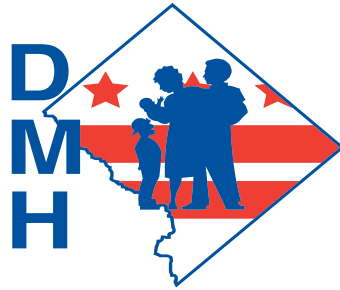


District of Columbia
Department of Mental Health



School Mental Health Program
Evaluation Report
2005-2007



Government of the District of Columbia

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The District of Columbia Department of Mental Health (DMH) would like to acknowledge all of the agencies and partners that have supported and enriched the School Mental Health Program (SMHP) over the last seven years. Our considerable growth and ability to serve would not have been possible without the vision, leadership and ongoing support of the D.C. Mayors office, City Council, and D.C. Public Schools as well as the participating D.C. public and charter school administrators and staff (principals, school counselors, social workers, teachers, security officers, nurses, secretaries).

Our success would not have been possible without the collaboration and support of our D.C. government sister agencies, the School Mental Health Coalition, and our continued partnerships with the many Core Service Agencies and community-based organizations that provide needed services to children, youth, adults, and families with mental health needs in the District of Columbia. Through your collective contributions we have been better able to achieve our vision and mission to address the needs of D.C. children, youth, and families for prevention, early intervention, and treatment services.

We are grateful to have had such talented, dedicated, hardworking, and creative mental health professionals working within the public and charter schools throughout these years. Their love of children and their respect for families have created a strong foundation from which to deliver a comprehensive array of traditional and non-traditional mental health services, and these clinicians continue to meet the ongoing challenges faced by our schools and communities with professionalism and grace. Our sincere gratitude goes out to all of the children, adolescents and families who entrusted us with so many aspects of their personal lives, and without whom, we never would have had the opportunity to learn how best to develop a responsive and comprehensive school-based mental health service delivery system.

The SMHP is now beginning to enter a new phase; having moved from an early development phase, through a period of rapid growth, to one reflecting maturity. To make this change successfully will require added responsibilities, accountabilities, and efficiencies of scale. The attached report provides a candid snapshot of SMHP efforts over a two year period and documents the myriad of successes as well as areas where the SMHP programs and services, and evaluation efforts, could be improved. It supports the SMHP commitment to ensuring that the needs of children, youth, and families in the District are being met.

TABLE OF CONTENTS

i. EXECUTIVE SUMMARY.....	5
I. INTRODUCTION.....	12
1.1 Overview of Report.....	12
1.2 Health & Mental Health Needs Among D.C. Youth.....	12
1.3 School Mental Health Programs & Services.....	16
II. DC SCHOOL MENTAL HEALTH PROGRAM (SMHP).....	18
2.1 Overview of the DC DMH SMHP.....	18
2.2 SMHP Program Vision & Mission.....	18
2.3 Types of Programs & Services Offered.....	19
2.4 SMHP Operational Characteristics.....	20
2.5 School Characteristics.....	21
III. EVALUATION OF SCHOOL MENTAL HEALTH PROGRAM SERVICES.....	23
3.1 Overview of the SMHP Evaluation Framework.....	23
3.2 Summary of Specific Evaluation Measures.....	25
IV. EVALUATION RESULTS FOR THE 2005-06 & 2006-07 SCHOOL YEARS.....	27
4.1 SMHP Service Utilization & Delivery Results.....	27
4.2 Clinical Services Evaluation Results.....	33
4.2.1 Clinical Outcome Evaluation Results.....	33
4.2.2. Client & Customer Satisfaction with Clinical Services.....	41
4.3 Primary Prevention & Early Intervention Evaluation Results.....	46
4.3.1 Evidence-Based Program Evaluation Results.....	46
4.3.2 Training & Workshop Evaluation Results.....	48
4.4 School Level Outcomes & Administrator Perceptions of School Climate.....	50
V. CONCLUSIONS & RECOMMENDATIONS.....	55
5.1 Conclusions & Recommendations Related to SMHP Programs & Services.....	55
5.2 Conclusions & Recommendations Related to SMHP Evaluation Activities, Measures, & Data Collection.....	56
REFERENCES.....	61
APPENDICES & TECHNICAL DOCUMENTS (Separate Document)	

EXECUTIVE SUMMARY

The D.C. School Mental Health Program (SMHP) is a school-based mental health program housed in the Office of Programs and Policy, Child and Youth Services Division in the D.C. Department of Mental Health. The SMHP offers a comprehensive array of services to children and youth enrolled in the D.C. public schools and their families. During the years evaluated, one qualified mental health professional was assigned by the SMHP to each participating public and public charter school. This SMHP clinician works collaboratively with school administrators, support staff, teachers, and parents to address the unique needs of children and adolescents enrolled in that school, as well as their families. SMHP clinicians offer an array of primary prevention, early intervention, and less intensive treatment services. Clinical services, such as individual, group, and family therapy are offered to youth and families in greatest need. Other SMHP services include mental health screening, focused behavioral and emotional assessments, staff consultation and training, crisis interventions, and limited case management.

