Building Comprehensive Mental Health Services across All MTSS Tiers.

Achilles N. Bardos, Ph.D.
University of Northern Colorado
School Psychology Program
abardos@Comcast.net

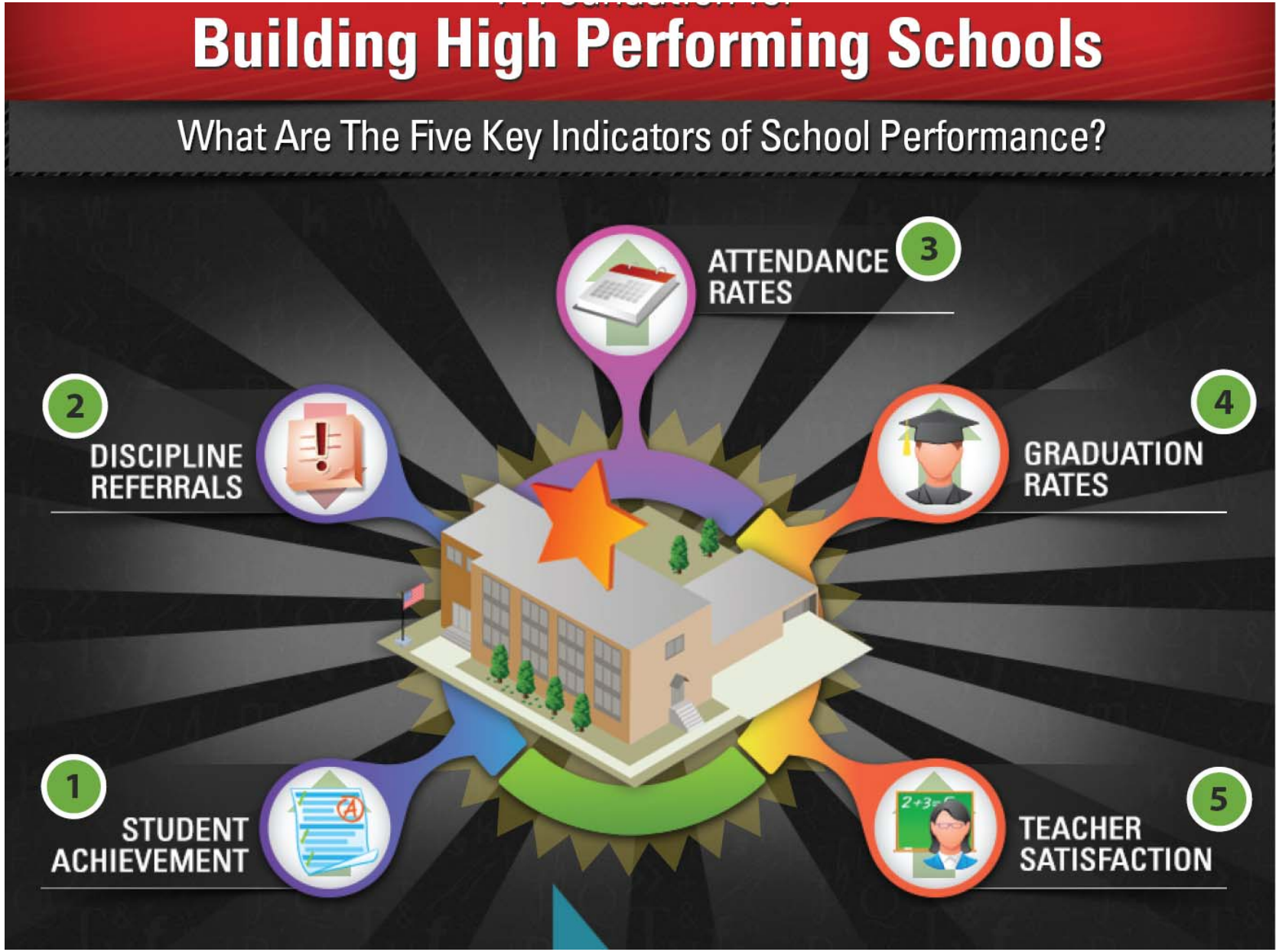


Background & Disclaimers

- Professional Training
  - Elementary education.
  - School psychology
- Professional Interests
  - Cognition, intelligence, LD, Plus.!!!
  - Test development.
- Beliefs in Practice
  - Need for science to support practice.
  - Solid Psychometrics in tools.
  - Evidence based interpretation.
- Co- author of tool (BIMAS) to be presented.

“Moving our neurons to get ready or prove that we are…”

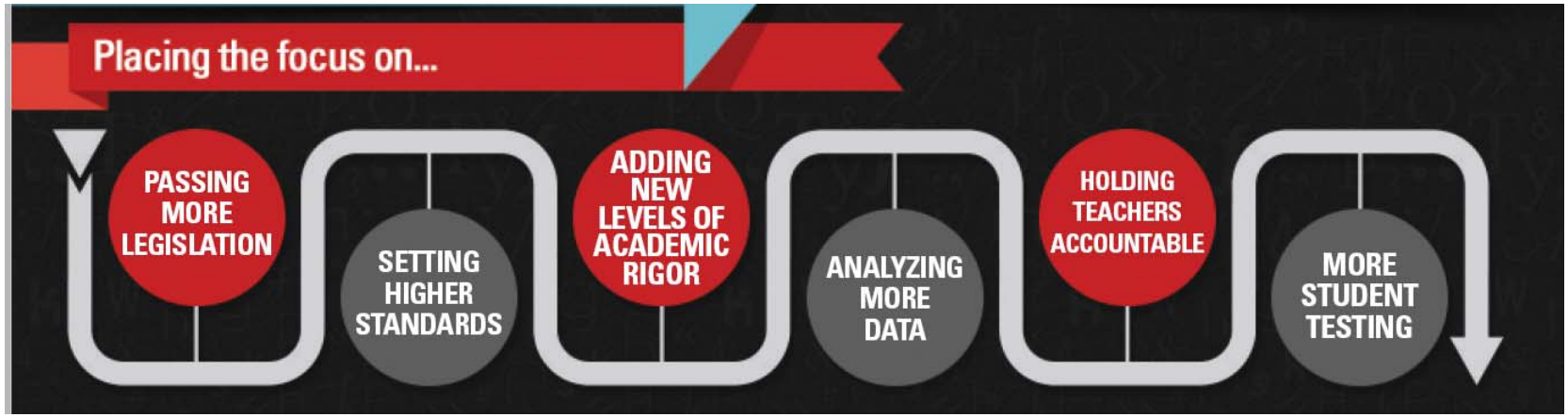
7H15 M3554G3 53RV35 7O PR0V3 H0W 0UR M1ND5 C4N D0 4M4Z1NG 7H1NG5! 1MPR3551V3 7H1NG5! 1N 7H3 B3G1NN1NG 17 WA5 H4RD BU7 N0W, 0N 7H15 LIN3 Y0UR M1ND 1S R34D1NG 17 4U70M471C4LLY W17H 0U7 3V3N 7H1NK1NG 4B0U7 17, B3 PROUD! 0NLY C3R741N P30PL3 C4N R3AD 7H15. PL3453 F0RW4RD 1F U C4N R34D 7H15.



- Adopted from flippen group

How Do I Improve These Indicators?

Current thinking suggests that we improve these indicators by...



Groundbreaking Research Demonstrates

High Performing Schools are Distinguished by *Exceptional Culture and Climate*

"If you have a child's heart, you have their head.™"

- **Flip Flippen**, Founder and Chairman, The Flippen Group

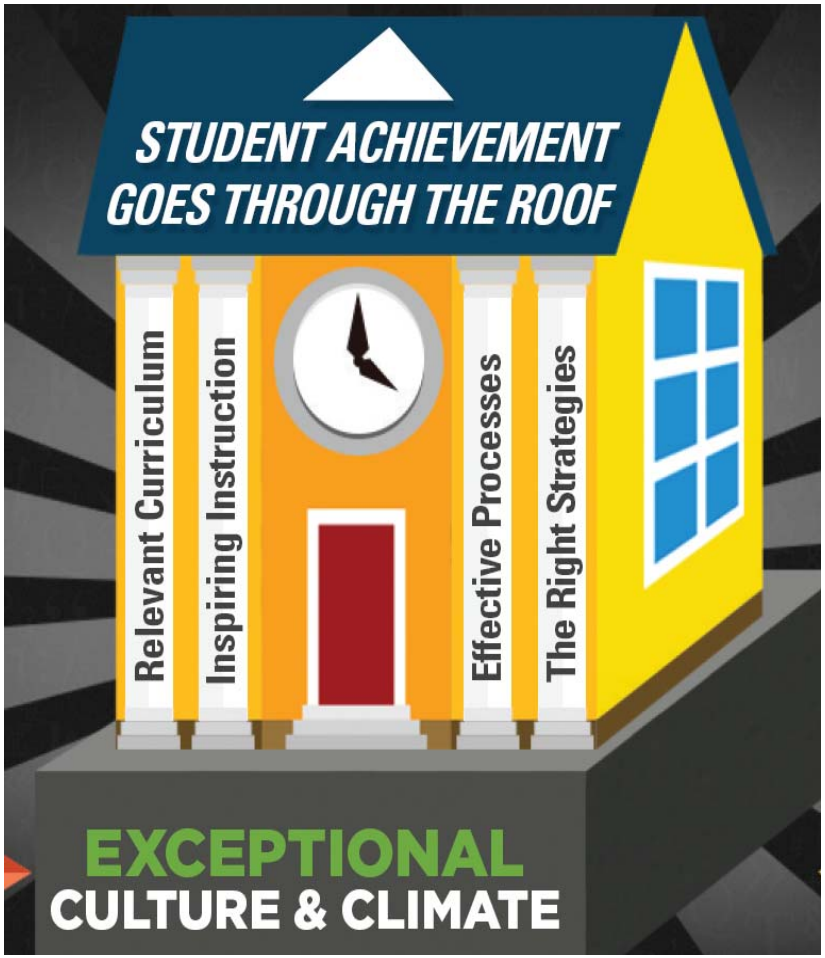
…..When we create a School Climate…..

- Supported by the building leader
- Implemented with fidelity by caring faculty

LEAD TO:

- Student acquisition of prosocial behaviors
- Decrease in student discipline referrals
- Increase in academic performance

Bandura's Social Learning Theory principles



General Social Emotional Skills

Schools that have introduces social-emotional skills curricula have shown…

- An increase in self–esteem
- Increase in attitude towards group work
- Increase in personal development
- Decrease in loneliness
- Decrease in discipline referral

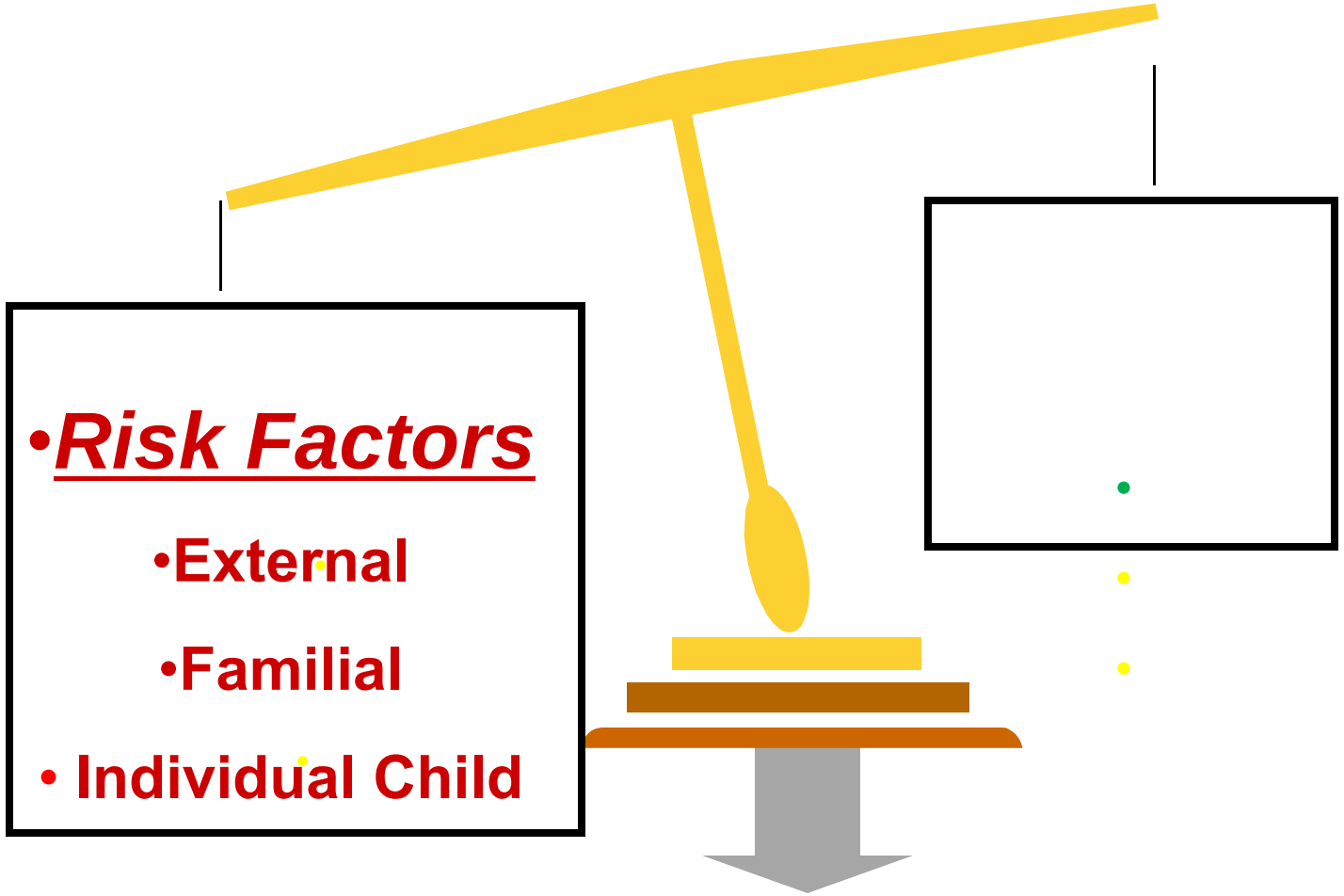
"THE BEST LAID PLANS OF MICE AND MEN OFTEN FAIL"

- Most change efforts in Education have resulted in limited success the last 25 years….
- Even when supported by federal or state government mandates or some economic support.
- Those studying these efforts report a success rate of about 20% for actual change.

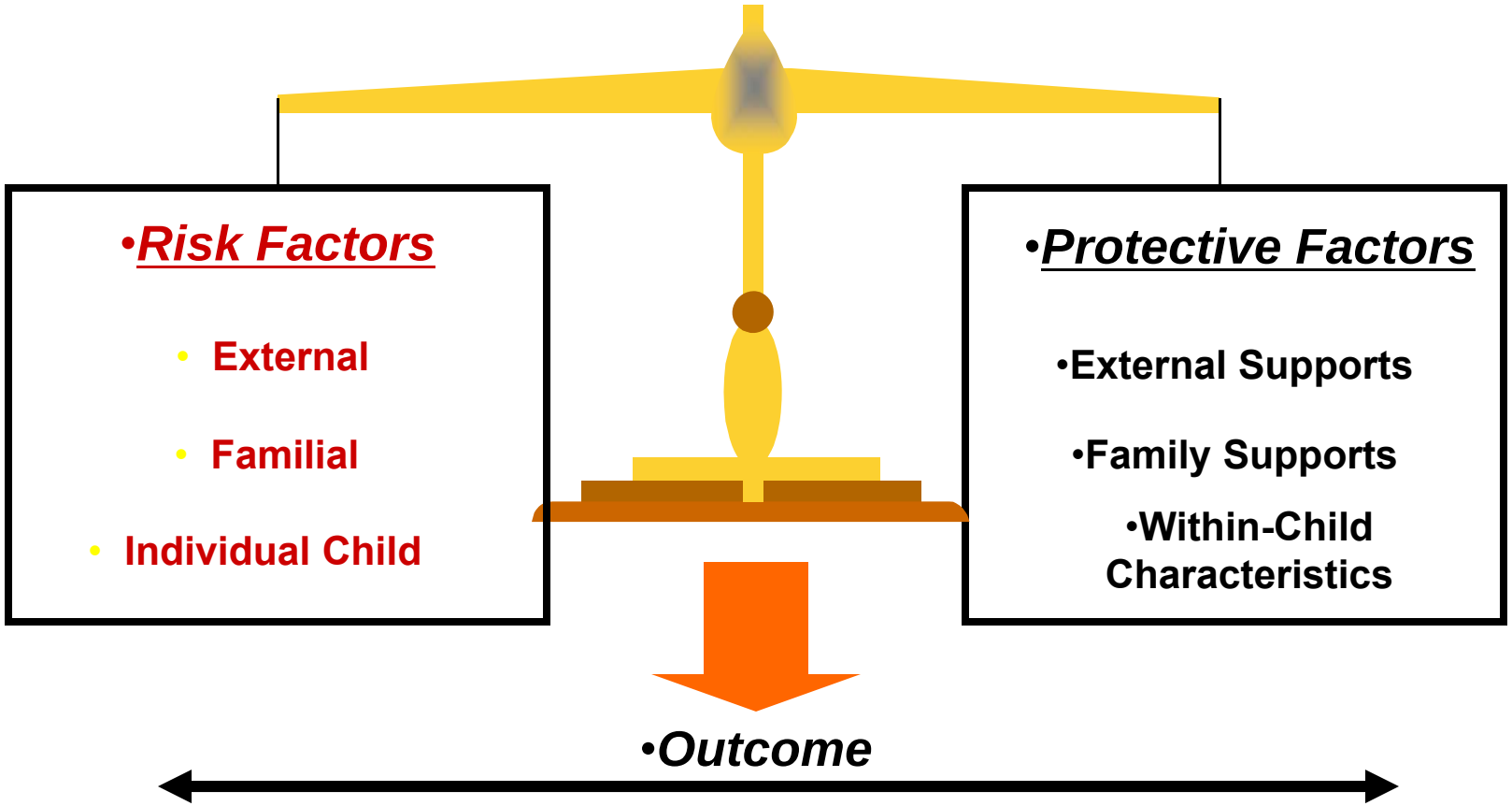
What are your road blocks?



