

**Existing knowledge on the interface between the educational system and  
families of students with behavior problems or disorders<sup>1</sup>**

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The findings are in the authors' own words and the conclusions reached are their own.

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## Table of Contents

<b>Introduction</b>	<b>3</b>
<b>Rationale – why address school/family partnerships in the prevention and treatment of childhood disruptive behavior?</b>	<b>4</b>
<b>Using a developmental-ecological perspective and public health framework to address children’s behavior problems by partnering families and schools</b>	<b>10</b>
<b>What interventions promote school-family partnerships and parent involvement in the context of reducing or preventing behavior problems?</b>	<b>12</b>
<b>School- and community-based interventions to reduce behavior problems that promote parent-school partnerships</b>	<b>17</b>
<b>Mental health treatment for behavior disorders</b>	<b>17</b>
<b>Early Childhood</b>	<b>17</b>
<b>Elementary</b>	<b>18</b>
<b>Middle School</b>	<b>19</b>
<b>High School</b>	<b>19</b>
<b>Prevention programs</b>	<b>22</b>
<b>Early Childhood</b>	<b>22</b>
<b>Elementary</b>	<b>26</b>
<b>Middle School</b>	<b>31</b>
<b>High School</b>	<b>31</b>
<b>Whole School prevention programs</b>	<b>32</b>

## Introduction

The goal of this project is to provide a review of the literature regarding what is known about relationships between parents/family and schools/educational systems for children with (or at-risk for) disruptive behavior problems (i.e. oppositional-defiant disorder, conduct disorder, and disruptive behavior problems). The terms 'behavior problems', 'conduct problems', and associated terms (e.g. disruptive behavior, oppositional behavior) are used interchangeably in this review. This review of the literature will include a synopsis of basic research on parental involvement in schools and its contribution to children's school behavior, and also applied research on school-based or school-related effective interventions that aim to improve children's behavior, incorporating a family/parenting component, such as improved family-school communication. These prevention or treatment interventions may be classroom-based, school- or educational-system based interventions, or community/family-based interventions with a significant school component.

For a review of the basic empirical research literature, only peer-reviewed articles were incorporated (chapters or books are cited only in discussions of theoretical or conceptual frameworks, or to illustrate programs of research). It is important to note that this was not an exhaustive review of all the data published on parent involvement and/or parent-school partnerships. Rather, the goal is to highlight recent findings that might shed light on the strategies and program that support adjustment for children at risk for, or demonstrating behavior problems or disorders. For the review of evidence-based practices (EBPs), or empirically-supported programs (ESPs; the terms are used interchangeably) the following methods were used: (i) review of three key United States federal databases of EBPs (the National Registry of Evidence-Based Programs and Practices, What Works Clearinghouse, and Model Programs Guide), (ii) a review a limited number of key peer-reviewed meta-analyses and literature reviews on behavior disorders prevention and treatment from the past 15 years, as well as key empirical articles from the past 10 years, and (iii) a Google scholar search using specific terms delineated in the Methods section, below.

In order to be included in the list of EBPs for this report, a program had to meet the subject matter criteria listed above, and be listed on a best practices databases (i.e. already have passed a thorough review of evidence) with a positive rating. Further details are provided in the methodology section, below.

Results of the literature review suggest that while the scientific evidence overwhelmingly supports the critical role of parenting in preventing and treating child behavior problems, and although children arguably spend most of their waking hours at school, relatively few interventions bridge the home-school gap. Those that do, fall into two categories: (i) school-based programs with a significant parenting component (e.g. parenting programs delivered at the school) and (ii) community-based programs with a significant school component (e.g., teaching

parents key school involvement skills). The listing of classroom-based and community-based treatment and prevention programs is categorized by developmental stage, as development matters, of course, in conceptualizing and treating conduct problems.

It should be noted that although every effort was made to do a comprehensive review it is possible that programs were missed if keywords did not include 'school'. For example, at least one parent training program that is well-known to the author (Parenting Through Change; Forgatch & DeGarmo, 1999) includes a significant school component that is not noted as a key term in literature searches. Similarly, at least two school-based programs (HighScope/Perry Preschool, and Chicago Child Parent Center) include significant family components that were not described in their listings on key evidence-based practices databases searched. In addition, because the focus here is on relationships between school and families in preventing or treating conduct problems, the author erred on the side of including school-based programs, even if the involvement of parents was not extensive. To be included in this literature search, parent involvement needed to go beyond notifications by the school (i.e. two-way communication was required). That is, school-based programs whose parent involvement was limited to letters or other information sent to parents (even if those letters required a signature sent back to school) were not included. However, some larger, universal prevention interventions (e.g. Positive Behavior Interventions and Supports/PBIS) parent involvement is not mandatory and not universal; this should be noted as a caveat to this report. Finally, no attempt was made to rank programs, because ranking requires extensive review of multiple sources that is far beyond the scope of this report. Instead, programs are listed alphabetically, within categories (i.e. type of program, developmental stage).

### **Rationale - why address school/family partnerships in the prevention and treatment of childhood disruptive behavior?**

#### Family and parenting influences on child behavior problems

There is a solid body of research evidence for a strong family influence in the etiology and maintenance of disruptive behavior disorders (Patterson, 1982). The vast majority of this research evidence comes from behavioral studies examining parent-child interactions within family settings that use a social learning or social interaction learning lens (Reid, Patterson, & Snyder, 2002). Relatively fewer studies have provided empirical evidence for psychodynamic theories about the development of problem behaviors, although the attachment literature (which grew out of a psychodynamic approach) has provided good evidence for the *infant* and early childhood foundations of interpersonal relationships and their psychosocial sequelae (Cassidy & Shaver, 1999). During infancy, arguably the key psychosocial developmental task is the establishment of a secure attachment relationship. As development proceeds, and children become more autonomous preschoolers, and subsequently transition to kindergarten, developmental tasks shift to the establishment and maintenance of self-regulatory skills. These skills – including

behavioral and emotional regulation - are crucial for adjusting to the school environment. In order to respond to the demands and the structure of the classroom, children need self-regulatory capacities, as well as social skills to navigate the school peer group. As children age, then, developmental tasks shift from attachment to behavior. Via parent-infant emotional/attachment relationships, children are provided a foundation for self-regulation, but direct behavioral modeling of interactions helps older children understand and learn appropriate behavior in interpersonal settings. Not surprisingly then, almost all the empirically-supported prevention and treatment programs for preschool and school-aged children at-risk for behavioral disorders focus on a behavioral perspective (e.g. parent training; National Research Council, 2009).

Patterson (G. R. Patterson, 1982, 2005) proposed a social interactional learning (SIL) model accounting for the development of childhood disruptive behavior. The model integrates social interaction and social learning perspectives, both of which emphasize the influence of the social environment on an individual's overall adjustment. The social interactional dimension assesses microsocial connections among family members and peers that become patterns of behavior contributing to child adjustment. The social learning dimension refers to the ways in which patterns are established through reinforcing contingencies. Based on family observational data, Patterson identified coercion as a key mechanism for child antisocial behavior (G. R. Patterson, 1982). The primary pathway to coercion begins with a wide variety of stressful life circumstances (e.g., poverty, health problems, and family transitions) and/or risk factors (e.g. young, single, unskilled, or poorly educated parents). These stressors amplify dysfunctional behavioral patterns within families and are associated with inconsistent, harsh or lax parental discipline. Within the SIL model, the impact of these stressors upon child outcomes is primarily determined by the extent to which they disrupt parenting practices. When stressors lead to increased coercive parenting and reductions in positive parenting (effective discipline, problem-solving, skill encouragement, monitoring and positive involvement), children increasingly engage in high rates of overt antisocial behavior (Calzada, Eyberg, Rich, & Querido, 2004; DeGarmo, Patras, & Eap, 2008; Mistry, Vanderwater, Huston, & McLoyd, 2002).

Coercive interchanges include irritable or aversive behavior generally initiated by a family member in the form of a conflict bout. A negative response (often including escalation) continues the conflict until it ends with a negative behavior. Coercion is thus maintained by negative reinforcement, such that the aversive behavior is maintained by the removal of the other person's aversive behavior. Examples include parent-initiated and terminated coercion, such as yelling or abuse to terminate a child's temper tantrum in response to a parental aversive behavior (saying no to a child's request), or child-terminated coercion, such as tantrums in the supermarket to yield a candy bar. In the latter example, the child is negatively and positively reinforced by terminating the parent's refusal *and* receiving a candy bar. This complex set of reinforcers has been termed a 'reinforcement trap' because

of the powerful set of contingencies operating in unison (Patterson, Reid, & Dishion, 1992).

