

# ELEMENTARY CORRESPONDENT

## EVALUATION REPORT ON THE FIRST-YEAR IMPLEMENTATION OF THE MOBILE OUTREACH SERVICES TEAM MODEL (MOST) IN AUBURN ELEMENTARY SCHOOLS

*A GRANT TO AUBURN ENLARGED CITY SCHOOL DISTRICT  
U.S. Department of Education  
Elementary and Secondary School Counseling Program*

Volume 1, Number 2 (January 2007)

### FIDELITY TO CHILD-CENTERED PLAY THERAPY MODEL TAKES HOLD IN ELEMENTARY MOST CLINICIANS' PRACTICE

#### *INTRODUCTION*

In October 2005, the Auburn Enlarged City School District (AECSD) received a 3-year grant to implement a school-based mental health intervention from the U.S. Department of Education, Elementary and Secondary School Counseling Program. The funded project, known as **Elementary MOST** (Mobile Outreach Services Team) is being implemented by AECSD's elementary schools in collaboration with the Partnership for Results.

In the first edition of the *Elementary Correspondent* (December 2006), the local evaluator, Youth Policy Institute (YPI), reported that the initiative was achieving impressive results during its first year of operation. Appropriately qualified staff were employed and thoroughly trained in a timely fashion in the model's procedures, assessment instruments, and

database. Project administrators have put in place the salient elements of the MOST model. During the first year of operations, the project is serving a client population with complex service needs that are likely to benefit from the intervention. Program outcomes, moreover, are very positive, and there is little doubt that Elementary MOST is, to a substantial degree, promoting the positive social, emotional, and educational development of participating students.

The previous edition of the *Elementary Correspondent* also indicated that the implementation of the project was maintaining high levels of fidelity to the program model in four significant areas: screening, assessment, service planning, and monitoring. This edition of the *Elementary Correspondent* continues to explore the

important issue of fidelity to established practices by evaluating the extent to which Elementary MOST clinicians are adhering to the salient elements of Child-Centered Play Therapy (CCPT), an evidence-based therapeutic intervention used with the project's younger clients. A subsequent evaluation report will examine adherence to Cognitive Behavioral Therapy (CBT), the therapeutic intervention frequently used with older elementary school students.

During the early months of the initiative, the four Elementary MOST clinicians received extensive training in CCPT principles and techniques. When implemented with adherence to its research-based model, CCPT is a complex therapeutic approach with numerous component strategies. To master this therapeutic model requires experience using the intervention, ongoing clinical supervision, and, as needed, follow-up training. In its early stages of implementation, the evidence suggests that the preparatory training and supervision provided by project staff is proving to be effective -- the Elementary MOST clinicians are achieving and maintaining a high degree of fidelity to the CCPT model.

### ***1. MEASURING FIDELITY TO CCPT***

The focus of this edition of the *Elementary Correspondent* is to determine the extent to which CCPT is being implemented by project clinicians with fidelity to the essential, or non-negotiable, elements of the

intervention. In order to measure levels of fidelity to the intervention, YPI developed the *Child-Centered Play Therapy (CCPT) Implementation Checklist*. It is a retrospective survey instrument that gauges the extent to which participating clinicians have implemented 18 essential elements (or "quality indicators") of CCPT as evidenced by the use of specific intervention strategies. The primary data collection strategies used to report the findings in this edition of the *Elementary Correspondent* were project clinician responses to the *Checklist* (n = 4), which was administered in November 2006, nine months after intensive preparatory training in CCPT was completed by the project clinicians.

The *Checklist* was developed by J. A. Mullen, Ph.D., who has extensive experience with CCPT as an academic and practitioner, and by P.B. Uninsky, JD, who has considerable expertise in instrument development and testing, particularly in the field of fidelity measurement. An instrument resource bibliography can be found at the end of this report.

