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Treating Children With Serious Emotional Disturbances in Schools and Community: The Intensive Mental Health Program

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Children with serious emotional disturbances pose challenges to psychologists and school personnel to find optimal ways to improve functioning. An intensive mental health program (IMHP) is described for providing comprehensive psychological services in a school-based therapeutic environment. Case vignettes illustrate the type and severity of the children's problems served in the IMHP with both successful and less successful outcomes. The article describes the principles and organization of services, including individual and group psychotherapy and behavioral management systems, and service coordination with caregivers, agencies, and the children's neighborhood schools. Challenges facing psychologists working with children, such as resolving turf issues and working collaboratively with other involved providers, are also addressed.

Children with serious emotional disturbances (SED) are often the most difficult for psychologists to treat and for schools to educate and manage. The complex nature of the disorders, coupled with involvement by multiple agencies, creates a challenge for effective intervention. Funding restrictions and questions regarding treatment outcomes have reduced residential or inpatient treatment, whether in the public or private sector. Consequently, schools are the de facto mental health service provider because school systems are mandated to serve children. Children with severe psychological and behavioral disorders often pose challenges to teachers and staff charged with meeting their educational needs. Special education concepts and values guide placement of these children in the least restrictive school environment, as operationalized under the Individuals with Disabilities Education Act (IDEA; 1990, 1997). The intent of these special education laws and regulations is to ensure that all children receive an appropriate education (Riccio & Hughes, 2001). This requirement compels schools to make every effort to teach a child in as regular a setting as possible and remove children from general education classes only when the nature or severity of disability prevents them from receiving a satisfactory education. School psychologists and clinical child psychologists are increasingly being called on to identify and diagnose children with the most serious emotional problems in the schools, provide counseling, design behavioral management interventions, and consult with families and other community agencies.

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Guided by special education laws, school personnel typically use a different nomenclature than mental health practitioners in categorizing children with SED, with such designations of emotional disturbance and behavioral disorders (EBD). Under IDEA, children with EBD are categorized as either emotional disturbance (ED) or other health impairment (OHI). ED may be diagnosed by the multidisciplinary team when a child exhibits a condition characterized by one or more of the following: (a) an inability to learn that cannot be explained by intellectual, sensory, or health factors; (b) an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; (c) inappropriate types of behavior or feelings under normal circumstances; (d) a general pervasive mood of unhappiness or depression; and (e) a tendency to develop physical symptoms or fears associated with personal or school problems (IDEA, 1990, 1997; Sect. 3001.7[c] 4[i]). This condition must exist over a lengthy period of time and must significantly and adversely affect school performance. Relatedly, the multidisciplinary team may categorize a child as OHI when an outside practitioner has diagnosed him or her with a chronic or acute physical or psychiatric condition that substantially interferes with educational performance. In contrast to school nomenclature, practitioners in traditional mental health systems often diagnose children with SED with multiple disorders from Axis I of the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–IV*; American Psychiatric Association, 1994). Diagnoses often include attention-deficit/hyperactivity disorder (ADHD), disruptive behavior disorders (BDs; oppositional defiant disorder, conduct disorder), anxiety, depression and mood disorders, pervasive developmental disorder, obsessive–compulsive disorder, and childhood schizophrenia (Greenbaum et al., 1996).

Diagnostic heterogeneity and other barriers, such as availability of funding and programmatic limitations, often lead to inadequate service delivery for children exhibiting emotional and behavioral disorders at the most severe levels. The problems are evident in that 5% of all children exhibit SED, whereas a much smaller percentage of these children receive any mental health services beyond behavior management during the school day (Reddy, 2001; U.S. Department of Health and Human Services, 1999). Mental health professionals involved with these complex cases need more training and experience to be effective in serving these children, adolescents, and their families (Roberts et al., 1998). Schools often place children with SED in special education classrooms for BDs, but long-range outcomes for these children remain bleak (Greenbaum et al., 1996). Therapeutic classrooms and day treatment programs, developed and operated away from schools such as in psychiatric units or mental health centers (Farley & Zimet, 1991; Zimet & Farley, 1991), are now less common because of financial constraints, staffing limitations, and concerns about effectiveness, generalizability, and restrictiveness of environments. Special education laws and the recognized connection between problematic functioning across schools, home, and community settings have created the need for greater collaboration and integration of services for children with SED, including mental health and educational programming. The problem remains of how best to treat this combination of educational, psychological, and behavioral problems. Although psychologists are called on to consult and develop comprehensive intervention programs for the complicated needs of these children, effective models for service delivery remain scarce.

