

BEST COPY AVAILABLE

ERIC

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

School-Based Wraparound: How Implementation and Evaluation Can Lead To System Change

Authors

Introduction Method Results Discussion References
Return to Table of Contents

Introduction

Specific special education initiatives in Illinois have been developed to implement wraparound models similar to those found in mental health and child welfare as a way to improve outcomes for children with emotional and behavioral disabilities (EBD) and their families. These programs provide and coordinate services that address all life domains, are strength-based and family-centered. Base-line data were collected on 81 students which included descriptive characteristics, student and family outcomes. Improvements were seen in family functioning, emotional and behavioral functioning of the students, and reduction in the use of psychiatric hospital days.

During the 1993-94 school year, the Illinois State Board of Education (ISBE) funded the Emotional and Behavioral Disability Partnership Initiatives. These projects have been involved in developing individualized services and supports for students with EBD in natural home, school and community settings. Given that these students have complex needs and often require multiple services, a critical component of these projects was to develop interagency networks that facilitate coordinated and comprehensive plans for students and families. These initiatives cultivated partnerships among community agencies and encouraged new ways to use existing resources and improve service delivery for students with emotional and behavioral disabilities (EBD). Along with the commitment to fund the operation of the projects, ISBE funded an evaluation of the projects.

Return to Top

Methodology

The evaluation of the EBD Partnership Initiatives is a longitudinal study of the effects of the individual supports and services on student, family and system outcomes. Various instruments were used to collect information on demographic characteristics, family functioning, parent satisfaction, student emotional and behavioral functioning, academic performance and school placements, out-of-home care and hospitalizations, and service receipt. For the purpose of this paper, five research questions were addressed.

1. Did family functioning improve during the course of project participation?
2. What factors were associated with parent satisfaction?
3. Did student functioning improve during the course of project participation?
4. Did out-of-home care change with respect to the number of days and level of restrictiveness?
5. How were local educational systems affected by the wraparound initiatives and what was their impact on local systems of care?

Sample Characteristics

Base-line data were collected on 81 students who were referred for services from September, 1993

through June, 1994. Students were predominately male (82%) with an average age of 14.64 years, ranging from 7.9 to 19.3 years. At the time of referral, 59% of the students scored in the clinical range on Internalizing Behavior and 50% scored in the clinical range on Externalizing Behavior as measured by the Children Behavior Checklist (CBCL; Achenbach, 1991). Forty-one of the students (51%) had at least one out-of-home placement prior to project participation.

With respect to family characteristics, slightly more than half (55%) of the families were two parent households. The majority of families were Caucasian (85%), followed by nine families who were African-American (11%). The average family income was $26,853.00.

Return to Top

Results

The first year evaluation results of school-based wraparound initiatives in Illinois demonstrated positive outcomes; however, these outcomes should be viewed with caution for two reasons. First, they represent findings from the first year of program participation and as yet sustained results have not been measured. Second, Time 2 data was not completed for every student. Preliminary analyses were conducted to test for selection bias. No differences were found between students with Time 2 data vs. students without Time 2 data. The tables in this summary reflect the sample number for each instrument.

Family Functioning

Family functioning was measured using the Family Adaptability and Cohesiveness Evaluation Scales (FACES: III; Olson, Portner & Lavee, 1983). Families completed these instruments at the time of referral and approximately one year after services began (see Table 1). Families who received wraparound services showed a significant improvement in adaptability and cohesiveness.

Family Satisfaction.

Family satisfaction was measured using nine items on the Time 2 Parent Survey. Families were asked to rank items addressing such issues as how the project improved family life, increased their ability to care for their child, and getting to know other parents. An overall satisfaction score was summed across the nine items. The results indicate that satisfaction with the project was associated with parent(s)' perception of inclusion in the decision making process regardless of the specific services that they received. With respect to new services, a positive correlation (r = .44*) was found with family satisfaction and assistance from project staff in obtaining government benefits (e.g., AFDC, SSI, Food Stamps).

Student Functioning

Emotional and behavioral functioning was measured using three instruments: the Children Behavior Checklist (CBCL), the Child and Adolescent Functioning Assessment Scales (CAFAS; Hodges, 1990), and the Teacher Report Form (TRF; Achenbach, 1991). All three instruments were completed at the time of referral and approximately 1 year later. No significant change was found from the TRF. Table 2 gives the results from paired t-tests for males and females from the CBCL. The results indicate that the females students showed significant improvements in Internalizing Behavior. Specifically, improvements were seen in the Withdrawn and Attention Sub-scales of the CBCL. Male students showed significant improvements on the Social Problem and Thought Problem sub-scales. Table 3 gives the results of paired t-tests for the sub-scales of the CAFAS. The results indicate that students who received individual supports and services through the Emotional and Behavioral Disability Partnership Initiatives improved in Role Performance and Moods as measured by CAFAS.

Out-of-Home Care

Out-of-home care was monitored using the Restrictiveness of Living Environment Scales (ROLES; Hawkins, Almeida, Fabry & Reitz, 1992). The instrument was completed at time of referral and 1 year after participation in the project (see Table 3). Students receiving wraparound plans had fewer out-of-home placements and spent fewer days in psychiatric hospitals after receiving wraparound services.

ERIC

Impact on Local Educational Systems and Service Systems
A self-evaluation tool was developed for project staff to examine their progress relative to specific target goals. These goals adhere to the basic system of care principles. It is believed that the way services are delivered, and the organization of services within the services system, are beginning to be more responsive to the individual needs of students with EBD and their families. Listed below are strategies developed and implemented by project staff to further their system change outcomes.

- Increase parental input in decision making role. Work with state level Illinois Federation of Families to train parents as facilitators. Develop forums (group meetings/support groups) where parents can exchange information and gain advocacy skills.
- Merge project staff positions with special education districts or community agencies to continue to facilitate the wraparound approach (i.e., school social workerp;family service facilitator).
- Merge project interagency councils with the Local Area Networks (LANs). (LANs is a mental health reform in Illinois bringing individualized care services to children with EBD and their families to their communities.)

Return to Top

Discussion

Historically, the education system has been more reluctant than mental health and child welfare systems to incorporate the wraparound tenets into their daily practice. This reluctance clusters around three main concerns. At the school level, is the teachers' receptivity to implement strategies and interventions needed to assist students in more inclusive settings (Clarke, Schaefer, Burchard & Welkowitz, 1992). At the administrative level, is the concern about liability and fiscal responsibility for providing the full array of life domain services identified in wraparound plans. And, at the community level, is the concern about the tension among interagency teams and who should coordinate and implement the plans (Lourie, 1994). These issues create challenges for the comprehensive and sometimes nontraditional aspects of wraparound in the educational system.

The findings from the evaluation of the Illinois Emotional and Behavioral Disability Partnership Initiatives begin to demonstrate how the wraparound process can be an effective means to serve students in school environments. The education system is a natural point of entry for children with EBD and they are in a position to develop partnerships with families and community stakeholders. Improvements in family and student outcomes, as well as the reduced need for psychiatric hospitalizations were demonstrated. Finally, project staff believe that the implementation of this project and approach has changed the larger system of service delivery in these schools and this impact may last beyond any artificial boundaries of the life of a project.
Return to Top

References

Achenbach, T. M. (1991). Manual for the children and behavior checklist (CBCL) and 1991 profile. Burlington, VT: University of Vermont.

Achenbach, T. M. (1991). Manual for the teacher's report form (TRF) and 1991 profile. Burlington, VT: University of Vermont.

Clarke, R. T., Schaefer, M., Burchard, J. D., Welkowitz, J. W. (1992). Journal of Child and Family Studies, 1 (1) 241-261.

Eber, L., Osuch, R., Redditt, C. (under review). Special edition of the Journal of Child and Family

Studies Special Issue on Children's Wraparound Services Research.

Hawkins, R., Almeida, M., Fabry B., & Reitz, A. (1992). A scale to measure restrictiveness of living environments (ROLES) for troubled children and youth. Hospital and Community Psychiatry, 43, 54-58.

Hodges, K. (1990). Child and adolescent functional assessment scale (CAFAS). Ann Arbor, MI: Eastern Michigan University.

Lourie, I. (1994). Principles of local system development for children, adolescents and their families. Kaleidoscope, Chicago, IL.

