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# Translating EBPs for Attention and Behavior Problems to School Settings: Practical Guidelines for Training School Clinicians

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In recent years, significant progress has been made in the development of evidence-based interventions for the treatment of ADHD (Weisz & Kazdin, 2010). Unfortunately, access to these interventions is limited, and the majority of children with attention and behavioral challenges fail to receive necessary evidence-based treatments (Owens et al., 2014). The expansion of school mental health programming has been identified as a mechanism for increasing treatment access (New Freedom Commission on Mental Health, 2003). School-based services circumvent the logistical barriers, financial limitations, and stigma associated with receiving mental health services at clinic and university settings. Clinicians staffed at school sites are typically better able to influence change in the environment where children spend most of their days, and can facilitate check-ins with parents and teachers more easily than clinicians working off-site (Frey, Sabatino, & Alvarez, 2013; Kelly, Berzin et al., 2010). School-based services are particularly relevant when delivering evidence-based interventions for children with attention and behavior problems, as these treatments include behavior modification strategies implemented at school by teachers and other staff and at home by parents and other caregivers (Evans, Owens, & Bunford, 2014; Pfiffner & Haack, 2014).

Utilizing evidence-based practices (EBPs) with students who have special needs, including impairing attention and behavior challenges, is a clear priority of current federal policies (No Child Left Behind, 2002; Yell, Shriner, & Katsiyannis, 2006). It is also a priority of school mental health program directors who, in a recent national survey, identified, "improving clinical staff knowledge of EBPs" as an urgent need (Center for School Mental Health [CSMH], 2012). However, there is a significant gap between current policy and the daily practice of school mental health professionals (SMHPs) (Kelly, Berzin et al., 2010; Kelly, Frey et al., 2010). Studies show that children with attention and behavior problems typically do not receive evidence-based interventions at school (Arcia, Frank, Sanchez-LaCay, & Fernáindez, 2010; Murray, Rabiner, & Hardy, 2011), and the usual services provided by SMHPs have little or no efficacy to support their use. These interventions typically include small group or individual child-focused interventions

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with limited engagement from parents and teachers (Kelly Berzin et al., 2010; O'Brien et al., 2011). This gap exists despite the fact that SMHPs are required to stay up to date with new treatment developments, maintain competency via in-service training, and express a strong desire to provide students with treatments that work (Frey et al., 2013; Kelly, Berzin et al., 2010; O'Brien et al., 2011). A weak link lies in the fact that existing training procedures are not effective at transferring EBPs into practice. Optimal training models, which incorporate active learning strategies, manualized interventions, and ongoing coaching and supervision (Beidas & Kendall, 2010), differ greatly from the model typically used to train SMHPs, namely, a one-time in-service workshop with handouts. The latter model has been aptly criticized as a "train and hope" approach with limited effect on clinical practice (Owens et al., 2014; Stirman et al., 2010).

While the developers and expert providers of EBPs have an opportunity to assist in closing the policy-practice gap by training SMHPs in the use of EBPs, few training programs exist to provide the platform for this challenging task (Lyon, Stirman, Kerns, & Bruns, 2011). Comprehensive programs must be suitable for training clinicians from a variety of clinical backgrounds, with varying levels of training and experience, who work in environments very different from university and clinic settings (Beidas & Kendall, 2010; Herschell, Kolko, Baumann, & Davis, 2010). For treatment developers and professionals who are providing training to SMHPs for the first time, the learning curve can be steep. In the current article, we describe a model for an SMHP training program in the use of EBPs for attention and behavior problems, and we summarize the lessons our team has learned during the multi-year process of developing and implementing this program. The model we will be referring to is the Collaborative Life Skills Program (CLS), which has been implemented at 30 elementary school sites to date. The CLS Program was adapted from a university-based, research-supported intervention for ADHD (Pfiffner et al., 2007, 2014). Our objective is to generate a resource that will share the practical knowledge we have gained and inform treatment developers who aim to expand the reach of their clinic and university-based interventions by implementing them in school settings.

