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ABSTRACT

This descriptive study in the Cleveland (Ohio) public school system evaluated the impact of an intensive, school-based mental health program. Forty-two African American elementary school students were referred for school-based mental services due to overt behavioral problems. Children were evaluated for risk status across three domains: community, family, and individual child. Data collected included client demographic information, diagnostic assessment information, family history, standardized ratings of child emotional and behavioral functioning, and client satisfaction data. The study found that the community had higher ratings across significant risk factors than the broader surrounding community, that 83 percent of families lived in poverty above and beyond the high poverty levels of their neighborhoods, that less than 10 percent of families were intact, and that the mental health needs of the referred children were substantive. The intervention program emphasized family-focused interventions and parental collaboration. The program demonstrated that effective parental collaboration can be achieved through intensive outreach efforts using a school-based model. High levels of both parent and child satisfaction were achieved. (DB)

Forging Partnerships with High-Risk Families through School-Based Mental Health Services

Introduction

Urban schools provide a pivotal platform from which to launch mental health services, particularly for high-risk youth and their families (Dryfoos, 1994). In a descriptive study evaluating the impact of an intensive, school-based mental health program, risk status was established by evaluating information across three important domains: community, family, and individual child. A high incidence of risk factors was found across all three domains in a referred sample of urban elementary school students. Intensive family focused interventions and parental collaboration were determined to be essential treatment targets for addressing multiple risk factors and ultimately improving academic performance in this group of referred children.

Method

Site and Participants

The Cleveland Public School system is the largest school system in the country ever to be taken over by a state board, and it has some of the lowest levels of educational achievement as measured by graduation rates, drop out rates and proficiency scores. The target population in this study is a group of students referred for school-based mental health services and their families at an elementary school in Cleveland, Ohio (K through 6th grade). Of this sample of 42 students, 88.1% were male, 11.9% female, and 100% were African-American. They ranged in age from 5.5 to 11.8 years with a mean age of 8.9 years.

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Children who are experiencing the most severe emotional and behavioral difficulties are referred for school-based mental health services by their teachers and principals. At the time of this study, 42 high-risk children and families were formally enrolled in services, with numerous other children receiving consultations. A private, non-profit agency provides intensive mental health and case management services to these children and families. Five full time staff are onsite either in the school or the community providing the following array of services: diagnostic assessment, individual and group therapy, in-home family therapy, family support groups, comprehensive case management, summer therapeutic programming, and training and consultation to the teachers.

Overall, the goals of the program are: (1) increase family involvement and stability in support of their child's educational achievement, and (2) improve the child's social and behavioral functioning. Continuity of services is maintained by providing intensive summer programming in order to build upon treatment gains made throughout the school year and to enhance social skills and peer relations necessary for successful school performance. At present time, there appears to be only a few mental health programs this intensive operating within a large urban school setting.

Data Collection

The data collected for this study included client demographic information, diagnostic assessment information regarding child and family history, standardized ratings of child emotional and behavioral functioning, and client satisfaction data. The standardized ratings of child emotional and behavioral functioning were obtained by using a reliable and valid behavioral rating instrument called the Devereux Scales of Mental Disorders (DSMD). The DSMD (Naglieri, LeBuffe, & Pfeiffer, 1994) is a 110-item behavior rating scale designed to evaluate behaviors related to psychopathology in children.

The DSMD can be completed by parents or teachers with item content based primarily on the DSM-IV. The DSMD has ten behavioral indices: a total score, three composite scores, and six subscale scores. The composites include internalizing–comprised of depression and anxiety subscales, externalizing–consisting of conduct and attention subscales, and critical pathology–consisting of autism and acute problems subscales. T-scores are used in reporting all scale scores with higher scores reflecting more severe psychopathology. Total score reliability coefficients range from .97 to .98; composite score reliability coefficients range from .86 to .98; and individual scale reliability coefficients range from .70 to .99. The total test T-score of 60 has been empirically determined to be the best cut-score for differentiating clinical from non-clinical samples. Scores between 60-65 are considered to be within the elevated range of clinically impaired behavioral functioning. Both parents (n=40) and teachers (n=32) were asked to complete DSMD's at the beginning and end of the school year.

Results

Community and Family Risk Factors

The neighborhoods in which the children in this sample reside were compared by census tract to their urban (city of Cleveland) and suburban (Cuyahoga county) counterparts on six measures of community risk (see Table 1; CANDO, 1996). The school clearly draws children and families living in high-risk communities as evidenced by the fact that these neighborhoods had higher ratings across all six significant risk factors in comparison to the broader surrounding communities. In addition, intake and diagnostic assessment information revealed that an overwhelming majority of the families (i.e., 83%) of the referred children lived in poverty, above and beyond the already high poverty levels for their neighborhoods (i.e., 48%).