The development and administration of the *Checklist* serves several purposes. First, fidelity of implementation is a critical independent variable when evaluating treatment outcomes. Variation in levels of adherence to a treatment model may result in disparate degrees of efficacy. Furthermore, in multi-site initiatives such as Elementary MOST, outcomes may differ significantly by building. If there is variability in outcome by site, implementation of the *Checklist* will

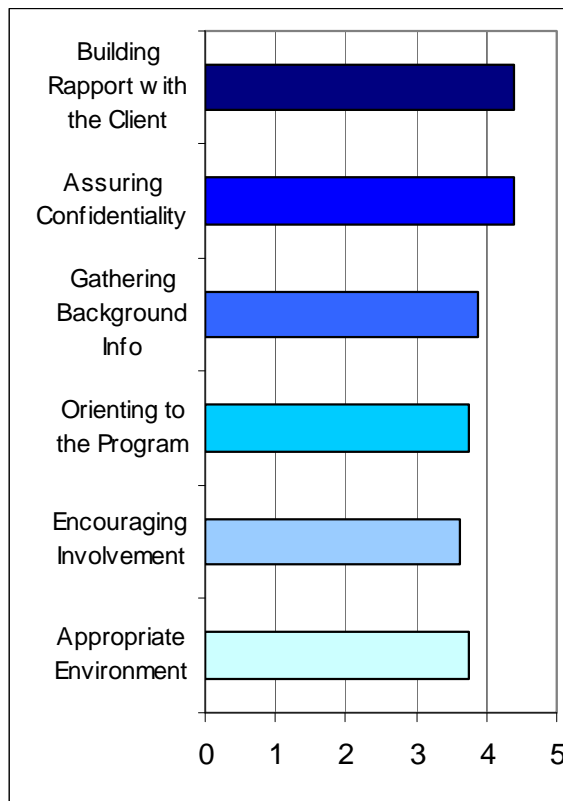
permit staff and evaluators to determine whether it is the result of building-specific variables (such as support for the program) or a lack of adherence to the model. Second, the *Checklist* serves practical purposes that may permit, if needed, ongoing improvements in service delivery. At this early stage of the project's implementation, the *Checklist* can provide project managers with timely, detailed information about problems in adherence to CCPT, which can be addressed by such measures as targeted clinical supervision and training. Finally, the fidelity measure also serves an important heuristic purpose, providing practitioners a redacted guide to the essential elements and strategies of CCPT.

### ***PROGRAM AREA I: INTRODUCING THE CCPT APPROACH***

The *Checklist's* first grouping of indicators encompasses six essential elements (or "indicators"), ~~and their component strategies,~~ that are associated with an effective introduction of the intervention by the therapist, along with each indicator's component strategies. These indicators are: (1) building rapport with the client; (2) assuring parents/caregivers (and clients, if they can understand the attendant issues) that information will be kept confidential; (3) thoroughly collecting background information to understand the child's perspective; (4) orienting the child to CCPT; (5) encouraging the child's involvement, play and verbalizations; and (6) developing and using an appropriate

play therapy environment. As is evident in **Figure 1**, *when introducing the CCPT approach, Elementary MOST clinicians are adhering very closely to the program model.*

**Figure 1:**  
Introducing the CCPT Project:  
Implementation of Key Indicators



For the first two indicators, building rapport and assuring confidentiality, the Elementary MOST clinicians reported average ratings of 4.2, indicating “complete implementation” in these areas.<sup>1</sup> Regarding the other four indicators, the average ratings, 3.8 to 3.9, indicating a level of implementation that was “moderate” but bordering on complete.<sup>2</sup> For each of these four

<sup>1</sup> A rating of “4” means that the clinician is “implementing most of the appropriate and relevant strategies” for the particular indicator, with an approach that is “systematic and organized with no major gaps”.

<sup>2</sup> A rating of “3” means that the clinician is implementing most of the appropriate and relevant strategies for the indicator, but that some gaps in implementation exist and improvements could be made.

indicators, “4” was the most common ratings.

Overall, these ratings indicate a high level of adherence to this key facet of CCPT practices and procedure. From interviews with the Elementary MOST clinicians, it is evident that this is due in large part to the 16 hours of intensive preparatory training in CCPT techniques provided by Dr. J.A. Mullen, and to the training in the MOST model by [the](#) program coordinator. In addition, fidelity to this area of the CCPT model is, to a certain extent, due to the highly structured activities developed by the Partnership for Results that are intrinsic to the MOST model. For example, the interagency database used in the project, CHARI, has well articulated time frames, reminders about essential activities, and data integrity checks that prompt practitioners to gather background information in a systematic manner. This level of adherence is also a result of routine supervision, accessible technical assistance from Partnership staff, and ongoing training from Dr. Mullen and other experienced CCPT clinicians.

