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Supporting Students with Emotional Disabilities in the Least Restrictive Environment

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Acknowledgements

- Prince George's County Public Schools
- Maryland State Department of Education (MSDE)
- School Partners
- Family Partners
- Research Support

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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).

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Prince George's School Mental Health Initiative (PGSMHI)

Prince George's County Public Schools

- 209 schools with approximately 129,000 students
- 2nd 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

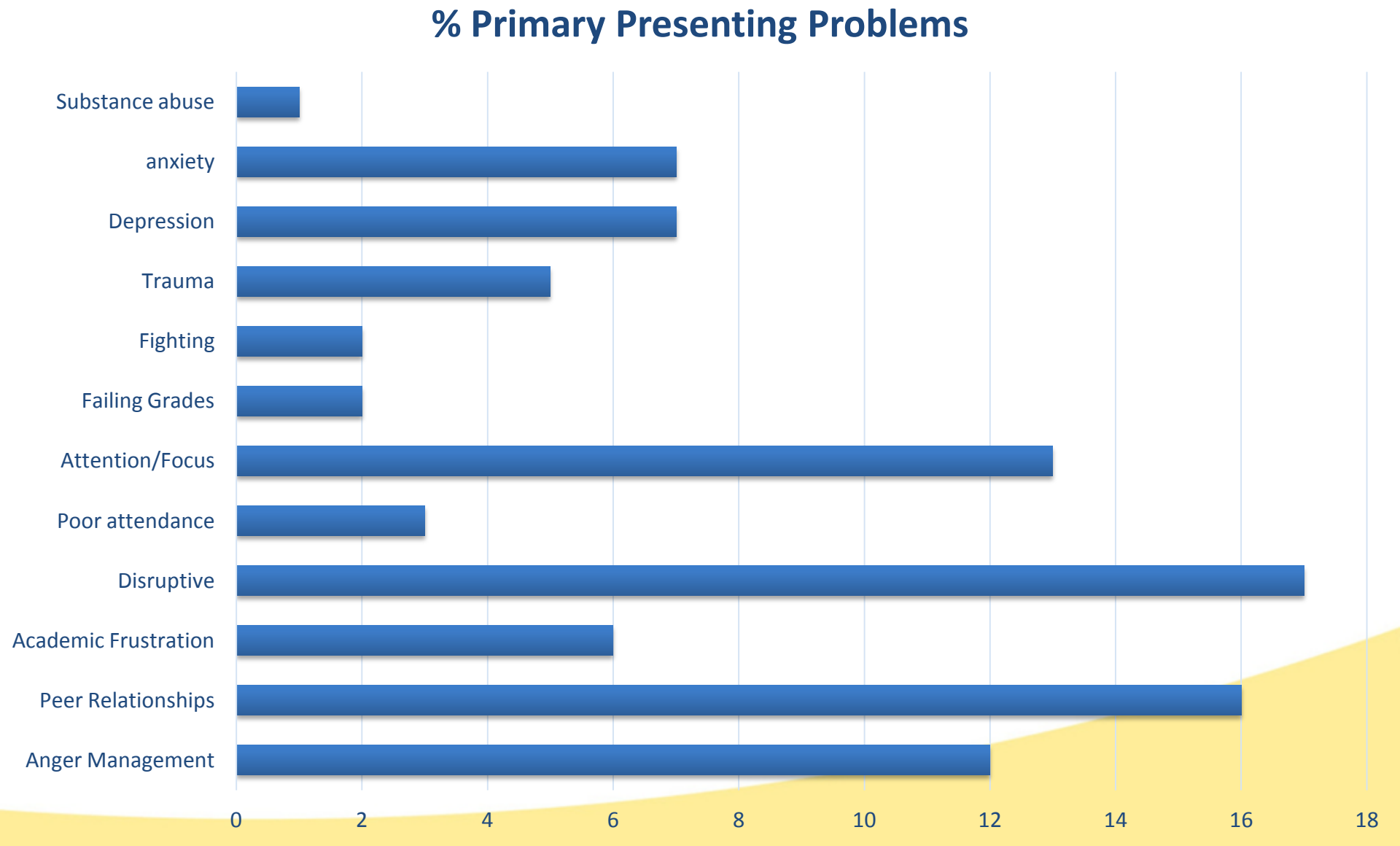
- 6% of students are identified as having an ED
- Total Public Schools: 212
- Total Nonpublic schools: 166

