Follow up to VA Joint Commission Questions

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Comes from a presentation led by Laura Porter specifically on Washington ACE study data. Washington state is leading the nation in data on this topic.

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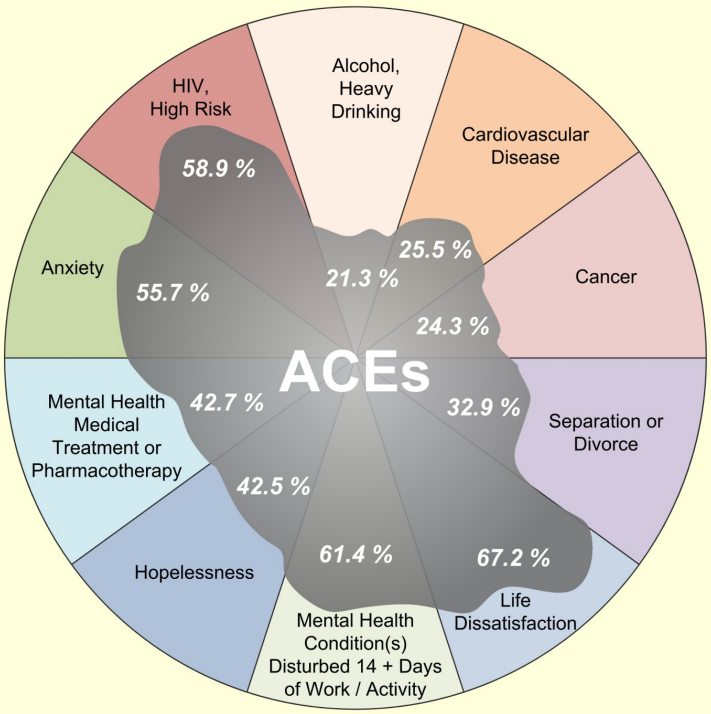
POPULATION ATTRIBUTABLE RISK

A large portion of many health, safety and prosperity conditions is attributable to Adverse Childhood Experience.

ACE reduction reliably predicts a decrease in all of these conditions simultaneously.



Washington looked at their ACE data and utilizing the statistical approach that allows for the prediction of attributable risk, came to the results presented in the slide above:

This research demonstrates in Washington, what percentage of these health conditions can be explained by this cohorts exposure to <u>one or more ACEs</u> prior to the age of 18.

The significance of these attributable risk scores is highlighted when considering that the CDC defines a significant core driver of a health condition is one that accounts for 10 percent or more of that conditions occurrence, as you can see, ACEs exposure accounts for much more attributable risk than that across multiple conditions.

Additional Information from Washington

Laura Porter and Melanie Gillespie present on Adverse Childhood Experiences (ACEs) and NEAR (Neuroscience, Epigenetics, ACEs, and Resilience) science to the Joint House Health Care & Wellness and Early Childhood Education & Human Services Committee January 21, 2015

http://www.healthygen.org/our-impact/news/adverse-childhood-experiences-aces-and-near-science-presentation-2015-legislative

2) CBITS – Cognitive Behavioral Intervention for Trauma in Schools

https://vimeo.com/104635861

Evidence Base of CBITS program from SAMHSA and evaluation of the quality of research (3 studies)

http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=153
- PDF of SAMHSA findings attached

http://www.dcfpi.org/wp-content/uploads/2014/07/Issue-Brief-4-Mental-Health-Services.pdf

- PDF of DC implementation of CBITs and some outcomes attached
- Dr. Jackson has reached out to contact in DC for more information

Summary of DC implementation of CBITs

Cognitive-Behavioral Intervention for Trauma in Schools (CBITS). CBITS provides 1-2 individual sessions and 10 group sessions for children who have been exposed to trauma and are experiencing post-traumatic stress symptoms. The service is available at all DC middle schools, two alternative schools and six education centers. A 2012 pilot in three middle schools found that CBITS improved attendance, reduced behavior infractions, reduced post-traumatic stress symptoms, and improved functioning for participants.

Los Angeles, California

School Mental Health, an office of the Los Angeles Unified School District, used a reflective learning group model (a weekly training and supervision process from pre-implementation to outcome evaluation) to implement CBITS during 2008-2010. They trained 107 staff, offered 117 groups, and served more than 700 students in approximately 100 schools.
After treatment, 81% of CBITS participants across grade levels 5-10 reported improvement in post-traumatic stress disorder symptoms with 63% falling below clinical range. Students showed even greater improvement at the two- to four-month follow-up. Of the clinicians surveyed during the 2008-2009 school year, 98% said they felt comfortable implementing CBITS, were able to treat traumatized students effectively, and planned to use CBITS again.

CBITS is now an approved Evidenced-Based Intervention under the Prevention and Early Intervention component of California's Mental Health Services Act. The County of Los Angeles Department of Mental Health and many other counties have adopted it via their implementation plans.

Peer support and Trauma Informed Care

Resources to assist agencies integrate consumers, survivors of violence and those recovering from substance abuse into the design and implementation of trauma-informed services include:

*Tips for Incorporating Peer-to-Peer Support into Your Program*7 at www.nctsn.org/nctsn_assets/pdfs/Pathways_PeertoPeerTipsheet.pdf

Consumer/Survivor/Recovering Women: A Guide for Partnerships in Collaboration by Laura Prescott.

Defining the role of consumer-survivors in trauma-informed systems," by Laura Prescott in *New Directions for Mental Health Services*, issue 89, pages 83–89, Spring 2001

Consumer/Survivor/Recovering Women: A Guide for Partnerships in Collaboration by Laura Prescott. Download the free pdf at www.prainc.com/wcdvs/pdfs/CSR Manual Final.pdf

The Essence of Being Real: Relational Peer Support for Men and Women Who Have Experienced Trauma by Jennifer L. Wilkerson. Free download at www.sidran.org/pdf/sige.pdf

RAND HEALTH

Helping Children Cope with Violence and Trauma

A School-Based Program That Works

RAND RESEARCH AREAS
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TERRORISM AND HOMELAND SECURITY

Violence is one of our most significant public health issues. Between 20 percent and 50 percent of children in the United States are touched by violence, either as victims or, even more commonly, as witnesses. Even more are exposed to natural disasters, accidents, and traumatic losses. The emotional impact may be profound. Children exposed to violence frequently develop post-traumatic stress symptoms. They are more likely to have behavioral problems, poorer school performance, more days of school absence, and feelings of depression and anxiety. Violence affects all racial, ethnic, and economic groups, but its burden falls disproportionately on poor and minority children—the very children whose mental health needs are least likely to be met by the health care system. School officials are often willing to provide help at school. But these professionals face an important question: What works? Until recently, there was no evidence base for determining the effectiveness of interventions to address these problems.

To fill this gap, a team of clinician-researchers from several institutions collaborated to develop, implement, and evaluate an intervention designed to help children traumatized by violence. The team included professionals from the RAND Corporation, the University of California, Los Angeles (UCLA), and the Los Angeles Unified School District (LAUSD) and has expanded over time to include colleagues at the University of Southern California and many community partners.

The program works. Students who participated in the program had significantly fewer post-traumatic stress symptoms, less depression, and less psychosocial dysfunction. The program was implemented successfully by school-based mental health clinicians. The participating schools, located in economically disadvantaged neighborhoods, have a large percentage of Latino students, demonstrating the program's ability to reach poor and minority children. And the program was welcomed by students, teachers, school officials, and parents.

