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Collaborative Home/School Interventions: Evidence-Based Solutions for Emotional, Behavioral, and Academic Problems.
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Introduction to Emotional, Behavioral, and Learning Problems in School-Age Children

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Emotional and behavioral problems are common reasons for referral to mental health and educational professionals within the school system. Although the proportion of children who qualify for special services because of an emotional disturbance is relatively small, teachers frequently voice concern about emotional and behavioral problems and feel the least prepared to address these issues. Such problems can lead to disruptive classroom behavior, poor peer relationships, and difficulties with learning. School-based mental health professionals are, therefore, often asked to assist with the treatment of such problems in the classroom, and the potential impact of these interventions is tremendous. Additionally, a number of students, including many of those with emotional and behavioral problems, have academic difficulties that need to be addressed. In this chapter, we provide an overview to the issues related to the identification and treatment of emotional, behavioral, and learning problems in school-age children. In addition to describing some of the more common problems seen in children, we outline the need for mental health services and discuss the rationale for implementing services in school settings. This chapter is intended to help provide background knowledge and, along with Chapter 1, set the stage for the remainder of the book, in which we discuss assessment and intervention of these problems in a collaborative arrangement with parents.

OVERVIEW OF COMMON PROBLEMS

Emotional, behavioral, and learning problems in children have been defined and discussed in a variety of ways. One of the most frequently used methods is the classification of problems into different categories. This is the method used in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994) as well

as in the federal special education guidelines (Individuals with Disabilities Educational Improvement Act of 2004 [IDEIA]). Although the DSM-IV is used infrequently in educational settings, it remains the most common way of describing and classifying disorders. Thus, it is important for school-based mental health professionals to have some working knowledge of the DSM-IV, even if they are not using DSM-IV diagnoses with children. A basic understanding of the DSM-IV will allow better communication with other mental health and medical professionals outside of the school system.

The DSM-IV classifies problem behaviors, including learning disorders, into different diagnostic categories. Some of these categories are more specific to children and adolescents and are listed in the section of the DSM-IV on *disorders usually first diagnosed in infancy, childhood, and adolescence*. There are 10 different categories listed in this section of the DSM-IV (see Table 2.1) and within each category there are specific disorders. For example, the category of attention-deficit and disruptive behavior disorders includes ADHD, conduct disorder (CD), oppositional defiant disorder (ODD), and disruptive behavior disorder not otherwise specified. In addition to the disorders listed in the chapter on childhood disorders, children and adolescents can be diagnosed with any of the disorders listed in the more "adult"-focused chapters of the DSM-IV. Particularly relevant to children and adolescents are the sections on mood disorders (including the depressive disorders) and anxiety disorders. Although the DSM-IV is commonly used when diagnosing or classifying children with emotional and behavior problems, its use is certainly not without controversy, and as noted previously, it is used much less frequently in school settings than in more traditional clinical settings.

When using special education guidelines to classify children, there is only one category that relates specifically to emotional and behavioral problems—emotional disturbance (ED)—and one that relates specifically to learning/academic problems—specific learning disabilities (SLD). As defined by IDEIA (34 C.F.R. sec 300.8), ED involves the following:

> A condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance:
>
> - An inability to learn that cannot be explained by intellectual, sensory, or health factors.
> - An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
> - Inappropriate types of behavior or feelings under normal circumstances.

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TABLE 2.1. DSM-IV Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

Mental retardation	Attention-deficit and disruptive behavior disorders
Learning disorders	Feeding and eating disorders of infancy or early childhood
Motor skills disorder	Tic disorders
Communication disorders	Elimination disorders
Pervasive developmental disorders	Other disorders of infancy, childhood, or adolescence

- A general pervasive mood of unhappiness or depression.
- A tendency to develop physical symptoms or fears associated with personal or school problems.

> Emotional disturbance includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance.

As can be seen, the ED category is somewhat of a "catch-all" category and includes a variety of different behaviors and symptoms. In addition to receiving services under the ED category, some students experiencing emotional/behavioral problems may receive services under other IDEIA categories. For example, children with ADHD who qualify for special education services are often served under the other health impaired category.

