UNDERSTANDING SCHOOL-BASED MENTAL HEALTH SERVICES FOR STUDENTS WHO ARE DISRUPTIVE AND AGGRESSIVE: WHAT WORKS FOR WHOM? [1]

Krista Kutash, Ph.D. [a]

[a] Research and Training Center for Children's Mental Health
Florida Mental Health Institute, University of South Florida, Tampa, FL

Abstract

This session will begin with a description of the evidence-base for mental health services that focus on disruptive or aggressive behaviors, and are appropriate for delivery in schools or are community services that may complement existing efforts in schools. Mental health services in this section are defined as any strategy, program, or intervention aimed at preventing and treating mental health problems in youth. These efforts can include programs focused at the universal, selective, and indicated levels of prevention commonly referred to as the three-tied model of prevention. Because there are a variety of sources describing evidence-base services, it is hoped that this review will start to identify the breadth and depth of the knowledge base so it can be implemented by practitioners and strengthened by future research efforts.

Evidence-Based Mental Health Interventions

Nationally, state policy makers and school boards demand more and better mental health services for all students. There are numerous attempts to increase the amount and types of mental health services in schools (Adelman, & Taylor, 2000). Recent studies indicated that virtually all schools have some type of mental health services available (Foster et al., 2005) and on average, schools offer 14 different programs aimed at improving the social/emotional learning of students (Zins, Weissberg, Wang, & Walberg, 2004). These efforts, however, are frequently not empirically-based interventions. The challenge, therefore, is to better coordinate and implement an array of evidence-based mental health interventions targeting specific behaviors across a heterogeneous population of students. In order to accomplish this task, a better understanding by mental health, school staff, and families of the universal, selective, and indicated evidence-based mental health interventions that can be implemented in schools is necessary. This section summarizes some of the current evidence-based programs that focus on disruptive and aggressive behaviors that can be implemented in schools

In 2006, Kutash and her colleagues (Kutash, Duchnowski, & Lynn, 2006) summarized the evidence-based mental health interventions for children complied by five national organizations, including: (1) The National Registry of Evidence-based Programs and Practices (NREPP) operated by the Substance Abuse and Mental Health Services Administration (SAMHSA; Schinke, Brounstein, & Gardner, 2002); (2) a report issued by the

[1] This paper is a Preface to "The Role of Mental Health Services in Promoting Safe and Secure Schools" by the author and Albert Duchnowski in the forthcoming series on *Effective Strategies for Creating Safer Schools and Communities*, to be published by the Hamilton Fish Institute and Northwest Regional Educational Laboratory with the support of the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice.

Collaborative for Academic, Social, and Emotional Learning (CASEL, 2003); (3) a review of programs by the Prevention Research Center for the Promotion of Human Development at Penn State (Greenberg, Domitrovich, & Bumbarger, 2000); (4) a review by the Center for the Study and Prevention of Violence (CSPV; Elliott, & Mihalic, 2004); and the US Department of Education report on behalf of the Office of Educational Research and Improvement (OERI; USEd, 2001). These five sources generated a list of 92 interventions with 23 percent of the programs appearing on more than one of the five sources.

Overall, within this listing of evidence-based programs, approximately one-third of the programs are designated as targeting substance abuse, trauma, or health problems while the remaining two-thirds address the regulation of emotions or social functioning in children and adolescents with 20 programs specifically focusing on the issue of disruptive and aggressive behavior. As a whole, the approaches focus equally on universal levels of prevention (53 percent) and selective/indicated levels of prevention (47 percent). The majority of the programs listed across these five sources are to be implemented in schools (58 percent) while 26 percent are to be implemented in community settings and 16 percent are to be implemented simultaneously in schools and in community settings. This finding clearly supports the notion that in order for evidence-based programs to be implemented, schools must be involved. The next sections describe a sample of universal, selective and indicated evidence-based programs that focus on disruptive and aggressive behavior that can be implemented in schools.

