

## Community Participation in the Treatment Development Process Using Community Development Teams

Steven W. Evans, Amy L. Green, and Zewelanjani N. Serpell

*Alvin V. Baird Attention and Learning Disabilities Center, James Madison University*

*Little literature exists about methods for adapting research-based treatments to typical practice settings. This report describes a 2-step process and associated methods used to adapt a school-based treatment program for middle-school youth with attention deficit hyperactivity disorder (ADHD) that operates in a controlled setting to one that can operate in a typical practice setting. Step 1 included a feasibility study that yielded important findings regarding potential obstacles to successful implementation. These data, along with original treatment manuals and literature on treatments for youth with ADHD, were utilized for Step 2—the Community Development Team (CDT) process. Data collected about the CDT process indicate that its strengths outweigh potential limitations. These methods are discussed in the context of successful collaborative procedures for developing and evaluating research-based treatments in practice settings.*

Although the field has moved toward the evaluation of treatment in community settings, there has been little description or research to guide investigators in methods for achieving genuine community collaboration in the treatment development process (Chorpita et al., 2002). This lack of information has limited the degree to which researchers and practitioners can successfully bridge the science–practice gap through collaboration in the development of effective treatments. Efforts to increase focus on integrating and developing treatments in community–practice settings have been aided by recent models of treatment development that reflect the need to conduct training and early trials in settings where the treatment will be delivered. There are two models of treatment development that include guidelines for this process: the Deployment-Focused Model (Weisz, Jensen, & McLeod, 2005) and the Stage Model of Behavioral Therapies Research (Rounsaville, Carroll, & Onken, 2001). These models were designed with a focus on clinic-based treatments and provide only general guidance to those developing school-based mental health treatments. In both models the early stages of

treatment development involve preparation of a set of manualized procedures based on clinical judgment, research literature, and experience with pilot cases. During these earliest stages the interventions are likely to change frequently as those developing the treatment learn from their experience.

One of the primary advantages of school-based mental health is the collaboration with educators and knowledge of the setting in which youth experience much of their impairment (Evans, Langberg, & Williams, 2003). Initial development and pilot testing of school-based interventions cannot occur in a controlled laboratory setting such as a research clinic but must occur in the schools. However, schools are not well suited to the trial and error of the early stages of treatment development, and educators do not have the time to focus on such a time-consuming process. Given the need to develop effective school mental health treatments, a school-based mental health program for middle-school youth with attention deficit hyperactivity disorder (ADHD) called the Challenging Horizons Program (CHP) was initiated as an after-school program (Evans, Axelrod, & Langberg, 2004). The after-school setting allowed researchers to collaborate with teachers and benefit from being in the school while developing, revising, and evaluating interventions in a semicontrolled setting utilizing staff under the direct supervision of the researchers. This setting facilitated the preparation and revision of manuals and training procedures, the refinement of assessment methods, and the pilot testing of the treatments, which are the primary goals in the first stages of the Stage Model of Behavioral Therapies Research (Rounsaville et al., 2001; Stage 1a, Phase 1 and 2) and the Deploy-

---

Amy L. Green is now at the epidemiology department at Virginia Commonwealth University.

This work was supported by grants from the Virginia Tobacco Settlement Foundation and the Alvin V. Baird Attention and Learning Disabilities Center.

We thank all of the parents and professionals who helped with this project and especially the leadership roles played by Frank Gearing, Krista Swensson, and Rich Ingram.

Correspondence should be addressed to Steven W. Evans, James Madison University, Alvin V. Baird Attention and Learning Disabilities Center, MSC 9013, Harrisonburg, VA 22807. E-mail: evanssw@jmu.edu

ment Focused Model (Weisz et al., 2005; Step 1). Implementation of the after-school CHP also allowed for the development and evaluation of methods for assessing outcomes (Evans, Allen, Moore, & Strauss, in press) and treatment integrity in school-based treatment programs. A description of CHP interventions and pilot data regarding the effectiveness of the CHP during the first 4 years have been reported elsewhere (Evans et al., 2004; Evans, Langberg, Raggi, Allen, & Buvinger, in press).

