

Home, School, and Community Partnerships



on behalf of students with emotional and behavioral disorders and their families.

Albert Duchnowski, Ph.D.,

Krista Kutash, Ph.D.

Research and Training Center for Children's Mental Health
University of South Florida - Tampa, Florida

Vestena Robbins, Ph.D.

Department of Mental Health - Frankfort, Kentucky

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Tampa Florida**



Presentation Overview

- Introduction – Al Duchnowski
- The System of Care – Al Duchnowski
- Evidence-based Services within a System of Care – Krista Kutash
- The Bridges Project – Vestena Robbins
- Wrap-up – Al Duchnowski





Home and Community Supports

Why do we need them?



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Children who have emotional and behavioral disorders have multiple and complex problems and needs

- Education
- Mental Health
- Child Welfare
- Health Care
- Juvenile Justice
- Family Support



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Why build home and community supports?



- NO single agency has the resources or the expertise to meet all these needs.

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Development of the System of Care

- 2003 The President's New Freedom Commission on Mental Health
- 1999 Mental Health: A Report of the Surgeon General
- 1992 Child, Adolescent, & Family Mental Health Services Program
- 1986 System of Care monograph published
- 1986 Office of Technology Assistance Report
- 1984 Child & Adolescent Service System Program (CASSP)
- 1982 Unclaimed Children
- 1978 President's Commission of Mental Health
- 1975 PL 94-142
- 1969 Joint Commission Report to Congress

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System of Care

3 Core Values

- Child Centered/ Family Focused
- Community Based
- Culturally Competent



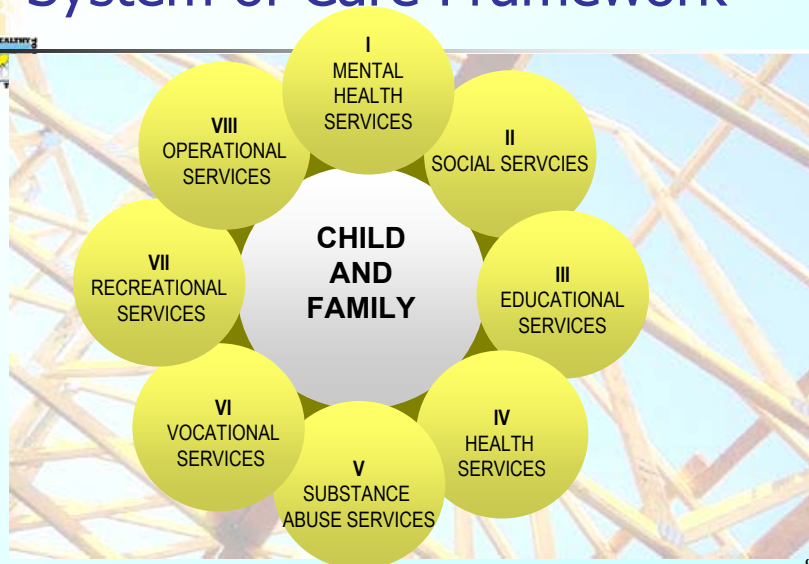
10 Guiding Principals

- Access to Service Array
- Individualized
- Least Restrictive
- Family Participation
- Integrated Services
- Case Management
- Early Identification
- Transition Services
- Effective Advocacy
- No Discrimination

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System of Care Framework



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Role of Families in System of Care

- **Mid-1900s:** Family members not involved in child's treatment.
- **1950-1960s:** Mental health professionals began to question the absence of families from their child's care. "Family therapy" as treatment became increasingly popular.
- **1960-1970s:** Families of children with developmental disabilities began advocating for increased family participation in children's health services.
- **1980s:** Mental health professionals questioned beliefs that family members were responsible for their child's mental health problems. Parents and supportive professionals continue to advocate for increased family participation in services.
- **1990s:** Systems of care offer services based on child and family strengths. Collaboration increasingly a goal of participants in system of care.

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Changing Roles of Families

- Cause
- Patient
- Credible Informant
- Equal Decision-Making Partner
- Evaluator/Research Partner
- Policy Maker



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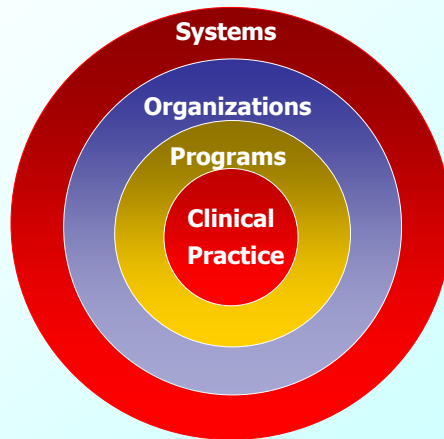
System of Care is NOT Wraparound

WRAPAROUND
System of Care

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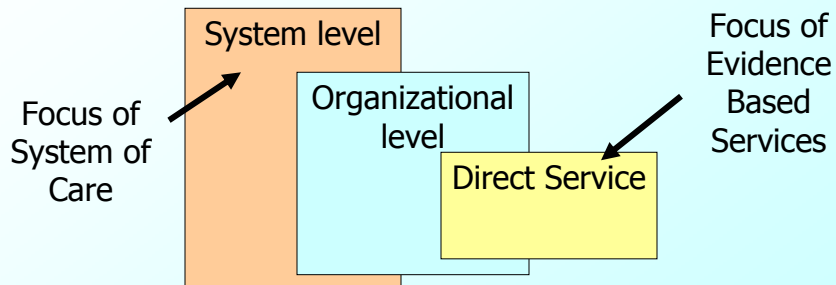
Think Systemically



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What is the role of evidence-based services within Systems of Care?



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Exploring the Evidence-base

■ *What is evidence?*



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The role of evidence-based services within a system of care

- Evidence is

- **Not:** somebody's opinion



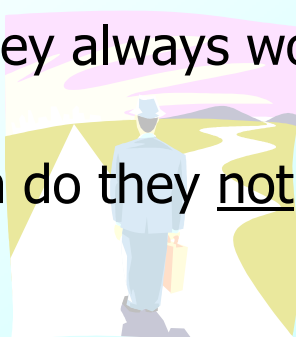
- It is:** systematic information gathered about the effectiveness of a service or intervention.

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Evidence-based Services

- Do they always work?
- When do they not work?



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Evidence-based Services

- When do they NOT work as intended?
 - No match between populations
 - Used on both girls and boys?
 - Rural and urban children and youth?
 - No match between problems
 - If it says it works for anger problems then it will work for depression too.
 - Not all aspects of the program implemented as planned.
 - Either by design or by drift



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Evidence-based Services

- Not all evidence-based services are created equally
- Look at "type of evidence"
 - Number and types of studies
 - Who were the studies conducted on?
 - Under what conditions were the studies conducted (in schools or in offices?)



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Evidence-based Services



- Examining the evidence base should be a group and community activity
 - What are the community needs?
 - What evidence-based services are designed to meet those needs.

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Evidence-based Services

- For children and youth with severe emotional disturbances



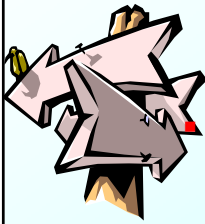
- Burns and Hoagwood (2002)
 - Case management services
 - Wraparound Process
 - Multisystemic Therapy
 - Treatment Foster Care
 - Mentoring
 - Family Education and Support

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Evidence-based Services

- Center for the Study and Prevention of Violence (CSPV)
 - 11 effective programs Big Brothers, Big Sisters,, Functional Family Therapy, "The incredible years", Life Skills Training, Multisystemtic Therapy, Treatment Foster Care
 - 21 Promising Programs (Good Behavior Game, Linking the interest of Families and Teachers (LIFT), Families and Schools Together (FAST) Track Program.