Olson, D. H., Portner, J., & Lavee, Y. (1985). FACES III. Family social science. St. Paul, MN: University of Minnesota
Return to Top

Lucille Eber, Ed.D.
Project WRAP Director

Ruth Osuch, Ph.D.
Evaluation Coordinator

Karen Rolf, M.A.
Research Associate
LaGrange Area Department of Special Education
1301 W. Cossitt Ave.
LaGrange, IL 60525
708/354-5730 Fax: 708/354-0733
Return to Top

[Home] [Search] [Index]

Table 1

Return to Top

Table 1
Change in Family Functioning
(N=46)

	Time 1		Time 2		
FACES Sub-scale	*mean*	*sd*	*mean*	*sd*	*Significance*
Adaptability	42.21	5.6	45.17	6.8	$p<.01$
Cohesiveness	48.04	4.6	53.86	10.3	$p<.01$

BEST COPY AVAILABLE

ERIC Full Text Provided by ERIC

Table 2

Return to Article

Change in CBCL Scores from Time 1 to Time 2 by Gender

	Time 1		Time 2		
Subscores	*mean*	*sd*	*mean*	*sd*	*p*
Withdrawn					
Males (n = 19)	5.1	2.80	4.2	2.89	.45
Females (n = 5)	6.8	2.16	3.8	2.16	.03*
Somatic					
Males	2.1	2.63	1.5	1.83	.28
Females	3.0	1.73	1.4	1.51	.18
Depressed					
Males	9.3	5.64	7.2	4.82	.14
Females	11.2	3.49	6.0	1.87	.07
Social Problems					
Males	6.2	3.85	4.4	3.61	.04*
Females	5.8	2.77	4.8	1.78	.35
Thought Problems					
Males	2.8	2.03	1.8	2.03	.01*
Females	2.6	2.07	2.0	1.22	.30
Attention Problems					
Males	10.1	4.40	8.1	4.53	.08
Females	11.2	2.77	6.8	3.19	.01
Delinquency					
Males	7.3	3.48	7.6	4.55	.71
Females	7.6	4.50	4.4	5.50	.14
Aggression					
Males	19.3	8.78	16.2	9.20	.07
Females	21.8	10.80	13.6	9.50	.06
Internalizing					
Males	15.7	8.46	12.4	6.75	.12
Females	19.8	5.21	10.4	3.57	.05*
Externalizing					
Males	26.6	10.77	23.9	11.79	.21
Females	29.4	15.04	15.0	14.76	.07

BEST COPY AVAILABLE

[Home] [Search] [Index]

Table 3

Return to Article

Table 3
Student Functioning

CAFAS	Time 1 mean	Time 1 sd	Time 2 mean	Time 2 sd	p
Performance	21.20	7.80	12.0	9.50	p < .01
Moods/Emotions	17.10	6.90	10.83	7.10	.04
Behavior	16.80	7.48	14.40	7.11	.13
Thinking	8.75	8.50	8.75	7.40	1.00
Drugs	5.65	8.95	6.52	9.82	.68

BEST COPY AVAILABLE

ERIC

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida, 1996

Identification of Students with SED: Correlates of State Child-Count Data

Authors

Introduction Method Results Discussion References
Return to Table of Contents

Introduction

The rate at which schools identify children as having serious emotional disturbances (SED) for the purpose of special education has been the subject of considerable controversy in recent years. The national rate (.89% of enrollment) represents roughly one-third to one-half of the estimated prevalence of children with emotional problems who need special education services (Institute of Medicine, 1989; U.S. Department of Education, 1994). This rate has remained quite stable since the national child count data was first collected and has been widely interpreted to mean that, in general, children with SED are significantly underidentified.

The national figure, however, does not tell the whole story. There is substantial variation across states in the rate of identification, ranging from .04 % to 2.15% of enrollment for the 1991-92 school year. This 50-fold difference between the lowest and highest rates suggests that states are identifying and serving children with emotional disturbances very differently. While the highest rate states fall within the estimated prevalence range (2-3%), most states fall well below these figures (U.S. Department of Education, 1994).

The present study examines relationships among state SED identification rates and a variety of economic and demographic variables. The purpose of these analyses was to investigate variables which may be relevant in predicting, planning for, and influencing state identification rates for children with SED. At a broader level, we examine the public policy implications of these relationships and describe further investigation which will clarify the picture.
Return to Top

Method

State identification rates for children with SED for 1992 were calculated from the national dataset used to produce the annual report to Congress. This dataset includes the number of children identified with SED in the public school system in each of the 50 states and the District of Columbia, as well as estimated enrollment figures for each state. The identification rates that were used are identical to those published in the Fifteenth Annual Report, within the limits of rounding error, except for isolated cases in which the figures were updated after the Annual Report went to print (U.S. Department of Education, 1993). For the present analyses, we used the ratio of the SED child count to the estimated enrollment for each state (SEDRATE).

Economic and demographic variables were extracted from the National Center for Educational Statistics, summarizing information relevant to education. On the basis of previous related work, we selected a set of economic and demographic variables judged likely to relate to the identification of SED children.

State demographic variables included geographic region, using NCES regional divisions (REGION); state per capita income (PERCAP); state per pupil revenue (PERPUP); and a ratio of per pupil revenue to per capita income (INDEX). According to the Education Digest, INDEX "reflects monies raised to educate the average public school student relative to the taxpayer's ability to pay" (National Center for Education Statistics, 1992). The primary race variable (WHITE) represented the percent of Caucasian students enrolled in public elementary and secondary schools in 1990. It should be emphasized that this distribution was for the public school population as a whole, not the ethnic distribution of the special education population, wherein minorities are often overrepresented. Finally, as a relative measure of school achievement level in the state, eighth grade math proficiency scores (MATHACH) were included in the variable set.

State economic variables included in the analyses were: (a) Total Expenditures Per Capita (TEPC), which consisted of state and local government expenditures for education services, social services and income maintenance, transportation, public safety, environment and housing, governmental administration, interest on general debt, and other general expenditures, including intergovernmental expenditure to the Federal Government; (b) Education Expenditure Per Capital (EEPC), which reflected state and local government expenditure on all education ; and (c) Elementary and Secondary Education Expenditure Per Capita (ESEEPC), representing state and local government expenditure on elementary and secondary education.

Elementary and Secondary Education Expenditure Per Capita figures, per pupil revenue, and per capita income figures were ranked and then converted to quartiles for the purposes of the ANOVAs reported below. In each case, the first quartile represents the states with the lowest incomes or expenditures while the fourth quartile represents the states with the highest. Regional divisions, expenditure per capita quartiles (EXPQRT), per pupil revenue quartiles (PRPQRT), and per capita income quartiles (PCIQRT) were compared in separate ANOVAs to examine the effects of these variables on SEDRATE. Correlation analyses were conducted to explore other relationships among the variables. A stepwise regression was performed, including all variables which displayed moderate relationships ($r > .30$) with SEDRATE. Finally, the earlier ANOVAs were run again, using as covariates those variables which entered into the stepwise regression to determine which variable possessed the best predictive value.
Return to Top

Results

SEDRATE was found to differ significantly across regions ($F = 6.47$; $p = .0009$). A Student-Newman-Keuls (SNK) means comparison revealed that Northeast states have significantly higher rates of SED identification than Midwestern, Southern, or Western states. The latter three do not differ from one another.

SEDRATE also differed across expenditure quartiles ($F = 4.09$; $p = .01$). The SNK test indicated that states spending the least on elementary and secondary education per capita (EXPQRT = 1) identify significantly fewer SED children. Quartile 2,3, and 4 did not differ on SEDRATE.
Per pupil revenue quartiles differed significantly in SEDRATE ($F = 5.56$; $p = .0024$). SNK means comparisons revealed that states with the highest per pupil revenue (PERPUP = 4) had higher rates of SED identification than states in quartiles one and two. States in the third quartile also had higher rates than states in quartile one.

The per capita income quartiles ANOVA also yielded a marginally significant effect ($F = 2.95$; $p = .04$). The SNK means comparison did not reveal significant differences among the means, although there was an orderly trend from the lowest per capita income states (PCIQRT = 1; SEDRATE = .57) to the highest (PCIQRT = 4; SEDRATE = 1.05).

The correlation analysis revealed three variables that were moderately related and positively related to SEDRATE: per pupil educational revenue (PERPUP; $r = .49$), per capita income (PERCAP; $r = .46$), and the NCES Index (INDEX; $r = .31$). No other significant correlations were found.
The stepwise regression procedure yielded a single variable in the final equation (PERPUP). The model

R-square was .24, indicating that about one-fourth of the variation in SED identification rate can accounted for by variation in the amount of educational revenue per pupil in the state.

The REGION ANCOVA with per pupil revenue as a covariate yielded a marginally significant regional effect (F = 2.53; p = .07). Comparison of adjusted least squares means indicated that Northeastern states continue to show higher identification rates than Southern and Western states; no other comparisons were significant.