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



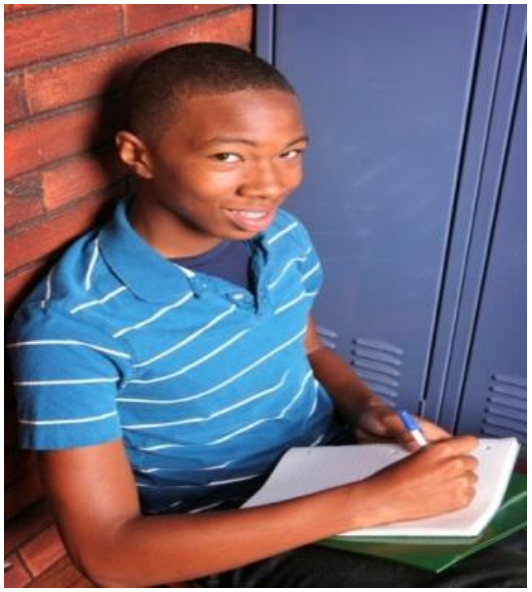
PGSMHI Goals

- 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

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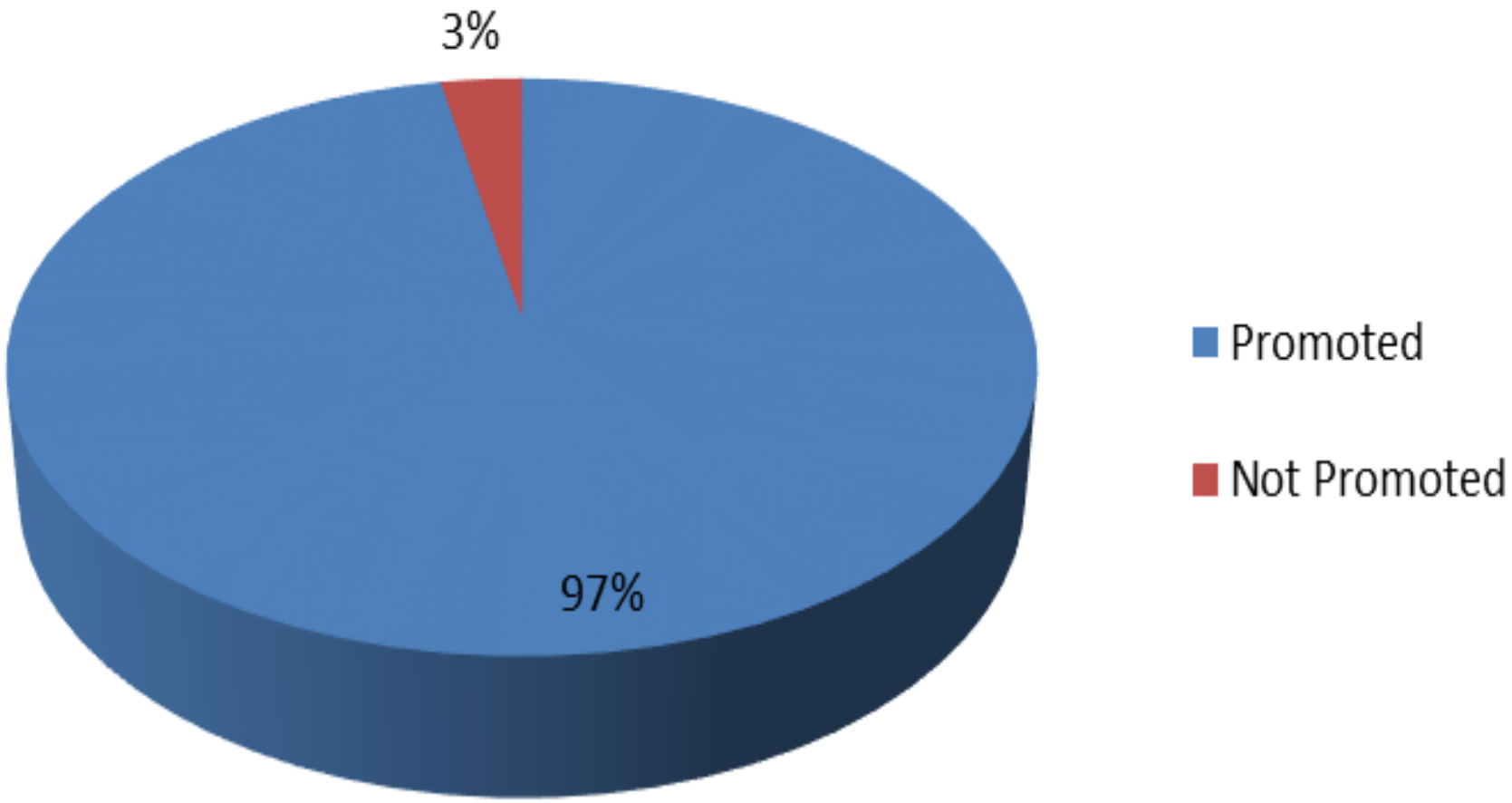
Outcome Measurement