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Evidence-based Services

- Safe and Sound: An Educators Guide to Evidence-based Social and Emotional Learning (SEL) Programs
 - List 80 programs to be used in classrooms. Both comprehensive and more narrowly focused programs are included. Also discusses how integrate efforts to avoid fragmentation.
 - Free – see Notes for web address



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Bridges Project

- An example of Systems of Care and evidence-based services



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Building Bridges of Support



- Promoting Home, School, and Community Partnerships in Eastern KY

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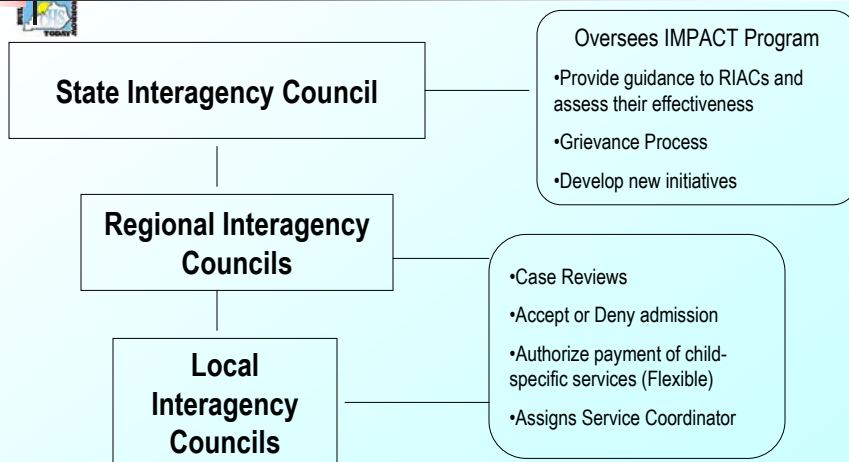
How We Got From There to Here

- **1986:** CASSP Office
- **1989:** Bluegrass IMPACT
- **1990:** KY IMPACT
- **1992:** Opportunities for Family Leadership
- **1993:** State Family Advisory Council
- **1995:** KPFC/First Parents Hired through RIAC grants
- **1998:** IMPACT Plus/Family support services become billable
- **1998:** Bridges Project (DMH) and KIDS (KDE)

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Building a Framework of Collaborative Services for Children with SED



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Building Bridges of Support

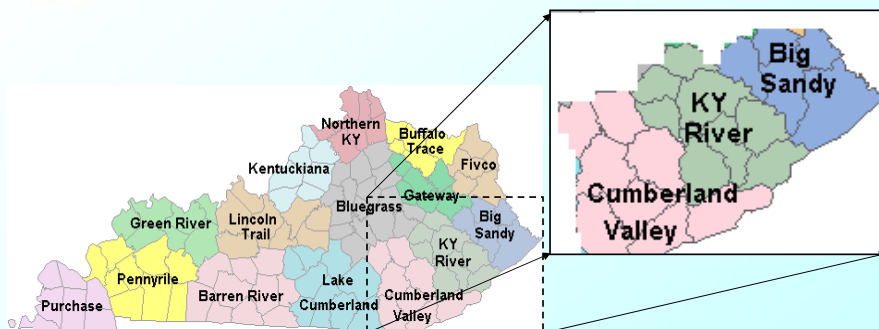


- Funded in 1998 by CMHS
- Designed to enhance the existing system of care
- Located in 3 rural, Appalachian regions of Eastern Kentucky

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One Community at a Time



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Regional Characteristics

■ Poverty

- 5 counties among poorest in nation
- 39% child poverty rate
- 6% unemployment rate

■ Child well-being

- 17 counties ranked among lowest in state



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Regional Characteristics

■ Rural, sparsely populated

- about 13% of state's total population (529,000)

■ Transportation

■ Literacy

- lowest level of literacy proficiency in state

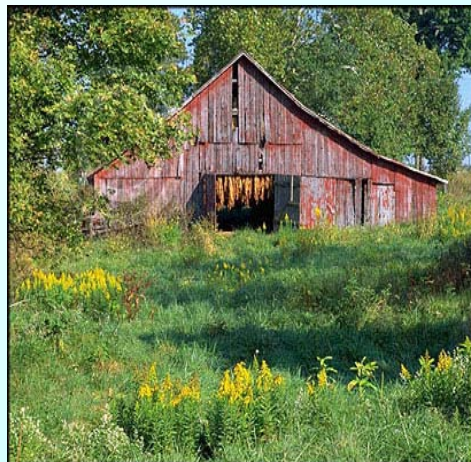


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Regional Characteristics

- Limited community services & resources
- Shortage of service personnel



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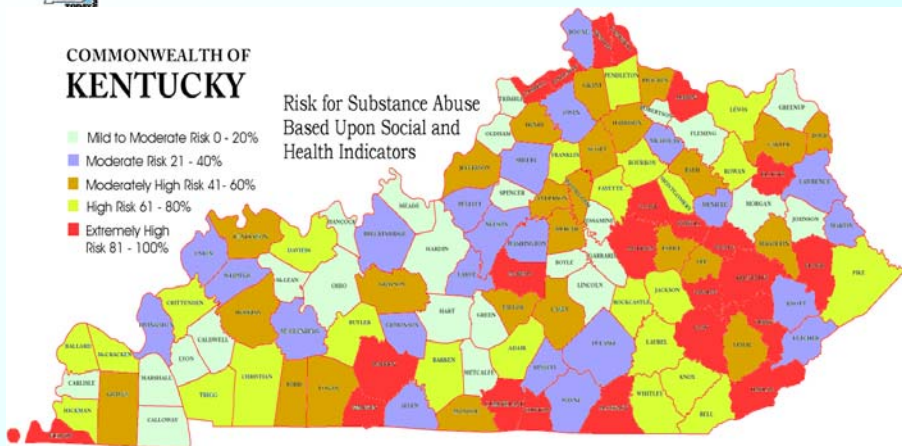


Substance Abuse Risk Index

COMMONWEALTH OF KENTUCKY

Risk for Substance Abuse
Based Upon Social and
Health Indicators

- Mild to Moderate Risk 0 - 20%
- Moderate Risk 21 - 40%
- Moderately High Risk 41 - 60%
- High Risk 61 - 80%
- Extremely High Risk 81 - 100%

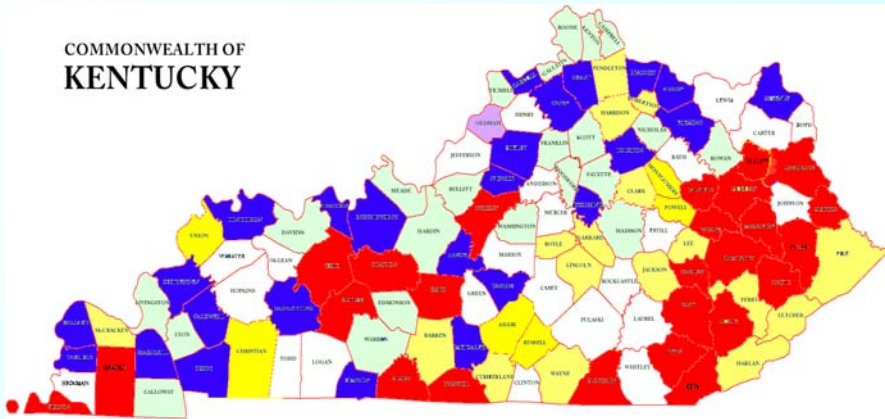


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Mental Health Risk Index

COMMONWEALTH OF
KENTUCKY



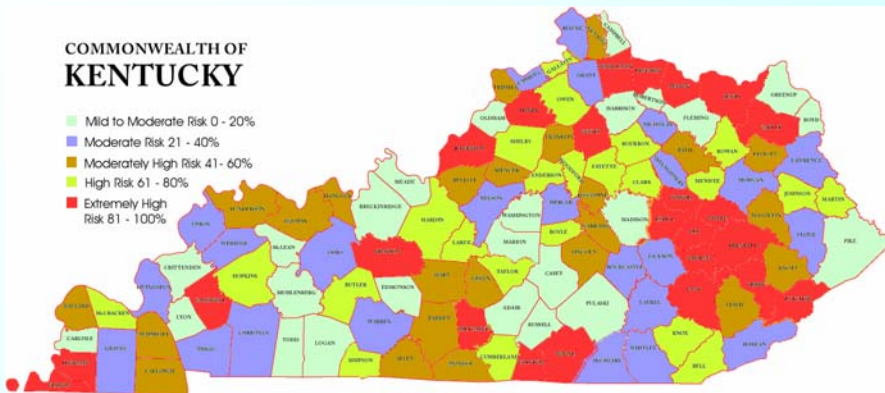
33



Sexual Assault & Family Violence Index

COMMONWEALTH OF
KENTUCKY

- Mild to Moderate Risk 0 - 20%
- Moderate Risk 21 - 40%
- Moderately High Risk 41 - 60%
- High Risk 61 - 80%
- Extremely High Risk 81 - 100%

