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# Building a “Culture of Trust”: The Cultural and Practical Challenges of School-Based Behavioral Health Care in Overseas Military Base Schools

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Zeke and his parents were in the Senior Counselor’s office of a high school on a military base overseas. Zeke’s father was preparing to deploy to a combat zone within 3 weeks. Zeke was facing a risk of not graduating. When the counselor informed Zeke and his parents of the likelihood of not graduating based on current performance, Zeke, a stoic 18 year old who liked to read fantasy novels, play video games and his guitar, began to cry. He said he didn’t want to disappoint his parents but was unsure if he could make up the work he had missed. He was particularly upset that his dad would be worried and distracted about Zeke when he needed to be more focused on his dangerous upcoming mission. He had also been struggling the past year to adjust to being in Germany after having lived his entire life in the United States. His family moved overseas for his father’s final assignment, but this required Zeke to move away from his friends and the high school he had attended for the three previous years just outside an army base in the Southeastern United States. With this information and the family in tears in her office, the Senior Counselor contacted the School-Based Behavioral Health provider on-site. An intake evaluation was conducted and treatment plan initiated the same day. Seven weeks later, after a

course of cognitive-behavioral therapy to address a long-standing anxiety disorder and solution-focused therapy to improve his academic production, Zeke completed his coursework successfully and graduated on time. His father, down-range in the Middle East, was able to watch his son graduate via satellite broadcast. Zeke had accomplished his goal and his father was able to continue his mission without distraction.

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## Introduction

This case vignette illustrates the benefit of having mental health professionals serving military adolescents in Department of Defense secondary schools overseas. The U.S. Army Medical Command (Army MEDCOM) has begun emphasizing the value of community embedded clinical service, following the lead of established practice in the civilian sector. In fact, school-based behavioral health (SBBH) is a central pillar of the U.S. Army Surgeon General’s Comprehensive Behavioral Health System of Care-Campaign Plan (CBHSOC-CP). The CBHSOC-CP is an organized and unified plan to address the growing behavioral health needs in today’s U.S. Army. This is based on the challenges facing the military due to 10 years of significant involvement in the War on Terror. This plan involves organizing effective and efficient behavioral health support for soldiers and their families based on the Army Family Covenant. This value-driven commitment to army families

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focuses on providing comprehensive health care support throughout the life span due to the risks and sacrifices that soldiers and their families make when serving. These support structures include a broad range of services for soldiers and families. The most prominent service line for the purposes of this chapter is SBBH. The CBHSOC-CP identifies SBBH as the preferred way to provide routine behavioral health services for children and adolescents. The foundational goal of the Army Family Covenant is to build of “culture of trust” between army families and the army itself. Providing SBBH services is an effort to improve upon the culture of trust by being more accessible and more effective than clinic-based care.

This chapter is a review of issues that one SBBH program has faced in entering into secondary schools in military bases overseas. First, a brief review of the impact of military life on dependents is presented followed by a brief review of the SBBH model in the U.S. Army. Specific issues that the SBBH program in Bavaria, Germany have encountered will be presented to review the cultural challenges of SBBH service delivery to military dependents overseas. Additionally, program structures that support cultural sensitivity will be presented.

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## Impact of Military Life on Adolescents and Families

That SBBH care has become the preferred method for service delivery for children and adolescents is a direct result of many studies that have identified the negative impact of a high tempo of cycles of deployment on military members and their families (Chandra, Burns, Tanielian, Jaycox, & Scott, 2008; Tanielian et al., 2008). Studies have found that adolescents in military families suffer higher rates of emotional and behavioral difficulties when compared to their civilian counterparts, particularly higher rates of anxiety and behavioral problems (Chandra et al., 2008). Gorman, Eide, and Hisle-Gorman (2010) found higher rates of outpatient mental health visits among children and adolescents of military families. Millean (2011) even found that military

dependent youth in one community (Hawaii) experienced greater rates of psychiatric hospitalizations. It is speculated that the military culture within which these children live is not necessarily the cause of problems. Hypotheses regarding the reasons for increases in anxiety and behavioral problems include impact of deployment separations on family and individual functioning and multiple transitions due to frequent moves (Chandra et al., 2008; Military Child Education Coalition, 2007; Tanielian et al., 2008).

