Family Driven Care

Are we there yet?

A road map for system transformation for family members, educators, and mental health professionals

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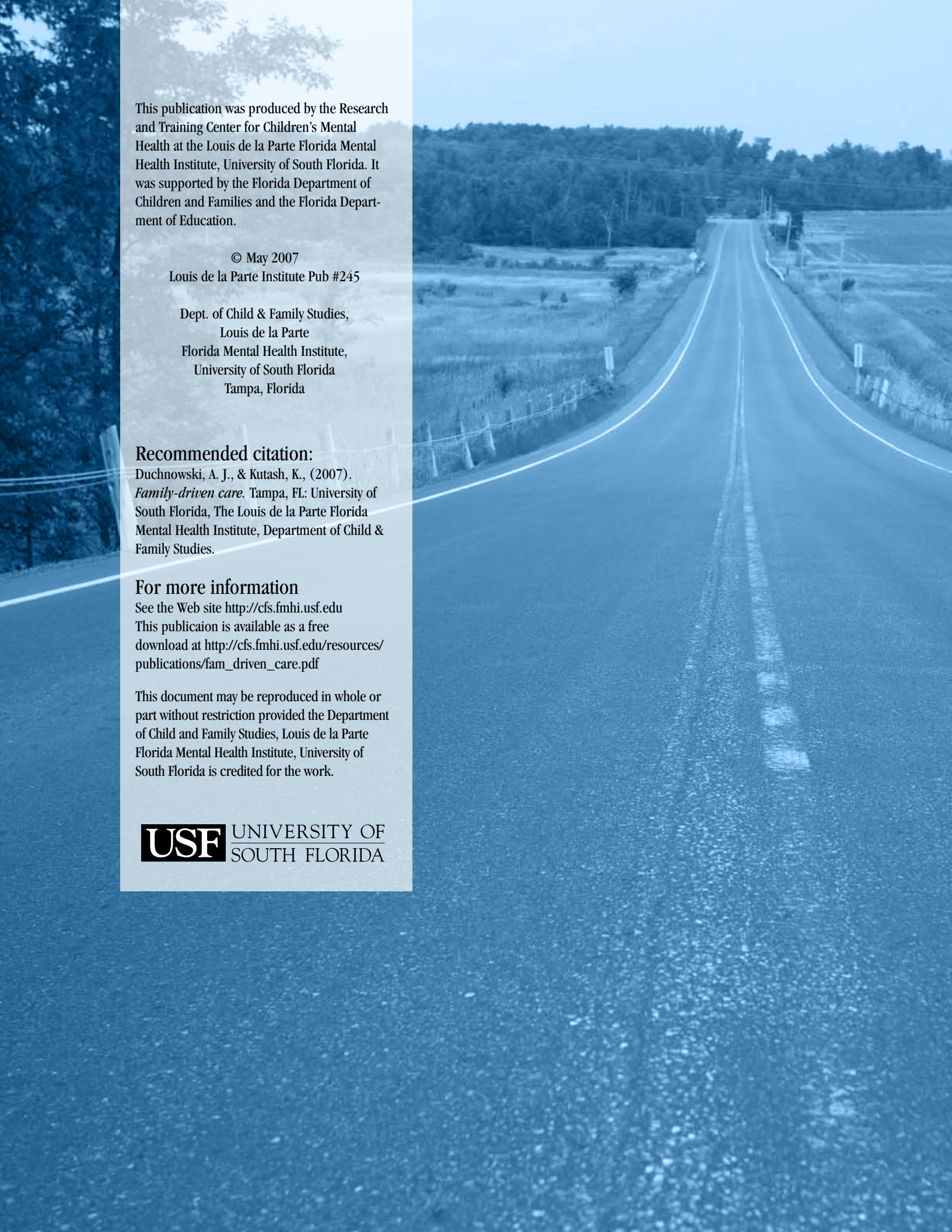

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An Emerging New Era

A number of challenges related to the welfare and functioning of America's families and their children are confronting the institutions charged with facilitating the achievement of an adequate quality of life for America's families and opportunities for the successful transition into adulthood for the present generation of children. For example, in spite of wide-spread efforts to reform America's schools, graduation rates and achievement levels of students continue to be disappointing. Despite the progress made in developing effective methods of preventing and treating emotional disturbances in children, the number of children in need of services continues to rise and the outcomes for these children continue to be the poorest compared to children with other disability conditions.

While these conclusions are synthesized from national data, the situation in Florida can be described as even more challenging than for most other states. With its burgeoning population, the mobility of its families and children, the severe shortage of trained professionals in all social service agencies, including teachers, and the resulting stress on public resources, the quality of life in Florida could be considered to be at-risk.

While the ultimate solution to these challenges may be the responsibility of the governor, the cabinet, and the legislature, all of us who work with children and families need to be aware of the most current information that provides frameworks and strategies to improve conditions within our sphere of influence. Likewise, Florida's families need to recognize and accept their role in achieving progress for themselves and their children.

A Call for Partnerships. National legislation and reports from several commissions and officials offer potential strategies that can be implemented locally to facilitate the process of reversing these negative trends. The No Child Left Behind Act (NCLB), Individuals with Disabilities Education Act (IDEA), the Report on the Nation's Mental Health by the U.S. Surgeon General, and the recent report of the President's New Freedoms Commission have all addressed the challenges presented above. While they all offer a host of proposed solutions, there are some common threads linking the initiatives and forming a blueprint for change. Each of these initiatives highlights the potential of schools to join in a "system transformation" process of reform and to serve as the hub for the deployment of resources to implement change. In addition, each initiative promotes the increased development of effective collaboration between all community agencies charged with contributing to the well-being of children and their families. Finally, each initiative promotes the involvement of families so they may become equal decision-making partners with professionals in determining the programs and treatment of their children. Most recently, this latter strategy has advanced to the conceptualization of system reform as a transformation to family-driven systems of care. That is, the educational and social-emotional programs for children will be most effective if they are family-driven and youth guided. The highest levels of effectiveness will be achieved when the transformation process occurs in a context of a shared vision and the valuing of the strengths of all of the partners.

Family Driven Care
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A road map for system transformation for family members, educators, and mental health professionals

This report is offered as a guide to assist in Florida's continuing process of transforming the systems of care and support for families that have children with emotional and behavioral challenges into effective systems that are family-driven. It is targeted to family members and middle level administrators in the education and mental health systems. In the education system, these would include building principals, and administrators of special education and pupil services programs. On the mental health side, the guide should assist children's mental health program directors in community mental health centers and other public sector provider agencies.

There are two major aims of this report. The first is to acquaint readers with the concept of family-driven care for children who have emotional and behavioral disturbances. Second, we will present information about evidence-based practices that are effective interventions to help the children and their families. With this information, families, educators, and mental health service providers will be in a better position to plan effective interventions for the children in their care. The report contains several sections that focus on a specific topic but there is a continuing theme that is present in each section: families, educators, and mental health service providers need to collaborate together to bring about the best possible outcomes for the children they all care about. In order to achieve this effective collaboration, there are new strategies to try, new information and skills to learn, and new beliefs and attitudes that must be incorporated by all three partners. Through such efforts, Florida's system of providing care will be transformed into an effective family-driven system.

Definitions 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; and
- determining the effectiveness of all efforts to promote the mental health and well being of children and youth.

(Osher, Osher, & Blau, 2006)

While the concept of "family-driven care" is new and evolving, there are emerging definitions in the field. The definition (see sidebar) is taken from 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.

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 Individual Educational Plans (IEP), admittedly with little success. 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 of these systems are beginning to use "family-driven" language. Transformation that is effective will require attitudinal change, new skills, re-deployment of resources, and time for all of this to occur. Transformation to family-driven care is complex, multi-dimensional, and in some cases revolutionary. Osher and her colleagues

(2006) list 10 principles that guide the development of family-driven care and these principles illustrate the multi-faceted nature of the task. For many of us, the adoption of these principles is visionary and definitely revolutionary. But for parents and their children, it is viewed as obligatory.

Ten guiding principles for 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.

(Osher et al., 2006)

Why Transformation? In this age of accountability, the bottom line is that the outcomes for children who have emotional and behavioral disturbances are not acceptable. Several studies have produced the now familiar litany that includes: low academic skills, poor attendance in school, frequent suspensions, frequent attrition from outpatient services, frequent involvement with the juvenile justice system, and transition to the adult mental health and criminal justice systems. Clearly, no single system should be the target of blame and all systems should realize the interdependence that is operating here. For example, schools are held accountable in Florida for demonstrating gains in FCAT scores for all students. Those students who have emotional and behavioral disturbances must take the FCATs and their scores must be counted in the school average. Principals are aware of the traditional low performance of these students, the lack of effectiveness of most interventions, and they realize the effect on the school report card. While some may devise methods to exclude these children from their school, others are searching for better programs. Likewise, mental health administrators are aware of the need for their agencies to provide more effective services for children in need. The goal of transformation to family-driven care is to achieve the outcomes desired by both of these systems.

Changing the Culture. The basic foundation of family-driven care is the partnership between families and the professionals who provide services for their children. To illustrate the potential strength of this partnership, we borrow an example from architecture. A triangle is one of the strongest configurations available when the support framework of a building is planned. In Figure 1 the partnership necessary in implementing family-driven care is presented as a triangle. In this triangle the sides and angles are equal; the supportive power is equally contributed. This partnership can serve as the impetus and support to change the culture that currently exists in most communities. The nature of the change is summarized in Table 1.

Figure 1. Components of an effective partnership

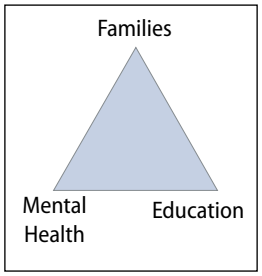


Table 1. Changing the community culture

FROM	TO
Blame, Suspicion, Mistrust, Condescension, Frustration, Litigation	Valuing Each Other, Strengths, Sharing a Common Vision, Pooling Resources, Respect and Understanding, Advocacy to Strengthen Families and All Systems

In order to achieve this change in the culture, there are strategies that can facilitate the process. These strategies will be amplified in this report along with resources available to support transformation efforts. The strategies include the following:

- The development of authentic collaboration between education and mental health systems
- Engaging families
- Supporting families in the transformation process
- Families increasing their involvement with the school
- Families giving their voice in the planning of mental health treatment for their children
- Increasing the use and effective implementation of evidence-based practices

The implementation of these strategies will be challenging, but there is a growing body of literature documenting successes in many communities including some in Florida. It is time to go to scale and bring about significant improvement in the outcomes for Florida's children.

The Evolving Role of Families

Evolving roles of families

- Cause
- Patient
- Credible informant about their child
- Partner in treatment planning
- Service evaluator and research partner
- Policy maker

A first step in the needed culture change involves the professional component of the partnership. 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," "schizophrenegenic 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 at present. The changing roles have progressed.

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 and is an on-going process.

In Table 2 we see that there are many ways that families act and are perceived. The early beliefs that families caused mental illness in their children or that they all required therapy themselves were challenged by data from new research. This does not deny the possibility that a family may abuse their children or neglect their children because of substance abuse, for example. Or that some parents may experience stress that is related to their child's disability. It does indicate that there are many causes of impaired functioning in children and we must not engage in unproven stereotypical thinking. Table 2 also reveals that new research indicated that parents could give valid and reliable information about their children that may differ from the perceptions of teachers. However, this came to be understood as important assessment information. In the 1980s and 90s the System of Care movement and wraparound programs 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 policy makers through the development of family-driven care.

