Addressing Barriers to Learning

New ways to think . . .

Better ways to link

Mental Health in Schools Center Training and Technical Assistance

Accountability should not simply be a mantra. It is an invaluable facet of effective practice; but it is just one facet and only makes sense when the other facets are properly planned and implemented.

Accountability:
Is it Becoming a Mantra?

How effective is the intervention?

Do you have data to support that approach?

Where's your proof?

The questions are so logical and simple to ask, *and* they can be so devastating in their impact. The problem is that such questions imply that relevant data are easy to gather, and so if data aren't available, the intervention must be ineffective or else those in charge are irresponsible. Usually ignored by the questioners are the many complexities associated with valid and ethical evaluation of major mental health and psychosocial problems.

Every mental health practitioner is aware of the importance of having data on *results.* All interveners want to be accountable for their actions and outcomes. But *it is* complicated.

Fundamental dilemmas stem from the limited validity and focus of available measures and the tendency for those demanding accountability to have inappropriate expectations that there can be rapid improvement even though youngsters and their families are exper-

Contents

iencing severe and pervasive problems. Most widely sanctioned evaluation instruments are quite fallible. Moreover, they are designed to measure results that require a lengthy course of intervention, thereby giving short shrift to immediate benefits (benchmarks) that are essential precursors of longer-range improvements. Ironically, demands for accountability tend not to take responsibility for the negative consequences that formal assessment has on some clients. Accountability pressures increasingly require the gathering of a significant amount of data during the first session with a client; many practitioners note that this practice interferes with building positive relationships and contributes to what is already too high an intervention dropout rate.

What are practitioners and program leaders to do?

Well, not surprisingly, they often look for assistance. The topics of evaluation, accountability, and quality improvement are among the most frequent requests for technical assistance and continuing education. As a result, the number of publications and technical assistance resources in the area has increased at an exponential rate. And, there are endless lists of measures (many that have not been appropriately validated). Unfortunately, the volume of materials and other resources is not an indication that fundamental evaluation concerns have been effectively addressed. The complications remain unresolved, the status quo remains unsatisfactory; and all that any of us can do at this point is to develop aids, guidelines, and standards for practice that strive for appropriate accountability while doing the least harm to youngsters and their families.

As an aid to those involved with mental health in schools, our intent here is to support evaluative efforts by highlighting a broad range of accountability indicators and outlining ways data related to such indicators currently can be gathered. In doing so, we differentiate three areas

for accountability (i.e., accountability to the society, to an institution such as schooling, and to youngsters and their families).

Accountability to Who?

In a seminal article on the evaluation of therapeutic outcomes, Strupp and Hadley (1977) stress how different the expectations of society and its institutions often are from those of individual clients.[1] Thus, it is imperative to understand accountability from the perspective of the various parties with special interests in the results of mental health and psychosocial interventions. For our purposes here, the focus is on (a) the *society* in general and the *institution of schooling* in particular and (b) those specific *youngsters and their families* who are the direct focus of intervention efforts.

Accountability to Society and to the Institution of Schooling

Society looks at the following types of general indicators to evaluate whether efforts related to psychosocial and mental health concerns are paying appropriate dividends:

- *Increases* in youth employment (ages 16-19)
- *Reductions* in
    >student mobility
    >youth pregnancy
    >sexually transmitted diseases
    >child abuse/neglect
    >youth arrest/citation
    >youth probation violations

- *Reductions* in
    >youth emergency room use for mental
        health and psychosocial related events
    >foster care placements
    >homeless youth
    >youth suicide rates
    >youth death rates

In addition, those responsible for schools are required to demonstrate effective fulfillment of their specific mission -- which is to educate the young in ways that meet society's needs. The primary indicators currently demanded by social policy are those that reflect academic achievement at a standard competitive with

other major countries. Thus, the emphasis is on increasing

- at all grades
    >achievement test scores
    >grades
    >other indicators of progress
        in academics (analyses of work)

- at high school level
    >number graduating (with a related
        reduction in the number dropping out)
    >number taking SATs
    >number continuing with post-secondary educ.

Because many youngsters are experiencing barriers to learning and performing at school, programs and services to address such barriers are increasingly essential to the ability of schools to accomplish their mission. Some major indicators for accountability related to these enabling or learning support programs are

- *Reductions* in
    >unexcused absences
    >tardies
    >suspensions/expulsions
    >referrals for misbehavior
    >referrals for learning problems

- *Increases* in
    >attendance
    >cooperation & work habits
    >fluency in English as Second Language

- *Reduction* in numbers designated as Learning
    Disabled or Emotionally Disturbed

Data for Accountability to Society and the Institution of Schooling

Data related to most of the above indicators are available from the records at school sites, school districts, and city/county agencies. Some schools also are involved in administering the Youth Risk Behavior Surveillance System (sponsored by the Centers for Disease Control and Prevention) which contains relevant indicators for use in monitoring changes over time. (Many communities and child advocacy groups are gathering local and statewide data on child well-being and publishing it as "Report Cards.") If data are not available, then efforts are needed to ensure relevant indicators are gathered and made accessible. And, appropriate steps should be taken to ensure that data can be disaggregated with respect to specific subgroups.

