Bringing the *Expanded* School Mental Health Movement to Eastern North Carolina

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Where are the handouts???

- If you want the slides or any of the materials you see today, go to:

http://schultzbk.wix.com/home

Click on "Resources"

The Pros and Cons of Working with Schools...

WHY SCHOOL MENTAL HEALTH?

Schools as Mental Health Provider

(Farmer, Burns, Philips, Angold, & Costello, 2003; Lyon, McCauley, & Vander Stoep, 2011)

- Schools are the *de facto* mental health system for most children and adolescents
  - Provide **70-80%** of all mental health services
- But the research-practice gap is particularly problematic in these settings…

The Research-Practice Gap

(Fixsen, Blase, Horner, Sims, & Sugai, 2013)

Although we largely know what works for children and adolescents, techniques/programs are rarely provided as intended (especially in schools)
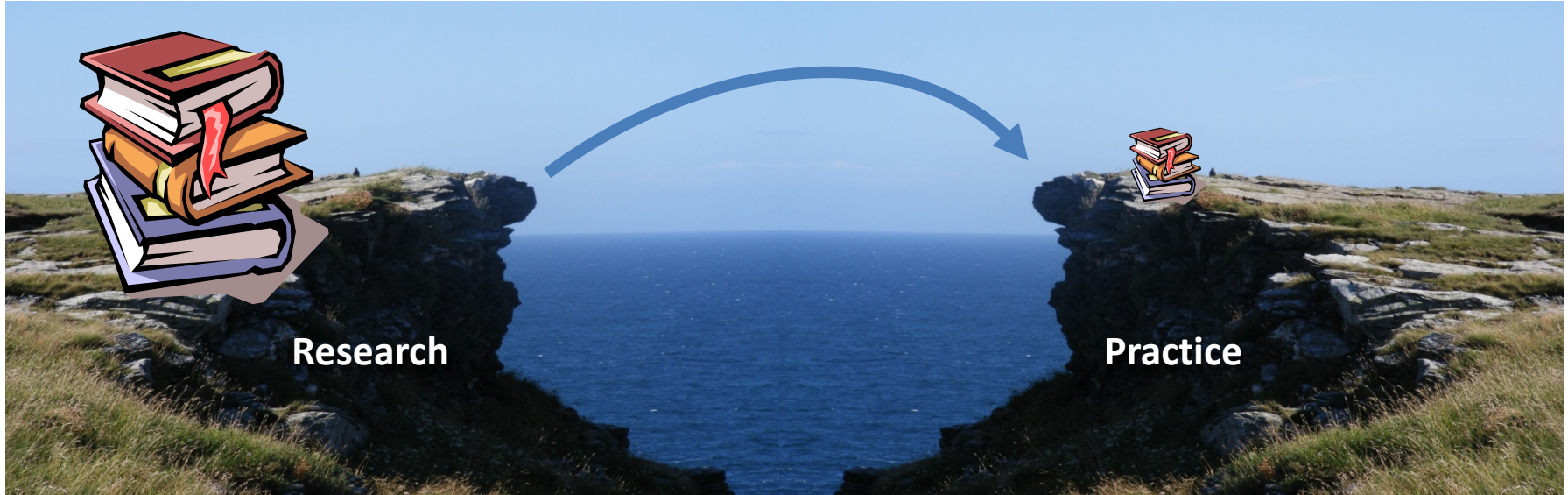
Research

Practice

The Research-Practice Gap

(Fixsen, Blase, Horner, Sims, & Sugai, 2013)

- When interventions are tested, they are tested in isolation
  - Policy, funding, capacity, and regulatory concerns are generally not taken into consideration
- Traditionally, interventions are packaged without a clear recipient in mind

And yes, they are fragile!

The Research-Practice Gap
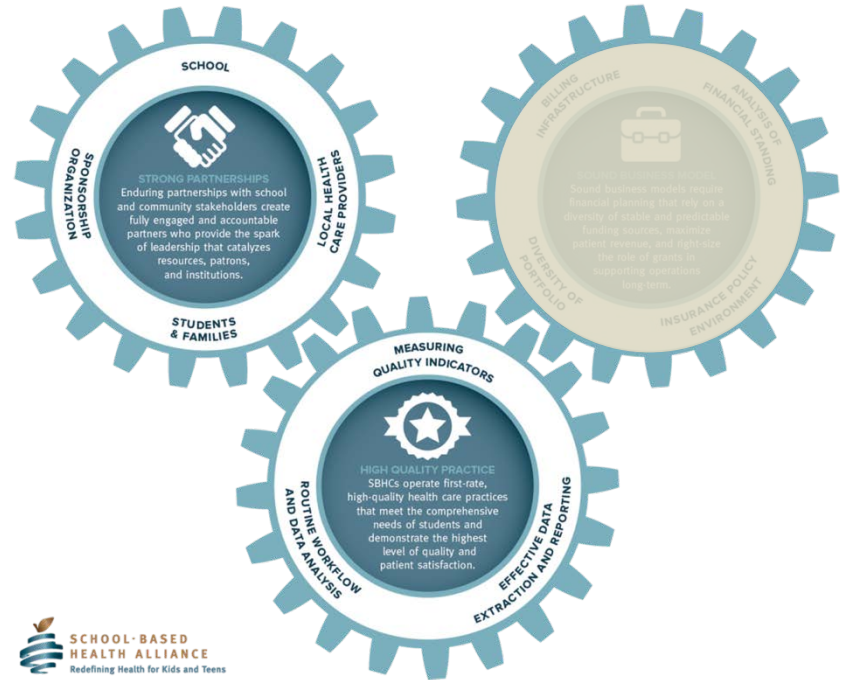
(Langley, Nadeem, Kataoka, Stein, & Jaycox, 2010)

