Home-School Collaboration and Children with Emotional and Behavioral Disorders: An Examination of School Services

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LOYOLA UNIVERSITY CHICAGO

HOME-SCHOOL COLLABORATION AND CHILDREN WITH EMOTIONAL AND BEHAVIORAL DISORDERS: AN EXAMINATION OF SCHOOL SERVICES

A DISSERTATION SUBMITTED TO THE FACULTY OF THE GRADUATE SCHOOL IN CANDIDACY FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

PROGRAM IN SCHOOL PSYCHOLOGY

BY

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CHICAGO, ILLINOIS

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ABSTRACT

The treatment for childhood emotional and behavioral disorders (EBD) is of significant concern within society. The research literature has frequently noted that parental involvement in the treatment of childhood EBD has a positive impact on outcomes in both school and community-based supports. The current study examined the relationship between parent involvement and school services received for children with emotional and behavioral needs. Parents of children with EBD were recruited from one large and two small on-line support groups. Results suggest that parents who reported satisfaction with school teams were more likely to receive research-based services and had a higher rate of school and community partnerships than those who were not satisfied. Relationships were found between the parent satisfaction with the schools and quality of communication, the severity of child behavior, and the level of parent stress. In general, parents in the current sample reported more services that were delivered in less resistive education settings, and were provided earlier, than other literature reports. Results are discussed, along with implications for school-based practice for children with EBD and school-community-parent partnerships.
CHAPTER ONE
INTRODUCTION

Childhood mental health disorders are often overlooked problem in America, impacting not only the child him or herself, but the family, community, and society as a whole. In all, about six billion dollars are being spent annually on mental health services for children (Burns, Hoagwood, & Mrazek, 1999). A minimum of 20% of children meets the criteria for a mental health disorder, but few ever receive treatment for their disability. Even when children are provided with supports, it is often too little and too late, with many services not implemented according to the best practices, and too costly for many families and society (U.S. Department of Health and Human Services, 1999). In light of these severe limitations in current mental health services for children, a number of recent public policy mandates -- including the Surgeon General’s Report on Children’s Mental Health, the President’s New Freedom Commission, and the Individual Disabilities Education act of 2004 -- have stressed the urgent need to address childhood emotional and behavioral disorders (EBD).

Currently fewer than 50% of children with emotional and behavioral disabilities receive adequate treatment (Koller & Bertel, 2006; Power, 2003). Of the families who start services for their child, about 40-60% discontinue these same efforts prior to completion (U.S. Department of Health and Human Services, 1999). Perhaps one of the most significant concerns with childhood EBD is adult outcome for these children.
Young adults with childhood mental health disabilities are more likely to live in poverty, be unemployed, drop out of high school, engage in criminal behavior, have few friends, and have less participation in the community than their non-disabled peers (Armstrong Derick, & Greenbaum, 2003; Bradley, Doolittle, & Bartolotta, 2008; Benitez, Lattimore, & Wehmeyer, 2005; Hayling, Cook, Greshman, State, & Kern, 2008). For many of these youth, their problems become worse over time. About 50% of adolescents with emotional and behavioral problems drop out of school compared to 29% of the students in other disability categories (Sitlington & Neubert, 2004).

According to some research, caregivers who are single parents live in poverty, or exhibit maladaptive parenting skills may contribute to emotional and behavioral disorders in their children (Loeber, 1990; Nelson, Stage, Duppong-Hurley et al., 2007; Patterson, Reid, & Dishion, 1992). Other literature, however, has also revealed the inverse of this relationship, noting the additional stress and financial strain faced by parents caring for these special needs children. This stress is often observed in the way caregivers report experiencing lowered perceptions of emotional support (Farmer & Burns, 1997; Quittner, Glueckauf, & Jackson, 1990) and feelings of disempowerment (Yatchmenoff, Koren, Friesen, Gordon, & Kinney, 1998). There has been much research suggesting that parents experience barriers to obtaining services and feel blamed for their child’s problems by professionals in the mental health industry (e.g., Farmer & Burns, 1997; Johnson & Renaud, 1997; Owens, Hoagwood, Horwitz, Leaf, Poduska, Kellam, & Ialongo, 2002; U.S. Department of Health and Human Services, 1999). There is evidence that these parental perceptions may be accurate as supported by the finding that many
mental health professionals blamed parents for the child’s emotional and behavioral difficulties (Johnson, Cournoyer, Fisher, McQuillan, Moriarty, & Richert, 2000).

In addition to examining factors pertaining to youth mental health needs, including the relationship between parenting practices and childhood EBD, research has focused on the impact that treatment within the school and community has on child mental health. Unfortunately much of the research suggests that current treatment models are not effective for these students. The Individual with Disabilities Education Improvement Act 2004 (IDEIA) requires that all children, including those with emotional or behavioral needs, receive appropriate school services. Although services exist within schools to help children with EBD be successful, the most common response to behavioral problems is often reactionary and punitive, and these actions, such as suspension and expulsion, are not effective (Koller & Bertel, 2006; Skiba, 2002). In addition, less than 1% of the student body receives services for emotional disability within special education (United States Public Health Service, 2001), and among these select few, most still experience negative adult outcomes. Part of the concern with the current special education service delivery is that students with EBD are more likely to be placed in restrictive settings, separated from their nondisabled peers, and offered supports do not directly address their specific emotional and behavioral needs (Wagner, Kutash, Duchnowski, Epstein, & Sumi, 2005). Finally, the parent-school relationship for caregivers of these children is often poor, which typically hinders the progress of the child, as well (Wagner et al., 2005).
As it concerns the greater community outside the school system, the current state of service delivery for children with EBD also falls well short of the public need. Part of the problem is that very few youth actually receive services within the community. The psychological systems of care are complex and fragmented, and there is a stigma associated with mental health needs and services (Owens et al., 2002). Burns, Costello, Angold et al. (1995) reported that 70 to 80% of children receiving services for mental health concerns were seen within the school, and for the majority of these children, this was the only service that was provided. There are many reasons why children are not receiving support through the community, which factors including high treatment costs and a perceived lack of effectiveness in current programs. Perhaps one of the most important variables in relation to whether or not a child with EBD received treatment involved parent perception of community services. The parents who had negative feelings about mental health services were less likely to seek out treatment for their child or follow through with appointments (Owens et al., 2002). In addition, it is often the most severe students who receive access to treatment, but the schools and communities are not working together in the provision of these supports (Burns et al., 1995).

Many public policies, in addition to scholarly research and articles, point to the problems with the current delivery system for children’s mental health services and the need for change. One of the strongest areas of consensus is for the need to integrate services between schools and the community with quality parental involvement (see Burns et al., 1995; Brener, Weist, Adelman, Taylor, Vernon, & Smiley, 2007; Elias, Zins, Graczyk, & Weissberg, 2003; Farmer et al., 2003). Through the call for more
collaboration between the home, schools, and community, researchers point to the importance of changing how schools approach mental health by adding evidence-based practices for the treatment of childhood EBD. For example, the President’s New Freedom Commission on Mental Health (2003) recommended that federal, state, and local child-serving agencies recognize and address the mental health needs of youth within the education system. This can be addressed through good prevention programs (Elias & Weissberg, 2000) and early intervention. Effective school-based efforts include services at the primary, secondary, and tertiary systems, such as found through Response to Intervention and Positive Behavioral Intervention Supports (Adelman & Taylor, 1998; 2000; Greenberg, Domitrovich, & Bumbarger, 2000).

Current educational practices must be examined for any systematic changes to be effective. There is a need for better training in the academic disciplines about how to prevent and intervene with mental health needs (Forness, 2005; Koller & Bertel, 2006; Weist & Christodulu, 2000). Schools are encouraged to integrate classroom-focused approaches, assistance for families, crisis intervention and prevention, transportation support, and community outreach and services (Taylor & Adelman, 2000; Wagner & Davis, 2006), all of which can be accomplished through multidisciplinary teams (Adelman & Taylor, 2000). There is evidence that school mental health programs improve educational outcomes by producing consistently higher test scores and lower absence and discipline referral rates (President’s New Freedom Commission on Mental Health, 2003). Perhaps one of the most important elements of change to school and community-based treatment is the way in which parents are treated and involved in the
process. In all treatment options, regardless of the setting, a significant change is needed so that parents are meaningfully involved and engaged in their child’s progress.

In order to address all of the problems that researchers have noticed in regard to the treatment of childhood EBD, along with the call for needed systemic change, approaches such as system of care or wraparound supports should be utilized. These include an increased focus on family involvement, collaborating with schools and the community, providing services in natural settings, ensuring greater cultural sensitivity, and giving resources to the child and family. Within this model of treatment, there is a heavy emphasis on family support (U.S. Department of Health and Human Services, 1999) and systems of care that allow for comprehensive, coordinated services between parents, schools, and the community (Hoagwood, 1997). This model has been used in mental health, education, child welfare, and the juvenile justice sectors (Burchard, Burns, & Surchard, 2002; Nordness, 2005). Through this process the school, community, and family work together as partners with a focus on interventions that are matched to the student’s needs in the least restrictive setting.

Although there is a clear call for change and recommendations for how to make the needed changes, the research on wraparound care, community-school collaboration, and a tiered model of school service delivery is minimal. Evidence generally supports wraparound services, especially when there is an individual case manager (Burns, Hoagwood, & Mrazek, 1999), but more research is required. Therefore, it is essential to begin examining the impact that this proposed model of care has on children, families, and parent-professional relationships.
CHAPTER TWO
REVIEW OF THE LITERATURE

Childhood emotional and behavioral disorders (EBD) are a significant problem in society. EBD includes a variety of psychological disorders including Attention Deficit Disorder, Oppositional Defiant Disorder, Conduct Disorder, Anxiety Disorders, Depression, Mood Disorders, Developmental Social Disorders, Autism and other conditions that impair a child’s mental health. It has been reported that 20% of all children meet the Diagnostic and Statistical Manual of Mental Disorders 4th Ed., Text Revision, (DSM-IV-TR) 2004 criteria with at least minimum psychological impairment, and 11% of these children have significant impairment, with 5% having extreme impairment. “Minimum impairment” means that the child has a mental health disorder but is able to function at home and in the community. “Significant impairment” suggests that the child has difficulty functioning in at-least one setting due to his/her disorder and “extreme impairment” means that the disorder has a significant impact on the child’s ability to function in multiple settings (U.S. Department of Health and Human Services, 1999).

Unfortunately, the current state of treatment, and the adult outcomes, for children with EBD is poor. The delivery of mental health services is complex and fragmented, and there is a stigma associated with both mental health needs and services (Owens et al., 2002). Given the current crisis, researchers and public policy experts have called for a
change in how the community, including schools, approaches the treatment of childhood emotional and behavioral disorders. In all of the policies, one of the strongest emphases is for the need to integrate services between the family, schools and community (see Brener et al., 2007; Burns et al., 1995; Elias et al., 2003; Farmer et al., 2003; Farmer & Farmer, 2001; Hoagwood, 2005; Hunter, Hoagwood, Evans, Weist, Smith et al., 2005; Power, 2003; Taylor & Adelman, 2000). In the following review, information about children with EBD, public policies pertinent to children’s mental health, the current state of school and community services, and the best practices that integrate the home, schools, and community will be presented.

**Children with Emotional and/or Behavioral Disorders**

A DSM-IV TR diagnosis during early childhood has been shown to be one of the strongest predictors of maladjustment in adolescence and adulthood (Armstrong et al., 2003; Huffman, Menligner, & Kerivan, 2000; Nelson et al., 2007). The behavioral and emotional problems of children with EBD tend to begin early in childhood (Bradley et al., 2008; Nelson et al., 2007; Wagner et al., 2005), but many children do not receive access to services until years later, if at all (Bradley et al., 2008; Forness, 2005; Power, 2003; Wagner et al., 2005). Research suggests that children who destroyed their own toys, had difficulty sleeping, were abusive to others, and were difficult to parent were more likely to develop emotional and behavioral problems (Nelson et al., 2007). Fewer than 50% of children with emotional and behavioral disabilities receive adequate treatment (Koller & Bertel, 2006; Power, 2003; U.S. Department of Health and Human Services, 1999), and about 40-60% of families who begin treatment for their child
terminate the services early (U.S. Department of Health and Human Services, 1999). The earlier the onset of the problems, the more likely the child is to develop serious antisocial problems in adolescence and adulthood (Fox, Dunlap, & Powell, 2002).

Many of the children with EBD come from impoverished environments. Four to eight percent of students in poverty have serious impairment. Fifteen percent of Caucasian students with EBD live in poverty compared to 51% of African American and 41% of Hispanic students with mental health disorders. Two-thirds of children in poverty with EBD are additionally diagnosed with ADD (Wagner et al., 2005). Children with EBD are more likely to experience multiple out of home placement changes through the welfare system compared to students without EBD, especially as they get older (Barth, Lloyd, Green, James, Leslie, & Landsverk, 2007).

Unfortunately, the mental health needs of children with EBD tend to get worse with age. Costello, Mustillo, Erkanit, Keller, Arngold, and Adrin (2003) examined the progression and prevalence of childhood mental health disorders over time. They found that by the age of nine to ten, 20% of boys and 31% of girls with a mental health disorder qualified for significant impairment. By the age of 16, 79% of the diagnosed boys and 58% of the diagnosed girls had severe impairment, indicating that for many of the youth, especially boys, the problems became worse with age and had a significant impact on their ability to function within the school, home, and/or community. In addition, 25% of the children had more than one diagnosis. The children with a history of psychiatric disorders were three times more likely than those with no disorder to have a future diagnosis.
Along with becoming more severe over time, emotional or behavioral disorders during childhood have a strong negative impact on adult outcomes. For example, young adults with childhood EBD are more likely to live in poverty, be unemployed, drop out of high school, engage in criminal behavior, have few friends, and have less participation in the community than their non-disabled peers (Armstrong et al., 2003; Bradley et al., 2008; Benitez, Lattimor, & Wechmeyer, 2005; Hayling et al., 2008). Usually the care that the child receives for his/her disability is not sufficient to produce successful adult outcomes, nor is it consistent with best practices (Forness, 2005; Power, 2003). The child’s ability to adapt to young adulthood tends to be poor. He or she has difficulty forming and maintaining interpersonal relationships, faces instability in living situations (Armstrong et. al., 2003) and employment (Bradley et al., 2008; Zigmond, 2006). Benitez, Lattimor, and Wechmeyer (2005) indicated that 42-72% of the students with EBD were unemployed during the first five years after high school. Interviews with young adults with EBD three years or more out of school found that they had frequent job mobility, earned little more than minimum wage, and had few friends (Zigmond, 2006).

Research has suggested that adult criminal behavior is associated with a history of emotional or physical abuse and previous contact with mental health agencies (Clare, Bailey & Clark, 2000; Davis, Banks, Fisher, & Graudzinskas, 2004). Forty to seventy percent of youth who are incarcerated have had co-morbid mental health illnesses (Koller & Bertel, 2006). Overall, the cost to society of maladaptive functioning of these adults is high (Cohen, 1998; Greenberg et al., 2000), which suggests an urgent need to understand and address the educational and emotional needs of children with EBD.
An Overview of Public Policies

The Joint Commission on the Mental Health of Children first addressed the emotional and behavioral needs of children in 1969. This report indicated that only a fraction of children in need of mental health services were receiving supports and that these services were ineffective (Huang, Stroul, Friedman, Mrazek, Friesen, Pires, & Mayberg, 2005). As a result, new approaches were formed, including the Child and Adolescent Service System Program (CASSP) in 1984 and Comprehensive Community Mental Health services for children and their families in 1992. These policies helped build systems to address the needs of serious childhood emotional and behavioral disorders. The core set of values from CASSP were to be comprehensive and include the following: individualized supports to each child and family; least restrictive educational setting; coordination at both system and service delivery levels; early intervention; and the engagement of families and youths as full partners (Huang et al., 2005; Pumariega & Vance, 1999). The early accomplishments of the CASSP solidified the concept of systems of care.

Despite these early policies, however, a need for improvement remained substantial as shown through the Mental Health: A Report from the Surgeon General in 1999 (Huang et al., 20005). This led to the creation of the U.S. Public Health Service (2000), President’s New Freedom Commission on Mental Health (2003), and other commissions such as the American Psychological Associations Working Group on Children’s Mental Health. All of these entities reported large gaps between the mental
health needs of children and the supports or services that are available (Tolan & Dodge, 2005).

During the U.S. Public Health Services Report of the Surgeon General’s Conference on Children’s Mental Health (2000), goals were proposed to improve the state of children’s mental health. These included: promote public awareness of children’s mental health and reduce stigma; implement scientifically-proven prevention and treatment services in the field of children’s mental health; improve assessment and recognition of mental health needs in children; eliminate racial/ethnic and socioeconomic disparities in access to mental healthcare; improve infrastructure for children’s mental health services and access to interventions across professions; increase access to and coordination of quality mental healthcare services; and monitor the access to, and coordination of, quality mental healthcare services. The goals in this report clearly indicated the need to systematically improve children’s mental health treatment.

Following the Surgeons General’s Report, the President’s New Freedom Commission on Mental Health (2003) recommended that federal, state, and local child-serving agencies recognize and address the mental health needs of youth within the education system. This policy suggested that dramatic improvement is needed in the mental health support systems for children and families. The report stated that most families, including those of a child with mental health needs who had adequate financial resources, found it difficult to access services, especially ones that were appropriate and effective. Part of the problem included an underdeveloped mental health care system for children, a focus on only those services for the most severe problems, and a lack of
integration among treatment, prevention, and promotion (Tolan & Dodge, 2005).
Although current policy is putting considerable emphasis on the development of strong
relationships between the school and community (Adelman & Taylor, 2000), it is not
high in the educational hierarchy. Even with the current policies, children’s mental
health remains minimally acknowledged as a health care need (Tolan & Dodge, 2005).
The aforementioned public policies specifically address the need for mental health
services in the schools. There is an emphasis on improved school-based mental health
services because schools are a natural setting to provide treatment. The educational
system can efficiently reach students and parents, monitor progress, and intervene when a
student is in crisis or needs support (Brener et al., 2007; Burns et al., 1995). Offering
services in schools improves treatment outcomes (U.S. Department of Health and Human
Services, 1999); when the family and community are involved in school-based mental
health services, student behavior improves, and there are fewer school discipline
problems (Michael, Dittus, & Epstein, 2007).
In regard to the educational systems responsibility to educate children with
emotional or behavioral needs, the Education for All Handicapped Children Act of 1975
(EHA-B) mandated that all disabled students were entitled to a free public education.
This encompassed special education services for children with EBD, which often
included individual, group, and family counseling, consultation with general education
teachers, and residential treatment (Hoagwood, 1997). The current EHA, as amended in
the Individual with Disabilities Education Improvement Act 2004 (IDEIA), ensures that
children with emotional and behavioral disorders receive appropriate school services.
In order to qualify for an Individualized Education Plan under IDEIA, 20 U.S.C.§ 1401 (3)(A)(i), students must exhibit serious deficits in emotional or social functioning, and their disability must have a negative impact on educational performance over an extended period of time 34 C.F.R. § 300.8(c)(4)(i)(A-E). Descriptors of the disability include an inability to learn that cannot be explained by other factors; an inability to build satisfactory relationships with peers and teachers; inappropriate behavior or feelings under normal circumstances; a general pervasive mood of unhappiness or depression; and the tendency to develop physical symptoms or fears associated with school or personal problems, 34 C.F.R. § 300.8(c)(4)(i)(A-E). At least one of the indicators must be present and must be serious, extend over time, and have a negative impact on the child’s educational progress. Some experts have argued the definition of Emotional and Behavioral Disorders within IDEIA is too ambiguous, resulting in poor service delivery to meet the mental health needs of children (Epstein & Walker, 2002; Greshman, 2005). Although up to 20% of children would qualify for an emotional or behavioral disorder under the DSM-IV, less than 1% of the student body receives services for emotional disability within the school setting (Wagner et al., 2005).

School Services for Childhood EBD

Children with emotional and behavioral disorders can be served in a variety of settings, such as early intervention, individual and family therapy, in- and out-patient hospitalization, and residential housing. The most common setting in which these children receive services is within the school (Burns et al., 1995; U.S. Department of Health and Human Services, 1999). For example, Burns et al. (1995) reported that 70-
80% of children receiving services for mental health concerns were seen within the school, and for the majority of these children, this was the only service that was provided. School-based services may include group or individual counseling, an Individualized Education Plan, a Behavior Intervention Plan, and integration of school, community, and family services.

Currently, schools are mandated to provide mental health services through special education, but the number of personnel available for children is often not sufficient to meet the students’ needs. In their study, Brener et al. (2007) examined the state of mental health services in schools. They found that 49% of schools have a policy in which a trained professional oversees or contributes to mental health and social services. Seventy-nine percent of schools have a student support team with 39% of the teams including staff from collaborating community agencies. More than three-fourths of schools had at least a part-time counselor, but less than two-thirds had a school psychologist, and fewer than half had a social worker. More than three-fourths of the states provided funding for staff development related to mental health. Overall, there is an insufficient number of mental health and social service providers in schools, and there is a great need for collaboration between schools and the community.

**Punitive Responses to Behavior Disorders**

Although services exist within schools to help children with EBD be successful, the most common response to behavioral problems is often reactive and punitive (Koller & Bertel, 2006; Skiba, 2002). For example, 47% of elementary students and 73% of high school students with emotional or behavioral concerns have been suspended or expelled
from school (Wagner et al., 2005). Research indicates that there is little or no evidence for the effectiveness of suspension and expulsion; these consequences typically do not reduce disruptive behaviors (Koller & Bertel, 2006; Skiba, 2002). Suspension is often used for minor offenses, such as disobedience and disrespect, attendance problems, and general classroom disruption. In addition, suspended students are more likely to demonstrate mental health problems, and suspension tends to reinforce the problematic behavior (Skiba, 2002).

High-school dropout is a significant problem for students with emotional and behavioral disorders. A behavior problem in school is a strong predictor of early dropping out (Vance, Fernandez & Biber, 1998). About 50% of adolescents with emotional and behavioral problems drop out of school, compared to 29% of the students in other disability categories (Sitlington & Neubert, 2004). Only 42% of EBD students who remain in school graduate with a diploma, compared to 75% of students nationally in the U.S. (U.S. Department of Education, 2008; U. S. Public Health Service, 2001). Unfortunately, many students who would qualify for school-based mental health services under IDEIA are never identified and do not receive support through the special education or general education setting. In fact, less than half of the students with mental health needs received behavioral intervention or mental health services within their schools (Bradley et al., 2008).
Special Education

Students who receive special education services under the Emotional Disability category are usually identified up to two years after students in other disability categories and spend more of their time in special education settings when compared to students eligible under other disability categories (Coutinho & Oswald, 1996; Sitlington & Neubert, 2004). Only 25% of students with EBD spend 70% or more of their time in general education classrooms (Bradley et al., 2008; Wagner et al., 2005). About 13% of EBD students are in separate educational facilities, 2 to 4% are in residential settings, and 2% are homebound (Bradley et al., 2008; U.S. Department of Education, 2002). Students with EBD are also more likely to have their school changed to a more restrictive educational setting than students with other disabilities (Wagner et al., 2005). These students are more often served in classrooms with peers who have the same disability, and are frequently perceived negatively by their teachers (Bradley et al., 2008). In their article, Dishion, McCord, and Poulin (1999) indicated that when students with behavior problems are placed together, such as in an alternative setting or self-contained classroom, the students are more likely to have an increase in problematic behavior when compared to students who were integrated with their non-disabled peers.