Just as families have played varied roles over the years in the provision of services for their children, they continue to function with diversity and uniqueness as they become included in the development of family-driven care. In the next section we examine the varied levels of involvement in which families are engaged.

Table 2. Evolution of the role of families

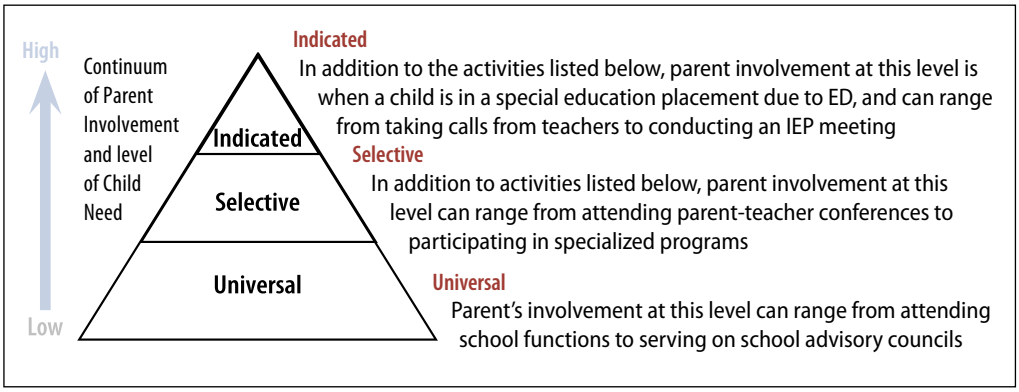
Mid-1900s	Family members not involved in child's treatment.
1950-1960s	Mental health professionals began to question the absence of families from their child's care. "Family therapy" as treatment became increasingly popular.
1960-1970s	Families of children with developmental disabilities began advocating 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 Different Levels of Parent Involvement

A major point of this report is that the level to which parents can be expected to be involved with the school and mental health system will vary considerably. Some parents are unable to be involved at any level while other parents are able to accept leadership roles. The efforts and strategies of schools to involve parents should vary as well in order to adequately meet the diversity that exists in families. Yet, if transformation of the service delivery system is to occur, staff in both the education and mental health systems should have as a goal to work with parents to help them reach the level of empowerment they desire.

To illustrate the array of school-related activities needed to engage families at all levels of empowerment, a framework is provided in Figure 2. We use the terms universal, selective, and indicated to differentiate the points on a continuum of parent involvement. It is important that school staff embrace that there is a variety of roles for parents to play within schools. A major part of the transformation process will require school staff to explore and establish multiple levels of parent involvement in the school system.

Figure 2. The range of parent involvement activities based on the need of student



Universal Interventions

The universal level, which forms the base of the pyramid in Figure 2, includes interventions designed to impact all participants, with no subgroup of particular focus. Thus, universal interventions for parent involvement are activities that parents and schools can engage in that improve the parent-school relationship for all families, not just families with children who have ED. For example, attending an IEP meeting would not be considered an activity at the universal level because only parents with children who have special educational needs participate. In contrast, attending a regularly scheduled parent-teacher conference would be considered a universal intervention because all parents are invited to participate regardless of the child's special needs status. However, even though universal-level activities are available to all families, the extent to which a parent engages in them will vary based on the parent's level of energy and skill, available time, and number of competing demands. It is important that school administrators recognize this variability and understand that they will need to reach out more to some parents than to others.

Epstein's Six Types of Involvement

Joyce Epstein and her colleagues (Epstein, Coates, Salinas, Sanders, & Simon, 1997) have developed a framework for thinking about parent involvement in schools. She has identified six types of potential involvement, which are:

Type 1: Parenting
Type 2: Communicating
Type 3: Volunteering
Type 4: Learning at Home
Type 5: Decision Making
Type 6: Collaborating with the Community

Type 1: Parenting

This type of involvement focuses on assisting parents in refining their child-rearing skills and assisting schools in better understanding the families they serve. Sample universal practices include:

- Offering information on child development for each age and grade level (e.g., through workshops, books, videos, tip sheets, or computerized messages)
- Offering parent education through trainings, classes, or through use of a lending library
- Developing family support programs that are responsive to family preferences
- Conducting annual surveys for families to share information about their children's goals, strengths, and needs

Type 2: Communicating

This type of involvement focuses on establishing effective parent-to-school and school-to-parent communication. Sample universal practices include:

- Offering flexible schedules for appointments
- Providing families with language translators when needed
- Holding back-to-school nights throughout the year to sustain contact between parents and teachers
- Establishing a regular schedule of notes, phone calls, email, and other forms of communication based on family preference

Type 3: Volunteering

This type of involvement focuses on developing opportunities to include families as volunteers through effective recruitment, training, and family-friendly scheduling. Sample universal practices include schools:

- Assessing parent skills, talents, interests, and availability through surveys or other methods
- Providing a parent room or family center where volunteers can gather, work, and network with other volunteers
- Expecting parents to volunteer and offering an array of opportunities
- Recognizing the expertise of parents and utilizing their skills in meaningful ways

The extent to which parents engage in universal-level activities varies based on their energy and skill levels, available time, and number of competing demands.

While Epstein's framework is a useful tool for parents and schools, it is but one of many resources available on parent involvement. Indeed, a resource guide compiled by the Harvard Family Research Project and available online (http://www.gse.harvard.edu/hfrp/projects/fine/resources/guide/knowledge_development.html) has identified over 100 organizations providing free materials about parent involvement in schools. School administrators are encouraged to take advantage of these resources for improving the quality of their parent-school partnerships.

Type 4: Learning at Home

This type of involvement focuses on creating learning opportunities for families to engage in with their children at home. Sample universal practices include:

- Providing interactive homework opportunities that require students to discuss what they are learning in class
- Establishing a homework hotline
- Providing summer learning packets
- Offering opportunities for families to participate in helping students set academic goals each year

Type 5: Decision Making

This type of involvement focuses on including families as participants in school decisions through PTA, committees, and other parent organizations. Sample universal practices include:

- Developing opportunities for parent leadership, such as PTAs, committees, and advisory councils
- Providing training to parents to increase their knowledge about educational issues and how to work effectively with schools
- Creating networks to link all families with parent representatives

Type 6: Collaborating with the Community

This type of involvement focuses on coordinating community resources provided *for* families and schools as well as resources provided to the community *by* families and schools. Sample universal practices include:

- Providing information for families about community health, recreational, social support, and other programs
- Families and schools providing services to the community (e.g., sponsoring a "Give Back Day," participating in recycling projects, or sharing art, music, or dramatic performances with the community)
- Developing school-business partnerships

A guide compiled by the Harvard Family Research Project has identified over 100 organizations that provide free resources on parent involvement.

Selective Prevention Interventions

For many parents, their first substantive contact with school personnel on an individual level occurs when their child first starts to show early signs of behavior problems. School staffs reach out to parents in hopes of offering programming that will stop the behaviors before they become more serious. These early intervention efforts are sometimes referred to as selective or targeted interventions (see Table 3). It is at this first encounter that expectations for future relationships between school staff and parents are established. It is a crucial time when parents are hearing for the first time there is something "wrong" with their child and are understandably upset and/or anxious. At the same time, school staff want to "do all they can do" to "fix" the situation with their available resources. There are many selective prevention interventions used with students who demonstrate signs of behavior problems and can be offered in small group sessions for children (social skills curriculums) or in individual sessions with the student (e.g., Functional Family Therapy). Many of these interventions have roles for parents as either participants in parent training activities or as monitors of home behaviors.

Table 3. Definitions of selective or targeted interventions

Selective Prevention Strategies target groups of youth identified because they share a significant risk factor and mount interventions designed to counter that risk (Weisz et al., p. 632, 2005)
Selective/Targeted Interventions 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. These interventions are considered to be "secondary prevention" (OSEP Technical Assistance Center on PBIS, n.d.).

At this stage of programming for a student, the parent-teacher relationship is critical. The quality of this newly forming relationship is paramount because most of the programming at this stage has a role for teachers or school staff and for parents. Furthermore, most programs "will not work" if the expected roles of the school staff and of parents are not fulfilled.

The most important questions parents can ask are ones which will help them to gain an understanding of the presenting problem and the plan to help correct the problem. Parents should be encouraged to ask, "How is this expected to help my child?" and school staff should be able to clearly articulate the logic of the program and the expected role of the parents in helping to correct the problem behavior. School staff should present a realistic picture of the time and effort parents are expected to expend and parents should be able to express the amount of effort they are realistically able to spend.

School staff are encouraged to develop a home-school communication system with parents as a way to keep parents informed of the progress their child is making. School staff and parents should decide together whether this communication system is by phone, email, or written notes brought home by the student. The communication system reflects the parent's preference rather than the convenience of the school staff. Some par-

ent advocates have suggested that parents begin a "diary" of the school staff and programmatic efforts that are tried with their child as this information may be useful in the future if additional programming is needed.

Indicated Interventions and Treatment

Children who have not responded to interventions at the selective level and are impaired in both academic and emotional functioning often experience an indicated level of care (see Table 4). Again, at this level of care parent involvement is crucial for improved child functioning, however, the role played by parents is very different from the roles provided in the universal and selective levels of care.

It is this level of care that parents are often introduced to the world of Special Education, which includes the Individuals with Disabilities Act, 504 regulations, the Individual Education Plan and related services.

Table 4. Definitions of indicated prevention and treatment

Indicated Prevention Strategies are aimed at youth who have significant symptoms of a disorder … but do not currently meet diagnostic criteria for the disorder.

Treatment Interventions generally target those who have high symptom levels or diagnosable disorders.

A national survey of parents of children in special education due to ED reveals that their children entered special education services at a very young age (usually around second or third grade). Furthermore, the age at which most students who have ED started special education services is similar to the age children with other disabilities (such as learning disabilities) start special education, however, these students with other disabilities were more likely to receive early intervention services, with only about one-third of the children with ED receiving early intervention services before entering special education (Wagner et al., 2005), see Table 5.

Table 5. National sample of parents whose children are in special education

	Parents with children in:			
	Elementary/Middle Schools		Secondary Schools	
Area	ED	Other Disabilities	ED	Other Disabilities
Age child first had difficulties	4.6	4.4	6.4	5.7
Age first received special education	7.8	6.7	9.0	8.2
Age first served by professionals	6.2	5.9	8.1	7.2
% of children who received early intervention or pre-school education	35%	45%	34%	59%

(adapted from Wagner et al., 2005)

Parents who have children with ED and in special education are generally less involved in their child's education and school activities than parents of children with other disabilities. About half to three quarters of the parents with children with ED in elementary and middle schools help their child with homework, attend events at school, and attend parent-teachers conference, although these rates drop drastically when the children attend secondary schools, Table 6.

Overall, parents with children who have ED are satisfied with their children's teachers, schools, and special education services with only 20% somewhat or very dissatisfied. This finding is consistent with other studies that reveal that parents are satisfied with whatever level of services they received. However, about 30% of parents with children with ED in the Secondary schools report it took a great deal of effort to obtain services and this percentage of parents is higher than for parents of children with other disabilities, see Table 7.

Table 6. National sample of parents whose children are in special education compared to general population

Percentage of parents who:	Parents with children in:					
	Elementary / Middle Schools			Secondary Schools		
	ED	Other Disabilities	General Population[a]	ED	Other Disabilities	General Population[b]
Help with homework five or more times a week	48%	56%	16%	18%	22%	3%
Volunteer at school	30%	48%	39%	15%	25%	26%
Attend a school or class event e.g., science fair, sports event)	66%	78%	68%	50%	64%	57%
Attend a parent-teacher conference	85%	86%	80%	73%	73%	52%

[a] Data are for elementary school students (National Center for Education Statistics, 1998).
[b] Data are calculated for 13- to 17-year-olds from the National Household Education Survey, 1999.