Children who experience significant academic problems (regardless of whether other problems are also present) may qualify for special education services under the SLD category. IDEIA (34 C.F.R. sec 300.8) defines an SLD as

> A disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, that may manifest itself in the imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations, including conditions such as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia.
>
> Specific learning disability does not include learning problems that are primarily the result of visual, hearing, or motor disabilities, of mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantage.

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In addition to defining problem behaviors by the diagnostic category or educational classification under which they fall, another common way to define and discuss emotional and behavioral problems is through empirically derived categories of behaviors. The most commonly used empirically derived categories are those of *externalizing problems* and *internalizing problems*. Externalizing problems are outer directed, such as aggression, "acting-out" behaviors, and hyperactivity. These behaviors are often described as behaviors that are disturbing to others rather than to the child him- or herself. Externalizing problems include symptoms of the DSM-IV disruptive behavior disorders as well as other problems that may not be part of a specific diagnosis or classification. In the research literature, the symptoms of these disorders are often referred to broadly as "conduct problems." As a group, conduct problems are among the most researched categories of childhood disorders. A substantial amount of literature suggests that conduct problems are stable over time for many children. About half or more of children continue to meet diagnostic criteria over time; those children who initially exhibit more severe symptoms are more likely to continue to exhibit symptoms over time (Loeber, Burke, Lahey, Winters, & Zera, 2000).

Internalizing problems are those that are more inner directed and cause significant distress for the child or adolescent. These problems include symptoms of DSM-IV mood and anxiety disorders as well as other behaviors that do not fall under a specific diagnostic category or classification (e.g., social withdrawal). Although there is less information

on the stability of internalizing problems over time, based on the available literature, it appears that for a substantial subset of children, these disorders too are likely to continue. For example, in several studies in which the Child Behavior Checklist has been utilized to assess stability of psychopathology over time, researchers have noted significant continuity for both internalizing and externalizing symptoms (e.g., Stanger, MacDonald, McConaughy, & Achenbach, 1996; Visser, van der Ende, Koot, & Verhulst, 1999).

In addition to the externalizing and internalizing distinction, various authors have discussed other broad categories of problems in children. For example, Kazdin (2004) discusses three additional broad categories of disorders: substance-related disorders, learning and mental disabilities, and severe and pervasive psychopathology. Substance-related disorders include difficulties relating to the use/abuse of substances such as alcohol, tobacco, and illegal drugs. Learning and mental disabilities include problems associated with academic functioning, encompassing mental retardation and learning disabilities. Severe and pervasive psychopathology includes disorders that are considered to be long-term problems that cause impairments in numerous aspects of the individual's life, such as schizophrenia and autism.

In this book we have chosen to discuss the treatment of problems by the broad categories of internalizing problems, externalizing problems, and academic/learning problems, because these categories will likely make up the vast majority of cases that are seen by school-based mental health professionals. In addition, the focus of this book is on treatments that can be implemented in collaboration with parents; therefore, it seemed useful to emphasize these three areas because there are either existing treatments geared toward children with these difficulties that make use of parents (e.g., parent training for externalizing problems; family-based therapy for anxiety problems) or treatments that can be easily adapted to include parents playing a key role (e.g., interventions for academic problems).