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

Grade Promotions



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

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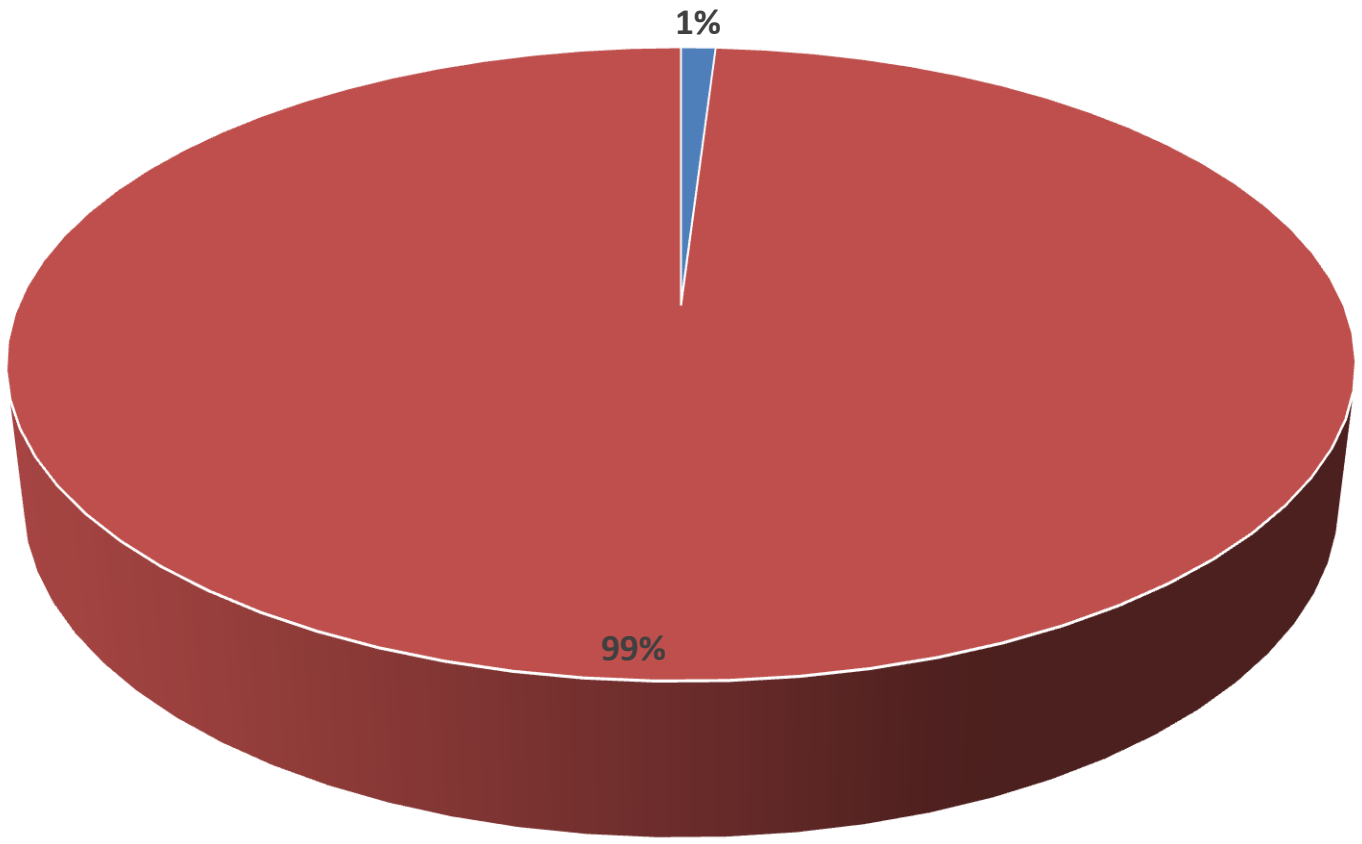
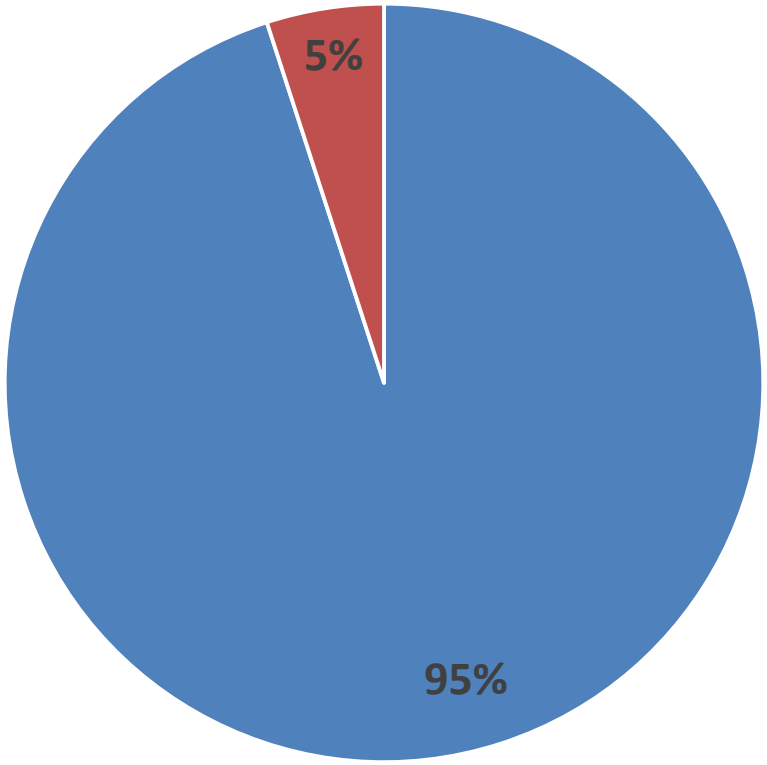
Outcomes and Clinical Progress