(adapted from Wagner et al., 2005)

Table 7. National sample of parents whose children are in special education and their report on satisfaction with special education

% of parents who report being somewhat or very dissatisfied with:	Parents with children in:			
	Elementary / Middle Schools		Secondary Schools	
	ED	Other Disabilities	ED	Other Disabilities
Student's school	22%	14%	29%	19%
Student's teacher	15%	10%	19%	14%
Sp. Ed. Services	20%	12%	22%	15%
% of parents who report putting a 'great deal' of effort into getting service the last 12 months	Not asked	Not asked	30%	17%

(adapted from Wagner et al., 2005)

Evidence-Based Efforts at Parent Involvement & Programs

Another major part of the transformation process will be to increase awareness of the empirical and evidence base for parent involvement and the array of services and supports that are available for youth with or at risk for developing emotional disturbances. This section will review the empirical literature on the linkage between parent involvement in the education of their children and academic achievement and mental health services that are empirically-based. This information is provided to stimulate discussions among local stakeholders on what services might be missing and what steps need to be taken in order to have effective systems.

Empirical Support for Parent Involvement

A recent search for empirical studies examining the effectiveness of parent involvement programs on the academic achievement of urban students resulted in over 10,000 published articles (Jeynes, 2005; Jeynes, 2007). The majority of these articles discussed the importance of parent involvement while only 93 described the results of studies exploring the effectiveness of various types of parent involvement on the academic achievement of elementary and secondary students. The inspection and analysis of these studies not only confirm the importance of parent involvement but also begin to provide insights into which parent involvement activities hold the strongest association with academic achievement in urban students' outcomes.

The overall results of these analyses reveal that for both elementary and secondary urban students, parent involvement is strongly associated with academic achievement. In general, students whose parents who report greater levels of involvement in their child's education exhibit better academic outcomes. This is consistent with our common understanding of parent involvement in suburban as well as rural areas. These studies however, are limited as they use a global measure of parental involvement and do not specify which aspects of parental involvement are associated with increased academic achievement. Additionally, little is known about effective ways to increase the level of involvement in parents who are minimally involved.

Initial results of studies of parent involvement programs aimed at increasing the involvement of parents of elementary urban students reveal that these programs are effective at increasing students' academic achievement (see Table 8). Perhaps more interesting is the type of activities exhibited by parents that are associated with academic achievement. The most effective is parent expectation. The ability to consistently express to their child that academic achievement is important is the parent behavior most strongly associated with academic achievement in children. Parents' attendance and participation in school functions and checking homework are not as strongly associated with their child's academic achievement. Further, it should be noted that the results of these studies about parent involvement in urban schools hold across gender and racial groups. These results have direct implications on how teachers and school staff should conceptualize parent involvement. Efforts aimed at getting parents to attend school functions should be supplemented with efforts to help parents build positive expectations for their children.

Table 8. Strength of association between types of parent involvement and academic achievement in urban students (Jeynes, 2005; Jeynes, 2007)

Area	Elementary Students* Overall Effect Size	Secondary Students ** Overall Effect Size
Global parent involvement	.74	.53[1]
Specific components of parental involvement		
Parent Expectations	.58	.88[2]
Reading to a child	.42	
Communication between parent and child	.24	.24
Parental style- supportive	.31	.40
Attendance and participation at school events	.21	.11
Checking homework	not significant	.32
Programs aimed at improving parent involvement	.27	.36

[1] For those studies that used sophisticated controls the effect size was .38

[2] Only significant with grades, not standardized test

*Elementary Students: 41 studies with the total number of participants exceeding 20,000; results were consistent for both girls and boys and across all racial groups)

**Secondary Students: 52 studies with the total number of participants exceeding 300,000; results were consistent for both girls and boys and across all racial groups

Empirically-Supported Mental Health Services

There are currently five organizations that list empirically-supported mental health programs for children: (1) Substance Abuse and Mental Health Services Administration (SAMHSA), (2) Collaborative for Academic, Social, and Emotional Learning (CASEL), (3) U.S. Department of Education (USDOE), (4) Prevention Research Center for the Promotion of Human Development at Penn State, and the (5) Center for the Study and Prevention of Violence (CSPV). Each has critically reviewed the literature base and compiled a list of community-based programs mental health programs that could be offered to families with children who have or are at-risk for an emotional disturbance. These five lists have been integrated to reveal all the programs that are recommended by these five organizations. The integrated list can be found in Appendix C. When the final list of programs is reviewed, some interesting trends emerge about the empirical base for mental health services for children and these trends are discussed below.

An Overview of Programs Designated as Empirically-Based

Of the 92 programs listed in Appendix C, the majority are from SAMHSA (n=56, 61%), and 21 programs (23%) appear in more than one of the five sources. This lack of programs being listed by more than one source is a reflection of the different requirements each source has for being "empirically-based" versus a real difference in the programs. An examination of the programs listed in Appendix C reveals that approximately one-third of the programs listed are designated as targeting substance abuse, trauma, or health problems, while the remaining two-thirds address the regulation of emotions or social functioning. Overall, program approach focuses equally on univer-

sal levels of prevention (53% or 48 of 90 programs) and selective/indicated levels of prevention (47% or 42 of 90 programs). Two programs were categorized as focusing on all three levels of prevention.

The majority of the programs (58%) listed in Appendix C take place in schools, while 26% take place in the community, and 16% take place in both the community and schools. It is clear that any discussion of school-based mental health services must also include the role evidence-based programs.

Thirty-five percent of the programs target children 12 years of age or younger, while 24% target children 12 years of age or over. The remaining programs target children covering a wide range of ages including 20% that serve youth who fall within the age range of 5 to 18 years of age while an additional 16% serve youth that fall within 10 to 18 years of age.

A majority of programs (61%) have a family component as part of the program, while a little less than half (47%) have a teacher component. The length of programs listed in Appendix C is equally divided with a third of the programs taking less than 3 months to implement, a third taking between 3 months 9 months to be implemented, while the remaining third require more than 9 months for full implementation.

Implementing Evidence-Based Practices: New Perspectives and New Roles

The development of empirically supported interventions to provide school-based mental health services for children (SBMH) has been an important advance for the field. However, the pace of scaling up the use of these interventions has not reached the point where evidence-based practice is the rule in the majority of the nation's schools, including those in Florida. In fact, the provision of any type of behavioral or mental health service to our most needy children, those who are served in special education programs because of emotional disturbances, is seriously lacking. Recently, a report on services received by a nationally representative sample of children who have emotional disturbances and are served in special education programs (Wagner, Kutash, Duchnowski, Epstein, & Sumi, 2005) documented the continuing lack of services for this population of students who have disabilities. While over 90% of all schools reported the availability of psychologists and counselors for students, less than 40% of students who have emotional disturbances received any mental health service at all. Only 31% of the elementary students and 45% of secondary students received behavioral support through a behavior support plan. In addition, only 19% of elementary and 22% of secondary students received the services of a social worker and 8% of elementary and 18% of secondary students received any type of family support service. There is a critical need to reduce this gap in services for this group of youth who are in need.

Both the education and mental health systems play an important role in providing SBMH services. However, the two systems have not produced a record of effective collaboration that has led to an extensive network of effective SBMH programs across the country. In order to more clearly identify the roles and influences of the mental health and education systems on SBMH, we have listed some factors in Table 9 described from the perspective of each system and how they may affect SBMH program imple-

mentation. As this table illustrates, there are more areas in which the differing perspective can impede collaboration compared to facilitating the implementation of effective SBMH programs. For example, the systems differ in their primary goal or purpose. The education system aims to improve academic outcomes for children who are experiencing psychosocial barriers that impede their education. Under the regulations of IDEA, children who have emotional disturbances are placed in special education programs if their academic progress is affected by their disability. Related services, that may include mental health services, are provided if the individualized education program (IEP) calls for these services. If academic progress is not considered to be impeded, the school system is not obligated to address emotional problems in children and rarely does, due to limited resources. In the mental health system, the assessment of emotional impairment is the primary determinant of eligibility for service, although the actual receipt of service depends on many factors including the availability of private or public funding. All life domains are considered by the mental system in treatment planning, including educational functioning, but it is not the primary factor in treatment determination.

Table 9. Contrasting perspective in school-based mental health

	Education System	Mental Health System
Overarching Influence	Individuals with Disabilities Education Act (IDEA)	Diagnostic and Statistical Manual (DSM)
Conceptual Framework	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, wareness,Improved Functioning
Common Focus	Improving Social and Adaptive Functioning Importance of and Need to Increase Availability, Access, and Range of Services	

Different Language is Used by Each System. The emergence of distinct conceptual frameworks describing the target behavior for each system has resulted in different terminology that goes beyond simple semantic differences. SBMH from the perspective of the education system is 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 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 Diagnostic and Statistical Manual or those children who 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 the observation that reports of programs and research from the different perspectives are frequently published in journals and texts that are not read by all the disciplines concerned with SBMH. 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 emotional disturbances.

Different Theoretical Foundations Influence the Two Systems. Different perspectives shape and guide the theoretical context in which practitioners in each system have been trained or have developed after their formal training. Clearly, these perspectives filter how they view the world, human behavior, and specific processes such as SBMH. For example, practitioners concerned with children who have emotional disturbances and trained in a College of Education are likely to be influenced by behavioral and social learning approaches. On the other hand, 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 bio-chemical premises among others. These theoretical perspectives guide thinking about the nature and goals of interventions as well as indicators of success. As a result, SBMH programs can be found that range from school-wide approaches to promote pro-social behavior as an alternative to aggression at recess to a course in coping with stress that uses cognitive-behavioral interventions to help students cope with irrational thoughts associated with depression.

Providers who do not embrace these fundamental concepts will probably not play a significant role in the future of mental health services for children in schools or the community.

Both the education system and the mental system have produced interventions aimed at skill training to promote the social and adaptive functioning of children and this may serve as a point for collaboration and the integration of effective services that will lead to improved outcomes for children. 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 emotional disturbances.

To some degree, the implementation of a synthesis of these three related processes 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. As the following sections will illustrate, 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. It is clear that the goals of the national transformation process are consistent with the development and implementation of these types of services.

Essentially, what is needed for the community, made up of children and families, schools, and mental health service providers, is to become an organized team 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;
- A Common Language communication is informative, efficient, effective, and relevant to all the members of the team, especially families;
- A Common Experience the actions, procedures, and operations are experienced by all the members of the team.

PBS, Wraparound, and RtI can provide a context in which this commonality can develop.

