REPORT ON

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EVIDENCE-BASED ASSESSMENTS • INTERVENTIONS FOR THE REAL WORLD

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Editor's Corner

Assessment and Treatment of Youth With Mood Disorders in Schools

This special issue of the *Report on Emotional & Behavioral Disorders in Youth* is focused on the assessment and treatment of youth with mood disorders in schools. Currently, more than half of youth with emotional/behavioral challenges, including mood disorders, receive either no treatment or inadequate treatment (Burns et al., 1995; Leaf et al., 1996; Weisz, 2004). Addressing mood disorders in schools is a priority, given that relatively large numbers of students (14%) are challenged by disorders such as major depressive disorder and bipolar disorder (Merikangas et al., 2010) and that school mental health (SMH) services are more likely than traditional approaches to reach these youth. Schools are uniquely positioned to provide mental health services to youth and their families (Stephan et al., 2007; Weist et al., 2003), and most youth who receive treatment are served in schools (U.S. Department of Health and Human Services, 1999). SMH services involve the provision of a full continuum of effective mental health services, including mental

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health promotion, prevention of social, emotional, and behavioral problems, and intervention for students in general and special education (Weist, 1997). Although SMH programs increase access to mental health services (Weist et al., 1999), reduce stigma associated with seeking mental health services (Albright et al., 2013; Nabors & Reynolds, 2000), promote generalization and maintenance of treatment gains (Evans, 1999), and provide an ecological context for helping youth and families (Atkins et al., 2001), the feasibility of implementing evidence-based SMH assessment and treatment strategies for youth contending with mood difficulties is not well understood.

SMH programs increase access to mental health services, reduce stigma associated with seeking services, promote generalization and maintenance of treatment gains, and provide an ecological context for helping youth and families.

This special issue of *EBDY* includes three articles that demonstrate SMH strategies for working with youth experiencing mood difficulties. The first focuses on the development of a risk assessment protocol for school personnel; the second uses case examples of a common elements approach as part of delivering evidence-based treatment in schools; and the third highlights the crucial, but challenging, effort to involve families in youth mental health treatment by presenting the perspectives of clinicians and caregivers participating in a program for youth with, or at risk for, mood disorders.

The first paper, by Sale and colleagues, presents a standardized protocol to be used within the school setting to serve adolescents who are experiencing significant mood disorders and the common correlate of suicidal ideation. In the context of a rural SMH program setting, which presents a host of risks for depression and suicidal ideation, Sale and colleagues developed the Prevention of Escalating Adolescent Crisis Events (PEACE) protocol as a comprehensive risk assessment and intervention plan for individual threats of suicidal or homicidal ideation. The PEACE protocol was designed to be implemented by a school-based mental health clinician in collaboration with other school personnel. The development and implementation of the protocol are discussed in relation to 33 separate documented crisis events involving 20 students and no completed suicide attempts.

The second paper, by Splett and colleagues, uses three case studies to illustrate the use of the common elements approach in the treatment of youth who have, or are at risk of developing, a mood disorder. The common elements approach distills common practice elements from the evidence-based practice literature found to be efficacious in the treatment of specific mental health problems. It has been shown to reduce implementation barriers and improve practitioners' access to evidence-based practices (Chorpita et al., 2007). The case studies presented by Splett and colleagues were drawn from the Student Emotional and Educational Development (SEED) project, a research study in which clinicians delivered an evidence-based model of assessment and a common elements treatment approach for youth with mood difficulties, in conjunction with additional practice elements that met the individual and unique needs of their clients and contexts. The case examples given highlight the ways in which clinicians, based on intake assessment data and clinical judgment, incorporated practice elements beyond those most commonly cited in the literature and included in the SEED project treatment manual to provide individualized, evidence-based treatment for their clients. Additional practice elements illustrated through case examples include relationship and rapport building,

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social skills training, and psychoeducation for caregivers.

The third article, by George and colleagues, focuses on family engagement from the perspective of clinicians and families involved in the SEED project. An intervention component of SEED included family engagement and empowerment strategies in which clinicians were trained as part of their general training to support provision of high-quality SMH services. This paper uses qualitative data from caregiver interviews and clinician focus groups to understand the barriers related to the acceptability and feasibility of delivering evidence-based treatment strategies in schools for youth experiencing mood difficulties. Findings suggest a number of potential training, logistical, and communication barriers, and the implications of involving families in SMH service provision are discussed.

Although offering mental health services in schools has improved access to treatment for youth with mood disorders, a research-to-practice gap continues to exist with regard to the implementation of evidence-based practices for treating this group. Building the capacity of SMH practitioners to intervene with youth experiencing mood disorders is critical, and ensuring that these approaches are acceptable, feasible, and effective remains an ongoing priority.

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A Note From the Publisher

Melissa W. George, Ph.D., is a developmental research psychologist at the University of South Carolina and is certified by the National Council on Family Relations as a Family Life Educator to promote healthy child and family functioning through a preventive approach in collaboration with families. Her research focuses on applications of family systems and child development research in child mental health treatment to advance high-quality, evidence-based mental health interventions and services in schools, especially integrated approaches targeting health and mental health.

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Low Base Rate, High Impact: Responding to Teen Suicidal Threat in Rural Appalachia

Rafaella Sale, Kurt Michael, Theresa Egan, Anne Stevens, and Cameron Massey*

Approximately 20% of adolescents experience significant mental health problems at any given time, and of those, 14.3% meet clinical criteria for a mood disorder such as major depressive disorder and bipolar disorder ((Merikangas et al., 2010). It is important to note that a current episode of major depression is one of the most common risk factors for a suicide attempt (Carlson, 2006) and that suicide is the third leading cause of death for 15- to 24-year-olds nationally and accounts for 12.2% of all deaths in this age group (Centers for Disease Control and Prevention [CDC], 2010). Furthermore, among this age group, 15- to 19-year-olds are at the highest risk for non-fatal suicide attempts (Carlson, 2006).

Individuals living in rural areas are at a greater risk for suicide than urban residents, and the gap between them has continued to widen over the past three decades.

Adolescents at Risk in Rural Areas

Individuals living in rural areas are at a greater risk for suicide than urban residents, and the gap between them has continued to widen over the past three decades (Singh & Siahpush, 2002). Rural adolescents therefore constitute a group for which it is particularly important to address depression, suicidal ideation, and the prevention of suicide. In the rural Appalachian region, adolescents exhibit higher than average school dropout, depression, and suicide rates (Michael et al., 2009). One county in western North Carolina—Ashe County—exhibited a suicide rate of 30.1 per 100,000 between 2004 and 2008, which was not only the highest rate of any of the 100 counties in the state, but was more than double the rate of a neighboring county (14.3 per 100,000), double the rate statewide (14.0 per 100,000), and nearly triple the national rate (11.3 per 100,000; CDC, 2010; Stevens et al., 2011). It is therefore essential to improve crisis prevention protocols for supporting students' mental health and preventing suicide.

According to data from the 2011 Youth Risk Behavior Survey (YRBS), an instrument commonly administered to high school students nationally, 16.8% of students in western North Carolina indicated that they had "seriously considered committing suicide in the past 12 months" as compared to 15.8% based on broad national norms (U.S. Department of Health and Human Services [DHHS], 2011). The numbers were higher for minority students, with approximately 25% considering suicide (Matthew & West, 2011). Of greater concern are the prevalence rates of suicide attempts that resulted "in an injury, poisoning, or overdose that had to be treated by a doctor or a nurse" among western North Carolina teenagers. The 12-month prevalence rate among North Carolina teens was 3.9% (Matthew & West, 2011), which was considerably higher than the national average (2.4%) among high school students (DHHS, 2011).

Despite the high prevalence of mental health problems among adolescents in rural settings, a variety of barriers prevent many of them from seeking or receiving adequate treatment. The 2009 National Survey of Counseling Center Directors indicated that only 17.5% of completed suicide cases in 2008 had been current or former counseling center clients (Calloway et al., 2012). The lack of treatment-seeking behavior for many individuals in rural environments may be due to transportation difficulties, financial concerns, a lack of qualified professionals and available resources, as well as stigma associated with receiving mental health care (Hirsch, 2006; Owens et al., 2011; Robinson & Rapport, 2002). One way to address some of these barriers is to provide mental health services within the school setting—that is, to bring the appropriate services directly to adolescents (Albright et al., 2013; Owens et al., 2008; Zirkelback & Reece, 2010). Developing and implementing a school mental health (SMH) program in western rural North Carolina was therefore a clear opportunity to confront the high incidence of adolescent mood disorders and associated risk behaviors, especially in the context of additional treatment-seeking obstacles specific to rural settings.

Increasing Access to Services Through School Mental Health Programs

School mental health centers facilitate increased access to appropriate care and typically provide individual, group, and family therapy, as well as community referrals, assessment, crisis intervention, school attendance intervention, and substance abuse services (Macklem, 2011; Michael et al., 2009; Owens et al., 2008; 2011). Adolescents who have participated in individual psychotherapy alone within an SMH center have shown significant improvement in teacher-reported classroom behavior, achievement, attendance, and discipline referrals, as well as self-reported scholastic confidence ($d = 0.45$; Baskin et al., 2010b). In addition, school-based individual psychotherapy interventions have been shown to improve mental health outcomes, especially for adolescents ($d = 0.59$; Baskin et al., 2010a), and specifically for teenagers living in rural Appalachia (Albright et al., 2013).

Integrating mental health services within schools has also been prioritized as a recommendation for preventing suicide by advocacy organizations such as the

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North Carolina Youth Suicide Prevention Task Force (North Carolina Department of Health and Human Services, 2004). This is likely because school personnel are on the front line in decision making and response when students report suicidal thoughts. For example, nearly all school social workers surveyed by a national professional organization reported working with at least one suicidal adolescent; 77% of those reported working with a student who had attempted suicide; 86% reported working with a student who had been hospitalized; and 18% had worked with a student who had died as a result of suicide (Singer & Slovak, 2011). Counselors, nurses, school psychologists, and other mental health professionals embedded within the school are in a unique position to deliver crisis prevention, response, and post-intervention to maximize students' mental health.

School suicide prevention strategies range from suicide awareness curricula aimed at encouraging self-disclosure of suicidal intentions to skills training to enhance protective factors (Underwood & Kalafat, 2009). School policies in place to direct the implementation of student education on suicide prevention may create an impetus for a safer school environment by prioritizing open communication among students, teachers, staff, administration, and parents. Unfortunately, schools in rural settings may be less likely than schools in urban areas to enact such policies, although they are just as likely to provide mental health services in response to a crisis. This may be due to a tendency to take a reactionary stance toward student crises rather than a preventive perspective (Mink et al., 2005).

Other prevention modalities consist of school-wide screening to identify those at risk for suicidal behavior and of training teachers, school counselors, and other personnel, who are often the "gatekeepers," to identify at-risk youth and make referrals as needed (STIPDA Rural Youth Suicide Prevention Workgroup, 2008). For example, the QPR Gatekeeper Training for Suicide Prevention, listed on the National Registry of Evidence-Based Programs and Practices (NREPP), trains school staff and community members to question the individual regarding suicidal thoughts and intentions, to persuade the individual to accept help, and to make the appropriate referral (NREPP, 2012). Trained gatekeepers exhibit increased suicide and prevention resources knowledge, self-efficacy, and confidence (Doan et al., 2012; NREPP, 2012).