Serving in the military necessarily means that one may be deployed or otherwise absent from one’s family for lengthy periods of time. In recent history, U.S. Army soldiers could expect to be deployed for half of their career with multiple deployments to war zones. These deployments remove parents from their children’s day-to-day life for 12 months at a time. For a period of time, these absences could have been as long at 15 or more months during the Iraq war surge of 2007–2008. In addition to the specific length of deployments, service members are often away from their family while training for deployment or attending intensive training schools. Regular and ongoing training, the daily life of a soldier when not deployed, often requires the soldiers to be away from home for physical training early in the morning (often well before dawn) and completion of training or other tasks well into the evening. This can keep a soldier from being present with their children for much of the workweek. Ideal child development that minimizes emotional or behavioral difficulties is based on consistency of care and on consistency of attachment figures present in a child’s life (Cummings & Davies, 1994; Gottman, 1997). Without that “secure base” (Bowlby, 1988), there is significant risk for the development of greater emotional and behavioral difficulties (Weinfield, Ogawa, & Sroufe, 1997; Weinfield, Sroufe, & Egeland, 2000).

The fact that one’s parent may be absent is one level of stress. However, the absences of parents for lengthy periods of time due to military deployment can add additional stress. Many children are acutely aware of the risk of potential loss of their parent when deployed (Military Child Education Coalition, 2007). This awareness can increase the

intensity of personally felt distress based on their parent's absence. In the civilian world, when one's father or mother is away for a long period of time for work their life is generally not at risk. For military adolescents, it is a real risk. Given that the core concept of anxiety is vulnerability, growing formal operational/abstract thinking allows the teen to consider the loss of their parent with greater realism, and with it an increase in anxiety (Beck & Emery, 1985; Yalom, 1980). This can impact the youth's understanding of relative meaning of her actions within the context of her life, for example, "if my dad could die, what does homework matter?"

For these reasons, it is likely that military youth will require significant behavioral health support. The increase in anxiety and behavioral problems alone suggest an increased need for this type of support. Therefore, the U.S. Army has been working to address the need identified in recent experience and studies.

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### **SBBH in the U.S. Army**

In the U.S. Army MEDCOM a specific model of SBBH care has been developed. Originally conceived at Tripler Army Medical Center, Michael Faran, M.D., Albert Saito, M.D. and their team developed a SBBH program model that emphasizes the ongoing collaboration between school personnel, behavioral health personnel, and families when providing behavioral health services in school districts that have large military dependent populations (Faran et al., 2002). This model is based on public health assumptions. These assumptions include the following: delivering services where the population is located rather than having them come to a specialty clinic; focusing on prevention in addition to intervention, and being engaged fully in supporting the whole educational system vs. a more limited "co-located" model of service delivery (Faran, 2010a). This model also supports increased access to care, increased focus on resiliency and wellness rather than deficiency, and helping to create systems and environments that support better functioning overall for military children and families.

In order to accomplish these goals, the Army MEDCOM Child and Family Behavioral Health Office (CAF-BHO) has emphasized a set of structural program elements for SBBH that support collaborative program development, continuous improvement, and maintenance. These structural program elements are triage teams (TRIAGE), building-level advisory (BLA) teams, and community-level advisory (CLA) teams. Of course, the central activities of SBBH programs include a wide range of clinical services such as evaluation and evidence-based treatment of behavioral, emotional, and mental disorders.

In order to effectively support the clinical needs of students in concert with school needs, the Army SBBH model encourages a regular inter-disciplinary and multiagency TRIAGE team meeting that engages in case coordination and staffing. It is at this meeting that much of the clinical collaboration among staff occurs.

Additionally, SBBH program providers engage their partner schools in prevention activities and faculty support. In order to accomplish these activities effectively, the Army SBBH model encourages the development of what are called BLA teams in each school. The purpose of a building advisory group is to have a team that can coordinate general services, identify emerging needs among students and faculty, and address concerns that are related to how the various agencies are working together. Given that coordination among various agencies can be difficult, it is the U.S. Army MEDCOM's conclusion that putting BLA teams in place in each school allows for the regular management of issues that could otherwise develop into problems in the delivery of services. Staff and administrators meet regularly and proactively to address mental health and agency coordination concerns rather than reactively meeting only when there are problems.

One last structure that is a part of the Army MEDCOM SBBH model is a CLA team. This team is comprised of leadership from the community within which SBBH programs are located in order to provide advice and consultative/collaborative oversight regarding how the SBBH program is being implemented in the schools in that locality. This allows for accountability to the

leadership in each community so that the SBBH program is tailoring their provision of services in a coordinated manner that fits the needs of that particular community.

While SBBH is the preferred model moving forward in the U.S. Army MEDCOM vision for behavioral health services, only a handful of bases currently have SBBH programs in place. Two of those programs are located outside of the U.S. in Germany, serving military dependents of soldiers stationed in support of European allies. The Bavaria-SBBH program will be described below.

