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Mental Health Intervention Teams: A Collaborative Model to Promote Positive Behavioral Support for Youth with Emotional or Behavioral Disorders

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This paper describes an innovative intervention model for promoting mental health and positive social adjustment for youth with emotional or behavioral disorders (EBD) in San Diego. More specifically, it highlights a unique partnership between several program divisions within the San Diego Unified School District (SDUSD), namely, the Mental Health Resource Center (MHRC) and the Emotional Disturbance Program (ED) and also includes research and evaluation consultation from the Child and Adolescent Services Research Center (CASRC). This collaborative service model was developed to expand and standardize evidence-based interventions for students in self-contained special education ED classrooms in order to improve their academic and social outcomes.

Keywords: School-based Services, Mental Health Intervention Emotional or Behavioral Disorders, Evidence-based Practices, Positive Behavioral Support.

The provision of appropriate educational and mental health services for youth with emotional or behavioral disorders (EBD) is a challenging endeavor for school systems (Landrum, Tankersley & Kauffman, 2003). While there has been substantial progress in the school-based services literature outlining positive behavioral support and evidence-based intervention for youth with EBD (Colvin, 2004; Lane, Gresham & O'Shaughnessy, 2002; Sprague & Walker, 2000; Webster-Stratton, Reid & Hammond, 2004), the extent to which these services are available in all classrooms remains unknown (Hunter, Hoagwood, Evans, Weist et al., 2005). Hunter and colleagues identified the following characteristics of effective school-based mental health programs, noting they are difficult to achieve: implementing and sustaining collaboration and training across school staff (i.e., teachers, para-educators, psychologists, etc.) and community providers (i.e., mental health clinicians), overcoming fiscal constraints, home-school collaboration, and progress monitoring program effectiveness.

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Prevalence Rates and Characteristics of Youth with EBD

Prevalence rates of EBD range from 6-10% of school-age youth (Kaufman, 2005), yet federal data indicate that less than 1% of students in the U.S. are identified under the special education handicapping code of Emotionally Disturbed (ED); and in the state of California, even fewer (0.31%) are served under this category (Hallahan & Kauffman, 2006). Inherent problems with the ED definition, lack of culturally appropriate assessment tools, as well as hesitation to negatively label students are potential reasons contributing to the under-identification (Kauffman, 2005). Despite this low identification rate, in 2002, 25,984 students in California alone were classified as needing special education services to address their emotional and behavioral needs (U.S. Department of Education, 2005). Given this sizable number of students, appropriate and accessible mental health supports are warranted.

Youth with EBD often demonstrate complex behaviors and co-occurring disorders (Kauffman, 2005). Youth served in ED special education have higher rates of mental health disorders than youth served by primary care, juvenile justice and mental health sectors (Garland, Hough, McCabe, Yeh, Wood, & Aarons, 2001). Yet national data indicate only 49% of students served as ED received mental health services and 55% had behavior management plans (U.S. DOE, 2005), a statistic revealing that nearly half did not receive necessary support.

Students with EBD often have recurrent contact with juvenile justice, are likely to live in single parent or foster homes, and are frequently economically disadvantaged (Coutinho, Oswald, Best & Forness, 2004; Hallahan & Kaufman, 2006). Males outnumber females within this category by 5 to 1 or more (Kauffman, 2005). ED is also among the five largest disability categories for all racial/ethnic groups except Asian/Pacific Islander, with African American students 2.25 and Native American students 1.30 times more likely than all other racial/ethnic groups combined to receive special education under ED and (U.S. DOE, 2005). Students with EBD also display significant deficits in academic achievement. Due to frequent off-task, disruptive, and defiant behavior, these students spend less time academically engaged and often fail to master basic academic skills (Gunter & Denny, 1998; Hinshaw, 1992). Students with EBD typically perform a year or more below grade level, and compared to students in all other disability categories, fail more courses, have higher absences, more grade retentions (Kauffman, 2005; Wagner, 1995) and unfortunately, have the highest drop-out rates (U.S. DOE, 2005).

Given the serious mental health and academic needs of the EBD population, they are more often educated outside the regular classroom than other students with disabilities. In fact, a large portion (30.7%) of students with EBD is educated outside the regular classroom for more than 60% of the school day (U.S. DOE, 2005).