This report summarizes results from an evaluation of SMHP services offered during the 2005-06 and 2006-07 academic years, and provides empirical evidence on the value of school-based mental health services delivered within the District of Columbia public and public charter schools. This report briefly summarizes the mental health needs of children, adolescents and families in the District of Columbia. An overview of the SMHP vision, mission, and the frameworks that guide the delivery of programs and services to address those needs is provided. A summary of the evaluation framework and data collected annually to assess the short- and longer-term impacts of the SMHP programs and services is also provided. The majority of the report focuses on a number of promising findings related to increases in SMHP service delivery and utilization, immediate impacts following participation in primary prevention and early intervention services, and longer term impacts for children and adolescents who receive specialized SMHP clinical services during a given year. Service satisfaction levels are also summarized, as are principal perceptions of school climate changes and several other key indicators of environmental change. Results from all of these data combined provide a mosaic against which the overall success of the SMHP can be evaluated.

Many of the 2005-2007 findings expand upon information presented in the 2000-2005 retrospective report. Our overall conclusion is that there has been considerable progress since the original SMHP 2000-2005 retrospective report both in terms of the delivery and evaluation of programs and services. The impact of these programs and services on youth and families continues to be quite positive. Yet, there is still room for program growth and service quality improvements that would be expected to yield additional positive emotional, behavioral, social, and academic outcomes.

SMHP Program Characteristics, Delivery & Utilization of Services

The total number of SMHP schools has increased by 32% since the last evaluation report; from 31 in 2004-05, to 34 in 2005-06 and 42 in 2006-07. There were close to 15,000 students attending a D.C. public or public charter school in 2005-06 and 17,600 youth attending a public charter school in 2006-07, which was served by SMHP clinicians. SMHP clinicians are more likely to be in schools where the greatest likelihood of health disparities and youth at increased risk for mental health problems exist; where more students are eligible for free/reduced lunches or a higher proportion of lower income, racial/ethnic minority students with lower academic achievement test scores are enrolled.

Substantial numbers of students, families, and school staff in these schools participated in various primary prevention, early intervention, and less intensive treatment services offered by SMHP clinicians. A total of 674 students in 2005-06 and 1,013 students in 2006-07 were formally referred for clinical services representing approximately 5-7% of the students enrolled in SMHP schools these two years. Nearly 80% of these referrals were seen by the SMHP clinician within the same month of referral, highlighting the responsiveness of SMHP clinicians to school and student needs. On average each month, across all SMHP schools, 350 (for the 2005-06 SY) and 444 (for the 2006-07 SY) youth walked-in for services each year. Anger management/ aggression, family problems, depression, grief or unresolved loss, peer relations/social skills, and disruptive behavior/attention seeking were the primary reasons for referrals and walk-ins.

Averaged across all schools, approximately 263 students were seen by a SMHP clinician per month in SY2005-06, and 314 students were seen per month in SY 2006-07. These statistics reflect an average clinician caseload of 7.7 and 7.1 students per school per month in SY 2005-06 and SY 2006-07 respectively. The total number of therapy sessions provided to students on the SMHP clinician caseload per year for all schools was as follows: individual counseling sessions (4,260 in 2005-06 and 5,762 in 2006-07), group counseling sessions (550 and 636 respectively), family counseling sessions (237 and 355 respectively). In SY2005-06, 1,231 students, and 1,700 in 2006-07, were seen for conflict resolution sessions. Consultations to parents (1,247 and 1,947), teachers and school staff (5,262 and 7,680), classroom observations (1,823 and 1,841), and home visits (218 and 143), as well as other SMHP clinical service activities, made up the majority of SMHP clinician activity.

Consistent with the growing programmatic emphasis on prevention and early intervention services and the interest in reaching the largest number of students possible, SMHP clinicians also provided a range of primary prevention and early intervention programs to students, staff, and parents. Enrollment in evidence-based programs with demonstrated efficacy in reducing or preventing mental health problems totaled, on average across all SMHP schools on a monthly basis, 913 school staff, students, and parents in SY2005-06 (about 28.6 participants per school per month), and a slightly lower average of 772 in SY2006-07 (reflecting about 17.9 participants per school per month). In SY2005-06, 79% of SMHP schools delivered evidence-based programs, increasing to 90% in SY2006-07. Early intervention counseling groups, many of which are promising practices but not evidence-based programs, are also offered in SMHP schools. On average, 148 (SY2005-06) and 93 (SY2006-07) students and/or parents were enrolled per month in early intervention group therapy/ counseling sessions across all SMHP schools (reflecting about 4.7 and 2.2 participants per school per month in either year). Other primary prevention activities, which are delivered in classrooms or school-wide and are not targeted to any particular population subgroups, were attended by 1,943 (SY2005-06) and 1,413 (SY2006-07) students, parents and staff on a monthly basis (reflecting about 60.7 and 32.9 participants per school per month in either year).