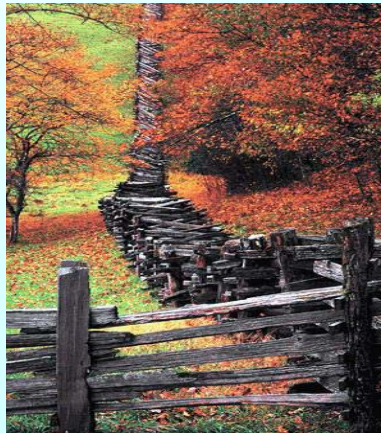


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Grant Objectives

- Service Expansion
- School-Based Partnerships
- Parent/Family Involvement
- System Level Improvement
- Training and Education Opportunities



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School Mental Health

Why do we need it?

- Schools as the *defacto* mental health system
- MH clinics aren't enough
- School-based services increase accessibility and lessen stigma
- Bridging the gap between home, school, and community
- Schools offer unique setting in which to promote the mental health of all children

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School Mental Health

What does the research say?

- Promoting safe and positive climates to enhance learning opportunities
- Implementing evidenced-based practices
- Addressing psychosocial barriers to learning
- Understanding the academic-behavior connection

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Building School-Based Partnerships



- School-based Staff:
 - Family Liaison
 - Intervention Specialist
 - Service Coordinator
 - Behavioral Consultant
- 20 campuses
 - all grade levels (PK-12)
 - alternative schools
- Continuum of positive behavioral interventions and supports (PBIS)

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Positive Behavioral Interventions and Supports



PBIS is a systems approach designed to enhance the capacity of schools to....

- Educate all students, especially students with challenging emotional and behavioral problems
- Adopt and sustain the use of effective practices

Sugai et al., 1999

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Organizational Change

"In a lot of organizations, change is like putting lipstick on a bulldog. There's a tremendous amount of effort involved, and most times all you get is some cosmetics– and an angry bulldog"

--Dave Murphy, San Francisco Chronicle



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Continuum of Schoolwide Behavioral Support

Academic Systems

Intensive, Individual Interventions

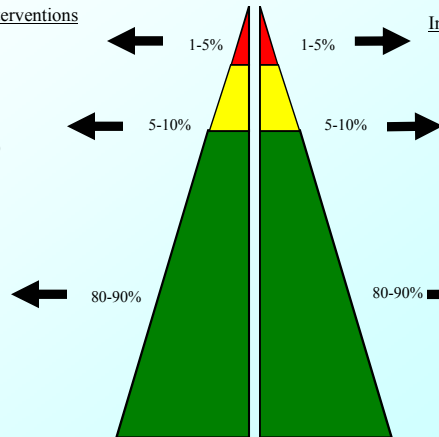
- Individual Students
- Assessment-based
- High Intensity

Targeted Interventions

- Some students (at-risk)
- Individual or Group
- High efficiency
- Rapid response

Universal Interventions

- All students
- Preventive, proactive



Behavioral Systems

Intensive, Individual Interventions

- Individual Students
- Assessment-based
- Intense, durable procedures

Targeted Interventions

- Some students (at-risk)
- Individual or Group
- High efficiency
- Rapid response

Universal Interventions

- All settings, all students
- Preventive, proactive

Eber, 2003

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Prevention at Each Level

■ UNIVERSAL

- Goal: To reduce new cases of emotional/behavioral problems and/or academic failure

■ TARGETED

- Goal: To reduce current cases of emotional/behavioral problems and/or academic failure

■ INTENSIVE/WRAPAROUND

- Goal: To reduce complications, intensity, severity of students with chronic emotional/behavioral problems and/or academic failure

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Similarities Across Levels

- Team-based decision making
- Consensus around proactive strategies
- Ownership by those closest to student; practical, real
- Use real data to guide interventions

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What is Wraparound?

Wraparound is . . .

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Wraparound Essential Elements

- Community-Based
 - Individualized, strengths-based, needs-driven
 - Culturally competent
 - Families as full and active partners
 - Team process
 - Flexibility
 - Balance of resources
 - Unconditional commitment
 - Collaborative process results in plan
 - Measurable outcomes monitored

Goldman & Burns, 1999

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Steps for Developing a Wraparound Plan

- Step 1: Initial Conversations (story)
- Step 2: Start Meeting with Strengths
- Step 3: Develop a Mission Statement
- Step 4: Identify Needs across Domains
- Step 5: Prioritize Needs
- Step 6: Develop Actions
- Step 7: Assign Tasks/Solicit Commitments
- Step 8: Document the Plan: Evaluate, Refine, Monitor Transition, & Celebrate Successes

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Wraparound... An Art and Science

Values Based Wraparound Process
Family-Centered, Flexible, Strengths-Based

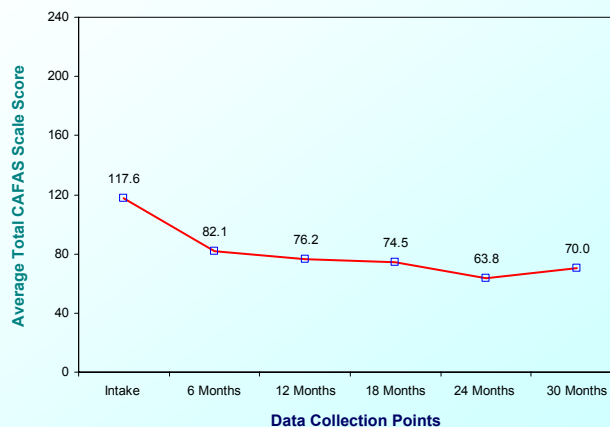
AND

Evidence Based Interventions
Science of Behavior Change
Effective Clinical (e.g., Medication, CBT) and
Academic Interventions (e.g., DI)

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Average Score of Child Functional Impairment* at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months

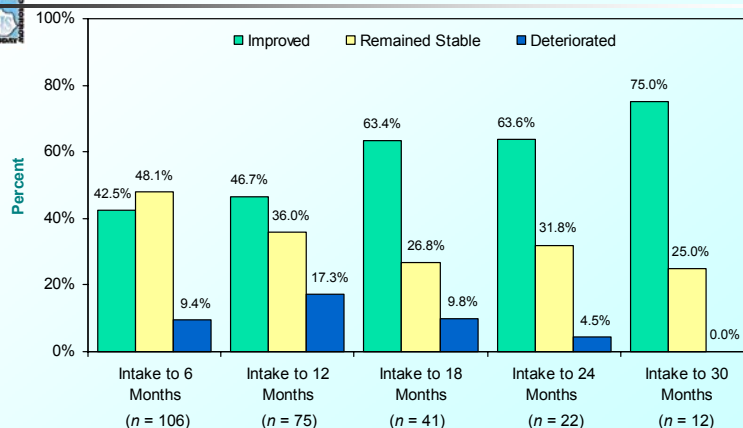


n = 29.

* Child functional impairment was measured by the CAFAS (Child and Adolescent Functional Assessment Scale). Please refer to the Appendix for more information on the CAFAS.