Intensive Mental Health Program

Purposes

We describe here an intensive mental health program (IMHP) designed to serve comprehensively the needs of elementary school children with SED. The IMHP is designed to enhance positive outcomes for children with serious emotional and behavioral difficulties in terms of psychological functioning, behavioral control, and academic performance through an integrated model of service and therapy. The IMHP has the additional goals of increasing access to mental health services, fostering interdisciplinary training of psychologists, and evaluating the effectiveness of the program through empirical research. The basic principles, as outlined by Vernberg, Roberts, and Nyre (2002), are that the IMHP attempts to (a) maintain placement both in the child's home and in the regular neighborhood school; (b) emphasize treatment guided by an empirically supported approach; (c) enhance cognitive and behavioral skills development; (d) link people across settings and events in therapeutic and collaborative relationships; (e) emphasize generalization and maintenance of behavioral changes; (f) collaborate with all stakeholders in a child-centered, family-focused, community-based, and culturally competent service delivery system; (g) continue assessment and diagnosis as ongoing processes; (h) maintain a developmental perspective on behavior and treatment; and (i) assist in the development of authoritative parenting styles for the child's caregivers.

Characteristics

The IMHP model has several distinguishing characteristics for delivering services within a half-day therapeutic classroom in a school setting while using a broad range of activities involving the family, community, and other educational settings. Treatment teams consisting of parents, psychologists, special education teachers, social workers, paraprofessionals, and community providers work together to develop an individual treatment plan for each child. Aspects of the model include (a) psychologists and social workers who design and provide the therapeutic components, supervision, and evaluation; (b) psychological consultation and intervention by the IMHP team as needed with parents and families, school personnel, and agencies; (c) individual and group psychotherapy, social skills and relaxation training, and other evidence-based practices provided by clinicians in the context of the therapeutic classroom; (d) special education teachers and paraprofessional educators who provide expertise in addressing academic needs; (e) individualized behavioral management programs that are established and monitored in the classroom and the child's neighborhood school as well as in the home; (f) medication trials conducted by IMHP staff as needed, in consultation with psychiatrists, nurse practitioners, and general medical practitioners; (g) service coordination of efforts by multiple agencies and staff, led by IMHP staff; and (h) continuous evaluation of components in the therapeutic classroom.

The psychologists' roles in this program are critical and diverse. They draw on the research expertise of the discipline when implementing empirically supported assessment and treatment as well as in day-to-day clinical decision making and in program evaluation of therapeutic outcomes.

The IMHP was developed and implemented in 1996 as a collaborative enterprise between the Lawrence, Kansas Public Schools and the Clinical Child Psychology Program at the University of Kansas. The program began with one classroom and expanded to four half-day classrooms capable of serving 24 children in a school district of 5,500 elementary school aged children. The program involves doctoral- and master's-level psychologists (with specialties in clinical child psychology), school psychologists, school social workers, special education teachers, paraprofessionals, classroom teachers, and school principals. The staffing requirements are extensive because of the intensity and comprehensiveness of services necessary to meet and respond appropriately to the children's needs. Typically, there are three professionals (special education teacher, paraprofessional, master's-level psychologists) directly available for six children, with an array of others involved in support services, treatment planning, and program evaluation.

Clinical Therapeutic Services in the IMHP

Admission and Treatment Plans

Before a child is accepted into the IMHP, evaluations are made of the child's psychological functioning, family situation, school performance and behavior, and previous treatments. Input is obtained from many sources, including the school psychologist from the child's neighborhood school; the child's general education teachers, special education teachers, and parents; and community providers. In addition, observations and additional formal assessments are conducted by the classroom therapists. Decisions regarding placement and services in the IMHP are ultimately made by the child's multidisciplinary individualized education plan (IEP) team and are subsequently delineated in the child's IEP.

