

School-Based Models



Chapter 9

Chapter 9: School-Based Models

Michael Stayed in the General Education Classroom

Introduction

Best Practices (Best Practices for Educating Students with Serious Emotional Disturbance in Their Local Public Schools and Communities) was a three year grant funded by the US Office of Education and Rehabilitative Services. The purpose of the grant was to use best practices in the development of programs and services for students with serious emotional disturbance (SED) and their families, so that the students could remain at their local public schools, or plans could be developed so that the students could return from alternative placements. The grant was a collaborative effort between local Vermont schools, the University Affiliated Program of Vermont (UAP), the Vermont Interdisciplinary Team for Intensive Special Education (State I-Team), and the Vermont State Department of Education, Division of Instructional Support Services. Mechanisms with local and state Departments of Education, Mental Health, and Social Services were developed to facilitate the model programs. The model programs and support services that were developed through involvement of the Best Practices project focused on parent and student centered services, family-school collaboration, collaborative teaming, classroom accommodations, peer support, instructional support services, teaching prosocial skills, interagency involvement, behavior management, and transition planning.

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Method

Subjects and Sites

A total of twenty-seven schools in twenty-two different school districts across Vermont participated as sites in this project. All the sites had students with serious emotional disturbance as defined by the Federal Educational definition of severe disabilities and serious emotional disturbance (P.L. 100-476 of 1990), or Vermont's Act 264 definition of severe emotional disturbance (Vermont Act 264 of 1988).

The school sites chosen for participation in the project met the following criteria: (a) administrative commitment at the building level for educating students with serious emotional disturbance within the regular education environment; (b) willingness to establish a "school-wide planning" process to assist in developing plans for implementing best practices for all students (Fox & Williams, 1991); (c) on-site case manager for each student with serious emotional disturbance involved in the project; (d) commitment from school administration and school staff to in-service training and participation in the project; (e) commitment to provide school based family support services and to involve parents in all aspects of students' programs; (f) commitment to communicate with and involve local mental health and social service agencies to support each student's program needs; and (g) willingness to use an individual student support team process (Hamilton, Welkowitz, Mandeville, Prue, & Fox, 1995) to assist in developing and implementing educational activities for at least one student with or at risk of serious emotional disturbance.

The thirty-six participating students with SED, in grades K through 12, were either at risk of removal from their educational setting or were returning to their regular educational setting from a more restrictive placement.

Intervention

An individualized approach to each student and school participating in this project was emphasized. A school planning team was formed at each school site. The school planning teams involved administrators, school board members, parents, regular educators, and special educators, a member of the school's instructional support team, other community mental health and social service agencies, and local community members. One focus of the school planning team was to examine existing educational practices and to recommend changes and improvements which would enhance the education of all students. Additional activities included: (a) identifying resources which were available to the school; (b) determining the availability of best practices for students; (c) identifying support needs of students, families, and staff; (d) identifying needed changes in school policy and service related delivery; and (e) developing an action plan for attainment of one goal as determined by the school planning team.

Individual student planning teams were formed around each child and their family. Members of these teams attended a Fall Institute which focused on using a functional assessment process (Hamilton et al., 1995) to determine areas of need for the student, identifying and making educational accommodations, and using a problem solving process to identify prevention, teaching, and response strategies for problematic behaviors by the student. Each individual student planning team typically included the student's parent(s), classroom teacher, special educator, guidance counselor, a member of the school's instructional support team, and the school principal. Extended Team members included the State I-Team regional consultant, representatives from mental health, social services, and other relevant community agencies.

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The purpose of the student's planning team was to support and assist the teacher in developing and implementing the student's educational activities, to provide a vehicle for home-school communication and support, and to develop transition plans between grade levels, schools, and into adulthood. Typical activities of the student planning team involved: (a) identifying training and information needs; (b) developing long-range educational plans for the student; (c) adapting and accommodating regular education activities; (d) problem solving and implementing strategies for problematic behavior; and (e) accessing mental health and social services agencies for needed services.

Evaluation

The project used quantitative and qualitative methodology to evaluate outcomes. Semi-structured interviews were conducted at the beginning and end of each school year with the students with SED, their peers, their parents, and their regular and special education teachers.

Surveys and questionnaires were completed at the beginning and end of each school year by the student's family, his or her peers' families, the student's administrator, and regular and special educator. Members of the students' individual support teams completed a survey in regard to their teaming process and their success in addressing the needs of students with SED. *T*-test analyses were conducted for each question to determine whether the participant's response prior to participation in the project was significantly different from their response following participation, support, and training.

A behavior checklist was also completed at the beginning of the school year and at the end of the school year by: (a) the student, if eleven years old or older, using the Youth Self Report (YSR; Achenbach, 1991b); (b) his or her teachers, using the Teacher's Report Form (TRF; Achenbach, 1991a); and (c) his or

her parents, using the Child Behavior Checklist (CBCL; Achenbach, 1991). *T*-test analyses were conducted to determine whether the scores were significantly different for each of these measures following training, support, and participation in the project.

Results

This project involved thirty-six students with SED who were in grades K through 12 in twenty-seven schools in twenty-two different school districts, their respective families, educational and related service providers, community based service providers, and communities. All but two of these students were successfully educated within the regular education classroom in their local public school.

Surveys and Checklists

There were no statistically significant differences in how the classmates' families ($N = 174$) responded to the Family Survey questions (see Table 1), or for the administrators' responses ($N = 13$) on the Administrator's Survey (see Table 2), between the first and second administration. Overall, their responses were neutral in regard to any of the given statements.

There were several statistically significant differences for the teachers' responses ($N = 30$) between the first and second administration (see Table 3) of the General Education Teacher Survey and Special Education Teacher Survey, and in how team members ($N = 118$) responded between administrations of the Individual Student Planning Team Survey (see Table 4).

There were no statistically significant differences between the pre- and post-administrations of the CBCL, YSR, and TRF. The students with SED continued to be perceived by others and themselves as having behaviors within the clinical range following participation in the project.

Table 1
The Families' Responses to Survey Statements (

- "My child feels comfortable interacting with children who have emotional difficulties."
- "My child feels more comfortable interacting with people who have emotional difficulties than I did when I was a youngster."
- "The opportunity to interact with a classmate who has emotional difficulties has had a positive impact on my child's social/ emotional growth."
- "My child feels positively about having a classmate who has emotional difficulties."
- "Having a classmate with emotional difficulties has interfered with my child receiving a good education."
- "Overall, I feel that having a classmate with emotional difficulties has been a positive experience for my child."

Note. Responses to the above questions were neutral, neither agreeing or disagreeing.

Table 2
Summary of the Administrator's Responses to Survey (

- "I would have a student with SED in my school if I had a choice."
- "I have been involved in developing the educational program for the student with SED."
- "I feel as if I'm doing enough to include the student with SED."
- "I am not afraid."
- "I have developed a relationship with the student with SED."
- "I think the specialists know what to do with students with SED."
- "I feel like I am getting support."
- "The student with SED's presence does not interfere with my ability to address the educational needs of my other students."
- "I feel very comfortable with the student with SED."
- "Given appropriate supports, I would welcome a student with SED in my school in the future."
- "(Having the student with SED in a general education class is having a positive impact on the other students.)"
- "(I believe any teacher can teach any child in his/her general education classroom.)"
- "(Getting to know kids with emotional problems is not very different from getting along with other people in life.)"
- "(The paraprofessionals have received adequate training.)"

Note. Responses enclosed in parentheses received a neutral endorsement, neither agreeing or disagreeing.

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Table 3
Summary Of The General And Special Educator's Responses To Survey

"I would have the student with SED in my class if I had a choice."

"I have been involved in developing the educational program for the student with SED." *

"I think of the student with SED as one of the students that I educate."

"I feel like I'm doing enough to include the student with SED."

"I am not afraid."

"I have had adequate training in how to adapt activities and lessons for the student with SED."

"I have developed a relationship with the student with SED."

"I think there are specialists who know how to help me with the student with SED."

"I feel like I am getting support."

"The specialists and other visitors who come in are not a problem or disruptive."

"It is not disruptive to have the student with SED receive specialized services."*

"The student with SED's presence does not interfere with my ability to address needs of my other students."*

"Having the student with SED in my general education classroom is having a positive social/emotional impact." **

"I believe any teacher (given support), can teach any child in his/her general education classroom."

"Getting to know kids with SED is not very different from getting along with other people in life."

"I feel very comfortable with the student with SED."*

"I include the student with SED in everything that we do even though his/her educational objectives may be different."

"The paraprofessionals assigned to my class have received adequate training."

"Given appropriate supports, I would welcome a student with severe emotional disturbance in my class in the future."