Universal Interventions

According to Weisz, Sandler, Durlak, & Anton (2005), universal strategies are "approaches designed to address risk factors in entire populations of youth – for example, all youngsters in a classroom, all in a school, or all in multiple schools – without attempting to discern which youths are at elevated risk" (p. 632). In developing universal interventions for schools, Farmer et al. (in press) suggest the following four questions to guide the choice and subsequent implementation of universal programs: (1) What general activities in the academic, social, and behavioral domains are associated with conflict and aggression in the school? (2) What universal interventions can be implemented school wide to address problems in each of the specific domains identified? (3) How do various problems impact each other across the different domains? and (4) How can different interventions be brought together to systematically address the collective contributions of these problems?

Some examples of universal interventions are presented in Table 1 (next page). Perhaps the two most common universal interventions include Promoting Alternative Thinking Strategies (PATHS; Kusche, & Greenberg, 1994) and Second Step: A violence prevention program (Frey, Hirchstein, & Guzzo, 2000). The PATHS curriculum has six sections that cover emotional literacy, self control, social competence, positive peer relations, and interpersonal problem solving skills. The program targets children between 5 and 12 years of age and can continue across five grade levels. Second Step is a school-based social-skills program for children 4 to 14 years of age that teaches social skills and socio-emotional skills aimed at reducing impulsive and aggressive behavior while increasing social competence. The program consists of in-school curricula, parent training, and skill development. Generally, approaches at the universal level of prevention include curriculums to be delivered within the classroom to teach specific behaviors and include opportunities for the students to practice the newly acquired skills. The key strategies for effective school-based prevention programming according to Greenberg and his colleagues (Greenberg et al., 2003) include teaching and reinforcing skills in students; fostering supportive relationships among students, school staff and parents; implementing systemic school and community approaches; starting programs before risky behaviors begin; and continuing multi-component across multiple years (see Table 2, next page).

Table 1. A sample of evidence-based universal programs (Kutash et al., 2006)

Program Name	List Cited*	School Based	Age Range	Length of Program	Family Component?	Teacher Component?
Paths – Promoting Alternative Thinking (PATHS)	A,B,C,E	Yes	5-12	5 yrs	Yes	Yes
Second Step: A Violence Prevention Program	A,B,E	Yes	4-14	15 - 30 wks	Yes	Yes
Responding in Peaceful And Positive Ways	A, B,E	Yes	12-14	3yrs	No	Yes
SMART Team: Students Managing Anger and Resolution Together	A	Yes	11-15	8 comp uter modules	No	Yes
Lion Quest Skills for Adolescents	A,E	Yes	6-18	Multi-year	Yes	Yes

*Codes for which list the program was cited:
A = SAMHSA http://www.modelprograms.samhsa.gov
B = Penn State http://www.prevention.psu.edu/pubs/docs/CMHS.pdf
C = CSVP http://www.colorado.edu/cspv/blueprints/
D = U.S. Department of Education http://www.ed.gov/admins/lead/safety/exemplary01/exemplary01.pdf
E = CASEL http://www.casel.org/projects_products/safeandsound.php

Table 2. Key strategies for effective school-based prevention programming involve the following student focused, relationship-oriented, and classroom and school-level organizational changes (Greenberg et al., 2003, p. 470)

1. Teach children to apply social and emotional learning (SEL) skills with ethical values in daily life through interactive classroom instruction and provide frequent opportunities for student self-direction, participation, and school and community service
2. Foster respectful supportive relationships among students, school staff, and parents
3. Support and reward positive social, health, and academic behavior through systematic school-family-community approaches
4. Multi-year, multi-component interventions are more effective than single component short-term programs
5. Competence and health promotion efforts are best begun before signs of risky behaviors emerge and should continue through adolescence

Selective Interventions

According to Weisz et al. (2005), selective interventions target "groups of youth identified because they share a significant risk factor and mount interventions designed to counter that risk" (p. 632). Selective strategies are used with students who require more than universal strategies but less than intensive individualized interventions. The purpose of selective or targeted interventions is to support students who are at-risk for or

are beginning to exhibit signs of more serious problem behaviors. Such interventions can be offered in small group settings for students exhibiting similar behaviors or to individual students. In developing selective interventions, Farmer, Farmer, Estell, & Hutchins (in press) suggest the following four questions to guide the choice and subsequent implementation of selective programs: (1) How are the universal strategies currently targeting the youth's academic, behavioral, and social adjustment and can they be strengthened? (2) What individual strategies can be put in place to ameliorate the youth's risk? (3) What individual interventions or supports can be put in place to maintain and build upon positive constraints and protective factors? and (4) How can the youth's progress be monitored in a positive and supportive manner to make sure the developmental system does not reorganize in a negative manner?