The children admitted to the IMHP have had recent disturbing behaviors, such as threats of self-injury or harm to others, physical and verbal attacks on classmates or teachers, and disorganized or bizarre behaviors, indicating a critical need for enhanced services. The children have received at least one *DSM–IV* diagnosis and in many cases, more. A diagnosis of disruptive BD with comorbid diagnoses of anxiety disorder, mood disorder, or psychotic features is a typical presentation. Students' scores from the Global Assessment of Functioning scale (GAF) range from 50 (indicating serious symptoms or impairment) to 20 (indicating violence, manic excitement, or danger of hurting self and others). Families of the children often reveal histories of child maltreatment, foster care placement, parental psychiatric or behavioral problems, and domestic abuse. Involvement by the state child protection and foster care services, juvenile/family courts, and mental health agencies in the community is common. In addition to behavioral and emotional problems exhibited by the child, he or she often has learning problems and is failing in school.

Individualized service plans are developed at admission for all children in the IMHP and are revised over time. These plans emphasize that there must be involvement and consistency in the realms of home, medical, academic, community agency coordination/communication, and therapy. For example, the treatment team may target enhanced parenting skills by developing strategies to increase positive interventions or to provide appropriate supervision and discipline of the child while at home. Medical consultation often includes evaluating the effectiveness of psychiatric medications as well as managing physical health problems presented by the child. Academic components are the primary focus for involved teachers, with assistance from paraprofessionals and therapists. IMHP therapists and social workers also attend to coordinating treatments and other services provided by other agencies (oftentimes numerous) and the child's neighborhood school (e.g., one child had 23 different agencies and contacts listed). The focus here is on getting all systems and persons to work toward treatment goals formed by consensus. Most commonly involved are the community mental health center, private psychological practitioners, social service agencies, and juvenile courts. This service coordination aspect frequently requires planning, linking, and monitoring services operationalized through meetings with agency staff, sharing reports, and frequent telephone calls to exchange information. The classroom therapist is often the convener of service coordination contacts, although other service agencies also take active roles.

While in the IMHP, clinically important information is gathered on each child through (a) daily point sheets for monitoring behavior exhibited at home, in the neighborhood school, on the bus, and in the IMHP; (b) daily symptom rating scales of psychological and behavioral symptoms evaluated by the therapists; (c) the Child and Adolescent Functioning Assessment Scale (CAFAS; Hodges, 2000; Hodges, Wong, & Latessa, 1998), completed three times per year; (d) the Behavioral Assessment Scale for Children (BASC; Reynolds & Kamphaus, 1992), completed twice a year; (e) the Diagnostic Interview for Children and Adolescents (DICA; Welner, Reich, Herjanic, Jung, & Amado, 1987), completed once per year; (f) the Parenting Stress Index (PSI; Abidin, 1995), completed once per year; (g) the Hope Scales (Snyder et al., 1996, 1997) for adults and children, completed twice per year; and (h) the HOME Scale (Caldwell & Bradley, 1994), completed twice per year.

Psychologists' Roles

The purposes of the IMHP are accomplished by the entire team acting in concert to the agreed-on goals of the individualized plans. We focus here on the psychologists' roles to illustrate their functions in creating an effective therapeutic environment. In the IMHP, therapists provide individual and group therapy and are responsible for directing the behavioral management system. This treatment component uses a token economy, response cost, and positive reinforcement components inside and outside of the classroom as empirically supported practices. Two therapists alternate days in the 3-hr classroom sessions, which allows out-of-classroom time for the therapists to engage in consultation with parents and other agencies, service coordination, and supervision. The classroom personnel meet at least once weekly for a team meeting to review progress, problems, discharge planning, and new admissions. The therapists meet 2 hr a week with a doctoral-level psychologist for supervision of individual and group psychotherapy, case conceptualization, and service coordination efforts.