Risk Factors



Risk and Protective Factors





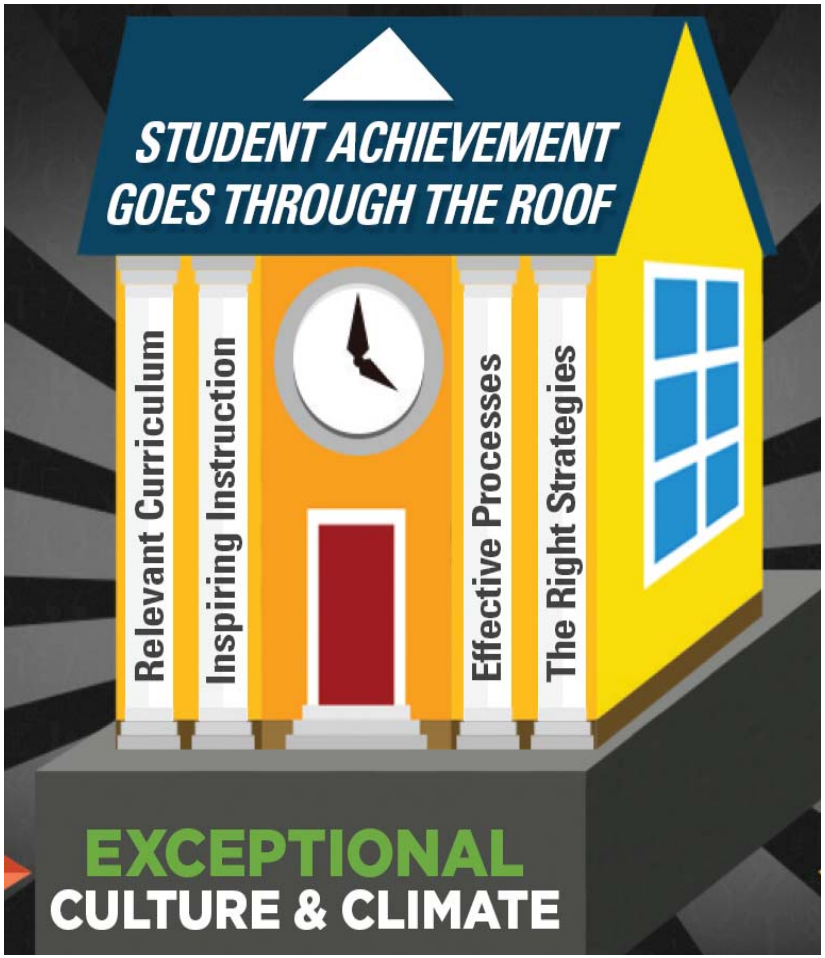
- WELCOME TO OUR CREW!

When we create a School Climate….

- Supported by the building leader
- Implemented with fidelity by caring faculty

LEAD TO:

- Student acquisition of prosocial behaviors
- Decrease in student discipline referrals
- Increase in academic performance



What do these schools look like?

Schools With **High** Levels of CBHM Fidelity

- 100% of students are screened for behavioral health concerns
- 76-100% of classrooms are using SEL curriculum
- Behavioral Expectations are identified in matrix, posted, and formally taught in every classroom
- SST relies on the use of data (e.g. CBM, BIMAS), evidence based interventions, and progress monitoring

Schools With **High** Levels of CBHM Fidelity

- MH Partner works collaboratively with school based staff (e.g. on school wide teams)
- Adequate time is provided for CBHM Professional Development
- Office Discipline procedures include the regular review of data for decision making purposes
- Family Engagement is emphasized

Schools with **Low** Levels of CBHM Fidelity	Schools with **Low** Levels of CBHM Fidelity
• Less than 25% of students are screened •0-25% of classes are using SEL curriculum •PBIS team does not exist •Behavioral Expectations have not been identified, are not all positive, are more than 5 in number	•No time is provided for CBHM Prof Development •MH Partner does not participate on school wide teams •No protocol for office discipline procedures exists

Something to ponder!!!

- Please take a moment….alone or with the person next to you.
- How do you define Mental Health?
- How are you asked/allowed to define Mental Health? What is your role in
  - Tier I
  - Tier II
  - Tier III services?

Hopes, and goals for our students

- Master Academics
  - reading, writing, math, science, history, art, languages, cultures) .

BUT ALSO

- Enhance social– emotional competence, character, health, and civic engagement
  (Metlife, 2002; Rose & Gallup, 2000).

SOCIAL– EMOTIONAL COMPETENCE

- interact in socially skilled and respectful ways;
- to practice positive, safe, and healthy behaviors;
- to contribute ethically and responsibly to their peer group, family, school, and community;
- to possess basic competencies, work habits, and values as a foundation for meaningful employment and engaged citizenship. (Greenberg, M., et. al., 2003).

Redefining the healthy Student

- Who is the healthy student?
  - Physical Health (screen for vision, hearing, speech)
  - Academic Health (achievement).
- Mental Health
  - There a strong link between behavior / emotions, mental health and academic performance!

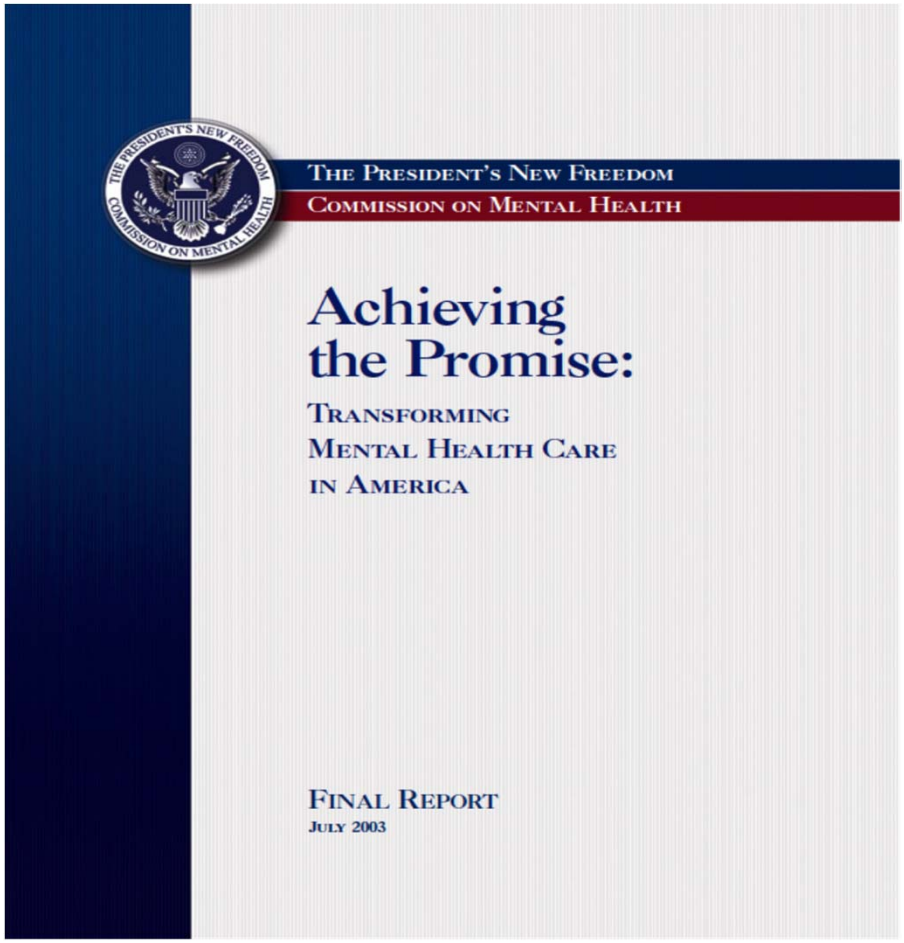
Why we can not afford NOT to

A National Epidemic!!!!!

TWO IMPORTANT REPORTS

- President's Commission on Special Education report (2002) - IDEA
  - Response to Intervention (RtI)

Mental Health Report (2003)



Dear Mr. President:

Yet, for too many Americans with mental illnesses, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery.

Today's mental health care system is a patchwork relic—the result of disjointed reforms and policies. Instead of ready access to quality care, the system presents barriers that all too often add to the burden of mental illnesses for individuals, their families, and our communities.

The time has long passed for yet another piecemeal approach to mental health reform.

(Michael F. Hogan, Ph.D., Chairman, President's New Freedom Commission on Mental Health-July 2003)

Children's Mental Health Needs, Disparities and School-Based Services: A Fact Sheet

Children's Mental Health Needs, Disparities and School-Based Services: A Fact Sheet

Updated February 28, 2012

Retrieved from:

http://www.healthinschools.org/News-Room/Fact-Sheets/MentalHealth.aspx





- **If Untreated, Childhood Disorders Can Lead to a Downward Spiral**
- In 1997, nearly 120,000 preschoolers under the age of six — or 1 out of 200 received mental health services.
- Each year, young children are expelled from preschools and childcare facilities for severely disruptive behaviors and emotional disorders.

U.S. Statistics On Mental Health

- About 20% of children present themselves with diagnosable disorders (i.e., U.S. Department of Health and Human Services, 1999).
- 3–6% of children with serious and chronic disorders (Kauffman, 1997).

YET!!!!

- **Behavior / Emotional screening occurs in less than 2% of districts across the U.S.**

NOW IS THE TIME

4: IMPROVING MENTAL HEALTH SERVICES

MAKE SURE STUDENTS AND YOUNG ADULTS GET TREATMENT FOR MENTAL HEALTH ISSUES

Because !!!!

White House June 2013
National conference on Mental Health

As President Obama said, "We are going to need to work on making access to mental health care as easy as access to a gun." Today, l[illegible] problems receive the treatment they illness are not violent, several recent illness can develop into crisis situatio more than just keep guns out of the hands of people with serious mental illness; we need to identify mental health issues early and help individuals get the treatment they need before these dangerous situations develop.

Less than half of children and adults with diagnosable mental health problems receive the treatment they need.

"…identify mental health issues early…"

MAKE SURE STUDENTS AND YOUNG ADULTS GET TREATMENT FOR MENTAL HEALTH ISSUES

- Three-quarters of mental illnesses appear by the age of 24, yet less than half of children with diagnosable mental health problems receive treatment.
- We can't do this alone. This is a team effort.
  - We need to **train teachers** and other adults who regularly interact with students to recognize young people who need help and ensure they are referred to mental health services.

We must Talk but also Act!!

We can not afford to choose the battles

Mental Health Needs (Illness)

vs

Mental Health (Wellness)

WE MUST FACE BOTH CHALLENGES

Mental Health - Wellness

- Emotional Well-being
  - Life satisfaction
  - Happiness, cheerfulness, peacefulness
- Psychological Well-being
  - Self acceptance, optimism, hopefulness, purpose in life, spirituality, positive relationships
- Social Well-being
  - Social acceptance; beliefs in the potential and goodness of society; personal self-worth; sense of community

Mental Health- Wellness

- We have begun to recognize that behavioral health is important….
  - PBS/PBIS programs
  - Strength based Assessments
    - DECA; DESSA; SEARS
    - PAWS & CAWS (under development—ask me about it)
- **Let's not forget those currently in need of services….there are many.**
  - **BIMAS**

- Common Behavior
- Disorders

Oppositional Defiant Disorder

- Prevalence: 1%- 11% (Avg. 3.5%)
  - 1.4:1 males to females
- Biological, Social and Psychological Factors
- Course: Early signs typically in preschool and gradually increase over time
  - Frequent and persistent pattern of

    - angry/ irritable mood (touchy, easily annoyed),

    - argumentative/ defiant behavior (purposely annoys others, often argues with others),

    - or vindictiveness (spiteful/ hurtful at least once).
  - Lasting at least 6 months
  - Often precedes Conduct Disorder but not always (higher risk when bx is defiant, argumentative and vindictive)
  - Higher risk for anxiety disorders and major depressive disorder when bx is typically an angry- irritable mood
- **Best time for identification is in preschool -> Early Intervention**

ODD cont'd

- Treatment
  - Preschool: Early Intervention (social skills, how to manage anger), individual talk therapy, home visits
  - Adolescence: talk therapy, social skills training, vocational training, relationship building, academic help
  - Parent Management Training
  - Cognitive Problem- Solving Skills Training
  - Medication: help treat the coexisting conditions
- Prognosis/ outcome
  - 2/3 of children who receive treatment will show a significant decrease in their problem behavior over three years
  - ~10% of children with ODD will later develop CD

Conduct Disorder

- Prevalence: 2-10% (median of 4)
  - Rates increase from childhood to adolescence
  - Higher in males than females
- Course: Symptoms typically emerge in childhood or adolescence
  - Initial symptoms are less serious- lying, shoplifting
  - Similar to ODD, bxs are more “cruel”
- Treatment
  - Family Therapy
  - Cognitive Behavioral Therapy
  - Medication (for coexisting conditions)

Conduct Disorder Cont'd

- Treatment
  - Family Therapy
  - Cognitive Behavioral Therapy
  - Medication (for coexisting conditions)

- Prognosis
  - Many individuals with CD- especially adolescent-onset and those with few and milder symptoms are able to have adequate social and occupational adjustments in later life.
  - Early onset (prior to age 10) have an increased risk of criminal behavior, anti-social personality disorder, and substance-related disorders.
  - Severity varies with age due to
    - Increased physical strength
    - Cognitive abilities
    - Sexual Maturity

Attention Deficit Hyperactive Disorder

- Occurs in 5% of children and around 2.5% of adults
- First observed as excessive motor activity as a toddler but can be difficult to identify before the age of 4
- Relatively stable but some can develop antisocial behaviors if left untreated.
  - As children age hyperactivity is less obvious but symptoms such as restlessness, inattention, poor planning and impulsivity persist.
- Best time for identification
  - School age therefore you rule out the “age” factor
  - But, can be identified in preschool

ADHD cont'd

- Treatment
  - Behavior Therapy
  - School Modifications/ Interventions
  - Medications (recommended to try other tx methods first)
- Prognosis/ outcome
- Typically continues into adulthood.
  - When left untreated children can develop negative social relationships and poor academic performance.
  - When treated about half will continue to have symptoms of inattention/ impulsivity as adults but they have strategies to help control the bx.
  - Risk of developing CD with ADHD
  - More likely to have a learning disorder, mood disorder, or anxiety disorder.

Learning Disabilities (SLD)

- Across reading, writing and math ~ 5-15%
- Typically occurs during elementary years
  - Early signs: lack of interest in playing games with language sounds, trouble learning nursery rhymes, mispronunciation, trouble with letters/ days of the week

Grade	Typical signs
Kindergarten	Difficulty learning letter-sound correspondence, fluent word decoding, spelling, or math facts
Grades 1-3	difficulty recognizing and manipulating phonemes, unable to read common one syllable words, trouble remembering number facts or arithmetic procedures. (start avoiding tasks)
Grades 4-6	Mispronounce and/or skip long multisyllable words, difficulty remember dates, names, telephone numbers. Poor spelling and poor written work.
Adolescents	May have mastered decoding but reading fluency is slow and trying, difficulty with reading comprehension and written expression, poor mastery of math facts.

SLD, cont'd

- Prognosis is fair when intervention is early and intense
  - In later life adults with SLD may avoid work activities that demand reading or writing
  - Problems with reading fluency/ comprehension, spelling, written expression and numeracy skills persist into adulthood
- Treatment
  - Interventions that target skill deficit
  - Referral to CSE-> SpED services
- Best time for identification-> EARLY

Internalizing Disorders

Anxiety Disorder	Developmental Age (onset)	Prevalence
Separation Anxiety Disorder	3-4 (preschool years)	4% (1.6%- adolescents)
Selective Mutism	<5 but may not be clinical until schooling begins	.03%-1%
Social Anxiety Disorder	Between the ages of 8-15	7%
Generalized Anxiety Disorder	Varies across life span	.9% Adolescents

- Anxiety disorders differ from developmentally normal fears/ anxiety in that they are excessive or persist beyond developmentally appropriate periods
- Best time for Identification: Early!