Wagner and Davis (2006) closely examined the services students with EBD receive in school. They found that through the Individual Education Plan, students with EBD often had modifications that included extended time on tests and assignment completion, frequent feedback from teachers, shorter or different assignments, slower-paced instruction, and different grading standards. About 75% of students with EBD
received extra time on tests, and up to half had tests read aloud; however, a small percentage received grades based on modified standards. About one in five students received social work services, three in ten students had case management, and up to 18% of families received family support, especially at the elementary level. There tended to be less support in high schools (Wagner & Davis, 2006).

In addition to the emotional and behavioral needs these students exhibit, they are likely to have academic deficits, poor grades, be retained (Bradley et al., 2008; Lane, Wehby, Little, & Cooley, 2005; Forness, 2005; Wagner et al., 2005; Wagner, Friend, Bursuck et al., 2006), and have language disorders (Wagner et al., 2005). Fifty years ago, Morse, Cutler and Fink (1964) indicated that the quality of the special education services for these youth was poor, which is still the case today. For example, transition plans are too general and do not prepare students for adult life (Sitlington & Neubert, 2004; Wagner & Davis, 2006). These students are unlikely to receive academic supports (Bradley et al., 2008) and have IEP goals that are similar to those for students with other disabilities (Wagner & Davis, 2006). There is also a considerable shortage of teachers who are qualified to teach students with EBD (Bradley et al., 2008), with many general education teachers taking on the task with very limited assistance, especially at the high school level. Many students with emotional and behavioral disorders are found eligible under Specific Learning Disability instead of Emotional Disability; in fact, children meeting the criteria for EBD are five times more likely to be identified under SLD (Forness, 2005). In most schools, neither the number of paraprofessionals nor class size changed when EBD students were integrated into the classroom. There is a need for increased teacher
training and co-teaching for classrooms that contain children with emotional or behavioral needs (Wagner, Friend, & Bursuck, 2006). Furthermore, teachers do not use positive attention as frequently as recommended for children with EBD, with current teacher praise rates reported to be as low as once per hour (Landrum, Tankersley, & Kauffman, 2005).

Kutash and Duchnowski (2004) examined the services received by 158 students with EBD. They found that the caregivers noticed most of the child’s problems at age five, with hyperactivity and aggression as the common behaviors, but many of the youth did not receive school-based services until third grade, or age nine. In the previous year, 18% of the students had an in-school suspension, and 38% had out-of-school suspension. Most of the school services for these children included individual counseling (63%) and group counseling (61%), and 72% of the student’s time was in a self-contained special education classroom. In all, 80% of the students had received outpatient services at some point, and 29% had received inpatient services. As the children got older, the school served as the primary mental health system, with 72% of the students receiving school-based services.

Lane, Wehby, Little, and Cooley (2005) compared self-contained classrooms and self-contained schools for 60 students with EBD. Students who were educated in self-contained classrooms had higher academic scores and fewer disciplinary problems when compared to students in self-contained schools. The social skills of the youth were equal in each setting, but students in the self-contained classes were more likely to have internalizing disorders. In relation to the youth’s growth over time, Lane et al. (2005)
found that there were no significant differences in terms of change with social skills and academic performance between students in self-contained classrooms and self-contained schools. In general, there was little academic growth or progress with social skills and disciplinary contacts in either group.

Students with EBD also have difficulties in regard to being an active member of the school community. For example, only 41% of parents of children with EBD strongly agreed that there is an adult at the school who cared about their child. Two-thirds of students with EBD were reported to get along with their peers “pretty well”, but were rated lower in social skills than non-disabled peers. They were less likely to participate in organized extracurricular activities (Wagner & Davis, 2006). Sacks and Kern (2008) found that adolescents with EBD rated the quality of their life lower than non-disabled peers. EBD students in private schools rated the quality of their life higher than EBD youth in public schools, and the parents of EBD students in both settings rated their children’s quality of life lower than their children did in terms of self and environment.

Part of the reason why there is an insufficient number of services available to meet the mental health needs of students within schools is because there is a lack of agreement about how best to implement school-based interventions (Hunter et al., 2005), or on the effectiveness of school-based programs (Hoagwood, 1997). Generally, the approaches traditionally utilized in schools, such as counseling and support provided through special education, have not worked. This is partly because it is difficult to meet the needs of children with EBD through school services alone (Epstein & Walker, 2002). In addition, there are not enough evidence-based programs because there are few
randomized trials in education (Forness, 2005). Schools often use research from clinical psychology, but it is not known if these interventions, such as cognitive-behavioral therapy, are implemented with integrity in the schools (Forness, 2005).

In addition to the problems with school-based mental health services, researchers have noted systematic problems in the way in which treatment is provided. One of the reasons why the services are not effective is that schools implement interventions, such as counseling, without involving the classroom teachers in the planning or implementation (Taylor & Adelman, 2000). A problem with the current system is that schools essentially try to change the student instead of looking elsewhere for the cause of the problem. For example, in many cases, a child’s problems develop as responses to their environment, and are not necessarily internal attributes of the child (Wagner & Davis, 2006; Weist & Christodulu, 2000).

**Parent Involvement with School-Based Services**

Given that the school services for children with EBD tend to be ineffective, it is not surprising that the parent-school relationships for these students are also frequently poor. In their review of special education services for students with emotional and behavioral disorders, Wagner et al. (2005) indicated that parents were often viewed by school personnel as not engaged and not caring about their child’s education. The authors indicated that these parents were more likely than caregivers of students with other disabilities to express dissatisfaction with the schools, teachers, and special education services. The parents reported that it required “a lot of effort” to obtain school-based services and they were more likely to go through mediation and due process
hearings when compared to parents of children with other disabilities. The parents indicated that they were highly involved in their child’s education. For example, most parents reported that they actively supported their child’s education at home by providing homework help at a higher rate than other parents, and they were more likely to attend parent-teacher conferences (Wagner et al., 2005).

There has been a significant amount of research suggesting that parental involvement in a child’s schooling has a tremendous impact on academic success (Christenson & Carlson, 2005; Christenson, Ronds & Gorney, 1992; Kohl, Lengua, & McMahon, 2000) and the child’s mental health (Hoagwood, Olin, Kerker, Kratochwill, Crowe, & Saka, 2007). The quality of the parent-teacher relationship is often related to the success of the child, if the student was doing well the relationships were often rated more positively. When the teachers reached out to parents in an attempt to improve communication, the parents were often receptive, which increased the quality of the relationship. In general, the teacher’s practices and attitudes towards parents are very influential in determining the level of parental involvement (Kohl, Lengua, & McMahon, 2000).

Unfortunately, many schools do not include parents to the extent necessary for services to work. About 40% of schools have met with parent organizations to discuss mental health services and have invited the family to tour mental health and social service facilities. Fewer than half of the schools that have drug and violence prevention programs have involved families in developing, implementing, and communicating about these services (Michael, Dittus, & Epstein, 2007).
Community-Based Services for Childhood Mental Health

There are a variety of contexts in which children can be treated for emotional and behavioral disorders within the community. These include outpatient therapy, hospitalization, residential treatment, and case management. Unfortunately, many of the youth who are in need of services are not treated through the community sector; 59% of youth who are referred to mental health care are never treated by a specialist (President’s New Freedom Commission on Mental Health, 2003). In addition, most of the children who obtained support through the education sector did not receive services within the community. For example, only 11-13% of children receiving school-based services had treatment within the community. Among the children who were seriously emotionally disturbed, only 40% of them received any services, but these children were more likely to have support from both the school and community than their less impaired EBD peers (Burns et al., 1995). Few youth entered services before the age of 5 or after 13. School programs were more likely to treat youth with less noticeable and previously undetected emotional problems when compared to the community. This was especially the case for children with internalizing disorders (Weist, Myers, Hasting, Ghuman, & Han, 1999).

Community-Based Service Options

There exist a variety of community-based treatment options for childhood mental health disorders. The U.S. Department of Health and Human Services (1999) and Burns, Hoagwood, and Mrazek (1999) both published reviews summarizing the existing research on community-based mental health treatment options for childhood EBD. These
include partial hospitalization/day treatment, residential treatment, inpatient treatment, intensive case management, therapeutic foster care, and crisis support services.

One of the most common forms of community-based treatment is outpatient therapy. This involves counseling and psychotherapy outside of a hospital or restricted setting. Usually children and families meet with a therapist on a regular basis in order to treat a mental health disorder, an approach utilized in 5-10% of applicable cases. Researchers have found that there is strong evidence for the benefits of psychotherapy, such as the cognitive-behavioral approach in controlled settings, but this does not necessarily transfer into practice. The majority of outpatient treatment interventions researched did not meet the criteria for highest level of empirical support, and there is not enough known about the effectiveness of treatment for a specific diagnosis. The research did find that therapy could reduce parent stress and teach parents strategies for managing their child’s behavioral problems through this treatment (U. S. Department of Health and Human Services, 1999).

The next intensive form of service involves partial hospitalization or day treatment. Through this approach, children receive specific and intensive treatment in a setting that is less restrictive than inpatient hospitalization. There is usually an integrated curriculum that combines education, counseling, and family involvement. The research on the effectiveness of partial hospitalization and day treatment is not conclusive. In general, the symptoms have improved following this service, especially with family involvement; including the family was found to be imperative to maintain the outcomes. This treatment is not used frequently because third party payers are reluctant to provide
support. The research suggests that child behavior and family functioning improve following partial hospitalization, but the impact on academic performance is mixed (Burns, Hoagwood & Mrazek, 1999; The U.S. Department of Health and Human Services, 1999).

The next restrictive treatment for childhood EBD is inpatient hospitalization. Most of the child mental health resources are spent on inpatient treatment, consuming about half of the resources. In this model, children are treated for mental health concerns within a hospital, in which they receive around-the-clock services until deemed is ready to transition back into the community. Both of the reviews indicated that inpatient hospitalization has the weakest evidence base of all the treatment models. This source of treatment requires more substantial research (Burns, Hoagwood & Mrazek, 1999; The U.S. Department of Health and Human Services, 1999).

When a child requires intensive and persistent around-the-clock care, residential treatment is often the next step. It involves full-time care in a mental health facility. Residential treatment is the most restrictive form of care, and although only 8% of children with EBD receive this service, about one-fourth of mental health money is spent on this treatment. There is generally a lack of research on residential treatment, and the current research has not demonstrated strong positive outcomes. Children who have serious violent and aggressive behavior do not seem to improve in this setting, and about 75% of youth treated at a residential treatment center have been remitted or incarcerated. The reports suggested that brief hospitalizations or intensive community-based services
could be more beneficial for these children (Burns, Hoagwood & Mrazek, 1999; The U.S. Department of Health and Human Services, 1999).

Other forms of treatment include case management, therapeutic foster care, and therapeutic group homes. Case management is a model of service delivery that appoints an individual to coordinate the provision of services for individual children and their families in need of supports from multiple service providers. Such systems have proved to be effective, especially when there is an individual case manager. Children with case management were more likely to stay in the community than be hospitalized and were hospitalized for fewer days compared to children who did not receive this care (Burns, Hoagwood & Mrazek, 1999; The U.S. Department of Health and Human Services, 1999). There is also evidence supporting the effectiveness of therapeutic foster care, but not for therapeutic group homes. In regard to crisis and support services, they are effective when there is a high degree of family involvement and a focus is placed on helping families get the support they need to cope with the stress that comes from caring for a child with EBD (U.S. Department of Health and Human Services, 1999).

The final common form of community-based treatment is multisystemic therapy. This involves an intensive, short-term home and family focused treatment approach for youth with severe EBD. This treatment intervenes in the family, peer group, school, and neighborhood to identify factors that contribute to the child’s problems. Research has found it to be effective; the youth had fewer arrests and shorter incarcerations (U.S. Department of Health and Human Services, 1999).
In all, about six billion dollars are being spent annually on mental health services for children (Burns, Hoagwood, & Mrazek, 1999). The cost of treatment is high for families and the treatment itself is rarely sufficient for the family and child’s needs (Power, 2003). In regard to funding, Medicate is the major source, and it requires that state and local departments of mental health provide childhood psychological services. The private sector uses health insurance money. Unfortunately, there is a large group of uninsured individuals and families who are trapped between the public and private sector (U.S. Department of Health and Human Services, 1999). Studies have shown that children with emotional and behavioral problems are costly to raise and educate. In comparison to other disabilities, emotional and behavioral problems are the most expensive to treat in North America (Cohen, Miller, & Rossman, 1994; Loeber, Green, Lachey et al., 2000).

Parent Involvement in Community-Based Services

All of the community treatment options have an expectation of high parental involvement; however, much of the research has suggested that not only is parent involvement poor, but parents are often viewed negatively by mental health professionals. For example, research has suggested that parents of children with EBD have maladaptive parenting styles and a number of characteristics that may cause emotional and behavioral disorders in their children (Loeber, 1990; Nelson et al., 2007; Patterson et al., 1992). Caregivers are more likely to be single parents, have family conflict, have parental depression, and utilize unpredictable and unstructured parenting practices (Campbell, Shraw, Gilliam, 2000; Frick, Lahey, Loeber, Stouthamer-Loeber et
al., 1992; Mesman & Koot, 2001; Northery, Wells, Silverman, Bailey, 2003; Owens & Shaw, 2008; Windle & Mason, 2004). Two of the strongest risk factors in relation to childhood emotional and behavioral disorders are low level of parental education and low-income background (Huffman et al., 2000; Smokowski, Mann, Reynolds, & Fraser, 2003). There is also evidence suggesting that poor parenting may indirectly influence antisocial behavior in children by promoting poor social competence and academic failure (Lochman, Barry, & Pardini, 2003).

Often research concludes that children are displaying behavioral and emotional difficulties because of parental deficits, instead of considering the impact that having a child with EBD can have on parent efficacy and familial stress (Nelson, Stage et al, 2007; Shelton & Frick, 1996; Windle & Mason, 2004). For example, Bayer, Sanson, and Hemphill (2006) argued that family stress is linked to childhood problems. The authors stated that because the parents are under stress, they are unable to respond to the child’s needs, which leads to negative parenting practices. In addition, they found that family stress predicted lower use of warm-engaged parenting practices, and higher over-involved or assertive parenting styles.

Perhaps one of the most important variables in relation to whether or not parents were involved and sought out treatment within the community involved parent perception of services. There has been much research suggesting that parents experience barriers to obtaining services and feel blamed for their child’s problems by professionals (e.g., Farmer & Burns, 1997; Johnson & Renaud, 1997; Owens et al., 2002; U.S. Department of Health and Human Services, 1999).
When parents were asked about their experience with mental health professionals, they indicated that personnel failed to share information with them, did not explain how the caregiver could help their child, did not teach coping skills, did not involve parents in treatment decisions, and did not value the parent’s expertise or help them find services (Farmer & Burns, 1997; Johnson & Renaud, 1997). Johnson et al. (2000) found that many mental health professionals blamed parents for the child’s emotional and behavioral difficulties. This assumption about parent’s causative role in the child’s mental health problems may often negatively impact treatment (Johnson & Renaud, 1997). In regard to mental health specialties, Johnson et al. (2000) found that social workers are actually more likely than psychologists to blame parents for the child’s problems. Psychologists were more in favor of telling parents specific ways to help the child, more likely to share information with the parent, and more willing to help with parent support groups.

The tendency for mental health professionals to blame parents for childhood EBD is considered to be a professional-centered philosophy. Some mental health professionals have argued that it is not adequate, but this mindset is dominant. Many times families are treated critically and in a condescending manner. This hurts family involvement in treatment, and the parents are not provided with the needed resources (Bickham, Pizaro, Warner, Rosenthal, & Weist, 1998; Burns, Hoagwood, & Mrazek, 1999; Ireys, Chernoff, Stein, DeVet, & Silver, 2001). There is a need to stop blaming parents within this expert-driven model and, instead, collaborate with parents and have a family-centered orientation to treatment (Fox, Gunlap, & Powell, 2002).
Parent Perception of Barriers

In addition to feeling blamed for their child’s disability, parents of children with emotional and behavioral disorders have reported experiencing barriers to treatment (Farmer & Burns, 1997). Parents who felt a higher degree of stress and a low quality of life and support reported more perceived barriers to mental health needs than those with less stress and more support. Neither socioeconomic status nor the severity of child dysfunction predicted perceived barriers, and the families who reported more barriers improved less. Many of the parents felt that the treatment made demands on them and was not addressing the child’s problems (Farmer & Burns, 1997; Kazdin & Wassel, 2000).

There are different types of barriers to service delivery, including the parent’s own perceptual and structural barriers to treatment. Structural barriers include availability, waiting lists, and insurance coverage. Perceptual barriers include feeling a lack of trust, stigma, or previous negative experiences with mental health providers. Thirty-five percent of parents reported a problem in obtaining mental health services, and parents who reported barriers had more difficulty with parenting their child and had more stress compared to parents who did not report barriers. They were also less likely to have a child that received services. Of those who reported barriers, 50% said it was with the entry to care, and 50% said that it was with obtaining additional services (Owens et al., 2002). Additional barriers include transportation and financial concerns (Brener et al., 2007).
In general, the researchers suggested that the mental health field must do a better job of helping families by providing psychological and social resources in response to the stress of having a child with EBD. Few community mental health service systems are designed to help parents gain confidence in caring for their child and obtaining the needed social support. Therefore, treatment should involve both support and education for parents. A focus needs to be placed on enhancing the caregivers’ confidence in parenting, reassuring them that their concerns are appropriate and important, focusing on their parenting strengths, listening, and communicating understanding (Farmer & Burns, 1997; Ireys et al., 2001).

*Parent Stress*

Although much of the literature has focused on the parents’ contribution to childhood EBD, some studies have examined the impact that having a child with a disability has on family and parent stress. Parent stress has been associated with the caregivers experiencing lowered perceptions of emotional support, greater symptoms of depression and anxiety (Farmer & Burns, 1997; Quittner, Glueckauf, & Jackson, 1990), feelings of disempowerment (Yatchmenoff et al., 1998), and difficulties with employment and finding child care (Brennan, Rosenzweig, Ogilvie, Wuest, & Shindo, 2007; Rosenzweig, Brennen, Huffstuffer, & Bradley, 2008). Farmer and Burns (1997) found that the stronger the negative impact of having a child with EBD was on the family, the more likely the parents were to seek out services for their child. The longer the child had the disability, the more stress the parents reported. The level of stress was significant, regardless of whether their child had externalizing or internalizing problems,
and neither income-level nor employment status were related to stress level (Yatchmenoff et al., 1998). Parents reported a greater sense of burden, however, when the child’s behaviors were severe. For example, 17% of parents with children who had just a diagnosis but no functional impairment reported stress, 18% of parents whose child only had functional impairment felt stress, but 39% of parents whose child had both a diagnosis and impairment reported that having a child with EBD impacted their personal well-being and put restrictions on personal activities (Angold, Messer, Stangl, Farmer, Costello & Burns, 1998).

Parents have reported that having a child with an emotional or behavioral disorder has a strong impact on employment and childcare, which are two of the biggest contributors to stress. For example, many parents of children with EBD stated that childcare was the most significant barrier to employment because the quality of care and knowledge of care providers was not sufficient to meet the child’s needs. This, in turn, negatively impacted the parent’s ability to have full-time employment (Rosenzweig et al., 2008). In another study, 63% of the parents’ indicated that the mental health needs of the children limited the caregiver’s work hours, and only 31% of the parents had jobs that allowed them to sometimes work at home. Single caregivers had significantly fewer support networks. In general, parents who reported a good work-family fit had a more rewarding job experience and less stress (Brennan, Rosenzweig, Ogilvie, Wuest, & Shindo, 2007).

In their study, Rosenzwig, Brennan and Olgivie (2002) interviewed parents of children with emotional and behavioral disorders about employment and childcare
arrangements. The parents in their study reported that they had sought to obtain employment that was compatible with the demands of caring for a child with EBD. This included jobs that had fewer hours of work, greater flexibility, and supportive coworkers. The parents also discussed the difficulty of finding adequate care providers, financially supporting childcare, and finding individuals who understand their child’s needs.

Kazdin and Whitley (2003) examined whether or not including stress management techniques as part of the treatment of childhood behavior problems had an impact on outcomes. Children were involved in individual and family treatment, and some of the parents also received stress management support. They found that parent and family functioning improved over the course of treatment for parents in the stress management group. The children had fewer behavior problems at home, and parent depression and symptoms of stress decreased. The authors argued that parent training was an important element of the intervention.

Models for Effective Treatment with the School, Home, and Community

Up to this point, the current state of childhood mental health has been discussed in relation to childhood characteristics, adult outcomes, school-based services, community treatment, and parent factors. The current state of the field strongly suggests that the needs of children with EBD are not being met. The literature explains that schools are not providing appropriate services for children, many community-based treatment options are not effective, children in need of services are not receiving any form of treatment, and that parents are often not meaningfully included in the services. There is little consensus on the causes, identification, and effectiveness of treatment for childhood EBD.
Currently there is a lack of coordination among service providers (Yatchmenoff et al., 1998), which may partly explain why children are not responding to or receiving appropriate treatment. Generally, programs that focused only on the child were not as effective as those that integrated the child, school, and home (Greenberg, Domitrovich, & Bumbarger, 2000).

Much of the literature calls for the need to improve school-based mental health services. Through the call for more collaboration between schools and community, researchers point to the need to change how schools approach mental health, the inclusion of school-based mental health centers, and utilization of evidence-based practices within the school context. This would involve staff training, prevention, early identification, early intervention, and treatment provided at the school with a strong family focus incorporated into services (President’s New Freedom Commission on Mental Health, 2003). It is imperative that children and families have access to appropriate and effective services, that the mental health needs of children are a primary focus within schools, and there is an emphasis on prevention (Tolan & Dodge, 2005).

In response to the problems with school-based treatment, there has been a great deal of literature discussing the system changes required in order to better help children with EBD. For example, there is a need for better training in the academic disciplines about how to prevent and intervene with mental health needs (Forness, 2005; Koller & Bertel, 2006; Weist & Christodulu, 2000). And schools must improve their efforts at integrating classroom-focused approaches, assisting families, providing crisis interventions (Taylor & Adelman, 2000; Wagner & Davis, 2006), multidisciplinary
teams, emergency and crisis intervention plans, and the training for competent behavior management (Adelman & Taylor, 2000). Perhaps one of the greatest needs is for prevention programs (Elias et al., 2003; Power, 2003). Elements of good prevention programs involve decision-making, problem solving, and communication (Elias & Weissberg, 2000), and include three-tiered models of services at the primary, secondary, and tertiary system levels (Adelman & Taylor, 1998; 2000; Greenberg et al., 2000).

**Three-Tiered Service Delivery**

The three-tiered model of service delivery is represented through systems such as Positive Behavioral Intervention Supports (PBIS) and Response to Intervention (RtI). There is a call for school-wide behavioral models such as those found in PBIS and RtI (Bradley et al., 2008; Forness, 2005; Power, 2003). This involves a continuum from primary prevention to targeted services at the school-wide, group, and individual level (Hoagwood, 1997). Unfortunately, few programs are systematically implemented at all three tiers (Hunter et al., 2005), and not all interventions involve the least-restrictive and non-intrusive interventions (Adelman & Taylor, 2000).