## Collaborative Life Skills Program (CLS)

*Student and SMHP Characteristics.* We are currently collaborating with a large urban school district to implement the CLS program. The district has 72 elementary schools, each with a half-time (2.5 days per week) or full-time SMHP. Of the 30 SMHPs that have participated in our program to date, 16 are staffed half-time at the school where CLS is implemented and 14 are staffed full-time. The SMHPs have a variety of education and training backgrounds, ranging from marriage and family therapy interns to licensed clinical social workers. On average, the SMHPs have worked in the mental health field for 8.3 years (range 2–17 years), in the district for 4.7 years (range 3 months–11 years), and at their current school for 2.3 years (range: 3 months–6 years). Less than 10% report using EBP strategies with students having attention and behavior problems in their work as SMHPs. The elementary schools within the district have an ethnically diverse student body, and this is reflected in our student participant characteristics: 39% more than one race, 29% Latino, 29% White, 23% Asian, 9% African American, 2% Pacific Islander. Students in the CLS program range from 7 to 11 years of age (mean = 8.39), and are between 2nd and 5th grades. All student participants are in a mainstream classroom for most of the day, living with a caretaker who is available to participate in treatment, and do not have a hearing or visual impairment, severe language delay, psychosis, or pervasive developmental disorder. Due to the cognitive demands of the program material, students must also have a full-scale IQ at or above 80 as measured by the Wechsler Abbreviated Scale of Intelligence (WASI; Wechsler, 2011). Children taking medication for attention or behavior problems are included, provided that their medication regimes are stable. Students in the CLS program are

required to have elevated symptoms of inattention and/or impulsivity/hyperactivity and associated impairment; however, a clinical diagnosis of ADHD is not required. We choose to focus on elevated symptoms and impairment rather than clinical diagnoses for several reasons: 1) CLS is intended to serve as a prevention program for students at risk for special education as well as an intervention for those who are already receiving special education services; 2) the CLS intervention, and its conceptual basis, applies to children with significant ADHD behaviors, whether or not they meet all of the criteria for a clinical diagnosis; and 3) requiring a diagnosis is often not feasible in school settings where assessment and clinical resources are limited.

*Student Screening Measures.* To establish the presence of elevated attention and behavior problems, parents and teachers complete a symptom severity rating scale, the Child Symptom Inventory (CSI; Gadow & Sprafkin, 1994) and the Impairment Rating Scale (IRS; Fabiano et al., 2006). Student participants are required to have six or more inattention symptoms and/or six or more hyperactive-impulsive symptoms indicated as occurring "often" or "very often" on the CSI by either the parent or teacher. These criteria served as an analog of the DSM-IV symptom count criteria for ADHD (McBurnett et al., 1999). To document cross-situational impairment, we require functional impairment in at least one domain on the IRS by both parent and teacher (score of 3 or greater). In addition to ADHD symptoms, measures of academic and social functioning are gathered at baseline, post, and follow-up. Detailed descriptions of the participant recruitment and screening procedures and the outcome measures are provided in the pilot study outcome papers (Pfiffner et al., 2014; Pfiffner et al., 2013).

*Program Development Process.* The CLS program was developed to address the gap in evidence-based school services for students with attention and behavior problems. Adapted from a research-supported clinic-based intervention for ADHD, CLS was modified for school-based delivery through collaboration with SMHPs. Prior to the first implementation of CLS at a school site, SMHPs and UCSF-CLS project psychologists made initial modifications to the treatment manuals to improve comprehensibility and ease of administration. An iterative development process followed across successive schools (2 schools in each of 3 cohorts). Each iteration included: 1) staff training for the SMHPs; 2) supervised implementation of CLS by SMHPs; 3) collection of SMHP data on intervention usability, fidelity, and feasibility; 4) collection of parent and teacher data on intervention fidelity and feasibility; 5) evaluation of satisfaction and student outcomes; and 6) post-intervention program evaluation to refine training materials and treatment manuals. Focus groups were held with SMHPs and administrators after each iteration to gather qualitative information about the feasibility of the CLS program and to brainstorm about improvements that could be made during future development phases. For additional details about the iterative development process, see Pfiffner and colleagues, 2011.

