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Evaluating a School-Based Day Treatment Program for Students with Challenging Behaviors

Antoine Lewis Hickman
College of William & Mary - School of Education

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Evaluating a School-Based Day Treatment Program for Students with Challenging Behaviors

A Dissertation
Presented to
The Faculty of the School of Education
The College of William and Mary in Virginia

In Partial Fulfillment
Of the Requirements for the Degree
Doctor of Education

by

Antoine Lewis Hickman

April 10, 2014
Evaluating a School-Based Day Treatment Program for Students with Challenging Behaviors

by

Antoine Lewis Hickman

Approved April 11, 2014 by

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Dedication

To my mother, Naomi Elizabeth Hickman, although you are no longer physically here on this Earth, your tenacious spirit continues to live through me. Thank you for pushing me passed where I thought my limits were. I did it Momma.

To my wife, best friend, and better half, Angela Nikisha Hickman, for holding down the fort, taking care of our first child, and allowing me to follow my dream of scholarship attainment. Your selfless devotion to me and our family while on this journey has made me love you more and more each day.

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Abstract

Jade County Public Schools has provided school-based therapeutic day treatment in its public schools for more than 10 years. This program was adopted by the school system to provide an intervention in the school and classroom to address the challenging behaviors of students with emotional and behavioral disorders.

Currently, three human services agencies provide school-based therapeutic day treatment services to students in Jade County Public Schools with the goals of increasing academic achievement, increasing school attendance, reducing undesirable behaviors and increasing desirable behaviors. Until now, there has not been a formal evaluation of the program to determine if improvements were needed to meet the established goals to meet the challenges of students with emotional and behavioral disorders, as intended.

This formative program evaluation of Jade County Public Schools’ School-Based Therapeutic Day Treatment program (DTX) was designed to provide school administrators, staff, parents, students and the agencies providing the school-based program with evidence-based information on the merit, worth, and value of the school-based mental health intervention and to identify areas of improvement needed to increase academic and behavioral outcomes for students with emotional and behavioral disorders (EBD) at Jade County Public Schools.

The methods utilized to conduct this evaluation sought to determine to what extent participation in the school-based day treatment program decreased behavior referrals, number of days of suspension, and number of suspensions and increased attendance and grade point averages for students with emotional and behavioral disorders. Also,
participants’ perceptions and lived experiences pertaining to the benefits, challenges or concerns, and aspirations for the program if it were to operate at its highest potential were explored. The results from analyzing quantitative and qualitative data collected to answer the five questions are addressed in this program evaluation.

Antoine Lewis Hickman

School of Education, Educational Policy, Planning, and Leadership

The College of William and Mary in Virginia
Evaluating a School-Based Day Treatment Program for Students with Challenging Behaviors
Chapter 1

Schools must explore the results of a growing body of empirical literature that have documented the impact of school-based mental health treatments and other interventions on child and adolescent outcomes (Hoagwood et al., 2007). Students with challenging behaviors consume a considerable amount of building administrators’ time and attention. In addition, students with challenging behaviors disrupt not only their own learning, but also the learning of their peers. With the emphasis in schools being on “standards-based reform”, federal, state, and local policy makers have increased their focus and have put pressure on schools to improve the academic achievement of all students (NCLB, 2001). According to Nolet and McLaughlin (2000), “Standards-based reform was a policy response to the dissatisfaction with the performance of American schools that has been growing in both the public and private sectors for a number of years” (p. 2). In order for public schools to meet the demanding accountability standards mandated by the No Child Left Behind Act of 2001 (Public Law 107-110) for all students by 2014, students with challenging behaviors mental and behavioral health needs must be integrated into the mission of schools (Kotaoka, Rowan & Hoagwood, 2009).
The Individuals with Disabilities Education Act [IDEA] (2004) requires schools to provide high quality individually designed instruction using evidence-based knowledge on how best to educate all children with disabilities. To accomplish the goals established by NCLB and IDEA, most of an administrator’s time and attention should be spent focusing on the overall goal of providing high quality education for all students. Nonetheless, accomplishing these goals will be impossible without addressing the needs of students who display challenging behaviors.

Addressing the mental health needs of students with challenging behaviors is a concern for all students – both in general and special education programs. Children and adolescents’ mental health issues can manifest as internalized or externalized problems (Kaufmann, 2001). The distinction between internalized and externalized problems is that suppressed issues and emotions are manifested internally, and aggressive, antisocial, under-controlled behaviors are exhibited externally. Severe depression, suicidal ideation, and eating disorders are examples of internalized problems manifesting in children and adolescents. In contrast, acts of violence against property or persons, drug use, disruptive behaviors at school, and trouble coping with difficulties are more externalized. Left without effective preventions and interventions, inappropriate behaviors eventually lead into highly troubling, law-violating, antisocial behavior (Lawson, Quinn, Hardiman, Miller, Jr., 2006). Epstein et al., (2008) stated, “An estimated one-third of students fail to learn because of psychosocial problems that interfere with their ability to fully attend to and engage in instructional activities” (p. 5). This is prompting public schools to look for new
approaches aimed at improving and reducing the negative effects of disruptive or distracting behaviors and increasing instruction and learning for all students.

The ultimate goal of the public school system is to provide students with the skills needed to be competent citizens in a free and democratic society. If no child is to be left behind there is a duty to provide prevention and intervention strategies that meet children’s psychosocial, emotional, behavioral and mental health needs. Failure to meet these needs presents barriers to their learning, academic achievement, and success in school, thereby increasing the probability that some children will ultimately be left behind (Lawson, Quinn, Hardiman & Miller, Jr., 2006). Clearly, there is a need for empirically assessed school-based mental health treatments in schools. More importantly, failure to address the behavioral and mental health needs of students with challenging behaviors significantly impacts their lives and the people’s lives they come in contact with now and in the future. This study is not being presented as a solution to the entire discipline problem in schools, but to identify an evidence-based intervention to improve outcomes for students with challenging behaviors.

Purpose of the Study

Conducting this program evaluation provides information that will assist in making improvements to a program that has been in place for several years without a formal evaluation. It will also help make decisions when consideration is given to implementing the program in other schools and districts, and developing policies related to the program’s usefulness (Sanders, 2000). Mertens and McLaughlin (2004) asserted that a program evaluation will explain how the program is to be delivered,
who the people are that will receive the program, and the program’s results. The Joint Committee’s (1994) definition stated “evaluation is the systematic assessment of the merit or worth of an object” (p. 3). A program’s merit refers to the intrinsic value of a program; for example, how effective its aims add value to the community. A program’s worth refers to extrinsic value to those outside the program, such as the larger community (Patton, 1997).

This study examines a school-based mental health intervention’s merit and worth as it relates to reducing the frequency of the most common types of undesirable behaviors presented by all students -- to include students in general and special education programs. Walker, Colvin and Ramsey (1995) stated, “If antisocial behavior is not changed by third grade, it should be treated as a chronic condition like diabetes. Moreover, it cannot be cured, but managed with the appropriate supports and continuing interventions” (p. 6). Therefore, the purpose of this study was to conduct a program evaluation of a School-Based Therapeutic Day Treatment Program (TDT) at the elementary and middle school levels, to include first through eighth grades, in a rural school district in Virginia, to empirically assess the intervention’s impact on addressing the behavioral and academic needs of students with challenging behaviors.

There is evidence that supports the contention that by addressing students’ education, health, and well-being (including mental health), students’ chances for becoming competent citizens increases (Lawson, Quinn, Hardiman, & Miller, Jr., 2006). To be presented in this study is an exploration of the literature regarding the impact students with challenging behaviors has on schools and society when their
mental health needs are not addressed. Also to be explored is a review of what the research literature reveals about the importance, effectiveness, and evolution of school-based mental health programs. Recommendations will be shared as to why TDT is being used as a school-based mental health intervention to address student behavior, attendance and achievement. Undergirding the methodology for this student intervention evaluation is a discussion of the essential components of scientifically based program evaluations.

**Statement of the Problem**

The Elementary and Secondary Education Act, referred to as No Child Left Behind (NCLB) (2001), requires the use of scientifically based research to improve educational practice. The law further defined scientifically based research as “rigorous, systematic, and objective procedures to obtain valid knowledge” about education programs or interventions. Similarly, the Individuals with Disabilities Education Improvement Act of 2004 [IDEA 2004] (2004) added that all personnel working with children with disabilities should be trained to use scientifically based instructional practices, to the maximum extent possible. Therefore, “the expectation is that evaluations will be conducted of programs using experimental and quasi-experimental methods to assess the impact of the programs with respect to intended results” (Mertens & McLaughlin, 2004, p. 8). In the next section, I will explore the history acknowledging that by bridging the gap between school and mental health, positive student outcomes can be expected.
National Perspectives on School-Based Mental Health

Although exclusionary practices such as detention, suspension, and expulsion continue to be the predominant strategies used to address discipline of students with challenging behaviors, Katoaka et al (2009) shared, in a historical review, that in the early 1900s the Children’s Bureau was formed to advocate for children’s social and emotional rights and to advocate against the mistreatment of children and adolescents (2009). Katoaka et al. continued by providing a chronology of significant events from the early 19th century to present to show how school-based mental health has evolved.

In April of 2002, President George W. Bush established the President’s New Freedom Commission on Mental Health in an effort to honor his commitment to Americans with disabilities (USDHH, 2003). Katoaka and colleagues (2009) further explained that the report was built on the framework of community mental health centers, partial hospitalization, specialized health care in outpatient settings, and a system-of-care framework. The President’s New Freedom Commission Report “emphasized a public health approach in which care is family centered and evidence based” (Katoaka et al., p. 1511). One of the recommendations by the commission to promote early detection in children and to provide treatment was to expand school-based mental health programs. In concert with this recommendation, several provisions of the No Child Left Behind Act (2001) also acknowledges the importance of prevention services in schools which may include mental health services. Katoaka et al., clarifies the relationship between the provisions and mental health services:
Title I, Part D (programs for children who are neglected, delinquent or at risk); Title I, Part H (dropout prevention); Title IV, Part A (Safe and Drug Free Schools); Title V, Part D, Subpart 2 (elementary and secondary school counseling programs); Title V, Part D, Subpart 3 (Partnerships in Character Education); and Title V, Part D, Subpart 14 (Grants to Improve the Mental Health of Children) (p. 1511)

In addition, mental health interventions fall under the IDEA mandates for schools to provide related services to students with disabilities (2004). Early Intervening Services under the provisions of IDEA “allows for the allocation of special education funding for research-based academic and behavioral support services for students who may be at risk of needing special education” (p. 1511).

The Center for School Mental Health Analysis and Action at the University of Maryland and the UCLA Center for Mental Health in Schools were both funded by the “Office of Adolescent Health within the Maternal and Child Health Bureau (Title V, Social Security Act) of the Health Resources and Services Administration, Department of Health and Human Services” (Hoagwood et al., 2007). Hoagwood et al. explain the purpose of these two centers is to provide innovative ways to integrate and implement school-based mental health programs in schools and to assist students and schools. These are the only two centers in the U.S. developed and designed to work towards this goal. Being that these two schools are the exception, mental health and education “categorically, fiscally, structurally, and scientifically” operate separately in the U.S. (Hoagwood et al., p. 66).
School-Based Mental Health and Academics

Being that studies on the impact of school-based mental health services are mostly done in isolation from the school setting, the impact of the interventions are poorly understood in terms of meeting the academic and behavior needs of all students. Studies need to be completed in the school setting to determine the extent participation in a mental health intervention has on academic achievement, attendance, and behavior. In order to integrate these services effectively into school programs it is necessary that empirically based research on school-based mental health interventions and the impact these services provide are clearly understood.

The National Association of School Psychologists (2004) suggested children’s mental health should be supported through interventions on three distinct levels: (1) environmental, (2) programmatic, and (3) individual. The environmental level emphasizes the creation of a healthy and supportive school climate. The programmatic level involves curricular and educational programming designed to address specific mental health issues. The individual level focuses on the provision of mental health interventions to address students’ identified needs. The research is clear that interventions need to address the link between academic, behavioral, and contextual factors in regard to children and adolescent mental health.

In a meta-analysis, Hoagwood et al. (2007) found 24 articles meeting the criteria for empirically based school-based mental health interventions for children and adolescents. They found the results to be effective treatments for students who displayed the challenging behaviors under clinical conditions. Consequently, Hoagwood et al. acknowledged that, “Despite the growing body of knowledge on
demonstrably effective services, little is known about the delivery of these interventions in settings where most children are able to receive services—school settings—nor about the impact that these services may have on children’s academic functioning” (p. 67.) Hoagwood et al. recommends that further study is needed on the impact of mental health interventions on academics and of academic interventions on mental health outcomes.

Although evidence based and empirically validated studies have shown mental health interventions as promising practices to address children and adolescents’ needs, the impact of school-based mental health practices on the academic and behavioral needs of students with challenging behaviors has been largely ignored (Hoagwood et al., 2007, p. 67). If researchers continue to study the impact of school-based mental health interventions in isolation without addressing the impact on academic, behavioral functioning as well as contextual factors as outcomes of interest, the significance of the interventions will be de-emphasized and the impact will remain poorly understood.

Many schools are continuing to use ineffective exclusionary practices, such as suspension, which neither appropriately addresses nor decreases the prevalence and incidence of behavior problems in schools (National Center for Education Statistics, 2006). To exacerbate the problem for schools even further is the dual system of responding to behavior problems of students in general and special education programs.
Dual System of Responding to Behavior Problems

The rise in aggressive and defiant behaviors in school settings has caused many parents, students, and lawmakers to expect school administrators to adopt zero-tolerance policies to decrease the rate of violent and undesirable behaviors (Evans, 1999). Mandates by the No Child Left Behind Act of 2001, Individuals with Disabilities Education Act of 2004 (IDEA 2004), as well as federal and state regulations have been developed pertaining to the education and discipline of students with disabilities. In order to meet the educational needs of all students, educators across the country are being forced to take a closer look at traditional disciplinary practices.

General Education. Suspension and expulsion are two of the most common disciplinary consequences used in schools to address student problem behaviors. Unfortunately, the research on suspension indicates that, despite its frequent use, it is not effective in reducing the behavior problems it is intended to address (Civil Rights Project, 2000; McCord, Widom, Bamba, & Crowell, 2000; McFadden & Marsh, 1992). High stakes accountability policies such as the No Child Left Behind Act and zero tolerance policies may explain why so many school administrators resort to exclusionary measures, such as suspension from school, in dealing with students displaying behavioral problems (Skiba, Peterson, & Williams, 1997).

Special Education. The Individuals with Disabilities Education Act (IDEA), passed in 1990, required schools to examine a special education student's inappropriate behavior by conducting a functional behavioral assessment (FBA) and to subsequently develop a behavioral intervention plan (BIP) to address the
inappropriate behavior (Murdick, Gartin & Crabtree, 2007). As early as the 1970s, court cases paved the way for Congress to enact legislation defining and codifying exclusionary disciplinary practices for students receiving special education services (such as Goss v. Lopez, 1975; Stuart v. Nappi, 1978; Doe v. Koger, 1979; S-I v. Turlington; Honig v. Doe, 1988). IDEA 1997 added the manifestation determination hearing to determine whether misconduct is a manifestation of a disability or due to inappropriate placement. The manifestation determination hearing guidelines were clarified in IDEA 2004. The amended Individuals with Disabilities Education Act (IDEA 2004) provide extensive procedural protections for children with disabilities. One of the goals of the law is to ensure that under appropriate circumstances, the impact of a student’s disability must be considered when enforcing disciplinary procedures for inappropriate behaviors. IDEA’s school discipline protections are designed to serve the overall goal of full inclusion of students with disabilities in public education.

IDEA recognized that a student’s disability may contribute to participation in certain types of misconduct. If the student’s conduct is caused by his disability or due to the school system’s failure to provide appropriate services and supports to address the impact of the disability, the system’s power to impose discipline is limited. Therefore, the schools are prohibited from excluding students with disabilities from receiving access to education.

Determining whether the student’s disability caused a disciplinary infraction is a critical issue under IDEA. The Act along with case law makes this law very
important to students and parents. It provides procedural safeguards and substantive protections for students with disabilities (Harvard Civil Rights Project, 2000).

When the student’s misconduct is not caused by his or her disability, and it has been determined the IEP has been properly implemented, the school may impose the same disciplinary action as they would for a student without a disability. If it is determined the behavior was a manifestation of the student’s disability, the IEP team must conduct a functional behavioral assessment and develop a behavior intervention plan if one has not already been developed. If a behavior intervention plan has been developed previously, it must be reviewed and, if appropriate, modification to the behavior intervention plan must be considered by the team. Additionally, the student should be returned to school unless the IEP team agrees to change the student’s placement.

Mallard and Seybert (1996) reported that students with disabilities were twice as likely to be suspended as students without disabilities, and that students identified as having an emotional or behavioral disability were 11 times more likely to be suspended. Students with learning and behavior disabilities are more prone to displaying behaviors that may lead to disciplinary actions (e.g., inability to self-regulate, misinterpretation of social cues). However, it must be understood that even while suspended or expelled, students with disabilities are still guaranteed a free and appropriate public education (FAPE). This same right is not guaranteed to students that have not been found eligible for services under the IDEA.

Schools combat this feeling of having their hands tied in regard to discipline of students with special needs by committing systemic violations of the rights of
students with special needs (Harvard Civil Rights Project, 2000). The Harvard Civil Rights Project defines systemic violations as:

Practices that affect large numbers of special education students, such as a categorical rule assigning all children with emotional and behavioral disorders to special classrooms or a pattern of either failing to diagnose students with disabilities or providing them with the legally required services and protections (p. 44)

In sum, discipline of students in general and special education poses a challenge for schools. Suspension and expulsion clearly does not work to address students' emotional, mental, and behavioral needs. If schools decide to systemically violate the rights of students with special needs who display challenging behaviors by placing them in special classes, buildings, and/or programs or fail to identify them and limit the services they need, the problems with behavior problems will continue to increase. According to the Committee on School Health of the American Academy of Pediatrics (2003), students who are suspended often are least likely to have supervision at home, are often from single parent families, and are those most in need of professional help. In addition, those students who frequently are suspended are more prone to dropping out of school and are more likely to become involved with the juvenile justice system (Baker et al., 2001). Therefore, it is imperative that schools explore evidence-based interventions that address these concerns.

**Significance of the Study**

Of utmost significance is the fact that children and adolescents who demonstrate aggressive, defiant, bullying, stealing, and noncompliant patterns of
behaviors are at high risk for school failure, truancy, dropout, alcohol and substance abuse, delinquency, social rejection victimization, suicide, violence, as well as persisting psychiatric, academic, and social impairments (Committee on School Health, 2004). An estimated 40% to 60% of students across urban, suburban, and rural settings become chronically disengaged in school as they progress from elementary to middle to high school. This does not account for the 15% to 40% (depending on ethnicity) of students who have already dropped out of school (Cataldi, Laird, & KewalRamani, 2009). Furthermore, students with challenging behaviors left with their emotional, behavioral, and mental health needs unmet participate in or experience multiple high-risk behaviors (e.g. substance abuse, sex, violence, depression, and attempted suicide). This is a major concern for all students, both general education and students receiving special education services. Compounding the typical stresses of human growth and development with poverty, racial bias, a disability, and physical, sexual, or substance abuse, as well as depression and other mental health issues, if left unaddressed, may predispose students for increased incidences of challenging and oft criminal behaviors.