Coercion is stable within and across *settings*, with a multiple correlation of .83 between the relative rate of reinforcement and the relative rate of child behavior (Snyder et al., 2008). The frequency and duration of conflict bouts is greater in families with antisocial children compared to those with better-adjusted children (Patterson, 1982; Patterson et al., 1992; Reid, Patterson, & Snyder, 2002) In a study of families with clinical levels of problems, conflict bouts occurred about once every 16 minutes and the observed relative rate of reinforcement was a significant predictor for measures of out of home placement and police arrest two years later (Dishion & Patterson, 2006; Snyder et al., 2008). Microsocial analyses of coercion indicated that longer conflict bouts were associated with increased likelihood for physical conflict (Patterson, 1982).

Coercive family processes (i.e. coercive parent-child interactions) and coercive interchanges with parents, siblings, and peers predict youths' conduct/behavior problems, delinquency, depression, school failure, drug use and related externalizing behaviors in children and youth (Bank, Patterson, & Reid, 1996; Capaldi, 1991; Dishion & Patterson, 2006; Patterson, DeBaryshe, & Ramsey, 1989; Conger, Patterson, & Ge, 1995).

Once a child starts school, coercive interactions may lead to a child's rejection by prosocial peer groups, (and acceptance/further reinforcement from antisocial peer groups), poor school behavior and performance, and further risks (Patterson, DeBaryshe, & Ramsey, 1989). Later in development, during the transition to middle school, peers replace parents as primary socializers and antisocial peer groups become powerful reinforcers of antisocial behavior. Dishion's work on peer contagion effects demonstrates the risks of unwittingly strengthening the antisocial peer group with 'therapeutic' or 'prevention' interventions that cluster antisocial peers together (e.g., Dishion & Tipsord, 2011).

#### The role of schools in influencing the trajectory of child behavior problems.

Given the amount of time children spend in school, as well as the crucial learning that takes place from both teachers and peers in the school environment, it is not surprising that schools have a key influence in the socialization of children (Reinke et al., 2009). Coercive processes learned at home are replicated in the school setting, where teachers may be drawn into coercive cycles with students who present with disruptive behaviors. Peers also play a crucial socialization role at school, where – unlike with adults in the home where coercive interactions are negatively reinforced – antisocial behaviors may be positively reinforced on the playground, and in the classroom. Thus, for example children displaying conduct problems may be reinforced by (and reinforce) antisocial peers, which maintains and further escalates the behavioral problems (e.g. Reinke & Herman, 2002). As development proceeds, behavior problems may generalize to other, related and developmentally

timed risks beginning in pre-adolescence (i.e. drug use, risky sexual behavior, truancy, school dropout, etc). A substantial body of evidence documents the longitudinal relationships from behavior problems to poor academic achievement across development (e.g. Hinshaw, 1992; Hill et al., 2004). For example, elementary aged aggressive behavior problems are linked to later school failure, social problems, poor achievement (Fergusson & Woodward, 2000; Malecki & Elliott, 2002) and school dropout in 12<sup>th</sup> grade (Kupersmidt & Coie, 1990).

Although beyond the scope of the current review, effective school interventions provide opportunities to reduce coercion in school settings by providing teachers and other staff with the tools to improve positive behavior management thereby reducing child behavior problems. Evidence indicates that improving behavior in the school setting also is associated with improved classroom performance, a critical outcome for school personnel and a key developmental outcome for children and youth. Moreover, interventions occurring within the school have particularly strong potential for changing outcomes because of the opportunity to reach large numbers of children simultaneously.

### Defining parental involvement in schools

For the purposes of this review, family-school involvement refers to a number of different ways in which parents are engaged with those who provide for their children's school education (teachers, counselors, social workers, psychologists, administrators, schools and school systems, etc), and are involved in academic/school activities at home. These activities might be specific to the child, such as the extent to which a parent is in communication with the child's teacher, is monitoring the child's school performance and behavior, and is working in partnership with the school to assist the child (e.g. behavior issues, homework completion, class participation, accommodations for learning challenges, etc). Parental involvement also applies more broadly to parental engagement in school governance, protocols, parent-teacher organizations, fundraisers, volunteering, etc. Parent involvement is generally assessed by examining communication with teachers, frequency of participation in school events and activities (Dearing, McCartney, Weiss, Kreider, & Simpkins, 2004; Dearing, Kreider, Simpkins, & Weiss, 2006) and sometimes by parents' values and aspirations for their children's education (Englund, Luckner, Whaley, & Egeland, 2004).

Scholars have conceptualized family-school involvement from a number of different perspectives. For example, some (e.g., Sheridan et al., 2012) have distinguished between two types of interface between families and schools: parent involvement in school, and family-school partnerships. Parent involvement refers to the individual participation of adult family members and caregivers in children's education to the goal of enhancing academic, social, and behavioral wellbeing (Fishel & Ramirez, 2005). Interventions to enhance parental involvement thus focus on improving parents' skills in home-school communication, monitoring homework, etc. Family-school partnerships refer to the development of approaches that enhance

relationships between systems (i.e. families and schools) by increasing coordination, and collaboration in order to support children's functioning (Albright & Weissberg, 2010). True partnerships between service providers (in this case schools) and families or community members are challenging and take time to evolve and implement but arguably yield longer-term investments from the partners involved (Elizur, 1996; Gewirtz, 2007). The interventions reviewed below focus on one or the other (or both) approaches but typically do not distinguish between partnership strategies/program elements, and parent involvement strategies.

Several scholars have applied the ecological approach (Bronfenbrenner, 1979) to children's development to the family-school interface. This approach elucidates how multiple spheres of influence (including families and schools) impinge upon the lives of children. Extending the ecological model to account for families' involvement in schools, Epstein (1987) described ways in which family-school involvement operates within overlapping spheres of internal (home) and external (school and community) influence. The external model suggests that students are more successful when their external contexts (home, school, and community) collaborate to promote children's school success. The internal model describes *how* relationships among individuals (e.g. teachers and parents) and institutions (e.g. family events at school) are associated with children's school success (Sheldon & Epstein, 2002). The model suggests that students whose internal and external models of influence (i.e. home, school, community) are more congruent are more successful in school. Six types of involvement, or interactions between school, community, and families, are hypothesized to contribute to student success (Epstein & Sanders, 2006). These include: (i) volunteering in school or community-school events, or projects (e.g. parent-teacher association, service-learning projects, etc); (ii) including parents in school decision-making, (iii) two-way communication between school and home about student progress or school events, (iv) providing parenting support to enhance knowledge about children's learning and development, (v) providing parents with information about school (e.g. homework, grading, etc) to strengthen academics at home, and (vi) community collaborations to access resources for students, their families, and schools.

Recent data from a series of meta-analyses suggests that the nature of parental involvement might be more subtle than simply overt, deliberate involvement with school and children's learning (Jeynes, 2011). These findings suggest that subtle aspects of parental involvement – for example, maintaining high expectations of offspring, communicating with children, and parenting style – may be more powerfully associated with student success than overt involvement, such as checking homework and attending school functions (Jeynes, 2007). For example, effect sizes for parental expectations were .58 and .88 standard deviation units for elementary and secondary school students, respectively. In contrast, the effect sizes for parent attendance at school functions and establishing household study rules averaged about .12 of a standard deviation (Jeynes, 2007).

## Connecting families and schools to address child behavior problems: Associations between parental involvement and reduced child behavior problems

A small but growing literature on parental involvement indicates its associations with children's positive behavioral, social (and academic) outcomes (Hill & Taylor, 2004; Hill & Dyson, 2009) although the empirical base has been predominantly cross-sectional and is particularly small for preschool aged children (Henrich & Blackman-Jones, 2006). The nature of parental involvement typically changes across a child's development. In the preschool years, school involvement typically takes the form of parents' involvement in activities in the classroom, and communication with teachers. There is a relative dearth of basic research on parental involvement in preschool settings. However, a recent study found that the frequency and nature of parental school involvement (volunteering in the classroom or the school, attending parent-teacher conferences, etc) positively associated with children's social skills ( $d = .55$ ) and negatively associated with problem behaviors ( $d = .47$ ; Powell et al., 2010). In a sample of disadvantaged children attending Head Start programs, Fantuzzo et al. (2004) found that school-based involvement was related to lower levels of children's disruptive peer play and lower conduct problems at school and at home.