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### **Bavaria-SBBH Program**

The Bavaria School-Based Behavioral Health Program has been in operation for 3 school years. The U.S. Army MEDCOM granted funding for this program in the Spring of 2009 to provide behavioral health services in five schools serving military dependents living at the two military communities that support the largest ground force training area outside of the U.S. as well as two regularly deploying brigade-size (approximately 4,000 soldiers) units. These schools include three elementary schools (K-5), one middle school (6-8), and one high school (9-12). The proposed and funded program was based directly on the U.S. Army MEDCOM model that included an emphasis on treatment and prevention services with the goal of including the recommended structures of coordination (TRIAGE, BLA, and CLA). The team is comprised of four clinical staff members (three licensed clinical social workers with specific child training and one child clinical psychologist who also serves as assistant director) serving a student population of approximately 2,600.

Within 2 months of inception, the average case load within the program had risen to above 20 for each provider. By the end of the first school year, average case loads were over 40 with only the assistant director of the program having a case load lower than 30. A quote from the movie *Field of Dreams* is an apt description, "Build it and they will come." The viability of the program was demonstrated early based on provider productivity.

Clinical services were provided and providers were integrated into a number of different school committees, including student success teams, crisis management teams, and even being included in the school improvement process in one school. Use of outcome measures demonstrated that effective care was being delivered based on significant improvement of pre- and posttreatment measurement of ratings of overall distress.

It was also found that the need was greater than projected. The program served approximately 12 % of the student population, but many referrals continued to be made to local clinic-based behavioral health providers and many students referred to B-SBBH were seen less frequently than might have been clinically indicated due to time pressure on the staff's schedule. During deployment cycles, deployment-related cases (cases in which the presenting problem is directly due to deployment or, if already existing, exacerbated by deployment) averaged 50 % in the schools and were as high as 82 % in one. The projected rate of military children requiring some form of mental health services approaches 25 % (Faran, 2010b). Therefore, our staffing along with the local school personnel has not been able to fully meet the referral demands in the military community from which the units deploy frequently.

In seeking consultation regarding the development of the program and addressing issues that arose in the secondary schools, many issues were identified that had not been addressed in specific training for U.S. Army SBBH program development. The following sets of issues confronted are included: the role of the SBBH provider and practical issues of providing clinically sound and ethical services for teens within the social context of a single school and small community; addressing adolescent cultural issues as behavioral health providers in a school and on a military base overseas; and being culturally sensitive in delivering services on a military base overseas. As a caveat, many aspects of the issues discussed are anecdotal. However, empirical literature on the development of SBBH for military families is still very limited (Faran, 2010a), so anecdotal observations such as those provided here should help build effective practices and research on them.

## **Issues in Serving Adolescents of Military Families in the Bavaria-SBBH Program**

### **Challenges of Multiple Roles for the Overseas Military SBBH Provider**

The nature of living and working on a military base overseas is that it functions like a small community, and the American community is socially isolated even in populated areas. Additionally, the role of an SBBH provider in secondary schools on an overseas military base is complicated due to the multiple professional relationships that they must maintain. Providers are clinical therapists to many individual children and their families; consultants to teachers, faculty, and staff; and provide educational or prevention presentations in the classrooms, making them appear to youth as part of the faculty. They are perceived differently with different roles by many people in a single setting, and in some cases friendships develop in the small communities often found in military bases overseas. Managing these multiple layers of relationships and associated role strain is critical to the success of a school-based provider in order to reduce the likelihood of dual-relationship difficulties (Bennett et al., 2006).

Given that SBBH providers work fully as a team, many functions that would never fall to a clinic-based behavioral health provider may fall to a school-based behavioral health provider. For example, clinic-based providers are rarely consulted when a student is facing some form of disciplinary action at school. School-based providers are often consulted in these cases and this can create a confusion regarding the definition of who is the client (child/family or the school administrator). With teens, in particular, a provider can risk their credibility (e.g., with the family) by being aligned with the school administration. Alternatively, each provider will necessarily work with multiple clients who know each other. Therefore, each provider may have information about a student from other students that they see or be told a story from a parent regarding another

parent or student. In these types of situations, managing roles is a necessary skill for each provider to develop so that they can clearly communicate and collaborate with others in the system and maintain therapeutic credibility with teens in the school. Therefore, the provider is placed in a "political" role in the community of the school with various constituencies. The provider must work to maintain their positive relationship with the various constituencies in order to be positioned to have the greatest positive influence.

Clearly, there are positive aspects of being a behavioral health provider in the school as well. The students, faculty, and staff all develop relationships with the provider outside of a therapy referral. Many of the referrals that one gets in a school are due to being known in the school where the children and teens become familiar with the provider's presence and see them as someone to turn to for assistance.