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Reliable Change Index (RCI) of Child Total Behavioral and Emotional Problems* from Intake to 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months

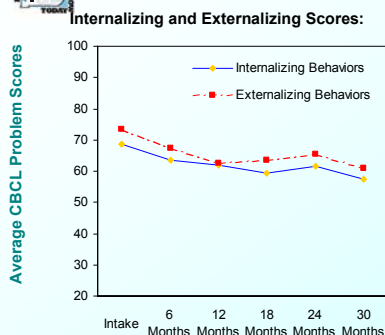


Data Collection Intervals

* Child behavioral and emotional problems were measured by the CBCL (Child Behavior Checklist). Please refer to the Appendix for more information on the CBCL, as well as the RCI (Reliable Change Index).

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Average Scores of Child Behavioral and Emotional Problems* at Intake, 6 Months, 12 Months, 18 Months, 24 Months, & 30 Months



Internalizing Behaviors	68.5	63.5	61.9	59.5	61.5	57.6
Externalizing Behaviors	73.6	67.4	62.7	63.6	65.3	61

Data Collection Points

n = 11.

* Child behavioral and emotional problems were measured by the CBCL (Child Behavior Checklist). Clinical range for internalizing and externalizing scores is between 60 and 63, while clinical range for the eight syndrome scales is between 67 and 70. Please refer to the Appendix for more information on the CBCL.

Eight Syndrome Scale Scores:

	Intake	6 Months	12 Months	18 Months	24 Months	30 Months
Withdrawn	63.3	62.5	58.8	57.0	61.6	57.6
Somatic Complaints	62.7	57.5	57.9	57.5	57.3	57.2
Anxious/Depressed	71.1	64.5	64.7	62.6	64.8	60.4
Social Problems	65.8	63.1	60.2	59.5	60.3	56.4
Thought Problems	69.3	62.1	62.1	60.5	63.6	60.8
Attention Problems	74.6	67.3	64.4	66.6	66.4	64.1
Delinquent Behaviors	69.4	65.8	61.3	64.6	65.0	62.4
Aggressive Behaviors	76.1	68.3	63.2	62.7	65.8	63.6

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Take Home Message

“Quality is never an accident; it is always the result of high intention, sincere effort, intelligent direction, and skillful execution; it represents the wise choice of many alternatives”

~Willa A. Foster

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WRAP-UP

- Multiple needs and problems requires a multi-agency response



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Wrap-UP

- Participation by Educators is critical at multiple levels:
 - State
 - District
 - Building
 - Classroom

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Wrap-up

- There is evidence of effective practice



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Teachers play a key-role

- Awareness
- Family Friendly
- Openness to Collaboration
- Enhanced Skills
- Implement



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Home, Family, and Community Supports

- What kind of system will you build?



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Home, School, and Community Partnerships



on behalf of students with emotional and behavioral disorders and their families.

**This presentation will be available on
our website on February 20, 2004.**

http://rtckids.fmhi.usf.edu/key_presentations.html

Notes and Resources

For the presentation

Home/Family and Community Support for Students with Learning and Behavioral Problems

by

Albert J. Duchnowski, Ph.D.
Departments of Special Education and Child and Family Studies
Louis de la Parte Florida Mental Health Institute
13301 Downs Blvd.
Tampa, FL 33617
Phone: 813/974-4618 Email: Duchnows@fmhi.usf.edu

Krista Kutash, Ph.D.
Research and Training Center for Children's Mental Health
Louis de la Parte Florida Mental Health Institute
13301 Downs Blvd.
Tampa, FL 33617
Phone: 813/974-4622 Email: Kutash@fmhi.usf.edu

Vestena Robbins, Ph.D.
Program Administrator
Kentucky Department of Mental Health and Mental Retardation Services
100 Fair Oaks Lane (Office 4W-C)
Frankfort, KY 40621
Phone: 502/564-7610 Email: Vestena.robbins@mail.state.ky.us

Session Overview

To deal with the seriousness and complexity of many children's problems, an array of services that go beyond traditional place-bound programs are needed. Today, it is essential that school systems develop partnerships and supports with various service providers within their communities (e.g., social services agencies, mental health agencies, vocational counselors). In this session, we will learn how some school systems have worked together with community service providers to successfully address the diverse needs of students with learning and behavior problems and their families.

Order of Presentation Topics

- A. Background of home, family and community supports for students with learning and behavioral problems
- B. The System of Care model
 - Values and Principles
 - Organization Placement of the System of Care
- C. The Changing Roles of Families
- D. Evidence-based, Home and Community Supports and Services
- E. Putting Systems of Care into Action in Kentucky
 - History of System of Care
 - Bringing the Model to Schools
 - The Three-tired Model
- G. Wrap-up

For additional copies of the PowerPoint slides used during the presentation on February 14, please go the web site of the Research and Training Center for Children's Mental Health, "Key Presentation" section and "click" on CCBD presentation by Duchnowski, Kutash, & Robbins (2004).

http://rtckids.fmhi.usf.edu/key_presentations.html

- A. Resources on the background of home, family and community supports for students with learning and behavioral problems
 - 1. U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999. *Chapter 3: Children and Mental Health*.
<http://www.surgeongeneral.gov/library/mentalhealth/home.html>

2. *Final Report for the President's New Freedom Commission on Mental Health* (July 2003) Child and Adolescent Subcommittee Report due out March 2004.
<http://www.mentalhealthcommission.gov/index.html>

B. The System of Care model

1. Definition of System of Care:

A system of care is a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their families (Stroul & Friedman, 1986, revised edition, page xx).

2. *A System of Care for Children and Youth with Severe Emotional Disturbances* (1994) by Beth A. Stroul and Robert M. Friedman. Download free copy at
http://rtckids.fmhi.usf.edu/soc_toc.html
3. *Building Systems of Care: A Primer* (2002). Shelia Pires (\$16.00) National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development, 3307 M Street, NW, Suite 401 -- Washington, DC 20007-3935 (202) 687-5000 PHONE -- (202) 687-1954 -- gucdc.georgetown.edu

4. The three core values of a system of care

1. The system of care should be child centered and family focused, with the needs of the child and family dictating the types and mix of services provided.

2. The system of care should be community based, with the locus of services as well as management and decision-making responsibility resting at the community level.

3. The system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.

5. The ten guiding principles of a system of care

1. Children with emotional disturbances should have access to a comprehensive array of services that address the child's physical, emotional, social, and educational needs.

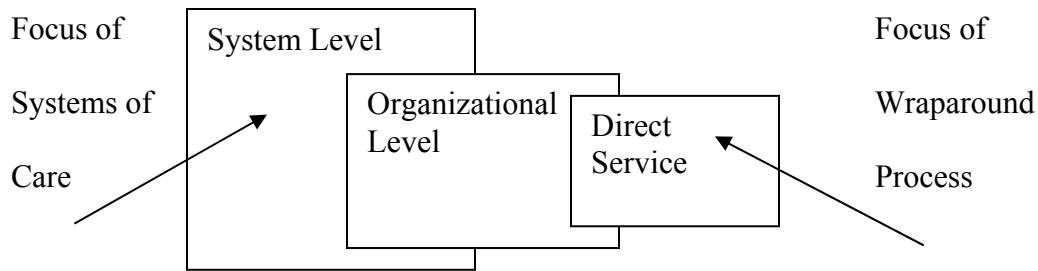
2. Children with emotional disturbances should receive individual services in accordance with the unique needs and potentials of each child and guided by an individual service plan.

3. Children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate.

4. The families and surrogate families of children with emotional disturbances should be full participants in all aspects of the planning and delivery of services.
5. Children with emotional disturbances should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.
6. Children with emotional disturbances should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children with emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Children with emotional disturbances should be ensured smooth transitions to the adult service system as they reach maturity.
9. The rights of children with emotional disturbances should be protected, and effective advocacy efforts for children and youth with emotional disturbances should be promoted.
10. Children with emotional disturbances should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

6. Systems of Care does not equal the Wraparound Process

Although both constructs share some core values, they are different. The System of Care is an organizational model that guides the delivery of mental health services to children and their families. It is implemented at the state and local levels. Many states have included the System of Care model in their Children's Mental Health Plan. This would have impact, for example, on how state administrators make resources available, supply technical assistance to local provider agencies, and establish program standards. Local level examples include the attempt of agencies to develop inter-agency agreements, implement home-based services as opposed to out-of-home treatment, and the inclusion of families in developing treatment plans. Wraparound is manifested at the clinical level. It is a process that guides how professionals interact with children and their families in planning treatment. The use of wraparound is facilitated in a community that has a well developed Systems of Care.



