THE 3-D APPROACH TO SCHOOL-BASED MENTAL HEALTH: DATA, DISSEMINATION, AND DELIVERY

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AGENDA

- School-Based Mental Health (SBMH)
- Why SBMH?
- The Impact of IDEIA on SBMH
- Barriers to SBMH
- Multi-tiered System

http://www.youtube.com/watch?v=4FsY0D66E0&feature=related
SCHOOL-BASED MENTAL HEALTH (SBMH)

- Who
- What
- Where
- When
- Why
- How

WHY SBMH?

- Long-term costs of failing to provide mental health services
- More complex difficulties later in life that are more costly to address and manage
- Schools have access to children and adolescents in need of services
- Schools have experience intervening to meet children’s mental health needs
- Children are required to attend school

(Mash & Barkley, 2006; IDEA, 2004; Carnegie Council Task Force on Education of Young Adolescents, 1989; Cash, 2008; Condition of Education, 2008; Stark et al., 2005; Mufson, Dorta, Moreau, & Weissman, 2005)
WHY SBMH? (CONT.)

- 21% of children and adolescents are in need of mental health services
- Mental health systems and educational systems only serve 20% of children and adolescents who are in need
- Schools remain the primary provider through delivery of special education services and single session contact
- Children and adolescents are more likely to seek support when school-based mental health services are provided

Research on the positive outcomes that result from school-based mental health services:

- Elementary schools that reduced their special education referrals and placements among at-risk students (for depression, AD/HD, and conduct disorder behavior) have improved their school climates.
- Schools that reduced their disciplinary referrals and grade retentions have also improved their school climates.
- Some studies have demonstrated that greater provision of school-based mental health services positively correlates with increased standardized test scores and with improved academic performance.

THE IMPACT OF IDEA 2004 ON SBMH

- In need of and eligible for special education
- 14 IDEA categories
- Schools are responsible for problems that interfere with a child's ability to learn
- School districts have reported an increased need for mental health services in light of decreased funding (Foster et al., 2005).
- Prevention services as a part of a tiered system
BARRIERS TO SBMH

- How do you structure services in the schools?
- Where do you start and where do you end services?
- Is it feasible to have school-based mental health services?
- How do you get “buy in” from teachers and administrators?

MULTI-TIERED SYSTEM

- Tier I: Universal Interventions - All Students
- Tier II: Supplemental Interventions - Some Students
- Tier III: Strategic Interventions - Few Students
- Tier IV: Intensive Interventions - Few Students

UNIVERSAL INTERVENTIONS

- Focus on prevention
- Based on school-wide data
- Identify and expand sources of strength within the system
- Identify and adjust problem areas
- Increase awareness of interdependent interactions within system
- Emphasize skill development

Adapted from © 2008 R. W. Christner & R. B. Mennuti (School-Based Mental Health: A Practitioner’s Guide to Comparative Practices)
WHAT ARE SOME EXAMPLES OF UNIVERSAL INTERVENTIONS?

- I Can Problem Solve (Shure, 2001)
- PATHS (Kusche & Greenberg, 1994)
- Social Problem Solving (SPS; Elias & Tobias, 1996)
- Friends for Children (Barnett, Lowry-Webster, & Turner, 2000)
- Olweus Bullying Prevention Program (Olweus & Limber, 1999)

TARGETED INTERVENTIONS
SUPPLEMENTAL AND STRATEGIC

**Supplemental**
- Assess problematic system factors (i.e., deficits in necessary skills within the environment, classroom issues)
- Consultation services
- Provide workshops and in-services for teachers
- Psychoeducation and skill building with staff

**Strategic**
- Identify and intervene with at-risk students regarding a particular issue
- Utilize group format and structured approaches (e.g., manualized approaches)

TARGETED INTERVENTIONS
SUPPLEMENTAL CONSULTATIVE INTERVENTIONS

- Cognitive-Behavioral Consultation (Christner & Stewart-Allen, 2004; Christner, Stewart, & Lennon, 2006)
- Classroom Interventions (e.g., behavior modification/management)
- Individual Positive Behavior Support
- Parent Consultation and Support
- Teacher In-service Training, Consultation, and Support
TARGETED INTERVENTIONS
STRATEGIC MANUAL-BASED INTERVENTIONS

Benefits

- Specific content to be addressed
- Clearly defined procedures to use
- Step-by-step procedures to follow
- Articulated activities to follow
- Starting and stopping point
- Outcome research

Difficulties

- Which manual do I choose?
- Not meeting the individual needs of clients
- Difficulty getting students to attend 15 to 20 sessions
- Addressing the students’ skills, but not the barriers, and difficulties that affect implementation

TARGETED INTERVENTIONS
STRATEGIC MANUAL-BASED INTERVENTIONS

**Anxiety**

- Coping Cat (Flaxery-Schroder & Kendall, 1996)
- Social Effectiveness Therapy for Children (Beidel & Turner, 1998)
- Child Anxiety Management Program (CAMP; Friedberg & Elamic in preparation)
- Cognitive-Behavior Group Therapy - Adolescent (CBGTA; Albano, 2000)
- Coping with Stress (Clarke, Lewinsohn, & Hops, 1990)
- Building Confidence (Wood, Piacentini, Southam-Gerow, Chu, & Signman, 2006)

TARGETED INTERVENTIONS
STRATEGIC MANUAL-BASED INTERVENTIONS

**Anger and Aggression**

- Coping Power Program (Larson & Lochman, 2002)
- Chill Out Program (Feindler & Etcon, 1986; Feindler & Gutman, 1996)
- “Keeping Cool!” (Dwivedi & Gupta, 2000)
- Aggression Replacement Training (ART; Goldstein, Glick, & Gibbs, 1998)
TARGETED INTERVENTIONS
STRATEGIC MANUAL-BASED INTERVENTIONS

> Depression
  > Coping with Depression (Clarke, Lewinsohn, & Hops, 1990, 2003)
  > ACTION Program (Stark & Kendall, 1996)
  > Coping with Stress (Clarke, Lewinsohn, & Hops, 1990)

INTENSIVE INTERVENTIONS

> Direct, ongoing intervention with identified students
> Group, individual, and family treatments aimed to address specific problems
> Often have multidisciplinary involvement within schools
> Evidence-based approaches – Manualized vs. Modular

MODULAR-BASED INTERVENTIONS

Benefits
  > Decreases the demands of manual-based programs
  > Uses specific techniques from manual-based programs
  > Uses outcome research to ensure specific interventions
  > Bases intervention on specific client needs

Difficulties
  > Must have good case conceptualization skills
  > Must use single case design and progress monitoring more efficiently to measure outcome
  > Must have a good understanding of the literature across various disorders
MULTIDIRECTIONAL APPROACH

Problem

Situational

Behavioral

Cognitive

Affective

A SAMPLE OF POSSIBLE MODULES

- Goal Setting
- Self-Monitoring
- Relaxation
- Problem Solving
- Social or Relational Skills
- Self-Instruction/Self-Talk/Self-Management
- Reattribution
- Cognitive Restructuring
- Behavioral Tasks

(Adapted from Christner & Mennuti, 2008; Christner in preparation)

QUESTIONS AND COMMENTS