---

[1]As these writers state: "*Society* is primarily concerned with the maintenance of social relations, institutions, and prevailing standards of sanctioned conduct. Society and its agents thus tend to define mental health in terms of behavioral stability, predictability, and conformity to the social code. ... The *individual client* ... wishes first and foremost to be happy, to feel content [and] thus defines mental health in terms of highly subjective feelings of well-being ... (p. 188). Strupp, H.H. & Hadley, S.M. (1977). A tripartite model for mental health and therapeutic outcomes with special reference to negative effects in psychotherapy. *American Psychologist, 32*, 187-196.

Accountability to Specific Youngsters and Families

Those who work in school districts to provide programs and services related to psychosocial and mental health concerns also are accountable to the specific individuals they help. Such accountability certainly can be seen as encompassing the indicators listed above. However, for individuals who must deal with major barriers, many of the above realistically are only good indicators of progress after a lengthy period of multifaceted, comprehensive, integrated intervention. More immediate accountability indicators are needed to demonstrate progress related to objectives that are the current and direct focus of psychosocial and mental health interventions (e.g., reductions in symptoms; enhanced motivation and psychological and physical well-being). Because data on such specific objectives are not readily available, the problem of *generating* relevant data arises -- as do some serious dilemmas. Efforts to answer the following questions lead to an appreciation of the many problems and issues.

What are the right indicators?

Endless arguments arise over indicators when they are discussed in highly *specific* and *concrete* terms. At a more abstract level, there is considerable agreement around three general categories: (1) client satisfaction (the youngster; the family), (2) reduction in the youngster's symptoms/problem behaviors, and (3) increases in positive functioning (the youngster; the family).

*How can appropriate **specific** and **concrete** indicators be identified for particular clients?*

The dilemmas that arise here reflect the problem of "Who is the client?" -- the youngster? the family? a teacher who made the referral? Additional dilemmas arise because the various involved parties often have different perspectives regarding what problems should be addressed. (And , of course, the intervener may have even another perspective.) A reasonable compromise is to gather evaluative data related to (1) the specific symptoms and behavior problems that led to the referral, (2) any objectives that the client wants help in achieving, and (3) specific objectives

that the intervener believes are warranted and that the client consents to add.

How should the deficiencies associated with existing measures be accounted for?

Although some measures are better than others and some are designated the best that exist, best should not be equated with good or good enough. All instruments we rely on currently have limited reliability and validity; also quite limited are the normative data for various subgroups. These limitations (1) call for using formal instruments only when they are necessary, (2) require full disclosure of limitations when findings are reported, and (3) warrant making extreme efforts to look for disconfirming evidence whenever findings suggest significant pathology.

How can the negative impact of gathering the data be minimized to an appropriate degree?

All evaluation has the potential to produce major negative consequences. The ethical obligation is to maximize benefits and minimize costs to clients. Putting aside the financial costs, it is clear that use of any formal measure can increase a client's distress and produce psychological reactance. It is likely that the high dropout rate among clients, in part, is a reaction to too much formal assessment during the first encounters with an intervener. Accountability requirements that mandate administration of formal measures before counseling is initiated may well be contributing to the low rate of youngsters who stay in counseling long enough to reap significant benefits. From the perspective of sound standards for practice, (1) no formal measures should be administered until the intervener judges that the relationship with the client is strong enough to mediate any distress and (2) measures should be personalized to assess only the specific and concrete indicators that are relevant to a

particular client.

Measures Relevant for Accountability to Specific Youngsters and Families

Below are listed a sample of promising instruments. Unless otherwise noted, the measure cited is reviewed in *Evaluating the Outcome of Children's Mental Health Services: A Guide for the use of Available Child and Family Outcome Measures* (1995) -- prepared by T.P. Cross & E. McDonald for the Technical Assistance Center for the Evaluation of Children's Mental Health Services.[2]

It is essential that interveners review and choose measures that minimize negative impact on clients. Proper personalization of assessment in the best interests of the client may even call for not using a measure in its entirety or in the way the developer prescribes. We recognize that this violates standardization of administration and makes interpretation more difficult, but just as empirically supported therapeutic strategies must be adapted to ensure a good fit with a client, so must assessment practices. In both instances, empirical support for prevailing practices is not so strong as to warrant rigid implementation. Also of value are data from functional assessments (increasingly being done when students are referred for behavior problems). Finally, some interveners use projective procedures and selected items from other measures (e.g., sentence completion, drawings and related stories, Childrens Depression Inventory) as a stimulus for discussion with clients. Client responses early and near the end of the period of intervention may be useful as supplementary evaluation data.

