

The PAX Good Behavior Game is an extremely powerful, time-efficient strategy for evidence-based treatment of a variety of DSM-IV diagnoses in elementary-school age children. It is a listed “best practice” not only for prevention but also for mental health treatment.

Key Benefits of the Good Behavior Game

Substantial evidence suggests that the Good Behavior Game can:

- ❑ Reduce directly observable symptoms of ADHD such as inattention and fidgeting, even for children not on medication.
- ❑ Reduce observable symptoms of Oppositional Defiance and Conduct Disorders,, whether or not the child is in therapy or the family is receiving interventions.
- ❑ Reduce the manifest symptoms of depression or PTSD, if the children given the roles, Tootles as the balance of the class becomes less disruptive and perceived threaten to such children via the Game.

Highest Quality Level of Scientific and Medical/Clinical Results

Both the American Psychologist (the official flagship journal of the American Psychological Association) and the Institute of Medicine (IOM) have called for the adoption of prevention, intervention and treatment practices for children that meet the very highest standards of science. The IOM standards are higher than those of the US Department of Education, the US Department of Health and Human Services and the Office of Juvenile Justice and Delinquency Prevention.

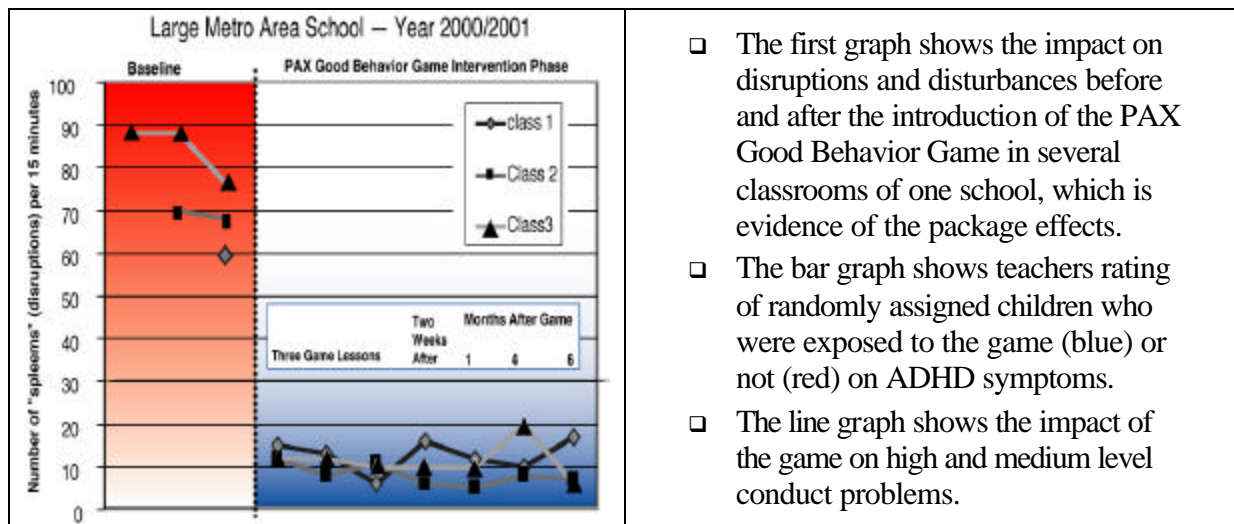
The Good Behavior Game meets “Grade 1” level evidence. This means that the Good Behavior Game has evidence from multiple well-designed, randomized, controlled trials and/or multiple well-designed interrupted time-series experiments that were conducted by two or more

independent research teams; and the preventive intervention has evidence of effectiveness in the intended settings with adequate training of personnel and monitoring of implementation and outcomes. In fact, the Good Behavior Game has been tested in three major randomized control trials by three different research teams, and has been studied in over 20 well-designed interrupted time-series experiments with 20 different research teams. Additionally, the current science-into-practice PAX Good Behavior Game package (materials, training, support, and monitoring) has shown evidence of effectiveness in multiple schools and geographic, cultural settings. The PAX Good Behavior Game appears to be first “kit” that an individual elementary teacher can use that meets the IOM standards for preventive interventions.