In their review, Turnbull, Edmonson, Griggs, Wickham et al. (2002) discussed the elements of Positive Behavior Intervention Support. PBIS focuses on enhancing positive behaviors, teaching appropriate behavioral skills, and intervening quickly when problem behaviors arise. All of these tiers must be addressed in order for this model to work. There is a heavy emphasis on data tracking through office discipline referrals. At the universal level, a school-wide positive reinforcement system is in place with three to five behavioral expectations that are clearly defined, and students must be taught the
behavioral expectations in each setting (i.e., in the classroom, in the hallway, in the bathroom, etc.). Students who are at-risk receive group-based support, and students with significant emotional or behavioral needs receive an individual support plan through a functional analysis of behavior and behavior intervention plan. This model also includes families and community supports, such as wraparound (Turnbull, Edmanson, Griggs, Wickham et al., 2002).

An important element of PBIS, especially for students receiving tertiary level supports, is a behavior plan. Behavior intervention plans are tools that can be used to help students with emotional and behavioral disorders. Components of effective behavior plans include operational definitions of the problem behavior, a functional assessment of why the behavior is occurring, and redesigning the environment to prevent the antecedent to the behavior from happening. Successful behavior plans are flexible and evolve with the needs of the student. They focus on the strengths of the child with an attempt to incorporate positive reinforcement. Behavior plans are based on data and are developed when the student’s problem behavior impedes learning. The most effective behavior plans are timely, carefully documented, and implemented in the least restrictive environments (Magg & Katsiyannis, 2006).

Unfortunately the focus on prevention and a three-tired model of service delivery is not being implemented effectively within the schools. In his article, Kauffman (1999) explained that schools often attempt to have prevention at the tertiary level, when the student is already in crisis, as opposed to before problems become severe. The prevention needs to be based on rewarding desirable behavior, effective instruction for
social skills, and support for general education teachers. The author explains that education alone cannot address the need for prevention services.

_School-Based Health Centers_

In order to help schools provide services for children, many researchers have noted the need of school-based health centers. These are community centers located in schools that provide medical and psychological care for students and their families. Usually the centers are associated with a local hospital and staffed by that hospital or community. School-based mental health programs help reach youth in need (Weist et al., 1999), and there is evidence that school mental health programs in these centers improve educational outcomes by decreasing absences and discipline referrals, and improving test scores (President’s New Freedom Commission on Mental Health, 2003). In schools that have these clinics, the most common referral is for mental health support or peer and family relationship difficulties. Up to 50% of the visits are for non-medical reasons (Adelman & Taylor, 2000). Unfortunately, few schools have school-based mental health programs (Weist & Christodulu, 2000), and they are usually underfunded (Taylor & Adelman, 2000). Therefore, very few schools provide services through a school-based health center (Brener et al., 2007); as financing for this type of school-based mental health is sparse (Hunter et al., 2005).

_Evidence-Based School Interventions/Programs_

Most of the effective practices for children with EBD are not routinely implemented in schools. These include positive teacher attention and praise, direct instruction, class-wide peer tutoring, self-monitoring, and continuous monitoring of
student performance (Landrum, Tankersley, & Kaufman, 2003). There is support for cognitive-behavioral therapy in the schools (Hoagwood, 1997); most of the effective school interventions involve counseling or parent training (Forness, 2005). Evidence-based school programs that address violence prevention, cognitive skill-building, changing school ecology, integrating families, schools, and the child, and that focus on child coping skills have been established, but are underutilized (Greenberg, 2000; Hoagwood et al., 2007).

Services that involve a behavioral or social learning component through Functional Analysis of Behavior and Behavior Intervention Plans have been found to help children function in school (Epstein & Walker, 2002). The most effective school based programs had interventions with behavioral approaches as opposed to non-behavioral techniques, and they used skill building with a focus on environmental / system changes (Greenberg et al., 2003). Elements of effective social and emotional learning curriculums included self-monitoring, emotional regulation training, and role-playing (Elias & Weissberg, 2000). In general, school-based prevention programs that have focused on social and emotional learning have decreased dropout and non-attendance rates (Elias, Zins, Grachzyk, & Weissberg, 2003; Greeberg et al., 2003).

Social skills interventions have been shown to be somewhat effective. The results have depended on how well the intervention matched the student’s skills and language level. The most important factor is that interventions are implemented early and with integrity (Landrum, Tankersley, & Kaufman, 2003). There is support for social skills training programs in regard to functional outcomes (Hoagwood, 1997). Most of the
social skills programs ignore specific deficits that children are experiencing and use the
same approach across groups of children. Social skills deficits can stem from a lack of
knowledge, performance, or social reinforcement. Therefore, there is a need to determine
the origin of social skills weaknesses and then match the intervention, which is planned
and structured, to the child’s needs. This effort is more likely to produce generalization of
improved social skills. The most effective social skills interventions included parent
involvement (Evans, Axelrod, & Sapia, 2000).

Other effective models have targeted functional academic and community-based
skills. Vocational education that incorporated self-determination goals and had transition
plans, which included paid work experience and parental involvement, helped youth with
post-secondary school functioning (Sitlington & Neubert, 2004). For example, Benitez et
al. (2005) implemented a self-determination career model intervention for high school
students with EBD, and found that it helped these students set and achieve goals.
Through this model, the transition plans and services provided were targeted towards
vocational skills. The researchers indicated that the improvement was somewhat related
to the student history and maturation level, rather than the treatment alone.

Additional school interventions that have worked for children with EBD include
paid work experience, counseling while in high school, and parental involvement. This is
especially true when the goal is to teach self-determination and the transition plans are
used correctly (Sitlington & Neubert, 2004). School programs that were supported by
community services, such as systems of care and wrap, were more beneficial than
inpatient day, residential, or hospital treatments. The most effective treatments combined behavioral and psychotherapy interventions (Etscheidt, 2002).

**Targeted Interventions for Parents**

Given that the research has demonstrated the importance of helping parents as part of the treatment for children with emotional and behavior disorders, a couple of models of service delivery have emerged that help parents manage and cope with having a child with EBD. The two common forms of parent treatment include parent training classes and parent support groups.

Research has demonstrated that parent training has a positive impact on child behavior, especially when the children are young (Conduct Problems Prevention Research Group, 1999; Burns et al., 1995; Burns, Hoagwood, & Mrazek, 1999; Farmer & Farmer, 2001; Hoagwood, 2005; Webster-Stratton & Reid, 2003). Training sessions frequently teach parents management techniques, problem-solving strategies, and ways in which to communicate with their children. The sessions have been found to help improve family interactions while also increasing the parent’s knowledge of childhood mental health (Hoagwood, 2005), thus leading to a greater percentage of effective service selections. Irvine, Biglan, Smolkowski, Metzler, and Ary (1999) provided parent skills classes to parents of at-risk middle school students. This program included parental monitoring, positive reinforcement, parent-child communication, and limit setting. The participating parents reported a reduction in the child’s problems, including antisocial and aggressive behaviors in. In regard to addressing Oppositional Defiant Disorder, parent training is the primary evidence-based treatment when it targets problematic family
interaction patterns that are thought to contribute to ODD (Northey, Wells, Siverman, & Bailey, 2003). Although parent training has been shown to be effective, it is usually focused on parents who do not demonstrate positive parenting skills.

There are some parents who have adequate parenting skills, but continue to feel stress and strain from having a child with emotional and behavioral disorders. In these situations, parent support groups can be beneficial. Families in group therapy have reported an increase in positive family interactions, increased perceptions of support in regard to raising a child with EBD, and increased utilization of appropriate mental health services (Burns, Hoagwood, & Mrazek, 1999; Fristad, Goldberg-Arnold, & Gavazzi, 2003; Hoagwood, 2005). Family support services are powerful, low-cost, and caregivers have reported that they are highly beneficial. The parents stated that the emotional support they received from family-focused treatment was the most helpful part of the process. This form of family support also increased access to information, improved problem-solving skills, and led to a more positive view among parents about their ability to care for and manage their child (Burns, Hoagwood, & Mrazek, 1999).

School-based support groups for parents of children with EBD were examined by McClend, Polio, and North, (2007). The parents were allowed to chose the topics that were discussed, which selected topics including family harmony, discipline, medication, parent-provider communication, developing social and life skills, child and adolescent development, anger management, and peer relationships. The participating parents also asked for more information about special education services and IEP’s. Afterward, most
members reported that the groups were a positive experience, and that they were now able to better manage their child’s disorder.

An important aspect of parent support groups is the leader. Ruffolo, Kuhn, and Evans (2006) interviewed parent leaders and professional leaders of support groups for parents of children with EBD. The authors examined components that enhance the quality of the group. Both parent and professional leaders reported that finding the right mix of personalities was important when developing an effective team, as well as having a positive view about treatment and a realistic approach to change. The professionals indicated that they needed to surrender their role as the “expert” when collaborating with parents. For them, it was important to have sufficient experience with families of children with EBD and they need to have confidence in the positive contribution they could make to the lives of the group participants. In general, crucial elements to effective parent support groups include ongoing feedback and collaboration.

*Early Childhood Treatment*

Another intervention method that has shown to be effective for children with emotional and behavioral disorders is early intervention. For example, 12-16% of one and two year-olds demonstrate a significant delay in social-emotional competencies, and 37% of these children continue to have problems in preschool (Conroy & Brown, 2004). There is an emphasis on the need for preschool and early schooling prevention and intervention programs for students with emotional and behavioral problems (Adelman & Taylor, 2000; Burns, Hoagwood, & Mrazek, 1999; Fox, Gunlap, & Powell, 2002; Smokowski et al., 2003), especially when parents are involved (Fox, Gunlap, & Powell,
Unfortunately early intervention programs are not common; many children at-risk for EBD are not identified, which means they do not gain access to early childhood services.

The Conduct Problems Prevention Research Group examined the impact of first grade intervention for conduct problems. They provided parent training, tutoring, social skills training, and home visits. The students who were in the experimental group had less aggressive behavior, healthier relationships with peers and teachers, and the parents reported more satisfaction with the child’s behavior compared to the control group (Conduct Problems Research Group, 1999). They also found that that quality of teacher implementation had a strong impact on the overall effectiveness of the intervention.

In their study, Reynolds and Robertson (2003) examined school-based early intervention in terms of adolescent outcomes for children receiving Title 1 services. The early childhood program consisted of family access to a school-based health clinic, academic support, and frequent and continuous parental involvement. They found that the children who received interventions were more likely to stay in school, had less maltreatment from their parents, and fewer criminal incidents. The authors emphasize the importance of parental involvement.

Despite the effectiveness of early childhood programs, there are still problems pertaining to how most institutions respond to behavior problems (Conroy & Brown, 2004). The current model of early childhood treatment is more reactive then preventative. There is little coordination between current policy and services, which could explain why early identification is not common, and the service delivery is not
consistent between sectors. For example, schools tend to use a behavioral approach, while community agencies are more constructivist. Another problem with early childhood treatment is that the teachers usually have far less training than instructors of older students. Therefore, there is a lack of knowledge about behavior management (Conroy & Brown, 2004).

Similar to an IEP, an Individual Family Service Plan (ISFP) provides early intervention support for children under IDEIA. Children who are in need of behavioral or emotional supports in order to be successful in preschool settings are eligible for this plan. The ISFP provides a case manager, documents the family strengths and needs, and describes services that will be provided for the family and child (Bailey & Bussee, 1992). In their article, Bailey and Buysse (1992) explain that these early intervention programs should focus on the child and family by including them in the decision-making process and enabling them to choose their own level of involvement.

Wraparound Support and Systems of Care

Generally, there is support for three main changes in the treatment of children’s mental health disorders. These include an increased focus on the families, services in schools, and community-based systems of care/wraparound. Within the wraparound model of treatment there is a heavy emphasis on family support (U.S. Department of Mental Health, 1999). Systems of care allows for comprehensive, coordinated services between parents, schools, and the community (Hoagwood, 1997), and provide effective treatment for children who have significant mental health needs with functional impairment (Tolan & Dodge, 2005). This approach has been used in mental health,
education, child welfare, and the juvenile justice sectors (Burchard, Burns, & Surchard, 2002; Nordness, 2005).

The goal of wraparound care is to provide a natural support system. Elements of wraparound include a team-driven process with multiple sectors working together, individualized interventions that are built on the child’s strengths, culturally competent practice, flexible approaches to service delivery and funding, formal and informal supports, and outcomes that are measured (Burchard, Burns, & Surchard, 2002; Farmer & Farmer, 2001; Nordness, 2005; Tolan & Dodge, 2005). Emotional support is perhaps the most helpful aspect of family support services for parents (U.S. Department of Mental Health, 1999).

Part of the National Institute of Mental Health’s mandate is to develop integrated systems of care across service sectors. There is a need to look beyond just the reduction of risk factors, and instead view the entire system and how the child, family, and community interact toward a common, positive goal (Farmer & Farmer, 2001). Family participation in services and planning requires a level of commitment from all sides. For example, parents need to have their ideas valued, have a role in the planning, agree with the plan for the child, indicate how well the plan meets the needs of the whole family, and feel that they are influencing the plan (Yatchmenoff et al., 1998).

There is limited research on the success of wraparound support and systems of care, but the existing research suggests promising outcomes. Evidence generally supports wraparound services, especially when there is an individual case manager (Burns, Hoagwood, & Mrazek, 1999). Children who were a part of the wraparound
process remained in the community months to years after treatment. This is unlike the
typical trend where the children move towards more restrictive placements over time
(Burchard, Burns, & Surchard, 2002). Wraparound care is effective when it is directed
toward the child and family needs, and integrates school and community services (Burns,
Hoagwood & Mrazek, 1999). Limitations of the research on wraparound care include a
lack of data available about participants’ degree of adherence to the interventions, as well
as inconsistencies in the level of implementation (Burns, Hoagwood & Mrazek, 1999).

Although there has been little research on the effectiveness of school-based
wraparounds, the results suggest that this may be a promising service delivery option for
children and families. Through this effort, schools are the entry point for the wraparound
process, but they retain the same community and familial representation as wraparounds
through other agencies (Eber, Surgai, McCord & Poulin, 2002; Epstein, Nordness,
Gallagher, Nelson, Lewis, & Schrepf, 2005; Osher 2001). Through the school-based
wraparounds, teachers are key stakeholders, there are interdisciplinary teams for the
child, and support is available before, during and after school (Eber et al., 2002). When
schools are the entry point to wraparound, the students were more likely to maintain less
restrictive educational placements, their academic performance improved, and there were
fewer residential placements (Epstein et al., 2005).

Stambaugh, Mustillo, Burns, Stephens, Baxter et al. (2007) examined the
outcomes of wraparound care and multisystemic therapy (MST). There were 320 youth
in the Center for Mental Health Services systems-of-care demonstration sites that were
included in the study. The participants received either wraparound care only,
multisystemic therapy only, or both wraparound and MST. Functional and clinical outcomes were examined at six-month intervals for 18 months. The results indicated that the children in all groups improved over time in both clinical symptoms and generalized functioning. The youth who received only MST improved at a faster rate and were more likely to move out of the clinical range of impairment by the end of the study when compared to those who received only wraparound support. Most of the children in the wraparound group remained at the borderline to clinical range on the Child Behavior Checklist. Generally, the researchers concluded that MST is effective for emotional and behaviorally disturbed youth, but wraparound care is a promising treatment option that needs to gain more empirical support. It is difficult to demonstrate the effectiveness of wraparound support because each treatment plan is different, and there is inconsistent implementation of the model.

**Purpose of the Study**

The research literature suggests that the current state of treatment for children with emotional and behavioral disorders is in crisis. In many cases the schools, community, and parents are not working together to help children. The literature calls for meaningful parental involvement in treatment, more service options in the schools, and school-community partnerships. The current study seeks to understand whether or not there is a relationship between parental report of quality school collaboration and the school services provided, the extent of school-community partnerships, the severity of child behavior, and the level of parent stress. The school-parent collaboration will be examined in terms of the quality of caregiver and school staff relationships, in addition to
how well the school-based teams are providing supports for the child and family. This study will add to the literature through examining whether or not evidence-based practices that include parent involvement and community collaboration relates to the parent reports of satisfaction and overall effectiveness of the services.

*Research Questions*

1. What is the descriptive information for (a) the children, (b) school services, and (c) school-community partnerships?

2. What are the relationships (a) among parent satisfaction with the school and child behavior, parent stress, and quality of parent-school relationships and (b) among quality of parent-school relationships and child behavior, parent stress, and parent satisfaction?

3. Is there a relationship between the school-based services received and parents who report (a) satisfaction with the schools and (b) quality parent-school relationships?

4. Is there a relationship between the frequency or type of communication with school staff and (a) parent satisfaction with the school and (b) quality of parent-school relationship?

5. Is there a relationship between the presence of school-community-parent partnership and (a) parent satisfaction with the school and (b) the quality of parent-school relationships?
6. Is there a difference in the school-based services for parents who report school-community partnerships compared to parents who do not report these collaborations?

7. Is there a relationship between parental report of the effectiveness of the school supports and the services that were provided?
CHAPTER THREE

METHODOLOGY

Participants

Participants were parents or guardians of children aged 3 to 19 with emotional or behavioral disorders (EBD). The respondents were recruited from one large and two small support groups for parents of children with EBD. A total of 136 parents chose to participate, with 84% of the participants completing the survey. Demographic characteristics of the parents are presented in Table 1. The respondents are overwhelmingly female, married, Caucasian, and have a modal age between 41 and 50 years old. Most of the participants have a median educational level that falls within the “college graduate” range with 27 of the caregivers having graduate or professional degrees. Similar to the parent educational level, the socioeconomic status (SES) of the respondents was positively skewed in comparison to the general population. The parents reported having the financial resources to seek out support for their child at a higher rate than is reported in the literature (Farmer & Burns, 1997). Most of the sample was middle class or above and lived in suburban settings. An analysis of the open-ended residence question indicated that the participants reside in all regions of the United States of America. In addition, the parents reported the percentage of mothers, fathers, grandparents, and other relatives in the child’s family that have mental health disorders:
mother-20%, father-19%, relatives-35%, and grandparents-21%. Of the respondents, 15% indicated that there is no history of mental health disorders in the family.

Table 1

Parents’ Demographic Information

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>105</td>
<td>92.9</td>
</tr>
<tr>
<td>Male</td>
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<td>7.1</td>
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<tr>
<td>Ethnicity</td>
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<td>0.0</td>
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<tr>
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<td>2.2</td>
</tr>
<tr>
<td>System Missing</td>
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<td>15.7</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
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<td>25-30</td>
<td>7</td>
<td>6.3</td>
</tr>
<tr>
<td>31-40</td>
<td>37</td>
<td>33.3</td>
</tr>
<tr>
<td>41-50</td>
<td>49</td>
<td>44.1</td>
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<td>51-60</td>
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<td>14.4</td>
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<tr>
<td>Over 60</td>
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<td>1.8</td>
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<tr>
<td>Education</td>
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<tr>
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<td>2.7</td>
</tr>
<tr>
<td>High school graduate</td>
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</tr>
<tr>
<td>Some college</td>
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<td>24.5</td>
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<tr>
<td>College graduate</td>
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<td>31.8</td>
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<tr>
<td>Some graduate courses</td>
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<td>9.0</td>
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<tr>
<td>Graduate/professional degree</td>
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<td>24.5</td>
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Table 1 (continued)

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<tr>
<th>Income</th>
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</thead>
<tbody>
<tr>
<td>Very poor, unemployed</td>
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<td>3.6</td>
</tr>
<tr>
<td>Working, but poor</td>
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<td>7.3</td>
</tr>
<tr>
<td>Working class</td>
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<td>8.2</td>
</tr>
<tr>
<td>Lower middle class</td>
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<td>15.6</td>
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<tr>
<td>Middle class</td>
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<td>38.5</td>
</tr>
<tr>
<td>Upper middle class</td>
<td>26</td>
<td>23.8</td>
</tr>
<tr>
<td>Upper class</td>
<td>3</td>
<td>2.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Living setting</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Rural</td>
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</tr>
<tr>
<td>Urban</td>
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<td>12.5</td>
</tr>
<tr>
<td>Suburban</td>
<td>73</td>
<td>65.2</td>
</tr>
</tbody>
</table>

Procedures

First, a pilot was conducted during August 2009 in order to test the reliability and validity of the survey. Participants were parents of children receiving special education services under the Emotional Disability or Autism criteria within Community Consolidated School District #15. Of the 100 parents who were asked to participate, 30 completed the survey.

For the current study, an on-line survey used the Survey Monkey server to gather information about parent and child experiences with school and community services during the time frame from August 2009 to January 2010. First, on January 14th, a link to the survey was posted on www.Conductdisorders.com, which is a large on-line support group for parents of children with emotional and/or behavioral needs. Some of the members chose to encourage other parents to participate by posting responses to the call
for participants. On January 31st the second official recruitment was posted on the website. At this time there was a much smaller number of respondents than expected; therefore, other parent support groups were contacted in an attempt to increase the sample size. The Asperser’s Syndrome List Subscriber Support (asperger.icors.org) and ADD/ADHD Forum (add.about.com) agreed to allow posts asking for participants. On the Asperger’s Syndrome List an email was sent through the listserve, and on the ADD/ADHD forum a post was placed within the Parents of Children with ADD section. Both of these efforts were made on January 25th. The number of parents who saw the posts from these two support groups is unknown however there was a total of 200 views to the post on ADD/ADHD forum.

At the beginning of February there continued to be a lack of response to the survey. On February 10th another post was placed on www.conductdisorders.com. Lastly, the final call for participants from www.conductdisorders.com was made with two separate posts on March 8th and March 10th. The number of potential parents who viewed the call for participants on www.conductdisorders.com is unknown; however, there were over 1,000 views to all the posts on this site. The survey was closed on March 13th.

There were 136 respondents with 114 completed surveys; 84% of the parents who started the survey finished. Based on the number of known views to the call for participants’ posts, it is estimated that 8-10% of the parents choose to participate. The survey was designed with branching so that some respondents did not view all the questions. For example, parents of children aged 0-3 did not answer questions about school services, and participants of children who did not have an IEP skipped questions
about IEP services. Although there were 114 completed surveys, not all respondents answered every question in a scale, which will reduce the N reported on some variables. Therefore, the total N varies for each research question.

Instrumentation

The School-Based Mental Health Services Survey consisted of four scales which measured parent stress, childhood behavior, parent satisfaction with the school, and the quality of parent and school relationships. Two indices pertaining to school-based services and school-home-community collaboration were created. Finally, descriptive questions about the child and family were included in the survey. Information about the survey scales and indices is provided below.