Therapists provide four psychotherapeutic components to children in the IMHP: (a) behavioral management procedures individualized for each child in the classroom, at home, and in the neighborhood school; (b) group therapy sessions four times weekly (30 min) and daily check-in groups to process recent events in the children's lives; (c) individualized therapy at least

twice weekly; and (d) crisis management as needed, with immediate response interventions conducted with neighborhood schools, bus drivers, parents, and the community. In individual and group therapy, therapists devote attention to behavioral, cognitive, and emotional domains. Therapy sessions frequently focus on social and emotional management training through behavioral and cognitive behavioral techniques, with in vivo practice and prompting throughout the day. In the cognitive domain, therapy issues commonly involve taking interpersonal perspectives, developing positive self-concepts, distinguishing between fantasy and reality, and cognitive restructuring. Expanding the range of emotions or exploring abuse history in relation to current behaviors may additionally be a therapeutic focus. The therapists also take primary responsibility for enhancing service coordination to improve children's adaptive functioning in all settings. The psychosocial interventions derive from the literature of empirically supported and evidence-based assessment and treatment from psychology and medical research (e.g., American Academy of Child and Adolescent Psychiatry, 1997; Hibbs & Jensen, 1996; Ollendick & King, 2000). These interventions are extended in application and combined with the best practices in special education (Weist, Evans, & Lever, 2003). Because of the ongoing clinical evaluation of the IMHP, the program also has a goal to contribute to the clinical science literature.

Funding and Support

The therapeutic classrooms in the IMHP are financially supported by the special education budget of the local school district. Each "slot" in the IMHP has been estimated to cost over $9,000 annually, with federal reimbursement lowering the cost to the district. Thus, some of the direct costs are reimbursed from state and federal funds for special education and mental health services. These expenses include the direct salary lines for the teachers, psychological therapists, and the psychologist consultants. In contrast to costs associated with a child's placement in more restrictive settings (juvenile detention facilities, hospitalization, or residential treatment centers), these expenses are considerably lower (e.g., one fifth the cost of juvenile detention, one tenth the cost of residential treatment, and one twentieth the cost of hospitalization; Vernberg et al., 2002). In addition, because findings indicate that the children typically transition to less restrictive educational environments within an average of 1 year (Nyre, Roberts, Jacobs, Puddy, & Vernberg, 2002), school administrators view the program as cost effective. Another indication of strong support for the program is the allocation of space and resources by building principals in their schools for the IMHP classrooms.

Clinical and Educational Outcomes

The IMHP received a grant from the United States Department of Education to fund a program evaluation of the outcomes (but not reimburse for the therapeutic or educational components). Assessment of treatment process and outcome is ongoing, primarily using information gathered for clinical decision making. Preliminary results indicate positive outcomes. For example, while in the program, the children overall met treatment goals of achieving 80% of the possible points on the daily point sheets for the classroom and neighborhood schools, indicating they exhibited appropriate behaviors targeted in the treatment phases. Changes in the children's adaptive functioning were further analyzed using CAFAS data (using clinically acquired information). The majority of the children who had completed the IMHP demonstrated considerable improvement overall, in addition to improvement for the individual domains of the CAFAS (Vernberg, Jacobs, Nyre, Puddy, & Roberts, 2003). Most children had returned to their neighborhood schools on a full-time basis. In contrast to their difficulties at admission, which included risk for removal from home, psychiatric hospitalizations, or school suspension/expulsion, most of the children at discharge were transitioned to and were performing well in their neighborhood schools and living with biological or adoptive families.