(1) Client Satisfaction (youngster; family)

Client Satisfaction Questionnaire (CSQ -- Larsen, et al. -- Portland State U. Version)

Youth Satisfaction Questionnaire (YSQ -- Portland State U.)

Vanderbilt Satisfaction Scales -- parents/caregivers and/or adolescent self-report

(2) Reduction in Youngster's Symptoms/Problem Behaviors

Child Behavior Checklist (CBCL -- Achenbach & Colleagues)
There are versions to be filled out by parents-caregivers, teachers, and youth self-report, as well as a direct observation form.

Child Assessment Schedule (CAS -- Hodges) -- self-reports from child and/or parents-caregivers

(3) Increases in Positive Functioning (youngster; family).

Child and Adolescent Functional Assessment Scale (CAFAS -- Hodges) -- intervener rating

Preschool and Early Childhood Functional Assessment (Hodges) -- intervener rating

Quality of Well-Being Scale[3] (QWB) -- client self-report

Family Environment Scale (Moos) -- family self-report

Family Empowerment Scale (Portland State U.) -- family self-report

_____

[2]Other instruments are reviewed in the guidebook; those included here seem most useful for practitioners concerned with mental health in schools. The guidebook is available by contacting the TA Center for the Evaluation of Children's Mental health Services at Judge Baker Children's Center, 295 Longwood Ave., Boston, MA 02115 (617) 232-8390.

[3]Reviewed in W.H. Hargreaves, M. Shumway, T. Hu, & B. Cuffel (1998). *Cost-Outcome Methods for Mental Health*. San Diego: Academic Press.

Sampling of Indicators with Respect to Different Accountability Demands

As should be evident from the preceding discussion, it can be extremely costly and time consuming to be accountable to all parties (see also Figure 1) with interests in the productivity of an intervention. In most situations, the realities that only a sample of data can be gathered (see Figure 2).

With respect to individual clients, the data sample should begin with assessment that has direct and immediate relevance to the specific objectives an intervener and client have agreed to pursue. Then, in response to accountability demands and in keeping with ethical and feasible practice, a subset of standardized items can be administered to stratified samples of clients. The particular subsets of items chosen should reflect matters of greatest concern to those demanding accountability. If the pool of items is large, then different subsets of items can be administered over time and later combined to provide a full picture of outcomes.

With respect to societal and institutional accountability, the data sample initially consists of that which can be readily gathered on a regular basis. Subsequently, again reflecting matters of greatest concern to those demanding accountability, step by step strategies can be developed to establish systems for amassing regular findings related to key variables and specific population subgroups.

Clearly, sampling requires considerable planning and careful implementation. A systematic evaluation plan must be developed, and there must be appropriate budgeting for its implementation. Many programs will require specific consultation in developing an appropriate sampling strategies.

Standards for Comparison

Whatever data are collected will be imperfect and only rarely will be easily interpreted. For accountability to be rational, there must be a reasonable set of standards for comparison. In asking how good an intervention is, the question must be answered in terms of *Compared to what?*

When it comes to mental health in the schools, the best comparisons are (a) data on the previous results of intervention efforts with comparable students and their families, (b) data on similar students/families at a school who have not yet been served (e.g., appropriate waiting list samples), or (c) data from a very similar school that does not have the programs being evaluated. The first approach calls for gathering a "baseline" of data before or in the early stages when an intervention is being developed. The latter approaches call for being able to gather the same data with nonserved groups. Again, the matters of systematic planning and appropriate budgeting are central considerations.

Finding out if interventions are any good is a necessity. But in doing so, it is wise to recognize that evaluation is not simply a technical process. Evaluation involves decisions about what, how, and when to measure, and these decisions are based in great part on values and beliefs. As a result, limited knowledge, bias, vested interests, and ethical issues are constantly influencing evaluation processes and the decisions made with respect to accountability.

Figure 1. Accountability as related to different intervention goals.