The EXPQRT ANCOVA with per pupil revenue as a covariate also yielded a marginally significant effect (F = 2.56; p = .07). Comparison of adjusted least squares means revealed that the states in the first quartile (i.e., lowest expenditures) identify significantly fewer SED students than states in the second quartile (p = .02) and states in the fourth quartile (i.e., highest expenditures) identify marginally significantly fewer SED students than states in the second quartile (p = .06). Other comparisons were not significant.

The PCIQRT ANCOVA with per pupil revenue as a covariate did not yield a significant per capita income quartile effect.
Return to Top

Discussion

Examination of the correlates of states' SED identification rates reveals that demographic and economic differences across the country may play role in the identification process. While these relationships do not explain the variation in SEDRATE, they point to some factors that may play a role in that variation.

While per pupil revenue is the strongest (and the only significant) single predictor of SED identification rates, it accounts for relatively little of the state variation. Further, when the effects of per pupil revenue variation are removed, states continue to show marginally significant effects for region and expenditure on elementary and secondary education.

While the significant effects of economic variables suggest that educational revenue is important, there are clearly other variables not included in the present analysis which also contribute to the range in SED identification rates. The continuing regional differences may indicate the need to examine social and political characteristics of states in order to better understand that variation.
It is perhaps equally illuminating to consider those characteristics of states which did not relate to the target variable. Size of the state, racial makeup (percent White), expenditures on human services, and achievement measures were all unrelated to the rate of identification of students with SED. These features which are sometimes thought to be associated with prevalence of SED are either unrelated or their relationship is masked by other contravening effects.

In sum, the present analyses offer some indications of the source of the variation in identification of SED students and hint at the significance of other constructs not included in the study. Further investigation, following the directions suggested above, is warranted to better understand how states identify children with emotional disturbance.
Return to Top

References

Institute of Medicine (1989). Research on children with mental, behavioral, and developmental disorders. Washington, DC: National Academy Press.

National Center for Education Statistics. (1992). EDSearch: 1992 condition of education and digest of education statistics. Washington, DC: Author.

U.S. Department of Education. (1993). To assure the free appropriate public education of all children with disabilities: Fifteenth annual report to Congress on the implementation of the Individuals with Disabilities Education Act. Washington, DC: Author.

U.S. Department of Education. (1994). To assure the free appropriate public education of all children with disabilities: Sixteenth annual report to Congress on the implementation of the Individuals with Disabilities Education Act. Washington, DC: Author.

Return to Top

Donald Oswald, Ph.D.
Assistant Professor
Department of Psychiatry
Medical College of Virginia
Box 980489
Richmond, VA 23298-0489
804/828-9900 Fax: 804/828-2645
E-mail: doswald@gems.vcu.edu

Martha Coutinho, Ph.D.
Associate Professor
Department of
Human Development and Learning
East Tennessee State University
Box 70548
Johnson City, TN 37614
615/929-4478 Fax: 615/615/929-5764
E-mail: coutinho@eduserve.east-tenn-st.edu

Return to Top

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Comparison of Children and Adolescents with Serious Emotional Disturbance Served in Hospital and in School

Authors

Introduction Method Results Discussion References
Return to Table of Contents

Introduction

This paper used administrative data to compare the characteristics of children and adolescents with SED from an urban county who were hospitalized in a regional state mental hospital with those of youth placed in special educational settings. This study also examined the array of public sector mental health services provided to these youths prior to their hospitalization or placement. The questions surrounding this investigation included:

- How likely is it for children who were hospitalized for SED to have received services in the special educational system during a previous school year?
- Are children who are treated in a state psychiatric hospital more likely to receive ambulatory treatment than children who receive special educational interventions for SED?
- What demographic and risk factors may differentiate between children and adolescents served in the two service systems?

Return to Top

Method

Data Sources

Data for this study came from large client-specific data sets for the 1991-1992 fiscal year. Mental health services information was extracted from Medicaid paid claims for inpatient, outpatient, and partial hospitalization for all eligible beneficiaries in a large northeastern city; from the county reporting system for recipients of specialty mental health services in the public sector; and from the regional state mental hospital (SMH). Each of these databases was limited to the 1992 fiscal year and to county residents. There were 10,942 MA records, 8391 county records, and 101 state mental hospital records.

The State Bureau of Education provided statewide data on children identified as having a serious emotional disturbance as prescribed in P.L. 94-142 and its amendments, or children placed in emotional support classrooms. These records, which were entered directly on site when Individual Educational Plans (IEPs) were submitted for the annual head count, contained demographic and placement information, including services received, location of intervention, percentage of time in special setting, and suspensions from school. In 1992 there were 24,437 records for the entire state, and 3433 for the county under study.

Analyses

Each of the Medicaid-reimbursed claims was identified by a sixteen-digit recipient code, assigned at the time of first request for approval of service. These numbers were issued sequentially by the Office of Medical Assistance. County mental health records carried a unique nine-digit client-specific eligibility number. In the state mental hospital records, eight-character facility-specific case numbers were assigned

to each patient, and social security numbers were also available on some client files. Special education (BSE) records contained an identification number constructed of the nine-digit administrative unit number which represented the school where the child's IEP was implemented, and up to nine more digits identifying the individual learner. However, except for the county mental health record numbers, which were less subject to change, none of these identifiers was unique and truly client-specific. Movement from one SMH inpatient facility to another or from one BSE setting to another, led to the attribution of a new and unrelated case number. Consequently, any individual receiving multiple services in the public sector could have been identified with several codes within and between service provider agencies.

In order to merge the data and determine an unduplicated count of children who received multiple services, and what array of services they received, all the while protecting confidentiality, an identifier was constructed of patient initials, birthdate and sex, using an algorithm comparable to those described elsewhere (Donaldson & Lohr, 1994; Goerge, Van Voorhis, & Lee, 1994). Successive sorting and merging of the data yielded a pool of 26,954 individuals. This pool represented about 8.7% of the county population for this age group (uncorrected 1990 U.S. Census count for children aged 3-17 in Urban County = 309,712). Descriptive analyses of socio-demographic and risk factors for the hospitalized and school-identified children were performed. Odds ratios and their confidence intervals were calculated to compare the special education and psychiatric inpatient service systems (Kahn & Sempos, 1989).
Return to Top

Results

Descriptive Analysis
There were 797 children and adolescents who received inpatient psychiatric care in the county, and 3,433 who had an IEP during the 1992 fiscal year. There was a majority of male youth in both inpatient mental health and special education, but the ratio of males to females in special education (4:1) was much higher. The mean age of children receiving special educational services was 12.7 years (SD = 2.9); mean age of inpatients was 12.8 years (SD = 3.1), and those in the regional state mental hospital was 14.3 years (SD = 2.1). Special education and community-based mental health services served a proportion of minority clients which was consistent with local demographics, but inpatient facilities served a much lower proportion of minority clients.

Of the 797 inpatient psychiatric clients, 101 were hospitalized in the regional SMH for children and adolescents. Twenty-nine percent of these patients had been hospitalized in a community psychiatric unit prior to transfer to the state hospital, for lengths of stay ranging from one day to more than six weeks; more than half of these prior hospitalizations had been billed as emergency interventions. More than half SMH youth (60%) had received community-based outpatient services in 1992, and 5% had also been served in partial hospitalization. Fifteen percent received intensive case management and four patients had also received "wraparound" mental health services in their homes or communities. Only four patients had been identified as SED in the schools prior to their inpatient stay. The majority of these patients (70%) were Medicaid eligible. Except for gender (100% male) and race (84% African American or Latino), the 26 youth who were admitted to the state facility from correctional facilities were comparable to the hospital population (28% prior hospitalization,
of which 60% were emergency).

Of the 3,332 youth with active IEPs who were not in the SMH, one third received mental health services in 1992. Of these 3% had an inpatient psychiatric stay in the community (85% of which were billed as emergency admissions), 17% received outpatient treatment (mean = 76 units, SD = 135 units), and 4% also had partial hospital treatment (mean = 20 units, SD = 47 units). One out of five of these youth lived in a state or private institution and 3% lived in correctional facilities. About two-thirds of children and adolescents with SED spent more than 60% of their day in a BSE setting, and were therefore separated from their agemates; 25% were not in their home school and were therefore separated from their neighbors. Eighty-two percent of those who spent more than half their school day in a separate placement were male, as were 86% of those who were suspended at least once; 80% of those who were suspended were African American or Latino youth. Nearly half (44%) of those in special education in 1992 had been referred for evaluation prior to 1985, and 5% had received inpatient mental services in

ERIC Full Text Provided by ERIC

community-based facilities prior to 1992.