A sample of selective interventions is listed in Table 3. For younger youth, *First Step to Success* (Walker et al., 1997) is implemented in the classroom with behavioral criteria set each day; for the in-home portion of the program, parents are taught to reward appropriate behaviors. For older youth *Functional Family Therapy* (Alexander, & Parsons, 1982) consists of 8-26 hours of direct service time with youth and family depending on the severity of disruptive behaviors and consists of five phases: engagement, motivation, assessment, behavior change, and generalization. A selective program that is community based but is growing in popularity as a school-based program is mentoring. The most popular is Big Brothers/Big Sisters (Grossman, & Tierney, 1998) which provides a formal mechanism for the development of positive relationships between at-risk youth and caring adults.

Table 3. A sample of evidence-based selective programs (Kutash et al., 2006)

Program Name	List Cited*	School Based	Age Range	Length of Program	Family Component?	Teacher Component?
First Step to Success	B	Yes	4-5	3 months	Y	Y
Functional Family Therapy	C	No	11-18	8-26 years	Y	N
Big Brothers/Big Sisters	B,C	No	5-18	1 year	N	N
Fast Track	B	Yes	6-12	School year	Y	N
Olweus Bullying Prevention Program	A**,C	Yes	6-18	School year	N	Y

*Codes for which list the program was cited:
A = SAMHSA http://www.modelprograms.samhsa.gov **before 2007
B = Penn State http://www.prevention.psu.edu/pubs/docs/CMHS.pdf
C = CSVP http://www.colorado.edu/cspv/blueprints/
D = U.S. Department of Education http://www.ed.gov/admins/lead/safety/exemplary01/exemplary01.pdf
E = CASEL http://www.casel.org/projects_products/safeandsound.php

Another popular area of evidence-based programming has been bullying prevention with wide-spread adoption of either the *Olweus Bullying Prevention Program* (Olweus, 1991) or the *Success in Stages: Build Respect Stop Bullying* program (Evers, Prochaska, Van Marter, Johnson, & Prochaska (in press). There has also been recent evidence that decreases in bullying has occurred in schools that have attended to the risk and protective factors within the school environment. For example, attending to the following five areas has been

associated with decreasing bullying: (1) teachers develop positive relationships with all students, (2) teachers make their academic programs interesting to students, (3) the school establishes different interventions strategies for children who need extra help (such as mentoring or after-school programs), (4) the school has definitive policies against bullying for students and prohibits teachers from shouting at children or ridiculing them, and (5) the school has a strong non academic program such as music, art, and dance (Orpinas, & Horne, 2006).

Indicated Interventions

According to Weisz et al. (2005), indicated prevention strategies are "aimed at youth who have significant symptoms of a disorder….but do not currently meet diagnostic criteria for the disorder" (p. 632). As stated earlier, there is very little difference between indicated prevention strategies and those interventions focused on treatment of a diagnostic condition. Farmer et al. (in press) suggest six questions to guide the choice and subsequent implementation of multi-level indicated programs and interventions that are targeted to these youth who have challenges in multiple domains: (1) What are the factors contributing to the youth's difficulties and how are they related to each other? (2) What services are needed to address the different problems and how should interventions be coordinated? (3) As an intervention prompts change in one domain, how does it affect other domains? (4) What problem areas are most likely to change and help support change in other domains? (5) As some problem areas are changing, what interventions can be used to change other domain areas that are more difficult to change? and (6) What natural supports and relationships can be developed that will help sustain the gains made in treatment?