Estimates of overall prevalence rates of mental health disorders in children are generally about 20%, although this varies depending on the population sampled, instruments used, and time frame considered. In a large-scale epidemiological study on children and adolescents (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003), the 3-month prevalence rate of mental health disorders in children ages 9 to 16 was 13.3%. Slightly more boys (15.8%) than girls (10.6%) were diagnosed with a mental health problem. In terms of age patterns, children in the 9- to 10-year age group had the highest rate of diagnoses; there was then a slight decline through ages 11 and 12 followed by another increase. Costello et al. estimated that by 16 years of age 36.7% of children had met criteria for at least one DSM-IV diagnosis. In a study with younger children (ages 5–9; Briggs-Gowan, Horwitz, Schwab-Stone, Leventhal, & Leaf, 2000), it was estimated that almost 17% had a DSM-III-R disorder, with approximately 7% having an internalizing disorder and 12% an externalizing disorder. Boys were noted to be at higher risk for externalizing disorders than girls, with no differences noted for internalizing problems. A study of adults (Kessler et al., 2005) revealed that half of all cases of mental health problems start by age 14, with average age of onset being particularly low for anxiety (11 years) and impulse-control disorders, including ODD, ADHD, and CD (also 11 years). Thus, mental health problems in children and adolescents warrant concern and attention, not just because of the potential for current negative outcomes but also because of the high likelihood that symptoms will continue over time.

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Although about a fifth of children nationwide have mental health problems, a much smaller number receive services under the special educational classification of ED. Only 7.9% of all students ages 6 to 21 receiving special education services fall under the ED classification (U.S. Department of Education, 2009). This makes up less than 1% of the total population of school-age children. Although it is not clear why there is such a large discrepancy between the total number of children with mental health problems and the number of children receiving school-based services within the ED category, it should be expected that there would be some discrepancy. By definition, children who are classified as ED must be underperforming academically. Although certainly a number of children with mental health problems do experience concomitant academic problems, many do not and even those who do may not experience them at a level required for an IDEIA classification. Thus, there are likely many children in our school systems who are not receiving special education services of any type but who are still in need of mental health services.

A larger portion of children receive special education services under the learning disability category than under the ED category. Approximately 4% of school-age children receive services in this category, making it the largest special education category: 46.4% of all children who receive special education services receive services under the SLD category (U.S. Department of Education, 2009). However, even though a large portion of children receive school-based services as SLD, estimates of the number of children who have learning problems are higher. For example, according to data obtained through the National Health Interview Survey (U.S. Department of Health and Human Services, 2009), 8% of children ages 3 to 17 have a learning disability; prevalence rates are higher in boys (10%) than in girls (5%). In a recent study using data from the National Survey of Children's Health, it was estimated that the lifetime prevalence of learning disability was 9.7%; children with special health care needs are more likely than others to have a learning disability (Altarac & Saroha, 2007). Other researchers have also found that children clinically referred for emotional and behavioral problems have a higher prevalence of learning disabilities than students in the general population (Mayes & Calhoun, 2006).

An even higher percentage of children experience significant difficulties in key academic areas that may hinder their performance in school and lead to lifelong difficulties. According to statistics published by the National Assessment of Educational Progress (NAEP, 2007a, 2007c), in 2007, 33% of fourth-grade students, 26% of eighth-grade students, and 27% of 12th-grade students scored below the basic level (defined as "partial mastery of the knowledge and skills that are fundamental for proficient work at a given grade"; p. 2) on reading assessments. In math assessments, 18% of fourth-grade students, 29% of eighth-grade students, and 39% of 12th-grade students scored below the basic level (NAEP, 2007a, 2007b). In writing, the NAEP, data indicate that 12% of eighth graders, and 18% of 12th graders are below the basic level (NAEP, 2008). Across all three of these academic areas, there were differences among ethnic groups, with Caucasian and Asian students scoring higher than African American, Latino, and Native American students. In addition, those students eligible for free or reduced-cost lunch had lower scores than children not eligible. In terms of gender differences, girls consistently scored higher than boys in reading and writing, and boys scored higher (but only by a slight margin) in mathematics. Given these data, clearly there are a number of children who are struggling academically who do

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not meet criteria for an SLD classification but who could likely benefit from interventions designed to increase their proficiency in academic skills.