Purpose of Intervention	*Accountability to Who?*	*Sampling of Objectives/Goals*
To meet *society's goals*	Accountable to society	Data are gathered on indicators that reflect society's purposes in financing the institution
To meet an *institution's goals*	Accountable to a specific institution	Data are gathered on indicators that reflect the institution's purposes
To meet the *personal goals of specific clients*	Accountable to specific clients	Data are gathered on indicators that reflect individual client's purposes in participating in an intervention
To meet some combination of society, institution, and individual goals	Combination of the above	Combination of the above

6

Figure 2. **E**valuation/accountability/results: Sampling indicators with respect to different accountability demands.

Accountability to Society
(to meet society's goals)

Increases in

S   >youth employment (ages 16-19)
   >readiness for adult employment

A   Reductions in
   >youth pregnancy

M   >arrests/citations/probation violations
   >Sexually transmitted diseases

P   >child abuse/neglect
   >emergency room use for mental health/psychosocial problems

L   >youth foster care placements/homelessness
   >youth deaths(suicide, homicide, result of high risk behaviors)

E

Accountability to a Specific Institution
O   (to meet the institution's goals)

e.g., schools

F   Increases in
   >academic achievement and grades
   >graduation rates
   >numbers taking college board exams

D   >numbers continuing on with post-secondary education
   >attendance/decreased tardies

A   Reductions in
   >referrals for misbehavior/learning problems

T   >numbers designated Learning Disabled/Emotionally Disturbed
   >numbers of dropouts

A

Accountability to Specific Client(s)
(to meet the personal goals of clients)

   >satisfaction with intervention
   >progress in addressing problems for which intervention
      was implemented (e.g., symptom reduction, increase in
      positive functioning)

Note: Not included here are indicators of negative effects that may accrue for individuals, interveners, institutions, and the society (e.g., the many psychological, social, and economic costs). Clearly, data on these matters is essential -- although they tend to be ignored in many so-called *results*-oriented demands for accountability.

Pressure to gather pre-intervention data in anticipation of measuring results seems like a straight forward practice when viewed through the lens of evaluation. But often those we are trying to help have a different view of the matter.

Increasingly, it is becoming common practice to administer several instruments (and do a variety of other "paper work") during the first session with clients. What is the impact of all this? We are hearing from practitioners who suggest that such activity is increasing client reactance and negative motivation.

It has always been hard to get the involvement of some youngsters and their families in counseling situations. No-show and drop out rates are high. The lesson of all this is that greater attention must be paid to enhancing the *motivational readiness* of those we want to help and, at the very least, interveners must minimize doing things that increase avoidance tendencies among clients.

In terms of everyday practice with youngsters, this means (1) discussing with parents/teachers what they should and should not say to youngsters in preparing them for the first visit to a mental health professional and (2) designing first visits around the concept of enhancing motivational readiness. Everyone needs to be honest and nonpunitive with a youngster in discussing who they are going to see (e.g., a counselor who will try to help make things better). Many students require a great deal of reassurance that going to see a counselor is not an indication that parents/teachers think the youngster is "mental" (e.g., crazy, retarded). Some react positively to the information that many other students are going and find it helpful.

Obviously, youngsters who already are well motivated require little to enhance their motivational readiness. For most, however, enhancing motivation toward participation in the intervention requires considerable attention. Because referrals usually far exceed mental health resources, it is commonplace for interveners to let difficult, unmotivated clients "drop out." Higher standards of practice call for intensive efforts to enhance the motivation of such individuals so that their problems can be addressed.

Young children initially often want the protection of a parent's (or friend's) presence. In these instances, activities may have to involve all who are present and do so in a way that feels nurturing and safe to the youngster. Premature pressure to give up the security of the parent or friend usually leads to significant psychological reactance that manifests itself as withdrawal, or various forms of anxiety and aggression.

Even with youngsters who don't require another's presence and may even prefer being alone, it can take several sessions to build the type of relationship that allows for productive one to one sessions. Again the need is for activities and techniques that establish a feeling of nurturance and safety and a sense that the counselor wants to and is able to help.

The motivational focus in subsequent visits shifts to the problem of maintaining good levels of motivation about continuing to attend and for working to overcome problems. This involves activities and techniques that continue to produce feelings of nurturance, safety, and faith in the counselor. And, it requires facilitating actions on the part of the youngster and changes in the surrounding environments that result in enhancement of feelings of competence, autonomy, and relatedness to others. The focus often is on how to handle feelings about something that has happened, taking steps current problems, planning how to deal with upcoming events, and so forth.

Finally, returning to the evaluation problem, the fact of major differences in motivational readiness points to the need to measure such differences so that data on results can be disaggregated with respect to initial motivation and subsequent shifts in motivation. Failure to account for motivation differences reflects serious naivete about the complexities involved in addressing the problems of youth.