* $p < .05$. ** $p < .01$

Table 4
Summary of Individual Student Planning Team Members' Responses to Survey (

- The current level of acceptance of students with SED by their teachers is high.
- Social, affective, self control and recreational skills are considered during assessment and developing goals and objectives.
- We develop plans (e.g. transition, vocational, social integration) for students with SED.*
- Each needed plan is developed by an educational team.
- Specific/ strategies are used to encourage ongoing communication with students' parents.
- The current level of parent involvement in student planning activities is high.
- The student's parents are provided opportunities to participate in developing their child's programs and services.
- Students with SED who attend the school are regularly scheduled into regular classes.
- At least one student with serious emotional disturbance at this school needs community based training.
- Students with SED need other types of instruction. (e.g., social, behavioral, affective).**
- Students with SED are regularly scheduled to participate in all regular school activities.
- Educational teams have members representative of the people needed to develop and implement programs.
- The schools commitment to team for students with SED is high.
- My commitment to participate in planning for students with SED is high.
- I am satisfied with the process used to develop students' individual program plans.
- A collaborative teaming process is regularly used to accomplish planning team tasks.
- Educational teams are independent in developing plans for individual students.
- (The current level of acceptance of students with SED by their peers and community members is high).
- (Vocational skills are considered during assessment and the development of long range goals and objectives).
- (Community-based training if needed, is provided on a regular basis).*
- (More specialized instruction is provided on a regular basis).
- Long term goals (goals to be achieved in two or more years in the future) are set for students with SED).
- (I am satisfied with our educational programs serving students with serious emotional disturbance).*

* $p < .05$. ** $p < .01$

Note. Responses enclosed in parentheses received a neutral endorsement, neither agreeing or disagreeing.

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Semi-Structured Interviews

The students did not specifically attribute their experiences to being in inclusive classrooms; however, three themes did emerge from the data that were related to going to school with typical peers. These included how students solve problems, how students cope with challenging situations, and a student's desire to help others.

All of the educators were asked what effect inclusion had on them professionally and personally. Their responses focused on: (a) quality of education for the student; (b) awareness of individual student differences and needs; (c) awareness of the needs of all students; (d) patience, workload and stress; and (e) style of teaching. When the responses from the two interview sessions with each teacher were compared, it was found that the educators' perceptions did not change. For example, if their perceptions were initially negative in regard to inclusion of students with serious emotional disturbance in the regular classroom, they remained negative, despite the student's program being successful overall.

With the exception of one participant, the special educators in this study felt that inclusion had made a positive impact on their professional and personal lives. One of the primary benefits was that the educators felt they were able to work as a team to serve these students.

With respect to parents' involvement in the team process, the results indicated that parents varied in the degree to which they felt like a full team member with an equal voice in decision-making. On one end of the continuum were parents who expressed minimal involvement with the teams, and at the other extreme were parents who indicated that they were "most definitely" full team members, with equal say in all decisions regarding their children.

Discussion

Students with SED are often viewed as the one group of students receiving special education services who cannot be successfully included within the regular classroom environment in their local public schools. Few studies, however, have been done in schools which fully include these students in the regular classroom.

In the Best Practices Project, the development and implementation of educational strategies which emphasized prevention and the teaching of replacement skills allowed almost all of the participating students to continue to receive their educational services within the regular education classrooms. The findings from the project evaluation suggest that with adequate school-wide planning and access to training, and use of an individual student support planning team process, peers, parents, administrators, special educators, and regular educators are willing to have students with SED within the regular classroom in their local public school.

Based on these initial findings, the above study is now being extended to include up to forty rural school sites across the nation. It is expected that participation as a site will lead to supportive and proactive interagency planning and inclusion of children and youth with SED in their general education classroom in their local public school in other rural states.

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Onward to Outcomes in the School of the Future

Introduction

In conjunction with the school reform and children's mental health movements, the concept of full service schools has received considerable attention in the last few years (Dryfoos, 1994). At the same time, increasing attention has been given to the need for outcome measures of effectiveness across the spectrum of health and human services. This summary reports on efforts to conduct longitudinal research to assess the efficacy of a comprehensive school-based service program in Texas, the School of the Future project.

The School of the Future, funded by the Hogg Foundation for Mental Health, was a five year demonstration project in four Texas cities: Austin, Dallas, Houston, and San Antonio. Each site received a grant of \$50,000 per year for five years to develop and coordinate health and social services through targeted schools in low income, predominantly ethnic minority locales. Services were provided for children from pre-natal care through age 15, and their families. The grant essentially provided salary and benefits for one full time position, the Project Coordinator, with a small operating budget. The grant was intentionally small enough that direct purchase of services was a very limited option, thus directing efforts of the Coordinators toward collaborative efforts with existing resources, or securing outside funding for services. The purpose was to develop a potentially replicable, affordable model of comprehensive service delivery which could be used in localities with limited financial resources.

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In addition to the one million dollars in direct grant support, the Hogg Foundation committed an equal amount to indirect support, primarily for evaluation of the project. The evaluation plan for the School of the Future was enhanced through consultation with directors of two earlier projects, Dr. James Comer (Comer, 1980; 1988) and Dr. Edward Zigler (Zigler, 1989), and a school-based service project in Philadelphia funded by the Center for Education in the Inner Cities (CEIC) Project at Temple University (Keir, Culler, & Diamond, 1993). An interdisciplinary team of evaluation research consultants was drawn from the University of Texas at Austin, the University of Texas Health Science Center in Houston, the University of Texas Health Science Center in San Antonio, and Southwestern Medical School in Dallas.

The purpose of the School of the Future evaluation was (a) to assist in site planning for program development, (b) to inform key decision makers including legislators, and (c) to develop a blueprint for replication of the model. Additionally, it was recognized that the development of a large scale longitudinal database of the physical and mental health of primarily Hispanic children from low income neighborhoods was unique and could foster additional on-going research. A total of approximately 12,000 students across the four program sites were included in the longitudinal database. This report focuses on one site (Site A) with about 3,000 students.

The intervention model represented in the School of the Future was based on an implicit *theory of practice* that a program of comprehensive integrated family social services, made accessible through local schools, will improve family functioning, student health, mental health, and academic performance. The *research question* which drove the evaluation efforts was: Given a shared vision of comprehensive services and community empowerment, can a targeted investment in a

single individual serve as a sufficient catalyst to identify, implement, and coordinate services to improve student mental and physical health, and academic performance?

Method

Evaluation Design

The evaluation included two primary components, a systemic analysis and an effectiveness study based on student outcomes. Although a number of students did receive direct services as a result of the School of the Future, the intervention was primarily a systemic intervention—the introduction of a single individual to serve as a catalyst for the development and delivery of comprehensive services. The *systemic analysis* was based on a process evaluation of program implementation, including (a) an ethnographic study of the community which included repeated key informant interviews, (b) a community needs/assets assessment completed by trained neighborhood volunteers, and (c) family interviews conducted at the end of the grant period. Finally, an impact study which evaluated the relative costs of bringing services into the community and the benefit achieved for the community was conducted.

The *effectiveness study* initially attempted to use a quasi-experimental design including a comparison school matched for ethnicity and percent free lunch. This was later altered, dropping comparison school data and instead attempting to develop matched comparisons within the target schools. In addition, longitudinal data was collected on individual students. Nationally normed instruments were complemented by school district data on student attendance, discipline and achievement. Changes in student mental health, self-esteem, and perceptions of school climate were evaluated. The study sample included all students enrolled in the target schools. Parental consent was declined for a small proportion of students ($\leq 5\%$).

Measures and Data Collection

The focus of the School of the Future is the student; its ultimate goal is to improve the quality of life for children. From earlier school-based efforts, we know that changes at the school level do not occur quickly. We looked for changes at the community level which could be linked to the project as well as changes in school climate, in families who received considerable direct services, and in the physical and mental health, self-concept self esteem, and academic achievement of students.

Student surveys comprised the primary instrument for data collection using standardized instruments. All students in the target schools served as the sample. Parent consent was secured prior to student inclusion. Middle school students annually completed a survey packet during a single class period which included Achenbach's Youth Self-Report (YSR) version of the Child Behavior Checklist (Achenbach, 1991a), the "School Life" section of the National Education Longitudinal Study (National Center for Education Statistics, 1988), and Rosenberg's Self-Esteem Measure (Rosenberg, 1965). School district data was also obtained including information on grades, standardized test scores, and attendance. District data were linked to individual student's survey responses. For elementary-aged students, teachers annually completed the Teacher Report Form version of Achenbach's Child Behavior Checklist (Achenbach, 1991b). School climate was measured using an annual administration of the "Teacher School Climate" survey of the National Education Longitudinal Study (National Center for Education Statistics, 1988).