*CLS Program Description.* The CLS program occurs over the course of a 12-week period and includes the simultaneous delivery of three components (teacher, parent, and student), each consisting of empirically supported treatments for attention and behavior problems. The teacher component includes behavioral consultation with the teacher, a classroom-based daily report card (DRC), and a homework plan. The DRCs contain a list of target behaviors that are rated by teachers multiple times throughout the day. Behaviors are typically related to work completion (e.g., getting started right away, staying on task), organization (e.g., keeping your desk area organized, turning in your homework), impulsivity/hyperactivity (e.g., raising a quiet hand, keeping your hands and feet to yourself), and peer relationships (e.g., showing good sportsmanship, asking peers to play). DRCs contain daily point goals, and parents provide rewards at home when daily goals are met (Fabiano et al., 2010; Owens et al., 2012). Individual DRC meetings led by the SMHP and attended by the students, parents, and teachers are held two to three times over the course of the program to establish the DRC goals and plans, and subsequently to assess progress, reward success, and troubleshoot problem areas. Teachers also attend an orientation meeting and a troubleshooting meeting to learn about general classroom behavior management strategies and to troubleshoot any issues that may arise with the daily report card, homework plan, or classroom behavior.

The parent component includes behavioral parent training (BPT) with additional strategies to address student skills and parenting stress. During BPT, the SMHP provides a group of six parents with psychoeducation and training in skills for managing attention and behavior problems at home. Ten weekly, 60-minute BPT sessions focus on improving parent-child relationships, increasing positive behaviors through the use of praise, routines, and home-based point systems, and reducing negative behaviors though the strategic use of punishment. Parents are also taught strategies for reinforcing the DRC and CLS student skills at home and strategies for coping with parenting stress (Evans et al., 2014; Barkley, 1997; Pelham & Fabiano, 2008; Pfiffner & Kaiser, 2016). All parents and caregivers who live with the child are encouraged to attend the groups. Parents who live separately participate in the program whenever this is feasible.

The student component includes 9 weekly, 40-minute student skills group sessions, during which students are taught strategies for improving independence, homework skills, organization, and social interactions (Pfiffner et al., 2007, 2014; Pfiffner & McBurnett, 1997). Skills are taught through instruction, role-plays, games, and in-vivo practice during sessions. These skills are reinforced by teachers and parents to promote generalization into naturalistic settings. Delivery is coordinated such that parents, students, and teachers are trained in their individual aspects of the treatment using the same terminology at roughly the same time. The net effect is to implement around-

the-clock support of student behavior across impairment domains in an active partnership of parents, teachers, and SMHPs. Results from the pilot study show significant improvement on all parent and teacher measures of attention and behavior problems, as well as organizational skills (Pfiffner et al., 2013). Early results from the randomized clinical trial support the efficacy of CLS relative to typical school or community practices for reducing attention and behavior problems. Students from schools assigned to CLS relative to those assigned to usual services had significantly greater improvement on parent and teacher measures of ADHD symptoms, organizational skills, social/interpersonal skills, and homework problems (Pfiffner et al., 2015).

### CLS Training Program

The CLS training program for SMHPs was developed concurrently with the CLS intervention and followed a similar iterative development process (Pfiffner et al., 2011). The CLS training model incorporates elements of empirically supported training approaches, including active learning techniques as well as ongoing coaching and performance feedback (Beidas & Kendall, 2010; Herschell et al., 2010; Noell et al., 2005). Detailed treatment manuals provide the foundation of the CLS program. These manuals include scripted session and meeting outlines, fidelity checklists, parent and teacher handouts for each session, detailed behavior management strategies, and guidelines for troubleshooting implementation challenges.