Key findings:

- Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) significantly reduced symptoms of post-traumatic stress and depression in students exposed to violence.
- School mental health clinicians successfully delivered the program.
- The program produced consistent results and was well accepted by students, parents, and teachers.
- A version of the intervention has been adapted for delivery by regular school staff with no mental health training.
- A new website that provides online training and support for mental health professionals to deliver CBITS is now accessible, free of charge: http://cbitsprogram.org

The First Randomized Controlled Study of a School Program to Help Children Traumatized by Violence

RAND, UCLA, and LAUSD began to collaborate in 1998 to conduct studies to determine the magnitude of violence exposure and post-traumatic stress symptoms among LAUSD schoolchildren and to develop effective interventions. The team developed and implemented an earlier program designed specifically for immigrant children, many of whom are subjected to violence in their country of origin, during their immigration to the United States, and/or after their arrival (often to

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a disadvantaged neighborhood). Building on the earlier work, the team designed and conducted a randomized controlled study in the 2000–2001 academic year. Students in the study attended one of two Los Angeles public middle schools in largely Latino neighborhoods. Psychiatric social workers from LAUSD administered a screening questionnaire to English-speaking sixth-grade students in the two schools. Students were eligible to participate in the program if they (1) had substantial direct exposure to violence, (2) had post-traumatic stress symptoms in the clinical range (a score of 14 or higher on the Child Post-Traumatic Stress Symptom Scale [CPSS]), and (3) were willing to discuss their symptoms in a group setting. Participants experienced a range of violence, from witnessing serious physical fights to being attacked with a knife or gun. A total of 159 students were eligible to participate; 126 actually participated (the parents of 28 children did not give consent, and five children elected not to participate). All 126 students completed the baseline assessments, 93 percent completed a three-month follow-up, and 90 percent completed both the three-month and the six-month follow-ups.

Students were randomly assigned to two groups. One group (the early-intervention group) started the program promptly; the other (the late-intervention group) was waitlisted for later in the school year. The intervention program, called the Cognitive-Behavioral Intervention for Trauma in Schools (CBITS), was developed at RAND in close collaboration with mental health clinicians at LAUSD. It consists of ten group sessions designed for inner-city schools with a multicultural population. Activities include training children in relaxation; dealing with negative thoughts; solving real-life problems; approaching anxiety-provoking situations; and coping with the violent event through talking, drawing pictures, and writing. The program is also designed to build both peer and parental support. In addition to the group sessions, the program included at least one individual session for each child, four group parenting meetings, and an educational presentation for teachers. The LAUSD school clinicians who delivered the program received two days of training and weekly supervision from the other members of the research team. To help ensure that the program was standardized, the clinicians followed the CBITS treatment manual (see the text box).

Participants Experienced Significant Mental Health Improvement

Data from students, parents, and teachers were collected at baseline, three months, and six months. These intervals enabled both early- and late-intervention groups to complete the program and to be tested in the same academic year.

Baseline: The 126 students enrolled in the program had substantial levels of exposure to violence. On average, students reported being a victim of 2.8 violent events and directly witnessing 5.9 violent events in the previous year. The mean CPSS score was 24, indicating moderate to severe post-traumatic stress symptoms. There were no significant differences between the early-intervention and late-intervention groups at the start of the program.

Three months: At three months, students in the early-intervention group had completed the program; students in the late-intervention group had not yet begun. Figure 1 compares the CPSS scores for the two groups. The early-intervention students showed substantial improvement. The magnitude of the difference between the two groups means that 86 percent of the early-intervention group reported less-severe post-traumatic stress symptoms than would have been expected without intervention. Figure 2 shows depressive symptom scores; the magnitude of the difference between the two groups means that 67 percent of the early-intervention group reported less-severe symptoms than would have been

Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) Session Outline

Session 1: Introduction of group members, confidentiality, and group procedures; explanation of treatment using stories; discussion of reasons for participation (kinds of stress or trauma).

Session 2: Education about common reactions to stress or trauma, relaxation training to combat anxiety.

Individual Session: Between sessions 2 and 6.

Session 3: Thoughts and feelings (introduction to cognitive therapy), "fear thermometer," linkage between thoughts and feelings, combating negative thoughts.

Session 4: Combating negative thoughts.

Session 5: Avoidance and coping (introduction to real-life exposure), construction of fear hierarchy, alternative coping strategies.

Sessions 6 and 7: Exposure to stress or trauma memory through imagination, drawing, and writing.

Session 8: Introduction to social problem solving.

Session 9: Practice with social problem solving and hot seat.

Session 10: Relapse prevention and graduation ceremony.

SOURCE: Jaycox LH, *Cognitive-Behavioral Intervention for Trauma in Schools*, Longmont, Colo.: Sopris West Educational Services, 2003.

Figure 1
Post-Traumatic Stress Symptoms at Baseline, Three Months, and Six Months

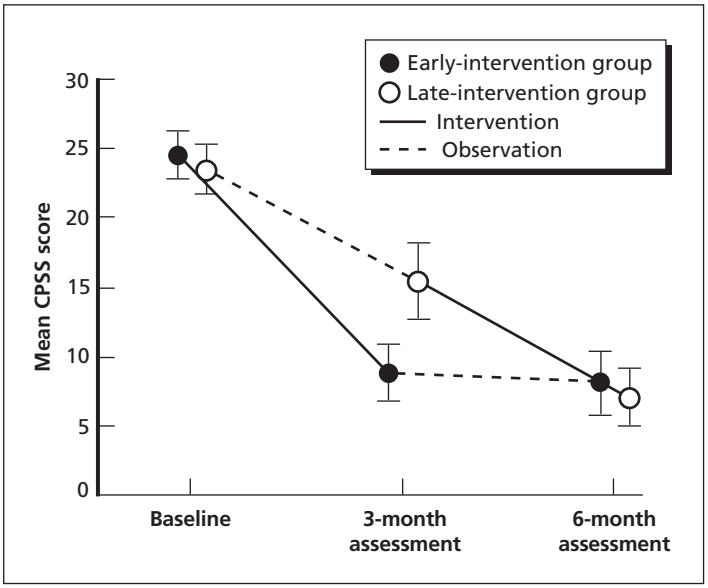
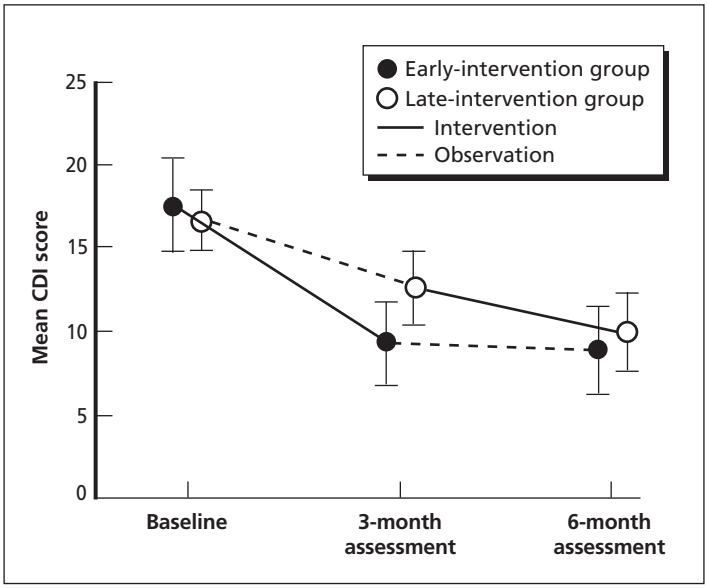


Figure 2
Depressive Symptoms at Baseline, Three Months, and Six Months



SOURCE: Stein BD, Jaycox LH, Kataoka SH, Wong M, Tu W, Elliott MN, and Fink A, "A Mental Health Intervention for School Children Exposed to Violence," *Journal of the American Medical Association*, Vol. 290, No. 6, August 6, 2003, pp. 603–611. Copyright © 2003, American Medical Association. All rights reserved.