The best improvements at discharge have been associated with greater consensus and coordination among various service providers, strong collaboration between the program and the child's neighborhood school, and active engagement with the caregivers (Nyre et al., 2002). The children with the best outcomes also exhibited sustained engagement with cognitive–behavioral therapies as well as with the behavioral management system. Children who responded well to treatment appeared to have a greater initial impairment in mood and self-harm indices, perhaps indicating areas of particular strength for the therapeutic interventions. It appears that moderate-to-severe impairment for indices of thought problems (stability of thought processes) and high material needs at intake are associated with poorer improvements overall. In addition, children with lower response to the program tend to have more *DSM–IV* diagnoses, are older at entry, and have fewer agencies assisting with services. These children spend considerably longer in the IMHP (almost twice as long as high and average responders), indicating the commitment of effort made to assist these children. The following three clinical case examples[1] illustrate the severe types of behaviors and diagnoses, the forms of intervention within the program, and the positive outcomes, as well as obstacles associated with poorer treatment responses.

Clinical Case Examples

Case 1

N.J. was a 10-year-old Caucasian boy referred to the IMHP because of concerns about a suicide attempt, depressive symptoms, repeatedly running away from home in the past, declining grades, messy and disorganized work, incidents of sexual harassment, somatic complaints (e.g., headaches, stomachaches), and suspicion of past physical and/or sexual abuse. N.J. required one-on-one attention throughout most of the school day and had few friends. In addition to being treated for a seizure disorder, N.J. had been previously diagnosed with bipolar disorder and was prescribed Lithium, Depakote, Imipramine, and Ritalin at the time of his admission to the IMHP. He was also receiving counseling services at a local community mental health center. On the basis of presenting concerns noted among several environments, four target behaviors were identified for N.J. within a week of admission to the IMHP: (a) refrain from comments about staff, other children, and their treatment; (b) increase on-task discussion; (c) be polite to

[1] Names have been replaced by random initials in the case examples and are not those of the children served in the IMHP to respect their privacy.

others; and (d) choose appropriate responses to frustrating circumstances.

During his first full month in the IMHP, N.J. earned 90% or more of points only 60% of the time. A review of case notes showed that N.J. was very responsive to individual therapy and participated well in group therapy. He demonstrated the skills taught in group therapy, such as using the behavioral skills and strategies effectively to calm down and to avoid receiving time out. N.J. became fully engaged in the group and individual therapy, and he appeared to make active use of cognitive–behavioral strategies learned in therapy. N.J. appeared to have a particularly high "buy-in" to the behavior program. It was noted that he became frustrated when his point sheet was not perfect and was disappointed when he did not earn the fun activities. Point sheets, meeting notes, and other correspondence in his file reflected high service coordination between the IMHP staff, neighborhood school staff, bus driver, father, and grandmother. The adults directly involved with N.J. often wrote extensive notes on his point sheets and attempted to clarify any confusion in his behavior plan. During his last full month in the IMHP, N.J. earned 90% or more of his points 100% of the time. He began to transition back to his neighborhood school after 7 months in the IMHP and successfully completed transition at 10 months.

Case 2

A.Z. was a 6-year-old Caucasian boy referred to the IMHP for exhibiting a variety of acting-out behaviors. His referral information indicated concerns with extreme noncompliance, defiance, suicidal ideation, fire setting, threats, and violence toward others. Other behaviors of concern were distractibility, academic difficulties, lying, nocturnal enuresis, destruction of property, and drug use within the immediate family. A.Z. was hospitalized for 30 days at age 4 years when he tried to attack his mother with a knife; afterward, he was released to live with his father. There were concerns about possible physical and sexual abuse by his father during this time. His father was killed in an accident approximately 1 year later. A.Z. lived with his mother after his father died and was hospitalized four times in 5 months. A.Z. also became involved with the juvenile justice system when a teacher pressed charges after A.Z. kicked him in the groin. Prior to admission to the IMHP, A.Z. had been diagnosed with ADHD, oppositional defiant disorder, and conduct disorder. Medications at admission included Zyprexa, Zoloft, and Ritalin.

A.Z. had received services under an IEP since age 3 years, when children in his preschool stated that they were afraid of him. He received a number of special services, beginning with Head Start and followed by one-on-one instruction in a resource room during kindergarten. A.Z. was in a self-contained BD classroom at the time of his referral. He sporadically received services through a community mental health center. The first three target behaviors identified for A.Z. were (a) follow directions, (b) raise hand before talking, and (c) keep hands and feet to self.