- Can't school-based practitioners use Tx manuals??? Oftentimes, *YES!*
  But it requires **adaptation** to overcome several implementation challenges…
  - Competing professional responsibilities
  - Lack of parental engagement
  - Lack of support from administrators and teachers
  - Session scheduling issues in schools
  - Mismatch between schools and treatment manuals
    - Cost of many treatment manuals is prohibitive
    - Time to learn a new manual can be burdensome
    - There are over **500 treatment manuals** out there!
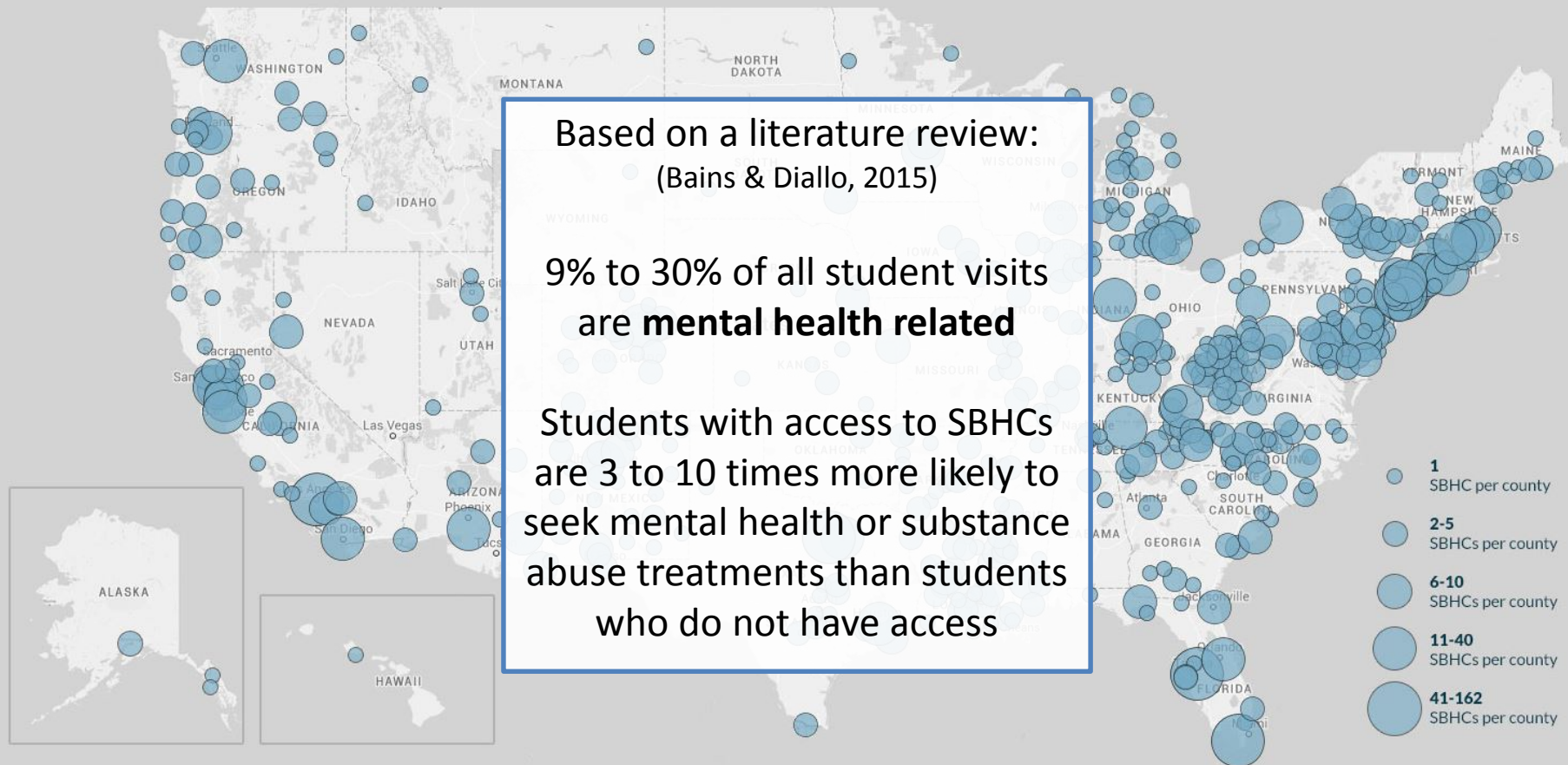
Biggest Challenge: Sustainability

(School-Based Health Alliance, n.d.)

- The greatest challenge moving forward is *sustainability*—a long-term "business plan"
  - But that is beyond our scope for today!

School-Based Health Centers Nationwide

Based on a literature review:
(Bains & Diallo, 2015)

9% to 30% of all student visits are **mental health related**

Students with access to SBHCs are 3 to 10 times more likely to seek mental health or substance abuse treatments than students who do not have access

1
SBHC per county

2-5
SBHCs per county

6-10
SBHCs per county
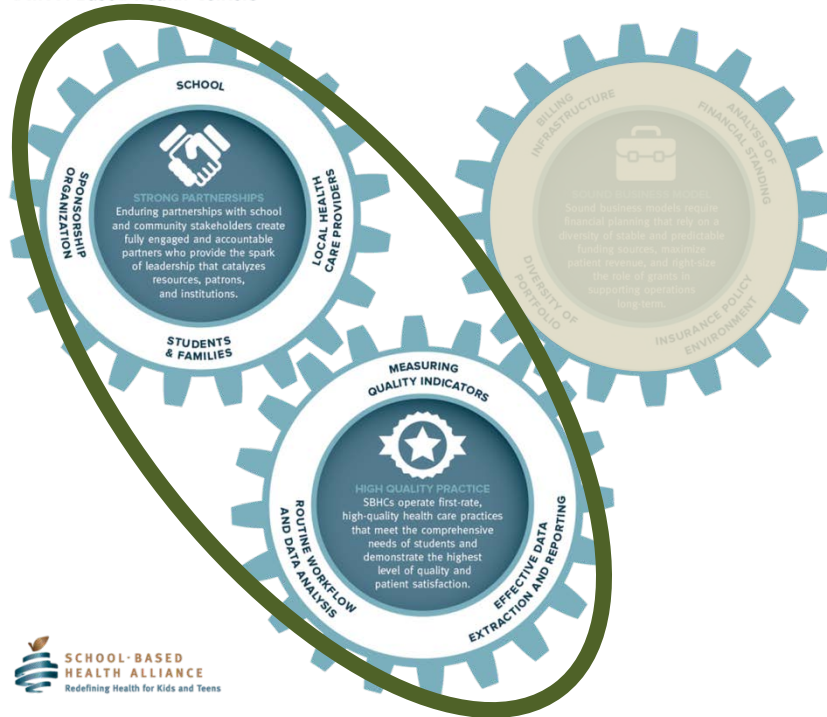
11-40
SBHCs per county

41-162
SBHCs per county

(School-Based Health Alliance, n.d.)