Effective crisis intervention hinges on a timely response to students in critical need, with the goal of reducing morbidity and mortality related to suicide (Gould et al., 2003). The National Association of School Psychologists (NASP) uses the comprehensive Prevent, Reaffirm, Evaluate, Provide and Respond, Examine (PREPaRE) model, which is designed to engender structure in preventing and responding to both school-wide and individual crises, such as suicidal behavior, within schools by detailing appropriate actions that may then be tailored to individual SMH centers or school districts (Brock et al., 2011). These include:

- Maintaining direct supervision of the student;
- Assessing the level of suicidal and/or homicidal risk of the student;
- Contacting a mobile crisis unit and/or the police;
- Contacting and supporting parents;
- Referring to community agencies;
- Constructing safety plans;
- Consulting with an interdisciplinary crisis team;
- Notifying school personnel;
- Documenting the event; and
- Following up within the school context post-crisis (NASP, 2001).

Other prevention modalities consist of school-wide screening to identify those at risk for suicidal behavior, and of training teachers, school counselors, and other personnel, who are often the "gatekeepers," to identify at-risk youth and make referrals as needed.

Although school-wide and targeted at-risk suicide prevention programs have been established (see Cooper et al., 2011, and Kalafat, 2003, for reviews of primary prevention), the impact of SMH centers on the response to suicidal ideation, attempts, and completed suicides has yet to be described or evaluated empirically.

Recognizing that youth suicide is both preventable and a major public health concern (Muehlenkamp et al., 2008; Rathus & Miller, 2002; Steele & Doey, 2007), this paper describes the development and implementation of one particular crisis protocol within an already established SMH center in rural Appalachia.

The Assessment, Support, and Counseling Center: A School Mental Health Program in Rural Appalachia

The Assessment, Support, and Counseling (ASC) Center is a broad-based SMH program created in the context of a university-community partnership. The ASC Center was established in two western North Carolina counties, first in 2006 and again in 2011. The ASC Center sites have been tailored to deliver psychological services through three primary modalities: individual cognitive behavioral therapy (CBT), group therapy, and crisis intervention, all embedded within the normal operation of the school day. The effectiveness of ASC Center services in significantly reducing psychological symptoms in the majority of those who consent to treatment has been documented in the literature (Albright et al., 2013).

In addition to treating students individually, it was imperative to systematically address the dearth of consistent policies and procedures in responding to crises within one particular site. Therefore, clinicians developed a crisis intervention protocol—the Prevention of Escalating Adolescent Crisis Events (PEACE; see Box 1)—in collaboration with school personnel. The PEACE protocol, developed as a guide to be used at the time of an individual crisis, established a common language for school personnel that increased efficiency. The protocol has provided school personnel and trainees with a systematic procedure to assess and intervene according to the level of suicidal and homicidal risk among the students who present for evaluation.

Study Method and Service Delivery

The high school in which the current study took place is located in the western

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North Carolina Appalachian mountain region. Serving as the only high school within the district, it enrolls approximately 1,000 students. The student population is 96% Caucasian and 4% "Other" (3% Hispanic, 1% African American), as measured by the Youth Risk Behavior Survey (Mathews & West, 2011).

Clinicians charged with implementation of the protocol were part of the SMH program, the ASC Center. The ASC Center at this particular high school was made up of two licensed psychological associates and one graduate intern, all under the weekly supervision of a licensed clinical psychologist. Students were referred by parents and school personnel for individual psychotherapy through the school counselors.

Study Procedure and Crisis Protocol

Clinicians at the ASC Center made the decision to construct the PEACE protocol because no alternative or effective standard protocol for individual crises existed within that particular high school. They developed the PEACE protocol according to standard risk assessment procedures and adjusted for feasibility of acceptance within a rural school context.

The PEACE protocol provides an easy-to-understand guide for clinician and school personnel collaboration. The code labels include a color system of green, yellow, orange, and red that mirror the degree of risk severity (Box 1). The protocol is implemented when *any* individual student or school personnel express *any* intention or ideation for *any* kind of violence. Therefore, a variety of situations could initiate use of the protocol. Examples include:

- A teacher who overhears a student's conversation concerning self-harm;
- An unsure school counselor meeting with a tearful student;
- A principal who notices odd behavior during a disciplinary event; or
- A concerned peer.

One example in the current study of a common initiating experience is when a teacher receives a writing assignment from a student that contains suicidal or homicidal content. Once an ASC Center clinician is notified, more information is collected

Box 1: The Prevention of Escalating Adolescent Crisis Events (PEACE) Protocol

Green:

- No suicidal or homicidal ideation
- Some past ideation or intent
- Fleeting, superficial ideation
- No intent or plan

Plan of action

1. Document time and extent of past or fleeting ideation
2. Assess coping skills

Yellow:

- Current thoughts of hurting others or self, but tend to be mildly to moderately intense
  - Labile with mood or external circumstances
  - Intent labile
- Self-injurious behavior may be present, but not extensive/inconsistent
- If in homicidal nature, no specific target (e.g., expresses desire to hurt people in general), nor specific to type of group (e.g., religious affiliation, sexual orientation)
- No specific plan or one that is unrealistic and largely unreasonable (e.g., holding one's breath)
- No or unreliable access to means

Plan of action

1. Further discussion is absolutely necessary.
2. Assess and implement alternative coping skills
3. Refer for services or modify treatment goals to include relaxation exercises/stress management
4. Use professional judgment and decide whether to notify school personnel
5. Seek supervision from a colleague
6. Document appropriately all steps taken
7. Follow up with the student

Orange:

- Current suicidal or homicidal ideation and intent
- Specific plan of hurting self or another individual that is realistic
- Potential but not definite access to means
- Does not need to have a past attempt
- Self-injurious behavior heightens risk

Plan of action

1. Contact supervisor; if not immediately available → seek advice from colleague, preferably a licensed therapist
2. Contact parents of student
3. Contact community provider's mobile crisis team
4. Notify school personnel/set up meeting with school personnel to coincide with parent meeting
   a. School principal involvement is optimal.
   b. If homicidal situation, Service Resource Officer is optimal.
   c. Involve individuals who are important in student's life (e.g., coach) but not those who would be oppressive or may project guilt/shame
5. Homicidal: assert Duty to Warn → contact parents of individual with whom the threat has been placed
6. Document all events and those involved

Red:

- Current suicidal or homicidal ideation and intent
- Specific and realistic plan for hurting self or others
- Clear target or clear group of individuals as target
- Past attempts or episodes hurting self or another individual(s)
- Self-injurious behavior
- Risk further heightened if there has been current or past legal allegations/charges of student harming others
- Access to reliable means

Plan of action

1. Contact supervisor; if not immediately available → seek advice from colleague, preferably a licensed mental health professional
2. Contact parents immediately
3. Contact community provider's mobile crisis team
4. Notify school personnel immediately
   a. Involve school principal and school guidance counselor
5. Schedule immediate meeting with a parent, school personnel, **and** Service Resource Officer
6. Notify authorities if Service Resource Officer not available or unwilling to take further action
7. Homicidal: assert Duty to Warn → immediately contact targeted individual and his/her parents, or take reasonable efforts to convey information
8. Document all events and those involved

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immediately from the student. The clinician maps the student's answers onto the PEACE protocol and decides which code (e.g., "Code Yellow") the student best matches at the time of inquiry (integrating past experiences and information from school personnel). A recommended plan of action should then be executed immediately.

An important caveat is that clinicians should use professional judgment and seek advice from colleagues in events of a suicidal or homicidal nature. A student may meet criteria for a "Code Yellow" crisis, but because of personality characteristics such as impulsivity and known circumstances at home (e.g., lack of adequate supervision), steps indicated for "Code Orange" may be necessary and more appropriate in a specific situation. In addition, individual cases are not expected to meet each criterion or profile described in the PEACE protocol. It is not necessary for all criteria to be satisfied in order for a plan of action to ensue according to a particular code. For example, if a child is expressing self-harm that is extensive or consistent but denying current suicidal intent, it may be to the child's benefit to break confidentiality and notify parents. The seriousness of the matter should be explained thoroughly to the student and approached thoughtfully to preserve the relationship and the student's trust.

Study Results

In the high school in rural western North Carolina where the crisis protocol was implemented, a total of 33 separate crisis events occurred that required 59.75 hours of documented clinical time during the 2012–2013 school year. Crisis hours were defined as time spent by an ASC Center clinician in active assessment of crisis severity with a student and school personnel, in decision-making time with colleagues and supervisor, and in family meeting, construction and discussion of a suicide or homicide prevention contract, documentation of event(s) and persons involved, and follow-up with parent and student post-crisis.

Over the course of the academic year, 20 students (base rate = 2%) were involved in these 33 separate crisis events. Each individual expressed some degree of serious suicidal thinking, suicidal intent with plan, or homicidal thinking or intent with plan. The majority of these individuals reported reliable access to means, including prescription medication or firearms. Of these 20 students, 55% were male and 100% were Caucasian. Precisely 50% of the students were in 9th grade at the time of crisis, 20% were in 10th grade, 20% were in 11th grade, and 10% were in 12th grade, as measured by amount of attained academic credits.

Across all 20 students, there were no completed suicides. None of the students that were assessed with the PEACE protocol made an attempt post-assessment that necessitated medical treatment. At the time of crisis, nine students were enrolled in ASC Center services and remained in treatment until the end of the school year (unless drop-out from school occurred; n = 3). Five of those students were expected to return for treatment through the ASC Center during the fall 2013 academic semester, and three were referred to a community provider for care during the summer. Three students were enrolled in ASC Center services immediately after an event. Three students dropped out of school for various reasons following a crisis event. Some students (n = 7) either refused treatment or were deemed appropriate for services and checkups through the school counselors post-crisis.

Analysis of Results

In rural areas, response time to adolescent crises is often inefficient or lacking altogether. Especially in a school context, it is important for a crisis to be met with data-based, efficient, and expeditious decision making. The hierarchical PEACE response protocol was designed by ASC Center clinicians to be used as an efficient assessment and decision-making tool. Although it was regrettable that the protocol had to be instituted at all, the results suggest that the most undesirable outcome, death by suicide, was prevented for 20 students across 33 separate events during the 2012–2013 year.

Although preliminary, these data suggest that a standardized protocol that uses common language and consistent procedures for approaching individual crisis situations reduces the uncertainty and inefficiency in responding to adolescents in need. When personnel within a school setting are aware of, and use, a system such as the PEACE protocol, the stress of a crisis situation is reduced and care can be provided in an effective manner. A crisis protocol that involves multiple individuals from the school, as well as the mental health providers, fits in better with the team approach to school-based mental health care than one in which a solitary individual attempts to liaise with the local community mental health clinic.

Study Limitations

The PEACE protocol is intended to be used as a template for the clinician to assess quickly the level of distress a youth is experiencing and then proceed with a plan of action without having to take time to administer, score, and interpret a more cumbersome measure. The administration of the PEACE protocol comes with two significant limitations. First, the PEACE protocol is based upon clinician judgment. The responding clinician should be one who has received adequate training in treating mental health issues in youth and also in dealing with crisis situations. In situations where accurate and concrete information is difficult to obtain, the PEACE protocol may be overly sensitive to the emotional state of the youth, and certain details may be unavailable at the time of evaluation. Clinicians must have adequate training and experience in high-stress situations in order to use the PEACE protocol judiciously.