As compared to the 2000-05 retrospective report, the SMHP clinicians remained responsive to the substantial numbers of student referrals and walk-ins, and continued to serve students and families on their caseload with more intensive mental health services. Parents were involved in all SMHP programs and services, although as was true in prior years and across schools more generally, they were less involved than other constituency groups. SMHP clinician caseloads and the numbers of therapy sessions being offered each year were slightly lower than in prior years. The hours spent per month on primary prevention and early intervention activities appeared to remain very similar to those reported in prior evaluation years.

Clinical Service Treatment Outcomes

During SY2005-2006 and 2006-07, clinical assessments were conducted in the majority of SMHP schools with students receiving, individual, group, and family therapy services. These data were collected to evaluate the impact of the SMHP clinical services before and after treatment on various domains of psychosocial functioning. Students who agreed and had parental consent to participate completed a standardized battery of assessments pre- and post-treatment. Clinical assessments were completed in SY2005-06 with 141 children (generally aged 6 to 12), and 178 adolescents (generally aged 13+). In SY2006-07, 167 and 177 assessments with children and adolescents were completed respectively. This reflects a substantial increase over SY2004-05, when these instruments were first pilot-tested with 33 children and 74 adolescents in these same age ranges.

Four primary focus areas, matching frequently reported presenting problems in previous years, were assessed: depression, disruptive behavior, anger, and aggression. Results from assessments collected before and after children and adolescents received SMHP clinical services identified significant improvements in both years in several clinical domains. Children's levels of anger and cognitions associated with anger decreased significantly pre-to-post treatment in SY2005-06 and 2006-07. Children in both years moved from a *mildly elevated* range before receiving services to an *average* range at the end of treatment. Depression and disruptive behavior levels among children receiving SMHP clinical services remained essentially the same pre-to-post treatment. However, the majority of children were not clinically depressed prior to receiving services and they remained non-depressed at end of treatment. Levels of disruptive behavior were similarly within the *average* range before and after treatment in SY2005-06.

Disruptive behaviors in SY2006-07 were within a *mildly elevated* range before and did not decline after treatment. Adolescents receiving SMHP clinical services in SY2005-06 significantly improved pre-to-post treatment in symptoms of aggression, particularly physical aggression and hostility, and in anger and hostility during SY2006-07. Pre-to-post treatment improvements were also found in depression symptoms among adolescents in SY2005-06, but not in 2006-07.

In sum, the results of this evaluation study suggest that the SMHP clinicians are fostering improvements in clients' clinical levels of functioning in the domains of anger/ aggression for both children and adolescents, and in adolescent depression. Children's depression levels or disruptive behavior levels, which tended to fall within the *average* or *mildly elevated* range at initial referral, remained essentially the same pre-to-post treatment. Results were similar to those found in SY2004-05, except that the decreases in children's anger levels were statistically significant in SY2005-06 and 2006-07. These evaluation findings either represent improvements in SMHP clinical services for younger children over SY2004-05 findings, and/or the ability to detect significant improvements with a larger group.

Satisfaction with SMHP Clinical Services

Satisfaction surveys are collected from children and adolescents who receive clinical services, as well as their parents. Survey questions generally focus on whether the SMHP clinicians help youth feel better, make better decisions, and get along better with their peers and families. The number of satisfaction surveys collected from children and adolescents increased substantially from SY2005-06 to 2006-07; 176 and 325 forms from children, and 144 and 242 from adolescents were collected each year respectively. Fewer parents/guardians typically complete satisfaction surveys; 19 were collected in SY2005-06 and 42 in 2006-07.

Children who received clinical services from the SMHP reported very high levels of satisfaction with services offered in both years. In both years, 97% (SY2005-06) and 98% (SY2006-07) of the responding children indicated that the counselor helped them to feel better, and 95% (SY2005-06) and 97% (SY2006-07) would come back to see the counselor if they needed help. Overall, youth in SY2005-2006 and 2006-2007 rated their experience with their SMHP clinician as *excellent*. They, on average, *strongly agreed* that their interactions with the clinician helped them feel better, make better decisions, and will help them in the future. They also *agreed* that interactions with their clinician helped them relate better to peers and family. Parents/ guardians felt that, on average, felt their experience with the clinician was *outstanding* in SY2005-2006 and *excellent* in SY2006-2007, and in both school years *strongly agreed* that the clinician worked with teachers and staff to better support their child in the classroom and, perhaps more importantly, that the clinician had taught them better ways to work with their child at home.