Results

Community Impact

The School of the Future project was perceived as clearly successful in all four cities. Though Hogg Foundation funding ceased in August, 1995, the project has continued and has been replicated in each of the original sites. More specifically for Site A, the School of the Future appears to have had considerable measurable direct impact on the community. Over \$670,000 in new money for direct services to children and families was generated, and more than thirty new service programs in areas of health, violence prevention, parenting support, mental health, recreation, and academic enrichment were secured and coordinated. As Figure 1 and Figure 2 reflect, about 1,000 children and families per year received direct services. When multiple contacts are considered, more than 16,400 instances of service provision per year were noted (65,000 for the entire project).

Figure 3 reflects results of a benefit to cost analysis based on program component over a four year period. Some service components, such as the health care center, had higher start-up costs than others. A benefit to cost analysis was also conducted for the Project Coordinator position. Though the ratio was less than 1.00 during the first two years of the project, indicating that supporting the Coordinator was more expensive than the return in dollar value of services secured, by year five that ratio exceeded 20:1. For the five year duration of the project, the benefit to cost ratio for the Project Coordinator was approximately 4:1. A number of indirect impacts were also identified repeatedly by key informants. Among these were the evolution of a neighborhood collaboration model for the city, development of important linkages with other organizations, and the development of parents as leaders and community advocates. A conservative estimate of the indirect monetary value of the

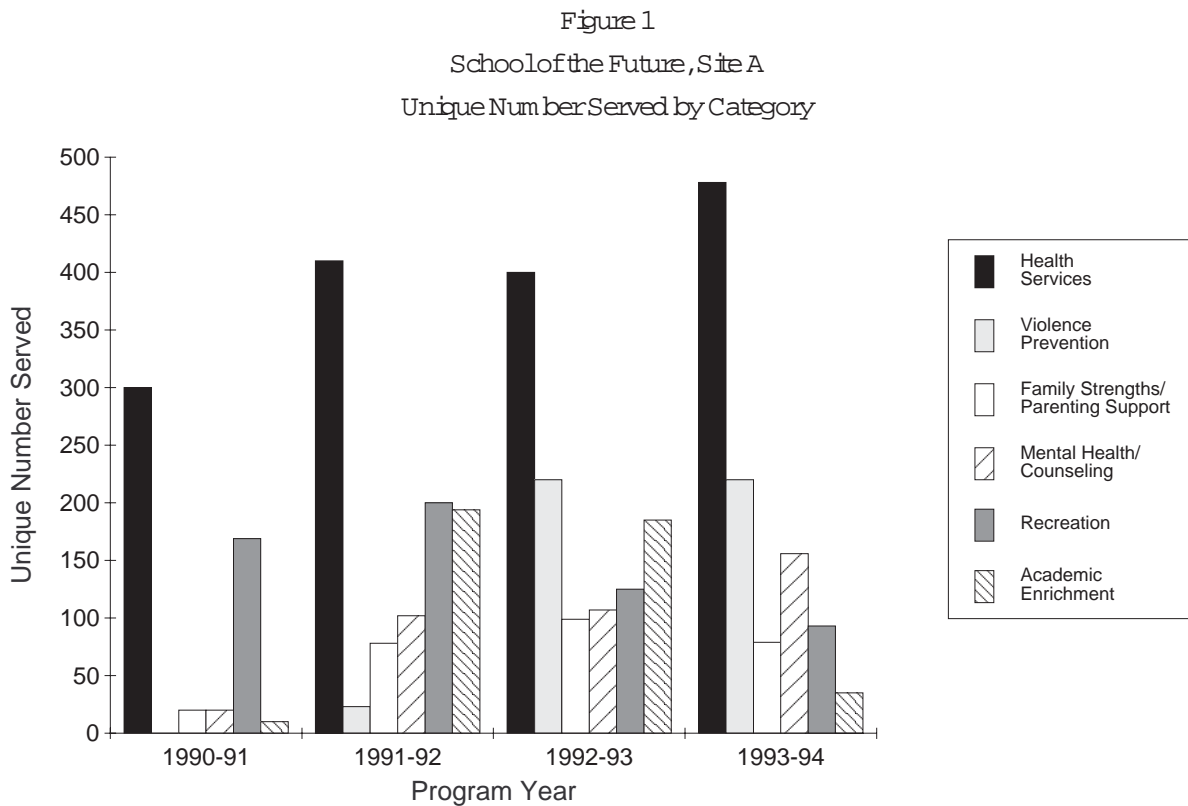
School of the Future project for the community was in excess of \$1.3 million.

Student Outcomes

While it can be argued that the School of the Future project had an important direct impact on the community, the question remained whether the intervention was effective in terms of student outcomes. Though only one site is presented in this report, and results are still considered preliminary, similar trends are apparent across the other sites. Using the norms associated with the Achenbach Youth Self-Report (YSR), students appeared much more similar to the referred sample than the non-

referred during the baseline period. This raised some questions for the research team regarding interpretation. For this reason, raw scores were used rather than the norms associated with the instrument. Table 1 summarizes results of the YSR. There was no sustained significant change as measured with the YSR ($p \leq .05$).

Student self-esteem was measured using the Rosenberg Student Self Esteem Scale. Two of the ten items on this scale demonstrated statistically significant change over the three years of administration. That change was in the desired direction. Student perceptions of school climate were measured using the instrument from the

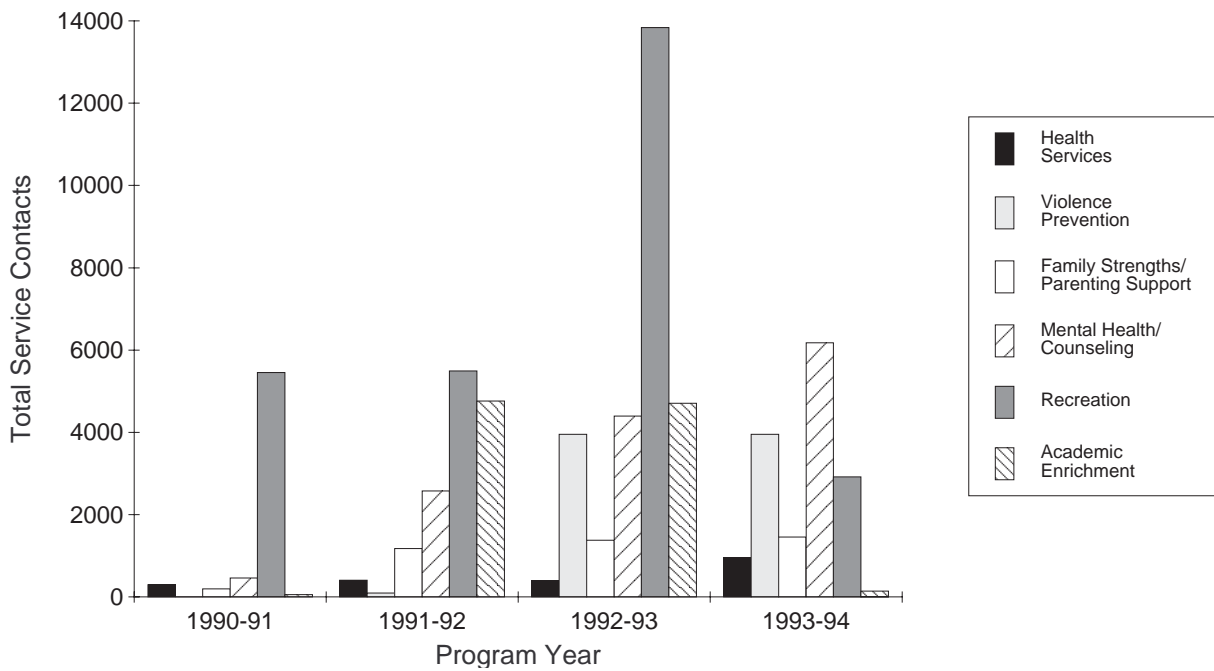


Onward to Outcomes in the School of the Future

Table 1
Achenbach Youth Self-Report, Site A
(raw scores)

Sub-Scales	1991-92 (N = 639)	1992-93 (N = 993)	1993-94 (N = 875)	1994-95 (N = 900)
Total Problems	53.35	51.62	50.18	50.55
Externalizing Scales	15.05	15.19	15.05	14.79
Internalizing Scales	17.24	16.11	15.37	16.01

