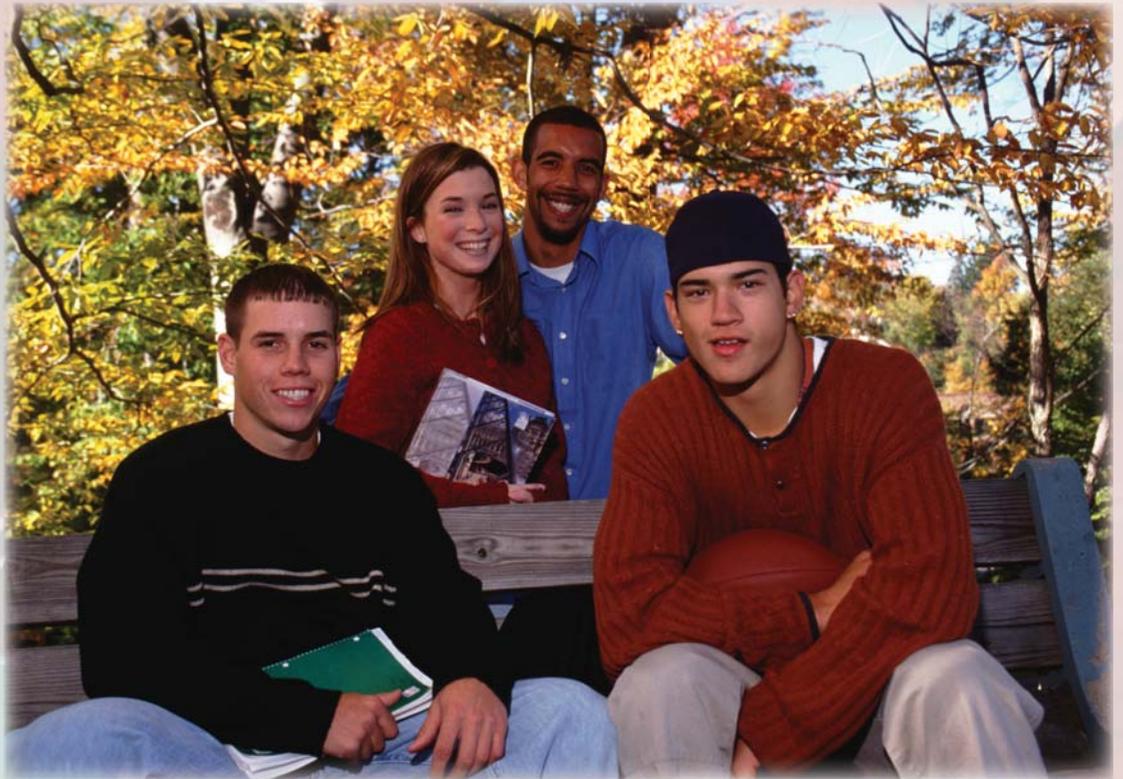


**Effective Strategies
for Creating Safer
Schools and
Communities**

The Role of Mental Health Services in
**Promoting Safe
and Secure Schools**



THE GEORGE WASHINGTON UNIVERSITY
GRADUATE SCHOOL OF EDUCATION
AND HUMAN DEVELOPMENT



NWREL
Northwest Regional Educational Laboratory


Hamilton Fish Institute

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The Role of

Effective Strategies for Creating

Mental Health Services

Safer Schools and Communities

in Promoting Safe and Secure Schools

Krista Kutash, Ph.D.
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About the Effective Strategies for Creating Safer Schools and Communities Series

School safety requires a broad-based effort by the entire community, including educators, students, parents, law enforcement agencies, businesses, and faith-based organizations, among others. By adopting a comprehensive approach to addressing school safety focusing on prevention, intervention, and response, schools can increase the safety and security of students.

To assist schools in their safety efforts, the Hamilton Fish Institute on School and Community Violence and the Northwest Regional Educational Laboratory (NWREL) have revised this series of five guidebooks intended to build a foundation of information that will assist schools and school districts in developing safe learning environments. The series identifies several components that, when effectively addressed, provide schools with the foundation and building blocks needed to create and maintain safe schools. Written in collaboration with leading national experts, these resources will provide local school districts with information and resources that support comprehensive safe school planning efforts.

Each guide provides administrators and classroom practitioners with a glimpse of how fellow educators are addressing issues, overcoming obstacles, and attaining success in key areas of school safety. They will assist educators in obtaining current, reliable, and useful information on topics that should be considered as they develop safe school strategies and positive learning environments. As emphasized in *Threat Assessment in Schools: A Guide to Managing Threatening Situations and to Creating Safe School Climates*, a joint publication of the U.S. Secret Service and the U.S. Department of Education, creating cultures and climates of safety is essential to the prevention of violence in school. Each guidebook retains this message as a fundamental concept.

Under No Child Left Behind, the education law signed in January 2002, violence prevention programs must meet specified principles of effectiveness and be grounded in scientifically based research that provides evidence that the program to be used will reduce violence and illegal drug use. Building on the concept in No Child Left Behind—that all children need a safe environment in which to learn and achieve—these guides explain the importance of selecting research-based programs and strategies. The guides also outline a sample of methods for addressing and solving safety issues schools may encounter.

About this series (continued)

Creating Schoolwide Prevention and Intervention Strategies, by Jeffrey Sprague, is intended to put the issue of schoolwide violence prevention in context for educators and outline an approach for choosing and creating effective prevention programs. The guide covers the following topics:

- Why schoolwide prevention strategies are critical
- Characteristics of a safe school
- Four sources of vulnerability to school violence
- How to plan for strategies that meet school safety needs
- Five effective response strategies
- Useful Web and print resources

School Policies and Legal Issues Supporting Safe Schools, by Thomas Hutton and Kirk Bailey, is a practical guide to the development and implementation of school and district policies that support safe schools. Section 1 provides an overview of legal and practical considerations to keep in mind and to address with local legal counsel when developing policies at the district level to prevent violence. Section 2 addresses specific situations and issues that may arise and discusses how the framework set forth in Section 1 bears on these questions.

Ensuring Quality School Facilities and Security Technologies, by Tod Schneider, is intended to help educators and other members of the community understand the relationship between school safety and school facilities, including technology. The guide covers the following topics:

- Crime Prevention Through Environmental Design (CPTED)
- Planning To Address CPTED: Key Questions To Ask
- Security Technology: An Overview
- Safety Audits and Security Surveys

The Role of Mental Health Services in Promoting Safe and Secure Schools, by Krista Kutash and Albert Duchnowski, explores the role of mental health services in developing and maintaining safe schools. The guide provides an overview of research-based school mental health models and offers guidance for school personnel and others on implementing mental health–related services, including the role that federal, state, and district policies play and the need for community involvement.

About this series (continued)

Fostering School, Family, and Community Involvement, by Howard Adelman and Linda Taylor, provides an overview of the nature and scope of collaboration, explores barriers to effectively working together, and discusses the processes of establishing and sustaining the work. It also reviews the state of the art of collaboration around the country, the importance of data, and some issues related to sharing information.

The Hamilton Fish Institute on School and Community Violence and the Northwest Regional Educational Laboratory hope that the guides in this series assist your school and its partners in creating a safe, positive learning environment for the children you serve.

About the Authors

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Contents

Section I: Introduction and Background	1
The Dynamics of Childhood Aggression: A Brief Summary	2
Education and Mental Health Collaboration	7
Heuristic Models of Mental Health Services	9
Section II: Achieving Safer Schools by Implementing Mental Health Strategies	17
Evidence-Based Mental Health Interventions	17
Family-Driven Care	27
Section III: Facilitating Implementation: A Blueprint for Community Action	33
Federal Policy	34
Public Health Approach	37
Adopting/Adapting the Public Health Model	43
Appendices	
A. WSIPP Results of Benefit-Cost Analysis of 61 Programs and Approaches	45
B. Resources	49
C. References	55

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Section 1.

Introduction and Background

Goal of the Guide

In this guide we describe the critical role of the mental health system for promoting and maintaining safe schools. The mental health system is broadly defined to include the theoretical foundations of developmental psychology, the models of mental health service delivery, and the evidence base that supports practices that relate to preventing and reducing aggression and violence in students in the school setting. The guide includes a discussion of the emerging concept of family-driven care and closes with a brief review of federal initiatives that support the implementation of school-based mental health services along with a presentation of the Public Health Model as a potential framework to guide communities in preventing and reducing aggression and violence in their children.



Why Mental Health?

Many teachers and administrators, as well as school board members, believe that the exclusive goal of the school is to teach children academic skills and that the emotional development of children is the responsibility of parents and other community agencies. Their slogan is that they are educators, not psychologists. Unfortunately, those who hold strongly to this belief have missed the substantial and still growing body of knowledge that describes the convincing relationship between the academic and emotional functioning of children and the effectiveness of schools in addressing this relationship (e.g., Zins, Weissberg, Wang, & Walberg, 2004). As administrators and teachers face the challenges of demonstrating academic progress in students in a climate of increasing aggression and violence, the importance of behavior and developmental science is unmistakable. Teachers and principals who do not have a working knowledge of developmental

psychology and behavior theory as it relates to the acquisition of academic and social/emotional skills of their students are missing a valuable tool in promoting effective, safe, and secure schools. This guide can serve as a primer for those who want to learn more about the relationship and mechanisms of academic and social/emotional learning and as a resource for those already engaged in implementing programs based on these interrelationships.

The Dynamics of Childhood Aggression: A Brief Summary

Today's elementary and secondary school educators are faced with extremely difficult challenges that are clearly undervalued by society. Consequently, it is especially frustrating to learn of a lack of progress or even failure in individual schools that could have been prevented with an understanding of and the implementation of state-of-the-art methods and procedures. A case in point is the frequent comment made by teachers and administrators that they do not have the time or inclination to engage in discussions of theory. As a result, they may not discuss their own beliefs and theories about student behavior and the relationships of their beliefs to programs or interventions they implement to change these student behaviors. For example, a group of teachers and administrators may subscribe to the theory that aggression in their students is linked to parental influences and low income. However, in choosing a program to help reduce student aggression, there was no meaningful discussion of their beliefs and they chose a social skills program that emphasized student communication skills. When the program yielded disappointing results, they failed to realize that they could have found a program that targeted other factors, such as school and family connectedness, interagency collaboration including income maintenance agencies, and increased empathy in adults and students. A program with these components is more compatible with their beliefs and might have generated more buy-in from the staff, which could have improved the outcome. Without an orientation toward the bigger picture, the evidence base, and the broad implications of resource allocation, time spent on curriculum and discipline committees will not be an effective or efficient use of staff time

Understanding the Social Function of Aggression

Developmental science (Cairns, 2000) and ecological approaches to treating troubled youth (Hobbs, 1982) have contributed important information for practitioners in the education system who aim

to reduce aggression and violence in their schools. Recently, Farmer, Farmer, Estell, and Hutchins (in press) presented an excellent review of the knowledge base describing the developmental dynamics of aggression. We know, for example, that throughout childhood youth use aggression to establish their social position among peers. Aggressive youth are often socially competent and perceived as popular by peers and teachers, even though they may not be liked. Interestingly, preschool aggression has been found to be positively correlated with social competence in later years.

The importance of these findings for school staff is not to indicate that aggressive behavior in youth is good, but that it is very prevalent. Consequently, programs to prevent and reduce aggression in students must be widespread and not focus exclusively on youth who are at risk. A prime example is the need for anti-bullying programs in schools. Research indicates that some bullies have been the victims of aggression, and most hold high social positions among peers and can engage them to actually support their behavior. Bullying is often unknown to adults and peers often do not report such behavior to authority figures (Orpinas & Horne, 2006). Anti-bullying programs are an ideal example of the need for schoolwide programs; this will be more fully discussed in Section 2.

Positive and Negative Constraints

In their review of the developmental aspects of aggression, Farmer and colleagues (in press) have also delineated another important concept from the mental health and developmental psychology literature that can be very helpful to school staff in choosing their strategies to reduce aggression and violence in the schools. A child's developmental system is made up of positive and negative constraints that can have an important impact on the child's behavior (Gest, Mahoney, & Cairns, 1999). Positive constraints include academic success, athletic competence, positive peer and adult relationships, and supportive adults. Negative constraints include academic failure, hyperactivity, social skill deficits, antisocial peers, and a lack of supportive adult relationships (Farmer & Farmer, 2001). Farmer and colleagues further delineate these factors into individual constraints and social constraints. The examples of academic success and athletic skill are positive individual constraints, while involvement with peers who have good social values and developing good relationships with caring adults are positive social constraints. A child who is lacking in positive individual constraints and is isolated from good social constraints is vulnerable to developing patterns of aggressive and antisocial behavior. If the child's developmental system is severely dominated by negative constraints, the

impact of an intervention only focused on one factor, such as a social skill deficit, is likely to be ineffective in the long run. The message for educators is that a multifaceted approach to reducing aggression and violence is needed to ensure safe and secure schools. The mental health system has noted that in the case of children who have very serious emotional and behavioral disturbances, complex and comprehensive approaches that are multidisciplinary are needed (Kutash, Duchnowski, & Lynn, 2006). Examples of comprehensive systemic programs will be described shortly in the discussion of models of mental health service delivery.