C. The Changing Roles of Families

1. History

Mid-1900s: Family members had little or no connection to their child's care.

1950-1960s: Mental health professionals began to question the absence of families from their child's care. "Family therapy" as treatment became increasingly popular.

1960-1970s: Families of children with developmental disabilities began advocating for increased family participation in children's health services.

1980s: Mental health professionals questioned beliefs that family members were responsible for their child's mental health problems. Parents and supportive professionals continue to advocate for increased family participation in services.

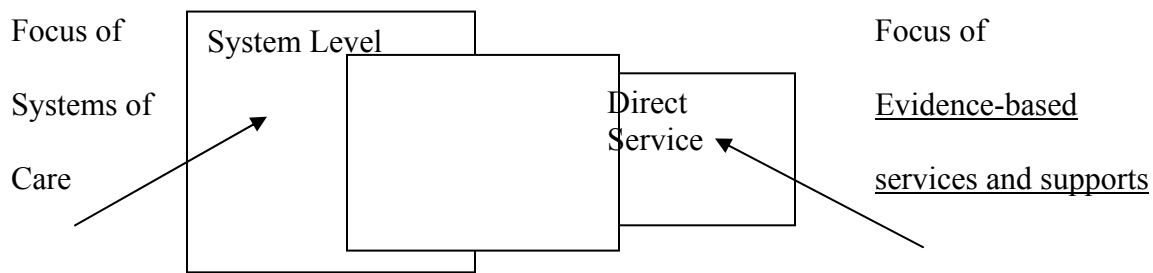
1990s: Systems of care offer services based on child and family strengths. Collaboration increasingly a goal of participants in systems of care.

2. National organization of family members with local chapters

Two important national organizations support families and advocate for improved services for their children. Each has a national office, state-wide chapters and local chapters. The National Alliance for the Mentally Ill (NAMI) advocates for adults and children who have serious mental illness. It was started by a group of parents who had adult children who were mentally ill and who were not receiving adequate service. Today, they have a division, the Child and Adolescent Network (NAMI-CAN) that is devoted to the issues affecting children and their families. Their website is www.nami.org.

The Federation of Families for Children's Mental Health was founded by families of young children who had a range of needs for mental health services and for whom services were inadequate. The Federation supplies support to families through local chapters and advocates for improvement in the system of care. Their website is www.ffcmh.org.

D. Evidence-based, home and community supports and services



1. Epstein, M.H., Kutash, K., & Duchnowski, A.J. (Eds.) (1998). *Outcomes for children with emotional and behavioral disorders and their families: Program and evaluation best practices*. Austin, TX: Pro-Ed. Second edition due out June 2004

2. *Community Treatment for Youth: Evidence-Based Interventions for Severe Emotional and Behavioral Disorders* (2002). Barbara Burns and Kimberly Hoagwood, Price: \$35.50 Oxford University Press (www.oup.com).

In chapter 1, *Reasons for Hope for Children and Families: A Perspective and Overview* In *Community Treatment for Youth*, Six evidence-based comprehensive interventions are listed on page 6.

Evidence-based interventions for severe emotional and behavioral disorders:

1. Case Management (see chapter 3): An approach to assessing, planning, and coordinating treatment, linking to formal or informal services; may be done by single case manager or team. A small caseload and greater intensity of services differentiates intensive case management from case management.
2. Wraparound (see chapter 4): A team approach to case management and treatment provision distinguished by no time limits, flexible funds, and other specified requirements.
3. Multisystemic Therapy (see chapter 5): Associated with family preservation: A clinician works with parents in the home and neighborhood around the management of child problems on a daily basis if necessary, but for a limited period of time (3-5 months).
4. Treatment Foster Care (see chapter 6): Foster parents with professional training are supervised to work with children who live in their homes.
5. Mentoring (see chapter 7): A nonprofessional with good child relationship skills helps children increase their engagement in school or in the community after school, up to 5 days a week.

6. Family Education and Support (see chapter 8): Often a parent-led group designed to increase understanding of childhood disorders and offer peer (parent) support to decrease the stress of other parents.

3. The Center for the Study and Prevention of Violence (CSPV), at the University of Colorado at Boulder, designed and launched a national violence prevention initiative to identify violence prevention programs that are effective. The project, called Blueprints for Violence Prevention, has identified 11 prevention and intervention programs that meet a strict scientific standard of program effectiveness. <http://www.colorado.edu/cspv/blueprints/>

1. Big Brothers Big Sisters of America

Big Brothers Big Sisters of America is the oldest and best known mentoring program in the United States. The program serves 6-18 year old disadvantaged youth from single-parent households. The goal is to develop a caring relationship between a matched youth and an adult mentor.

2. Bullying Prevention Program

The Bullying Prevention Program has as its major goal the reduction of victim-bully problems among primary and secondary school children. It aims to increase awareness of the problem, to achieve active involvement on the part of teachers and parents, to develop clear rules against bullying behavior, and to provide support and protection for the victims of bullying.

3. Functional Family Therapy

Functional Family Therapy is a short term, easily trainable, and well-documented program. The program involves phases and techniques designed to engage and motivate youth and families; change youth and family communication, interaction, and problem solving; and help families better deal with and utilize outside system resources.

4. The Incredible Years

A set of three comprehensive, multi-faceted, and developmentally-based curriculums for parents, teachers, and children designed to promote child emotional and social competence for children ages 2-8.

5. Life Skills Training

Life Skills Training is a drug use prevention program that provides general life skills training and social resistance skills training to junior high/middle school students. The curriculum is taught in school by regular classroom teachers.

6. Midwestern Prevention Project

This community-based program targets adolescent drug use. The program uses five intervention strategies designed to combat the community influences on drug use: mass media, school, parent, community organization, and health policy change. The primary intervention channel is the school.

7. Multidimensional Treatment Foster Care

This program is an effective alternative to residential treatment for adolescents who have problems with chronic delinquency and anti-social behavior. Community families are trained to provide placement, treatment and supervision to participating adolescents.

8. Multisystemic Therapy

This program targets chronic and violent juvenile offenders and specific factors in each youth's and family's environment (family, peer, school, neighborhood) that contribute to antisocial behavior. The goal of the intervention is to help parents deal effectively with their youth's behavior problems, including deviant peers and poor school performance.

9. Nurse-Family Partnership

Nurse-Family Partnership is a program that sends nurses to homes of pregnant women who are predisposed to infant health and developmental problems in order to improve parent and child outcomes. Home visiting also promotes the cognitive and social-emotional development of the children, and provides general support and parenting skills to the parents.

10. Project Towards No Drug Abuse

Project TND is a drug abuse prevention program that targets high school age youth at traditional and alternative high schools. The curriculum, taught by teachers or health educators, contains twelve 40-minute interactive sessions, and focuses on motivations to use drugs, social skills, and cognitive processing skills.

11. Promoting Alternative Thinking Strategies

Promoting Alternative Thinking Strategies (PATHS) is an elementary school-based intervention designed to promote emotional competence, including the expression, understanding and regulation of emotions.