Figure 2
School of the Future, Site A
Total Service Contacts, by Category



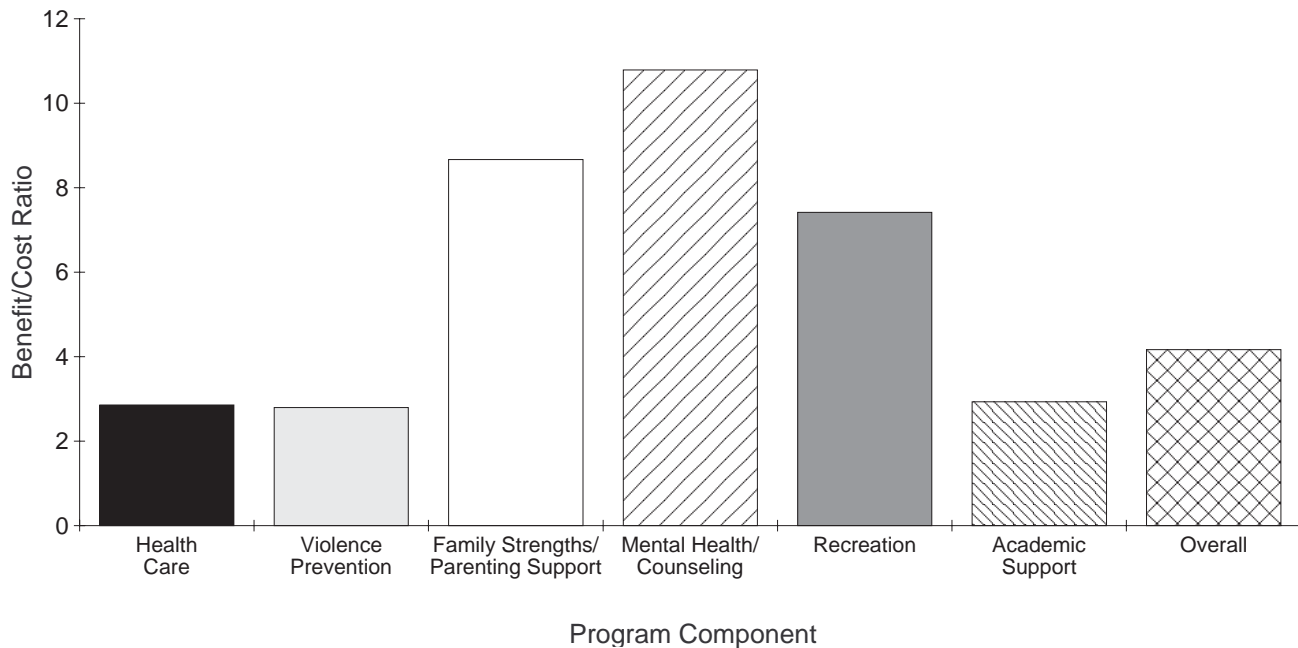
National Education Longitudinal Study (NELS). Eight of the thirteen items in this scale demonstrated significant change over time ($p \leq .05$). Unfortunately, the direction of change, in each instance, was contrary to the desired direction.

Discussion

The School of the Future model is essentially a systemic intervention. There were considerable outcomes in the community which can be arguably linked to the intervention. There were no changes in student mental health, self-esteem, or school climate which could be linked to the intervention.

The use of a small targeted investment in a single individual did serve as a sufficient catalyst to identify, implement, and coordinate services; however, these services have had no measurable effect to date on student mental health, physical health, or academic performance. This may be due to such factors as insufficient strength of the intervention, inadequate timeline, inadequate sensitivity of instruments, or inappropriate sampling for evaluation. There may have been a poor match between level of intervention and design of the effectiveness evaluation, or this may have been the wrong intervention if change in student mental health is the desired outcome.

Figure 3
School of the Future, Site A
Benefit to Cost Analysis by Category



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The Florida Inclusion Network Survey Analysis and Implications

Introduction

The Regular Education Initiative (REI) was first proposed by Madeline Will, the former Assistant Secretary for the Office of Special Education and Rehabilitative Services, in the mid 1980s. The REI is a service delivery model combining special education expertise and general education expertise. REI intended to prevent student failure, instead of identifying failure. Inclusion is a component of REI. Inclusion refers to the successful participation of students having special needs within the continuum of regular education programs and the community. Inclusion means modifying traditional teaching methods, curriculum, and visions so that a broader spectrum of services and techniques is available to all students. Inclusion celebrates and accommodates diversity by pooling resources and sharing responsibilities. By bringing together general and special education teachers, learners would receive the best of both worlds and the number of children with disabilities educated in segregated programs would be greatly reduced.

Inclusion has taken on a variety of meanings and perceptions. Educators disagree about the nature of inclusion. Some proponents of inclusion promote “full inclusion” for all students and desire to eliminate the continuum of services currently available. Others advocate inclusion as part of a continuum of services designed for individual students. Feelings about inclusion vary greatly and opinions expressed about inclusion range from the excitement of teaming to deliver services to worries about job loss and increased

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responsibilities without proper compensation or training. For some educators, inclusion is the only way to teach. For others, it is one of the ways to serve learners. The only aspect of inclusion agreed upon by most professionals is the need for educating people about inclusion and the need for further research in this area.

Method

The Florida Inclusion Network sought to determine professional knowledge of and feelings about inclusion. A total of 180 general educators, special educators, administrators, and support personnel in the northeastern area of Florida were surveyed. These four groups were asked to respond to the following questions:

1. "What is inclusion?"
2. "How do you feel about inclusion?"
3. "How do you think inclusion will affect you?"

A total of 260 surveys were sent out, with 70% returned for analysis. Respondents were classified in terms of the position held (e.g., general educator), years of experience (e.g., 0-5 years, 6-10 years, 10-20 years, and over 20 years), and grade level placement (e.g., Pre K-6th grade, middle school, or high school). Answers for the first question were coded into one of three categories: (a) knowledgeable, (b) somewhat knowledgeable, or (c) least knowledgeable. Answers for question two were coded into one of three categories: (a) feelings expressed positively, (b) feelings expressed positively but with reservations, or (c) feelings expressed negatively. Analysis of the answers to question three were categorized by content. Consequently, survey results were analyzed qualitatively and quantitatively.

Due to the categorical nature of the data, nonparametric measures were used for analyses. Alpha was preset at .01. Researchers chose to be conservative due to the large sample size. A chi

square procedure, used to detect differences in terms of knowledge about inclusion, showed that not all respondent groups are equally knowledgeable about inclusion, $\chi^2(6, N = 180) = 19.63, p < .01$. Figure 1 shows knowledge level across groups. Seasoned educators, however, did not differ from beginning teachers in terms of their knowledge about inclusion. Knowledge about inclusion also appears to be unaffected by grade level. When analyzing knowledgeable responses of general and special educators, no apparent difference between the two exists. When analyzing the least knowledgeable responses, however, the two groups do not respond similarly. When comparing knowledgeable versus least knowledgeable responses for special and general educators, a phi coefficient of .412 demonstrates a significant degree of association between group membership and level of knowledge. A particular degree of knowledge about inclusion is clearly associated with whether respondents are general or special educators.

An overall chi square analysis of feelings about inclusion shows that groups differ on this dimension, $\chi^2(6, N = 176) = 20.7854, p < .01$. Some groups feel more strongly about inclusion than others, as depicted in Figure 2. Again, years of experience and grade level placement do not have a significant impact on feelings. A chi square, based on negative feelings alone about inclusion, shows there are differences among the groups, $\chi^2(3, N = 64) = 42.88, p < .01$. The number of negative responses is proportionally higher in at least one group. A phi coefficient of .34 demonstrates a significant association between group membership and negative responses.

Responses to the third question, how inclusion affects the respondents, varied widely. The majority of responses were focused on pragmatic issues. General educators were concerned with limited planning time and preparation for teaching students with special needs within a general classroom setting. Comments include:

The Florida Inclusion Network Survey Analysis and Implications

I feel I would be burdened more than I already am in planning and carrying out activities for all children of all abilities. I feel I would need to return to school to learn how to deal with many more child-related problems that are prevalent in society today.

Inclusion makes it harder for me to assist and help all of my students when the disabled/disadvantaged student demands more of me and takes time away from other children who also need me.