Teachers and other school staff who work with, refer students to, or seek consultation from the SMHP clinicians also complete satisfaction surveys, as do the school principals. Items on these forms generally focus on the extent to which SMHP clinicians are perceived to be knowledgeable, provide valuable services and interventions to the school, and work collaboratively with teachers and other school staff, and youth and their family members to strengthen the school mental health program and meet critical needs. A total of 118 (SY2005-06) and 215 (SY2006-07) teachers and other staff completed satisfaction surveys. On average teachers/staff who returned the survey characterized their overall experience with the SMHP clinician as *outstanding*. They *strongly agreed* that the clinician was making a positive difference in the lives of students, as well as on the school and its mental health program, and the clinicians were active participants during school meetings, providing valuable input on mental health interventions to support students. School administrators from approximately 80% of the schools completed surveys in both years, and they on average *agreed* that the SMHP clinician was knowledgeable about mental health issues relevant to students enrolled at their school, and the vast majority in both SY2005-2006 and 2006-2007 stated that they wanted the SMHP clinician to return to their school the following year. These results indicate that, although programmatic adjustments and expansion occurred, the quality of services delivered did not suffer.

Primary Prevention & Early Intervention Evaluation Results

Prevention activities include educational workshops, classroom presentations, small groups, consultation, and training to help students, family members, or school staff acquire new information or skills that promote the mental health of children and families. Several evidence-based programs with scientific research demonstrating their effectiveness have been approved by the SMHP for delivery in schools. One such program was evaluated in SY2005-06 and 2006-07. Good Touch/Bad Touch, was designed for children to prevent or interrupt sexual abuse. Data collected on the immediate impact of this program indicated significant improvements in functioning after participation.

Other primary prevention and early intervention activities included SMHP sponsored or led workshops and/or training to various constituencies within the schools. The number of workshops offered, the number of evidence-based programs offered, and the number of evaluation forms collected in SMHP schools increased substantially from SY2005-06 to 2006-07. The workshops offered addressed a broad range of topics pertinent to schools. There was an increase in the diversity of program participants, and an increase in the number of evidence-

based program participants across these two years. Workshop evaluations from youth and adults in both years were generally very positive.

Assessments of School Climate & School Level Outcomes

School climate, and the quality of the social atmosphere, can have a significant impact on the learning taking place among children and adolescents. Principals with a SMHP clinician in their school were asked in both years to rate their perceptions of the school climate, and to rate improvements on several critical indicators within their schools. Most principals reported that their school appeared safer, more organized, and the school climate was generally improved from the previous year. The majority of school principals believed that student attendance had improved, and the number of students repeating a grade decreased over the prior year. Most felt that the number of expulsions, and Level I and II suspensions, had declined. And, nearly half or more indicated the numbers of disciplinary referrals and referrals to special education services for emotional disturbance had declined over the prior year.

Conclusions & Recommendations

SMHP clinicians are offering a broad range of services within participating schools, and are serving considerably more children, adolescents and families each year. Evidence suggests that all of these mental health related programs and services, whether focused on primary prevention, early intervention, or less intensive treatment, are being well received by all constituencies within SMHP schools. Data consistently suggest that the SMHP clinicians provide valuable programs and services, the programs are perceived as useful, and the recipients of clinical services are satisfied. Furthermore, this evaluation report provides strong evidence that the SMHP programs and services are having short- and longer term impacts in areas important to student learning and academic success. Gains in student knowledge, reductions in trauma symptoms, anger, aggression and depression levels, and continued improvements in perceptions of the school climate combined suggest that the SMHP is successfully fulfilling its vision and mission. The additional conclusions and recommendations that follow are intended to heighten this success.

Related to SMHP Programs & Services:

- School mental health services appear to be making a difference in student functioning overall and the SMHP clinicians should continue the valuable efforts.
- The overall satisfaction levels were quite high and a testament to how well SMHP clinical services are being received by recipients in SMHP schools. Some changes in satisfaction scores observed over the two years and differences among items within the survey are worth exploring further. Clarity about the significance of these discrepancies may be accomplished through interviews with respondents and/or discussions with clinicians.
- DMH should seek ways to promote broader use of a variety of the evidence-based programs that are approved and available to SMHP clinicians, especially if they have documented impact with this population of students. When selecting EBPs for approval, consideration of program length and feasibility of delivery is important to program sustainability.

- DMH should ensure that more schools have access to workshops and helps to support this activity by sharing workshop and presentation materials in order to minimize additional burden on SMHP clinicians.
- Parents were involved in all SMHP programs and services, although as was true in prior evaluation years and schools more generally, they were fewer parents involved. It will, therefore, be important for DMH to help SMHP clinicians increase outreach efforts to parents at all levels of program implementation and evaluation to achieve maximum effect overall.
- School climate data, as reported by principals, suggest the need for the DMH to promote expanded use of evidence-based programs designed to prevent school bullying, harassment and youth violence, to include issues related to dating violence, and the special needs of GLBTQ youth in SMHP schools.