Parent Stress. Parent stress was measured utilizing the Caregiver Strain Questionnaire (Brannan, Heflinger, & Bickman, 1997). This instrument includes 21 items measuring parent stress as a result of having a child with EBD. In their study, Brannan et al. (1997) surveyed 984 families of children with emotional or behavioral disorders. Each item was rated on a 5-point scale ranging from not at all to very much a problem. Example items include “interruption of personal time”, “missing work or neglecting duties”, “feeling sad or unhappy”, “worrying about the family’s future”, “resentment” and “anger”. The authors conducted exploratory and confirmatory factor analysis, which resulted in three factors: objective caregiver strain, internalized subjective caregiver strain, and externalized subjective caregiver strain. Brannen et al. (1997) examined the global stress measure with all items and the results showed adequate internal consistency with a Cronbach alpha of .93.
Child Emotional and Behavioral Symptoms. The emotional and behavioral characteristics were examined utilizing a modified version of the Achenbach System of Empirically Based Assessment Child Behavioral Checklist for Ages 6-18 (CBCL/6-18) (Achenbach & Rescorla, 2001). The original CBCL reported internal consistency of the scale scores to be reliable with Cronbach alphas ranging from .78-.97. The Total Problems Composite on the CBCL resulted in a Cronbach Alpha of .94.

The modified scale for the current study was used. It includes 30 items, as opposed to 112 from the original CBCL, which assessed the severity of child emotional and behavioral problems. The current scale utilized a seven-point index (1 = never a problem, 2 = very rarely, 3 = rarely, 4 = sometimes, 5 = often; 6 = very often, 7 = always) as opposed to a three-point index from the CBCL (0 = not true; 1 = Somewhat or Sometimes True; 2 = Very True or Often True). Modified versions of the CBCL have been used previously in two separate surveys, and in both cases it demonstrated strong internal reliability.

The decision to use a modified version of the CBCL is two-fold. First, the reduction of items likely increased the number of completed surveys. The survey is composed of many questions, and it is important to ensure that participants are motivated to complete the instrument in its entirely. Second, a seven-point index allows for greater variability among items, which provides a more accurate understanding of the children’s emotional and behavioral characteristics. This response format also ensures that each participant has an option that adequately describes his/her opinion of the child’s behavior. The 30 items on the modified version for this study used exactly the same wording as the
original CBCL. The items chosen for analysis represent a diversity of childhood emotional or behavioral problems such as “inattention”, impulsivity”, “lying” “executive functioning deficits” “learning problems at school”, “dangerous to self”, “dangerous to others”, “obsessive behavior”, and “mood swings”.

**Parent Satisfaction.** Parent satisfaction with school-based support teams was measured utilizing a modified version of the *Family Satisfaction Tool (FS-T)*, which was developed by the Illinois Positive Behavior Intervention Supports (PBIS) network. The scale consists of 15 items in which the parents indicate to what extent the members of the school team demonstrated behaviors on the following scale: 1 = not at all; 2 = slightly; 3 = somewhat; 4 = a great deal. This scale specifically sought to assess how well the school team met the needs of the child and family. Example of item responses include “treated you with respect”, “eased your worries about the future well-being of your child”, and “helped you understand how to use strengths and needs to work with your child”, “helped you obtain services for your child and family you were unable to obtain before” and “gave you information about your community resources”. No information about the reliability and validity of this instrument is available. For the current study, a five-point scale was used to allow for greater variability among items (1 = not at all; 2 = slightly; 3 = somewhat, 4 = most of the time; 5 = almost all the time).

**Quality of Parent and School Relationships.** Parents were asked to indicate the quality of parent-school relationships with teachers, administration, and support staff. Parents indicated how frequently they felt “respected”, “like an equal partner”, “understood”, “blamed for their child’s difficulties”, “intimidated”, “confused” and
“angry” when communicating with Teachers, Administration, and Support Staff. This scale is intended to determine how parents felt when working with school personnel. The items were asked separately for each of the above mentioned school staff roles since it is possible that the parent relationships are different with personnel depending on the staffs’ responsibilities. If no difference is found among the quality of relationships with the teachers, administration, and support staff, the Quality of Parent-School Relationship will include all of the items from the separate staff questions on one index.

In order to assess the nature of parent-school communication, the parents were asked how frequently they communicated with school staff and how often they interacted through email, phone, a team, and one-on-one in person. They also indicated whether or not they participated on special education, problem-solving, wraparound, and 504 teams.

School Services. Parents answered many questions, using multiple choice and yes/no response options, about the school services their child received from August 2009 and January 2010. All parents, regardless of whether or not their child received special education services, were asked to state the type of setting in which the child received his/her education, the child’s level of academic skill and cognitive ability, and whether or not the child experienced detentions, suspensions, or expulsions for his/her behavior at any time while in school. Participants stated whether or not their child changed schools or classrooms as a result of the student’s behavior.

All parents, regardless of their child’s Individual Education Plan (IEP) status, were asked to indicate whether or not the student received school-based services for at least one month from August 2009 to January 2010. This index included 12 items such
as “after-school support”, “social work/counseling”, “small group instruction”, “parent training classes”, and “individualized behavior plan”. To follow up these questions, parents stated whether or not the school-based support addressed 9 needs such as “emotional/impulse control”, “organization”, “following directions”, and “attention”.

Caregivers of children who received special education services were asked questions about the nature of these services. For example, they indicated the primary eligibility, at what age the child was found eligible, the service setting, and which supports were provided through the IEP. There were 11 IEP service options such as “social work”, “modified assessments”, “small group instruction”, and “individual behavior intervention plan”. At end of the survey, parents indicated whether or not they felt that the school services were effective.

*School-Community Partnership.* The final index from the School-Based Mental Health Services Survey examined school-community partnership. Parents were asked multiple choice and yes/no questions in an attempt to assess whether or not the school and community worked with the parents to help the child. For example, parents indicated if the school and community collaborated together to formulate a treatment plan, the extent to which the family was included in this plan, and if the school-parent-community partnership was helpful. Parents also stated whether or not their child received treatment through the community and, if so, what services were provided.

*Pilot.* This author conducted a pilot analysis in order to determine whether the above scales and indices were valid and reliable. Despite the pilot sample being a small, fairly homogenous sample (n = 30), the results indicated that the scales and indices were
valid and reliable. The inter-item correlation on each scale was strong. The Cronbach alphas were all satisfactory with the following results: Family Satisfaction Tool $\alpha=.94$; Quality of Parent-School Relationships scale $\alpha=.95$; Caregiver Strain Questionnaire $\alpha=.96$; and modified Child Behavior Checklist (CBCL) $\alpha=.80$.

In addition to examining the reliability of each scale, the indices and descriptive data were examined to ensure that participants appeared to understand the questions. There were no items with a significant number of “not applicable, not sure, or unable to determine” responses. At the end of the survey the parents were asked to provide feedback about the questions, and no respondents suggested any changes. Therefore, the survey was determined to be reliable and valid.

**Analysis**

Analysis of the data for each research question was done through utilizing standard linear regression and crosstab analysis. The specific statistical analysis utilized will depend on the research question being addressed.

**Instrument reliability and validity.** Before each research question was answered, internal reliability statistical procedures were utilized to ensure that the constructs from the modified Child Behavior Checklist, Caregiver Strain Questionnaire, Family Satisfaction Tool, and Quality of Parent-School Relationships scales were strong. When the coefficient alphas were at least moderately high (above .70), a grand mean for each scale was computed and inter-correlations were examined among items. In addition to computing the grand mean, the above four scales were re-coded into the original intervals to increase the interpretability of the analysis. The participants’ means for each scale
were coded on the 1 to 5 interval for the Caregiver Strain, Family Satisfaction Tool, and Quality of Parent-School Relationships scales, and from 1 to 7 on the modified CBCL. The exact scale mean to interval codes were as follows: 0-1.5 = 1; 1.6-2.5 = 2; 2.6-3.5 = 3; 3.6-4.5 = 4 and 4.6-5 = 5. This was the same for the modified CBCL with 4.6-5.5 = 5; 5.6=6.5 = 6 and 6.6-7= 7.

Before examining the Quality of Parent-School Relationships scale, the negative items were reversed so that a response of almost always on the “blamed for your child’s difficulties”, “intimidated”, “confused”, and “angry” items were reverse-coded as a response of almost never on the “respected”, “like and equal partner”, and “understood” items. This recoding was done because in order for the scale to be reliable and valid, the scores must be coded and computed to have the same conceptual meaning. Therefore, the scale went from 1 = a negative feeling to 5 = a positive feeling. It is expected that parents who have a negative relationship with the school would agree to items such as “blamed” and “angry” but would disagree to items such as “respected” and “understood”.

Following the recoding, the scale was split into responses based on Teachers, Administration, and Support Staff. Cronbach’s Alpha was determined for each of these indices. Since all were reliable, correlations were computed between the three scales to determine whether or not they have a positive significant relationship. The three scales will be combined to form the Quality of Parent-School Relationships scale. See the preliminary analysis in the beginning of the results chapter for specific information about the validity of this scale.
Research question analyses. If the scales are found to be reliable and valid, the following research questions will be addressed.

1. What is the descriptive information for (a) the children, (b) school services, and (c) school-community partnerships?

   The primary analysis will include frequency data. The data will present the demographic information about the children, percentage of children who have received various forms school-based services from August 2009 to January 2010, and frequency data about school-community-parent partnerships.

2. What is the relationship (a) among parent satisfaction with the school and the child behavior, parent stress, and quality of parent-school relationships scales and (b) among quality of parent-school relationships and the child behavior, parent stress, and parent satisfaction scales?

   Two separate MANOVA analyses will be conducted to answer this question. In the first analysis, the Family Satisfaction Tool will be used as the independent variable, and the dependent variables will be the grand mean on the Caregiver Strain, modified CBCL, and Quality of Parent-School Relationship scales. For the second analysis (part b), the Quality of Parent-School Relationship scale will be the independent variable, with Family Satisfaction Tool, Caregiver Strain, and modified CBCL as the dependent variables.

   If the MANOVA’s are found to be significant and demonstrate adequate tests of homogeneity, the relationship between the independent variable and dependent variables will be analyzed through univariate analyses.
3. Is there a relationship between the school-based services and parents who report (a) satisfaction with the schools and (b) quality parent-school relationships?

Two separate analyses will be conducted using univariate techniques. For the first analysis (part a), the dependent variable will be the Family Satisfaction Tool and the independent variables will include 39 items examining school-based services. Since there were many school supports, combining all of the items in one univariate analysis would not be feasible given the study’s number of respondents. Therefore, the items will be grouped based on similarity to reduce the number of separate univariate analyses needed. In total, there will be eight analyses with the Family Satisfaction Tool as the dependent variable.

First, the school interventions index will be broken down into four indices with the following groupings: (1) daily point sheet and self-monitored his/her own behavior; (2) parent training, parent support group, and parent/child group; (3) behavior plan, individual social work, group social work, and social/anger management skills group, and (4) before/after school help, small group or 1-on-1 support, and extracurricular activities.

The next analysis will examine what behaviors the above supports addressed, which will include nine items. Whether or not the child has an IEP, in what setting he/she was served, and how well the child was meeting the IEP goals will also be examined. This will be followed by an analysis of 11 services provided through the IEP. The final univariate analysis will examine parent satisfaction in relation to expulsions, suspensions, and detentions received.
To answer part (b) of this question, the Quality of Parent-School Relationship will be the dependent variable with school-based services as the independent variables. The exact same univariate analyses will be conducted as described in part (a). Therefore, there will be eight separate univariate analyses with Quality of Parent-School Relationship as the dependent variable.

4. Is there a relationship between the frequency or type of communication with school staff and (a) parent satisfaction with the school and (b) quality of parent-school relationship?

Univariate analyses will be conducted to answer part (a) and (b) of this question. For part (a) the Family Satisfaction Tool will be the dependent variable and survey questions about the frequency and type of communication will be independent variables. For part (b) the Quality of Parent-School Relationship scale will be the dependent variable and parent-school communication questions will be the independent variables. One univariate analysis will be conducted for each part.

5. Is there a relationship between the presence of school-community-parent partnerships and (a) parent satisfaction with the school and (b) the quality of parent-school relationships?

Univariate analyses will be conducted to answer part (a) and (b) of this question. For part (a) the Family Satisfaction Tool will be the dependent variables and survey questions about parent-school-community partnerships will be independent variables. For part (b) the Quality of Parent-School Relationship scale will be the dependent variable.
and parent-school-community partnerships will be the independent variables. One
Univariate analysis will be conducted for each part.

6. Is there a difference in the school-based services for parents who report
school-community partnerships compared to parents who do not report these
collaborations?

To answer this question crosstabs will be computed with community-school
partnerships and the 39 school-based service items. The chi-square statistic will be
reported for each analysis. The specific school-based services will include the following
items: school intervention matrix; what behaviors the supports address; whether the child
had suspensions/expulsions/detentions during the current school year and in the past; the
types of teams the parent is a member of; and whether the child has an IEP and what
services are provided through the IEP.

7. Is there a relationship between parental report of the effectiveness of the
school services and the services that were provided?

Univariate analyses will be conducted with the parental report of school
effectiveness as the dependent variable and the school-based services as the independent
variable. The same approach will be taken as in research question three; there will be
eight separate univariate analyses conducted to examine the 39 school-based services. In
addition, whether or not the parent experienced school-community partnership will also
be examined in a univariate analysis as the independent variable.
CHAPTER FOUR

RESULTS

Before interpreting the analyses, data was coded and checked for errors. Items that were left blank or scored “not applicable or unable to determine” were coded as missing data.

*Reliability Analysis*

The Family Satisfaction Tool, Quality of Parent-School Relationships, Caregiver Strain and modified Child Behavior Checklist scales were examined to ensure that previous estimates of reliability held for this particular sample.

A Cronbach alpha was computed for the Family Satisfaction Tool ($\alpha=.94$), indicating that the scale demonstrated adequate reliability. In addition, the corrected item-total correlations fell within the preferred range, with the lowest correlation being .476. The results suggest that the internal structure for the scale is valid, meaning that the items contribute to overall measurement of parent satisfaction with the school’s ability to help the family and child.

For the Quality of Parent-School Relationship scale the reliability was first analyzed for Teacher, Administration, and Support Staff separately. A Cronbach alpha was computed for Teacher ($\alpha=.92$), Administration ($\alpha=.94$) and Support Staff ($\alpha=.93$), demonstrating adequate reliability for each scale. Corrected item-total correlations fell within the preferred range, with the lowest being .583. The results suggested that the
internal structure for each scale was valid; therefore, correlations were conducted between the three scales and positive significant relationship were found: Teacher and Administration (n = 104; r = .884; p = .00), Teacher and Support Staff (n = 97; r = .814; p = .00), and Administration and Support Staff (n = 95; r = .796; p = .00). Since all of the correlations were positive and strong, the three scales were combined into one scale measuring the quality of parent-school relationships. The Cronbach alpha indicated adequate reliability (α = .971) and the lowest inter-item correlation was .573.

The Caregiver Strain scale was examined with all 21 items reported in the Brannan, Heflinger, and Bickman’s (1997) study. The Cronbach alpha was found to be adequate (α = .93). Corrected item-total correlations fell within the preferred range, with the lowest being .322. The results suggest that the internal structure for the scale is valid, indicating that the items contribute to overall measurement of parent stress.

Finally, the validity of the modified Child Behavior Checklist was examined. A Cronbach alpha was conducted for all 30 items, which resulted in an alpha of .89, demonstrating adequate reliability. Corrected item-total correlations fell within the preferred range, with the lowest being .157. Removing this item from the scale did not raise the Cronbach alpha; therefore, all 30 items remained in the scale. The results suggest that the internal structure for the scale is valid, indicating that the items contribute to overall measurement of child behavioral and emotional problems.

Given that all scales were found to be reliable, the mean and standard deviation scores were computed and are displayed in Table 2. Results on the Family School Tool indicate that the parents were, on average, only slightly to somewhat satisfied with the
school team’s ability to help meet the needs of the child and family. When examining the Quality of Parent-School Relationships, however, the parents feel that they are treated with respect, understood, and not blamed for their child’s problems by school personnel. A paired sample T-Test found that the Quality of Parent-School Relationships mean was significantly higher than that of the Family Satisfaction Tool \( T(95, 107) = 15.5, p = .001 \). On the Caregiver Strain Questionnaire, the parents reported moderate levels of stress ranging from sometimes a problem to often a problem, and on the modified CBCL the child behavioral symptoms ranged from infrequently a problem to sometimes a problem.

Table 2

*Mean and Standard Deviation Scores for the Family Satisfaction Tool, Quality of Parent-School Relationships scale, Caregiver Strain Questionnaire and modified Child Behavior Checklist (CBCL)*

<table>
<thead>
<tr>
<th>Scale</th>
<th>N</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Satisfaction Tool</td>
<td>107</td>
<td>2.56</td>
<td>.913</td>
</tr>
<tr>
<td>Quality of Parent-School Relationship</td>
<td>114</td>
<td>3.71</td>
<td>.921</td>
</tr>
<tr>
<td>Caregiver Strain Questionnaire</td>
<td>113</td>
<td>3.47</td>
<td>.782</td>
</tr>
<tr>
<td>Modified CBCL</td>
<td>112</td>
<td>3.41</td>
<td>.988</td>
</tr>
</tbody>
</table>

*Note:* Ratings for Family Satisfaction Tool and Quality of Parent-School Relationships were on a five point scale (1 = not at all; 2 = slightly; 3 = somewhat; 4 = most of the time and 5 = almost all of the time); Caregiver Strain was on a five point scale (1 = not at all; 2 = infrequently a problem; 3 = sometimes a problem; 4 = often a problem; 5 = very often a problem); and modified CBCL a 7 point scale (1 = never a problem; 2 = very infrequently a problem; 3 = infrequently a problem; 4 = sometimes a problem; 5 = frequently a problem; 6 = very frequently a problem; 7 = always a problem).
Question One

1. What is the descriptive information for (a) the children, (b) school services, and (c) school-community partnerships?

Child Demographic Information. The results indicated that the majority of the children are male (80%), Caucasian (77.6%), and not adopted (77%). The children’s current ages were well distributed between 4 and 18 years old. Many of the children’s emotional and/or behavioral problems started between the ages of birth to two (42.6%) and the first professionals to notice the problems were in the school (62.7%). In all, 35.1% of the children received early childhood support and the modal range of diagnosis was 4-6 years old (41.7%). It was reported that 89.6% of the children have a DSM-IV diagnosis, and a psychiatrist gave the diagnosis (33.6%). The parents stated that most of the children take medication for the emotional/behavioral needs. The children are also, for the most part, living at home with the caregiver (89.2%) (refer to Table 3 for detailed child demographic information).
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>25</td>
<td>19.2</td>
</tr>
<tr>
<td>Male</td>
<td>105</td>
<td>80.8</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>104</td>
<td>80.0</td>
</tr>
<tr>
<td>African American</td>
<td>08</td>
<td>6.2</td>
</tr>
<tr>
<td>Latino</td>
<td>03</td>
<td>2.3</td>
</tr>
<tr>
<td>Bi-racial</td>
<td>14</td>
<td>10.8</td>
</tr>
<tr>
<td>Asian</td>
<td>01</td>
<td>0.8</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-3</td>
<td>01</td>
<td>.8</td>
</tr>
<tr>
<td>4-6</td>
<td>13</td>
<td>10.0</td>
</tr>
<tr>
<td>7-9</td>
<td>34</td>
<td>26.1</td>
</tr>
<tr>
<td>10-12</td>
<td>24</td>
<td>19.6</td>
</tr>
<tr>
<td>13-15</td>
<td>29</td>
<td>22.3</td>
</tr>
<tr>
<td>16-18</td>
<td>21</td>
<td>16.1</td>
</tr>
<tr>
<td>19 and over</td>
<td>06</td>
<td>4.6</td>
</tr>
<tr>
<td><strong>Adoption status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>26</td>
<td>19.4</td>
</tr>
<tr>
<td>No</td>
<td>104</td>
<td>77.6</td>
</tr>
<tr>
<td><strong>Living Situation</strong></td>
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<td></td>
</tr>
<tr>
<td>At home with me</td>
<td>116</td>
<td>89.2</td>
</tr>
<tr>
<td>In licensed foster care</td>
<td>01</td>
<td>0.8</td>
</tr>
<tr>
<td>With a relative/friend</td>
<td>04</td>
<td>3.1</td>
</tr>
<tr>
<td>In Residential Treatment Center</td>
<td>07</td>
<td>5.4</td>
</tr>
<tr>
<td>In Juvenile Justice System or prison</td>
<td>02</td>
<td>1.5</td>
</tr>
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</table>
**Table 3 (continued)**

<table>
<thead>
<tr>
<th>Age emotional/behavioral problems appeared</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Birth to 2</td>
<td>55</td>
<td>42.6</td>
</tr>
<tr>
<td>3-5</td>
<td>50</td>
<td>38.2</td>
</tr>
<tr>
<td>6-8</td>
<td>13</td>
<td>6.2</td>
</tr>
<tr>
<td>9-11</td>
<td>05</td>
<td>3.9</td>
</tr>
<tr>
<td>12-14</td>
<td>05</td>
<td>3.9</td>
</tr>
<tr>
<td>15-17</td>
<td>01</td>
<td>.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Professional who first noticed the child’s difficulties</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>School or preschool staff</td>
<td>84</td>
<td>68.9</td>
</tr>
<tr>
<td>Pediatrician</td>
<td>18</td>
<td>14.8</td>
</tr>
<tr>
<td>Psychologist/Psychiatrist</td>
<td>20</td>
<td>16.4</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>DSM-IV diagnosis</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>120</td>
<td>92.3</td>
</tr>
<tr>
<td>No</td>
<td>07</td>
<td>5.4</td>
</tr>
<tr>
<td>Not sure</td>
<td>03</td>
<td>2.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age received DSM-IV diagnosis</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth-2</td>
<td>02</td>
<td>1.7</td>
</tr>
<tr>
<td>2-3</td>
<td>21</td>
<td>17.5</td>
</tr>
<tr>
<td>4-6</td>
<td>50</td>
<td>41.7</td>
</tr>
<tr>
<td>6-8</td>
<td>29</td>
<td>24.2</td>
</tr>
<tr>
<td>9-11</td>
<td>09</td>
<td>7.5</td>
</tr>
<tr>
<td>12-14</td>
<td>07</td>
<td>5.8</td>
</tr>
<tr>
<td>15-18</td>
<td>02</td>
<td>1.7</td>
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</table>

<table>
<thead>
<tr>
<th>Early Childhood services</th>
<th></th>
<th></th>
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<tr>
<td>Yes</td>
<td>39</td>
<td>35.1</td>
</tr>
<tr>
<td>No</td>
<td>72</td>
<td>64.9</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Professional who provided the DSM-IV diagnosis</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatrician/Family Doctor</td>
<td>24</td>
<td>20.2</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>40</td>
<td>33.6</td>
</tr>
<tr>
<td>Psychologist</td>
<td>30</td>
<td>25.2</td>
</tr>
<tr>
<td>Neuropsychologist</td>
<td>12</td>
<td>10.1</td>
</tr>
<tr>
<td>Hospital/clinical evaluation team</td>
<td>13</td>
<td>10.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication status</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Has medication and takes it</td>
<td>88</td>
<td>67.7</td>
</tr>
<tr>
<td>Has medication but refuses to</td>
<td>07</td>
<td>5.4</td>
</tr>
<tr>
<td>take it</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Took medication in the past year,</td>
<td>05</td>
<td>3.8</td>
</tr>
<tr>
<td>but not currently</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has been prescribed, for other</td>
<td>08</td>
<td>6.2</td>
</tr>
<tr>
<td>reasons we chose for them not to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>take it</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No, does not have medication</td>
<td>22</td>
<td>16.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Has an IEP</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>80</td>
<td>69.0</td>
</tr>
<tr>
<td>No</td>
<td>36</td>
<td>31.0</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Grade eligible for IEP</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Early childhood</td>
<td>20</td>
<td>25.0</td>
</tr>
<tr>
<td>Kindergarten</td>
<td>10</td>
<td>12.5</td>
</tr>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>16</td>
<td>20.0</td>
</tr>
<tr>
<td>2&lt;sup&gt;nd&lt;/sup&gt;</td>
<td>08</td>
<td>10.0</td>
</tr>
<tr>
<td>3&lt;sup&gt;rd&lt;/sup&gt;</td>
<td>06</td>
<td>07.5</td>
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<tr>
<td>4&lt;sup&gt;th&lt;/sup&gt;</td>
<td>03</td>
<td>03.8</td>
</tr>
<tr>
<td>5&lt;sup&gt;th&lt;/sup&gt;</td>
<td>05</td>
<td>06.3</td>
</tr>
<tr>
<td>6&lt;sup&gt;th&lt;/sup&gt;-8&lt;sup&gt;th&lt;/sup&gt;</td>
<td>06</td>
<td>07.5</td>
</tr>
<tr>
<td>9&lt;sup&gt;th&lt;/sup&gt;-12&lt;sup&gt;th&lt;/sup&gt;</td>
<td>06</td>
<td>07.5</td>
</tr>
</tbody>
</table>

School-Based Services. The majority of the children were currently receiving their education within the public school setting (79.7%). Other settings included private schools (4.9%), home schooled (3.3%), the juvenile justice system (2.4) a self-contained special education school (6.5%) and residential placement (3.3%). Many of the children demonstrated adequate academic skills. For example, most of the children’s math skills
were rated as average (30.6%) or above average (21.5%). The same pattern was found for reading, with 31% reading at the average range, 24% reading above average, and 21% reading well above average. Science and social studies skills were also rated as average (42% for both), but writing skills were perceived as areas of weakness with only 23% of the children displaying average and 11% above average skills. The parents indicated that 63% of the children passed the state standardized assessment, and that 89% of the children’s cognitive skills were average to well above average. The results suggest that most of the children in this sample demonstrate the cognitive and academic skills necessary to make adequate academic progress in school.