Need for an Integrated Educational and Mental Health Treatment Model

There is considerable pressure for schools to address both the mental health and educational needs of youth with EBD. According to a consensus statement by the School Mental Health Alliance (Hunter et al., 2005) "*health, and especially mental health, is a fundamental cornerstone for ensuring that all youth have an equal opportunity to succeed at school and that no child is left behind"* (p. 8). Along a similar note, the No Child Left Behind Act recommends "*student access to quality mental health care by developing innovative programs to link the local school system with the mental health system"* (p. 427) (Office of Elementary and Secondary Education, 2002). Lastly, the Individuals with Disabilities Education Act (IDEA) requires that state and local educational agencies equip school personnel with skills to appropriately address serious behaviors and student mental health (IDEA, 2004).

Because of their daily access to children and families, school personnel are well positioned to

address significant academic and mental health issues; however, school personnel alone cannot provide all needed services. The EBD population often requires services from multiple community agencies (Farmer & Farmer, 1999) that are ideally, integrated and coordinated with one another as well as with school services (Zanglis, Furlong, & Casas, 2000).

San Diego Unified Schools Mental Health Resource Center

The Mental Health Resource Center (MHRC) as part of the Parent, Community and Student Engagement Branch of SDUSD (established in 2001) is funded by county monies and a Safe Schools Healthy Students grant. The MHRC provides mental health prevention and intervention to reduce violence and substance abuse, decrease emotional symptoms, improve behavior, and raise student achievement and attendance. MHRC provides assessment, case management, and treatment for students at all grade levels in both regular and special education. Key components of the MHRC include early screening, accessibility of mental health service, coordination with community mental health providers, and parental involvement. Its multi-disciplinary and multicultural staff consists of clinical psychologists, licensed mental health clinicians, social workers, school counselors, behavioral rehabilitation specialists, and psychiatrists. Lastly, the MHRC coordinates, operates and oversees a multitude of programs and uses several evidence-based interventions. A list of MHRC programs is provided on Table 1.

SDUSD Special Education Programs for Youth with EBD and District Demographics

Over 800 SDUSD students require supports and services under the ED category. SDUSD ED classes are located in 45 comprehensive school sites (elementary, middle and high school). Additionally, 40 ED classes are located in more restrictive alternative settings (i.e., non-public day and residential treatment centers). Recommended class size is 10 students for primary classes, and 12 for upper, middle and senior classes. In 2006, the ethnicity of the students classified as having ED was 29% Latino, 34% Caucasian, 3% Asian/Pacific Islander, 33% African American and 1% American Indian. In the same year, 42% of the district students were Latino, 26% Caucasian, 17% Asian/Pacific Islander, 14.5 % African American and .5% American Indian.

It is important to note the diversity of the SDUSD, as it provides the context for all specialized programs. There is a rising culture of economic poverty in San Diego's inner-city schools, as the city's border location contributes to drug trafficking and a growing population of migrant workers from Mexico and Central/South America. Influxes of Asian and East African refugees contribute to language barriers, ethnic tensions, and unemployment. Twenty-eight percent of the district students are English learners and 55% receive free/reduced lunch.

MHRC and ED Program Collaboration

A partnership between the MHRC and the ED program was established to address the need for added mental health support in classrooms by restructuring the way district services are delivered. Through a series of planning meetings, a continuum of services was developed. The primary goal was to deliver intensive services to students and their families in their local neighborhoods in order to prevent more restrictive placement (out of neighborhood) of students with EBD. Additional objectives included reducing suspensions and increasing academic achievement among students with EBD, as well as improving teacher retention in ED classrooms. By providing teachers with a larger repertoire of therapeutic interventions, it was hypothesized that teachers would be better equipped to address the unique