Diagnosing Disruptive Behavior Disorders

In addition to the important information from developmental theory and science, teachers and administrators can benefit in their planning for safe school programs by becoming better acquainted with the terminology and processes used by clinical psychology and psychiatry that classifies children as having a disruptive behavior disorder. Ever since the passage of the Education of All Handicapped Children Act in 1975 (PL 94-142) and its reauthorization in 1994 as the Individuals with Disabilities Education Act (IDEA), there has been much controversy around children who are classified as having emotional disturbances and needing special education. In the 1970s and early 1980s there were attempts to exclude disruptive children from special education by referring to them as “socially maladjusted,” a term intended to be used to differentiate children who were in the juvenile justice system and whose education was not supported by funds from PL 94-142. Even today, there are school districts in which administrators contend that children who are disruptive are not disabled and are not eligible for special education classification and the due process rights associated with disability. Also, today many of these administrators may use the term “conduct disorder” to describe disruptive children who they feel should not be in special education programs. Ironically, the results of several epidemiological studies indicate that more than two-thirds of children placed in special education programs for emotional disturbances have the diagnosis of conduct disorder, yet more than half of these children also meet criteria for internalizing diagnoses such as anxiety or depression (see Friedman, Kutash, & Duchnowski, 1996, for a review).

While special educators have become more sophisticated in their knowledge and understanding of the relationship between disruptive behavior and disability, their colleagues in general education are not

typically trained in, or have access to, information from the psychological literature describing disruptive behavior. Therefore, in Table 1 we present the diagnostic criteria for the two major categories of disruptive behavior, Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD), taken from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994). There are more recent revised versions of the DSM but the diagnostic criteria have not changed.

Educators may note that the behaviors describing these diagnostic categories are frequently observed in school students and that these behaviors are the targets of many violence prevention programs. However, it is important to note that for a diagnosis to be made, the behaviors must be long standing—six months for ODD and 12 months for CD—and there must be a pattern of several behaviors present. In addition, the impairment caused by the disorder must be clinically significant and manifested in social, academic, or occupational functioning. The establishment of criteria is important because a diagnosis becomes a trigger for the onset of services, especially in the public sector, which is heavily dominated by the medical model.

The prevalence of ODD and CD is not precisely determined by research, but is generally agreed to be between 6 percent and 9 percent of children and youth. Furthermore, ODD and CD are likely to be evident at an early age, before eight and as young as five or six years old. These findings support the critical need for both prevention and early identification programs.

In summary, there are significant numbers of children in our nation's schools who have serious emotional and behavioral disorders that are manifested by aggressive, disruptive, and sometimes violent behavior. Most of these children do meet the criteria for having a disability, require special education or accommodations, and have the protections accorded by IDEA and the Americans with Disabilities Act (ADA). School staff could spend their time and resources more productively in developing effective programs for these students rather than by devising ways to exclude them from school. While we have noted that academic and emotional/behavioral functioning are interrelated and need to be addressed by the school, we also note the realization that no single agency has the expertise or the resources to adequately meet the needs of children who exhibit serious disruptive behavior or who may be at risk for such behavior and require effective prevention programs. Interagency collaboration, particularly between the education and mental health systems, is the mechanism we propose to meet this challenge and is the topic of the next section.

Table 1.
DSM-IV Criteria for the Diagnosis of ODD and CD

Oppositional Defiant Disorder

- A. A pattern of negativistic, hostile, and defiant behavior lasting at least six months, during which four (or more) of the following are present:
1. Often loses temper
 2. Often argues with adults
 3. Often actively defies or refuses to comply with adults' requests or rules
 4. Often deliberately annoys people
 5. Often blames others for his or her mistakes or misbehaviors
 6. Is often touchy or easily annoyed by others
 7. Is often angry and resentful
 8. Is often spiteful or vindictive
- (Note: Consider a criterion met only if the behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level.)
- B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning
- C. The behaviors do not occur exclusively during the course of a Psychotic or Mood Disorder
- D. Criteria are not met for Conduct Disorder

Conduct Disorder

- A. A repetitive and persistent pattern of behavior in which the basic rights of others and major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following 15 criteria in the past 12 months, with at least one criterion present in the past six months.

Aggression to People and Animals

1. Often bullies, threatens, or intimidates others
2. Often initiates physical fights
3. Has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
4. Has been physically cruel to people
5. Has been physically cruel to animals
6. Has stolen while confronting the victim (e.g., mugging, purse snatching, extortion, armed robbery)
7. Has forced someone into sexual activity
8. Has deliberately engaged in fire setting with the intention of causing serious damage
9. Has deliberately destroyed others' property (other than by fire setting)
10. Has broken into someone else's home, building, or car
11. Often lies to obtain goods or favors to avoid obligations (i.e., "cons" others)
12. Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)

Serious Violations of Rules

13. Often stays out at night despite parental prohibitions, beginning before age 13
 14. Has run away from home overnight at least twice while living in parental or parental surrogate home (once without returning for a lengthy period)
 15. Often truant from school, beginning before age 13 years
- B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning

Education and Mental Health Collaboration

Both the education and mental health systems play an important role in providing services and supports to children who have emotional and behavioral disorders (EBD) as well as preventing disorders in children who may be at risk. However, the two systems have not produced a record of effective collaboration, contributing to the disappointing outcomes for this group of children. While there are areas of commonality in the two systems, there are some fundamental differences between them that affect their perspective in serving children who have EBD. Table 2 contains a list of some key factors that shape the perspectives of the two systems. These factors can serve as barriers to more effective collaboration.

As Table 2 illustrates, there are more areas in which the differing perspective can impede collaboration compared to facilitating the implementation of effective services. For example, the emergence of distinct conceptual frameworks describing the target behavior for each system has resulted in different terminology that goes beyond simple semantic differences. Services and programs from the perspective of the education system are likely to be described as meeting the needs of children who have “behavior disorders or challenging behaviors,” or preventing such behaviors. The number of discipline referrals to the principal’s office is a major outcome measure, along with improved academic achievement, especially in math and reading. Programs and interventions implemented by the mental health system target children who are mentally ill or emotionally disturbed and who meet the criteria for a diagnosis in the current edition of the DSM, or those that may be at risk for mental illness. The emphasis is on diagnosing and treating in order to improve functioning and reduce relapse and reoccurrence. Functioning in school is one domain of interest, along with home and community. One consequence of the difference in vocabulary used in each system is that reports of research from the different perspectives are frequently published in journals and texts that are not read by all the disciplines concerned with children who have EBD. This results in a failure to understand the different approaches to intervention across disciplines and impedes the implementation of comprehensive, effective programs at a level of scale needed for significant improvement in outcomes for the millions of children affected by EBD.

Additionally, researchers and practitioners are shaped and guided by the theoretical context in which they have been trained or have developed after their formal training. Clearly, these perspectives filter how they view the world, human behavior, and how they conceive of services for children who have EBD. For example, researchers and practitioners

Table 2.
Contrasting Perspectives in the ED and MH Systems

	Education System	Mental Health System
Overarching Influence	Individuals with Disabilities Education Act (IDEA)	Diagnostic and Statistical Manual (DSM)
Conceptual framework, language	Behavior disorders Challenging behavior Academic deficits	Psychopathology Abnormal behavior Impaired functioning
Important theoretical influences	Behaviorism Social learning theory	Psychoanalytic approaches Behavior theory Cognitive psychology Developmental psychology Biological/Genetic perspectives Psychopharmacology
Focus of intervention	Behavior management Skill development Academic improvement	Insight Awareness Improved Emotional Functioning
Common focus	Improving social and adaptive functioning importance of and need to increase availability, access, and range of services	

trained in a college of education are more likely to be influenced by behavioral and social learning approaches. In contrast, those trained in a psychology department in a college of arts and sciences are more likely to have been exposed to a broad array of theories that include psychodynamic, behavioral, cognitive-behavioral, and neurological and biochemical premises, among others. These theoretical perspectives guide thinking about the nature and goals of interventions, as well as indicators of success. As a result, programs for children who have or who are at risk for EBD can range from approaches like Teaching Recess, an alternative to aggression at recess that uses a schoolwide approach to promote prosocial behavior (Todd, Haugen, Anderson, & Spriggs, 2002) to Multisystemic Therapy, which uses cognitive-behavioral interventions, strategic family therapy, and behavioral parent training to help students cease antisocial behavior while increasing positive behavior (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998).

Fortunately, we are at a point in time when many representatives from the education and mental health communities have become aware of the potential for improved emotional, behavioral, and academic functioning of students as well as the promotion of safe and secure schools through effective collaboration between the two systems (Kutash et al., 2006). These professionals are engaged in initiatives that aim to achieve effective collaboration. This guide is part of this initiative. To this end, we now present a description of the major models and frameworks promoted by the mental health system to assist in developing

school-based programs that may better meet the needs of children who have EBD and to promote safe and secure schools.

Heuristic Models of Mental Health Services

Much of the adult population associates mental health services with an office-based scenario consisting of one-on-one talk therapy. While office-based psychotherapy is an important component of mental health services, today the mental health system is composed of an array of services that range from prevention, through intensive treatment, to after-care and recovery support. In the following section we describe several influential models or frameworks of mental health services provision.

The Mental Health Spectrum

Mrazek and Haggerty (1994) conceptualized the Mental Health (MH) Spectrum to describe the continuum of services and interventions designed for children who are considered to be mentally ill or emotionally disturbed, or at-risk. They originally developed the spectrum as a framework for prevention research in the broad mental health field, and its effectiveness as a guiding framework in the field is evidenced by continued reference to it and adaptations by more recent MH services researchers. An example is the recent adaptation by Weisz, Sandler, Durlak, and Anton (2005), presented in Figure 1. In their updated framework they link evidence-based prevention and treatment and include health promotion/positive development strategies to the MH Spectrum as a component that precedes universal prevention strategies. They emphasize the “permeable” separation between indicated prevention strategies and treatment and promote a focus on evidence-based practice as a unifying construct throughout the entire spectrum. The framework proposes that strengths reside in youth, families, communities, and culture, which are depicted in the center of the illustration. Interventions that offer support are arrayed in the upper semi-circle and setting locations in the lower semi-circle.

While the role of the mental health system in the schools has not always been readily accepted or effectively implemented, Weisz and his colleagues have brought attention to the need for school-mental health collaboration by clearly identifying “school” as a setting for many mental health interventions in the spectrum of services. This fits well with the growing movement to expand school-based mental health services that are provided by community mental health centers (Weist, Lowie, Flaherty, & Pruitt, 2001). The framework developed by Weisz and colleagues (2005) is the result of an extended period of research, analysis

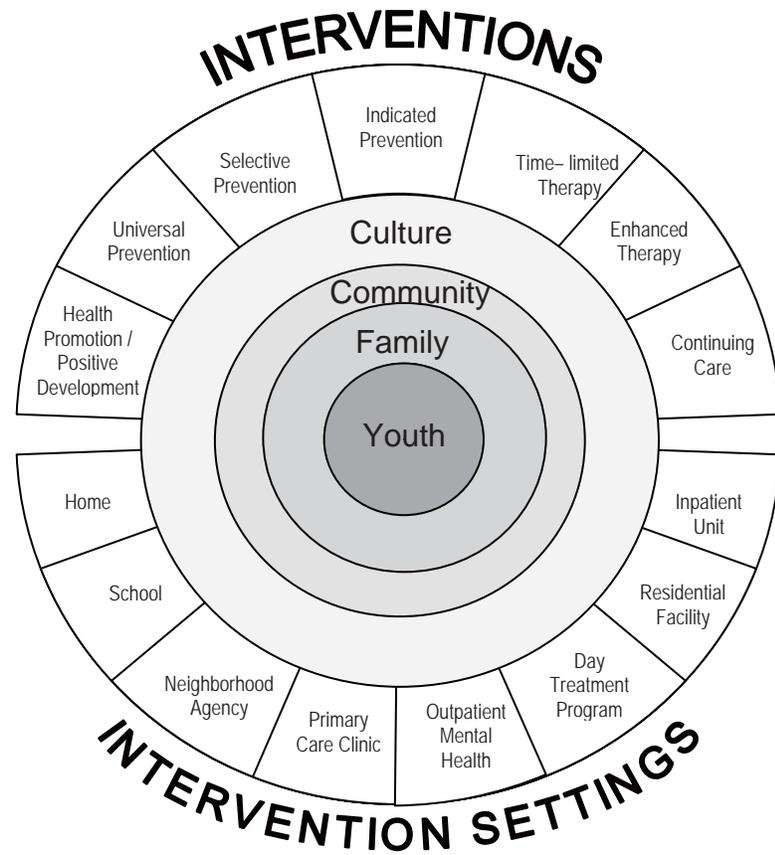


Figure 1. Reprinted, with permission, from Weisz, J., Sandler, I., Durlak, J., & Anton, B. (2005). Promoting and protecting youth mental health through evidence-based prevention and treatment. *American Psychologist*, 60(6), 628–648.

of findings, advocacy, and rethinking the process of providing mental health service to children by the broad mental health community.

While the Mental Health Spectrum describes discrete services and interventions provided by mental health professionals, researchers have identified the multiple and complex problems of children who have EBD. Their multiple needs cut across the boundaries of social service agencies. In response, the mental health community has produced important models and frameworks aimed at achieving more effective collaboration and integration of services between the many agencies that have some responsibility for ensuring the emotional well-being of children.