Positive Behavior Supports

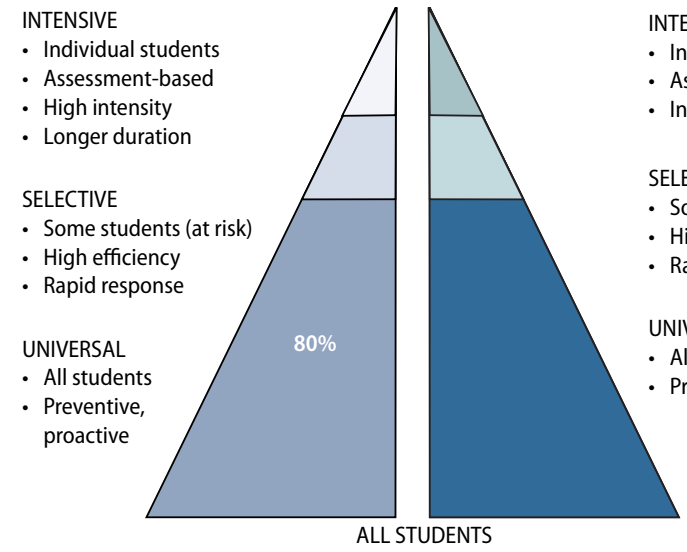
During the last 20 years, positive behavior support (PBS) has emerged from applied behavior analysis (ABA) as "a newly fashioned approach to problems of behavior adaptation" (Dunlap, 2006, p. 58). ABA developed in the 1960s as a science in which instrumental learning principles such as positive reinforcement and stimulus control were used to bring about changes in behavior that were socially important.

In the 1980s and 1990s PBS advanced to offer a broad array of interventions that used the concepts and principles of ABA along with those of other disciplines. PBS 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 school-wide issues (Sugai & Horner, 2002).

Currently, PBS may be considered 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).

The success of PBS with individual cases of problem behavior and the growing body of research supporting the effectiveness of school-wide PBS has prompted the federal Department of Education to support the implementation of PBS in the nation's schools. In fact, IDEA mandates PBS and FBA to be used to reduce challenging behaviors in students who have disabilities. PBS is often described as operating in a three-tiered model (see Figure 3).

Figure 3. The three-tiered model



Note. Adapted from Response to intervention: Policy considerations and implementation (p. 22), by the National Association of State Directors of Special Education, 2006, Alexandria, VA: Author.

School-Wide Universal Interventions in PBS. The purpose of school-wide PBS is to create positive school environments for all students. It is a proactive approach that replaces the need to develop individual interventions for multiple students who engage in similar inappropriate behaviors. Before universal interventions are implemented in a school, several steps need to occur to ensure success. First, a large majority of the school staff, usually 80%, must agree to implement the intervention. A consensus needs to emerge concerning the target behavior(s) for the intervention, i.e., what behavioral needs in the school will be addressed. Then, training has to occur that includes information about the theoretical approach of PBS as well as the methods used in implementation. When a school agrees to implement a PBS universal intervention, the staff is committing to the use of a process, not an isolated intervention.

Selective/Targeted Interventions in PBS. Simply stated, in the PBS model selective interventions are used with students who require more than universal strategies but less than intensive individualized interventions. The purpose of selective interventions is to support students who are at-risk for more serious problem behaviors. Implementing a selective intervention begins with an assessment to identify the purpose of the problem behavior through a functional behavioral assessment (FBA). Next, a support plan is developed that may include such interventions as teaching the student a functionally equivalent replacement behavior for the problem behavior or rearranging the environment to reduce the probability of the problem behavior occurring. As illustrated in Appendix C of this report, the mental health system has produced several empirically supported interventions. Many of these interventions such as anger management and bully-proofing programs

that can be group administered and are aimed at the selective intervention level. An important departure from traditional mental health assessment techniques is the reliance on an FBA to help determine the need for an intervention at this level.

Intensive/Indicated Individualized Interventions in PBS. When problem behaviors are dangerous, highly disruptive, and may result in social or educational exclusion, more intensive interventions are needed. In developing these interventions it should be noted that although the aim is to individualize, the methods of PBS are standardized and follow a specific plan. An FBA will be conducted and a multi-disciplinary team (including families) will meet and develop a plan. The mental health system can offer a variety of evidence-based interventions for consideration by the team (see Appendix C). For example, empirically supported techniques such as cognitive-behavioral therapy are effective interventions for challenging behaviors at this level of intensity and should become a component of a treatment plan. Additionally, at this level of intensity a psychological assessment may be an important complement to the FBA and is another area in which the mental health community should be part of the PBS process.

Overall, PBS has been implemented in numerous schools nation-wide. The PBS model, in summary, emphasizes four perspectives:

1. **The use of the three-tiered approach.** There is a perspective that the majority of emotional/behavioral challenges can be prevented by establishing an environment that promotes the frequent occurrence of positive behavior in children.
2. **An instruction emphasis.** Skill development in social and emotional competency are taught in the same way as academic skills and are considered part of the total goal of effective functioning in children.
3. **A functional perspective.** There is an emphasis on the purpose or function of behavior. The FBA is an effective tool in identifying the function of specific target behaviors.
4. **A priority for sustainability.** Interventions are sought that provide a large impact from the smallest change. Multiple approaches are used to raise the probability of success and data are collected to monitor progress.

The implementation of PBS requires different levels of involvement and engagement by the three partners that make-up the team. In Table 10 these roles are summarized.

Table 10. Possible roles in PBS

	ED	MH	Families
Universal	• Primary role is building school-wide support	• Consultation on identifying target behaviors • Provide health promotion	• Be aware of and support school programs
Selective/Targeted	• Conduct FBA • Facilitate team meetings • Monitor progress	• Enhance assessment with psychological evaluation • Provide evidence-based interventions	• Provide information • Identify strengths in home setting
Intensive/Indicated	• Conduct FBA • Report on progress • Facilitate team meeting • Monitor progress	• Psychological assessment • Evidence-based intervention	• Provide information • Express opinions about needed intervention • Support intervention at home • Be engaged

Wraparound Services

Table 11. Essential elements of wraparound

- Community based
- Team-driven
- Families as partners
- Individualized and strengths-based
- Culturally competent
- Flexible funding
- Balance of formal and informal supports
- Unconditional commitment
- Collaboration
- Outcomes determined and measured

Wraparound is currently one of the most popular service coordination strategies being implemented for children with emotional disturbances. The wraparound process is defined as a strategic planning process that results in a unique set of community services and natural supports that are individualized for a child and family to achieve a positive set of outcomes and is made up of ten essential elements listed in Table 11. Wraparound is a frequently used approach when implementing a PBS oriented intervention at the indicated or intensive level.

As illustrated in these essential elements, the wraparound process is very consistent with the principles of family-driven care. In fact, both PBS and wraparound are based on similar principles that serve as the basis for family-driven care. On the one hand, the use of all these different terms may be confusing but actually it is encouraging to note that all of these processes are now converging on the unifying concept of family-driven care.

The mental health community should be familiar with and comfortable with wraparound since it developed along with the concept of a collaborative, integrated system of care for children who have emotional disturbances. As Table 11 indicates the language of PBS and wraparound are very similar and illustrative of the common vision that exists in the education and mental health communities.

Response to Intervention (RtI)

The third component of the synthesizing context is Response to Intervention abbreviated as RtI. While RtI is not new, it was incorporated into the 2004 revisions of IDEA, it is currently receiving much attention and there are important links in RtI to family-driven care that make a description of the process important in this report. The integration of mental health services into RtI probably represents the greatest stretch in the attempt to establish a team response to improving emotional/behavioral functioning in children. This is true, to some degree, because RtI was initially developed to assist educators in determining the need to place children into special education programs for students who have learning disabilities. Much of the initial descriptions of RtI made extensive use of language relating to instruction and curriculum. However, the similarities between RtI and PBS, and the general problem solving approach RtI promotes led those educators concerned with children who have emotional/behavioral challenges to realize the importance of RtI in developing interventions for this group of children. Consequently, RtI is now promoted as an important behavioral strategy as well as one for instructional improvement. This has opened the way for the mental health community to fill an important role in implementing RtI for children who are experiencing emotional/behavioral challenges.

What is RtI? Response to Intervention (RtI) is an emerging approach in the diagnosis of learning and behavior problems that holds considerable promise. In the RtI model, a student with academic delays or behavior challenges is given one or more research-validated interventions. The student's academic progress and behavior is monitored frequently to see if those interventions are sufficient to help the student to catch up with his or her peers or improve behavior. If the student fails to show significantly improved academic

skills or behavioral functioning despite several well-designed and implemented interventions, this failure to "respond to intervention" can be viewed as evidence of an underlying learning or emotional disability requiring more intensive strategies. RtI is the practice of providing high-quality instruction and interventions matched to student need, monitoring progress frequently to make decisions about changes in instruction or goals and applying child response data to important educational decisions.

RtI is based on the following core principles:

- We can effectively teach all children.
- Intervene early.
- Use a multi-tier model of service delivery.
- Use a problem-solving method to make decisions within a multi-tier model.
- Use research-based, scientifically validated interventions/instruction to the extent available.
- Monitor student progress to inform instruction.
- Use data to make decisions.
- Use assessments for three different purposes: (1) screening applied to all children to identify those who are not making progress at expected rates; (2) diagnostics to determine what children can and cannot do in important academic and behavioral domains; and (3) progress monitoring to determine if academic or behavioral interventions are producing desired effects.

Three key components of RtI are:

- **High-quality instruction/intervention**, which is defined as instruction or intervention matched to student need that has been demonstrated through scientific research and practice to produce high learning rates for most students. Individual response is assessed in RtI and modifications to instruction/ intervention or goals are made depending on results with individual students.
- **Learning rate and level of performance** are the primary sources of information used in ongoing decision making. Learning rate refers to a student's growth in achievement or behavior competencies over time compared to prior levels of performance and peer growth rates. Level of performance refers to a student's relative standing on some dimension of achievement/performance compared to expected performance (either criterion- or norm-referenced). Decisions about the use of more or less intense interventions are made using information on learning rate and level. More intense interventions may occur in general education classrooms or pull-out programs supported by general, compensatory or special education funding.
- **Important educational decisions** about intensity and likely duration of interventions are based on individual student response to instruction across multiple tiers of intervention. Decisions about the necessity of more intense interventions, including eligibility for special education, exit from special education or other services, are informed by data on learning rate and level.

As we can see, RtI has many components and terminology that is similar to PBS and compatible with family-driven care. Assessment is a very integral component of RtI and there are specific roles that emerge for the mental health community in the implementation of RtI. In an RtI problem-solving model, assessment is directly linked to three strategic purposes: screening; diagnostics; and progress monitoring.

- Screening in RtI is an assessment that is provided to all students with the express purpose of identifying (as early as possible) students who are not making expected progress, students who are at risk for developing emotional/behavioral problems, and to assess the effectiveness of prevention interventions that are in place.
- Those students identified through screening are provided with diagnostic assessments to ascertain specific skill strengths and deficits.
- After targeted intervention is provided, progress monitoring is employed with students to evaluate the effectiveness of interventions and to determine the intensity of interventions and resources needed to support student learning.

The function of assessment in RtI is to identify at-risk students as early as possible and to gather relevant data to support decision making about implementing strategies. The mental health community can provide assessment tools that are sensitive to detect changes in student behavior over time and link the move from screening to diagnostics to progress monitoring.

The use of a structured, problem-solving process is a requisite component of RtI. A structured, systematic problem-solving process assists in the identification of student learning needs and has some basic components. These components include the following:

- problem identification,
- analysis of the problem to hypothesize why it is occurring,
- developing a plan to address the problem,
- evaluating the student's response to the intervention/ plan selected,
- identification of groups of students with similar learning needs and concerns.

The problem-solving approach in RtI is often summarized as follows: define the problem; analyze why it is occurring; develop a plan to solve the problem; and evaluate progress. This sequence is very close to the PBS process and the mental health community can collaborate in the RtI process by providing expertise in assessment and evidence-based interventions for the problem solving plan.

While RtI has been developed as an educational process, parents and mental health service providers need to become familiar with its use. RtI offers much potential to establish effective prevention and early intervention mechanisms for academic problems and also for emerging emotional/behavioral problems. In the spirit of the partnership, there

is a role for families, educators, and mental health service providers in implementing RtI. The challenge is how to effectively disseminate this information so that it can be utilized by all the members of the partnership.