During the elementary years, parent-teacher communication around daily school tasks (homework, in-class behavior and performance, etc) is key to parental involvement. In a longitudinal study examining the influence of parent involvement for elementary aged children, increased parent involvement over a year of elementary school (reported by both parents and teachers) was associated with decreases in problem behavior and increases in social skills (Nokali et al, 2010). While more longitudinal research is needed, these findings suggest that increasing parental involvement may result in longer-term improved child behavior and academic functioning.

In the adolescent years, parent's discussions with their students, and parent-teacher-youth problem-solving and discussions about the future appear to be most developmentally appropriate (Hill & Taylor, 2004). For adolescents demonstrating problem behavior, parent involvement might also include monitoring and troubleshooting with both the student and school personnel around truancy, school dropout, behavior plans or special education accommodations, etc.

The middle school years are a particularly vulnerable time for adolescents, because puberty effects, increasing independence, influence of antisocial peers, and reductions in parental involvement are a potent mix in their associations with multiple problem behaviors. For example, Fosco, Stormshak, Dishion, & Winter (2012) found that strong parental monitoring and father-youth connectedness were longitudinally associated with reductions in problem behavior in 6<sup>th</sup>-8<sup>th</sup> grade youth, while sibling conflict predicted increases in problem behavior over time.

In a study with high school youth, Hill and colleagues found that parents' involvement in 7<sup>th</sup> grade directly resulted in reduced school behavior problems in 8<sup>th</sup> grade, resulting in improved school performance in 12<sup>th</sup> grade (Hill et al., 2004). Increased social control appears to be a key mechanism underlying associations between parental school involvement and children's academic achievement because parents can support school staff by representing another source of social constraint for children (McNeal, 1999). By being involved in their child's school life, parents establish relationships with teachers and other school personnel, understand school policies and behavioral expectations, and can work in tandem with school personnel to shape appropriate behaviors (Hill et al., 2004). Similarly, better home-school communication increased rule clarity and reinforcement of appropriate school behavior at home, resulting in better on-task behavior and fewer disruptive behaviors at school (Leach & Tan, 1996).

It is important to note that socio-demographics may also effect parental involvement. For example, parents from higher socio-economic status backgrounds appear to see themselves as collaborators with schools, with unfettered access to be involved. In contrast, low-income and poorly educated parents may face both psychological (feeling intimidated by the school environment) and physical (less time, fewer financial resources, and greater stress) barriers to being involved in their child's schooling (e.g., Lareau, 2003). Among adolescents, Hill and colleagues (2004) found that, for parents with lower education, school involvement was not effective in reducing youth behavior problems. However, among highly educated parents, academic involvement predicted reductions in school behavior problems, and in turn, achievement.

The treatment and selected/indicated EBPs listed in this report typically target parental involvement factors such as increasing parental communication with a child's teacher and social worker, as well as helping parents to advocate for their children in the school. Universal prevention interventions typically focus on broader parental involvement in school and parent-school partnerships (e.g. volunteering, decision-making, etc).

### **Using a developmental-ecological perspective and public health framework to address children's behavior problems by partnering families and schools**

Effective prevention and treatment programs are ecologically-based; that is, they target the multiple domains within which children develop, modifying malleable risk and protective factors and processes in the child's environment. These include both intra- and interpersonal processes, as well changes to both family and school environments, (see Greenberg, Domitrovich, & Bumbarger, 2001).

*The Initiative for Applied Education Research's Expert Team for Research on Therapeutic Interventions for Children with Behavioral Difficulties and Disorders* notes that: "In recent decades, social and economic changes have taken place in Israel which have caused, among other things, a decrease in employment security as

well as the stability of family frameworks, a rise in violence (by children and directed towards them) and a general increase in children's exposure to behaviors that could endanger them. All these are serious risk factors for disruptive behaviors and disorders. They raise ever-growing challenges and require that the (Ministry of Education's Psychological Counseling Service) PCS significantly expand and improve treatment options" (2013).

An increasing body of evidence suggests that while direct services are key to remediating children's behavioral difficulties, the larger context within which they are provided is critical to the success of these services (Stroul & Friedman, 1986). The larger system is responsible – among other things – for the identification and screening of children's behavior problems, policy decisions regarding how to deal with disruptive children in the school and educational system settings, and how to train teachers and other school personnel regarding disruptive behavior. In addition, both risk and functioning are heterogeneous across school populations, requiring schools to offer services for a continuum of child behavioral needs from mild or at-risk, to severe.

A public health approach to children's disruptive behavior is consistent with this concern. This framework, which data show to be a powerful approach for child behavior and related problems (e.g. Prinz et al., 2009) is illustrated in Figure 1. The public health approach recognizes that within any given population, the vast majority of individuals only require a relatively low level of (universal) intervention, with others who are at-risk requiring more attention (i.e. selective, or indicated intervention approaches, or treatment; (Biglan, 1995; Stormshak & Dishion, 2002). In the United States, as well as other countries, public health approaches to addressing children's disruptive behavior have introduced interventions that modify contingencies at a combined family and school/educational system level. For example, Norway has a countrywide public health approach to disruptive behavior that combines whole-school interventions (Positive Behavior Interventions and Supports/PBIS) with school-, clinic- and community-based interventions for higher risk children (Parent Management Training-Oregon Model/PMTO and Multi-systemic Therapy/MST) (Ogden, Hagen, Askeland, & Christensen, 2009). Norway's initiative, started in the late 1990s has shown success in decreasing child behavior problems (Ogden & Amlund-Hagen, 2008). Within a public health approach, different nomenclatures are in use to describe how the heterogeneity of needs is addressed within any given system. Many in the educational system favor the 'response to intervention' approach, which provides a framework for assessing, identifying and providing behavioral (and educational) resources to children in need of services (eg., Hawken, Vincent, and Schumann, 2008).

This review of interventions starts by considering treatments targeting the highest risk children (i.e. those already manifesting behavior disorders), and subsequently progresses to describing empirically-supported preventive interventions to reduce behavior problems for at-risk youth, and finally, universal prevention programs to prevent behavior problems. This review addresses single and multi-component

interventions in both school and community settings whose goal is the reduction of child behavior problems at the individual (treatment) or group (prevention) level. Because the focus of interest for this report is the interface between families and schools, listed below are empirically supported interventions to improve children's behavior by (among other strategies) improving relationships and communication between schools and parents.

### **What interventions promote school-family partnerships and parent involvement in the context of reducing or preventing behavior problems?**

Interventions that are described below include treatment and prevention interventions; school-based, classroom-based, and community-based interventions; those delivered in groups, and individually. All interventions targeted the reduction or prevention of behavior problems at school, and all addressed the nexus of parents and schools – i.e., parent-school partnerships/parental involvement in school, and improving parents' (and sometimes teachers' and parents') behavior management strategies. The vast majority of these interventions have their theoretical basis in behavioral approaches, with a few programs emerging from family systems perspectives.

#### Methodology for finding empirically-supported interventions

In order to yield interventions that act at the interface of school and family/parenting, the following searches were conducted:

- (i) US federal databases of evidence-based practices (EBPs) – specifically:
  - a. the Department of Education's (Institute of Education Sciences) What Works Clearinghouse (<http://ies.ed.gov/ncee/wwc/>),
  - b. the National Registry of Evidence-based Programs and Practices of the Substance Abuse and Mental Health Services Administration (NREPP) <http://www.nrepp.samhsa.gov/>, and
  - c. the Department of Justice's Office of Juvenile Justice and Delinquency Prevention Model Programs Guide <http://www.ojjdp.gov/mpg/>
- (ii) Google Scholar
- (iii) The US Department of Education's Education Resources Information Center (ERIC) <http://www.eric.ed.gov/>,
- (iv) The Campbell Collaboration <http://www.campbellcollaboration.org/>, and the Cochrane Collaborative <http://www.cochrane.org/>.

Searches of the best practices databases used search terms allowed by those databases, detailed below.

Searches of Google Scholar, and the Campbell and Cochrane databases were aimed at finding literature reviews of evidence-based treatment and prevention interventions. The following search terms were used (to find both interventions and

basic research reported earlier in the rationale section): *parenting, parental involvement, externalizing behavior, disruptive behavior, behavior problems, oppositional-defiant disorder, conduct disorder, mental health, intervention, prevention, treatment, family involvement, system-level interventions, school-based interventions, parenting, parent attitudes, parent participation, parent teacher cooperation, partnerships in education, school community relationship, school community programs.*

To be included, a program must have met the following criteria [a and (b or c)]:

- a. Reduction of behavior problems as a key outcome variable,
- b. Be based in the school context, AND incorporate some element of parental involvement OR
- c. Be a family-based or community/clinic-based intervention incorporating an element of school involvement.