Biggest Challenge: Sustainability

(School-Based Health Alliance, n.d.)

- Instead, I want to focus on building partnerships with schools and transporting high quality services into those settings…
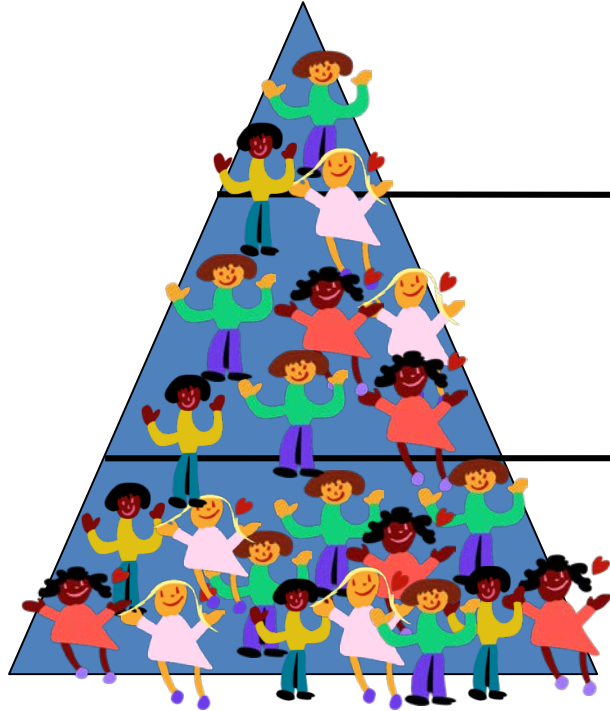
Building Meaningful **Relationships**…

PARTNERING WITH SCHOOLS

Understanding the School Setting

(Slide from Sharon Stephen)

Intervention/Indicated:

Cognitive Behavioral Intervention for Trauma in Schools, Coping Cat, Trauma Focused CBT, Interpersonal Therapy for Adolescents (IPT-A)

Prevention/Selected:

Coping Power, FRIENDS for Youth/Teens, The Incredible Years, Second Step, SEFEL and DECA Strategies and Tools, Strengthening Families Coping Resources Workshops

Promotion/Universal:

Good Behavior Game, PATHS to PAX, Positive Behavior Interventions and Support, Social and Emotional Foundations of Early Learning (SEFEL), Olweus Bullying Prevention, Toward No Tobacco Use

Understanding the School Setting
(Weist et al., 2011)

- Administrators are most concerned with academic outcomes, so SMH is often marginalized
  - Mental health-achievement connection is doubted
- "Extra" services are often seen as *special education*
- Teams in schools often serve perfunctory roles
- Little or no support for securing resources
- FERPA limits communication with agencies (cf. HIPAA)

Speaking Different Languages…

TRUE STORY →
(with a random picture from the Internet)

- Community mental health agency was contracted to provide SMH for a district
- After one year, they presented results to school board:
  - Number of sessions
  - Length of sessions
  - Teacher satisfaction
- The contract was <u>cancelled</u>. *Why?*

Overcoming SMH Challenges
(Weist et al., 2011)

- Underscore the mental health-achievement connection
- Be clear on roles: Map everyone's roles and responsibilities (as well as resources)
  - Write a "memorandum of understanding"
- Create a team that meets regularly to problem solve implementation needs
  - Periodically assess the quality of the collaboration
- Augment existing services, do not supplant them

Overcoming SMH Challenges

- The challenges, however, can be overwhelming

- In our target area:
  - "Tier 1" county economies
  - School counselor caseloads are 1:367
  - Health care provider shortage area (USDHHS)

West Edgecombe Middle School

Year	Teacher turnover
2010-11	33%
2011-12	29%
2012-13	15%
2013-14	23%
2014-15	59%
2015-16	41%

NC principal vows to 'break this cycle' after 60% of teachers leave in one year (8/24/16; WRAL.com)*

Teleconsultation offers one option for communicating with teachers.
This is a screenshot from a three-year study we completed in June 2016.
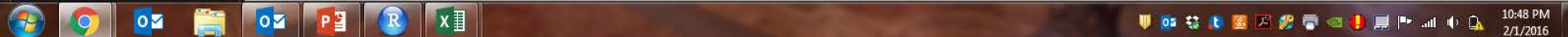
Desktop videoconferencing offers features conducive to meaningful consultation, but technical problems ruined nearly 10% of planned sessions.

Transporting **High Quality Practices** to Schools…

MODULAR THERAPIES

Looking at the Elements

(Chorpita, Daleiden, & Weisz, 2005b)