Examples of indicated programs are presented in Table 4 (next page). For young children, between 8 and 12 years of age, *Incredible Years* (Webster-Stratton, 1992) can be implemented in schools and is used as both a selective and indicated prevention program. The program uses four formats: 18 to 22 two-hours weekly Dina Dinosaur group therapy sessions for children; 60 Dina Dinosaur lesson plans for the classroom; 12 to 14 two-hour weekly parenting groups; and 14, two-hour teacher classroom management sessions. The *Earlscourt Social Skills Group Program* (Pepler, King, Craig, Byrd, & Bream, 1995) is aimed at reducing aggression in elementary school students through twice weekly, 75-minute group sessions for 12 to 15 weeks. Sessions teach eight basic skills in program modules, classroom activities, and homework. Training sessions are also offered to parents.

There are several indicated programs that are community-based which may augment school programs. Two of these are *Multisystemic Therapy* (MST; Henggeler et al., 1986) and *Brief Strategic Therapy* (Szapocznik, Hervis, & Schwartz, 2003). MST targets older adolescents and has an average duration of 60 contact hours over four months. Intervention strategies are integrated into social ecological contexts (including the school system) and include strategic family therapy, structural family therapy, behavioral parent training, and cognitive behavior therapy. *Brief Strategic Therapy* can be used with students between the ages of 6 and 17 and is delivered in 60 to 90 minute sessions over the course of 8 to 12 weeks. A counselor meets with the family and develops a therapeutic alliance, diagnoses family strengths and problem relations, develops a change strategy, and helps implement those strategies.

In summary, there are many evidence-based mental health programs aimed at strengthening the emotional and behavioral competencies of children and youth that can be implemented in school and target reducing disruptive and aggressive behavior. In recognition of the importance and complexity of implementing evidence-based practices in community settings, the Center for Mental Health Services will release, in late 2007 or early 2008, a guide specifically focusing on the selection and adoption of evidence-based practices for youth with disruptive behavior disorders. This guide will provide materials to help community members determine which evidence-based practice might match their community needs and how much it costs to implement these programs.

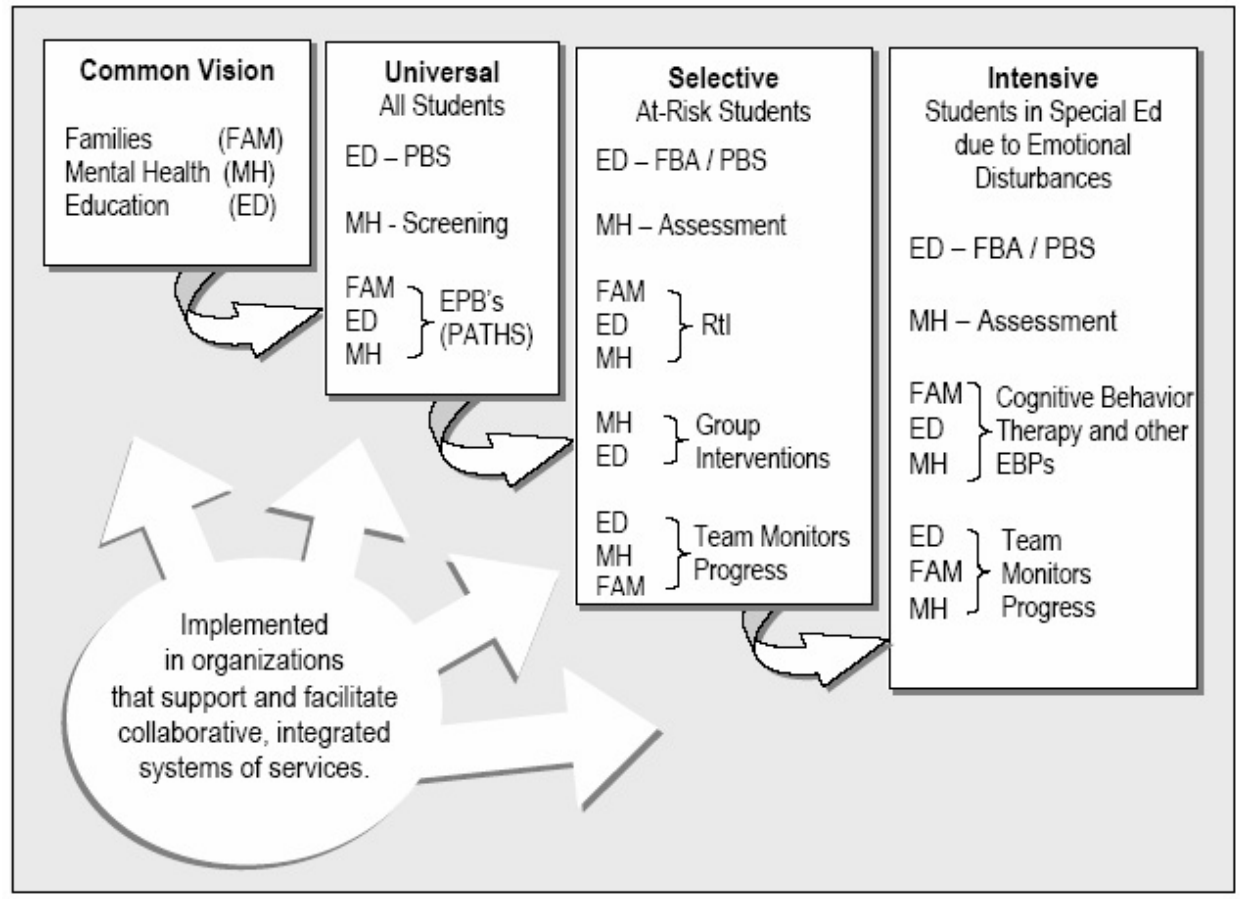
In schools, implementation of programs must be conducted in an integrative manner so that teachers, school staff, and parents each understand their role in the implementation and the expected outcomes. In an integrative team based model of supporting positive emotional and behavioral functioning, see Figure 1 (next page), there is a common vision for families, mental health and education staff. Additionally, there are programs implemented at the universal, selective, and indicated levels that integrate PBS, MH programs and Response to Intervention strategies (RtI) in an organizational environment that supports and facilitates collaborative, integrated systems of service.