This review notes, but does not evaluate the level of involvement of each system (i.e. school vs. home). However, programs were not included if family involvement was limited to a child taking home his school notes or information from a particular program; more extensive involvement by parents was required – e.g. active communication with the teacher, collaborating on projects with the child, coming to school programs, volunteering in the classroom, etc.

In addition, for a program's inclusion in the list below, the program must be included on a federal 'best practice' database (i.e. NREPP, What Works, Model Programs Guide/MPG) AND have an exemplary or effective rating on the MPG, over 3.0 (on a 0-4 scale of research quality) on the NREPP database for outcomes related to behavior problems, or an evaluation of positive effects on What Works. If a program yielded a lower rating on one of the above databases than another, the higher rating was taken.

Also reviewed, in order to ensure that key interventions were not missing, were Cochrane, Campbell and key, highly-cited peer-reviewed meta-analyses and literature reviews of evidence-based treatment and prevention interventions for externalizing disorders/problems (e.g., Brestan & Eyberg, 1998; Burns, Hoagwood, & Mrazek, 1999; Farmer, Compton, Burns & Robertson, 2002; Greenberg, Domitrovich, and Bumbarger, 2001; Maughan, Christiansen, Jenson, Olympia, & Clark, 2005). Finally, although they are not peer reviewed publications, two influential books on treatment and prevention: Weisz and Kazdin's *Evidence-based psychotherapies for children and adolescents*, (2010) and the Institute of Medicine/ National Research Council's *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities* (2009) – were also reviewed in order to ensure that no key prevention or treatment intervention was missing from the above review. Only one intervention that was not listed on any of the databases above but was listed in a book and met inclusion criteria was ultimately included (Chicago Child Parent Center/CPC).

Because none of the above reviews or databases focus specifically on the school-parent interface in the treatment of conduct problems, *further support* (i.e. at least one article, or mention within the database description of the program) was sought for evidence that the specific evidence-based intervention demonstrated both parent and school involvement in addition to impacting child behavior problems at school.

The search yielded 22 interventions at the school-family interface: 6 treatment interventions, and 16 prevention interventions (15 of the prevention programs are classroom or community-based, and one is whole school/education system-based).

It is important to note that the interventions listed below were only evaluated for the quality of their research evidence and NOT for their readiness for dissemination, or implementation, or for the populations studied. This information is readily available and freely downloadable from the websites noted above. For readers interested in information about EBPs in order to conduct implementations of such interventions in school or community settings, it is crucial to note that implementation matters! That is, issues such as training and coaching, fidelity monitoring, implementation policies and practices, financial costs, and sustainability are key factors to consider when making decisions about implementing a particular EBP (see, for example, Forgatch, Patterson, & Gewirtz, in press).

The following paragraphs document how interventions were elicited. Databases have set search terms, as described below. Several programs appeared in more than one database; these are starred, but a description of each is included just once.

From the What Works Clearinghouse – a search using ‘student behavior’ as outcome, yielded 19 interventions. Only four of those interventions specifically focused on externalizing/disruptive behavior problems (others focused on character education, academic achievement, cognitive abilities). The interventions include: First Step to Success\* (early childhood; selective prevention), The Incredible Years\* (early childhood and elementary; both a treatment and prevention intervention); Early Risers\* (elementary, selective and indicated prevention), and Coping Power\* (middle school, indicated prevention).

From SAMHSA’s NREPP, a search using ‘mental health promotion’ and ‘mental health treatment’ as areas of interest, ‘crime’, ‘delinquency’, ‘education’, ‘mental health’, and ‘violence’ as outcomes, ‘school’, ‘home’, and ‘other community settings’ as settings in which the program is delivered, and for all races, ages, and genders, yielded 121 interventions. However, only 12 of these interventions include both school and family components. These interventions include: Brief Strategic Family Therapy\* (elementary – high school; treatment), Chicago Parent Program\* (PS; selective prevention), Guiding Good Choices (elementary-middle; universal prevention), Families and Schools Together\* (FAST; elementary; universal, selective, and indicated prevention), Multi-dimensional family therapy\* (elementary through high school; treatment), Multi-systemic therapy for juvenile offenders\* (elementary

through high school), Multidimensional Treatment Foster Care\* (MTFC; high school, treatment), ParentCorps (preschool; universal prevention), Parenting Through Change\*<sup>2</sup> (elementary; selective prevention); Positive Action (K-12<sup>th</sup> grade; ), Safe and Civil Schools Positive Behavior Interventions and Supports (PBIS; K-12<sup>th</sup> grade; universal, school-wide prevention program), and Strengthening Families (PS-10<sup>th</sup> grade; universal, selective, and indicated prevention).

From OJJDP's MPG, a search using available search terms of 'aggression' and 'delinquency' as key outcomes (no mental health or behavior disorders available as search terms), all populations, all phases of the juvenile justice continuum, program types 'academic skills enhancements', 'classroom curricula', 'bullying', 'cognitive behavioral therapy', 'family therapy', 'parent training' and 'school classroom environment', and all populations, with exemplary or effective ratings, yielded 79 programs. Most of these programs were limited to a single system (i.e. school or family) without the involvement of the other. Several of these programs had already been listed from the earlier two searches; others did not reach the 'effective' or 'exemplary' ratings. Just three programs emerged that had not been previously listed: Linking the Interests of Families and Teachers (elementary, high school; prevention), the Adolescent Transitions Program (middle and high school; prevention and treatment), and the Perry Preschool Program/HighScope Curriculum (preschool, prevention).

A review of the books mentioned above revealed just one program that was not included in the database searches: the Chicago Child Parent Centers/CPC. This preschool prevention program has strong evidence for its effectiveness and met criteria for inclusion listed above.

In all, twenty two programs are reviewed below; 6 treatment programs, and 16 prevention programs. Two of these programs have both prevention and treatment variants (Incredible Years, and Parenting Through Change/PMTO) and hence are listed twice - once in each of the prevention and treatment categories.

Details on each of the programs are listed below; consistent with the public health framework outlined earlier, treatment programs are reviewed first, followed by indicated, selective, and universal prevention programs. For each intervention, a key overview publication is provided for reference. Within each category, attention is paid to developmental stage for which the intervention is appropriate. Each intervention is further described according to its intervention content, key outcomes, the specific nature of the parent/family-school interface, who delivers the program, and delivery setting and format. It is important to note that all of these programs may be delivered by school staff, although in some cases (e.g. treatment) protocols require licensed mental health professionals such as educational

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<sup>2</sup> Parenting Through Change is a prevention program of the Parent Management Training-Oregon/PMTO model, which also includes individual treatment.

psychologists or social workers. Further details are noted below. All interventions are appropriate for both genders, unless otherwise specified. Interventions are listed according to developmental stage (preschool, elementary, middle school, high school).

Following description of the programs, key issues in program delivery are addressed; specifically, the crucial role of school and community mental health providers (school counselors, and school and community social workers and educational psychologists), and the infrastructure of school-based mental health services for behavior disordered and at-risk children.

### **School- and community-based interventions to reduce behavior problems that promote parent-school partnerships**

#### **Treatment Programs**

##### **1. The Incredible Years/IY (Webster-Stratton & Reid, 2010)**

*Developmental stage:* Preschool-Elementary

*Key outcomes:* Parenting skills, child externalizing problems, self-regulation, teacher classroom management, parents' involvement with school and teachers

*Intervention Content:* The Incredible Years treatment programs were designed to thwart and treat behavior problems when they first begin (infant/toddler through elementary school age) and to intervene in multiple areas through parent, teacher, and child training. The three programs work jointly to treat and prevent conduct problems, and increase social and emotional competence in young children.

1. The Incredible Years *parent programs* for parents of preschoolers (3-5 years), and school-age children (6-12 years). Program length varies from 12 to 20 weekly group sessions (2-3 hours each). The programs focus on strengthening parent-child interactions and relationships, reducing harsh discipline, and enhancing children's social, emotional, and language development. Parents learn how to nurture school readiness skills, to partner with teachers to promote their children's academic, social skills, and emotional self-regulation and to reduce conduct problems. Each program includes protocols for use as a prevention program or as a treatment program for children with conduct problems.