The System of Care Model

Perhaps the most influential of these collaborative models is the System of Care (SOC), first described by Stroul and Friedman (1986) in

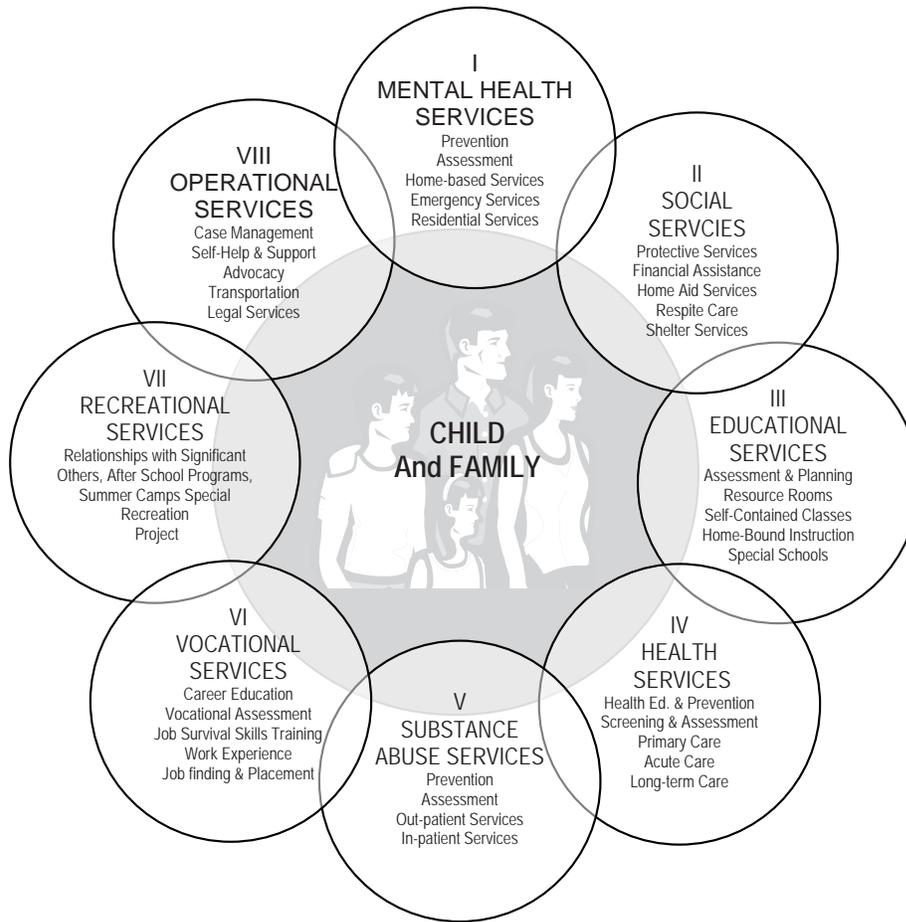


Figure 2. System of Care Framework. Reprinted, with permission, from Stroul, B. A., & Friedman, R. M. (1986). *A system of care for severely emotionally disturbed children and youth*. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

their monograph, which has come to serve as the blueprint for children's mental health services in this country (Kutash et al., 2006).

The System of Care (SOC) was developed for children with severe emotional and behavioral problems, persisting for at least a year, and resulting in impairment in multiple domains of functioning (see Figure 2). Children who are served by the SOC will most likely (though not always) be in special education programs in school. Their families may be clients of the child welfare system, and some children may be involved with the juvenile justice system. These children have more health problems than peers with other types of disability, and as they get older co-occurring substance abuse problems increase (Greenbaum et al., 1998).

The SOC can provide crisis intervention, long-term therapy, and hospitalization if necessary. Out-of-home placements such as foster care, deten-

tion, and residential treatment may be provided but intensive family preservation services are also available. At this intensive level of service the “Wraparound” approach may be used in a community. Essential to Wraparound is the notion that the child and the family are central: services are individually tailored to the strengths and needs of the family and are “wrapped around” them rather than the child being placed into a program because of his/her diagnosis or pattern of behavior (Eber, Sugai, Smith, & Scott, 2002; Robbins & Armstrong, 2005; VanDenBerg & Grealish, 1996). Policymakers and practitioners need to understand that the SOC and Wraparound are more of a philosophy of support for children and families rather than a specific intervention. They are heavily value laden and promote strengths-based assessment, families being accepted as equal decision-making partners, culturally competent services, and a commitment to least restrictive, community-based treatment.

The SOC and Wraparound are designed for children exhibiting the most severe level of impairment; ideally, there will be a community team of professionals joined by the family and their advocates who are engaged in developing an individualized treatment or service plan. There should be a level of collaboration to ensure that the plan will be compatible with an existing Individualized Education Plan (IEP) if the child is in a special education program. Because of the complexity of the problems and the services array, a case manager is available to support the family and assist the agencies to better coordinate service delivery. While a community may designate a lead agency to implement the SOC, it must be recognized that all agency representatives and the family are equal decision-making partners.

The SOC is more than 20 years old now, with Wraparound being slightly more recent. Funded by the Children’s Community Mental Health Services Act of 1992, over 140 communities and tribal nations have implemented SOC’s affecting several thousands of children. In general, the engagement of schools in this initiative has been weak and the overall effectiveness of the SOC has been mixed but promising (Kutash, Duchnowski, & Friedman, 2005). This is unfortunate because the resources from the SOC grants combined with grants from the Department of Education’s Safe and Healthy Schools initiative could advance a community’s efforts significantly to prevent and reduce violence in schools as well as the community.

Interconnected Systems

Given the barriers facing the traditional mental health system in its attempts to implement services that are more integrated, accessible,

and effective, a framework guided by a public health strategy and based on collaboration between systems has emerged as an alternative approach for implementing mental health services for children. This framework, which we call Interconnected Systems (see Figure 3), is composed of a continuum of services that aims to balance efforts at mental health promotion, prevention programs, early detection and treatment, and intensive intervention, maintenance, and recovery programs (Van Landeghem & Hess, 2005). The framework is a series of three interconnected ovals representing systems of prevention, systems of early intervention, and systems of care. The framework has been most clearly articulated and promoted by the Center for Mental Health in Schools at UCLA (Adelman & Taylor, 2006) and the Center for School Mental Health Assistance at the University of Maryland (Weist, Goldstein, Morris, & Bryant, 2003). In this framework, resources from the school and the community are pooled to produce integrated programs at three levels of service need.

Positive Behavior Support

The final model discussed in this section, Positive Behavior Support (PBS), is technically not an exclusive mental health model, though it has its roots in behavior theory. PBS has emerged from applied behavior analysis (ABA) as “a newly fashioned approach to problems of behavior adaptation” (Dunlap, 2006, p. 58). ABA developed in the 1960s

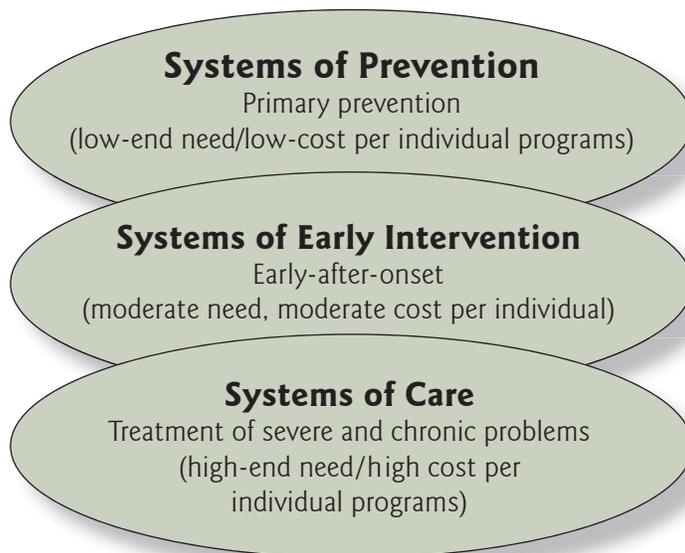


Figure 3. The Interconnected Systems. Adapted from Adelman, H. S. & Taylor, L. (2006).

as a science in which instrumental learning principles such as positive reinforcement and stimulus control were used to bring about changes in behavior that were socially important. In the 1980s and 1990s PBS advanced to become a broad array of interventions that used the concepts and principles of ABA along with those of other disciplines. Today, PBS may be considered to be a developing applied science “that uses educational and systems change methods (environmental redesign) to enhance quality of life and minimize problem behavior” (Carr et al., 2002, p. 4). When PBS is used to develop an intervention for an individual it is accompanied by a functional behavioral assessment (FBA) to develop an effective behavioral support plan. FBA is defined as “a systematic process of identifying problem behaviors and the events that (a) reliably predict occurrences and non-occurrences of those behaviors and (b) maintain the behaviors across time” (Sugai et al., 1999, p. 13).

PBS was originally developed as an alternative to aversive control of extremely serious and often dangerous behaviors of people who were developmentally disabled. In recent years, however, the application of PBS has expanded to include students with and without disabilities in a variety of settings such as school, home, and community. Today, PBS addresses a broad range of academic and social/behavioral challenges and has transformed from a singular focus on individual case planning to systems level implementation especially involving schoolwide issues (Sugai & Horner, 2002).

The success of PBS with individual cases of problem behavior in children is supported by the requirements in the 1997 amendments to IDEA mandating PBS and FBA to be used to reduce challenging behaviors in students who have disabilities (Sugai & Horner, 2002). Research is beginning to emerge supporting the effectiveness of PBS at the systems level, particularly as a schoolwide preventive intervention to reduce the incidence of problem behaviors and increase student learning (see, for example, Nelson, Martella, & Marchand-Martella, 2002). In addition, there is a growing body of literature describing the integration of PBS with system of care principles and Wraparound in school settings at the selective and indicated levels (Eber et al., 2002; Robbins & Armstrong, 2005). The increased attention to PBS as an effective tool in managing a variety of academic, social, and emotional/behavioral problems validates its potential as an important model of school mental health. It is also noteworthy that some of the leaders in the PBS field have expressed interest in integrating PBS with the children’s mental health system, a further indication of the need for decisionmakers to keep abreast of the developments in the PBS field (School Mental Health Alliance, 2005).

Descriptions of PBS are often accompanied by a triangle-shaped graphic that illustrates its use in universal interventions, at-risk or selective interventions, and intensive individual interventions (Sugai & Horner, 2002; see Figure 4). As this figure suggests, about 80 percent of all children do not have serious problems and universal interventions are sufficient for them. About 15 percent of children are at risk and require targeted or selective interventions that often are group administered. This leaves about 5 percent of children who require intensive individualized interventions. Interestingly, these percents correspond to the children's mental health epidemiological findings that about 20 percent of all children, at a point in time, have a diagnosable disorder that meets DSM criteria while about 5 percent of all children have a serious and persistent disorder (Friedman et al., 1996).

The approach of PBS is referred to as a three-tiered model in that it makes use of universal, selective, and indicated interventions. The three-tiered model is an effective rubric for organizing and describing the evidence base for mental health interventions and will be elucidated in the following section.

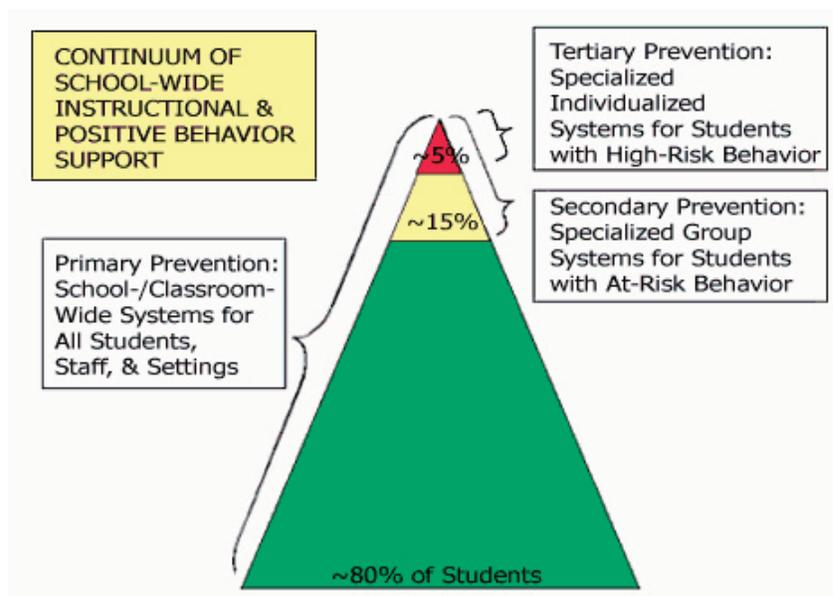


Figure 4. Reprinted, with permission, from the OSEP Technical Assistance Center for Positive Behavioral Interventions and Support.

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Section II.

Achieving Safer Schools by Implementing Mental Health Strategies

This section will begin with a description of the evidence base for mental health services that focus on disruptive or aggressive behaviors, and are appropriate for delivery in schools or are community services that may complement existing efforts in schools. Mental health services in this section are defined as any strategy, program, or intervention aimed at preventing and treating mental health problems in youth. These efforts can include programs focused at the universal, selective, and indicated levels of prevention commonly referred to as the three-tiered model of prevention. Because there are a variety of sources describing evidence-based services, it is hoped that this review will start to identify the breadth and depth of the knowledge base so it can become implemented by practitioners and strengthened by future research efforts. This section ends with a description of a new model of family involvement, Family Driven Care, where families are partners with professionals in providing care for their children.



Evidence-Based Mental Health Interventions

Nationally, state policymakers and school boards demand more and better mental health services for all students. There are numerous attempts to increase the amount and types of mental health services in schools (Adelman & Taylor, 2000). Recent studies indicated that virtually all schools have some type of mental health services available (Foster et al., 2005) and on average, schools offer 14 different programs

aimed at improving the social/emotional learning of students (Zins et al., 2004). These efforts, however, are frequently not empirically based interventions. The challenge, therefore, is to better coordinate and implement an array of evidence-based mental health interventions targeting specific behaviors across a heterogeneous population of students. In order to accomplish this task, a better understanding by mental health, school staff, and families of the universal, selective, and indicated evidence-based mental health interventions that can be implemented in schools is necessary. This section summarizes some of the current evidence-based programs that focus on disruptive and aggressive behaviors that can be implemented in schools.