TABLE 1. *MHRC Programs*

	Program Description	Evidence-Based Interventions
General Education		
1. Alternative Learning for Behavior and Attitude (ALBA)	Mental health clinicians located on ALBA sites provide immediate access to services (assessment, evaluation, & treatment). Over 1,200 students screened for mental health disorders, over 700 students received group, individual, or family therapy, & over 350 received transition (reintegration back to neighborhood school) counseling.	Multisystemic Therapy (Henggeler et al., 1998) Botvin Life Skills (Botvin, 1998)
2. Early Childhood	MHRC provides mental health supports to young children through consultation, assessment, referral, & parent training.	Second Step (Commitee for Children, 1998; Grossman et al., 1997)
3. EPSDT (Medi-Cal) School Site Provider	Coordinates assignment & oversight of community mental health contracted EPSDT providers delivering individual, group & family services at 60 schools.	
4. Multi-Systemic Therapy (MST)	MHRC provides MST services to families of students at ALBA Schools and Clark Middle. MST is an evidenced-based practice which addresses delinquency, gang activity, physical assault, & school truancy.	Multisystemic Therapy (Henggeler et al., 1998)
5. School Attendance Review Board (SARB)	MHRC provides assessment, individual & family counseling to students with significant attendance problems.	
6. School Site Support	School sites can purchase mental health staff to provide services, consultation, & staff training for working effectively with challenging students & families.	
Special Education		
1. AB2726	MHRC has contracted with Children's Mental Health to provide individual & family therapy to students who need mental health services through the IEP process.	

2. Day Treatment	Marcy School & New Dawn full-day rehabilitation program provide comprehensive treatment services to special needs elementary, middle, & high school students.	Second Step (Commitee for Children, 1998; Grossman et al., 1997) Strengthening Families (Kumpfer et al., 2007)
3. Intensive Outpatient Program (IOP)	IOP pilot project attaches a mental health team to one ED elementary or middle school classroom for an entire semester and then moves to a new class the following semester, leaving behind case management services in first classroom. The IOP team consists of a mental health therapist, a rehabilitation technician, a case manager, a part-time psychiatrist and targets three key environments/people: a) classroom teacher & support staff, b) parent/caregiver, and c) students. Intervention components teach appropriate social & behavioral skills through positive behavioral support.	Second Step (Commitee for Children, 1998; Grossman et al., 1997) Strengthening Families (Kumpfer et al., 2007)
4. Deaf & Hard of Hearing (DHH)	MHRC provides treatment services to DHH students w/ emotional/behavioral needs.	
5. Licensed Childrens Institutions	LCI supports general & special education students in shelters, foster youth facilities, psychiatric hospitals & day treatment programs. MHRC staff collaborates with outside agencies providing treatment & ensures success during student transitions.	
6. Mental Health Intervention team (MHIT)	MHIT provides services to all elementary & middle schools that have SDC-ED classrooms on site. MHIT Teams help to structure classrooms, develop point systems/token economies, assist school teams in developing, implementing, and monitoring behavior support and behavior intervention plans (BSP/BIP), conduct group therapy for anger management, social skills, etc. (once or twice per week), and provide individual therapy (30 -60 minutes per week) that is dependant upon student and family needs.	The Incredible Years (Webster-Stratton et al., 2004) Strengthening Families (Kumpfer et al., 2007) Pilot Project: The Parent Project (Chibnall & Abbruzzese, 2004)
7. Special Education Program Support	Assists with consultation, hiring mental health staff & program supervision (TRACE, Diagnostic Learning Center)	

challenges of this population, resulting in fewer disciplinary actions that place students outside of the class (i.e., principal's office, counseling department). A final goal was to improve student achievement and behavior by engaging and empowering parents to be active members of intervention teams.

According to these program objectives, the partnership established a continuum of integrated educational/mental health programs for students classified as ED, which included direct service to students, consultation with teachers on meeting the mental health and behavioral needs of students with EBD, and parent training. This initiative was implemented by the Mental Health Intervention Teams (MHIT).

Mental Health Intervention Teams (MHIT)

The MHIT program provides services to all elementary and middle schools on regular school campuses that have self-contained ED classrooms onsite. Program components include classroom behavioral interventions, consultation services, case management, traditional individual and group psychotherapy, and family outreach and parenting groups.

MHIT consists of 6 teams (1 mental health clinician and 1 rehabilitation specialist) to serve ED classrooms. The employment qualifications required for a mental health clinician include: a) a master's degree in psychology, counseling, social work, or related field; b) licensure as a marriage and family therapist, clinical social worker, or clinical psychologist; and c) four years of post-license experience in counseling and youth/family crisis intervention. For the rehabilitation specialist position, a college degree or license is not essential, however, three years of behavior modification experience (training, experience and/or education) with emotionally disturbed or conduct-disordered youth in a mental health setting, preferably in inpatient hospitalization, intensive day treatment, or residential treatment, is required. A clinical psychologist supports all MHITs and provides neuropsychiatric assessment on complex cases as well as case consultation. Lastly, a psychiatrist is also available to provide medication management and consultation for youth.

