Supporting Students with Emotional Disabilities in the Least Restrictive Environment

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Prevalence

- Among all students, students in SPED account for approximately 13% of student enrollment and rates of students with ED are just under 1% (USDoE, 2016)

- Among all students with disabilities, 6% of e.s. and m.s. and 11% secondary school students are receiving services for ED (Kutash et al., 2005)

- Considerable variability exists among state identification rates and students with EBD’s are consistently underidentified (Wiley et al., 2011; Reddy & Richardson, 2006)
Students with ED

- Less social interaction and competence
- Engage in more negative interactions with peers/teachers
- Higher rates of externalizing and internalizing symptoms
- Lower academic performance
- More frequent contact with juvenile justice
- More family stressors
- Greater likelihood of being male and African-American

Bradley et al., 2008; Bradley et al., 2004; Wagner et al., 2005; MSDE, 2009
Students with ED

• According to Wagner and colleagues (2006), students with ED tend to:
  – Attend larger schools with higher rates of students with disabilities
  – Spend less time in general education than students with other disabilities
  – Receive little mental health or behavioral support services
  – Receive limited family support
National Outcomes

• Little academic improvement over time (Siperstein et al., 2011)

• High rates of suspension and expulsion relative to peers in special education (Blackorby et al., 2003)

• High rates of poor post-school outcomes (Bradley et al., 2008)

• Approximately 35% of students with ED dropped out of school in 2012-2013 (USDoE, 2016)
Maryland Data

- 6.7% of all Maryland students in special education are identified as having an emotional disability

- Placements in restrictive settings

- Significant variability across jurisdictions in identification rates

- Disproportionality for African American and male students

- Students with ED have the highest dropout rate of approximately 50%, a 35% suspension rate, and have the poorest employment outcomes

MSDE (2010, 2013)
Interventions for Students with ED

• Less than half of the students with ED typically receive mental health or family support services in the school setting (Wagner et al., 2006).

• Great variability in funding and organizational structure of the supports for youth with ED (Kutash, Duchnowski, & Green, 2011).
  – "pull out" services
  – milieu therapy
  – wraparound approach

• Intervention content is not always clear (Kutash, Duchnowski, & Green, 2011).
Prince George’s School Mental Health Initiative (PGSMHI)
**Prince George’s County Public Schools**

- 209 schools with approximately 129,000 students
- 2\textsuperscript{nd} largest school system in Maryland
- Urban area, close proximity to Washington, DC
- Approximately 64% of students receive free/reduced lunch
- Approximately 11% SPED
- 61.4% African-American
- 29.6% Hispanic/Latino
PGCPS Data 2014-2015

- 6% of students are identified as having an ED
- Total Public Schools: 212
- Total Nonpublic schools: 166
Student Demographics

• Of the enrolled students:
  – 74% male
  – 80% Black/African American

• Primary Educational Disability categories:
  – 73% Emotionally Disabled
  – 9% Other Health Impairment
  – 8% Specific Learning Disability
  – 7% Autism
Primary Presenting Problems

% Primary Presenting Problems

- Substance abuse
- Anxiety
- Depression
- Trauma
- Fighting
- Failing Grades
- Attention/Focus
- Poor attendance
- Disruptive
- Academic Frustration
- Peer Relationships
- Anger Management

Chart showing the percentage of primary presenting problems.
**PGSMHI Goals**

- Divert students who are at risk for entering non-public educational settings.
- Complement existing special education programs with a mental health component.
- Improve student functioning
- Improve school climate
- Increase knowledge of community resources
- Provide training and support to PGCPS school staff
**PGSMHI Enrollment Criteria**

Enrollment in ED Transition Program or SPED and at risk of entering nonpublic setting:

- Suspensions/disciplinary referrals
- Academic Progress
- Behavioral/Emotional Functioning
- Psychiatric History
- FBA/BIP
- Staff reports

- Family consent and willingness to collaborate with PGSMHI team
PGSMHI Program Model

SCHOOLS:
• 2 elementary schools
• 2 middle schools
• 4 high schools

STAFFING:
• 4 Licensed Counselors (cover 1 school)
• 2 School Social Workers (cover 2 schools)
• 3 Case Managers (cover 2-3 schools)
• Psychiatric Support/Consultation
Services Provided by the PGSMHI

- Assessment
- Individual therapy
- Group therapy
- Family therapy
- Classroom prevention
- Small group prevention
- Psychiatrist consultation
- Crisis management
- Teacher & staff consultation
- Consultation with other providers
- School-wide mental health promotion
- Family support
- Case Management
- Telepsychiatry
Outcome Measurement
**Outcome Data Utilization**