The training process begins with a one-day session for SMHPs covering the basic behavioral principles upon which the program's components are based, as well as the first teacher, parent, and student sessions. The training method incorporates multiple interactive formats, including didactic presentations, worksheets, video modeling, and role-play exercises. The remaining training occurs over a 12-week period (CLS implementation phase) while SMHPs are delivering CLS for the first time. During this phase, expert consultants observe each session and provide immediate feedback to SMHPs. In addition, group consultation meetings are held weekly to troubleshoot challenges and to review upcoming session content. Weekly consultant team meetings are also conducted to troubleshoot areas of difficulty and prevent drift from the training protocol. Results from the treatment development phase of our program show that the CLS training methods are successful in achieving high SMHP implementation fidelity and satisfaction (Pfiffner et al., 2011, 2013). Early findings from our current randomized clinical trial show similar effects (Pfiffner et al., 2015).

Throughout the process of developing the school-based intervention and clinician training program we identified areas where additional consultation and logistical support were needed to support the implementation process. These needs are presented as guidelines below. While the CLS intervention and training program are provided as models, these guidelines are intended for consideration in the implementation of school-based mental health programs more broadly to improve usability, fidelity, and feasibility of these programs.

## PRACTICAL GUIDELINES

### Clarify Expectations and Help SMHPs Adjust Their Workload

When SMHPs enroll in a training program for a new empirically supported intervention, they must carve out time in their schedules, restructure their days, and take on roles and responsibilities that may not have previously been included in their positions. Our consultants support SMHPs in making these adjustments by identifying an SMHP's current role and work style, and providing tailored coaching and collaborative problem solving in the areas of time management, limit setting, and identifying other members of the school staff that can temporarily assume some of the SMHP's tasks. For example, when an SMHP signs up for the program, we promptly advise them to take on fewer individual cases or small groups during the initial CLS implementation period. Minimizing commitments up front is much easier than reducing a caseload post-hoc or trying to learn and implement a new, intensive program while overscheduled.

To help SMHPs accurately estimate their CLS time commitments, we provide a detailed consultation and intervention schedule and detailed prep-time estimates. Even with this information, some SMHPs hesitate to reduce their caseload. This is where tailored coaching and collaborative problem solving is helpful. We work with SMHPs to identify the reasons behind their hesitation, and we then help them come up with alternative solutions. For example, when SMHPs are seeing multiple students for individual sessions, we help them consider which of these students may be suitable for a small group intervention. Creating a small social skills group for four students, for example, can free up three additional clinical hours each week while continuing to provide the required services. Throughout this process, it is important for the consultant to frame the SMHP's involvement in the CLS program as an upfront investment of time and effort over 12 weeks that will ultimately allow them to be more efficient and effective with a large number of students. This framework often helps SMHPs shift their own perspective and fully commit to the time required for the initial training program.

During the program, we also strive to help SMHPs streamline their scheduling of CLS meetings to minimize the logistical burden and time commitment. The extra support and troubleshooting in this area from the consultants is important, particularly for SMHPs who are most accustomed to providing direct services to students rather than collaborating with parents and teachers. In these instances, the increased scheduling and logistical burden that comes with parent and teacher meetings can be an unexpected challenge. One simple, but important strategy that has improved parent attendance at meetings is to hold parent groups at drop-off time rather than after school or in the evening. Parents are able to attend the groups much more consistently when they are held first thing in the morning. Other relatively small adjustments can also significantly reduce the scheduling burden for SMHPs. For example, SMHPs are encouraged to schedule multiple DRC meetings

(with the parents, students, and teacher) back-to-back, fitting in at least two into one after-school period. This allows SMHPs to squeeze six after-school meetings into three days, rather than have these meetings consume a full six days of their after-school schedule. We also encourage the SMHPs to schedule the following DRC meeting during the current meeting, when everyone can consult their calendars at the same time. This reduces the painful back and forth that is inherent in the usual scheduling process. These simple strategies have a surprisingly large impact on how effectively the program is implemented at each school site.