NOTE: CDI = Children's Depression Inventory, an assessment tool and scale for measuring child depression.

expected without intervention. In addition, parents of students in the early-intervention group reported that their children were functioning significantly better.

Six months: At six months, both groups had completed the program. The group that received CBITS after the waiting period also showed substantial improvement in symptoms, and the group that had received CBITS earlier maintained their gains.

Classroom Behavior Stayed About the Same

Teachers assessed each student's shyness and anxiety, learning skills, and acting-out behavior in the classroom. Teachers observed only slight improvements throughout the study period. Possible explanations include the following: A student's classroom behavior is affected by many factors, not just the child's mental health; there may be a time lag before improved mental health translates into improved behavior; teachers may be more attuned to disruptive behavior than to anxiety or depression; or perhaps the program simply does not affect classroom behavior.

SSET: A Version of CBITS for Nonclinical School Personnel

As the CBITS program began to be disseminated nationally, the CBITS research team sought feedback from teachers, school counselors, clinicians, and national experts on how to make their program easier for schools to implement. The result was an adaptation of CBITS: Support for Students Exposed to Trauma (SSET). SSET keeps the same cognitive-behavioral approach and ten group-session structure as CBITS, but the clinical aspects of the original program have been modified to allow them to be used by teachers and other nonclinicians. Changes include the following:

- Instructors use the lesson-plan format familiar to teachers.
- Individual student sessions and optional parent sessions are eliminated.
- Students draw or write about their traumatic experiences rather than recounting them one-on-one with a counselor.

SSET Pilot Test. Beginning in 2005, SSET was pilot-tested for two years in two Los Angeles middle schools, one in the San Fernando Valley and the other in South Central Los Angeles. Most of the students were Latino and came from lower socioeconomic backgrounds, and more than half were English learners. Of the students screened for participation in SSET, 58 percent met the initial study criteria: They had experienced symptoms of post-traumatic stress disorder (PTSD). The final pilot test sample consisted of 76 students with appropriate parental and student consent to participate in the study. Three teachers and one school counselor

without any specific mental health clinical background were trained to deliver SSET. Each of the four instructors led four SSET groups; each group met once a week during the school day and received a total of ten lessons. Half of the students were given SSET immediately, while the start of the other half was delayed until the first intervention group had ended. The latter group of students served as controls.

Students were surveyed to measure their trauma symptoms at baseline, at three months after the first group had completed SSET, and at six months after the control group had completed the program. Additional assessments focused on the instructors' ability to faithfully deliver quality SSET lessons. Both students' parents and teachers were surveyed about the students' behavior at home and at school, and students were surveyed about their own symptoms and behaviors.

Promising Results. Even in this small pilot test, the results indicate that SSET can be implemented successfully by teachers and school counselors without mental health training to address violence-related PTSD and depression, especially in low-income, urban students. The pilot test results showed that, overall, students showed small reductions in trauma symptoms, with those having a high level of symptoms before taking SSET benefiting the most. In addition, both students and parents reported good-to-high satisfaction with the program. Teachers reported small improvements in student behavior, although parents did not.

CBITS Update

The new CBITS training website is available for mental health professionals interested in learning to deliver the CBITS intervention:
http://cbitsprogram.org

The CBITS manual is available from Cambium Learning:
http://store.cambiumlearning.com

CBITS was used successfully to help children who were affected by Hurricane Katrina with post-traumatic stress symptoms.

Adaptations and materials are available for special populations, including students in foster care and special education.

Work is ongoing to study different ways to disseminate programs like CBITS to schools.

CBITS resources are disseminated through the Trauma Services Adaptation Center for Schools and Communities, part of the National Child Traumatic Stress Network.

The RAND CBITS website includes a list of CBITS and SSET publications; information about user products, including program manuals; and related links:
http://www.rand.org/health/projects/cbits.html

A CBITS Dissemination Website: Making CBITS Training More Accessible

In March 2011, the CBITS team made CBITS training materials available online. Districts and schools now have the option of in-person or online training for mental health professionals who intend to deliver CBITS. The program's website (http://cbitsprogram.org/) allows mental health professionals to register free of charge for an online CBITS course to support training. The site also provides additional support resources, including a discussion board, an ask-the-expert feature, quick tips, and implementation materials.

Conclusions

Extensive research since 2000 has supported the team's initial study results: CBITS has significantly helped students cope with the devastating effects of violence. Students who participate in the program report fewer symptoms of post-traumatic stress, depression, and psychosocial dysfunction. CBITS is now recognized as a recommended practice by several national agencies that assess the quality of mental health interventions, including the Centers for Disease Control and Prevention's Prevention Research Center, the Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Registry of Evidence-Based Programs and Practices, and the U.S. Department of Justice's Office of Juvenile Justice and Delinquency Prevention.

CBITS has been implemented widely across the United States and abroad and is also being actively disseminated through SAMHSA's National Child Traumatic Stress Network. Since 2001, the CBITS team has supported use in several states in the United States and in other countries, including

- California, Colorado, the District of Columbia, Illinois, Louisiana, Maryland, Mississippi, Missouri, Montana, New Jersey, New Mexico, Tennessee, Washington, and Wisconsin
- Australia, China, Guyana, and Japan.

The program is designed to build resilience and coping skills, so it is possible that the short-term effects identified by research will be lasting. The team hopes that the program will form the basis of continuing efforts to provide long-term help to victims of violence. ■

This research highlight summarizes RAND Health research reported in the following publications:

Stein BD, Kataoka S, Jaycox LH, Wong M, Fink A, Escudero P, and Zaragoza C, "Theoretical Basis and Program Design of a School-Based Mental Health Intervention for Traumatized Immigrant Children: A Collaborative Research Model," *Journal of Behavioral Health Services and Research*, Vol. 29, No. 3, August 2002, pp. 318–326.

Jaycox L, Stein BD, Kataoka S, Wong M, Fink A, Escudero P, Tu W, and Zaragoza C, "Violence Exposure, Posttraumatic Stress Disorder, and Depressive Symptoms Among Recent Immigrant Schoolchildren," *Journal of the American Academy of Child and Adolescent Psychiatry*, Vol. 41, No. 9, September 2002, pp. 1104–1110.

Jaycox LH, *Cognitive-Behavioral Intervention for Trauma in Schools*, Longmont, Colo.: Sopris West Educational Services, 2003.

Kataoka S, Stein BD, Jaycox LH, Wong M, Escudero P, Tu W, Zaragoza C, and Fink A, "A School-Based Mental Health Program for Traumatized Latino Immigrant Children," *Journal of the American Academy of Child and Adolescent Psychiatry*, Vol. 42, No. 3, March 2003, pp. 311–318.

Stein BD, Jaycox LH, Kataoka SH, Wong M, Tu W, Elliott MN, and Fink A, "A Mental Health Intervention for School Children Exposed to Violence," *Journal of the American Medical Association*, Vol. 290, No. 6, August 6, 2003, pp. 603–611.

Jaycox LH, Kataoka SH, Stein BD, Wong M, and Langley A, "Responding to the Needs of the Community: A Stepped Care Approach to Implementing Trauma-Focused Interventions in Schools," *Report on Emotional and Behavioral Disorders in Youth*, Vol. 5, No. 4, 2005, pp. 85–88, 100–103.

Kataoka SH, Fuentes S, O'Donoghue V, Castillo-Campos P, Bonilla A, Halsey K, Avila JL, and Wells KB, "A Community Participatory Research Partnership: The Development of a Faith-Based Intervention for Children Exposed to Violence," *Ethnicity & Disease*, Vol. 16 (Supplement), Winter 2006, pp. S89–S97.

Ngo V, Langley A, Kataoka S, Nadeem E, Escudero P, and Stein BD, "Providing Evidence-Based Practice to Ethnically Diverse Youths: Examples from the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) Program," *Journal of the American Academy of Child and Adolescent Psychiatry*, Vol. 47, No. 8, August 2008, pp. 858–862.