PREVENTION AND INTERVENTION

In addition to formal diagnoses or significant levels of emotional, behavioral, and academic problems, there are children and adolescents who are considered to be at risk for the development of such problems. There is also an increasing recognition that anyone can develop significant emotional and behavioral problems, even those with no known risk factors. Given this, there is increased emphasis on prevention within the field of school psychology and mental health. Indeed, many argue that the role of psychology and mental health should not be restricted to reducing problems but should also include efforts to optimize functioning. This is consistent with the role of schools in general. Few would argue that schools should focus their efforts only on addressing learning problems, without attention given to optimizing the education for all of the eager and adept learners. There is abundant literature on the role of school-based services for early intervention, showing that prevention is a viable and important goal both clinically and economically (e.g., Gilliam & Zigler, 2000; Niles, Reynolds, & Roe-Sepowitz, 2008; Ou & Reynolds, 2006). Further, the literature on mental health and behavioral problems suggests that involvement of parents and coordination of services across setting are keys to effective prevention (Greenberg, Domitrovich, & Bumbarger, 2001). In addition to being a proactive approach to mental health, such prevention programs can help to reduce the stigma associated with the utilization of services and help to establish a community norm for parental involvement.

Although terminology varies, prevention programs are typically classified into one of three categories (e.g., see OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports at *www.pbis.org*): *Primary* or *universal* programs are those offered to the general public or a whole group (e.g., a schoolwide antibullying campaign); *secondary* or *selective* programs are those offered to individuals or subgroups who are considered to be at risk by virtue of biological, psychological, or social risk factors (e.g., a social skills program for those identified as being rejected by their peers in a schoolwide screening); and *tertiary* or *indicated* programs are offered to high-risk individuals who do not meet diagnostic criteria for a disorder but who have detectable symptoms that place them at risk (e.g., a group intervention for youth with subclinical symptoms of depression). Of course, these categories are not mutually exclusive, and there are several prevention programs intended to address all three levels (e.g., the Triple P—Positive Parenting Program; Sanders, 1999, 2007).

These levels of prevention/intervention efforts are often represented through use of the triangle model presented in Figure 2.1 (e.g., OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports, n.d.). As can be seen, the lower portion of the triangle accounts for the most children in a school setting: those who are not currently exhibiting significant emotional, behavioral, or academic problems. At this level, primary prevention would occur and would be focused on universal interventions for all students to reduce the number of new cases of problems. At the second level of the triangle are children who are considered to be at risk for developing problems. The focus here is on secondary

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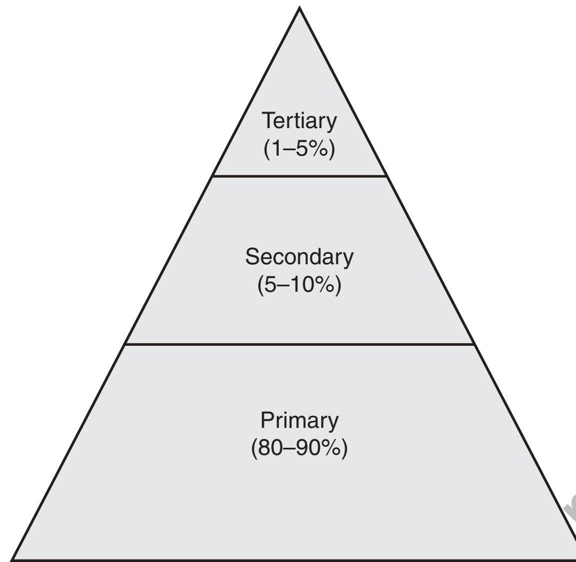

FIGURE 2.1. Prevention triangle.

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prevention, in which students typically receive targeted group interventions. At the top of the triangle are children who are currently exhibiting significant emotional, behavioral, or academic problems and are in need of more intensive interventions, or tertiary prevention, geared toward reducing problematic behavior and increasing prosocial behaviors.

Social and Emotional Learning Programs

Social and emotional learning (SEL) strategies are becoming increasingly discussed and researched as a primary prevention strategies. As defined by the Collaborative for Academic, Social, and Emotional Learning (CASEL, 2008), SEL programs allow children to obtain competency in the following areas (p. 1):

- Self-awareness, including recognizing emotions.
- Self-management such as impulse control.
- Social awareness, including empathy and perspective taking.
- Relationship skills such as communication and conflict management.
- Responsible decision making, including adequate problem solving.