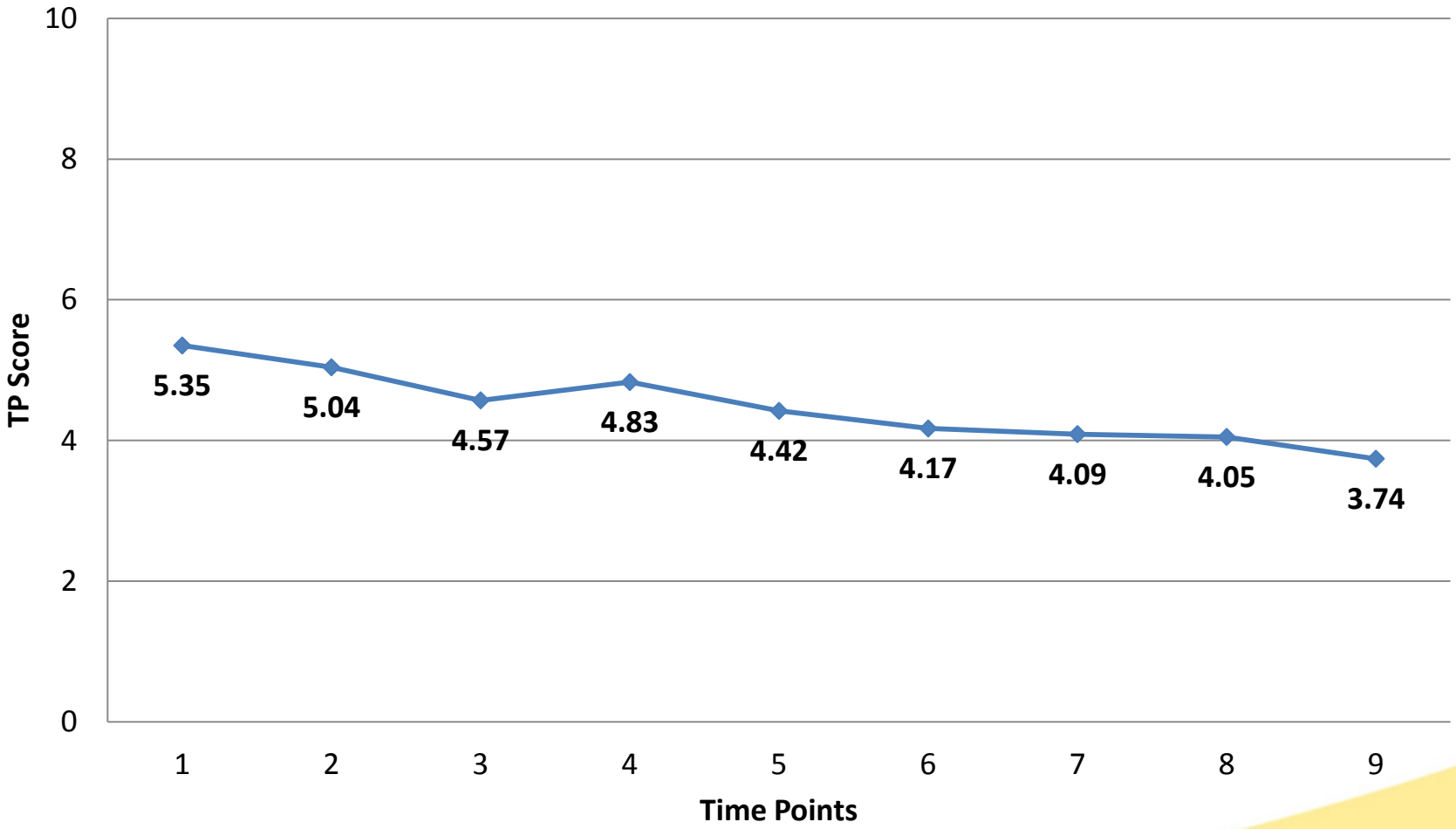
Student Placements in Non-Public