There are a total of 25 component strategies in this program area (introducing CCPT). The four clinicians reported implementing 97% of them. At this stage of the project implementation, none of the clinicians indicated that they were implementing any strategy at the highest level, that is, without significant weaknesses or gaps.

In their notes, clinicians indicate several areas of improvement that could be

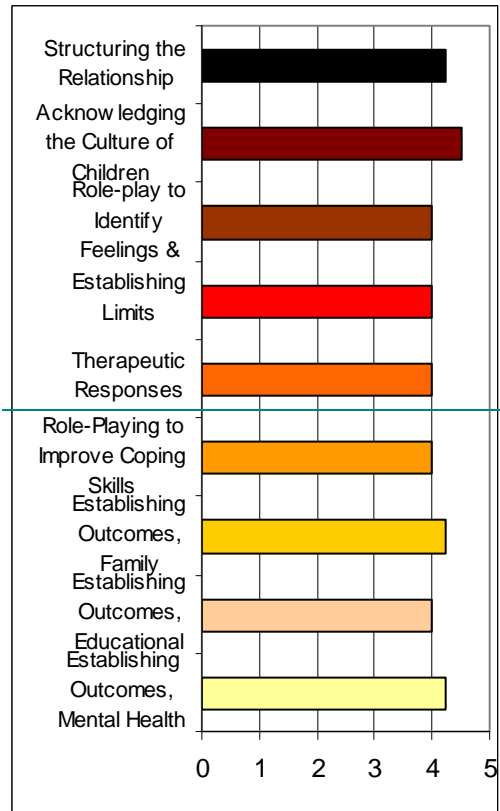
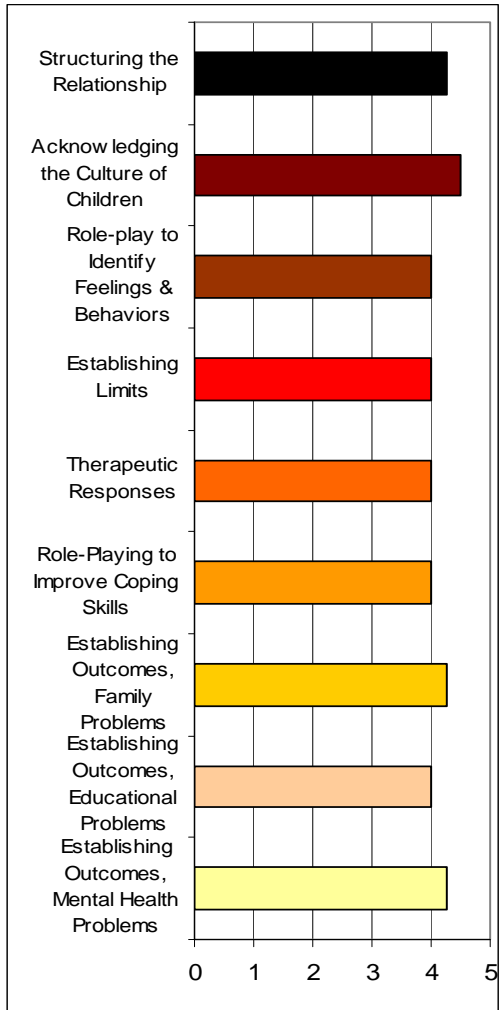
readily addressed by project supervisors. Several clinicians are indicating that they occasionally find it difficult to set aside time to enter data into CHARI promptly. One clinician indicates a need to improve skills in the indicator related to encouraging involvement. Perhaps the most common problem is that Elementary MOST clinicians do not consistently have access to the same space for their CCPT sessions, making it difficult, at times, to avail themselves of an appropriate play therapy environment.

## ***PROGRAM AREA II: TREATMENT***

The *Checklist's* second grouping of indicators encompasses nine indicators regarding –CCPT treatment, along with each indicator's and their–component strategies that are associated with CCPT–treatment. The treatment indicators are: (1) introducing the parameters and nature of play therapy to structure the relationship; (2) acknowledging the child's developmental and socio-cultural perspective; (3) engaging in role play to help the client identify feelings and behaviors; (4) the setting of limits (as needed) to provide additional structure and maintain safety; (5) providing ongoing therapeutic responses; (6) using role-playing and play to improve coping and problem solving skills; establishing outcome indicators to improve, where needed, the child's communication, relational and coping skills when (7) family problems and/or (8) educational problems are diagnosed; and (9) establishing outcome indicators to improve, where

needed, social and emotional competencies when mental health problems are diagnosed. As is evident in **Figure 2**, *the approach of the Elementary MOST clinicians to the treatment indicators exhibits a high level of fidelity to the therapeutic model; it is uniformly systematic and organized with no major gaps in the use of critical strategies.*