Anxiety Disorders Cont'd

- Course:
  - Although the age of onset varies for most anxiety disorders, individuals report feeling stressed throughout their life
  - Typically arises as a result of a stressful event
    - Anxiety persists beyond normal (>1-6 months)
  - Overall course is chronic
    - May wax and wan during times of stress
- Treatments
  - Psychotherapy
    - Cognitive Behavioral Therapy (CBT)
    - Exposure Therapy
    - Mindfulness
  - Medications

Obsessive- Compulsive Disorders

Obsessive- Compulsive Disorders	Developmental Age (onset)	Prevalence
OCD	14 years old	1.2%
Body Dysmorphic Disorder	12-13 years old	2.4% (2.5%-female 2.2%- male)

•Risk Factors:

- Temperamental: greater internalizing symptoms, higher negative emotionality and behavioral inhibition in childhood
- Environmental: Physical and sexual abuse and other stressful/ traumatic events increase the chance of development
- Genetic: greater increase if first-degree relatives have OCD

OCD cont'd

- Course
  - Can be difficult to diagnosis in children as they may not be able to fully voice/ understand their obsessions (mental thoughts)
  - Left untreated remission rates are low (20%)
  - Onset in childhood/ adolescence can lead to a lifetime of OCD; however,
    - 40% of individuals with onset of OCD in childhood/ adolescence may experience remission by early adulthood
- Treatments
  - Psychotherapy:
    - Cognitive Behavioral Therapy (CBT)
    - Exposure and Response Therapy (ERT)
  - Medications:

Depressive Disorders

Depressive Disorders	Developmental Age of onset (average)	Prevalence
Disruptive Mood Dysregulation	~7 years old MUST be before 10	2%-5%
Major Depressive Disorder	Increases with puberty, but can occur earlier	7%
Persistent Depressive Disorder	Childhood/ Adolescence	.5%

- In children the predominant mood may be irritability rather than sadness:
  - Manifesting as over-activity, aggression, antisocial behavior
- Best time for identification: Early!
- Prognosis can be poor when no intervention/ treatment is provided

Course and Treatment

- Course
  - Disruptive Mood Dysregulation: symptoms may change as children mature
  - Major Depressive Disorder: variable, rare to experience remission, longer it is left untreated the higher the chance of personality, anxiety, substance use disorder
  - Persistent Depressive Disorder: has an early onset- associated with a higher likelihood of comorbid personality disorders; fairly poor prognosis
- Treatment
  - Psychotherapy
    - Cognitive Behavior Therapy
    - Interpersonal Therapy
    - Psychodynamic Approach
  - Medication

- Anxiety, OCD and Depressive disorders all have an increased risk for suicide…
- The comorbidity between these three increases that risk…

We need to be cognizant of this and refer/ intervene with students who are suffering.

Autism Spectrum Disorder

- Prevalence: 1%, 1 in 68 children (1 in 42 boys, 1 in 189 girls)
- Signs are typically recognized during the first 12-24 months of age
  - May include early developmental delays, losses of social or language skills.
  - Delayed language development, lack of social interest or unusual social interactions, odd play, unusual communication patterns.
  - Odd/ repetitive behaviors become more apparent over time.

Autism Cont'd

- Treatment
  - ABA
  - Occupational Therapy
  - Medication (for coexisting conditions)
- Autism is a lifelong disorder but as children age they "gain" new skills (i.e. interest in social interactions)
  - Small portion of ASD population will "decline" with time (behaviors become worse over time)
- Best time for identification-> EARLY INTERVENTION

Mental health Needs

- In 2000, there were **70.4** million children 17 or under in the US (26 % of the population).
- **64 %** were white, non-Hispanic;
- **16** % Hispanic,
- 15 % African-American,
- 4 % Asian-Pacific, and
- 1 % American Indian/Alaskan Native.

- In 2010, there were **74.2** million children 17 or under in the US (26 % of the population).
- **54 %** were white, non-Hispanic;
- **23** % Hispanic,
- 14 % African-American,
- 4 % Asian-Pacific, and
- 5% all others

Children's Mental Health Needs, Disparities and School-Based Services: A Fact Sheet

Children's Mental Health Needs, Disparities and School-Based Services: A Fact Sheet

Updated February 28, 2012

U.S. Statistics - CDC

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Supplement / Vol. 62 / No. 2
May 17, 2013

Mental Health Surveillance Among Children — United States, 2005–2011



Of the population ages 9—17

- 21 % experienced the signs and symptoms of a DSM disorder during the course of a year.
- 11 % experienced significant impairment
- 5 % experienced extreme functional impairment.
- **On average, only one-fourth of children in need of mental health care get the help they need.**

U.S. Statistics On Mental Health

Social-emotional problems among young children* are common.

- Between 9.5 and 14.2 percent of children between birth and five years old experience social-emotional problems that negatively impact their functioning, development and school-readiness.[3]
- Approximately 9 percent of children who receive specialty mental health services in the United States are younger than 6 years old.[4]
- Boys show a greater prevalence of behavior problems than girls.[5]

U.S. Statistics On Mental Health

Mental health disorders in young children

Disorder	Prevalence
Anxiety Disorders	1 to 11%
Simple Phobias	1 to 11%
Oppositional Defiant Disorder	1 to 26%
Conduct Disorder	1 to 5%
Attention Deficit/Hyperactivity Disorder	1 to 7%

Disparities

- Minorities have less access to mental health services and are less likely to receive needed care.
- Minorities in treatment often receive a poorer quality of mental health care.
- Minorities are underrepresented in mental health research.

WE NEED TO ACT !!!
Importance of mental health services

- **Students with behavioral/emotional problems:**

  - lower grades

  - poorer reading skills

  - drop-out rate > 50%

  - worst social & academic outcomes of any disability group (Bradley, Dolittle, & Bartolotta, 2008)

- **Loss of instructional time**
- **Teacher Attrition**

WE NEED TO FIND….

- **WHO NEEDS HELP NOW**
  - **Universal screening**
  - **Progress monitoring (PM)**
    - **Makes us accountable**
    - **Helps us build relationships with families**
- **We Know who to ask for help…**
  - **Teachers, Parents, the Kids**
- **We Know where to implement effective programs...**
  - Schools are the ideal setting for large-scale, broad based mental health screening of children and adolescents (Wu et al., 1999)

Why Build Relationships?



•If you have the families next to you, supporting you and observing your efforts for their child, you may not have to deal with the following factors that contribute to conflict…

Factors That Contribute to Parent-School Conflict in Special Education

- *lack of trust.?*
- *Relationships are strained with building staff/leadership.*
- *Some parents will argue that there "Must be somewhere, something else for their student" However, "Special Ed is <u>not</u> a place".*
  - *Clash in how school sees student and how parents see student.*

Factors That Contribute to Parent-School Conflict in Special Education

- *Parents report that Gen Ed is unwilling or unable to support students with IEPs.*
- *Reciprocal valuation not present between stakeholders.*
- *Student behavior/social emotional/mental health are areas of significant concern.*
- *Strategies/interventions at each tier are lacking.*

Factors That Contribute to Parent-School Conflict in Special Education

- *Instructional rigor/differentiation for students with an IEP is a concern. Students are not making progress and progress monitoring is lacking.*
- *PD does not reach all staff and is not creating sustainable improvement. Lack of teacher effectiveness impact student outcomes.*

Factors That Contribute to Parent-School Conflict in Special Education

- *Knowledge of Special Ed by both parents and staff.*
- *Secondary transition services are the erosion of vocational/career opportunities challenges student success.*
- *Building level problem solving teams (RtI or MTSS) are not well defined.*

Factors That Contribute to Parent-School Conflict in Special Education

- *Lack of follow through with agreed upon plans at the school.*
- *Procedural non-compliance by school.*
- *Lack of clear and frequent communication between school and parent.*

WE NEED TO FIND….

- **WHO NEEDS HELP NOW**
  - **Universal screening (the new and improved NCLB)**
  - **Progress monitoring (PM)**
    - **we must be accountable**
    - **use PM to build relationships**

- **We Know who to ask for help…**
  - **Teachers, Parents, the Kids**

- **We Know where to implement effective programs...**
  - Schools are the ideal setting for large-scale, broad based mental health screening of children and adolescents (Wu et al., 1999).



Role of Schools and School Psychologists

Schools are in a key position to identify mental health problems early and to provide a link to appropriate services. Every day more than **52 million students** attend over 114,000 schools in the U.S. When combined with the **six million adults** working at those schools, almost **one-fifth of the population** passes through the Nation's schools on any given weekday. Clearly, strong school mental health programs can attend to the health and behavioral concerns of students, reduce unnecessary pain and suffering, and help ensure academic achievement.

Negative Long term outcomes

- 75% of children with significant **externalizing behaviors** (severe tantrums, disobedience) eventually engage in predictable and serious law breaking and antisocial behavior (e.g., Reid, 1993).

- **Internalizing disorders** (anxiety, depression) result in increased rates of pathology and lower rates of socialization and academic attainment (Hops, Walker, & Greenwood, 1988).
  - ¾ of students with EBD have been suspended or expelled from school (National Longitudinal Transition Study 2 [NLTS2], 2004).
  - rates increase from elementary to middle to high school transition.

THE REMEDY?

Early Identification

- **early identification & intervention** appears to be the "**most powerful course of action** for ameliorating life-long problems associated with children at risk for [EBD]" (p. 5). Hester et al. (2004)
- **Younger children** are more likely to be responsive to and maintain the positive outcomes from early prevention and intervention programs (Bailey, Aytch, Odom, Symons, & Wolery, 1999
- intervening early can **interrupt the negative course** of some mental illnesses.

GOAL 4

Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice.

RECOMMENDATIONS

4.1 Promote the mental health of young children.

4.2 Improve and expand school mental health programs.

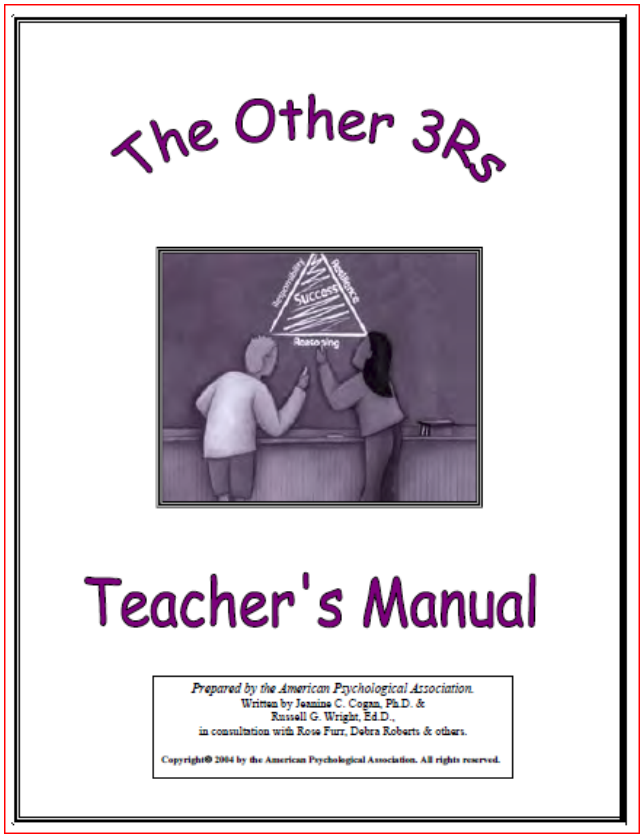
4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.

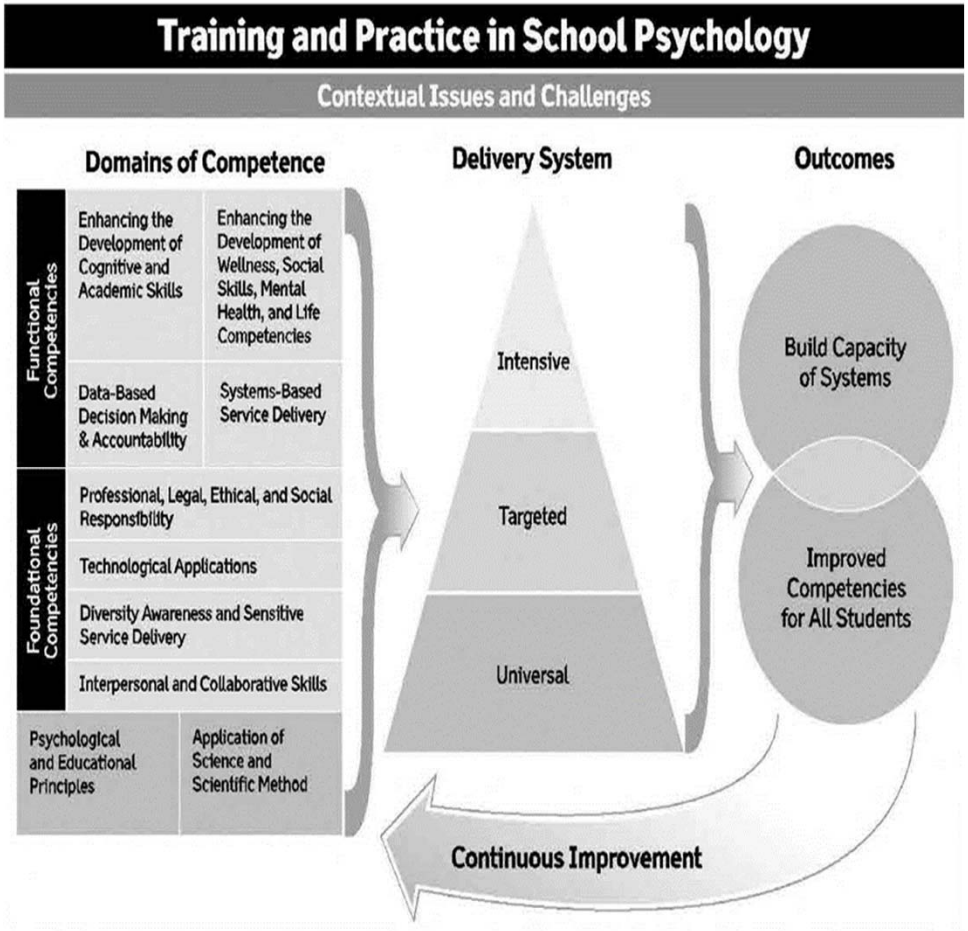
4.4 Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.

What have we been doing?

10 years plus in the making!!!

What have we been doing?





Resposibility

Resilience

Reasoning

Mental Disorders …

- *"..are an important public health issue in the United States because of their prevalence, early onset, and impact on the child, family, and community, with an estimated total annual cost of $247 billion.*
- *"..surveillance during 1994–2011 has shown the prevalence of these conditions to be increasing"*

(CDC, May 2013)

APA – 3Rs

The Other 3Rs



Teacher's Manual

Prepared by the American Psychological Association.
Written by Jeanine C. Cogan, Ph.D. &
Russell G. Wright, Ed.D.,
in consultation with Rose Furr, Debra Roberts & others.

Copyright© 2004 by the American Psychological Association. All rights reserved.

APA – 3Rs

Why Are the Other 3Rs Important?

Fundamental Research Underpinnings

The Other 3Rs project is based on two lines of research findings:

1. **Responsibility, resilience,** and **reasoning** can be learned. Although some people suggest that these three skills are innate human traits, the prevailing understanding among researchers is that they are skills that can be taught and learned.

2. Once they are learned, **responsibility, resilience,** and **reasoning** will lead to measurable increases in academic achievement. Research shows that these learnable attributes are associated with student success in academics and life.

APA – 3Rs

Possible outcomes for students from learning the Other 3Rs include:

- ✓ Improved study skills,
- ✓ Improved attendance,
- ✓ Improved classroom climate,
- ✓ Improved relationships,
- ✓ Increased collaboration and
- ✓ Increased achievement.

Additionally, these attributes may also support teacher's ability to manage the classroom.
For example, when students take responsibility for their own and each other's learning they contribute to a classroom climate of collaboration.

APA – 3Rs



Being accountable for one's own actions and inactions and the consequences of those actions and inactions.

- ✓ **Personal responsibility**
  - "It's up to me to create what I want."
  - "It's up to me to make it happen."
  - "How I act matters."
- ✓ **Academic Responsibility**
  - " Good grades result from my efforts"
  - " If I want to learn it is up to me"
  - " If I don't understand, I have to ask."
- ✓ **Social Responsibility**
  - **Considering other peoples' points of view.**
    - "I care about what you have to say"
  - **Concern for the common good.**
    - "I care about what is good for all of us, not just for me."
  - **Giving help and seeking help.**
    - "I will help you."
    - "I need help."



Good grades result from my efforts!