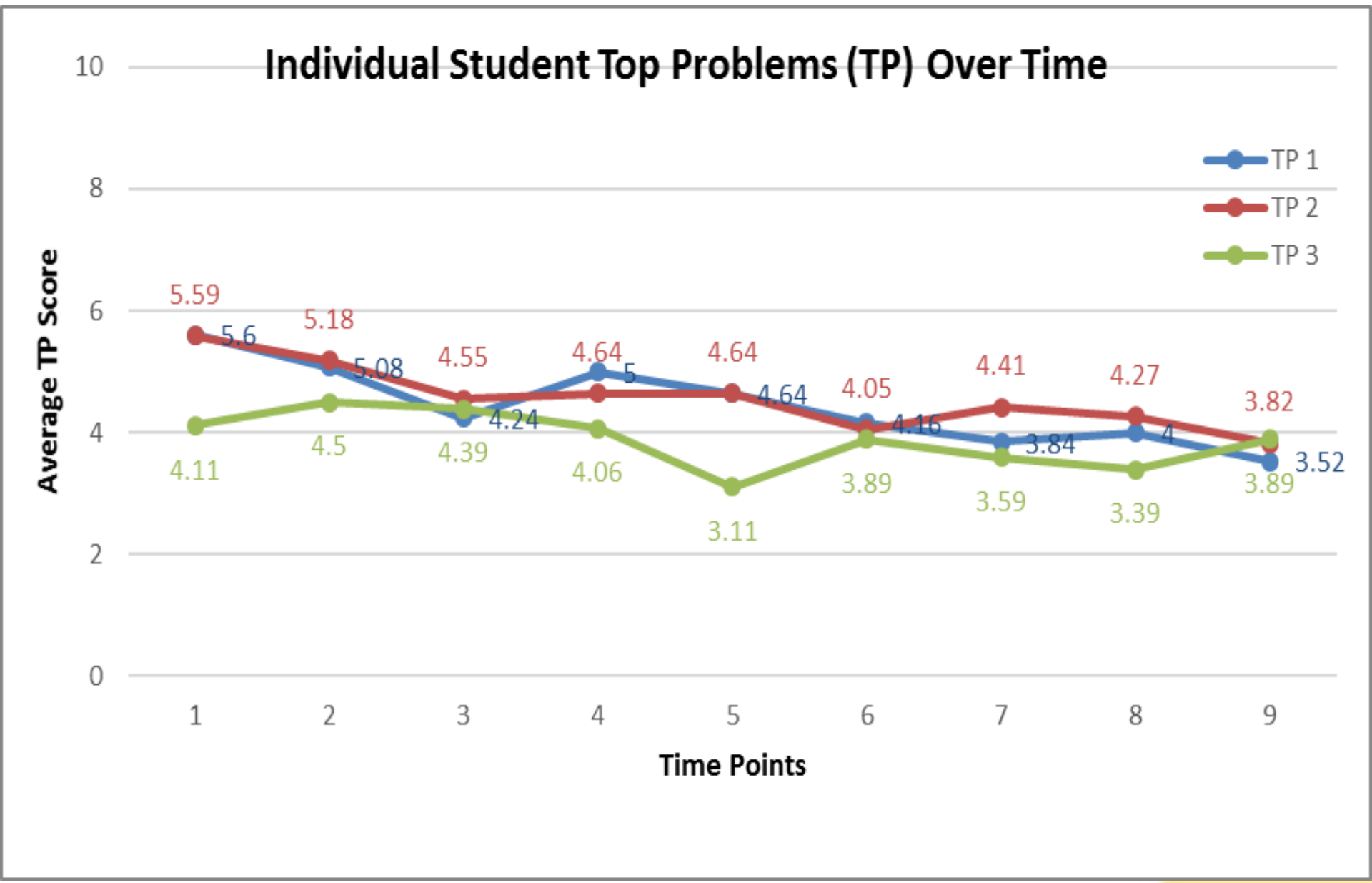
Location of Students Referred to Non Public Schools