Related to SMHP Evaluation Activities, Measures & Data Collection:

- Despite acknowledged limitations in evaluation design, it is recommended that DMH continue to collect pre-posttest data on clinical treatment outcomes and interpret them accordingly with caveats about the limitations of results obtained from evaluation designs that do not include a comparison group. Future DMH SMHP studies might consider utilizing other methods suggested that would strengthen conclusions drawn from program evaluation efforts, and potentially expand those assessments to other indicators such as school performance or social adjustment (e.g., disciplinary referrals, truancy, or fighting).
- Maintaining consistency within and across years in clinical data collection is important to the assessment of trends over time in the quality of clinical services. Because the collection of pre-and-posttreatment data was low, and DMH introduced a new general screening assessment of functioning scale in SY2007-08 (i.e., the Ohio Scales), policies need to be put in place to ensure that if a student is given the new screener or a specialized scale (e.g., a depression or aggression measure) at the beginning of treatment, that same scale should be administered at the end-of-the-year or treatment – irrespective of age or general improvements identified through the Ohio Scale scores-- so that pre-to-post changes in clinical functioning can be consistently measured among all youth receiving clinical services.
- There may be unmet needs for mental health services that were not able to be met due to a lack of parental consent, or child assent, and needs met that were not able to be assessed. In order to demonstrate programs success, it is critical that the DMH data base reflects all of the clinical assessments being undertaken, and how many clinical cases never materialize due to lack of parental consent or child assent.
- In order to ensure that satisfaction survey information is collected from as many people as are touched by the SMHP clinical services as possible and response rates are known, a tracking system should be put into place to permit more specific information on the distribution and return of satisfaction surveys. Alternatively, it may be possible to expand collection methods by using web-based surveys that would not depend on clinician collection. Focus groups may offer more nuanced feedback to supplement data currently collected from satisfaction surveys since overall satisfaction levels are high and do not capture any dissenting views.

- In order to increase more widespread SMHP clinician use of the array of approved evidence-based programs, it is important for DMH to identify appropriate evaluation designs and measures to assess the process of implementation, the acceptability and/or barriers to implementation, and the pre-to-post effectiveness of each evidence-based program available, and to provide feedback on those findings to SMHP clinicians and school staff.
- In order to more accurately determine how many different types of workshops and sessions are delivered and the extent that they address school needs, it is important that DMH ensure that SMHP clinicians are collecting workshop forms from all participants submit their workshop forms. It is also important that DMH verify that workshops are being conducted in accordance with unique SMHP school needs identified in assessments conducted at the beginning of each school year. This will increase the likelihood that limited resources are used efficiently.
- DMH should implement a record keeping system that will permit SMHP clinicians to show how many students, staff and parents they work with, how frequently they are seen, and precisely what interventions they are providing to each person touched by the program. Specificity in reporting could be achieved by revising the monthly data collection procedures and excel worksheets, making it possible for clinicians to more fully detail what programs and services they have delivered and the number of participants and sessions for each. An investment in an electronic data tracking system is recommended over the long term to improve the reliability of data collection and reduce the current burden on clinicians. Either improvement would provide a means of better understanding and interpreting results obtained by clarifying the breadth of the services and the number of participants impacted.
- Consideration should be given to assuring that the school climate questions clearly measure perceptions from the perspective of school leaders. It would be helpful if DMH presented results from the overall evaluation findings each year to participating schools along with plans for improvement to address staff and administrator concerns. Doing so could serve multiple purposes: it would provide some feedback to stakeholders, it would send the message that completing the DMH assessment forms is taken seriously, that staff and administrators are being heard, and that their completion of these assessments will, in fact, influence improvements in SMHP programs iteratively. Furthermore, the discussions that accompany these presentations could be used to clarify some of the nuances of administrator and staff perceptions using actual data results. Additionally, informal discussions with school principals may be warranted to explore how school climate forms are being answered, why certain response trends were observed, and how the forms could be improved. It would also be worthwhile to evaluate the perceived impact of the SMHP from those with even greater decision-making power, such as assistant superintendents. DMH should also continue to work directly with schools to compare administrator perceptions of program impact and actual, objective data on violence, disciplinary referrals, and attendance.
- If it is indeed the desire and intent of the SMHP to demonstrate school level changes over time, then it will be important to consider a different methodological approach to evaluating such changes and to consider the role of other mediating factors. Individual level outcomes and school climate changes may be more appropriate indicators of DMH SMPH impacts and future program evaluation efforts may be better served by concentrating on these areas.

I. INTRODUCTION

1.1 Overview of Report

This report summarizes results from an evaluation of SMHP services offered during the 2005-06 and 2006-07 academic years, and provides empirical evidence on the value of school-based mental health services delivered within the District of Columbia public and public charter schools. This report briefly summarizes the mental health needs of children, adolescents and families in the District of Columbia. An overview of the SMHP vision, mission, and the framework that guides the delivery of programs and services to address those needs is provided. A summary of the evaluation framework and data collected annually to assess the short- and longer-term impacts of the SMHP programs and services is also provided. The majority of the report focuses on a number of promising findings related to increases in SMHP service delivery and utilization, immediate impacts following participation in primary prevention and early intervention services, and longer term impacts for children and adolescents who receive specialized SMHP clinical services during a given year. Service satisfaction levels are also summarized, as are principal perceptions of school climate changes and several other key indicators of Program impact. Results from all of these data combined provide a mosaic against which the overall success of the SMHP can be evaluated.