**Figure 2:**  
Treatment:  
Implementation of Key Indicators



For each of the nine treatment indicators, the Elementary MOST clinicians reported average ratings of 4.0 to 4.2, indicating “complete implementation” in these areas (see footnote 1, page 3). This high level of adherence was consistent. Only one clinician rated ~~two or more of more than one of~~ one of the nine indicators with a “3”, and no clinician indicated a level of implementation below 3.

There are a total of 40 component strategies in this program area (CCPT treatment). The four clinicians reported implementing 98% of them, with only one clinician who did not believe that s/he had implemented all 40 strategies. Notwithstanding this exceptionally high level of adherence to the model, none of the strategies were

implemented at the highest level (without significant weaknesses or gaps).

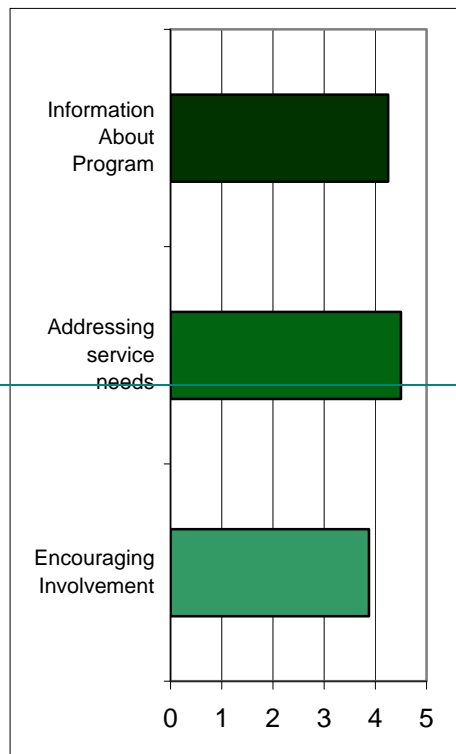
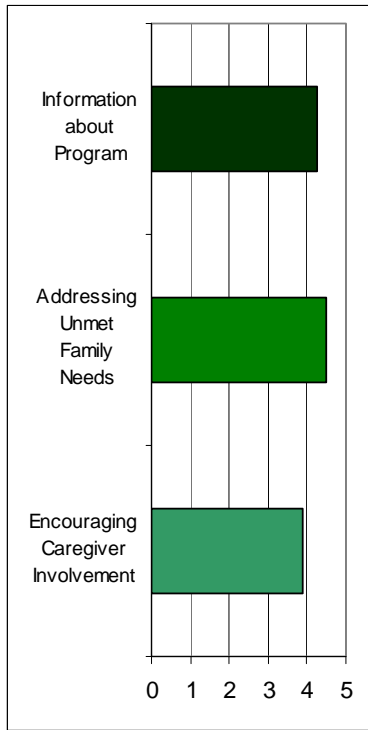
Interviews with project clinicians and program supervisors indicate that this consistent and high level of adherence to the CCPT model is the result of intensive preparatory training, ongoing clinical supervision by clinicians experienced in this therapeutic approach, and by the highly articulated components of the MOST model, such as the Partnership's inter-agency database and assessment instrument.

In their *Checklist* notes, project clinicians noted a few areas that could be improved. Half of the respondents felt that their grasp of role-playing techniques, while improving, could be enhanced. Two clinicians indicated that they needed to work on improving their ability to provide ongoing therapeutic responses that helped the children gain insight into their behaviors and work toward solutions to problems. The dominant theme of the *Checklists*, however, was indisputably one of confidence in their developing techniques. This confidence translates into a strong sense of efficacy. All respondent clinicians reported that implementation of the MOST model in general, and the CCPT model in particular, was resulting in substantial improvements in the social, emotional, and problem-solving skills of their clients.