Each MHIT has a caseload of 6-8 ED classes (a mix of elementary & middle schools). While these teams support the ED classrooms in a variety of ways, the primary focus is to provide service at three main levels:

Classroom/Teacher: The MHIT provides behavior and classroom management strategies to teachers and para-professionals. Teams help to structure classrooms, develop point systems/token economies, and assist school teams in developing, implementing, and monitoring function-based behavior support and behavior intervention plans (BSP/BIP).

Individual Child/Youth: The MHIT conducts group therapy for anger management, social skills, etc. (once or twice per week), and provides individual therapy (30 -60 minutes per week) for those students and families needing more intensive treatment.

Parent Outreach: The MHIT provides outreach to parents of students with ED. Substantial time each week is spent calling and visiting family homes to build trust and recruit caregivers to attend weekly parenting groups using empirically supported curricula (see *Evidence-Based Intervention* section below). MHIT staff also provides parent education on various topics and if necessary, refers them to adult mental health resources in the community.

Evidence-Based Intervention Components Implemented by MHIT

The MHIT staff was trained in one or more of the following interventions: a) The Incredible Years, b) Strengthening Families, and c) Parent Project. The MHRC sent several MHIT staff to training in one or more of the above interventions or arranged for trainings to be conducted locally in San Diego. The

MHRC plans to roll-out further training on these interventions as well as "refresher/booster" trainings during Summer 2007 to ensure all MHIT staff are trained in the three programs by the 2007-08 academic year.

The Incredible Years (IY): Elementary Classrooms: The *Incredible Years: Parent, Teacher, and Child Training Series* is a comprehensive curriculum to promote social competence and prevent, reduce, and treat aggression and related behavior problems in children ages 3-10. The parent intervention is ideally delivered in 2-hour, weekly parent group sessions lasting 20 weeks. The child component is designed as a "pull out" treatment program for small groups of children exhibiting conduct problems, and is to be delivered in 2-hour weekly group sessions lasting 20-22 weeks. The teacher training program is focused on strengthening classroom management strategies, promoting children's prosocial behavior and school readiness, and reducing aggression and non-compliance. This component can be used to train a variety of school staff (i.e., teacher, aides, psychologists, school counselors).

All IY intervention components have been evaluated and positive findings have been replicated by independent investigators on different ethnic populations and age groups (Webster-Stratton & Hammond, 1997; Webster-Stratton, Reid & Hammond, 2001; Webster-Stratton et al., 2004). Participation in the IY was associated with improvements among culturally diverse, socio-economically disadvantaged populations with mental health problems, including young children diagnosed with Obsessive Compulsive Disorder (ODD), Conduct Disorder (CD) and/or Attention Deficit Hyperactivity Disorder (ADHD). The IY has been modified for Spanish speaking families, which is appropriate for the linguistic diversity present in SDUSD.

The Strengthening Families Program (SFP). Middle School Classrooms: The *Strengthening Families Program* is a 14-session parenting and family skills training program designed to increase resilience and reduce risk among youth 10-14 years of age through skill-building, improved parenting practices, and strengthened relationships between children and parents (Kumpfer, Alvarado & Tait, 2007; Molgaard, Kumpfer & Spoth, 1994). This SFP involves groups of 4-12 parents in a *Parent Skills Training* group conducted during the first hour of each weekly session and a separate *Children's Skills Training* group to be held concurrently. In the second hour the families are split into two multifamily *Family Skills Training* groups that are facilitated by two MHIT group leaders. Families are taught and encouraged to practice observation, monitoring, therapeutic play, communication, and positive discipline skills.

SFP has been associated with improvements in parent competencies, adolescent substance-related risk, and school engagement, as well as long-term academic success (Spoth, Randall & Shin, in press). The SFP has also been adapted for multiethnic populations, including economically disadvantaged and urban youth (Kumpfer, Alvaredo, Smith & Bellamy, 2002).