The children’s expulsion, suspension, and detention experiences were examined. For the current school year, 5% of the students had been expelled, 26.3% of the students received at least one suspension, and 25.2% had at least one detention. The respondents report that 16% of the students had been expelled in prior years, 56% had been suspended in previous school years, and 62% had received detentions in the past.

Parents reported whether or not their child had received various supports and interventions for one month or longer from August 2009-January 2010. The most common supports were child self-monitored his/her behavior (49%), individual social work (41%), small group or 1 on 1 academic support (49%), and individual behavior plan (48%). The less common supports were parent/child group, parent training, parent support group, social skills or anger management group, group social work, before or after school support, extracurricular activities, and a daily point sheet. In all, 23% of the children without an IEP received one or more of these services, meaning that they
occurred within the general education setting. The school asked a little more than half of the parents for their consent before the services were provided without an IEP (59%) (see Table 4).

Table 4

*Number and Percentages of School Supports Received*

<table>
<thead>
<tr>
<th>Support/Intervention</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily point sheet</td>
<td>37</td>
<td>32</td>
</tr>
<tr>
<td>Before/after school support</td>
<td>20</td>
<td>17</td>
</tr>
<tr>
<td>Self-monitored behavior</td>
<td>54</td>
<td>49</td>
</tr>
<tr>
<td>Individual social work</td>
<td>48</td>
<td>41</td>
</tr>
<tr>
<td>Group social work</td>
<td>34</td>
<td>28</td>
</tr>
<tr>
<td>Social skills/anger management</td>
<td>39</td>
<td>34</td>
</tr>
<tr>
<td>Small group/1 on 1 support</td>
<td>58</td>
<td>49</td>
</tr>
<tr>
<td>Behavior plan</td>
<td>57</td>
<td>48</td>
</tr>
<tr>
<td>Parent training</td>
<td>09</td>
<td>07</td>
</tr>
<tr>
<td>Parent support group</td>
<td>15</td>
<td>13</td>
</tr>
<tr>
<td>Parent/child group</td>
<td>03</td>
<td>03</td>
</tr>
<tr>
<td>Extracurricular activities</td>
<td>47</td>
<td>40</td>
</tr>
</tbody>
</table>

Participants were asked to report what behavioral or emotional needs the above supports addressed. The ratings were as follows: relationships with adults (37%); organization (40%); unstructured settings (41%); aggressive behavior (44%); homework
completion (45%); emotional/impulse control (53%); relationships with peers (54%); 
attention (55%); and following directions (56%).

Following an examination of the services that were being received for all students, 
parents of children with Individual Education Plans were asked specific questions about 
the nature of these special education services. The majority of the parent’s reported that 
their child does had an IEP (n = 80; 69%). Most of the children were eligible under 
Emotional Disability (39%), followed by Autism (23%). Other categories include Other 
Health Impaired (18%), Specific Learning Disability (6%), Speech/Language (4%), 
Developmental Delay (3%) and other (9%). Many of the children were first eligible for 
services before 2\textsuperscript{nd} grade. The breakdown of when the IEP started was as follows: 
early childhood – 25%; Kindergarten – 13%; 1\textsuperscript{st} grade – 20%; 2\textsuperscript{nd} grade – 10%; 3\textsuperscript{rd} grade – 
7.5%; 4\textsuperscript{th} grade – 4%; 5\textsuperscript{th} grade – 6%; 6\textsuperscript{th} - 8\textsuperscript{th} grade – 7.5%; 9\textsuperscript{th} - 12\textsuperscript{th} grade – 7.5%. The 
most common service setting was a resource room (32.5%), followed by general 
education with little support (28.8%). In all, about 23% of the students were serviced in 
self-contained, therapeutic, or residential placements with 14% having a split between 
general education and special education classrooms.

The parents reported that the children were receiving a variety of supports through 
the IEP. Over 50% of the children with an IEP had extended time on tests, assessments 
in small group settings, modified assessments, social work, and an individual behavior 
tervention plan. The less common supports included summer school, speech/language, 
modified grading, and small group instruction (refer to Table 5). The parents were split 
in terms of how well they felt the IEP goals were being met. The breakdown was as
follows: “is meeting some of the goals” (36%), “is meeting most of the goals “(26%), “not meeting his/her goals” (18%), “meeting about half of the goals” (13%), and “meeting almost all of the goals” (7.5%).

Table 5

*Number and Percentages of IEP Supports Received*

<table>
<thead>
<tr>
<th>Support</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended Time</td>
<td>49</td>
<td>68</td>
</tr>
<tr>
<td>Small group testing</td>
<td>44</td>
<td>61</td>
</tr>
<tr>
<td>Small group instruction</td>
<td>36</td>
<td>47</td>
</tr>
<tr>
<td>Modified assessments</td>
<td>41</td>
<td>54</td>
</tr>
<tr>
<td>Modified grading</td>
<td>25</td>
<td>36</td>
</tr>
<tr>
<td>Social Work</td>
<td>36</td>
<td>51</td>
</tr>
<tr>
<td>Speech</td>
<td>24</td>
<td>32</td>
</tr>
<tr>
<td>Behavior plan</td>
<td>40</td>
<td>52</td>
</tr>
<tr>
<td>One on one support</td>
<td>26</td>
<td>32</td>
</tr>
<tr>
<td>Summer School</td>
<td>19</td>
<td>24</td>
</tr>
</tbody>
</table>

*School-Community-Parent Partnerships.* The majority of the parents stated that the school and community did not work together to help their child (61%; n = 68). In all, 26% of the parents report a community-school collaboration during the 2009-2010 school year (n = 29), and 11% (n = 13) reported that there was no partnership this year, but there had been one in the past. Of the parents who had collaboration, the majority were
included in the treatment planning (e.g., almost all the time – 42%, most of the time – 40%, about half the time – 7%, and a little bit – 10%). In addition, when asked if the school-community partnership helped their child; the responses were as follows: not at all – 7%; a little bit – 20%; somewhat – 32%; much of the time – 20%; most of the time – 22%. The mean rating on how well the partnership was working was 3.39 with a standard deviation of 1.23.

Parents also were asked to state whether or not their child was receiving supports within the community. For this question, the majority of the parents stated that their child was currently receiving services (64%). In all, 64% of the children had treatment in the community, but for only 24% of the students the school and community were working together. A chi-square analysis, however, did not find this difference to be significant (refer to Table 6 for the frequency of students in each category). In terms of the community services being received, 89% of the children were provided with individual counseling, 48% with family therapy, 26% with child group therapy, 9% with outpatient supports, 17% with inpatient hospitalization, and 24% with case management during the 2009-2001 school year. Finally, the reports about the burden of the costs of these services was distributed into categories as follows: “I did not pay for these services” – 22%; “I paid for them and it was not a burden” – 21%; “I paid for services and it was a burden some of the time” – 22%; “the cost of the services was a burden” – 22%; and “the cost of the services was a significant burden ” – 12%.
Table 6

*Number of Students who Received Community-Based Supports and Home-School-Community Collaboration*

<table>
<thead>
<tr>
<th>The School and Community Collaborated</th>
<th>Child received services in the community</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Yes</td>
<td>22</td>
</tr>
<tr>
<td>No</td>
<td>40</td>
</tr>
<tr>
<td>Not this year</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>71</td>
</tr>
</tbody>
</table>

*Question Two*

2. What is the relationship (a) among parent satisfaction with the school and child behavior, parent stress, and quality of parent-school relationships and (b) among quality of parent-school relationships and child behavior, parent stress, and parent satisfaction?

*Parent Satisfaction.* A one-way multivariate analysis (MANOVA) was conducted to determine the effect of parent satisfaction with the schools on caregiver stress, the severity of the child’s emotional or behavioral problems, and the quality of parent-school relationships. Significant difference was found Wilks’s Λ = .458, $F(4, 97)= 6.904, p = .00$, meaning that there was a relationship between parent satisfaction with the school and caregiver stress, child behavior problems and the quality of parent-school relationship together. The homogeneity of variance was met (Box’s M = 40.633, p = .101), suggesting adequate variance between items. In order to understand how parent satisfaction was contributing to the dependent variables, a univariate analysis was
examined. Significant results were found with parent satisfaction and caregiver stress $F(4, 97) = 2.56, p < .05$, and with parent satisfaction and the quality of parent-school relationships $F(4, 97) = 10.646, p = .001$. No significant relationship was found between parent satisfaction and child behavior problems $F(4, 97) = 1.031, p = .396$. The majority of the variance in the model was explained through the relationship between parent satisfaction and the quality of parent-school relationship (refer to Table 7).

The parents who were satisfied with the school much of the time to almost all the time reported a positive relationship with the school. The trend for parent satisfaction with the school and stress, however, was not linear. The mean scores found that the parents who were under the most stress were either not at all satisfied or satisfied almost all of the time. Although the child behavior and parent satisfaction with the school was not significant, a similar trend between satisfaction and child behavior was found as with parent stress and satisfaction.

Table 7

<table>
<thead>
<tr>
<th>Satisfaction Category</th>
<th>CBCL M</th>
<th>CBCL SE</th>
<th>Caregiver Strain M</th>
<th>Caregiver Strain SE</th>
<th>Quality of Relationship M</th>
<th>Quality of Relationship SE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>3.8</td>
<td>.27</td>
<td>3.9</td>
<td>.20</td>
<td>2.3</td>
<td>.2</td>
</tr>
<tr>
<td>Slightly</td>
<td>3.5</td>
<td>.14</td>
<td>3.4</td>
<td>.11</td>
<td>3.6</td>
<td>.10</td>
</tr>
<tr>
<td>Somewhat</td>
<td>3.2</td>
<td>.23</td>
<td>3.6</td>
<td>.17</td>
<td>4.0</td>
<td>.17</td>
</tr>
<tr>
<td>Much of the time</td>
<td>3.2</td>
<td>.26</td>
<td>3.3</td>
<td>.20</td>
<td>4.5</td>
<td>.19</td>
</tr>
<tr>
<td>Almost all the time</td>
<td>3.7</td>
<td>.49</td>
<td>4.1</td>
<td>.37</td>
<td>4.8</td>
<td>.36</td>
</tr>
</tbody>
</table>

Note: Ratings were on a five point scale (1 = not at all to 5 = almost all the time/very often a problem) for Parent Stress and Quality of Relationship and a seven point scale for CBCL (1 = never a problem to 5 = always a problem). * $p < .05$; **$p < .01$. 
Quality of Parent-School Relationship. A MANOVA was run with the Quality of Parent-School Relationship as the independent variable and caregiver stress, child behavior problems and parent satisfaction with the school as dependent variables. A significant relationship was found between the variables Wilks’s Λ = .406, $F(4, 97) = 7.618$, $p = .001$ and the homogeneity of variance was met (Box’s M = 21.751, $p = .358$). Univariate analysis indicated a significant relationship between the quality of parent-school relationships and the severity of child behavior $F(4, 97) = 2.068$, $p = .05$, and parent satisfaction and quality of parent-school relationship $F(4, 97) = 10.425$, $p = .00$. The results indicated that the relationship between parent satisfaction with the school and quality of parent-school communication contributed most highly to the model. No significant relationship was found between parent stress and the quality of parent-school relationships $F(4, 97) = 1.885$, $p = .120$ (see Table 8).

The means suggest that parents reported being satisfied with the school teams when they feel that their relationships with school staff were positive “much of the time” to “almost all of the time”. In addition, the parents who indicated less severe child behavioral or emotional problems experienced a more positive relationship with the school staff. Although caregiver strain was not significantly related to the quality of parent and school relationships, the parents who were experiencing less stress expressed a higher quality relationship.
Table 8

Mean and Standard Error Scores of Caregiver Strain Questionnaire, Modified CBCL, and Family Satisfaction Tool by Quality of Parent-School Relationship Categories

<table>
<thead>
<tr>
<th>Quality Relationship Category</th>
<th>CBCL* M</th>
<th>SE</th>
<th>Caregiver Strain M</th>
<th>SE</th>
<th>Family Satisfaction** M</th>
<th>SE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost never</td>
<td>4.0</td>
<td>.66</td>
<td>4.2</td>
<td>.51</td>
<td>1.4</td>
<td>.45</td>
</tr>
<tr>
<td>Rarely</td>
<td>3.8</td>
<td>.35</td>
<td>3.9</td>
<td>.28</td>
<td>1.4</td>
<td>.24</td>
</tr>
<tr>
<td>Sometimes</td>
<td>3.9</td>
<td>.17</td>
<td>3.8</td>
<td>.14</td>
<td>2.0</td>
<td>.12</td>
</tr>
<tr>
<td>Much of the time</td>
<td>3.4</td>
<td>.16</td>
<td>3.5</td>
<td>.17</td>
<td>2.7</td>
<td>.11</td>
</tr>
<tr>
<td>Almost always</td>
<td>3.1</td>
<td>.23</td>
<td>3.5</td>
<td>.15</td>
<td>3.6</td>
<td>.15</td>
</tr>
</tbody>
</table>

Note: Ratings were on a five point scale (1 = not at all to 5 = almost all the time/very often a problem) for Parent Stress and Family Satisfaction and a seven point scale for CBCL (1 = never a problem to 5 = always a problem). *p < .05; **p < .01.

Question Three

3. Is there a relationship between the school-based services received and parents who report (a) satisfaction with the schools and (b) quality parent-school relationships?

Satisfaction with the School. Univariate analyses were conducted to determine the relationship between satisfaction with the school-based teams and the type of school services the child received. Given the number of school-based items, eight univariate analyses were conducted. Significantly higher levels of satisfaction were found with having a daily point sheet $F(1, 100) = 2.461, p < .05$, extracurricular activities $F(1, 100) = 5.203, p < .05$, and having a behavior plan $F(1, 100) = 7.877, p < .01$. Interactions were found for before/after school support and extracurricular activities $F(1, 100) = 5.572, p < .05$, and between small group instruction and extracurricular activities $F(1, 100) = 6.746, p < .01$. An examination of the mean satisfaction scores indicated that parents were
more satisfied when children received both before/after school support and extracurricular activities (M = 3.12; SE = .34) compared to children that had the support but were not in extracurricular activities (M = 2.16; SE = .37). In terms of extracurricular activities and small group instruction, the mean scores indicted caregivers were more satisfied for children receiving both supports (M = 2.7; SE = .21) compared to students receiving neither (M = 2.2; SE = .30). Nonsignificant findings were with before/after school supports, individual or group social work, social/anger management skills group, parent training, parent/child group, parent support group, small group/one on one support, and self-monitoring (refer to Table 9).

There were no differences found for parent satisfaction and whether or not the interventions addressed emotional/impulse control, organization, homework completion, following directions, attention, relationships with peers, relationships with adults, aggressive behavior, and behavior in unstructured settings. No significant results were found for whether or not the child had experienced expulsions, suspensions, or detentions during the current school year or in the past. Services pertaining to having an IEP were also examined in terms of parent satisfaction with school services utilizing univariate analyses. There was not a difference in parent satisfaction regardless of whether or not the child had an IEP; however, parents reported higher satisfaction when the student was meeting his/her IEP goals $F(4, 70) = 4.961, p < .01$ (refer to Table 10). Non-significant differences were found for parent satisfaction and any of the IEP services being provided (i.e., extended time, social work, and one-on-one support).
Quality of Parent-School Relationships. Univariate analyses were conducted to examine if parents experienced a different relationship with schools in regard to the type of services their child received. None of the school-based services (i.e., daily point sheet, behavior plan, self monitoring, parent training, etc.) were found to be significant, meaning that the parents reported similar quality of relationships with school staff regardless of the services (refer to Table 9). In addition, there was no difference in the quality of relationship and what behaviors the intervention addressed (i.e. organization, attention, impulse control).

No significant differences in the quality of relationships and whether the child had experienced expulsions, suspensions or detentions were found. In addition, univariate analyses on IEP services were non-significant in relation to the quality of parent-school relationships. The only significant relationship was with how well the child was meeting his/her goals $F(4,70) =4.482, p <.05$. The participants reported a higher quality of relationship when the child was meeting his/her IEP goals (see Table 10).
Table 9

*Estimated Marginal Mean and Standard Error scores for Parent Satisfaction and Quality of Parent-School Relationship by School Supports Received*

<table>
<thead>
<tr>
<th>Supports</th>
<th>Parent Satisfaction</th>
<th>Quality of Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes M SE</td>
<td>No M SE</td>
</tr>
<tr>
<td>Daily point sheet</td>
<td>2.9 .20 2.4 .13*</td>
<td>3.9 .18 3.7 .12</td>
</tr>
<tr>
<td>Before/after school help</td>
<td>2.5 .27 2.5 .11</td>
<td>3.8 .23 3.7 .10</td>
</tr>
<tr>
<td>Self-monitor behavior</td>
<td>2.8 .17 2.4 .17</td>
<td>3.8 .15 3.7 .16</td>
</tr>
<tr>
<td>Individual social work</td>
<td>2.2 .20 2.5 .26</td>
<td>3.4 .20 3.8 .24</td>
</tr>
<tr>
<td>Group social work</td>
<td>2.3 .27 2.5 .19</td>
<td>3.6 .26 3.6 .18</td>
</tr>
<tr>
<td>Social/anger management skills group</td>
<td>2.5 .24 2.3 .21</td>
<td>3.6 .22 3.6 .21</td>
</tr>
<tr>
<td>Small group/1-on-1</td>
<td>2.7 .16 2.3 .20</td>
<td>3.7 .13 3.8 .14</td>
</tr>
<tr>
<td>Behavior Plan</td>
<td>2.9 .18 1.9 .25*</td>
<td>3.7 .18 3.4 .24</td>
</tr>
<tr>
<td>Parent Training</td>
<td>2.8 .41 2.9 .23</td>
<td>3.9 .42 3.7 .21</td>
</tr>
<tr>
<td>Parent support group</td>
<td>3.0 .34 2.8 .28</td>
<td>4.1 .30 3.7 .28</td>
</tr>
<tr>
<td>Parent/Child group</td>
<td>3.3 .58 2.6 .22</td>
<td>4.0 .53 3.8 .26</td>
</tr>
<tr>
<td>Extra Curricular</td>
<td>2.7 .16 2.3 .20*</td>
<td>3.9 .30 3.5 .12</td>
</tr>
</tbody>
</table>

Note. Ratings were on a five point scale (1 = not at all to 5 = almost all the time).

*p < .05; **p < .01.

Table 10

*Mean and Standard Error for How Well the Child is Meeting his/her IEP Goals with Family Satisfaction Tool and Quality of Parent-School Relationship Scale*

<table>
<thead>
<tr>
<th>IEP rating category</th>
<th>Parent Satisfaction**</th>
<th>Quality of relationship**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M SE</td>
<td>M SE</td>
</tr>
<tr>
<td>Not meeting the IEP goals</td>
<td>2.0 .29</td>
<td>3.1 .24</td>
</tr>
<tr>
<td>Meeting some of the goals</td>
<td>2.2 .17</td>
<td>3.5 .16</td>
</tr>
<tr>
<td>Meeting about half of the goals</td>
<td>3.6 .30</td>
<td>4.1 .27</td>
</tr>
<tr>
<td>Meeting most of the goals</td>
<td>2.7 .21</td>
<td>4.1 .22</td>
</tr>
<tr>
<td>Meeting almost all of the goals</td>
<td>3.4 .40</td>
<td>4.8 .43</td>
</tr>
</tbody>
</table>

*p < .05; **p < .01.
Question Four

4. Is there a relationship between the frequency or type of communication with school staff and (a) parent satisfaction with the school and (b) quality of parent-school relationship?

Parent Satisfaction. Parents who communicated frequently with the school staff reported more satisfaction with the school-based teams $F(5, 101) = 2.804, p < .05$. Caregivers who communicated daily were the most satisfied ($M = 2.9; SE = .220$), followed by weekly ($M = 5.25; SE = .145$), once a month ($M = 2.46; SE = .354$), twice a month ($M = 2.0; SE = .31$), quarterly ($M = 2.14; SE = .371$), and less than four times a year ($M = 1.0; SE = .567$). There was not a significant difference found between parent satisfaction and the type of communication. This means that parents were equally happy with the school regardless of whether they communicated through phone, email, on a team, or one-on-one. No differences were found between parent satisfaction and being a member of a special education, problem solving, or wraparound team.

Quality of Parent-School Relationship. Univariate analysis was conducted between the quality of parent-school relationships and communication. There were no significant findings, indicating that the quality of the parent-school communication was about the same regardless of how frequently the parents and school communicated, the means through which they conversed, and participation on the specific types of school-based teams.
Question Five

5. Is there a relationship between the presence of school-community-parent partnership and (a) parent satisfaction with the school and (b) the quality of parent-school relationships?