### Gain the Support of School Administrators

For SMHPs, the process of making adjustments to their caseload and taking on a new role at the school can be facilitated by support from school administrators. We encourage all SMHPs to discuss CLS with their school principal when they first express interest in participating. We then schedule a meeting with the school principal and our own clinician/trainers to present the research findings that support our intervention, outline the benefits to the school community, provide a detailed overview of the three intervention components, and clarify the time commitments required from the SMHP and teachers. This process helps gain the support of the principal upfront and opens the door for the SMHP and principal to work collaboratively when adjusting the SMHP caseload and responsibilities. Occasionally, principals express concern that the time commitment required for CLS training and implementation will make the SMHP less available to respond to crises as they arise. This is particularly true in schools where mental health services are typically employed primarily when a problem has escalated to a crisis level. Generally this reactionary, crisis-management model of intervention is less effective than a more proactive approach that allows the SMHP to intervene before crisis points have been reached (Kelly, Frey et al., 2010). Therefore, we highlight the fact that the CLS program provides an opportunity for SMHPs to plan proactive, research-based interventions that work to prevent unwanted behaviors and interrupt negative behavior cycles.

This model of employing proactive EBPs fits solidly within the Response to Intervention (RTI) framework that has been adopted nationwide (Kelly, Frey et al., 2010). Describing the CLS intervention to school administers within the context of RTI can be helpful. As summarized by Kelly and his colleagues (2010), RTI consists of four overarching principles: 1) support services should seek to increase the capacity of school personnel or parents to implement practices that can be sustained independently over time; 2) services should include evidence-based or high quality practices that are implemented with fidelity; 3) interventions should be organized within a three-tiered framework with Tier 1 representing school-wide interventions, Tier 2 representing small group interventions for students, and Tier 3 representing intensive individualized interventions; and 4) decisions regarding intervention selection, duration, and effectiveness should be made based on data collected at the school-wide and individual student levels. Within the context of RTI, CLS is described as a 1) capacity-building intervention that trains SMHPs, teachers, and parents in the skills necessary to support students with attention and behavior problems in the classroom and at home; 2) an evidence-based intervention that is implemented with a high degree of fidelity; 3) a Tier 2 or Tier 3 intervention that is delivered in a small group format and tailored to meet the needs of individual students; and 4) a program that monitors student progress through data collected from parents and teachers on a daily and weekly basis. Through this lens, the CLS program is easily viewed as more than simply a discrete intervention that serves a limited number of students, but rather as an opportunity to build capacity within the school staff to provide effective and efficient behavioral interventions for many students and families.

### Understand the Expanded Value of Consultation for SMHPs

SMHPs are professionals who typically enter training programs with a great deal of valuable knowledge about school mental health and solid clinical skills. It is important to approach the training collaboratively rather than via the hierarchical supervision model that is typically employed in university and medical settings. From a literal standpoint, we refer to our weekly meetings as "consultation" rather than "supervision" and refer to our psychologists as "consultants." We also explicitly convey the message that while the consultants are experts in the intervention, the SMHPs have expert knowledge of their school setting, as well as the students, teachers, and parents. CLS can only be implemented successfully when both sets of expertise are used jointly. Each SMHP's knowledge of their school's unique climate and logistical challenges is essential and is frequently discussed during consultation meetings. Factors related to over-extended teachers, large class sizes, and a disproportionate number of high needs students and families all must be considered in order for CLS to be implanted successfully. We encourage SMHPs to use their knowledge to help set appropriate expectations and to empathize with and support teachers when they are feeling overwhelmed. The SMHPs' prior knowledge of students and families participating in the CLS program is equally as helpful, particularly in the absence of the full diagnostic assessment that typically is conducted when the intervention is delivered in a clinic setting. Often SMHPs are aware of prior interventions that have been provided for a student, family dynamics that may impact the program's effectiveness, and the parents' history of positive or negative experiences with the school. For example, when parents have previously expressed frustration with the services their child has or has not received at the school, they may appear defensive or standoffish at the start of the parent group sessions. Having an understanding of the family's history can help the SMHP remain supportive and encouraging while the parents settle into the group and begin to see progress from the intervention. Last, SMHPs also bring a great deal of knowledge about additional resources available at the school, in the after-school program, or

through community partnerships. For high needs families, tapping into these programs can provide additional support and help bolster the family's success with the CLS program.