Following the initial stages of the aforementioned treatment development models, the next step for the after-school model was to conduct a clinical trial. However, concerns that many communities might not be able to afford this model led us to consider an alternative mode of treatment delivery for the CHP. Because many of the CHP interventions could be provided by educators, school counselors, and others during the regular school day, we decided to develop an integrated model as an alternative that would include many of the interventions in the CHP but were modified so that they could be provided by school-employed educators and mental health professionals. This report describes the process by which we initially assessed the feasibility of this integrated model of the CHP, utilized Community Development Teams (CDTs) to repeat the primary tasks of the first treatment development stages, and then ultimately modified the manual and training procedures for use in an integrated model. In addition to psychosocial and educational interventions, the CHP includes medication algorithms and a Web-based care coordination system. Although these components were also developed using a CDT process, due to space limitations this article describes only the development of the psychosocial and educational interventions.

## Methods

### Participants

Community members who occupied the same positions as individuals we expected to implement the integrated model of the CHP were recruited to answer questions about the feasibility of the integrated model in comparison to the after-school model. Study participants were 69 faculty and staff from five middle schools in the Shenandoah Valley, Virginia, and included 48 regular-education teachers, 9 special-education teachers, 5 school counselors, and 4 school-level administrators (3 did not report an occupation). This sample represents approximately 25% of the total number of educators employed in the five schools. The five middle schools were selected because they were part of the same community as two of the middle schools that had agreed to participate in a clinical trial of the integrated model. All teachers, counselors, and

administrators in each of the five schools were invited to participate in the study through the central office administrators in the districts and the building principals. Participants reported being in their current occupation for an average of 11.98 years ( $SD = 10.22$  years). Approximately 84% of the sample was female ( $n = 58$ ), and the age range was between 21 and 60 ( $M = 37.69$ ).

### Procedure

Institutional Review Board approval and permission from the school district administrators were attained prior to scheduling assessment days through school principals. The assessment sessions were held at the schools, and meetings began with participants signing consent for participation. They were asked to read vignettes describing adolescents with ADHD, listen to an oral presentation about the CHP interventions and the two different models of program delivery, and complete a Feasibility Questionnaire. All participants received \$50 as compensation for their time.

### Measures

The Feasibility Questionnaire assesses three domains of feasibility: acceptability (how likely it is the program will be accepted as a valid intervention), practicability (how practical the program is for implementation in a typical middle school), and obstacles to implementation (factors that might prevent educators from using these interventions). The acceptability portion of the Feasibility Questionnaire consisted of the Behavior Intervention Rating Scale (BIRS; VonBrock & Elliot, 1987). The 24 items on the BIRS require participants to respond on a 7-point Likert-type scale indicating the extent to which they agree or disagree with statements regarding program acceptability. The BIRS consists of three distinct factors that assess acceptability of an intervention: Acceptability, Effectiveness, and Time of Effect (how long it would take to produce a meaningful effect; Elliot & VonBrock Treuting, 1991). Although psychometric data other than the factor analysis are not available on the BIRS, this instrument is a modification of the Intervention Rating Profile (Martens, Witt, Elliot, & Darveaux, 1985), which has been found to have good reliability (Cronbach's  $\alpha = .98$ ; Martens et al., 1985) and external validity (Von Brock & Elliot, 1987). In this sample, coefficient alphas demonstrated good reliability, with estimates of .97 for the Acceptability factor, .92 for the Effectiveness factor, and .87 for the Time of Effectiveness factor.

Both the practicability and obstacles to implementation portions of the Feasibility Questionnaire consisted of researcher-generated Likert-type and open-ended questions specific to the CHP. The practicability questions were comprised of questions that asked respondents to indicate on a scale of 1 (*easy to accom-*

plish) to 5 (impossible to accomplish) how easy it would be for each of the following school personnel to implement each model of CHP: regular-education teachers, special-education teachers, school counselors, assistant principals, and principals. The section on obstacles asked respondents to list, in rank order, obstacles to implementing CHP as an after-school and in-school program. All the obstacles listed were collated and reviewed, and five categories were defined: time, staffing, family and student participation, communication and coordination, and available resources. Each participant's data was then coded according to the five defined categories by two independent raters. Interrater agreement was good (over 90%), and when disagreement occurred, Amy L. Green resolved the discrepancy.