Student Avg. Top Problem Score

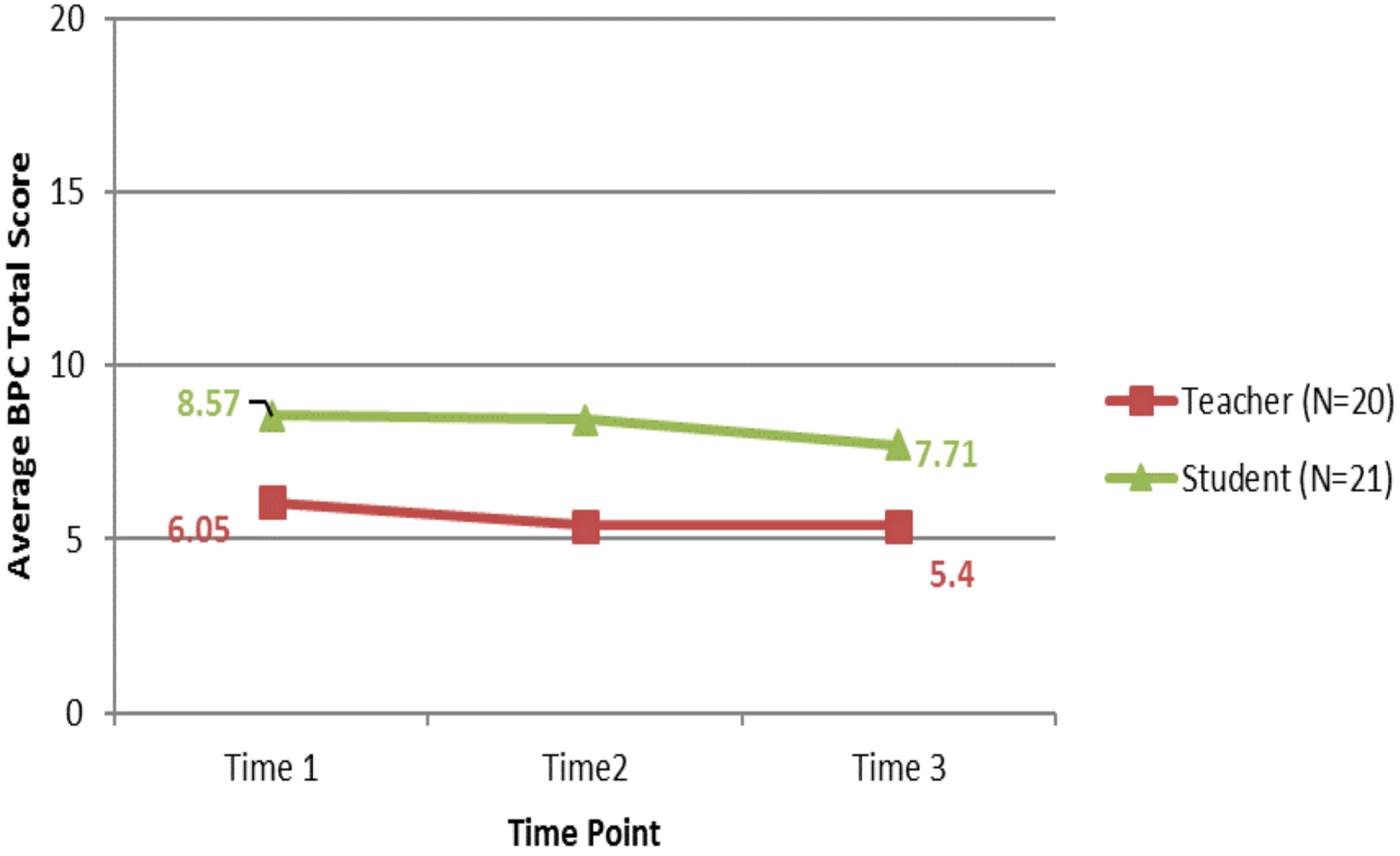


- N = 31 students
- Problems are rated on a scale from 0-10

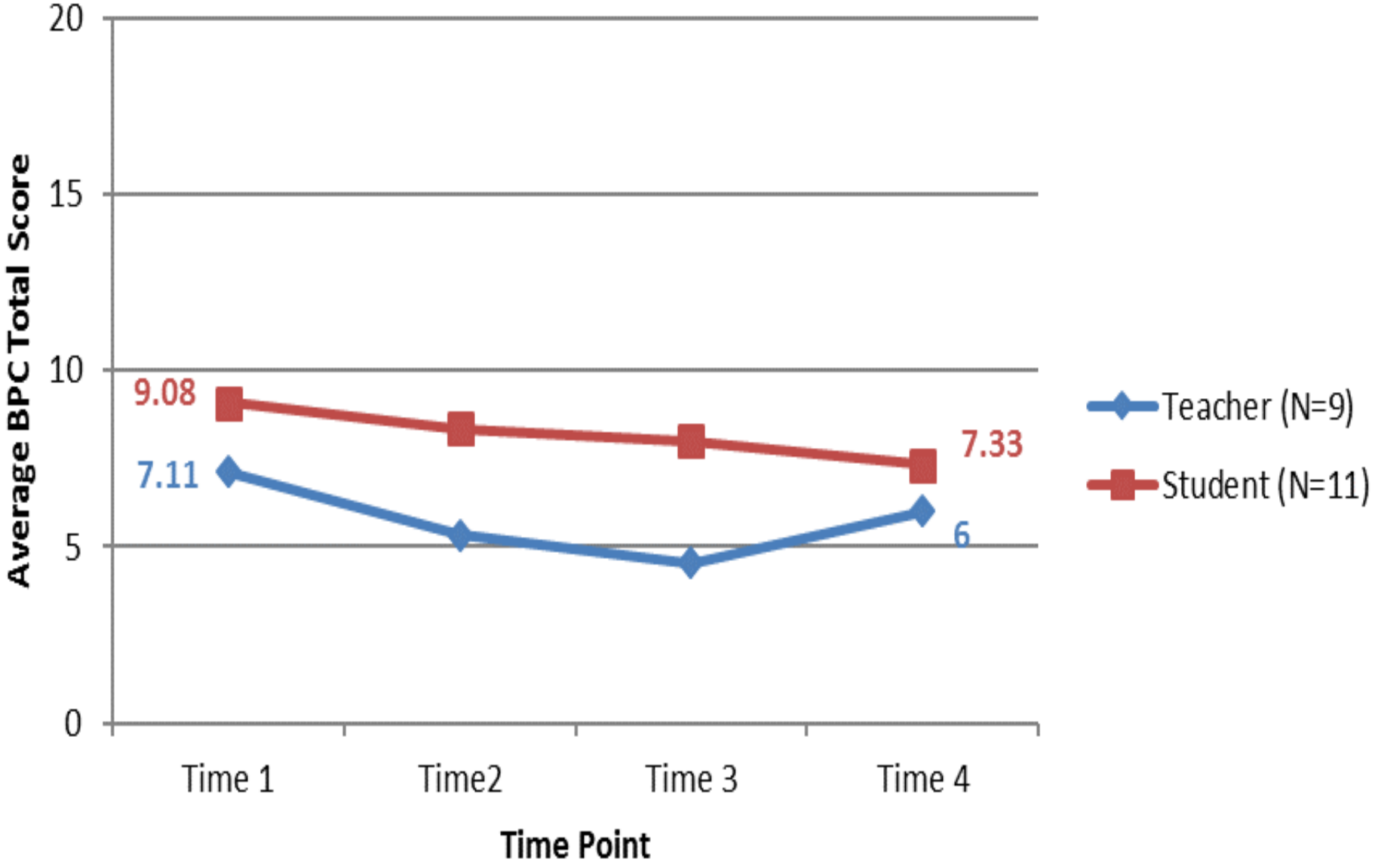