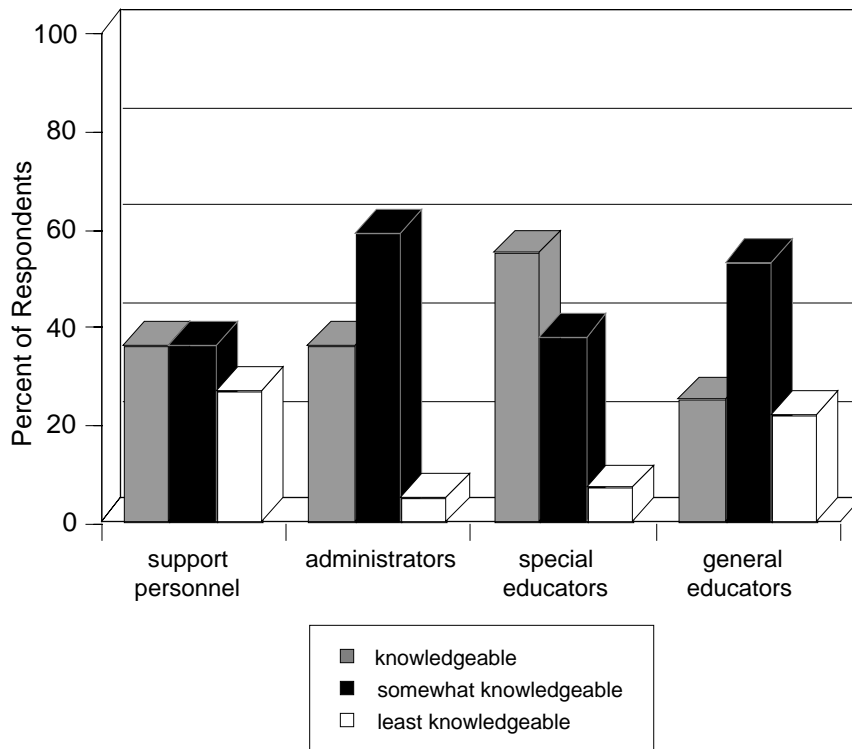
Special educators reported fears of job loss and changing responsibilities. Example responses include, “If implemented, I would become either a teacher on a rolling cart or a highly educated

teacher’s aide,” and “Inclusion will eliminate jobs.” Administrators’ comments focused on accessing appropriate resources to implement inclusion, providing adequate training for teachers, and “selling” the idea to parents. On the positive side, teachers responded favorably to a team approach to education, and to the opportunity to learn from each other. Example comments from general and special educators, respectively, are:

If there are students having difficulty with a concept then one of us can take these students and work with them.

Inclusion would allow team teaching and having an opportunity to work in the classroom with a peer would allow me to learn more and improve techniques.

Figure 1
Knowledge about Inclusion



Implications

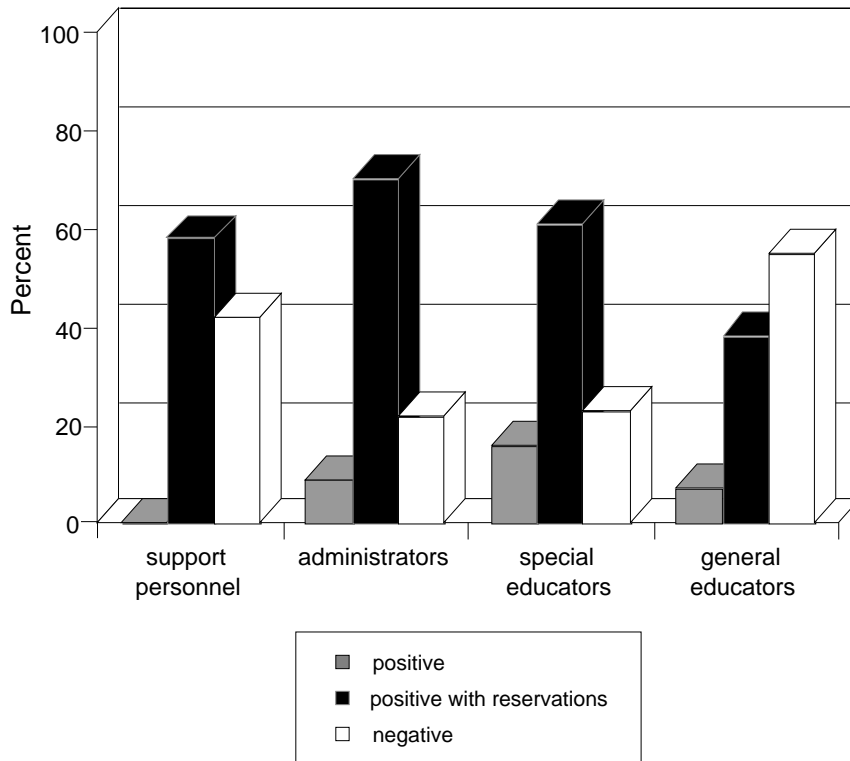
Teacher education is needed if inclusion is to remain a system of delivery for special needs students. Because groups of educators differ in their knowledge about inclusion, instruction must be provided, so that a common understanding of inclusion can be established

Groups differ in terms of their feelings about inclusion. Negative feelings, in particular, are expressed disproportionately across groups of educators. Reasons for negative feelings about inclusion, however, need to be understood for general and special educators alike. Do negative feelings arise from limited inclusion knowledge or

experience with an unsupported inclusive model? The answer is unclear. Further research into inclusion is warranted.

The personal perceptions of the effects of inclusion vary. Concerns expressed by educators reveal the need for implementing appropriate models of inclusion, if inclusion is to survive into the twenty-first century. The concerns expressed by sampled educators, such as impact on planning time, job security, and changing responsibilities, must not be overlooked. Inclusion is not the only answer to problems encountered within a dual system of education. It is, however, a delivery system that must be carefully considered in the education of students with disabilities.

Figure 2
Feelings about Inclusion



Staff Development and the Inclusion of Middle School Students with EBD in Regular Education: Preliminary Findings from Project DESTINY

Introduction

Including students with Emotional or Behavioral Disorders (EBD) in general education classrooms, while desirable in many respects, has been controversial among those concerned with education and children's mental health (Fuchs & Fuchs, 1994; MacMillan, Gresham, & Forness, 1996; U.S. Department of Education, 1995). Critics have suggested that this practice may not be in the best interests of the students, their classmates, or the school community as a whole (Kauffman, 1993). A specific concern has been that, in order to effectively educate students with EBD, general educators need to broaden their knowledge in this area (Jones & Jones, 1990; Knitzer, 1982; Knitzer, Steinberg, & Fleisch, 1990).

Enhancing general educators' knowledge in the area of EBD is one of several issues being investigated in Project DESTINY (Designing Educational Support Teams through Interdisciplinary Networks for Youth with Emotional or Behavioral Disorders), a three year research project, funded by the U.S. Office of Special Education and Rehabilitative Services (Barringer & Cheney, 1995; Cheney & Barringer, in press) and designed to evaluate models for school-based service delivery to students with EBD. This summary concerns our preliminary findings regarding: (a) the knowledge and skills of teachers from two of our intervention schools; (b) the effects of two types of staff development activities (i.e., didactic presentations and case studies on teachers' perceptions of their competence in the area of EBD); and (c) the effects of increases in teachers' perceptions of their own competence on the academic and social functioning of their students.

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Method

Setting

Data were collected at two New Hampshire middle schools. School A, with an enrollment of 520 students (grades 6-8), is located in a community of 9,500 residents, 98% of whom are Caucasian. School B is located in a community of 75,000, also primarily Caucasian (96%), enrolling 875 students (grades 7-9).

Participants

Participants from School A included 27 general education teachers and 3 special educators, with an average of 17 years of experience. A total of 21 had Masters degrees and 9 had Bachelor's degrees. In school B, there were 30 general and 4 special education teachers, with an average of 15 years of experience. A total of 20 had Masters degrees, and 14 had Bachelors degrees.

Using the Systematic Screening for Behavior Disorders (SSBD; Walker & Severson, 1992), teachers identified students as either typically developing or having EBD. Requests for permission to participate in the project were mailed to parents of the children whose scores were the top three on internalizing and externalizing scales from each class as well as parents of classmates considered typical by their teachers. Students having permission were then assessed using the rating scales. Finally, groups of students were designated based on the results.

Teachers, students, and parents then completed the appropriate Achenbach (1991) behavior checklist and the Social Skills Rating System (SSRS; Gresham and Elliott, 1990). Students also completed the Reynolds Adolescent Depression Scale (RADS; Reynolds, 1989). Students whose T-scores were greater than 60 on any of the Achenbach broad band scales, or above 70 on the RADS, were placed in the group with EBD. A total of 22 students with

EBD (14 males, 8 females; age $x = 12.9$) were identified in school A, and 20 students with EBD (12 males, 8 females; age $x = 13.2$) were identified in school B. Twenty-seven students were identified as typical for their age and grade in school A (14 males, 13 females; age $x = 12.6$), and 19 were identified in School B (8 males, 11 females; age $x = 13.3$); all of these students scored within the average range on the screening measures.

Procedure

During the 1994-95 school year, the Project DESTINY Team (i.e., a clinical psychologist, a special educator, and a family social worker) engaged in two types of staff development: (a) the first being a series of eight didactic workshops, on such topics as developing partnerships with families, clinical syndromes, and crisis intervention techniques (Cheney & Barringer, in press); and (b) a series of bi-monthly case studies of students, which included members of the school staff, and, whenever possible, the parents and students themselves.