APA – 3Rs

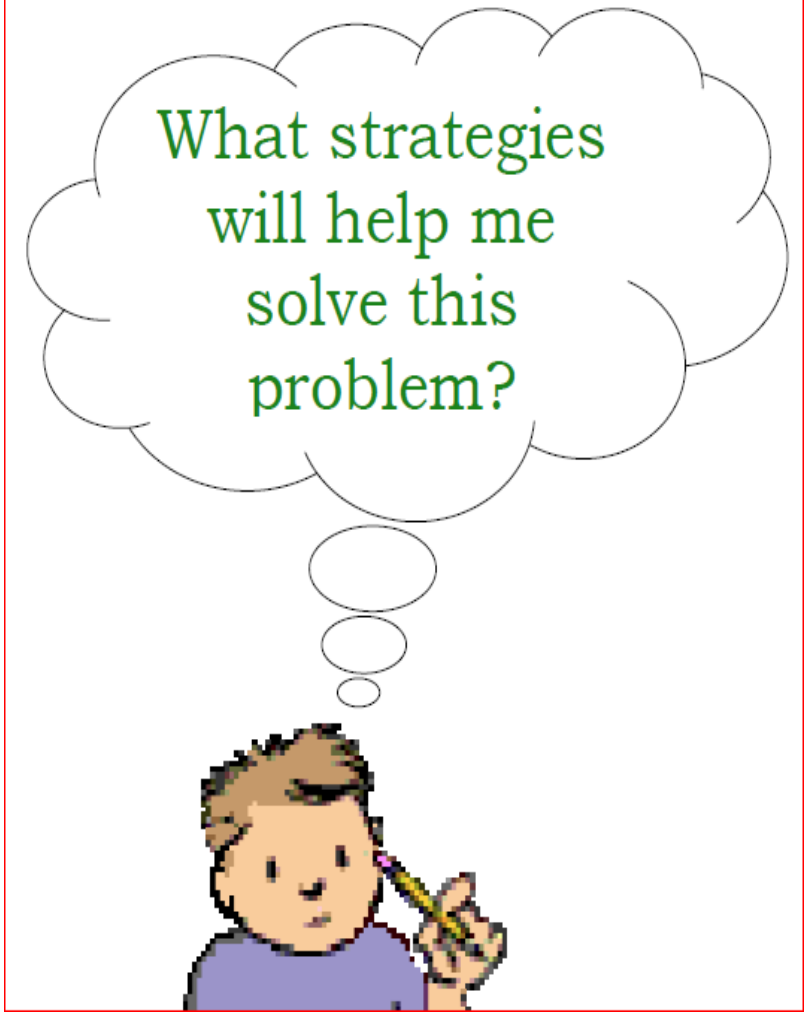
Reasoning



Thinking that utilizes explicit and/or implicit rules.

Reasoning in the Other 3Rs program focuses on effective problem solving particularly with regard to academic challenges.

✓ **Rules**
"If I am going to think clearly about solving a problem (or reaching a goal) I need clear rules to follow."



APA – 3Rs



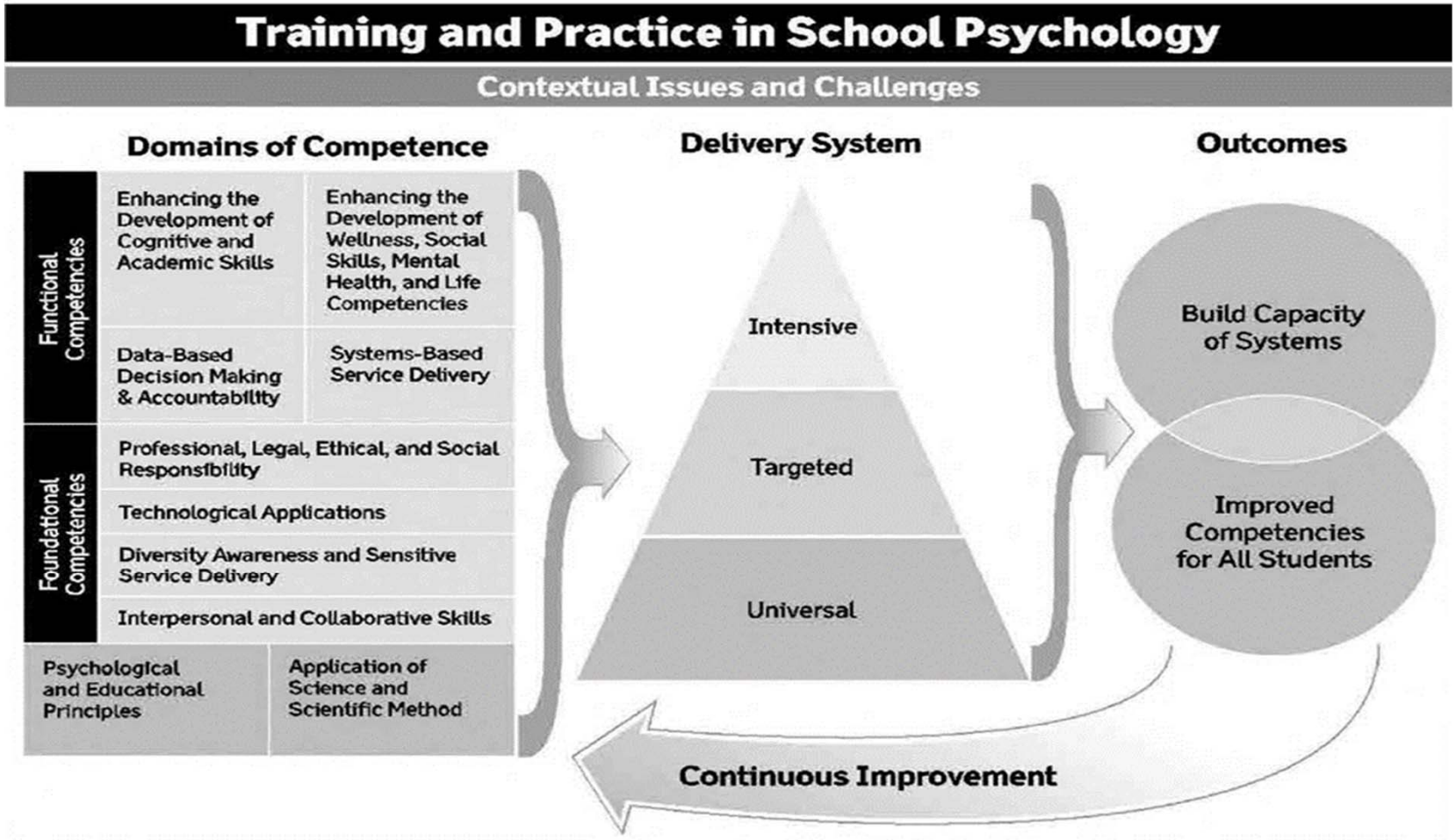
Competently surmounting challenges, both inside and outside of school.

- ✓ **Challenges & difficulties are a normal part of life:**
  - "Challenges are normal. We all have them."
- ✓ **Persistence/Determination**
  - "If at first I don't succeed I will try again."
  - A cautionary note for this message is that people can take their determination to an extreme and become obsessive about reaching a goal. Encourage students to find a balance.
- ✓ **View obstacles as challenges to be overcome** (approach challenges by keeping things in perspective and seeing them as opportunities for learning).
  - "What can I learn from this?"
  - "How can I approach this challenge?"



Challenges are normal. We all have them.

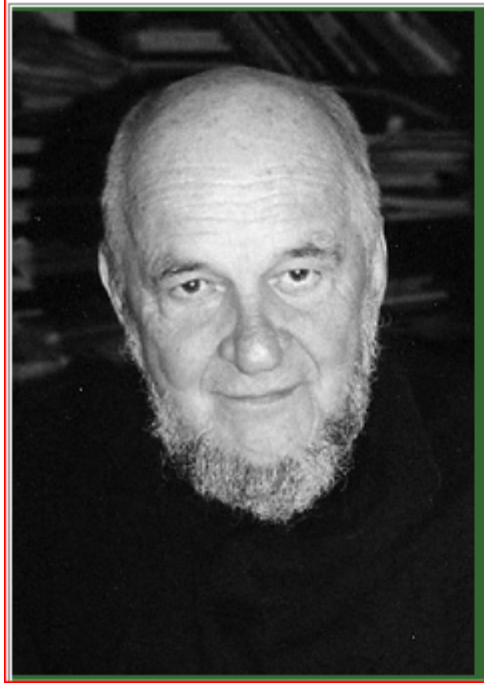
What have we been doing?
NASP



A Public Health Model

http://www.uvm.edu/~galbee/bio.htm

George W. Albee



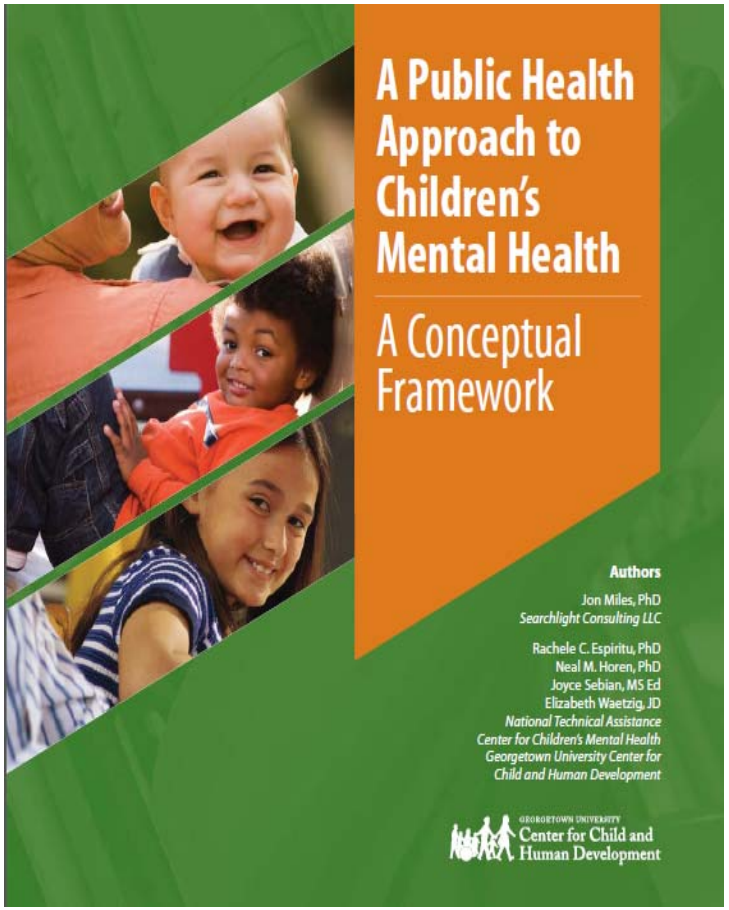
George W. Albee, Ph.D.
Professor Emeritus
Department of Psychology
University of Vermont
Burlington, Vermont 05405
Tel: (802) 656-2670

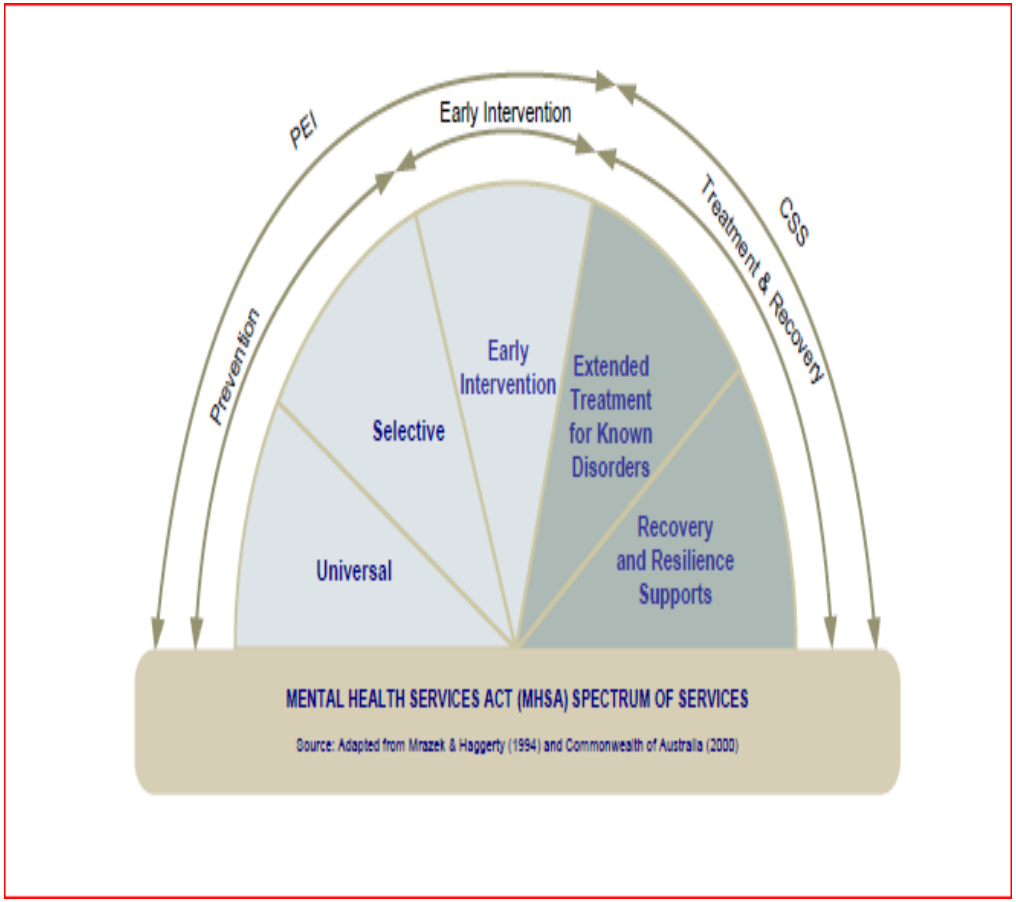
7157 Longboat Drive North
Longboat Key, FL, 34228
Email: gwalbee@webtv.net

C.V.

"*No mass disorder afflicting mankind is ever brought under control or eliminated by attempts at treating the individual.*“

A Public Health Approach

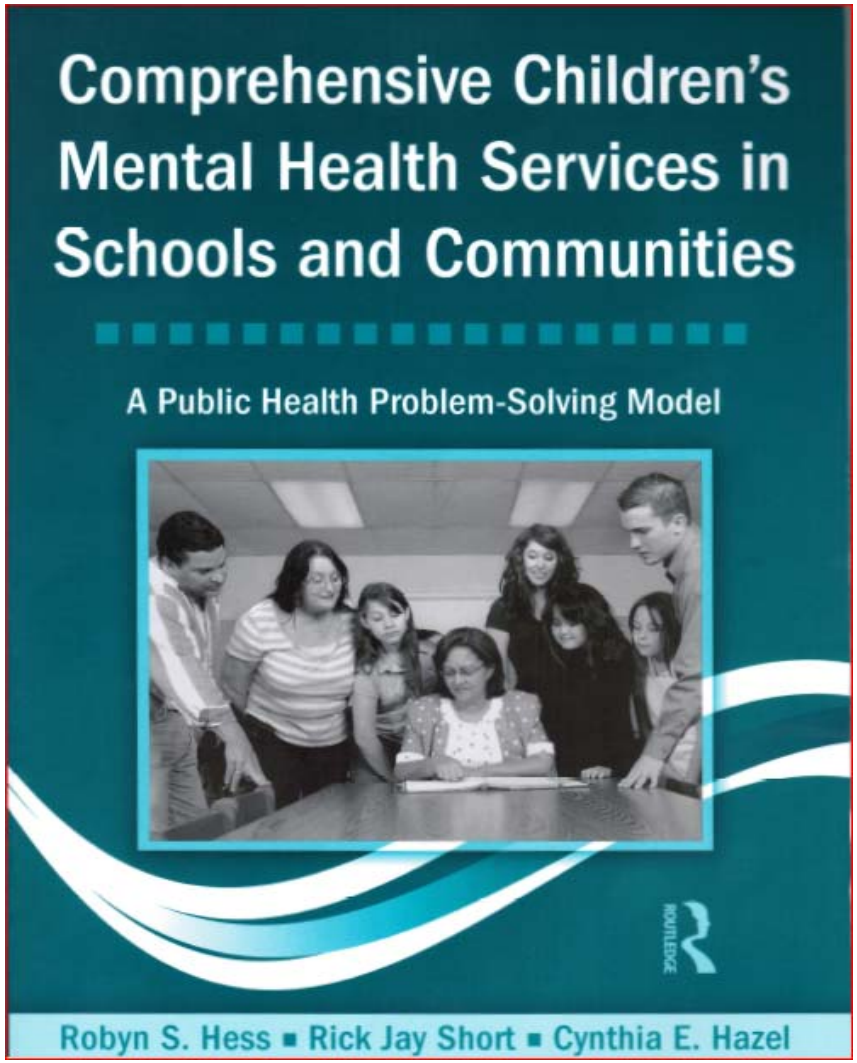




Levels of Prevention

- Universal:
  - Comprehensive multifaceted program
  - Targets entire student population
    - PBIS; Second Step, Strong Kids, etc.
- Selective
  - Services provided to a specific group (not individuals)
  - Identified through common risk factor (i.e. poor attendance)
  - Can be focused on group or surrounding system
- Indicated
  - Individuals displaying symptoms of mental health difficulties
  - May be comprehensive or targeted
  - Specific to individual

Assessment in a PHM



- A core function of the PHPSM
- Population based assessments (e.g., screening)
- Goal is to identify elements that can be changed, and
- Changes in these elements result in improved outcomes for the population

Other proposed solution(s)

RtI

PBS/PBIS

MTSS

Responsiveness to Intervention

•Academic Systems

•Intensive, Individual Interventions
•Individual Students
•Assessment-based
•High Intensity

•1-5%

•Targeted Group Interventions
•Some students (at-risk)
•High efficiency
•Rapid response