## Results and Discussion

Initial analyses focused on determining if the participants believed that the integrated model of the CHP was as feasible as or more feasible than the after-school model and therefore warranted development. A subscale score was obtained for each participant on the three BIRS factors that assess program acceptability (Acceptability, Effectiveness, Time of Effect) for both program models. Table 1 displays results from paired samples *t* tests contrasting the subscale scores to determine if differences existed between the two program models on each of the BIRS factors. Results indicated that acceptability scores for the after-school model ( $M = 75.09$ ,  $SD = 14.92$ ) and the integrated model ( $M = 83.68$ ,  $SD = 10.49$ ) differed significantly,  $t(64) = -4.34$ ,  $p < .001$ ,  $\eta^2 = .23$ . These findings indicate that the integrated model was perceived as significantly more acceptable than the after-school model and the effect size for this difference was large (Cohen, 1977). Effectiveness scores for the after-school model ( $M = 32.43$ ,  $SD = 6.51$ ) and the integrated model ( $M = 33.77$ ,  $SD = 5.43$ ) did not differ significantly,  $t(68) = -1.83$ ,  $p = .07$ ,  $\eta^2 = .05$ . Time of Effect scores for the after-school model ( $M = 8.13$ ,  $SD = 2.65$ ) also did not differ significantly from those for the integrated model ( $M = 8.39$ ,  $SD = 2.61$ ),  $t(68) = -.96$ ,  $p = .34$ ,  $\eta^2 = .01$ . Taken to-

gether, these results indicate that the integrated model was viewed as more acceptable than the after-school model without any compromise in the perceived effectiveness or time to realize effects. There were no differences in any of the dependent measures as a function of gender and there were no significant correlations between dependent measures and number of years in occupation or participant age.

Participants' perceptions about how practicable it would be for various school personnel within the school (regular-education teachers, school counselors, special-education teachers, assistant principals, and principals) to implement each model of CHP was assessed using a within-participants analysis of variance with personnel type and program model as factors. Results indicated that practicability ratings for the two models were significantly different,  $F(1, 88.34) = 35.71$ ,  $p < .001$ , specifically that the integrated model ( $M = 2.95$ ,  $SD = 0.82$ ) was rated as more practicable than the after-school model ( $M = 3.62$ ,  $SD = 0.87$ ). Results also indicated a significant interaction between personnel type and program model,  $F(2.97, 190.34) = 9.33$ ,  $p < .01$ ,  $\eta^2 = .13$ , suggesting that the perceived practicability of the CHP for various school personnel to implement were different for each model. To examine practicability of the program for each of the personnel types, a one-way analysis of variance was run separately for the after-school and integrated school program model, with Personnel Type as the factor. Results indicated that for the after-school model practicability ratings for the different personnel types did not significantly vary,  $F(2.53, 164.60) = 2.79$ ,  $p = .051$ ,  $\eta^2 = .04$ . However, perceived practicability for the various personnel for the integrated model did,  $F(2.63, 168.01) = 7.74$ ,  $p < .001$ ,  $\eta^2 = .11$ . Pairwise *t* test comparisons indicated that for the integrated model implementing CHP interventions was perceived as more practicable for special-education teachers than for regular-education teachers, assistant principals, and principals (see Table 2 for means and standard deviations). Additionally, program implementation was rated as more practicable for school counselors than for assistant principals or principals. Results indicated that participants did not perceive differences in practicability between special-education teachers and school counsel-

**Table 1.** Means, Standard Deviations, and Paired *t*-Test Results Comparing BIRS Subscale Scores for the After School and Integrated Models of the CHP

BIRS Subscale Items	After School Model		Integrated Model		<i>t</i>	<i>df</i>	<i>p</i>	$\eta^2$
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>				
Acceptability Items 1 to 15	75.09	14.92	83.68	10.49	-4.34	64	.00	.23
Effectiveness Items 17, 18, 20, 21 to 24	32.43	6.51	33.77	5.43	-1.83	68	.07	.05
Time of Effect Items 16, 19	8.13	2.65	8.39	2.61	-0.96	68	.34	.01

Note: BIRS = Behavior Intervention Rating Scale; CHP = Challenging Horizons Program. The possible range of scores for each of the BIRS subscales is as follows: acceptability (15 to 105); effectiveness (7 to 49); time of effect (2 to 14). Cohen's (1977) benchmarks for  $\eta^2$  are .01 = small, .06 = medium, .14 = large.