The issue of multiple role management may, however, limit the types of interventions one may choose because a part of any attempted intervention is to limit any unintentional harm (Bennett et al., 2006). When delivering behavioral health services to adolescents, in addition to individual and family modalities, group-based interventions are often recommended. However, confidentiality concerns regarding adolescents within the same school often arise when group interventions are attempted. For instance, when SBBH providers in the middle and high school began developing groups within their schools, in every possible case of group composition they found likely conflicts among the group members that would keep the group from being initially successful. Since the group member client pool was approximately 500–600 (the population each of the middle and high schools) and all were in the same environment, most youth are acquainted with each other and have ongoing relationships. In this environment, the providers could identify enough students for a variety of sustainable groups reflecting critical themes (emotion management, anxiety, social skills, etc.). It was often found that in trying to identify a group of teens to work with each other, they often came from socially conflicting groups (e.g., reflecting different



“classes” of soldiers), making the engagement in therapy tenuous due to initial mistrust of other members. An alternative approach could be to work with teen groups that already exist (naturally formed peer groups). The problem is that for many in existing peer groups, treatment may not be appropriate, even if one or a few of a group would be candidates. Therefore, the SBBH program has tended to err on the side of more individual approaches in order to protect confidentiality and treatment integrity but this decision comes with the downside of potentially limiting the number of students who can be reached.

### **Adolescent Culture and the SBBH Provider**

Please note that most of the Army SBBH programs at the present time operate mostly with students and families in elementary schools (Faran, 2010a), giving the Bavaria program a unique opportunity to explore service delivery with adolescents and their families in the middle and high school in the program. Here we describe some of the unique issues encountered in working with adolescents from military families.

Adolescence is often described as a “subculture” in which there are separate rules, power relationships, and values as well as different ways of communicating (Murphy, 1997; Selekman, 1993). Adults in a school often do not have awareness of much of what is communicated among teens. SBBH providers, however, often have access to that information. When information, such as trends regarding risky behavior, various cliques and bullying, etc. becomes available through the clinical contact, there are more options available to a SBBH provider than a clinic-based provider. With that information, consultation can occur with the rest of the school team toward the development and implementation of interventions that might address the risky behaviors in question. Additionally, staff may be educated in the ways that adolescents are communicating with each in order to raise their “adolescent IQ” and become more aware themselves of the trends that are occurring. For instance, one

day at the high school, a number of students had used face paint to apply “NO H8” to their left cheek. An SBBH provider and an Adolescent Substance Abuse Counselor (ASACS; another outside agency) both found out in separate clinical sessions that this was a way of supporting lesbian/gay/bisexual/transsexual (LGBT) peers. With this information, the SBBH and ASACS counselor addressed the working BLA group to discuss whether there was a problem with LGBT bullying/acceptance. This has led to a needs assessment to determine what response may be required. Our role as SBBH providers allows us to be a “humint” or human intelligence asset for the adult system (school/community) in order to more effectively address concerns that arise from within the subculture of adolescence.

Another issue within the adolescent subculture is that of confidentiality and protection of information about them as well as their peers (Jacob & Feinberg, 2002). The SBBH provider may work with youth who have relationships with other youth on their case load. A provider may become aware of information from one teen regarding another teen’s behavior. This has implications for the therapeutic relationship with each teen in question, but also for the limits of confidentiality. For instance, when a girl describes what happened at a party over the weekend and in the story information regarding another client’s behavior is disclosed the provider now must consider how to manage that information. For most disclosures, there are few problems with considering the information hearsay and not introducing that information into a session. The provider then only has to ensure that the information she heard does not obviously inform her approach so that the other client is identified, which would constitute a breach of confidentiality (Bennett et al., 2006).

Greater consideration of the information is required when the information includes risky behavior and safety issues. One must address safety issues when there is information regarding reasonable risk of harm to self or others. If the information that the teen discloses includes, for example, that a friend was cutting herself over the weekend, then additional steps must be considered.

However, the teen who disclosed the information must be cared for during the process of disclosure and the insuring of safety of all involved. Therefore, a good informed consent process includes informing each client about the program's responsibilities for ensuring safety when information about someone else, as well as themselves, is made known. The risks and benefits of disclosure and how each provider might handle the disclosure are reviewed generally at the beginning of therapy and more specifically when students make a disclosure regarding a peer (Jacob & Feinberg, 2002). Having teens understand in advance what may happen goes a long way to keeping therapeutic relationships intact when forced to disclose or support the disclosure of concerns for safety regarding others. In the above circumstance, it is often desirable to encourage the teen to meet with the school counselor (often accompanied by the SBBH provider) to disclose their safety concerns directly. The SBBH provider, then, as part of the larger mental health team in the school, has activated the other resources available within the school system to follow up with safety assessments based on the facilitated disclosure by the peer. This approach also allows for the ongoing confidentiality of the student's relationship to the SBBH provider outside of the school's counselors and administrators.