### ***PROGRAM AREA III: WORKING WITH FAMILY MEMBERS***

The *Checklist's* third grouping of indicators includes three indicators related to working with family members and their component strategies. These indicators include: (1) providing parents and caregivers a thorough review of the treatment program, including ample opportunity for them to air questions and discuss concerns; (2) addressing unmet service needs of the families by collaboratively developing integrated service plans; and (3) encouraging the ongoing involvement of parents and caregivers in the intervention. As is indicated in **Figure 3**, the *Elementary MOST clinicians, when working with family members, are adhering very closely to the program model.*

**Figure 32:**  
Working with Family  
Members Treatment:  
 Implementation of Key Indicators



For each of the three treatment indicators, the Elementary MOST clinicians reported average ratings of 3.9 to 4.2, indicating close to or “complete implementation” in these areas. As in the second program area, the high level of adherence was consistent; only 2 of 12 ratings was neither a “4” or “5”.

There are a total of 9 component strategies in this program area (working with families). The level of adherence to the therapeutic model, while high, was lower than in the other two treatment areas. The four clinicians reported implementing 67% of the strategies. ~~Notwithstanding this exceptionally high level of adherence to the model, none~~ As in the other treatment areas, none of the strategies were implemented at the highest level (without significant weaknesses or gaps). ~~The most problematic area, at this early stage of CCPT implementation, involves the development of integrated service plans.~~ Half the clinicians were experiencing difficulty in engaging parents and caregivers in discussing appropriate service referrals. Three of the four clinicians indicated that they had not successfully implemented strategies that would successfully encourage family members to participate in their service referrals once they were made.

~~Client-reported data on frequency of substance use:~~ To gauge the impact of MOST- ElemEd services on the frequency of use, YPI analyzed client reports to clinicians

on the frequency of substance use for 2 groups: (1) where services were completed and the cases closed; and (2) where cases have been open at least 100 days and services not yet completed. In both groups, clients use substances other than alcohol and marijuana, including prescription drugs, inhalants, cocaine, and Ecstasy, but their use is so infrequent that treatment outcomes for these substances are statistically insignificant. For the 46 completed MOST ElemEd cases, 29% of the clients reported a cessation of drinking, 24% indicated a reduced intake, 27% experienced no change, and 20% were using alcohol more frequently. In the case of marijuana, 31% of these clients reported that they were no longer using the substance, 24% indicated a reduced intake, 21% experienced no change, and 24% reported increased use. For the second group, cases open at least 100 days where services are incomplete, ??% of the clients reported a cessation of drinking, ??% indicated a reduced intake, ??% experienced no change, and ??% were using alcohol more frequently. In the case of marijuana, ??% of these clients reported that they were no longer using the substance, ??% indicated a reduced intake, ??% experienced no change, and ??% reported increased use.

**CONCLUSION.**

Nine months after intensive CCPT training, Elementary MOST clinicians are implementing the intervention with

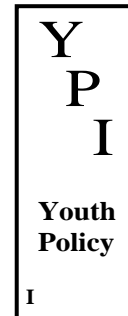
a consistently high degree of adherence to the therapeutic model. This success in rolling out a complex model is the result of a effective preparatory training, routine technical assistance in critical elements of a highly structured MOST model, and ongoing clinical supervision and training. This is not to say that there is no room for even higher levels of fidelity. YPI contemporaneously administered the Checklist with two Partnership clinicians who have several years of experience with CCPT techniques. In 13 of the 18 indicators, these experienced clinicians had higher average scores than the Elementary MOST clinicians. If training and technical assistance continue to be provided for the project clinicians, there is every reason to expect continued, even higher, levels of adherence to the CCPT model over the course of the following year.

*For further information about this edition of the Elementary Correspondent or about the evaluation of the Auburn Enlarge City School District's Elementary MOST project, please contact:*

~~Philip B. Uninsky, JD~~  
~~Executive Director~~  
Youth Policy Institute, Inc.  
(315) 824-~~05303605~~

*For further information about this edition of the MOST Correspondent or about the evaluation of the Auburn Enlarge City School District's Elementary MOST-ELEMENTARY project, please contact:*

Philip B. Uninsky  
Executive Director  
Youth Policy Institute, Inc.  
(315) 824-3605