4. The Center for the Study and Prevention of Violence (CSPV), at the University of Colorado at Boulder also lists 21 Promising Programs

1. ATLAS (Athletes Training and Learning to Avoid Steroids)
2. Brief Strategic Family Therapy (BSFT)
3. CASASTART (Striving Together to Achieve Rewarding Tomorrows)
4. Families That Care - Guiding Good Choices (GGC)
5. FAST (Families and Schools Together) Track Program
6. Good Behavior Game
7. Intensive Protective Supervision Project
8. I Can Problem Solve (ICPS)
9. Iowa Strengthening Families Program
10. Linking the Interests of Families and Teachers (LIFT)
11. Parent Child Development Center Programs
12. Perry Preschool Program
13. Preventive Intervention
14. Preventive Treatment Program
15. Project Northland
16. Project PATHE (Positive Action Through Holistic Education)
17. Project Status (Student Training Through Urban Strategies)
18. School Transitional Environmental Program (STEP)
19. Seattle Social Development Project
20. Syracuse University Family Development Research Program (FDRP)
21. Yale Child Welfare Project

5. How to Intervene: What Programs Work? Evidence-Based Interventions

This website offered by the Substance Abuse and Mental Health Services Administration (SAMHSA) provides a list of model and promising resilience-enhancing and violence prevention programs that have been identified by several different organizations, both governmental and nongovernmental.

The SAMHSA Model Programs featured on their web site have been tested in communities, schools, social service organizations, and workplaces across America, and have provided solid proof that they have prevented or reduced substance abuse and other related high-risk behaviors. Programs included have been reviewed by SAMHSA's National Registry of Effective Programs (NREP). This Web site serves as a comprehensive resource for anyone interested in learning about and/or implementing these programs.

The link to the homepage is:

<http://modelprograms.samhsa.gov/template.cfm?page=default>

They have 3 levels of programs listed: promising, effective, and model programs.

The link will take you to the matrix and a listing of the programs:

http://modelprograms.samhsa.gov/matrix_all.cfm

6. Safe and Sound: An Education Leader's Guide to Evidence-Based Social and Emotional Learning (SEL) Programs

Based on a three-year study funded by the Institute of Education Sciences (IES) and the Office of Safe and Drug-Free Schools (OSDFS) in the U.S. Department of Education, *Safe and Sound* is the most comprehensive and inclusive guide to SEL programming available. This guide provides a road map for schools and districts that are launching or adding social, emotional, and academic learning programs. The guide reviews 80 multiyear, sequenced SEL programs designed for use in general education classrooms. Among these programs are both comprehensive and more narrowly focused programs, such as drug education or anti-violence programs that can be combined with others. *Safe and Sound* also offers guidance to educational leaders on how to integrate normally isolated or fragmented efforts with other school activities and academic instruction by providing a framework for “putting the pieces together.” You can download *Safe and Sound* and the companion CD-ROM documents for free, or order printed copies that include the CD-ROM. Web address: www.casel.org

7. Additional Resources

1. The School-based Mental Health Project at UCLA (<http://smhp.psych.ucla.edu>)

The School Mental Health Project (SMHP) was created in 1986 to pursue theory, research, practice and training related to addressing mental health and psychosocial concerns through school-based interventions. To these ends, SMHP works closely with school districts, state agencies, the New American Schools Urban Learning Center model, and organizations and colleagues across the country. Its accomplishments include: (1) introduction and operationalization of a model for a comprehensive, multifaceted approach to addressing barriers to student learning and promoting healthy development -- such an approach for enabling learning provides a unifying framework for policy and practice (initial work supported through the U.S. Department of Education) (2)

leadership training, capacity building, and ongoing technical assistance for the mental facets of school-based health centers (initially supported by a grant from the Robert Wood Johnson Foundation) and (3) establishment in 1995 of a national *Center for Mental Health in Schools*.

2. Center for School Mental Health Assistance (CSMHA) University of Maryland at Baltimore, Department of Psychiatry (<http://csmha.umaryland.edu/>)

This center provides leadership and technical assistance to advance effective interdisciplinary school-based mental health programs. It strives to support schools and community collaboratives in the development of programs that are accessible, family-centered, culturally sensitive, and responsive to local needs. CSMHA offers training, a forum for the exchange of ideas, and promotes coordinated systems of care that provide a full continuum of services to enhance mental health, development and learning in youth. The center's 5 objectives are to (1) provide technical assistance and consultation, (2) conduct national training and education, (3) analyze and promote discussion on critical issues, (4) gather, develop, and disseminate relevant materials, and facilitate networking between programs and individuals involved in and/or interested in school mental health. CSMHA disseminates a newsletter three times a year and maintains a toll free telephone for assistance 888/706-0980.

3. The What Works Clearinghouse – www.w-w-c.org

The what Works Clearinghouse (WWC) was established in 2002 by the U.S. Department of Education's Institute of Education Sciences to provide educators, policymakers, researchers, and the public with a central, independent, and trusted source of scientific evidence of what works in education. It is administered by the Department through a contract to a joint venture of the American Institutes for Research and the Campbell Collaboration. What Works Clearinghouse, 2277 Research Boulevard, MS 6M Rockville, MD 20850, Phone: 1-866-WWC-9799.

E. Putting a System of Care into Action – A case example: Kentucky

Schools as Critical Partners in System of Care Efforts

Throughout the history of this country, schools have been the context for instituting broad social change. A public expectation has arisen that, in addition to providing an education sufficient to prepare students for life after graduation, schools will address the physical, social, and mental health concerns that serve as barriers to learning. Despite the daunting nature of this task, some public schools have risen to the challenge by instituting programs and processes designed to address a range of physical, mental health, and psychosocial issues, including increased special education and student support services, school-based health clinics, family resource and youth

service centers, full service schools, and referral networks with community agencies. Few schools, however, have sufficient resources to adequately meet the needs of their students, particularly those with severe emotional and behavioral challenges.

It is evident that the complex physical, mental health, and psychosocial needs of many of our youth cannot be adequately addressed by a single child-serving agency. Recent widespread efforts have been undertaken to develop comprehensive, coordinated, interagency systems of care to allow youth with challenging problems to receive services in their homes, schools, and communities. These system of care approaches create mechanisms for linking schools with community child-serving agencies and are designed to promote collaboration among parents, educators, and other services provides so that services for youth with multi-system needs can be coordinated and integrated.

Despite the acknowledged importance of education within system of care efforts, studies have found schools to be only marginally involved in system of care efforts. Schools however, have the potential to be optimal places to serve as a base for system of care efforts because

- ❑ youth spend a large amount of time in school;
- ❑ school systems usually possess well-trained personnel and support services;
- ❑ there is less stigma attached to schools than other social service agencies and thus greater likelihood that families and youth will access services;
- ❑ the location of services at school can decrease common barriers to service delivery, such as time and transportation; and
- ❑ there is a strong relationship between academic underachievement, particularly in reading, and mental health challenges.

It has only been very recently, however, that an interest in school-based services has emerged, and schools have begun to serve as the host for providing integrated and coordinated services.

Evolution of Kentucky's System of Care and School-Based Mental Health

Kentucky has over a decade of experience in designing and implementing community-based systems of care for youth with severe emotional disabilities (SED) and their families. This rich history began when the Kentucky Department for Mental Health and Mental Retardation Services (KDMHMRS) responded to the national recognition that the needs of youth with SED were not being adequately met and the subsequent call to action through the development of the Child and Adolescent Service System Program (CASSP) Initiative. In 1986 the KDMHMRS received monies directed toward developing a CASSP office in the Division of Mental Health (DMH) within the KDMHMRS. This office was instrumental in providing technical assistance related to children's mental health services, creating a Children and Youth Services Branch within the DMH, and developing an interagency task force aimed at crafting a statewide framework for delivering services to youth with SED in a manner consistent with CASSP principles.

These initial efforts led to the procurement of a Robert Wood Johnson Foundation grant in the late 1980s that facilitated the development and implementation of a service coordination model, known as Bluegrass IMPACT, in central Kentucky. In addition to establishing a coordinated, interagency approach to service delivery, this model provided funding for services not traditionally available, such as mentoring, school-based services, and intensive in-home therapy. The success of the Bluegrass IMPACT model raised the awareness of the Kentucky General Assembly regarding the plight of the children's mental health system in the state and led to the passage of legislation in 1990 that defined Kentucky IMPACT. This plan codified into law the statewide replication of the Bluegrass IMPACT model and established the State Interagency Council and 18 Regional Interagency Councils to provide oversight and coordination of program implementation.