### **The SBBH Provider and Military/ German Cultural Considerations**

One of the significant issues when providing behavioral health services for youth on a military base overseas is the placement of that base in a different culture. The U.S. Army and other military bases that are located overseas often support more than just the military members. Many military members have the option of having their whole family stationed with them when based overseas. Therefore, the family can follow their military parent and continue to live together during lengthier assignments (typically 2–3 years). Many of these overseas bases have existed for decades. Two more prominent cultural issues arise from this situation. The first is that civilians

who live overseas are subject to the civilian laws of the host nation based on a Status of Forces Agreement (SOFA), essentially a treaty that governs how the U.S. Army and its members and dependents are to operate within a foreign country. The second is that there are many bi-cultural families who are members of the military, making the cross-cultural implications of understanding and working overseas directly related to clinical work.

The SOFA rules govern how military civilians are treated in the host nation. In Germany, SOFA regulations stipulate that civilians working for the U.S. Military are governed by German laws. The implications for this in working with teenagers in secondary schools are that one must consider the differences in typical American laws regarding such things as age of consent and the legal age for alcohol and tobacco consumption. For example, in Germany, the drinking age for beer is 16 years old, while for wine and hard alcohol it is 18 years old. Understanding that many of the secondary school students can legally have access to alcohol may impact the possible clinical responses to its use among whom Americans might consider minors. While it is clear that the program would never support children under the age of 21 drinking, how the therapist addresses this issue to maintain clinical credibility with the teen is likely to be impacted. In the U.S., it is easy to say that alcohol use is illegal for one's age, therefore if it is used, then illegal actions are being taken and that must be considered as one of the potential consequences of youth substance use. But in Germany, that argument is less clear and often clinicians and parents have more difficulty convincing their American children of the dangers of use when the host nation supports its use by its laws.

Insuring that teens understand their legal responsibilities is also a critical aspect of clinical care within this cross-cultural setting. Another consideration regarding age of consent is how one applies that to decisions regarding provision of services (Bennett et al., 2006). When providing behavioral health services as an American organization serving American dependents subject to the laws of a foreign country, competing

regulations may apply. When providing services to military children on bases in the U.S., the age of consent for entering into a professional relationship without parental consent is governed by the state in which the military base is located. This varies from state to state. Overseas, however, federal regulations governing provision of services may be inconsistent with the foreign laws and SOFA status.

The SBBH program had to consider how to address consent for services particularly for children 15 years and older. The program could have provided services to them if they sought out services without their parents' knowledge as federal regulation allows for medical care, substance abuse care, and care for reproductive decisions. However, there were additional considerations. One was regarding maintenance of confidentiality of the youth's access to services due to billing procedures. The SBBH services are paid for through the military members' health care coverage which does not typically incur a cost that the parent experiences. Not all students who could access care are military dependents. In the cases of military civilian employees or contractors, the parents' private insurance is billed when services are provided. Therefore, it was possible for parents to become aware of their child's involvement in SBBH services through receiving a bill in the mail or through access to their medical records. This is not the most desirable means for informing parents of their children's involvement in behavioral health services (even though students may have the legal right to access this care independent of their parents' authorization).

The ethical consideration of being able to protect a client's confidentiality as well as appropriately address informed consent with the potential risks of involvement with behavioral health led us to consider requiring parental permission for all students served by the program regardless of age (including students in high school aged 16–18). This was made easier knowing that a number of other services in the school allow students to access them without parental permission, including school counselors and school psychologists and the ASACS counselor, all of which are funded differently than a fee-for-service model.

While SOFA status and federal regulations could have allowed for some youth to be able to have access to SBBH care without parental knowledge or permission, it is the value of our program that parents in the military overseas should be intimately involved in the mental health care of the children, particularly if we are addressing not just the individual student's functioning, but how that impacts the family and vice versa. The program concluded in this instance that requiring parental permission for all students regardless of age would be appropriate.

Surrounding military bases overseas, the local population is integrated into the structure of service as many are employed on the base. Due to this close relationship, many military members meet and marry people from the local population. Often military members return to an overseas tour in a country from which their spouse originates. This leads to having bi-cultural families. While any generalizations regarding German and American cultural differences are suspect, understanding that differences exist must be taken into account when addressing family functioning issues that are often present when supporting teens with behavioral health services. Being sensitive to the possibility of cultural differences or historical contexts that differ is important. One must have an ear for different perceptions based on cultural heritage/experience (Sue & Sue, 2007).