- Problems were rated on a scale from 0 -10
- N = 31

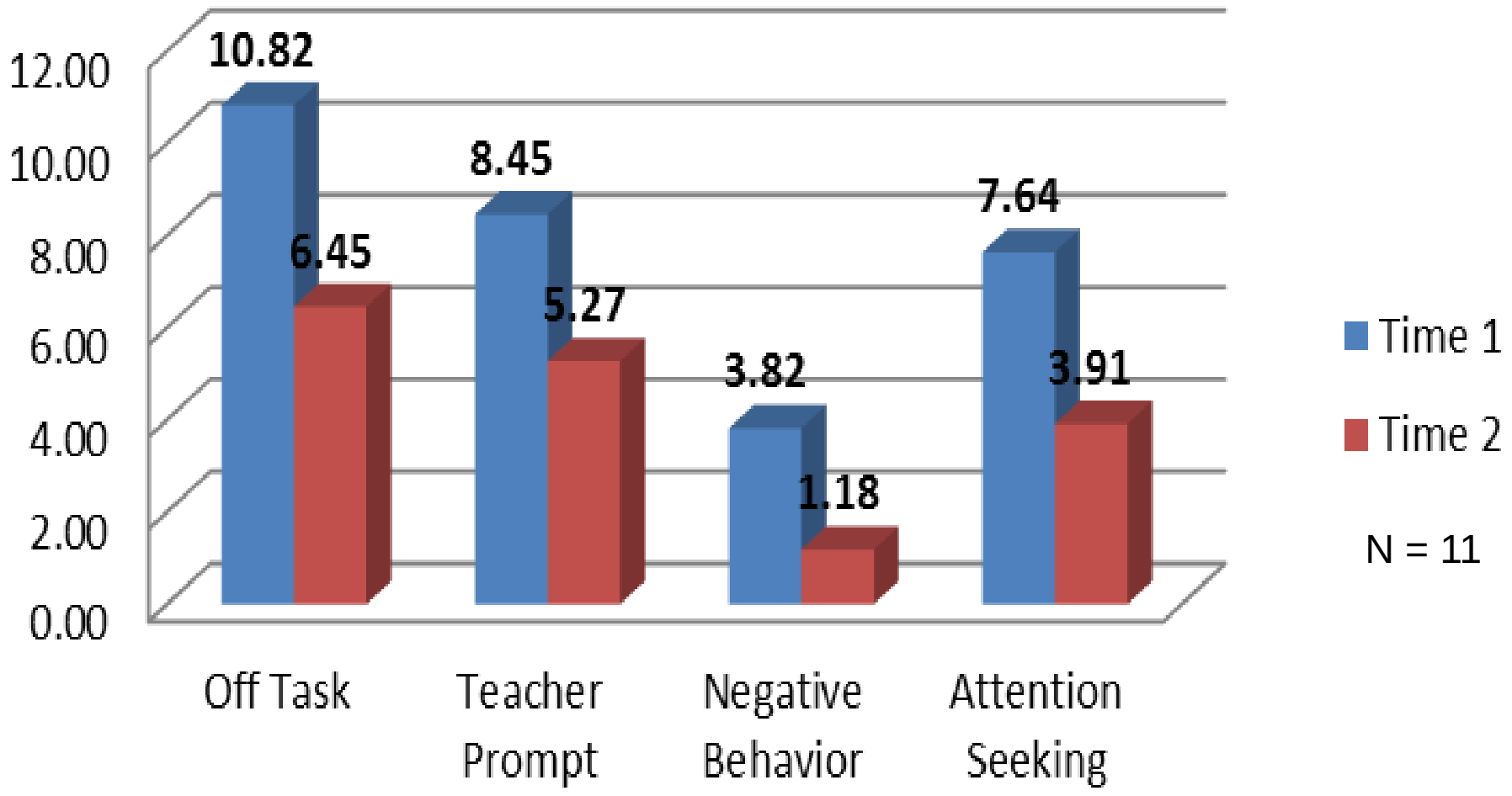
BPC Total Problem Scores: Initial - Time 3



