Mental Health Practice in Today’s Schools

Issues and Interventions

Raymond H. Witte
G. Susan Mosley-Howard

Editors

Grounded in a tiered intervention approach to school psychological practices, this text focuses on preventive and proactive services that are integrated at the school-wide and classroom levels, as well as more intensive mental health services for the most vulnerable students.

In addition to addressing core issues such as screening for at-risk students, response to intervention (RTI) and mental health, culturally sensitive practices, community services and supports, law and ethics, and the role of micro-skills in daily practice, this text also covers critical topics such as bullying and cyber-bullying, physical and sexual abuse, suicide prevention and intervention, school crisis response, threat assessment, and substance abuse. Chapters feature illustrative case examples as well as summaries of key concepts. Facilitating knowledge and awareness of evidence-based mental health practices in schools for practitioners at every level of service, this textbook is also an essential resource for graduate students in school psychology, school guidance and counseling, school social work, and educational leadership.
Mental Health Practice in Today’s Schools
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This work is dedicated to my family and especially my parents who sacrificed so much in order for me to have a chance to go to school and pursue my dreams. I would also like to express my eternal gratitude to the men and women who serve in the military. As a grateful citizen, I thank you.

—RHW

Derek, Jessica, Jacqueline, Jonathan—you are my inspiration. Jerolene (Mom), the best teacher I know—your work has always informed my work.

—GSM-H
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Preface

Mental health professionals who work in today’s schools face the challenge of addressing the social, emotional, and cognitive needs of millions of children while attempting to serve as effective consultants who address systemic educational issues. Although the task is daunting, school-based mental health professionals can draw upon myriad resources to enhance their knowledge, form interdisciplinary teams to leverage diverse points of view and expertise, and amass a variety of emerging tools to inform their work.

Never before have the skills possessed by mental health professionals been so important. By most measures, approximately 20% of young people experience a significant mental health problem; environmental issues of poverty, violence, and familial stress impact children and adolescents in ways that hinder their educational performance (Merikangas et al., 2010). Most of these children do not receive mental health services; for the majority of them school serves as the only potential source of support services (Merikangas et al., 2011). At the same time, never before has the educational system been so demanding, requiring children and educators alike to acquire skills and demonstrate those skills on high-stakes tests or employee assessments and statewide rating reports. Diminished funding, increased accountability, and psychosocial stressors complicate the picture even more.

While the aforementioned issues compete for attention, mental health status remains an all-important imperative. Professionals operating within schools need to become skilled at how to address children’s mental health issues and this text is designed to assist with building that awareness. Fortunately, mental health and educational research has never been so rich. Emerging trends in evidence-based practice, therapeutic interventions, and academic strategies have come together to form highly effective tools. Mental Health Practice in Today’s Schools: Issues and Interventions provides an understanding of some of these strategies.
and knowledge bases to enhance practice. This textbook examines key mental health issues and challenges that practitioners encounter when administering services in the school setting. Across the chapters, the Response to Intervention (RTI) model with tiered intervention is followed, along with the necessity of integrating therapeutic services and practices into the daily instruction of the classroom. This professional reference serves as a valuable resource for mental health professionals including school psychologists, clinical psychologists, guidance counselors, school social workers, and other community mental health providers, as well as professional educators including teachers, principals, and district school administrators.

We hope that this resource helps you to complete your professional mission of helping all children under your care. As we all know, mental health matters!

The goals of this text are to:

- Provide understanding of the relationship among mental health intervention, support, and impact within the school setting
- Examine the tiered intervention model and how mental health services and behavior support can be delivered to all students based on their level of need
- Supply knowledge and awareness of mental health screening instruments and how they can be used to help identify at-risk students
- Provide awareness and sensitivity to cultural issues and practices that influence mental health counseling and consultation services
- Disperse knowledge and awareness of evidence-based mental health practices for use in the schools
- Expand the practitioner’s knowledge and skills regarding high-need issues and challenges relating to students’ mental health

REFERENCES


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CHAPTER 1

Response to Intervention and Mental Health Intervention

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LEARNING OUTCOMES

On completion of this chapter, the reader should be able to:

• Describe the Response to Intervention (RTI) Model and its potential application to student problems that affect academic outcomes
• Use a decision-making process to select an appropriate RTI classification level
• Understand the need to consider both the problem severity and effectiveness of evidence-based treatments (EBTs) with specific racial/ethnic groups when implementing RTI
• Comprehend the implications and challenges of utilizing an RTI-approach to address problem behaviors