Putting it All Together

Approaches that are most effective at meeting the mental health needs of children require that the actions of school and mental health staff and parents are integrated and coordinated. Additionally, these approaches require a continuous review of the progress the child is making in developing the skills and abilities to regulate their behaviors and emotions. Implementation of approaches that use a continuous feedback, problem solving approach to delivering services that empower students and families are most effective in meeting the long term needs of children and families. However, with all the innovations and attention to evidence-based treatments, it is easy to get confused between the strategies aimed at the universal, selective, and indicated levels of services and the roles of staff, parents and children in each of these approaches. Figure 4 provides an example of some of the activities that can occur within a system that is dynamic and includes services ranging from universal supports to indicated treatment. The roles of families, educators, and mental health service providers are specified.

Professionals in both the mental health and education fields are actively working to integrate the latest treatments, supports, and strategies into classrooms and treatment settings. In these attempts to integrate the latest strategies by mental health and educational specialist, it is also important that professionals in education keep informed of the developments in the mental health field and mental health professionals keep informed of the developments and policy initiatives in education. This will require unique cross-training of staff in each field and specialized training materials devoted to the goals of understanding the two separate cultures. In Table 12 the activities of the each member of the collaborative team has been illustrated in terms of the levels of empowerment and skills needed to achieve effective service integration. It is through this exchange of information between the two professions and with parent advocacy organizations that collaboration and transformation of the service delivery system will occur.

The successful implementation of PBS, wraparound, and RtI is dependent upon an effectively functioning team. No single agency has the resources or expertise to resolve all instances of challenging behavior in children, especially at the intensive/indicated level. No plan will be totally successfully without the involvement of families at the planning and implementation levels. While this is well known by educators and mental health service providers, we have yet to implement collaborative processes at a level at which we can observe improving outcomes in the children who are served. The transformation to family driven systems will demand the implementation of effective, collaborative systems of service delivery in schools and the community. School districts and schools that do not provide such services will not be compliant with federal regulations governing the implementation of special education programs. Community agencies that provide mental health services for children will need to adopt and adapt these kinds of services or they will not be part of the future of service provision in schools and the clinic. Direct service

Figure 4. Supporting positive emotional/behavioral functioning: A team-based model

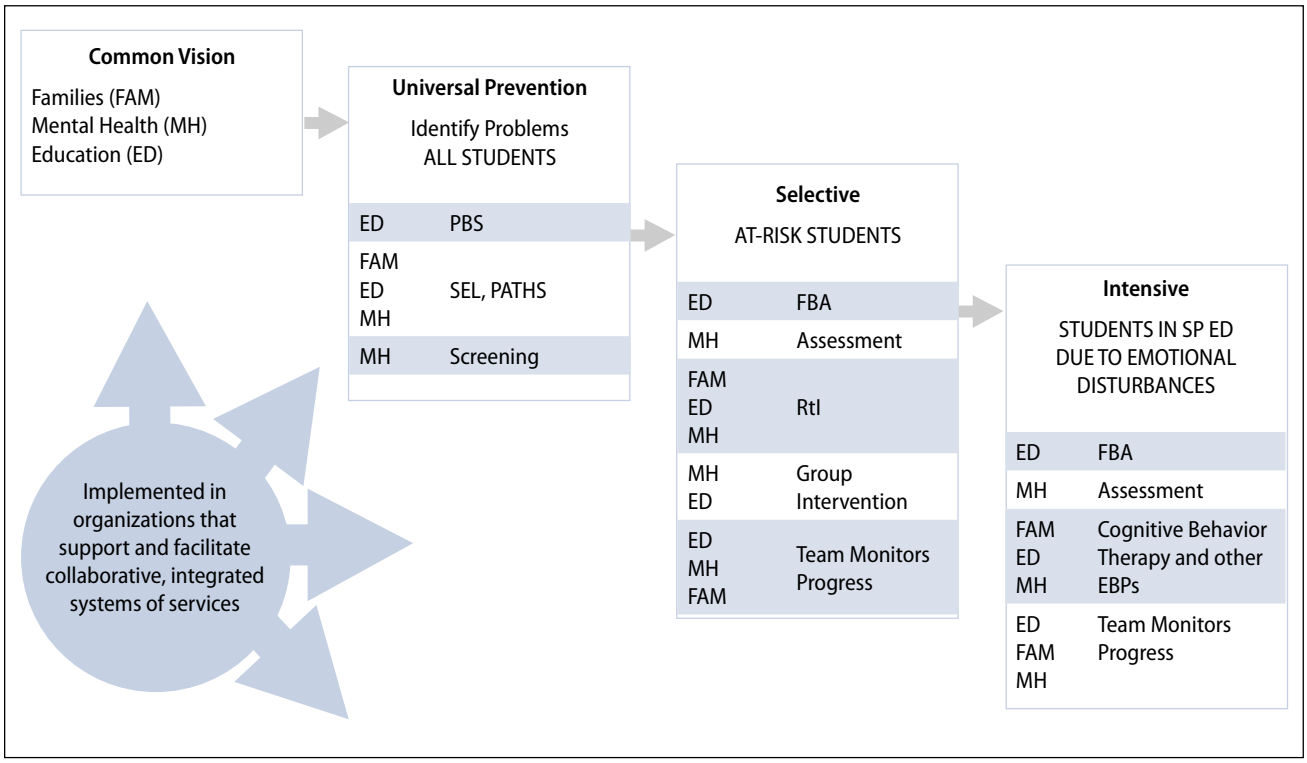


Table 12. The role of staff and parents at the Universal, Selective, and Indicated levels of care

Level	Universal	Selective	Indicated
School	• School-wide PBS • SEL curriculum (e.g., PATHS	• Classroom PBS • Response to Intervention • FBA • Teacher Directed skills and curriculum	• Special Ed placement • Specialized Curriculum • Specially trained teacher
Mental Health	• Mental Health Promotion Activites	• Specialized Mental Health Services — Counseling	• Warparound services • Medication
Parent	• Aware of activites of school	• Equal decision maker • Skills taught at school reinforced at home	• Directs care and IEP
Level of empowerment, problem solving and specialized skills	Low		High

providers in both education and mental health agencies can not be expected to transform the service delivery system alone. They will need support from their organizations in the form of training and policy development that facilitates this new model. Further, system level change in the areas of policy and financing, for example, will be needed to sustain these changes over time. In the sections above we have described and identified roles and activities for the collaborating partners to achieve this type of service system.

What Barriers Inhibit Parents from Participating in School-Related Activities?

To begin the transformation to family-driven care, the factors inhibiting parent involvement need to be explored so that strategies can be developed to overcome these barriers. When asked about factors that inhibit parents from more actively participating in school-related activities, parents who have children with ED and served in special education settings gave varied responses but four clear themes emerged:

- Parents feel overwhelmed and isolated by lack of information
- Parents feel intimidated by unequal power
- Parents feel blamed and disrespected by school personnel
- Parents have experienced poor school customer service

Parents feel overwhelmed and isolated by lack of information

Parents consistently reported frustration and hopelessness when trying to navigate the multiple systems serving their children. Several reported feeling overwhelmed by this process. Specifically, parents mentioned their difficulty trying to make sense of the "alphabet soup" of IEP language, confusion about their rights and how to enforce them (e.g., what to do if a school fails to follow through on an IEP), and not knowing where to turn for help with other child-related problems (e.g., mental health). They also reported feeling a strong sense of isolation and wishing for social support. Indeed, this shared sense of parental isolation was evident throughout the focus group meetings and afterwards, as parents lingered in the hallway, comparing stories and exchanging phone numbers with each other, seemingly reluctant to leave.

Parents feel intimidated by unequal power

Similarly, parents reported feeling intimidated walking into a room full of professionals for their child's IEP meeting. Several mentioned feeling like nobody was in their corner. Even more concerning, parents reported feeling "guilted" into signing the IEP even when they did not completely understand it. One parent stated "You feel like if you don't sign right then and there, you don't really want to help your child." Parents also noted that they have expertise with their children that could be useful to schools, but that their experiences in IEP meeting have been to have professionals talk at them, rather than with them, about their children.

Parents feel blamed and disrespected by school personnel

Parents reported feeling frustrated by the lack of understanding of ED that they have encountered from teachers and school administrators. They feel that because their children's disabilities are invisible, the children are simply labeled as "bad kids." This stigma is damaging to both the children and their parents, who feel they are being blamed by school personnel for raising these "bad kids." Possibly because of this sense of being blamed, parents are very sensitive to being talked down to and resent teachers who,

in the words of one parent, "speak to me like I'm the child." Parents also shared how difficult and hurtful it is for them when they feel that school personnel do not like their children and are trying to find ways to suspend them to keep them out of the school. They feel that school personnel do not understand the level of parental stress, lack of emotional energy, and practical concerns (e.g., transportation) that keep them from more actively participating in school-related activities.

Unwelcoming School Experiences for Parents

- Being ignored by office personnel when they arrive at the school
- Arriving at scheduled school appointments and being made to wait for an hour
- Being told "you should have called first" when they drop by the school unannounced
- Being told that they cannot observe their child's class without a scheduled appointment

Parents have experienced poor school customer service

Given their past negative school experiences and sense of being blamed for their children's behavior problems, it is not surprising that parents of children with ED chafe at receiving poor school customer service. As one parent noted, "If you don't relate [well] to me, you won't relate to my child." They cited a number of experiences that, taken cumulatively, create an unwelcoming environment for parents when they visit their child's school.

Parents also expressed irritation with being connected to voice recordings and voice mailboxes when they call the school. In the words of one frustrated parent, "it takes an act of Congress to talk to a real person." For parents of children with ED, it can be anxiety-provoking to be unable to speak with someone at the school who can update them on the status of their child, particularly if that child requires medication or has recently experienced escalating behavioral problems.

What makes parents feel welcome?

When asked what makes them feel welcome and supported by the school, parents were equally forthcoming with their thoughts. Most of them were extremely satisfied with their children's current school situation (a special education center for children who have ED) and highlighted factors that were different from situations they had experienced in the past. Findings from the focus groups indicate the following:

Parents feel welcome when they are treated with respect

Parents report that they feel welcome when they believe school personnel respect them and view them as partners in helping their children. Several parents indicated that respect is an important factor in their decision to become more involved with the school. When asked to describe what they view as respectful treatment, parents mentioned the following:

An important aspect of parents feeling respected is the attitude of teachers and other school personnel toward parents. Parents indicated that the tone set by the principal pervades the entire school. If the principal makes a point of recognizing parents, greeting

them warmly, and encouraging them to call anytime, then other school personnel tend to follow suit and parents feel welcome. In addition, parents mentioned that when they see other parents visiting the school for similar reasons (e.g., seeking IEP information or meeting with teachers) this sends a message that parents are truly welcome at the school.

Parents feel welcome when the school seems to have their child's best interests at heart

Parents reported feeling welcome when teachers seem to genuinely like their children and have their best interests at heart. They were particularly impressed by teachers who found something positive to say about their child when the child's behavior was at its worst. Hearing something positive about their children is important to all parents, but even more so to parents of children with ED, who are frequently barraged with reports of their child's failings. Parents stressed that they understand their children have behavioral difficulties, but hearing nothing but negative feedback is discouraging to them and makes them wonder if the teacher likes their child. In contrast, when a teacher is able to identify and highlight a child's strengths, this helps to balance out the negative feedback and encourages the parent to more actively partner with the teacher in problem-solving.