A number of programs targeting these areas have been developed (see *www.casel.org*). Most of these programs are intended to be implemented within the school setting, often by regular classroom teachers.

Research to date on SEL programs indicates that they can have positive benefits on a variety of factors, including decreased mental health problems, decreased substance use, increased school attendance, and increased academic achievement. Effects of these programs were noted to be more positive when programs were of longer duration, addressed

behaviors in multiple settings (including the home setting), and had support from key leaders in the school setting (e.g., CASEL, 2008; Greenberg et al., 2003). Although some SEL programs do systematically involve families (e.g., PATHS: *www.preventionscience.com/prevention-programs/paths/research-development.php*; Second Step: *www.cfchildren.org*) many do not (see CASEL, 2003, for a summary). Those that do involve families have three common themes, as identified by Patrikakou and Weissberg (2007):

- Communication between home and school: Parents are informed about what children are being taught at school and parents are provided with ideas for how to reinforce these skills in the home setting.
- Parent involvement at home: Programs include strategies and materials that can be used by parents in the home setting.
- Parent involvement at school: Parents are encouraged to attend school or classroom activities.

The CASEL web site also has a variety of resources for parents that practitioners may find useful, regardless of whether a schoolwide SEL program is in place. These resources include a packet with ideas for working with parents and a list of things parents can do at home to help their children develop social–emotional competency, including focusing on their children's strengths, talking about feelings, and helping children problem solve.

Although there are an increasing number of primary and secondary prevention programs, especially those that can be implemented in the school context, the interventions discussed in this book are aimed at the tertiary prevention level. We acknowledge that primary and secondary interventions, such as SEL programs, are important, and we encourage school-based mental health professionals to seek out resources and programs focused on these. However, with the focus of this book on parent-assisted interventions, the majority of these will be implemented with students already experiencing some problems. Parents can certainly be a key part of primary and secondary prevention efforts, and some of the interventions described in this book have been or could be adapted to fit within this model. However, given the more comprehensive nature of primary and secondary prevention programs, parent components are typically just one part of these programs, with more work being done within the school context. Therefore, we have focused our efforts on describing in more detail the specifics of interventions that can be implemented in collaboration with parents.

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EVIDENCE-BASED PRACTICE

Another recent development within the psychology treatment literature, including school psychology, is an emphasis on *evidence-based practice* (EBP). The concept of EBP originated within the medical field, with David Sackett and his colleagues at the Centre for Evidence-Based Medicine being some of the key original proponents of EBP. Within psychology, one of the first steps toward formally discussing and defining EBP came in 1995 when Division 12 (Clinical Psychology) of the American Psychological Association developed criteria for what they termed "empirically validated treatments." This terminology was subsequently

changed to "empirically supported treatments" (ESTs). Today the term "evidence-based practice" has become the more common term to reflect a broader definition of treatment methods that have empirical support. As originally outlined by Division 12, there were two categories of ESTs: well-established and probably efficacious. The criteria for ESTs as specified in this report and later modified slightly by Chambless et al. (1998) are summarized in Table 2.2. The criteria for ESTs are based on the outcomes of efficacy studies involving randomized controlled trials (RCTs), in which participants are randomly assigned to receive either the treatment being studied or no treatment (wait-list or control group) or an alternative treatment. Treatments conducted as part of RCTs are generally manualized and tightly controlled, with trained therapists delivering the interventions, often in a university

TABLE 2.2. Criteria for Empirically Supported Treatments

A *well-established* treatment is one that meets the following criteria:

I. At least two good group design experiments demonstrating efficacy in one or more of the following ways:
   A. Superior to pill or psychological placebo or to another treatment.
   B. Equivalent to an already-established treatment in experiments with adequate statistical power (about 30 per group).

or

II. A large series of single-case design experiments ($n \geq 9$) demonstrating efficacy. These studies must have:
   A. Used good experimental designs.
   B. Compared the intervention with another treatment as in I.A.