The need for mental health support in schools has never been so great. Nearly 20% of youths have or report a mental health problem or emotional and behavioral disorders (EBDs; Merikangas et al., 2010). Children with EBDs have high suspension rates and low graduation rates (Merikangas et al., 2010; U.S. Department of Education, 2005). Addressing mental health issues that impact students is an intricate and essential requirement for improving academic performance.
An increasing number of effective approaches can be used to improve student mental health outcomes. Yet, despite the growing number of existing EBTs to meet the mental health needs of kindergarten through 12th-grade students, these interventions are not always organized in a manner that would enable school officials to select the most appropriate intervention(s) for a specific student and/or behavioral problem. RTI, a decision-making method aimed at matching students to appropriate services, has the potential to address this limitation. Schools nationwide have successfully used RTI to improve the academic and behavioral problems of children (Denton et al., 2013).

The aim of this chapter is to demonstrate the application of RTI to mental health issues that may originate outside the classroom but can directly affect academic performance in the classroom. In addition, strategies for considering the needs of diverse school-age youths are illustrated. The chapter defines RTI and presents its core components followed by a presentation of the current status of RTI work including some challenges with using the model. This chapter outlines mental health interventions related to the core components of RTI. Next, each intervention level of or tier in the RTI approach is described and demonstrated through a vignette. Along with the vignettes, a decision tree is introduced to facilitate the decision-making process required to address a student’s needs. Finally, the implications, challenges, and future directions for applying RTI are discussed.

BACKGROUND ON RESPONSE TO INTERVENTION

RTI, a multilevel, district-wide system for identifying and addressing early learning or behavioral difficulties, is aimed at preventing school failure by matching students to appropriate interventions or support services based on the severity of the problem. RTI affords educators and school-based mental health professionals an opportunity to identify, intervene with, and support students with learning and behavior issues. Using RTI to address behavioral problems relies on identifying the target behavior(s) and augmenting the intensity of the intervention (e.g., primary, secondary, or tertiary) based upon assessment data and the needs of a specific student (National Center on Response to Intervention, 2010).

The RTI process begins with quality instruction (academic context), universal screening, and positive behavioral supports (PBS; mental health context). The core of the RTI approach includes leveraging effective intervention strategies, progress monitoring, and data-based decision making (National Center on Response to Intervention, 2010). Data-based decision making refers to the use of ongoing objective data to make determinations regarding students and their appropriate treatment.
RESPONSE TO INTERVENTION AND MENTAL HEALTH INTERVENTION

(Gresham, 2007). Throughout the entire RTI process, the underlying principles include high-quality instruction, research-based academic and behavioral intervention, progress monitoring, and an integrative or collaborative team approach (Hawken, Vincent, & Schumann, 2008). Focusing on tier intensity, treatment efficacy, and individual student attributes are all critical to strengthening the RTI approach. (For more on cultural responsive treatment and universal screening issues, refer to the description of culturally sensitive mental health services in Chapter 5 and the discussion of screening at-risk students in Chapter 2.) For that reason, identifying not only the intensity of the interventions needed by students but also matching the students to interventions with proven efficacy within the context of their personal attributes (e.g., age, gender, culture, language) may maximize RTI outcomes.

Gresham (2007) contended that an RTI approach has the following four advantages. First, the emphasis on the early identification of behavioral difficulties increases the likelihood of extinguishing problem behaviors before they escalate in severity. Second, an RTI approach stresses a risk versus a deficit treatment model. A risk model approach assumes the intervention will ameliorate the student’s problem, whereas a deficit model too often simply adjusts services to the student’s functioning without the expectation of change. The third benefit, the use of standardized screening procedures, potentially reduces the likelihood that referrals are more a reflection of teacher biases rather than student needs. Fourth, the assignment of students to EBTs increases the probability of positive outcomes over procedures that simply place students in programs established for those with a higher likelihood of school failure (e.g., special education).