•5-10%

•Universal Interventions
•All students
•Preventive, proactive

•80-90%

•Behavioral Systems

•1-5%

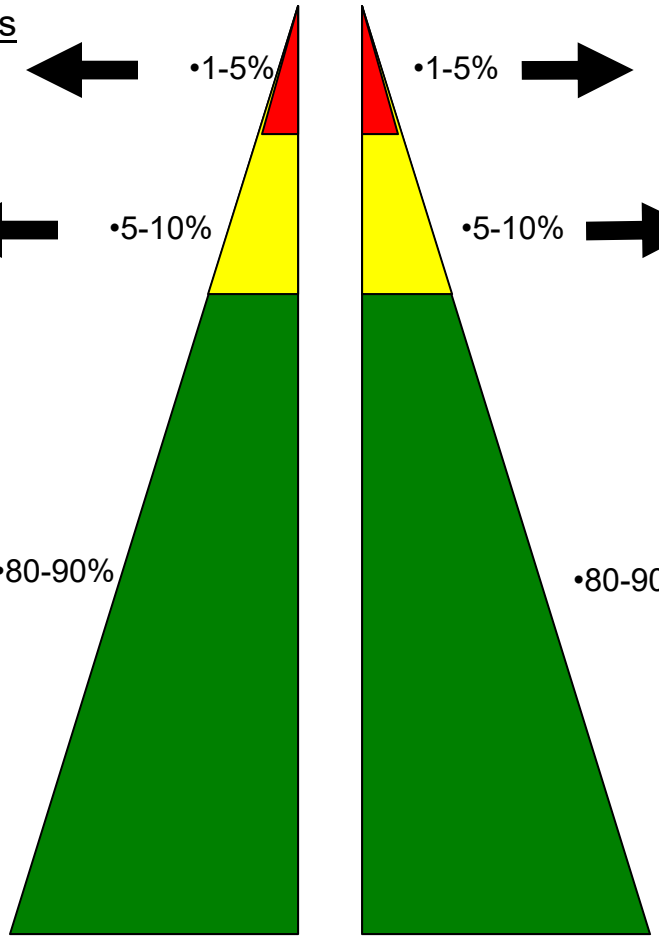
•Intensive, Individual Interventions
•Individual Students
•Assessment-based
•Intense, durable procedures

•5-10%

•Targeted Group Interventions
•Some students (at-risk)
•High efficiency
•Rapid response

•80-90%

•Universal Interventions
•All settings, all students
•Preventive, proactive

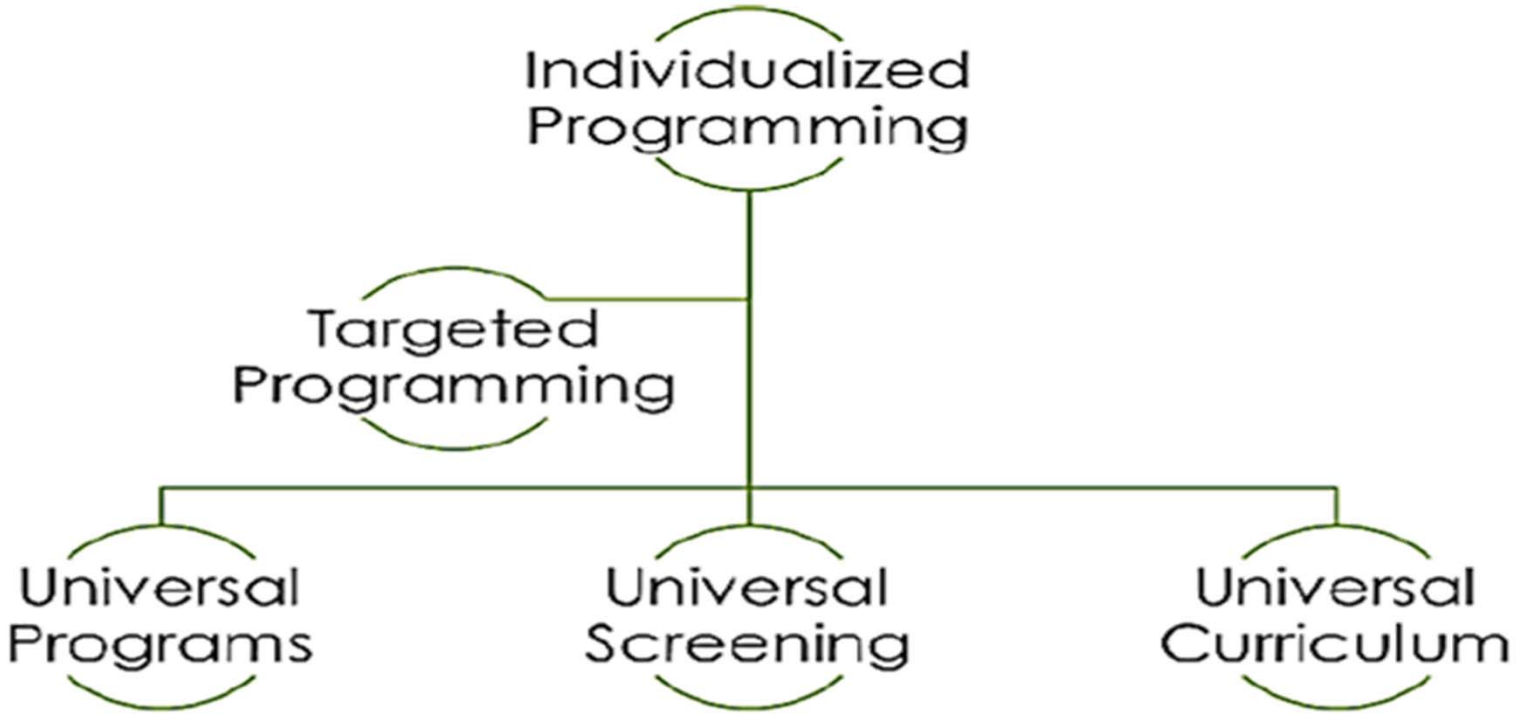


What is the R and the I in RTI: Interventions with Evidence and Determining Response

Kimberly J. Vannest, PhD

Pearson Webminar, February 2013

Big Picture



Levels of Intervention

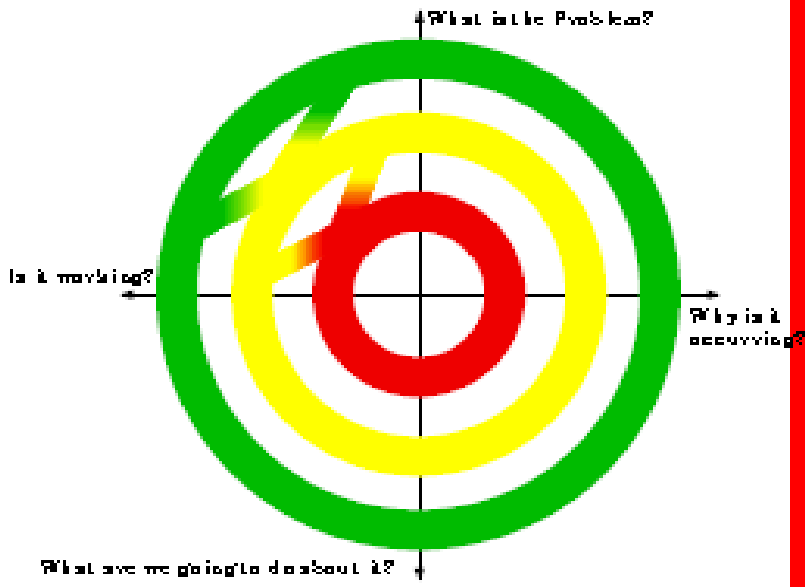
EXPANDED

TARGETED

UNIVERSAL



Teaching and Supporting ALL STUDENTS' Academic and Social Competency Success



Tier 1: Prevention for All

Tier 2: Strategic Instruction and Intervention Services and Supports

Tier 3: Intensive Need or Crisis Intervention Services and Supports

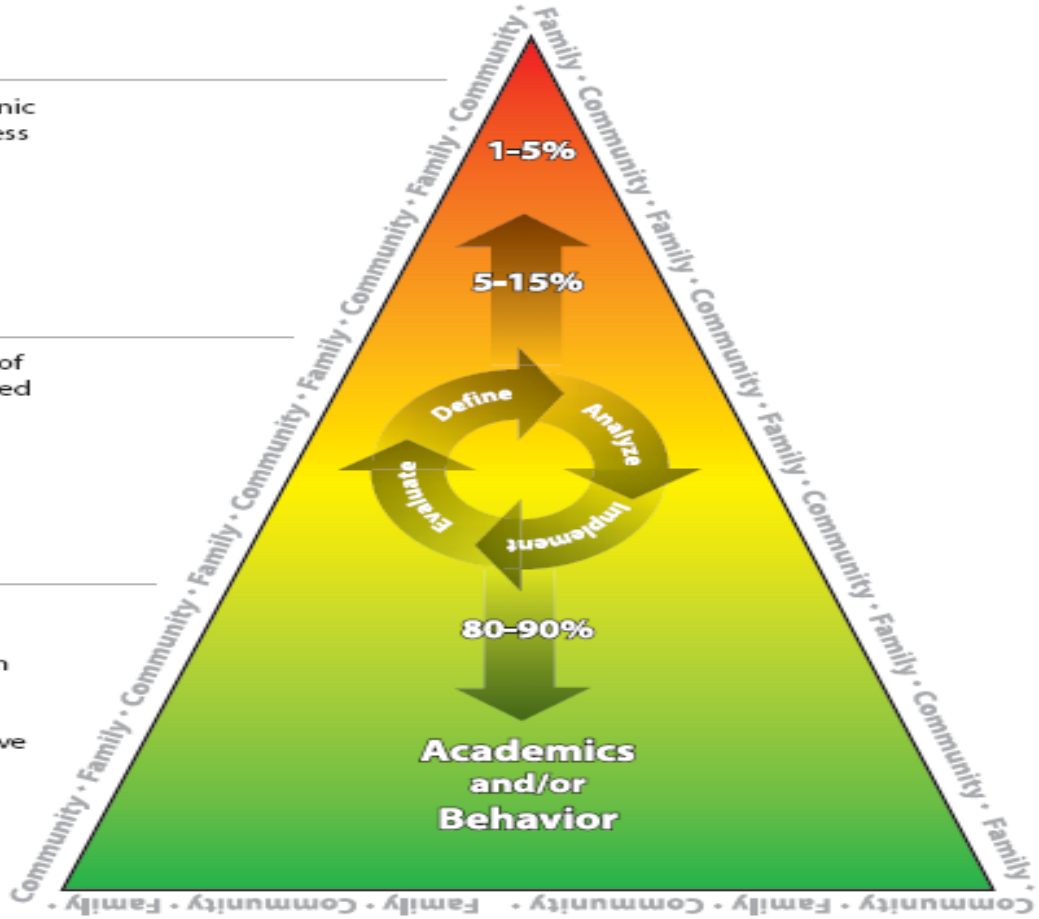
Response to Intervention (RtI)

Colorado Multi-Tiered Model of Instruction & Intervention

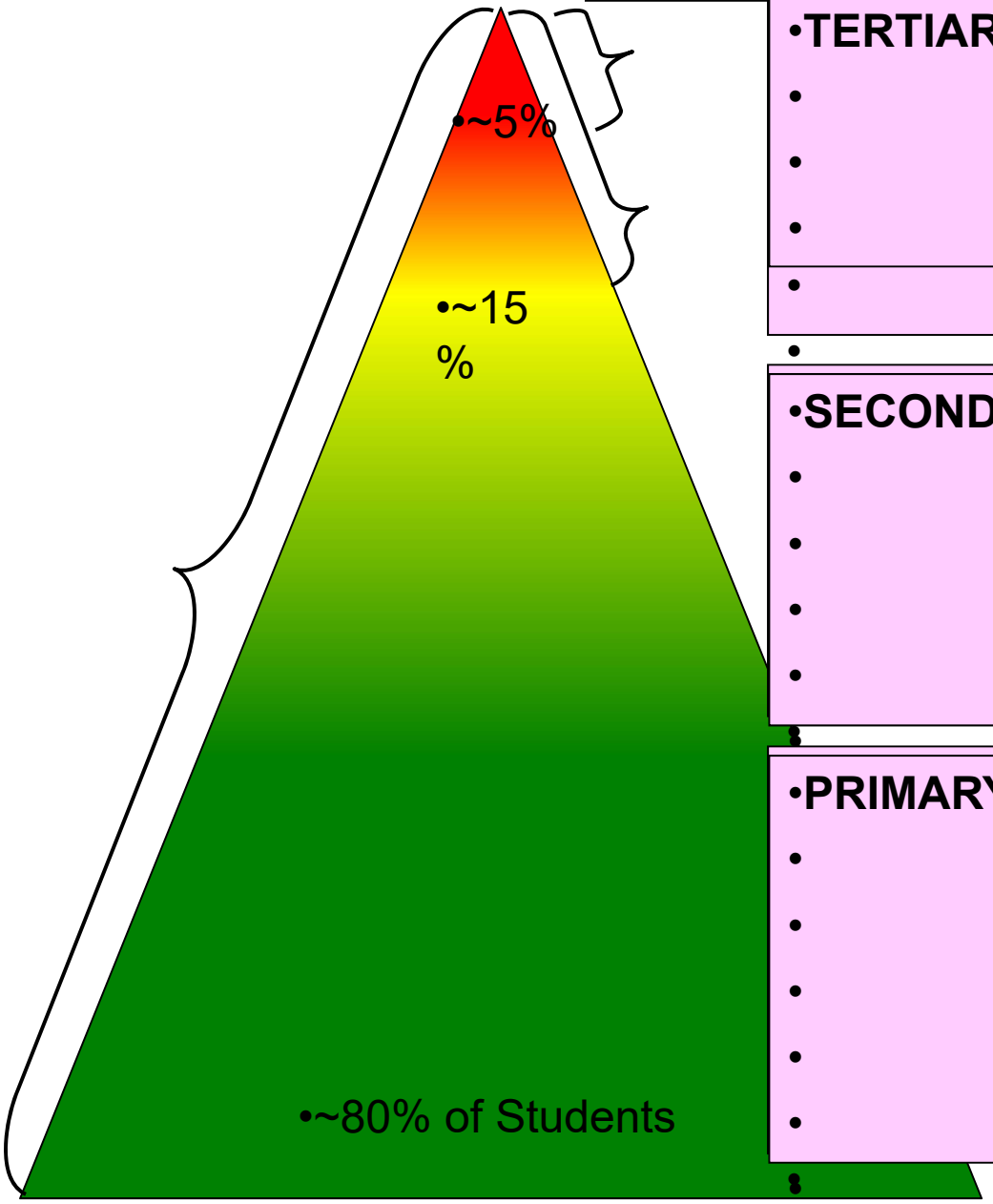
Intensive Level
Interventions are provided to students with intensive/chronic academic and/or behavior needs based on ongoing progress monitoring and/or diagnostic assessment.

Targeted Level
Interventions are provided to students identified as at-risk of academic and/or social challenges and/or students identified as underachieving who require specific supports to make sufficient progress in general education.

Universal Level
ALL students receive research-based, high quality, general education that incorporates ongoing universal screening, progress monitoring, and prescriptive assessment to design instruction. Expectations are taught, reinforced, and monitored in all settings by all adults. Discipline and other data inform the design of interventions that are preventative and proactive.



•ESTABLISHING CONTINUUM of SWPBS—PBIS web site



•TERTIARY PREVENTION

-
-
-
-

•SECONDARY PREVENTION

-
-
-
-

•PRIMARY PREVENTION

-
-
-
-
-

Academic-Behavior Connection

- "Viewed as outcomes, achievement and behavior are related; viewed as causes of each other, achievement and behavior are unrelated. In this context, teaching behavior as relentlessly as we teach reading or other academic content is the ultimate act of prevention, promise, and power underlying PBS and other preventive interventions in America's schools."

- Algozzine, Wang, & Violette (2011), p. 16.

Algozzine, B., Wang, C., & Violette, A.
academic
M
Mc
Nel
Wang
100-109.

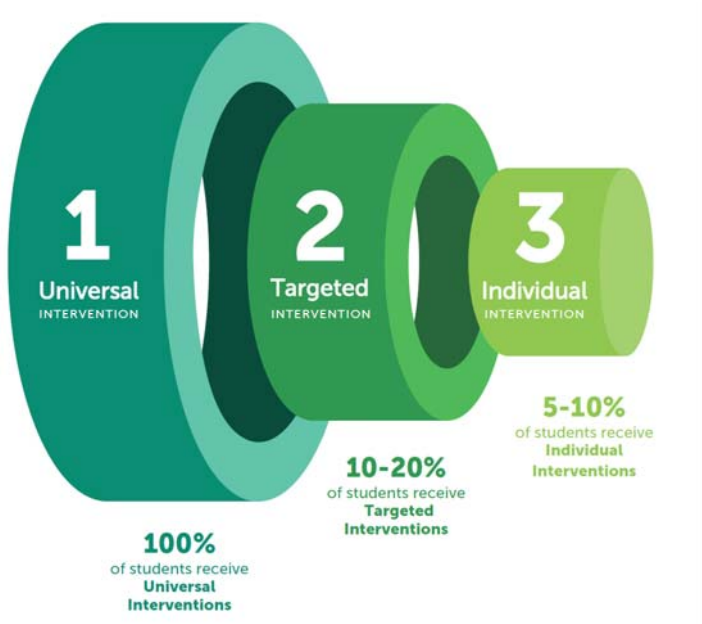
MTSS for Behavior

or

Delivery of Comprehensive Behavioral Health Services for ALL students

MTSS for Behavior or Delivery of Comprehensive Behavioral Health Services for ALL students

A Comprehensive Behavioral Health Model (CBHM) is a district wide response to the need for behavioral health support for all students in our schools. CBHM is a multi-tiered system designed to give all students access to high-quality behavioral and mental health support.