**Table 2.** Means and Standard Deviations for Practicability of the Integrated CHP for Various Personnel

School Personnel	<i>M</i>	<i>SD</i>
Practicability for Regular Education Teacher	2.9462	0.87
Practicability for Special Education Teacher	2.5308	0.99
Practicability for School Counselor	2.8231	1.00
Practicability for Assistant Principal	3.1923	1.10
Practicability for Principal	3.2077	1.10

Note: CHP = Challenging Horizons Program.

ors. These findings may be attributable to the fact that school counselors and special-education teachers are frequently responsible for individualized interventions and are therefore perceived to be equally well positioned to provide CHP interventions.

Results from the open-ended questions regarding perceived obstacles to implementation indicated that most participants felt it would be difficult to find adequate time during the school day to implement CHP interventions while fulfilling their regular responsibilities. This finding highlighted the importance of finding ways to integrate interventions with current practices and to emphasize these during training. Other obstacles listed included difficulties obtaining and maintaining participation from all parties (i.e., staff, students, families), thus reinforcing the importance of providing support for staff implementing the treatment program. For example, providing technical assistance and follow-up training is likely to be critical to maintaining support for the program. Promoting the leadership role of a team of staff members within the school may also help to influence the school culture in favor of the treatment program. Some educators described potential problems related to coordination among school staff; thus suggesting that the consistency with which the program is implemented may depend, at least in part, on individual staff members accepting responsibility for coordinating the interventions for each student.

The findings from the feasibility study supported continuing with the development process for an integrated model of CHP. Our sample of professionals in positions similar to those who would be asked to implement these interventions rated the integrated model as more acceptable than the after-school model without compromising perceived effectiveness. Results further suggested special-education teachers and school counselors may be key providers in the implementation process, and obstacles related to time demands on school staff, maintaining motivation and commitment over time, and coordination of care need to be considered. The other lesson learned from this process was that maintaining the involvement of a group of these professionals by inviting them to participate on a CDT was likely to be valuable. We did not invite teachers from schools that might participate in a clinical trial because the CDT process would thoroughly inform teachers

about the CHP interventions, including those who may be assigned to the community control condition. Teachers having invested in the development process may resist being part of the control condition for something they helped to develop.

### CDTs

Researchers have commented on the importance and potential benefits of collaboration between researchers and practitioners during treatment development to enhance the eventual dissemination of a scientifically supported treatment into typical practice settings (e.g., Chorpita et al., 2002; Martell & Hollon, 2001; Weisz, Weiss, & Donenberg 1992). We believe that this collaboration should come very early in the treatment development process and the CDTs are one mechanism to accomplish this. This is especially critical for school mental health interventions because progress in the development process requires cooperation and collaboration with professionals in local school districts as well as other institutions.

Participants on the CDTs included community members whose task was to help investigators create manuals and training materials for the integrated model of the CHP. This involved returning to the initial steps of the two treatment development models reviewed previously to prepare to advance the development of the CHP Integrated Model. The CHP has three components, including school-based psychosocial treatment, medication, and a Web-based care coordination system. Participants were assigned to one of the three CDTs, each established to address one of the three components of the integrated program model. We were members of all three teams, and the participants on the Psychosocial CDT included ourselves (clinical psychologist, graduate student, and developmental psychologist), director of special education for local district, school counselor, two special-education teachers, two regular-education teachers, and four parents of adolescents with ADHD. Participants were recruited from the feasibility study and through flyers distributed to local public schools and pediatric practices. Flyers briefly described the CHP and requested volunteers to participate as team members to assist in the development of the program. The flyer also indicated that volunteers would receive monetary compensation for their time (\$50 per meeting attended). The sample was self-selected, as participants contacted research staff to volunteer.