Despite this wealth of knowledge, relationships with teachers and other school staff, and access to additional resources for students, the SMHPs in our training program often report feeling professionally isolated at their schools. This is due primarily to the fact that they are frequently the only mental health provider housed at their school site, and have limited contact with SMHPs at other schools. They report that consultation from other mental health providers is one of the things they appreciate most about the CLS training program. Therefore, we find that making our consultants easily accessible outside of formal meetings reduces feelings of isolation and provides additional support for SMHPs as they cope with the stress and challenges of learning and implementing a new program.

### Prioritize Teacher Engagement and Adherence at the Outset

Like many empirically supported interventions for attention and behavior problems, the classroom component of CLS relies on teachers for its day-to-day implementation. Having teacher buy in at the start of the program is central to the student's success. The degree to which teachers are motivated to implement CLS can vary greatly, for reasons ranging from teacher beliefs about the causes of student attention and behavior problems to their preexisting relationships with the students and families. To improve teacher engagement and adherence, we provide direct coaching for SMHPs in strategies for partnering with teachers. We also include small, but meaningful acts of appreciation for participating teachers (e.g., snacks at meetings, notes of thanks and encouragement in mailboxes, weekly check-ins by the SMHP). To provide positive role models and examples of the program's feasibility and success, we include video testimonials from past CLS teachers in our initial teacher-training meeting. When leading the group teacher meetings that occur midway through the CLS program, SMHPs maintain a positive, productive tone by asking teachers to begin by sharing at least one improvement that they have seen in their student. Meetings are also highly structured, with outlines and clear meeting objectives provided to teachers. This helps keep meetings on track and discourages teachers from engaging in unproductive venting about students and colleagues.

As with all classroom interventions, there is variability in the consistency and quality of implementation, even among the most motivated teachers. Not surprisingly, teachers who have a more structured classroom management style and are enthusiastic about the program seem to integrate the daily intervention into their classroom most easily. Teachers struggling with organizational skills, classroom structure, and motivation are identified early in the implementation process. Consultants work closely with the SMHPs who coach teachers on strategies for improving adherence. These strategies include frequent teacher check-ins focused on providing encouragement and support and modeling behavior management techniques (e.g., strategic use of praise, giving effective instructions, etc.). If a teacher continues to struggle with implementation, SMHPs are taught to gather data to identify points where the system is breaking down. For example, in cases where the teacher is not checking the student's daily report card the required three times per day, the SMHP has the teacher walk them through a typical school day, highlighting the times when the student's daily report card should be checked. Modifications to the CLS daily report card are then made. Often these changes are quite basic, and yet they have a large impact. For example, the timing of the check-ins may be changed to better fit the classroom schedule, smartphone alarms and visual cues may be incorporated to act as reminders, or the number of daily check-ins may be reduced to once or twice a day.

To help SMHPs provide quality consultation to teachers, and lead teacher meetings (as well as parent and student groups) with a high degree of fidelity, we provide detailed training materials that facilitate the clinician's ability to deliver the intervention independently, while minimizing amount of time they must spend preparing and rehearsing for sessions. The session materials contain, word for word, everything that the SMHP needs to convey to teachers (as well as parents and students) in order to teach each CLS strategy. While this format was labor-intensive to develop, the scripted content has proven extremely valuable. It allows the SMHPs to feel more confident when leading the meetings and fills in the knowledge gaps that the SMHPs may have due to differences in training backgrounds and levels of experience. We also provide extensive troubleshooting sections in each of our manuals. These sections provide responses to the most frequently asked questions from parents and teachers, and they help SMHPs anticipate some of the challenges that may arise during the session. These troubleshooting sections are reviewed during each consultation meeting, and independently by the SMHPs when they prepare for their group sessions.

In addition to providing detailed written materials, we utilize video clips in our training. These clips show previously trained SMHPs implementing CLS sessions, and model the optimal way to teach a CLS strategy. They are typically shown before the role-play portion of our consultation session. We also videotape current SMHP trainees as they lead their sessions, and have these SMHPs view their own recordings with their consultant. The consultant highlights areas of strength and troubleshoots problem areas where the SMHP is having difficulty implementing the intervention with a high degree of fidelity. SMHPs are often reluctant to watch themselves on film, but they almost always report afterward that it was a very valuable training exercise.