Both schools participated in the didactic training and were scheduled to complete case studies. However, due to leadership issues and contract negotiations, only School A participated in case studies. The case studies were highly structured meetings intended to develop individualized plans for students with EBD. Information concerning 4 developmental factors (biological, interpersonal, affective, and cognitive) was collected using teacher, student, and parent versions of the same data collection forms (a sample of the student form is presented in Figure 1). Using this information, staff, students, and parents then met to identify those areas of the student's development in which support was needed. Student supports were specified in each relevant developmental area, and dates were set for review in order to assess the effectiveness of these supports. In contrast, teachers in school B met

Teacher Knowledge & Skills

Figure 1 Sample Case Study Form (student version)

CASE STUDY ASSESSMENT AND PLANNING FORM (student version)
FACTORS INFLUENCING SOCIAL/EMOTIONAL DEVELOPMENT
AND CLASSROOM PERFORMANCE
Craig Barringer, Ph.D.

Student's Name:

Grade:

Date:

Directions: Please check the items that describe you or tell where you need help. Thanks.

A. Relationships with family I live with (circle):

Stepmother Mother Stepfather Father Grandparents Other

- 1. My mother (stepmother) doesn't understand me.
- 1. My father (stepfather) doesn't understand me.
- 1. My family has problems that bother me.
- 4. My family has had some bad experiences.
(Circle): Death Job Loss Divorce Fire Move Court
- 5. My family is involved in counseling.
- 6. My parent(s) help me if I want to join activities like band, sports, school trips, etc.
- 7. My parents treat me as if I were much younger.
- 8. My behavior at home is often a problem.

B. Relationships with other students

- 1. I have trouble making or keeping friends.
- 2. I get too excited and bother other kids.
- 3. Group activities are hard for me.
- 4. I am sometimes mean to other kids at school.
- 5. I don't usually try to help other kids.
- 6. I get angry very quickly if someone says something bad about me or someone I like.
- 7. I sometimes have trouble sharing experiences and feelings with friends.
- 8. I'm friends with kids who get into trouble.
- 9. If I get angry it's hard for me to talk about it.

C. Relationships with teachers

- 1. I don't like following a teacher's directions.
- 2. I get mad if the teacher tells me my work, or behavior is not good.
- 3. I really don't like talking with teachers.
- 4. My life is really none of my teacher's business.
- 5. It's hard for me to ask my teacher for help.
- 6. I don't like the way the teacher makes me feel.
- 7. Sometimes I want my teacher to do things for me that I should do myself.
- 8. Teachers are too bossy.
- 9. I can be rude to my teachers at times.

D. Behavioral expression of feelings.

- 1. I feel restless and have trouble staying in my seat.
- 2. Sometimes I act without thinking.
- 3. I get nervous when I try to do schoolwork.
- 4. I try not to be noticed.
- 5. I'm shy (or scared) around other people.
- 6. I sometimes get mad and hit people.
- 7. I like to be the boss-not have a boss.
- 8. I'll do anything not to do schoolwork.
- 9. Being in groups of kids makes me nervous.
- 10. Clowning around with friends gets me in trouble.
- 11. I think I should do what I want even if other kids or teachers don't like it.
- 12. I sometimes have no idea why I act as I do.
- 13. I no longer do activities that I use to enjoy.
- 14. Sometimes I give up because I feel that things won't ever get better.
- 15. I'll do something over and over until it's perfect.
- 16. I won't try an activity unless I'm sure I'll do well

E. Verbal expression of feelings:

- 1. I don't like to talk about my feelings.
- 2. Sometimes I tell people too much.
- 3. I don't say anything unless I'm really angry.
- 4. If somebody criticizes me I tell them off.
- 5. I let people know what will happen if they go against me.
- 6. I have problems that are too big to talk about.
- 7. I tell people things are never going to get better.
- 8. If I think somebody has made a mistake or looks bad, I laugh or let them know.
- 9. I tell people that I'm really not too good at things
- 10. I can make other kids laugh at me if I want to.
- 11. I don't tell anyone I feel mad or in a bad mood.
- 12. I say "I don't know, or I don't care" so I don't have to answer.
- 13. I tell teachers that I'm scared, but they don't do anything about it.
- 14. There are things that I can't tell anyone, or I'll be in trouble at home.
- 15. Sometimes I get too loud.
- 16. I wish I could tell somebody how unhappy I am.
- 17. I get nervous talking in groups, so I don't talk.

F. Grades

- 1. I have trouble with reading.
- 2. I have trouble with math.
- 3. I have good grades.
- 4. I am satisfied with my grades.
- 5. Trying to do schoolwork puts me in a bad mood.
- 6. As far as school goes, I'm just not too smart.
- 7. I have trouble writing neatly.
- 8. I have trouble with spelling.

G Self Management

- 1. Not able to work by myself (without a teacher).
- 2. Not being able to finish work because I am involved with other things.
- 3. Losing my place and/or having trouble following along with class.
- 4. Not knowing what to do without being told.
- 5. Not handing in assignments on time.
- 6. Not having my papers & books organized.
- 7. Not having time to finish my work.
- 8. Not remembering what I read.
- 9. Not remembering what I'm told.
- 10. Not controlling my temper.
- 11. Not following classroom rules.
- 12. Not getting to class on time.
- 13. Not remembering to bring my books home for homework.
- 14. Not having a good place to do my homework.
- 15. Going along with others when I know they're wrong.
- 16. Not using the skills I know I have.

informally with the consultants, raising questions about students of concern. Students and parents did not participate in these meetings.

Measures

In both schools, the measures discussed below were administered at the beginning and end of the school year.

Teacher Knowledge and Skills Survey (TKSS). Based on two recently published lists of competencies for educators of students with EBD (Braaten, 1993; Bullock, Ellis, & Wilson, 1994), a 45 item measure of teachers' perceptions of their knowledge and skills related to EBD was constructed. A factor analysis of these items from 114 teacher surveys identified six factors, which included 36 items that accounted for 74% of the variance. The six factors were used as subscales, all of which had both acceptable internal consistency (five scales exceeded .8 and one scale $\alpha = .75$) and item to total correlations (.4 - .7).

Students' social and emotional functioning were measured using two rating scales: the *Teacher Rating Form* (Achenbach, 1991), a 113 item scale, that assesses internalizing and externalizing behavior problems, and the Social Skills subscale of the *Social Skills Rating System* (Gresham & Elliott, 1990), which measures student progress on 30 desirable behaviors. In addition, students' grade point averages were computed for core classes in Math, Language Arts, Social Studies, and English, and attendance was recorded as days absent across a 175 day school year.

Results

Teacher Knowledge and Skills

Pre- and post-test subscale scores for teachers from schools A and B are included in Table 1. A MANOVA indicated significant pre-test differences between the two groups of teachers

(Hotellings $T^2 = .77$, $df = 6,58$, $p < .01$) on all but one factor (i.e., Classroom Behavioral Assessment). In general, teachers from School A rated themselves as more knowledgeable than those from School B on the pre-test administration of the TKSS. With the exception of the Classroom Instruction subscale of the TKSS, teachers from School B had a mean rating below 3 (moderate level of competence) on a five point scale for all knowledge/skill areas. The mean score for teachers from School A was below 3 on the Theory and Characteristics, Background and Eligibility, and Classroom Behavioral Assessment subscales.

A subsequent MANCOVA with repeated measures, using teachers' pre-test scores as covariates, indicated significantly higher post-test scores (Hotellings $T^2 = .35$, $df = p < .01$) for teachers from school A. Univariate tests showed that these differences were significant ($p < .05$) for all subscales of the TKSS except Classroom Behavioral Assessment.

Teachers' Ratings of Students

In order to discern the impact of teacher education on student performance, student measures were examined. A MANOVA with repeated measures, using TRF and SSRS data, also indicated significant pre-test differences between schools on the Social Skills subscale ($F = 16.08$, $df = 1,76$, $p < .001$), as well as a significant Student Group x School interaction ($F = 9.82$, $df = 1, 76$, $p < .01$). In both schools, typically functioning students scored higher than students with EBD on measures of social skills, but this difference between student groups was significantly greater in School B than in School A. The results of a MANCOVA, covarying pre-test differences between schools, showed only the expected significant post-test difference between students identified as having EBD and those identified as typically functioning.

Teacher Knowledge & Skills

Table 1

Teacher Knowledge & Skills Survey: Pre- and Posttest Mean Scores* for Scales 1-6

Instructions: This is a survey of teachers' knowledge and skills concerning students with emotional and behavioral problems. Please rate yourself by circling the appropriate number (1-5) for each of the following 36 competency items on subscales 1-6. Thanks for your help!