Despite the growing popularity of RTI, several specific implementation gaps are evident. First, the focus has been on managing challenging behaviors in the school setting (e.g., conduct problems, bullying, calming an agitated student, bus conduct, behavior with substitute teachers). Efforts to apply RTI to behaviors or problems that originate outside the school setting (e.g., mental health disorders) yet negatively impact academic performance are restricted. Second, previous applications of RTI to behavioral problems were primarily limited to identifying the intensity of the intervention (e.g., primary, secondary, or tertiary) appropriate for a specific student. However, that focus ignores that the efficacy of a specific EBT may vary across racial/ethnic groups. Therefore, identifying not only the intensity of the interventions needed by students but also matching the students to interventions with proven efficacy for their racial/ethnic group may improve RTI outcomes even further. Finally, no universal algorithm is available to assist busy school officials in matching students’ needs with the appropriate EBTs.
The next sections address these issues by describing in more detail the process used in a RTI approach. Because selecting interventions to use with groups or individual students can be daunting, the school team may find it useful to craft a decision-making process or a decision tree to provide a consistent frame of reference to undergird the intervention selection process. Vignettes are also presented to illustrate the use of a decision tree and to assist with selecting an appropriate intervention for each tier. These examples are intended to illustrate how the RTI process might be used to make uniform decisions about appropriate interventions for students.

RESPONSE TO INTERVENTION TIERS

An RTI approach assumes that students vary in the intensity of the services they require. As established earlier, the RTI approach usually consists of three intervention levels. Accordingly, the interventions appropriate for students at one level of need may be inappropriate for those at a different level. The three RTI levels of intervention are referred to as Tier 1 (primary), Tier 2 (secondary), and Tier 3 (tertiary; Figure 1.1; National Center on Response to Intervention, 2010).

Students enter into the RTI process in many ways including (a) schools may implement a RTI Tier 1 intervention curriculum for all students without incorporating intervention screens (e.g., drug prevention intervention); or (b) schools may screen students and place them into an appropriate tier intervention.

![Figure 1.1](image)

**FIGURE 1.1** Visual depiction of the tiers. Each tier shares certain common aspects (i.e., accessible to all students, monitored progressively, evidence-based) and sometimes requires interdisciplinary collaboration.
depending on the assessment of the severity of the problem (e.g., drug prevention intervention for students at risk for current or future substance abuse). Another tool that may assist with the application of the RTI process is a decision-tree approach. School staff members are often bombarded with multiple tasks. Within this overwhelmingly busy environment, it is easy to make judgments that lack the methodical process needed for quality intervention decisions. A decision-tree approach is offered here to illustrate how schools can streamline and systematize intervention decisions for students (Figure 1.2; Evans, Serpell, Schultz, & Pastor, 2007; Farrell, Meyer, & White, 2001; Henggeler et al., 1991; Horn, Dino, Kalsekar, & Fernandes, 2004; Liddle et al., 2001; Marsiglia, Ayers, Gance-Cleveland, Mettler, & Booth, 2012; Masia-Warner et al., 2005; Stevens, Leybas-Amedia, Bourdeau, McMichael, & Nyitray, 2006; Winters, Fahnhorst, Botzet, Lee, & Lalone, 2012). This decision-tree approach has been used in both clinical and field settings with beneficial impact in standardizing and systematizing the intervention decision-making process. A more detailed description of each tier and decision-tree use follows with examples of evidence-based interventions along with vignettes illustrating the application of RTI to a mental health problem.

**FIGURE 1.2** Visual representation of EBT selection process that can be adapted within a school system.

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Tier 1 Interventions

Tier 1 interventions are the least intensive of the three intervention levels. These interventions are universal and designed to be appropriate for all students. In Tier 1 (primary level), the instruction, screening, PBS, or behavioral curriculum are delivered to the largest number of students (80%–100%) and provide all students with universal supports within the general education classroom. Tier 1 behavioral intervention examples include social skills programs and psychoeducational programs designed to teach targeted skills (e.g., stress reduction, anger management). Data screening in this tier may include school-wide climate surveys, incidence mapping, and rating scales for emotional risk and social skills (e.g., Behavioral and Emotional Screening System [BESS] or Youth Risk Behavioral Survey [YRBS]).

The Life Skills Training Middle School (LST-MS) Program is an intervention that can function as a Tier 1 level substance use intervention. LST-MS is a universal curriculum appropriate for all middle-school adolescents between the ages of 11 and 14. The aim of LST-MS is to arm adolescents with both knowledge and social skills for resisting social pressures to use drugs, alcohol, or cigarettes. LST-MS was developed to be effective for all adolescents but later was culturally adapted to be appropriate for African American and other ethnic minority adolescents (Botvin et al., 1989; Botvin & Botvin, 1992). The intervention utilizes cognitive-behavioral techniques to address social and psychological factors associated with early onset substance use. The three major components—drug-resistance skills, personal self-management skills, and general social skills—are helpful for reducing substance use among adolescents.