2. The Incredible Years Dinosaur School small group *treatment* program consists of 18-22 weekly sessions (2 hours each) offered jointly with the parent training programs. The child program improves social and emotional competencies, such as understanding and communicating feelings, using effective problem-solving strategies, managing anger, practicing friendship and conversational skills, and behaving appropriately in the classroom.

3. The Incredible Years *teacher program*. This provides monthly workshops to early childhood and elementary school teachers of young children (3-8 years) delivered by a trained facilitator over a total of 42 hours. The program focuses on strengthening classroom management; promoting children's prosocial behavior, emotional regulation, school readiness, and cooperation with peers and teachers; and reducing classroom aggression. The training also trains teachers to support school involvement by parents, and enhance consistent behavior management across school and home settings.

In each program, facilitators use videotaped vignettes to structure the content and stimulate group discussions, problem solving, and practices related to participants' goals.

*What is the nature of the family/school interface?* As noted above, key content of the program focuses on increasing parents' involvement in, and communication with school staff, and the skills of classroom teachers to engage parents. Both teachers and parents are taught similar child behavior management skills.

*Who delivers the intervention?* Group leaders are counselors, social workers, psychologists, nurses, and educators.

*Intervention setting and format:* Schools, homes, outpatient clinics, other community settings.

## **2. Parent Management Training-Oregon Model/PMTO (Forgatch & Patterson, 2010)**

*Developmental stage:* Elementary

*Key outcomes:* child behavior problems (parent, & teacher report), parenting practices, child drug use, arrests, academic adjustment, child depression. Children with behavior problems are referred through schools, mental health clinics, and the child welfare system.

*Intervention Content:* PMTO is delivered as an individual treatment by extensively trained therapists in weekly sessions with parents (and sometimes children) lasting an average of 6-9 months. This parent training program focuses on teaching core positive parenting skills that have been demonstrated to be associated with reductions in child conduct problems: skill encouragement, effective discipline, problem-solving, monitoring, and positive involvement.

*What is the nature of the family/school interface?* Although the intervention is typically community-based, a focus of several of the sessions is home school communication. Parents are taught how to monitor their children's progress at school, communicate with teaching and administrative and counseling staff, engage in problem-solving, and help children with home-school routines (e.g. getting a

backpack ready for school each morning, mastering the homework routine, etc). For example, in one session, parents role play resolving a conflict with a school professional; the home practice assignment for another session requires parents to complete a sheet of information about their child's teacher, schedule, key school phone numbers, etc.

*Who delivers the intervention?* Masters level human service professionals (social workers, psychologists, marriage and family therapists).

*Intervention setting and format:* PMTO treatment is delivered as an individual family-level intervention in parents' homes, clinics, or schools. PMTO is also available as a prevention program (known as Parenting Through Change, described below).

### **3. Multi-dimensional treatment foster care/MTFC (Smith & Chamberlain, 2010)**

*Developmental stage:* Middle school – High School

*Key outcomes:* school attendance and homework completion, delinquent activities, days in locked settings, substance use, pregnancy rates

*Intervention Content:* MTFC is a community-based intervention for 12-17 year olds with serious behavior problems and delinquency, and their families. It was developed as an alternative to removal from the home, group home treatment or government facilities for youths. Youths are typically referred to MTFC after previous programs (out-of-home placements, family preservation attempts) have been unsuccessful. Youth are referred by juvenile courts and probation, mental health, and child welfare agencies, to temporary, MTFC-trained and supervised foster families, while their biological family prepares for their return following the program. MTFC youth have a consistent reinforcing environment with mentoring and strong encouragement to develop academic and life skills. Teens are given a highly structured daily schedule with clear limits and expectations, and are helped to avoid deviant peer groups. MTFC typically lasts 6-9 months.

*What is the nature of the family/school interface?* The NREPP report on MTFC notes that "In the United Kingdom, programs have expanded the MTFC teams to include an educational worker to provide liaison and coordination with schools, which is made necessary by the role of educational institutions in treatment and case management of enrolled children with serious behavior problems".

*Who delivers the intervention?* Key intervention agents are highly trained and supervised foster parents. Program supervisors (each with less than 10 cases) provide case coordination with family and individual therapists, skills trainers, and a foster parent liaison/trainer.

*Intervention setting and format:* Intervention takes place in the foster home, with biological and foster families, and with the youth. As noted above, the UK adaptation includes school liaisons to provide coordination with school personnel.

#### **4. Multi-Systemic Therapy/MST (Henggeler & Schaeffer, 2010)**

*Developmental stage:* Middle school - High School

*Key outcomes:* peer aggression, arrest rates, incarceration rates, criminal activity, alcohol and drug use, family functioning

*Intervention Content:* MST addresses the multidimensional nature of behavior problems in troubled youth by targeting factors in the adolescent's social network that contribute to antisocial behavior. The primary goals are to lessen antisocial behavior, improve family functioning and school performance, and reduce out-of-home placement through hospitalization, residential treatment or incarceration. MST helps families mobilize child, family, and community resources. MST typically lasts approximately 4 months, with multiple therapist-family contacts occurring weekly in different settings (home, school, etc). Behavioral, cognitive behavioral, and pragmatic family therapy techniques are used.

*What is the nature of the family/school interface?* MST therapists work in the home and the school, ensuring clear communication between parents and teachers to promote healthy adolescent behavior.

*Who delivers the intervention?* Typically masters trained clinicians in social work, psychology, and counseling.

*Intervention setting and format:* Outpatient, school, home. Therapists work with a small number of families (about 5 at a time), treatment averages 4 months, with several sessions per week. But there is no fixed length, and therapists are available 24/7.

#### **5. Brief Strategic Family Therapy/BSFT (Szapocznik, Schwartz, Muir, & Brown, 2012).**

*Developmental stage:* Adolescence/middle and high school

*Key outcomes:* conduct problems, aggression with peers, treatment engagement, family functioning

*Intervention Content:* BSFT aims to prevent, reduce, and/or treat adolescent behavior problems including drug use, conduct problems, delinquency, and deviant peers, improve prosocial behaviors such as school attendance and performance; and improve family functioning, including positive parenting, and parent's involvement with the child and his or her school and peers.

BSFT therapeutic techniques include joining, diagnosing, and restructuring. The therapist "joins" the family by encouraging family members to behave in their normal fashion. The therapist then diagnoses repetitive patterns of family interactions. Restructuring refers to the change-producing strategies that the therapist uses to promote new, more adaptive patterns of interaction.

*What is the nature of the family/school interface?* A key goal of BSFT is to improve parental involvement at school, as well as the target youth's school performance and behavior.

*Who delivers the intervention?* Trained mental health professionals (psychologists, social workers, counselors)

*Intervention setting and format:* Outpatient clinic, homes; BSFT is typically delivered in 12-16 family sessions but may be delivered in as few as 8 or as many as 24 sessions, depending on the severity of the communication and management problems within the family.

## **6. Multi-dimensional family therapy/MDFT (Liddle, 2013)**

*Developmental stage:* Middle and high school

*Key outcomes:* delinquent and other problem behaviors, substance use, treatment retention, school performance

*Intervention Content:* MDFT is a comprehensive, family-based and multisystem clinic or partial hospitalization/day treatment program for adolescents with conduct disorder, substance use problems, and co-occurring mental health and substance use disorders, as well as other problem behaviors. MDFT aims to increase effective coping and problem-solving skills for better decision making among the teen. MDFT also targets improved family functioning as a protective factor against substance abuse and related problems. MDFT includes modules targeting four areas of social interaction: (1) the adolescent's interpersonal functioning with parents and peers, (2) parents' parenting practices and adjustment, (3) parent-adolescent communication, and (4) communication between family members and key social systems (schools, child welfare, mental health, juvenile justice).

*What is the nature of the family/school interface?* Core elements of the treatment focus on home-school communication and improving youth functioning in school.

*Who delivers the intervention?* Master's-level therapists and a bachelor's-level or paraprofessional case manager

*Intervention setting and format:* Homes, correctional, outpatient settings; 12-16 weekly or biweekly 60 to 90 minute sessions.

## **Classroom and community-based prevention programs**

These programs also are ordered according to developmental stage, with preschool first.