Table 4. A sample of evidence-based indicated programs (Kutash et al., 2006).

Program Name	List Cited*	School Based	Age Range	Length of Program	Family Component?	Teacher Component?
Incredible years	AC	Yes	2-8	Up to 22 weeks	Yes	Yes
Multisystemtic Therapy	A C	No	12-17	4 months	Yes	No
Brief Strategic Family Therapy	A	No	6-17	8-12 weeks	Yes	No
Adolescent Transition Program	B	No	10-14	12 weeks	Yes	No
Earlscourt Social Skills Group Program	B	Yes	6-12	12-15 weeks	Yes	Yes

*Codes for which list the program was cited:
A = SAMHSA http://www.modelprograms.samhsa.gov
B = Penn State http://www.prevention.psu.edu/pubs/docs/CMHS.pdf
C = CSVP http://www.colorado.edu/cspv/blueprints/
D = U.S. Department of Education http://www.ed.gov/admins/lead/safety/exemplary01/exemplary01.pdf
E = CASEL http://www.casel.org/projects_products/safeandsound.php

Figure 1. An integrative team-based model of positive emotional and behavioral functioning in children and youth



References

Adelman, H. S., & Taylor, L. (2000). Looking at school health and school reform policy through the lens of addressing barriers to learning. *Children's services: Social policy, research, and practice 3*(2): 117-132.

Alexander, J. F., & Parsons, B. V. (1982). *Functional family therapy: Principles and procedures*. Carmel, CA: Brooks/Cole.

Collaborative for Academic, Social, and Emotional Learning (CASEL). (2003). *Safe and sound: An education leader's guide to evidence-based social and emotional learning (SEL) Programs*. Chicago: Author.

Elliott, D. S., & Mihalic, S. (2004). Issues in disseminating and replicating effective prevention programs. *Prevention Science, 5*(1), 47-52.

Evers, K. E., Prochaska, J. O., Van Marter, D. Johnson, J. L., & Prochaska, J. M. (in press). Transtheoretical-based bullying prevention effectiveness trials in middle schools and high schools. *Educational Research*.