Parents feel welcome when school personnel reach out to them through telephone calls

Similarly, parents reported that they appreciate it when teachers make the effort to call them at home to problem-solve, offer support, or give positive feedback about the child. They are particularly impressed when school personnel are willing to call on weekends if they do not connect during the week. Experiencing positive contact with the school is extremely important to parents of children with ED. Parents reported feeling isolated due to their children's problems and indicated that in previous school situations, they typically did not hear from the school unless there was a problem. One of the things they reported being most impressed with in their child's current school situation is school personnel reaching out to their families. One parent described feeling overwhelmed with gratitude when the principal called her at home because he had heard that there was an illness in the family. Parents agreed that these calls do not have to be long—they can just be "check-in" calls. What is most important is the thought and genuine concern of the person making the call.

Parents feel welcome when the school provides opportunities for them to connect with other parents

Parents indicated that they feel welcome when the school provides opportunities for them to connect with other parents. Programs that are designed specifically for parents, such as informational gatherings, PTA meetings, or student award ceremonies, are especially desirable. One parent noted that it is clear the school is reaching out to parents "when it throws you that rope." These programs allow parents to network with each other in addition to enjoying the informational or entertainment benefits these programs offer. Interacting with other parents of children with ED enables parents to normalize their own experiences, support each other, and share ideas and resources. Not surprisingly, parents spoke very positively about schools that provide them with a forum in which to mingle and connect with other parents.

Achieving Greater Parent Involvement

In addition to the information obtained above, in-depth interviews were conducted with Parent Connectors. Parent Connectors are parents of children with ED who maintain telephone contact with other parents (10 parents each) throughout the school year, offering emotional support and connecting them with community resources. When asked about ways to achieve greater parent involvement in schools, the Parent Connectors offered the following suggestions:

1. To increase parent involvement, school administrators first need to understand why some parents are reluctant to come to the school. The reasons may be different for each school but possible barriers include the parent's embarrassment about socioeconomic issues (e.g., clothing in poor condition, transportation problems), language barriers, fear of feeling stupid in a meeting filled with professionals, or inconvenient hours (particularly for single parents). Once the specific barriers are identified, interventions can be developed to eliminate them.
2. Because parents of children with ED often feel stigmatized and isolated, they may be reluctant to attend PTA or other parent-focused meetings unless they are explicitly welcomed and encouraged to participate by those organizations. Simply extending the invitation to attend a meeting is not sufficient. Planned and coordinated outreach to parents of children with ED is the best way to solicit their participation and ensure that they feel genuinely welcomed.
3. Schools need to understand how overwhelming the IEP experience is for parents and take steps to make the process more parent-friendly. Some helpful first steps include:
   - Using parent-friendly language and minimizing the use of jargon. For example, do not refer to the meeting as the "IEP meeting" but rather a "team meeting to explain and discuss the IEP."
   - Explaining the purpose of the IEP, why it is important, and how it will help the child. Parents sometimes think that the document is simply another school-generated form and do not understand how it will help their child.
   - Encouraging parents to bring a friend, relative, minister, or other support person with them to the meeting.
   - When possible, being flexible about IEP meeting times. Remember that just because parents are having difficulty arranging a time to come to the school does not mean that they do not care about their children's education.

     In addition, many parents are not being informed about the IEP as an avenue for helping their child. One parent who returned to her child's school repeatedly in an effort to find help for him reported that she was never told about the IEP by the school and was instead told that she was to blame for her child's problems. It was not until this parent became associated with a parent organization that she learned about her child's right to an IEP.

4. Parents of children with ED often have long histories of negative school experiences. To foster a climate of trust, schools need to make efforts to ensure that every interaction with school personnel is positive for parents. One parent noted, "Even if a parent is at the school because her child's been suspended, she should feel supported by the school and not feel blamed for the child's bad behavior." Some steps to increase the likelihood that parents will visit the school include:
   - Ensuring that parents are spoken to politely on the telephone when they call the school.
   - Inviting parents to school plays, awards ceremonies, informal "coffee and doughnuts" get-togethers, and other positive school events early in the school year. Parents may then feel more motivated to come to the school for IEP and other meetings later in the school year.
   - Providing transportation, childcare, and a stipend to parents for attending a school function will increase the likelihood that reluctant parents will attend.

Strategies to Strength-Based, Family-Driven Care

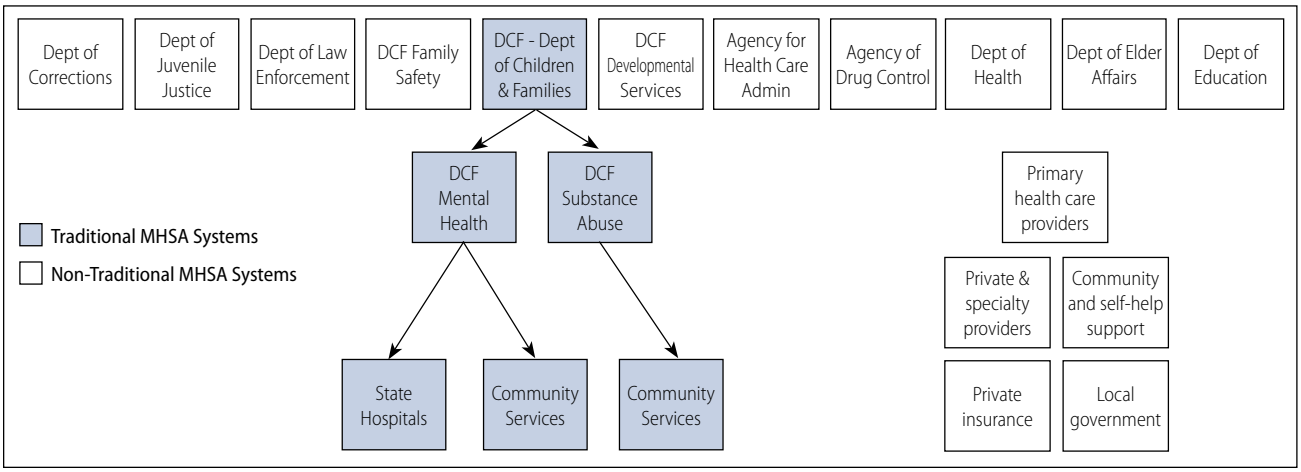
Accessing the Mental Health System

A recent national study of parent of children who are in special education due to emotional disturbance reveals that these parents have a more difficult time obtaining services than any other disability group (Wagner, et al., 2006). This challenge faced by parents nationally suggests that an examination of how families access mental health services in Florida is warranted. So how do parents access mental health services in Florida? The answer is: it depends. Access to children's mental health services in Florida depends on three factors: level of need (severity), financial and insurance status, and where you live.

Generally speaking, the Department of Children and Families (DCF), a state agency, is considered the lead agency in providing public mental health services in Florida. Because of the decentralized nature of DCF, the relative autonomy of DCF district administrators, and the unique characteristics of distinct geographic areas, there is little uniformity across the state with respect to how district offices are structured and managed or how the services delivery systems are configured. Currently, DCF has organized the state into 15 districts (see Appendix A). It is also privatizing many of the services that were previously provided by DCF staff especially in the area of child welfare (Florida Commission on Mental Health and Substance Abuse, 2001). Since this privatizing, there are now a multitude of agencies that provide mental health services.

However, DCF is not the only provider of public mental health services and because of an extensive diffusion of responsibilities and roles, a blurring of service system boundaries has occurred. In contrast to a few centralized systems of the past, today Florida has at least 10 different funding streams involved in the provision of public mental health and substance abuse services (See Figure 5). As managed care has emerged as a financing strategy, for-profit entities have emerged as major care providers (Florida Commission on Mental Health and Substance Abuse, 2001).

Figure 5. Florida's mental health/substance abuse services



The first determination in accessing mental health services is the severity or need for immediate services. If the child is in imminent danger of hurting themselves or others, parents can access emergency crisis services though calling 911. Under Florida's civil commitment statue, which is known as the "Baker Act" (s.394, F. S., 2004), any individual may be involuntarily held in an approved facility for up to 72 hours for involuntary examination, when there is reason to believe that the person has (a) mental illness and (b) may be harmful to self or others or neglectful. Judges, mental health professionals, and law enforcement officials may initiate examinations. Between 2000 and 2004, 36,511 children received emergency examinations and represented 16% of the 277,932 examinations given over this time period. The average age at the time of the examination was a little over 14 years of age with half of the examinations being conducted on youth between the ages of 15 and 17. The majority of examinations (63%) were initiated by law enforcement officers while one third (33%) were initiated by mental health professionals. The remaining examinations (4%) were initiated via ex-parte orders from judges. One-fifth of the children experienced more than one examination over the four year period ranging from 2 to 24 admissions and these multiple admissions accounted for 44% of all children with examinations. This study conducted by Christy, Kutash, and Stiles (2006) documents that a significant number of children experience emergency mental health services and that these emergency services play a significant role in the state wide mental health delivery system.

If parents suspect a mental health or emotional difficulty and it is not a crisis, the most common source of information for parents is their child's pediatrician. Parents should also be encouraged to reach out to school social workers and school psychologists who are often well informed of community resources. Parents should also be encouraged to call 2-1-1, the number for human services resources recently developed nationally. The Florida 2-1-1 Network is a cooperative effort of the Florida Alliance of Information and Referral Services and the United Way of Florida to fulfill the mandate of SB 1276, adopted by the Florida State Legislature in 2002, to make 2-1-1 available to every person in Florida. The Network is a collaboration of the eleven active 2-1-1 regional and local call centers that currently serve 33 of our 67 counties, providing 2-1-1 access to 75% of the population of Florida, and handling over 500,000 calls per year.

For parents whose children are Medicaid eligible, mental health services are offered through mental health clinics and an approved network of private providers. For parents who have private insurance, they should be encouraged to ask their carrier the limits of their mental heath benefit (for example, some carriers limit individual counseling sessions to 12 sessions per year). Parents who are not Medicaid eligible and have no private insurance coverage have the most difficulty accessing services and represent a challenge to the public mental health service delivery system. Often, the only mental health and support services these families can access are supplied by the support staff at schools underpinning the important role of schools in the delivery of mental health services for children. Overall, parents seeking mental health care should be encouraged to contact their local DCF official or local SEDNET Director (see Appendices A and B for contact information).

Because accessing services represents a challenge for parents of children who are developing or have an emotional disturbance, more efforts should be focused on providing school

staff with written materials on how to access local mental health resources. Additionally, more parent advocates should receive training on accessing services and these advocates can then assist other parents to navigate the system as well as support their journey.

Family Voice and Choice

As mentioned earlier, transformation to family-driven care will require innovation and, in some cases, revolution. Implementing family voice and choice is, for most of us, revolutionary. That is to say, the traditional processes in special education and mental health services have been expert driven, lacking in resources, and geared toward compliance with any relevant law or regulation. When families learn to access the service system as described above, they will probably encounter what has been called "service as usual" or standard practice. The professionals will be happy to find one reasonable service option to offer a family and most families will feel relieved to get that. With transformation, we are proposing that families join professionals in assessing the strengths and needs of a child, and that an array of possible services is developed from which the family chooses the best fit for them. Is this an unrealistic dream? The answer is a resounding NO! There are many communities across the country and some in Florida that are implementing the beginnings of family-driven care. It is neither easy nor impossible. It does require new beliefs, new ways of thinking, and new methods. For many, it will be revolutionary.

How can the process begin? As in most reform movements there are small steps 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. These include:

- 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.