Next, the data clearly shows in terms of emotional, behavioral, and mental health prevalence data that America’s students are in crisis; consequently, student discipline continues to rank high as one of the most significant issues facing schools today (Rose & Gallup, 2007). Judging from the incidence and prevalence rates of these issues among school-age children, the problems are increasing. Despite the fact that school administrators use suspension and expulsion in an attempt to decrease violence, drug use, and truancy, and to manage challenging behaviors, the American
Bar Association (ABA) is opposed to the zero-tolerance policies schools have adopted as a result of the Gun-Free Schools Act of 1994 (P.L.103-882). In 2001 the ABA voted to end zero-tolerance policies because it is their belief that schools should not mandate automatic suspension or expulsion for rule violations without investigating the specifics of a given incident. Although the ABA (2003) is against zero-tolerance policies, they advocate for schools to use interagency collaboration to address the physical health, mental health, and safety needs of students to “decrease the likelihood that students will engage in behaviors requiring disciplinary action” (p. 1206).

The No Child Left Behind Act (NCLB) requires educators provide classroom instruction and interventions that are scientifically based. In accordance with both IDEA of 1997 and the reauthorized Individuals with Disabilities Education Improvement Act of 2004 (IDEIA), schools are also mandated to provide positive behavioral interventions and supports (PBIS) to address problem student behavior. The legislation requires schools to provide more proactive interventions and less reactive, punitive, restrictive, and exclusionary measures to lead to more positive outcomes for students with emotional and behavioral disabilities. School-wide positive behavior interventions and supports (SWPBIS) has emerged over the past 20 years as an empirically validated, proactive, preventative, and data-driven framework to respond to students with challenging behaviors (Simonsen, Jeffrey-Pearsall, Sugai and McCurdy, 2011). The SWPBIS framework is comprised of a three-tiered continuum of prevention-based supports (Sugai & Horner, 2002; Horner, Sugai, Todd, & Lewis-Palmer, 2005). Similar to the response to intervention model (RTI),
Tier 1 supports all students in the school with proactive behavior management practices. Tier 2 focuses on the behavioral needs of a small group of students (~15%) who display behaviors that are not responsive to Tier 1 supports and require more targeted assistance. Tier 3 supports individual students (~5%) whose behaviors are not responsive to Tier 1 and Tier 2 strategies and practices and require more intensive, individualized, and specialized interventions (Simonsen, Jeffrey-Pearsall, Sugai and McCurdy, 2011). The three tiered system of supports provides positive and effective discipline to meet the diverse needs of an increasingly diverse population of students. The framework is applicable in the elementary, middle, and high school settings (Virginia Department of Education, 2009). Therefore, the overall significance of this study is that it assists in bridging the gap between research and practice within the fields of education and behavioral and mental health to ultimately meet the needs of all students, yet specifically the ~5% of students who do not respond to Tier 1 and Tier 2 practices and need more intensive, specialized, and individualized interventions.

Although similar studies have been conducted as evidenced by the research from the Center for School Mental Health at the University of Maryland School of Medicine (www.schoolmentalhealth.org), this study is the first formative program evaluation of a School-Based Therapeutic Day Treatment Program in the Mid-Atlantic States for children and adolescents being provided by a local Community Services Board and two private mental health care providers in a rural school district for students in kindergarten through eighth grades. Another major difference from this study and others is that Therapeutic Day Treatment research has taken place at
sites outside of the school or in self-contained classrooms in schools. A third difference is that this study will not only look at differences in behavioral and academic functioning in isolation but at the impact of the intervention on attendance, behavior, and academics. Hence, the significance of this study is that a program evaluation will provide evidence of the qualities of the intervention and how the program can be improved so that others may use it. Questions related to the goals of the program will be answered. However, it is recommended that a logic model be developed prior to developing specific questions to evaluate a program (Mertens & McLaughlin, 2004).

Logic Model

As asserted, the purpose of this study was to evaluate a school-based day treatment program for children and adolescents with EBD. A Logic Model of Program Structure and Design (see Appendix A) was developed for the DTX program. “The logic model serves as a useful advance organizer for designing evaluation and performance measurement, focusing on the important elements of the program and identifying what evaluation questions should be asked and why and what measures of performance are key” (McLaughlin & Jordan, 2004, p.7.) This logic model was created utilizing the template constructed by the University of Wisconsin’s extension program (2003). Using this design, the creation of the logic model of a program can assist in explicitly stating assumptions on how a program is supposed to work, which can lead to the increased potential for evaluation usefulness (Rossi, Lipsey, & Freeman, 1999).
The Logic Model of Program Structure and Design for the DTX program, in Appendix A, assists in explaining the program theory by depicting the priorities of the program as well as the programs' inputs, outputs, and outcomes. The priorities include providing quality mental health services to children and adolescents to increase appropriate behaviors and decrease inappropriate behaviors resulting in increased academic achievement. The investments in this program include time; hiring and retaining qualified mental health providers; training on mental health strategies and interventions; and coordination of services. The program provides (outputs) individual assessments, individual and group therapy, behavior modification, and crisis intervention in the school environment, as well as family counseling. The desired outcomes gradually progress from identification and assessment of students in need of intensive mental health treatment to no longer needing the intervention. Inherent in this program and process are assumptions and external factors influencing success, participation, and completion of the program. This model illustrates the need for a descriptive outcome evaluation for the DTX program. In the next section, the research questions answered by completing this evaluation are provided.

**Research Questions**

School-based Therapeutic Day Treatment is a promising practice for addressing the needs of all children and adolescents who display challenging behaviors. As discussed thus far, NCLB and IDEA require schools to provide evidence-based interventions to meet the needs of students in public schools. The overarching goal of this study was to answer the question, to what extent does a
school-based Therapeutic Day Treatment Program (TDT) address the academic, behavioral and mental health needs of elementary and middle school students who display challenging behaviors? The school-based behavioral intervention will be evaluated at the elementary and middle-school levels to determine if it is a promising intervention for addressing the needs of children and adolescent students, with behavioral challenges, in general education and special education programs. The expectation for some students is that specific behaviors may continue, but the rate and severity will decrease. Surprisingly, “outcome studies on school-based mental health models are limited, as are outcome studies on typical delivery methods of outpatient mental health services” (Committee on School Health, 2004, p. 1840). This formative program evaluation will answer the following questions pertaining to School-Based Therapeutic Day Treatment:

1. To what extent does participation in a school-based day-treatment program reduce identified undesirable behaviors in elementary and middle school students with emotional and behavioral disorders, in terms of:
   a. Number of behavior referrals
   b. Number of days of suspension, and
   c. Number of suspensions per year?

2. To what extent does participation in a school-based behavioral intervention program increase identified desirable behaviors in elementary and middle school students with emotional and behavioral disorders, in terms of:
   a. Attendance
   b. Grade point average?
3. What do parents, teachers, building level program administrators or guidance counselors, and DTX providers perceive to be the benefits of the program?

4. What do parents, teachers, building level program administrators or guidance counselors and DTX providers perceive to be the challenges or concerns of the program?

5. What are the aspirations of parents, teachers, building level program administrators or guidance counselors, and DTX providers if the program were to operate to its highest potential?

Definition of Terms

*Children and adolescents with challenging behaviors* refers to students in general and special education programs who have a history of displaying common undesirable behaviors in school, but are not limited to: Fighting, hitting, stealing, lying, cheating, using drugs, arguing with teachers, breaking classroom rules, out-of-seat and partial out-of-seat behavior without permission, touching others' property without permission, vocalization, and aggression towards parents, teachers, and administrators (O'Leary, Kaufman, Kass, & Drabman, 1970).

*Discipline* in this study is being defined as enforcing a sanction on a student as a consequence for undesirable behavior. The goal of discipline is to decrease undesired behavior and to increase desired behaviors. Schools use discipline and behavior interventions as a consequence for undesirable behaviors. Evans (1999) explains, “discipline, punishment, and behavior interventions are interrelated” (p. 11).
School-based Therapeutic Day Treatment (DTX) refers to a highly structured and supervised program that assists children in achieving their potential in the least restrictive environment. The program is provided to students in the regular public school setting and allows children to participate in a normal community setting with all available supportive resources. It offers a broad range of clinical services and support to address the behavioral and emotional problems of students with EBD, aged 5 to 21. The clinical services include; individual, group, and family therapy with an emphasis on improving functioning through skills training, anger management, substance abuse prevention and education, daily living skills, parenting education and support, and psychiatric consultation for medication education and management. It is designed to deter behaviors that could cause an out-of-school or out-of-home placement.

Summary

This chapter introduced that discipline and behavior problems are still significant problems in the nations’ public schools, and that school officials are yearning for interventions that work, being that suspension, expulsion, and other exclusionary practices clearly have not. The purpose of this study was to complete a program evaluation of a School-Based Therapeutic Day Treatment Program designed to address the academic, behavioral, and mental health needs of children and adolescents in kindergarten through eighth grade, in a rural school district in Virginia. Presented in the statement of the problem was that federal, state, and local government and school officials recognize the importance of empirically assessed,
behavior-based prevention and intervention standards as a result of the requirements of NCLB and IDEA. Therefore, a brief overview of how educational researchers define “evidence-based” research, and one form of evidence-based research – program evaluation, was explained. Additionally, the national perspectives on school-based mental health, school-based mental health and academics were presented to explain the paucity of evidence-based research on school-based mental health, specifically School-Based Therapeutic Day Treatment. Even though this research study has the potential to benefit all children who display challenging behaviors, in terms of student discipline, students in general education programs and special education programs may be disciplined differently. With that said, the dual system of responding to behavior problems was explained as it applies to students in general and special education programs. Next, the significance of the study presented several startling and disappointing facts and statistics about children and adolescent outcomes, therefore elucidating the importance of evaluating programs for evidence-based results. Finally, the research questions to be answered and the definition of terms were provided. Chapter 2 will provide a review of the research literature related to the topics that undergird this study.
Chapter 2

Review of Literature

Teachers across the United States are eager for information and evidence-based interventions that reduce behavior problems and increase success for children with emotional and behavioral disorders. Many different methods have been developed to address and manage students’ behaviors in schools. Research studies evaluating the relative effectiveness of these methods can be overwhelming to educators. The myriad interventions available in the literature may be difficult to navigate. Furthermore, conflicting results produced by some investigations may make identifying appropriate interventions even more difficult for school staff.

An Internet search using the keywords “interventions to address behavior problems” on Education Research Digest yields thousands of articles on the topic. As is true in areas of human services beyond education, behavior studies are laden with “many theories, expert recommendations, and fads” (Lloyd, Forness, & Kavale, 1998, p. 195). Some interventions are widely adopted because teachers, parents, or administrators, have a “feeling” that the proposed interventions will work. Other interventions are adopted because the ideas on which they are based or the words that are used to promote them have appeal (i.e., they look good and feel right (Lloyd et al.,
1998). For these reasons, research on educational interventions e.g., academic, behavior, and special education, sometimes produces conflicting and controversial findings. As a result it is difficult to formulate precise recommendations for interventions in the school setting.

In this chapter the definition, prevalence, and significance of the issues related to how students with behavior problems impact public schools in the U. S. will be provided. Next, a description of the dual system of discipline procedures school administrators are required to utilize in response to behaviors displayed by students in general and special education will be presented. Then, terms and the legal foundation for requiring researchers and practitioners to investigate and implement evidence-based interventions will be shared. Also, the difficulty, cautions, and complexities associated with completing evidence-based research studies on students with emotional and behavioral disorders (EBD) will be presented. Finally, a review of the evolution of school-based mental health programs and interventions to address student/adolescent mental health issues is provided in this chapter.

**Definition of Behavior Problems**

In order to conceptualize the current study, a definition of the term behavior problems is necessary. One problem researchers face when identifying effective interventions for students with behavioral problems is identifying a common definition for the population that includes both general and special education students. A multitude of terms used worldwide include: students with emotional and behavior difficulties; social, emotional, and behavior difficulties (SEBD); special education needs (SEN); behavior problems; emotional and psychiatric difficulties; disruptive
students; students who are seriously emotionally disturbed (SED); and students that are aggressive that meet the American Psychiatric Association's *Diagnostic and Statistical Manual IV of Mental Disorders* (DSM-IV) criteria for conduct disorder, oppositional defiant disorder (ODD), or disruptive behavior disorder- not otherwise specified (DBD-NOS) disorder (Gulchak & Lopes, 2007).

For the purpose of this study the term “students with emotional and behavioral disorders (EBD)” will be used. The use of this term will denote students (up to 22 years of age) in several categories: (1) who meet the definition of serious emotional disturbance (SED) as defined by the Individuals with Disabilities Education Improvement Act of 2004 (IDEA), (2) with a DSM-IV diagnosis and problems in personality development and social functioning that have existed for at least one year, or (3) without a DSM-IV diagnosis or found eligible for SED as defined by IDEA, who have environmental factors or psychological stressors such as poverty or a history of abuse in addition to poor coping skills and social skills that increase the probability that the child will experience serious mental illness as an adult (Lee, 2004).

**Students with Emotional and Behavioral Disorders**

The term students with emotional behavior disorder (EBD) is not to be confused with seriously emotionally disturbed (SED) or emotionally disturbed (ED)—terms often used interchangeably; however, EBD includes those students labeled as SED or ED and includes those who are at-risk for a label of SED, ED, or serious mental illness in adulthood. The IDEA (2004) and the Substance Abuse and Mental Health Services Administration (SAMSHA) both have definitions of SED. A
closer look at the three individual definitions follows. The reader should reference the following descriptions of each category as the discussion of behavior problems is provided.

**IDEA's definition of SED.** The Individuals with Disabilities Education Improvement Act of 2004 (P.L. 108-446) is the law that ensures services for students with disabilities (birth through age 21) throughout the United States. This law defines serious emotional disturbance as:

A condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child’s educational performance:

1. An inability to learn that cannot be explained by intellectual, sensory, or health factors;
2. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
3. Inappropriate types of behavior or feelings under normal circumstances;
4. A general or pervasive mood of unhappiness or depression; or
5. A tendency to develop physical symptoms or fears associated with personal or school problems.

The term includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance.
SAMHSA’s definition of SED. The Substance Abuse and Mental Health Services Administration (SAMHSA) is the U.S. Federal agency charged with improving the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses. SAMHSA uses the following definition of serious emotional disturbance to qualify children with emotional and behavioral problems for services:

Persons from birth up to age 18 who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV, that resulted in functional impairment which substantially interferes with or limits the child’s role or functioning in family, school, or community activities (SAMSHA, 1993, p. 29425).

At Risk of EBD

The past 25 years has experienced a sustained and productive surge of research on conduct disorder and antisocial behavior problems (Patterson, Reid, & Dishion, 1992). An increasing number of studies have identified antecedents that are predictive of later serious behavior problems. The presence of these antecedents has been shown to be clearly evident well before school entry (Severson & Walker, 2002).

A failure or inability to comply with school rules is often cited as the leading cause for students to be at-risk for future emotional and behavioral disorders (Walker, Colvin, & Ramsey, 1995). Children and adolescents who demonstrate aggressive and
noncompliant patterns of behavior are at high risk for developing persisting psychiatric, academic, and social impairments (Graham, Rutter, & George, 1973; Lane, Gresham, & O'Shaughnessy, 2002; Reid, 1993). Students who experience externalizing behavior problems early in their school careers are at serious risk for a host of long-term adjustment problems including school dropout, delinquency, and adjustment disorders in adulthood (Kazdin, 1987). Pupils with internalizing behavior problems early in their school careers are similarly at serious risk for school and peer adjustment problems, which include academic underachievement and peer neglect or rejection (Lane et al., 2002). Children and adolescents who demonstrate aggressive, defiant, bullying, stealing, and noncompliant patterns of behaviors, poor academic performance, truancy, alcohol and substance abuse, delinquency, violence, as well as persisting psychiatric, academic, and social impairments are the students being identified as at risk for EBD (Lane et al., 2002).

Prevalence of Behavior Problems

How big is this problem? How many children and adolescents are involved? Providing an accurate account of the prevalence and significance of behavior problems in schools for students with EBD is difficult due to the failure to agree upon one particular definition and identifier. It is important to realize that there are differences of opinion regarding what qualifies as a behavior problem and regarding the process for assigning these often stigmatizing labels. A paucity of research on the prevalence of behavior problems may also exist because of the cultural differences in views regarding what are considered to be behavior problems (Tucker, 1999). A
behavior that is accepted in one sub-culture may be disapproved of or punished in another.

The Joint Commission on Mental Health of Children (1970) estimated that 2 to 3 percent of children suffer from severe mental disorders and that another 8 to 10 percent suffer from emotional disorders that require some intervention. In 1977, the National Institute of Mental Health (NIMH) while referring to 65,191,000 individuals under 18 years of age, reported that an estimate of 10 million children were in need of emotional, behavioral and mental health services while only 600,000 were receiving formal services (Hersh, S.P., 1977). According to the National Institute of Mental Health (1990) the prevalence of mental and emotional problems in children and adolescents was as high as 22% (NIMH, 1990).

More recent reporting by Bradley and Monfore (2004) noted from a U.S. Department of Education report that 80% of students with EBD were male, 30% of students with EBD are educated outside of the general education classroom for the majority of their school day, and 50% of the students with EBD dropped out of school before graduation. They also report that 72% of high school-age students with EBD were suspended or expelled from school compared to only 22% of students without EBD (Bradley & Monfore, 2004).

The different mental health and education definitions impact the data reporting and prevalence rates of students with EBD. According to the SAMHSA definition, an estimate of 22% or 10 million youth are eligible for EBD services (Satcher, 2000). The IDEA definition results in an estimate of 446,635 children nationwide that are receiving services. It must be noted that the IDEA numbers reflect children who are
attending public schools nationwide and have gone through the child find process required by the law (Whorton, Siders, Fowler, & Naylor, 2000).

Evidence Based Interventions

A major focus for current policy and systems change efforts in education and mental health is the extent to which states are investing in practices and procedures that are supported by rigorous research evidence. Any claim that a practice or procedure is "evidence-based" should be framed in the context of (a) explicit description of the procedure/practice, (b) clear definition of the settings and implementers who use the procedure/practice, (c) identification of the population of individuals who are expected to benefit, (d) terms used to define or describe the study, (e) description of the assessment instruments, and (f) the specific outcomes expected (Odom et al., 2005). Two important laws in public school education, NCLB and IDEA, require interventions to be investigated prior to systematically adopting them.

Relevance to NCLB and IDEA

The Elementary and Secondary Education Act, referred to as No Child Left Behind (NCLB) (2001), requires the use of scientifically based research to improve educational practice. The law further defined scientifically based research as "rigorous, systematic, and objective procedures to obtain valid knowledge" about education programs or interventions. Similarly, the most recent reauthorization of the Education for All Handicapped Children's Act of 1975; the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) (2004), added that all personnel working with children with disabilities should be trained to use
"scientifically-based instructional practices, to the maximum extent possible".

Therefore, "the expectation is that evaluations will be conducted of programs using experimental and quasi-experimental methods to assess the impact of the programs with respect to intended results" (Mertens & McLaughlin, 2004, p. 8). It can be concluded from these initiatives that the goal for all children, including students with special needs, is to increase their opportunities to have a quality education.