Odds ratios (OR) and their 95% confidence intervals (CI) were calculated to test for reliable differences between youth served in these two service systems. Of those who received mental health services in the community in 1992, children who were hospitalized in the regional SMH were almost six times as likely as those in BSE to have received outpatient services in 1992 (OR = 5.9 ; CI 4.1, 8.6). Three percent of SMH patients and one percent of children receiving BSE services also received inpatient services in FY 1992, and there was no difference in the rates of partial hospitalization (about 4%) between the two groups. African American and Latino youth were more likely than Euro-American youth to receive only BSE services (OR = 1.6, CI 1.4, 1.9); Euro-American children were twice as likely as African American and Latino youth to receive BSE services in an institutional setting (OR = 2.2; CI 1.8, 2.6), and about twice as likely to receive community-based inpatient psychiatric services (OR = 2.0; CI 1.6, 2.4). Euro-American youth were marginally more likely to receive mental health treatment in the SMH (OR = 1.5; CI 1, 2.3), but African American and Latino youth were more likely to be in the forensic unit of the SMH (OR = 3.5; CI = 1,11).
Return to Top

Summary and Conclusions

Integration of data sets from several service systems for children with serious emotional disturbance served in the public sector of an urban county yielded records for about 8.7% of the child and adolescent population. The current study sought to identify differences in demographic patterns and levels of care within and between state psychiatric hospital and special education service systems. Descriptive analysis of recipients of these two services for children revealed few system-specific differences: both represented greater than 70% male and 70% or more African American and Latino youth; 70% of the state hospital population was Medicaid eligible. State hospital patients tended to be slightly older than children served in special education; youth in forensic placements in the SMH were older. Youth in more restrictive placements in both service systems were disproportionately male (82% to 100%) and African American or Latino (80% to 84%).

The greatest contrast between the systems was the proportion of children who received other mental health services during the 1992 fiscal year: 64% of those in the SMH received other mental health services (particularly outpatient treatment) during the year, compared to about one-third of youth in SED placement in the BSE system. It was quite unlikely for children hospitalized in the state psychiatry facility to have been placed in SED special education services prior to hospitalization; this suggests that these patients were functioning adequately in the school setting, that their behaviors were not disruptive in spite of their serious emotional disturbance, or that their emotional and psychiatric needs otherwise went unnoticed in the classroom. This issue deserves further research.
Developing integrated service system data sets like the one described here and in Goerge, Van Voorhis and Lee (1994) is a labor-intensive undertaking, but one that produces an invaluable resource for program planners and service researchers. Analysis of the unduplicated count of recipients across service systems can assist in identifying trends in service delivery, patterns of cross-system communication, and dimensions of risk factors and resilience in the community.
Return to Top

References

Donaldson, M. S., & Lohr, K. (Eds.). (1994). Health data in the information age: Use, disclosure, and privacy. Washington, DC.: National Academy Press.

Goerge, R., Van Voorhis, J., & Lee, B. J. (1994). Illinois' longitudinal and relational child and family research database. Social Science Computer Review, 12(3), 351-365.

Kahn, H. A., & Sempos, C. T. (1989). Statistical methods in epidemiology. New York:

Oxford Press.
Return to Top

Suzanne Markel-Fox, Ph.D., NCSP
NASMHPD Research Fellow
E-Mail: suzanne@server.section.upenn.edu

Edna Kamis-Gould, Ph.D.
Research Assistant Professor
E-Mail: edna@server.section.upenn.edu

Kathleen A. Foley, M.H.S.A.
Project Manager
E-Mail: foley@server.section.upenn.edu
Center for Mental Health Policy and Services Research
University of Pennsylvania Medical School
3600 Market Street, 7th Floor
Philadelphia, PA 19104-2648
215/ 662-2886 Fax: 215/349-8715
Return to Top

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

One Year Outcome Findings of the Vanderbilt School-Based Counseling Evaluation Project

Authors

Introduction Method Results Discussion References
Return to Table of Contents

Introduction

The Vanderbilt University School-Based Counseling Evaluation Project (SBCEP) is a federally funded, children's mental health services research program designed to evaluate the effectiveness of a collaborative in-school counseling program relative to a tutoring program and traditional community based services. Our program addresses four primary areas: (1) the early identification of disturbance in at-risk youngsters; (2) the relative accessibility and utilization of psychological services; (3) the prevention of costly and restrictive placements; and (4) the effects on students' adjustment.

Estimates of psychological and behavioral disturbance among children from socially and economically disadvantaged backgrounds are overwhelming. Unfortunately, these at-risk youngsters often do not receive needed psychological resources, whether it be due to a lack of appropriate and accessible mental health services, or because their families lack the transportation or finances necessary to obtain treatment.

This evaluation project was grounded in pilot work demonstrating the feasibility of executing a collaborative system of care between mental health and school personnel in the school setting. In our school-based programs, qualified, trained and licensed mental health clinicians provided a range of services to youngsters at school. The Vanderbilt school-based counseling programs first were established in three pilot schools and provided comprehensive mental health services to youngsters referred by their classroom teachers. Teacher, principal and parent anecdotal report, together with clinical observation, suggested the programs were successful. In light of the recent political and economic climate of decreasing availability of funds for non-traditional mental health services, a systematic evaluation of the effectiveness of the program was proposed. The SBCEP represented an experimentally controlled effort to demonstrate the impact of school-based services on service use, accessibility, and children's mental health.
Return to Top

Method

Nine Metropolitan Nashville schools were selected and invited to participate in the research. Three schools served as comparison sites, with 30 - 40 youngsters from each school referred for traditional, community-based, out-patient treatment; and six were treatment sites, with 30 - 40 children from each school randomly assigned to receive either school-based counseling (SBC) or academic tutoring (AT). These groups allowed us to experimentally determine the effectiveness of our school-based counseling services.

In all schools, youngsters were selected for participation based on a set of multi-informant indicators of psychological adjustment. Based on research suggesting that child self-report and teacher referrals may

overemphasize certain problems and underemphasize others, student selection was based on school-wide mental health screenings conducted with children, their peers, and teachers.
These assessments consisted of a series of mental health measures and were administered twice yearly. Specifically, measures were selected/designed to tap six domains of psychopathology, including: delinquency, aggression, hyperactivity, depression, anxiety, and somatization. Reports from each informant were weighted based on the relative validity of specific informants' reports when considering a particular area of psychopathology. What results from this combination of informants and weighting of scores is a total psychopathology score which allows us to select children representing a broad range of emotional and behavioral disturbances. Concurrence among at least two reporters was a necessary condition for participant selection. Therefore, if a youngster self reported very high levels of depression but the report is not confirmed by teacher or peer report, that child was not selected. A score of at least one standard deviation above the mean was required in order to be considered eligible for enrollment.

In addition to a total psychopathology score, data from these school-wide screenings were used to determine a particular child's primary problem area, the domain of psychopathology where difficulties were most severe. A number of our analyses were centered around this primary problem domain because we hypothesized that improvement in functioning would be most evident when a child's most serious emotional or behavioral problem was considered. Also, for each child identified, we determined a secondary problem area which represented scores on the domain of psychopathology for which they received the second highest score.

Our program also included a family interview prior to enrollment. Therefore, for each child, we had teacher, self, peer and parent report of adjustment over time. For the most part, we considered the weighted sum of the school informants together, given their similar context, and the parent report as a separate score.

Students were in the 2nd to 5th grades at the time of our initial assessment (Spring 1993). They ranged in age from 7 to 14, with a mean age of about 10 years, and about 63 % were from minority backgrounds. Greater than 70% of the students enrolled in these urban schools received free school lunches, an indication of the level of poverty. Over 20% of students in these public schools evidenced serious behavioral and emotional problems. Based on our home interviews, it was evident that the families and children we treated would not be receiving consistent mental health services if not for our program.

Counseling services were provided at school, during regular school hours. They were comprehensive, and could include combinations of individual, group, parent treatment, family therapy, teacher consultation, and psychiatric consultationp;in fact, any services traditionally found at local community mental health centers. Some of the strengths of having a school-based counselor included:

- accessibility for consultation with teachers regarding classroom management; opportunities for immediate feedback regarding behavior management strategies;
- readily accessible observation of youngsters in structured and unstructured settings;
- more realistic understanding of child's academic environment;
- ability to educate teachers regarding the kind of information that is most useful in developing a treatment plan;
- immediate accessibility;
- school as a safe place fostering parent/family involvement in treatment;
- availability for participation in school team meetings;
- ability to provide teachers with a different perspective on students;

- early identification of student difficulties, ability to teach school personnel to recognize early indicators of maladjustment;
- more consistent treatment participation; and
- ability to support school-wide curriculum for school-wide impact (e.g., anti-drug use programs, anti-violence programs).