### **7. Chicago Parent Program (Gross et al., 2009)**

*Developmental stage:* Preschool

*Key outcomes:* child behavior problems, parenting self-efficacy, parental discipline, corporal punishment

*Intervention Content:* The CPP is a parent training program to reduce behavior problems in children ages 2 to 5. Two trained leaders deliver 2-hour group sessions using video vignettes to present challenging parent-child situations which stimulates discussion and problem-solving related to child behavior and parenting skills. Sessions target positive relationships with children (e.g., family routines and traditions, using praise and encouragement), behavior management (e.g., effective discipline, following through), stress management, and problem-solving skills. Home practice assignments help parents apply the skills learned in group.

*What is the nature of the family/school interface?* The CPP has been implemented in multiple preschool and Head Start settings by school staff for parents.

*Who delivers the intervention?* CPP group leaders must have a minimum of a high school degree or equivalent

*Intervention setting and format:* CPP is implemented in 11 weekly group sessions followed by a booster session 4 to 8 weeks later.

### **8. First Step to Success (Walker et al., 2009)**

*Developmental stage:* Preschool

*Key outcomes:* Behavior problems, social functioning, academic performance

*Intervention Content:* First Step to Success is an early intervention program targeting children in kindergarten to 3<sup>rd</sup> grade who are at risk for developing aggressive or antisocial behavior. The curriculum includes three interconnected modules: screening, classroom intervention, and parent training. The school intervention module, Contingencies for Learning Academic and Social Skills (CLASS), aims to decrease problem behavior and increase prosocial behaviors. A behavior coach works with the teacher while the teacher observes and learns the techniques to implement the program. The student is taught to recognize and replace inappropriate behaviors with appropriate ones, which are subsequently reinforced by classroom peers who are taught positive strategies to support the

student. The student accrues points toward his or her behavioral goal. If the student reaches a daily goal, he or she gets to choose an activity designed for the whole class to enjoy. The parenting component (HomeBase) is implemented in concert with the CLASS program at school and focuses on: communication, cooperation, limit setting, problem solving, friendship making, and confidence development.

*What is the nature of the family/school interface?* Trained behavior coaches work with both school personnel and parents, ensuring consistent communication of behavior management strategies across settings.

*Who delivers the intervention?* Consultants are teachers, counselors and teacher aides.

*Intervention setting and format:* A trained behavior coach works with each student and his or her class peers, teacher, and parents for 50 - 60 hours over a 3-month period. The behavior coach meets with the student's parents/caregivers for approximately 45 minutes per week for six weeks. The CLASS module requires 30 program days across three phases (coach, teacher, and maintenance) for completion.

## **9. The Perry Preschool Program/HighScope Curriculum (Schweinhart et al., (2005).**

*Developmental stage:* Preschool (birth to five years old)

*Key outcomes:* Child externalizing problems, academic success, teen pregnancy, socioeconomic outcomes (longer-term)

*Intervention Content:* The program is a preschool/early childhood center-based curriculum that targets children as active learners. Two curricula target infants and toddlers (birth to three) and preschoolers (three to five years old). Children participate in the program for one to three years.

*What is the nature of the family/school interface?* Families received a home visit once per week from the child's preschool teacher.

*Who delivers the intervention?* Preschool teachers

*What training and coaching is required?* A variety of workshops are offered to teachers to provide information and training on the HighScope curriculum.

*Intervention setting and format:* School

## **10. The Chicago Child-Parent Centers (CPC; Reynolds, Temple, Robertson, & Mann, 2001; Miedel & Reynolds, 2000)**

*Developmental stage:* Preschool

*Key outcomes:* Behavior problems, child maltreatment, school performance, physical health

*Intervention Content:* The CPCs provide comprehensive preschool and family support to children and parents living in disadvantaged neighborhoods. The program is a school-based individualized curriculum to promote children's social and cognitive development. Parents are actively involved in their children's learning.

*What is the nature of the family/school interface?* Parents must commit to volunteer at least one half day each week in their child's classroom. In addition, a family support component includes a home visit on entrance to the program, case management and referral support.

*Who delivers the intervention?* The intervention is delivered by trained preschool teachers. Each classroom (of 6-8 children) also has a teacher's aide. Each center also has a trained lead teacher.

*What training and coaching is required?* All teachers must be certified early childhood education providers. It is unclear whether training specific to CPC is provided; no uniform curriculum is delivered across centers.

*Intervention setting and format:* School

## **11. The Incredible Years/IY Prevention Program (Webster-Stratton & Reid, 2009)**

*Developmental stage:* Preschool-Elementary

*Key outcomes:* Parenting skills, child externalizing problems, self-regulation, teacher classroom management, parents' involvement with school and teachers

*Intervention Content:* The Incredible Years prevention programs were designed to prevent behavior problems in early childhood (infant/toddler through elementary school age) and to intervene in multiple areas through parent, teacher, and child training. The three programs work jointly to prevent conduct problems, and increase social and emotional competence in young children.

1. The Incredible Years *parent prevention programs* for parents of preschoolers (3-5 years), and school-age children (6-12 years). Program length varies from 12 to 20 weekly group sessions (2-3 hours each). The programs focus on strengthening parent-child interactions and relationships, reducing harsh discipline, and enhancing children's social, emotional, and language development. Parents learn how to nurture school readiness skills, to partner with teachers to promote their

children's academic, social skills, and emotional self-regulation and to reduce conduct problems.

2. The Incredible Years Dinosaur School *child training* prevention program includes 60 classroom lesson plans (approximately 45 minutes each) for three age levels, beginning in preschool through second grade (3-8 years). Teachers deliver the program at least twice each week over consecutive years. The programs focus on strengthening parent-child interactions and relationships, reducing harsh discipline, and enhancing children's social, emotional, and language development. Parents learn how to nurture school readiness skills, to partner with teachers to promote their children's academic, social skills, and emotional self-regulation and to reduce conduct problems.

2. The Incredible Years Dinosaur School small group *treatment* program consists of 18-22 weekly sessions (2 hours each) offered jointly with the parent training programs. The child program improves social and emotional competencies, such as understanding and communicating feelings, using effective problem-solving strategies, managing anger, practicing friendship and conversational skills, and behaving appropriately in the classroom.

3. The Incredible Years *teacher program*. This provides early childhood and elementary school teachers of young children (3-8 years) 42 hours of monthly workshops delivered by a trained facilitator. The program focuses on strengthening classroom management; promoting children's prosocial behavior, emotional regulation, school readiness, and cooperation with peers and teachers; and reducing classroom aggression. The training also trains teachers to support school involvement by parents, and enhance consistent behavior management across school and home settings.

In each program, facilitators use videotaped vignettes to structure the content and stimulate group discussions, problem solving, and practices related to participants' goals.

*What is the nature of the family/school interface?* As noted above, key content of the program focuses on increasing parents' involvement in, and communication with school staff, and the skills of classroom teachers to engage parents. Both teachers and parents are taught similar child behavior management skills.

*Who delivers the intervention?* Group leaders are counselors, social workers, psychologists, nurses, and educators.

*What training and coaching is required?* Group leaders are required to train and certify with an IY trainer and mentor.

*Intervention setting and format:* Schools, homes, outpatient clinics, other community settings.

## **12. ParentCorps (Brotman et al., 2011)**

*Developmental stage:* Preschool

*Key outcomes:* parenting practices, child behavior problems, parental involvement in school, academic achievement

*Intervention Content:* ParentCorps is a family-centered preventive intervention to improve healthy development and school success for young children (ages 3-6) in families living in low-income communities. ParentCorps helps parents promote their children's development by working with early childhood educators. Parenting strategies that are taught include: structure and routines for children, nondirective play, encouraging compliance, selective ignoring of mild misbehaviors, and effective discipline. Child groups are led by trained classroom teachers who target children's social, emotional, and self-regulatory skills by using interactive lessons, and play. Teachers promote skills using complementary strategies to those taught to parents.

*What is the nature of the family/school interface?* Many of the curriculum activities occur at the parent-school nexus. Coordinated parent and child groups are held in schools, delivered by school staff. A key goal is improving parents' involvement in children's education, in addition to reducing conduct problems. After each session, teachers provide feedback to parents regarding the child's progress in skill development and goal attainment.

*Who delivers the intervention?* Teachers, mental health professionals

*Intervention setting and format:* Early childhood education or child care settings; a weekly series of fourteen 2-hour group sessions, which occur concurrently for parents and children. Parent groups include approximately 15 participants and facilitated by trained mental health professionals; child groups are facilitated by teachers.