Proportion of manuals including these elements (0% – 100%)
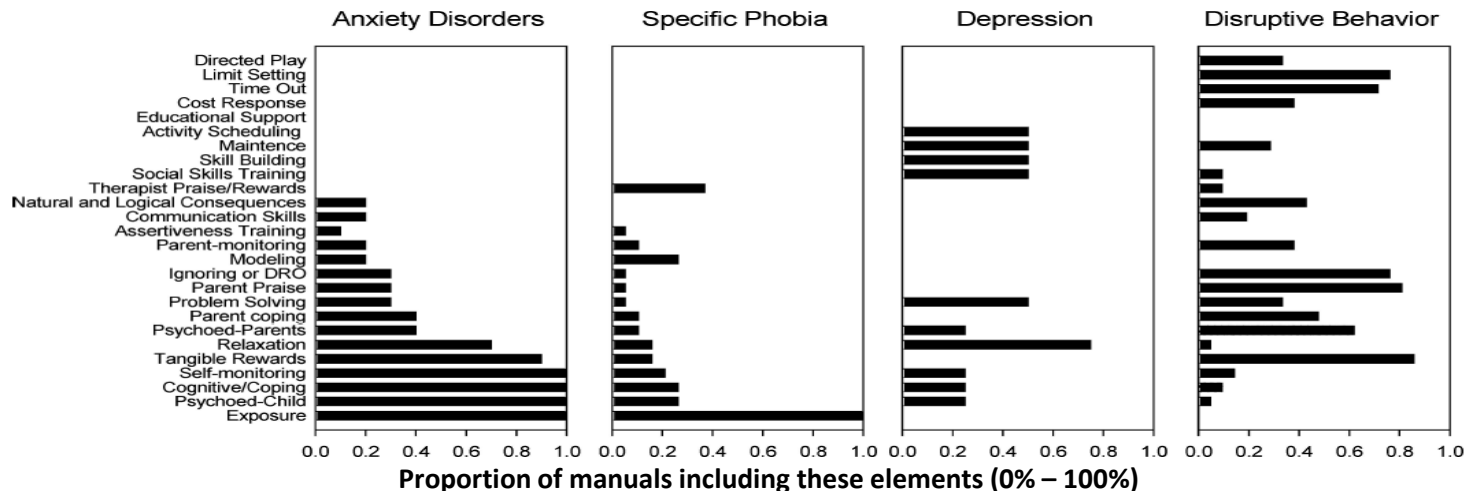
- Early work[1] in this area found clear differences in protocols based on what population (problem area) was targeted…

[1] Using a list of 26 practice elements and 49 evidence-based treatment protocols

Looking at the Elements

(Chorpita & Daleiden, 2009)
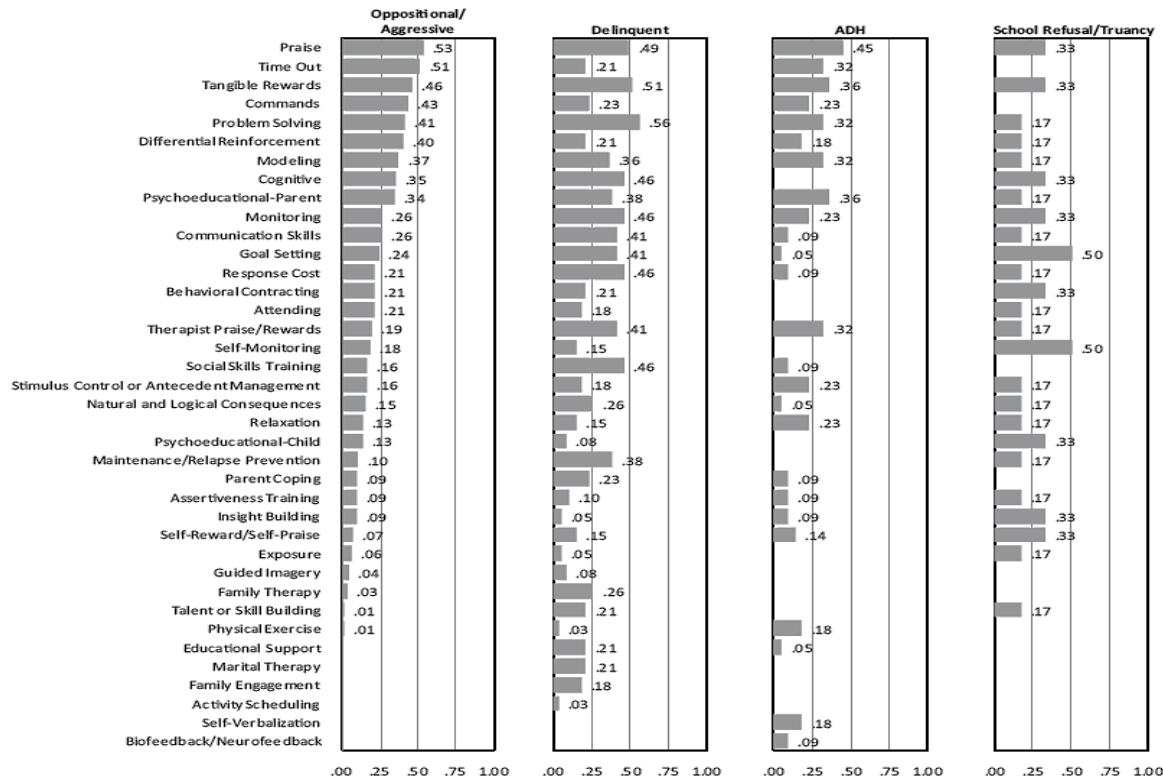
- For example, the most common elements for externalizing disorders include praise, time-out, rewards, goal setting, and problem solving.

Much larger project… 615 treatments from 322 RCTs!!!

Standardized Modules

(Chorpita, Daleiden, & Weisz, 2005a)
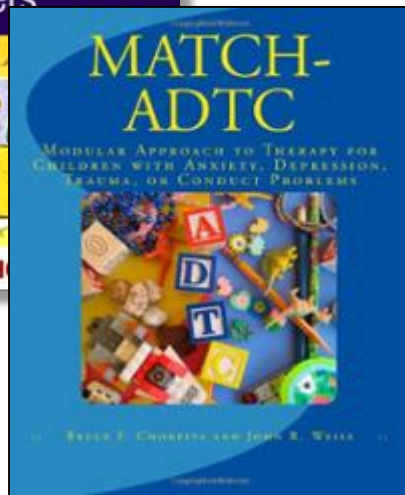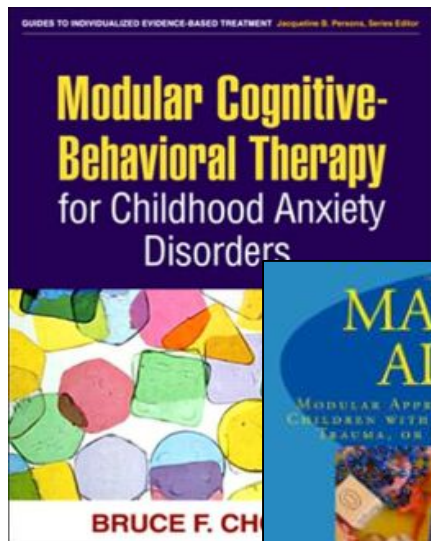
- These efforts have led to two modularized therapy "manuals"
  - **A**nxiety
  - **D**epression
  - **T**rauma
  - **C**onduct problems