Botvin, Griffin, Diaz, and Hill-Williams (2001) examined the efficacy of LST-MS in an urban majority African American school district. The 29 participating schools were categorized as high-, medium-, or low-smoking prevalence schools. Entire schools within each category were then randomly assigned to either the control condition or to the LST intervention, which included 15 sessions in the seventh grade and 10 booster sessions in the eighth grade. Classroom teachers delivered the intervention. The students in schools implementing the intervention later reported less smoking, drinking, drunkenness, inhalant use, and polydrug use than controls. Although most students respond well to these broad-based experiences, some students may not respond adequately. Should that occur, these students could be referred to receive more intensive interventions (e.g., Tier 2). The following case of Keisha illustrates a situation in which a Tier 1 intervention was appropriate.
Tier 1 Vignette

Keisha is an African American girl in the seventh grade at an inner-city school in the northeastern region of the United States. She had no reported behavioral problems in school and was considered a “gifted” student by all of her teachers. There was no evidence that she ever experimented with drugs. Noticing the increasing drug trends in the surrounding community, the school decided to implement a district-wide prevention program. Using the school’s decision tree as shown in Figure 1.2, the school selected a culturally adapted version of LST-MS intervention because the EBT was appropriate as a Tier 1 intervention and had demonstrated efficacy with African American students. Keisha participated with the rest of her class. Every week for 15 weeks, Keisha’s teacher Ms. Jones implemented this curriculum for Keisha and her classmates. During each class session, Keisha participated in group discussions and received homework assignments about drug prevention skills to practice outside of the classroom. At the conclusion of the drug prevention intervention, Keisha continued to exhibit positive behavior in school and reported no use of cigarettes, alcohol, or any other illegal substance.

Tier 2 Interventions

Tier 2 interventions are mid-range interventions appropriate for students whose at-risk status mandates more than a Tier 1 intervention and for students whose target behavior(s) was not responsive to Tier 1 efforts. Tier 2 interventions are targeted toward those students in need of more support (approximately 10%–15% of all students). Tier 2 interventions may include prevention groups focused on identified problem areas (e.g., anger management, substance abuse, parental divorce). Tier 2 data-gathering practices might include classroom observations, or functional behavioral assessment (FBA) with a particular student (to determine environmental contributors, antecedents, sustaining factors, frequency, patterns across subjects or time-of-day and task demands, self-monitoring, or reinforcement plans), or behavioral reports of student conduct or behavior. Again, data are obtained to monitor or determine intervention impact (e.g., anxiety scale, observation data, etc.).

Tier 2 interventions are typically provided in an adult-led, small-group format (National Center on Response to Intervention, 2010). Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) is a mental health intervention that could be used as a Tier 2 intervention. This school-based, 10-session group intervention addresses posttraumatic stress disorder (PTSD),
depression, or anxiety symptoms related to exposure to trauma. The sessions include a combination of didactic presentations, cognitive-behavioral group activities, and games, as well as the completion of individual worksheets. Stein et al. (2003) implemented CBITS in two middle schools in a largely Latino, socio-economically disadvantaged school district in East Los Angeles. Trained clinicians screened all sixth-grade students and selected those who met the following criteria for potential participation: exposure to three or more violent events, clinically significant PTSD symptoms, willingness to discuss their exposure to violence in a group setting, and not demonstrating behavior that would disrupt the group. Eligible participants were randomly assigned to either the CBITS condition or to a wait-list control. Three months after baseline, CBITS participants self-reported fewer PTSD and depressive symptoms than the wait-list control group. The parents of CBITS participants also reported less psychosocial dysfunction in their children than parents of the wait-list control group. The following vignette examines a Tier 2 intervention for symptoms of PTSD.

**Tier 2 Vignette**

Carlos is a 12-year-old Latino boy in the sixth grade. He attends an inner-city school and lives in the nearby urban community. Carlos lives with his mother and two siblings in a small apartment building. One year ago, Carlos’s mother allowed her younger brother, David, to move into their home. David was heavily involved in local gang activities and, at times, would get into altercations with other gang members in the parking lot outside of the apartment complex. Carlos participated in a school-wide Tier 1 program. (The school implemented the GREAT [Gang Resistance Education and Training] from the Bureau of Justice Assistance and the Office of Juvenile Justice and Delinquency Prevention [OJJDP].) However, his teacher referred him to the school counselor because he reported on his GREAT survey that he had witnessed gang violence and because his teachers and mother noted academic and behavioral struggles. Carlos witnessed rival gang members brutally attack his uncle on at least three occasions, resulting in multiple arrests and hospital visits. Carlos had nightmares about the fights and worried constantly about the next attack.