- Increasingly important in SMH
- More attention on accountability due to funding climate
- Need evidence of SMH programs efficacy
- Growing demand on SMH programs to use outcome data to
  - Provide evidence of service quality and impact on student, family and school outcomes
  - Utilize data to inform service delivery via quality assessment and improvement
Brief Problems Checklist
Assessment Measure

• Brief Problems Checklist (Chorpita, Reise, Weisz et al., 2010)
  – Standardized on youth aged 7-13 (grades 1-9) and their caregivers
  – Youth in treatment in school-based and community agencies
  – High correlations with Child Behavior Checklist (CBCL- Achenbach & Rescorla, 2001) and Youth Self Report (YSR) of CBCL
**Brief Problems Checklist (BPC)**

- 12-item measure
- 2 versions - child informant and caregiver/teacher informant
- 2 scales - Internalizing and Externalizing (6 items on each) and Total Problems Scale
- Items are scored by informant from 0-2
- Total Problems Scale ranges from 0-24
- Higher scores indicate increased problems
- Rating behavior within the last 30 days
**BPC Assessment Procedure**

- Brief Problems Checklist are completed by youth, caregiver, and teacher/school staff within 30 days of enrollment.
- After enrollment, BPC is administered by program staff once/school quarter.
- In some cases, BPC is completed over the phone with caregivers.
- BPC is administered to students aged 7 and older.
Top Problems Assessment Measure

- **Top Problems** measure (Weisz, Chorpita, Frye et al., 2011)
  - Standardized on youth aged 7-14 and their caregivers

- High correspondence between youth and caregiver top problems and Internalizing/Externalizing scales
**Top Problems (TP) measure**

- Can be completed by youth, caregivers, school staff
- Informant identifies problems that are most important to them
- Problems are rated from 0 ("not at all a problem") – 10 ("a huge problem") to identify how significant the problem is for the student
- Informant-guided assessment is helpful as perspectives of problems often vary
**TP Assessment Procedure**

- Top Problems are identified by youth, caregiver, and teacher/school staff within 30 days of enrollment.
- Top Problems are rated by youth every individual therapy session unless student is in crisis.
- Top Problems are rated by caregivers and teacher/school staff once/school quarter.
- Administered to youth ages 10 and older.
Outcomes and Clinical Progress
Student Placements in Non-Public

- 99% Maintained
- 1% MRE
Location of Students Referred to Non Public Schools

- 95% Outside Transition
- 5% Transition Programs
Student Avg. Top Problem Score

• N = 31 students
• Problems are rated on a scale from 0-10
Problems were rated on a scale from 0 - 10
N = 31
BPC Total Problem Scores: Initial - Time 4

Average BPC Total Score

Time Point

Time 1 | Time 2 | Time 3 | Time 4

Teacher (N=9):
- Time 1: 9.08
- Time 2: 7.11
- Time 3: 7.11
- Time 4: 6.00

Student (N=11):
- Time 1: 9.08
- Time 2: 7.11
- Time 3: 7.33
- Time 4: 7.33
Student Observations: High School

- Off Task: Time 1 = 10.82, Time 2 = 6.45
- Teacher Prompt: Time 1 = 8.45, Time 2 = 5.27
- Negative Behavior: Time 1 = 3.82, Time 2 = 1.18
- Attention Seeking: Time 1 = 7.64, Time 2 = 3.91

N = 11
Student Observations: Middle School

- Off Task: Time 1 - 16.50, Time 2 - 9.50
- Teacher Prompt: Time 1 - 11.00, Time 2 - 8.86
- Negative Behavior: Time 1 - 0.93, Time 2 - 1.93
- Attention Seeking: Time 1 - 7.86, Time 2 - 4.86

N = 14
Limitations/Challenges

- Attrition of students
- Limited parent data
- No control or comparison group
- Extreme variability in functioning
- Reporting bias
- Time periods between assessments varies
- Inconsistency between ratings and self-report
Summary

• Nonpublic placements utilized less frequently
• Trends in improvements in behavior on TP and BPC
• Student observation data illustrated improvements in behavior
• Students ratings on BPC higher than their teachers
• BPC can be useful in tracking treatment/IEP goals
Questions/Future Directions

• Which measures are most sensitive to changes in behavior?
• Is a 3-point scale sensitive enough to detect changes in behavior?
• What were the BPC and TP ratings for students who showed significant improvements in classroom behavior?
• Do certain types of problems show greater improvement over time?
• How can we increase parent feedback?
• Others?
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