Standardized Modules

(Chorpita, Daleiden, & Weisz, 2005a)
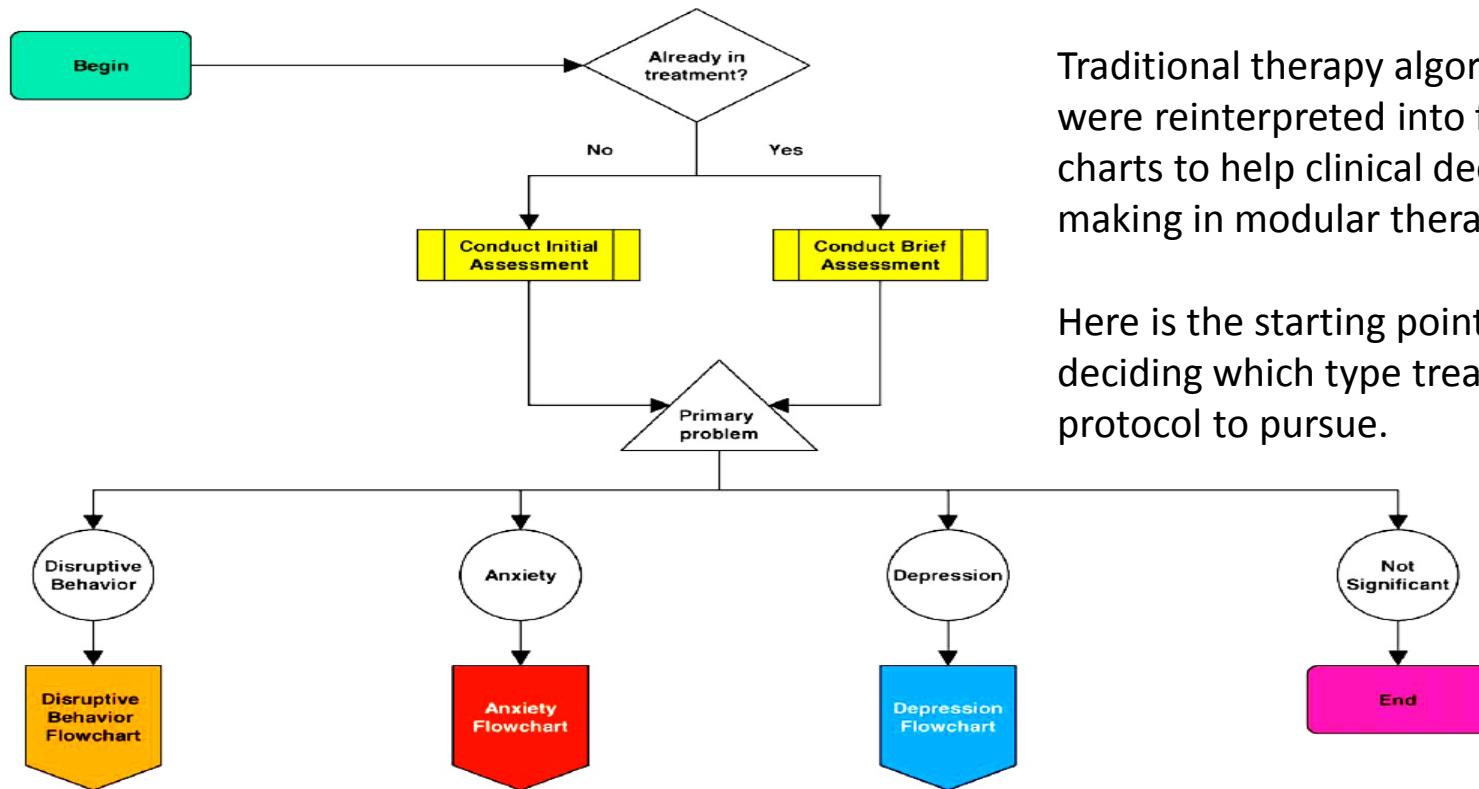
Traditional therapy algorithms were reinterpreted into flow-charts to help clinical decision making in modular therapies.

Here is the starting point in deciding which type treatment protocol to pursue.

Standardized Modules

(Chorpita, Daleiden, & Weisz, 2005a)