The second potential limitation of the PEACE protocol is related to the first, in that clinicians are asked to undertake a plan of action solely based on the self-report of the adolescent. If the clinician is unfamiliar with the teenager, the circumstances, or is away from the school, key information is likely to be missed. Broader assessment measures typically take into account reports from teachers and parents, yet these are time consuming and may delay care to the student. When using the PEACE protocol, it is reasonable for a clinician to elevate the degree of risk (e.g., orange rather than yellow) in the absence of important information. It is often the case that when addressing a crisis during the school day, obtaining information from parents and/or teachers may be difficult or even impossible; therefore, a more conservative approach is indicated.

Future Directions

Plans for the future include revising and updating the PEACE protocol. Revisions include evidence-based adaptations made for minorities living within the rural school context (e.g., migrant worker populations) and for younger children in middle school settings. In addition, we aim to construct a systematic post-crisis protocol on steps that are imperative for relapse prevention. These events could include problem solving on how to make up lost class time, notifying teachers without releasing details that may be discriminatory in nature, and enabling

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smoother transitions to therapy enrollment whether through a school mental health program or a community mental health service. Finally, psychoeducation for teachers and school personnel regarding warning signs and dysfunctional mood symptoms could act as a preventive factor for future crises.

In summary, there is a considerable need to respond to adolescents who present with mental health crises at school, especially suicidal or homicidal ideation. Moreover, the response should be systematic, expeditious, data based, and consistently executed by an interdisciplinary cadre of qualified personnel. The data on the newly developed PEACE protocol implemented in rural western North Carolina, although preliminary, indicate PEACE is one potential framework that appears to have promise in preventing a low base rate, but catastrophic, outcome. Even though the number of youth requiring significant crisis intervention was relatively low (2%), the task at hand—attempting to prevent suicide—is daunting and anxiety provoking for clinicians and school personnel alike. Despite the fears mental health professionals may have, to do nothing in the face of these unpleasant realities would be ethically questionable. However, to do something that is not systematic or data based would be unconscionable. It is imperative to continue advocating for the delivery of effective SMH services to youth in our schools, especially those who present with violent ideation and the common correlates of this ailment.

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The Common Elements Approach to Treating Mood Disorders in Youth: Case Examples From School Settings

by Joni W. Splett, Sara C. Schmidt, Aidyn L. Iachini, Heather E. Page, and Cameron Massey*

National estimates identify mood disorders as the third most prevalent mental health condition faced by young people in the United States. More than 14% of U.S. youth ages 13 to 18 have experienced a mood disorder, and upward of 11% have experienced a mood disorder significant enough to cause severe functional impairment (Merikangas et al., 2010). Without effective intervention, youth are at increased risk for poor school performance, suspension/expulsion, dropout, delinquency, suicidal ideation/attempts, interpersonal difficulties, comorbid mental health concerns (e.g., substance abuse), and impaired functioning into adulthood (King et al., 2001).

School-Based Mental Health Treatment for Youth

Building the capacity of school mental health (SMH) practitioners (e.g., social workers, school psychologists, psychiatrists, etc.) to intervene with youth experiencing mood disorders is critical, particularly because many youth do not receive mental health services unless they receive them at school (Burns et al., 1995; Rones & Hoagwood, 2000). Delivery of mental health services in the school setting has a range of benefits, including maximizing access to school-employed professionals such as school counselors, school psychologists, and school social workers, and collaborating community mental health professionals such as clinical psychologists, community social workers, and child and adolescent psychiatrists (Weist et al., 1999). Benefits such as reduced transportation times, reduced stigma, and the provision of a full continuum of services to prevent *and* treat mental health concerns also make schools an ideal point of intervention (Weist, 1997). Offering mental health services in schools can also facilitate involvement of families in care and promote coordination with other community programs (Weist, 2005).

Challenges to Implementing Evidence-Based Practices. In order to maximize effectiveness and achieve the desired outcomes of SMH services, implementation of evidence-based practices (EBPs) that align with the individualized needs of youth is oftentimes advantageous (Chorpita et al., 2007). Although there are challenges to implementing EBPs across all treatment settings, recent research has highlighted particular challenges faced by providers in school settings (Atkins et al., 2003; Evans & Weist, 2004; Ringeisen et al., 2003). Limited time, competing responsibilities, and lack of administrative support are just a few of the many barriers that can impede the ability of SMH practitioners to provide evidence-based mental health services (Langley et al., 2010). Many SMH practitioners may be hesitant to use EBPs, particularly those that include treatment manuals, because these practices are perceived to hinder rapport building and to reduce opportunities for clinical judgment and decision making (Addis & Krasnow, 2000; Chorpita et al., 2007; Schaeffer et al., 2005). Numerous EBPs are also difficult to obtain, and training SMH practitioners on a wide range of manuals and/or programs is often not feasible in the educational setting (George et al., 2013; Schaeffer et al., 2005; Schiffman et al., 2006). In addition, there are few, if any, EBPs available for several childhood disorders, and many EBPs may not be specific enough to meet the unique needs and characteristics of all children (Schiffman et al., 2006).

Many SMH practitioners may be hesitant to use EBPs, particularly those that include treatment manuals, because they are perceived to hinder rapport building and to reduce opportunities for clinical judgment and decision making.

The Common Elements Approach. In response to these and other barriers hindering the transportation of EBPs into practice, a new model—frequently referred to as the "common elements" or "practice elements" approach—was recently introduced by Chorpita, Daleiden, and Weisz (2005). This approach identifies common techniques (i.e., elements) found efficacious across several evidence-based treatments for a variety of different mental health disorders. The common elements approach has received significant national attention and has been suggested by SMH leaders as a viable strategy for improving the quality of SMH practice (Stephan et al., 2010; Weist et al., 2009). Among the many strengths of the approach is its ease of implementation and its encouragement of supplementing and/or adapting known EBPs to fit the unique needs of clients, problems, and contexts (Chorpita et al., 2007). This feature increases opportunities for SMH practitioners to use their clinical judgment, theory, and decision-making skills while also ensuring that the strategies employed are empirically supported. Furthermore, it

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helps SMH practitioners individualize treatment services by selecting practice elements that meet the unique needs of clients and are feasible based on the contexts in which they serve them (Chorpita et al., 2007).

The purpose of this paper is to present the common elements approach to the treatment of adolescents with mood disorders, highlighting case examples of the ways in which SMH practitioners have used this approach in practice. These examples illustrate how SMH providers can both maximize the use of EBPs to match the unique needs of their clients and minimize the barriers commonly faced when trying to integrate these strategies into practice.

The common elements approach, developed largely through the work of Hawaii's Department of Health, Child and Adolescent Mental Health Division (Chorpita et al., 2005), is based on the Distillation and Matching Model (DMM). This model breaks evidence-based manuals down into distinct elements (i.e., specific EBPs) and then allows practitioners to access and search a database of these common practice elements to match the specific characteristics and needs of their client. The database is available online through a paid subscription with PracticeWise, LLC (*http://www.practicewise.com/*; please note that this is not an endorsement of PractiseWise). Subscribers can search the database by selecting specific demographic characteristics and problem types. The database search then provides a listing of practice elements from those most supported in the research to those that have fewer studies demonstrating empirical support (i.e., fewer common elements). Practice guides specific to each practice element are also provided on this site. These guides provide a more detailed description of each practice element and include a checklist of steps for implementing the practice tips.

Distillation of the common elements, or practices, of evidence-based manualized treatments has improved access to the treatment literature for practitioners (Borntrager et al., 2009). The approach has also reduced demands on training, resources, and organizational infrastructure while increasing practitioners' opportunities for autonomy, creativity, clinical judgment, and decision making (Chorpita et al., 2007). As noted, a significant benefit of the approach is its synthesis of a wide range of EBPs that enable practitioners to identify which practice elements are most supported in the current literature for a specific client problem. The additional benefit, however, is that it offers the practitioner flexibility to use clinical decision making to identify which practice elements to incorporate based on the unique needs of the client and context (Chorpita et al., 2007).

The approach has also reduced demands on training, resources, and organizational infrastructure while increasing practitioners' opportunities for autonomy, creativity, clinical judgment, and decision making.

Treatment of Youth With Mood Disorders. The common elements approach has identified more than 30 elements regarding the treatment of youth with mood disorders. According to a search of the PracticeWise database by problem type, the most frequently supported practice elements identified in the practice elements profile for the treatment of youth with mood disorders include:

- Cognitive therapy;
- Activity selection;
- Child psychoeducation;
- Self-monitoring:
- Maintenance/relapse prevention;
- Goal setting; and
- Problem solving (Chorpita et al., 2007).

Other, less common, practice elements (i.e., practice elements for which there is evidence supporting their effectiveness, but fewer studies have demonstrated that effectiveness) identified by PracticeWise for treatment of depressed mood include:

- Communication skills;
- Social skills training;
- Parent/caregiver psychoeducation;
- Guided imagery;
- Behavioral contracting;
- Relaxation; and
- Relationship/rapport building (Chorpita et al., 2007).

As a practitioner, you can enter more specific information regarding your client's characteristics, such as age, grade, gender, race, or ethnicity, to further narrow the list of common elements. With access to this knowledge and training in these practice elements, practitioners are able to more easily match the specific characteristics of their clients with the literature base and to develop empirically supported treatment plans that meet the individual needs of their clients. For example, an SMH practitioner working with a female student with major depressive disorder who also reports frequently losing her temper during interpersonal interactions may begin treatment with the most common practice elements such as cognitive therapy and activity selection, but may also incorporate communication skills (i.e., a less common practice element) with the student to build her skills around more effectively asserting herself and remaining calm in difficult situations.

We present three case examples to illustrate how SMH clinicians delivering a manualized intervention based on the most frequent practice elements for the treatment of youth with mood disorders were able to incorporate additional practice elements from the mood disorder practice element profile to meet the individualized needs of their clients. We begin by describing the school-based treatment and research setting in which each clinician worked. We then present three case examples, each highlighting use of one additional practice element—relationship/rapport building, social skills training, and family communication skills—in conjunction with the practice elements included in the manual. Finally, we describe implications for future research and practice specifically within the context of the school setting.

Case Examples: Treatment and Client Characteristics

The case examples presented here come from school-based clinical work in an urban-suburban county school district in a southeastern state. The school district serves more than 26,000 students of whom approximately 60% are African-American students and 46% qualify for free or reduced lunch. Clinicians provided services at both a high school (grades 9 through 12) and middle school (grades 6 through 8) as part of a larger pilot research study called the Student Emotional and Educational Development (SEED) project.

The SEED project sought to develop and evaluate the feasibility of an assessment and modular intervention strategy based on the common elements approach for students

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with, or at-risk for, a mood disorder. A modular manual was created based on the most frequently evaluated practice element profile for the treatment of youth with mood disorders and included the following practice elements:

- Child psychoeducation;
- Cognitive restructuring;
- Behavioral activation;
- Communication and social skills training;
- Problem solving; and
- Maintenance and relapse prevention.

In addition, the manual included brief modules for anxiety, substance use, and grief if these problems were indicated. With the exception of child psychoeducation and maintenance/relapse prevention, the modular approach allowed for clinician flexibility in the order of practice elements presented, as well as the number of sessions focused on a practice element. Treatment duration for all SEED cases ranged from 6 to 11 sessions, and treatment for the three cases presented below ranged from 10 to 11 sessions. The SEED study also allowed for tailoring as needed, through the incorporation of additional practice elements within the mood disorder practice element profile. These decisions were based on intake data and presenting concerns, as well as consultation with members of an interdisciplinary team helping to support effective assessment and intervention delivery.