Last, when meeting and communicating with teachers, we have also developed a few relatively simple strategies that help things go more smoothly. In general, teachers are far more likely to read emails and training tools that are brief, focused, use a larger font size, and

have fewer words. We provide SMHPs with templates and one-page teacher handouts that meet these requirements. For example, to ensure that teachers are aware of the skills taught in the student group each week, SMHPs distribute an 8.5 x 11 inch poster describing the "Skill of the Week." The large font and brief text on these posters make them easy to read and easy to post in the classroom to share with the students. Communicating with teachers face to face can also be challenging. While we strongly encourage the SMHPs to check in briefly each week with every teacher, these meetings often become unwieldy because teachers are eager to discuss additional students or vent about other issues. To streamline this discussion, we have created checklists of essential meeting items and a brief two-item survey about the student's progress. The checklist and survey provide structure for the interaction, and SMHPs report feeling more confident in setting limits around the discussions with the teachers. Overall, we find that when the SMHPs are able to develop an understanding of each teacher's style and process, recognize that the teachers may be overwhelmed by factors outside of the CLS program, and modify the classroom component of the program to make implementation easier, they are able to positively influence teacher engagement, adherence, and enthusiasm for the program.

## CONCLUSIONS

Exporting clinic-based EBPs to school settings requires the development of effective training programs for SMHPs. Treatment developers and expert providers of EBPs have the opportunity to provide a much needed service by developing and delivering these training programs. Exporting clinic-based EBPs to school settings comes with a host of practical and logistical challenges which can adversely impact fidelity and the quality of implementation. The CLS training program provides one model for training SMHPs and implementing EBPs in school settings. The challenges faced in developing and implementing CLS were addressed through an expanded conceptualization of traditional training—one that goes beyond the nuts and bolts of the intervention and addresses organizational and contextual factors as well as the need for additional consultation skills focused on working with parents and teachers. Increased accessibility to EBPs is highly dependent on implementing these interventions outside of the traditional university clinic and laboratory settings. We encourage treatment developers to incorporate training programs for providers in these settings into their development process to increase capacity for EBP delivery across settings.

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# Using the CAS2 in the Comprehensive Assessment of ADHD

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Given the complexity and presentation of ADHD symptoms across multiple settings, as well as the elevated number of comorbidities these children experience, evaluators must consider a multidimensional set of data in making the diagnosis. They must also understand the implications of the diagnosis in the child's life as well as in planning and monitoring treatment. Assessment of ADHD must consider not only the symptoms of the condition but differential diagnosis and coexisting behavioral, learning, and emotional problems (Guevremont, DuPaul, & Barkley, 1990). Some symptoms of ADHD can occur in a variety of childhood disorders, including those related to anxiety, depression, family dysfunction, physical and sexual abuse, intellectual handicap, and language disorders. Twenty years ago, Michael Gordon noted that the symptoms of ADHD rarely occur in isolation and are by no means unique to ADHD (Gordon, 1995).

Psychological validity of norm-referenced measures to identify, define, and determine the severity of symptoms of ADHD has been repeatedly questioned (Barkley, 1991; Barkley & Grodinsky, 1994). ADHD is a condition defined by behavior in the real world. It is not unexpected that psychological and neuropsychological measures frequently fall short in defining and identifying symptoms of the disorder in comparison to naturalistic observation, history, and organized report in the form of questionnaires. The diagnosis of ADHD requires gathering of behavior over time in multiple settings and examination of that behavior relative to the diagnostic criteria in DSM-5. In this article, we advocate for the use of the Cognitive Assessment System–Second Edition (CAS2; Naglieri, Das, & Goldstein, 2014a), which is a neuropsychological measure of basic psychological processes. In addition, the CAS2 Rating Scale (Naglieri, Das, & Goldstein, 2014b) can be used to evaluate behav-