A.Z. displayed a number of disturbing behaviors while in the IMHP, including running out of the school building and digitally extracting feces from his rectum and smearing it on two other students. During his first 2 years in the IMHP, A.Z. earned 90% or more of points only 37.5% of the time. During this time period, therapist notes indicated that A.Z. had trouble transitioning to group therapy and avoided participating in individual therapy by running out of the room, climbing onto staff mailboxes, and otherwise acting out. Suspensions, hospitalizations, moving, and illness caused A.Z. to miss a number of school days. A.Z. made great progress during his last year in the program. Although he still disliked talking about feelings, A.Z. participated well in group and individual therapy. His mother consistently attended school meetings, wrote additional notes on his point sheets, and participated well during in-home family therapy. His individual therapist met frequently with his neighborhood school staff, particularly as A.Z. began to transition back. At the time of discharge, A.Z. earned 90% or more of his points 80% of the time. A.Z. initially transitioned from the IMHP into a full-day BD classroom with counseling from an outside therapist and the school counselor. However, follow-up calls with his neighborhood school teachers indicated that he was spending increased time in a general education classroom.

Case 3

P.L. was a 12-year-old Caucasian girl referred to the IMHP because of concerns regarding anger and aggression toward peers, immature behavior, escape into fantasy, disruptive classroom behavior to avoid work and gain adult attention, low frustration tolerance, non-compliance with classroom rules and teacher directions, impulsivity, the need for one-on-one supervision to complete work, and other oppositional behaviors. P.L. had few friends and poor social skills prior to entering the IMHP. P.L. had been previously diagnosed with oppositional defiant disorder and ADHD–combined type and was prescribed Ritalin and Zoloft at the time of her admission to the IMHP. She also received weekly individual counseling services by a private psychologist during her participation in the IMHP.

P.L. was abandoned by her mother during infancy, spent 18 months in foster care, and was adopted by her maternal great grandparents at the age of 2 years. She had a brief psychiatric hospitalization at the age of 4 years, as well as a history of physical and sexual abuse. P.L. also sustained a closed head injury approximately 1 year prior to admission to the IMHP when she was hit in the head with a bat. She had been prescribed asthma medications (Ventolin, Beconase, Intal) since the age of 2 years. P.L. had received services in an early childhood program for behavioral concerns (immature and inappropriate social skills) at age 3 years but had not been referred to special education services in elementary school until age 8 years. Her preadmission assessment report indicated numerous academic and behavioral concerns, such as poor self-control, impulsivity, aggression, hostility toward others, and the need for one-on-one supervision for learning to occur. Four target behaviors were identified: (a) follow directions, (b) act respectfully toward others and property, (c) stay focused on own behaviors and less on others in the classroom, and (d) use age appropriate communication.

A review of case notes showed that P.L. was not very responsive to individual therapy and was sometimes disruptive during group therapy. During individual therapy, she was often impulsive and had a difficult time concentrating on specific activities. P.L. also had a difficult time generalizing what was practiced in individual therapy into practical situations with peers. Her impulsiveness and poor social behaviors often served to alienate others during group

therapy, as her responses were odd and inappropriate. Peer relations continued to be a significant difficulty for P.L. throughout her involvement in the IMHP. Many times, she did not realize how her strange behaviors and responses served to isolate her from her peers. P.L. often engaged in fantasy that focused on themes of violence and horror. She also did not realize the degree to which her responses made other youth uncomfortable. At times, P.L. was able to identify appropriate responses and interactions in therapy, but she had trouble generalizing to the classroom. Additional skills addressed in therapy included stress reduction, social skills, accepting consequences, identifying emotions, relaxation strategies, problem-solving skills, and understanding her mother's absence. P.L. struggled with "buying-in" to the behavior program because positive reinforcement and earning rewards had little motivation for her once her behavior escalated to the point to necessitate a time out. Throughout her involvement in the IMHP, she continued to struggle with peer interactions. Often, negative interactions with others in the program precipitated cursing, aggressive behavior, or retreat into fantasy play when she would often crawl around the classroom growling, hissing, and attempting to scratch others. During her treatment in the IMHP, medications were monitored by a psychiatrist from the community mental health center and P.L. was able to discontinue all asthma medication.