Jaycox LH, Langley A, and Dean KL, *Support for Students Exposed to Trauma: The SSET Program*, Santa Monica, Calif.: RAND Corporation, TR-675-NIMH, 2009. As of April 14, 2011:
http://www.rand.org/pubs/technical_reports/TR675.html

Cohen JA, Jaycox LH, Mannarino AP, Walker DW, Langley AK, and DuClos J, "Treating Traumatized Children After Hurricane Katrina: Project Fleur-de-Lis," *Clinical Child and Family Psychology Review*, Vol. 12, No. 1, March 2009, pp. 55–64.

Jaycox LH, Langley AK, Stein BD, Wong M, Sharma P, Scott M, and Schonlau M, "Support for Students Exposed to Trauma: A Pilot Study," *School Mental Health*, Vol. 1, No. 2, June 2009, pp. 49–60.

Jaycox LH, Cohen JA, Mannarino AP, Walker DW, Langley AK, Gegenheimer KL, Scott M, and Schonlau M, "Children's Mental Health Care Following Hurricane Katrina: A Field Trial of Trauma-Focused Psychotherapies," *Journal of Traumatic Stress*, Vol. 23, No. 2, April 2010, pp. 223–231.

Langley AK, Nadeem E, Kataoka SH, Stein BD, and Jaycox LH, "Evidence-Based Mental Health Programs in Schools: Barriers and Facilitators of Successful Implementation," *School Mental Health*, Vol. 2, No. 3, September 2010, pp. 105–113.

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RB-4557-2 (2011)

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program is a school-based group and individual intervention designed to reduce symptoms of posttraumatic stress disorder (PTSD), depression, and behavioral problems; improve peer and parent support; and enhance coping skills among students exposed to traumatic life events, such as community and school violence, physical abuse, domestic violence, accidents, and natural disasters. CBITS has been tested primarily with children in grades 3 through 8, as in the three studies reviewed in this summary. It also has been implemented with high school students. Students who have participated in CBITS evaluations have been individually screened for trauma and/or were exposed to a catastrophic weather event such as Hurricane Katrina.

CBITS relies on cognitive and behavioral theories of adjustment to traumatic events and uses cognitive-behavioral techniques such as psychoeducation, relaxation, social problem solving, cognitive restructuring, imaginal exposure, exposure to trauma reminders, and development of a trauma narrative. The program includes 10 group sessions and 1-3 individual sessions for students, 2 parent psychoeducational sessions, and a teacher educational session. It is designed for delivery in the school setting by mental health professionals working in close collaboration with school personnel.

Descriptive Information

Areas of Interest	Mental health promotion
Outcomes	**Review Date: March 2010** 1: PTSD symptoms 2: Depression symptoms 3: Psychosocial dysfunction
Outcome Categories	Mental health Social functioning
Ages	6-12 (Childhood)
Genders	Male Female
Races/Ethnicities	Black or African American Hispanic or Latino White Race/ethnicity unspecified
Settings	School
Geographic Locations	Urban
Implementation History	Since it was first used in the 2000-2001 school year, CBITS has been implemented widely across the United States and is being actively disseminated through the National Child Traumatic Stress Network. Implementation sites have been located in California, the District of Columbia, Illinois, Louisiana, Maryland, Mississippi, Montana, Tennessee, and Wisconsin, among other States. Internationally, CBITS is being implemented in Australia, China, Guyana, and Japan.
NIH Funding/CER Studies	Partially/fully funded by National Institutes of Health: Yes Evaluated in comparative effectiveness research studies: Yes
Adaptations	CBITS has been adapted for use with traumatized Latino immigrant children, and worksheets and parent handouts have been translated into Spanish. The program also has been adapted for use in American Indian reservation schools to reflect the traditional culture and wellness practices of the participating tribes. In

	addition, program worksheets have been adapted for use among low-literacy populations and youth in foster care.
Adverse Effects	No adverse effects, concerns, or unintended consequences were identified by the developer.
IOM Prevention Categories	Selective Indicated

Quality of Research

Review Date: March 2010

Documents Reviewed

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

Study 1

Stein, B. D., Elliott, M. N., Tu, W., Jaycox, L. H., Kataoka, S. H., Fink, A., et al. (2003). School-based intervention for children exposed to violence [Reply]. Journal of the American Medical Association, 290(19), 2542.

Stein, B. D., Jaycox, L. H., Kataoka, S. H., Wong, M., Tu, W., Elliott, M. N., et al. (2003). A mental health intervention for schoolchildren exposed to violence: A randomized controlled trial. Journal of the American Medical Association, 290(5), 603-611.

Study 2

Kataoka, S. H., Stein, B. D., Jaycox, L. H., Wong, M., Escudero, P., Tu, W., et al. (2003). A school-based mental health program for traumatized Latino immigrant children. Journal of the American Academy of Child and Adolescent Psychiatry, 42(3), 311-318.

Study 3

Jaycox, L. H., Cohen, J. A., Mannarino, A. P., Walker, D. W., Langley, A. K., Gegenheimer, K. L., et al. (2010). Children's mental health care following Hurricane Katrina: A field trial of trauma-focused psychotherapies. Journal of Traumatic Stress, 23(2), 223-231.

Supplementary Materials

Foa, E., Johnson, K. M., Feeny, N. C., & Treadwell, K. R. (2001). The Child PTSD Symptom Scale: A preliminary examination of its psychometric properties. Journal of Clinical Child Psychology, 30(3), 376-384.

Jaycox, L. H., Stein, B., Kataoka, S., Wong, M., Fink, A., Escudera, P., et al. (2002). Violence exposure, posttraumatic stress disorder, and depressive symptoms among recent immigrant schoolchildren. Journal of the American Academy of Child and Adolescent Psychiatry, 41(9), 1104-1110.

Morsette, A., Schuldberg, D., van den Pol, R., Swaney, G., & Stolle, D. (2009). Culturally informed cognitive behavioral interventions for trauma symptoms: Group therapy in rural American Indian reservation schools. Manuscript submitted for publication.

Outcomes

Outcome 1: PTSD symptoms	
Description of Measures	The Child PTSD Symptom Scale (CPSS), the children's version of the Posttraumatic Diagnostic Scale for Adults, was used to assess PTSD symptoms. The CPSS is a 17-item self-report measure that asks children to rate how often in the past month they were bothered by symptoms on a scale from 0 (not at all) to 3 (almost always), yielding a total score ranging from 0 to 51, with higher scores indicating more PTSD symptoms.
Key Findings	In one study, 6th-grade students who reported exposure to violence and had clinically significant PTSD symptoms (CPSS score > 14) were randomly assigned to a group receiving CBITS or to a wait-list control group. After adjustment for baseline scores, the intervention group had a significantly lower mean CPSS score at 3-month follow-up than the wait-list group (8.9 vs. 15.5; $p < .001$). The effect size for this finding was large (Cohen's $d = 1.08$). At 6-month follow-up, after the wait-list group completed the CBITS intervention, the difference between the intervention and wait-list groups' mean CPSS scores was no longer significant (8.2 vs. 7.2). In another study, students in grades 3-8 with trauma-related depression and/or PTSD symptoms were compared after receiving CBITS or being placed in a wait-list control group. From baseline to 3-month follow-up, the intervention group's mean CPSS score decreased significantly from 19 to 13