1.2 Health & Mental Health Needs Among D.C. Youth

The majority of the more than 75,000 children and adolescents attending Washington, D.C.'s public and public charter schools are of ethnic minority descent—approximately 83% are African-American and about 11% are Hispanic (National Center for Education Statistics, 2008)—and live in a city where persistent poverty, chronic violence and unemployment exceeds the national average (Giorgis & Roberts, 2001). Indeed, 49% of school-aged youth in DC are eligible for free lunch. Thirty-three percent of the population of youth 18 years and younger in D.C. live below the poverty level, over 44% are raised in single-parent households, and over 54% live in high-poverty neighborhoods where 20% or more of the neighborhood lives below the poverty level (U.S. Census Bureau, 2000), all of which increase the risk for debilitating outcomes (Evans, 2004). Additionally, 17% of females and 26% of males aged 18-24 years do not graduate from high school, increasing the likelihood of greater difficulty later in life (Annie E. Casey Foundation, Kids Count Census Data Online, 2000).

Other environmental factors that place children in the District at increased risk for mental health problems include: high/elevated exposure to lead levels, increased exposure to aggression and violence, increased risk of substance abuse, especially marijuana, and high risks of depression and suicidal behaviors (e.g., CDC YRBS, 2003; CDC, 2004). Elevated exposure to violence in D.C. places youth at especially high risk for trauma and victimization, a fact that is amplified among youth residing in economically disadvantaged areas of D.C. Table 1 highlights several of the above and some additional health indicators that place D.C. youth at risk for detrimental outcomes later in life.

Table 1. Child Health/Economic Indicators in the District of Columbia & the United States.				
Indicator			2001	2005
Teen death rate by accident, homicide, or suicide (ages 15-19) (deaths per 100,000)	DC		126	85
	US		50	49
Child death rate (ages 1-14 years) (deaths per 100,000)	DC		33	24
	US		22	20
Percent of teens who drop out of HS (ages 16-19 years)	DC		11%	8%
	US		9%	7%
Percent of children living with parents who do not have full time jobs	DC		40%	49%
	US		25%	34%
Percent of families with children headed by single parent	DC		57%	65%
	US		28%	32%
Percent of children in poverty	DC		26%	32%
	US		16%	19%

Source: Kids Count 2005 Data Book Online

D.C. Youth Compared to U.S. Youth. Results from the Youth Risk Behavior Survey (YRBS) conducted every two years and reported by the Centers for Disease Control and Prevention (CDC) underscore the high levels of risk affecting District senior high school age youth compared to the United States (U.S.) youth. Comparisons made between D.C. and U.S. youth as a whole in SY2004-05 and 2006-07 identified several noteworthy differences that deserve brief discussion (Table 2). Further details are provided in Table 4, Appendix A.

Compared to all youth in the U.S. these two years, D.C. youth had higher rates of suicide attempts, greater fear of safety at school, more concerns about being threatened with weapons, physical fighting and serious injuries due to fights, dating violence, and instances of carrying weapons. Most of these differences were significant in SY2005-05 and 2006-07. The consequences of witnessing violence are well documented (Schuler & Nair, 2001).

Table 2. Risk Behaviors Among D.C. Senior High School Students Compared to Students Nationwide for 2005 and 2007.

Health-Risk Behaviors		2004-05	2006-07
Felt sad or hopeless almost every day for more than two weeks	DC	21.8%	26.8%
	US	28.5%	28.5%
Seriously considered attempting suicide during 12 months preceding survey	DC	10.8%	14.9%
	US	16.9%	14.5%
Attempted suicide one or more times in the past 12 months	DC	12.3%	12.2%
	US	8.4%	6.9%
Did not go to school because they felt unsafe at school or on their way home from school on one or more of the past 30 days	DC	9%	14.4%
	US	6%	5.5%
Carried a weapon such as a gun, knife, or club at least once in the past 30 days	DC	17.2%	21.3%
	US	18.5%	18.0%
Threatened or injured with a weapon such as a gun, knife or club on school property one of more times during the past 12 months	DC	12.1%	11.3%
	US	7.9%	7.8%
Physical fighting on school property during the past 12 months	DC	16.41%	19.8%
	US	13.6%	12.4%
Injured in a physical fight and had to be treated by a doctor or nurse one or more times in the past 12 months	DC	7.5%	9.6%
	US	3.6%	4.2%
Being hit, slapped, or physically hurt on purpose by a boyfriend or girlfriend in prior 12 months	DC	11.2%	17.1%
	US	9.2%	9.9%

Source: CDC Youth Risk Behavior Survey, 2005 & 2007.