In regards to psychopathology, our outcome measures could be placed into one of four groups:

1. Primary Problem Domain, which, as mentioned earlier, represents the problem area for which a child received the highest rating prior to services. Thus, for one child this variable might represent a standardized depression score, whereas for another child it might represent an aggression score;
2. Total Problem Score, which represents the sum of the various measures, across all domains;
3. Internalizing Problems, which include depression, anxiety, and somatization; and
4. Externalizing Problems, which represent aggression, delinquency, and hyperactivity.

These outcome measures also were grouped by informant, including: Teacher, Self-Report, Peer, and Parent.

These were our dependent variables. All analyses compared the functioning of our Counseling versus Tutoring children at the end of the first academic year of services, adjusting for their functioning at the beginning of the year. The primary independent variable was Group, which was the Counseling versus Tutoring comparison. However, we also were interested in the relation between outcome and several other factors: We were interested in whether treatment was more effective: (1) with girls versus boys; (2) with older versus younger children; and (3) with children whose primary problem area was Internalizing Problems versus children whose primary problem area was Externalizing Problems. So we tested the interaction of each of these effects with Group measures.
Return to Top

Results

It was the Primary Problem Area which we believed would be the most likely to change as a result of our intervention. When parent report of a child's primary problem area was considered as the outcome criterion, our data revealed no significant differences between AT and SBC children. In fact, when we controlled for the level of disturbance prior to our intervention, a trend emerged for students enrolled in SBC to do marginally worse than those youngsters enrolled in AT. This finding is consistent with previous research from Weisz and Weiss who found that 6 months following service provision, parents of children in the control group reported no significant improvement over children in the treatment group.

Similarly, a trend was evident in parents' reports of their children's social strengths: Although nonsignificant, parents' report of students enrolled in AT indicated marginally greater social competence than students receiving SBC at the end of one year of treatment. When parents' reports on the CBCL TOTAL scores were considered, the trend for greater improvement in functioning again favored AT children over SBC children. When scores for internalizing and externalizing difficulties were analyzed separately, however, this trend disappeared.

When we looked more closely at children's primary problem areas, grouping them according to whether they represented externalizing behavioral problems or internalizing difficulties, a significant Group x Primary Problem Area interaction emerged. Specifically, for children with internalizing problems (i.e., depression, anxiety, somatic complaints), enrollment in SBC resulted in more gains in parent reported social skills, whereas for children with externalizing problems (i.e., delinquency, hyperactivity, aggression), the opposite was true; students enrolled in AT scored better on measures of social skills.

ERIC Full Text Provided by ERIC

The combined, total psychopathology scores from teacher, self and peer ratings revealed no significant differences or trends for AT and SBC children with respect to primary problem domain. Also, when considered independently, analyses of teacher and peer report did not reveal differences in primary problem domain based on group (AT or SBC). Analysis of children's self-reported level of adjustment, however, revealed a significant interaction between type of intervention (AT or SBC) and type of primary and secondary problem areas. Specifically, children who had Internalizing Problems as their primary and secondary problem areas reported similar gains in functioning, whether enrolled in AT or SBC. However, students evidencing primary and secondary symptoms of externalizing disorders made significantly more gains in self-reported adjustment when enrolled in SBC than when offered AT. Additionally, students with primary and secondary problem areas representing characteristics of both internalizing and externalizing difficulties made greater gains in AT than SBC services.

Finally, we examined gender and age differences in our data. No evidence for Sex x Group interactions emerged. However, our data revealed a significant Age x Group interaction which suggests that children 10 years and under, but not adolescents, enrolled in AT report greater improvement in functioning than children in SBC.
Return to Top

Implications

These data represent a small part of the big picture of the School-Based Counseling Project. We've focused exclusively on our psychopathology outcome measures. Some trends suggest improvement, while other findings highlight the lack of differences. These data were consistent with naturalistic assessments of children's mental health services documenting little change in targeted behaviors. One year of service provision might not be enough, given the severity of these children's problems. Perhaps findings after two years of intervention will provide a more positive picture.

In addition to psychopathology indicators, we will examine school-wide indicators of adjustment (e.g., grades, disciplinary measures, absences, restrictive educational placements) which may be linked in important way to the availability of an on-site mental health counselor. We will also scrutinize the activities of our school-based counselors. For example, some clinicians favor a more cognitive behavioral style, others favor a more play-therapy focus to treatment; some more actively consult with school personnel, where others work more exclusively with the children.
Return to Top

References

Achenbach, T. M. (1983). Manual for the child behavior checklist and revised child behavior profile. Burlington, VT: University of Vermont, Department of Psychiatry.

Achenbach, T. M. (1991). Manual for the Youth Self-Report and 1991 Profile. Burlington, VT: University of Vermont, Department of Psychiatry.
Return to Top

Vicki S. Harris, Ph.D.

Julie Jacobs

Bahr Weiss, Ph.D.

Thomas F. Catron, Ph.D.
Vanderbilt University
1207 18th Avenue South

Nashville, TN 37212
615/343-2070
Return to Top

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Interagency Collaboration Efforts with Families with Severe School Refusal Problems

Authors

Introduction Method Results Discussion References
Return to Table of Contents

Introduction/Purpose

The research demonstration project, Outcomes of Parent- and Provider-Designed Systems of Care (CMHS 5HD5SM50736), is discussed in detail in Armstrong, Evans, Tannen, and Scudder (1995) and in Evans, Armstrong, Thompson, and Lee (1994). Two rural counties in upstate New York have been provided equal funding to compare the processes and outcomes of systems enhancements based on very different principles. In Essex County, the naturally occurring experiment of Families First provides a demonstration of the principle of parent involvement taken to its logical conclusion, being an organization designed to build a partnership between families and professionals and to develop services which respond to families stated needs. Herkimer County, on the other hand, has developed a provider-designed, school-based, family-therapy enhancement to their mental health services for children.

Families First under the guidance of Naomi Tannen, its director, has been providing a broad range of services to the community for over two years. Services include phone support, resource library, respite, financial and transportation assistance, trainings and workshops, and social events. Families First employs two half-time Intensive Case Managers (ICM) who also work as family advocates, and a home-care provider. In addition, many parents are employed in a wide range of roles. Families First is constantly working at both the case level and the county administrative level to convince other agencies to involve families in decision-making, with varying levels of success. The research discussed in this presentation provides detailed examples of this work.

Return to Top

Method/Procedures

Three methodological approaches are being used to assess the processes and outcomes in the two counties: a treatment outcome study, a network analysis study and a combination of qualitative methodologies. The qualitative research presented here was conducted in Essex County by the first author, and involved comparing two service participants' experiences in order to explore Families First's progress in family involvement and interagency collaboration. These histories provide examples of the practical ways in which agencies choose or are required to work with each other, often requiring face-to-face discussions and documentation in which opinions are openly expressed. By looking at interagency collaboration, we can assess the position of agencies vis-á-vis Families First as this new agency seeks to insert itself into the traditional system of agencies and as it seeks to change the attitudes and behaviors of those entrenched agencies.

Severe school refusal was chosen for this study from the various problems of the more than 30 children and families helped by Families First's ICM program, because, almost uniquely, clarity of assessment of successful treatment is possible: the youth returns to daily school attendance. The two families were selected because both the students, Christie and Darlene (pseudonyms), and their family situations had

strong similarities, because they were introduced to Families First at approximately the same time, and because their experiences of the system of care were very different.

In-person, in-depth interviews were conducted with family members, with the Intensive Case Manager, and with many other service providers and administrators, as well as through phone conversations. Meetings at Families First and conversations with staff members kept the researcher abreast of developments. Where Darlene was concerned, interagency meetings and a court hearing were observed. Documentation was gathered from many sources.

Two Cases Of Severe School Refusal

Christie's and Darlene's circumstances had much in common superficially. Christie was 12 and Darlene 14. Both lived in small family units in rural towns with large extended families close by. They were academically successful when attending school. Both not only refused verbally to go to school but fought violently not to be taken inside, and were out of school almost every day of fall 1993. Both schools were obliged to file a PINS petition or be able to show reason for not doing so. Both families were reported for child abuse by neighbors who saw that the girls were not going to school and that furious arguments were going on. Both mothers blamed themselves in part for the defiant behavior. Darlene's family seemed to have more social and cultural capital (Bourdieu, 1986) than did Christie's. Darlene's mother had been a foster mother for seven years. Her older sister had been a model student. Though never having lived with them, Darlene's father maintained a positive supportive relationship with Darlene and her mother. A retired corrections officer and successful business owner, his two sons were high-school graduates. Realizing the school avoidance problem was too much for her, Darlene's mother drew on her connections in the town and the county for help, to get Darlene to school, and to get a psychiatric evaluation and appropriate treatment.