One example of having to consider cultural issues came up when one SBBH provider spoke with a German mother (whose daughter was struggling with issues of depression and self-harm). The mother discussed her parents' history, relating that her father and mother were significantly impacted by the aftermath of World War II. Apparently they had been born just before the war, and their earliest memories were of deprivation, maltreatment by their own government and by occupying forces, and self-hatred they saw in their parents and others due to the history of participation in Hitler's regime. This led to a life of silence and interpersonal remoteness that then translated into significant criticism of their daughter. This story of trans-generational emotional abuse opened the door for increased compassion and insight into the experience of



the client and her mother along with a cultural exploration of the impact of historical experiences on current functioning. Significant criticism that the mother made of the daughter was framed as a continuation of the cultural "self-hatred" stemming from the aftermath of World War II. The case led to a resolution involving "re-writing" the history of the family (that had a split between the American optimism of the father and the German pessimism of the mother) into a set of realistic values and judgments. The daughter appreciated hearing the historical context (to which she had not been privy due to a cultural and family value of silence regarding emotional issues) and this helped to allow herself to give up her self-injury. She was able to see the self-injury as a continuation of self-hatred within a historical/cultural context. This layer of meaning-centered work, coupled with specific behavioral interventions, led to an elimination of self-injury and the development of greater self-compassion. This was particularly possible as the mother began to reduce her criticisms and increased her compassionate statements to others in the family as well as increasing her self-compassion.

### **Outcomes Management, Feedback Informed Treatment, and Cultural Sensitivity in SBBH**

No matter what type of clinical work is done, the focus of psychotherapy and behavioral health services in recent years has been its value; does it actually do anything to improve the functioning of those it serves? SBBH is no different. Funders are interested in supporting programs that provide value in terms of impact on functioning of those served. Of course, the key consideration in determining value is what type of outcome is desired. Levison-Johnson, Dewey, and Wandersman (2009) described a process of determining outcomes in collaboration with stakeholders in any social service endeavor that they coined "Getting To Outcomes (GTO)." While the Bavaria-SBBH program has not specifically used this 10-point process to determine the outcomes sought, the GTO framework

has informed our thinking regarding improving outcomes management when looking to the future.

Targeting and achieving improvement in clinical outcomes are necessary for any behavioral health program. Levison-Johnson et al. (2009) suggest considering the impact of the service provision by an agency not only on the individuals served by the program, but the impact of the services on the functioning of the partner agencies that support the service being provided. In the case of the Bavaria-SBBH program, it is important to consider how behavioral health services impact the larger mission of the schools served. Questions to consider beyond clinical improvement in identified behavioral health problems include the following: How is the service impacting students' academic functioning, behavior, and attendance? Are there impacts on overall school atmosphere? Are there impacts on families, soldiers, and soldier readiness? These questions are more difficult to answer as the lines of causality are more difficult to determine. It is the goal of the program to continue to engage in a collaborative effort to identify the larger community impact of our program in these schools.

The initial focus of the Bavaria-SBBH program on outcomes, however, has been in determining the clinical impact of our therapeutic efforts. This should be an established practice for any behavioral health service as there is quite a large literature on tracking clinical outcomes (Hubble, Duncan, Miller, & Wampold, 2010). The central task is to identify which measures to use for determining clinical effect. While it may be desirable to use diagnosis-specific measures to determine impact of clinical work for individual clients, these types of scales are more difficult to use to aggregate program effectiveness. Therefore, scales that track changes in overall distress of the youth or parent regarding the presenting concerns that can be used regardless of the identified diagnosis are desirable. Additionally, client ratings of change are more reliable than clinician ratings of change in determining impact, therefore client ratings are desirable (Hubble et al., 2010).

Beyond reliability and validity, feasibility for a rating scale is an important consideration.

Brown, Dreis, and Nace (1999) concluded after surveying practicing therapists that any measure taking longer than 5 minutes to administer, score, and interpret is not likely to be regularly used. This results in incomplete program outcome data if many clients are not included in the evaluation. Unfortunately, most measures of outcome are designed for research rather than clinical purposes and result in a much longer time for administration, scoring, and interpreting and then not used in a collaborative manner with the client (Brown et al., 1999).

Statistically, all measures used to track therapeutic change load primarily on the factor of client's subjective distress (Duncan, Miller, & Sparks, 2004) and this subjective distress is a primary factor in leading clients to seek services. In our experience, one set of outcome measures focuses primarily on subjective distress and appears to be the most feasible in respect to the amount of time involved in administration, scoring, and interpretation; the Outcome Rating Scale (ORS) and Child Outcome Rating Scale (CORS) (Miller & Duncan, 2004). Internal consistency of this ultra-brief measure (takes about a minute to complete, and an additional minute to score and interpret) is high at 0.93 and concurrent validity of the ORS has been demonstrated by high correlations with the Outcome Questionnaire (Campbell & Hemsley, 2009; Miller, Duncan, Brown, Sorrell, & Chalk, 2006). The Outcome Questionnaire is a 45-item scale that provides overall ratings of distress as well as identifying levels of distress in different areas of a person's life (Lambert, 2010). The ORS (for ages 12 and up) and CORS (for ages 6–11) are 4 item scales that provide distress ratings of individual, relationship, academic/school functioning along with a rating of overall distress (Miller & Duncan, 2004). Therefore, the ORS/CORS provides much of the same information that the Outcome Questionnaire provides but in a much briefer format. This allows for clinicians to feasibly track outcome of every session. In doing so, the clinician can track change from intake to any future point and determine whether individual distress has been positively affected. A more complete picture of clinical effectiveness can be seen with

this approach than with one that focuses on just pre- and postmeasure data points due to a data from a larger proportion of clients enrolled in the program (Hubble et al., 2010).