In 2006, Kutash and her colleagues (2006) summarized the evidence-based mental health interventions for children compiled by five national organizations, including (1) The National Registry of Evidence-based Programs and Practices (NREPP) operated by the Substance Abuse and Mental Health Services Administration (SAMHSA); (Schinke, Brounstein, & Gardner, 2002); (2) a report issued by the Collaborative for Academic, Social, and Emotional Learning (CASEL), (2003); (3) a review of programs by the Prevention Research Center for the Promotion of Human Development at Penn State (Greenberg, Domitrovich, & Bumbarger, 2000); (4) a review by the Center for the Study and Prevention of Violence (CSPV); (Elliott & Mihalic, 2004); and the U.S. Department of Education report on behalf of the Office of Educational Research and Improvement (OERI), (2001). These five sources generated a list of 92 interventions, with 23 percent of the programs appearing on more than one of the five sources.

Overall, within this listing of evidence-based programs, approximately one-third of the programs are designated as targeting substance abuse, trauma, or health problems while the remaining two-thirds address the regulation of emotions or social functioning in children and adolescents with 20 programs specifically focusing on the issue of disruptive and aggressive behavior. As a whole, the approaches focus equally on universal levels of prevention (53 percent) and selective/indicated levels of prevention (47 percent). The majority of the programs listed across these five sources are to be implemented in schools (58 percent) while 26 percent are to be implemented in community settings and 16 percent are to be implemented simultaneously in schools and in community settings. This finding clearly supports the notion that in order for evidence-based programs to be implemented, schools must be involved. The next sections describe a sample of universal, selective, and indicated evidence-based programs that focus on disruptive and aggressive behavior that can be implemented in schools.

Universal Interventions

According to Weisz and colleagues (2005), universal strategies are “approaches designed to address risk factors in entire populations of youth – for example, all youngsters in a classroom, all in a school, or all in multiple schools – without attempting to discern which youths are at elevated risk” (p. 632). In developing universal interventions for schools, Farmer et al. (in press) suggest the following four questions to guide the choice and subsequent implementation of universal programs: (1) What general activities in the academic, social, and behavioral domains are associated with conflict and aggression in the school? (2) What universal interventions can be implemented schoolwide to address problems in each of the specific domains identified? (3) How do various problems impact each other across the different domains? and (4) How can different interventions be brought together to systematically address the collective contributions of these problems?

Some examples of universal interventions are presented in Table 3. Perhaps the two most common universal interventions include Promoting Alternative Thinking Strategies (PATHS) (Kusche & Greenberg, 1994) and Second Step: A violence prevention program (Frey, Hirschstein, & Guzzo, 2000). The PATHS curriculum has six sections that cover emotional literacy, self-control, social competence, positive peer relations,

Table 3.
A Sample of evidence-based universal programs

Name	List Cited*	School Based	Age Range	Length of Program	Family Component?	Teacher Component?
1. Paths–Promoting Alternative Thinking (PATHS)	A, B, C, E	Yes	5–12	5 yrs.	Yes	Yes
2. Second Step: A violence prevention program	A, B, E	Yes	4–14	15–30 wks.	Yes	Yes
3. Responding in Peaceful and Positive Ways	A, B, E	Yes	12–14	3 yrs.	Yes	Yes
4. SMART Team: Students Managing Anger and Resolution Together	A	Yes	11–15	8 computer models	No	Yes
5. Lion Quest Skills for Adolescents	A, E	Yes	6–18	Multi-year	Yes	Yes

*Codes for which list the program was cited:

A = SAMHSA: <http://www.modelprograms.samhsa.gov>

B = Penn State: <http://www.prevention.psu.edu/pubs/docs/CMHS.pdf>

C = CSVP: <http://www.colorado.edu/cspv/blueprints/>

D = USDOE: <http://www.ed.gov/admins/lead/safety/exemplary01/exemplary01.pdf>

E = CASEL: http://www.casel.org/projects_products/safeandsound.php

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and interpersonal problem-solving skills. The program targets children between 5 and 12 years of age and can continue across five grade levels. Second Step is a school-based social-skills program for children 4 to 14 years of age that teaches social skills and socio-emotional skills aimed at reducing impulsive and aggressive behavior while increasing social competence. The program consists of in-school curricula, parent training, and skill development. Generally, approaches at the universal level of prevention include curriculums to be delivered within the classroom to teach specific behaviors and include opportunities for the students to practice the newly acquired skills. The key strategies for effective school-based prevention programming according to Greenberg and his colleagues (Greenberg et al., 2003) include teaching and reinforcing skills in students; fostering supportive relationships among students, school staff, and parents; implementing systemic school and community approaches; starting programs before risky behaviors begin; and continuing multi-component across multiple years (see Table 4).

Table 4.
Key strategies for effective school-based prevention programming involve the following student focused, relationship-oriented, and classroom and school-level organizational changes

1. Teach children to apply social and emotional learning (SEL) skills with ethical values in daily life through interactive classroom instruction and provide frequent opportunities for student self-direction, participation, and school and community service
 2. Foster respectful supportive relationships among students, school staff, and parents
 3. Support and reward positive social, health, and academic behavior through systematic school-family-community approaches
 4. Multi-year, multi-component interventions are more effective than single component short-term programs
 5. Competence and health promotion efforts are best begun before signs of risky behaviors emerge and should continue through adolescence
-

Reprinted, with permission, from Greenberg, M.T., Weisberg, R.P., O'Brien, M.U., Zios, J.E. Fredericks, L., Resnik, H., et al. (2003) Enhancing school-based prevention and youth development through coordinated social, emotional, and academic learning. *American Psychologist*, 58 (6/7), 466-474.

Selective Interventions

According to Weisz and colleagues (2005), selective interventions target “groups of youth identified because they share a significant risk factor and mount interventions designed to counter that risk” (p. 632). Selective strategies are used with students who require more than universal strategies but less than intensive individualized interventions. The purpose of selective or targeted interventions is to support students who are at risk for or are beginning to exhibit signs of more

serious problem behaviors. Such interventions can be offered in small group settings for students exhibiting similar behaviors or to individual students. In developing selective interventions, Farmer et al. (in press) suggest the following four questions to guide the choice and subsequent implementation of selective programs: (1) How are the universal strategies currently targeting the youth's academic, behavioral, and social adjustment and can they be strengthened? (2) What individual strategies can be put in place to ameliorate the youth's risk? (3) What individual interventions or supports can be put in place to maintain and build upon positive constraints and protective factors? and (4) How can the youth's progress be monitored in a positive and supportive manner to make sure the developmental system does not reorganize in a negative manner?

A sample of selective interventions is listed in Table 5. For younger youth, *First Step to Success* (Walker et al., 1997) is implemented in the classroom with behavioral criteria set each day; for the in-home portion of the program, parents are taught to reward appropriate behaviors. For older youth *Functional Family Therapy* (Alexander & Parsons, 1982) consists of 8–26 hours of direct service time with youth and family depending on the severity of disruptive behaviors, and consists of five phases: engagement, motivation, assessment, behavior change, and generalization. A selective program that is community based but is growing in popularity as a school-based program is mentoring. The most popular is Big Brothers/Big Sisters (Grossman & Tierney, 1998), which provides a formal mechanism for the development of positive relationships between at-risk youth and caring adults.

Table 5.
A sample of evidence-based selective programs

	Name	List Cited*	School Based	Age Range	Length of Program	Family Component	Teacher Component?
1	First Step to Success	B	Yes	4 – 5	3 mo.	Yes	Yes
2	Functional Family Therapy	C	No	11 – 18	8 – 26 hrs.	Yes	No
3	Big Brothers/Big Sisters	B, C	No	5 – 18	1 yr.	No	No
4	Fast Track	B	Yes	6 – 12	School year	Yes	No
5	Olweus Bullying Prevention Program	A**, C	Yes	6 – 18	School year	No	Yes

*Codes for which list the program was cited:

A = SAMHSA: <http://www.modelprograms.samhsa.gov> **Before 2007.

B = Penn State: <http://www.prevention.psu.edu/pubs/docs/CMHS.pdf>

C = CSVP: <http://www.colorado.edu/cspv/blueprints/>

D = USDOE: <http://www.ed.gov/admins/lead/safety/exemplary01/exemplary01.pdf>

E = CASEL: http://www.casel.org/projects_products/safeandsound.php

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Another popular area of evidence-based programming has been bullying prevention with widespread adoption of either the Olweus Bullying Prevention Program (Olweus, 1991) or the Success in Stages: Build Respect Stop Bullying program (Evers, Prochaska, van Marter, Johnson, & Prochaska, 2004). There has also been recent evidence that decreases in bullying have occurred in schools that have attended to the risk and protective factors within the school environment. For example, attending to the following five areas has been associated with decreasing bullying: (1) teachers develop positive relationships with all students, (2) teachers make their academic programs interesting to students, (3) the school establishes different intervention strategies for children who need extra help (such as mentoring or after-school programs), (4) the school has definitive policies against bullying for students and prohibits teachers from shouting at children or ridiculing them, and (5) the school has a strong nonacademic program such as music, art, and dance (Orpinas & Horne, 2006).

Indicated Interventions

According to Weisz and colleagues (2005), indicated prevention strategies are “aimed at youth who have significant symptoms of a disorder . . . but do not currently meet diagnostic criteria for the disorder” (p. 632). As stated earlier, there is very little difference between indicated prevention strategies and those interventions focused on treatment of a diagnostic condition. Farmer et al. (in press) suggest six questions to guide the choice and subsequent implementation of multi-level indicated programs and interventions that are targeted to these youth who have challenges in multiple domains: (1) What are the factors contributing to the youth’s difficulties and how are they related to each other? (2) What services are needed to address the different problems and how should interventions be coordinated? (3) As an intervention prompts change in one domain, how does it affect other domains? (4) What problem areas are most likely to change and help support change in other domains? (5) As some problem areas are changing, what interventions can be used to change other domain areas that are more difficult to change? and (6) What natural supports and relationships can be developed that will help sustain the gains made in treatment?

Examples of indicated programs are presented in Table 6. For young children, between 8 and 12 years of age, Incredible Years (Webster-Stratton, 1992) can be implemented in schools and is used as both a selective and indicated prevention program. The program uses four formats: 18 to 22 two-hour weekly Dina Dinosaur group therapy sessions for children; 60 Dina Dinosaur lesson plans for the classroom; 12 to 14 two-hour weekly parenting groups; and 14 two-hour teacher class-

room management sessions. The Earls court Social Skills Group Program (Pepler, King, Craig, Byrd, & Bream, 1995) is aimed at reducing aggression in elementary school students through twice weekly, 75-minute group sessions for 12 to 15 weeks. Sessions teach eight basic skills in program modules, classroom activities, and homework. Training sessions are also offered to parents.

Table 6.
A sample of evidence-based indicated programs

Name	List Cited*	School Based	Age Range	Length of Program	Family Component	Teacher Component?
1 Incredible years	A, C	Yes	2–8	Up to 22 wks.	Yes	Yes
2 Multi-systemic Therapy	A, C	No	12–17	4 mo.	Yes	No
3 Brief Strategic Family Therapy	A	No	6–17	8–12 wks.	Yes	No
4 Adolescent Transition Program	B	No	10–14	12 wks.	Yes	No

*Codes for which the program was cited:

A = SAMHSA: <http://www.modelprograms.samhsa.gov>

B = Penn State: <http://www.prevention.psu.edu/pubs/docs/CMHS.pdf>

C = CSVP: <http://www.colorado.edu/cspv/blueprints/>

D = USDOE: <http://www.ed.gov/admins/lead/safety/exemplary01/exemplary01.pdf>

E = CASEL: http://www.casel.org/projects_products/safeandsound.php

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There are several indicated programs that are community-based which may augment school programs. Two of these are Multi-systemic Therapy (MST) (Henggeler et al., 1986) and Brief Strategic Therapy (Szapocznik, Hervis, & Schwartz, 2003). MST targets older adolescents and has an average duration of 60 contact hours over four months. Intervention strategies are integrated into social ecological contexts (including the school system) and include strategic family therapy, structural family therapy, behavioral parent training, and cognitive behavior therapy. Brief Strategic Therapy can be used with students between the ages of six and 17 and is delivered in 60- to 90-minute sessions over the course of eight to 12 weeks. A counselor meets with the family and develops a therapeutic alliance, diagnoses family strengths and problem relations, develops a change strategy, and helps implement those strategies.

Cost-Benefit Analysis

A common concern of program administrators is the cost of implementing a new program as compared to the expected benefit from the new program. To address this concern, the Washington State Institute for Public Policy (WSIPP) (Aos, Lieb, Mayfield, Miller, & Pennucci, 2004) issued a report on the benefits and cost of evidence-based programs. As mandated by the Washington state legislature, this report focused on a limited number of programs and only examined those approaches that focused on reducing the following negative social outcomes: (a) crime, (b) substance abuse, (c) teen pregnancy, (d) suicide, (e) child abuse and neglect, and (f) increasing the positive social outcome of educational attainment.

To be included in this report, a program or approach had to have one rigorous evaluation that targeted one of the six outcomes listed above and had to be applicable to real-world settings. Additionally, some programs and approaches were excluded because the measured outcomes could not be monetized. For example, an outcome for one program included changes on a scale that measured psychopathology (e.g., changes on the Child Behavior Checklist) to document symptom reduction. The change in scale score could not be associated with a monetary amount and therefore the program could not be part of the WSIPP analysis. Changes in standardized scale scores (i.e., symptom reduction) is a common outcome tool for mental health researchers, suggesting that many mental health programs may have been excluded from the WSIPP analysis due to this requirement.