		School A	School B
1. Background & Eligibility Items:	Pre	2.50	2.02
	Post	3.88	2.97
a. Legal issues re: EBD/SED b. Confidentiality and privacy of records. c. Common DSM-IV childhood syndromes. d. Role of educators & other professionals in assessing EBD. e. Community services for which students with EBD are eligible. f. Relationship of EBD to other disabilities. h. How to refer students with EBD for additional services.			
2. Classroom Instruction Items:	Pre	3.55	3.27
	Post	4.34	3.83
a. Establishing a positive & caring classroom environment. b. Learning activities that promote positive peer interaction. c. Coordinating activities with other staff &/or volunteers. d. Modifying curriculum based on students' performance. e. Providing a consistent classroom environment. f Teaching critical thinking, decision making & problem solving. g. Supporting cultural diversity in the classroom			
3. Social Interventions Items:	Pre	3.30	2.40
	Post	3.82	3.20
a. Procedures for helping students solve interpersonal problems. b. Implementing schoolwide approaches that promote prosocial behavior c. Commercial curriculum for promoting social development. d. Individualized methods for promoting peer relationships. e. Developing crisis intervention plans. f. Classroom management of students' behavior.			
4. Classroom Behavioral Assessment Items:	Pre	2.68	2.62
	Post	3.81	3.43
a. Assessing & evaluating emotional patterns of students. b. Using a variety of recording procedures for charting behavior c. Assessing & diffusing students in crisis. d. Teaching students to monitor their own behavior.			
5. Teaming Skills Items:	Pre	3.75	2.76
	Post	4.33	3.20
a. Methods for effective team building. b. Strategies for facilitating group interaction.			
6. Theory and Characteristics of EBD Items:	Pre	2.75	2.80
	Post	4.24	3.45
a. Definitions of Emotional Disturbance b. Emotional/behavioral characteristics of students with EBD c. Theories of EBD			
*Note: Scores range from 1 (none) to 5 (mastery)			

Attendance and Grades

Students' attendance and grades were also examined as indicators of the effect of teacher education on student performance. In School A, the attendance of students with EBD ($M = 172.56$, $SD = 5.3$) was comparable to the attendance of students in the typical group ($M = 171.73$, $SD = 6.9$). In contrast, students with EBD from School B attended school fewer days ($M = 164.88$, $SD = 13.90$) than students in the typical group ($M = 173.70$, $SD = 5.6$). An ANOVA of the absence data yielded a significant Group x School interaction ($F = 4.57$, $df = 1, 78$, $p < .05$).

As expected, the grade point averages of students with EBD were generally lower than those of students in the typical group across schools (see Table 2). Mean grade point averages across quarterly marking periods, however, were stable for both groups of students in school A, but only for the group of typically functioning students in School B. In School B, students with EBD showed both considerable variability in their mean grade point averages across the four marking periods, and a significant decline ($F = 4.37$, $df = 1, 76$) from the first to the fourth quarter. Using first quarter grades in a subsequent MANCOVA with repeated measures, however, failed to yield significant differences.

Discussion

Despite the obvious design limitations, preliminary analyses of these data have been useful in pointing out the nature of differences between the participants, and in shaping our staff development activities accordingly. With regard to the latter, our preliminary findings suggest that not all staff development methods provide the same results. When combined with traditional in-service presentations, the case study component of the model seemed to enhance outcomes for staff members. Thus, our greatest success was in school A, in which the leadership demonstrated a strong commitment to

Table 2
Students Grades* by Quarter

	Quarter			
	1	2	3	4
School R				
Typical	3.4	3.3	3.3	3.4
EBD	2.2	2.0	2.2	2.1
School S				
Typical	2.8	2.8	2.7	2.8
EBD	2.0	1.4	1.7	1.7

* Note: Grade point averages are based on the following scale: A=4; B=3; C=2; D=1; F=0.

regular meetings involving teams of teachers, students, and parents. These meetings were devoted to sharing information, developing individualized action plans within a structured, developmental framework, and, in so doing, building important relationships among the participants. When compared to students in school B, students with EBD in school A had higher grades, less fluctuation in grades across marking periods, and higher attendance rates.

The case study process was also designed to increase the accuracy of teachers' attributions regarding the causes of behavioral problems. We know that teachers who attribute a student's behavior to factors beyond the student's control (e.g., family relationships, bio-medical issues, financial hardship, etc.), are generally more supportive than those who regard all rule violations as strictly volitional (Brophy, 1985). With respect to this issue, teachers from School A reported that case studies left them with both a deeper understanding of the material presented in didactic workshops and a more differentiated picture of students and their families.

Based on their deeper understanding of the students' and families' unique needs, teachers appeared better able to selectively and appropriately use the tools that had been presented in didactic

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seminars. Our preliminary findings suggest that the plans developed during case studies had little impact on teachers' evaluations of students' social-emotional functioning, but may have influenced both attendance and grades. During the second year of Project Destiny, we have been collecting data that bear more directly on the relationship between our measure of staff development and measures of students' functioning. In addition, we have added control schools to this year's design.

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School-based Mental Health Programs: Issues for Implementation and Evaluation

Introduction

The school system has been underutilized as an avenue to obtain the objectives of the *Healthy Children 2000* document which contains national objectives and strategies for significantly improving the health of children (Public Health Service, 1991). In particular, the provision of mental health services within the context of the school environment enhances the accessibility and normalization of mental health services to populations of children and their families (Mash & Barkley, 1989; Meeker, DeAngelis, Berman, Freedman & Oda, 1986; Office of Disease Prevention and Health Promotion, 1993). The concept of health would be inclusive of psychosocial and emotional needs without stigmatization.

The purpose of this study was to develop, test, and evaluate a mental health intervention program implemented within the school environment. The particular program entitled "Self-Management Intervention Program for School-Age Children with Chronic Health Conditions and Their Parents" focused on the promotion of self-regulatory and stress management skills to enhance coping with a chronic health condition. The program was carried out immediately after school hours and involved 3 components: (a) twelve child group sessions; (b) three parent group sessions; and (c) 1-2 home visits.

Method

A pre- and post-test design was used to examine child, family, and system outcomes. Program outcomes were collected at various time points to represent short term and long term effects. The target

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group included children 7 to 14 years of age with a chronic health condition of six months or longer duration and identified by the school nurse as having difficulty coping with the stresses associated with the health condition. A total of sixty-five children participated in the program, representing 17 different schools in two school districts.

Six program implementation and evaluation issues with associated resolutions will be discussed.

Implementation and Evaluation Issues

The *first* issue relates to the non-categorical approach to programs that are disseminated in the community such as the school system. Typically, within the health care system, programs are organized around diagnostic groupings related to physical and mental health disorders. However, when implementing programs within the community, it is often not feasible to use categorical groupings due to the few children found in any one category. From a theoretical perspective, “generic functional skills” such as stress management and coping are relevant for many disorders; thus, it may be more important to organize programs around functional issues rather than the disorder. Stigmatization is also minimized when programs emphasize life skills. In this self-management program, children had a variety of chronic physical health conditions associated with mental health symptoms. The program’s intervention focused on the self-regulatory skills of self-observation, self-monitoring, self-instruction, self-reinforcement, and self-evaluation. The intervention also addressed emotion-focused and problem-focused stress management skills. When using a non-categorical approach, several program design and evaluation challenges need to be considered. Variability within treatment groups, applicability to one’s specific condition, and generalizability to the family home environment pose several challenges.

Specific program components were incorporated in this study to address these challenges. For example, a family home visit was made to each family to develop individualized goals associated with the school based program goals. During each group session, attention was paid to individualized goals.

The *second* issue relates to accessibility and normalization. The program was implemented within a school building located within the child’s neighborhood and was supplemented by 1-2 home visits. Interviews with the children and parents consistently confirmed that the convenient location of the program and lack of stigma associated with the school program setting contributed to success in recruitment and the nearly 100% attendance rate. Children were more responsive to teachers’ and counselors’ encouragement to enroll in the program because its setting was school based, accessible, and did not have the stigma often associated with a “mental health center.”

The *third* issue focuses on program integrity for both process and content. Program integrity is particularly important because multiple groups were conducted in different school sites. Assuring program integrity is a challenge when the intervention program is carried out in a school/community based environment. A curricular manual was developed with several measures of integrity obtained for group process variables (cohesion, cooperation, support, etc.), educational process components (instruction, demonstration, application to home environment, reinforcement, etc.), and program content (specific self-regulatory and stress management knowledge and skills). By measuring program integrity, the variability in the program process and content was monitored and analyzed by various statistical analyses. The relationship between program outcome results and program integrity could then be determined.