This is the sequence of elements in the PASCET manual (treatment for depression)
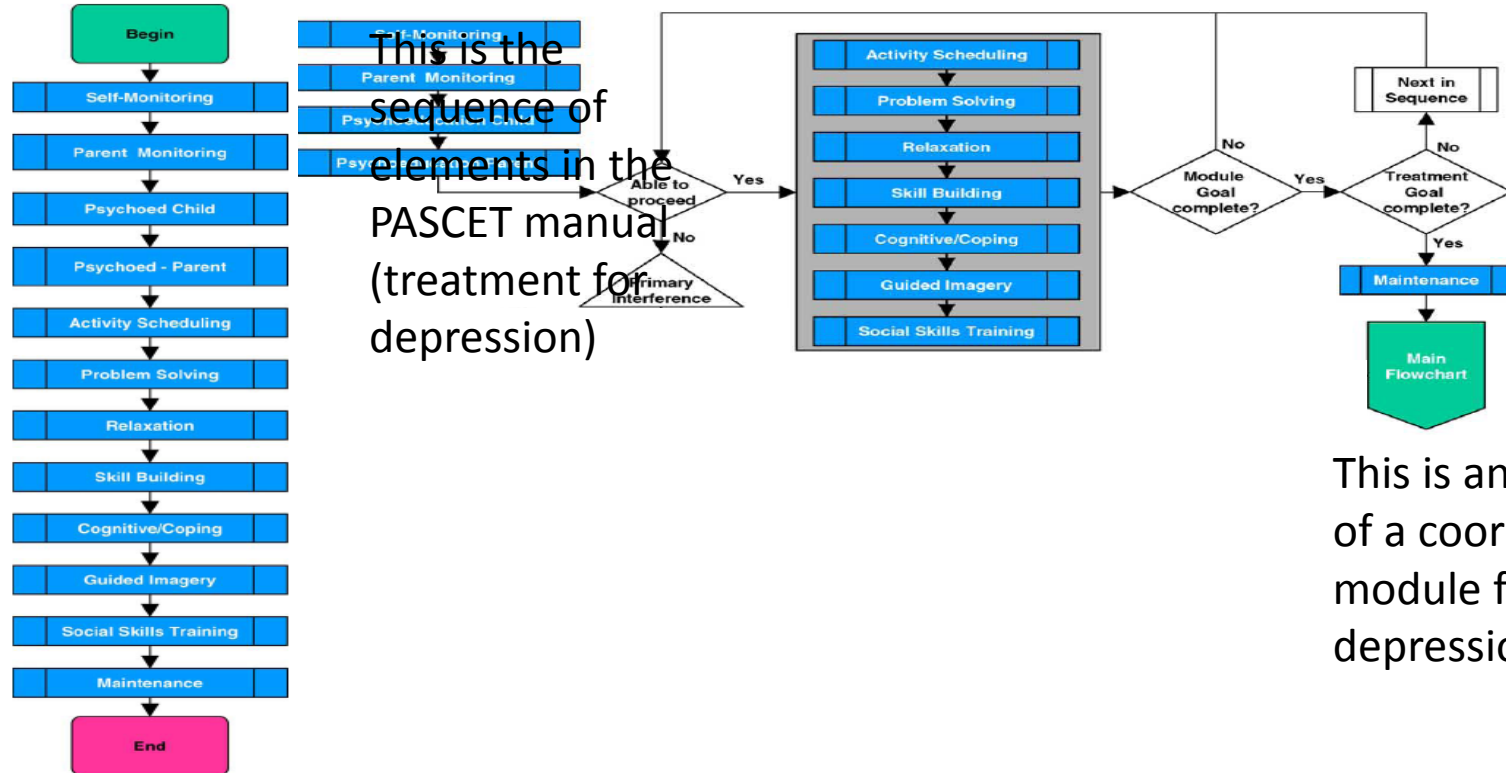
This is an example of a coordination module for depression.

Standardized Modules

(Chorpita, Daleiden, & Weisz, 2005a)
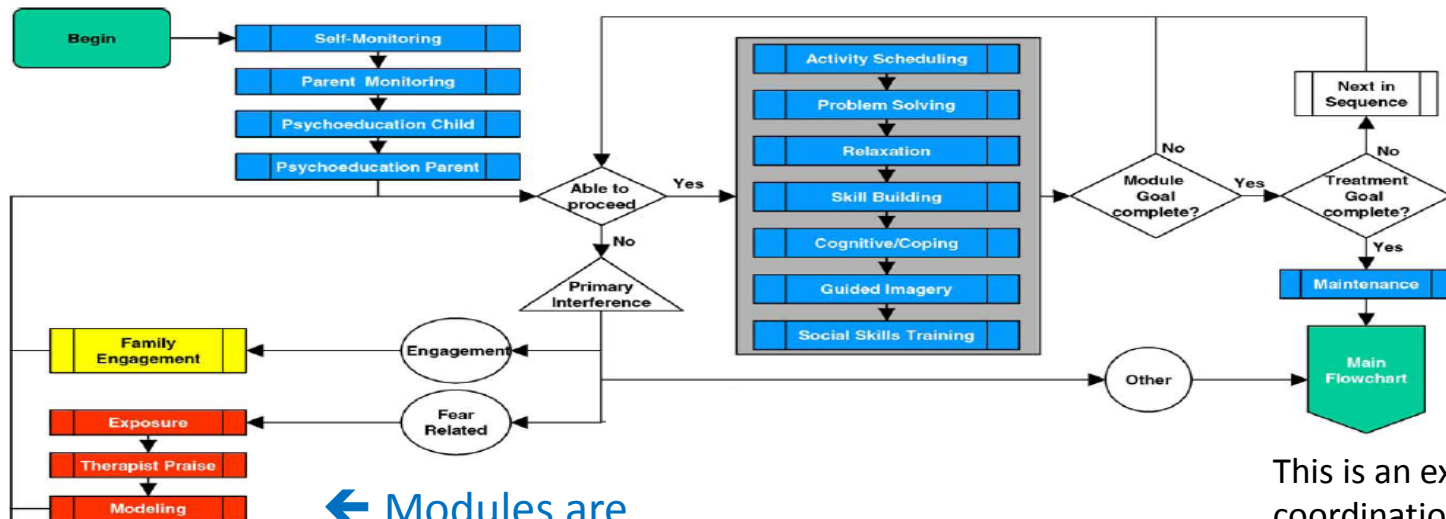
← Modules are brought in from other EBPs to address individual needs.

This is an example of a coordination module for depression.

It offers a menu of options, but with a default sequence suggested.

Standardized Modules

(Chorpita, Daleiden, & Weisz, 2005a)

Traditional Tx Manuals

- Sequencing decisions are done in advance and tested (less clinical judgment)
- Promotes systematic innovation (any changes are whole treatment changes)
- Creates barriers for competitors

Modular Therapies

- Increased product flexibility and variety
- Incremental innovations can revolutionize the way we test new interventions
- Simplifies training into learning modules rather than learning whole manuals

But does it work?

TESTING THE MODULAR CONCEPT

Are Modular Therapies Effective?