The analysis yielded benefit minus cost information for 61 evidence-based programs and approaches. The 61 programs are listed in the Appendix, along with the benefit minus cost estimate per youth, the number of studies or trials used to calculate the cost-benefit analysis, and the social outcomes influenced by each program. These analyses point out the money that can be saved by a system with the proper implementation of these programs. For example, these analyses revealed that Multi-systemic Therapy (MST) can save the system \$9,000 per youth. That is, it cost \$9,000 more to place a youth in a restrictive setting such as detention or jail than to implement MST. The Adolescent Transitions Program can save the system \$1,938 per youth and Functional Family Therapy, when implemented in the state of Washington, was found to save \$14,000 per youth over the use of restrictive settings such as residential or hospital care.

What is especially interesting about this report is the unique approach taken to evaluate approaches to be included and described. WSIPP clearly states that they wanted strategies targeted at specific out-

comes rather than programs that may fit into a school or be classified as a mental health program. For example, they targeted empirically supported approaches that reduce crimes committed by adolescents. While committing a crime would certainly be considered a negative outcome and is often considered poor functioning for a teen attending a mental health program, is such a program targeting crime reduction a mental health program? Is a program that targets the prevention of teen pregnancy a “mental health program”? This focus on a wide variety of outcomes in this analysis points to the array of outcomes and functioning typically subsumed under the topic of mental health interventions.

In summary, there are many evidence-based mental health programs aimed at strengthening the emotional and behavioral competences of children and youth that can be implemented in school and target reducing disruptive and aggressive behavior. In recognition of the importance and complexity of implementing evidence-based practices in community settings, the Center for Mental Health Services will release, in late 2007 or early 2008, a guide specifically focusing on the selection and adoption of evidence-based practices for youth with disruptive behavior disorders. This guide will provide materials to help community members determine which evidence-based practice might match their community needs and how much it costs to implement these programs.

In schools, implementation of programs must be conducted in an integrative manner so that teachers, school staff, and parents each understand their role in the implementation and the expected outcomes. In an integrative, team-based model of supporting positive emotional and behavioral functioning, there is a common vision for families, mental health, and education staff (see Figure 5). Additionally, there are programs implemented at the universal, selective, and indicated levels that integrate PBS, MH programs, and Response to Intervention strategies (RtI) in an organizational environment that supports and facilitates collaborative, integrated systems of service.

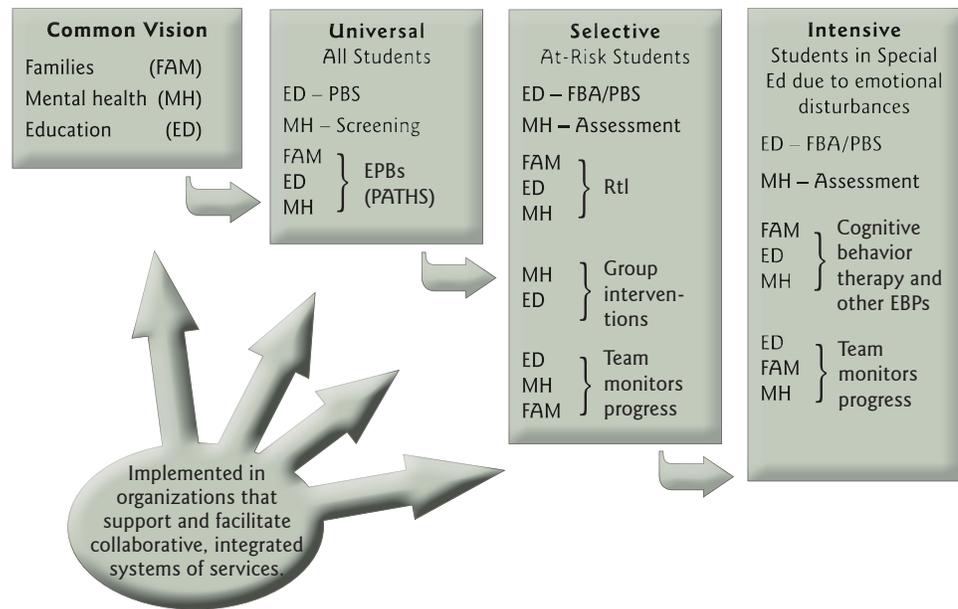


Figure 5. An integrative team-based model of positive emotional and behavioral functioning in children and youth

Family-Driven Care

There is also growing support across the country to transform the mental health system into one that is more responsive and accessible to consumers and families. In the case of services for children, the term “family-driven care” is used to describe this process of transformation. While the concept of family-driven care is new and evolving, there are emerging definitions in the field. A definition has been proposed in a working draft of a training guide developed through collaboration between the national office of the Federation of Families for Children’s Mental Health and the federal Substance Abuse and Mental Health Services Administration (SAMHSA) (Osher, Osher, & Blau, 2006); see Table 7 for the definition.

The concept of family-driven care is new for most of us although it has roots in both the education and mental health systems. For many years now, IDEA has called for family and student-directed Individualized Educational Plans (IEP), admittedly with little success. Practitioners of PBS have promoted person-centered planning and have engaged families in the treatment of children. In the mental health field, the System of Care model and Wraparound services have promoted a planning process for treatment that is family focused. Today, under the transformation initiative, both the ED and MH systems are beginning to use “family-driven” language. Transformation that is effective will require

Table 7.
Definition of Family-Driven Care

“Family-driven” means families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory, and nation. This includes:

- Choosing supports, services, and providers
- Setting goals
- Designing and implementing programs
- Monitoring outcomes
- Participating in funding decisions
- Determining the effectiveness of all efforts to promote the mental health and well-being of children and youth

Reprinted, with permission, from Osher, T.W., Osher, D., & Blau, G. (2006). *Shifting gears to family-driven care: Ambassadors tool kit*. Rockville, MD: Federation of Families for Children’s Mental Health.

attitudinal change, new skills, redeployment of resources, and time for all of this to occur. Transformation to family-driven care is complex, multi-dimensional, and in some cases will be revolutionary. Osher and colleagues (2006) list 10 principles (see Table 8) that guide the development of family-driven care, and these principles illustrate the multi-faceted nature of the task. For many practitioners the adoption of these principles is visionary and definitely revolutionary, but for parents and their children it is viewed as obligatory.

Changing the Culture

Many education and mental health professionals, during their training, have been presented with faulty information about the causal relationship between parent characteristics and the emotional and behavioral characteristics of their children. Concepts such as “ice-box mother,” “schizophrenogenic mother,” parents who put their children in double-bind situations where they must fail, etc., do not have supporting evidence and the results of rigorous studies disprove their validity. Unfortunately, the influence of these rejected theories continues to affect how many professionals perceive families. Professionals need to incorporate into their understanding of families the concept that the roles of families have changed over time and continue to evolve. These roles have changed due to new research, federal initiatives, and new interventions for children who have emotional and behavioral disturbances. This evolution encompasses the last six decades, is an ongoing process, and is summarized in Table 9.

Table 8.
Principles of Family-Driven Care

-
- Families and youth are given accurate, understandable, and complete information necessary to set goals and to make choices for improved planning for individual children and their families.
 - Families and youth, providers and administrators, embrace the concept of sharing decision making and responsibility for outcomes.
 - Families and youth are organized to collectively use their knowledge and skills as a force for systems transformation.
 - Families and family-run organizations engage in peer support activities to reduce isolation, gather and disseminate accurate information, and strengthen the family voice.
 - Families and family-run organizations provide direction for decisions that impact funding for services, treatments, and supports.
 - Providers take the initiative to change practice from provider-driven to family-driven.
 - Administrators allocate staff, training, support, and resources to make family-driven practice work at the point where services and supports are delivered to children, youth, and families.
 - Community attitude change efforts focus on removing barriers and discrimination created by stigma.
 - Communities embrace, value, and celebrate the diverse cultures of their children, youth, and families.
 - Everyone who connects with children, youth, and families continually advances their own cultural and linguistic responsiveness as the population served changes.
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The early beliefs that families caused mental illness in their children or that all family members required therapy themselves were challenged by data from new research. This does not deny the possibility that a family may abuse or neglect their children because of substance abuse, for example. Some parents may experience stress that is related to their child's disability and may benefit from therapy. The research literature does indicate that there are many causes of impaired functioning in children, but we must not engage in unproven stereotypical thinking.

In the 1980s and 1990s the System of Care movement, Wraparound programs, and PBS emerged to help children who have emotional and behavioral disturbances. At this time families began to be accepted as partners in planning effective treatment for their children. More recently families have been trained and given the role of evaluators of programs that are intended to help their children. This has evolved into the current role of families as policymakers through the development of family-driven care.

Table 9.
Evolution of the Role of Families

Mid-1900s	Family members not involved in child's treatment.
1950–1960s	Mental health professionals began to question the absence of families from their child's care. "Family therapy" as treatment became increasingly popular.
1960–1970s	Families of children with developmental disabilities began advocating for increased family participation in children's health services.
1980s	Mental health professionals questioned beliefs that family members were responsible for their child's mental health problems. Parents and supportive professionals continue to advocate for increased family participation in services.
1990s	Systems of care offer services based on child and family strengths. Collaboration increasingly a goal of participants in system of care.
2000s	Emergence of family-driven care.

The basic foundation of family-driven care is the partnership between families and the professionals who provide services for their children. This partnership can serve as the impetus and support to change the culture that currently exists in many communities. From the perspective of families the current culture promoted by the professional community is too often characterized by blame, suspicion, mistrust, condescension, frustration, and litigation. A shift is needed to a culture that values each partner, focuses on strengths, shares a common vision, pools resources, shows respect and understanding of each other, and advocates to strengthen families and the systems that serve them.

Strategies need to be implemented through schools, PBS programs, and mental health centers that will support families in the transformation process and increase the degree to which families are engaged with professionals. In this way family involvement in the education and treatment of their child who has EBD will increase with an ultimate positive impact on the child's functioning and outcomes.

Families Need Information

Families will play a critical role in the transformation to a family-driven system of care. While they cannot be expected to master the service delivery system at the level of a professional, they will need to become familiar with basic components of the major models of service cur-

rently available. Both the education system and the mental health system have produced interventions aimed at skill training to promote the social and adaptive functioning of children as well as academic improvement. Three important processes, Positive Behavior Supports (PBS), Wraparound, and Response to Intervention (RtI) offer frameworks that are congruent and can serve to help unify the efforts of education staff, mental health practitioners, and families to provide evidence-based practices to improve the functioning of children who have EBD.

To some degree, the implementation of a synthesis of evidence-based instructional techniques and mental health services will require a restructuring of how services are provided, what kinds of services are provided, and a mutual understanding of the language, theories, and perspectives by members of each system. These three processes require a team approach (that includes families), an emphasis on problem solving, a need to ensure continuous progress, and the use of interventions that are empirically supported and aimed at the development of skills to improve functioning. The goals of the national transformation initiative are consistent with the development and implementation of these types of services.

Essentially, what is needed is the development of an organized team, made up of children and families, schools, and service providers, that has three basic features: (a) common vision—the mission, goal, and purpose of the team that provides support and service to children who have emotional disturbances is shared by all the stakeholders and serves as the basis for decision making and action planning; (b) common language—communication is informative, efficient, effective, and relevant to all the members of the team, especially families; and (c) common experience—the actions, procedures, and operations are experienced by all the members of the team.

As in most reform movements there are both small and large steps that can be taken to achieve desired change in how care is provided. Osher and colleagues (2006) have proposed some examples of methods and procedures to increase family voice and choice (see Table 10). One of the most important choices facing families seeking treatment for children who have EBD is to decide which intervention to request for their child. Today, the practice community has produced an impressive list of interventions that have been tested with rigorous evaluation techniques and are considered to be evidence-based practices.

Table 10.
Examples of Methods to Increase Family Voice

- Ensure that meetings occur at times that are realistic for families to attend
 - Conduct meetings in culturally and linguistically competent environments
 - Ensure that family and youth voices are heard and valued
 - Ensure that families and youth have access to useful, usable, and understandable information and data
 - Provide sound professional expertise to help families make decisions
 - Share power, authority, resources, and responsibility
 - Construct funding mechanisms to allow families and youth to have choice
-

Reprinted, with permission, from Osher, T.W., Osher, D., & Blau, G. (2006). *Shifting gears to family-driven care: Ambassadors tool kit*. Rockville, MD: Federation of Families for Children's Mental Health.

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Section III.

Facilitating Implementation: A Blueprint for Community Action

There is a long history in this country, going back to the end of the 19th century, of providing mental health services for children in our schools. Now, as we enter the 21st century, there is an increased interest in and hope that school-based services may play a larger role in better meeting the needs of the millions of children who have emotional disturbances, especially those children who commit anti-social and violent acts. Through more effective implementation of school-based mental health services, the academic and social/emotional outcomes for these children are expected to improve, leading to an adulthood that is healthier and marked by a better quality of life.



Clearly, the current problems of aggression and violence in America's schools are a formidable challenge for educators and the communities served by our nation's schools. There is reason for some optimism from the many initiatives and programs described in the literature today, especially in the other titles in the *Effective Strategies for Creating Safer Schools and Communities* series. The challenge for schools and districts is to develop strategic plans that will enable them to implement the best practices described in these materials, to implement them with fidelity to the program model, and to engage community stakeholders (including families) to form the necessary collaborative partnerships that will ensure meeting the challenge.