Further criteria for both I and II:

III. Experiments must be conducted with treatment manuals.

IV. Characteristics of the client samples must be clearly specified.

IV. Effects must be demonstrated by at least two different investigators or teams of investigators.

A *probably efficacious* treatment is one that meets the following criteria:

I. Two experiments showing that the treatment is statistically significantly superior to a wait-list control group.

or

II. One between-group design experiment with clear specification of group, use of manuals, and demonstrating efficacy by:
   A. Superior to pill or psychological placebo or to another treatment.
   B. Equivalent to an already-established treatment in experiments with adequate statistical power (about 30 per group).

or

III. A small series of single-case design experiments ($n \geq 3$) with clear specification of group, use of manuals, good experimental designs, and comparison of the intervention with pill or psychological placebo or another treatment.

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or other research setting. In addition, there are often strict inclusion and exclusion criteria regarding participation in RCTs, which historically have excluded individuals with more complex presentations of a disorder. In part, because of some of these issues, there has been debate as to whether efficacy studies and the resulting conclusions drawn are the best way to obtain and summarize data on what works in everyday practice, where clinicians are not working with a carefully chosen population following a specified treatment protocol.

More recently, the American Psychological Association 2005 Presidential Task Force on Evidence-Based Practice (2006) has expanded on the traditional definition of ESTs to more broadly incorporate interventions for which there is empirical support but that do not necessarily meet the EST criteria. As defined by the task force, *evidence-based practice in psychology* (EBPP) involves "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 273). Thus, rather than rely solely on RCTs to draw conclusions regarding what works and what does not, EBPP allows for the inclusion of a variety of research evidence in making informed practice decisions. As elaborated on by Spring (2007), evidence-based clinical practice can be viewed as a three-legged stool in which each of the three components are taken into account when determining the best course of action for an individual client. These "legs" consist of the best available research evidence; the client's values, characteristics, preferences, and circumstances; and clinical expertise. Clinical decision making in an evidence-based practice model involves the integration of these legs to develop the best intervention for each individual client. Outcomes obtained from RCTs and other empirical research, including systematic empirical reviews, contribute to the best available research evidence but, in this model, are not the only pieces of information to be considered when developing evidence-based treatments. Clinical expertise involves a number of factors, including the ability to form a good interpersonal relationship with the client; the ability to assess, plan, and monitor in a treatment setting; and the ability to evaluate and apply research in a clinical context (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006; Spring, 2007). Client values and preferences involve taking into account client preferences for one type of treatment over another, clients' ability to access certain treatments, and clients' basic values (including those based on, e.g., religion, race). One of the key concepts in considering patient values and preferences is making sure to attend to the client as an individual and to develop treatment plans and goals with the individual needs of the client in mind. By emphasizing the individuality of clients, practitioners get away from the "one size fits all" idea. Of course, this is not to suggest that treatments that have no empirical support should be implemented just because a client expresses preference for such a treatment. It is important to remember that each of the three aspects of EBPP must be taken into account and balanced to provide the optimal treatment for each client.

Although much of the literature on EBP has been generic to the field of psychological practice, within the field of school psychology specifically the concept of EBP has also been drawing an increased amount of attention as evidenced by special journal issues (e.g., *School Psychology Quarterly*, Vol. 17, No. 4, 2002; *School Psychology Quarterly*, Vol. 20, No. 4, 2005) on the topic of EBPs in general (as with the 2002 issue) or specific evidence-based interventions (as with the 2005 issue on evidence-based parent and family interventions). In addition, a Task Force on Evidence-Based Interventions in School Psychology was

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created in 1998. This task force is a joint effort of Division 16 (School Psychology) of the American Psychological Association and the Society for the Study of School Psychology. It is also endorsed by NASP. As stated on their website (*www.indiana.edu/~ebi*), the mission of this task force is:

- To examine and disseminate the knowledge base on what prevention and intervention programs or approaches for children, youth, and families demonstrate empirical support for application in the school and community.
- To extend the knowledge base through facilitating sound research methodologies, technologies, and innovations.