Simultaneous reform efforts were occurring in education with the creation of a multidisciplinary task force that studied and revised state guidelines for identifying students with emotional and behavioral disabilities as well as the passage of the Kentucky Educational Reform Act (KERA) in 1990. While KERA mandated significant changes in financing, governance, and curriculum to improve the learning and achievement of all of Kentucky's students, some initiatives directly affected students with mental health issues, such as the creation of Family Resource and Youth Service Centers and the development of extended school services for students at risk.

With statewide implementation of the IMPACT model, Kentucky also instituted a comprehensive program evaluation effort incorporating both process and outcome data collection to assess the effectiveness and quality of the system of care. A five-year evaluation of the program revealed significant reductions in the psychiatric hospitalization of children and thus service costs; clinical gains in behavioral functioning; and improvements in family support, placement stability, and family satisfaction with services. The evaluation also revealed limited coordination and integration between education and other child-serving agencies, the continued underidentification of students with emotional problems, and less positive school-related outcomes for these youth. To that end, the Kentucky DMH applied for and received a six-year Comprehensive Community Mental Health Services for Children and their Families Program grant to expand its system of care for youth with SED and their families. The initiative, The Bridges Project, works within the existing system of care infrastructure but emphasizes the **development and promotion of school-based mental health interventions and family involvement**. The Bridges Project has been implemented in 20 schools, including pre-kindergarten through high school and alternative school settings, within the Appalachian region of the state.

The Bridges Project: Moving From Co-Existence to Collaboration in the Delivery of School-Based Mental Health Services

Given the predominately rural nature of Kentucky, many community mental health centers (CMHCs) operate as the primary providers of behavioral health services for youth and their families within each of the 14 mental health service areas of the state. The CMHC has become the agency to which school districts most frequently refer youth with emotional and behavioral

needs. Regional children's mental health services directors report school-based mental health as one of the fastest growing program areas in the state.

A variety of school mental health service delivery mechanisms are being implemented to address the mental health needs of students across Kentucky. These delivery mechanisms range from school personnel referring and encouraging families to seek services at the local CMHC or with state agency or private providers to the expanded school-based mental health model available through the Bridges Project in the southeastern portion of the state. The Bridges Project extends school-based mental health services beyond the traditional mental health consultation model to a comprehensive three-tiered model of mental health service delivery that focuses on providing prevention, early intervention, and intensive services to all children and youth in the school.

Staffing. Within the Bridges Project, the delivery of school-based mental health services is accomplished through a partnership with school personnel, families, and a Student Service Team (SST). The SST is comprised of a service coordinator, family liaison, and intervention specialist who are employees of the regional CMHC but housed on the school campus. The *service coordinator* serves as a case manager for children and youth identified with severe emotional and behavioral disabilities by facilitating wraparound team meetings and linking the family with natural supports and formal resources in the community. These individuals are bachelor's level service providers who receive training in service coordination and team facilitation strategies. The *family liaison*, the parent of a youth with an emotional or behavioral disability, serves in a professional role by providing peer-to-peer mentoring to family members and building local and regional family support networks. There are no formal educational requirements for this position; however, these individuals must complete a certification process through Opportunities for Family Leadership, the state office for family leadership. The *intervention specialist* is a mental health clinician with a Master's degree or the professional equivalent who has received additional training in functional behavioral assessment and the development of behavior intervention plans and school-based supports. Each school also has access to a *regional behavior consultant* who provides assistance to schools in the implementation of schoolwide strategies and supports and consultation on individual and group behavioral interventions.

The implementation of a continuum of mental health services and supports is based upon a positive behavior support (PBS) framework. Defined as a "broad range of systemic and individualized strategies for achieving important social and learning outcomes while preventing problem behavior" (Turnbull et al., 2002, p. 377), PBS has expanded from a focus on individual children to a system-wide intervention approach for schools. This proactive data-based approach focuses on providing multiple levels of intervention to address the academic and mental health needs of all youth, not just those with the most challenging behaviors. The assumption underlying PBS is that a continuum of effective behavior supports is required to meet the needs of all youth in a school.

Providing a Continuum of Mental Health Services and Supports

The implementation of a continuum of mental health services and supports is based upon a positive behavior support (PBS) framework. Defined as a “broad range of systemic and individualized strategies for achieving important social and learning outcomes while preventing problem behavior” (Turnbull et al., 2002, p. 377), PBS has expanded from a focus on individual children to a system-wide intervention approach for schools. This proactive data-based approach focuses on providing multiple levels of intervention to address the academic and mental health needs of all youth, not just those with the most challenging behaviors. The assumption underlying PBS is that a continuum of effective behavior supports is required to meet the needs of all youth in a school.

Based on a three-tiered prevention model, PBS is a research-based approach for promoting prosocial behavior of all students (universal interventions and supports), those at-risk for or beginning to exhibit problem behavior (targeted interventions and supports), and those with chronic and severe emotional and behavioral problems (intensive interventions and supports). The application of school-wide PBS can enhance system of care approaches for students with intensive needs by providing an environment of proactive interventions across all students and a school-wide systems approach to prevention and early intervention.

Universal Interventions. Universal interventions constitute a form of primary prevention and focus on promoting the mental health and prosocial behavior of all students. Universal approaches are typically effective at preventing problem behavior for the majority (80-90%) of students. These strategies focus on enhancing protective factors in the school, home, and community while preventing the development of problems through the efforts of all school personnel and caregivers. Essentially, universal interventions are focused on creating a positive school climate that increases school safety and positive student-adult relationships.

Coordination and oversight of universal interventions rests with the Positive Behavior Support Team, a team that includes full representation of school personnel (i.e., administration, teachers at all grade levels, certified staff, specialized support staff), mental health, families, and the community. Through their attendance at ongoing trainings and monthly meetings, the Positive Behavior Support Team is responsible for planning, monitoring, and maintaining the schoolwide intervention program (Lewis, 2001; Scott & Nelson, 1999). Regional behavior consultants are available to “coach” teams as they move through this process. Schoolwide interventions might include developing a set of clearly defined school-wide rules and expectations for student behavior, establishing school-wide approaches for teaching and reinforcing expected prosocial behaviors, and re-designing routines, schedules and environments to prevent, minimize, or eliminate disruptive behavior. Schoolwide initiatives specific to mental health promotion may include mental health education and awareness activities (e.g., the inclusion of a mental health column in the school newsletter, S.O.S. Suicide Prevention Program), mental health promotion (e.g., Red Ribbon Week; Child Abuse Prevention Month; Baby, Think It Over), and parent networking and parent education (e.g., library of mental health resources for parents, parent education and support groups).

Targeted interventions. The establishment of effective universal strategies and supports will likely result in a significant reduction in student discipline problems. Not all students, however, are responsive to universal interventions, and an estimated 5-10% require interventions targeted specifically for their unique needs. Targeted interventions are designed for youth who are at risk, or beginning to exhibit signs of emotional and/or behavioral problems and are administered individually or in small groups.

School-based screening committees have been established to review referrals and determine whether youth require targeted or intensive services. The composition of this team varies from school to school depending upon the level of behavioral expertise of individual members, but typically includes a school administrator, intervention specialist, family liaison, and special educator. These individuals meet on an as-needed basis to review referrals and collect necessary data to determine the level of service intensity required for a student. For example, behavioral observations may be conducted or school discipline records may be reviewed to gather needed information. If deemed in need of a targeted intervention, the team utilizes a strengths-based problem-solving process to develop a behavioral intervention or treatment plan to address the targeted problem area. Targeted interventions may include, for example, mentoring, tutoring or other academic support, or the development of a positive behavior plan.

Intensive Interventions. Despite implementation of effective universal and targeted interventions, there remain 1-5% of youth that requires more intensive interventions to succeed. These students have chronic and complex emotional or behavioral needs that span home, school, and community settings and require a comprehensive multi-agency treatment approach. Similar to other communities implementing system of care initiatives, the Bridges Project applies a **team-based wraparound process** to design and implement individualized service plans. School-based Bridges personnel facilitate the development of an individualized wraparound team whose members can identify and build upon the unique strengths and needs of the youth and his or her family. This team is comprised of the youth, his or her family, and other community members

selected by the family. Other team members may include school personnel, service providers, and natural community supports that do or could potentially have a positive impact on the youth and family (e.g., extended family members, clergy, coaches, and peers).