The clients identified in the case examples presented below all met inclusionary criteria for the study based on data collected during the intake assessment. Measures administered during the intake assessment included:

- The Behavior Assessment System for Children–Second Edition;
- The Parent Rating Scale and Self-Report of Personality (BASC-2 PRS and BASC-2 SRP; Reynolds & Kamphaus, 2004);
- The Beck Depression Inventory–II (BDI-II; Beck et al., 1996); and
- The Mini International Neuropsychiatric Interview (MINI; Sheehan, 2010).

The BASC-2 is a multi-observer measure of behavioral functioning in youth (Reynolds & Kamphaus, 2004). The BDI-II is a 21-item self-report measure designed to assess students' feelings of depressive symptoms in the previous two weeks (Beck et al., 1996). The MINI is a brief, structured interview designed to identify the major Axis I psychiatric disorders in the tenth revision of the *International Classification of Diseases* (ICD-10; WHO, 1990) and the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; APA, 1994) (Sheehan et al., 2010). Students meeting at-risk cut-offs on the BASC-2 PRS or SRP Internalizing or Depression Scales and/or the BDI-II, and/or a DSM-IV diagnosis of a mood disorder (dysthymic disorder, bipolar disorder 1, bipolar disorder 2, major depressive disorder, cyclothymic disorder, adjustment disorder with depressed mood) from diagnostic interviewing with the MINI were eligible to participate in the study. Exclusionary criteria for the project included students who had been diagnosed with pervasive developmental disabilities, intellectual disability, or an autism spectrum disorder. At the first and last session, students also completed the Youth Outcome Questionnaire (YOQ; Burlingame et al., 2004). The YOQ is a 30-item measure that assesses students' perceptions of treatment effects and addresses concerns and symptoms across problem types and disorders (e.g., mood disorders, anxiety disorders, conduct problems, attention problems, interpersonal concerns).

The clients described below ranged in grade level from 8th to 10th grade. All were African-American students. Given that the majority of students in the clinicians' school settings and in the study sample were African American, the case examples appear representative of the broader student population. Client names have been changed to protect confidentiality.

The case examples presented in the next section provide a description of specific practice elements along with a relevant clinical example of the ways in which the element was implemented in conjunction with a manualized treatment for youth with mood disorders. Additionally, the authors hope to demonstrate both the flexibility of this approach in meeting the unique needs of clients and the feasibility of using this approach within SMH practice. Please note that these case examples are not intended to demonstrate or evaluate the effectiveness of the common elements approach or the specific practice elements reviewed.

Given Andrea's poor interpersonal skills, building a strong therapeutic alliance was particularly important because she felt that she had failed in many interpersonal relationships.

Case Example 1: Relationship/Rapport Building

Studies suggest that establishing a strong therapeutic alliance is important for obtaining desired treatment outcomes (Karver et al., 2006; Martin et al., 2006; Shirk & Karver, 2003; Stice et al., 2007). In a meta-analysis examining nonspecific factors in therapy, the strongest predictors of positive treatment outcomes were therapists' interpersonal skills, direct influence skills, and the willingness and actual participation of clients in treatment (Karver et al., 2006). Rapport building is defined by PracticeWise as strategies in which the primary aim is to increase the quality of the relationship between the youth and the therapist (Chorpita et al., 2012). There are two primary aims of relationship/rapport building: (1) to connect with the child by learning more about his or her experiences and interests or by engaging in enjoyable activities together; and (2) to convey to the child through verbal and nonverbal means that you are a positive, trustworthy, and consistent source of support. The case example below describes the need for and incorporation of strong relationship/rapport building strategies into the treatment of depression and anxiety for Andrea.

Andrea is a 16-year-old African-American female who lives with her mother, father, and younger sister. She described all of these relationships as good. At her intake appointment, Andrea reported moderate levels of depression, which were supported by her BDI-II score of 19 and her at-risk score of 65 on the anxiety subscale of the BASC-2 SRP. Andrea's experienced anxiety was mostly brought on in social situations or in the face of potential conflict with her peers. Andrea believed she was bullied by classmates because of her shyness. Given Andrea's poor interpersonal skills, building

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a strong therapeutic alliance was particularly important because she felt that she had failed in many interpersonal relationships. Cultivating the therapeutic relationship provided Andrea with an opportunity to be successful in this regard, particularly as she experienced such a substantial disconnect with her peers. It also was important to create a nonjudgmental environment for Andrea because she often felt judged in her relationships, which contributed to her poor interpersonal skills.

Building a therapeutic alliance with Andrea started by listening to her current issues and concerns without being judgmental. She was particularly sensitive to others' impressions of her, so it was especially important to create a safe space for her not only to talk about her problems, but also to have an impartial listener. Validation was a substantial component to building a strong therapeutic alliance with Andrea, so the therapist spent time each session reassuring her that her thoughts, feelings, sensations, and behaviors in relation to other students teasing her were understandable.

The next step to cultivating this relationship was supporting Andrea in developing her own goals for treatment. As a result of selecting her therapy goals, Andrea seemed to be more engaged in the therapeutic process. The therapist would also ask her at the end of each session if everything she wanted to discuss that day had been covered. This helped her feel like an active participant in the therapeutic process rather than a passive patient taking direction from the therapist. Andrea and the therapist worked together to choose tasks that facilitated her therapy goals and with which she felt relatively comfortable and willing to commit to completing. For example, to address her self-isolation, she made a list of her friends and rated them according to how difficult it would be to reconnect with each one. Andrea's assignment was to call the least intimidating friend and slowly work her way up the list to the most intimidating. She was very apprehensive about completing this task and suggested using text messaging initially so the task would not be as daunting. Andrea sent text messages to several of her friends while in session, thus decreasing her apprehension because she did not have to complete the task alone. Andrea and her therapist discussed all possible outcomes so that she felt prepared to reach out to her friends in an attempt to reestablish these relationships. This strategy was very effective, and by the end of the therapy sessions, Andrea was able to communicate with old friends on the phone and in person before school with significantly fewer anxiety symptoms. Building a strong therapeutic alliance made this task easier because Andrea felt supported by the therapist.

At the conclusion of treatment, Andrea's depressive symptoms on the BDI-II fell from a 19, indicating moderate levels of depression, to an 8, indicating minimal levels of depression. Andrea's scores on the anxiety subscale of the BASC-2 SRP fell from a t-score of 65, which falls in the at-risk range of scores, to a t-score of 42, which falls within the average range of scores. Her scores on the YOQ decreased from the initial assessment score of 56, which falls in the clinically significant range, to a post-treatment assessment of 32, which falls within the normal range of scores. As a result of the intervention and extra effort to establish a strong therapeutic relationship, Andrea and the therapist were able to work collaboratively toward her treatment goals and to improve her overall mood and interpersonal relationships.

However, he still reported intermittent suicidal ideation and interpersonal struggles, and his BASC-2 SRP scores on social stress and interpersonal relations remained in the clinically significant range.

Case Example 2: Social Skills Training

Deficits in social skills have been shown to predict increases in depressive symptoms in middle adolescence (Nilsen et al., 2012). Research suggests that, compared to students in a control condition, students who receive social skills training report higher social self-efficacy and lower internalizing symptoms (Harrell et al., 2009). According to PracticeWise, there are four goals for social skills training:

1. To note the importance of being positive in interactions with others;
2. To teach the child verbal and nonverbal social behaviors;
3. To practice social skills and provide feedback; and
4. To encourage the child to practice his/her new social skills with others.

Below, we discuss the incorporation of social skills training into treatment for depression for Marquise.

Marquise is a 14-year-old African-American male. He lives with his mother and younger sister; he does not have a relationship with his father. At his intake appointment, Marquise reported severe levels of depression, as supported by his score of 36 on the BDI-II, as well as frequent suicidal ideation. Furthermore, social interactions with his peers tended to cause Marquise great distress. He reported that his unique interests left him feeling isolated from peers and that he had lost several friends over the past year. Marquise craved attention from peers, but attempts at humor frequently resulted in further isolation and teasing. This was reflected in his BASC-2 SRP scores at his initial intake assessments; scores on both social stress and interpersonal relations were within the clinically significant range. Marquise had limited insight into his problems with his peers, responding, "I'm not sure," when asked why a particular interaction had gone awry. Upon further analysis, it became clear that Marquise's social patterns were cyclical. He would become anxious when first chatting with peers. Then, during the conversation, a peer would act in a way that made Marquise feel embarrassed or threatened, at which point Marquise would shut down, either stop talking altogether or simply walk away. This peer rejection perpetuated Marquise's anxiety, rendering him increasingly nervous about the prospect of interacting with his classmates. Together, he and his therapist worked on various verbal and nonverbal social skills, including tone of voice, body language, entering conversations, and changing the topic of discussion.

Marquise readily agreed to participate in in-session role plays, although he tended to become nervous and laugh. Together, he and his therapist developed a list of social situations where he could practice his new social skills. Outside of session, however, Marquise struggled to practice his new skills. At the conclusion of treatment, Marquise's depressive symptoms fell from a 36 to a 19 on the BDI-II, which represents an improvement in symptoms of depression. However, he still reported

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intermittent suicidal ideation and interpersonal struggles, and his BASC-2 SRP scores on social stress and interpersonal relations remained in the clinically significant range. Although the reduction of depressive symptoms was an important first step for Marquise, clinical concerns related to anxiety and social skills were still indicated. Thus, at the end of the school year, Marquise was referred for further treatment.

Case Example 3: Family Communication Skills

Improving communication skills among family members is critical for adolescents with mood disorders. Research suggests that youth who perceive a lower level of open communication with their parents experience poorer psychological adjustment (Xiao et al., 2011). In addition, research indicates that adolescents who are depressed are more likely to have conflict in their relationships with their parents (Sheeber et al., 2007). Parent-adolescent communication also has been found to be inversely related to adolescent loneliness and depression (Brage & Meredith, 1994). The family-oriented communication skills practice guide from PracticeWise (entitled "Communication Skills—Advanced") discusses two goals: (1) to organize a discussion of topics by identifying which topics the family has difficulty discussing without conflict, and (2) "to teach and practice communication skills to members of the family to improve positive relations among family members." Below, we discuss how the latter goal was used in working with Jasmyn and her parents.

Jasmyn is a 13-year-old African-American girl who lives with her parents and older sister Lia. Bright and engaging, Jasmyn was in all honors classes with plans to attend a magnet program at a local high school in the fall. During her initial assessment, she reported having suicidal thoughts two to three times per week. Jasmyn reported that her difficulties stemmed from interactions with her family, from whom she frequently felt isolated and distant. In particular, Jasmyn stressed that her mother seemed to care "more about my grades than she does me, as a person." At her intake assessment, Jasmyn's score on the YOQ was a 36, which falls within the clinically significant range. Although her BDI-II indicated mild symptoms of depression (score = 18), her responses on the diagnostic clinical interview (MINI) revealed current and lifetime major depressive disorder, as well as current suicidal ideation.

At the outset of treatment, Jasmyn showed strong insight into her situation. She admitted to spending a great deal of time in her room rather than trying to engage with her family. In addition, Jasmyn mentioned several instances in which one of her family members said something that upset her and, rather than discuss the incident, she allowed it to fester. As treatment progressed, Jasmyn was better able to monitor her negative moods and supply alternate interpretations for events; however, she still reported conflict with her parents—her mother, in particular—and feared that discussing her problems with them would compel them to "abandon" her.