With regard to substance use, D.C. youth appear to have lower alcohol consumption rates across nearly all indicators (e.g., lifetime use, past 30 day use, binge drinking), glue sniffing and cocaine use (SY2004-05 only) compared to all youth in the U.S. However, rates vary significantly from 2005 to 2007 in relation to other substance use with SY2006-07 data showing that D.C. youth had higher rates compared to U.S. youth on several substances. And, while national rates for several indicators appeared to be decreasing, or remaining constant, the rates among D.C. youth appeared to increase between 2005 and 2007. For example, although the U.S. rates of high school students reporting feeling sad or hopeless almost every day for at least two weeks remained the same 2005 to 2007, the rates among D.C. youth increased significantly across these two years ($p < .01$). While rates of youth weapon carrying (such as a gun or knife) increased from 17% to 21% between 2005 and 2007; the rates among youth across the U.S. remained around 18% over this interval. Comparisons across years (i.e., 1993, 1999, 2005, and 2007) on the District of Columbia YRBS were calculated for this report, and are shown in Appendix A, Table 5, along with a written summary.

Risks Among Gay, Lesbian, Bisexual and Questioning Youth. For the first time in 2007, the D.C. YRBSS collected information related to sexual orientation. Out of 1,532 youth who responded, 88% ($n=537$ male; $n=814$ female) self-identified themselves as heterosexual,

and the remainder indicated that they were gay or lesbian (3%), bisexual (5%), or not sure (4%). Findings available in a report on-line ¹, suggested that gay, lesbian, bisexual, and questioning youth (GLBQ youth) in DC Public Schools are at substantially increased risk, experience significant disparities in health and wellness, and a hostile school climate characterized by bullying and harassment attributable to presumed or real sexual identity. Specifically, 9% (n=144) youth indicated experiencing at least one incident of harassment in the past 12 months because someone thought the youth was gay, lesbian, or bisexual (GLB), with 2% indicating the highest incidence of “12 or more times”. Approximately 26% of GLB youth (compared to 11% of heterosexual youth) indicated that they have stayed home one or more days in the month preceding the survey because they felt unsafe in or on their way to school. Moreover, 31% of GLB youth seriously considered attempting suicide in the past 12 months compared to 14% of heterosexual youth, while 33% of GLB youth actually attempted suicide at least once in the past 12 months (compared to 9% of heterosexual youth). Similar patterns were also evident in drug use, with 39% of GLB youth reporting lifetime use of marijuana, compared to 17% of heterosexual youth. Examination of all risk factors and indicators suggest that GLB youth in DC are especially vulnerable and in critical need for mental health programs and services.

Mental Health & Academic Achievement. Strong associations between health and academic achievement have been identified and are receiving increased attention in the scientific literature as well as other publications.² Research suggests that school health and mental health programs can have positive impacts on educational outcomes, as well as on health risk behaviors and health outcomes (Carlson, et al., 2008; Murray, Low, Cross & Davis, 2007; SSDHPER, Taras, 2005a-b; Taras, Potts, Datema, 2005a-d). Data from the 2003 Youth Risk Behavior Survey were analyzed by CDC to identify associations between several of the above risk behaviors and academic grades in the prior 12 months; results are available on line for review ³. Violence and violence-related behaviors were strongly and *negatively* associated with academic grades (CDC, 2003).⁴ Thus, as student’s grades decreased, reported violence and violence-related behaviors increased. This pattern was consistent in self-injurious thoughts and behaviors as well; students with A’s and B’s were less likely to have attempted suicide in 12 months prior

¹ Source: http://www.k12.dc.us/offices/oss/hivaid/pdfs/GLBT_fact_sheet.pdf

² Source: Centers for Disease Control & Prevention: http://www.cdc.gov/HealthyYouth/health_and_academics/

³ Source: http://www.cdc.gov/HealthyYouth/health_and_academics/pdf/health_risk_behaviors.pdf

⁴ Source: http://www.cdc.gov/HealthyYouth/health_and_academics/pdf/unintentional_injury_violence.pdf

to the survey than students with C's and D/F's. Self-reported alcohol and substance use were also negatively associated with academic grades (CDC, 2003)⁵. Details are provided in the referenced report and in Appendix A.

1.3. School Mental Health Programs & Services

The Substance Abuse and Mental Health Services Administration (SAMHSA) its 2005 report on the first national survey of school mental health services in the United States. The report includes a representative sample of about 83,000 public elementary, middle, and high schools and findings demonstrate that schools are the primary site of care for the majority of children and adolescents receiving mental health services (U.S. Department of Health and Human Services, 2005). The survey indicates that one-fifth of students receive mental health services during the school year for a number of concerns, including the top three general problems: social, interpersonal, and family problems.