	(p < .001), while the wait-list group had a nonsignificant decrease from 18 to 16. In addition, in a subsample analysis of students with clinically significant PTSD symptoms at baseline (CPSS score > 11), the improvement in mean CPSS score was significantly greater for the intervention group (from 20 to 13) than for the wait-list group (from 19 to 16; p < .05). In a third study, students in grades 4-8 who reported significant levels of mental health symptoms including PTSD were randomly assigned to receive CBITS or Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). Mean CPSS scores improved significantly from baseline to 10-month follow-up in both groups, decreasing from 22.82 to 12.00 for the TF-CBT group (p < .01) and from 21.98 to 15.81 for the CBITS group (p < .001). While both treatments led to a significant reduction of PTSD symptoms, the difference between groups was not statistically significant.
Studies Measuring Outcome	Study 1, Study 2, Study 3
Study Designs	Experimental, Quasi-experimental
Quality of Research Rating	3.1 (0.0-4.0 scale)

Outcome 2: Depression symptoms	
Description of Measures	Symptoms of depression were assessed using the Children's Depression Inventory (CDI). The CDI is a 27-item self-report instrument that assesses cognitive, affective, and behavioral symptoms of depression in children. Twenty-six of the 27 items were used; 1 item assessing suicidality was removed at the request of school personnel. For each item, the child was asked to describe his or her feelings during the past 2 weeks, with three possible response options associated with scores of 0 (an absence of symptoms), 1 (mild symptoms), and 2 (definite symptoms). Scores range from 0 to 52 points, with higher scores indicating more depressive symptoms.
Key Findings	In one study, 6th-grade students who reported exposure to violence and had clinically significant PTSD symptoms (CPSS score > 14) were randomly assigned to a group receiving CBITS or to a wait-list control group. After adjustment for baseline scores, the intervention group had a lower mean CDI score at 3-month follow-up than the wait-list group (9.4 vs. 12.7; p = .014). The effect size for this finding was small (Cohen's d = 0.45). At 6-month follow-up, after the wait-list group completed the CBITS intervention, the difference between the intervention and wait-list groups' mean CDI scores was no longer significant (9.0 vs. 10.0). In another study, students in grades 3-8 with trauma-related depression and/or PTSD symptoms were compared after receiving CBITS or being placed in a wait-list control group. From baseline to 3-month follow-up, the intervention group's mean CDI score decreased significantly from 16 to 14 (p < .001), while the wait list group's mean CDI score remained unchanged at 16. In addition, in a subsample analysis of students with clinically significant depression symptoms at baseline (CDI score = 18), the improvement in mean CDI score at 3-month follow-up was significantly greater for the intervention group (from 23 to 18) than for the wait-list group (from 24 to 23; p < .05). In a third study, students in grades 4-8 who reported significant levels of mental health symptoms including PTSD were randomly assigned to receive CBITS or TF-CBT. Mean CDI scores improved significantly for both groups from baseline to 10-month follow-up, decreasing from 15.43 to 11.14 for the TF-CBT group (p = 0.17) and from 13.40 to 9.72 for the CBITS group (p < .001).
Studies Measuring Outcome	Study 1, Study 2, Study 3
Study Designs	Experimental, Quasi-experimental
Quality of Research Rating	3.0 (0.0-4.0 scale)

Outcome 3: Psychosocial dysfunction	
Description of Measures	Psychosocial dysfunction was assessed using the 35-item Pediatric Symptom Checklist (PSC). This instrument asks the child's parent to rate the frequency of the child's emotional and behavioral problems on a scale from 0 (never) to 2 (often), yielding a total score of 0 to 70 points, with higher scores indicating greater dysfunction.
Key Findings	Sixth-grade students who reported exposure to violence and had clinically significant PTSD

	symptoms (CPSS score > 14) were randomly assigned to a group receiving CBITS or to a wait-list control group. After adjustment for baseline scores, the intervention group had a significantly lower mean PSC score at 3-month follow-up compared with the wait-list group (12.5 vs. 16.5; p = .007). The effect size associated with this finding was medium (Cohen's d = 0.77). At 6-month follow-up, after the wait-list group completed the CBITS intervention, the difference between the intervention and wait-list groups' mean PSC scores was no longer significant (9.4 vs. 8.9).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	3.4 (0.0-4.0 scale)

Study Populations

The following populations were identified in the studies reviewed for Quality of Research.

Study	Age	Gender	Race/Ethnicity
Study 1	6-12 (Childhood)	56% Female 44% Male	100% Race/ethnicity unspecified
Study 2	6-12 (Childhood)	50% Female 50% Male	100% Hispanic or Latino
Study 3	6-12 (Childhood)	56% Female 44% Male	48% White 46% Black or African American 5% Hispanic or Latino 1% Race/ethnicity unspecified

Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see Quality of Research.

Outcome	Reliability of Measures	Validity of Measures	Fidelity	Missing Data/Attrition	Confounding Variables	Data Analysis	Overall Rating
1: PTSD symptoms	4.0	4.0	2.0	3.0	2.0	3.5	**3.1**
2: Depression symptoms	4.0	3.5	2.0	3.0	2.0	3.5	**3.0**
3: Psychosocial dysfunction	3.5	4.0	3.0	3.5	2.5	4.0	**3.4**

Study Strengths

Relevant and psychometrically sound measurement instruments were used in the studies. The measures have high levels of reliability and validity and have been widely used in other studies. Missing data were handled well and were factored into analyses (e.g., analyses used multiple imputation; intent-to-treat was used in two of the studies). A variety of analyses were used across the three studies, and the analyses generally were appropriate for the type of data collected.

Study Weaknesses

Despite the availability of a treatment manual and clinician training, the methods used to assess intervention fidelity varied across the three studies and overall were not systematically strong. Several important confounding variables were not resolved in the studies, including baseline differences between completers and noncompleters, lack of blinding to treatment condition, a mixed approach to

making condition assignments, and differential attrition across treatment groups.

Readiness for Dissemination

Review Date: March 2010

Materials Reviewed

The materials below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.

Cognitive Behavioral Intervention for Trauma in Schools Dissemination Toolkit

Jaycox, L. (2004). Cognitive Behavioral Intervention for Trauma in Schools. Longmont, CO: Sopris West Educational Services.

Program Web site, http://www.tsaforschools.org/index.php?option=com_content&task=view&id=81&Itemid=69

Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see Readiness for Dissemination.

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating
4.0	4.0	3.5	**3.8**

Dissemination Strengths

Implementation materials are thorough and well developed. The manual and toolkit are easy to read, well organized, and clearly formatted. Detail is provided on screening students for appropriateness for inclusion in the program. Training packages are comprehensive and varied. The developers are clear about the skills and competences required by clinicians and supervisors who implement the program. Ongoing support is provided via remote telephone consultation and an online peer support network and resource library. Several options for fidelity monitoring are described, including the scoring of live or audiotaped sessions, therapist self-ratings, and supervision, and forms and rating instructions are included. Fidelity monitoring is stressed as an important component of the program.

Dissemination Weaknesses

The quality assurance materials contain no cultural competency measurement component despite an emphasis on cultural adaptations of the program. Further, there is minimal explanation as to how supervisors should interpret the changes in participants' scores from pre- to posttest and how they should analyze this information.

Costs

The cost information below was provided by the developer. Although this cost information may have been updated by the developer since the time of review, it may not reflect the current costs or availability of items (including newly developed or discontinued items). The implementation point of contact can provide current information and discuss implementation requirements.

Item Description	Cost	Required by Developer
Manual	$40 each	Yes
Background reading information	Free	No
Adaptation materials	Free	No
Students and Trauma DVD	$15 each	No
2-day, on- or off-site training (includes pretraining consultation)	$4,000 for 12-15 participants, plus travel expenses	No

Clinical consultation	$200 per hour	No
Fidelity checklists with instructions	Free	No
Review of tape recordings for fidelity monitoring	$100 per hour	No

Additional Information

The cost of implementation can be calculated based on the salary of a full-time, school-based mental health professional who is devoted to delivering CBITS. One professional can screen students in the general school population and select students with elevated symptoms, delivering up to 30 CBITS groups per academic year (6-8 students per group), for a total of about 210 students. Assuming an approximate staffing cost of $90,000 per year for a full-time social worker, the estimated cost per participant is $430.