Parent Satisfaction. Univariate analyses were conducted with satisfaction as the dependent variable and school-community partnership status as the independent variable. Parents who reported that the school and community worked together were significantly more likely to be satisfied with the school based teams $F(2, 111) = 5.65, p < .01$ (refer to Table 11). Respondents were also more satisfied when they perceived the partnership as helping their child $F(4, 32) = 4.248, p < .01$. About one-third of parents reported that the partnership was somewhat effective (35%; satisfaction M = 2.7, SE = .236), with an equal number stating a little bit effective (19%; satisfaction M = 2.1, SE = .30), effective much of the time (19%; satisfaction M = 3.3, SE = .30) and effective most of the time (19%; satisfaction M = 3.8, SE = .30). Only 8% of the parents reported that the collaboration was not at all effective; the mean satisfaction was 2.6 with a standard error of .40 for these respondents. There was no significant difference found between satisfaction with the school and how much the parents were included in the treatment planning; however, 77% of the parents who experienced these partnerships indicated that they were involved most of the time or almost all the time.

Quality of Relationships. Univariate analyses were conducted with quality of parent-school relationship as the dependent variable and school-community partnership as the independent variable. Although parents who worked with the community and
schools to help their child reported greater satisfaction with the schools, they did not state that the quality of parent-school relationships were different from those of parents who did not have school-community partnerships. There were no significant differences found based on how involved the parents were in the training and how effective the treatment was with helping their child (refer to Table 11).

Table 11

*Mean and Standard Error for the Presence of School-Community Partnerships by Family Satisfaction Tool and Quality of Parent-School Relationship Scale*

<table>
<thead>
<tr>
<th>Presence of school-community partnership</th>
<th>N</th>
<th>Parent Satisfaction*</th>
<th>Quality of Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>M</td>
<td>SE</td>
</tr>
<tr>
<td>Yes, there is currently a partnership</td>
<td>26</td>
<td>2.9</td>
<td>.19</td>
</tr>
<tr>
<td>No, there is no partnership</td>
<td>58</td>
<td>2.2</td>
<td>.13</td>
</tr>
<tr>
<td>Not this year, but in the past</td>
<td>12</td>
<td>2.8</td>
<td>.27</td>
</tr>
</tbody>
</table>

Note. Ratings were on a five point scale (1 = not at all to 5 = almost all the time).

*p < .05; **p < .01

*Question Six*

6. Is there a difference in the school-based services for parents who report school-community partnerships compared to parents who do not report these collaborations?

Chi-square analyses were conducted to evaluate whether different school-based services were being received for children of caregivers who reported school-community partnerships when compared to families that did not have these collaborations. A significantly larger proportion of parents who participated in school-home-community
collaboration indicated a higher incidence of the following services: individual social work $\chi^2 (1, N = 94) = 14.831, p = .00$; group social work $\chi^2 (1, N = 97) = 4.400, p = .036$; small group or one-on-one supports $\chi^2 (1, N = 96) = 5.158, p = .020$; parent/child group $\chi^2 (1, N = 95) = 7.413, p = .024$; and daily point sheet $\chi^2 (1, N = 92) = 4.200, p = .038$.

Before/after school supports $\chi^2 (1, N = 94) = 3.21, p = .073$ and have a behavior plan $\chi^2 (1, N = 96) = 3.041, p = .081$ approached significance. The services that were not significant included child self-monitored his/her behavior, social skills or anger management group, parent training, parent support group, and extra curricular activities.

Further results found that the parents who experienced school-community collaboration reported that the above services addressed specific behavior problems at a higher rate than no school-community collaboration. The chi-square findings were as follows: impulse control $\chi^2 (1, N = 90) = 2.583, p = .001$; organization $\chi^2 (1, N = 88) = 6.056, p = .014$; homework completion $\chi^2 (1, N = 88) = 7.837, p = .005$; attention $\chi^2 (1, N = 88) = 10.156, p = .001$; relationships with peers $\chi^2 (1, N = 90) = 8.452, p = .004$; relationship with adults $\chi^2 (1, N = 88) = 8.824, p = .003$; aggressive behavior $\chi^2 (1, N = 89) = 11.098, p = .001$; and unstructured settings $\chi^2 (1, N = 86) = 3.773, p = .052$.

The children of parents who reported school-community collaboration were more likely to have been expelled during the current school year $\chi^2 (1, N = 96) = 3.972, p = .046$. These parents were also more likely to have a child with an IEP $\chi^2 (1, N = 94) = 4.030, p = .045$. Most of the IEP services, including the setting, were not different for parents engaged in community collaboration and those without the collaboration except for modified assessment $\chi^2 (1, N = 65) = 3.847, p = .050$ and social work $\chi^2 (1, N = 62) = 4.82$. 
6.567, \( p = .010 \). Lastly, the parents included in school-community collaboration were more likely to be a member of a response to intervention problem-solving team \( \chi^2 (1, N = 84) = 13.773, p = .001 \) and wraparound team \( \chi^2 (1, N = 87) = 4.075, p = .04 \).

**Question Seven**

7. Is there a relationship between parental report of the effectiveness of the school supports and the services that were provided?

Univariate analyses were conducted to determine if there is a relationship between the effectiveness of school services and the type of support being received. The effectiveness of school supports was rated as follows: 1 – not at all; 2 – sometimes; 3 – half the time; 4 – most of the time 5 – almost always. The mean score for this scale was 2.38 with a standard deviation of 1.18. Given the number of school-based items, eight different analyses were conducted with effectiveness as the dependent variable.

In terms of the school intervention matrix, significant differences were found for the parents who attended a school-based parent support group \( F(4, 100) = 8.894, p = .004 \); social skills/anger management group approached significance \( F(4, 100) = 4.967, p = .06 \). In addition, significant interaction was found for small group support and extracurricular activities \( F(6, 100) = 6.570, p = .03 \), and the interaction between parent training and parent support group approached significance \( F(4, 100) = 3.909, p = .09 \). Parents who reported no small group support or extracurricular activities felt that the services were less effective (\( M = 1.85; SE = .360 \)) compared to students who received both (\( M = 2.39; SE = .274 \)). Caregivers who participated in both parent training and parent support group
indicated that the services were more effective (M = 4.0; SE = .572) than those who received neither (M = 2.28; SE = .336) or just parent training (M = 1.5; SE = .80).

Nonsignificant findings were found for before/after school supports, individual or group social work, social or anger management skills group, parent training, parent/child group, behavior plan, daily point sheet, self-monitoring, and extra curricular activities. There were no differences found for rating of effectiveness and whether or not the interventions addressed emotional/impulse control, organization, homework completion, following directions, attention, relationships with peers, relationships with adults, aggressive behavior, and unstructured settings. No significant results were found for whether or not the child had experienced expulsions, suspensions, or detentions. There was no difference found with parent satisfaction and the child having an IEP, and no significant results were found for parent satisfaction with any of the IEP services provided (i.e., extended time, social work, and one-on-one support). Parent’s reported a higher rate of effectiveness, however, when the students were meeting their IEP goals $F(4, 73) = 10.964, p = .001$.

Finally, the level of effectiveness and the presence of a home-school-community collaboration were examined. The parents who reported partnerships were more likely to feel that the school services were effective $F(2, 100) = 4.383, p = .015$. When the school and community worked together, the parents stated that the services worked almost half of the time (effectiveness M = 2.86; SE = .217) as opposed to only sometimes for parents who did not experience these partnerships (effectiveness M = 2.12; SE = .145). Parents who had a partnership in the past, but not this year, were also more satisfied than parents
who did not have school-community relationships (effectiveness $M = 2.67; SE = .338$).

The parents also stated higher effectiveness when they felt that the partnership was helping their child $F(4, 40) = 4.871, p = .005$. 
CHAPTER FIVE

DISCUSSION

The purpose of this study was to examine the relationship between parental report of home-school collaboration in the treatment of childhood EBD and the school services received. Through this, the presence of school-community partnerships, the severity of child mental health needs, and parent stress were assessed. Home-school collaboration was defined as the quality of caregiver and school staff relationships, as well as parent satisfaction with how effective school-based teams were at providing supports for the family. The study sought to understand whether or not the presence of evidence-based school practices, including school-community collaboration, related to the quality and nature of parent-school partnerships, and the overall rated effectiveness of the school-based.

The public polices in regard to the treatment of childhood emotional and behavioral disorders place a strong emphasis on the need to meaningfully include parents in services being provided for the child’s mental health disorder (see Burns et al., 1995; Brener et al., 2007; Taylor & Adelman, 2000). This includes providing emotional support for parents through communicating understanding and not placing blame (Fox et al., 2002), and ensuring that caregivers receive the needed supports and resources to help the child and family (Farmer & Burns, 1997; Ireys et al., 2002).
To understand the relationship that the parents in the current sample had with the schools, the Quality of Parent-School Relationship scale was used. On average, parents reported positive collaboration with school staff most of the time. Although the research has indicated that the quality of home school relationships are frequently poor (Wagner et al., 2005), and that caregivers feel blamed by professionals for their child’s problems (Farmer & Burns, 1997; Johnson, 1997; Owens et al., 2002; U.S. Department of Health and Human Services, 1999), the results from the current sample suggest that the school professionals are doing an adequate job of ensuring that the parents feel respected, understood, are treated as an equal partner and are not blamed for their child’s problems. The presence of a positive home-school relationship is an essential component of effective mental health services for children, and the current findings suggest that these relationships may be improving.

In regard to parent satisfaction with the school’s ability to provide effective treatment and supports, however, caregivers were satisfied only slightly to some of the time, as measured through the Family Satisfaction Tool. Most of the time the parents felt that the school staff members were not meeting the needs of the child and family. The results are congruent with previous research in which parents have expressed dissatisfaction with the schools, teachers, and special education services’ ability to help their child (U.S. Department of Mental Health, 1999). Therefore, the supports being provided for the child and family did not include the parents and address needs to an extent that was beneficial for the whole family.
The difference between the scales suggests that the quality of the parent-school relationship and the professional’s ability to provide meaningful supports for children and families are two different domains of home-school collaboration for childhood EBD. The quality of relationship rating was significantly higher than the parental satisfaction rating, indicting that the participants had positive interactions with the school staff, but this collaboration is not sufficient to meet the child and family needs. In the literature, the need for parent-school collaboration has been strongly noted, but the nature of this relationship for families of children with emotional and behavioral disorders has not been defined (Farmer & Burns, 1997; Johnson, 1997). The results here suggest that including and respecting parents is important, but not the only aspects of effective parent collaboration. Within these partnerships, the family needs and strengths must be attended to as well.

In regard to parent stress, the participants reported moderate levels of stress as a result of having a child with EBD on the Caregiver Strain Questionnaire. This corresponds to the literature, which suggests that having a child with EBD is stressful for parents (Farmer & Farmer, 1997; Quittner et al., 1990; Yatchmenoff et al., 1998). The caregivers in this sample reported that their child’s disability had an impact on their daily lives, their feelings about themselves, and relationship with others. The severity of the child’s behavioral symptoms, as measured through the modified CBCL, was reported to range from infrequently a problem to sometimes a problem. The results suggest that the average child in this sample has a moderate level of mental health disability, corresponding with the literature that 11% of children with EBD have significant
impairment and 5% have extreme impairment (U.S. Department of Health and Human Services, 1999).

Question One

1. What is the descriptive information for (a) the children, (b) school services, and (c) school-community partnerships?

Child Demographics. Unlike previous reports, the majority of the children in the current sample are Caucasian and live with both parents in a middle-class household (Huffman et al., 2000; Smokowski et al., 2003). The parents indicated that most of the children are currently taking medication for their mental health needs. Many of the children’s emotional and/or behavioral problems started between the ages birth to two, which corresponds with previous studies indicating that behavioral and emotional problems tend to begin early in childhood (Bradley et al., 2008, Nelson et al., 2007) and that parents usually notice the problems before the age of 5 (Kutash & Duchnowski, 2004). In all, 35% of the children received early childhood support, meaning that about 12% of the children who had early onset did not receive early childhood services. There were more children in the current sample that were provided with early childhood intervention than has been found in previous studies in which most children did not receive services until years after the problem is noticed (Bradley et al., 2003; Forness, 2005; Power, 2003). The prevalence of early childhood treatment in the current sample is promising given that it has been shown to be effective (Adelman & Taylor, 2000; Burns et al., 1999; Fox et al., 2002, Smokoski et al., 2003), especially when supports occur in the school and are delivered with integrity (Conduct Prevention Research Group, 1999).
Many of the children have a DSM-IV diagnosis and the most common age of the diagnosis was between four and six years old. The school personnel, as opposed to other professionals, first noticed the emotional/behavioral problems and most of the children with an IEP were found eligible before second grade. This is also unlike previous reports that most students are identified for special education services up to two years after they received a diagnosis (Coutinho & Oswald, 1996; Sitlington & Neubert, 2004), with many children not receiving school services until third grade (Kutash & Duchnowski, 2004).

It is possible that the sample demographics had an impact on why more of the youth in this study received early childhood intervention or special education services than reported in previous studies. Many of the parents in the current sample are highly educated, married, and reported incomes of middle class or above. This is the opposite of what other studies have stated about the characteristics of parents of children with emotional or behavioral needs (Campbell et al., 2000; Frink et al., 2003, Huffman et al., 2000; Owens & Shaw, 2008; Smokowski et al., 2003; Windle & Mason, 2004). The parents had the education and resources to seek out early childhood supports, including an IEP or ISFP, for their children.

School Services. In regard to the school services, the majority of the children were currently receiving their education within the public school setting. A small percentage of students were serviced in a self-contained special education school (6.5%) or residential placement (3.3%). This is slightly lower than research reports indicating that
about 13% of students with EBD are in separate educational facilities with 2 to 4% in residential settings (U.S. Department of Education, 2002).

Parents reported that 5% of the students had been expelled, 26% of the students received at least one suspension, and 25% had at least one detention during the current 2009-2010 school year; 16% of the students had been expelled in the past, and 56% had been suspended in previous school years. The suspension rate is similar to Kutash and Duchnowski’s (2004) study, which found that in the previous year, 18% of students had in-school suspensions, and 38% had out-of-school suspensions. In general, research has demonstrated that 47% of elementary school students and 73% of high school students with EBD have been suspended or expelled from school (Wagner et al., 2005). Although the suspension and expulsion rates for the current sample are not as high as other reports, it is problematic that up to 16% of students have been expelled and 56% suspended during their school career. These punitive actions have frequently been shown to be ineffective; in fact, they tend to increase problematic behavior (Koller & Bertly, 2006; Skiba, 2002).

The majority of the participants indicated that their child received supports in the school, which is consistent with research suggesting that the educational system is the most common place for children to gain access to treatment (Burns et al., 1995; Department of Health and Human Services, 1999). More than half of the students in this sample were provided with behavior-based services in the school, which is unlike previous reports that behavioral interventions were offered to less than half of the students with EBD (Bradley et al., 2008). The services that are considered evidence-
based such as a behavior plan (Tunball et al., 2002; Magg & Katsyannis, 2006), self-monitoring (Landrum et al., 2003), and counseling (Hoagwood, 1997) were being provided for about 50% of the students in this sample. Unfortunately, other effective supports such as instruction on social skills (Hoagwood, 1997; Kaufman, 1999; Landrum et al., 2003), continuous monitoring of student performance (i.e., daily point sheet) (Landrum et al., 2003), parent training (Conduct Problems Prevention Research group, 1999; Burns et al., 1995; Farmer & Farmer, 2001; Forness, 2005), and parent support groups (Burns et al., 1999; Fristad et al., 2003; Hoagwood, 2005), were used by fewer than 50% of these students. The parent treatment options were provided for less than 15% of the caregivers. Finally, 40% of children participated in extracurricular activities, which is consistent with findings that fewer than half of the youth with EBD are involved in activities outside of school hours or in the community (Wagner & Davis, 2006).

The majority of the parents reported that the child has an Individual Education Plan (69%). The prevalence of IEPs in the current sample is quite high, especially compared to other findings that many students who would qualify under IDEIA for Emotional Disability are not identified (Bradley et al., 2008). Most of the children were eligible under Emotional Disability and Autism. Again, this is unlike other research findings that most students with mental health needs were found eligible under Specific Learning Disability (Forness, 2005). For the current sample, many of the parents reported that their child has adequate academic and cognitive skills, which may explain why fewer students have Learning Disability eligibility. Students with Emotionally
Disturbance in special education have typically been found to have concomitant academic deficits (Bradley et al., 2008; Lane et al., 2005; Wagner et al., 2006).

The most common service setting for the students with an IEP was a resource room followed by general education with little support. In all, about 23% of the students received services in a self-contained, therapeutic, or residential setting. This is very much unlike previous research findings that only 25% of students with EBD spend 70% or more of their time in general education classrooms (Bradley et al., 2008; Wagner et al., 2005) and 72% of the student’s time was in a self-contained special education classroom (Kutash & Duchnowski, 2004). The current finding is positive given that the students with EBD tend to progress more when integrated with their non-disabled peers (Wagner & Davis, 2006).

Supports the children were receiving through an IEP, such as extended time on tests, were consistent with previous research finding about the most common services provided for students with Emotional Disturbance (Kutash & Duchnowski, 2004; Wagner & Davis, 2006). The parents were split in terms of how well they felt the IEP goals were being met. Most of the parents indicated that the child was meeting some of the goals.

In general, the descriptive information about the supports the children received is unlike that reported in the literature. The children in this sample had services that were effective, were provided early, and were delivered in the least restrictive educational setting. This discrepancy could reflect a positive change occurring in the school system, but it could also be due to the sample demographics. When comparing this sample to other descriptive studies about children with EBD, the parents in this study had a higher
education level and income, were Caucasian and the children were raised in two parent households. This may suggest that the overall supports the child is receiving for his/her disability is related to parent demographic factors, as opposed to the unique child and family needs.

**Parent-school Partnerships.** Most of the parents reported that the school and community did not work together to help their child. In all, 26% of the parents stated that there was a community-school collaboration during the 2009-2010 school year and 11% endorsed that there was no partnership this year, but there had been one in the past. This is congruent with literature stating that there is currently a lack of coordination among service providers (Yatchmenoff et al., 1998). Of the parents who reported collaboration, the majority stated that they were included in the treatment planning and that the school-community partnership helped their child.

Although few parents reported community partnerships, many caregivers endorsed that their child received services within the community. In all, 64% of the children were provided with treatment in the community during the current school year, which is higher than has been stated in the literature (Burns et al., 1995; Weist et al., 1999; U.S Department of Health and Human Services, 1999). The students were also more likely to receive supports in the least restrictive environment (i.e., counseling versus hospitalizations) and evidence-based services such as case management and wraparound (Burns et al., 1999). This is unlike what is found in the literature that many community treatments are provided through in-patient hospitalization and that few children receive
supports through a system of care approach (U.S Department of Health and Human Services, 1999).

The high level of community services, but lack of home-school-community partnership suggests that many of the parents in the current sample experienced fragmentation between childhood mental health service providers (Owens et al., 2002; U.S. Department of Health and Human Services, 1999). It is likely that more children in the current sample had a higher rate of community supports because the parents had the resources needed to pay for the services. Had the parents not demonstrated financial means, there may have been fewer children receiving the community-based treatment, as shown through the literature (Burns et al., 1995). The children also received the less restrictive treatment options. Since the parents demonstrated the resources to pay for community support, perhaps they were able to get services early before the problems became severe and required intensive care. In all, the parents reported an equal level of burden to non-burden in relation the cost of community treatment.

**Question Two**

2. What is the relationship (a) among parent satisfaction with the school and child behavior, parent stress, and quality of parent-school relationships and (b) among quality of parent-school relationships and child behavior, parent stress, and parent satisfaction?

The parents who were satisfied with the school’s ability to help their family and child reported a positive relationship with the school -- those who were dissatisfied had lower quality relationships. In order for parents to perceive that the school was helping
their child and family, they needed to feel that their relationship with the school was positive. For the parents who felt blamed or disrespected by the school, the collaboration was poor, which would make it very difficult for the school teams to help meet the needs of the child and family. These results are in line with research indicating that negative parent-school relationships hinder the success of treatment (Michael et al., 2007).

Caregiver stress was also related to parent satisfaction with the school; however, the stress had both a highly positive relation to satisfaction and a very negative relationship with how well the school was meeting the child and family needs. This could suggest that school professionals handled children with EBD and their families with different approaches when the caregivers were experiencing high levels of stress. First, for the parents who reported a negative experience, the schools may not have known how to provide support or did not have the capacity to help the parents under a great deal of stress (Epstein & Walker, 2002). This is in line with literature indicating that parents who report stress as a result of having a child with mental health needs have experienced more barriers to meeting the needs of their child than less stressed caregivers (Farmer & Burns, 1997; Kazdin & Wassell, 2000). On the other hand, for the parents who were satisfied and under much stress, school personnel could have provided a great deal of support for the family because the child problems were severe and the family was in high need of support (see Fox et al., 2002).

Although the relationship between child behavior and parent satisfaction with the school was not significant, the same trend between the two was found as with stress and satisfaction. The parents of children with the most severe behavior problems indicated
being both not at all satisfied and very satisfied with the school. It is again possible that schools do not have the capacity to help children with severe problems (Epstein & Walker, 2002), while some schools could have provided a great deal of support for the children with significant needs (Kauffman, 1999).

A relationship was found between the quality of parent-school relationships and both parent satisfaction with the school and the severity of child behavior. The parents who reported fewer behavioral or emotional problems in their child experienced a more positive relationship with school staff. This corresponds with literature suggesting that when the student is doing well, the home-school relationship is rated positive by caregivers and teachers (Kohl et al., 2000). Although caregiver stress was not significantly related to the quality of parent and school relationships, the parents who experienced less stress expressed a higher quality relationship. This suggests that parents were more likely to have negative feelings about the collaboration with the school (i.e., feel blamed and disrespected) when they were under more stress. This relates to research findings that parents felt blamed, disempowered, and perceived lower levels of support when their child’s difficulties were causing significant stress (Farmer et al., 1997; Yatchmenoff et al., 1998).

The results again suggest that the parent report of the quality of their relationship with the school and satisfaction with the supports are two very different elements of home-school collaboration. The parents who felt little stress and whose child’s disability was not severe seemed to feel positive about their interactions with the school. On the other hand, parent stress and child severity had either a highly positive or negative
relation to satisfaction. This implies that schools could improve their interactions with parents under stress or who have children with significant needs; it also points to the inconsistency of the schools ability to help high need children and families. In this study, some school personnel collaborated with the caregivers very well while others do a poor job of working with parents to provide the needed supports.

Questions Three and Four

3. Is there a relationship between the school-based services and parents who report (a) satisfaction with the schools and (b) quality parent-school relationships?

4. Is there a relationship between the frequency or type of communication with school staff and (a) parent satisfaction with the school and (b) quality of parent-school relationship?