## Bibliography

- Axline, V. M. (1949). Play therapy experiences as described by child participants. *Journal of Consulting Psychology*, 14, 53-63.
- Axline, V.M. (1947). *Play Therapy*. NY:Ballantine Books,
- Axline, V.M. *Dibs: In Search of Self*. NY:Ballantine Books.
- Campbell, C. A. (1993). Play, the fabric of elementary school counseling programs. *Elementary School Guidance & Counseling*, 28 (1), 10-16.
- Cerio, J.D. (1994). Play therapy: A brief primer for school counselors. *Journal for the Professional Counselor*, 9 (2), 73-80.
- Cochran, J. L. (1996). Using play and art therapy to help culturally diverse students overcome barriers to school success. *The School Counselor*, 43, 287-297.
- Gil, E. (1991). *The healing powers of play: working with abused children*. New York, NY: The Guilford Press.
- Gil, E. (1994). *Play in family therapy*. New York, NY: The Guilford Press.
- Ginott, H. G. (1959). The theory and practice of "Therapeutic Intervention" in child treatment. *Journal of Consulting Psychology*, 23, 160-166.
- Ginsberg, B. G. Catharsis. (1993) In Charles E. Schaeffer (Ed.), *The Therapeutic Powers of Play*, North Vale, NJ: Jason Aronson, Inc., 107-141.
- Guernsey, L. (1983). Client-centered (non-directive) play therapy. In C. Schaefer & K. O'Connor (Eds.), *Handbook of Play Therapy*. New York: J. Wiley & Sons, 21-64.
- Guernsey, L. (1984) Play therapy in counseling settings. In T. Yawkey (Ed.), *Child's Play: Developmental and Applied*. Hillsdale, NJ: Lawrence Erlbaum Associates, 291-316.
- Kranz, P.L; & Lund, N.L. (1993). 1993: Axline's eight principles of play therapy revisited. *International Journal of Play Therapy*, 2(2), 53-60.
- Landreth, G. & Wright, C. S. (1997). Limit setting practices of play therapists in training and experienced play therapists. *International Journal of Play Therapy*, 6, 41-62.
- Landreth, G. L. (2002). *Play therapy: The art of the relationship* (2nd ed.). NY: Brunner-Routledge.

- relationship. *The Journal of the Professional Counselor*, 14, 25-36.
- Mann, D. (1996). Serious play. *Teacher's College Record*, 97(3), 446-449.
- Matorin, A. I., & McNamara, J. R. (1996). Using board games in therapy with children. *International Journal of Play Therapy*, 5(2), 3-16.
- McCalla, C.L. (1994). A comparison of three play therapy theories: psychoanalytical, Jungian, and client-centered. *International Journal of Play Therapy*, 3(1), 1-10.
- Moustakas, C. E. (1953). *Children in play therapy: A key to understanding normal and disturbed emotions*. New York, NY: McGraw-Hill.
- Nemiroff, M.A., & Annunziata, J. (1996). *A child's first book about play therapy*. Washington, D.C: American Psychological Association.
- Oaklander, V. (1988). *Windows to our children*. (4th ed.). Highland, NY: The Gestalt Journal Press.
- Orton, G. L. (1997). *Strategies for counseling with children and their parents*. Pacific Grove, CA: Brooks/Cole.
- Phillips, E., & Mullen, J. (1999). Client-centered play therapy techniques for elementary school counselors: Building the supportive relationship. *The Journal of the Professional Counselor*, 14, 25-36.
- Post, P. (2001). Child-centered play therapy for at-risk elementary school children. In A. A. Drewes, L. J. Carey, & C. E. Schaefer (Eds.), *School Based Play Therapy* (pp. 105-122). NY: John Wiley & Sons, Inc.
- Ray, D., Bratton, S., Rhine, T., & Jones, L. (2001) The effectiveness of play therapy: Responding to the critics. *International Journal of Play Therapy*, 10(1), 85-108.
- Roopnarine, J. L., Johnson, J.E. & Hooper, F. H. (Eds.) (1994). *Children's play in diverse cultures*. Albany, NY: State University of New York Press.
- Tanner, Z., & Mathis, R. D. (1995). A child-centered typology for training novice play therapists, *International Journal of Play Therapy*, 4(2), 1-13.
- Uninsky, P.B. and Kelsh, T. (2005) *Cognitive Behavioral Therapy (CBT) Implementation Checklist*. Youth Policy Institute.
- Webb, N. B. (Ed.) (1991). *Play therapy with children in crisis: A case book for practitioners*. New York, NY: The Guilford Press.
- ~~Webb, W. (1992). Empowering at-risk children. *Elementary School Guidance and Counseling*, 27, 96-103.~~