**Evidence-Based Interventions for Addressing Behavior Problems**

As discussed earlier, there has been extensive research on behaviors related to students with EBD. It must be reiterated that there is an inconsistency between definitions from different systems. Studies conducted by Skiba et al. (1994) demonstrate that even definitions within the same system are ambiguous and problematic for professionals to interpret (Lee, 2004). Having an agreed upon definition of EBD to include students in general education as well as those receiving special education services would enable educators to more easily identify effective evidence-based practices for those students in need of behavioral interventions.

In addition to the inconsistency of definitions, evidence-based research on students with EBD and special education is considered to be the "hardest of the hardest to do" because of the variability of the participants (Odom et al., 2005, p. 139), the greater ethnic and linguistic diversity that, unfortunately, occurs in special education because of overrepresentation of some minority groups (Donovan & Cross, 2002), and the complexity of the educational context (Guralnick, 1999). One difficulty is that emotional and behavioral disorders consist of internalizing and externalizing behaviors. Moreover, students may also be served in various programs.
That being the case, the Institute for Educational Sciences (IES) recommends that researchers focus on the questions of effectiveness and employ high-quality research methods to address the research questions.

A review of the literature regarding evidence-based interventions revealed a significant number of studies related to addressing behavior problems. In this section a review of current treatment options professionals use to manage students with behavioral disorders will be described. Specifically, the treatment options reviewed include behavioral interventions in school settings.

**Behavioral Interventions**

Many behavioral interventions are based on social and emotional learning theory and have widespread acceptance for use with the children with EBD (Dieksta, 2008; Greenberg, Weissberg, O’Brien, Zins, Fredericks, Resnik, & Elias, 2003; Weissberg, Kumpfer, & Seligman, 2003; Wilson, Gottfredson, & Najaka, 2001; Zins, Weissberg, Wang, & Wahlberg, 2004). Zins and his colleagues (2004) described social and emotional learning as the process of integrating cognition, emotion, and affect around different skill sets including self-awareness, self-management, relationship management, and responsible decision making. Behavioral theory posits that all behavior is learned and can be changed through positive or negative reinforcement (Thomlison & Thomlison, 1996). Interventions based on behavioral theory tend to define acceptable behaviors and provide positive reinforcement when behaviors occur or negative reinforcement when acceptable behaviors do not occur.

Research shows that behavioral interventions are effective in reducing negative behaviors in children with EBD (Kiser et al., 1996; Milin, Coupland,
Walker, & Fisher-Bloom, 2000; Musser, Bray, Kehle, & Jenson, 2001). As a result, human service professionals have created and implemented behaviorally based interventions in a variety of settings. Two of these settings are public schools and community-based mental health facilities. The focus of this review will be on public school settings.

The use of school-based interventions allow children with EBD access to specialized services and satisfies federal mandates regarding the education of children with disabilities (Hendrickson, Gable, Conroy, Fox, & Smith, 1999). School-based interventions are often multidisciplinary and involve parents or primary caregivers. These interventions may be as simple as schools adopting token economy systems, providing training for teachers, parents or community members, conducting behavioral assessments for each child or providing summer programs for students and family advocates (Musser et al., 2001; Kutash, Duchnowski, Sumi, Rudo, & Harris, 2002; Briar-Lawson, Lawson, Collier, & Joseph, 1997). More comprehensive school-based interventions may involve schools providing comprehensive mental health services such as individual, group, or family therapy, support groups, and referrals for medication (Weist, Nabors, Myers, & Armbruster, 2000). Some examples of school-based behavior interventions follow.

**Applied Behavior Analysis Therapy.** Applied Behavior Analysis Therapy (ABA) is the design, implementation, and evaluation of environmental modifications to produce socially significant improvement in human behavior (Lewis et al., 2004). ABA includes the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. ABA uses antecedent stimuli and
consequences, based on the findings of descriptive and functional analysis, to produce practical change. ABA is based on the belief that an individual’s behavior is determined by past and current environmental events in conjunction with organic variables such as genetics. Thus, it focuses on explaining behavior in terms of external events that can be manipulated rather than internal constructs that are beyond our control.

Examples of evidence-based intervention practices for EBD from the Lewis et al. (2004) study found the following principles of applied behavior analysis are often used in interventions identified as effective in the United States: (a) teacher praise for positive reinforcement; (b) providing opportunities for students to respond during instruction; (c) functional behavior assessment (FBA); (d) behavior intervention plan; and (e) social skills instruction.

Positive Behavior Interventions and Supports. Positive Behavior Interventions and Supports (PBIS) is a highly researched, evidence-driven intervention system with data to support that by incorporating its strategies in schools; it has reduced disciplinary incidents, increased a school’s sense of safety, and improved student’s academic outcomes. The premise of PBIS is that continual teaching, modeling, recognition, and rewarding of positive student behavior will reduce unnecessary discipline (OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports, 2014). Further, PBIS may promote a climate of greater productivity, safety and learning.

PBIS is not a packaged curriculum but an approach that schools have to integrate within their organizational systems. Teams working with administrators and
behavior specialists, provide the training, policy support and organizational supports needed for (a) initial implementation, (b) active application, and (c) sustained use of the core elements (Bradshaw, Reinke, Bevans, & Leaf, 2008; Horner, Sugai, Todd, & Lewis-Palmer, 2005). School-wide PBIS has resulted in overall decreases in problem behavior displayed among all students within school buildings and districts studied (Colvin, Sugai, Good, & Lee, 1997; Lewis, Colvin & Sugai, 2000; Sugai et al., 2005). School-wide PBIS should be viewed as a research-proven strategy to reduce overall levels of problem behavior in schools.

Similar to Response to Intervention (RtI), Positive Behavior Interventions and Supports is grounded in differentiated instruction. PBIS is a problem-solving model designed to prevent inappropriate behavior through teaching and reinforcing appropriate behaviors. The PBIS framework offers a three-tiered continuum of prevention based supports systematically applied to students based on their demonstrated level of need, and addresses the role of the environment as it applies to development and improvement of behavior problems. The three tiered structure of PBIS include universal behavioral supports (Tier 1), secondary behavioral supports (Tier 2), and tertiary behavioral supports (Tier 3) (Bohanon et al., 2012). Tier 1 is intended to address the needs of approximately 80% of the student body to include defining, teaching, and acknowledging appropriate behaviors. Tier 2 focuses on 15% of the student body. Tier 2 uses data for decision making and planning, as well as the use of progress monitoring data to determine if students are responding to the interventions provided in their current program of support. Tier 3, intended to address 5% of the population with challenging behaviors, focuses on functional
behavior assessment and more frequent progress monitoring of data beyond that used when using Tier 1 and Tier 2 supports (Bohanon, et al., 2012).

Although PBIS is supported by numerous positive examples in the research literature as an evidence-based proven prevention and intervention framework, most studies show sufficient success with 80% (Tier 1) of the population (Bradshaw, Reinke, Bevans, & Leaf, 2008; Horner, Sugai, Todd, & Lewis-Palmer, 2005; OSEP 2014). The Office of Special Education Programs Center on Positive Behavior Interventions (2014) published a brief titled “Is School-Wide Positive Behavior Support and Evidence-Based Practice? A Research Summary.” The document shared 43 separate references to research for the remaining 20% of the students receiving Tier 2 and Tier 3 interventions. Of the studies presented, 85% of them made reference to three commercially available programs. The remaining interventions 15% focused on individual strategies and processes. Clearly, the research base is strong for the interventions shown, however the level of complexities, range of problems, and contexts presented by the students identified as Tier 3 is too great to accommodate the needs of this population. At the same time PBS serves as a promising practice to increase educators’ use of research-validated practices at the individual student level (Lewis et al., 2004; Safran & Oswald, 2003; Simonsen, Jeffrey-Pearsall, Sugai & McCurdy, 2011).

The research suggests that when students have not successfully responded to Tier 1 and Tier 2 supports, additional individualized and specialized intervention is required to facilitate success for the students (Scott, Alter, Rosenberg, Borgmeier, 2010; Bohannon, et al., 2012). At Tier 3 the school team’s focus must shift to
conducting more formalized functional behavior assessment (FBA) of the student's data, which should include data examined from interventions attempted at Tiers 1 and 2. At this stage of the continuum, the classroom teacher should have an active problem-solving role, and a more in-depth data collection process through one-on-one consultation should take place. If the behaviors continue, a more comprehensive FBA is necessary and a behavior intervention plan (BIP) should be developed, implemented, and monitored. The BIP should match services, time, and resources to the student's demonstrated needs. Scott et al. (2010) explain the FBA and BIP process as "a continuum of progressively more formal and intense procedures and practices that, while necessary for a small number of students, will be insufficient without continued application of both primary and secondary systems as part of a cumulative package of interventions" (p. 524). If the student continues to respond poorly to the plan, direct observation by non-classroom personnel may become necessary. Additionally, the need for a multidisciplinary team to assist with developing an individualized educational or treatment plan may emerge, although this is generally reserved for students in special education programs (OSEP, 2014).

The three-tiered framework is useful in establishing practices and systems that emphasizes (a) support for all students across the whole school, (b) an integrated and graduated collection of interventions that increases in intensity and specificity, and (c) use of student responsiveness or data to evaluate and adapt intervention decisions (Simonson, Jeffrey-Pearsall, Sugai, & McCurdy, 2011). However, as discussed, students at Tier 3 represent a small proportion of students who present the most extreme and challenging behaviors and also require intensive and specialized
interventions that may extend beyond the typical public school environment. The school may need to explore support from behavioral or mental health professionals to develop more specialized behavioral intervention plans.

**Social Emotional Learning.** The concept of social emotional learning (SEL) involves the process of integrating cognition, emotion, and affect around different skill sets including self-awareness, social awareness, self-management, relationship management, and responsible decision making. Zins, Weissberg, and Wang (2004) presented a large body of empirical research demonstrating that SEL is linked to academic success. This research study was important because it provided a detailed description of many successful programs. Each of the studies was equally important because they showed how each program enhanced student’s success e.g. improved attendance, school connectedness and test scores. Unlike No Child Left Behind’s dependence on test scores and programs that promote curriculum only, SEL addresses other factors that impact academic and social success. These factors include: school attitudes (e.g. motivation, responsibility, attachment), school behaviors (engagement, attendance, study habits), and school performance (e.g. grades, subject mastery, test performance). Payton et al. (2008) provided a technical report on three scientific reviews that examined the impact of SEL programs on attitudes, behavior, emotional distress, and academics. They found the programs to be effective in school and in the communities of urban, suburban, and rural settings for students from diverse backgrounds who displayed behavior and emotional problems and for those that did not. Although a promising intervention, large-scale evaluation research has not been
published in peer-reviewed journals. Therefore, more work is needed on this intervention.

**Evaluation of Program Effects**

Several researchers have used single-subject research designs to evaluate the effectiveness of school-based interventions (e.g., Salend, Whittaker, & Reeder, 1992; Theodore, Bray, Kehle, & Jenson, 2001). Salend et al. used an A-B-A-B design to evaluate the effectiveness of a peer-mediated behavior management system (N=20). The teacher established a list of specific behaviors for students to demonstrate. The researchers monitored the frequency and intensity of behaviors during a 6 to 8 day period to establish a baseline. The class was then divided into two groups. Group A had 8 students and group B had 12. At the end of each day, the teacher asked the two groups to recall their specific group behavior and use a researcher-created tool to decide on a group behavior rating. The group compared their self-rating to the rating the teacher gave them. If the groups rating matched the teacher’s, they were awarded a prize. Results indicated the number of inappropriate behaviors that decreased. The results also indicated that the children maintained this decreased level of problem behaviors seven weeks after the intervention.

Theodore et al. (2001) used an A-B-A-B- design to determine whether providing random rewards for positive behaviors decreased a child’s frequency of negative behaviors (N=5). Theodore and colleagues monitored students’ behaviors during a baseline period of three weeks. During the intervention period the teacher randomly rewarded students’ positive behaviors; students did not know beforehand when or which behaviors would be rewarded. After two weeks, the teacher
discontinued the random reward system. Then the teacher repeated the intervention and subsequent withdrawal. Results indicated that students’ negative behaviors decreased during the entire study. However, decreases were most apparent during the intervention period.

The effectiveness of a school-based behavioral intervention for children with EBD has been demonstrated in studies by Salend et al. (1992) and Theodore et al. (2001). The designs permitted the researchers to collect data during multiple intervention and baseline phases. Therefore, researchers could examine changes and determine whether these changes continued during the intervention and withdrawal periods. These studies, even though the sample sizes were small, demonstrated that teachers could make simple modifications to address student behavior.

Additional studies that examined school-based behavioral interventions included studies that evaluated the use of comprehensive behavioral assessments as part of a plan to improve the behavior of individual students. March and Horner (2002) evaluated the functioning of children with serious emotional disturbance (n=24) from a suburban school system and posited reasons for their negative behaviors. The intervention consisted of each child working with his or her parents and teachers to develop a written behavior contract. The behavior contract was specific for each student and contained specific goals that each child would achieve daily. During the school day, each of the student’s teachers provided feedback about his or her behavior. At the end of each day, teachers provided a brief written evaluation of the students’ behavior and provided a copy for students to give their
The students were rewarded if they had obtained written feedback from all their teachers.

To measure outcomes, March and Horner (2002) administered the *Functional Assessment Checklist for Teachers and Staff* to teachers. In addition, they examined the number of office referrals, lunch detentions, or regular detentions for students participating in the intervention. Descriptive statistics indicated that children engaging in negative behaviors to gain peers' or adults' attention decreased the frequency of negative behaviors during the intervention. However, those students who engaged in negative behaviors to avoid class work showed little improvement in the frequency of negative behaviors. Consequently, understanding the goal of these behaviors may help in the selection of appropriate interventions.

A similar intervention was evaluated by Kennedy et al. (2001). Kennedy and colleagues studied the impact of behavioral assessments and person centered planning on the behavior of children with EBD (N=3). The researchers administered the Functional Analysis Observation Form to the students' teachers. Next, the researchers, teachers, and special education personnel met and reviewed the results of the *Functional Analysis Observation Form*. The researchers asked the group to determine students' strengths, challenges, and how negative behaviors were maintained, and how this knowledge could be incorporated into each class period. Descriptive statistics indicated that two (out of three) children decreased the frequency of negative behaviors and maintained their progress throughout the remainder of the school year.
These two small-scale studies demonstrated the importance of a comprehensive assessment for each child (March & Horner, 2002; Kennedy et al., 2001). In addition, the researchers demonstrated the necessity of including multiple persons in the assessment process. This is important because a child with EBD may exhibit different behaviors across different systems (e.g., home, community, or school). Understanding if patterns exist between these systems is important in developing behavioral contracts. March and Horner speculated that children engaging in negative behaviors to avoid tasks may require more intensive interventions.

Researchers have also evaluated the effectiveness of studies that involve the direct partnership for school personnel with professionals such as social workers and psychologists. Viggiani et al. (2002) examined a behavioral intervention that included a collaborative effort between a social worker and teacher. The intervention consisted of a social worker and a teacher working together in a classroom. Viggiani and colleagues sought to determine whether students participating in the intervention increased attendance, positive behavior, and grades. The researchers selected four classrooms, two to receive the intervention (n = 36 and n = 20), and two to serve as comparison groups (n = 22 and n = 18). Most of the students were males from lower-income families. Outcome measures included report cards, a count of the number of times parents participated in school meetings or activities, and post test questionnaires. ANOVA analysis indicated that at the end of the grading period, there were statistically significant differences between the intervention groups and comparison groups. The grades and positive behaviors in the classroom increased for students in the intervention group.
A collaborative intervention between school psychology interns and teachers was evaluated (Noell, Duhon, Gatti, & Connell, 2002). The intervention included school psychology interns providing consultation and guidance for four teachers working with children with difficult behaviors (n = 8). The teachers met with the school psychology interns and devised a behavior modification plan for each student. Each teacher implemented the recommended plans and documented the results. In addition, the teachers attended trainings conducted by the psychology interns. At the conclusion of the intervention, teachers reported that students engaged in fewer problematic behaviors. In addition, teachers reported that the consultation process was helpful and that they were pleased with the quality of information provided by consultants.

**School-based Interventions.** The aforementioned school-based interventions are more classrooms specific. There are additional school-based interventions for students with or at risk of EBD that are more comprehensive and may incorporate numerous systems. For example, Kutash, Duchnowski, Sumi, Rudo, & Harris (2002) evaluated a program for children with serious emotional disturbance. The program consisted of school personnel, parents, and community agencies attending a 12-hour training program on assessing children and implementing behaviorally-based intervention strategies. The researchers recruited two groups of students, an intervention group (n = 23) and a comparison group (n = 31) as well as school staff (n=13) to participate in the intervention. Descriptive statistics indicated that the groups of children were predominately male, White, and non-Hispanic.
Kutash and colleagues (2002) administered the Child Behavior Checklist and the Child and Adolescent Functional Assessment Scale to the children’s parents, the Wide Range Achievement Test to the children, and the Knowledge Inventory and Teacher Knowledge and Skills Survey to the teachers. The researchers administered the instruments before, during, and after the intervention. Results indicated that children, school, and community participants benefited from the intervention. School staff increased their knowledge of children with serious emotional disturbance and the students participating in the program showed a decrease in problem behaviors.

These studies demonstrate the effectiveness of school-based behavioral interventions. These interventions may involve an entire class of children with serious emotional disturbance or teachers developing behavior plans for specific children with EBD (Musser et al., 2001). One shared characteristic of all of the behaviorally-based school interventions is that they involve a degree of collaboration. This may mean collaboration between teachers, parents, and community leaders (Kutash et al., 2002) or collaboration between students and teachers (Theodore et al., 2001; Musser et al., 2001; Salend et al., 2002). Other interventions may include working specifically with other professionals such as social workers (Viggiani et al., 2002). More specifically, in order to be successful, school-based DTX requires collaboration between the school staff and additional human services professionals.

In a Summary of Recognized Evidence-Based Programs (2008) compiled by the Center for School Mental Health, University of Maryland School of Medicine (http://csmh.umaryland.edu), a list was compiled from a survey of 152 school mental health programs from across the country. The list provided targeted age/grade level
information, topics addressed by each program, structure of each curriculum, and evidence-based program recognition. The characteristics of these programs included a focus on externalizing behaviors, substance use, school failure, sexual activity, trauma, academics, and prosocial behavior. To be included on this list, the Center for School Mental Health required that agencies that vetted the programs listed adhere to the requirements established under the Education, Research, Development, Dissemination, and Improvement Act of 1994 to evaluate educational programs and recommend them as promising or exemplary programs. To be included on Summary of Recognized Evidence-Based Programs Implemented by Expanded School Mental Health Programs, the programs:

- Must provide evidence of efficacy and effectiveness based on a methodologically sound evaluation
- Have goals that are clear and appropriate for the intended population and setting
- Provide a rationale underlying the program that is clearly stated, and the program’s content and processes are aligned with its goals
- Shall take into consideration the characteristics of the intended population and setting (e.g., developmental stage, motivational status, language, disabilities, culture) and the needs implied by these characteristics.
- Include implementation processes that effectively engage the intended population
- Will describe how the program is integrated into schools’ educational missions
• Must provide necessary information and guidance for replication in other appropriate settings.

A careful review of the 152 interventions developed and implemented to address the needs of children and adolescents, clearly shows there is no one best intervention to serve all students with EBD and the need for further evaluation.