The teacher’s referral also included a note indicating that Carlos had been repeatedly sleepy and jumpy in class. After explaining his nightmares, the counselor referred Carlos to the CBITS program at his school. Using the decision tree, the counselor along with the school team selected CBITS because the school’s decision-making process suggested that CBITS is effective as an intervention for reducing PTSD symptoms among Latino adolescents who are at the Tier 2 level of risk. Carlos participated in 10 weekly sessions with seven of his peers who had
similar traumatic experiences. Themes of the sessions included education on trauma, ways to combat anxiety, coping strategies, and social problem solving. The group also completed homework assignments each week. At the conclusion of treatment, Carlos’s anxiety and stress scores were lower than his prescores, and he reported feeling less stressed and was having fewer nightmares.

**Tier 3 Interventions**

Tier 3 interventions, the most intensive of the RTI model, are aimed at a small number (about 1%–5%) of students who either are not responding adequately to a Tier 2 intervention or are already demonstrating significant levels of the target behavior(s). Students placed in Tier 3 receive the most intensive support. Tier 3 interventions are usually individualized to meet the needs of the target child/adolescent. Common strategies explored at Tier 3 are specific behavior plans, individualized counseling (greater frequency and intensity), collaboration with outside agencies (clinicians, family therapists, juvenile justice systems, physicians for psychotropic medication, etc.), and parent conferences. Throughout the intervention, data progress monitoring occurs, including using scales, behavior charting, observation, and psychological assessment to determine student response to intervention. The education professional (e.g., teacher, counselor) continuously monitors a student’s progress to determine the need for modification in the intervention plan. When the school-based mental health teams are making these decisions, multiple issues must be considered (see Figure 1.2 for a representation of this process). The following vignette, however, is an example of a student who received multitiered interventions as his behavior escalated.

**Tier 3 Vignette**

Aaron is a Caucasian boy who attended eighth grade in a school district that offered the generic LST program to all students. During his ninth grade, a teacher found what looked like marijuana in the boys’ bathroom, and Aaron was one of a group suspected of flushing more of the drug down the toilet. Their counselor completed a substance abuse assessment indicating that all the boys’ substance abuse attitudes placed them at risk of substance abuse involvement. Consequently, using the decision-tree process, the school team assigned all the boys to the Tier 2 Strengthening Families Program (SFP; Kumpfer, DeMarsh, & Child, 1989). By high school, Aaron tested positive for methamphetamines, when the school conducted random drug tests for his soccer team. At that time, Aaron admitted to using methamphetamines regularly. The counselor conducted a substance abuse and family assessment that revealed some family challenges.
possibly contributing to his drug use. Aaron lived with his father and younger sister. His older brother had recently been sentenced to prison for drug possession. Aaron’s father worked two jobs to support the family. Aaron’s mother, suffering from bipolar disorder (BD), had been in and out of psychiatric hospitals for the past decade and had minimal contact with the family. The counselor also noted that Aaron’s grades were low and that he had just been placed on probation for frequent truancy and bullying.

The school determined that the Tier 2 intervention had been inadequate. Aaron was now appropriate for a Tier 3 level intervention. The school officials referred Aaron to the Multidimensional Family Therapy (MDFT) Program because MDFT has demonstrated efficacy in treating White school-aged youths (adolescents) with significant substance abuse problems. A trained therapist met with Aaron, his father, and his sister in their home for 2 hours on a weekly basis over a 6-month period. The therapist conducted an assessment to identify factors that contributed directly and indirectly to the target problems. She found that Aaron’s dad worked third shift and did not return home in time to ensure that his children attended school. In addition, friends of Aaron’s older brother had been providing Aaron with meth-amphetamines. Thus, limited parental supervision was a direct factor and his older brother’s drug problem was an indirect factor. The therapist worked with the family to increase supervision and support for Aaron. After the intervention, Aaron experienced

**FIGURE 1.3** RTI (Response to Intervention) process starting with Tier 1 through Tier 3 interventions.

LST, Life Skills Training; MDFT, Multidimensional Family Therapy; SFP, Strengthening Families Program
less truancy and drug use, and his grades were improving. (See Figure 1.3 for a representation of how Aaron transitioned through the tiers.)