Christie's family, on the other hand, was under great stress: relatives' illnesses, their recent moving, and her father's unemployment and protracted workman's compensation case. They had no parent/child roles and no family routine. Christie's parents had become as physically withdrawn as Christie and rarely left the house. Neither parent had much schooling. There was little contact with the community outside the extended family.

Parent Involvement and Interagency Collaboration Efforts

The school referred Christie and her family to the mental health clinic, whose staff introduced them to Families First. Families First and the school psychologist convinced the principal and school board of a psychiatric problem, providing time for evaluation by a psychiatrist and for modeling of normal parent/child roles and routines by Families First's home-care provider. When Child Protective Services were called in, they agreed an evaluation was needed and agreed to split the costs with the school and Families First. The psychiatrist found by the school psychologist was respectful of and encouraging to Christie's family; her practical recommendations laid the groundwork for a treatment plan designed collectively by family members and agencies. Positively-reinforced incremental steps were designed and carefully attended by the ICM and the school psychologist to reintroduce Christie to school, where changes were made to provide welcome and support. Once Christie was established in a school routine, Families First shifted focus to helping her parents become independent of the family. Christie's mother now works as a parent advocate at Families First. Christie went to school all through fall, 1994 and winter, 1995.

Darlene's school had less patience for her resistance to school. Threats of removal from home had succeeded with other students, so they filed a PINS (Person in Need of Supervision) petition in October 1993 which led to a court-ordered 30-day residential evaluation and the shifting of Darlene's custody from her mother to Social Services. Darlene's mother's prior requests for help from Social Services, with whom she had worked as a foster parent, fell on deaf ears. The evaluation blamed the parents and recommended long-term residential treatment. Families First became involved while the family appealed, working with Darlene's family and the school to implement a desensitization treatment plan, made in collaboration with a child psychologist, an expert on school refusal, hired by Families First. Having made curriculum changes, the school had little tolerance for less than total attendance. Darlene's problems took a toll on Families First: much extra time was needed to talk and meet with lawyers, and to help with violent outbursts at home, as well as the expected difficulties of implementing the treatment

plan.

Attendance having been up and down, the court decided that Darlene should live with her father while awaiting residential placement. Darlene's responsible behavior over the summer impressed Families First but not Social Services, who placed her in a facility an hour from home. In September 1994, Darlene revealed she had been sexually assaulted at her home school. For Families First and their consulting psychologist this news explained her school avoidance. Her father increased his efforts with the courts to get her home. But Darlene then became pregnant and this was seen by Social Services as another indication of incompetent parenting. Despite the family's and Families First's efforts to negotiate her return home, Social Services moved Darlene in January to a facility for pregnant girls further from home where education was not a priority, despite its being the motivating factor in the initial placement. Finally, Darlene's father's home was evaluated and in March the court gave custody to her father.
Return to Top

Conclusions

The striking difference between the following descriptions illustrates the gap between alternative solutions to the problem of school phobia. The Social Services lawyer characterized Darlene's family as intergenerationally dysfunctional:

> Her familial history suggests that she will simply be another teenage mother without a high school education, with parents who are dysfunctional, who have raised a dysfunctional child, and now want to help raise a dysfunctional grandchild.

This view of Darlene's family as essentially a bad influence is completely the opposite of the view of the consulting psychologist:

> Darlene has been alienated from her family by the abuse of a stranger and her fear of revealing this secret. It seems to me only a further exacerbation of this wound to keep Darlene, at this point, from her familyp; a family who wants to nurture her, by whom she wants to be nurtured, and who, until she was so cruelly and secretly misused, was able to provide her totally adequate care. It is inconceivable to me that she could be transferred to an unfamiliar environment at even greater distance from her home when her parents are so willing to provide for her and her unborn child.

Definition of the problem and the range of possible actions are tightly shaped for service providers by their agency's mandate and history; some agencies welcome family involvement in planning solutions while others do not. Through dealing with Christie's and especially Darlene's problems, Families First has learned much about how to build successful collaborations so that residential placement is agreed to be the last resort.

Some, though not all, of the variables which contributed to the extension of the trials and tribulations of Darlene and her family are related to agency collaboration efforts:

1. Agency knowledge of new services can be important: perhaps ICM may have been too new a concept for Social Services and the judge, and perhaps now Families First and the ICM program will be given a second chance to show what can be accomplished at home. Social Services appears to remain skeptical and further interviews will provide valuable insight into their perspectives.
2. The school's experience will also be telling. School perspectives on school refusal can shape crucial moments, such as non-attendance being considered truancy or an emotional problem.
3. Lawyers' disregarding the importance of interagency collaboration may be detrimental to collaborative efforts when the courts are involved, increasing conflict among involved agencies.
4. Shifts in the personnel can alter the atmosphere: in this case, change of lawyers may have made

things more difficult, change of judges may have facilitated Darlene's going home.

Return to Top

References

Armstrong, M. I., Evans, M. E., Tannen, N., & Scudder, E. (1995). Outcomes of parent-and provider-designed systems of care: Research plan and service system design. In C. Liberton, K. Kutash and R. Friedman (Eds.), The 7th Annual Research Conference Proceedings: A System of Care for Children's Mental Health (pp.179-186). Tampa FL: University of South Florida, Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

Bourdieu, P. (1986). The forms of capital. In J. G. Richardson (Ed.), Handbook of Theory and Research for the Sociology of Education (pp. 241-58). New York: Greenwood Press.

Evans, M. E.; Armstrong, M. I.; Thompson, F. & Lee, J. (1994, Winter). Assessing the outcomes of parent- and provider-designed systems of care for children with emotional and behavioral disorders. Psychiatric Quarterly, 65(4), 257-272.
Return to Top

Fiona Thompson, Ph.D.
Research Scientist II
518/473-9730 Fax: 518/474-7361
srthom@iris.rfmh.org

Mary E. Evans, Ph.D.
Interim Director
518/474-7209 Fax: 518/474-7361
srevans@iris.rfmh.org
Bureau of Evaluation and
Services Research
New York State
Office of Mental Health
44 Holland Avenue, 7th Floor
Albany, NY 12229

Note: Naomi Tannen, founder and Executive Director of Families First, has read and commented upon this paper in draft form, and some of her comments may have been incorporated into the final paper. However, the analysis presented in this paper does not necessarily reflect the views of Naomi Tannen and Families First. The responsibility for the research, the analysis, and the presentation of findings remains with the authors.
Return to Top

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Day Treatment for Children with Emotional and Behavioral Disorders: A Program Evaluation

Authors

Introduction Method Results Discussion References
Return to Table of Contents

Introduction

This study sought to answer several pertinent questions about the Lincoln Public School (LPS) Behavioral Skills Program (BSP). First, the study looked at whether students referred to BSP exhibited a level of behavioral and emotional problems and experienced levels of psychosocial stressors which was higher than the general population of students with Behavioral Disorders (BD). Second, this study sought to document the outcome of treatment by measurement of change in academic achievement, behavioral assessments, and performance of behavioral goals. Third, this analysis attempted to determine if students in this program had relatively more success in certain types of behavioral goals compared to other types of goals.
Return to Top

Method

Participants

Thirty students identified as having a BD, in grades Kindergarten through 9, enrolled at BSP during the 1993/94 academic year were included as participants in the study. Males made up over 97% of the participant group. Students of European descent made up 68% of the participant population, 24% were of African American decent, and 8% were of Native American heritage. The participants had been unsuccessful in less restrictive treatment alternatives, and 74% had a history of psychiatric hospitalization.

Procedure

The Child Behavior Checklist-Teacher Report Form (CBCL-TRF; Achenbach & Edelbrock, 1991) was completed by home school teachers and BSP teachers at the beginning of the academic year or shortly after admission to determine initial levels of problem behaviors. Total problem scores, as well as externalized and internalized behavior scores, were compared to CBCL-TRF ratings collected by Conoley & Peterson (1989) on a state-wide sample of children verified as BD served in regular schools in Nebraska.

School records, court records and other official documentation were collected to determine the number and type of psychosocial stressors students had experienced. This information was compared to research findings documenting the number of stresses associated with severe maladjustment and with similar data collected from other samples of students with BD in Nebraska and in other published research.