Replications

Selected citations are presented below. An asterisk indicates that the document was reviewed for Quality of Research.

Cohen, J. A., Jaycox, L. H., Mannarino, A. P., Walker, D. W., Langley, A. K., & DuClos, J. L. (2009). Treating traumatized children after Hurricane Katrina: Project Fleur-de-Lis. Clinical Child and Family Psychology Review, 12(1), 55-64.

Dean, K., Langley, A., Kataoka, S., Jaycox, L. H., Wong, M., & Stein, B. D. (2008). School-based disaster mental health services: Clinical, policy, and community challenges. Professional Psychology: Research and Practice, 39(1), 51-57.

Feldman, E. (2007). Implementation of the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) with Spanish-speaking, immigrant middle-school students: Is effective, culturally competent treatment possible within a public school setting? (Doctoral dissertation, University of Wisconsin-Madison, 2007). Dissertation Abstracts International, 68(A), 1325.

Jaycox, L. H., Langley, A. K., Stein, B. D., Wong, M., Sharma, P., Scott, M., et al. (2009). Support for students exposed to trauma: A pilot study. School Mental Health, 1(2), 49-60.

Kataoka, S. H., Fuentes, S., O'Donoghue, V. P., Castillo-Campos, P., Bonilla, A., Halsey, K., et al. (2006). A community participatory research partnership: The development of a faith-based intervention for children exposed to violence. Ethnicity & Disease, 16(1 Suppl. 1), S89-S97.

Kataoka, S., Nadeem, E., Langley, A. K., Jaycox, L., Stein, B. D., & Wong, M. (in press). Implementing school mental health programs in post-Katrina Louisiana: A focus group study. American Journal of Preventive Medicine.

Morsette, A., Swaney, G., Stolle, D., Schuldberg, D., van den Pol, R., & Young, M. (2009). Cognitive Behavioral Intervention for Trauma in Schools (CBITS): School-based treatment on a rural American Indian reservation. Journal of Behavior Therapy and Experimental Psychiatry, 40(1), 169-178.

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Consider these Questions to Ask (PDF, 54KB) as you explore the possible use of this intervention.

Web Site(s):

- **http://www.cbitsprogram.org**

DC Fiscal Policy Institute

UNLOCKING OPPORTUNITIES: SERVICES THAT HELP POOR CHILDREN SUCCEED IN THE CLASSROOM

Part 4: Helping Students Facing Mental Health Challenges

By Soumya Bhat and Jenny Reed

Improving mental health services provided through schools is a critical part of improving school outcomes in the District. Children who grow up in poverty are exposed to high levels of trauma and stress that impacts their ability to do well in the classroom.

Schools are the largest provider of mental health services across the country and a logical place to identify students with mental health needs. Moreover, children are more likely to engage in mental health services in a school setting compared to other outside services.

> "Over the past 20 years, policies and programs that integrate mental health services into the schools have burgeoned, and research continues to demonstrate their positive impacts on educational and mental health outcomes."
>
> "The Impact of School Mental Health: Educational, Social, Emotional, and Behavioral Outcomes," University of Maryland, School of Medicine, Center for School Mental Health.

The District provides a variety of services to address the mental health challenges of students in schools, but they are not found at all schools, and many schools have mental health staff with caseloads that are too large to provide adequate services. The Children's Law Center (CLC) estimates that 5,000 DC children are in need of mental health services, but not receiving them, and that many children are forced to wait far too long to see a mental health professional.

The District should increase services and funding to better meet the mental health needs of students in the following ways:

- **Expand Access to School Mental Health Programs:** The District set a goal of having a mental health program in every school by 2016-17, but currently only 36 percent are covered.
- **Expand the Use of Positive Behavior Intervention and Supports to all Schools:** These programs, which focus on encouraging desired behaviors rather than punishing negative behavior, increase attendance, and reduce the need for suspensions and special education referrals.
- **Create Trauma-Sensitive School Environments in All Schools:** DCPS uses a number of programs that can help students address trauma, but they are not available system-wide and often are only available to a small number of students with the greatest needs. Schools in Massachusetts, San Francisco, Washington State and Wisconsin have all implemented trauma-sensitive environments serving all students.
- **Increase the Availability of School Social Workers and Psychologists:** More than one-third of DC schools have too few social workers and psychologists to meet the needs of their students.
- **Improve Data Sharing across Agencies Serving Children and their Families:** Children with socio-emotional needs and their families often receive services from multiple District agencies. But a lack of information sharing

across agencies can mean that efforts are duplicated, unnecessarily re-started, and problems facing the child and family are not fully understood by the various agencies working with them.

Background: The Mental Health Challenges of Low-Income Students.

Low-income children are more often exposed to trauma and stress during their developmental years, leading to high rates of emotional or social problems.[1] These children are more likely to have problems in school, be absent, suspended or expelled, or drop out.[2] Exposure to trauma and stress makes it hard for children to develop secure attachments to caregivers that help them handle stress in their lives.[3] Repeated exposure can lead to chronic, toxic stress which hinders development of key skills necessary for learning, including memory, attention, and language.[4]

Research has found that children with toxic stress performed worse on academic tests than their unstressed counterparts.[5] According to Paul Tough, the lack of these "executive function" skills can impact how well children do in the classroom where they need to concentrate, interact with others, sit still and follow instructions.[6] Constant exposure to trauma can make kids feel unsafe, even at school, and that lack of safety can make them more likely to act out or withdraw at school in response to stress. This can make it more likely that students are disciplined at school and/or are not prepared to learn.

The Department of Behavioral Health estimates that the incidence of mental health illness in DC is similar to the incidence nationally. This would mean that about one in four to five DC children meets the criteria for a severe mental health disorder and one in 10 has a serious mental health problem that impacts their ability to function day-to-day.[7]

Schools, working with mental health organizations, are a critical provider of mental health services. Locating mental health services in schools leads to greater accessibility and use of mental health services. One study found that 96 percent of students who were referred for assistance in a school with a SMH program began services, while just 13 percent of students referred to community based clinical treatment began services.[8]

Given the number of children with unmet mental health challenges in DC, a strong system of supports for DC students can play a critical role in making sure students are attending school ready to learn.

What DC Does to Help Students with Mental Health Challenges.

Mental health

[1] Evans, G. W., "*The Environment of Childhood Poverty*", American Psychologist, Vol. 59, No. 2, February/March 2004, pgs. 77-92

[2] Stagman, S. & Cooper, J., "Children's Mental Health: What Every Policymaker Should Know," National Center for Children in Poverty: Mailman School of Public Health, Columbia University, April 2010. Available at: http://www.nccp.org/

[3] Tough, Paul, "How Children Succeed: Grit, Curiosity, and the Hidden Power of Character," Houghton Mifflin Harcourt Publishing Company, New York, NY (2012).

[4] Evans, G.W; Brooks-Gunn; J. & Klebanov, P., "Stressing Out the Poor: Chronic Psychological Stress and the Income-Achievement Gap," Pathways Magazine, Winter 2011, Stanford Center on Poverty and Inequality.

[5] Evans, G.W; Brooks-Gunn; J. & Klebanov, P., Winter 2011.

[6] Tough, Paul (2012)

[7] Children's Law Center, "Improving the Children's Mental Health System In the District of Columbia," (2012), available at www.childrenslawcenter.org

[8] Center for School Mental Health, "The Impact of School Mental Health: Educational, Social, Emotional, and Behavioral Outcomes," University of Maryland School of Medicine. Available at: http://csmh.umaryland.edu/Resources/Reports/CSMH%20SMH%20Impact%20Summary%20July%202013.pdf

services in most DC Public Schools are provided by a school psychologist, social worker or counselor. Some schools also provide additional services supported by the Department of Behavioral Health.