In each vignette, school-aged youths with different issues were assigned to interventions based on their level of risk. Matching the student to the appropriately tiered EBT proved to be a significant factor in the successful outcome of these cases. An additional aspect in all three cases was the continued monitoring and data collection regarding progress to ensure that each youth was getting the correct level of care. In Aaron’s case, when his problems escalated, he advanced to Tier 2 and, subsequently, to Tier 3 interventions.

EVIDENCE-BASED TREATMENTS, RESEARCH, AND PRACTICE IN RESPONSE TO INTERVENTION

RTI interventions are required and expected to be EBTs regardless of the tier. This section describes three specific questions inherent in using EBTs. The first question is: What criteria must an intervention meet to be classified as evidence-based? In addition, an EBT may be efficacious with one racial/ethnic group but not another. Accordingly, the second question is: What criteria render an EBT appropriate for a specific target group? Beyond determining whether an intervention is evidence-based and efficacious, RTI school districts must have an efficient method for selecting appropriate EBTs. Therefore, the third question is: What is the best way to organize the information so that school officials can easily select the most appropriate intervention?

Nathan and Gorman (2002) classified EBTs into six types, according to the strength of the research design in the outcome paper. Type I research designs randomly assign participants into treatment and control groups, use measures with demonstrated reliability and validity, and conduct appropriate statistical analyses. In Type II studies, at least one of the aforementioned Type I criteria is absent but the design is not considered to have a fatal flaw. Since the remaining four classifications are weaker designs, the extent to which they meet the criteria for an EBT is questionable.

The American Psychological Association (APA) Presidential Task Force on Evidence-Based Practice (2006) maintained that cultural appropriateness should be considered in selecting appropriate EBTs. Huey and Polo (2008) operationalized APA’s recommendation by establishing the conditions necessary to conclude that the evidence supports the efficacy of an intervention for a specific target group. Specifically, Huey and Polo proposed that studies demonstrating effectiveness for a specific group must meet at least one of the following conditions: (a) at least 75% of the sample must be members of the target group; (b) data for the target group must be analyzed in separate statistical analyses; or
(c) moderation analyses must demonstrate no racial/ethnic differences in the effectiveness of the treatment on target outcomes. Once EBTs meet the requirements for both scientific design and cultural effectiveness, a classification system may foster appropriate decision making.

A decision tree provides an efficient visual approach to enable school officials to select an appropriate EBT. Figure 1.2 is an example of a decision tree with three steps. The target behavior(s) for the intervention must first be identified. Since the level of intervention (i.e., Tier 1, 2, or 3) depends on the severity of the presenting problem, selecting the appropriate level of severity ranging from minimal risk to demonstrating the problem behavior is an important next step. Finally for Tier 3, specific interventions can then be selected while considering the demographic characteristics of the student (e.g., age, gender, race/ethnicity, and language of the target participants). Following this framework potentially enables EBTs to be easily mapped onto a model that can become a useful resource for teachers, school-based mental health professionals, and administrators within the school setting.

SUMMARY

The discussion so far has focused on strategies for utilizing RTI to develop district-wide approaches to addressing student mental health issues. Much of the existing RTI work focuses on behaviors or academic performance that occur in the classroom. Resources for applying RTI to behavioral concerns that may extend beyond the school (e.g., externalizing, internalizing, ADHD, substance abuse, mental health) are somewhat limited. Consequently, while this approach may be new to some school settings, RTI can be used with academic and behavioral-oriented issues. This section describes several implications, challenges of utilizing an RTI approach, and necessary future directions for moving RTI into new areas.

Implications

Our review suggests that RTI, a framework originally designed to address academic issues, can be extended to developing school district–wide plans for addressing behaviors and problems that, although they may originate outside of the school setting, certainly influence academic outcomes. Earlier, we presented examples of using an RTI approach to address substance involvement and PTSD symptoms. However, RTI may also be useful for selecting appropriate EBTs to address mental health issues (e.g., anxiety, social anxiety) and risky behaviors (e.g., sexual risk behaviors) other than substance abuse and PTSD symptoms. (See Chapter 18, “Mental Health Intervention Case Studies.”)
In addition, the vignettes described earlier demonstrated that busy school staff might benefit from a decision-tree format. The decision tree provides an efficient method for selecting the most appropriate EBT for a specific adolescent. Our cases illustrated the use of an RTI decision tree to select an appropriate EBT for two very specific concerns: substance use and PTSD symptoms. Obviously, each school system will need to develop its own decision tree tailored to the needs of its students and the EBTs available to their schools.