The Parent Project Pilot: Middle School Classrooms: The *Parent Project* was created for parents of adolescents, 11-19 years of age, with difficult or unmanageable behaviors. Because several of the EBD students presented significant delinquent and highly destructive behaviors (i.e., substance use, gang involvement, practice of the occult, running away, violence toward others and suicide), the MHIT staff developed lessons that directly tackled these serious behaviors. Using a structured, self-help support group model, parents learn and practice specific prevention and intervention strategies to address each of the above mentioned behaviors. The PP lasts 10-16 weeks and includes two intervention units. Unit I, *"Laying the Foundation for Change,"* consists of six activity-based instructional units. Typically, each unit is delivered via a weekly three-hour session. Unit II, *"Changing Behavior and Rebuilding Family Relationships,"* includes 10 topic-focused parent support group sessions, which are delivered via weekly two-hour blocks. Sessions provide parents with emotional support and include an activity-

based parenting skills component. The PP has been featured by the Office of Juvenile Justice and Delinquency Prevention as a promising community and school program to decrease serious delinquent behavior (Chibnall & Abbruzzese, 2004), however; this program has not been sufficiently researched and is presently considered a pilot project.

MHIT and School Staff Interface

At each school with an onsite ED classroom a designated liaison assists the MHIT. More specifically, this liaison can be any school staff member on campus (i.e., school counselor, district resource teacher, vice principal, school psychologist, etc.) who agrees to orient the MHIT with the school, coordinate shared office space, and attend weekly/monthly meetings with the MHIT, ED classroom staff, and support personnel.

At the beginning of the school year, the MHIT conducts direct observation and interviews (both semi-structured and informal) with ED teachers and school staff to determine the level of support that is needed and builds relationships in that classroom. MHIT clinicians reported that in some classrooms, ED teachers demonstrated exceptional classroom organization, behavior management skills, and effective instructional practices. These classrooms generally required minimal *classroom* support, with occasional *individual child* crisis intervention services or consultation for particularly difficult students and moderate (i.e., weekly) concentration on *parent/family* outreach. Other ED classrooms require significant and ongoing support in developing classroom reinforcement systems, teaching positive behavioral support strategies, and adjusting instructional practices to be more appropriate for students. Such classes often required intense individual child services and significant parent outreach, resulting in high involvement (i.e., daily) of the MHIT with that particular class. In essence, the MHIT developed an individualized program of support for each classroom on their caseload.

MHITs adjust support services to accommodate differing levels of student mainstreaming into general education, which varies by school. In the majority of self-contained ED classes, students remain with the same teacher and peer cohort for most of the school day, with some students mainstreaming as appropriate. However, approximately 30% of middle school programs do not have a "core" ED classroom and instead, students are fully mainstreamed into regular classes with itinerant support. In these schools, the MHIT attempted to maintain contact with several general education teachers and the special education teacher regarding student progress and/or behavioral support plans. But it was difficult to provide consultation services to each of the general education teachers and to provide direct services in the individual classrooms. Additionally, as youth are in different general education classes, it was a challenge to find common class periods to conduct group therapy sessions.

MHIT Interface with School Psychologists:

Most of the MHITs communicate several times per week with the school psychologist on site. The MHIT staff provides the school psychologist with assessment and/or treatment information on the students they serve such as, their history of mental health support services, informal and formal behavioral observation data, behavioral rating scales results, and group or individual therapy progress updates. MHITs and school psychologists work together to jointly support ED teachers and classroom aides with implementation of behavioral support services (i.e., especially on days where one or the other is not working at the school site), monitor teacher implementation of intervention strategies, make referrals for additional mental health services (i.e., AB3632, etc.), and co-facilitate child therapy groups. The sustained behavioral and mental health support to the ED classes frees the school psychologist to provide

more services to general education students (i.e., Student Study Team, 504 process, prevention efforts, behavioral consultation, etc.), which may prevent ED referrals. Further collaboration occurs regarding parent outreach, as school psychologists and MHIT staff work to engage parents of ED students to become more active in their child's academic and behavioral interventions. Both MHITs and psychologists attend all Individual Education Plan (IEP) meetings, as well as weekly and monthly meetings with ED teachers and school administration.

The MHITs may also interact with one of four psychologists who are assigned (full-time) to a single school with multiple ED classes. In these instances, the cross-coordination and communication between the MHIT and ED school psychologist occurs several times a day as they work together in multiple ways to support students with ED and their families. The ED program intends to hire four additional ED project school psychologists for the 2007-08 year.