The vast majority of DCPS schools have both a school social worker and psychologist. However, school psychologists focus largely on special education: conducting needs assessments, designing interventions for students, and evaluating progress. Social workers provide counseling, home visits, assessments, and other services to help address students' emotional and social growth. They also provide significant support to students enrolled in special education services.

In school year 2014-15, DCPS has 77 full-time equivalent psychologists in schools and 18 in the central office. All but 14 schools have at least a half-time psychologist, and 44 percent have a full-time, or more than full-time psychologist(s). DCPS also employs 162 full-time equivalent social workers in schools and five in the central office. All but five schools have at least one part-time social worker, and 81 percent have a full-time, or more than one full-time, social worker(s).

DC Public Schools meets the industry standard for the ratio of psychologists and social workers to students on a city-wide basis. However, not all schools meet the industry standard. The National Association of School Psychologists recommends one psychologist for every 500 to 700 students. Across the system, DCPS has a ratio of approximately 502 students per psychologist, the lowest in the region.[9] On a school by school basis however, just under two-thirds of schools also meet this threshold, but approximately 1 in 3 do not. Twelve of these schools have no school psychologist. In the past, central office social workers have been used at schools to help with service delivery.

The School Social Work Association of America recommends one social worker per 400 students. Across the system, DCPS has a ratio of one social worker per 286 students. But on a school by school basis, just under two-thirds of schools meet this threshold. Of the schools that do not meet this threshold, more than half are located in zip codes where 20 percent or more of the children live below the poverty line. Five of these schools do not have social work positions. In the past, central office social workers have been used at schools to help with service delivery.

DCPS offers five evidence-based services to assist students with mental health needs:

- **Mental Health Consultation**. This voluntary practice is available in all schools and makes social workers available on a weekly basis to give feedback to teachers who are struggling with work related concerns such as teacher/student power struggles or problem classroom behaviors. A 2012 pilot of the program in 18 elementary schools showed that nine in ten students who participated in the program reduced their behavior infractions.[10]

[9] Thompson, Tisha, "Most D.C. Area School Districts Fall Short of Recommended Number of Psychologists," NBC-4, available at: http://www.nbcwashington.com/investigations/Most-DC-Area-School-Districts-Fall-Short-of-Recommended-Number-of-Psychologists-258546661.html?_osource=SocialFlowFB_DCBrand

[10] Information on the 2012 pilots for the Mental Health Consultation, CBITS and SPARKS are from a DC Public Schools fall 2012 powerpoint entitled: "Evidence Based Practices and Treatments." Contact the authors for a copy of the powerpoint.

- **Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)**. CBITS provides 1-2 individual sessions and 10 group sessions for children who have been exposed to trauma and are experiencing post-traumatic stress symptoms. The service is available at all DC middle schools, two alternative schools and six education centers. A 2012 pilot in three middle schools found that CBITS improved attendance, reduced behavior infractions, reduced post-traumatic stress symptoms, and improved functioning for participants.
- **Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)**. SPARCS provides interventions for children experiencing complex post-traumatic stress disorder symptoms. This program is available in all DC public high schools, nine middle schools, five education campuses, and four alternative school settings, including the Youth Services Center and Incarcerated Youth program. A 2012 pilot operated in six high schools found that SPARCS improved attendance, reduced behavior infractions, reduced post-traumatic stress symptoms, and improved functioning for participants.
- **Cannabis Youth Treatment (CYT).** CYT is a brief five-session treatment intervention available for adolescents in all DCPS high schools. The primary goal of CYT is to reduce and/or eliminate marijuana use and associated problems that affect students.
- **Child Centered Play Therapy (CCPT).** This treatment approach is a time-limited, evidence-based early intervention to help young children learn how to self-regulate emotions and develop improved executive functioning skills. Child Centered Play Therapy is a 14-week program that includes a parent intake and follow-up session, 4 child assessment sessions, and 10 play therapy sessions. The therapy is offered in 90 percent of all elementary schools.

DCPS also uses positive behavioral intervention and supports (PBIS) in nine schools, using the "Students Forward" model.[11] PBIS is a prevention and intervention program that focuses on teaching desired positive behaviors rather than on suppressing negative behaviors. It includes a review of the school's discipline policy and uses positive reinforcement to encourage more behaviors to be dealt with in the classroom rather than a trip to the principal's office. National research shows that PBIS reduces discipline, behavioral problems, and referrals to counseling and special education services.[12]

School Mental Health Program. The School Mental Health Program (SMH), operated by the DC Department of Behavioral Health (DBH), provides full- or part-time clinicians in participating schools. Unlike school psychologists, who must also spend a significant amount of time on special education services, SMH clinicians are solely focused on mental health services. In school year 2014-15, the program operates in 46 public schools and 15 charter schools, with about half located in Wards 7 and 8. (See **Table 1**.) The program also plans to expand to additional six DC public schools and 2 public charter schools in school year 2014-15. Just under three-quarters of the programs

[11] The schools are: Eliot Hine Middle School, Hart Middle School, Jefferson Academy Middle School, Johnson Middle School, Kelly Miller Middle School, Kramer Middle School, Sousa Middle School, Stuart Hobson Middle School, and Cardozo High School.

[12] Barrett, S., Eber, L., and Weist, M. (Eds.), "Interconnecting School Mental Health and School-Wide Positive Behavioral Support," University of Maryland School of Medicine, Center for School Mental Health. Available at: http://csmh.umaryland.edu/Resources/Reports/index.html

operating in DCPS have full-time staff, while in public charter schools, three-fourths do.

Table 1
Locations of School Mental Health Programs by Ward, SY 2014-15

Ward	Number of School Mental Health Programs
1	9
2	1
3	1
4	4
5	7
6	8
7	13
8	19

The program provides prevention and early intervention services for the entire school. It also provides individual, group and family counseling services for students with higher needs. Almost 1,700 students were referred to the SMH program in 2013-14 by Primary Project staff, teachers, administrators, school counselors and social workers, and families. Over two-thirds of those referred were assessed and referred to care. Of those 1,200 referrals, 630 students received treatment services from a clinician and 200 were referred to outside mental health services. Clinicians are expected to maintain a caseload of 12-20 children across school placements, depending on referrals and needs. **Table 2** (see next page) displays the demographics of the children seen for treatment.

DBH uses the Ohio Scales outcome measurement tool to look at the effectiveness of the treatment programs. The tool measures problem severity and functioning every 90 days over the course of treatment. Of the parents, students, and clinicians who completed the forms, all reported fewer behavioral and emotional symptoms and improved everyday functioning after treatment.

Legislation adopted in 2012, the South Capitol Street Memorial Amendment Act, set a goal of having mental health programs in 50 percent of DC schools by school year 2014-15 and in all schools by 2016-17.[13] Yet funding through FY 2015 is only sufficient to locate the program in 77 schools (36 percent of all schools), even with additional funding over the past two years to add 25 schools.

The District will need to provide additional funding to expand the program and meet the goal of full coverage.

Primary Project. The Primary Project, operated by the Department of Behavioral Health, is an early intervention program aimed at identifying and treating socio-emotional problems before they develop into more serious socio-emotional or mental health issues. Primary Project serves children in pre-school through 3rd grade who have mild problems with socio-emotional adjustments to the classroom. The program was implemented in 19 DC public schools, four DC public charter schools, and 17 child development centers in school year 2013-14. More than three-fourths of the sites are DC public schools, and half are in schools in Wards 7 and 8.

