WAY TO GO

School Success for Children with Mental Health Needs

* The drawings in these Fact Sheets were produced for Way to Go by students in two programs operated by Washington Very Special Arts: the School for Arts in Learning (SAIL), a public charter school serving children K-12, and the ARTiculate employment training program.

FACT SHEET #3

Effective Mental Health Services Integrated with Schools: What Works

Schools and Mental Health

Many children with mental health problems experience difficulty in school. Yet often their only access to mental health services is through their school, even though they need intensive services that are available only through community mental health resources. To improve outcomes for these children in school and in the community, schools and mental health systems must collaborate.

Public mental health systems recognize the value of furnishing services to children with complex needs in ways that are supportive of their families and build on child and family strengths. Services should be provided in the most normal environment possible, allowing children to stay at home when feasible or in a home-like setting when out-of-home care is required. Services also need to be individualized, culturally competent and comprehensive.

Systems of Care

Because these children are often engaged with more than one child-serving system, mental health agencies at the national, state and local levels have promoted interagency systems of care, with values and principles that encourage success, safety and permanency in the home, school and community. A system of care is a partnership between agencies, service providers, families and youth, with the various stakeholders functioning as a multi-agency team.

Principles to Follow

Interagency collaboration in a system of care enables children to be identified for services, referred for the most appropriate interventions and to have a single plan of care, ensuring that every agency works toward the same goals. Such systems also allow for more efficient use of resources, because a system can bring all resources to the table to fund what a joint planning team sees as the most important services. A system of care approach has significant advantages for the public agencies, as well as for the families and children.

Outcomes from Systems of Care

Systems of care have a long history. The first demonstrations occurred in the mid-1980s. The federal initiative to fund systems of care includes an evaluation component, which has shown that systems of care increase the number of children served and that:

- ☆ Children's behavioral and emotional strengths increase and their behavioral and emotional problems decrease.
- ☆ Children's functional impairments decrease.
- ☆ Out-of-home placements decrease.
- ☆ Law-enforcement contacts decrease.
- ☆ School attendance improves, as does school performance.
- ☆ Disciplinary actions in school are reduced.

Systems of Care and Schools

When working with schools, systems of care may take several approaches. One that has proved very effective is for community mental health staff to be placed in a school building, continually available to both children and staff. Co-location means that these staff are there five days a week, throughout the school day. The school provides the space (and in some cases contributes to the salary costs), but the staff are employees of community mental health, making it easier for them to bill Medicaid and other third-party healthcare payers.

Alternatively, schools may choose to participate within the system of care and have school personnel (such as school social workers or psychologists) be on the child's service team, while children and families go to a mental health facility or other community setting to access services. Although this may be less effective than co-location, it ensures a single plan of care, based on system of care principles.

Much less effective is the provision of isolated mental health services by schools, either in the school building or through placement in more restrictive settings.

Effective Services Also Needed

In addition to reorganizing systems to emphasize collaboration, it is vital to offer services that will lead to improvement. Over the past decade or so, evidence on effective children's mental health services has grown rapidly[1]—although more research remains to be done. As in other fields, it takes time for practitioners on the front line to accept new approaches and to receive the needed training, mentoring or technical assistance.

Successful interventions typically involve multiple components that target classroom, home and peer environments. They must also take into account each child's developmental stage and environment (including family environment). Families are central both to understanding the child's problems and in delivery of treatment or services.

Most Effective Services

Schools and families will find that if the services are not supported by evidence or best-practice research, children's functioning will not improve as expected. A wide range of effective services exists for children.[2] Evidence-based services are those shown through randomized trials to outperform usual practice. Also encouraged are best practices that show substantial improvements in child functioning but have not yet been studied as intensively. The service interventions with the best evidence of effectiveness are:

- intensive home-based services;
- intensive case management;
- crisis services;
- therapy (see below);
- family education and support (see below);
- multi-systemic therapy;
- multi-modal treatment for attention deficit/hyperactivity disorder
- assertive community treatment;
- medications and medication management;
- therapeutic foster care;
- integrated treatment for mental health and substance abuse, and
- supported employment (relevant for adolescents).

School-based and community-based services should take into account findings from more than 400 published clinical trials showing beneficial, problem-specific and du-

rable effects of certain mental health interventions for a variety of childhood conditions, including depression, phobias and anxiety disorders, ADHD and conduct disorders.[3] Particularly effective are family-based cognitive behavioral therapy, functional family therapy and self-control therapy. Parent training on the child's disorder and how to manage it has also proved effective, particularly for disruptive disorders.[4]

Successful Interventions in Schools

For educators, it is important to know what types of interventions have the strongest evidence of effectiveness when furnished in a school setting. According to a group of leading researchers, the following are the most effective school-based services:[5]

- targeted classroom-based contingency management for children with ADHD and other conduct problems;
- behavioral training and consultation to enable teachers to recognize mental health problems and help them accommodate students with challenging behavior;
- cognitive group interventions to modify adolescents' depressive thinking styles, and
- group intervention to teach social problem-solving skills to elementary school children with elevated depressive symptoms.