To date, the task force has developed their *Procedural and Coding Manual* (see www.indiana.edu~ebi/projects.html) (in 2003), intended to be used to assist in the process of identifying, reviewing, and coding outcome studies to create summaries of evidence-based interventions. The task force has five different domains in which task force members are working to summarize treatments:

1. Academic intervention programs
2. Comprehensive school health care
3. Family intervention programs
4. Schoolwide and classroom-based programs
5. School-based intervention programs for social–behavioral problems

Although these domains and associated committees are in place and there are overviews of what each of these domains covers, reviews of evidence-based treatments within most of these domains are not yet available. However, in a 2005 special issue of *School Psychology Quarterly*, evidence-based parent and family interventions were summarized. In a series of articles, authors reviewed the research support for parent/family interventions across a range of populations and specific treatment methods, including early childhood family-focused interventions, parent involvement interventions, parent education, parent consultation, parent training, and family–school collaboration. As summarized by Ollendick (2005), some of the conclusions that can be drawn from the 115 studies reviewed across the different articles are as follows:

1. There is greater support for interventions that are part of a multicomponent package, those that are focused, and those that involve active collaboration among schools, parents, and students.
2. There are a number of methodological shortcomings in many of the studies reviewed, suggesting the need for more rigorous studies as well as the careful consideration of methodological problems when interpreting results.
3. The most effective treatments involved behavioral or cognitive-behavioral methods such as parent training, contingency management, and home/school notes.
4. The field needs to work toward identifying who is most likely to benefit from what intervention through examining mediators and moderators of treatment.

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In an earlier publication not associated with the work of the task force, Rones and Hoagwood (2000) reviewed the effectiveness of school-based mental health services. They divided their review into several categories of behavioral issues, including emotional and behavioral problems, depression, conduct problems, stress, and substance use. Within each of these categories, the authors discussed universal prevention programs (those designed to prevent emotional and behavioral problems in all students) and indicated prevention programs targeted toward students already displaying significant symptoms. Within each of these areas, the authors identified a number of studies in which effective, as well as not-so-effective, interventions had been implemented within a school setting. Across programs, the authors identified five key components that included (p. 237):

1. Consistent program implementation.
2. Inclusion of parents, teachers, or peers.
3. Use of multiple modalities.
4. Integration of program content into general classroom curricula.
5. Developmentally appropriate program components.

Many of these points are in line with the conclusions drawn by Ollendick (2005). Based on these reviews, it is clear that effective interventions can be implemented within a school context and that parents and families may play an important role in maximizing the effectiveness of interventions.

Consistent with the American Psychological Association's initial criteria for empirically supported treatments, Division 53 (Child Clinical and Adolescent Psychology) and the Network on Youth Mental Health have developed a web site, Evidence-Based Treatment for Children and Adolescents (*sccap.tamu.edu/EST*), in which evidence-based treatments for anxiety disorders, depression, ADHD, and conduct/oppositional problems are discussed. It is important to note that the treatments summarized have been mostly evaluated in non-school settings. Although more research on the adaptation of these treatments to the school setting is needed, it seems likely that these interventions can be applied (perhaps with some modifications) in school settings.

It is important to keep in mind that these summaries of evidence-based interventions are only one part (one leg) of the EBP model. Thus, when developing treatment plans, practitioners need to integrate the information from these reviews with their clinical expertise and the preferences of the students and families they serve. To assist practitioners with developing a broader knowledge of the evidence available to support different interventions for externalizing, internalizing, and academic problems, each of the chapters in this book that focus on the treatment of these problems includes a review of some of the empirical support for the different treatment methods discussed.