As research suggests, youth who perceive greater problems with their families are less likely to improve with treatment (Crawford & Manassis, 2001). Thus, Jasmyn and the therapist discussed ways of incorporating her parents into treatment in a way that would be effective rather than alienating. various factors that contribute to and maintain depressive symptomatology, including poor parent-child communication. When Jasmyn joined the session, she appeared nervous; however, as the session continued, she began to open up, explaining what she needed from her mother. In response, Jasmyn's mother validated her perspective and offered some insight of her own. Both Jasmyn and her mother vowed to keep lines of nonjudgmental communication open.

At the end of treatment, Jasmyn reported that communication had greatly improved among her family members and that she felt her parents better understood her emotional difficulties. She felt more confident speaking up for herself and initiating conversations with her mother. Although Jasmyn still shied away from letting others know when they had hurt her feelings, she promised to continue to work on these skills after the conclusion of therapy.

Although Jasmyn was enthusiastic about inviting her father into a session, she was nervous about including her mother, who she felt would feel blamed and grow defensive.

Although Jasmyn was enthusiastic about inviting her father into a session, she was nervous about including her mother, who she felt would feel blamed and grow defensive. Jointly, the decision was made to first invite Jasmyn's father to attend a session, where the therapist would provide psychoeducation on depressive symptoms and discuss effective communication skills including avoiding confrontation, active listening, and perspective taking. Jasmyn's father serves as her primary confidant in the home, and because of this, he was receptive during a joint session to the introduction of new communication skills and very understanding of Jasmyn's feelings. Despite this, in the weeks following the session with her father, Jasmyn continued to express anxiety about inviting her mother into a session. Together, Jasmyn and the therapist explored her feared consequences of meeting with her mother, as well as skills she could use if the session became too difficult. Jasmyn and her therapist decided that the therapist would meet first with Jasmyn's mother to establish collaborative goals and set the tone for the session. In light of Jasmyn's concerns that her mother would feel blamed, the therapist discussed the

Several strategies were used successfully with regard to working on communication skills with Jasmyn and her family.

- First, the clinician developed a strong rapport with Jasmyn, which helped facilitate her and her parents' trust in the therapeutic process.
- Second, the therapist taught communication skills with Jasmyn and each of her parents separately. This allowed Jasmyn to feel more comfortable in the sessions, thereby increasing the likelihood of her effectively learning and using the skills.
- Third, neutral topics were used as initial examples for the different speaking and listening skills. This helped Jasmyn and her parents familiarize themselves with the skills in a less threatening environment before delving into more difficult topics.

Of note, there were many preexisting factors that enabled successful engagement of Jasmyn's parents and subsequent motivation to work on communication. There was already a level of "buy in" from Jasmyn's father, who had consented for her to participate in the SEED project and completed

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the intake assessment. Both parents worked relatively flexible jobs, allowing them to travel to school in the middle of the morning. Finally, Jasmyn's parents also expressed high levels of concern regarding their daughter's mental health and were therefore motivated to support her however they could.

By the end of treatment, Jasmyn's score on the BDI-II had fallen from a 19 to a 14, indicating an improvement in symptoms of depression. Jasmyn's score on the YOQ had fallen to a 22, which was no longer in the clinically significant range

Discussion

This paper offers an overview and relevant case examples to illustrate the implementation of the common elements approach in the school-based treatment of youth with mood disorders. Specifically, the case studies provide real-life examples of the ways in which additional practice elements—relationship/rapport building, social skills training, family communication skills—can be implemented in conjunction with a flexible, modular treatment manual to meet the individual needs of clients. Together, these case examples have implications for practitioners and researchers alike.

Practice Implications. Several practice implications can be derived through these illustrative case examples. First, as described in the examples above, the use of data was instrumental in guiding clinical decision making. In particular, data were used by SMH clinicians to identify both the individual needs of the clients, as well as the additional practice elements needed to supplement the modular approach to treatment. In addition, data collected from the YOQ were used to monitor client progress over the course of treatment. Together, the assessment tools used by clinicians in this study illustrate how critical data are for SMH practice and offer potential data collection measures for others to consider.

The case examples described above also demonstrate how additional practice elements can be implemented using an approach comfortable for both the client and clinician. In these case examples, the clinicians reported using strategies preferred by their clients. For example, in the case of Andrea, text messaging was used to support initial relationship building with peers. Likewise, the clinician working with Jasmyn met her request to meet with her father first and then meet with her mother in later sessions. SMH practitioners may consider similar strategies in implementing each of these practice elements, or new and different strategies might also be considered to target the same practice element. Here again, the common elements approach encourages and supports this flexibility in practice.

These case examples also broadly illustrate common practice elements one might consider incorporating when treating youth at risk for, or currently experiencing, a mood disorder. Oftentimes, youth may present with other co-occurring symptoms that need to be addressed throughout the course of treatment. Social skill deficits, parent/family challenges, and poor interpersonal skills are just a few examples that might be encountered in practice. SMH clinicians should consider how the additional practice elements described here may be compatible with more commonly used approaches and strategies for the treatment of youth with mood disorders.

The case examples described above also demonstrate how additional practice elements can be implemented using an approach comfortable for both the client and clinician.

Although this paper helps illustrate how EBPs can be incorporated into school-based treatment for youth with mood disorders, some limitations to these case examples should be noted. First, even though a flexible, manualized approach was used, the time constraints of the school year imposed limitations on the duration of treatment. Therefore, it is possible that additional practice elements may have been incorporated as the needs of the clients changed over time. Referrals were made to other providers for continued treatment if indicated. Furthermore, it is important to note that while the PracticeWise database and the assessment tools used in this study provided valuable clinical information, there was a cost associated with use of these tools.

Research Implications. Several implications for research can be derived from this work and the limitations noted above. For example, as noted above, future research should focus on evaluating the outcomes associated with implementation of a modular, manualized treatment approach *and* incorporation of additional practice elements. Given that the population of youth with mood disorders is varied, and that among the many assumed benefits of the common elements approach are its adaptability and individualizing features, continued efforts to understand how these affect client outcomes should be prioritized. Similarly, process evaluations that continue to document the barriers and facilitators in using this approach, particularly within school-based settings, are also needed. It is also important to further understand the requisite professional development and training needs, as well as the organizational resources required, to implement this approach in schools.

Conclusion

Overall, this paper offers illustrative case examples to highlight how EBPs for treatment of youth with mood disorders can be incorporated into SMH practice. Given the growing numbers of youth experiencing these disorders, implementing EBPs is an important practice priority. The common elements approach described here offers a way to provide the EBPs that are consistent with methods that support clinician autonomy and that respond to the unique and individual needs of client systems.

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Clinician and Caregiver Perspectives on Family Involvement in School Mental Health Services for Youth Receiving Mood Disorders Treatment

by Melissa W. George, Heather L. McDaniel, Kurt Michael, and Mark D. Weist*

Despite advances in evidence-based practices in child and adolescent mental health, along with the movement toward comprehensive mental health services in schools (Weist et al., 2014), involving families in care remains a challenge (Hoagwood et al., 2001). Currently, more than half of youth with emotional/behavioral challenges, including mood disorders, receive either no treatment or inadequate treatment (Burns et al., 1995; Leaf et al., 1996; Weisz, 2004). Addressing mood disorders in schools is a priority, given that 14% of students are challenged by these disorders (e.g., major depressive disorder and bipolar disorder) and that school mental health (SMH) services are more likely than traditional approaches to reach these youth (Grunbaum et al., 2004; Marsh, 2004; Merikangas et al., 2010). National momentum toward delivery of services in schools has removed a number of barriers to treatment, but effective strategies to engage and empower families are still emerging (McDaniel et al., forthcoming 2014). Although involving families in treatment is critical, it is often challenging (McDaniel et al., forthcoming 2014), and an examination of barriers to family involvement in delivering evidence-based treatment is needed to narrow the research-to-practice gap. The current paper considers clinician and caregiver perceptions of family involvement in the context of evidence-based treatment in schools for adolescents experiencing mood difficulties.

Family involvement in youth mental health services has been conceptualized across numerous dimensions, from attendance at intake appointment to retention in sessions across treatment. McKay and Bannon (2004) consider engagement as beginning with acknowledging a child's mental health problem, connecting to relevant services, and completing with the child receiving services. Family engagement in services has also been expanded to encompass ongoing retention in treatment (McKay et al., 1998). Central to family engagement is using a collaborative style with families, rather than the "professional-centered" model in which the clinician serves as the expert. The "expert" approach can lead professionals to treat families in a denigrating manner that is associated with families disconnecting from care (Bickham et al., 1998). Involving families in youth mental health services is believed to be foundational to achieving positive youth outcomes (Hoagwood et al., 2010), yet there are alarmingly high no-show rates, ranging from 28% to 62% (Harrison et al., 2004; McKay et al., 2005; McKay et al., 1996); poor attendance rates, with 40% to 60% attending fewer than four sessions; and abrupt drop-out rates (McKay et al., 2002).

Family involvement is a critical factor in attaining and sustaining positive outcomes (National Institute of Mental Health, 2001). Families are crucial partners in treatment as advocates, consumers, and implementers of strategies to improve their child's well-being. In addition, although clinicians have expertise, families are a valuable information source, can provide details about the strengths and difficulties associated with their respective families, and often have ample time to work with their child(ren) as well as to monitor progress. Recent reviews have noted the strong influence of family systems in mental health interventions (Chorpita et al., 2005; Weersing & Weisz, 2002). Moreover, although research has largely been limited to youth exhibiting disruptive behavior disorders, it is expected that family involvement is important for all youth and families, and the diverse spectrum of presenting problems in youth, including "internalizing" problems such as depression, anxiety, and the experience of trauma should be examined (Barmish & Kendall, 2005; Ingoldsby, 2010; Stark et al., 2006). Indeed, national mental health policy calls for families to become active consumers of services and for children and youth to receive more comprehensive services (President's New Freedom Commission, 2003).

Mental health providers face complex challenges when involving families in services. Clinicians may worry that involving caregivers could complicate the treatment process (Bickham et al., 1998; Center for School Mental Health [CSMH], 2002) and that alignment with family members may compromise the relationship with the client. Youth or caregivers may also express unwillingness for caregivers to be involved; for example, youth may fear familial disapproval for seeking services or may wish to obscure the problems for which they are seeking help (Bickham, et al., 1998; CSMH, 2002). Moreover, clinicians and families have identified numerous logistical barriers, such as scheduling conflicts, perceptual barriers, stigma related to mental health problems, long waiting lists, and other contextual barriers that make involvement challenging (Gopalan et al., 2010; McKay & Bannon, 2004). In addition, clinicians' lack of prior training or experience in providing services to families (CSMH, 2002) may add to the challenges.

Although providing SMH programs and services affords numerous benefits for youth and families, there are certain obstacles to engaging families that are unique to the school setting (Stephan et al., 2007). Families have identified concrete barriers to involvement, including:

- Lack of transportation or childcare;
- Lack of understanding of mental health and mental health services; and

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- Difficulty connecting to services during school hours (Bickham, et al., 1998; CSMH, 2002; Koroloff et al., 1994).

Families have also expressed concerns about confidentiality. This is understandable for SMH, where a variety of people (e.g., other students, school staff) could become privy to confidential student and family information if mishandled. Stigma about mental health services and problems is often a significant barrier to care for families (Bickham et al., 1998; CSMH, 2002; Federation of Families for Children's Mental Health, 1998), which may be compounded by negative interactions with the school (e.g., being contacted by the school only when there are problems with their child), and past negative personal experiences with schools (Bickham et al., 1998).