Research and Community Partnership: MHRC/SDUSD and CASRC

The Child and Adolescent Services Research Center (CASRC) at Rady Children's Hospital-San Diego is a NIMH funded center comprised of a multi-disciplinary consortium of investigators as well as community representatives from the public system of care (i.e., mental health, child welfare, juvenile justice, education, alcohol/drug, primary care). CASRC conducts mental health services research that spans clinical epidemiology studies linked to evidence-based practice, effectiveness and quality of care studies, and implementation studies. CASRC has a long standing relationship with the MHRC and has conducted program evaluation and provided consultation on evidence-based interventions for youth with a range of academic and behavioral needs. Members of CASRC and the MHRC meet monthly to discuss school-based services and research collaborations. This relationship provides a unique and valuable opportunity to study large-scale specialty mental health care taking place in the real world context of schools.

Preliminary Evaluation of MHIT

Process Evaluation: In 2005-06, the MHITs served 37 ED classrooms on comprehensive sites. This start-up year consisted of a) building relationships and integrating with educational and administrative staff, b) identifying evidence-based interventions for elementary and middle school populations, c) deciding the appropriate amount of time spent in each class, d) assessing the correct balance of elementary and middle school ED classes on team caseloads, e) determining levels of clinical supervision, f) scheduling formal training for MHIT members on chosen interventions and g) provision of consultation services to classroom teachers.

For 2006-07, the MHIT provided services to students in 38 ED classes on comprehensive school campuses. This second year involved a) provision of direct services to students and parents, b) continuing consultation to classroom teachers, c) hiring additional MHIT staff, d) training new MHIT staff on the IY and SFP, e) training all staff on the new PP intervention, f) working to build relationships at newly assigned schools or with new ED teachers, and g) working with school administrative staff on discipline and suspension policy.

Outcome Evaluation: Members of CASRC, MHRC, and MHIT are trying to secure grant funding for the outcome evaluation component of the MHIT program. Evaluation meetings have focused on how to best capture outcome variables; a process which remains quite challenging as MHIT services vary in intensity within and across the individual stakeholders: students, parents, and teachers. It is important to note, that limited evaluation data have been collected to date (as focus has been on program development

and implementation), however, an evaluation plan has been drafted. The outcome evaluation is designed to collect information from each stakeholder:

Classroom/Teacher: Classroom teacher acceptability and satisfaction with the MHIT model was assessed with a 15-item survey. Additionally, this survey was administered to school staff who support the ED class (i.e., school counselors, administrators, psychologists). All school staff completed the survey anonymously. A survey response rate of 34% was obtained. The MHIT staff (the clinician and rehabilitation specialist) completed a longer 30-item survey for each assigned ED class. The MHIT survey response rate was substantially higher at 82%. Table 2 contains a portion of the results which addresses the quality of the MHIT and school staff relationship. The overwhelming majority of ED teachers and school staff report having a positive relationship with their MHIT, maintaining effective team communication, and feeling supported by the model. MHIT staff report was also positive, although included more variable responses.

Several open ended survey questions asked *"what impact did the MHIT have in your classroom?"* Teacher responses included "*MHIT helped me a great deal with classroom management, they put a great system in place and I followed it"* as well as *"the anger management and peer interaction groups the MHIT conducted were great…problem behavior decreased in frequency while learning increased."* Surveys for the 2006-07 year were administered.

ED teacher retention was also tracked. In the year prior to the MHIT program (2004-05), there existed a 50% ED teacher turnover rate, with only 19 of the original 38 elementary and middle school teachers remaining in the program. Following the first year of MHIT, 29 of 37 ED teachers remained (78% retention rate), with 8 teachers leaving for the following reasons: moving out of state, moving to general education or RSP program, or receiving promotions.

Future evaluation efforts will focus on formal implementation of treatment integrity measures incorporated by the IY and SFP developers for the classroom interventions. This will be a staged process, with independent observers assessing the treatment integrity of the MHIT staff as they train the classroom teachers and school staff and model strategies with students. Subsequently, the school psychologists and MHIT will jointly monitor the treatment fidelity of the classroom teachers as they use intervention strategies. Lastly, informal measures assessing classroom organization, structure, and climate will also be collected.

Individual Child/Youth: Individual student evaluation will consist of educational indicators (i.e., grades, attendance, academic achievement, IEP goal attainment, impairment ratings, educational placement maintenance, etc.) and will be downloaded from the Standards, Assessment, and Accountability department in SDUSD at the end of each academic year, beginning with the 2006-07 year. In addition, single subject methodologies will be employed to chart and monitor individual student behavioral progress.