An additional advantage to assessing outcomes every session is that it creates an opportunity to utilize an awareness of measurable progress (or lack thereof) to inform a collaboration with the client in choices about the direction of treatment in service to the goal of positive and meaningful change (Lambert, 2010). A growing literature supporting the use of outcome measures to track change every session and include that information in the therapeutic conversation has developed in the past decade (Hubble et al., 2010; Lambert, 2010). The American Psychological Association's task force on Evidence Based Practice (2006) concluded that evidenced-based practice is not reflected just in the application of specific therapies for specific diagnoses as is often the interpretation, but the application of treatment efforts made in collaboration with the client based on information regarding the individual preferences of the client as well as relative progress toward treatment goals. This approach has been come to be known as Feedback Informed Treatment, or FIT. Lambert's (2010) research over the past decade has suggested that a significant positive impact on clinical outcomes is obtained not only when therapists have access to real-time information regarding clients' ratings of distress relative to their intake scores, but also when this information is shared in real time with the clients so that the therapeutic endeavor is informed by whether progress is being made. Direct discussions regarding progress can then happen, creating a collaborative relationship with a focus on the outcome.

One of the primary factors that contribute to overall outcome in therapy is the therapeutic alliance (Hubble et al., 2010; Asay & Lambert, 1999; Norcross, 2010; Wampold, 2001). Therefore, if one is to assess what to change if progress is not being made in therapy the therapeutic alliance is one factor that cannot be overlooked. The therapeutic alliance can be measured, and client ratings of therapeutic alliance are found to be more directly related to outcome than therapist ratings

(Norcross, 2010). One set of measures that are a companion to the ORS are the Session Rating Scale (SRS) and Child Session Rating Scale (CSRS) (Miller & Duncan, 2004). The SRS/CSRS are similar in that they are ultra-brief; can be administered, scored, and interpreted in under a few minutes; and has the advantage of allowing for a direct conversation regarding the feedback from a client about the therapeutic alliance in real time. This conversation allows for the therapist to solicit feedback from the client about three central factors contributing to overall alliance: the *relationship* or the degree to which the client felt heard, understood, and respected; the *goals and topics* of the session or the degree to which the therapist focused on issues of pertinence to the client; and the *approach or method* or the degree to which the therapist's approach is a good fit for the client. An additional factor is also assessed; an *overall* rating of the degree to which the session was "right" or there was "something missing" for the client. These factors allow for a collaborative discussion with the client regarding their experience of each session. If positive progress is being made, then this information, while valuable, may have little bearing on the ultimate outcome, but if the client is reporting little progress or is worsening, then it is extremely important to address alliance problems. Changing what one does based on negative feedback regarding the perception of the therapeutic approach with an individual client can have a significant impact on the ultimate outcome of therapy (Anker, Duncan, & Sparks, 2009; Lambert, 2010).

Changing or clarifying how one relates to the client, the approach or method used, the goals identified, or some other aspect of therapy delivery that the client identifies are specific options arising from the unique context of the therapy with that individual or family for response with the goal of improving outcomes. Many only focus on the approach or method ("Does Cognitive Behavioral, or Solution-Focused, or Multi-Systemic Therapy work best for this diagnosis/client?") and do not directly consider the other aspects of service delivery. Certainly, there is quite a bit of evidence to suggest that many approaches, techniques, or aspects of models are

more likely to work for various types of problems/diagnoses for youth (Chorpita, Daleiden, & Weisz, 2005; Kazdin, 2004). This probabilistic approach is important to include in decision-making regarding treatment options. The literature regarding evidenced-supported therapies suggests, however, that no approach or method, no matter how much evidence regarding relative efficacy in particular circumstances exists, will work with every single client (Kelley, Bickman, & Norwood, 2010). Making a decision to apply evidenced-supported therapies tied to specific populations and diagnoses based on probabilistic inferences will still result in some treatment failures. Some authors even suggest that there is relative equivalency of the effectiveness of many approaches of therapy for many disorders in youth (Kelley et al., 2010; Miller, Wampold, & Varhely, 2008). FIT essentially ties choices for treatment model, method, and approach to feedback from the client regarding outcome and alliance. The questions FIT-informed therapists ask in every case are the following: "Is the treatment working for this client, in this circumstance, within the context of this specific therapeutic relationship?" And "If not, what should I change; the what (model/technique/modality) of treatment, the how (alliance) of treatment, the how often (frequency) of treatment, or the 'who' (therapist) of treatment?"