In this paper, we present clinician and family perspectives on family involvement in SMH services for youth with mood difficulties in order to understand the perceptions, barriers, and recommendations for family involvement in this unique service setting. As part of developing and testing an interdisciplinary training model for supporting the delivery of evidence-based treatment for youth with mood difficulties, graduate students pursuing specialization in SMH were trained in family involvement strategies as a core component of the delivery model. We briefly describe the intervention as a context for understanding the family-involvement training component of the project, describe our procedures and measures for assessing clinician and family perspectives, and present results relating to parent and clinician perspectives on family involvement in SMH services.

Study Method and Participants

Study participants included 13 caregivers of adolescents who took part in the Student Emotional and Educational Development (SEED) program, an evidence-based model of assessment and treatment for youth experiencing or at risk for mood disorders. Caregivers participating in SEED had an adolescent (mean age = 13.8; range = 12 to 18 years) in a middle school (grades 6 through 8; n = 11) or high school (grades 9 through 12; n = 8) in an urban-suburban school district in the southeastern region of the United States serving more than 26,000 students. School-based clinicians worked with school personnel to identify students potentially experiencing mood difficulties and conducted systematic screening for the same. Similar to the demographics of the school district (60% African American and 46% receiving free or reduced lunch), the majority of caregivers participating in SEED were African American (58%), female (79%), and a biological parent (68%). Forty-two percent of caregivers had adolescents receiving free or reduced lunch.

Study Procedure

School-based clinicians implementing SEED integrated the treatment protocol within the context of practicum or field work placements for their graduate training programs in school psychology, clinical-community psychology, and social work. The study was reviewed and dually approved by the institutional review boards for the school district and sponsoring university. After completion of caregiver consent and youth assent, parents and adolescents completed questionnaire measures at baseline. Students were determined to be eligible based on meeting criteria for being at risk for a mood disorder using clinical scores on measures of internalizing problems or a clinical diagnostic interview administered to the adolescent. Eligible students received the individually tailored SEED program, described in more detail below, in their school. Upon completion of the SEED program, students and families completed post-assessments; interviews were conducted with parents to collect feedback on their participation in the program; and a focus group was used to assess clinician trainees' feedback on implementing SEED, including barriers to implementation, areas of improvement, and perceived usefulness and support for delivering the program.

Clinician Training on Family Involvement as Part of SEED

The SEED program was developed based on the literature on evidence-based practices (EBPs) for youth with mood disorders using the common elements strategy (Chorpita et al., 2005). This strategy capitalizes on the idea that many manualized EBPs have "common elements" that can be "distilled" for specific problem areas, and once a large number of manualized EBPs are condensed to a smaller number of common elements, a clinician can exercise clinical judgment to individualize a treatment plan using the common elements (Chorpita et al., 2005). Research indicates that modular evidence-based strategies may be more acceptable to clinicians than manualized interventions and may offer greater flexibility in treatment delivery than traditional, manualized EBP strategies (Borntrager et al., 2009; McHugh et al., 2009). Based on "modules" of most of the commonly implemented and evidence-based strategies for students with mood disorders (Chorpita et al, 2007), a manual was developed that gave guidance for the integration of up to 12 modules into client sessions. This approach and its application based on specific client needs is discussed further in the paper by Splett and colleagues in this special issue of *EBDY*. Taking advantage of the strengths of the common elements approach, clinicians used their clinical judgment to select and adapt modules based on the presenting needs of the student and family. In addition to using this flexible, manualized approach, clinicians were trained to involve and engage families in mental health treatment through the use of role plays, scripts, and problem solving during supervision.

Research indicates that modular evidence-based strategies may be more acceptable to clinicians than manualized interventions and may offer greater flexibility in treatment delivery.

Caregiver Interview. At the end of the school year, after clinicians had delivered the SEED program, post-assessments with students and caregivers were completed in person or by phone. As part of the post-assessment, caregivers were interviewed about their involvement in the SEED program, including their satisfaction, extent of involvement, and helpfulness for the child. Interviews were audio-recorded, transcribed, and coded to identify themes in caregivers' responses about their satisfaction with their involvement. Individual caregiver interviews were coded by two research assistants who collaborated to identify the themes addressed in each question and to extract exemplary quotations. Themes were defined as any statement or idea that was mentioned by two or more individuals.

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Clinician Focus Group. Clinicians were invited to share their experiences in delivering the SEED program, specifically reflecting on the feasibility, acceptability, and the effectiveness of both the training and the intervention strategy. A research assistant not connected with the project conducted the 90-minute focus group with five of the clinicians; the focus group was audio-recorded, transcribed, and later analyzed for themes specific to family involvement in the SEED program, including satisfaction with training, feasibility of family involvement, and recommendations. Themes were defined as any statement or idea that was stated in the group.

Study Results: Caregiver Perspective

Satisfaction With the Provision of Services in School. When asked, "Do you think having SEED in your child's school was a good thing?"100% of the parents answered affirmatively. Additionally, when asked, "Do you think SEED would have been better in another location?" only one parent was unsure. However, two of the parents indicated that, although the school was indeed the best place, they felt that providing the program after school hours might be more conducive. They felt that if the program were provided outside of school hours, their student would not miss any instructional time and that it might allow the therapist to spend more time with their student than they could otherwise spend during the school day.

Involvement in School Mental Health Services. Most caregivers indicated that they would like to have been more involved in the SEED program, with only four of 13 (30.7%) caregivers indicating that they were happy with their level of involvement in their student's SMH services. The majority of caregivers (69.3%) indicated that they would like to have been more involved and identified a variety of ways that this could have happened. Some caregivers indicated that they would like to receive information from the clinician about what was covered in their child's therapy session. Caregivers also indicated that they recognized the importance of their role in supporting their adolescent and wanted to know ways that they could help their child in the home. The following statement from a caregiver exemplifies this theme:

> I still wish I had gotten more insight as to what was discussed so I could have a, you know, some idea of how to help her, because she's still acting out in school and still having issues and getting into fights and stuff like that. So, I don't know, I just wish you guys could communicate more with the parents.

Among the four caregivers who indicated that they were happy with their involvement, two noted that they were accepting of their minimal involvement because they perceived that a confidential relationship between the therapist and student was needed. Amplifying this theme, when asked if she was "happy with the amount [she] was involved in SEED," one caregiver stated:

> To a certain point, because I know that in order to get very true answers or very true what's going on at school, that you have to keep some confidentiality from the parent, as long as it's not where the child will be hurt themselves, so to a certain extent, yes.

Barriers to Family Involvement. Ten of 13 caregivers (76.9%) indicated barriers to their involvement in their student's SMH services. Only one caregiver indicated that he/she had logistical barriers. More specifically, this caregiver identified time constraints as a barrier, stating that:

> Sometimes I would just read emails [from the clinician] but not necessarily respond to them immediately due to my other obligations and things.

The other nine caregivers stated that they faced barriers to involvement that reflected poor collaboration with the clinician, a problem they perceived could have been easily remedied by the clinician. Caregivers noted lack of contact with their child's clinician as a barrier to their involvement by saying things such as, "In between, to me, it was like too long in between talking to y'all again"; "I could have been more involved"; "I just didn't know"; and "I just wish you guys could communicate more with the parents." This statement from a caregiver clearly depicts this barrier:

> And we are both open to suggestions in regards to, you know, how we can be better parents, you know, we don't know it all—we never, you know, profess to know it all. But when we were going through the SEED program I would ask her, you know, what'd you talk about and she couldn't give me a clear and concise answer, so I expected, you know, to be contacted at least during the midway period and let me know: "Hey, this is where we're going; this is the progress she's making; this is what she needs to work on a little bit more," and there was no communication, period.

"I still wish I had gotten more insight as to what was discussed so I could have . . . some idea of how to help her, because she's still acting out in school and still getting into fights. . . . So, I don't know, I just wish you guys could communicate more with the parents."

Study Results: Clinician Perspective

Here we present the themes identified in clinician focus groups about family involvement in the services and satisfaction with the provision of services in schools.

Provision of Services in School. When discussing the provision of youth mental health services in schools, clinicians stated that they felt it was "really good to meet kids where they are" and that students "like knowing that there is someone in the school." However, clinicians also indicated that they felt providing mental health services in schools may be a barrier to involving parents. For example, in a clinic setting, the parent would be present because the parent would bring the child, whereas at school, the parent is not necessarily there, suggesting that "sometimes the parents are a little resistant" to attending. One clinician concisely described this idea:

> Sometimes it is not good to do it in the school because it is good to have parent involvement, and they know that we can call them, and it's not always easy to catch them. And just not having the parent there, that can be a negative side of doing it at school.

Specific barriers to family involvement that were identified in relation to the school setting included challenges in contacting parents and "parents can't take time off work to come into the school." As a

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proposed resolution, clinicians suggested that someone who "had the ability to work beyond school hours" might be more effective in meeting with parents. Thus, although clinicians felt SMH services assisted in connecting youth to needed services, they also felt that the school setting posed various barriers to family involvement.

Role Constraints. Clinicians indicated that their role in the school as trainees may have imposed some constraints on flexibility that could assist with involving families. In relation to scheduling and access to resources, one clinician stated:

> I have been in contact with all of the parents. I have brought one parent in, but in terms of coordinating working or coming into therapy at the right time, that has been an even bigger barrier; [regarding] my own time commitment. I think that if I were there every day, then I would be bringing in parents a lot more. And that's just restrictions of my schedule, restrictions of space in the school for when it is convenient for them to have me.

Similarly, many clinicians also mentioned competing responsibilities as a barrier to family involvement. For example, a clinician said:

> Like we were expected to fill a role in the school and then this [SEED] just got thrown on top of that. And the role that we were expected to fill is like an eight-hour-a-week job. And so we have eight hours in the school one day a week where we are expected to do our own assessments and take on our own cases outside of this project and do projects with teachers, and all of these other components. And once this got up and running, this completely took over my day.

Although this perspective was voiced by a trainee, it is likely that a full-time SMH clinician would encounter many of these issues as well. For example, oftentimes clinicians are assigned to multiple schools, forcing them to segment their time and likely rendering flexible scheduling with families nearly impossible, as well as dealing with the challenges of competing responsibilities.

Training and Support. In discussion of the training that clinicians received through participation in the SEED project, many clinicians felt that they needed additional or different training and support for involving families. Several clinicians mentioned that the training was at a level that was "kind of below what I needed right now" due to differences in clinician's previous training in clinical skills and evidence-based practice. This was acknowledged with clinicians stating that this was difficult to do "with different clinical levels; you can't just assume that people know what they are doing" and not start at a level that tried to address everyone's needs. Alternatively, some clinicians indicated that the support was insufficient and that they needed additional training. One clinician stated:

> I think that, . . . we have a lot of experience working with kids just in the program that we are in, but not so much; like my experience working with families is like assessment based and not the therapy part and, so I don't feel like I have the training part to do family counseling. And that was, I mean, I don't have the experience at all. And so, versus someone who is in the clinical program who has been working with families, and so I feel like they really miss that piece if they want us to do the family engagement. We received no training on doing family counseling at all. It was just like, well do it, and that is not something that I am going to go do when I don't have any competency in that area.

The clinicians' differing perspectives on the adequacy of training is likely due to varying experiences in their graduate program training, because trainees were in school psychology, clinical/community psychology, and social work. Although they were all being trained to support student mental health in the schools, their training likely emphasized different aspects of SMH service provision (e.g., assessment, intervention, case management).