Academic achievement was assessed using a pre-post comparison of performance on the Kaufman Test of Education Achievement-Brief Form (KTEA; Kaufman & Kaufman, 1985) in reading, spelling, mathematics, and composite scores. The test was administered at the beginning of the academic year or

ERIC

shortly after admission and again at the end of the academic year.

Behavioral change was assessed by making a pre-post comparison of CBCL-TRF's completed at the beginning of the school year or shortly after admission and the results of a second set of ratings taken at the end of the academic year by both home school and BSP teachers. Behavioral change was also assessed by tracking the change of three behavioral goals from each participant's Individual Education Plan (IEP). These goals were continually tracked during each class period at BSP. A zero tolerance level was maintained. If the child, at anytime in the class period, did not achieve the goal, it was marked as not successful. Daily averages on these goals were converted to 8 week averages, calculated four times over the course of the school year.

The success students exhibited on the various types of goals was analyzed to determine if there was any differential progress. IEP goals were coded based on a manual of IEP goals used by the Lincoln Public School District. The goal categories included classroom skills, mainstreaming and adjustment, self esteem and self concept, coping skills, peer and adult interactions, and personal responsibility.

Treatment
The Behavioral Skills Program (BSP) is a collaborative program conducted by Lincoln Public Schools and Lincoln/Lancaster Child Guidance Center in operation since 1986. The program provides therapeutic services in home schools and intensive therapy and educational services in a self-contained site that students are bused to daily. Generally, students attend an hour or two a day at the home school and add time as appropriate for the student. The program is designed to focus on academic and behavioral skills development and the treatment of critical mental health issues.
Return to Top

Results

The results of the initial CBCL-TRF and the level of psychosocial stressors BSP students experience indicated that BSP students were significantly more disturbed than the general population of students with BD. When both internalized and externalized ratings were included, 69% of BSP students had behavior problem levels in the clinical range. The CBCL-TRF scores provided by home school and BSP teachers were significantly correlated (.55 -.51).

When compared to scores of a state wide sample of students verified as BD, it was found that BSP students problem behavior ratings were significantly higher. BSP students received a mean total problem score of 68. The mean rating of externalized behaviors for BSP students was 69 and the state wide sample was 60. Internalized behavior scores for BSP students were 64 compared to 50 for the state wide sample (Conoley & Peterson, 1989).

Students served by BSP experienced high levels of psychosocial stressors. Previous research indicates that the presence of 3 psychosocial stress factors put children at risk of severe social maladjustment (Siefer, Sameroff, Baldwin & Baldwin, 1992). The data collected indicated
that BSP students experienced a mean of 10.6 psychosocial stress factors. Secondary students (grades 6-9) had a mean of 12 stress factors and elementary students (grades K- 5) had a mean of 9 stress factors.

This study addressed the question whether students at BSP demonstrated significant positive change in academic achievement. Overall, students made significant improvement in all three achievement subtests of reading, spelling, and mathematics, as well as in composite scores. Not only do these results indicate students were maintaining normally expected achievement progress, they were making marked increases in academic achievement. In addition, total risk positively correlated ($r = .45$) with academic achievement test improvement. In other words students entering with high degrees of psychosocial stressors showed the most improvement in academic achievement scores.
The CBCL-TRF was used to detect significant change in teacher rating of the behavior problem level of students over the course of the year. The BSP teachers indicated that, overall, students showed improvement in total problem scores and internalized scores, and no improvement in externalized behaviors. Elementary student ratings showed more improvement than secondary students.

Specifically, elementary students' total problem scores decreased by 4 points and externalized behavior scores decreased by 3 points. Internalized problem behaviors showed a significant drop of 5 points. Home school teacher ratings of both elementary and secondary students showed a .25 increase in total problem scores, a 3 point decrease in internalized behavior, and a 2.3 increase in externalized problem scores. Overall, no significant deterioration in behavior scores was evident.

Assessment of behavioral change was also documented by tracking IEP goals. There were 18 goal comparisons possible, and of these 13 comparisons showed improvement and 5 showed significant improvement. Five comparisons showed no improvement or a slight decrease. However, no comparison of IEP goals showed a significant decrease.

Documentation of progress on IEP goals indicated that students made immediate improvement in behavior. Behavior changes plateaued over time, but the plateaus were much better than the baseline levels of performance. Overall, BSP students achieved IEP goals 80% of the time in the program. This compares favorably with students with BD studied by Conoley & Peterson (1989) which found that students with less severe disturbances exhibited on-task behavior 78% of the time.

A final question was whether BSP students made differential progress on various types of behavior goals. The results showed that BSP students were relatively more successful on classroom skills goals and self esteem goals over other types of goals.
Return to Top

Discussion

It is evident that students referred to BSP exhibit a significantly more severe level of problem behaviors and individual and family psychosocial stressors than the general population with BD. Students of BSP experienced high levels of psychosocial stressors that were associated with significant maladjustment. These results provide a quantified measure that BSP students exhibit a level of behavioral and emotional dysfunction to warrant the level of intervention provided by the program.

It is of particular interest that students at BSP did exhibit significant improvement in academic achievement. This is a remarkable finding in the context of previous research indicating that, in general, day treatment programs do not do a good job in supporting such gains. This result may confirm the view that children with BD respond best to treatment environments that provide opportunity for academic success, that reward prosocial behavior, that provide positive relationships with adults who model and train prosocial behavior and values, and that focus on student strengths and adjustment to the educational environment (Goldstein, Harootunian & Conoley, 1994; Knitzer, Steinberg, & Fleisch, 1990).

Performance on IEP behavior goals proved to be a more responsive indicator of behavior improvement than the CBCL-TRF. As a result, changes of teacher ratings of problem behaviors were small or not significant in most cases. It should be noted that the comparison of problem behavior ratings did not indicate any significant deterioration. Given the severity of problems and psychosocial stressors the participant population experience, the lack of deterioration of problem behavior ratings may be seen as an indicator of positive progress.

BSP is an environment which focuses on development of trusting adult/student relationships, that maintains safety, that can provide extensive amounts of time to resolve behavior problems, and where there is a persistent pursuit to find a way to teach each child. The improvement in IEP goals in the category of classroom skills and self esteem suggest that BSP is an environment that can manage aggressive behavior and at the same time give these children an opportunity to succeed and learn to self manage their behavior. Elementary students made the largest gains in both academic and behavioral measures, indicating early intervention is an important treatment consideration.
The implications for future study are that results and continued data collection can be used to determine what program components are most effective and to assure that the program continues to maintain its success in developing academic and behavioral skills for children with severe levels of BD.

Return to Top

References

Achenbach, T. M. & Edelbrock, C. (1991). Manual for the Child Behavior Checklist and revised Child Behavior Profile. Burlington, VT: University of Vermont.

Conoley, J. C., & Peterson, R. (1989, August). Diagnosis and service delivery in childhood behavior disorders. Paper delivered at the annual meeting of the American Psychological Association. New Orleans, LA.

Conoley, J. C. (1995, January). Evaluation report: Behavioral skills program. Evaluation conducted for Lincoln Public Schools, Lincoln, NE.

Goldstein, A. P., Harootunian, B., & Conoley, J. C. (1994). Student Aggression. New York: Guilford.

Kaufman, A. S., & Kaufman, N. L. (1985). Kaufman Test of Education Achievement: Brief Form Manual. Circle Pines, MN: American Guidance Service.

Knitzer, J., Steinberg, Z., & Fleisch, B. (1990). At the schoolhouse door: An examination of programs and policies for children with behavioral and emotional problems. New York: Bank Street College of Education.

Seifer, R., Sameroff, A. J., Baldwin, C. P., & Baldwin, A. (1992). Child and family factors that ameliorate risk between 4 and 13 years of age. Journal of the American Academy of Child and Adolescent Psychiatry, 31, 893-904.

Return to Top

Jerry Oestmann, M.A.
Psychotherapist
Lincoln Public Schools
2320 N 57 St., Suite 1
Lincoln, NE 68507
402/436-1924 Fax: 402/436-1930

Return to Top

[Home] [Search] [Index]

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida, 1996

Designing, Implementing, and Evaluating a School-Based Psychoeducational Group for Children with Behavioral Problems from Families with Substance Abuse Issues

Authors

Introduction Method Results References
Return to Table of Contents

Introduction

Research indicates that children from families with substance abuse issues suffer increased rates of social and emotional problems. Sometimes, though not always, these problems emerge in the form of behavioral acting out in school. School personnel are often unaware of the child's family circumstances and the child is labeled as "the problem." Even in those cases where familial substance abuse is known or suspected, resources to adequately address the child's needs are lacking. As such, children from families with substance abuse issues may advance through school acquiring increasingly poor academic and behavior records without needed intervention.