**Day Treatment Intervention**

Day treatment creates an environment where clients receive, “daily comprehensive therapeutic experiences that do not require removing children from their homes or families” (Kaplan & Sadock, 1998, p. 1274). Peers of similar ages are grouped together and spend a designated amount of time participating in therapeutic activities such as social skills games, structured field trips, recreational skills groups, educational groups, and processing groups. The child is the client; however, the day treatment staff also provides education and support to the family. In this manner the teaching staff is an integral part of the therapeutic process and facilitates a process whereby children and their parents learn skills that enable them to have more positive interactions with each other.

Day treatment programs sometimes work collaboratively with school systems. Whitfield (1999) evaluated a day treatment program functioning in conjunction with a school system. Whitfield sought to determine whether a program implemented at the day treatment program could reduce school violence. The intervention consisted of a 12 session cognitive behavioral program that included self-instruction, self-assessment, self-evaluation, arousal management, and adaptive skills development. Whitfield used a single subject design that included multiple baselines across
subjects. The researcher asked 16 males attending the school-based day treatment program (8 to receive the intervention and 8 to serve as a comparison) to participate in the study. Whitfield administered the State-Trait Anger Expression Inventory to the children and had staff record the child’s daily behavior on the Staff Daily Report. Data were collected during a 2 to 4 week baseline period. After the baseline period, Whitfield administered the 12-session intervention. Whitfield plotted each participant’s results on graphs. Results from the graphs indicated that students participating in the intervention increased their level of self-control and their ability to manage their anger. Participants maintained these results after six-months of completing the program.

The research is limited regarding the overall effectiveness of school-based day treatment interventions to decrease the frequency of negative behaviors. However, the research is emerging and promising. Further investigation into this area of study is warranted. The overarching goal of each of these interventions is to assist children in overall improvement in behavior to increase their academic performance. The studies presented thus far demonstrated that children participating in school-based interventions or behaviorally-based day treatment programs decrease the frequency of negative behaviors under certain conditions.

Summary

The impact of students with emotional and behavioral disorders on public schools in the U.S. has been provided. A discussion of the dual system of responding to behaviors was presented as it relates to the discipline procedures school administrators utilize to address the problem. Terms and the legal foundation for
requiring researchers and practitioners to investigate and implement evidence-based interventions were outlined. The complexities associated with completing evidence-based research studies on students with EBD were also presented. Finally, reviews of evidence-based interventions as well as the evolution of school-based mental health programs and interventions to address student/adolescent mental health were presented.

Schools across the United States are eager for information and evidence-based interventions that reduce behavior problems and increase success for children with emotional and behavioral disorders. Many different methods have been developed to address and manage student’s behaviors in schools. Unfortunately, many of these studies are not evidence-based as required by NCLB and IDEA. It is our responsibility as educators to take the time to investigate the use of interventions that have been proven to work with certain populations of students given the conditions presented in the research. It is understood that it may be hard to match the same type of child with the same issues, from similar demographics, socio-economic status, background, cognitive level, disability, and ethnicity. However, if proven successful, the school-based DTX program can change the way students with EBD are served in public schools across America.

Chapter one provided an overview of the current issues related to students with EBD. Chapter two provided a review of the literature related to those issues. Chapter three will explain the methods to be used to evaluate the school-based DTX program in detail.
CHAPTER 3

Methods

It is evident that implementing interventions such as those presented in the previous chapter to decrease the prevalence and rate of behavioral incidences and to increase school attendance and academic performance of students with emotional and behavioral disorders (EBD) is a start in the right direction. Jade County Public Schools has provided school-based therapeutic day treatment in its public schools for more than 10 years. However, until now, there has not been a formal evaluation of the program to determine if improvements were needed to meet the goals established for addressing the behavioral and academic needs of students with emotional and behavioral disorders, as intended.

This formative program evaluation of Jade County Public Schools’ School-Based Therapeutic Day Treatment program (DTX) is intended to provide school administrators, staff, parents and students with evidence-based information on the merit, worth, and value of a school-based mental health intervention for students with emotional and behavioral disorders (EBD). Although there are three agencies providing the school-based therapeutic day treatment program in Jade County Public Schools, the findings from this evaluation will focus on areas of improvement needed
overall to operate at its maximum potential to promote better outcomes for students
with challenging behaviors.

As a Medicaid funded program and governed by the Department of Medical
Assistance Services (DMAS), there are certain rules, regulations, and requirements
agencies providing school-based therapeutic day treatment programs must adhere to
in order to operate. As the Logic Model in Appendix A shows, the priorities for
DTX are the same regardless of which agency provides the program: reduce
undesirable behavior; increase desirable behavior; increase attendance; and increase
academic performance. However, each agency may offer programs and services
above and beyond the basic DMAS requirements different from their counterparts.

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DTX are the same: reduce undesirable behavior; increase desirable behavior; increase
attendance; and increase academic performance. However, each agency offers
programs and services above and beyond the basic DMAS requirements and different
from their counterparts.

As stated, the focus of this evaluation is on the overall school-based day
treatment program being provided in Jade County as it pertains to the goals and
priorities set forth in the logic model for school based day treatment programs. The
final results are reported based on the overall program improvements needed and not
as three separate program evaluations or to determine which individual agency out
performs the other. A recommendation for further study for Jade County Public
Schools and other school districts to complete individual program evaluations on each
of the agencies providing school based day treatment programs to include all
stakeholders and narrow the focus to each individual agency. Additional
recommendation for future study and evaluation are provided.

Rationale for Study Design

Prior to presenting the design of the study, it is important to provide an
explanation distinguishing program evaluation from theoretical research. Mertens
and McLaughlin (2004) explain that the focus of an evaluation may be on a program;
it's purpose is to change the way people think about or act in regard to the program.
Theoretical research puts greater emphasis on knowledge generation while evaluation
uses the knowledge to inform decisions within a specific context. Different research
methodologies are needed to address the variables and complexities associated with
educational research, especially in special education research. The identification of
effective practices in special education has resulted from “employing multiple
methodologies (Odom et al., 2005, p. 138). Rossi, Freeman, and Lipsey (1999)
define program evaluation as, “the use of social research procedures to systematically
investigate the effectiveness of social intervention programs that are adapted to their
political and organizational environments and designed to inform social action in
ways that improve social conditions” (p. 20). Sanders and Sullins (2006) described
program evaluation as, “the process of systemically determining the quality of a
program and how it can be improved” (p. 1). Therefore, the research needs to be
applied in the instructional setting to determine if it is effective in addressing
students' needs. The overall purpose of a program evaluation is to aid in making informed decisions in regard to educational or social programs.

As discussed, there are several types/models of program evaluation. These include but are not limited to: program improvement (formative evaluation); program accountability (summative evaluation); needs assessment; dissemination of promising practices; and policy formation/assessment (Rubin & Babbie, 2001; Mertens & McLaughlin, 2004). The two most common types of program evaluation are formative and summative.

Formative evaluations are used to assist staff in making mid-course corrections in the program design and delivery to increase the probability of success. “Formative evaluation is done by developers while the program or product is under development, in order to support the process of improving its effectiveness” (Gall et al., 2003, p. 570). Formative evaluations are those that answer questions concerning the program’s processes. Is the program working well or not? What are the areas that need improving? How do the school staff, administrators, and program providers perceive the processes? Formative evaluations are usually focused on new or existing programs that are in transition.

In contrast, summative evaluations assess the effectiveness or worth of fully developed programs. Summative evaluations are those that answer questions concerning the success of the program. Was the program worth the expenditure? Is the program achieving the ends for which it was funded? Were the intended outcomes reached and did the program cause the changes?
The program to be evaluated in this study grows out of a formalized agreement between Jade County Public Schools and the three school-based DTX providers that has been in existence since 2008. There has not been a formal program evaluation conducted to date to determine if the program is truly being implemented as designed. Additionally, although there have been data discussions concerning individual students, as well as the perceived benefit to addressing students mental health needs to decrease inappropriate behaviors and increase academic achievement, an evidence-base has not been established. A formative program evaluation will help the schools tweak or make “mid-course corrections in the design or delivery of the program to increase the probability of success” (Mertens & McLaughlin, 2004, p. 20).

**Evaluation of the Jade County Public Schools’ School-Based Therapeutic Day Treatment Program**

A formative evaluative study was conducted because there was interest in whether the multiagency school-based day treatment program in Jade County Public Schools being provided by Provider 1; Provider 2; and Provider 3 is providing behavioral and academic benefits to the students as intended. The goals for these three programs incorporate the expectations of the school board, administrators, teachers, parents as well as the mental health staff who provide the DTX services.

Both qualitative and quantitative data were utilized to determine the merit, worth, value, and how they may be improved for sustainability. “No reputable evaluator would presume to make evaluative judgments without first assembling a solid base of evidence (Fitzpatrick, Sanders, & Worthen, 2011, p. 381). In program evaluation it is often necessary to use more than one method or approach because
there are very few questions that may be answered by only one strategy. Glesne (2006) explained that qualitative research involves a description of meanings in the natural setting to understand some social phenomena from the perspectives of those involved. Patton (1987) explained that, “Qualitative methods permit the evaluator to study selected issues, cases, or events in depth and detail; the fact that data collection is not constrained by predetermined categories of analysis contributes to the depth and detail of qualitative data (p.8)”.

Qualitative approaches involve observations, focus groups, interviews, or surveys to compile “information-rich” data. Patton (2002) further describes studies as being information rich as “those from which one can learn a great deal about the issues of central importance to the purpose of the research (p. 46)”.

The information gathered might be from what is seen, heard, or read from people, places, events, and activities. It involves applying analytical techniques to transform or change social conditions. Quantitative research assumes an objective reality “to describe and explain features of this reality by collecting numerical data on observable behaviors of samples and by subjecting these data to statistical analysis” (Gall et al., 2003, p. 634). Once reduced to quantifiable bits of information, researchers make generalizations from the study group to other persons and places.

Utilizing mixed methods in program evaluation aids in increasing the validity of the study, gaining a “fuller understanding of the construct of interest”, and initiating new ideas and thinking (Fitzpatrick et al, 2011, p. 386). As discussed earlier “the expectation is that evaluations will be conducted of programs using experimental and quasi-experimental methods to assess the impact of the programs
with respect to intended results” (Mertens & McLaughlin, 2004, p. 8). This evaluation assists in closing the gap between research and practice and increases the opportunities for all children, including students with special needs, to have a quality education. Therefore, these goals were the impetus to the evaluation questions, design, data collection, and analysis.

**Evaluation Questions**

The questions answered in this formative evaluation are:

1. To what extent does participation in a school-based day-treatment program reduce identified undesirable behaviors in elementary and middle school students with emotional and behavioral disorders, in terms of:
   a. Number of behavior referrals
   b. Number of days of suspension, and
   c. Number of suspensions a year?

2. To what extent does participation in a school-based behavioral intervention program increase identified desirable behaviors in elementary and middle school students with emotional and behavioral disorders, in terms of:
   a. Attendance
   b. Grade point average?

3. What do parents, teachers, building level program administrators or guidance counselors, and DTX providers perceive to be the benefits of the program?

4. What do parents, teachers, building level program administrators or guidance counselors and DTX providers perceive to be the challenges or concerns of the program?
5. What are the aspirations of parents, teachers, building level program administrators or guidance counselors, and DTX providers if the program were to operate to its highest potential?

Context

Jade County Public Schools is a medium-sized rural school district in the Mid-Atlantic States. During the 2012-13 school year, the school district served approximately 14,427 students. There were 19 schools (12 elementary, 4 middle, 3 high). The student population consisted of 55.94% African American, 36.82% Caucasian, 1.59% Asian, and 5% identified self as Multi-Ethnic. The population of students eligible for special education services totaled 13% and 37.7% of the students was eligible for free and reduced meals. For the purposes of this program evaluation, I utilized extant data from 84 students in grades kindergarten through eighth grade that participated in the DTX program at the 12 elementary and four middle schools during the 2011-12 school year.

Intervention: School-Based Day Treatment (DTX)

The service definition of Therapeutic Day Treatment (DTX), according to the U.S. Department of Medical Assistance Services [DMAS] (2008), is that DTX provides psychotherapeutic interventions combined with education and mental health treatment. The program is designed to increase functional life skills and to deter behaviors that could cause an out-of-home and out-of-school placement. DTX programs shall provide the following services: a comprehensive assessment, psychoeducational programming, case management, group therapy, individual therapy, educational support, therapeutic recreation, and crisis intervention to assist the child
in effective self-management of behavior. Activities include social skills training in areas including, but not limited to individual and group problem solving, anger management, community responsibility, and self-esteem enhancement. Each DTX site functions within a school and has a team consisting of a site supervisor, clinician(s), and case manager(s). The case manager provides direct services daily, including case management, psycho educational programming, and crisis intervention. The clinician also provides direct services daily, including psycho educational programming, individual therapy, and crisis intervention. The site supervisor oversees the day-to-day operations of the site. The program follows the academic calendar with a modified schedule during the summer.

**Student Criteria for Enrollment.** In accordance with DMAS criteria for admission, children and adolescents qualify for this program if they are at risk of removal from their school or community, who have an emotional or behavior disorder and meet the criteria for a student with an Emotional Disability or are at risk of an Emotional Disability and who have a parent or guardian willing to participate in services. Children and adolescents must have one of the following emotional or behavior problems that: (a) interfere with learning; (b) require year-round treatment in order to sustain behavioral or emotional gains; (c) cannot be handled in self-contained or resource classrooms for students identified as emotionally disturbed without receiving services; (d) would otherwise be placed on homebound instruction; or (e) include deficits in social skills; (f) peer relations; or (g) dealing with authority; are (h) hyperactive, (j) have poor impulse control, or are (k) extremely depressed or (l) marginally connected with reality. Additionally, they must display two of the
following on a continuing or intermittent basis: are at risk of hospitalization or an out-of-home placement because of conflicts with the family or community; need repeated interventions by mental health services, the judicial system, or school guidance; or exhibit difficulty in cognitive ability and may be unable to recognize personal danger or inappropriate social behaviors.

To be eligible for the school-based DTX program children must meet DSM-IV TR (APA, 2000) criteria for mental illness for a diagnosis of EBD, have an intelligence quotient of 70 or above, be Medicaid-eligible, and attend public school. The minimum cognitive functioning requirement assumes that each child is able to recognize differences between appropriate and inappropriate behaviors, understand cause and effect relationships, and examine the risks and the benefits of engaging in positive social behaviors.

An independent clinical assessment must be conducted by the local Community Services Board (CSB) prior to the authorization of new service requests. A parent or legal guardian of a child or youth who is believed to be in need of Therapeutic Day Treatment must contact the local CSB to schedule an appointment. The parent and the child must be assessed by an independent assessor at the local CSB office prior to authorization for services.

To participate in this Medicaid funded program, children and adolescents must qualify for Medicaid services. However, in an agreement between the Local CSB and the Family Assistance and Planning Team (FAPT) funds are set aside annually to serve up to six students in schools served by the Local CSB who may not be Medicaid eligible. Students that are neither Medicaid eligible nor selected as one
of the six students in schools served by the local CSB are not eligible to participate in
the DTX program.

Provider 1. Provider 1 is assigned to three elementary schools, two middle
schools and one alternative school. The program currently serves a total of 21
students in grades 1-8. The program offers behavior management, counseling
services, and pro-social skill development groups. These therapeutic interventions are
offered one-on-one, in small groups and in the classroom (if needed) to help students
achieve success. Provider 1’s interventions focus on developing trusting relationships
built on mutual respect, therefore eliminating the need for physical interventions. All
services are delivered by qualified mental healthcare providers. Additionally,
individual and family counseling are offered to the youth and family members to help
address the underlying causes of acting-out behaviors in the educational setting. The
program also utilizes music and movement to encourage rapid learning and academic
growth. Areas of focus are empathy, impulse control, problem solving, emotional and
anger management.

Provider 2. Provider 2 is assigned to four elementary schools and one middle
school and currently serves 28 students in grades 1-8. The program serves children
and adolescents at risk of serious emotional disturbance in order to combine
psychotherapeutic interventions with education and mental health treatment. Services
include: evaluation, medication education and management, opportunities to learn
and use daily living skills, social and interpersonal skills training, and individual,
group, and family counseling.
Provider 3. Provider 3 is assigned to four elementary and one middle school. Provider 3 currently serves 24 students in grades 1-8. Provider 3 provides psychotherapeutic interventions combined with educational support and mental health treatment. The services offered include: comprehensive bio-psychosocial assessment; daily individualized behavioral modification / classroom management; daily psycho-educational / social skills training groups, crisis intervention; individual therapy; case management; educational support; therapeutic recreation; and family therapy.

Participants

Teachers. Teachers were selected because they could provide rich, first-hand information on students’ academic and behavioral performance before, during and after participating in DTX. Additionally, teachers work directly with the DTX program providers and were able to provide their perspective on the overall benefits and challenges of the program. Both a General or Special Education teacher and an alternate familiar with the DTX program, from each elementary and middle school were nominated by their building administrator to participate in the program evaluation process.

Building Level Administrators or Guidance Counselors. Dependent upon the size of the school or the order of duties assigned in certain schools, either the principal, assistant principal or guidance counselor may handle student conduct referrals and discipline. They are also responsible for making referrals to the DTX providers, making contact with parents, and monitoring the progress of the students in the DTX program. Therefore, the building level school administrator or guidance
counselor responsible for discipline at each elementary and middle school was selected to participate in the program evaluation.

**Parents.** According to the DMAS, the program is designed to increase functional life skills and to deter behaviors that could cause an out-of-home and out-of-school placement. Additionally, the student’s parents must provide consent for their child to participate and agree to participate in the program. As the link to both home and school, parental participation in this evaluation was important to ascertain their perception of the value and worth of this intervention and how to improve the program to reach its highest potential. A parent and an alternate from each elementary and middle school were nominated by the building level administrator to participate in this evaluative study.

**DTX providers.** Each school site is assigned a Program Manager, Field Supervisor, Coordinator, and a Qualified Mental Health Provider (QMHP) from the DTX provider assigned to their school. Program Managers and Field Supervisors are responsible for oversight of their various programs at the various locations throughout the school system. The QMHP works in the school on a daily basis and provides the intervention to the students. QMHPs must have at least a bachelor’s degree in a human services field or in special education from an accredited college with at least one year of clinical experience with children and adolescents, or be a licensed mental health professional. Qualified Mental Health Providers from each agency representing each school being served were selected to participate in the program evaluation.
Each of these groups of participants: teachers; parents; building level administrators or guidance counselors; and DTX providers were purposefully selected to ensure information rich data from a range of perspectives. They have the greatest amount of insight into the program being evaluated from a practical perspective. These groups were separated into homogenous groups based on the agency providing the DTX program in the schools where they work or their child attends. Both the Institutional Review Board (IRB) at the College of William and Mary and Jade County Public Schools approved my protocol to use extant student data and focus groups as data sources.

Data Sources

Review of extant data. To answer Evaluation Questions 1 and 2, I elected to utilize extant student data from 2010-11, 2011-12, and 2012-13 for all students enrolled in the DTX program between July 1, 2011 and June 30th 2012. This allowed me to determine the difference in discipline, academic performance, and attendance before, during, and after the students' participation in the program for up to one school year. No additional student data or assessments were required as part of this evaluation.