Further diagnostic assessment information revealed that less than 10% of the families were intact with both biological parents, and almost 10% of the youth were in foster care. Nearly 60% of the children's biological parents or current caretakers have experienced a significant substance abuse problem, and close to half have some history of criminal incarceration (also including the children's older biological siblings).

Child Functioning

In regards to child emotional and behavioral functioning, as measured by the DSMD total score, the mean parent rating was 60.64. For the conduct and depression subscales, the mean parent ratings were 64 and 61.8 respectively. Teachers, on the other hand, rated children higher, with a mean total score of 63, and conduct and depression ratings of 66.3 and 65.2 respectively (see Figure 1). On the DSMD total score, teachers rated fifty-nine percent of the school sample above the clinical cut off score of 60, and 25% were in the very elevated range above 70. For the conduct subscale, 78% of the sample were above the cut off score of 60, and 31% were above 70. For the depression subscale, 71% of the sample were above 60, and 28% above 70.

The mental health needs of the referred children in the school-based sample are substantive and challenging to treat, and particularly problematic as observed by their teachers. The combination of elevated internalizing (depression) and externalizing (conduct) scores raises numerous concerns about the impact of family and environmental risk factors (Crespi, 1996). For children with severe emotional disturbances, including those in our school sample, heightened aggressiveness and depressive symptomatology (i.e. social withdrawal) may represent significant obstacles to successful adaptation.

Outreach & Parent Involvement

In other studies (Bien & Bry, 1980; Blechman, Taylor, & Schrader, 1981), parent involvement has been shown to be beneficial in improving academic effort, grades, and attendance of students evidencing low commitment to school. In order to quantify parental involvement, average parent contacts

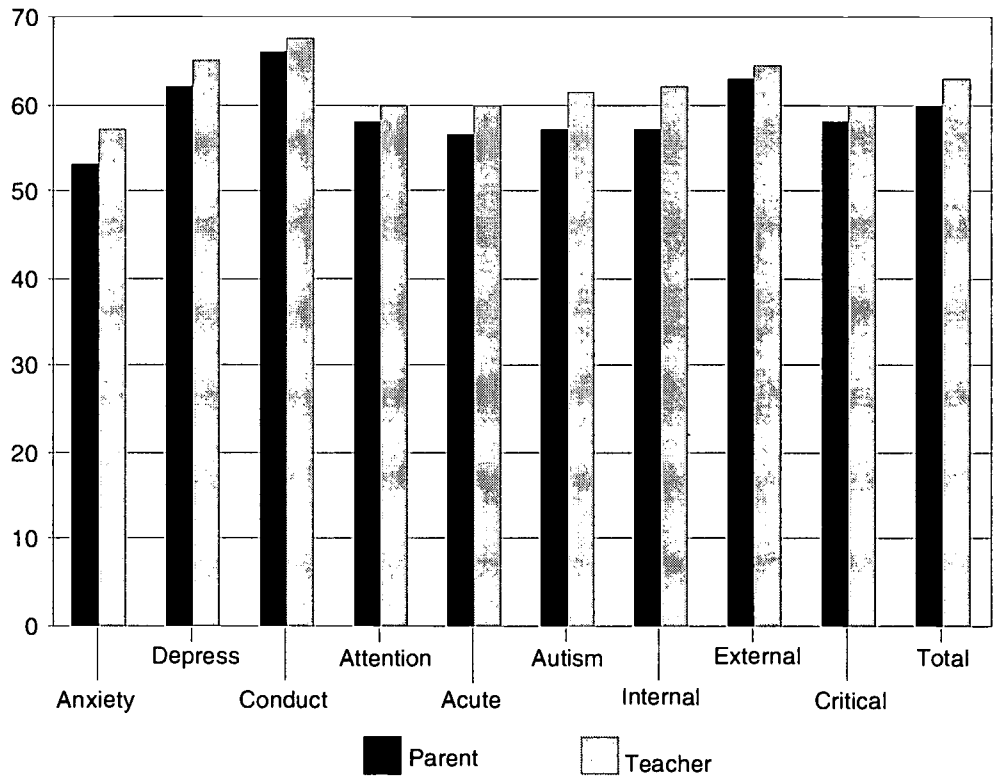
Table 1
Incidence of Community Risk Factors