(Weisz, Chorpita, Palinkas, Schoenwald, Miranda, Bearman, et al., 2012)

Boston-Hawaii

500 Youths screened for eligibility

167 Youths excluded
  77 Family not interested
  65 Not eligible
    56 Primary problem criterion
    4 Age criterion
    3 Language criterion
    2 Court involvement
  24 Lost to research team (eg, did not show for pretreatment assessment)
    1 Lost funding for services

333 Youths assessed at pretreatment assessment

130 Youths excluded
  125 Not eligible
    121 Primary problem criterion
    2 No therapist availability
    1 Required out-of-home placement
    1 Moving away
  5 Family not interested

96 Therapists randomized, trained
203 Youths allocated

Modular Condition	Standard Condition	Usual Care
28 Therapists	29 Therapists	27 Therapists
70 Youths allocated 8 Did not receive intervention 62 Received intervention	69 Youths allocated 9 Did not receive intervention 60 Received intervention	64 Youths allocated 8 Did not receive intervention 56 Received intervention
62 Youths available for analysis	59 Youths available for analysis	53 Youths available for analysis

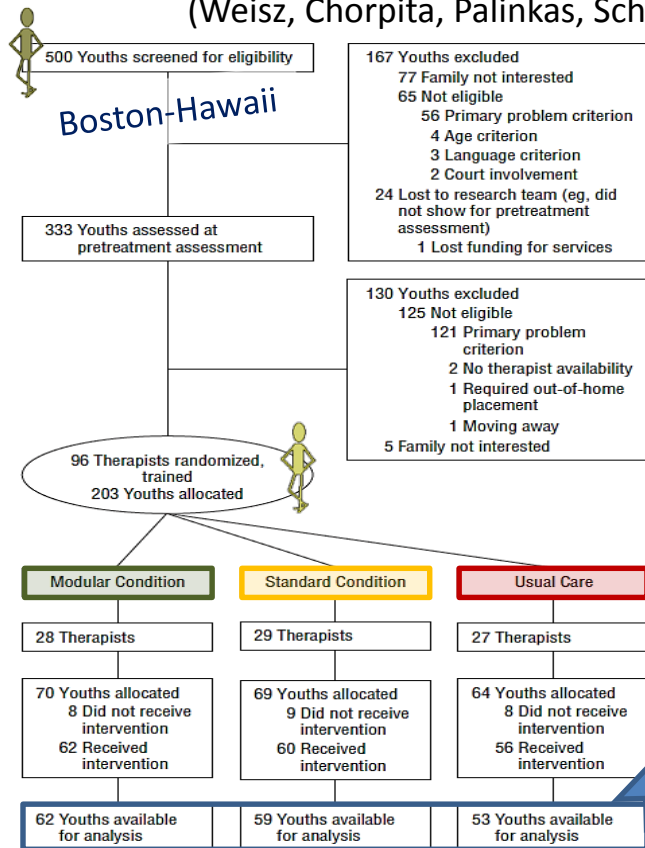**Table 1. Diagnostic Composition of Sample of 174 Clinically Referred Youths 7 Through 13 Years of Age**

Diagnosis	Youths, No. (%) Primary	All
ADHD (any type)	8 (4.6)	101 (58.0)
Combined type	3 (1.7)	50 (28.7)
Predominantly inattentive type	3 (1.7)	27 (15.5)
ADHD NOS	2 (1.1)	23 (13.2)
Predominantly hyperactive-impulsive type	0 (0.0)	1 (0.6)
Adjustment disorder (any type)	2 (1.1)	4 (2.3)
Adjustment disorder with mixed anxiety and depressed mood	1 (0.6)	2 (1.1)
Adjustment disorder with mixed disturbance of emotion	1 (0.6)	1 (0.6)
Adjustment disorder with depressed mood	0 (0.0)	1 (0.6)
Anxiety disorder (any type)	51 (29.3)	99 (56.9)
Specific phobia	0 (0.0)	51 (29.3)
Separation anxiety disorder	22 (12.6)	47 (27.0)
Generalized anxiety disorder	19 (10.9)	40 (22.9)
Social phobia	6 (3.4)	21 (12.1)
Obsessive-compulsive disorder	4 (2.3)	7 (4.0)
Posttraumatic stress disorder	0 (0.0)	6 (3.4)
Panic disorder without agoraphobia	0 (0.0)	1 (0.6)
Conduct-related disorder (any type)	74 (42.5)	115 (66.1)
Oppositional defiant disorder	23 (13.2)	87 (50.0)
Conduct disorder	50 (28.7)	27 (15.5)
Disruptive behavior disorder NOS	1 (0.6)	1 (0.6)
Eating disorder NOS	0 (0.0)	4 (2.3)
Elimination disorder	0 (0.0)	1 (0.6)
Mood disorder (any type)	29 (16.7)	76 (43.7)
Major depressive disorder, single episode	12 (6.9)	34 (19.5)
Dysthymic disorder	6 (3.4)	22 (12.6)
Major depressive disorder, recurrent	5 (2.9)	8 (4.6)
Depressive disorder NOS	4 (2.3)	8 (4.6)
Mood disorder NOS	2 (1.1)	3 (1.7)
Bipolar disorder	0 (0.0)	1 (0.6)
Selective mutism	1 (0.6)	2 (1.1)

[1] Block randomization by training level (doctorate versus master's) was used to ensure equivalence across conditions

Are Modular Therapies Effective?

(Weisz, Chorpita, Palinkas, Schoenwald, Miranda, Bearman, et al., 2012)

- Used MATCH, based on three treatment manuals: *Coping Cat, Primary and Secondary Control Enhancement Training*, and *Defiant Children* (PT). Sequence is altered based on client progress.

Modular Condition

- Depending on the primary concern at intake, participants received either *Coping Cat, Primary and Secondary Control Enhancement Training*, or *Defiant Children*.