Florida's Multi-Tiered System of Supports

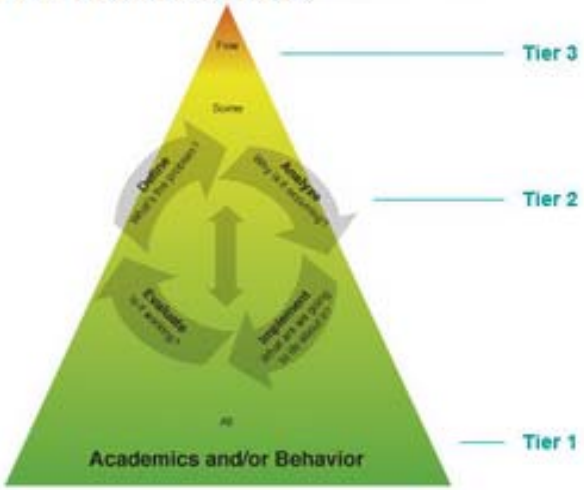
Florida's MTSS

Response to Intervention (RtI) has been described in Florida as a multi-tiered system of supports (MTSS) for providing high quality instruction and intervention matched to student needs using learning rate over time and level of performance to inform instructional decisions.

Phase 1 of implementation for Problem-solving and Response to Instruction/Intervention, came to a close in 2011. Phase II of the statewide implementation of a MTSS has emerged. Read more about the history and future of MTSS in Florida.

Multi-Tiered Framework

This system is depicted as a three-tiered framework that uses increasingly more intense instruction and interventions matched to need.



Problem-Solving Process

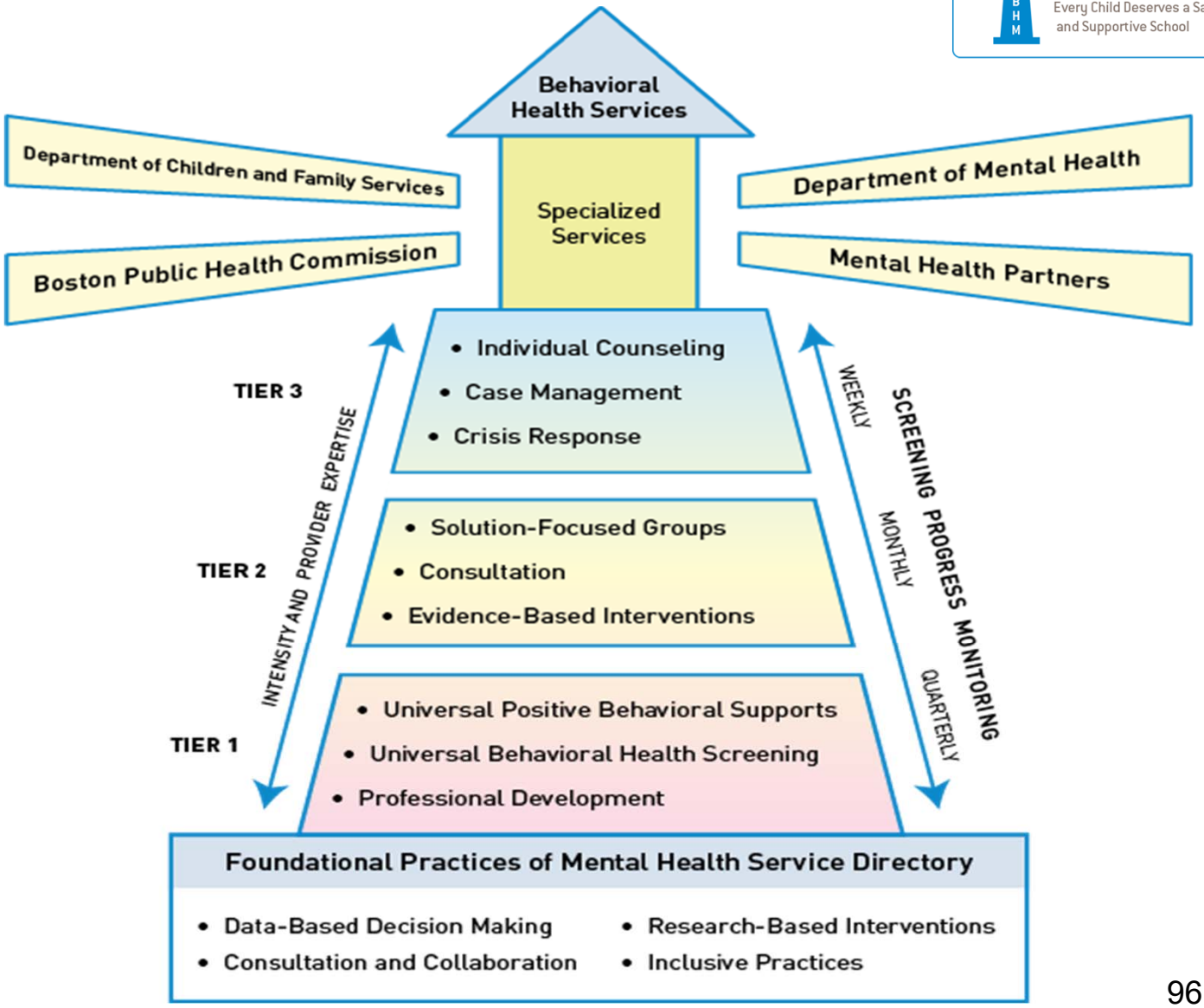
The problem-solving process is critical to making the instructional adjustments needed for continual improvement.



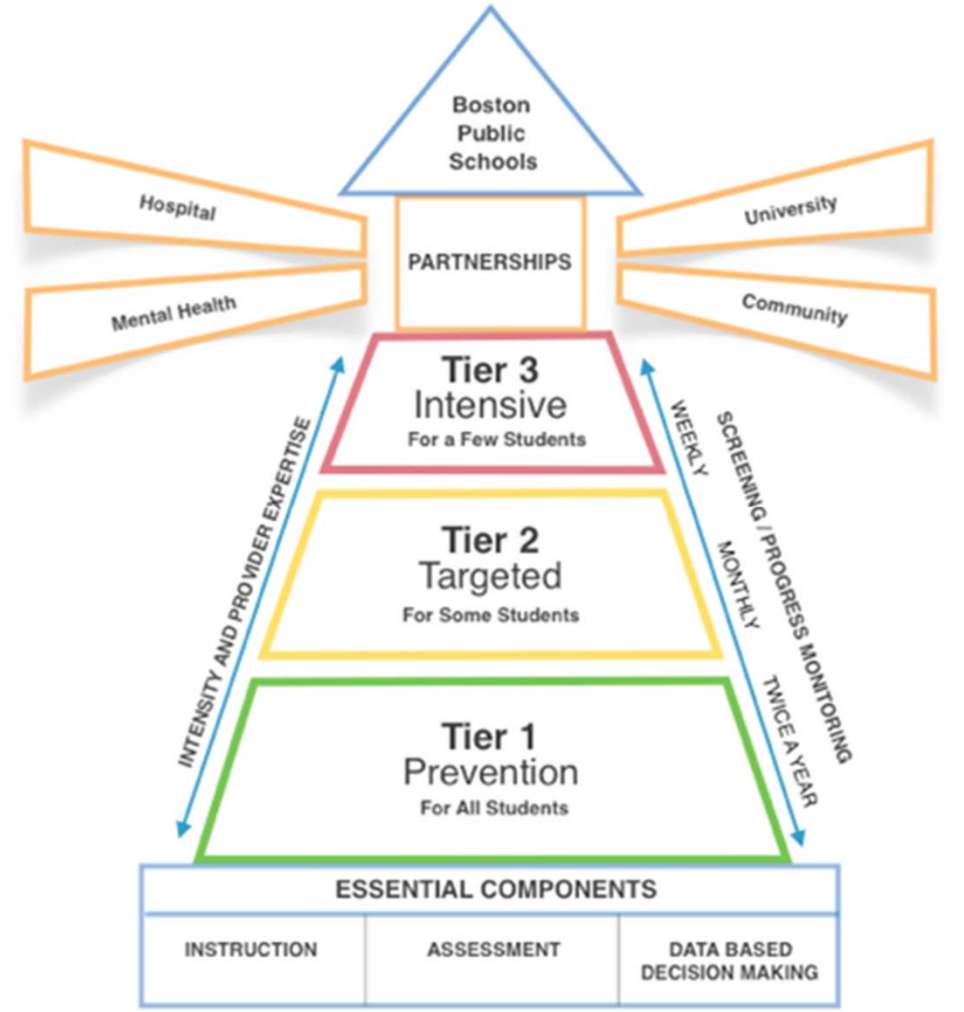
Department of Elementary & Secondary Education MTSS



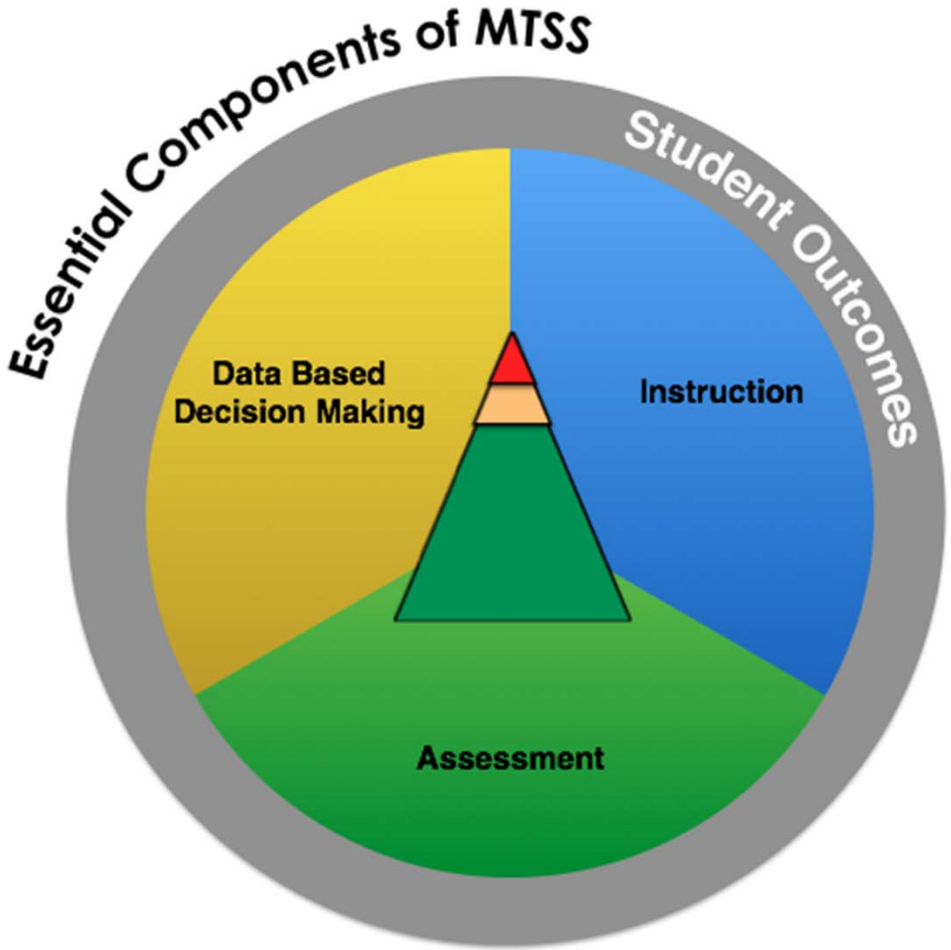
BPS Comprehensive Behavioral Health Model



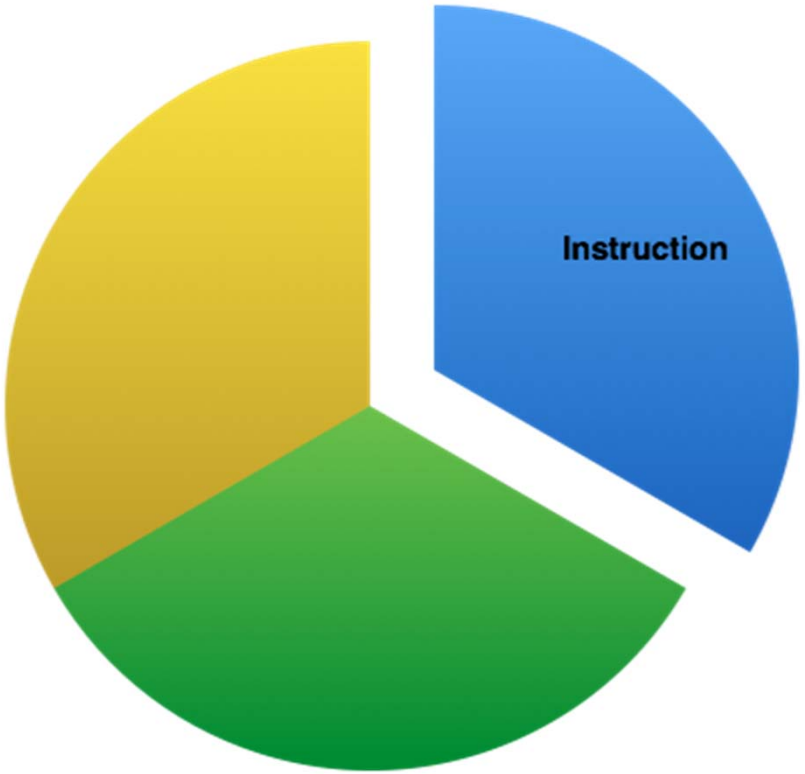
BPS Comprehensive Behavioral Health Model



Boston Public Schools
Every Child Deserves a Safe and Supportive School


Essential Components of MTSS
Student Outcomes
Data Based
Decision Making
Instruction
Assessment

	WHAT	WHY	HOW
INSTRUCTION	• School Wide Positive Behavioral Interventions and Supports (SWPBIS)	Students need to know behavioral expectations throughout the school building in order to be successful in the school environment	Organize the school environment to prevent problem behaviors and reinforce positive behaviors
	• Social Emotional Learning (SEL) Curricula	Students need social and emotional skills to successfully navigate interactions with peers and adults	Instruction in fundamental social skills, such as empathy, relationship building, and conflict management
ASSESSMENT	• Universal Screening	Schools need universal data from all students to understand the strengths of instructional programming, as well as areas of need.	Collect objective information that can be used to guide instruction at multiple levels (e.g. school, grade, class, and individual student)
DATA BASED DECISION MAKING	• Problem Solving Teams & Data Based Decision Making	School teams need to understand how to use universal assessment data to make systemic decisions about instruction	School teams are effectively organized to promote efficient data-based decision making.