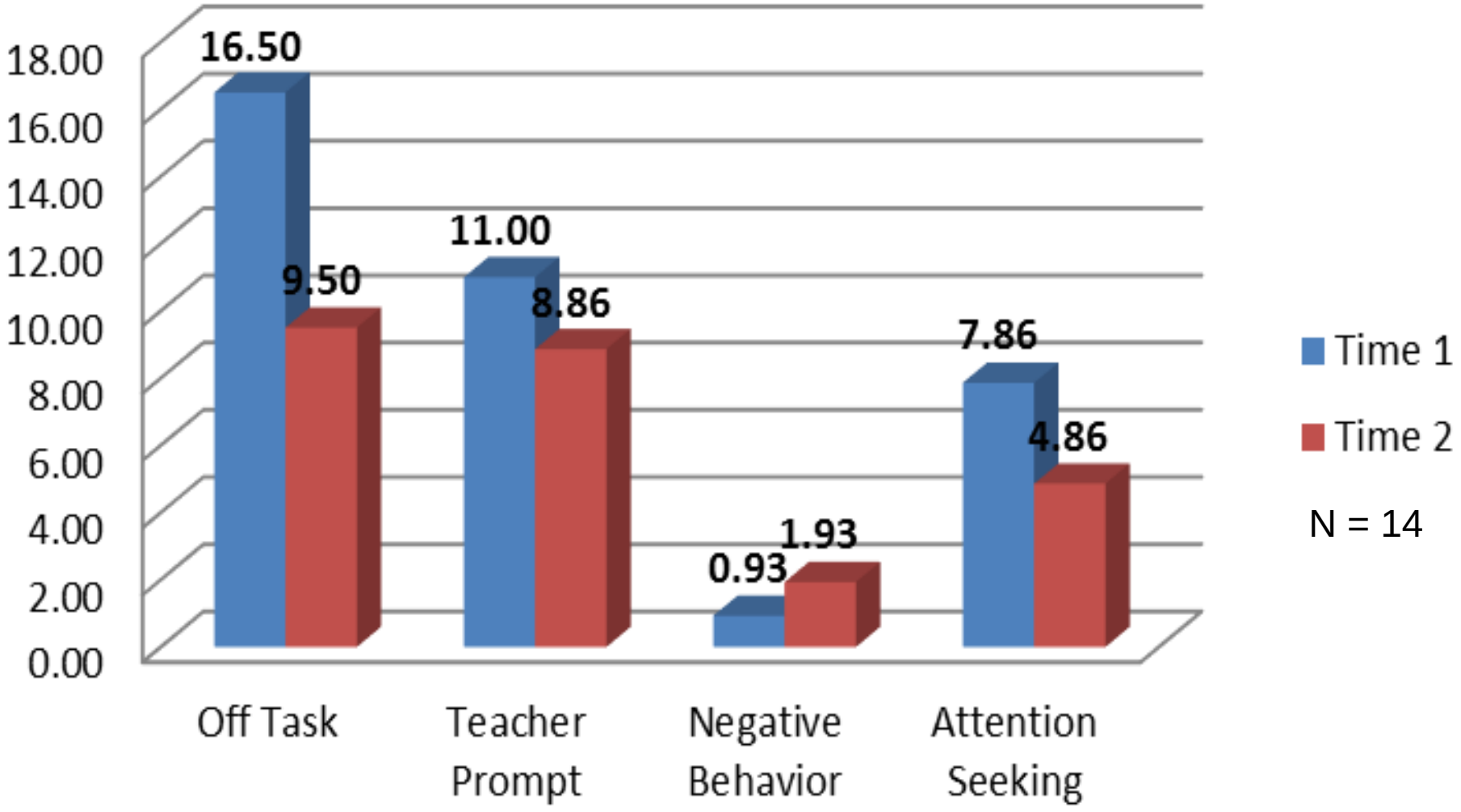
BPC Total Problem Scores: Initial - Time 4



Student Observations: High School



Student Observations: Middle School



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?

Contact Information

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