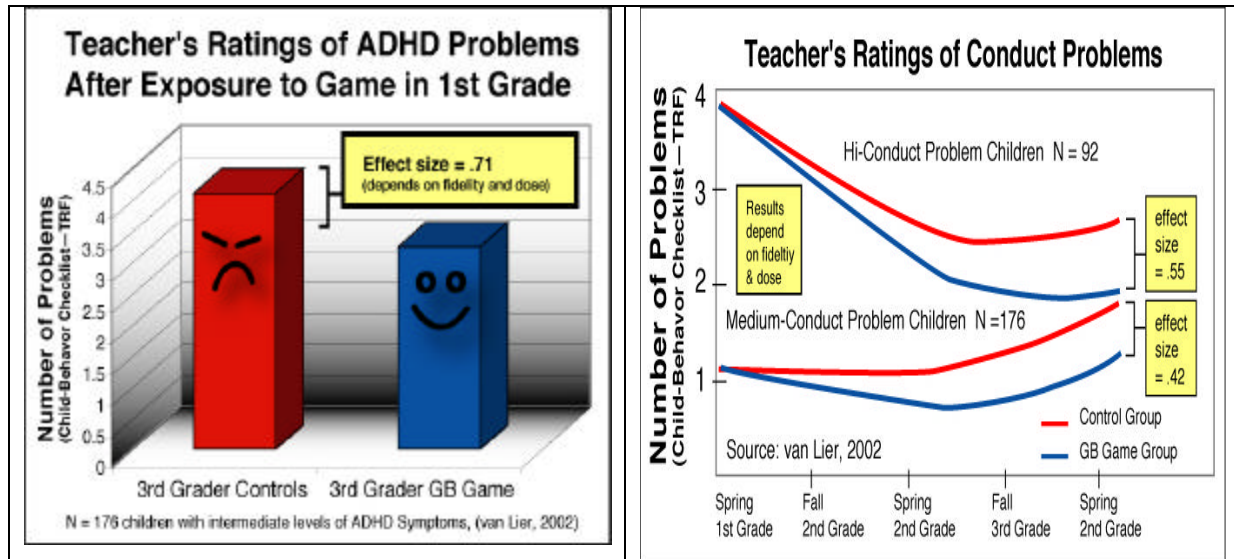
Some of these findings are reviewed the 2002 article in “The Good Behavior Game: A Best Practice Candidate as a Universal Behavioral Vaccine,” *Clinical Child and Family Psychology Review*, 5, 273-297, 2002. Additionally, a monograph by Pol A.C. van Lier (2002), *Preventing Disruptive Behavior in Early Elementary Schoolchildren Impact of a Universal Classroom-Based Prevention*,” ISBN 90-6734-077-4 provides new data not available at the time of the review, which is graphed herein.

On the next page, we have reproduced some graphs of results that will be of interest to mental health professionals, families, and others. It is important to note that effects sizes for these results, which is how scientists judge interventions, is quite good considering that PAX Good Behavior Game is the approximate cost of 2-3 mental visits, yet affects all 20-30 children directly in the classroom plus documented lifetime effects.

Figure 1: Selected Mental Health Related Results



- ❑ The first graph shows the impact on disruptions and disturbances before and after the introduction of the PAX Good Behavior Game in several classrooms of one school, which is evidence of the package effects.
- ❑ The bar graph shows teachers rating of randomly assigned children who were exposed to the game (blue) or not (red) on ADHD symptoms.
- ❑ The line graph shows the impact of the game on high and medium level conduct problems.



Mental-Health Professional Roles in the PAX Good Behavior Game Implementation

In the field trials of the PAX Good Behavior Game kit, we have had considerable opportunity to assess different models of implementation. While we do not have a published paper on those models yet, this letter provides some instructive insights into the trials and how mental-health professionals, medical staff (nurses, public-health specialists, special educators, etc.) might be effectively involved in the success of the Game.

- ❑ Recommendation #1: The Game must be operated by the children's main teachers.

A few settings had a misguided adventure in which the teaching staff wanted counselors and others to run and play the Game as the primary agents of change in the classroom. This defeats the purpose of the Game, which is for the children use their prefrontal cortex for inhibition and increase attention to the learning activities during the normal course of instruction if the Game is only played in the child's classroom by a mental health professional or other certified staff, while the teacher exits the room.

- ❑ Recommendation #2: In School-Wide Implementations, a few people can go room to room dramatizing the story and vision lesson

Some assistance dramatizing the story can be beneficial to the classroom teacher, provided that he or she stays and fully participates—including immediate implementation of the Game (perhaps with the visitors helping to coach).

- ❑ Recommendation #3: Mental-health staff can increase the confidence of the classroom teacher and success for children with DSM-IV externalizing diagnoses IEPs with pre-training of such children.