P.L. had 44 time outs while in the IMHP classroom for hitting and kicking walls, chairs, and others; making threats of physical harm to peers and staff; biting others; using objects as weapons; turning over desks; running away from school grounds; and throwing objects. Point sheets, meeting notes, and other correspondence in her file reflected a poor level of service coordination between the IMHP staff, neighborhood school staff, bus driver, caretakers, and the individual therapist involved with P.L. However, caretakers and staff regularly used point sheets to communicate information about behaviors with each other. During her last full month in the IMHP, P.L. earned 90% or more of her points 75% of the time. P.L. left the program after 8 months when her caretakers moved out of state.

Clinical Case Examples: Program Progress

The first two children (N.J. and A.Z.) and 74% of all children served in the IMHP are currently functioning relatively well in their neighborhood schools in considerably less restrictive settings than prior to their involvement with the IMHP. Their success in treatment appears to be related to several factors, including maximizing service coordination among professionals in involved agencies and with parents, good "buy-in" to the contingency program and the group and individual therapy from the child and family, and generalization of cognitive–behavioral coping strategies learned in therapy.

The third child (P.L.) is an example of a less positive outcome to the intensity of services provided in the IMHP (i.e., a nonresponder). Several aspects of the course of treatment in the IMHP stood out as possible contributors to this lack of improvement. These include poor service coordination among ancillary agencies, continuing problems in her family and home life, and less acceptance of the program components by the child and her parents. The results of the repeated CAFAS administrations, demonstrating the changes over time in child functioning in various domains, are presented in Table 1.

Conclusions

As a clinical treatment program, the ongoing program evaluation of the IMHP is subject to the difficulties of conducting field research on intervention effectiveness. Consistent with special education laws, the IMHP does not randomly assign children to the program versus to an alternate treatment control group. Another restriction in conducting such effectiveness research is that the problems exhibited by the children are highly heterogeneous. The IMHP offers a model to serve children with SED in a school district with extraordinary commitment and flexibility. This commitment is apparent from the teachers and principals, as well as from the administration (i.e., special education coordinator, superintendent, school board). As illustrated in the vignettes, successes can be achieved through the intensive efforts of psychologists and multiple partners in an intensive mental health program provided in established school systems. Nonoptimal outcomes also illustrate the difficulties posed by the needs and behaviors of the children served. Although the majority of children demonstrated significant change, some did not. Often for these children, maintenance of functioning, with no further regression, may be the best outcome

Table 1
Functioning on the Child and Adolescent Functioning Assessment Scale at Intake and Discharge for Three Clinical Cases

	Youth functioning scales									Caregiver functioning scales	
Case	School	Home	Community	Behavior	Mood	Self-Harm	Substance Use	Thinking	Total	Need	Support
N.J.											
Intake	30	0	0	30	30	30	0	0	120	0	0
Discharge	0	0	0	0	0	0	0	0	0	0	0
A.Z.											
Intake	30	30	20	30	20	0	0	0	130	0	0
Discharge	10	0	0	0	0	0	0	0	10	10	10
P.L.											
Intake	30	0	10	30	20	10	0	20	120	0	10
Discharge	20	10	0	30	20	0	0	20	100	0	10

Note. Level of impairment for the Child and Adolescent Functioning Assessment Scale scores are as follows: 0 = minimal or no, 10 = mild, 20 = moderate, and 30 = severe. Behavior = behavior toward others; Self-Harm = self-harmful behavior; Total = Total for the youth functioning scales on the basis of eight scales; Need = material needs; Support = family/social support.

that can be currently achieved, although efforts at improving service and supporting research need to continue.