In this section we will review major federal policies and initiatives that support school districts in collaborating with the mental health system

to develop safe and secure schools. School staff members need to be aware of policies that can facilitate the implementation of collaborative efforts, as well as the parameters within which these efforts need to operate. The section will close with a presentation of the *Public Health Model*, which is proposed as a blueprint for action for schools, particularly at the district level, to engage the community and work toward achieving safe and secure schools with students who are functioning well academically and emotionally.

Federal Policy

While the mechanisms for schools to effectively implement violence prevention programs are still being developed, there is no lack of federal policies, regulations, and initiatives promoting the implementation of school-based mental health services in order to significantly increase access to mental health services for children and to subsequently improve a range of outcomes including social and emotional functioning and academic progress. It is no exaggeration that all federal agencies that have responsibility for some aspect of the well-being of children and youth have some reference to at least collaborate with schools to better achieve their own particular mission as it relates to the welfare of the children they serve. The lion's share of these policies and initiatives emanate from the various branches of the U.S. Department of Education (US ED) and the U.S. Department of Health and Human Services (US HHS).

Arguably, the Individuals with Disabilities Education Act (IDEA), originally passed in 1975 as the Education for all Handicapped Children's Act, is the most comprehensive piece of federal legislation to affect children who have disabilities and their families, including children who have emotional disturbances. In the case of children who have emotional disabilities, however, IDEA is narrowly focused on students who have an identifiable disability that may affect various life domains but *must also interfere with the student's educational achievement*. The interpretation of eligibility criteria at the local level has resulted in the continuous under-identification of this disability group. There has never been more than 1 percent of the school-age population identified and served in special education programs for students with emotional and behavioral disturbances, despite prevalence estimates closer to 5 percent (Kutash et al., 2006). For children who meet eligibility under IDEA, related services needed to ensure an appropriate education are prescribed as an entitlement of the Act. Related services may include psychological counseling, the implementation of behavioral plans based on functional behavioral assessments, and the inclusion of positive behavioral interventions and supports.

Legislation aimed at achieving improvement for all children and youth is the No Child Left Behind Act (NCLB) signed into law in 2002 by President Bush. In NCLB, the emotional functioning of all children is specifically addressed in Title V of the Act, which outlines initiatives aimed at ensuring the emotional well-being of America's youth. Some examples of strategies offered under NCLB include character education, safe and drug-free school initiatives, violence prevention programs, and specific programs for children who are neglected, exposed to violence, or at risk for failure due to low income. In both Acts, interagency collaboration is encouraged to enhance service capacity. Because approximately three-fourths of children who receive any mental health service at all receive it through the school system (Burns et al., 1995), the attention to the provision of mental health services to children in schools by ED is most appropriate as the school system can be considered the *de facto* mental health system for children in this country.

In addition to these initiatives in the U.S. Department of Education, a significant set of sentinel public health findings were summarized in the Surgeon General's *Report on the Mental Health of the Nation* (US DHHS, 1999), which documented the extent of unmet mental health needs for both adults and children, and the burden to the nation in terms of lost and ruined lives as well as devastatingly high financial costs. In chapter three of the Surgeon General's report, issues specific to children were presented, including evidence of a strengthening of the knowledge base over the past decade on efficacious treatments and services for children who have serious emotional disturbances. Unfortunately, these efficacious services present many challenges to the provider network when they attempt to transfer these interventions and programs to community-based settings. The net result is that unmet needs continued into the new millennium, prompting a call for a transformation of the mental health system in this country into one that is more responsive and has the capacity to better meet the mental health needs of its citizens.

In April 2002, President Bush appointed the New Freedom Commission on Mental Health, charging the Commission to "study the mental health service delivery system, and to make recommendations that would enable adults with serious mental illnesses and children with serious emotional disturbance to live, work, learn, and participate fully in their communities" (President's New Freedom Commission on Mental Health, 2003, p.1). The Commission adopted two broad principles to guide its work. These were (a) services and treatments must be consumer and family centered, with a real commitment to giving choices and options, and (b) a focus on recovery and resilience, increasing consumers' ability to cope with challenges, not just reduce

symptoms. The Commission utilized the action word “transform” as the hallmark characteristic of the reform activities it would promote. Of the six goals identified by the Commission, Goal Four states that “*early mental health screening, assessment, and referral to services are common practice*” (p. 57).

Goal Four promotes the mental health of children and recommends the improvement and expansion of school mental health programs. While the Commission agreed that the mission of schools is to educate students, it also noted that children who have EBD have the highest rates of school failure. The Commission further noted that school is where children spend most of their day and echoed the Surgeon General in identifying school as the ideal location for implementing the whole range of mental health services from prevention to treatment. To this we would add that there is a growing body of research (e.g., Greenberg et al., 2003; Zins et al., 2004) which examines the reciprocal nature of academic and emotional functioning. Early findings support the conclusion that learning strategies for children who have EBD should include both academic and emotional/behavioral components.

Need for Advocacy

School staffs and School-Community Advisory Councils need to become familiar with these federal policies and initiatives in terms of the potential to redeploy resources into supporting programs that promote safe and secure schools. In some cases this may lead to a change in “business as usual” in a school or district. As we know, change does not always come easy. However, if a community identifies significant unmet needs in children that are not being adequately addressed by current programs, it may be time to rethink what the current practices are and what alternatives may exist. There are several options that school districts have with regard to the use of IDEA and NCLB funds that are termed “discretionary.” There also are federal and state grants aimed at reducing school violence. This series of guides offers a multitude of innovative possibilities that are evidenced-based for the schools and the communities they serve to consider in meeting the goal of achieving safe and secure schools.

The challenge for schools and communities is to devise mechanisms that will facilitate the use of the information base that exists and the available resources to implement desired innovative programs. Part of the answer lies in the federal initiatives and laws mentioned above. A thorough analysis of the four initiatives we briefly described would reveal a common thread. All four initiatives promote the use of the “public health model” to achieve better outcomes for children. We

propose that the public health model can serve as a blueprint for a community to promote and enhance the use of the best available evidence-based practices to achieve the desired academic and emotional/behavioral outcomes for their children in safer and more secure schools.

Public Health Approach

In many reports in the literature, the discussion of the public health model does not go beyond the emphasis on the development of strategies for prevention through the implementation of universal, selective, and indicated interventions. While prevention certainly is a fundamental principle, the model is richer and more encompassing. The public health model has its focus on populations rather than individuals; that is, society is the client (Strein, Hoagwood, & Cohn, 2003). The interaction of risk and protective factors in individuals is examined at the community level. Decisions are data-based and the goal of public health research is to develop specific interventions that are targeted toward enhancing protective factors and reducing the risk factors that lead to undesirable outcomes.

The public health model may be conceived of as having four components or steps (see Figure 6). The first component is a focus on the population as opposed to individuals. Surveillance, which entails defining a specific problem through systematic information collection at the population level, is the major mechanism used in this component. The goal is to be able to describe the scope, characteristics, and the consequences of a problem facing the community. In the second step the causes are identified through an analysis of the risk and protective factors, their correlates, and how these factors could be modified to decrease the risk. In the third step interventions are developed and evaluated. The interventions are on a continuum that includes health promotion/positive individual development, universal prevention interventions, selective interventions, and indicated interventions. The fourth step consists of activities to scale up implementation at a level that will have a significant positive impact on the population. In this step effective practices are implemented and monitored and their cost effectiveness is evaluated.

This is a comprehensive approach aimed at reducing the negative consequences of a condition or behavior. However, it is also practical, makes use of multi-disciplinary involvement, and monitors costs and benefit. In the following section, the four components of the public health model are described in terms of how a community may use this model to develop and implement a comprehensive system of school-based mental health services that can focus on the promotion of safe and secure schools.

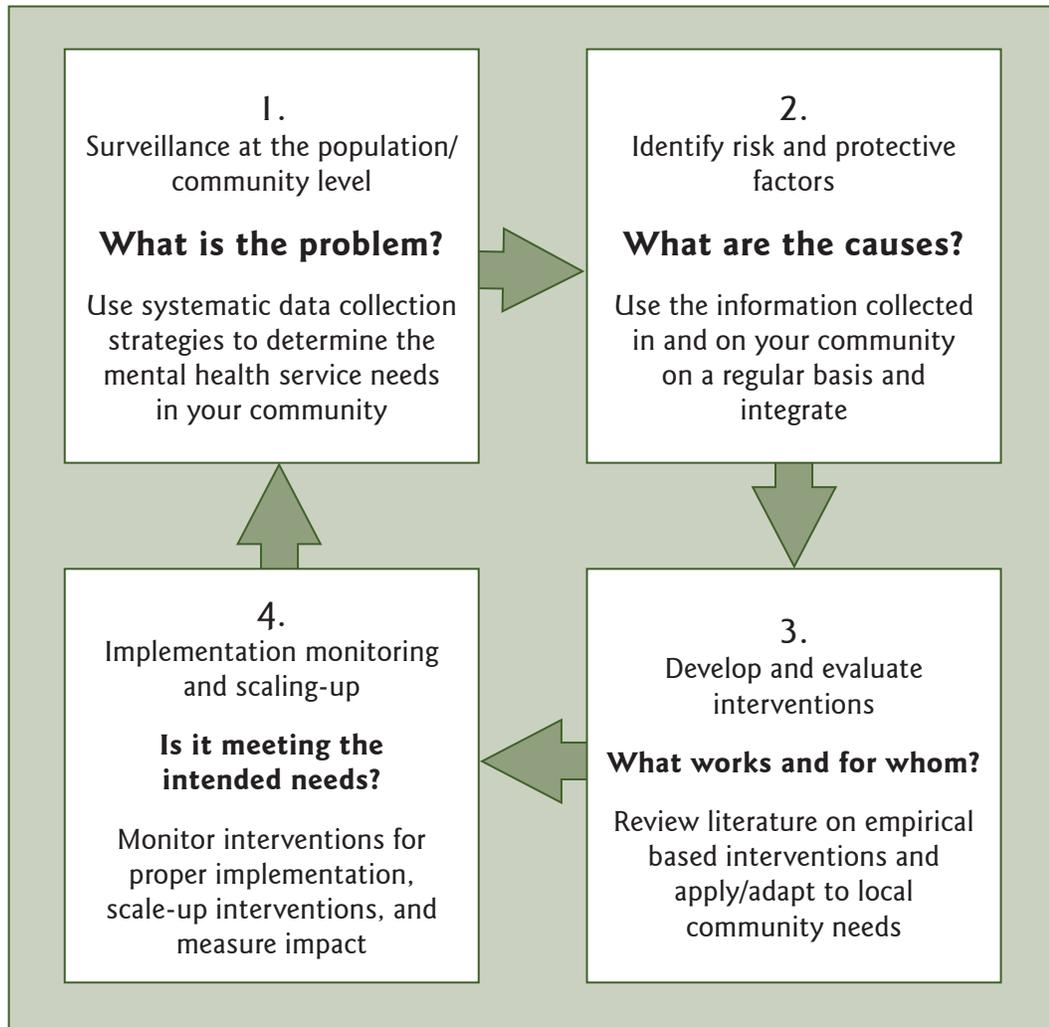


Figure 6. Four Steps for the Public Health Model

Step 1. Focus on the population

When a community decides to use a public health model to guide the implementation of school-based mental health services for its school age children and youth, the first step involves “surveillance,” a technical term used by public health practitioners. It means the community will seek answers to the question, “What is the problem in our community?” Surveillance entails systematic data collection to produce information for action. For example, the community would want to know the degree to which the mental health needs of its children are being met, the gaps in service delivery, and the potential for effective services to contribute to meeting the needs. In a public health approach, the focus is on all the school-aged children, not just those with the most severe emotional disturbances or those who may be at risk for anti-social behavior. Consequently, the school district is

a major player in the surveillance process as opposed to individual schools or classrooms.

Surveillance information can be derived from districtwide data, census information, county health department data, and other similar data bases. This information will help produce estimates of the magnitude of the problem, and possible geographic and demographic relationships, and lead to the development of strategies for improved outcomes. High-quality surveillance in a community will facilitate progress to the next step that attempts to identify the risk and protective factors that contribute to the manifestation of undesirable conditions.

Step 2. Risk and protective factors

In the public health model potential causes of problems are identified through analysis of risk and protective factors. It should be noted that risk and protective factors are not causes or cures themselves but rather are statistical predictors that have a theoretical and empirical base. Risk factors are personal characteristics or environmental conditions that have been empirically demonstrated to increase the likelihood of problem behavior. Some examples of risk factors are gender, family history, lack of social support, reading disabilities, and exposure to bullying. These factors vary in terms of their malleability to change. Protective factors are personal characteristics or environmental conditions that have been empirically established to interact with risk factors to reduce the likelihood of the occurrence of problem behavior. Examples of protective factors include caring parents and teachers, social competence and problem-solving skills, schools that establish high expectations for all students and supply the supports necessary for all students to achieve these expectations, and the opportunity to participate in positive activities in school and the community. As in the case of risk factors, these protective factors vary in the degree to which schools and child-serving agencies can promote them, but they all have been empirically demonstrated to reduce the effects of risk factors.

As the research base on risk and protective factors expands, it is becoming clear that there needs to be a balance in addressing the reduction of risk factors—a deficit approach—and promoting protective factors—a strengths-based approach. Schools and community partners need to keep in mind that the hallmark of the public health model is data-based decision making, along with a commitment to using the best available interventions, the next component of the model. Effective surveillance and information on the population will lead to the identification of local risk and protective factors. This will enable the community to apply and adapt the most relevant evidence-based innovations in the next step of implementing the model.