Satisfaction with the School. Parents reported higher satisfaction with the school teams when their child was receiving the following supports: a daily point sheet, extracurricular activities, and a behavior plan. This corresponds with research suggesting that behavior plans (Magg & Katisyannis, 2006) and continuous monitoring of student behavior (Bradley et al., 2008) are effective services for children because they tend to be individualized to the child’s needs and provide frequent feedback on how the student is progressing. The strong relationship between extracurricular activities and parent satisfaction could mean that the child’s strengths are being utilized and the school is helping to meet the needs of the child both in and outside of the classroom.
When the children were in both extracurricular activities and before/after school interventions, the parents were more satisfied than children who received the services but were not in extracurricular activities. Caregivers also were more satisfied when students who received small group support were involved with extracurricular activities. In general, these results are consistent with findings that it important for children who receive instruction in small group or self-contained settings to be integrated with their non-disabled peers (Lane et al., 2005) and capitalize on student strengths as a part of treatment (see Burchar et al., 2002; Eber et al., 2002). One way this can be accomplished is through extracurricular activities. In addition, extracurricular activities provide the children with lessons on social skills and peer interactions in a naturally occurring context. In this sample, ensuring that children with EBD were involved with extracurricular activities appeared to help meet the needs of the child and family.

Parents who communicated frequently with the school staff reported a higher level of satisfaction with the school-based teams; those who spoke daily were more satisfied than the caregivers who talked with school staff less than four times a year. The literature has reported that frequent communication with parents helped the schools meet the child and family needs. Therefore, an important element of effective parent-school collaboration is frequent communication between families and school staff (Hoagwood et al., 2007; Wagner et al., 2005). The parents were equally happy with the school teams regardless of the means through which they communicated (i.e., email or in person).

There was no difference found between with parent satisfaction and the child having an IEP; however, parents reported higher satisfaction when the student was
meeting his/her IEP goals. No significant differences were found for parent satisfaction with any of the IEP services (i.e., extended time, social work, and one-on-one support). These results suggest the school’s ability to provide effective treatment pertained to how well the team addressed the individual child’s needs opposed to general supports often found in an IEP. Treatment has been found to be more effective when it is tailored to the child’s individual needs (see Brener et al., 2007; Farmer et al., 2003, Taylor & Adelman, 2000) and the current findings point to higher parent satisfaction with specific supports received, not the presence or absence of an IEP.

*Quality of Parent-School Relationships.* The only significant finding between the quality of parent-school relationships and school-based services was with how well the child was meeting his/her IEP goals. These results suggest that the specific school supports, including whether or not the child had an IEP, were not related to whether or not the parent felt respected and understood by school staff. How frequently caregivers communicated with the school team did not influence the relationship; also, the means through which they spoke was not related to collaboration. In general, the parents felt that they had a positive interaction with school staff regardless of how effective the school services were at improving the child’s emotional or behavioral difficulties. Although positive communication is needed for parent-school collaboration (e.g., Farmer et al., 2003), schools must also ensure that they are providing treatment that meets the needs of children and families (Farmer & Burns, 1997; Ireys et al., 2000).
Question Five

5. Is there a relationship between the presence of school-community-parent partnership and (a) parent satisfaction with the school and (b) the quality of parent-school relationships?

Parent Satisfaction. Parents who reported that the school and community worked together were more likely to be satisfied with the school-based teams’ ability to provide supports for their children and family. The caregivers were more satisfied when they perceived the partnership as helping their children and most of the parents felt that the collaboration was effective. These results are not surprising given that when the family and community are involved in school-based mental health services, the treatment is more likely to be effective (Greenberg et al., 2000; Michael, Dittus, & Epstein, 2007). In addition, these findings support the multiple calls for parent-school-community collaboration (see Burns et al., 1995; Brener et al., 2007; Taylor & Adelman, 2000). Therefore, the parents were meaningfully involved in the planning and treatment provided for their children, which is what the literature suggests is an essential component of home-school-community collaboration (see Burns et al., 1995; Brener et al., 2007; Taylor & Adelman, 2000).

Even though the parents were more satisfied with the school teams when the community was involved, the average satisfaction rating for this group was only ‘some of the time’, suggesting that the teams were not fully meeting the needs of the family and child. Although community and school collaboration increased the parent satisfaction with the school, this was not enough to ensure that the treatment was beneficial.
Establishing home-school-community partnerships is an important first step in providing treatments that build on child and family strengths and meet the needs of the child in the school, home and community (e.g., Presidents New Commission on Mental Health, 2003; U.S. Department of Health and Human Services, 1999); however, these partnerships must focus on providing resources that help the families.

*Quality of Relationships.* Although parents who were engaged in home-school-community partnerships reported greater satisfaction with the schools, they did not state that the quality of parent-school relationships were different than those of parents who did not have school-community partnerships. These findings are similar to what was found in question three; the services and supports provided appear to be unrelated to the quality of interactions between parents and the school staff.

*Question Six*

6. Is there a difference in the school-based services for parents who report school-community partnerships compared to parents who do not report these collaborations?

Parents who had home-school-community collaboration reported a higher proportion of many school-based services compared to parents who do not have this partnership. These supports included: before/after school help, individual social work, group social work, small group or one-on-one supports, behavior plan, parent/child group, and daily point sheet. Most of these services were evidence-based and were provided to the children; however, it is important to note that a parent/child group was one of these supports. This suggests that the parents participating in school-community
collaboration gained access to treatment that helped the whole family, not just the child, which is an important element of effective home-school-community collaboration (see Burns et al., 1999; Hoagwood, 1997; Fristad et al., 2003). The parents who experienced school-community collaboration indicated that the services addressed specific behavior problems, such as impulse control and following directions, at a higher rate than those with no school-community partnership.

Parents who reported school-community collaboration were more likely to have a child who has been expelled during the current school year, which could suggest that school and community collaborations were more frequent for children with significant risk of school failure. Literature suggests that the children with the most severe problems received more school and community supports (Burns et al., 1995); however, it is not known if these children were more likely to have the community and school working together, as found in this study.

The children with school-community partnerships had proportionally more IEPs than children and families without these collaborations. Most of the IEP services, including the educational setting, were not different for participants with community collaboration. Given that many researchers have noted that the number of students who would qualify for an IEP were underrepresented in special education (i.e., Bradley et al., 2008), it is possible that the community partnership helped the child receive the needed supports. In addition, since most of the children with school-community involvement were likely to receive evidence-based supports, but were not placed in restrictive educational settings, the presence of an IEP did not suggest that these children were
provided with ineffective services commonly found for EBD children with IEPs. For example, previous research indicated that these children were frequently in self-contained settings, received supports that only addressed academic deficits, and the parent-school relationships for children with EBD were often poor (Wagner et al., 2005).

The parents with school-community collaboration were more likely to be a member of a problem-solving or wraparound team. These teams often focus on meaningful parent involvement in addition to addressing the unique strengths and needs of the child and family. This corresponds to the systematic school changes called for through Response to Intervention and Positive Behavior Intervention Supports (Adelman & Taylor, 1998; 2000; Greenbert et al., 2000) as well as the research on the positive impacts of wraparound services (see Hoagwood, 1997; Tolan & Dodge, 2005; U.S. Department of Mental Health, 1999).

Overall, parents in this sample that had home-school-community collaboration were more satisfied with the school’s ability to help their child, their child received more school-based supports, and the teams that worked with the family were more likely to focus on supports that meet the child’s needs in all settings when compared to families with no community collaboration. All of this was not accomplished through only school services. This finding corresponds with literature stating that professionals cannot meet the needs of students with EBD through school services alone (Epstein & Walker, 2002).

Question Seven

7. Is there a relationship between parental report of the effectiveness of the school supports and the services that were provided?
Parents were more likely to report effective school services when the children were involved with a social skills/anger management group, and when the parent attended a school-based support group. The caregivers who received both parent training and parent support groups reported the services being more effective than those who received neither treatment nor just parent training alone. Given that supports for parents, such as parent support groups, were related to a higher overall effectiveness, the school-based treatment designed to help them appeared to be as more effective than when there was no parent group (Hoagwood et al., 2007). Caregivers of children who received small group instruction and extracurricular activities rated this combination as effective. This again points to the importance of ensuring that children with EBD were involved in activities outside of school hours or in the community as much as possible (Wagner & Davis, 2006).

Similar to the findings from other research questions, the parents who participated in home-school-community partnerships were more likely to feel that the school services were effective. The results from this study provide support for the need to integrate services that address the child and family within the school and community settings (Adelman & Taylor, 2003; Forness, 2005; Tolan & Dodge, 2005).

Implications for Practice

The research findings in the current study have implications for the importance of including parents in the treatment of childhood mental health disorders, for providing services within the school setting, and for the families, schools, and community to work together in the provision of these services. The literature suggests that the current system
of treating childhood mental health disorders is not effective, and as a result, policy study
groups, such as the U.S. Department of Mental Health (1999) and the Presidents New
Freedom Commission (2000), have called for systematic changes. These include
meaningful parental involvement, service delivery within the school, and school-
community collaboration.

Few studies have examined parental perceptions and experiences with childhood
mental health services, and of the studies that have been completed, the results have not
been positive (Bickham et al., 1998; Farmer & Burns, 1997; Owens et al., 2002). The
literature has called for meaningful parental involvement in terms of services for
childhood mental health, but how that is defined for practice has not been strongly
delineated. The current findings suggest that having a positive relationship with the
parents is different from the professional’s ability to help the child and family, thus
impacting parental satisfaction with the school staff. This difference between the types of
collaboration suggests that professionals must build a positive relationship with
caregivers and work at effectively meeting the needs of the child and family. Positive
relations alone did not have an impact on the quality of services received for the child.

An important aspect of collaboration and parent involvement requires that the
school, home, and community work together. Public and private child mental health
community agencies need to seek out and embrace school and community partnerships.
Services such as case management and wraparound supports should be utilized
frequently. Approaches that focus only on the child, such as outpatient therapy or
individual counseling, may not be as effective at meeting the complex needs of the child
and family as those that include the school and parents (Burns et al., 1999). Through working with schools and families, community agencies could potentially reach more children who are in great need of services, provide supports and resources to families, and minimize barriers to treatment (Farmer & Burns, 1997). Embracing this collaboration early may prevent the need for restrictive community supports such as residential placements, which would reduce the cost and burden of treatment for the family and society.

Implications for Schools

This study provides many implications for schools. Perhaps one of the most significant findings is that the quality of school-parent relationship is different than the school’s ability to meet the needs of the child and family. It is imperative that schools build quality relationships with parents (Hoagwood, 2005), but the personnel must also provide treatment and resources that fit the strengths and needs of the child and the family (U.S. Department of Health and Human Services, 1999). The parents need to feel that school personnel are understanding and respectful in order for collaboration to be effective; however, professionals also must ensure that they are helping families gain access to the treatment and resources that will be beneficial for their child. An attempt must also be made by schools to build quality relationships with all caregivers, especially those who have children with severe emotional or behavioral problems and are under a significant level of stress as a result of having a child with EBD.

A second implication for schools is that their ability to help meet the needs of the child and family will be strengthened when there is partnership with the community.
Through this model, professionals will be able to provide supports for the child in and outside of school, which helps the family gain access to resources within the community. It is very difficult, if not impossible, for schools alone to meet the diverse and complex needs of childhood EBD (Greenberg et al., 2000). These community partnerships are strengthened when there are teams that use the wraparound approach (Hoagwood, 1997), especially when the entry to the wraparound process occurs through the school (Eber et al., 2002; Epstein et al., 2005). Teachers and other school personnel who know the child are more likely to be a member of these wraparound teams when they occur in the school, which often leads to more effective school services that are implemented with integrity (Eber et al., 2002).

Schools are also in a position to provide early intervention supports for parents and children. Although most of the parents in the current sample reported receiving early childhood services, there are many parents of children with EBD who do not have access to these supports (Adelman & Taylor, 2000). Whether these are provided through an ISFP or program in the community that includes academic services, early intervention has been shown to be highly effective in mediating and preventing the long-term consequences of early emotional or behavioral problems (see Burns et al., 1999; Conroy & Brown, 2004; Fox et al., 2002).

Not only must schools provide meaningful parent involvement, community collaboration, and early intervention supports, there are multiple services and systems delivered within the school that can help children with EBD. In order for schools to best meet the needs of children with mental health disabilities, they should provide
professional training for staff so that personnel have the resources needed to ensure an appropriate education for these children (Cheney et al., 2002). A reduction in the use of punitive actions such as suspensions, expulsions, and detentions is called for (Skiba, 2002). Instead, a focus must be placed on the prevention of mental health problems. For example, schools should utilize interventions and systems commonly found within a Response to Intervention (RTI) or Positive Behavior Intervention Supports (PBIS) framework. These include individualized behavior plans, continuous monitoring of student behaviors, and the child self-monitoring of his or her behavior. These interventions focus on prevention and using treatment that are provided within a tiered-system. For children who demonstrate a high need of support within a PBIS or RTI system, the services provided are individualized to the child’s needs, are continuously monitored in regard to their effectiveness, and include wraparound supports that address the needs of the child and family (Greenberg, 2000; Huang et al., 2005; Kauffman, 1999).

A final implication for schools is the need for parent-focused services. These can include parent training, parent support groups, and parent / child groups and activities. The research on these groups has shown positive outcomes for the child and family, yet few parents have access to these types of supports (see Conduct Problems Prevention Group, 1999; Hoagwood, 2005; McClend et al., 2007). In this current sample, very few parents received this service within the school setting, but those who did reported more effective outcomes for their child. In addition, all of the parents in the current sample were recruited from on-line support groups, thus demonstrating their need to have social
and practical support to help them cope with having a child with EBD. Schools are an opportune place in the community to provide access to these supports for parents.

*Implications for School Psychologists*

School psychologists are key individuals within the schools to promote evidence-based services that include parental and community involvement. They have the professional training necessary to provide effective and culturally competent practices, which are required for the school-based supports to work (U.S. Department of Health and Human Services, 1999). Because of this training, school psychologists make effective leaders by ensuring that the recommended system changes that utilize a three-tired model of service delivery, with a focus on prevention and proactive approaches to handling emotional or behavioral problems, are implemented. They can help provide professional development to staff and administration, as well as promote education to caregivers about parenting practices and the school supports (see www.nasponline.org).

The needed school-based approaches require that professionals be trained in child development and data based decision-making, which school psychologists are. This knowledge will increase the likelihood that supports are being provided that match the child’s needs, that these interventions are developmentally and culturally appropriate, are monitored frequently, and are delivered with integrity. In addition, school psychologists can advocate for positive-oriented and preventative practices as opposed to punitive and reactionary approaches to childhood behavioral or emotional difficulties. Through consultation with school staff and parents, school psychologists can help meet the needs
of youth with EBD, help teachers utilize effective classroom techniques, and help parents
gain access to the needed resources.

Not only are school psychologists in a position to lead system changes and
promote best practices in childhood emotional and behavioral services, they may also
provide treatment for children with EBD in the schools. This includes supports such as
individual and group counseling, social skills groups, and parent training or parent
support groups. School psychologists also have the skills to develop behavior
intervention plans, in addition to screening, evaluation and identification of children with
emotional or behavioral needs (see www.nasponline.org).

Limitations of the Study

A limitation of the study is the sample. First, the sample is fairly homogenous
with many of the participants reporting Caucasian ethnicity, a college education, and at-least middles class income. This is unlike the demographics of parents of children with
EBD that have been reported in other research (Huffman et al., 2000; Smokowski et al.,
2003). It is possible that the parents in the current sample had unique experiences with
the treatment of their child’s disability. For example, the services received in the schools
and community, and their level of involvement in these supports, could be unlike parents
with other demographic characteristics. All the parents in this sample sought out on-line
support groups. This implies that they were actively engaged in attempting to find
support for managing their child’s needs. These parents could, therefore, be more likely
to seek out services within the school and community than other parents of children with
EBD.
The emotional and behavioral needs of the children in this study were diverse, which could impact the implications of the findings. The sample was taken from online support groups that agreed to participate. Therefore, children with needs ranging from ADHD, ODD, and Aspergers were included in the study. A more targeted representation of mental health disorders may have demonstrated a relationship between parent collaboration and school services based on the child’s disability. The implications for treatment of specific mental health needs should be made with caution.

A second limitation is the sample size. Recruitment of participants for this study was laborious, which means that the parents who choose to participate may have been more interested in sharing their experience with schools and treatment of their child’s disability than those who did not participate. These parents may have had unique experiences different from the majority of parents of children with EBD. Although 114 parents completed the survey, there are many questions in which the number of responses fell below 100. This is due to the range of emotional and behavioral needs the children in this sample display, along with the parent experiences. For example, only 29 parents reported community and school partnerships. It is possible that with a larger sample, more relationships would have been found between parental involvement and school-based services received. The relatively small sample size could have decreased the power of the data analyses. With a small sample, the generalization and implications of the findings should be made with caution.

A third limitation to the study is the number of analyses needed to answer the research questions. It is possible that significant findings were due to the number of
analyses that were run, meaning that one would expect significant findings by chance alone. In order to attempt to counter this effect, items were grouped together in the analyses. In regard to home, school, and community collaboration, little is known about the exact nature of this partnership for the participants. The analyses were based on the caregivers stating ‘yes’ or ‘no’ to ‘the school and community worked together’. The nature of the partnership was not defined, meaning that it could have ranged from one meeting with all present to a detailed treatment plan that addressed supports in all settings.

Finally, a limitation of this study is that it relies on parent reports. There is no independent measure of whether or not the supports produced positive or negative outcomes for the children. Given that it is based on parent perception, a parent could rate the supports effective or ineffective, which may be in contrast to what data or other individuals' perceptions may suggest. It is possible that the parents did not know or understand some of the supports, such as wraparound or self-monitoring, which could have impacted the results. It is also not known what the child’s needs were, and whether or not the treatment that was being provided for the child and the family was matched to the needs. An assumption was made in this survey that parents were motivated to be involved in the treatment of their child’s treatment and would like to build quality relationships with professionals; it is possible that, in some cases, the school staff have worked at building this relationships but ran into resistance from the parents. However, since all parents chose to be a member of a support group, it is unlikely that they were disinterested in working with professionals to help their child.
Suggestions for Future Research

In the current study, the quality of parent-teacher relationships and the participant’s satisfaction with the school’s ability to help the child and family appeared to be two different elements of parental involvement. Future research could further examine what high-quality parent collaboration for students with EBD means, and the impact it may have on student outcomes. No other studies were found that examine parental involvement with childhood EBD with these two constructs. Given that the current findings indicated a consistent difference in how these two forms of parent involvement were related to the parent experience and mental health supports received, a clear definition of parent involvement and collaboration should be examined further. If future research were to find the same results, professionals would have guidance about what quality parental involvement consists of and what they can do to ensure that the needs of the family are being met.

An implication of the findings is that when the community and school work together, parental involvement in the process is increased; the children receive evidence-based school supports. These services have a positive relation with parent report of satisfaction with collaboration and treatment effectiveness. Future studies should examine naturally occurring home-school-community partnerships in comparison to treatment without this collaboration to determine whether or not findings are similar. The outcomes for the children with partnerships compared to those that do not receive such supports should be tested. This would require before and after analysis of the child behaviors, parent stress, and parent involvement with the treatment. Although there is
much support for home-school-community collaboration through policies and the literature, there are few strong empirical studies about the outcomes of these partnerships.

Next, future research could empirically examine the academic and emotional/behavioral outcomes of students in school systems that utilized Response to Intervention and/or Positive Behavioral Intervention Supports. Comparisons between schools that do not use these systems, schools where the systems are developing, and schools in which the system is fully implemented could be made. This would help future understanding of the relationship between school-based supports and outcomes for children, especially in relation to the impact of prevention. Within the context of this research, the influence the system has on parental involvement could also be examined.

Finally, longitudinal research helps with understanding the long-term effects that home-school-community collaboration, early intervention, and school supports have on adult outcomes for children with emotional or behavioral needs. Given that the prospects for many of these children are currently poor, it is imperative to understand the long-term effects of the services that the children receive.
APPENDIX A

SCHOOL-BASED MENTAL HEALTH SURVEY
Childhood mental health services survey

Intro

INTRODUCTION

THANK YOU for your interest in completing the School-based Mental Health Services Survey. This survey is designed to collect information about the services your child has received for his/her emotional or behavioral needs during the current 2009-2010 school year. In order to fully understand the impact of these services, you will be asked questions about your child's behavior and the level of stress you are experiencing as a result of having a child with emotional and/or behavioral needs. If you do not have a child with emotional or behavioral needs, please exit the survey at this time.

Consent

To provide CONSENT to complete this on-line survey, please read the following:

I understand that the survey will ask me questions about my child's behavior, stress, and services that my child has received for his or her unique needs. My consent is voluntary, I may skip any questions I do not wish to answer, and I may withdraw at any time before completing the survey. Further, I understand that my individual answers to all questions are anonymous and will not be associated with either my real name or any online nickname I use. I understand that although I will be completing this survey on a secure server at SurveyMonkey.com and my computer's IP address will not be available to the researchers, that confidentiality will be maintained to the degree permitted by the technology used.

I understand that this research is for Laura Svanlund's dissertation and is supervised by Dr. Martha Ellen Wynne. There is no direct benefit to participating in this survey, however the research may lead to improved treatment for childhood emotional and behavioral disorders. The survey will take approximately 20 minutes to complete.

By CLICKING THE NAVIGATION ARROW BELOW ("Next page"), I give my consent to participate in the CHILDHOOD MENTAL HEALTH SERVICES SURVEY.*

If you do not consent, please click "Exit this survey" in the upper right hand corner of this page.

Directions
Childhood mental health services survey

This survey is intended for parents or caregivers of children who have some level of emotional or behavioral needs. If you are a grandparent, step-parent, adoptive parent, or foster parent who cared for a child, please consider yourself the child's parent for this survey. If you have more than one child with childhood emotional or behavioral needs, please select the child with the most serious concerns and who is between 6 and 18 years old to focus on when answering survey questions.

There are questions that will ask you to recall information about your child's experiences during the current 2009-2010 school year. Please take your time and do your best to respond as accurately as possible. Feel free to stop the survey at any time and complete it later, so long as you will be able to return to the same computer.

You are free to skip any questions, but there are a few questions that are marked with an asterisk (*). For these questions you must select a response in order for the survey to move forward and select the next appropriate question for you.

Please scroll down to see all questions and to reach the "Next page" navigation arrow at the bottom of the page. This will be easier if you enlarge your browser window as much as possible.

Thank you VERY MUCH for your time,

Laura Swainland, M.Ed, NCSP
School Psychology Doctoral Candidate
Loyola University Chicago
Institutional Review Board Approval #20131

<table>
<thead>
<tr>
<th>General child information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How many children with emotional or behavioral needs to you have?</strong></td>
</tr>
<tr>
<td>☐ None</td>
</tr>
<tr>
<td>☐ One</td>
</tr>
<tr>
<td>☐ Two</td>
</tr>
<tr>
<td>☐ Three</td>
</tr>
<tr>
<td>☐ Four or more</td>
</tr>
</tbody>
</table>

| **How many children WITHOUT emotional or behavioral needs to you have?** |
| ☐ None |
| ☐ One |
| ☐ Two |
| ☐ Three |
| ☐ Four or more |

**Child Info. page 2**

The next set of questions is about the child with emotional or behavioral needs. If you have more than one child choose the ONE AGED 6-18 WHO IS THE MOST SEVERE.
Childhood mental health services survey

Is your child a

☐ Boy
☐ Girl

Was your child adopted?

☐ yes
☐ no

If yes, how old was the child when adopted?

How old was your child when the emotional/behavioral symptoms first appeared?

☐ Birth
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ 10
☐ 11
☐ 12
☐ 13

Child information page 3

Which professional first noticed your child’s problems?