The psychosocial development team met monthly for 6 months. Based on findings from the feasibility study, it was agreed that discussions should address the following questions: (a) Considering constraints on time, which interventions in the after-school program manual could be feasibly implemented as is or incorporated into existing activities and which would re-

quire adjustment to be implemented during the regular school day? (b) What changes need to be made to the interventions to facilitate implementation by school personnel? (c) Who at the middle school could implement each of the interventions? (d) What procedures would be needed to successfully train and support the staff implementing interventions?

The first CDT meeting served as an orientation and education session. Introductions were made, the CHP after-school program was explained, and the purpose of the team was outlined. Steven W. Evans presented information on ADHD and the treatment of adolescents with this disorder. Participants were provided with an annotated bibliography of relevant research, including current treatment literature with summaries written in nonprofessional language. These were provided to help educate the participants about the state of the literature so they could consider this information when providing feedback about the procedures. Team members also reviewed the CHP after-school model manual and were provided a history and description of the program and some research findings. Finally, participants were told how to access a discussion board to be used for communication between meetings. The discussion board was a password-protected Web site that provided a forum for researchers and development team members to post comments and exchange ideas regarding the program and its implementation.

Subsequent meetings involved proceeding through the interventions that comprise the after-school program and asking the team members the questions listed previously. Each intervention was presented and then discussed and evaluated by team members. Some interventions were completely eliminated. For example, part of the social skills group intervention in the after-school program involved videotaping students and then having them view and critique their own social behavior. This intervention was viewed as impractical for school staff to implement during the school day and was therefore eliminated. Some interventions were characterized as unlikely to be implemented but still kept in the new manual with modifications. For example, the after-school program includes instruction and practice on taking notes in class and from text (Evans, Pelham, & Grudberg, 1995). Individual instruction in taking notes was perceived as unlikely to occur because sufficient individual instruction time was not available. Team members thought that this activity would be good for teachers to implement on a class-wide basis because it is likely to benefit all students, and this suggestion was added to the description of this intervention in the manual. Finally, some interventions were endorsed as very feasible and were kept in the manual without any changes. One such intervention, organization skills, involves students meeting regularly with an adult and comparing their book bags, binders, and lockers to a list of organizational criteria.

Adherence to these criteria is then encouraged, recorded, and reinforced.

At times making modifications to the manual based on team member feedback was a challenging compromise as we worried whether changes would reduce the effectiveness of the services. However, this concern was balanced with the fact that procedures that are not acceptable would not be implemented with fidelity and, as a result, would not achieve their desired effectiveness. In some cases the compromise was easy. For example, the matching game (see DuPaul & Stoner, 2003) procedures used in the after-school program were shortened to facilitate its implementation at the end of a class period. Team members believed that this shortened version would increase the likelihood that the technique would be used, and we were confident that despite the abbreviation, the core necessary components could be maintained. As noted by the authors of both treatment development models described previously (Rounsaville et al., 2001; Weisz et al., 2005), the initial phases of manual development frequently require investigators to use clinical judgment based on experience, theory, and relevant research to make decisions such as these. In our process, final recommendations by the team were decided by consensus with dissenting opinions noted. The team members knew that the ultimate decision regarding what would be included in the manual was one made by the investigators. However, they also knew that we were genuinely interested in their feedback and ideas, and this was communicated to them regularly. This process was not undertaken as a token exercise but as a genuine effort to increase the effectiveness and feasibility of our procedures.

The teams also identified individuals who could implement each intervention. This served two purposes. First, it held the group accountable to judgments of feasibility for interventions because they had to describe who could do them and when. Second, it helped the investigators provide suggestions about expertise and training necessary for particular staff to implement the interventions in the manual. Although we initially attempted to identify the correct person for each intervention, the feedback from the team indicated that we should instead offer options. The team pointed out that the expectations of educators and staff resources vary considerably from school to school and leaving this part flexible would allow the faculty to adapt implementation practices per their strengths and resources.