The role of psychologists is integral to the development and successful implementation of the entire program but most specifically for the active therapeutic components and service coordination. Although children with SED are difficult to treat, their outcomes can be greatly improved through intensive and comprehensive application of evidence-based interventions. Psychologists often may not become involved in services for children with SED and their families unless affiliated with an inpatient or residential treatment unit. Therapeutic programs of the type described here offer opportunities for innovative work by psychologists who wish to make a difference in the lives of children with challenging problems.

The IMHP represents a psychological service in schools with an extraordinary involvement by professional psychologists. Because school psychologists have traditionally held positions within school settings, the potential for turf problems might be raised when clinical child psychologists enter the system. The impetus for this collaboration came from a member of the school psychology staff who had received training in the clinical child psychology program, along with his doctoral training in school psychology. The other members of the special education team, from the district administration to EdS-level psychologists, were integrally involved to secure their meaningful contributions. Although aware of potential tensions, the clinical child psychologists and school personnel developed over time a great deal of mutual respect and appreciation for the expertise and experience contributed by all participants. One of the university-based psychologists had a background in teaching and school psychology that perhaps facilitated this sense of shared endeavor. We do not intend to paint an overly sanguine picture, but we consider this collaboration to be a very collegial enterprise. There was only one incident in our collective memory for which turf issues could have had a negative impact. An applicant denied an EdS position elsewhere in the district misrepresented the program to a national Listserv as an attempt by clinical child psychologists to "take over" school psychology positions. Within the program, the roles are carefully maintained that the master's-level clinical child psychologists and the supervising doctoral psychologists do not assume any of the legally mandated roles of the school psychologists. No EdS positions were removed when the IMHP was started. We truly believe that potential problems within the psychology groups and with other disciplines have been diffused by attitudes and behaviors of mutual respect for the knowledge and contributions of professionals, regardless of their backgrounds.

The program runs very much as a team, with contributions valued from the teacher and paraprofessionals in addition to those from the educational specialists and the doctoral- and master's-level psychologists. As with any service program involving numbers of contributing professionals, disagreements arise occasionally over plans and implementation, but open discussions by the treatment teams and the oversight committee most often correct these problems with a focus on what is best for the child. In addition, interactions between the school psychologists, the clinical child psychologists, and the child psychiatrist working with the children in the IMHP tend to be data driven rather than opinion laden. The program uses highly trained and well-supervised therapists, with overview and collaborative contributions by different professions functioning in a partnership. This collaborative approach in providing psychological services for children with SED based in schools will be increasingly necessary (Nyre, Vernberg, & Roberts, 2003). Training for those services is important in clinical and school psychology programs, often requiring changes in curriculum and clinical experiences (Riccio & Hughes, 2001; Roberts et al., 1998). Clinical child psychologists can find new opportunities by combining empirically supported treatments of children with serious emotional and behavioral disorders with the expertise of those in schools, who may be particularly challenged by the severity and multiplicity of the problems presented by these children. Although the IMHP arrangement involves a university–school district collaboration, other professional psychologists with similar competence and expertise might contribute to schools in this manner.

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Call for Nominations: *Rehabilitation Psychology*

The APA Publications and Communications (P&C) Board has opened nominations for the editorship of ***Rehabilitation Psychology*** for the years 2006–2011. Bruce Caplan, PhD, is the incumbent editor.

Candidates should be members of APA and should be available to start receiving manuscripts in early 2005 to prepare for issues published in 2006. Please note that the P&C Board encourages participation by members of underrepresented groups in the publication process and would particularly welcome such nominees. Self-nominations are also encouraged.

Rehabilitation Psychology will transition from a division publication to an "all APA" journal in 2006, and the successful candidate will be involved in making suggestions to the P&C Board and APA Journals staff about the transition process.

Gary R. VandenBos, PhD, and Mark Appelbaum, PhD, have been appointed as cochairs for this search.

To nominate candidates, prepare a statement of one page or less in support of each candidate. Address all nominations to

Rehabilitation Psychology Search Committee
Karen Sellman, Search Liaison
Room 2004
American Psychological Association
750 First Street, NE
Washington, DC 20002-4242

The first review of nominations will begin December 8, 2003. The deadline for accepting nominations is **December 15, 2003**.