More generally, some clinicians felt unsupported in reaching out to families. One clinician described a specific instance in which she felt a colleague was unsupported in this way:

> And this is your thing but . . . I took it very personally, like they were kind of pressing the issue one time when you were trying to get with a parent. And they were saying like go meet them at their car. And you were very adamant about it, and obviously I didn't say anything about it at the meeting, but it was one of those things where you are basically pushing someone off the cliff when they have clearly expressed that they are uncomfortable about it. And if it is supposed to be a kind of team thing, and we all go help out each other, then why can't you go do it?

Analysis of Results

The current study garnered information about clinician and caregiver perspectives regarding family involvement in SMH services and satisfaction with the provision of services in schools using caregiver interviews and a clinician focus group. We aimed to elicit perceptions of, and to identify advantages and barriers, while informing strategies for involving families in SMH services. Clinicians and caregivers provided complementary perspectives on the importance of family involvement yet, consistent with previous research, identified a number of challenges to engaging families in SMH services. Both clinicians and families believed that service provision in school is beneficial but that a number of training, logistical, and perceptual barriers exist.

Engaging families in SMH was positively received by caregivers, and they identified school as a good location. However, caregivers and clinicians indicated practical barriers involving scheduling and the problem of connecting only during school hours with parents and students. In convergence with the existing literature on family involvement, parents acknowledged the difficulties that accompany this approach, such as time constraints, because the traditional school-based clinician role to provide services only during the hours of the school day makes scheduling between clinicians and parents challenging. Moreover, caregivers recognized that removing students from class to provide services reduces instruction time that the student would otherwise receive in class. The length of class periods and getting students released from class may also present logistical obstacles by reducing the amount of time that clinicians can work with students.

Despite acknowledging some logistical barriers to coordinating appointments between clinicians, youth, and families, caregivers overall believed schools to be effective locations for providing mental health treatment. This is consistent with current perspectives on the importance of providing mental health services in schools, because the setting affords a number of advantages, including increasing access to services, reducing no-show rates, and improving youth retention in services.

The majority (69.3%) of caregivers responded that they would like to have been more involved in their student's services. Although it was difficult to identify

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the extent of family involvement for each family, it is important to acknowledge that caregivers recognized the importance of their involvement and wanted to be involved. Identification of the specific aspects of caregivers' involvement in their youth's treatment was lacking; therefore, future research is needed to help identify critical components of parent involvement to promote further clinician-caregiver partnership.

Results also suggested that caregivers recognized the need for adolescents to have independence and a confidential relationship with their clinician. Some parents were mindful of the need for such a relationship between their adolescent and the assigned clinician and felt that it would promote a more honest discussion about what the youth was going through at home or at school. It appears that some parents were interested in balancing their need to be involved in treatment with the teenager's desire for autonomy in the therapeutic relationship. It may be that integrating comprehensive psychoeducation in a treatment session with the parent could help elucidate an appropriate role for them in their youth's treatment (see Splett et al., in this issue, for specific case examples from the SEED program).

Overall, caregivers mentioned obstacles to their involvement in their youth's services that primarily indicated poor collaboration with the clinician. Maintaining contact and effective communication between families and clinicians appears to be necessary for promoting engagement of families in treatment. Indeed, parents provided suggestions on how they could be more involved through receiving information on what was covered in their student's therapy session and/or in learning ways that they could support their adolescent. Despite a parent's admission that she did not always respond in a timely way or at all to clinician emails, she indicated that she had read them. Although it should not be the only means of connecting with parents, virtual means of providing support to families may be one aspect of more comprehensive approaches to involving caregivers in treatment.

With results indicating that caregivers would like to be more involved in SMH therapy with their adolescents, and clinicians indicating that they do not have the necessary training and support, there seems to be a need to train SMH providers in family involvement strategies that can be used in the school setting. This is especially important in determining pre-service and in-service training needs for SMH professionals. Clinicians felt that they needed additional or different training to prepare them to involve families, and they also indicated a need for more support in reaching out to families. They indicated that this was likely due to their differing, discipline-specific graduate training for working as clinicians in schools. Some clinicians indicated needing more training for how to provide therapy because they felt more self-efficacious in child assessment, whereas others felt they had adequate training in child therapy but not necessarily in working with the family system. Yet, some of the clinicians believed that the training was elementary in nature and did not support their skill development at their own level of expertise and experience. Addressing the individual needs of each clinician can be challenging, and strategies for determining individualized implementation support for training clinicians to use evidence-based practice and treatment approaches are needed. Indeed, a current avenue of research by the authors of this paper examines implementation support for clinicians through bimonthly training and once monthly, individualized coaching in which a supervisor observes a school-based family session and provides suggestions for family involvement strategies in session.

It could be that low buy-in from clinicians is contributing to poor family involvement even though a specific component of the program addressed engaging families.

Study Limitations

A limitation of the current study was that fidelity to the family involvement component of the SEED program was not assessed. That is, it could be that low buy-in from clinicians is contributing to poor family involvement even though a specific component of the program addressed engaging families. If clinicians were not on board with the importance and benefit of involving families, this could have hindered their use of family engagement strategies. We did not measure or identify the deficiency in family involvement, so it is unclear if it was an issue of training or of usage. It may be that family involvement training for clinicians was adequate but that skill usage was low among clinicians, which would be associated with poorer outcomes. If it is an issue of training or implementation support, providing clinicians with more evidence of the benefits of involving families, as well as acknowledging the difficult nature and ongoing challenges of involving families may be needed.

Identifying the current training, experiences, and skills in working with families may also be beneficial in determining the level and need for ongoing support. Additionally, family involvement strategies may be more strategically built in to ongoing supervision to build clinician self-efficacy for working with families. Improving ongoing monitoring of skill usage in comprehensive interventions, such as SEED, can be challenging but is an important aspect of improving implementation support for clinicians to deliver evidence-based treatment for youth. Future research is needed to more clearly document skills usage and to build in accountability and monitoring of family engagement strategies. Strategies to enhance the delivery and accountability of family involvement strategies and evidence-based practice in SMH are significant and under-researched areas that are beginning to be pursued by the research team.

Regarding methodology, small sample size may limit the generalizability of the findings. In the parent interviews, inhibited participants may be less likely to share their thoughts and may feel somewhat influenced by the interviewer. In the clinician trainee focus group, group consensus may inhibit dissenting comments. In addition, some experiences of clinician trainees may not generalize to full-time SMH providers. For example, it is plausible that a full-time provider may experience different role constraints and different training and implementation supports.

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Conclusion

The unique challenges of involving families of adolescents experiencing internalizing problems in mental health services are not well understood. Identification of the specific challenges of this population is needed to inform strategies for helping clinicians involve families in a manner that is supportive for all partners involved. As the implementation of EBPs becomes increasingly connected to policies mandating disbursement of state and federal grant money (President's New Freedom Commission, 2003), and the importance of family-driven services is further emphasized in the positive outcomes associated with EBPs, the operationalization of family involvement skills and their translation into policies could have enduring impacts. The findings of the current study are important for understanding perceptions of the barriers to family involvement in SMH services, because clinicians identified role constraints, scheduling, and competing responsibilities to be barriers to family involvement in this environment. Further research is clearly needed to understand the complexity of the issues surrounding family involvement in youth mental health services.

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From the Literature: What's Hot . . . What's Not

by Lorraine Dubuisson*

Evaluating Legacy for Children

Behavioral and Socioemotional Outcomes Through Age 5 Years of the Legacy for Children Public Health Approach to Improving Developmental Outcomes Among Children Born Into Poverty

Kaminski, J.W., Perou, R., Visser, S.N., Scott, K.G., Beckwith, L., Howard, J., Smith, C., & Danielson, M.L.
American Journal of Public Health
103:1058–1066, 2013

This study evaluates Legacy for Children, a program created by the Centers for Disease Control that targeted mothers and children living in poverty. Because poverty has such a deleterious effect on many facets of children's lives and because those effects can persist into adulthood, Legacy for Children was designed to improve developmental outcomes for children born into poverty. The program states:

> The 3 tenets of the Legacy philosophy hold that: the quality of the mother-child relationship is critical to healthy child development, there are multiple pathways to positive mother-child relationships (i.e., there is no single "right" way to parent), and mothers can have significant positive impact on their children's development, no matter what their circumstances.

In practice, Legacy consisted of weekly group meetings that provided impoverished mothers with a support network and sense of community as well as information on a variety of parenting topics. Legacy for Children operated out of both Miami and Los Angeles, and the majority of participants were either black or Hispanic. Using data reported by mothers on the Brief Infant-Toddler Social and Emotional Assessment (BITSEA), the Devereux Early Childhood Assessment (DECA), and the Strengths and Difficulties Questionnaire (SDQ), the study found fewer behavioral concerns at three years and/or five years of age among children whose mothers had participated in the program.

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Emotional Recognition in Children With Anxiety Disorders

Effects of Age and Subtype on Emotional Recognition in Children With Anxiety Disorders: Implications for Cognitive-Behavioural Therapy

Lee, T.C., Dupuis, A., Jones, E., Guberman, C., Herbert, M., & Manassis, K.
The Canadian Journal of Psychiatry
58:283–290, 2013

This study examines whether children ages six to 11 who have been diagnosed with anxiety disorders have difficulty recognizing the emotions of others. Prior to this study, good assessment tools to measure emotional recognition in children with anxiety disorders were not regularly used. Here, researchers use a sophisticated assessment tool, the Mood Assessment via Animated Characters (MAAC), which goes beyond static facial cues to include bodily cues and situational cues that point to specific emotions. The MAAC consists of a number of short, nonverbal cartoon snippets that demonstrate different emotions. Findings suggest that on the whole, children with anxiety disorders identify the emotions of others with the same proficiency as children who have not been diagnosed with anxiety disorders; however, children with separation anxiety disorder (SAD) experience more difficulty with emotional recognition, and children with generalized anxiety disorder (GAD) experience difficulties that disappear as they age. In fact, many deficits in emotional recognition in the group studied were corrected with age. Nevertheless, these findings suggest that children with SAD and GAD could benefit from interventions designed to help them correctly identify the emotions of others.

Kidney Disease and Steroids in Children

Psychosocial and Cognitive Function in Children with Nephrotic Syndrome: Association With Disease and Treatment Variables

Manti, P., Giannakopoulos, G., Giouroukou, E., Georgaki-Angelaki, H., Stefanidis, C.J., Mitsioni, A., Stergiou, N., Mihas, C., Chrousos, G.P., Magiakou, M.A., & Kolaitis, G.
BioPsychoSocial Medicine
7:1–7, 2013

Nephrotic syndrome, a kidney disease, is characterized by the potential for frequent relapse and is treated with steroids. In this study, researchers examined a sample of Greek children drawn from two children's hospitals in Athens, Greece, to determine the relationships among psychosocial and cognitive function, the disease, and its treatment. Separating the effects of the disease itself from the effects of its treatment with steroids proved difficult. Children with nephrotic syndrome exhibited more internalizing problems than the healthy control group. Frequent relapses, the severity of the disease, the length of steroid treatment, and how long children had been sick contributed to internalizing problems; however, whether nephrotic syndrome or the steroids used to treat it are to blame remains unclear. Because the children participating in this study were taking relatively low doses of steroids at the time of the study, additional research on a sample of children who are taking higher doses of steroids to treat nephrotic syndrome is recommended.