Teacher training can be similarly helpful, and programs to train and support teachers have been found to reduce negative classroom behavior.

Helping Families

Assistance to parents is often a key part of effective services. There are evidence-based interventions for the family as well as for the child. Parent education and training reduces relapse rates and facilitates recovery from mental disorders. It involves educating the family about the disorder, teaching problem-solving skills and showing how to recognize and defuse crises in the early stages, as well as crisis assistance.

Implementation Lags

Unfortunately, implementation of the most effective treatments is slowed by several factors. These include insufficient resources for training and follow-up support for practitioners, inadequate reimbursement rates, time constraints and resistance from practitioners. Clinicians most often respond positively to changing their practice when they can see that the new treatment is more effective and can be incorporated into their current practice relatively easily. It is also extremely important to provide ongoing mentoring and technical assistance to practitioners newly trained in a service, to ensure that the training translates into a real change in day-to-day practice.

Evidence-based practices are not universally accepted. Some argue that most of the evidence comes from controlled clinical trials with selected participants (who often have only one diagnosis), not from real-world settings where children have complex problems. However, when evidence-based practices are implemented with fidelity to the model, the results for children in real-world situations are generally positive.[6] Providing services that are known to be less effective is certainly not recommended.

Evidence-based research is also criticized because of the limited populations who participate in trials. In particular, there is concern that the findings may not translate well for ethnic and minority children. While this is a valid point, the answer is to prioritize research on such populations, not to continue offering them services known to be less effective.

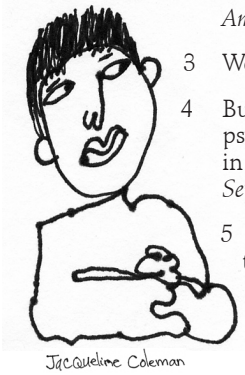
Funding Patterns In addition to uneven results in changing practitioner behavior, evidence of effectiveness does not always change the funding patterns for mental health services. For example, as the Surgeon General's report states, even though evidence for the effectiveness of residential treatment centers is weak, nearly a quarter of the national outlay on child mental health is spent on care in these settings. Schools and other child-serving agencies, make significant use of residential placements for children found to meet the definition of emotional disturbance under the IDEA. Many community interventions have much stronger evidence for effectiveness.

Less Effective Services Furthermore, there is significant evidence that grouping together children who have significant behavioral issues only increases the likelihood that problem behavior will become the norm. Children learn from peers in these settings, and the normal behavior of children placed in group settings is poor. In the absence of good role models, behavior deteriorates, and these youth bring the newly learned behaviors back into their school and community when they return.

Also not listed as an evidence-based practice are traditional office-based talk therapy, group homes and day treatment.

What to Do In conclusion, there is every reason to focus mental health policy on:

- developing interagency systems of care that include the education system;
- ensuring early identification of problems;
- providing services using a strengths-based, family-driven approach;
- funding the most effective treatments, tailored to the child's individual needs;
- emphasizing services that enable children to remain at home with their families or in settings that are home-like;
- providing the full array of services the child requires, in the amount and for the duration that is needed for achieving desired outcomes;
- providing psychoeducation and other supports to families to help them keep their child at home and to reinforce issues that are addressed in treatment;
- supporting teachers so they too can identify and refer children who need mental health services early, as well as managing all children in their classroom effectively.



1 Weisz, J.R. & Jensen, P.S. (1999). Efficacy and effectiveness of child and adolescent psychotherapy and pharmacotherapy. *Mental Health Services Research.* 1:3, Plenum Publishing Corporation.

2 U.S. Department of Health and Human Services (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD:Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health; New Freedom Commission on Mental Health (2003). *Achieving the Promise: Transforming Mental Health Care in America*. Final report. DHHS Pub. No. SMA-03-3832. Rockville, MD.

3 Weisz & Jensen (1999).

4 Burns, B.J., Compton, S.N., Egger,H.L. et al. (2002). An annotated review of the evidence base for psychosocial and psychopharmacological interventions for children with selected disorders. Chapter in Burns, B.J. & Hoagwood, K., Eds., *Community Treatment for Youth : Evidence-Based Interventions for Severe Emotional and Behavioral Disorders*. New York/Oxford: Oxford University Press.

5 Hoagwood, K., Burns, B.J., Kiser, L., Ringeisen, H., Schoenwald, S. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*. 52:9, 1179-1189.

6 Angold, A., Costello, E.J., Burns, B., et al. (2000) Effectiveness of non-residential specialty mental health services for children and adolescents in the "real world." *Journal of the American Academy of Child and Adolescent Psychiatry*. 39:2, 154-160.