It can greatly facilitate classroom success if the children with serious behavior problems have pre-training with the Game in a smaller context, with lots of coaching and reinforcement.

□ Recommendation #4: Arrange Home Tootle Notes for Children in Active Treatment

Children who are actively in treatment or in need of active treatment can benefit from more positive Tootle Notes to home or the office for their successes.

□ Recommendation # 5: Children who are seriously emotionally disturbed can benefit by classroom coaching.

Sitting behind a child who has serious behavior problems, cueing their “Go PAX” and “Stop Spleems” can improve their performance and generalization. It is also useful to non-verbally cue the teacher to deliver selective praise for “Go PAX” to that child. The reason that both are important is that substantial research suggests that such children are not noticed for their good behavior during instruction, and they use negative behavior very effectively to acquire accidental reinforcement from adults and peers.

□ Recommendation #6: Shy, Withdrawn or Victimized Children as Team Captains

A mental-health professional can help a teacher make sure that shy, withdrawn, depressed or victimized children are team captains. The clinical outcome data on the Game show that it is an extremely helpful intervention for internalizing symptoms as well as obvious externalizing symptoms, and teachers are not as skilled as mental health professionals in identifying such children.

□ Recommendation #7: Make the Game part of IEPs and 504 Plans

Because of the clinical and scientific evidence, the Game is an extremely important part of IEPs or 504 plans. For children with externalizing symptoms, the migration or placement to more restrictive conditions is reduced 30% or better. The Game is extremely cost effective, and the data tools in the kit enable precise measurement of progress and compliance with the IEP or 504 plan, which is an important risk management issue.

□ Recommendation #8: Make Sure ALL staff and district personnel know that the Game fully complies with NO CHILD LEFT BEHIND

Understanding that the GAME complies with No Child Left Behind helps adoption and implementation of the procedure for maximum benefit to the school, teacher, child and family. The Hazelden website has a special section devoted to the PAX Good Behavior Game, which contains download and other information that may be helpful here.

Combining Treatment Modalities and the PAX Good Behavior Game

The Game has been shown to be effective when combined with other interventions as evidence-based parent training (e.g., the Incredible Years, Families and Schools Together-FAST) as well as other classroom interventions to improve teaching and learning (e.g., classwide peer tutoring,

rapid pace instruction, mastery learning). The Game has positive effects above and beyond medication, and works in combination with medication—with some indications that doses can be lowered (a potentially important issue if a child is showing adverse side-effects to medication).

Using PAX Good Behavior Game Tools to Measure Clinical Outcomes

Increasingly, mental-health providers must have documentation of treatment effects. The PAX Good Behavior Game is the only prevention-intervention kits for individual teachers that provides such tools. It has three appropriate tools:

❑ The Precision Spleem (disruptions) Observation Form

In clinical assessments, the tool may be used by observing a normative peer and a target child, coding disruptions (Spleems). The normative peer data and clinical case child's data are graphed for several baseline observations (before introducing the PAX Game), then observations continue (about once a week) monitoring the target child and normative peer. This is a powerful clinical monitoring protocol.

❑ The Precision Planned Activity Checklist Observation Form

Not all children who need mental health services are disruptive. Some may have trouble with attention and engagement, particularly if they are depressed, anxious, or have PTSD symptoms, may have greater difficulty actually in their learning activities. The Planned Activity Check is very useful to determining how well engaged they are. In the same vein as Precision Spleem observation, the mental health observer selects a normative peer and the target child to observe. One can collect a baseline, and then a once a week progress check to observe the child's development of engagement skills.

❑ The Strengths and Difficulties Questionnaire.

The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioral screening questionnaire. It can be completed in five minutes by the parents or teachers of children ages four to sixteen. There is also a self-report version for children ages eleven to sixteen. Download the questionnaire, including scoring procedures, at www.sdqinfo.com (a printable scoring version) or www.youthinmind.net (an online scoring version). The same instrument is being used in the National Survey of Households. This instrument is in almost every language, and provides clinical norms and changes for ADHD symptoms, depression symptoms and conduct problems among other factors. Before starting the Game, give the SDQ to the teacher(s) and the family. If the implementation of the Game is well done, then you may give the SDQ in 10-15 weeks later probably expect to see measurable changes. Among children with more serious diagnoses, one would want to use the observational procedures in addition to the SDQ, since a lack of change on the observations would suggest that more Game experience, different rewards, more tootles, etc. might be needed to achieve results.