The task of compiling an accurate list of students enrolled in DTX after July 1, 2011 and discharged no later than June 30, 2012 was compiled with assistance from the DTX providers, school staff, and cross referenced with the student information system. The data collected from the student information system included number of referrals, number of suspensions, total number of days suspended, number of unexcused absences, grades and demographic information from 2010
through-2013. The data were compiled into an Excel spreadsheet and organized for statistical analysis. The students’ names and identifying information were redacted prior to manipulating, analyzing and interpreting the data.

**Focus Groups.** Focus groups are usually comprised of 7 to 10 individuals who have been assembled together for the purpose of providing rich information about a research topic (Gall et al., 2007, p. 244). The focus group interview as Krueger and Casey (2009) explain is a “carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, nonthreatening environment” (p. 2). Unlike the interview, which is usually completed one respondent at a time, a focus group stimulates participants to “state feelings, perceptions, and beliefs that they would not express if interviewed individually” (Gall et al., 2007, p. 245). The overall goal of focus groups is to capture what people really think and feel and to provide full self-disclosure (Krueger and Casey, 2009). In order to get people to provide full self-disclosure, the facilitator must get the participants to trust and feel comfortable. To assist in making the participants feel comfortable the environment should be permissive, non-judgmental, non-authoritative, and encouraging.

Krueger and Casey (2009) explained that ideally the focus group should be composed of strangers who have something in common, and they should be told what it is they have in common to make them feel more comfortable. However, it is not always possible to group strangers given the program or phenomena being evaluated or studied. In this program evaluation the teachers, building administrators or guidance counselors, and program providers are familiar with each other due to the
roles they serve in. The parents may or may not have been familiar with one another prior to the evaluation.

The focus group technique is based on the premise that people often need to listen to questions, comments, understandings, and opinions of others to clarify their own. A skilled focus group facilitator will build on the conversation of the participants to get the rich information needed to explain the phenomena being evaluated. Fitzpatrick et al., (2011) explained the role of the focus group facilitator is to introduce and describe the process, moderate the responses of more vocal members, encourage less participative members, monitor questions and clarify ambiguities. The facilitator should ensure that questions lead to “answers that inform the evaluation questions for the study, while encouraging participants to share thoughts, opinions, and specific examples of experiences related to the phenomena being discussed. Glesne (2006) warned that discussion facilitation skills, in particular, are important. The focus group facilitator, unlike in an individual interview, simply asks questions to initiate discussion. The participants in the group interview are responsible for expressing their views, opinions and perceptions of the topic. The facilitator is responsible for promoting creative discussion in an interactive and permissive environment. The facilitator must be familiar with managing group dynamics, moving the conversation along and avoiding the common error of relying on short, force-choice questions, or having respondents raise their hands to questions (Fitzpatrick et al, 2011). To avoid this error Fitzpatrick et al., recommends having the group led by a trained facilitator or moderator along with an assistant to observe body language, take notes, and assist in interpreting the session.
In addition, audio or video recording the sessions, transcribing, and interpreting the transcripts for themes will provide the rich data desired by utilizing the focus group as a method of data collection. Prior to the evaluation, the group facilitators were trained in group interviewing techniques, to include how to monitor the group dynamics and how to assist in moving the group along while staying on topic to collect rich data pertaining to the research questions.

I chose focus groups as a data collection procedure because I was interested in getting the perceptions, feelings, insights and a diversity of perspectives from various stakeholder groups pertaining to the DTX program being provided to the students in Jade County Public Schools. I wanted to obtain and provide a rich in-depth description and understanding of the merit and worth of the DTX program to determine the benefits, challenges, and areas needed to improve upon for the program to reach its maximum potential for our students.

Asking questions that lead to answers to the research questions is the overall goal of focus groups. Well-run focus groups have a trained group facilitator and a moderator. In addition, the questions being asked provide rich information that leads to the answer to the research questions. This does not occur by happenstance. Krueger and Casey (2009, pp. 38-39) share that good focus group questions should evoke conversation, use words the participants would use when talking about the issue, be easy to say, be clear, be short, be open-ended, be one dimensional, and include clear, well-thought-out directions. Krueger and Casey (2009) further explain the importance of using the questioning route strategy. The questioning route is
described as a “sequence of questions organized in complete, conversational sentences to foster consistency” (p. 38).

Careful review of Developing Questions for Focus Groups (Krueger, 1998) has influenced my decision to utilize the questioning route strategy. As a novice evaluator this strategy is recommended because it requires me to think about the words, phrases, and questions in advance and to craft them in a way that guide the participants toward answering the research questions. The focus group questioning route I plan to use will include the five categories of questions recommended by Krueger (2009): “opening, introductory, transition, key and ending” (pp. 38-41). These categories lead the discussion from minimal importance to a level of importance relative to analysis.

Being that there are three DTX agencies providing the school-based day treatment program throughout Jade County Public Schools in 12 elementary and four middle schools, I originally established 12 focus groups composed of 3 teacher groups, 3 parent groups, 3 building level administrator or guidance counselor groups, and 3 groups of DTX providers with representation from each agency. Due to time and budget constraints, as well as lack of participation from varying groups, I was only able to conduct 3 building level or administrator groups, 3 DTX provider groups, 1 teacher group and 1 parent group with representation for each agency composed of 2 to 6 people in each group.

Participants in the focus groups were broadly representative of the elementary and middle schools as well as representative of the three DTX agencies. The evaluation involved a purposeful sample of 33 participants: 30 female and 3 male; 5
parents; 9 administrators or guidance counselors; 7 teachers; and 12 DTX providers. Surprisingly, the representation of participants by agency was equal at 11. Three of the 5 parents were parents of students with disabilities and 3 of the 7 teachers were special education teachers.

Scheduling the focus groups was a difficult task due to the time constraints. Meetings were held in comfortable, confidential, warm, welcoming environments, with food and refreshments provided. I invited participants by email, phone, and even follow-up calls and emails. I sent a copy of the Informed Consent Form via email to everyone that had email with the invitation to participate. I had copies available upon their arrival.


I began each focus group by requesting the participants’ permission to record and I then read the Informed Consent Form verbatim. Afterwards I asked them to sign and provide a pseudonym to identify themselves. Several preferred I select the pseudonym and inform them when I provide them a copy of the report. After I filed the Informed Consent Forms, I followed this questioning route for all 8 groups as approved by the IRB:

1. Opening question: Everyone answers this question. The purpose was to get the participants comfortable and engaged.
a. Tell us who you are and your relationship is to Jade County Public Schools.

2. Introductory questions: “Typically these are open ended questions that allow participants to tell about how they see or understand the issue, service, or product under investigation” (Krueger, 2009, p. 39).

   a. When you hear the term school-based therapeutic day treatment program (DTX), what is the first thing that comes to mind?

   b. When you hear Provider 1, Provider 2 or Provider 3 (based on the group), what is the first thing that comes to mind?

3. Transition questions: These questions helped transition the discussion from the less important to questions more relevant to the research questions.

   a. When you were first made aware of the DTX program, what were your expectations?

   b. What would you say are the goals of the DTX program?

4. Key Questions: “These are usually the first questions to be developed by the research team and the ones that require the greatest attention in the analysis” (Krueger, 2009, p. 40). Their two questions took up the most time.

   a. What do you perceive to be the benefits of the program?

   b. What do you perceive to be the challenges or concerns of the program?
5. Ending questions: Three types of questions help to bring closure to the discussion: “all things considered question, the summary question, and the final question” (Krueger, 2009, p. 40).

a. All things considered questions. This question gave the participants the opportunity to reflect on what was shared and to clear up any conflicting views that may have been presented earlier in the discussion.

i. If the program were to operate at the highest potential, what would you expect?

ii. If there were a magic wand that you could wave to make this program operate at maximum potential, what would you want to see?

b. Summary question. After a brief (2 to 3 minute) review and summation of what was discussed, the participants were asked if the summation was adequate.

i. Did I accurately capture what was shared here?

c. Final question. The purpose of the final question was to make sure that the purpose of the focus group had met the expectations as explained in the consent and overview that all of the critical components had been addressed.

i. Is there anything we should have talked about but didn’t?

Immediately following each focus group, my co-facilitator and I reviewed our notes together to capture and discuss anything the other may have missed and to identify
any themes, body language, or perceptions gleaned from the participants. All of focus groups and debriefing activities were recorded and labeled with the group name and date. I transcribed the notes and the debriefing as well as had several of the focus groups transcribed by a third party to aid in analysis of the focus group data.

Data Analysis

Quantitative and qualitative data have been analyzed in this mixed methods formative program evaluation. To answer research questions 1 and 2, quantitative analysis of the data were utilized. Descriptive statistics were used to determine the extent participation in Jade County Public Schools school based day-treatment program has on reducing identified undesirable behaviors and increasing identified desirable behaviors in elementary and middle school students. Percentages, means, and standard deviations are used to describe, organize, compare, and summarize students’ behavioral data. An EXCEL database was built to include raw data on the number of behavioral referrals, number of days suspended, number of suspensions, attendance, and grade point averages for all students who participated in the DTX programs in 2011-12. Students’ names were replaced with ID numbers and coded by the evaluator. The data were then downloaded into the Statistical Package for the Social Sciences (SPSS) for statistical analysis. A one-way repeated measures analysis of variance (ANOVA) was utilized to determine the difference in behavior referrals, days suspended, number of suspensions, attendance and grade point average the semester before, during, and after for students who participated in the DTX program in 2011-12.
To answer research questions 3, 4, and 5, qualitative analysis was utilized. Focus group analysis is different from quantitative analysis. In focus groups, data collection and data analysis occur at the same time. In quantitative analysis data collection stops and data analysis starts at a certain time. Focus group analysis is "systematic, verifiable, sequential, and continuous" (Krueger & Causey, 2009, p. 115). The focus groups for this program evaluation were scheduled to allow time for the moderator and co-facilitator review notes, ideas gleaned during the focus group, check the recording, and to plan for the next group. As the focus groups were occurring, I kept in mind that I was attempting to acquire the answers to the research questions. At the end of each group we identified themes that continued to reoccur as well as identified new themes based on the questions and from the various groups, schools and agency representatives. While debriefing I took time to read research questions and utilized my notes and the notes and feedback from the co-facilitator to prepare a list of codes and themes to look and listen for when I was going to listen to the recordings, transcribe, and review the transcriptions provided by a third party. I was also able to develop a list of follow up questions I needed to ask the next group.

Patton recommends that the evaluator, "Do your very best with your full intellect to fairly represent the data and communicate what the data reveal given the purpose of the study" (2002, p. 434). The digital audio recordings were immediately transferred to my personal computer where they were securely housed until they were transcribed. I am the only person that knows the code to my computer. Once the recordings were transferred from the digital recorder they were deleted from the digital recorder. Once they were transcribed, they were deleted from my personal
computer. I acquired the services of a third party transcriptionist for four of the groups that went over 75 minutes and had 5-6 participants. I transcribed the rest of notes and debriefings. The participants were not identified in the recordings. The average length of time for the focus groups ranged between 60-75 minutes. I used word and Excel spreadsheets to analyze the focus group data.

Table 1 represents how data from discipline reports, attendance reports, grade reports, focus groups and the perspectives of parents, teachers, school level administrators and guidance counselors, and day treatment program providers were collected and analyzed to answer the research questions.
Table 1.

**Program Evaluation Data Collection and Analysis**

<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Data Sources/Collection</th>
<th>Data Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To what extent does participation in a school-based day-treatment program decrease identified undesirable behaviors in elementary and middle school students, in terms of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. The number of behavior referrals per year?</td>
<td>Discipline record of students enrolled in the DTX program in 2011-12 to include total number of referrals the year before, during, and after enrollment in the DTX program.</td>
<td>Descriptive statistics using one-way repeated measures ANOVA.</td>
</tr>
<tr>
<td>b. The number of suspensions per year?</td>
<td>Discipline record of students enrolled in the DTX program in 2011-12 to include total number of suspensions the year before, during, and after enrollment in the DTX program.</td>
<td>Descriptive statistics using one-way repeated measures ANOVA.</td>
</tr>
<tr>
<td>c. The number of days suspended per year?</td>
<td>Discipline record of students enrolled in the DTX program in 2011-12 to include total number of days suspended the year before, during, and after enrollment in the DTX program.</td>
<td>Descriptive statistics using one-way repeated measures ANOVA.</td>
</tr>
<tr>
<td>2. To what extent does participation in a school-based behavioral intervention program increase identified desirable behaviors of elementary and middle school students, in terms of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Attendance per year?</td>
<td>Attendance reports and report cards for students enrolled in the DTX program in 2011-12.</td>
<td>Descriptive statistics using one-way repeated measures ANOVA.</td>
</tr>
<tr>
<td>b. Grade point average per year?</td>
<td>Grade reports of students enrolled in the DTX program in 2011-12 from the year before, during, and after enrollment in the DTX program.</td>
<td>Descriptive statistics using one-way repeated measures ANOVA.</td>
</tr>
</tbody>
</table>
3. What do parents, teachers, building level program administrators or guidance counselors, and DTX providers perceive to be the benefits of the program?

Stakeholders from each of the three DTX providers were broken down into the following focus groups:
- 1 Parent Focus Group
- 1 Teacher Focus Group
- 3 Building Level School Administrator or Guidance Counselor Focus Groups
- 3 Focus Groups of All three providers

Qualitative description of information from focus group interviews. Focus groups were recorded and transcribed. Transcriptions were coded for themes.

4. What do parents, teachers, building level program administrators or guidance counselors, and DTX providers perceive to be the challenges or concerns of the program?

Stakeholders from each of the three DTX providers will be broken down into the following focus groups:
- 1 Parent Focus Group
- 1 Teacher Focus Group
- 3 Building Level School Administrator or Guidance Counselor Focus Groups
- 3 Focus Groups of All three providers

Qualitative description of information from focus group interviews. Focus groups were recorded and transcribed. Transcriptions were coded for themes.

5. What are the aspirations of parents, teachers, building administrators, and guidance counselors if the program were to operate to its highest potential?

Stakeholders from each of the three DTX providers will be broken down into the following focus groups:
- 1 Parent Focus Group
- 1 Teacher Focus Group
- 3 Building Level School Administrator or Guidance Counselor Focus Groups
- 3 Focus Groups of All three providers

Qualitative description of information from focus group interviews. Focus groups were recorded and transcribed. Transcriptions were coded for themes.

Researcher’s Perspective

As a self-proclaimed behaviorist, I have always realized the significance of the relationship between behavior and education. Simply stated, it is difficult to learn in a class that is disruptive. It is difficult for a student to learn when he is being disruptive, talking, acting out, or his behaviors result in his removal from the classroom or learning environment. As a former teacher, mental health counselor, and coordinator of a special education day school, and currently, director of special
education, my experiences helped me to realize the significance of the relationship between mental health, behavior, discipline, and academic achievement.

In 2007 as a special education administrator for Jade County Public Schools, I assisted in fully implementing the School-Based Day Treatment Program, a program being piloted in one of the elementary schools, into every school in the school district. To address the needs of all of the students who may have needed the intervention, three agencies were selected to provide the DTX program. As with many interventions put in place in schools, evaluation take place after it has been implemented to answer the questions, is it working, how well is it working, and how do we know?

As the Director of Special Education, I have invested a significant amount of time assisting in the oversight of the program as it has evolved over the past few years. However, the program is not a program designed for students identified to receive special education services only. As the data reflects, there are more students in general education than students receiving special education services. As the researcher/internal evaluator, I am aware that I may have bias for the program. It has been my perception over the past years, from the comments and responses from parents, teachers, administrators, and day treatment providers that the students are doing better because of the services provided. The small group and individualized therapy sessions with qualified mental health providers have been appealing and is in line with what we believe to be best practice. I am also cognizant of the fact there is always room for improvement at all levels.
During this evaluation, I used several strategies to make this process less threatening to avoid sabotage by participants. Although I am not responsible for the day-to-day monitoring of this program, I understand that others may view me as such because I am a central office administrator. Therefore, I had to make every effort to make accommodations for the participants in this program evaluation to be as comfortable as possible to avoid them not being as forthcoming in their answers or participation. I sent out a request to participate and immediately informed them that it was not a requirement or mandate to attend. If they responded that they had to think about it or appeared resistant, I reassured them that I was completing this evaluation for the purpose of meeting dissertation requirements and to improving student outcomes. I provided food and refreshments and obtained the services of a female non-authoritative co-facilitator.

In contrast, I am also aware of the fact that some of the participants may be overly participative and may embellish answers to give me what they think I might want to hear. Yet, I am mindful of those facts, that is why I took the time to schedule multiple focus groups involving more than thirty people in addition to obtaining the assistance of a co-facilitator, audio recorded each session, and transcribed the groups and notes, as well as recorded and transcribed the debriefing between me and the co-facilitator.

Finally, the research says that it is extremely important for the person doing the program evaluation to immerse themselves in the data and be an active participant in the process. That is why I chose to co-facilitate the focus groups as opposed to relying on someone else to capture the themes and attempt to explain them to me.
have learned so much from this process. I will share what I have learned and found out about the School-Based Therapeutic Day Treatment Program at Jade County Public Schools in Chapter 4.

**Ethical Considerations**

This study was conducted in a manner in accordance with the ethical guidelines from the American Psychological Association (APA) and the College of William and Mary’s Institutional Review Board. Also, the Council for Exceptional Children’s (CEC) formal code of ethical guidelines for conducting research with special populations was followed. The CEC is specific that the rights and welfare of participants be protected and that results are published accurately and with high quality of scholarship (Council for Exceptional Children, 1997). Mertens and McLaughlin (2004) also caution when conducting research on special populations to be “alert to the implicit value commitments and consequences that attend categorizing individuals as learning disabled, mentally retarded, and so on.” (p. 152). Therefore, the anonymity of each of the participants in the study has been protected. The participants have been provided with informed consent and were informed that they could discontinue participation in this formative program evaluation at any time. Every attempt has been made to ensure that employees of the school system and the day treatment providers evaluated were neither exploited nor pressured to answer questions they may have felt uncomfortable answering because the evaluator is a central office administrator. Written permission from the school system being evaluated was obtained prior to conducting this evaluation.
Limitations and Delimitations

This purpose of this formative program evaluation was to determine whether the multiagency school-based day treatment program in Jade County Public Schools being provided by Provider 1, Provider 2, and Provider 3 was being implemented as designed and if improvements are needed to improve behavioral and academic outcomes for students with emotional and behavioral disorders. This evaluation is limited to making improvements to the program being provided in Jade County Public Schools to students with mental health, behavioral health, and academic concerns. Another limitation is that students often move throughout the district or are suspended or expelled from school while participating in the intervention. Additionally, quite often, due to the needs of the students and their families, they may be receiving wraparound services to include school-based DTX.

Although there were more than 30 participants in the focus groups, scheduling conflicts or other personal reasons prohibited all of the participants invited from participating. Consideration was given to including students as participants, however given the sensitive nature of the therapeutic day treatment intervention and concerns with maintaining confidentiality and anonymity of the student population by the students, participation was limited to parents, teachers, school administrators and guidance counselors, and day treatment providers.