Instruction

Tier 1 Instruction



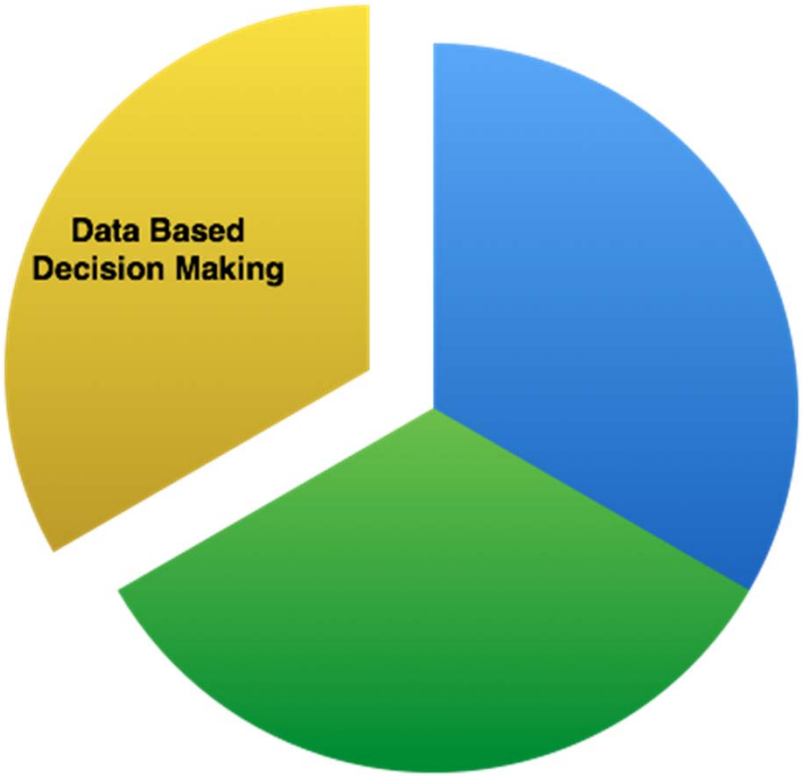
+

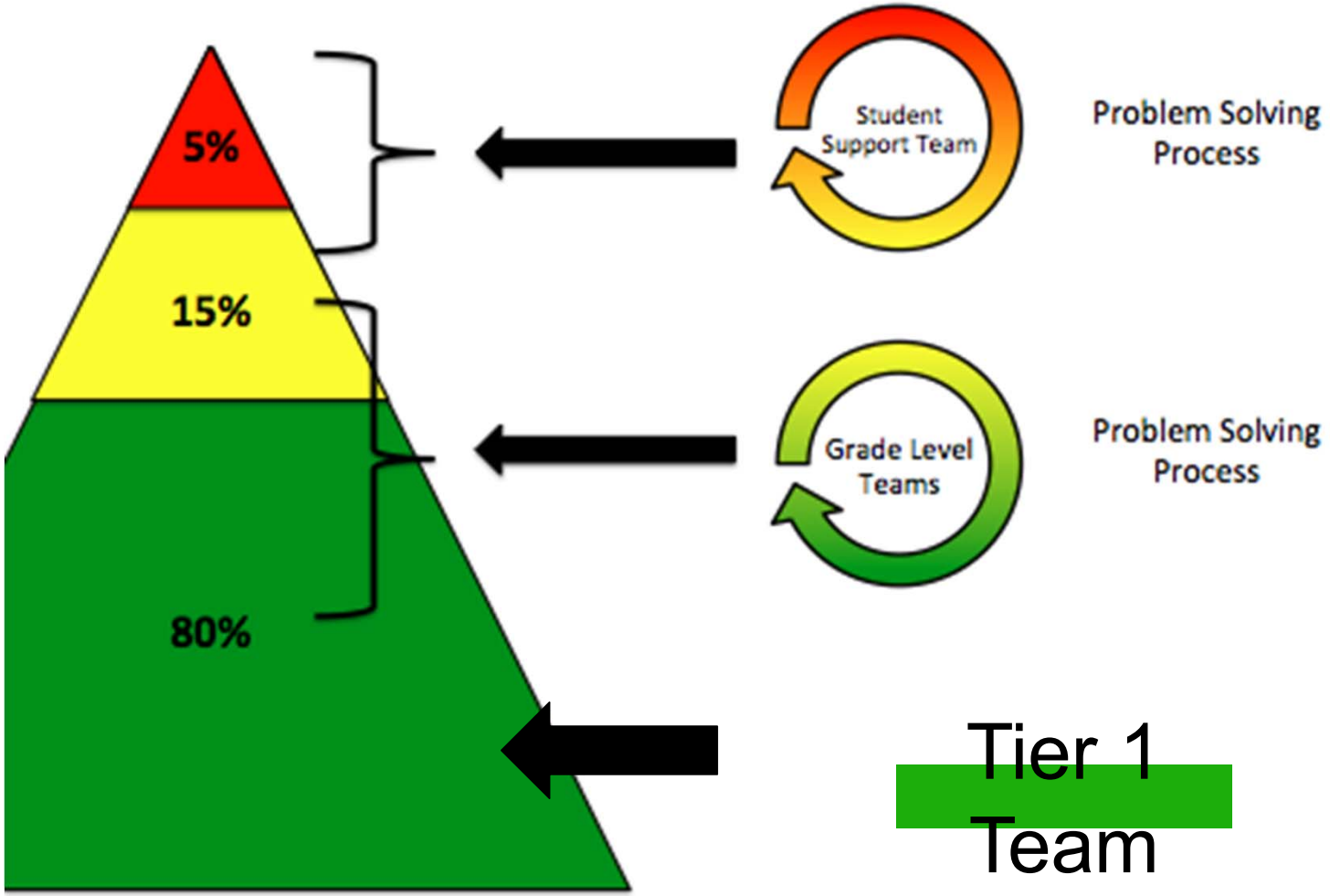
1. • EXPECTATIONS DEFINED
2. • EXPECTATIONS TAUGHT
3. • REINFORCEMENT SYSTEM
4. • CONSEQUENCE SYSTEM
5. • DATA SYSTEM

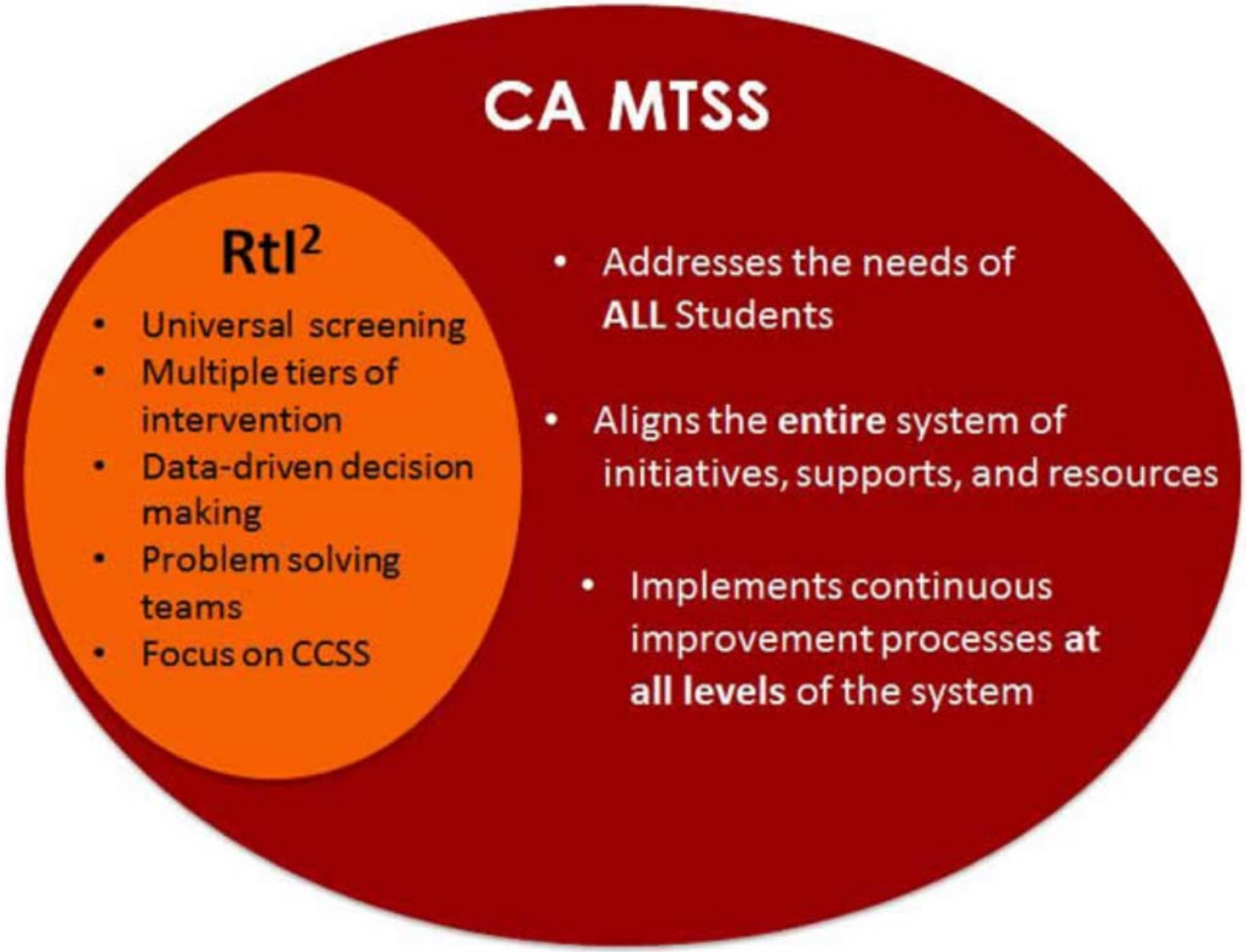
"Social Emotional Learning"

"P.B.I.S."
Positive Behavioral Interventions & Supports

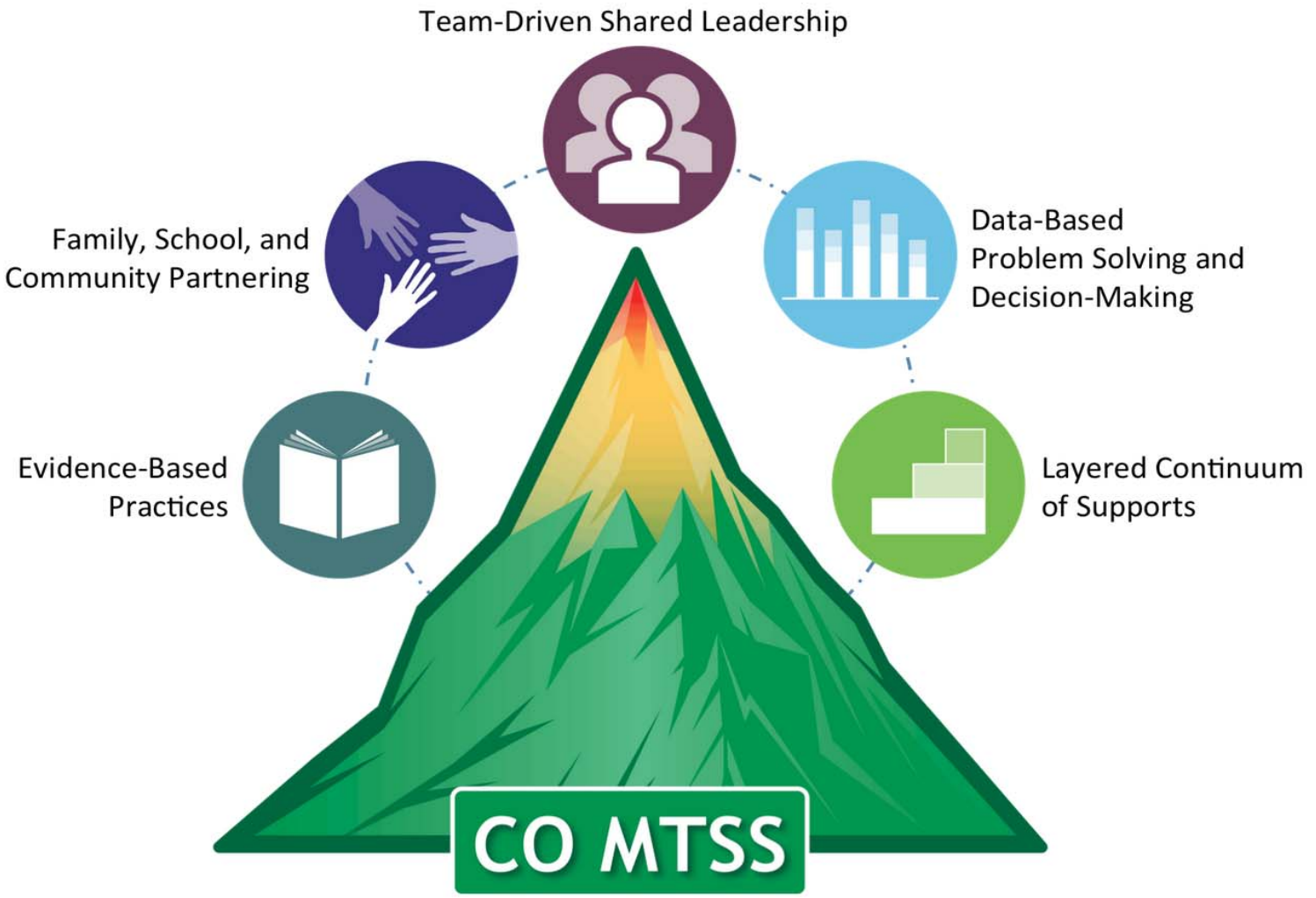

Assessment


Data Based
Decision Making


5%
15%
80%
Student Support Team
Problem Solving Process
Grade Level Teams
Problem Solving Process
Tier 1 Team


CA MTSS
RtI2
• Universal screening
• Multiple tiers of intervention
• Data-driven decision making
• Problem solving teams
• Focus on CCSS
• Addresses the needs of ALL Students
• Aligns the entire system of initiatives, supports, and resources
• Implements continuous improvement processes at all levels of the system

Multi-Tiered System of Supports (MTSS)



MTSS – an overview from CDE



MTSS Essential Components

- Shared Leadership
- Data-Based Problem Solving and Decision Making [Universal Screening and Progress Monitoring]
- Layered Continuum of Supports
- Evidence-Based Instruction, Intervention, and Assessment Practices
- Family, School, and Community Partnering

1. Shared Leadership



MTSS Essential Components

- Shared Leadership
- Data-Based Problem Solving and Decision Making [**Universal Screening and Progress Monitoring]**
- Layered Continuum of Supports
- Evidence-Based Instruction, Intervention, and Assessment Practices
- Family, School, and Community Partnering

Data-Based Problem Solving and Decision Making

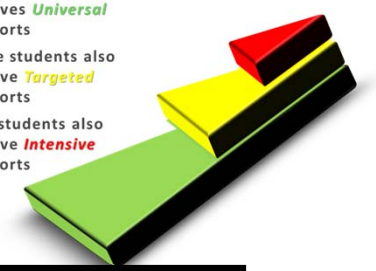
A process used by stakeholder teams from multiple settings to analyze and evaluate information related to planning and implementing effective instructional strategies matched to student needs (CDE)

Data Based Problem Solving



Layered system of support

- Every student receives *Universal* supports
- Some students also receive *Targeted* supports
- Few students also receive *Intensive* supports



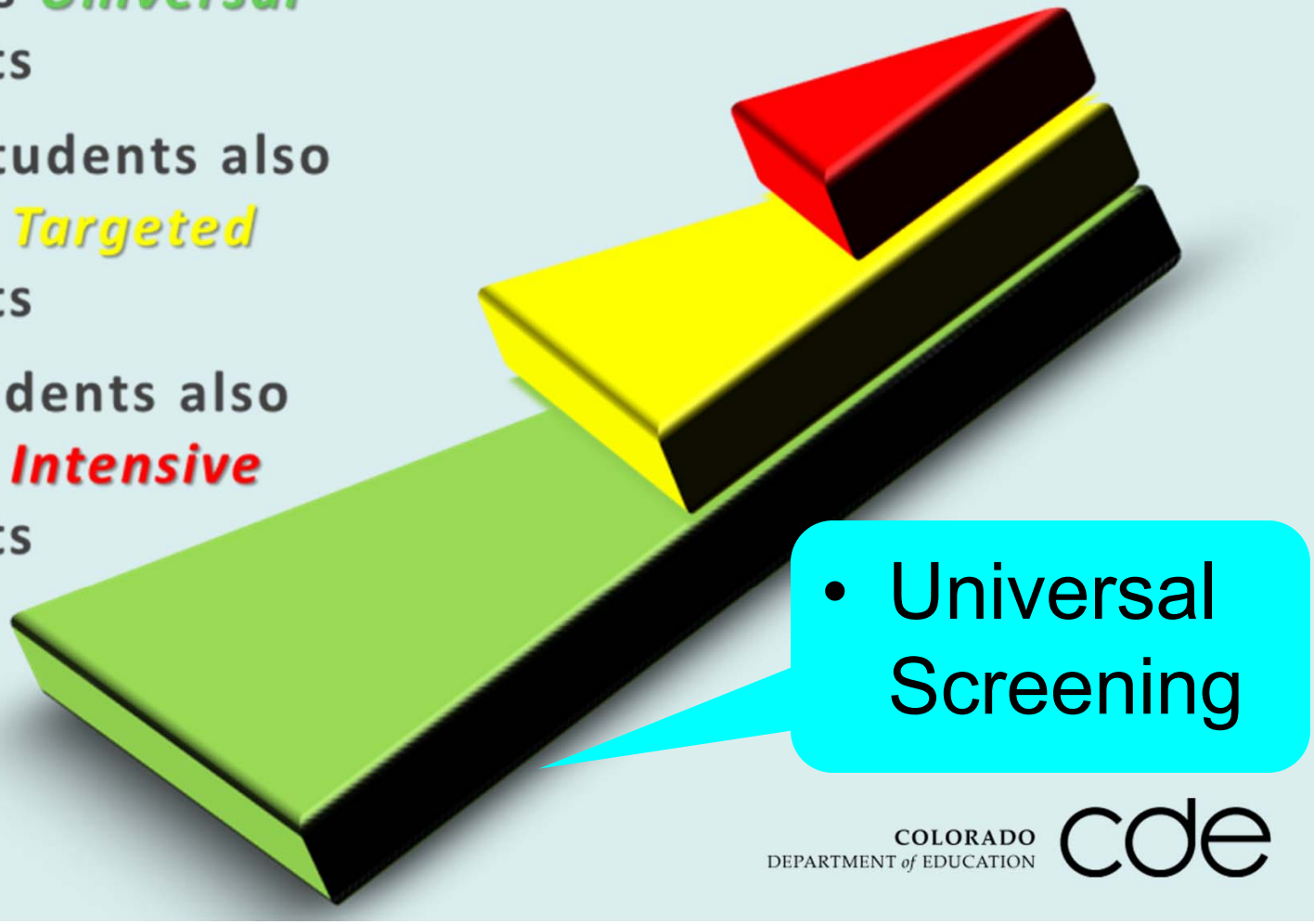


MTSS Essential Components

- Shared Leadership
- Data-Based Problem Solving and Decision Making
- Layered Continuum of Supports
- Evidence-Based Instruction, Intervention, and Assessment Practices
- **Universal Screening and Progress Monitoring**
- Family, School, and Community Partnering

Layered Continuum of Supports

- Every student receives ***Universal*** supports
- Some students also receive ***Targeted*** supports
- Few students also receive ***Intensive*** supports



- Universal Screening

COLORADO
DEPARTMENT *of* EDUCATION cde

A. UNIVERSAL SCREENING

- ***Universal screening*** *is…a repeatable data collection of academic and behavior skills of ALL students..*
  - *that is quick, administered about 3 times a year*
  - *identifies students or groups who might extra support*
  - *shows how functional the curriculum and instruction are*
  - *and detects whether or not students are making acceptable progress*

A. Universal Mental Health Screening Assessments- what to measure!!

- What are your targets/ Constructs?
- Must have a conversation of how we approach and define Mental Health.
  - No matter the outcome…better than no action
- Format (rating scales, interviews, record reviews, observations) ---→ $$$$$
- Informant type (parent, teacher, self)
- Recommended timing/frequency

Two approaches to MH screening

A. Screen to evaluate the assets children have by evaluating **protective factors** or **social emotional skills**

- Protective factors lead to
  - resilient outcomes (e.g., good mental health)
  - positive behavioral and psychological outcomes
  - improved academic performance
  - CAWS invitation!!!