School-Based Mental Health Programs

The *fourth* issue involves the conceptualization of program outcomes. The selection of program outcomes should capture the comprehensive nature and inter-relationship among the complexity of effects relevant to the child, family, and system. Program outcomes were categorized as: (a) *child focused* (behavioral-emotional problems, self system, health behaviors, and symptoms of stress); (b) *family focused* (relational and functional); and (c) *system focused* (school attendance, number of health visits to school nurse and/or primary care physician). Program outcomes were conceptualized as *primary* and *secondary* in that secondary outcomes would occur if positive change had occurred in the primary outcomes. For example, a positive change on a child's self-regulatory knowledge and skills coupled with fewer symptoms of stress could be associated with the secondary effects of fewer visits to the school nurse. Both short-term and long-term effects were examined for patterns across time and for the sequencing of primary versus secondary outcomes.

The *fifth* issue relates to the generalization and transfer of program effects to daily living at home and in school. Two inter-related questions were asked. Did children demonstrate new knowledge and skills within the program sessions? If so, to what extent did the children apply their newly obtained knowledge and skills to daily living at home and school? In other words, was the child able to transfer learning from the program sessions to other settings? These evaluation questions were answered by obtaining data from parents, teachers, and school nurses. The schools who participated in the study varied in the type of community based environments offered to children including mental health education and clinical services. Thus, the availability of school resources designated to support the study's intervention program influenced the extent that the intervention generalized to the school environment. Parents indicated that

periodic booster sessions after completion of the intervention would have been helpful in order to support and sustain the newly learned behavioral patterns over time.

The *last* issue relates to individual differences, differential program effects, and program matching. Designing programs both for populations and for subgroups within populations may be a way to resolve the delicate balance issue of recognizing individual variations within populations and thus matching variations within program to variations within populations. The variations in the schools' emphasis on mental health resources and services reflected to some extent the community's attitudinal and financial support of these services. The design and efficacy of school based intervention programs need to take into consideration the broader context of the community.

As indicated in the federal document, *School Health: Findings from Evaluated Programs* (1993), school health programs and evaluations varied considerable across the nation. While ideally school health programs need to address the full range of health promotion services, including mental health, the majority of school health programs are not comprehensive. Program design and evaluation need to be considered carefully in order to generate a data base that offers insight into how school programs may assist families and communities in meeting the many needs of school-aged children.

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The Elementary Mental Health Operations Evaluation

Introduction

A 1986 Needs Assessment report conducted for the Juvenile Welfare Board (JWB), an independent special taxing district that funds delivery of children's services through other agencies, identified Pinellas County Florida as an area where children with emotional handicaps (EH) were undermet. In response, JWB began funding four Elementary Mental Health Operations (ELMHO) programs in Pinellas County. The purpose of the ELMHO programs was to provide school-based mental health services to the children and their families to help elementary students with emotional disabilities learn to cope with their issues well enough to mainstream back into less restrictive academic settings. The program's intentions were to demonstrate the effectiveness of intensive mental health intervention with this EH population with "mild to moderate" disabilities through improvements in behavior, increased mainstreaming, and decreased placement in more restrictive settings.

Method

Subjects/Sites

There were four program sites; three of the sites involved students with emotional disabilities while the fourth site was moved within months of inception to a center for students with severe emotional disturbances (SED) as a result of the school system relocating the students.

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Intervention/Program

The programs would address: (a) the child's behavioral problems and level of functioning through individual, group, and family counseling; (b) identified family problems through parent training and family counseling; and (c) consultation with teachers to help them develop problem solving strategies to work with these children.

The ELMHO program process was simple and straightforward. After a teacher referred the child, the therapist assessed the eligibility of that child. If parental permission was received, individual, group, and family counseling, case management, and psychiatric/psychological examinations were provided. The child could exit the program for reasons such as mainstreaming, "graduating" to middle school, leaving the school, or lack of progress. The program provided services in a natural setting, thought to be less threatening to families than agency-based mental health services.

Measurement

The evaluation of this program consisted of: (a) interviews including those with parents, school principals, social workers, program supervisors, agency directors, and JWB staff ($N = 62$); (b) school record reviews of all EH students at 3 target schools, a sample of SED students at the SED center, and all EH students at two non-ELMHO schools ($N = 396$); (c) case record reviews ($N = 100$); and (d) case studies ($N = 11$).

Results

Length of Stay

Participants stayed in the program longer than was originally intended. Evaluation data suggest that children with the most severe rather than mild to moderate disabilities were referred to the program. These children needed long term care beyond the prevention and early intervention

components the ELMHO program was intended to provide. This excessive length of stay also reflected an apparent dependency on the program. Many ELMHO children reported not being ready to leave EH classrooms, and some reported that they intentionally misbehaved to stay. Parents expressed concern over what they would do when their children were promoted to middle school.

Parental Participation

The evaluation showed that involvement of the whole family in the interventions was critical to significant progress. If parents did not "buy into the program," then the child could be confused by the expressed wishes of the parents/family and the wishes of the program, limiting or preventing bonding among participants. It appeared that many of the families being served by the programs had a multitude of issues, making work with families difficult outside of the structured classroom setting.

Findings showed that more families/siblings needed to be involved in these programs. Service level numbers and comments by families indicated that children were often being served in isolation. Given the issues surrounding these families, nontraditional parent involvement strategies may need to be employed. It appears that the programs should also support development of community support services outside of mental health agencies so that families are able to independently seek additional help in the community.

Service Need

Accessing families through the school is a non-threatening way to reach individuals who might otherwise not seek help. There appeared to be a need for an increase in both the amount and types of mental health services available in this setting for children identified with an EH educational status. The level of services provided by the

The Elementary Mental Health Operations Evaluation

schools did not always meet the identified need of the child, because resources remain scarce within the school system.

School System Issues

According to the school system, there was no clear system in place to track students through the mainstreaming process. This made the development of some goals and objectives for ancillary programs, such as ELMHO, more difficult. As it currently operates, the goal of mainstreaming may not be a measurable, realistic objective for this program. Methods to recruit and serve children with less severe disabilities need to be developed, the desired outcomes need to be redefined, and/or a new approach to serving the intended target families needs to be considered.

Another issue is the need for trained teachers. According to the school district informants, there is a critical shortage of exceptional education teachers. Children can be negatively impacted by limited teacher training.

A final issue is that of appropriately ending services to children and families. The ELMHO program served the majority of the children with emotional handicaps in these four schools, making it difficult to close cases on children who have not left the classroom and/or school. The children may not understand why they no longer receive “special attention.”

Service System Issues

Concern arises in regard to labeling young children with both mental health diagnoses and exceptional identification by the schools. Labeling can lead to self-fulfilling prophecies for failure in the client. By focusing on children with less severe levels of disability, labeling may be prevented.

Mental health agencies have begun to bill Medicaid, insurance, and/or families for the

ELMHO services. Several concerns regarding this practice include: (a) the program was originally free to families and is still seen as such; (b) there is a need for a diagnosis/label to obtain reimbursement; and (c) the potential exists to have clients selected on the basis of income source, or to have treatment plans designed around what Medicaid/insurance will pay rather than on the needs of the client.

Carryover of clients from one year to the next was also found to be excessive and distorted true service levels due to a lag in record keeping. Cases closed during this program year at one site averaged 31 months from the last contact and the case being closed. Cases at other sites ranged from 5 months to 12 months between last contact and cases closing. Some of this lag was due to delaying paperwork until the slower summer months of the program.

The SED Center

The SED Center did not appear to be an appropriate site for the ELMHO program, for a number of reasons:

- Documentation (i.e., medical history, lost records, etc.) required by the program was consistently deficient.
- These children had more severe impairments than the population that the program model was designed to serve. The center had a very structured environment; the center’s point and level systems did not provide teachers the flexibility to adequately accommodate individualized treatment goals. Children were required to complete two transitions before going back to their regular school, making this process long and difficult for these children.
- Most of the children in the SED program were Medicaid eligible. As before mentioned, there are concerns surrounding utilization of Medicaid-driven rather than client-driven admission and service levels.

Discussion

The original intent of the ELMHO program was to provide prevention and early intervention for children newly diagnosed as having emotional disabilities to help stabilize and mainstream them back into regular education classes. It slowly evolved into a program which appeared to serve children with the most severe problems, providing stabilization for them until they “graduate” to middle school. After leaving the program, the gains made while in the program appeared to be lost, and the children’s problems continued to increase in severity. The “drift” between program intent and function clearly needs to be addressed. A beginning point might include the development of a problem solving team, including both representatives from JWB and the mental health agencies, with input from the school system.