Although there is no claim of generalization to other school districts or programs, “Research findings as accumulated knowledge also serves to improve practice by enhancing understanding of that practice” (Rossman & Rallis, 2003, p. 21). In parallel fashion, if another school district or program identifies elements and
strategies from this evaluation, it may help another population of students with mental
health, behavioral health and academic concerns.
Chapter 4

Results

The purpose of this formative program evaluation of Jade County Public Schools’ School-Based Therapeutic Day Treatment program (DTX) is to provide evidence-based information on the merit, worth, and value of a school-based mental health intervention for students with emotional and behavioral disorders (EBD) that has been in place for approximately 10 years. Although there are three individual agencies providing the intervention in Jade County Public Schools, the results of this evaluation will be reported on the overall program as the specific goals for the program are to increase desirable behaviors, academic achievement and attendance, and decrease undesirable behaviors. Agency specific improvements identified will be shared with the stakeholders directly, specifically Jade County Public Schools and the specific agencies providing the treatment. The extant quantitative data and qualitative focus group data pertaining to the five evaluation questions will be addressed in this chapter. The results that follow were collected and analyzed during February and March of 2014.
Extant Student Data

To answer Evaluation Questions 1 and 2, I elected to utilize extant student data from 2010-11, 2011-12, and 2012-13 for all students enrolled in the DTX program between July 1, 2011 and June 30th 2012. Utilizing descriptive statistics I was able to determine how students performed in the areas of discipline, academic performance, and attendance the years before, during, and up to one year after their participation in the DTX program. No additional student data or assessments were reviewed as part of this evaluation being that the goals of the DTX program are to increase desirable behaviors, academic achievement and attendance, and decrease undesirable behaviors as shown in the Logic Model of Program Development (see Appendix A).

The task of compiling an accurate list of students enrolled in DTX after July 1, 2011 and discharged no later than June 30, 2012 was compiled with assistance from the DTX providers, school staff, and cross referenced with the student information system. The data collected from the student information system included number of referrals, number of suspensions, total number of days suspended, number of unexcused absences, grades and demographic information from 2010 through 2013. The data were compiled into an Excel spreadsheet and organized for statistical analysis. The students’ names and identifying information were redacted prior to manipulating, analyzing and interpreting the data. To provide an overall picture of the 84 kindergarten to eighth grade students who participated in the DTX program in 2011-12, a brief description follows.
**Student Demographics.** Of the complete dataset of 84 students, more than half (53%) were students in the general education program. The remaining 47% were students with an identified special education disability in accordance with the Mid-Eastern States’ regulations governing students with disabilities. Of the students with disabilities, students with other health impairments were represented the most (16%), followed by students with an emotional disability (14%), specific learning disability (8%), intellectual disability (2%), and autism (2%). Black students represented 87% (n=73) of the population, White students 12% (n=10), and Hispanic and other ethnicities represented 1% of the total cases.

**Focus Groups**

Eight focus groups, including three building-level administrator or guidance counselor groups, three DTX provider groups, one teacher group and one parent group with representation from each agency composed of two to six people in each group were facilitated. Each of the three building-level administrator or guidance counselor groups and DTX provider groups were organized according to the individual agency that provides the service. For instance, there was a Provider 1 administrator or guidance counselor group, a Provider 2 administrator or guidance counselor group, and a Provider 3 administrator or guidance counselor focus group. Due to time constraints, scheduling conflicts brought on by inclement weather, one of the worst in more than 15 years in the Mid-Eastern states, as well as time constraints, the parent and teacher groups were consolidated. However, there was representation of parents and teachers familiar with the services being provided by each of the individual day treatment agencies in each group.
Participants in the focus groups were broadly representative of the elementary and middle schools. The evaluation involved a purposeful sample of 33 participants: 30 female and 3 male; 5 parents; 9 administrators or guidance counselors; 7 teachers; and 12 DTX providers. The representation of participants by agency was evenly balanced at 11. Three of the 5 parents were parents of students with disabilities and 3 of the 7 teachers were special education teachers. I co-facilitated the focus groups along with a former Special Education Director from a neighboring school system. Both she and I participated in an online focus group moderator training prior to initiating the first focus group.

At the conclusion of each focus group interview, we debriefed on our perceptions of conversations, answers to the questions, themes that appeared in previous focus groups, new thoughts and themes, body language, and the overall feel of the groups. I transcribed all of the groups that consisted of three or less people as well as all notes from the debriefing. I used a third party transcription service for groups of four or more people. However, I did not have the focus groups transcribed verbatim due to budget constraints. Neither did I transcribe the recordings verbatim. I used the notes and debriefing notes to confirm and validate what my co-facilitator and I thought were themes. As I listened to approximately 14 hours of recordings to fill in gaps or missing information, and reviewed more than 300 pages of transcribed material, additional themes jumped out causing me to especially appreciate this iterative process. The quantitative and qualitative data analysis and interpretations provide the answers to the evaluation questions.
As designed, an analysis of the extant student data answered evaluation questions 1 and 2. Answers to evaluation questions 3, 4, and 5 are answered by data compiled from answers to questions 6, 7, and 8 in the focus group interview protocols from the eight focus groups.

Evaluation Question 1

To what extent does participation in a school-based day-treatment program reduce identified undesirable behaviors in elementary and middle school students, in terms of (a) number of referrals per year (b) number of days suspended, and (c) number of suspensions per year?

Descriptive statistics utilizing the repeated measures analysis of variance (RM-ANOVA) model summarizes the variance over time for the year prior to participation (2010–2011), the year students participated in the program (2011–2012), and the year after they participated in the program (2012–2013) for (a) number of discipline referrals per year (b) number of days of suspension, and (c) number of suspensions per year. The RM-ANOVA was conducted using the statistical software package SPSS. Tables 2-8 summarize the results of the RM-ANOVA analysis for each of the variables.

Tables 2, 4, and 6 provide descriptive statistics for the years 2010–13 for all students that participated in the program (n = 84). Table 2 provides descriptive statistics for total number of discipline referrals. Table 4 provides the descriptive statistics for total number of days of suspension. Table 6 provides descriptive statistics for total number of suspensions. Immediately following the tables of descriptive statistics is the RM-ANOVA calculations for each variable. For Tables 3,
5, 7, and 8, the column labeled *Type III Sum of Squares* tells how much variability is explained by the intervention effect. There is also an *error* term, which is the amount of unexplained variation across the conditions of the repeated measures variable (2010–2013). These sums of squares are converted into *mean squares* by dividing by the degrees of freedom (\(df\)). The column labeled *F* is the statistic that represents the ratio of systematic variance to unsystematic variance. The value of the F-ratio is then compared against a critical value of \(df\). The column labeled *Sig.* is the exact significance level for the F-ratio. If the significance of F is less than .05 then the differences are regarded as statistically significant, that is, that they did not happen by chance.

**Question 1a.** Table 2 shows that students received the highest number of referrals during the year the students participated in the program. This, however, is not significantly greater as compared to the corresponding years. Table 3 shows there was not a significant effect of the school-based therapeutic day treatment program on number of behavior referrals as the significance of F is greater than .05 at .147 for the years prior, during, and after participation in the program.

Table 2.

*Descriptive statistics for discipline referrals*

<table>
<thead>
<tr>
<th>Year</th>
<th>Mean</th>
<th>Std. Error</th>
<th>95% Confidence Level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lower Bound</td>
</tr>
<tr>
<td>Prior</td>
<td>4.484</td>
<td>.627</td>
<td>3.231</td>
</tr>
<tr>
<td>During</td>
<td>5.500</td>
<td>.654</td>
<td>4.191</td>
</tr>
<tr>
<td>After</td>
<td>4.290</td>
<td>.736</td>
<td>2.819</td>
</tr>
</tbody>
</table>
Table 3.  
RM-ANOVA results for number of behavior referrals

<table>
<thead>
<tr>
<th>Source</th>
<th>Type III</th>
<th>df</th>
<th>Mean</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sum of Squares</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>52.355</td>
<td>2</td>
<td>26.177</td>
<td>1.949</td>
<td>.147</td>
</tr>
<tr>
<td>Error</td>
<td>1638.312</td>
<td>122</td>
<td>13.429</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Time)

**Question 1b.** Table 4 shows that the mean is higher for number of days of suspension during the year the students participated in the program. Table 5 shows there was not a significant effect of the school-based therapeutic day treatment program on total number of days of suspension as significance of $F$ is greater than .05 at .117 for the years prior, during, and after participation in the program.

Table 4.  
Descriptive statistics for total number of days of suspension

<table>
<thead>
<tr>
<th>Year</th>
<th>Mean</th>
<th>Std. Error</th>
<th>95% Confidence Level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lower Bound</td>
</tr>
<tr>
<td>Prior</td>
<td>10.516</td>
<td>1.708</td>
<td>7.102</td>
</tr>
<tr>
<td>During</td>
<td>13.597</td>
<td>1.807</td>
<td>9.983</td>
</tr>
<tr>
<td>After</td>
<td>10.194</td>
<td>2.074</td>
<td>6.046</td>
</tr>
</tbody>
</table>
Table 5.

**RM-ANOVA results for total number of days of suspension**

<table>
<thead>
<tr>
<th>Source</th>
<th>Type III</th>
<th>df</th>
<th>Mean</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sum of</td>
<td>Square</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>437,645</td>
<td>2</td>
<td>218.823</td>
<td>2.186</td>
<td>.117</td>
</tr>
<tr>
<td>Error</td>
<td>12211.68</td>
<td>122</td>
<td>100.096</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Time)

**Question 1c.** Table 6 shows the lowest number of suspensions occurred during the year after the students participated in the program. There was a significant effect of the school-based therapeutic day treatment program on total number of suspensions as Sig. is less than .05 at .031 for the years prior, during, and after participation in the program. Since there was a significant effect, post hoc tests were completed to identify differences between prior, during and the year after. The results are shown in Table 8.

Table 6.

**Descriptive Statistics for total number of suspensions**

<table>
<thead>
<tr>
<th>Year</th>
<th>Mean</th>
<th>Std. Error</th>
<th>95% Confidence Level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lower Bound</td>
</tr>
<tr>
<td>Prior</td>
<td>2.387</td>
<td>.382</td>
<td>1.624</td>
</tr>
<tr>
<td>During</td>
<td>2.677</td>
<td>.364</td>
<td>1.949</td>
</tr>
<tr>
<td>After</td>
<td>1.726</td>
<td>.281</td>
<td>1.164</td>
</tr>
</tbody>
</table>
Table 7.

**RM-ANOVA results for total number of suspensions**

<table>
<thead>
<tr>
<th>Source</th>
<th>Type III</th>
<th>df</th>
<th>Mean</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sum of</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Squares</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>29.495</td>
<td>2</td>
<td>14.747</td>
<td>3.590</td>
<td>.031</td>
</tr>
<tr>
<td>Error</td>
<td>501.172</td>
<td>122</td>
<td>4.108</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Time)

Table 8.

**RM-ANOVA contrasts for total number of suspensions by year**

<table>
<thead>
<tr>
<th>Source</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior vs. During</td>
<td>5.226</td>
<td>1</td>
<td>5.226</td>
<td>.740</td>
<td>.393</td>
</tr>
<tr>
<td>During vs. After</td>
<td>56.145</td>
<td>1</td>
<td>56.145</td>
<td>8.023</td>
<td>.006</td>
</tr>
</tbody>
</table>

Table 8 shows that a post hoc test revealed significant effect of the school-based therapeutic day treatment program on total number of suspensions with a significant increase between the prior year and the year during students' participation and a more significant decrease comparing the year during treatment and the year after.
Summary of results for Evaluation Question 1. Taken together these results reveal there was not a significant difference in number of referrals or number of days suspended. However, there was a significant difference in total number of suspensions. More specifically, there was a significant decrease in the number of times students were suspended the year after they participated in the program.

Evaluation Question 2

To what extent does participation in a school-based behavioral intervention program increase identified behaviors in elementary and middle school students in terms of (a) attendance and (b) grade point average?

The repeated measures analysis of variance (RM-ANOVA) model was utilized to determine the extent participation in the school-based program had on attendance and grade point average over time for the year prior to participation (2010 – 2011), the year the students participated in the program (2011 – 2012), and the year after they participated in the program (2012 – 2013).

Tables 9-13 summarize the results of the RM-ANOVA analysis for each of the variables. Tables 9 and 11 provide descriptive statistics for the years 2010 – 13 for all students that participated in the program (n = 84). Table 9 provides descriptive statistics for school attendance. Table 11 provides the descriptive statistics for grade point average. Immediately following the tables of descriptive statistics is the RM-ANOVA calculations for each variable. For Tables 10 and 12, the column labeled Type III Sum of Squares tells how much variability is explained by the intervention effect. There is also an error term, which is the amount of unexplained variation across the conditions of the repeated measures variable (2010 –
These sums of squares are converted into mean squares by dividing by the degrees of freedom (df). The column labeled $F$ is the statistic that represents the ratio of systematic variance to unsystematic variance. The value of the F-ratio is then compared against a critical value of df. The column labeled Sig. is the exact significance level for the F-ratio. If the Sig. of $F$ is less than .05 then it is significant.

**Question 2a.** Table 9 shows a consistent pattern of attendance for the students participating in the program. Table 10 shows there was not a significant effect of the school-based therapeutic day treatment program on school attendance as Sig. is greater than .05 at .158 for the years prior, during, and after participation in the program.

Table 9.

*Descriptive Statistics for school attendance*

<table>
<thead>
<tr>
<th>Year</th>
<th>Mean</th>
<th>Std. Error</th>
<th>95% Confidence Level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lower Bound</td>
</tr>
<tr>
<td>Prior</td>
<td>.916</td>
<td>.009</td>
<td>.897</td>
</tr>
<tr>
<td>During</td>
<td>.896</td>
<td>.011</td>
<td>.874</td>
</tr>
<tr>
<td>After</td>
<td>.914</td>
<td>.011</td>
<td>.893</td>
</tr>
</tbody>
</table>
Table 10.

**RM-ANOVA results for school attendance**

<table>
<thead>
<tr>
<th>Source</th>
<th>Type III</th>
<th>$df$</th>
<th>Mean</th>
<th>$F$</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sum of Squares</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>.015</td>
<td>2</td>
<td>.007</td>
<td>1.872</td>
<td>.158</td>
</tr>
<tr>
<td>Error</td>
<td>.454</td>
<td>114</td>
<td>.004</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Time)

**Question 2b.** Table 11 shows a slightly lower grade point average the year after participating in the program. Table 12 shows a significant effect of the school-based therapeutic day treatment program on grade point average as Sig. is less than .05 at .010 for the years prior, during, and after participation in the program. Since there was a significant effect, post hoc tests were completed to identify specific differences between years. The results are shown in Table 13. Table 13 shows that a post hoc test reveals significant effect of the school-based therapeutic day treatment program on grade point average the year after participating the program.
Table 11.

*Descriptive statistics for grade point average*

<table>
<thead>
<tr>
<th>Year</th>
<th>Mean</th>
<th>Std. Error</th>
<th>95% Confidence Level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lower Bound</td>
</tr>
<tr>
<td>Prior</td>
<td>2.052</td>
<td>.123</td>
<td>1.805</td>
</tr>
<tr>
<td>During</td>
<td>2.073</td>
<td>.125</td>
<td>1.822</td>
</tr>
<tr>
<td>After</td>
<td>1.710</td>
<td>.161</td>
<td>1.386</td>
</tr>
</tbody>
</table>

Table 12.

*RM-ANOVA results for grade point average*

<table>
<thead>
<tr>
<th>Source</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>3.585</td>
<td>2</td>
<td>1.792</td>
<td>4.841</td>
<td>.010</td>
</tr>
<tr>
<td>Error</td>
<td>31.105</td>
<td>84</td>
<td>.370</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Time)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 13.

*RM-ANOVA for contrasts of grade point average by year*

<table>
<thead>
<tr>
<th>Source</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior vs. During</td>
<td>.018</td>
<td>1</td>
<td>.018</td>
<td>.022</td>
<td>.884</td>
</tr>
<tr>
<td>During vs. After</td>
<td>5.683</td>
<td>1</td>
<td>5.683</td>
<td>11.650</td>
<td>.001</td>
</tr>
</tbody>
</table>
Summary of results for Evaluation Question 2. A repeated measures ANOVA was conducted to compare the extent that participation in the school-based day treatment program had on school attendance and grade point average. School attendance did not significantly differ from students’ participation in the school based day treatment. Student attendance averaged 89-91 percent in the years prior, during, and after participation in the program. The results of the analysis of the effect of the program on grade point average revealed a significant difference. However, although significant, the importance of this analysis is that students’ grade point averages decreased the year after participation in the program. Discussion and recommendations to address this will be provided in Chapter 5.

Evaluation Question 3

What do parents, teachers, building level program administrators or guidance counselors, and DTX providers perceive to be the benefits of the program?

Four themes describe the participants’ perceived benefits of the school-based day treatment program in the study. Support, Behavior Management, Linkage, and Positive Impact on Others represent the story the data tell. Narrowing the more than 250 codes down to these four themes took several passes through the transcripts and recordings. Table 14 illustrates the themes from the transcripts and recordings from the various focus groups. As you can see, the codes do not neatly fit under one theme, however, the story the data tell is compelling.
Table 14.  

Themes and Coding for Perceived Benefits of Day Treatment Program

<table>
<thead>
<tr>
<th>Themes</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support</td>
<td>Third Party&lt;br&gt;Different View&lt;br&gt;Counselor&lt;br&gt;Time for Academics&lt;br&gt;Time for Discipline&lt;br&gt;Time for Testing&lt;br&gt;Team&lt;br&gt;Advocate&lt;br&gt;Relationship/Rapport&lt;br&gt;Outlet</td>
</tr>
<tr>
<td>Behavior Management</td>
<td>Classroom management&lt;br&gt;Discipline&lt;br&gt;Anger management&lt;br&gt;Social Skills&lt;br&gt;Crisis Prevention</td>
</tr>
<tr>
<td>Linkage</td>
<td>Mental Health Resources&lt;br&gt;Liaison Between Home and School&lt;br&gt;Wraparound Services</td>
</tr>
<tr>
<td>Positive Impact on Others</td>
<td>Role Model&lt;br&gt;Positive Impact on Entire School&lt;br&gt;Support for All Kids</td>
</tr>
</tbody>
</table>

**Support.** Beginning with the first focus group until the last group, when asked, “What do you perceive to be the benefits of the program for students?” the theme was evident that it was “support” whether it was stated or implied from words like “assistance,” “coverage,” “standing in the gap,” or “sounding board,” the message was clear that there is a perception that the DTX providers across all three agencies were there to provide support. Instinctively, participants began to share how they perceived the DTX providers benefitted them in their particular roles as school administrators or guidance counselors, parents, or teachers.

Principals and assistant principals commented that the DTX providers benefitted them by allowing them to focus on other big picture things such as
"focusing on academics, test scores, and being the instructional leader in the building." Guidance counselors, who in some buildings also handle discipline and additional administrative duties, noted how the support provides them with opportunities to provide group-counseling sessions, scheduling, and test preparation. Teachers noted that not only are the DTX providers a sounding board or an outlet for the students, but for them as well. Teachers felt a benefit of the program was having a person familiar and experienced in behavior management and intervention strategies in their classroom and around the school to help them with students with challenging behaviors. They perceived it to be a benefit to the clients of the DTX program and other students as well. Special Education teachers agreed and went further to share how beneficial the DTX providers' expertise was when initiating functional behavioral assessments and developing behavioral intervention plans.

Participant #302 voiced her perception of the program in terms of support: by explaining how it has benefitted her child, sharing:

All programs have pros and cons, and we have had some hiccups along the way, but I have seen a turnaround since he has been in the program. Although we have tried several interventions, the support of the DTX provider has helped to pull it all together by giving my child one-to-one attention, building relationships, communicating with me and the school, and working with the teacher to write IEP behavioral goals.