## **13. Parenting Through Change (Forgatch & DeGarmo, 1999)**

*Developmental stage:* Elementary

*Key outcomes:* behavior and conduct problems, parenting practices

*Intervention Content:* PTC is a group-based parent training intervention that focuses on improving parenting by targeting 5 key PMTO parenting practices (see PMTO listing above).

*What is the nature of the family/school interface?* Group leaders spent 2-3 sessions (of 14 sessions overall) focusing on improving parents' involvement in schools,

communication with school staff, and increasing compliance with homework and other school-related routines at home.

*Who delivers the intervention?* Masters level professionals including guidance counselors, psychologists, and social workers

*Intervention setting and format:* Schools, community settings. Groups are 14 weeks long, and meet for 90 minutes each week.

#### **14. Early Risers (August, Realmuto, Hektner, & Bloomquist, 2001)**

*Developmental stage:* Elementary

*Key outcomes:* conduct problems, social skills, parenting self-efficacy, self-regulation, academic performance

*Intervention Content:* Early Risers is a multi-component preventive intervention (selective and indicated) to reduce conduct problems among children at-risk by virtue of early problem behaviors, or high-risk circumstances. Program advocates deliver the program in schools and community centers. The program includes both child and family components: (i) an afterschool and summer camp component targeting social skills, (ii) school-based monitoring and mentoring, (iii) a parent training and case management component, and (iv) family fun nights (combined parent-child activities).

*What is the nature of the family/school interface?* Family advocates deliver the program across settings, providing monitoring and mentoring in the school (i.e. communicating with teachers, sharing school information with parents, and supporting parents to be more involved at school and for their child.

*Who delivers the intervention?* Family advocates; bachelors level individuals with community social service experience.

*Intervention setting and format:* Schools, community centers, homes; the program is delivered over a 2-3 year period.

#### **15. Guiding Good Choices (Hawkins & Catalano, 2003)**

*Developmental stage:* Grades 4-8 (ages 9-14)

*Key outcomes:* delinquency, substance use, parenting behaviors, depression symptoms

*Intervention Content:* Guiding Good Choices (previously known as Preparing for the Drug Free Years) is a universal parent training program delivered to parents in school settings, by school personnel. Its goal is to help parents navigate and guide

their children through early adolescence. The program targets strengthening family behavioral expectations, increasing bonding, reducing family conflict, and increasing parental involvement to reduce child risk of substance use onset.

*What is the nature of the family/school interface?* The program is delivered in school settings, with the involvement of school personnel.

*Who delivers the intervention?* Workshop leaders are school and community human service providers.

*Intervention setting and format:* Schools; a five session intervention

## **16. Strengthening Families Program/SFP (Kumpfer, Molgaard, & Spoth, 1996)**

*Developmental stage:* Preschool to 10<sup>th</sup> grade

*Key outcomes:* child externalizing (behavior, conduct) problems, internalizing symptoms, parenting practices, parenting efficacy, family relationships

*Intervention Content:* SFP comprises three life-skills courses designed to improve child resilience and reduce risk factors for child behavior and emotional problems. The Parenting Skills sessions teach parents to increase appropriate child behaviors through attention and rewards, clear communication, effective discipline, substance use education, problem solving, and limit setting. The Children's Life Skills sessions are designed to help children learn effective communication, understand their feelings, improve social and problem solving skills, resist peer pressure, understand the consequences of substance use, and comply with parental rules. In the Family Life Skills sessions, families engage in structured family activities, practice therapeutic child play, conduct family meetings, learn communication skills, practice effective discipline, reinforce positive behaviors in each other, and plan family activities together.

*What is the nature of the family/school interface?* Groups take place in schools, and families participate together, as well as separately, in the school setting.

*Who delivers the intervention?* Group leaders (school and community staff) deliver the parent and child groups.

*Intervention setting and format:* Schools, delivered in 14 weekly, 2-hour sessions.

## **17. Positive Action (Flay, Allred, & Ordway, 2001)**

*Developmental stage:* K-12<sup>th</sup> grade

*Key outcomes:* problem behaviors (discipline referrals, behavior problems, substance use, suspensions), school absenteeism, family functioning, academic achievement

*Intervention Content:* Positive Action is a comprehensive program to improve problem behaviors such as substance use, violence, suspensions, disruptive behaviors, dropping out, and sexual behavior, as well as school performance. It also targets parent-child bonding, family cohesion, and family conflict. Positive Action has materials for schools, homes, and community agencies. All materials are based on the same key concept - that one feels good about oneself when taking positive actions - with explanatory sub concepts (positive actions for the physical, intellectual, social, and emotional areas) that elaborate on the overall theme. The program components include grade-specific curriculum kits for kindergarten through 12th grade, drug education kits, a conflict resolution kit, sitewide climate development kits for elementary and secondary school levels, a counselor's kit, a family kit, and a community kit. All the components and their parts can be used separately or in any combination and are designed to reinforce and support one another.

*What is the nature of the family/school interface?* Groups for parents are led in schools, by school and community personnel. A key goal is to encourage collaboration of parents and teachers for a healthy school climate.

*Who delivers the intervention?* Group leaders – school and community social service professionals.

Intervention setting and format: School, 6 units, with scripted 15-minute lessons for each module

### **18. Families and Schools Together /FAST (McDonald, Billingham, Conrad, Morgan, & Payton, 1997).**

*Developmental stage:* kindergarten to 6<sup>th</sup> grade

*Key outcomes:* problem behaviors, social skills, academic competencies

*Intervention Content:* Families and Schools Together (FAST) is a multifamily group intervention targeting child wellbeing by building relationships between families, schools, and communities. The program's objectives are to reduce family stress and improve family wellbeing, and, for children, improve behavior, prevent school failure, and substance use. Participants in the multifamily group work together to enhance protective factors for children, including parent-child bonding, parent involvement in schools, parent networks, family communication, parental authority, and social capital, to reduce childhood aggression and improve social skills and attention spans. FAST includes three components: outreach to parents, eight weekly multifamily group sessions, and ongoing monthly group reunions for up to 24

months to support parents as the primary prevention agents for their children.

*What is the nature of the family/school interface?* The intervention targets the nexus of families and schools by explicitly building relationships among the systems for children's wellbeing. Parent involvement in children's schooling is a focus, for example, and groups are co-facilitated by parents and school staff.

*Who delivers the intervention?* Collaborative teams of parents/caregivers, professionals (e.g., substance abuse or mental health professionals), and school personnel facilitate the groups, which meet at the school at the end of the school day.

*Intervention setting and format:* Schools, groups of up to 30-50 students and their families may participate in one cycle. Multifamily groups include 8 sessions plus up to 24 monthly booster sessions.

### **19. Linking the Interests of Families and Teachers/LIFT (Eddy, Reid, & Fetrow, 2000)**

*Developmental stage:* Elementary (1<sup>st</sup> – 5<sup>th</sup> grade)

*Key outcomes:* behavior problems, delinquency, academic problems, family functioning, aggression,

*Intervention Content:* LIFT has three main components: (i) classroom-based child social skills training, (ii) the playground Good Behavior Game, and (iii) parent management training. Systematic communication between parents and teachers is core to LIFT, with a "LIFT" line installed in each classroom for parents to talk directly with their child's teacher as needed. Child social skills training is held during the school year and includes specific sections: instruction and discussion about a social and problem-solving skill, skill practice in groups, a group cooperation game and free play time, and review and presentation of daily rewards. The Good Behavior Game takes place during the free play part of the social skills training program, and targets positive peer skills on the playground. Children earn rewards during the game by showing prosocial behaviors. Parent Management Training is delivered to groups of 10-15 parents over six weekly 2.5 hour sessions focusing on positive reinforcement, problem solving, parental school involvement, discipline, and communication.

*What is the nature of the family/school interface?* The interface is the core of the LIFT program – teachers and parents as co-collaborators to support children. Ongoing communication is fostered, and parental involvement in their children's education is key to intervention content.

*Who delivers the intervention?* Teachers, and other school staff (counselors, psychologists, social workers)

*Intervention setting and format:* Schools. Child training is provided in the classroom and parent training is provided in 6, 2.5 hour sessions at the end of the school day or in the evening.