Most of the recommendations proposed by Osher and her colleagues can be achieved if the members of the partnership—families, mental health, & education—change beliefs and ways of thinking as described in earlier sections of this report. Constructing more flexible funding mechanisms will present the greatest challenge to most communities. However, it must be stated that some communities have done this. It isn't easy, it isn't impossible. In these communities administrators have struggled through the process of putting everything on the table and examining all options. Medicaid funds, the permission for pilot programs using Medicaid funds, discretionary funds in IDEA, small start-up grants for innovation, and federal grants have all served as mechanisms for communities seeking to achieve family choice.

Services, Skills, and Supports. Once a community develops a mechanism to fund family choice, the question becomes, "What will they be offered?" As our earlier discussion of evidence-based practices illustrated, professionals must be sure that the interventions offered to youth and their families have an empirical foundation that supports their effectiveness. This leads to a very difficult point. Out patient therapy (either in a mental health center office or in an office in a school building) is the major mental health service offered to children and youth. We also know, through the results of scores of studies, it is the least effective intervention for children with emotional and behavioral disturbances. Why? Further studies have revealed that when provided in community settings, most therapists do not adhere to constructs of the therapeutic model and therefore, its effectiveness is diminished. If this is the situation, why should families not be offered other choices of intervention?

We now know that there are several programs called Social-Emotional-Learning (SEL) programs that are effective in improving the academic and emotional functioning of children. These programs teach skills that help children respond appropriately in challenging situations and engage in pro-social behavior. Resources for evidence based practices are obtained in the appendix of this report. The research from SEL challenges educators and mental health professionals to learn about these empirically-supported interventions and make them available to children and their families.

How can it happen?

- Include SELs on IEPs
- When schools contract with mental health agencies for services, require SELs
- Pupil services staff and teachers can implement some SELs
- There are several SELs that have family components, families need to receive training to carry out their part in implementation

When families are asked to describe what promotes family voice and choice, they say it helps to have:

- Peer support and family directed assistance with information, rights, and procedures;
- Troubling behavior addressed in a rehabilitative and therapeutic rather than a punitive manner;
- Collaborative (wraparound) planning - all agencies together with families tailor education, mental health, and other services to the child's and family's needs;
- Service coordinators (social workers, probations offices) with a mental health background who provide caring, helpful advice;
- In-home and crisis intervention services and other direct services (Osher et al., 2006).

Readers need to remind themselves that there are communities in which these practices are being implemented. Our task in Florida is to adopt and adapt to achieve the goal of implementing family-driven care.

Policies that Promote Family Partnerships

The momentum is mounting to transform the service delivery system for children who have emotional and behavioral disturbances and their families into one that is family-driven. While all the child serving agencies (child welfare, juvenile justice, health care, education, and mental health) are partners in the transformation process, the education and child mental health systems are moving steadily forward, guided by several federal initiatives and legislation. The three partners in the transformation process -- families-mental health-education – should know that these initiatives and legislation offer guidance as well as mandates to achieve the goal of family-driven systems of care. Specifically, two pieces of legislation and the reports of two Presidential Commissions support the opinion that parent involvement must progress to the point where families determine the nature of educational and social services for their children. The laws are the Individuals with Disabilities Education Act (IDEA) (re-authorized recently but still in revision), and the No Child Left Behind Act of 2002 (NCLB). In 2002 President Bush appointed the President's Commission on Excellence in Special Education and that same year he created the New Freedom Commission on Mental Health which filed their report in 2003.

The Individuals with Disabilities Education Act (IDEA) (PL 94-142) was first signed into law in 1975 as The Education for All Handicapped Children Act. It was amended and re-titled in 1992. The most current version of IDEA (PL 105-17) was signed into law in 1997. IDEA was designed to provide guidelines for the provision of special education services to students with disabilities, ensuring that these students are provided with free and appropriate public education, free and fair evaluations, that Individualized Education Programs (IEPs) are developed for each special education student, and that guardians are provided safeguards and the opportunity to participate in the development of their child's education plan. The law addresses the rights of special education students and their parents, such as the right to comprehensive and objective evaluations; the least restrictive educational environment appropriate for the student; confidentiality; and required consent for evaluation, placement, and provision of services.

The involvement of parents as active members of a child's educational team has become a stronger emphasis in schools over the last few years. Whereas a few years ago, educational planning and implementation for special education students was completed by educational staff almost exclusively (specifically, the child's special education teacher), IDEA requires active engagement of parents. Parents are allowed to invite anyone to a meeting regarding their special needs child. In the meeting, parents identify the child's strengths, needs, goals and objectives, educational programming needed for the student to meet long-term goals, and discuss the child's least restrictive environment. Further, as participants of the child's IEP team, parents should discuss evaluation/re-evaluation needs, need for extended school year services, school-wide achievement testing or alternative assessments, and (for older students) transitional services. IDEA has clearly spelled out the role of parents in determining their child's special education program.

The No Child Left Behind Act (NCLB) (PL 107-110) was signed into law on January 8, 2002. This document provides a detailed description of goals set forth for the

educational system under the Bush administration. The primary purpose of the Act is to improve achievement of students by:

- Increasing accountability for student performance
- Focusing on what works (research based programs and practices)
- Reducing bureaucracy and increasing flexibility (increasing flexible funding at the local level), and
- Empowering parents

Over the years since NCLB became law, the emphasis on developing parent empowerment has focused on increasing the opportunities for parents to exercise choice when their child's school does not meet the standards of the law. In the interest of promoting informed parental choice, the Act requires that individual schools develop a "report card" that is disseminated to parents. The report card provides aggregate data on the achievement of students within the school. It addresses the adequate yearly progress of students and schools are required to inform parents if it has a School Improvement Plan due to lack of progress for three consecutive years. Furthermore, parents are afforded the opportunity to choose another public school or charter school to obtain supplemental education services for their child if he/she attends a school that has an improvement plan.

While critics of the Act have argued about the effectiveness of vouchers and school choice in improving the achievement of America's school children, the language used to describe the role of parents is clear and forceful. Parents are given a major role in determining how and where their child is to be educated if certain conditions emerge in their home school.

In addition to these laws, the reports from two commissions appointed by President Bush address the issue of family involvement in determining services for their children who have special needs and require special services. "A New Era: Revitalizing Special Education for Children and Their Families" (2002) is the report of the President's Commission on Excellence in Special Education. Like NCLB, this report calls for an emphasis on results as opposed to documenting compliance in the implementation of IDEA. Evidence-based practices and rigorous research to evaluate the practices are major activities promoted in the report. In addition, increased family involvement is presented in terms of school choice when a child's program consistently fails to produce adequate yearly progress. As in NCLB, parents are taken to a level of empowerment at which they may choose a different school for their child if the child's progress is considered to be unsatisfactory over a period of time. Again, this is a very powerful mechanism aimed at self-determination of parents in designing the education program for their child.

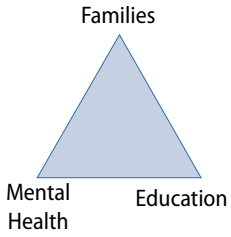
"Achieving the Promise: Transforming Mental Health Care in America" (2003), is the report of the President's New Freedom Commission on Mental Health. This report addresses many issues that need to be resolved within our mental health system, and it includes many underlying themes such as lack of access to care (including funding), issues related to cultural competence, and stigma. However, the first principle identified by the Commission for the successful transformation of the mental health system is that

"services and treatments must be consumer and family centered, geared to give consumers real and meaningful choices about treatment options and providers—not oriented to the requirements of bureaucracies" (President's New Freedom Commission on Mental Health, 2003, p. 7). The Commission identified six goals that must be achieved to transform the mental health system and Goal 2 is to involve consumers and families fully in orienting the mental health system toward recovery.

Since the Commission made strong recommendations about collaboration with schools in the treatment of children who have mental illness we can assume that the principles, goals, and ideas promoted in the report apply to the education system in their efforts to educate children who have emotional and behavioral disturbances. In this report we have a strong mandate to have consumers and families develop and choose the types of service they want as well as the provider of these services. In addition, the Commission introduces the concept of recovery to the process, giving families the mandate to orient providers to services that will promote recovery for their children. This is a recent development in the field and it is hoped that the education community will meet this challenge through effective collaboration with their mental health partners and authentic collaboration and involvement with parents.

Clearly, the education and mental health communities have a foundation of federal laws and initiatives promoting the effective involvement of families in developing a service system for their children who have special needs. It is encouraging that through the national Transformation Initiative local communities are beginning to show progress in this endeavor. Florida is poised to work toward transformation in earnest and develop a system of family-driven care.

Promoting family-driven care: An action agenda for the partnership



The information presented in this report will not produce any change in the degree of family-driven care available in Florida until specific action steps are taken to help promote the ideas, skills, attitudes, and beliefs that have been described. Clearly, the changes advocated for in this report will require time to be accomplished. Moreover, all three of the partners will have work to do.

While implementing family-driven care in Florida will cost more in terms of time, resources, and effort, the lack of effective family-driven care will cost significantly more in terms of continuing poor outcomes for children, a new generation of dependent young adults, and increasing expenditures for custodial care in Florida's prisons. This scenario is supported by over ten years of longitudinal research.

Some short and long term action steps:

1. Get the word out to every teacher, principal, social worker, psychologist, and counselor that having positive expectations about a child has been shown to be the single most effective intervention to improve academic and social functioning in children. Have every school get this message to every parent and guardian as well.
2. Use school in-service training days to increase awareness of and skills to use evidence-based practices. Require mental health provider agencies to use evidence-based practices. Be aware that there are not evidence-based practices suitable for every situation but we can go a long way to increase their use for situations that are appropriate both in school and in the clinic. Stop using only "treatment as usual." It doesn't work.
3. Build an army of knowledgeable, competent, and passionate family leaders across the state.
4. Create a Parent Leadership Academy for families that have children with emotional and behavioral disturbances. There are examples of several organization focused on parent involvement (e.g., the Miami-Dade County Public Schools Parent Academy) and organizations that train parents of special needs students (e.g., the Parent Leadership Development Project also in Miami). However, the complexity of issues related to children who have emotional and behavioral disturbances require an organization specially addressing these issues. Consultation on this topic should begin with such organizations as chapters of the Federation of Families for Children's Mental Health, NAMI, and CHADD.
5. Charge every Florida SEDNET Director with the goal of training a cadre of 10 family leaders within 2 years in their region.
6. Have every school produce a brochure that gives families information about how to specifically access mental health service in their community.
7. Monitor and adapt the current efforts of the New York State Department of Mental Health's Parent Empowerment Program (PEP). New York State Office of Mental Health is currently engaged in training a cadre of parent advocates on a standardized set of parent empowerment and knowledge materials. This cadre of parent advocates will support parents who are accessing mental health services for their children.