Support from the perspective of the DTX providers includes being an "advocate" or "third party" to speak for and on behalf of the students that cannot appropriately verbalize their emotions. Similarly, the participants reported that the
program supports the efforts of the school by communicating between the school and home and vice versa.

Communication home takes place in the form of reporting on how a student's day went, to communicating the specifics of a behavioral incident to the parent when the student's and school's explanation of events conflicted. In the classroom, DTX providers reportedly supported the teachers by doing walkthroughs and "quick checks" on students on their caseload as well as those students in the classroom who were not clients. Finally, they perceived that once they had established rapport with the teacher, they were able to communicate to them behavior management strategies they could use with the students with emotional and behavioral disorders as well as overall behavior management strategies.

**Behavior management.** The codes under the behavior management theme tell the story of the participants' perception of benefits of the program as it pertains to student behavior. The perception was that students with emotional and behavioral disorders received less discipline referrals because of the focus on anger management, socially appropriate behavior, and self-control. Specific strategies used by the DTX staff included meeting the students at the bus in the morning, conducting goal setting meetings as soon as they arrived, delivering the students' point sheets to the teacher each day, doing quick checks throughout the day, and providing individual therapy sessions.

Meeting with students in the morning helped to determine if the student had a rough night or morning before arriving to school and to assess how the day was going to go. The goal setting meetings helped the student to focus on specific goal(s) for
the day. The teachers were made aware of the goal by the daily point sheet. The benefit of the point sheet was that it helped teachers and staff to reinforce students’ goals throughout the day.

The “quick checks” helped prevent crisis when the DTX provider was able to address situations before they occurred. If there was a recognized issue, the DTX staff might pull the student from the class to address the situation and provide the student with strategies to work through the issue. An alternative intervention was for the DTX provider to remain in the class with the student while they worked out a solution, or introduced another activity to assist them in working through whatever the issue may have been.

Teachers and administrators noted that being available during transition times was another benefit. Transition times include moving from one subject to the next as well as transitioning from one location in the building to another location, such as the restroom, cafeteria, resource, etc. Often minimal interaction from the DTX staff was necessary. Participant #SAR shared, “We usually just provide them with positive reinforcement, such as ‘Good Job!’ or ‘Remember your goal for today.’ That was often enough to keep them on track.” Administrators and guidance counselors also agreed that a huge benefit of having the additional “eyes” and “hands” in the classes and around the school during transitions times was helpful, as Participant #15, explained, “They assist in making sure kids that (pause), well you know how kids can be! They make sure other kids don’t set them off, and that sort of thing. Warding off those incidents before they occur, was one of the biggest benefits.”
In addition to providing behavior management strategies to the students, classroom management strategies, as Participant #1373 shared, was a perceived benefit to teachers:

I am a master’s level English teacher. In my studies, the least amount of time was spent on behavior management and classroom management. I definitely haven’t had any training in working with students with emotional and behavioral disorders. My only training in working with students with disabilities has been in school district trainings and mini-workshops and maybe a class or two in my school law course. Having someone designated to address student behavior was a definite benefit to me.”

Participant #21 agreed that as an administrator, having someone to assist teachers with behavior management and classroom management strategies was a significant benefit because of the push for inclusion and a focus on test scores, participation rate on assessments, and providing a safe environment conducive to learning. The building administrators and guidance counselors perceived the program improved “behavior through interventions”. Participant #13, a building administrator, stated:

I have worked in several schools in the district that had day treatment providers in them. A benefit in terms of behavior was they could help teachers with classroom management. Many teachers have trouble with classroom management when they have students with mental and behavioral issues. General education teachers were trained more in content, therefore the DTX provider can provide them with suggestions and things like where to
position themselves in the class, how to set up the room, to limit interaction with the student when they are in the crisis phase, and how to avoid power struggles with the students.

Participant #12 felt strongly that the DTX provider at her child’s school has the ability to get her child to see things differently from anybody else at school or home. She also reported how the behavior management piece helps with the students’ “self-esteem,” “coping skills,” “leadership skills,” “self-control,” and “communication skills.” Students learn to “communicate better so they can be better understood.”

The DTX provider #*517 perceived the benefits to students include a “role model” or “mentor” to help them “behave better because the students have someone that holds them accountable.” Similarly, DTX provider Fortitude added, “The students’ attendance in school increases because they have someone that is looking for them and not simply calling their name to check attendance. They know they will be missed and we will call or go by to check on them.” DTX provider Emme followed up with, “We meet them where they are, and help them grow from there.” The relationship the students develop with the DTX provider was different from the teacher, guidance counselor, and parent because “we don’t have authority to punish or suspend.”

Linkage. The most frequently communicated perceived benefit in terms of linkage was the DTX providers’ ability to link or transfer information between home and school and vice versa. The teachers reported they “can’t always find the time” to contact parents, or at least as “frequently as some students may need.” Parents
communicated, “They cannot always get off work, get transportation, meet or talk during a teacher’s planning bell, or work around the teachers’ schedules.” The participants in the various focus groups communicated they perceived the DTX providers’ ability to link the family to community resources the schools with which they were unfamiliar. It was a perceived benefit because the schools aren’t always aware of “mental and behavioral family issues” that may be impacting the student.

Teacher #129r expressed:

Parents and families do not always share personal and familial information with the schools. They do not tell us because they know we are mandated reporters. They also do not know how a student’s home life impacts his school performance, especially those with a disability. However, they often share that information with the DTX providers.

The term linkage was stated often and implied. It was the perception of all stakeholders that a benefit to having the program in the schools was that it provided the missing link needed in the schools for students to access behavioral and mental health resources and wraparound services.

Positive impact on others. Although the DTX providers were only assigned a caseload of no more than six students per Qualified Mental Health Provider, the perception was that they had a substantial positive impact on other students, staff, administrators, parents, and other programs and agencies in the school community. In the teachers’ focus group, they shared stories of how other children had benefitted from certain students being in the program because when their behaviors improved, it created a better, less hostile learning environment. Additionally, because of the DTX
providers' constant presence in the room, other students had established relationships with them. "The students do not differentiate between DTX provider, teacher, teacher assistant, etc. They just see adults."

**Summary of results for Evaluation Question 3.** It was evident from the conversations with the participants that there are many perceived benefits of the DTX program from all stakeholders involved, especially students. Also communicated during the focus groups was the fact that like any other program, the program itself was only as good as the individuals providing the program or intervention. There are also challenges and concerns in certain areas that prohibit the program from operating at maximum potential. Those challenges and concerns will be discussed in Evaluation Question 4.

**Evaluation Question 4**

*What do teachers, building administrators or guidance counselors, and DTX providers perceive to be the challenges or concerns of the program?*

Question number seven on the structured list of questions in all eight focus groups asked, "What do you perceive to be the challenges or concerns of the program?" By the time we got to this question, most of the groups were warmed up, interactive, and engaged in in-depth conversation regarding their perceptions of the challenges. Many felt strongly about the challenges they had faced and shared descriptive examples. On certain occasions, they were more than ready to share their challenges and concerns with the program.

The participants' engaged in passionate conversations in regard to the challenges and concerns they have faced over the years at various schools and also in
various school systems that also had school-based day treatment programs. I did not
have to interject or ask many follow-up questions while on this question, as I did on
several of the previous questions. Yet, I did make sure to make frequent spot checks
to ensure that I captured and understood specific challenges or concerns. My co­
facilitator did the same. The final coding worksheet I developed in Excel reveals that
many of the concerns and challenges with the program are stakeholder specific and
were not necessarily shared or communicated across all groups. Surprisingly, the
data reveals the same issues were expressed by stakeholders in similar positions
regardless of the provider or agency, and across all elementary and middle school
levels. To further clarify my point, principals and guidance counselors, DTX
providers, teachers, and parents expressed similar concerns but not across groups.
The transcripts for this section yielded rich data with more initial codes and pages of
written material than either of the other questions. It required me to make more than
four passes through the coding process to narrow the themes down to five themes.
The five major themes pertaining to the participants' perception of challenges or
concerns revealed from the coding process include:

- Understanding Program Specifics
- Referral Process
- Parent Participation
- Personnel
- Space

A review of the results as they pertain to these themes follows.
Understanding program specifics. In evaluation question number three, the results of the perceived benefits of the program to the students, staff, school as a whole, and the parents were presented by the participants. Also, one of the questions asked of the participants in the focus groups was the question, "What would you say are the goals of the DTX program?" Unfortunately, no one in any of the groups articulated there was an academic and attendance goal established for this program, not even the DTX staff. As the conversations flowed, several staff implied that grades and attendance would improve. Statements made were similar to Parent #1116 who stated, "If he gets his behavior under control, he will do better in school." Again, although the goals of the program were implied, they were not articulated by the program participants. The perception was that this program was a behavioral program and the only goal for this program was to work with the kids to change their behavior.

All three groups of DTX staff expressed their frustration with their perception that neither the school staff nor the parents knew what it was the other was supposed to do. DTX staff #1 explained how much more effective the program would be if everyone understood the purpose of the program and what each person’s role was in the process of treating the students in the program. Additionally, DTX Provider #2 continued:

Although reading is not a quick fix, in a year or less when a student is enrolled in an intensive reading program, growth in reading usually occurs, but the reading problem is not fixed. The DTX program is not designed to fix the emotional and behavioral disorder, but to provide strategies and interventions
that assist the child in learning to manage their emotions, behavior, or mental health disabilities and to function as a productive citizen. There isn’t a cure for mental illness, yet treatment could help to decrease or extinguish the duration, intensity, and frequency of the behavioral episodes. However, it takes time and cooperation at all levels to make substantial change in a students’ behavior, especially when there are significant identified mental health issues.

As explained by the DTX providers, the concern with the seeing the program as a “quick fix” was that it makes it difficult for the students because the expectation was that the child should immediately comply with rules because they are now in treatment. The reason why this was a concern was because neither staff nor parents understood the intervention nor did they realize that when an intervention was introduced, the behavior usually increases before it decreases. Participant #1104 continued, “In reality, the behavior may not increase, yet more attention, data collection, and emphasis on addressing a particular behavior increases. Therefore, it gives the perception that the behavior was occurring more.”

DTX providers further communicated their concern that more kids could benefit from this intervention, but the teachers thought that students with severe behaviors were the only students that qualified for the program. There were other children in the class that were displaying behaviors or characteristics of a child with an emotional disorder, but because “they aren’t acting out” they fell through the cracks. These students often go untreated because the teachers did not know the characteristics, what to do with the student, or where to get help for the student.
School administrators and guidance counselors, teachers and parents echoed the DTX staffs’ perception of the challenges as it pertained to actually knowing what they actually do with the children other than provide the supports and other perceived benefits. Administrators went on to voice that they really do not understand what it was the DTX providers do because they have not actually participated in group sessions or had any specific training or explanation of what they actually do to help the students.

The administrators and counselors had the perception that the program was working; yet they had not seen any data to validate their perception. Their perception was based on their experience that once a student was enrolled in the DTX program, they saw the “frequent fliers’ in the discipline office far less than they used to. Administrators were also concerned with not being kept abreast of students’ progress while in the program. One principal’s concern was that, “After I make the referral to the DTX provider, I don’t know where they are in the process. I usually don’t even know if they met the criteria to be in the program or not unless something happens or I ask.” This concern was related with the concern regarding the referral process.

**Referral process.** The referral process was expressed as a major concern for all groups. I gleaned from the conversations that the referral process was not being followed the same across the school district. As designed, all referrals should go through the building administrator or guidance counselor or designee, however the principal was ultimately responsible for referring to the DTX providers. Focus group discussions revealed that in some schools teachers made referrals for DTX directly to the DTX provider without going through the building administrator for approval. The
administrators voiced this as being a concern because there are teachers who have classroom management issues and it may not be the students' behavior that warrants the program. Additionally, this posed a challenge for school administrators and guidance counselors when the DTX provider contacted parents before someone from the school contacted them. One administrator admitted that teachers in her building had been directed to make the referrals directly to the DTX provider because she was unaware of the official process for making the referral. Participant #16 communicated that the division had not provided training on the process or program to the administrators for more than five years. Since that time, there were new principals, assistant principals, and guidance counselors who simply did not know the referral process or their roles and responsibilities as it pertained to the DTX program.

All focus groups noted the challenge posed by the requirement of the Department of Medical Assistance Services (DMAS) in 2011 for all new cases to have an independent clinical assessment prior to authorization for therapeutic day treatment programs. This process was called the VICAP process. One of the challenges the process caused was the length of time it takes to receive authorization. Another concern was when students were not provided authorization due to lack of data. It was noted that the data requested for authorization was not the type or kept in the form needed for authorization. Teachers manage discipline differently. They do not write referrals for every behavior infraction. The expectation was that teachers exhaust every effort to serve the student in their classroom. Teachers and administrators have varying tolerance levels, therefore when a student is referred, there may or may not be a significant number of referrals to submit as data for
authorization. Therefore, the challenges together, length of time and awaiting authorization to find out the student isn’t eligible, causes significant frustration and delays services and supports for students in crisis at a time when the schools feel they have exhausted all intervention options. As this is a Medicaid funded program, only students that qualify for Medicaid or receive one of the slots paid for by the Local CSB and FAPT may participate in the program. In some instances parents’ private insurance may allow them to enroll in day treatment programs, however even the co-pay for the working class parents can be quite expensive.

An additional challenge the VICAP process caused was the requirement that parents must make an appointment and participate in a face-to-face assessment with the local Community Services Board prior to authorization. Groups shared that parents have various challenges with scheduling and attending the VICAP. Issues noted by parents as possible challenges for parents were transportation issues, stigma about receiving mental health services, concerns the program may impact other Medicaid services, lack of trust in the school, lack of trust in an additional intervention after participating in numerous others, and the fact that parents have mental health issues or limitations as well. Additionally, the DTX providers cannot, according to DMAS, transport parents to the VICAP interview. Therefore the responsibility to participate was on the parent. All agreed that parent participation was important. However, parent participation was a theme that also emerged as a challenge or concern.

**Parent participation.** Parent involvement was noted as a challenge in terms of the referral process as well in addition to being a challenge once students were in
the program. There is a requirement for the parents to participate in the program for it to be effective. Participant #2307 expressed her concern by saying:

"Parents sometimes, block our calls, refuse to open the door, do not respond to written messages, or believe it was not their problem, it was the students. Since it was a requirement for treatment, if they refuse to participate, we are forced to end treatment".

Parents present a challenge to treatment when they devalue the process and services because of lack of understanding of the intervention or due to their frustration from lack of success with previous interventions. As expressed by teachers, parental involvement was an issue for typically developing students and programs. It was their perception that it was multiplied significantly by parents of students with behavioral issues as the students get older because they have tried a number of interventions, but have not found that “fix”. Lastly, in terms of parent participation, Participant #19 shared:

Parents get offended when they receive recommendations to try at-home strategies. Additionally, they may refuse services for their child because they feel that school personnel or other parents will think they are not doing their job as parents by getting help. So their pride gets in the way, while their child continues along the disciplinary continuum, when they could be receiving help.

**Personnel.** Groups identified high staff turnover, the need for more male staff, DTX staff selection, monitoring and evaluation as challenges. Each of these concerns presents a challenge for the students in terms of rapport and relationship
building. As noted in the discussion of benefits, support, rapport, and relationship building was perceived to be what really benefited this population of students. As expressed by the parents and administrator groups, although little can be done when staff leave the agency, when DTX providers are moved in the middle of the year or near the end of the year, it presents a challenge to the students emotionally because that one person they see as an advocate and confidante moves on, leaving them to start all over.

Students served in the group are predominately African-American male students. The lack of sufficient male staff DTX providers was seen as a challenge and concern to the success of the program. Many of these children are believed to have a need for male role models, specifically African American males.

Administrators are concerned by the lack of supervisory authority they have with staff from the DTX agencies. In addition, they would like to be more involved with the selection and evaluation of staff assigned to their building. The perception was that some staff have been assigned to their schools with little consideration given to the culture and climate of the building and the population of students being served. In terms of monitoring and evaluating staff, administrators presented they have not been asked for feedback on DTX providers’ performance.

**Space.** The final theme presented as a challenge and concern was space to provide individual and group therapy. Understandably, many schools in Jade County are crowded. Many of the locations where therapy takes place are shared with other programs. The issue, as presented by the DTX providers, across all programs was the issue with space in terms of confidentiality. Often, topics are sensitive, delicate, but
most importantly confidential. When others are present or enter in what should be confidential sessions, it limits the success of the therapy and trust or possibly breakthroughs with the student.

**Summary of results for Evaluation Question 4.** Focus group participants perceived the challenges or concerns of the school-based therapeutic day treatment program to: understanding program specifics including the referral process, which includes the VICAP process; parent participation; personnel; and space and confidentiality. These challenges are concerning. However, the groups were also provided with the opportunity to provide their perception of how to move the DTX program to maximum potential. The data pertaining to that answer are presented in Evaluation Question 5.

**Evaluation Question 5**

*What are the aspirations of parents, teachers, building level program administrators or guidance counselors, and DTX providers if the program were to operate to its highest potential?*

Parents, teachers, administrators and guidance counselors, and DTX providers offered a plethora of answers to this question from “one DTX staff person assigned to each grade level,” “all parents participate,” “all students referred for the services would be found eligible, “a separate program for boys and girls” to “Jade County Public Schools no longer needing this program because the program “fixed” all of the student’s with behavioral problems issues.” After several passes through my coding worksheet, I was able to narrow the themes down to Academic Progress, Behavioral Progress, and Clear Understanding of Program and Procedures.
Academic progress. A theme pertaining to academic progress and grades emerged from the focus groups when asked about their aspirations for the program. Overall, the groups shared the aspiration for students to increase their academic performance and have an opportunity to feel good about school and learning. Participant #20, a building administrator summed it up when he asserted:

If this program were to operate at its highest potential the students in the program would learn to love school, their attendance would increase, their behavior would decrease, and they would finally see some academic success. They would feel good about themselves. Their self-esteem, social skills, and communication skills would improve. They would not be treated as the bad kid all the time, but would have the opportunity to be seen as positive leaders in the building. We are in the business of serving kids and seeing them graduate. If this program were to operate at its highest potential, that is what I would aspire for it to do.

Behavioral progress. The second set of aspirations was for discipline referrals to decrease to “almost non-existent”. A decrease in referrals would result in decreased in-school and out-of-school suspensions, expulsions, and as one of the parents communicated, “a decrease in crime in the community by students who are suspended or expelled from school.” “There would be less students out of class.” “Teachers would have a better chance to teach.” Participant #17 voiced how time consuming it was to deal with discipline issues when she shared:

A whole day can be lost when completing an investigation, meeting with witnesses, writing up the report, and contacting the parent. If more than one
student is involved, the time is multiplied. So, if the program was to operate at its highest potential, administrators would be able to spend more time being the instructional leader in the building, training teachers, monitoring the success of students, and creating a positive school environment.

The success of the students receiving special education services would also be obtained. The development and implementation of more effective behavior intervention plans and IEP goals would be written. Operating at highest potential would mean that DTX providers would train teachers in effective behavioral intervention strategies and assist with tracking data and monitoring progress. Eventually, operating at highest potential would mean no longer needing a program like DTX to address in-school behaviors.