Yoga Intervention for EBDs

Yoga in an Urban School for Children With Emotional and Behavioral Disorders: A Feasibility Study

Steiner, N.J., Sidhu, T.K., Pop, P.G., Frenette, E.C., & Perrin, E.C.
Journal of Child & Family Studies
22:815–826, 2013

Yoga is associated with a plethora of benefits, including improved attention and coping skills, an increased ability to relax, and increased self-awareness, plus all the attendant benefits of exercise. This pilot study explored the feasibility of using yoga in a school setting as an intervention for students with emotional and behavioral disorders. Using the non-religious Yoga Ed Program, the study followed 37 fourth and fifth graders with emotional and behavioral disorders as they participated in yoga sessions at school two times a week for one hour. Yoga Ed incorporates breathing, meditation, and holding a variety of physical poses. Teachers, parents, yoga instructors, and students all reported information regarding

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the implementation of the program and its efficacy. Comments from all four groups were largely positive, and the study indicates that yoga as an intervention for emotional and behavioral disorders seems promising. However, a high degree of collaboration between schools and the program implementers is necessary because scheduling sessions so that they do not interfere with academic instruction is difficult.

Improving Writing Skills of Students With EBDs

STOP and DARE: Self-Regulated Strategy Development for Persuasive Writing With Elementary Students With E/BD in a Residential Facility

Ennis, R.P., Jolivette, K., & Boden, L.J.
Education and Treatment of Children
36:81–89, 2013

This is the first study of self-regulated strategy development (SRSD) conducted in a residential facility at the elementary level for students with emotional and behavioral disorders. Students with such disorders are more likely than their classmates to have reading, writing, and math deficits:

> SRSD is designed to address difficulties with writing as well as attitudes, beliefs, and motivation related to the writing process. The SRSD six-stage model includes procedures for goal setting, self-monitoring, self-instruction, and self-reinforcement which may generalize to other settings and maintain when taught to mastery in whole-class, small group, or individual settings.

Students in residential care receive round-the-clock psychological and educational support services, making their experience of SRSD much different from other groups of students who have previously been studied. Over the course of six weeks, 16 students in a residential care setting received SRSD training using the STOP and DARE acronyms. STOP stands for "Suspend judgment, Take a side, Organize ideas, and Plan more as you write." DARE stands for "Develop your topic sentence, Add supporting ideas, Reject at least one argument for the other side, and End with a conclusion." To measure the success of the intervention, students were given persuasive writing prompts that required them to put forth an argument and support it appropriately; each writing session lasted 45 minutes. The essays generated were evaluated in terms of quality, length, and whether they demonstrated a grasp of the elements of essay writing, such as the inclusion of a thesis and supporting details. At the end of the intervention, writing improved in length and quality and demonstrated a grasp of essay elements; this improvement persisted for six weeks after the end of the intervention.

Literature Review of Uses of Memantine

Memantine: A Review of Possible Uses in Child and Adolescent Psychiatry

Hosenbocus, S., & Chahal, R.
Journal of the Canadian Academy of Child & Adolescent Psychiatry
22:166–171, 2013

In this literature review, Hosenbocus and Chahal discuss studies that examined the off-label use of memantine, which is approved in Canada to treat Alzheimer's disease. Memantine has been shown to curtail the excessive glutamate activity that has been linked to the development of several psychiatric disorders in children and adolescents. The authors' review discovered a dearth of well-controlled studies of the drug's use in children and/or adolescents, but they discuss in detail the few studies in which memantine was used to treat autism spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD), schizophrenia, obsessive compulsive disorder (OCD), major depressive disorder (MDD), bipolar disorder (BD), abnormal eating behaviors, and anxiety disorders.

Factors Contributing to Behavior Problems in Children

Effect of Gene, Environment, and Maternal Depressive Symptoms on Pre-Adolescence Behavior Problems—a Longitudinal Study

Agnafors, S., Comasco, E., Bladh, M., Sydsjö, G., DeKeyser, L., Oreland, L., & Svedin, C.G.
Child and Adolescent Psychiatry and Mental Health
7:1–10, 2013

Using data collected by the South East Sweden Birth Cohort Study, researchers in this study explored the connections among environmental trauma (such as traumatic life events), post-partum and ongoing maternal depression, genetic factors, and behavior problems in children. The study followed nearly 900 mothers and their children from the time the children were three months old until they were 12 years old. Although post-partum depression was not found to have lasting effects on children's behavior, children whose mothers displayed depressive symptoms at the 12-year mark were more likely to have behavior problems. Traumatic life events were found to have some negative effects on children's behavior, and the study also found "a main gene effect of 5-HTTLPR."

> ***"Suspend judgment, Take a side, Organize ideas, and Plan more as you write. . . . Develop your topic sentence, Add supporting ideas, Reject at least one argument for the other side, and End with a conclusion."***

PCIT Pilot Study

The Effectiveness of Group Parent–Child Interaction Therapy With Community Families

Nieter, L., Thornberry, Jr., T., & Brestan-Knight, E.
Journal of Child and Family Studies
22:490–501, 2013

In this pilot study, 17 families with children ages two to eight participated in Parent-Child Interaction Therapy (PCIT), a therapy that teaches parents to more effectively manage their children's behavior. The families were primarily of low socioeconomic status, and PCIT took place in a community-based setting. During sessions, children controlled the first portion of the therapy, and parents led the second portion. Families who participated were provided dinner, childcare for children not participating in the study, and transportation to therapy if necessary. Parents who completed the therapy demonstrated fewer inappropriate parenting behaviors, and their children exhibited fewer behavior problems. Parents also reported decreased stress levels. The article ends with suggestions for implementing PCIT more effectively based on the findings of the pilot study.

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Mental Health Surveillance

Mental Health Surveillance Among Children—United States, 2005–2011

Perou, R. Bitsko, R., Blumberg, S., Pastor, P., Ghandour, R., Gfroerer, J., et al.
Morbidity and Mortality Weekly Report
62:1–35, 2013

Following an in-depth discussion of the impact of mental health disorders on children, this article describes a variety of agencies collecting data about public health and their collection methods. The agencies include the Autism and Developmental Disability Monitoring Network, the National Health and Nutrition Examination Survey, the National Health Interview Survey, the National Survey of Children's Health, the National Survey on Drug Use and Health, the National Violent Death Reporting System, the National Vital Statistics System, the School-Associated Violent Death Surveillance Study, and the National Youth Risk Behavior Survey. This study brings together information collected in differing contexts and for differing reasons to form a more nuanced understanding of mental health in American children. Mental health issues discussed in this article include attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), conduct disorder (CD), autism spectrum disorders (ASDs), mood and anxiety disorders (including depression), substance use, tic disorders, and suicide.

Identifying Genes Responsible for Anxiety in Children

First Genome-Wide Association Study on Anxiety-Related Behaviours in Childhood

Trzaskowski, M., Eley, T.C., Davis, O.S.P., Doherty, S.J., Hanscombe, K.B., Meaburn, E.L., Haworth, C.M.A., Price, T., & Plomin, R.
PLoS One
8:1–7, 2013

Using data gathered on 2,810 seven-year-olds by the Twins Early Development Study (TEDS), this study is the first genome-wide association study on anxiety-related behaviors in childhood. Researchers used a new technique "that allows estimation of the total genetic variance captured by [single-nucleotide polymorphism] SNPs on a genome-wide DNA array, even though it does not identify which SNPs are responsible for the genetic influence."

Findings suggest that an accumulation of small genetic factors is responsible for anxiety in children rather than one or two "smoking gun" genetic factors. The article ends with a recommendation to increase sample size in future genome-wide association studies.

Findings suggest that an accumulation of small genetic factors is responsible for anxiety in children rather than one or two "smoking gun" genetic factors.

Day Hospitals for Young Children

Implementing Psychiatric Day Treatment for Infants, Toddlers, Preschoolers and Their Families: A Study From a Clinical and Organizational Perspective

Furniss, T., Müller, J.M., Achtergarde, S., Wessing, I., Averbeck-Holocher, M., & Postert, C.
International Journal of Mental Health Systems
7:1–12, 2013

In this article, researchers describe the mental health care offered at the Preschool Family Day Hospital for Infants, Toddlers, and Preschoolers and Their Families located at Münster University Hospital in Germany. This hospital's treatment plan was developed as part of the ongoing mission of mental health care providers worldwide to deliver appropriate mental health care to very young children. Because family plays a vital role in the development of mental illness in children, parents and siblings of the child with mental illness are treated concurrently at the Day Hospital. Information gathered by the Day Hospital is also used by the legal system for assessment purposes. The Day Hospital employs the intermittent treatment concept; rather than staying in the hospital for long periods of time, families receive shorter and more intense bursts of treatment that allow children to spend most of their time at home. Another component of treatment consists of deliberately separating parents and children into different therapy groups and then reuniting them. The article contains detailed descriptions of the treatment plan, including group treatment sessions and videotaped interactions between parents and children.

All Children in Focus

The Effects and Costs of the Universal Parent Group Program—All Children in Focus: A Study Protocol for a Randomized Wait-List Controlled Trial

Lindberg, L., Ulfsdotter, M., Jalling, C., Skärstrand, E., Lalouni, M., Rhodin, K.L., Månsdotter, A., & Enebrink, P.
BMC Public Health
13:1–12, 2013

All Children in Focus is an intervention intended to engender more effective parenting skills. It is directed at parents in general rather than being targeted to those parents whose children have already been diagnosed with a disorder or who are displaying health or behavior problems. The study took place in Sweden where 600 parents with children ages three to 12 participated in a four-session program. Assessments were made directly following the intervention and again six months later. The sessions of All Children in Focus were titled "Showing Love," "Being There," "Showing the Way," and "Pick Your Battles." Data collection and analysis is still ongoing in this study.

Maternal Attachment and Social Skills

Predictors of a Child's Social Skills as It [sic] Relates to Mother Attachment Styles and Mother Anxiety Levels Among Students in Grades (1–3)

Alsaraireh, K.S.
Journal of Social Sciences
9:22–28, 2013

Working with data collected from children in grades one through three in Amman City, Jordan, this study explores the relations among maternal attachment styles, anxiety, and children's social skills. Children and mothers were assessed using the Attachment Style Questionnaire (ASQ), the Social Skills Rating System (SSRS), and the Trait Anxiety Inventory (TAI). Maternal anxiety was found to be negatively associated with children's social skills, but:

> The multiple regression analysis revealed that there were four predictors of mother attachment style that had a significant impact on a child's social skills. These predictors included "confidence," "need for approval," "preoccupation with relationships confidence" and "relationships as secondary." ■

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Calendar of Events, February 2014 – March 2014

February

13-15 **AASA National Conference on Education.** Nashville, TN. Sponsor: American Association of School Administrators. Website: *http://nce.aasa.org/*

18-21 **NASP 2014 Annual Convention.** Washington, DC. Sponsor: National Association of School Psychologists. Website: *http://www.nasponline.org/conventions/2014/index.aspx*

19-22 **LDA 51st Annual International Conference.** Anaheim, CA. Sponsor: Learning Disabilities Association of America. Website: *http://www.ldaamerica.org/conference/index.asp*

March

2-5 **The 27th Annual Children's Mental Health Research & Policy Conference.** Tampa, FL. Sponsor: Department of Child & Family Studies, University of South Florida. Website: *http://cmhconference.com/*

19-22 **17th National School Social Work Conference.** Chicago, IL. Sponsor: School Social Work Association of America. Website: *https://m360.sswaa.org/event.aspx?eventID=80548&instance=0*

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