## **20. Coping Power (Lochman & Wells, 2004)**

*Developmental stage:* Middle school (4<sup>th</sup> – 6<sup>th</sup> grades)

*Key outcomes:* externalizing behavior, social adjustment

*Intervention Content:* *Coping Power* is a preventive intervention (indicated) designed for children approaching the transition to middle school who are identified by their teachers as aggressive and/or disruptive. *The intervention provides* cognitive-behavioral group sessions for children and behavioral training groups delivered to their parents. The child component teaches behavioral and personal goal setting, awareness of feelings, use of coping self-statements, distraction techniques, relaxation methods, organizational/study skills, and refusal skills. The parent component focuses on identification of prosocial and disruptive behavioral targets in children, rewarding appropriate child behaviors, giving effective instructions, establishing age-appropriate rules and expectations for children, applying effective consequences to negative child behavior, and establishing ongoing family communication through weekly family meetings. Parents learn to support the social-cognitive skills children are meant to acquire through *Coping Power*. The group intervention sessions for children and parents are augmented with regularly scheduled, brief individual contacts designed to promote generalization of skills to the children's natural environment.

*What is the nature of the family/school interface?* The interface primarily relates to the school as location for the delivery of both components. School personnel (teachers, counselors) deliver both components. In the parenting intervention, parents become familiar with their child's school life.

*Who delivers the intervention?* School staff and community social service professionals.

*Intervention setting and format:* The parent component consists of 16 group sessions, and the child component includes 34 50-minute group sessions, typically delivered in a school setting over a 10-18 month period.

## **21. Adolescent Transitions Program/ATP (including the Family Check-Up; Dishion & Kavanaugh, 2000; Connell, Dishion, Yasui, & Kavanagh, 2007)**

*Developmental stage:* Middle schools

*Key outcomes:* behavior problems, delinquency, drug use, family functioning, school performance

*Intervention Content:* The ATP is a multi-level family-focused intervention (at universal, selective, and indicated levels of prevention) targeting reduction of child problem behaviors using parent- and child- intervention components. Each level builds on the prior level. At the universal level, school personnel engage families, establish norms for parenting practices, and disseminate information about problem behaviors by establishing a family resource center to provide resources and brief consultations with a parent consultant. Also at the universal level, students participate in six life skills lessons. Weekly interactive parent-child activities engage parents of high-risk youth and support positive parenting practices. The selective level of the ATP is the Family Check-Up, a 3-session motivational interviewing intervention consisting of an intake, a family assessment, and a feedback session, and targeting family engagement and parenting behavior change. At the indicated level, parents receive behavioral family therapy, and case management services (based upon the Family Check Up results). Program activities may also include individual family meetings, parent group meetings, and teen group sessions, as well as monthly booster sessions over a 3-month period following program completion. Many exercises are completed by parents and children together.

*What is the nature of the family/school interface?* Key to program content is engaging families within the school setting in order to (i) impact child success at school, and (ii) increase parental involvement in the school setting. Weekly interactive parent-child activities ensure ongoing engagement of both parents and school staff.

*Who delivers the intervention?* Trained school and community facilitators.

*Intervention setting and format:* Schools; format depends upon intervention level (see description above).

### Whole school interventions

## **22. Safe and Civil Schools Positive Behavior Interventions and Supports (PBIS; Sugai & Horner, 2009)**

*Developmental stage:* K-12<sup>th</sup> grade

*Key outcomes:* reduction of student problem behaviors, positive school climate, reduction in discipline referrals,

*Intervention Content:* PBIS is a school-wide initiative that targets the school's routines, structures, and resources in its application of a behavior-based systems approach. PBIS implements a continuum of services whereby all students receive school-wide support: consistent rules and limits, encouragement, and clear expectations across all school settings. Strategies target multiple domains within the

school including the hallways, cafeteria, and playground, as well as the classroom, and individual student and adult staff behavior to increase positive behaviors. Consistent with a public health approach, PBIS provides supports along a continuum of services—universal, selected, and indicated interventions. Students who do not respond to the universal strategies in place for the whole student body may receive small group-based services; those requiring individualized treatment (an estimated 5% students) receive school-based individual mental health services (behavioral treatment).

*What is the nature of the family/school interface?* Parents are involved on multiple levels and based upon individual preference, no single model of parent involvement exists. For example, parents are included in the planning and advisory teams for PBIS.

*Who delivers the intervention?* All school personnel

*Intervention setting and format:* School, varies by type of intervention (universal, selective or indicated).

### **What do we know – and what remains to be learned - about interventions addressing the school-family interface for children exhibiting, or at-risk for conduct problems?**

The past two decades have seen an upsurge in the development and testing of empirically-supported treatment and prevention interventions to address children's conduct problems. A subset of these interventions occurs at the interface of school and family – capitalizing on the assets of each context to prevent and reduce behavior problems in the classroom. These interventions are delivered in homes, schools, and communities; they span preschool through adolescence, and they target children of different risk levels. Although these interventions are not large in number, they offer several options for schools and school districts to weigh in considering their responses to the problem of disruptive behavior.

Despite the fact that effective programs exist, much remains to be learned about the mechanisms through which these programs work, and in particular, which components of programs are key. For example, the basic research on parent involvement reported earlier, indicating the importance of subtle aspects of parent involvement (e.g. expectations) compared with more overt, activity-related parent involvement (Jeynes, 2011), suggests that interventions focused on these aspects might be more influential in promoting child adjustment. However, most interventions are 'one size fits all' approaches, delivering an array of skills and activities with no data on what specific components are most effective. Far more research is needed to dismantle program effects as well as to understand key (e.g. family and individual characteristics that might function as moderators of intervention.)

Beyond the scope of this report but critical to consider in selecting an intervention are *implementation* issues. The inchoate science of implementation seeks to understand the key factors influencing effective implementation of EBPs. EBPs are typically not designed for ‘off the shelf’ use of a curriculum manual. Instead, they require specific training, ongoing coaching, organizational policy or practice change, and attention to issues of fidelity (i.e. how to implement the program as it was intended, adhering to key program components, and ensuring high quality of delivery). This issue is crucial because several studies have demonstrated how simply introducing effective programs into community practice does not guarantee their use by those trained. Indeed, recent studies suggest that 25%-33% of practitioners trained in a parenting EBP *never used it* (Sanders, Prinz, & Shapiro, 2009; Asgary-Eden & Lee, 2011). Moreover, EBPs have shown no benefit when delivered in routine practice settings (Jaycox et al., 2011) likely because insufficient attention is paid to elements of implementation. Thus, selecting an EBP is simply the first step in a long road to effectively implementing EBPs for children’s behavior problems.

### **The special roles of educational psychologists, social workers, and school guidance professionals in preventing and treating conduct problems**

A key related factor to consider in addressing children’s behavior problems in schools is how to ensure that *all* children and youth have access to intervention services. The movement towards implementing evidence-based practices to address behavior and other problems affecting children in schools is inextricably linked with the expansion of school-based mental health services across the USA (George, Taylor, Schmidt, & Weist, 2013). School-based mental health services were spawned of the combined need for therapy for students with emotional and behavioral disorders, and lack of time available by school social workers and psychologists to provide for students’ needs. These services now include community mental health professionals who are co-located in schools, providing regular mental health care to students without the need for students to present to outpatient clinics after school hours. These programs are enabling more children to receive services (Stephan, Weist, Kataoka, Adelsheim, & Mills, 2007) by taking advantage of the school context as an accessible and convenient way to engage students and families. In the USA, federal and state policies have also contributed to the burgeoning of school-based mental health services by allocating funding to incentivize community practitioners to provide services in schools, as long as those services are evidence-based (e.g. Hogan, 2003). There is no doubt that schools are excellent places to engage youth in therapy, as long as the school-based mental health clinic is private, protected, and can also engage parents and families to come into the school (Langley et al., 2010).

Moreover, school-based mental health clinics enable the cross-fertilization of competencies among community and school mental health professionals. This may enable, for example, cross-training of psychologists in the school and community on specific EBPs, and assessment tools/methods. In one project, for example, school and community psychologists and social workers were jointly trained in a parent

training intervention and together delivered multi-family parent training groups in the school during the evenings. The school psychologists and social workers knew the families, but the community providers were a bridge to broader community resources for the families (Gewirtz et al, 2010).

While treatment requires delivery by a mental health professional, the advantage of embedding effective prevention programs in the school setting is the availability of school counselors and other professionals and paraprofessionals to deliver these prevention programs (resources allowing). Indeed, this, and the reduced cost of delivering prevention vs. treatment programs may be two factors accounting for the large growth in the implementation of evidence-based conduct problem prevention programs in schools over the past twenty years across the USA. As a 'system-of-care' serving at-risk children, schools offer a powerful portal for the prevention and treatment of child behavior problems.

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