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NEED FOR SCHOOL-BASED SERVICES

As noted earlier, it is estimated that nationwide one in every five children has a mental health disorder, and these problems can have a significant and long-lasting impact on the

child, his or her family, and society as a whole. Given the negative long-term outcomes associated with many emotional and behavioral problems, there is a clear need for services. Unfortunately, only a small portion of children and adolescents who are in need of mental health services actually receive them, currently estimated at about 20%. Although there have been somewhat inconsistent findings related to race/ethnicity and utilization of mental health services, several studies have noted lower utilization rates for African American and Latino youth compared with Caucasian youth (e.g., Elster, Jarosik, VanGeest, & Fleming, 2003; Kataoka, Zhang, & Wells, 2002). Angold and colleagues (2002) found that although Caucasian children were more likely to use specialty mental health services than were African American children, there was little disparity between groups in terms of school-based services. Children who are uninsured have been also noted to have lower utilization rates than those with public or private insurance (Kataoka et al., 2002). Of children who do receive mental health services, the majority receive services within the school setting (e.g., Rones & Hoagwood, 2000).

In addition to a lack of service initiation is the problem of premature termination of services. Estimates are that 40 to 60% of children terminate therapy prematurely (Kazdin, 1996). Early dropout has been related to a variety of factors, including the initial severity of child behavior problems (those children who have greater problem behaviors are more likely to prematurely terminate services; Kazdin, 1996) as well as a poor relationship with the therapist or the perception that therapy is not helpful (Kazdin, Holland, & Crowley, 1997). Although some of these individuals who drop out of therapy may have made some improvements, by definition premature termination means that these individuals were still in need of treatment.

Although it is clear that mental health services are underutilized initially and that many youth who access services do not continue with them, it is not clear exactly what factors contribute to this underutilization. Hypothesized reasons for low service use include the lack of recognition that services are available and effective, the cost of treatment, the stigma associated with receiving mental health care, and parent dissatisfaction with services. In addition, long wait lists for specialty child services may lead to the inability of children to receive needed services, even when these other barriers are not present (U.S. Department of Health and Human Services, 1999).

With schools as a location for mental health care services, many of the barriers to mental health care can be decreased. School-based services are free of charge, and there may be less stigma associated with receiving treatment in the schools (where it may not be as obvious what types of services are being provided) than in a community mental health clinic. In addition, even if parents are not aware of the availability of mental health services, other adults who are in contact with the child (e.g., teachers) are and can play an important role in making the initial referral for services. Of course, not all barriers are eliminated when providing school-based services. Parents may still not be interested in participating (or in having their child participate) and may still be dissatisfied with the services provided. In addition, a shortage of school psychologists and other school-based professionals with specialized training is frequently a barrier to provision of services in the schools. However, given that children spend a significant portion of their day in school and that the educational system is already the service entry point for the majority of youth who receive mental

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health services (Farmer, Burns, Phillips, Angold, & Costello, 2003), the schools seem like a logical place to attempt to extend services so that more children who are in need of mental health supports can receive assistance.

Although school-based mental health services can certainly fill a void in service access for many children, as noted in Chapter 1, it is important to keep in mind that some children may need services beyond what can be provided in the schools. Particularly for children with more severe emotional and behavioral problems, additional services and supports, such as medications, may be necessary to promote optimal functioning. It is important for school-based mental health professionals to know when to refer and to assist parents in the referral process. Although the schools are the most common place for children to access services, at least one study suggests that children who initially access services in the schools may be less likely to access mental health services provided in other venues, including specialty mental health settings and general medical settings (Farmer et al., 2003). We recognize that in some school systems professionals may be reluctant to refer for outside services because of the wording of state laws or the concern that the school district may be held financially liable for outside services. Some of these issues were addressed in more detail in Chapter 1, and we also attempt to address these in the three treatment-focused chapters.

CHAPTER SUMMARY

Emotional, behavioral, and academic problems are commonly seen in school-age children. Unfortunately, many children who exhibit such difficulties do not receive the needed help. School-based services, for children experiencing current problems as well as those considered at risk for such problems, are a viable means of getting services to the children who need them most. Empirical support for interventions, including those delivered in a school-based context, is growing. It is important for all mental health professionals, including those providing services in the schools, to stay current with regard to EBP and ensure that the interventions being delivered are those that are most likely to have a positive effect. In addition, ongoing progress monitoring as part of working within a problem-solving model, discussed more in the following chapter, is an important part of providing services in any context.

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