Risk Factor	Neighborhoods in School Sample	City of Cleveland	Suburbs
% Below Poverty Level (1989)	32.0 %	29.0 %	5.0 %
% of 5-11 Year Olds Below Poverty Line (1989)	48.0 %	43.3 %	7.6 %
# of Infant Deaths/1000 Live Births (1994)	21	16	10
% Medicaid Recipients (1995)	37.2 %	30.0 %	4.7 %
# of Substantiated Abuse Cases/100,000 Children (CCDHS Data-1994)	4270	3880	907
# of Violent Crime Offenses/100,000 Juveniles (Juvenile Court Data-1995)	593	542	128

(telephone & face to face) were tracked by school-based staff during a sixteen-week period from 2/10/97 to 5/26/97. The program averaged 38 children during that time period and totaled 803 contacts (i.e. face to face or phone) for an average of 1.3 family contacts per child per week. Engaging and forming therapeutic relationships with parents and caretakers are critical program components to this intensive treatment model. By increasing the stability of the families, caretakers and parents are more able to nurture and promote the educational achievement of their children. Due to aggressive outreach efforts, parental involvement in the school-based support groups for referred children exceeded that of the school-wide PTA (Parent/Teacher Association) meetings.

At the end of the school year, both the parents and children in the program (N=38) completed a satisfaction survey (Rouse, MacCabe, & Toprac, 1995). There were two versions of the survey with similar questions and slightly different wording depending on if the respondent was a child or caretaker. There were approximately 30 child respondents and 34 parent/caretaker respondents (out of a total of 38). Overall, 91% of the parents or caretakers were happy with the services provided through the school-based mental health program (see Figure 2). Approximately 73% felt that their child was doing better since starting the program, and they were happy with the progress that their child and family made. The children evidenced similar positive responses on their portion of the

Figure 1
DSMD Ratings For School Sample



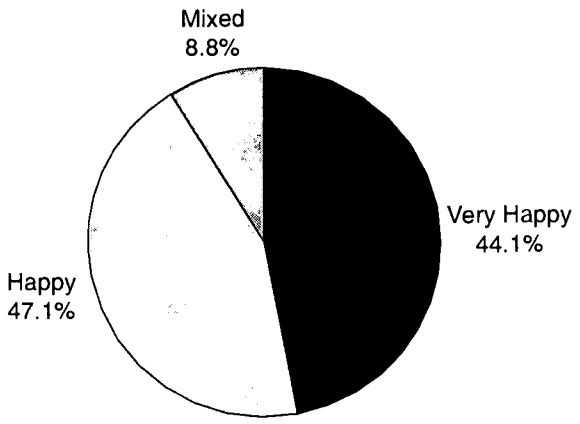
client satisfaction surveys. Over 96% of the children were happy or very happy with the services. About 63% of the children reported that their families were doing better since starting the program, another 17% said their families were about the same, and 3% said their families were much worse.

Discussion

The risk factor information from this study is alarming both in its scope and severity. Family focused interventions and parental collaboration appear to be essential treatment targets in order to simultaneously address the multiple domains encompassing the individual child, family, community, and school. Of particular concern were the high levels of depressive symptomatology reported by both parents and teachers in this sample of children who were referred for overt behavioral problems. One interpretation of this finding is that for a substantial portion of students, depressive symptomatology may be a response to the high levels of risk exposure, and consequently, may underlie or contribute to the disruptive behavior. Therefore, interventions that can simultaneously target the depressive symptomatology may yield improvements in the disruptive behavior. This supports the importance of using a family focused and community based approach, in combination with school and classroom based interventions. One appeal of this kind of strategy is that many of the interventions are strengthened by the fact that they target risk factors implicated in a range of disorders, including drug abuse, antisocial behavior, delinquency, and later adult criminality.

Results of this study confirmed that effective parental collaboration can be achieved through intensive outreach efforts using a school-based model. We discovered that many of the families that were engaged in the school-based model were reluctant to follow through with traditional

Figure 2
Q1. How did you feel about the services?



outpatient mental health referrals. In addition, high levels of both parent and child satisfaction were achieved through the use of this model. A major deterrent, however, in providing more family-based community treatment was the tremendous need for mental health staff to assist teachers in the classroom environment with behavior management issues. When children, families, schools, and communities are beleaguered by the accumulation of serious psychosocial risk factors, the urgency to provide school (i.e. classroom) versus family-based interventions can be daunting. Succeeding in both of these important domains will ultimately be necessary for academic achievement.

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