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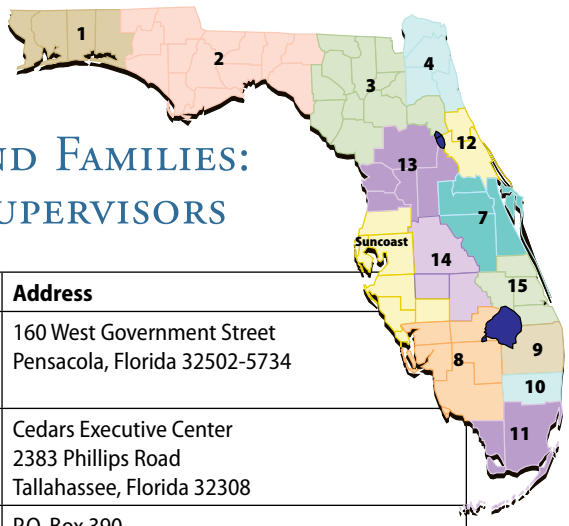
Appendix A



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Appendix B

Florida Department of Education

Division of K-12 Public Schools, Bureau of Exeptional Education and Student Services

FY 2005-06	SEDNET-Multiagency Network for Students with Severe Emotional Disturbances	
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Appendix C

Compendium of Evidence-Based Behavioral Health Programs Listed on any of Five Sources by Prevention Level (Indicated, Selective, and Universal)

	Prevention Level / Focus	List Cited	School, Community, or Both	Age Range*	Length of Program+	Family Component (Y/N)	Teacher Component (Y/N)
Indicated (17 programs)							
	Social / Emotional						
1	Brief Strategic Family Therapy	A	C	6 – 17 yrs	8 – 12 weeks	Y	N
2	Counselors Care (C-CARE) and Coping and Support Training (CAST)	B	S	14 -18 yrs	2 hours (C-CARE) 6 weeks (CAST)	N	N
3	Early Risers: Skills for Success	A	B	6 – 10 yrs	3 years	Y	N
4	Family Effectiveness Training	A	C	6 – 12 yrs	13 weeks	Y	N
5	Multidimensional Treatment Foster Care	C, D	B	12 -18 yrs	Avg. stay 7 months	Y	N
6	Queensland Early Intervention and Prevention of Anxiety Project	B	S	7-14 yrs	10 weeks	Y	N
	Substance Abuse						
7	Multidimensional Family Therapy	A	C	11 – 18 yrs	Avg. of 4 months	Y	N
8	Not on Tobacco	A	B	12 – 24 yrs	10 weeks	N	N
9	Project EX	A	S	14 – 19 yrs	6 weeks	N	N
10	Reconnecting Youth	A	S	14 – 18 yrs	One semester	Y	Y
	Violence / Aggression						
11	Adolescent Transitions Program (ATP)	B	C	10 – 14 yrs	12 weeks	Y	N
12	Anger Coping Program	B	S	9 – 12 yrs	12 – 18 weeks	N	N
13	Attributional Intervention (Brainpower Program)	B	S	10 – 12 yrs	6 weeks	N	N
14	Earlscourt Social Skills Group Program	B	S	6 – 12 yrs	12 – 15 weeks	Y	Y
15	Montreal Longitudinal Experimental Study	B	B	7 – 9 yrs	Two years	Y	N
16	Multisystemic Therapy (MST)	A, C	C	12 – 17 yrs	Avg. of 4 months	Y	N
17	Peer Coping Skills Training	B	S	6 – 12 yrs	Approx. 22 weeks	N	Y
Indicated / Selective (11 programs)							
	Social / Emotional						
18	Incredible Years	A, C	S	2 – 8 yrs	Up to 22 weeks	Y	Y
19	Families and Schools Together (FAST)	A	C	4 – 12 yrs	8 – 12 weeks	Y	N
	Substance Abuse						
20	CASASTART (Striving Together to Achieve Rewarding Tomorrows)	A, D	C	8 – 13 yrs	Up to 2 years	Y	N
21	Leadership and Resiliency Program (LRP)	A	B	14 – 17 yrs	Up to 4 years	N	N
22	Parenting Wisely	A	C	9 – 18 yrs	Self-administered	Y	N
23	Project Success	A	C	14 – 18 yrs	8 – 12 sessions	Y	N
24	Residential Student Assistance Program	A	C	14 – 17 yrs	5 – 24 weeks	N	N
	Violence / Aggression						
25	FAST Track	B	S	6 – 12 yrs	School Year	Y	N
	Trauma						
26	Cognitive Behavioral Therapy for Child Sexual Abuse	A	C	3 – 18 yrs	12 sessions	Y	N
27	Trauma Focused Cognitive Behavior Therapy	A	C	3 – 18 yrs	12 - 16 weeks	Y	N
	Healthy Babies						
28	Nurse-Family Partnership Program	A, C	C	0 – 3 yrs	Up to 2 years	Y	N
Selective (14 programs)							
	Social / Emotional						
29	Across Ages	A	B	9 – 13 yrs	Continuous	Y	N
30	PENN Prevention Program	B	C	10 – 13 yrs	12 weeks	N	N
31	Primary Mental Health Project	B	S	4 – 10 yrs	School Year	N	N
32	Stress Inoculation Training I	B	S	16 – 18 yrs	13 sessions	N	N
33	Stress Inoculation Training II	B	S	13 – 18 yrs	8 sessions	N	N
	Aggression / Depression						
34	Coping with Stress Course	B	S	13 – 18 yrs	15 sessions	N	N
35	First Step to Success	B	B	4 – 5 yrs	Approx. 3 months	Y	Y
36	Functional Family Therapy	C	C	11 – 18 yrs	8 – 26 hours	Y	N
37	Social Relations Program	B	S	10 – 11 yrs	School Year	N	N

	Prevention Level / Focus	List Cited	School, Community, or Both	Age Range*	Length of Program+	Family Component (Y/N)	Teacher Component (Y/N)
	Trauma						
38	Children in the Middle	A	C	3 – 12 yrs	2 – 4 months	Y	N
39	Children of Divorce Intervention Program (CODIP)	B	S	8 – 15 yrs	9 – 16 sessions	N	N
40	Children of Divorce Parenting Program	B	C	8 – 15 yrs	12 sessions	Y	N
41	Family Bereavement Program	B	C	7 – 17 yrs	15 sessions	Y	N
	Mentoring						
42	Big Brothers/Big Sisters	B, C	C	5 – 18 yrs	One year or longer	N	N
Selective /Universal (9 programs)							
	Social / Emotional						
43	Dare to be You1	A	B	2 – 5 yrs	12 weeks and boosters	Y	Y
44	Project Achieve	A	S	4 – 14 yrs	3 years	Y	Y
45	SAFE Children: Schools and Families Educating Children	A	B	4 – 6 yrs	20 weeks	Y	N
46	Strengthening Families Program	A	C	6 – 12 yrs	7-14 weeks and boosters	Y	N
	Substance Abuse						
47	All Stars	A	B	11 – 14 yrs	9 – 13 weeks	Y	Y
48	Keepin' It REAL	A	S	10 – 17 yrs	10 lessons and booster	N	Y
49	Project ALERT	A, D	S	11 – 14 yrs	11 weeks and boosters	N	Y
50	Project Toward No Drug Abuse	A, C	S	14 – 19 yrs	4 – 6 weeks	N	Y
	Aggression						
51	Olweus Bullying Prevention Program	A, C	S	6 – 18 yrs	School Year	N	Y
Universal (39 programs)							
	Social / Emotional						
52	Al's Pals: Kids Making Healthy Choices	A	B	3 – 8 yrs	23 weeks	Y	Y
53	Caring School Community	E	S	5 – 12 yrs	School Year	Y	Y
54	Child Development Project	A, B	S	5 – 12 yrs	Up to 3 years	Y	Y
55	Families that Care: Guiding Good Choices	A	C	8 – 13 yrs	5 – 10 weeks	Y	N
56	Good Behavior Game	B	S	5 - 7 yrs	2 years	N	Y
57	High/Scope Educational Approach for Pre-School & Primary Grades	A, E	S	3 – 5 yrs	School Year	Y	Y
58	Improving Social Awareness – Social Problem Solving	B	S	8 – 14 yrs	School Year	N	Y
59	Life Skills Training	A, C, D, E	S	11 – 16 yrs	3 years	N	Y
60	Linking the Interests of Families and Teachers (LIFT)	B	S	6 – 11 yrs	10 weeks	Y	Y
61	Lions Quest Skills Series	A, E	S	6 - 18 yrs	Multiyear	Y	N
62	PATHS: Promoting Alternative Thinking Strategies	A, B, C, E	S	5 – 12 yrs	5 years	Y	Y
63	Positive Youth Development Program	B	S	11 – 14 yrs	15 weeks	N	N
64	School Transitional Environment Project (STEP)	B	S	Transitioning students	School Year	N	Y
65	Seattle Social Development Project	B	S	6 - 12 yrs	School Year	Y	Y
66	Skills, Opportunities, And Recognition (SOAR)	E	S	6 – 12 yrs	Multiyear	Y	Y
67	Social Decision Making and Problem Solving Program	E	S	6 – 12 yrs	25-40 lessons per year	N	Y
68	Suicide Prevention Program I	B	S	12 - 14 yrs	12 weeks	N	N
69	Suicide Prevention Program II	B	S	16 – 17 yrs	7 weeks	N	N
	Substance Abuse						
70	Athletes Training and Learning to Avoid Steroids (ATLAS)	A, D	S	13 - 19 yrs	10 sessions	Y	Y
71	Class Action	A	S	14 – 18 yrs	8-10 weeks	Y	Y
72	Communities Mobilizing for Change on Alcohol	A	B	13 -20 yrs	Continuous	N	N
73	Family Matters	A	C	12 – 14 yrs	3 months	Y	N
74	Keep a Clear Mind	A	S	8 – 12 yrs	4 weeks	Y	Y
75	Midwestern Prevention Project	C	B	12 – 18 yrs	5 years	Y	Y
76	Project Northland	A, D	S	10 – 14 yrs	3 years	Y	Y
77	Project TNT: Towards No Tobacco Use	A, D	S	11 - 14 yrs	10 days and boosters	N	Y
78	Project Venture	A	B	11 - 15 yrs	Continuous	N	Y
79	Protecting You/Protecting Me	A	S	6 – 11 yrs	5 years	N	Y
80	Start Taking Alcohol Risks Seriously (STARS) for Families	A	B	11 – 14 yrs	5 – 10 weeks	Y	N
81	The Strengthening Families Program: For Parents & Youth	A, D	C	10 – 14 yrs	7 weeks and booster	Y	N
82	Too Good For Drugs	A	S	5 – 18 yrs	School year	Y	Y

Appendix C: Compendium of Evidence-Based Behavioral Health Programs

	Prevention Level / Focus	List Cited	School, Community, or Both	Age Range*	Length of Program+	Family Component (Y/N)	Teacher Component (Y/N)
	Aggression / Violence						
83	I Can Problem Solve (ICPS)	B, E	S	4 – 12 yrs	School Year	Y	Y
84	Responding in Peaceful and Positive Ways (RIPP)	A, B, E	S	12 – 14 yrs	3 years	N	Y
85	Safe Dates	A	S	12 – 18 yrs	9 sessions	Y	Y
86	Second Step: A Violence Prevention Program	A, B, E	S	4 – 14 yrs	15 to 30 weeks	Y	Y
87	SMART Team: Students Managing Anger and Resolution Together	A	S	11 – 15 yrs	8 computer modules	N	Y
88	Teaching Students to be Peacemakers	A	S	5 – 14 yrs	School Year	N	Y
89	Too Good for Violence	A	S	5 – 18 yrs	School Year	N	Y
	Health Promotion						
90	Know Your Body	E	S	6 – 12 yrs	School year	Y	Y
Universal/ Selective/Indicated (2 programs)							
91	Creating Lasting Family Connections (CLFC)	A	C	11 – 15 yrs	20 weeks	Y	N
92	Positive Action	A	S	5 – 18 yrs	School Year	Y	Y

1 This is a different program than D.A.R.E. (Drug Abuse Resistance Education)

* Programs reporting grades were converted to the approximate age of student in each grade level

+ Sessions generally last 40 minutes to 1 hour

Codes for which lists cited the program:

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