Parent Outreach: During 2006-07, MHITs conducted parenting groups and reported variable attendance ranging from 35-65%. Increased attendance was reported for groups that provided childcare and food. Barriers to parent participation included transportation to the school. Future evaluation of parenting groups will include administration of IY and SFP measures (i.e., parenting scale, parent satisfaction questionnaire etc.) to parents/caregivers to assess behavioral support skills and program satisfaction. Independent observers will also assess treatment integrity of the MHIT staff as they train parents on intervention strategies.

Lastly, at all service levels, qualitative research methods will be used to answer questions that quantitative data may be unable to answer. Qualitative methods (i.e., focus groups, key informant inter-

views) describe complex phenomena such as the experiences and interpretation of events by people with different stakes and roles. Additionally, these approaches can describe complex settings (schools, classrooms, etc.) and interactions (families, teachers, students) (Sofaer, 1999). It is intended that evaluation results will provide ongoing feedback to the program staff as well as inform the research community on the feasibility and effectiveness of implementing evidence-based interventions within the framework of the MHIT service delivery model.

MHIT Implications and Future Directions

The MHIT is a collaborative service delivery model using school-based mental health teams to implement evidence-based interventions to promote positive social adjustment for youth with EBD and their families as well as support classroom teachers. This model is aligned with research suggesting that integrating mental health intervention within schools and classroom settings can improve school climate and attitudes about mental health as well as support teachers who serve children and adolescents with EBD (Bruns, Walrath, Glass-Seigel, & Weist, 2004).

By joining educational staff and clinical providers in the classroom to treat students with EBD, the MHIT has addressed a long standing barrier in the provision of mental health services – lack of infrastructure to support mental health programs (Hunter et al., 2005). MHIT staff does not service youth in isolation, but is integrated into the existing special education class unit and is part of the support staff working closely with school psychologists and other personnel. Thus, mental health services are weaved into the daily classroom curricula rather than fragmented.

TABLE 2. *MHIT Program Survey Results*

Survey Question		School Staff Surveys (N=17)	MHIT Staff Surveys* (N=61)
How would you describe the relationship between you and your Teacher or MHIT team member?	Very Good	15 (88%)	33 (54%)
	Good	1 (6%)	23 (37%)
	Fair	1 (6%)	4 (7%)
	Poor	0 (0%)	1 (2%)
Do you feel supported by your Teacher or MHIT team member?	Yes	16 (94%)	42 (69%)
	Sometimes	1 (6%)	17 (28%)
	No	0 (0%)	2 (3%)
Do you feel you communicate/collaborate effectively with your Teacher or MHIT team member?	All the Time	14 (82%)	28 (46%)
	Most of the Time	2 (12%)	20 (32%)
	Could Improve	0 (0%)	9 (15%)
	There are Difficulties	1 (6%)	4 (7%)
	Not at All	0 (0%)	0 (0%)
Do you have established weekly or monthly meetings involving the teachers and MHIT team members?	Yes	13 (76%)	47 (77%)
	No	4 (24%)	14 (23%)

* The MHIT staff completed more than one survey

The MHIT model may offer districts a template for combining fiscal and personnel resources from separate departments to provide expanded services. Hunter and colleagues (2005) posit that one of the most salient obstacles to implementing mental health interventions in schools is a lack of funding to support and sustain them. By integrating program components and combining fiscal resources to develop the MHIT, a more efficient use of resources may be possible resulting in increased services to students *and* teachers beyond what is likely when mental health and educational programs work in isolation.

One strength of the MHIT model is the parenting programs. Parents of children with EBD are typically difficult to engage due to countless negative interactions they have had with school personnel regarding their child's behavior. Yet, by co-locating mental health services within special education classes, the MHIT model may provide better access to mental health services for students/families who would not otherwise seek individual or family counseling. In addition, the emphasis on developing parenting skills that foster prosocial behavior in youth rather than criticize parenting skills may encourage parental engagement in the groups. Finally, the parent lessons also promote parent-to-parent support systems that can last beyond the class sessions.

Lastly, the integration of clinical mental health providers and school personnel provides a truly multidisciplinary approach, allowing cross-discipline training to occur. School staff learn about psychological symptomotology and diagnoses, while MHITs become familiar with effective instructional practice and IEP goals and objectives. Additionally, the involvement of district administrative staff and school services researchers has enhanced this MHIT model by providing a practitioner-researcher collaborative to working with youth having EBD.

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