- The Preschool Affective Wellness Scale
- The Children and Adolescence Wellness Scale
- The Journey to Wellness Scale

Two approaches to MH screening

B. Screen to identify children's **current** MH needs

- Externalizing behaviors
- Internalizing behaviors
- Cognitive/Attention
- Socialization





Children's Mental Health



Mental health in childhood means reaching developmental and emotional milestones, and learning healthy social skills and how to cope when there are problems.

BASICS
Overview of children's mental health

DATA & STATISTICS
Data and statistics highlights

SYMPTOMS & TREATMENT
Symptoms, diagnosis, and treatment

RESEARCH
CDC's research on children's mental health

RELATED CONDITIONS
Other conditions related to children's mental health

ARTICLES
Scientific articles and key findings

Children's Mental Health: What's New

- Policy Brief: Access to Mental Health Services for Children in Rural Areas
- Article: Differences in health care, family, and community factors among children in rural and urban areas
- Commentary: Access to mental health care in rural areas
- Policy Report: Strategies for behavioral health integration

A. Universal Mental Health Screening Assessments- what to consider!!

Some work needs to be done prior to UA.

- Screening NOT a one person activity.
- Get to know and become friends with your IT director and staff.
- Conduct a Tier-I: Staff needs assessment
  - Find out if your district subscribes to a web-based software to deliver surveys
    - (survey monkey, Qualtrics, e-survey)

PLANNING FOR UNIVERSAL SCREENING

Is my school ready to do this?	Yes	No	Not sure	If no or not sure, document next steps
Is staff committed to developing and improving the social, emotional, and behavioral health of students?				
Does school staff understand the misconceptions and stigma associated with behavioral health?				
Does staff understand the connection between behavioral health and academic achievement?				
Does staff understand how to protect student and family privacy?				
Has staff been educated about confidentiality?				
Is there a referral process in place?				
Is staff familiar with the school's referral process?				
Has staff learned how to guard against labeling students who may need extra behavioral health support?				
Have families, school staff, mental health professionals, and other representatives from the community been included in the discussion about universal screening?				
Does the school have adequate resources to follow up with students after they are screened?				
Does the school have district approval?				

Universal Screening

- *Build a Team (school-family-community)*
- Generate Buy-in and Support
- Show justification, need and benefit of Universal Screening.
- Promote and market your work. How does it fit with the school's mission?
- What is current identification process (referral process)?
- Do you over-or under-identify students with mental health needs?

Universal Mental Health Screening Assessments- what to consider!!

- Be prepared to follow-up before you even start.
- Consider when to do the screening.
  - Is “being OK” in the Fall sufficient?
- Consider developmental/educational periods.
    - Elementary to Middle School
    - Middle to High

Be prepared to follow-up before you even start.

Resource Mapping

(Group Activity)

Resource Mapping

In your current setting, list the mental health programs and supports (in the school or in partnership with the community) that are available. In the second column, list the goals or targeted areas of these programs. Finally, consider the degree to which the program is working and the sources of data that help you determine its effectiveness.

Universal Level of Prevention		
Current Programs	Program Goals:	Effectiveness

Copyright © 2012 by Robyn S. Hess, Rick Jay Short, & Cynthia E. Hazel. From Hess, Short, & Hazel, *Comprehensive Mental Health Services in Schools and Communities: A Public Health Problem-Solving Model* (Routledge, 2012). Permission to reproduce is granted to purchasers of this text.

Be prepared to follow-up before you even start.

Resource Mapping

(Group Activity)

Selective Level of Prevention		
Current Programs	Program Goals:	Effectiveness

Copyright © 2012 by Robyn S. Hess, Rick Jay Short, & Cynthia E. Hazel. From Hess, Short, & Hazel, *Comprehensive Mental Health Services in Schools and Communities: A Public Health Problem-Solving Model* (Routledge, 2012). Permission to reproduce is granted to purchasers of this text.

Be prepared to follow-up before you even start.

Resource Mapping

(Group Activity)

Indicated Level of Prevention

Current Programs	Program Goals:	Effectiveness

Copyright © 2012 by Robyn S. Hess, Rick Jay Short, & Cynthia E. Hazel. From Hess, Short, & Hazel, *Comprehensive Mental Health Services in Schools and Communities: A Public Health Problem-Solving Model* (Routledge, 2012). Permission to reproduce is granted to purchasers of this text.

Scenario - A progressive principal !!!!

- As a school principal, Mrs Smith would like to implement a comprehensive MTSS plan in her building in order to have information about her students' academic skills and overall mental/behavioral health. She wants to determine and discuss present programs and if needed implement new ones.

This progressive principal believes in PREVENTION

- She starts her new year **now**.!!!
- To help of all of her students she focuses on PREVENTION.
- To PREVENT we need to know what we are dealing with …
- We need data…

THE CHALLENGES.???

Challenges??

- Find a screening tool
- Determine the logistics of collecting data
- Have an easy access to group data
  - Grade
  - Teacher
- Address immediate student needs

A. Universal Mental Health Screening : consider technical adequacy of tools!!

- Norms
- Various indices of reliability
  - internal consistency
  - Test retest
  - Inter-scorer
- Validity
  - Content
  - Concurrent
  - Screening Accuracy.

A. Universal Mental Health Screening : consider technical adequacy of tools!!

Overall correct classification rate (hit rate)	The percentage or proportion of correct group classifications made using the test scores. The higher the value, the better the scale is at correctly classifying cases.
Sensitivity	The ability of the test to correctly detect clinical cases in a population (i.e., the proportion of the **clinical cases** predicted by the test to belong to the clinical group).
Specificity	The ability of the test to correctly identify general population cases (i.e., the proportion of **general population** cases predicted by the test to belong to the general population group).

A. Universal Mental Health Screening : consider technical adequacy of tools!!

False-positive rate	The percentage of children identified by the test as having a clinical condition who, based on previous diagnosis, do not have a diagnosis. The lower the value, the better the scale is at correctly classifying cases.
False-negative rate	The percentage of children identified by the test as not having a clinical condition who, based on previous diagnosis, do have that disorder. The lower the value the better the scale is at correctly classifying cases.
Negative predictive power	The percentage of children identified by the test as **not having** a clinical condition who, based on previous diagnosis, **do not have** that disorder. The higher the value, the better the scale is at correctly classifying cases..
Positive predictive power	The percentage of children identified by the test **as having** a clinical condition who, based on previous diagnosis, **have** that disorder. The higher the value, the better the scale is at correctly classifying cases.

Screening is not new!

- Henry, M., & Rudder, J. (1963). An evaluation of a process for screening school children with emotional handicaps. *Journal of School Psychology, 1*, 28–32.
- However…universal screening for problem behavior…
  - has not been placed in the context of a systems approach (e.g., SW-PBS)
  - has not been placed in an RtI context
  - has not been linked to progress monitoring
  - has not always been linked to intervention (e.g., classification, eligibility focus)

Mack D. Burke John Davis Cole Davis (2011) CCBD, 2011 conference, New Orleans

School Psychology Review,
2010, Volume 39, No. 3, pp. 364–379

Developing a Change-Sensitive Brief Behavior Rating Scale as a Progress Monitoring Tool for Social Behavior: An Example Using the Social Skills Rating System—Teacher Form

Abstract. Research has been unsuccessful at revealing an analogue to curriculum-based measurement in the area of progress monitoring for social behavior. As a result, there is a need to develop change-sensitive, technically adequate, feasible progress monitoring tools for social behavior that represent general outcome measures of performance. The purpose of this research was to develop and evaluate the technical

Canadian Journal of
School Psychology
Volume XX Number X
Month XXXX XX-XX
© Sage Publications
10.1177/0829573507307693
http://cjsp.sagepub.com
hosted at
http://online.sagepub.com

Development of a Change-Sensitive Outcome Measure for Children Receiving Counseling

Scott T. Meier
University at Buffalo
James L. McDougal
State University of New York at Oswego
Achilles Bardos
University of Northern Colorado

RtI & Behavior

School Psychology Forum:
RESEARCH IN PRACTICE
VOLUME 4 • ISSUE 2 • PAGES 1–14 • Summer 2010

The Use of Change-Sensitive Measures to Assess School-Based Therapeutic Interventions: Linking Theory to Practice at the Tertiary Level

Amanda L. Lannie
Devereux Center for Effective Schools
Robin S. Codding
University of Massachusetts, Boston
James L. McDougal
State University of New York at Oswego
Scott Meier
State University of New York at Buffalo

MTSS - Things to consider

A. Universal Screening
   – Psychometric/technical issues

B. Progress Monitoring
   - **Universal monitoring (UA1, UA2)**
   - **Change-sensitive items**

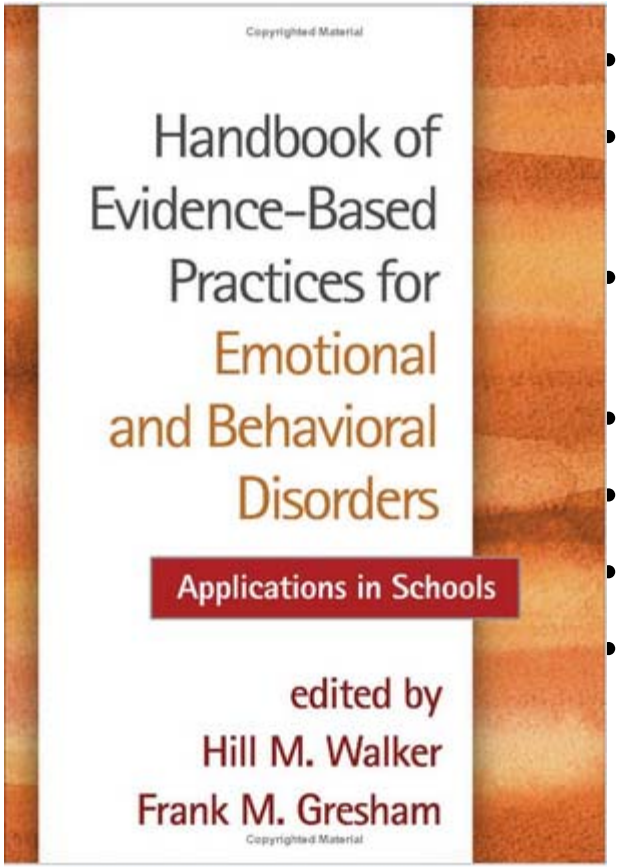
C. Determine evidence-based practice

B. Progress monitoring…

- is a scientifically based practice used to systematically assess student's performance, evaluate the effectiveness of intervention strategies, and monitor reductions in problematic behaviors. The goals of this system are to provide educators with a framework for determining the effects of interventions and monitoring special education student's goals and objectives.
- The typical approach for monitoring behavioral progress utilizes social and behavioral measurement scales. Research has shown that many social skills and behavioral scales are too general for behavioral progress monitoring (Gresham, 2005).

B. Change Sensitive Measures Characteristics

Cook, Volpe & Delport, (2014)



- Technically adequate (reliability, validity).
- Sensitive to short term changes in behavior performance
- Can be administered repeatedly in short period of time (i.e. once a week)
- Reflects general or overall performance
- Does not require a great deal of teacher training.
- It is NOT intervention specific.
- Constructing one is a sequential process and does not involve a single study.

Effect size estimates.

- Effect Size (ES) is a measure of the strength of change. Typically employed to determine if groups (e.g., intervention versus control) show differences over time, ES has also been adapted in the literature for examining whether individuals exhibit change over time (see Clement, 1999).
- To examine change in an individual's scores over time, we can compute ES for each subscale or total score.

Effect size estimates

Table 5.8. Effect Size Interpretations for Individual Clients on the BIMAS Standard

Effect Size	Interpretation for Behavioral Concern Scales	Interpretation for Adaptive Scales
≤ -1.50	Much Improved	Much Worse
-.50 to -1.49	Improved	Worse
-.50 to +.50	No Change	No Change
.51 to 1.49	Worse	Improved
≥ 1.50	Much Worse	Much Improved

- Clement, 1999

Reliable Change Index (RCI)

(Jacobson & Truax, 1991).

- Has a clinically significant change occurred for a student?
- the RCI formula employs an individual's pre and post scores, the pretest standard deviation for a group of scores, and a reliability estimate for the test.

MTSS - Things to consider

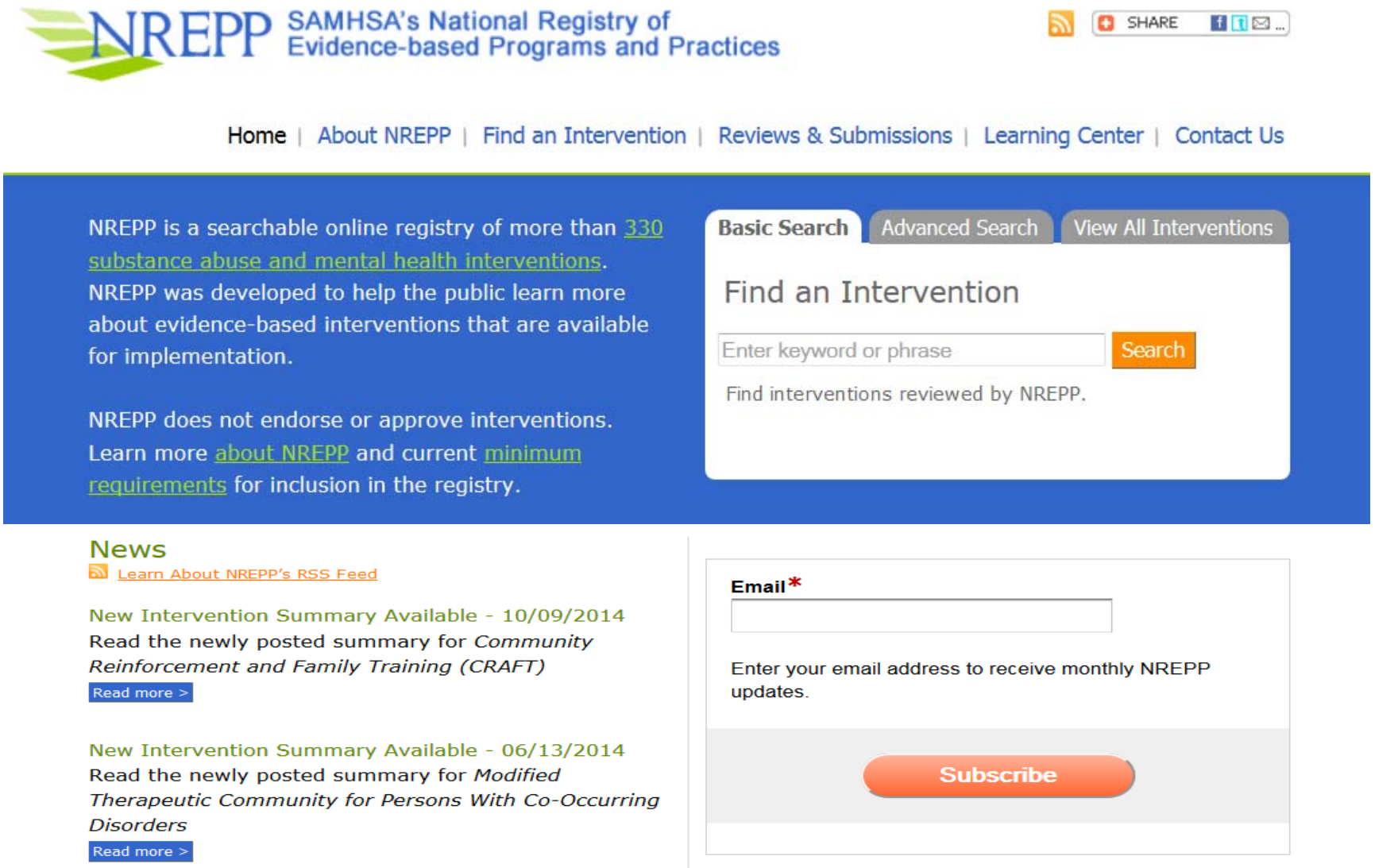
A. Universal Screening
   - Psychometric/technical issues

B. Progress Monitoring
   - Psychometric
     - Universal monitoring (UA1, UA2)
     - Change-sensitive items

C. Determine evidence-based practice

C. Determine evidence-based practice

http://nrepp.samhsa.gov



The Challenge of MTSS!!

WORKING WITH ALL STUDENTS

Challenges??

- Find a screening tool
- Determine the logistics of collecting data
- Have an easy access to group data
  - Grade
  - Teacher
- Address immediate student needs



Behavior Intervention Monitoring Assessment System

By James L. McDougal, Psy. D., Achilles N. Bardos, Ph.D., & Scott T. Meier, Ph.D.

BIMAS- Where are we coming from?