Step 3. Develop and evaluate interventions

As the guides in this series illustrate, the past several decades have seen a plethora of innovative and empirically based interventions developed and aimed at meeting the emotional and behavioral needs of youth and preventing and reducing violence in communities. Many of these interventions and strategies depend on schools for implementation. Efforts also have been made to distill these interventions into the level of prevention they address (i.e., universal, selective, indicated/treatment) and an assessment of the empirical strength of each. While we seem to have many empirically supported approaches and interventions, we probably do not have a perfect match between the array of problems presented by youth covering the entire developmental continuum and empirically supported approaches. It is widely recognized that many youth have multiple or co-occurring problems that are not adequately addressed by the current selection of interventions.

However, many of the effective strategies that are available are not being implemented. This is especially true in the area of universal prevention. Prevention is an area in which we have a long history of empirical support; see, for example, *From Neurons to Neighborhoods* (Shonkoff & Phillips (2000), and Greenberg et al (2003). There are two school-based universal programs, PATHS and schoolwide use of PBS, which are beginning to be implemented in schools nationwide. We need to document the use of these strategies and their effectiveness in various types of communities.

Another challenge is to get empirically supported selective and indicated programs integrated into schools. Communities are creating interesting strategies to increase the awareness of the various empirically supported programs. The state of Hawaii formed work groups to study empirically based programs and determine which programs would be most applicable to their populations (Chorpita & Taylor, 2001; Chorpita et al., 2002). Ohio has a statewide initiative to increase awareness of evidence-based practices (Ohio Department of Mental Health, 2001), as well as an initiative to increase the empowerment of teachers in delivering school-based mental health services (Paternite, 2004). Other communities nationwide are active in building school-based mental health services—we know that close to half of all schools have multidisciplinary teams that meet at least monthly, and approximately 55 percent of schools report having a contract with an outside agency to provide mental health services (Kutash et al., 2006).

An additional challenge inherent in the delivery of school-based mental health services is the need to direct our attention to improving academic outcomes for students with EBD. Until recently, little attention

had been directed to the academic issues for students with emotional and behavioral disorders. This may be partly due to teacher preparation programs that focus predominantly on the social and behavioral characteristics and needs of this population, and the misconception held by many educators that students must behave properly before academic learning is possible (Lane, 2004). Recent research suggests that, in some instances, students may act out to avoid aversive academic tasks—tasks that do not match the students' level, i.e., either being too easy or too difficult (Lane, 2004). This is an important factor in understanding some aggressive behavior in children.

Other research is beginning to explore the therapeutic relationship of academic interventions and the reciprocal relationship between academic success and decreases in negative behavior. In a study of the efficacy of psychotherapy, Catron, Harris, and Weiss (1998) revealed that students with behavior disorders who received academic tutoring improved their behaviors as much as the students who received individual counseling. In addition, there is a growing body of research that academic success is associated with a decrease in problem behavior (Gottfredson, Gottfredson, & Skroban, 1996; Lane, O'shaughnessy, Lambros, Graham, & Beebe-frankenberger, 2001; Lane et al., 2002). This research suggests that mental health professionals may need to support classroom teachers in instructional activities and classroom management to a greater degree than previously recognized.

Step 4. Implementation monitoring and scaling up

The final step in the public health model addresses the issue of implementation. Recently, numerous efforts have been initiated to better understand the factors associated with the successful implementation of evidence-based practices in community-based settings. We are currently just beginning to understand the complexity of scaling-up innovative interventions for wide-scale community adoption. Both the National Implementation Research Network (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005) and the Prevention Research Center for the Promotion of Human Development at Penn State (Greenberg, Domitrovich, Graczyk, & Zins, 2005) have conducted extensive reviews of the literature in this area.

The research results are clear: providing training on innovative techniques to staff without adequate follow-up (e.g., coaching and supervision) is not effective and will result in flawed implementation and outcomes that do not match those achieved by program developers. While most program developers provide manuals and initial training sessions for their programs, very few offer mechanisms for the ongoing moni-

toring of implementation quality. Without continued support of staff as they implement these new approaches and without the ongoing monitoring of implementation, most programs will not be implemented as planned and the promised outcomes will not materialize. Fixsen and colleagues (2005) suggest that the key to successful implementation is a combination of supportive policies, community involvement, and an organizational infrastructure able to supply post-training support and conduct process and outcome evaluations (see Table 11).

Table 11.
Four factors to successful implementation

Implementation is most successful when:

- Carefully selected practitioners receive coordinated training, coaching, and frequent performance assessment
 - Organizations provide the infrastructure necessary for timely training, skillful supervision and coaching, and regular process and outcome evaluations
 - Communities and consumers are fully involved in the selection and evaluation of programs and practices
 - State and federal funding avenues, policies, and regulations create hospitable environment for implementation and program operations
-

Reprinted, with permission, from Fixsen, D.L., Naoom, S.F., Blasé, K.A., Friedman, R.M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature* (FMHI Pub. No. 231). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, National Implementation Research Network.

Greenberg and colleagues (2005) remind us in their review that for innovations implemented in schools, factors at the school, district, and community levels influence the quality of program delivery. Without support and active involvement of the community and district, most innovations adopted at the school level will not succeed. Additionally, along with collecting information on the level of implementation of an innovation, school personnel and practitioners should examine and record factors that substantially affect the quality of implementation in their setting and share this information with the developers of the program and the field. It is through the collection and dissemination of information on implementation in a variety of schools that the field will move forward. Daleiden and Chorpita (2005) present an extended discussion of how evidence-based services have been integrated into information system, performance measurement, and feedback tools. They offer an excellent framework for schools and communities to use as they start this important process.

These various factors associated with the proper implementation on innovative interventions will call for new roles for school staff and community workers and new partnerships with parents and family members, as well as new activities for the various stakeholders involved in implementing school-based mental health programs. While the tasks may be formidable, it is achievable and the results will be most rewarding.

Adopting/Adapting the Public Health Model

The Public Health Model is comprehensive and involves most of the major social service agencies in a community. However, school staff should realize that such an effort is necessary to counter the negative effects of aggression and violence in schools. Aggression and violence are as much a problem for the community as they are for the school. Therefore, an approach involving interagency collaboration will have a greater chance of bringing about success.

As noted, several federal initiatives promote the adoption of the public health model, there is regulatory support for it, and even resources. But progress is slow, and adoption and implementation of the model will require a new way of thinking in most school districts and communities. For those who want to take on the challenge of implementing this innovative approach, there are new resources emerging on a regular basis. Information like this series of publications will be invaluable aids to those seeking to improve the climate of their schools and outcomes of the students. We hope this guide on the role of the mental health system will contribute to this effort. Figure 7 contains an example of how a school district and a community can use the public health model as a framework to develop an effective program to produce safe and secure schools through the prevention and amelioration of aggression and violence in their youth.

Assess the boundaries of the problem	Identify risk and protective factors	Develop and evaluate interventions	Implementation monitoring & scaling-up
<p>What is the problem?</p> <p>Use systematic data collection strategies to determine the specific educational and mental health challenges in your community relating to aggression in youth.</p>	<p>What are the causes?</p> <p>Use the information collected on your community to identify the individual and social constraints relating to aggression in youth.</p>	<p>What works and for whom?</p> <p>Review literature on empirically based interventions and apply/adapt to local community needs.</p>	<p>Is it meeting intended needs?</p> <p>Monitor interventions for proper implementation, scale-up interventions, and measure impact.</p>
<p>Steps To Identify Priority Problems</p> <ul style="list-style-type: none"> Establish a task force composed of school advisory councils and mental health planning team members that has resources and authority for engaging in decision making for service planning. Use existing data to create a composite picture of the amount of violence committed by youth in the community. Existing data should be examined for indicators of aggressive and violent behavior in youth in your community to help direct actions. Examples: <ul style="list-style-type: none"> What is the rate of juvenile arrests for violent crimes in your community? What are the rates of suspensions and dropping out of school in your community? What are some indicators of substance abuse problems among the youth in your community? What are the rates of behavior referrals in schools due to fighting? Prioritize the problems to be addressed. 	<p>Steps To Identify Risk & Protective Factors</p> <ul style="list-style-type: none"> Identify individual and social risk and protective factors for each prioritized problem. Risk factors are those conditions that increase the likelihood of a negative outcome for children. Protective factors are conditions that reduce the probability of the negative outcome. Examine the empirical literature and condense the information to identify the risk and protective factors associated with the priority problem. Examples: <ul style="list-style-type: none"> A common risk factor associated with the problems of aggression and substance use is negative peer influence. What is the capacity of the community and each school for providing clubs, extracurricular activities, supervised after-school programs? A common risk factor for aggression in youth is school failure. What programs exist for the early identification and remediation of at-risk learners? What is the capacity to provide parents with positive parenting skills? To what extent are teachers effective in working with diverse populations of students and families? Integrate the community data with the research literature to identify and prioritize risk and protective factors needing to be addressed in your community. 	<p>Steps To Implement Evidence-Based Programs and Practices</p> <ul style="list-style-type: none"> Use the research literature to identify evidence-based programs and practices that are appropriate for addressing the prioritized risk and protective factors in your community. Communities need to be aware of the need to integrate and balance the implementation of universal, selective, and indicated interventions. After universal interventions have been established, the effectiveness of implementing selective and indicated interventions will be facilitated. The task force must also investigate the feasibility of implementing the selected evidence-based program for issues such as cost of the program, staff training necessary for implementation, and cultural relevance. Additionally, Task force members should outline the resources needed to support the implementation of the selected intervention over the life of the program. A task force that prioritizes aggression and substance abuse for possible action, for example, could examine the feasibility of implementing the following programs: <ul style="list-style-type: none"> For aggression: the PATHS Program (Promoting Alternative Thinking Strategies) is a universal prevention program that teaches skills such as self-control, social competence, and interpersonal problem-solving skills. An example of an indicated intervention is the Anger Coping Program, which uses a group setting to reduce anti-social behavior. For substance use: the Midwestern Prevention Project focuses on drug abuse prevention with classroom-based sessions and parent involvement. 	<p>Steps for Implementation, Monitoring, and Scaling-Up</p> <ul style="list-style-type: none"> Create infrastructure to examine and monitor youth and community outcomes to determine the effectiveness of efforts. Create quality assurance standards and training opportunities to support the dissemination and widespread adoption of successful efforts.

Figure 7. Implementing the Public Health Model: A Community Example

Appendix A.

WSIPP Results of Benefit-Cost Analysis of 61 Programs and Approaches

WSIPP results of benefit-cost analysis of 61 programs and approaches (cont.)

Program	Benefit-cost estimate per youth	Number of Studies	Prevention of Crime	PREVENTION OF			IMPROVED Educational Outcomes
				Substance Abuse	Teen Pregnancy	Child Abuse & Neglect	
Youth Substance Abuse Prevention Programs (cont.)							
10 Project ALERT (Adolescent Learning Exp. in Resistance Training)	\$54	6		✓			
11 STARS for Families (Start Taking Alcohol Risks Seriously)	(\$18)	10		✓			
12 DARE (Drug Abuse Resistance Education)	(\$99)	38			✓		
Teen Pregnancy Prevention Program							
1 Teen Outreach Program	\$181	5			✓		✓
2 Reducing the Risk Program	(\$13)	4			✓		
3 Postponing Sexual Involvement Program	(\$54)	7			✓		
4 Teen Talk	(\$81)	3			✓		
5 School-Based Clinics for Pregnancy Prevention ¹	(\$805)	8			✓		
6 Adolescent Sibling Pregnancy Prevention Project	(\$2,641)	3			✓		
7 Children's Aid Society – Camera Project	(\$9,093)	3			✓		
Juvenile Offender Programs							
1 Dialectical Behavior Therapy (in Washington)	\$31,243	1	✓				
2 Multidimensional Treatment Foster Care (v. regular group care)	\$24,290	2	✓				
3 Washington Basic Training Camp	\$22,364	Not listed					
4 Adolescent Diversion Project	\$22,290	4	✓				
5 Functional Family Therapy (in Washington)	\$14,315	1	✓				
6 Other Family-Based Therapy Programs for Juvenile Offenders ¹	\$12,441	6	✓				
7 Multi-Systemic Therapy (MST)	\$9,316	6	✓				
8 Aggression Replacement Training (in Washington)	\$8,805	1	✓				
9 Juvenile Offender Interagency Coordination Programs ¹	\$8,100	4	✓				
10 Mentoring in the Juvenile Justice System (in Washington)	\$5,073	1	✓				
11 Diversion Programs with Services (v. regular juvenile court process) ¹	\$1,865	6	✓				
12 Juvenile Intensive Probation Supervision Programs ¹	(\$1,482)	6	✓				
13 Juvenile Intensive Parole (in Washington)	(\$5,992)	Not listed					
14 Scared Straight	(\$11,056)	8	✓				
15 Regular Parole (v. not having parole)	(\$12,478)	Not listed					
Other National Programs (excluding Washington)							
1 Functional Family Therapy	\$26,216	6	✓				
2 Aggression Replacement Training	\$14,846	4	✓				
3 Juvenile Boot Camps	\$8,474	10	✓				
4 Juvenile Intensive Parole Supervision	(\$5,992)	7	✓				

¹Indicates an approach, not a packaged program

²Indicates examined "out-of-home placements"