**Clear understanding of program and procedures.** This theme speaks to the need for all participants wanting clear procedures in regard to the referral process, the eligibility process, the VICAP process, roles and responsibilities of all stakeholders to include students, teachers, school administrators, and day treatment providers, understanding of the intervention and data collection, as well as everyone being made aware of the students' progress. If the program were to operate at its highest potential, everyone involved in the process would be operating at his or her highest potential.

**Summary of Results for Evaluation Questions 1-5**

This chapter has presented my exploration, along with responses from 33 participants consisting of parents, teachers, administrators and mental health professionals, into a behavioral based intervention that has been in place for more
than 10 years without a formal program evaluation. As I have shown, a formal program evaluation of the school-based day treatment program was well overdue. The richness of the data from the quantitative data analysis and the qualitative focus group data provides a diversity of perspectives in the context of their lives in regard to the perceived benefits, challenges, and aspirations of key stakeholders. These perspectives in conjunction with the statistical information will guide the conclusions to be presented in Chapter 5.
Chapter 5

Implications

Although schools across the country use detention, suspension and expulsion, and other punitive strategies to discipline students with emotional and behavioral disorders, student discipline continues to be one of the major issues facing public schools today (Bushaw & Gallup, 2008; Bushaw & McNee, 2009; Rose and Gallup, 2007). In addition to the use of these exclusionary practices frequently enforced by schools to address the most common problematic behaviors (e.g., opposition, defiance, and aggression), students are often referred for possible special education placement (Christie, Nelson, & Jolivette, 2004). Discipline data clearly show that detention, suspension, expulsion, and other exclusionary practices, do not help to reduce student discipline problems (Christle, Nelson, & Jolivette; Civil Rights Project, 2000; McCord, Widom, Bamba, & Crowell, 2000; McFadden & Marsh, 1992). Students with emotional and behavioral disorders, who already have issues with trust in school, may display inappropriate behaviors as a strategy to avoid addressing these or other issues and to get out of coming to school (Bryk & Schneider, 2002). As such, removal from the classroom setting or the school environment may exacerbate the problem, since those students likely to be suspended
or expelled are those most in need of adult supervision and professional help (Epstein, Atkins, Cullinan, Kutash, & Weaver, 2008).

Jade County Public Schools has provided school-based therapeutic day treatment in its public schools for more than 10 years. This program was adopted by the school system to provide an intervention in the school and classroom to address the challenging behaviors of students with emotional and behavioral disorders.

Currently, three human services agencies provide school-based therapeutic day treatment services to students in Jade County Public Schools with the goals of increasing academic achievement, increasing school attendance, reducing undesirable behaviors and increasing desirable behaviors. However, until now, there has not been a formal evaluation of the program to determine if improvements were needed to meet the established goals to meet the challenges of students with emotional and behavioral disorders, as intended.

This formative program evaluation of Jade County Public Schools' School-Based Therapeutic Day Treatment program (DTX) was intended to provide school administrators, staff, parents, students and the agencies providing the school-based program with evidence-based information on the merit, worth, and value of the school-based mental health intervention and to identify areas of improvement needed to increase academic and behavioral outcomes for students with emotional and behavioral disorders (EBD) at Jade County Public Schools.

The methods utilized to conduct this evaluation sought to determine to what extent participation in the school-based day treatment program decreased behavior referrals, number of days of suspension, and number of suspensions and increased
attendance and grade point averages for students with emotional and behavioral disorders. Also, participants’ perceptions and lived experiences pertaining to the benefits, challenges or concerns, and aspirations for the program if it were to operate at its highest potential were explored. The results from analyzing quantitative and qualitative data collected to answer the five questions are addressed in this chapter.

**Discussion of Findings**

Analyses of the extant student data revealed a significant decrease in the total number of suspensions students received the year after participating in the DTX program. However, the data analyses did not reveal a significant difference in the overall number of behavioral referrals or number of days students were suspended. Yet, the data analysis showed the actual number of days remained the same over time. There are a number of possible reasons the number of days of suspension remained the same although the number of suspensions significantly decreased.

Focus group data from the parents’ and DTX providers’ perceptions suggested that once the students are placed in the program or complete the program, the immediate expectation from teachers and administrators was for the students in the program to behave more appropriately. DTX providers noted, "Two students can be in the class and display exactly the same behavior, yet the student in the program may be sent out immediately while the other student may receive a warning." An additional reason, per the focus group discussions was that given the extra support by the DTX program to the students and the class the actual number of referrals that a student would receive was suppressed because the DTX provider was available to address the behavioral infraction by removing the student to process the behavior,
communicate with the parent or administrator, and provide an immediate in-school or classroom consequence. The question these data raise then, are students in the program receiving harsher punishments for behaviors? Additionally, teachers and parents communicated their belief that students needed to stay in the program longer than a year with a plan for follow-up for up to a year after completion of the program.

Quantitative data analysis also revealed there was not a significant difference in school attendance as a result of participation in the program. Yet, there was a significant decrease in students’ grade point average, specifically a year after completion of the program. This further supports the concern presented by parents in the focus group that students need to be in the program for longer than a year.

The results of the quantitative data analysis are also reflective of the focus groups’ perceptions that the program reduces the number of suspensions students receive. However, the results are in contrast to the participants’ perceptions that the program decreases referrals, days of suspension, and as a result of improved behavior, attendance and grades improve. As noted by one of the school administrators, academic success is the result of behavior management, but it is not necessarily the focus of the program.

The overall perception of the benefits of the program included, “support,” “behavior management,” “linkage to mental health supports, community resources, and school to home,” as well as “positive impact on others” that also includes students not enrolled in the program. The perceived benefits of the program were qualities of the program that participants in the focus groups thought were favorable and wanted to continue in the schools. As noted, several parents in the focus groups
shared specifics on how beneficial the program was to their children in terms of behavior, attendance and grades. Administrators, counselors, and teachers expressed their perceptions of the importance of the support the program provides to the classroom and the school community as a whole. One principal even initiated one of the focus group discussions with the statement, “Do not take them out of my building. I have an awesome DTX provider in my building.” Staff also shared their observations of certain students’ behaviors decreasing and their grades increasing as a result of their participation in the DTX program.

The participants also recognized the efforts of the DTX providers with assisting with classroom management, hallway transitions, taking on extra-roles, as well as assisting with students not even on their caseload. There was also the benefit of their ability to link the home to school and vice versa as well as linking the families to wraparound services.

The challenges and concerns presented during the focus groups included a lack of understanding the program specifics, the referral process, parental participation, personnel and space. Although the challenges were not the same at each building, collectively these concerns obviously impacted the overall program. It was communicated in several groups that the programs were only as good as the people operating them.

Students and staff move. Personnel changes occur. There was also a perception that more students may be eligible for the program but were denied the program because of insufficient data to support the referral. Participants could not accurately verbalize the goals of the program nor did they understand the purpose,
procedures, roles and responsibilities. Administrators and guidance counselors responsible for referrals have not received a detailed training on the intervention, yet they have been tasked with managing and approving referrals to the program.

The referral process creates a challenge due to delays in determining eligibility as well as requirement that all students receive a VICAP assessment and all parents have to participate prior to authorization of services. The delay or denial of authorization may be attributed to insufficient data from the school. Teachers expressed that they are familiar with the type of data needed for students to be found eligible. It was their perception that there will frequently be insufficient data because teachers attempt to handle in class behaviors as much as possible.

In addition to communicating benefits and challenges or concerns, the participants shared aspirations for the program to operate at its highest potential. The aspirations were expressed as things needed to improve the program. The areas of improvement include providing all stakeholders with clear understanding of the expectations of all involved. The participants are aware that many involved in the program and process are not really clear what they are supposed to do or what the other person is doing. They also expressed that something needs to be done to make the referral process more transparent. All stakeholders need a review of criteria and documentation needed for students to qualify for the program to avoid delays. The process also needs to be more appealing to parents. Certain parents also need assistance with accessing the services. Finally, there was a strong belief that the program needs more men. While more than half of the students in the program are African American Males, there are a very few men working with these young men.
There was a plea in one of the groups to implement an initiative to attract more men to the program.

**Reflection**

Ten years ago the local Community Services Board was piloting this program in an elementary school in the district. School-Based Day Treatment was something new to the school district and across the state. Prior to bringing the programs into the schools, treatment was provided in either clinical settings or in after school programs. The literature review in Chapter Two discussed the evolution of the programs from clinics to school settings. Chapter Two also describes findings from various studies where the program was being provided in clinical settings and evaluated behavior in isolation from the school settings or peers. There were isolated studies in after school programs and clinical settings. Until now there has not been a formative program evaluation of a School-Based Day Treatment program that looked at the extent participation in the program reduces inappropriate behavior and increases academics and attendance.

My professional background is in behavior management and behavior modification. I have been in the field of special education for 21 years. I worked with students with emotional disabilities in various capacities i.e., self-contained classrooms, group homes, and residential facilities. When I was made aware of the program and the opportunity for students with emotional and behavioral disorders to be provided with an opportunity to be successful, I wanted all of the students to have an opportunity to receive the treatment. Therefore I convinced my supervisor at the time to allow me to explore providing the program in all our schools. She agreed.
Since the local community services board did not have the capacity to serve all of the schools and students needing the service in our division, the division entered into an agreement with the local Community Services Board and two private agencies to provide the intervention. Over the years there has been the perception of the benefits to the students, schools, parents, etc. as was revealed in the focus groups. However, there was never a formal evaluation of the program by the school district or either of the agencies.

Five years ago I started this process of evaluating the program. I have collected information and participated in various conversations with all involved. As a district administrator I have been privy to hearing both positive and not-so positive aspects of the program over the years, but had not been able to confirm or deny what was fact or not. Now, to actually see the program evaluation come to fruition in the past two months makes me appreciate the ideas, thoughts, suggestions, and themes that evolved from this process. This process of reviewing extant data and talking to key stakeholders from a research standpoint with evaluation questions linked directly to the goal and design of the program has satisfied the intended purpose of identifying areas of improvement to increase student outcomes. I am sharing all of this at this point in this study, because I think it is extremely important to do so prior to sharing my interpretations and recommendations.

Admittedly, I wanted all of the data to reveal that participation in this program significantly reduces inappropriate behaviors and increases academics and school attendance. I wanted to say, “Finally, there is something schools can do for students in general and special education programs with discipline problems to address
challenging behaviors other than suspend, expel, or refer for special education services.” However, I remained open to the outcome because I am fully aware of the difficulties involved with completing research on this population of students. As I shared in Chapter Two, the inconsistency of evidence-based research on students with emotional and behavioral disabilities and special education is considered to be the “hardest of the hardest to do” because of the variability of the participants (Odom et al., 2005, p. 139), the greater ethnic and linguistic diversity that, unfortunately, occurs in special education because of overrepresentation of some minority groups (Donovan & Cross, 2002), and the complexity of the educational context (Guralnick, 1999).

Being fully aware of my personal bias, I decided to complete a program evaluation utilizing quantitative and qualitative data triangulation to involve as many people in it as possible to provide their lived experiences in their own voices, and not mine. Again, the groups were co-facilitated, recorded, transcribed, and coded according to themes.

**Interpretations**

The quantitative analyses in the first two evaluation questions did not yield significant results; however from the participants lived experiences, they saw the benefits of the program for some students, some teachers, some parents, and other staff and students. The overall perception was that the program works for students with emotional and behavioral disorders. Parents and teachers in the focus groups and in other settings have commended the program for “turning my child around”.

The quantitative analyses revealed there were no significant differences in number of referrals, number of days suspended, and attendance for students that
participated in the DTX program in 2011-12 based on data from the years prior, during and after participation. Student's grade point averages dropped significantly the year after they completed the program. However, there was significant decrease in number of suspensions for this population.

Although there are a number of variables to be considered when doing research on this population, including the small sample size of 84 students, the quantitative data analyses were consistent with what was reported in the focus groups. Thirty-three people shared their perspectives on the goals, benefits, challenges, and aspiration for the program. They conveyed that the intervention was perceived to be a behavioral intervention with minimal focus on academics.

In order for the program to meet the intended goals, the focus needs to be on the goals and the students' individualized services plans should reflect that purpose. Prior to that, there should be an awareness of the goals by the staff. None of the 33 participants articulated what the goals were when asked in the focus groups. Again, as shared earlier, only one person implied that increased academic achievement would be a by-product of the program. However, based on the data analysis, it was not.

There was a substantial amount of data in regard to the support the DTX staff provide to the students, staff, parents, and school. Yet, there was not any in terms of supporting the DTX program. Conversely, it was communicated throughout all of the groups that there was not a real understanding of the goals, purpose, processes, or the interventions being provided. There was the challenge of the parents not participating, as they should. There was the concern that the teachers become offended when the DTX providers offered support. The DTX workers voiced that
securing a confidential space to work with the students was a challenge and a concern.

In order for this program to meet the goals it is intended to meet, a clearer understanding of the program goals, procedures, roles and responsibilities is necessary. Once that has occurred, there needs to be a concerted effort by all to work together and not in isolation. The DTX provider alone cannot reach all of the goals of the program. Their focus was on behavior modification, behavior management, counseling, treatment, and therapy. Additionally, they have a caseload of no more than six. They are required to provide those students with up to 2 hours a day of services. Building administrators, teachers, and others need to be aware of this fact. They are contracted to serve those six students and not be held accountable for meeting the needs of all others. They are not contracted Jade County Public School staff. They provide a service funded by Medicaid. They must be allowed to focus on the students they are assigned.

Since I have reviewed the raw data, the data from descriptive statistics, and the data from focus groups, I know for a fact there are students who have improved behaviorally and academically by participating in the day treatment program. One of the parents of one of those students participated in the focus group. The school-based day treatment program can work for some children if operated with fidelity. According to Parent # 302, fidelity of implementation means,

Parents must do their job. Teachers must do their job. Day-treatment staff must do their job. The student must do the best he can do. I have seen a turnaround. He was a traumatized child. He was eating pampers, feces,
stealing, hoarding food, and really bad off. The strategies included a lot of overcorrection and redirection. Last year he was suspended 15 times. He hasn’t been suspended this year. He was not able to count to six. This year he is on honor roll. He was tearing up the class and throwing chairs. He was getting suspended for being disruptive. Between the therapy, the day-treatment program, medication, following the IEP, and being stern and consistent, he is making significant progress. Consistency is key. I am hopeful they keep him in the program.

I also know for a fact in order to provide an evidence-based, statistically significant program for this challenging population, everyone involved needs to understand the goals, purpose, roles and responsibilities, and do their part. Everyone, in this instance includes Jade County Public School district leaders, administrators and counselors, teachers, DTX providers, parents, and students.

**Recommendations for School-Based Day Treatment Programs**

School-Based Day Treatment is a promising program to address the challenging behaviors of students with emotional and behavioral disorders. Jade County Public Schools has invested more than 10 years in the program. Although Medicaid funds the program, there has been an investment in time, resources, space, technology, and access to the students.

Although this evaluation yielded less than favorable results in terms of reducing behavioral referrals and days of suspension, and increasing grade point average and attendance, there was a significant decrease in number of suspensions. Since one of the goals of this evaluation was to identify an intervention that decreases
the number of out of school suspensions for this challenging population, this program helps to bridge the research to practice and adds to the knowledge base.

Additionally, focus group data revealed significant benefits to students other than what was evaluated in this study. The following recommendations will be beneficial to any school district considering implementing or making improvements to their School-Based Day Treatment Program.

1. Organize district level and regional teams consisting of district and school level administrators, teachers and day treatment program providers committed to focusing on connecting academic goals to behavioral goals. This team will plan, implement, and monitor systemic school-based day treatment improvement plans at all levels. The purpose of the regional teams will be to develop and maintain a clear understanding of program specifics and roles and responsibilities of all stakeholders. Regional teams will meet quarterly to review progress toward goals as established. The district-level team will meet every semester to review progress toward goals.

2. The school-based day treatment improvement plan will include ongoing professional development activities in the areas of behavior management and mental health interventions for teachers and staff that will include trainings provided by DTX program staff and administrators. The trainings may be provided face-to-face or online.

3. The school based day treatment improvement plan will include ongoing professional development activities with an academic focus to be provided
by the school and district level staff with required participation by DTX providers. The trainings may be provided face-to-face or online.

4. Require DTX providers to provide a frequent and consistent report on the progress of students in the school receiving services, eligible for services, and those denied services.

5. Require DTX providers to conduct progress-monitoring meeting with the teachers of the students enrolled in the DTX program to organize, plan, and discuss students enrolled in program.

6. Require DTX providers to allow the principal to participate in the selection of staff assigned to their building. Additionally, require DTX providers to allow input from principals in DTX staff evaluation. This can be in the form of an agreed upon observation or evaluation form.

7. Conduct a formative program evaluation every three years of the individual programs. Provide feedback to all stakeholders.

Final Thoughts

This formative program evaluation was the first of its kind in the Mid-Eastern States. It was long overdue in Jade County Public Schools since the school-based day treatment program has been in place for more than 10 years without any evaluation of the extent that participation has on behavior and academics. The need for an evidence-based program for students with emotional and behavioral disorders is well needed. While it was evident from the evaluation that improvement was needed in communicating the goals, program specifics, referral process, and implementation, it was important to note that focus group data revealed an appreciation for the support
as communicated by staff, teachers and parents. Additionally, it was notable from focus groups the perceived benefit the DTX program has had on students identified by focus group participants. It was also recognized that the quantitative data revealed a decrease in suspensions. Therefore making it plausible that with a focus on program improvement and turning the challenges into benefits, as intended, the next evaluation of the program will yield evidence of decreased referrals and number of days suspended, and an increase in grade point averages and attendance for students with emotional and behavioral disorders.

This formative evaluation process has been a learning experience for this evaluator, the co-facilitator, and the participants. I am looking forward to implementing strategies to improve the programs’ focus. Additionally, I am looking forward to completing similar evaluations on programs currently in place that have not been evaluated.
Appendix A

Logic Model of Program Structure and Design
PROGRAM STRUCTURE AND DESIGN OF SCHOOL-BASED DAY TREATMENT PROGRAM

Planning – Implementation – Evaluation

Program Action - Logic Model

**Inputs**

**Outputs**

Activities - Participation

**Outcomes - Impact**

- **Short Term**
- **Medium Term**
- **Long Term**

**Situation**

DTX is a behaviorally based intervention for children and adolescents at risk of requiring an out of school placement.

**Priorities**

- Increase desirable behaviors, school attendance, and academic achievement and reduce undesirable behaviors.

**What we invest**

- Staff (Case Managers, Clinicians, Site Supervisors);
- Training to staff (initial and ongoing training);
- Time, Individual and Group Therapy to students.

**What we do**

- Assessment; Behavior modification;
- Case management;
- Individual counseling;
- Group counseling;
- Crisis intervention;
- Collection of outcome Data; Family Counseling.

**Who we reach**

Children and Adolescents (ages 5-18) who are at risk of an out of school placement or more restrictive services; Must meet criteria for an Axis I diagnosis.

**What the short term results are**

- Learning
- Identifying children and adolescents at risk of an out of school placement through the assessment process; initiate DTX services

**What the medium term results are**

- Action
- Participants make progress towards ISP goals; Marked reduction in undesirable behaviors and increase in desirable behaviors.

**What the ultimate impact(s) is**

- Conditions
- Participants no longer require DTX services to maintain appropriate behavior and academic achievement within their school, home, and community.

**Assumptions**

**External Factors**

**Evaluation**

Focus - Collect Data - Analyze and Interpret - Report
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