Challenges

Despite the benefits of an RTI approach, school systems implementing RTI may encounter several significant challenges. First, some EBTs may not fit neatly into the RTI format. In addition, some EBTs that focus on more than one behavior (e.g., substance abuse and conduct disorder) may not be appropriate for adolescents requiring a Tier 1 intervention for one problem but a Tier 3 intervention for the other. For example, MDFT has demonstrated effectiveness for students with Tier 3 level substance abuse and acting out behaviors (e.g., anger control, impulsive behaviors). Therefore, the appropriateness of MDFT for an individual demonstrating acting out behaviors but no substance use is unclear.

A second challenge facing an RTI approach is the selection of EBTs demonstrating effectiveness for diverse classrooms. Tier 1 and Tier 2 interventions are, by definition, meant for larger groups of students (perhaps even entire classrooms). If these groups are ethnically diverse, it may be difficult to identify a specific EBT with demonstrated efficacy for each ethnic group. Furthermore, it may be unfeasible for a school to select separate Tier 1 and/or Tier 2 interventions for the different ethnic groups. Instead, the school might select an intervention proven effective for the largest number of students. Since Tier 3 interventions are more likely to be individually tailored, classroom diversity is less of an issue.

A third challenge is that a small number of interventions appropriate for most students may be less effective for a specific subgroup. For example, Dishion (1995) found that participating in a small group, Tier 2 type, substance abuse prevention EBT actually had the iatrogenic effect of reinforcing deviant behavior in a group of at-risk Caucasian youth. This may be a particular concern when implementing school-wide Tier 1 interventions.

The training required to deliver EBTs is another challenge to implementing an RTI in school systems. Teachers and other school personnel typically implement Tier 1 and 2 interventions. Conceivably, however, an appropriate EBT may require more training in mental health than most teachers and other school officials have acquired. For example, among those articles in our decision tree reporting the amount of time required to train teachers or
counselors to implement the EBT, the minimal amount of training required was 8 hours. The costs (e.g., teacher or counselor salaries and trainer costs) of providing adequate training may exceed the training budgets of many school systems. Moreover, the costs of providing Tier 3 interventions that are typically individualized and require mental health specialists may be even higher.

We have argued for the use of RTI to match students to interventions appropriate for their individual needs. Educators and mental health professionals need to take considerable care in assessing, determining an appropriate tiered intervention, monitoring, and validating the RTI-EBT efficacy for the target student(s).

**Future Directions**

Our overall conclusion is that an RTI approach may assist school systems in meeting the mental health needs of their students. However, several steps may facilitate the future use of RTI to address problems that originate outside the classroom but affect academic outcomes. First, classifying EBTs as appropriate Tier 1, 2, or 3 interventions is an essential task for the future. Classifying EBTs at the national level would be much more efficient than relying on individual school systems to accomplish that task.

Second, an important component of leveraging RTI-EBTs is ensuring their appropriateness for the target students. (This is discussed further in Chapters 2 and 18.) Therefore, developing decision trees that inform school staff about the efficacy of an intervention is of paramount importance. However, more research examining the efficacy of EBTs with specific target groups is required to develop such decision trees.

**CONCLUSION**

The first aim of this chapter was to demonstrate the application of RTI to mental health issues that originate outside the classroom but may affect academic performance. A second aim was to expand the application of RTI by illustrating a strategy for considering the needs of diverse children and adolescents.

Prior evidence has demonstrated that using the RTI framework to match students to appropriate EBTs for school-based problems is effective and has successfully improved adolescent outcomes. This chapter expands RTI to include problem behaviors that originate outside the school setting but also influence academic outcomes. Categorizing interventions according to problem, target student demographic characteristics, and efficacy are all important. Use of algorithms such as the proposed decision tree can benefit school officials deciding which EBT best fits a student.
Future research is needed to determine the most effective EBT for specific target groups. The evidence for using RTI in other applications is strong, and this chapter aids in broadening its use for mental health.

**RESOURCES**

RTi success.org

*Life Skills Training Middle School (LST-MS)*


*Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)*


*Multidimensional Family Therapy (MDFT)*


**REFERENCES**