Some children from families with substance abuse issues, particularly girls, internalize their fears, frustration, loneliness, and anger, adopting a more isolated, withdrawn presentation. These children are rarely noticed by school personnel at all and their psychosocial problems are likely to be entirely unaddressed.

Substance abuse is a major contemporary social problem, particularly in America's inner cities, where treatment resources are few. Consequently, children living in low-income, inner-city communities are at particular risk for the psychosocial problems attendant upon familial substance abuse. There is an urgent need for services for these children; public schools provide an opportune location for such intervention.

This paper describes the development and testing of a structured school-based psychoeducational group intervention designed to address common psychosocial difficulties presented in school settings by children who experience familial substance abuse. This two-year project was funded by a grant from the New York Community Trust to the first author. Data presented are based on first year findings.
Return to Top

Method/Procedures

Sites/Subjects
Three inner-city Philadelphia elementary schools, selected for their locations in communities known for high rates of drug trafficking and drug-related crime, participated in this project. During the project's first year, eight treatment groups were conducted in two of these schools, one located in a predominately African-American low income community in West Philadelphia, and the other in a racially and ethnically diverse neighborhood of poor and working class families.
In each participating school, project staff presented an informational session on substance abuse to all third through fifth grade classes. Parents were notified that substance abuse education would be taking place in their child's school including small group discussions; they were requested to contact the school

principal if they did not wish their child to participate. At the end of each classroom presentation, children who wished to discuss additional worries or concerns about substance abuse in their families or neighborhoods were invited to sign up to participate in a series of small groups to be held in the school. The names of children indicating a desire to participate were reviewed by school guidance personnel and those with classroom behavior problems and/or whose families were known or suspected of being substance-involved were targeted. One hundred eight subjects were selected in the two schools.

The 50+ study subjects in each school were randomly assigned to two groups; half received the intervention in the Fall semester and the other half in the Spring, thereby forming a naturally occurring control group for subjects participating in the Fall groups.

Intervention/Program

The intervention was designed to follow the format of a widely used, highly structured curriculum for groups of children of parents with alcoholism entitled, "Children Are People, Too." This curriculum uses an 8 to 10 session treatment model, each session following a similar format with repeated opening and closing exercises.
A specific issue relevant to the psychosocial concerns of children who have family issues of alcoholism is addressed in each session. Topics included: identifying and appropriately managing feelings about parental addiction, personal safety issues, understanding substance abuse, how to interact with peers, and others.

Because the "Children Are People, Too" curriculum was designed to be used in conjunction with addictions treatment for a parent with alcoholism and presupposes the support and involvement of a second, parent who does not drink, many aspects had to be revised for a population where children often live with a single parent who is frequently unable to address his/her addiction. Another significant difference was that most children in our sample were concerned with the effects of crack-cocaine and other illicit drugs on family members, rather than alcohol dependence, although many times these co-occurred. Drug-related violence both within the family and in the neighborhood was also a primary concern of our subjects and is unaddressed in the "Children Are People, Too" curriculum.

Finally, the "Children Are People, Too" curriculum relies heavily on the verbal ability of participants. Our subjects tended to have limited verbal skills and, thus, were highly dependent on other forms of self-expression such as drawing, singing, and story-telling. Also, because many of the children had learning disabilities, attention deficits, and problems with impulse control, we found it necessary to make significant adaptations to the curriculum to accommodate the special needs of these children.

Groups were held once a week during school hours for 10 consecutive weeks during the fall and spring semesters. Each group session lasted one hour and followed a highly structured format. Pre- and post-testing were done at the first and last group sessions.

Measurement/Instruments

All subjects were tested at three points in time: in early Fall before any groups were held, in late Fall after the first round of groups, and in late Spring after the second round of groups took place. Data were gathered on both experimental (Fall group participants) and control subjects (Spring participants) in this way.

Three standardized self-report instruments were used. Each instrument was selected to reflect an issue found in previous research or in clinical observation to be of particular concern to children from families with substance abuse issues. Instruments used included: the Nowicki-Strickland Locus of Control Questionnaire (Nowicki & Strickland, 1973); the Children's Loneliness Questionnaire (CLQ; Asher & Wheeler, 1985); the Self-Perception Profile for Children (Harter, 1985). Data on subjects' classroom performance and behavior were collected from teachers using the Teacher's Report Form (TRF) of the Child Behavior Checklist (Achenbach & Edelbrock, 1986). Group leaders also rated participants with regard to their perceived levels of comprehension of the key concepts contained in the curriculum.
Return to Top

Results and Implications

Findings from the first year of this project, though limited because of the small sample size (48 experimental subjects and 48 controls completed treatment and data collection) suggest that a structured psychoeducational group intervention of relatively brief duration aimed at children from families with substance abuse issues can help to decrease inappropriate classroom behavior and other social difficulties. Teachers' reports on the TRF indicated significant changes in several areas of classroom behavior, including peer relations, interpersonal aggression, and disruptive conduct.
Group leaders' ratings of participants' comprehension of group concepts illustrate the importance of adapting a standard curriculum to the needs of the population treated. Slightly over half of the children (N= 56) who participated in the intervention during the first year understood half or fewer of the concepts presented. Just forty-five percent (N= 47) understood most or all concepts presented.

We hypothesized that a child's level of comprehension of concepts would affect the degree of change that took place on the independent variables measured including self-concept, loneliness, locus of control, and classroom behavior. However, analysis of variance found no significant association between level of comprehension and the degree of change reported on these dependent variables.

Finally, findings from the self-report instruments were mixed. The Children's Loneliness Questionnaire found higher than average levels of loneliness among the subjects in this studyp;a finding consistent with the clinical literature on the effects of parental substance use on children. On the other hand, locus of control scores for study participants were close to published norms for same-age children, an unexpected finding given the literature which suggests that children from substance-involved homes are more likely to demonstrate externalized locus of control. Similarly, mean scores on the subscales of the Self-Perception Profile for Children were very close to normative means published by the instrument's author (Harter, 1985).

T-tests were carried out on each of the dependent variables to determine if there were significant changes on any of the dimensions assessed. Only the Children's Loneliness Questionnaire showed significant pre- and post-test differences, with significantly lower scores post-treatment for the treated group

($N = 43$; $T = 2.3421$; $p = .02$). This finding suggests that children who participated in the intervention achieved one of the project goals: to decrease social isolation and connect with other children with similar experiences with familial substance abuse.
Additional data are currently being collected during the second project year which will allow for more data for analysis and greater confidence in study findings.
Return to Top

References

Achenbach, T. M. & Edelbrock, C. (1986). Manual for the teacher's report form and teacher version of the Child Behavior Profile. Burlington, VT: University of Vermont Department of Psychiatry.

Asher, S. R. & Wheeler, V. A. (1985). Children's loneliness: A comparison of reject and neglect peer status. Journal of Consulting and Clinical Psychology, 53, 500-505.
Harter, S. (1985). Manual for the Self-Perception Profile for Children. Denver: University of Denver.

Nowicki, S. & Strickland, B. R. (1973). A locus of control scale for children. Journal of Consulting and Clinical Psychology, 40, 148-154.
Return to Top

Martha Morrison Dore, Ph.D.
Associate Professor

Columbia University School of Social Work
622 West 113th Street
New York, NY 10025
212/854-5461 Fax: 212/854-2975
E-mail: mmd6@columbia.edu

Eda Kauffman, M.S.W.
Research Assistant and Doctoral Student
School of Social Work and Social Research
Bryn Mawr College
5334 Green Street, 3rd Floor
Philadelphia, PA 19144
215/438-7733

Lani Nelson-Zlupko, M.S.W.
Research Assistant and Doctoral Student
University of Pennsylvania School of Social Work
16 Rockland Court
Wilmington, DE 19810
302/475-5965
Return to Top

ERIC Full Text Provided by ERIC

U.S. Department of Education
Office of Educational Research and Improvement (OERI)
National Library of Education (NLE)
Educational Resources Information Center (ERIC)

NOTICE

REPRODUCTION BASIS

This document is covered by a signed "Reproduction Release (Blanket) form (on file within the ERIC system), encompassing all or classes of documents from its source organization and, therefore, does not require a "Specific Document" Release form.

This document is Federally-funded, or carries its own permission to reproduce, or is otherwise in the public domain and, therefore, may be reproduced by ERIC without a signed Reproduction Release form (either "Specific Document" or "Blanket").

EFF-089 (9/97)