A related discussion revolved around concerns articulated by participants in the feasibility study about the coordination of services. Team members shared these concerns, and discussion of this as a potential problem resulted in the establishment of a mentor for each child. The mentor role involves maintaining communication with teachers and parents, meeting regularly with the student, prescribing various psychoso-

cial interventions, and maintaining a “treatment plan.” It was decided that the mentor role could be assumed by any school staff member (e.g., regular- or special-education teachers, administrators, school counselors or social workers, special-education aides). Although mentors may provide some of the interventions, they were not expected to provide all of them. Instead, they work with colleagues to arrange services (e.g., school counselor may provide social skills interventions). The team suggested that carefully matching the student with a mentor who has the capabilities, time, and personality to meet the student’s needs would be important. In addition, the team noted that mentors would need continuous support, especially during the first year.

Various models of training and support were suggested and debated by team members. The team ultimately recommended that an initial training session focus on the entire program but that an expert should be frequently available in the building to achieve continuity and fidelity. The on-site expert need not directly provide any of the CHP services but should coach, instruct, and provide support for the mentors and others trying to implement the interventions. In addition to expertise with the interventions, the team members emphasized the need for this person to have excellent interpersonal skills and experience with teacher consultation.

In addition to providing valuable feedback on the CHP interventions, the experience with the team also provided some important lessons about community–investigator collaboration. For example, many team members reacted to the initial presentation of some treatment outcome literature with comments that it was completely irrelevant because the services described could not be feasibly provided in the school. They were similarly dismissive of some of our proposals but worked with us to compile interventions that achieved the best possible balance between what is practical and what is effective. Successful collaboration and communication depended on establishing comfort levels that fostered an open sharing of opinions and “going out on a limb” with ideas and suggestions.

Finally, we would be remiss if we did not mention that the use of the development team process is not without challenges and limitations. For instance, a team that operates poorly could alienate parents and professionals in a community and make it difficult to conduct clinical research. The process also involves sharing the spotlight and respecting and celebrating the expertise of people with far less training than the researchers. If these activities are uncomfortable for investigators, then the risks associated with these procedures probably outweigh the benefits. Additionally, there are parents and practitioners in many communities whose rationale for a particular method is based on the tradition of their discipline yet is very inconsistent

with what is known by researchers to be effective. These community members may be particularly motivated to participate on CDTs given that it provides a forum to share practices they perceive as impressive with the hope that they will gain reinforcement from others. Conflict resulting from these situations and other disagreements can sabotage the process but can also enhance it if group leaders can effectively maintain respect among group members and use disagreement as further rationale for the need for collaborative research.

## Conclusions

The feasibility assessment and CDTs gave us considerable credibility during subsequent training sessions with teachers, physicians, and nurses as we began to implement the clinical trial. Procedures we were imparting did not solely reflect the opinion of researchers but rather ones that had been collaboratively developed with teachers, parents, and others with “real-world” experiences similar to those of the trainees. This credential was particularly valuable when confronted with skepticism and criticism from individuals not eager to embrace anything novel. Furthermore, when training staff in the schools to implement the integrated CHP, we encouraged them to give us additional feedback on the interventions and training procedures.

Part of the impetus for creating models for treatment development was the recognition that a demarcated scientific development process to prepare for the randomized clinical trial was lacking (Rounsaville et al., 2001). However, despite the value gained in establishing a sequence of activities associated with development stages, there is a great need to specify how researchers might structure activities to ensure that these activities yield a feasible set of interventions or a practical manual and training procedures. Model creators acknowledge that the initial steps in treatment development can take a variety of forms depending on the intervention and the extent to which it is an established method (Rounsaville et al., 2001; Weisz et al., 2005). We propose that the variation can also be induced by the context in which a treatment is expected to take place and who is expected to implement the treatment. In our case, the context dictated a collaborative development process to ensure feasibility and practicability during the very first steps of the development process.

We find that much of working within school systems revolves around relationship building and buy-in. Our use of the feasibility study prior to manual completion and a CDT process to guide manual development and training procedures paved the way for training and the subsequent randomized clinical trial, so much so that we anticipate repeating this process at subsequent stages of our research. When we have collected much of the data from our initial clinical trial,

we plan to present this information to a CDT before progressing to our Stage 2 larger scale clinical evaluations. We will ask the CDT to provide feedback on interpretation of the findings, next steps, and potential modifications to the program design. The feedback we received from team members about the CDT process was very positive, and members reported that overall it was an educational experience that influenced their values regarding quality care. The most common complaint was that the process did not go on long enough.