☐ School or preschool staff
☐ Pediatrician
☐ Psychologist/Psychiatrist

Has medication for an emotional or behavioral problem been prescribed for your child?

☐ Yes, and takes the medication(s)
☐ Yes, but refuses to take the medications
☐ Took medication within the previous year, but it has been discontinued
☐ Has been prescribed medication, but for other reasons we chose for him/her not to take it
☐ No / does not take medication
### Childhood mental health services survey

Does your child have a DSM-IV diagnosis?* (This would include a diagnosis such as Depression, Bipolar, ADD, ADHD, Oppositional Defiant, Autism, and so on.)  
- [ ] Yes  
- [ ] No  
- [ ] Not Sure

#### DSM only

What type of professional provided the FIRST DSM diagnosis your child received?  
- [ ] Pediatrician / Family Doctor  
- [ ] Psychiatrist  
- [ ] Psychologist  
- [ ] Neuropsychologist  
- [ ] Hospital/Clinical Evaluation Team

How old was your child when he/she received the FIRST DSM diagnosis?  
- [ ] Birth to 2  
- [ ] 2-3  
- [ ] 4-6  
- [ ] 6-8  
- [ ] 9-11  
- [ ] 12-14  
- [ ] 15-18

#### Living situation

Which of the following best describes your child’s living situation?  
- [ ] Is living at home with me  
- [ ] Is in licensed foster care  
- [ ] Living with a relative/ friend  
- [ ] Is in a residential treatment center  
- [ ] Is in the juvenile justice system or prison  
- [ ] Is a run-away/missing/on the street
## Childhood mental health services survey

**What is your child’s race or ethnic group?**

- Caucasian
- African American
- Latino/Hispanic
- Asian
- Native American
- Bi or multi-racial

**How old is your child?**

- 3
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16

## School questions

**Please indicate which best describes your child’s educational setting.**

- Public School
- Private School
- Home Schooled
- Juvenile Justice System School
- Specialized school for students with EBD / Special Education School
- Residential

**Please indicate your child’s level of academic skill for the following**

<table>
<thead>
<tr>
<th>Subject</th>
<th>well below average</th>
<th>below average</th>
<th>average</th>
<th>above average</th>
<th>well above average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Math</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reading</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Writing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Science</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Sciences</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**What would you estimate are your child’s cognitive (intellectual) skills?**

- Well below average
- Below average
- Average
- Above average
- Well above average

---

School questions page 2
Childhood mental health services survey

Please answer the following:

Did your child pass on your state standardized assessment?

- Yes: ☐
- No: ☐
- Prefer not to respond: ☐

Was your child expelled during the current school year?

- Yes: ☐
- No: ☐
- Prefer not to respond: ☐

Was your child expelled from school in the past?

If expelled, please explain why:

Please indicate how many detentions and days suspended your child experienced:

<table>
<thead>
<tr>
<th>Detentions during current school year</th>
<th>None</th>
<th>One</th>
<th>2-3</th>
<th>3-5</th>
<th>5-7</th>
<th>7-9</th>
<th>More than 10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Detentions before the current school year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Suspensions during current school year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Suspensions before the current school year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

School questions page 3

Did your school change the child’s CLASS OR TEACHER as a result of his/her behavior during the current school year?

- Yes: ☐
- No: ☐

Did your child change SCHOOLS as a result of his/her behavior during the current school year?

- Yes: ☐
- No: ☐

School questions page 4
# Childhood mental health services survey

Please indicate whether or not the following occurred at school for a MINIMUM OF ONE MONTH during the current school year

<table>
<thead>
<tr>
<th>Daily point sheet with expected behaviors specified (teacher scored)</th>
<th>Yes</th>
<th>No</th>
<th>Unable to determine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before/After-school support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child self monitored</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>his/her behavior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social work services/counseling (Individual)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social work services/counseling (group)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social skills / anger management training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Small group or 1-on-1 instruction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavior plan specific to my child</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent training classes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent support group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent/child group at school</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extra Curricular activities</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## School questions page 5

Did the school-based support address the following:

<table>
<thead>
<tr>
<th>Emotional/Impulse Control</th>
<th>Yes</th>
<th>No</th>
<th>Unable to determine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homework Completion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Following Directions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationships with Peers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationships with Adults</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aggressive or destructive behavior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavior during unstructured settings (I.e., playground, bus, lunchroom)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Childhood mental health services survey

Were any of these services provided WITHOUT an Individual Education Plan (IEP)? *

☐ Yes
☐ No
☐ Not sure

If yes, which one(s)?

---

General Education consent

Please indicate which statement best describes how the school obtained CONSENT for the school-services without an IEP.

☐ The school asked for my consent before providing any services
☐ The school provided some service, and then asked for my consent to continue or add more support
☐ The school did not ask for my consent at any time for the general-education services

School questions page 6

Did you personally help your child with homework during the current school year?

☐ Yes
☐ No

If yes, please describe how frequently

---

Is there a school-based health center at your school that you/your child utilized?

☐ Yes
☐ No
☐ There is a health center, but my family did not use it

IEP
Childhood mental health services survey

Does your child have an Individual Education Plan (IEP) / receive special education services?*

☐ Yes
☐ No
☐ Not sure

IEP page 1

What is your child's PRIMARY eligibility in special education?

☐ Specific Learning Disability
☐ Emotional Disability
☐ Speech / Language
☐ Other Health Impaired
☐ Developmental Delay
☐ Autism
☐ Cognitive Disability (MMI)
☐ Other

In what grade was your child first eligible for special education services?

☐ Early Childhood
☐ Kindergarten
☐ 1st
☐ 2nd
☐ 3rd
☐ 4th
☐ 5th
☐ 6th-8th
☐ 9th-12th

IEP page 2

Which best describes your child's special education service setting?

☐ General Education setting with little support
☐ General Education with Support (resource)
☐ Split between General Education and Special Education Classrooms
☐ Special Education Self-Contained classroom
☐ Therapeutic / Alternative special education school
☐ Residential treatment
### Childhood mental health services survey

Please state how well your child is meeting his/her IEP goals:

- [ ] Not meeting his/her goals
- [ ] Meeting some goals
- [ ] Meeting about half of the goals
- [ ] Meeting most of the goals
- [ ] Meeting almost all of the goals

### IEP page 3

#### Are the following services provided through your child's IEP?

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
<th>No</th>
<th>Do not know / NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended time on tests and quizzes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Small group setting for tests</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Small group instruction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modified assignments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modified grading</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social work services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech and language services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One-on-one aid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Summer school</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-high school transition planning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavior Intervention plan</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### IEP back in

#### How frequently did you communicate with school staff during the current school year?

- [ ] Daily
- [ ] Weekly
- [ ] Twice a month
- [ ] Once a month
- [ ] Quarterly / about 4-8 times during the year
- [ ] Less than four times a year
### Childhood mental health services survey

Please indicate how frequently you communicated with school staff through the following

<table>
<thead>
<tr>
<th></th>
<th>Daily</th>
<th>Once a week</th>
<th>Twice a month</th>
<th>Once a month</th>
<th>Quarterly (4-8 times)</th>
<th>Less than four times a year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Phone</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>In person with a team</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>In person one-on-one</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

#### 504

**Does your child have a 504 plan?**

- ☐ Yes
- ☐ No
- ☐ Not sure / Do not know what a 504 plan is

#### 504 page 2

**What disability is the 504 plan for?**

**How well did the school follow the 504 plan?**

- ☐ Not at all
- ☐ A little bit
- ☐ About half the time
- ☐ Most of the time
- ☐ Almost all the time

#### Team participation
### Childhood mental health services survey

Did you participate in the following FORMAL TEAMS with school staff during the current school year? (If you know you will be having a special education or 504 meeting later this school year please mark yes.)

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
<th>No</th>
<th>Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special Education (IEP)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem Solving</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Focus on your child’s response to services with measurable outcomes; most likely through general education)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wraparound (school and community representation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>504 meeting</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Communication

When communicating with your child’s TEACHERS, how frequently did you feel the following?

<table>
<thead>
<tr>
<th>Feeling</th>
<th>Almost Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Much of the time</th>
<th>Almost always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understood</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intimidated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respected</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blamed for your child’s difficulties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Like an equal partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confused</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

communication page 1
**Childhood mental health services survey**

When communicating with your school's ADMINISTRATION, how frequently did you feel the following?

<table>
<thead>
<tr>
<th></th>
<th>Almost never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Much of the time</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respected</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Like an equal partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blamed for your child's</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>difficulties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intimidated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understood</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confused</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Communication page 2**

When communicating with your school's SUPPORT STAFF, how frequently did you feel the following? (i.e. social worker; psychologist; nurse)

<table>
<thead>
<tr>
<th></th>
<th>Almost never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Much of the time</th>
<th>Almost always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blamed for your child's</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>difficulties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confused</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Like an equal partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respected</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understood</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intimidated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Childhood mental health services survey

To what extent have the members of the school demonstrated the following during the current school year:

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Slightly</th>
<th>Somewhat</th>
<th>Most of the time</th>
<th>Almost all the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheduled meetings at convenient times for you to meet</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Returned phone calls in a timely manner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Included you in decisions about your child and family</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treated you with respect</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved your family’s quality of life</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved your ability to care for your child</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Eased your worries about the future well-being of your child</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Given you information about community resources</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helped you understand your child’s strengths</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helped you understand your child’s needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helped you understand your family’s strengths</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helped you understand your family’s needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helped you understand how to use strengths and needs to work with your child</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helped you obtain services for your child and family that you were unable to get before</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased your ability to get involved with your child’s school</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
### Childhood mental health services survey

During the current school year, did the school and community work together to provide services for your child? *(Community would include private psychologists, local agencies, hospital personnel, etc.)*

- [ ] Yes
- [ ] No
- [ ] Not Sure
- [ ] Not this year, but during the 2008-2009 school year

#### Community-school support page 2

To what extent did the school and community include YOU in the treatment planning?

- [ ] Not at all
- [ ] A little bit
- [ ] About half the time
- [ ] Most of the time
- [ ] Almost all the time

Did you the school / community partnership help your child?

- [ ] Not at all
- [ ] A little bit
- [ ] Somewhat
- [ ] Much of the time
- [ ] Most of the time

### Family stress
### Childhood mental health services survey

Living with a child, adolescent or adult with emotional and behavioral problems can be stressful for the family. Listed below are some possible problems that caregivers and/or other family members could experience. Please indicate to what degree, if any, these stresses PRESENTLY IMPACT YOU AND YOUR FAMILY.

<table>
<thead>
<tr>
<th>Problem Description</th>
<th>Not at all a problem</th>
<th>Infrequently a problem</th>
<th>Sometimes a problem</th>
<th>Often a problem</th>
<th>Very often a problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interruption of personal time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missing work or neglecting other duties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disruption of family routines</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family member having to do without things</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family member suffering</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental/physical health effects</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child having trouble with neighbors or law</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial strain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less attention paid to any family member</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disruption of family's relationships</td>
<td></td>
<td></td>
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<tr>
<td>Disruptions of family's social activities</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling socially isolated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling sad or unhappy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling embarrassed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relating well to child</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling angry toward child</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling worried about child's future</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling worried about family's future</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling guilty about child's illness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling resentful toward child</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling tired or strained</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toll taken on family</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Childhood mental health services survey

**Did (does) your child receive early childhood support (before kindergarten) for his/her emotional or behavioral needs?**
- Yes
- No
- Not Sure

**During the current school year did your child receive services for his/her emotional or behavioral needs within the community? (e.g. counseling, hospitalization, etc.)*
- Yes
- No
- Not Sure

---

## Community support page 2

**During the current school year, did your child receive the following COMMUNITY-BASED support?**

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
<th>No</th>
<th>Prefer not to respond</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual counseling/therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group Therapy (with other children)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-Patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case management / Wraparound</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Please indicate which of the following best describes the COST of the services**
- I did not pay for these services
- I paid for some of the services, but it WAS NOT a burden
- I paid for the services and it was a burden only some of the time
- The cost of the services was a burden
- The cost of the services was a SIGNIFICANT burden
# Childhood mental health services survey

Please answer the following items based your child's behavior within the past six months

<table>
<thead>
<tr>
<th>Item</th>
<th>Never a problem</th>
<th>Very infrequently a problem</th>
<th>Infrequently a problem</th>
<th>Sometimes a problem</th>
<th>Frequently a problem</th>
<th>Very frequently a problem</th>
<th>Always a problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inattention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impulsivity</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lying</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stealing</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Executive functioning deficits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning problems in school</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning problems at home</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homework difficulties</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dangerous to self</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dangerous to others</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Language delay</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Wetting or soiling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleeps too little</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obsessive behavior</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Too dependent for age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cruelty to animals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specific fears/phobias</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jealous of siblings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low self-esteem</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inappropriate friends</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aches and pains (without cause)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inappropriate sexual acts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hoarding</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Meltdowns&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mood swings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talks too much</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
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Childhood mental health services survey

More child / parent characteristics

The following questions will provide some basic information about you that can be used to understand your responses about your child. None of the information will allow you to be personally identified. If there are any questions you would rather not answer, you may skip them.

The person who is responding to this survey is the child’s

- [ ] Mother
- [ ] Stepmother
- [ ] Father
- [ ] Stepmother
- [ ] Grandmother
- [ ] Grandfather
- [ ] Other

Please indicate your current marital status.

- [ ] Married
- [ ] Divorced
- [ ] Separated
- [ ] Remarried
- [ ] Single
- [ ] Partnered
- [ ] Widowed

Parent characteristics page 2

Where do you reside?
(State, province, or country only)

Do you currently live in an area that is

- [ ] Rural
- [ ] Urban
- [ ] Suburban
Childhood mental health services survey

What is your race or ethnic group?
- Caucasian
- African American
- Latino/Hispanic
- Asian
- Native American
- Bi or multi-racial

Parent characteristics page 3

Please indicate which response best describes your highest level of education
- Primary school (K-8)
- Some high school
- High school graduate
- Some college
- College graduate
- Some graduate courses
- Graduate / professional degree

At present, how would you rank your family’s total income level?
- Very poor, unemployed
- Working, but poor
- Working class
- Lower middle class
- Middle class
- Upper middle class
- Upper class
- Prefer not to respond
- Other (please specify)

Parent characteristics page 4
### Childhood mental health services survey

**What is your age?**

- [ ] under 20
- [ ] 20-25
- [ ] 26-30
- [ ] 31-35
- [ ] 36-40
- [ ] 41-45
- [ ] 46-50
- [ ] 51-55
- [ ] 56-60
- [ ] over 60
- [ ] Prefer not to respond

**Is there a history of mental illness in your family?**

- [ ] Yes, mother
- [ ] Yes, father
- [ ] Yes, grandfather or grandmother
- [ ] Yes, other relatives
- [ ] No
- [ ] No information available
- [ ] Prefer not to respond

If yes, what is/are the diagnosis(es):

[ ]

### Overall satisfaction

**Please indicate which statement best describes the current school year for you and your child**

- [ ] This is a typical year
- [ ] This year has been worse than normal
- [ ] This year has been better than normal
### Childhood mental health services survey

**Do you think the school services have been effective?**

- [ ] Not at All
- [ ] Sometimes
- [ ] Half the time
- [ ] Most of the time
- [ ] Almost Always

### Feedback

Please provide further information or details about the services your child has received during the current and past school years, as well as the impact these services have had on your family.

**THANK YOU FOR YOUR TIME AND SUPPORT!**
APPENDIX B

INSTRUCTIONS FOR PARENTS AND INFORMED CONSENT
INTRODUCTION AND CONSENT

THANK YOU for your interest in completing the Childhood Mental Health Services Survey. The Childhood Mental Health Services Survey is designed to collect some information about the services your child has received for his/her emotional or behavioral needs within the school and community over the past year. In order to fully understand the impact of these services, you will be asked questions about your child’s behavior and level of stress you are experiencing as a result of having a child with emotional and/or behavioral needs. If you do not have a child with emotional or behavioral needs, please exit the survey at this time.

To provide CONSENT to complete this on-line survey, please read the following:

"I understand that my consent is voluntary, that I may skip any questions I do not wish to answer, and that I may withdraw at any time before completing the survey. Further, I understand that my individual answers to all questions are anonymous and will not be associated with either my real name or any online nickname I use. I understand that although I will be completing this survey on a secure server at SurveyMonkey.com and my computer's IP address will not be available to the researchers, that confidentiality will be maintained to the degree permitted by the technology used. No absolute guarantees can be made regarding the confidentiality of electronic data.

By CLICKING THE NAVIGATION ARROW BELOW ("Next page"), I give my consent to participate in the CHILDHOOD MENTAL HEALTH SERVICES SURVEY."

If you do not consent, please click “Exit this survey” in the upper right hand corner of this page.
GENERAL SURVEY INSTRUCTIONS

This survey is intended for parents or caregivers of children who are experiencing childhood emotional or behavioral problems. If you are a grandparent, step-parent, adoptive parent, or foster parent who cared for a child, please consider yourself the child's parent for this survey. If you have more than one child with childhood emotional or behavioral problems, please select the child with the most serious problems to focus on when answering survey questions.

There are questions that will ask you to recall information about your child's experiences during his or her early childhood, as well as during the current 2008-2009 school year. Please take your time and do your best to respond as accurately as possible. Feel free to stop the survey at any time and complete it later, as long as you will be able to return to the same computer.

You are free to skip any questions, but there are a few questions that are marked with an asterisk (*). For these questions you must select a response in order for the survey to move forward and select the next appropriate question for you. Each of these questions has a "prefer not to respond" choice, which, while giving no information about the topic of the question, qualifies as "a response," and will allow the survey to proceed.

Please scroll down to see all questions and to reach the "Next page" navigation arrow at the bottom of the page. This will be easier if you enlarge your browser window as much as possible.

Thank you VERY MUCH for your time,

Laura Swanlund, M.ED, NCSP
School Psychology Doctoral Candidate
Loyola University Chicago
APPENDIX C

CALL FOR PARTICIPANTS
Dear Parent,

My name is Laura and I am a graduate student in school psychology at Loyola University Chicago. I would like to invite you to participate in my dissertation study, which is a survey for parents of children with emotional and/or behavioral needs (i.e. ADD/ADHD, Autism spectrum, Anxiety, Depression, ODD, and so on). I am interested in hearing about your experience with the services and treatment that your child has received within the school and community.

The survey is for parents of children aged 3 to 19 who have emotional and/or behavioral needs and live in the United States. Please participate regardless of whether or not your child is receiving services. The goal of this study is to understand the extent to which children are receiving support for their needs, and the parent experience with the services.

The survey takes only about 20 minutes to complete. I can’t thank you enough for considering participation in this study. Your voice is extremely important in potentially improving the quality of treatment children receive.

Just click on the following link to participate. You may also copy and paste the link into your browser.

http://www.surveymonkey.com/s/R5FBHKC

Do not hesitate to contact me with any questions.

Thank You!

Laura Swanlund, M.Ed, NCSP
School Psychology Doctoral Candidate
Loyola University Chicago
lswanlu@luc.edu
APPENDIX D

PILOT INSTRUCTIONS AND INFORMED CONSENT
INTRODUCTION

THANK YOU for your interest in completing the School-based Mental Health Services Survey. This survey is designed to collect information about the services your child has received for his/her emotional or behavioral needs within the school during the 2008-2009 school year. In order to fully understand the impact of these services, you will be asked questions about your child’s behavior and the level of stress you are experiencing as a result of having a child with emotional and/or behavioral needs. If you do not have a child with emotional or behavioral needs, please exit the survey at this time.

You are participating in a pilot of this survey, meaning that your responses will not be used for the final research project. Your participation in the pilot is extremely important in order to ensure that the survey is reliable and valid. Please feel free to give written feedback on the survey. For example, please indicate when you do not understand a question, when you feel that there is no answer you can provide for a question, and any suggestions that you have for improvement.

Again, that you for your time and support!

ON-LINE CONSENT

To provide CONSENT to complete this on-line survey, please read the following:

I understand that the survey will ask me questions about my child's behavior, stress, and services that my child has received for his or her emotional needs. My consent is voluntary, I may skip any questions I do not wish to answer, and I may withdraw at any time before completing the survey. Further, I understand that my individual answers to all questions are anonymous. I understand that although I will be completing this survey on a secure server at SurveyMonkey.com and my computer's IP address will not be available to the researchers, that confidentiality will be maintained to the degree permitted by the technology used.

I understand that this research is for Laura Swanlund's dissertation and is supervised by Dr. Martha Ellen Wynne. There is no direct benefit to participating in this survey, however the research may lead to improved treatment for childhood emotional and behavioral disorders. The survey will take approximately 20 minutes to complete.

By CLICKING THE NAVIGATION ARROW BELOW ("Next page"), I give my consent to participate in the CHILDHOOD MENTAL HEALTH SERVICES SURVEY."

If you do not consent, please click “Exit this survey” in the upper right hand corner of this page.
PAPER COPY CONSENT

I understand that the survey will ask me questions about my child's behavior, stress, and services that my child has received for his or her emotional needs. My consent is voluntary, I may skip any questions I do not wish to answer, and I may withdraw at any time before completing the survey. Further, I understand that my individual answers to all questions are anonymous.

I understand that this research is for Laura Swanlund's dissertation and is supervised by Dr. Martha Ellen Wynne. There is no direct benefit to participating in this survey, however the research may lead to improved treatment for childhood emotional and behavioral disorders. The survey will take approximately 20 minutes to complete.
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VITA

Laura Swanlund is originally from northwest Illinois. Prior to her graduate studies at Loyola University Chicago, Laura attended the University of Illinois at Chicago where she received her Bachelor’s in psychology. Upon the completion of her undergraduate studies, Laura entered the Ph.D. program in School Psychology in 2004.

Throughout her time at Loyola, Laura has conducted survey and qualitative research on the parental experiences of having a child with emotional and behavior needs. She was a graduate assistant for IASPIRE, where she helped develop assessment tools and evaluate RTI. In all, Laura presented 13 papers, mini-skill, and poster presentations at the National Association of School Psychologist and American Educational Research Association conferences. She is revising two manuscripts for publication, and taught numerous graduate courses in school psychology and research methodology.

Currently Laura is a certified in the state of Illinois and is a nationally certified school psychologist. She has been working as a school psychologist for Community Consolidated School District #15 for three years. During this time she has lead PBIS and RTI intervention teams, provided staff development and training, conducted and presented action research projects, and engaged in many other school psychology related activities. She has supervised two practicum students. Laura is also the Operations Manager for Girls Rock! Chicago, a non-profit organization dedicated to enhancing young women’s self-esteem and feelings of empowerment through music.
DISSERTATION APPROVAL SHEET

The Dissertation submitted by Laura Swanlund has been read and approved by the following committee:

Martha Ellen Wynne, Ph.D., Director
Associate Professor, School of Education
Loyola University Chicago

Pamela Fenning, Ph.D.
Associate Professor, School of Education
Loyola University Chicago

David Shriberg, Ph.D
Assistant Professor, School of Education
Loyola University Chicago

Rosario Pesce, Ph.D.
Part-Time Lecturer, School of Education

The final copies have been examined by the director of the Dissertation Committee and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the Dissertation is now given final approval by the committee with reference to content and form.

The Dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

____________________________________
Date                          Director’s Signature