Farmer, T., Farmer, E., Estell, D., & Hutchins, B. (in press) The developmental dynamics of aggression and the prevention of school violence. *Journal of Emotional and Behavioral Disorders*.

Foster, S., Rollefson, M., Doksum, T., Noonan, D., Robinson, G., & Teich, J. (2005). *School mental health services in the United States, 2002–2003* (DHHS Publication No. SMA 05-4068). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Frey, K. S., Hirchstein, M. K., & Guzzo, B. A. (2000). Second Step: Preventing aggression by promoting social competence. *Journal of Emotional and Behavioral Disorders 8*(2): 102-112.

Greenberg, M. T., Domitrovich, C., & Bumbarger, B. (2000). *Preventing mental disorders in school-age children: A*

review of the effectiveness of prevention programs. Prevention Research Center for the Promotion of Human Development, College of Health and Human Development, Pennsylvania State University. Retrieved March 6, 2006 from http://www.prevention.psu.edu/pubs/docs/CMHS.pdf

Greenberg, M. T., Weissberg, R. P., O'Brien, M. E., Zins, J. E., Fredericks, L., Resnik, H., et al. (2003). Enhancing school-based prevention and youth development through coordinated social, emotional, and academic learning. *American Psychologist 58*: 466-474.

Grossman, J. B., & Tierney, J. P. (1998). Does mentoring work? An impact study of the Big Brothers Big Sisters. *Evaluation Review* 22: 403–426.

Henggeler, S. W., Rodick, J. D., Borduin, C. M., Hanson, C. L., Watson, S. M., & Urey, J. R. (1986). Multisystemic treatment of juvenile offenders: Effects on adolescent behavior and family interactions. *Developmental Psychology 22*: 132-141.

Kusche, C., & Greenberg, M. (1994). *PATHS: Promoting Alternative Thinking Strategies*. South Deerfield, MA: Developmental Research Programs, Inc.

Kutash, K., Duchnowski, A. J., & Lynn, N. (2006). *School-based mental health: An empirical guide for decision makers*. Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies, Research and Training Center for Children's Mental Health.

Olweus, D. (1991). Bully/victim problems among schoolchildren: Basic facts and effects of a school-based intervention program. In D. J. Pepler & K. H. Rubin (Eds.), *The development and treatment of childhood aggression*, pp. 411 - 448. Hillsdale, NJ: Erlbaum.

Orpinas, P., & Horne, A. M., (2006) *Bullying prevention: Creating a positive school climate and developing social competence.* Washington, DC: American Psychological Association.

Pepler, D. J., King, G., Craig, W., Byrd, B., & Bream, L. (1995). The development and evaluation of a multisystem social skills group training program for aggressive children. *Child & Youth Care Forum 24*: 297-313.

Schinke, S., Brounstein, P., & Gardner, S. E. (2002). *Science-based prevention programs and principles, 2002* (DHHS Publication No. SMA 03-3764). Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration.

Szapocznik, J., Hervis, O. E., & Schwartz, S. (2003). *Brief strategic family therapy for adolescent drug abuse* (NIH Publication No. 03-4751). Rockville, MD: National Institute on Drug Abuse.

U.S. Department of Education (USEd). (2001). *Exemplary and promising safe, disciplined, and drug-free schools programs, 2001.* Washington DC: Author.

Walker, H. M., Kavanagh, K., Golly, A. M., Stiller, B., Severson, H. H., & Feil, E. G. (1997). *First Step to Success*. Longmont, CO: Sopris West.

Webster-Stratton, C. (1992). *The incredible years: A trouble-shooting guide for parents of children ages 3-8 years.* Toronto, Canada: Umbrella Press.

Weisz, J., Sandler, I., Durlak, J., & Anton, B. (2005). Promoting and protecting youth mental health through evidence-based prevention and treatment. *American Psychologist 60*(6): 628-648.

Zins, J. E., Weissberg, R. P., Wang, M. C., & Walberg, H. J. (Eds.). (2004). *Building academic success on social and emotional learning: What does the research say?* New York: Teachers College Press.