Although the utility of the feasibility study and subsequent CDT process clearly worked as a mechanism to facilitate the initial stages in the development of the CHP interventions, future research needs to examine the viability of these collaborative procedures for other types of treatment. This process may operate differently with a different set of provider participants, especially if providers have fundamentally different approaches to treatment (e.g., teachers and psychiatrists). Future research will also need to evaluate or test the extent to which the CDT collaborative procedures facilitate successful implementation. Finally, other examples of collaborative procedures for enhancing the science–practice divide are needed and represent an important and understudied area of research in our field.

### References

- Chorpita, B. F., Yim, L. M., Donkervoet, J. C., Arensdorf, A., Amundsen, M. J., McGee, C., et al. (2002). Toward large scale implementation of empirically supported treatments for children: A review and observations by the Hawaii Empirical Basis to Services Task Force. *Clinical Psychology: Science and Practice*, 9, 165–190.
- Cohen, J. (1977). *Statistical power analysis for the behavioral sciences*. New York: Academic.
- DuPaul, G. J., & Stoner, G., (2003). *ADHD in the schools: Assessment and interventions strategies* (2nd ed.). New York: Guilford.
- Elliot, S. N., & VonBrock Treuting, M. (1991). The Behavior Intervention Rating Scale: Development and validation of a pre-treatment acceptability and effectiveness measure. *Journal of School Psychology*, 29, 43–51.
- Evans, S. W., Allen, J., Moore, S., & Strauss, V. (in press). Measuring outcomes in school based treatments: Reliability and validity of teachers' ratings in middle schools. *Journal of Abnormal Child Psychology*.
- Evans, S. W., Axelrod, J. L., & Langberg, J. (2004). Efficacy of a school-based treatment program for middle school youth with ADHD: Pilot data. *Behavior Modification*, 28, 528–547.
- Evans, S. W., Langberg, J., Raggi, V., Allen, J., & Buvinger, E. (in press). Development of a school-based treatment program for middle school youth with ADHD. *Journal of Attention Disorders*.
- Evans, S. W., Langberg, J., & Williams, J. (2003). Treatment generalization in school based mental health. In M. Weist, S. Evans, & N. Lever (Eds.), *Handbook of school mental health* (pp. 335–348). New York: Kluwer/Plenum.
- Evans, S. W., Pelham, W., & Grudberg, M. V. (1995). The efficacy of note-taking to improve behavior and comprehension of adolescents with attention deficit hyperactivity disorder. *Exceptionality*, 5, 1–17.
- Martell, C. R., & Hollon, S. D. (2001). Working together on shifting ground: Researcher and clinician collaboration in clinical trials. *The Behavior Therapist*, 24, 144–146.
- Martens, B. K., Witt, J. C., Elliott, S. N., & Darveaux, D. X. (1985). Teacher judgments concerning the acceptability of school-based interventions. *Professional Psychology: Research and Practice*, 16, 191–198.
- Rounsaville, B. J., Carroll, K. M., & Onken, L. S. (2001). A stage model of behavioral therapies research: Getting started and moving on from stage I. *Clinical Psychology: Science and Practice*, 8, 133–142.
- Von Brock, M. B., & Elliot, S. N. (1987). Influence of treatment effectiveness information on the acceptability of classroom interventions. *Journal of School Psychology*, 25, 131–144.
- Weisz, J. R., Jensen, A. L., & McLeod, B. D. (2005). Development and dissemination of child and adolescent psychotherapies: Milestones, methods, and a new deployment-focused model. In E. D. Hibbs & P. S. Jensen (Eds.), *Psychosocial treatments for child and adolescent disorders: Empirically based approaches* (2nd ed., pp. 9–39). Washington, DC: American Psychological Association.
- Weisz, J. R., Weiss, B., & Donenberg, G. R. (1992). The lab versus the clinic: Effects of child and adolescent psychotherapy. *American Psychologist*, 47, 1578–1585.

Received July 19, 2004

Accepted June 7, 2005