Wraparound, a promising practice for improving outcomes for this population, incorporates a family-centered and strengths-based philosophy to guide service planning. Wraparound planning generally follows an **eight-step process**.

- ❑ The **first step** in the planning process includes initial conversations. The team facilitator (i.e., service coordinator) meets individually with the child, the caregiver(s), school personnel, and others on the team that have knowledge of the child and family across life domains. This gives each party a safe setting in which to share their perspective of the strengths and barriers prior to the team's first meeting. Conversations are ended with an identification of the strengths and resources of the child, the family, the person being interviewed, and the community at large, setting the stage for the strengths-based approach utilized in the formal team meeting.
- ❑ The **second step** is to begin the team meeting with a review of the strengths identified through the initial conversation process. Barriers and challenges are not ignored, but rather are approached through a discussion of how the previously identified strengths of the youth, other team members, and community can best be utilized to address them.
- ❑ Upon listing strengths of all involved parties, developing a team mission statement is the **third step**. The team mission statement is positive, focused and brief (Eber et al., 2002). Ideally the mission statement should "fit on a bumper sticker," e.g., "Jake will live at home and succeed at school." The team mission statement identifies a goal not only for the child, but also for the team as a whole, and gives the team a point to which it can return if the team meeting should get disorganized or off track.
- ❑ The **fourth step** in the process is the identification of the child and family's needs across life domains. All team members may not have had the opportunity to be involved in an initial conversation, so the team meeting may be the first time some members have a chance to identify needs. This part of the process is not a time for team members to rehash all of the barriers and challenges the child and family is experiencing, rather it allows the team to identify current needs of child and family.
- ❑ Following need identification, the **fifth step** for the team is prioritization of the needs. Safety issues, if they exist, are prioritized, followed by needs that are important to the child, caregiver(s), and others who spend a large amount of time with the child (i.e., school personnel). It is important in this phase to narrow the focus to three or four areas to be addressed in the short-term. As prioritized needs are met, future team meetings begin to focus on less critical areas identified in step four.

- ❑ The **sixth step** is developing actions through which needs will be addressed. Team members identify existing resources and/or design individualized interventions using a blend of formal and informal services and supports.
- ❑ **Step seven**, typically completed in conjunction with the previous step, involves assigning tasks related to the identified actions and soliciting commitments from team members and others involved with the family to ensure that actions are completed according to timelines.
- ❑ Finally, in **step eight**, the team facilitator documents a summary of the process on a designated wraparound planning form. This document serves as the foundation for future team meetings and subsequent planning. Careful monitoring of implementation and outcomes across multiple life domains (i.e. social/emotional, medical, basic needs, academic, living environment) is ongoing and is the responsibility of all team members. If through the evaluation and monitoring process, identified actions are deemed ineffective or a crisis situation arises, the team will revisit earlier steps in the process to develop an alternate plan.

The wraparound process is a key component of the full continuum of PBS in the Bridges schools as it is the mechanism for ensuring that proactive, outcome-based interventions for the students with the most intensive needs and their families are developed in a creative yet efficient manner.

Closing Statements

The Bridges Project represents a significant shift in the role of mental health providers in schools. The investment of mental health resources into school-wide prevention, early intervention, and the facilitation of school-based wraparound teams expands traditional mental health models to an integrated, strengths-based approach. The application of system of care principles through a school-based wraparound approach has allowed schools in the Bridges Project to experience success with some of their most challenged and challenging youth, in such areas as improved behavioral functioning, decreased problem behavior, and increased academic performance. While these changes are encouraging, much work remains to determine how to positively impact other life domains, such as substance use, delinquency, and physical health.

Partnerships between mental health and education around systemic models such as PBS can provide a structure for more efficient and effective delivery of mental health services. Assisting schools in developing Schoolwide proactive systems around behavior can improve school capacity to prevent problem behaviors from occurring or escalating. This creates an environment more conducive to identifying youth in need of mental health supports earlier and potentially at a point when services may be more effective and less costly.

As previously stated, this requires a significant change in the traditional delivery of mental health to include assistance with school-wide prevention, early intervention and building competencies with the system of care concept and related tools such as school-based wraparound. The

development of a school-based continuum of care that uses evidence-based practices commensurate with demonstrated needs of students is a concept that may be useful for other mental health providers seeking models for efficiently and effectively organizing their supports and services. Being part of the day-to-day environment of the school through a school-wide PBS approach, and assisting in improving overall learning environments for all students can be considered a long-term investment of mental health resources.

Case study illustrating a universal intervention



Case study illustrating a targeted intervention

A Targeted Intervention in Action.... Homework Helpers

A review of referrals to the Bridges school-based screening committee revealed a group of five elementary-aged males who were having difficulty with homework completion. Through a problem solving process, the screening committee determined that a small group intervention would be implemented as a first step to address this issue. The intervention specialist sent caregivers an information packet including tips for setting up an effective study environment at home and assisting children with homework. On Monday mornings, the students met with the intervention specialist to receive their weekly homework tracking form and participate in skill-building sessions related to organization, study habits, and goal setting. On Fridays, students met with the intervention specialist again to conduct a progress check of homework completion, celebrate student successes, and assist those who did not meet their goals. Anecdotal evidence suggests that for some students, participation in the Homework Helpers group led to improved self-perception, social interactions, grades, and parent satisfaction with student progress.

Case study illustrating school-based wraparound**Jake's Story**

Jake is a 13-year-old middle school student being raised by his maternal grandmother. At the beginning of his fifth grade year, he had been enrolled in five other schools across three states. Jake's family changed schools frequently as a result of the inability to address his behavior within the school system.

Jake currently attends a school that is participating in the Bridges Project. Jake is beginning his second year at the school. Since enrolling there, he has had a total of 3 office referrals. In the past, he averaged 3 office referrals a week!

In other schools, Jake worked from the time he got home until bed time trying to finish his homework, but was still failing almost all classes. His family was told he would be in reform school by the time he was 12. He now completes his homework quickly in the evening, and he consistently receives A's and B's.

In other programs, professionals encouraged Jake's family to put him on medication, but did not discuss the importance of other supportive services. His grandmother describes past school and mental health services as disjointed and prescriptive. Due to the coordinated supports provided to Jake and his family by school and mental health personnel through the Bridges Project, Jake's grandmother receives fewer calls from the school and can focus on supporting her family rather than leaving work to meet with school personnel. She reports feeling that she is now working in partnership with the school, rather than fighting against them.

Through her family's involvement in Kentucky's system of care, Jake's grandmother has learned about how to survive his disability. She is always getting ideas about new things to try and how to modify them if they don't work... She has called it a "life changing experience." Jake and his grandmother now present at state and national level conferences to share his success story with other families and professionals. The improvements in the family's quality of life testify to the importance of providing coordinated services, focusing on strengths rather than deficits, and including the family as an equal partner at all levels of decision making.

Case study illustrating school-based wraparound (continued)

These notes are excerpted from the following two chapters:

Robbins, V., & Armstrong, B.J. (in press). The Bridges Project: Description and evaluation of a school-based mental health program in Eastern Kentucky. In M.H. Epstein, K. Kutash, & A.J. Duchnowski (Eds.), *Outcomes for Children and Youth with Emotional and Behavioral Disorders and their Families: Programs and Evaluation Best Practices, Second Edition*. Austin, TX: Pro-Ed.

Armstrong, B.J., **Robbins, V.**, Collins, K., & Eber, L. (in press). The Bridges Project: Meeting the Academic and Mental Health Needs of Children through a Continuum of Positive Supports. In Kristen E. Robinson (Ed.), *Advances in School-based Mental Health: Best Practices and Program Models*. Kingston, NJ: Civic Research Institute.