Standard Condition

Usual Care

- Clinicians used what they would typically use, and clinical supervision occurred as would normally in the setting (8% overlap)
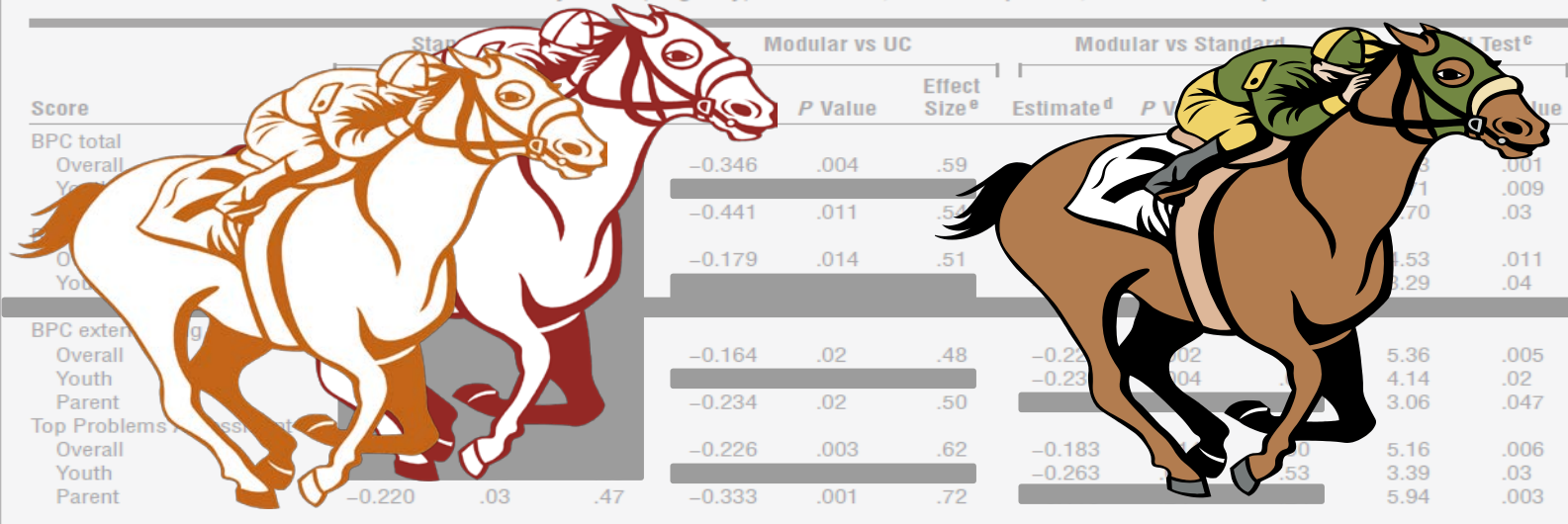
Trained together on all three manuals over six days; received ongoing supervision from project supervisors

Are Modular Therapies Effective?

(Weisz et al., 2012; Chorpita et al., 2013)

12 Outcomes

Table 2. Coefficient Estimates for Condition by Time (Log Day) for Overall, Youth-Reported, and Parent-Reported Scores[a]

Score	Standard...			Modular vs UC			Modular vs Standard			... Test[c]
					P Value	Effect Size[e]	Estimate[d]	P V...		...lue
BPC total										
Overall				−0.346	.004	.59				.001
Youth										.009
				−0.441	.011	.5...		.70		.03
Overall				−0.179	.014	.51		4.53		.011
Youth								3.29		.04
BPC externalizing										
Overall				−0.164	.02	.48	−0.2...	.02	5.36	.005
Youth							−0.23...	.04	4.14	.02
Parent				−0.234	.02	.50			3.06	.047
Top Problems Assessment										
Overall				−0.226	.003	.62	−0.183	....	5.16	.006
Youth							−0.263	.53	3.39	.03
Parent	−0.220	.03	.47	−0.333	.001	.72			5.94	.003

Abbreviations: BPC, Brief Problem Checklist; UC, usual care.
[a] There was a total of 174 youths for each analysis.
[b] All standard vs UC comparisons are regarded as nonsignificant, following initial correction for multiple tests (see Results).
[c] Omnibus test of group by log day (comparing the 3 treatment groups).
[d] Estimate of the group × log day interaction, adjusted for all other effects in the model. A negative interaction indicates that the treatment group to the left showed a faster reduction in problem severity over time than the group to the right (eg, in the modular vs UC column, a negative sign means that severity was reduced more quickly during modular treatment than during UC).
[e] Effect size (ie, magnitude of the difference in rates of change expressed in SD units) is the ratio of the difference in rates of change divided by the square root of the time trend variance; it indicates the absolute value of the standardized magnitude of the effect.

What about Schools?

(Michael et al., 2016; Weist et al., 2009; Weist et al., 2014)
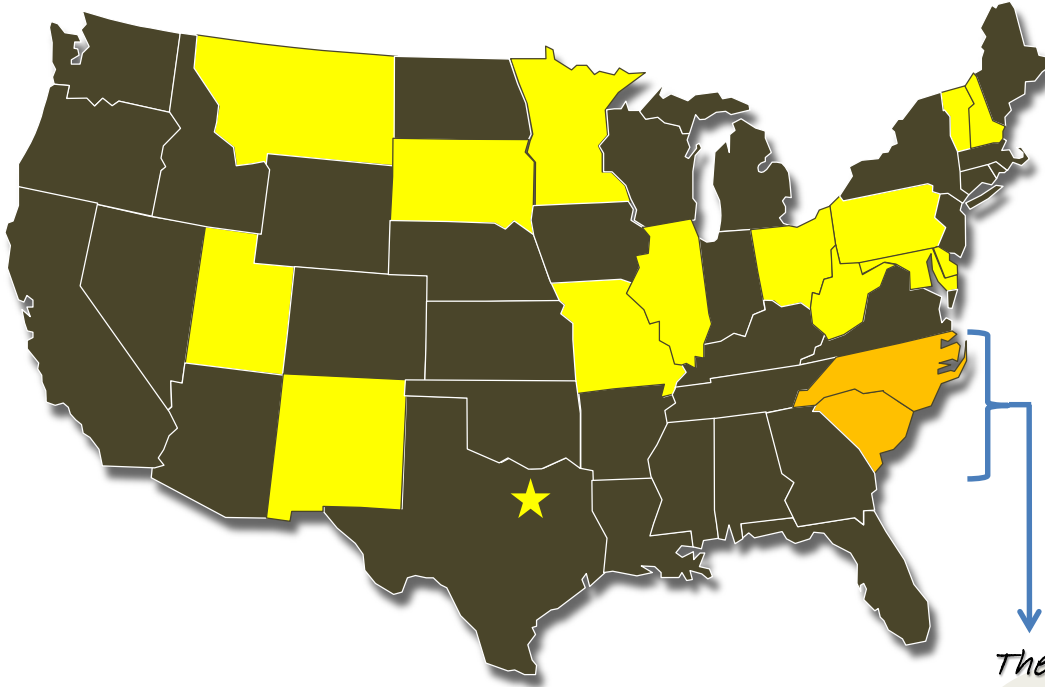
Recent studies have examined modular therapies in schools.

Results are promising: The quality of school-based treatments appears to improve following training and support of modular EBTs.

The Carolina Network for School Mental Health
www.carolinanetwork.org

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