The Bavaria-SBBH has chosen to utilize the ORS/CORS and SRS/CSRS for the above reasons. The use of these scales to engage in FIT also has an impact on cultural responsiveness. The impact is seen when addressing those within the culture of teens. FIT is necessarily a transparent process. This transparency is often novel when experienced by teens. Teens and children, in general, typically experience adults as exerting control from their legitimate position as holding greater power. This often leaves the teen in a position of passive acceptance of the direction of therapy, letting the adult lead the process. The teen, then, is not fully engaged in the therapy. When a Feedback Informed therapist solicits feedback from the teen not only about progress toward goals, but also about their criticisms regarding the delivery of the service, then the

therapist is reducing the power differential in a direct way and inviting the youth to more actively participate in their own therapy. This collaboration enhances the ownership of the therapy by the teen. It engages the teen in a cooperative effort that allows for the teen to not only be more involved in the treatment, but to encourage them to “lead the way” to change by allowing them greater decision-making power in the process (Duncan, 2011; Murphy, 2008). In this way, the teen’s strengths and capabilities are identified and capitalized upon through the exploration of what the teen likes, doesn’t like, and finds effective or not in the therapeutic experience. These discussions can lead to identifying the processes of change that will fit for the teen. The therapist also models for the teen an appreciation of “mistakes” in service of improvement.

Seeking feedback from not just the teen, but from parents as well, can increase the cultural sensitivity of the therapist. If a therapist follows up with the administration of the SRS and CSRS with questions for the clients about how their approach fits with their cultural backgrounds, then the client can inform the therapist directly about how they wish to work and what approaches do or do not fit for them. Ultimately, the research has suggested that the use of client ratings of outcome and alliance enhance outcomes (Lambert, 2010). When therapists and clients work collaboratively and transparently, cultural differences can be addressed directly rather than guessed at and the outcomes are likely to be better (Lambert, 2010).

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## Review and Conclusions

Zeke reported at the end of treatment that he appreciated that the SBBH provider ‘respected me enough’ to ask his thoughts regarding how change would happen. He stated that he had been in therapy before, in middle school, to address the very same issue of academic production, but that the therapist ‘had all the ideas’ and ‘none of them worked for me.’ He also said that leaving school to go to an office in the clinic ‘made me feel like something was really messed up with me,’ but that stopping in an office just down the hall from his Language Arts class for a talk every couple of weeks made therapy ‘like a drive-up window’ during his school day. He also liked that he could

‘see’ his progress in the scores on the ORS, showing that he felt differently about himself than he had on the first day. He said he felt most proud of the fact that he knew his father, while in Afghanistan, was watching him walk across the stage and receive his diploma.

The U.S. Army leadership is committed to making sure stories like Zeke’s occur more often when it could have ended up in failure with greater complications for those who serve. It is a part of the Army Family Covenant to provide services that support the best functioning of the soldier and their families throughout their life span. With this case and many others the U.S. Army’s SBBH Program initiative has been helping to build the *culture of trust* with the families and soldiers who make so many sacrifices in their service. This *culture of trust* is the central cultural consideration in serving the military and their members. It is the intent of Bavaria-SBBH to continue to develop a culture of trust and collaboration with the military community in service of their youth, and by extension, their soldiers. For a culture of trust to develop among the soldiers and families and the behavioral health institutions, these institutions must be positioned to maximize their benefit, must be responsive to their needs, and must be open to adopting a mindset that the stakeholders have significant input in the delivery of these services (Tanielian et al., 2008). In providing for care in the schools, SBBH is positioned to maximize the benefit of behavioral health services. In adopting structures for success such as CLA and BLA groups, and adopting a FIT approach, SBBH is developing a stance that is responsive to needs and holds a mind-set that stakeholders should have significant input in the delivery of services. In fact, these structures form the basis of SBBH programs engaging in culturally sensitive practice. Advisory groups and FIT approaches advocate for and support collaborative discussion of all issues pertinent to the successful implementation of SBBH programs and individual treatment. In this manner, the programs and providers can be sensitive to the stated needs of the community, as well as individual clients.

This review has the goal of identifying some of the practice issues that face SBBH providers



and programs in secondary schools on military bases overseas. These issues are not presented from a perspective of having settled them completely, rather that the thought processes regarding addressing them are highlighted so that others may learn as we have learned from other's real-world struggles in implementing best practice. Building a *culture of trust* is based on establishing collaborative relationships that value the sharing and learning from successes and mistakes that all are bound to make when important issues are addressed (Wenger et al., 2002).

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