Children with mild difficulties receive one-on-one assistance from a DBH Child Associate. Children needing more intensive services are referred to an appropriate professional, such as a DBH school mental health clinician. In school year 2013-14, over 3,000 children were screened with the

[13] A19-0344, "The South Capitol Memorial Amendment Act of 2012"

program and 558 were referred to the Primary Project for services.

Table 2 Demographics of Children in Treatment Who Completed Clinical Forms in SY 2011-12 (total 462)		
Grade Level of Student		
PK-2nd Grade	112	25%
Grades 3-4	53	12%
Grades 5-6	77	17%
Grades 7-8	133	29%
Grades 9-12	77	17%
Total	452	
Sex		
Male	226	49%
Female	234	51%
Total	460	
Age		
3-5 years	24	5%
6-10 years	168	37%
11-13 years	157	34%
14+ years	109	24%
Total	458	
Race/Ethnicity		
African American	399	86%
Hispanic	52	11%
White	4	1%
Other	7	2%
Total	462	
Source: Department of Behavioral Health		

Early evaluations indicate that the program is helping students make positive adjustments to the classroom. Teachers reported that participating students improved their task orientation, behavioral control, assertiveness and peer social skills.[14] In school year 2014-15, the Primary Project expanded to 56 locations, up from 40 the previous school year.

Improving Services for Children with Mental Health Challenges. Students getting school-based mental health services see improvements in test scores, attendance and grade point averages as well decreased behavioral problems and an improvement in social functioning.[15] Evidence from DC's school mental health program found that parents, clinicians and students all reported fewer behavioral and emotional symptoms after treatment and everyday functioning improved.

These findings suggest that strengthening the District's mental health services in school settings is an important part of helping unlock the potential of all students, especially low-income students.

Expand Access to School Mental Health Programs. The District should act as quickly as possible to expand the School Mental Health (SMH) program to all DC public schools and public charter schools. The District is already behind the goal of reaching 50 percent of schools by the 2014-15 school year. With current funding supporting programs in 77 schools, or 36 percent of all schools, DC would need to add 137 schools over the next two school years, which would cost about $11million.[16]

The District should also look to expand the Primary Project program to more high-need elementary schools and child development centers. Helping

[14] Data received via email from the Department of Behavioral Health. Contact the author for more details.
[15] Center for School Mental Health, "The Impact of School Mental Health: Educational, Social, Emotional, and Behavioral Outcomes," University of Maryland School of Medicine. Available at: http://csmh.umaryland.edu/Resources/Reports/CSMH%20SMH%20Impact%20Summary%20July%202013.pdf
[16] This report assumes an average cost of $77,333 per school based on FY 2015 funding per school.

to identify children early on who need additional socio-emotional support can make it easier for both teachers, students and their families to address issues before they reach a crisis level.

Expand the Use of Positive Behavior Intervention and Supports to all Schools.

As noted, the District uses Positive Behavior Intervention and Supports in nine DC public schools. Schools that have implemented PBIS effectively have seen reductions in discipline issues and reduced referrals to counseling and special education services.[17] DC should expand the use of PIBS to all schools, starting with high-needs schools first.

Create Trauma-Sensitive School Environments in All Schools.

Schools can play a key role in how students who experience trauma adjust to the classroom by changing the entire school environment to allow students to feel safe and supported.[18] DCPS uses a number of programs that can help students address trauma, such as Positive Behavioral Intervention and Supports (PBIS), Cognitive Behavioral Intervention for Trauma in Schools (CBITS) and Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS). Yet, in the case of CBITS and SPARCS, they are only available to a small number of students with the greatest needs in schools. And PIBS is only available in nine DC schools.

More work needs to be done to ensure that DC's schools are truly trauma-sensitive. According to a forthcoming paper by the Children's Law Center on trauma sensitive schools, other cities and states, such as Massachusetts, San Francisco, Washington State and Wisconsin, are leading the way in this area and have created models for trauma-sensitive school environments that rely on different school-wide programs than DCPS is currently using. All staff who interacts with students must understand trauma, how it impacts children and how to respond appropriately so that students feel safe.

The positive results from DC's CBITS and SPARCS services highlight how addressing trauma can benefit both the students and the school. Expanding trauma-sensitive environments to all students in the school can help ensure a wider range of children experiencing trauma can benefit, not just those with the most severe needs.

Increase the Availability of School Social Workers and Psychologists.

School social workers are key providers of mental health services in schools. Yet, more than one-third of DC Public Schools have too few social workers to meet the needs of their students. In addition, more than one-third of DC Public Schools have too few psychologists to meet the needs of students. DC should expand the number of social workers and psychologists at schools where the number students per social worker and/or psychologist is above the recommended threshold, starting with the highest poverty schools first.

[17] Barrett, S., Eber, L., and Weist, M. (Eds.), "Interconnecting School Mental Health and School-Wide Positive Behavioral Support," University of Maryland School of Medicine, Center for School Mental Health. Available at: http://csmh.umaryland.edu/Resources/Reports/index.html

[18] Tishelman, A.C., Haney, P., Greenwald O'Brian, J and Blaustein, M. (2010), "A Framework for School Based Psychological Evaluations: Utilizing a "Trauma Lens," Journal of Child and Adolescent Trauma, 3(4): 279-302, 280.

Case Study: An Approach to School Turnaround for High Poverty Schools

The District is using a targeted model – called Turnaround for Children model – which provides a "fortified environment" for students with greatest need – those with behavioral and academic challenges. Turnaround for Children schools provide positive behavioral supports to reduce stress, build positive relationships with adults and fellow students, and ultimately boost readiness to learn.

A central component of the Turnaround model is the development of a student support system, both inside and outside of the school. A trained social worker is placed inside the school, and special intervention teams are created to discuss and monitor interventions for at-risk students. Outside of the school, connections are made with community mental health partners and other social service providers to meet the needs of students with more urgent challenges.

Turnaround for Children schools also provide professional development for teachers to build a safe, supportive classroom environment. Instructional coaches train teachers on ways to improve student engagement and effectiveness of classroom, including constructive approaches to disruptive behavior. Turnaround also works with school leaders to ensure complete buy-in and help them develop a data-driven plan to improve overall school performance.

This model was initially implemented in New York, where intensive services led to suspensions falling 27 percent, severe incidents falling 18 percent, and chronic absenteeism falling 11 percent.[1]

Turnaround is currently in use in five DC Public Schools -- Wheatley, Orr, Henley, Patterson, and Walker Jones – with possible expansions to additional schools. Estimated to cost about $300,000 per school annually, the program is currently funded with a combination of public (Title I) and private dollars.

For more information, see www.turnaroundusa.org

Improve Data Sharing Across Agencies to Ensure a Comprehensive Continuum of Care for Children and their Families.

Children with socio-emotional needs and their families are often receiving services from multiple District agencies. But a lack of information sharing across agencies can mean that efforts are duplicated, unnecessarily re-started, and problems facing the child and family not fully understood by the various agencies working with them.

In its review of the disappearance of Relisha Rudd from the DC Family Shelter, the District acknowledged this problem and recommended that the Department of Behavioral Health, Department of Human Services and Child and Family Services review their policies and amend them as needed to facilitate proper information sharing. In addition, they recommended that a cross-agency task force be created to identify families most at-risk and how best to serve them.[19] DC should work quickly to implement these recommendations as well as ensure that the appropriate staff at DCPS and public charter

[19] Government of the District of Columbia, Office of the Deputy Mayor for Education and Office of the Deputy Mayor for Health and Human Services, "Summarized Findings and Recommendations: Review of Interactions with RR and Her Immediate Family and District Government Agencies," September 2, 2014.

schools also have access to critical information when treating children with socio-emotional needs. It is important though that this be done in a way that doesn't interfere with families' rights to confidentiality under current law.