WSIPP results of benefit-cost analysis of 61 programs and approaches

Program	Benefit-cost estimate per youth	Number of Studies	PREVENTION OF					IMPROVED Educational Outcomes
			Prevention of Crime	Substance Abuse	Teen Pregnancy	Child Abuse & Neglect		
Pre-K Education Programs								
1 Early Childhood Education for Low Income 3- and 4-Year-Olds ¹	\$9,901	106	✓		✓		✓	
2 HIPPIY (Home Instruction Program for Preschool Youngsters)	\$1,476	6					✓	
3 Parents as Teachers	\$800	8			✓		✓	
4 Parent-Child Home Program	(\$3,890)	6					✓	
5 Even Start	(\$4,863)	2					✓	
6 Early Head Start	(\$16,203)	3					✓	
Child Welfare/Home Visitation Programs								
1 Nurse Family Partnership for Low Income Women	\$17,180	15	✓	✓			✓	
2 Home Visiting Programs for At-risk Mothers and Children ¹	\$6,077	25		✓	✓		✓	
3 Parent-Child Interaction Therapy	\$3,427	1					✓	
4 Healthy Families America	(\$1,263)	12		✓			✓	
5 Systems of Care/Wraparound Programs ^{1, 2}	(\$1,914)	3					✓	
6 Family Preservation Services (excluding Washington) ^{1, 2}	(\$2,531)	15					✓	
7 Comprehensive Child Development Program	(\$37,397)	2					✓	
8 The Infant Health and Development Program	(\$49,021)	1					✓	
Youth Development Programs								
1 Seattle Social Development Project	\$9,837	7	✓	✓		✓	✓	
2 Guiding Good Choices (formerly PDFY)	\$6,918	6	✓	✓				
3 Strengthening Families Program for Parents and Youth 10-14	\$5,825	5		✓				
4 Child Development Project	\$432	4	✓	✓				
5 Good Behavior Game	\$196	1		✓				
6 CASA START (Striving Together to Achieve Rewarding Tomorrow's)	(\$610)	4	✓	✓				
Mentoring Programs								
1 Big Brothers/Big Sisters	\$48	4	✓	✓			✓	
2 Big Brothers/Big Sisters (taxpayer cost only)	\$2,822	4	✓	✓			✓	
3 Quantum Opportunities Program	(\$15,022)	8	✓		✓		✓	
Youth Substance Abuse Prevention Programs								
1 Adolescent Transitions Program	\$1,938	3		✓				
2 Project Northland	\$1,423	3		✓				
3 Family Matters	\$1,092	2		✓				
4 Life Skills Training (LST)	\$717	33		✓				
5 Project STAR (Students Taught Awareness and Resistance)	\$694	6		✓				
6 Minnesota Smoking Prevention Program	\$506	2		✓				
7 Other Social Influence/Skill Building Substance Prevention Programs	\$485	130		✓				
8 Project Towards No Tobacco Use (TNT)	\$274	10		✓				
9 All Stars	\$120	13		✓				

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Appendix B.

Resources

Evidenced-based mental health programs

National Registry of Evidence-based Programs and Practices (NREPP)

www.nrepp.samhsa.gov/about.htm

The National Registry of Evidence-based Programs and Practices (NREPP) is a searchable online registry of mental health and substance abuse interventions that have been reviewed and rated by independent reviewers.

The purpose of this registry is to assist the public in identifying approaches to preventing and treating mental and/or substance use disorders that have been scientifically tested and that can be readily disseminated to the field. NREPP is one way that Substance Abuse and Mental Health Services Administration (SAMHSA) is working to improve access to information on tested interventions and thereby reduce the lag time between the creation of scientific knowledge and its practical application in the field.

Society of Clinical Child and Adolescent Psychology Division 53, American Psychological Association & the Network on Youth Mental Health: Evidence-Based Treatment for Children and Adolescents

www.effectivetherapy.com

The purpose of this site is to inform the general public as well as practitioners regarding the most up-to-date information about mental health practice for children and adolescents. While there are many approaches for treating various psychological disorders, the treatments listed here have been evaluated scientifically for efficacy and will be updated as new treatment research is completed.

Michigan Association of Children's Mental Health

http://www.acmh-mi.org/41447_ACMH_Booklet.pdf

Offers a Guide for Families (2004) regarding evidence-based mental health practices. Helps families and youth prepare for meetings with providers. This Guide contains sample questions that families may ask to assess the fit of the evidence-based practice with their own families.

Office of Juvenile Justice and Delinquency Prevention's Model Programs Guide (MPG)

<http://www.drugabuse.gov/pdf/prevention/RedBook.pdf>

Office of Juvenile Justice and Delinquency Prevention's Model Programs Guide (MPG) is designed to assist practitioners and communities in implementing evidence-based prevention and intervention programs that can make a difference in the lives of children and communities. The MPG database of evidence-based programs covers the entire continuum of youth services from prevention through sanctions to reentry. The MPG can be used to assist juvenile justice practitioners, administrators, and researchers to enhance accountability, ensure public safety, and reduce recidivism. The MPG is an easy-to-use tool that offers a database of scientifically proven programs that address a range of issues, including substance abuse, mental health, and education programs.

Preventing Drug Use Among Children and Adolescents: A Research-Based Guide for Parents, Educators, and Community Leaders (Second Edition)

<http://www.drugabuse.gov/pdf/prevention/RedBook.pdf>

This edition includes updated principles, new questions and answers, new program information, and expanded references and resources aimed at preventing and treating substance abuse in youth.

Implementation of evidence-based practices

Resource Guide for Promoting an Evidence-Based Culture in Children's Mental Health

<http://www.systemsofcare.samhsa.gov/ResourceGuide/assessfinancial.html>

Guide provides information on planning for the implementation of evidence-based practices including how to finance the practices, how to train staff, leadership needed to implement evidence-based practices, and how to include quality improvement efforts in the implementation of evidence-based practices.

National Implementation Research Network

<http://nirn.fmhi.usf.edu/default.cfm>

The mission of the National Implementation Research Network (NIRN) is to close the gap between science and service by improving the science and practice of implementation in relation to evidence-based programs and practices. Recent monograph: *Implementation Research: A Synthesis of the Literature* is available as a free download from site.

Family organizations

Federation of Families for Children’s Mental Health

<http://www.ffcmh.org/>

A national family-run organization dedicated exclusively to helping children with mental health needs and their families achieve a better quality of life. The Federation provides leadership for a nationwide network of family-run organizations, focuses the passion and cultural diversity of our membership to be a potent force for changing how systems respond to children with mental health needs and their families, and helps policymakers, agencies, and providers become more effective in delivering services and supports that foster healthy emotional development for all children.

Other centers

Research and Training Center for Children’s Mental Health

<http://rtckids.fmhi.usf.edu/default.cfm>

The Research and Training Center for Children’s Mental Health works to strengthen the empirical foundation for effective systems of care, and improve services for children with serious emotional or behavioral disorders and their families. Since 1984, Center staff have addressed this mission through conducting an integrated set of research, training, consultation, and dissemination activities. The recent monograph *School-Based Mental Health: An Empirical Guide for Decision-Makers* (Kutash et al., 2006) is available through a free download at <http://rtckids.fmhi.usf.edu/rtcpubs/study04/default.cfm>.

Portland Research and Training Center on Family Support and Children’s Mental Health

<http://www.rtc.pdx.edu>

The Center’s activities focus on improving services to families whose children have mental, emotional, or behavioral disorders through a set of related research and training programs.

National Center for Cultural Competence

<http://www.georgetown.edu/research/gucdc/nccc/>

Despite recent progress in overall national health, there are continuing disparities in the incidence of illness and death among African Americans, Latino/Hispanic Americans, Native Americans, Asian Americans, Alaska Natives, and Pacific Islanders as compared with the U.S. population as a whole. The National Center for Cultural Competence seeks to address these issues through: training, technical assistance, and consultation; networking, linkages, and information exchange; and knowledge and product development and dissemination.

Center for Mental Health Services

<http://www.mentalhealth.org/cmhs/>

The Center for Mental Health Services (CMHS) leads federal efforts to treat mental illnesses by promoting mental health and by preventing the development or worsening of mental illness when possible. Congress created CMHS to bring new hope to adults who have serious mental illnesses and to children with serious emotional disorders. CMHS was established under the 1992 ADAMHA Reorganization Act, Public Law 102-321, that mandates CMHS' leadership role in delivering mental health services, generating and applying new knowledge, and establishing national mental health policy. CMHS is a component of the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services.

Systems of Care Net

<http://systemsofcare.samhsa.gov/>

This site serves as a resource for information about systems of care as a guiding approach and philosophy for providing comprehensive community-based behavioral health care to children, youth, and their families. The site also contains information about grant programs and technical assistance available from the Child, Adolescent, and Family Branch of the Center for Mental Health Services, SAMHSA.

National Technical Assistance Center for Children's Mental Health, Georgetown University

<http://www.georgetown.edu/research/gucdc/cassp.html>

The National Technical Assistance Center for Children's Mental Health is part of the Georgetown University Child Development Center. Located in the nation's capital, the mission of the Georgetown TA Center is to assist states and communities in building systems of care that are child- and family-centered, culturally competent, coordinated, and community based. Since 1984, NTAC has been serving as a national resource center for policy and technical assistance to improve service delivery and outcomes for children and adolescents with, or at risk of, serious emotional disturbance and their families.

School Mental Health Project (SMHP)

<http://smhp.psych.ucla.edu/>

The SMHP was created in 1986 to pursue theory, research, practice, and training related to addressing mental health and psychosocial concerns through school-based interventions. To these ends, SMHP works closely with school districts, local and state agencies, special initiatives, and organizations and colleagues across the country. In

1995 the project established its national Center for Mental Health in Schools as part of the federal mental health in schools program.

**University of Maryland Center for School Mental Health
Analysis and Action**

<http://csmh.umaryland.edu/who/>

The mission of the Center for School Mental Health (CSMH) is to strengthen policies and programs in school mental health to improve learning and promote success for America's youth. Through participation in and development of a broad and growing Community of Practice, the CSMH analyzes diverse sources of information, develops and disseminates policy briefs, and promotes the utilization of knowledge and actions to advance successful and innovative mental health policies and programs in schools. The CSMH works with a wide range of stakeholders invested in integrated approaches to reduce barriers to student learning, including families, youth, educators, mental health and other child system staff, advocates, legislators, researchers, and government officials.

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Appendix C.

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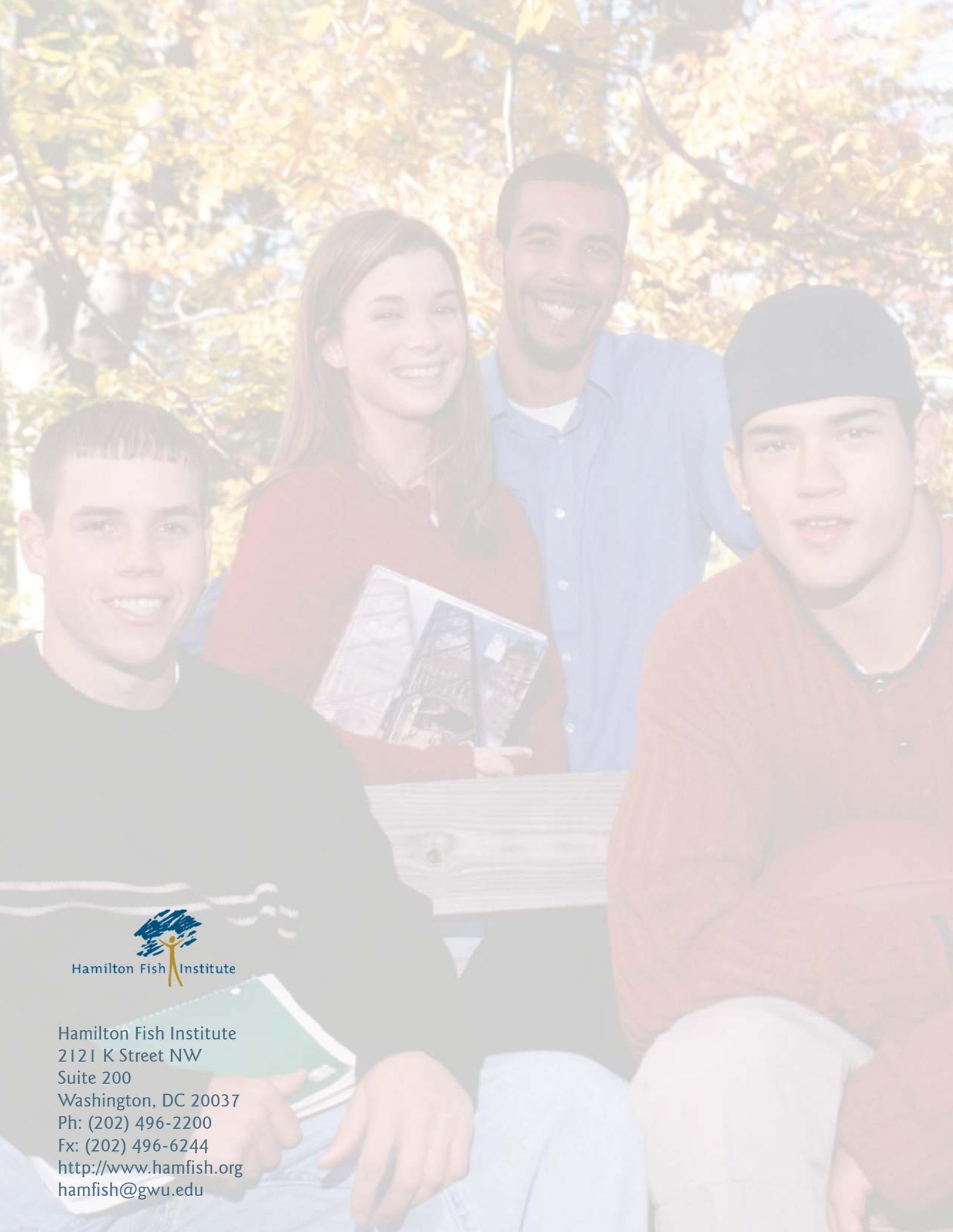
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