Research studies have confirmed that the unique advantage of school-based mental health services is that they are accessible and utilized by identified students (Armbruster & Lichtman, 1999; Weist, 1997). Although establishing successful school-based mental health programs requires attention to a number of contextual and systemic variables (Acosta, Tashman, Prodent, & Proesch, 2002) such efforts can yield significant benefits for inner-city public school settings in particular (Costello-Wells, McFarland, Reed, & Walton, 2003). Students referred for school-based mental health services are more likely to follow up on the referral than those referred to community-based treatment (96% vs, 13%) (Catron, Harris, & Weiss, 1998). Furthermore, students who receive school-based mental health services show improvements in behavioral and emotional outcomes. Many children and youth who receive SMHP services learn positive coping skills and exhibit fewer disruptive behaviors as well, and report high rates of satisfaction with the services they receive. Perceived school climate, or the quality of the social atmosphere and learning environment (Moos, 1979), also appears to be impacted by school mental health programs (Bruns, Walrath, Glass-Siegel, & Weist, 2004).

A recent review of studies that examined the association between academic outcomes and school mental health services found that the impact of school mental health interventions on educational outcomes appears modest, does not seem to last, and is poorly understood (Hoagwood, et al., 2007). The Hoagwood review points out that the academic outcomes included

⁵ Source: http://www.cdc.gov/HealthyYouth/health_and_academics/pdf/alcohol_other_drug.pdf

in many research studies (i.e., grades, test scores, school drop out) do not necessarily have a direct relationship to mental health interventions conducted. Other variables such as the number of disciplinary actions and classroom factors (i.e., teacher behaviors, classroom organization, and school climate) appear to have a stronger effect on academic outcomes and educational performance and these disciplinary and classroom factors appear more readily influenced by mental health interventions. Although caution is suggested, there are examples of previous research findings that may illuminate the impact of school mental health services:

- The Dallas Public Schools Youth and Family Centers reported a 31% decrease in course failure among students served by their school-based clinics (Jennings, Pearson, & Harris, 2000).
- The University of Maryland's School Mental Health Program reported that the mean G.P.A. scores for elementary students seen four or more times for mental health services over one academic year improved from 1.8 to 2.1 (University of Maryland, 1999).
- The South Carolina (2001) SMHP reported that following treatment, positive coping scores increased, 99% students remained out of trouble, 93% remained in school, and 92% remained with their families.
- The Dallas Public School Youth and Family Centers reported a 95% decrease in disciplinary referrals and a 32% decrease in absences among students receiving services from their school-based clinics (Hall, 2000).
- The Linkages to Learning program in Montgomery County, Maryland, that includes school-based health and mental health services, reported significant decreases in negative behaviors as indicated by scores on standardized clinical assessment tools (Fox et al., 1999).
- A pilot study conducted by the University of Maryland reported that high school students receiving school mental health treatment (as compared to a reference group not receiving those services) showed significant decreases in depression, improvements in self-esteem, and increases in protective factors and improved functioning following treatment services; 89% of students reported they were doing better, and 80% reported that their families were doing better (Nabors & Prodent, 2000; Nabors & Reynolds, 2000).
- Elementary school teachers in Baltimore rated school climate as being more positive in schools with SMHP programs than those at non-SMHP schools (Bruns, Walrath, Glass-Siegel, & Weist, 2004).
- Teachers made more referrals for students with emotional or behavioral problems to mental health professionals in schools with a SMHP whereas in schools without such programs, referrals were largely made to special education staff or administrators (Bruns, Walrath, Glass-Siegel, & Weist, 2004). There was also a significant difference in perceptions of mental health resources available between teachers in schools with SMHP programs versus those without.
- The SMHP was perceived by school administrators to have a positive and meaningful impact on overall school climate (Bruns, Walrath, Glass-Siegel, & Weist, 2004).

II. D.C. SCHOOL MENTAL HEALTH PROGRAM (SMHP)

2.1 Overview of the D.C. Department of Mental Health (DMH) School Mental Health Program (SMHP)

The D.C. Department of Mental Health's (DMH) School Mental Health Program (SMHP) is primarily a prevention/early intervention community-based mental health program provided in schools to benefit children and youth experiencing behavioral and/or emotional problems that may be functioning as barriers to their learning. Family involvement through treatment planning, outreach, consultation and evaluation, is integral to the success of the program, as is the consultation, training, and education offered to school staff and administrators to assist them in creating more supportive environments in which students can thrive. Ongoing feedback from parents/caregivers, students, principals, teachers, and child advocates contributes to the program's success. The SMHP serves as an access point to a comprehensive system of care, both as gatekeeper and advocate, assuring children can access services at the appropriate level of care. SMHP clinicians serve a vital role as brokers for intensive mental health services and family supports and facilitators for access to a range of necessary social services. Thus, school-based mental health services are a critical component of a comprehensive system of care under a family-centered practice model.

2.2 SMHP Program Vision & Mission

Vision Statement:

All students learn in a safe, supportive and responsive environment where the SMHP:

- Positively impacts every student in schools with a SMHP presence
- Involves families in all levels of care and program development
- Fosters and develops student and family utilization of internal and external resources to promote students' academic, social and emotional success
- Consults and collaborates with all service providers involved in the system of care for students with mental health and co-occurring disorders, meeting the diverse needs of students and their families
- Provides technical assistance to school staff, administrators and caregivers.

Mission:

The mission of the Department of Mental Health (DMH) School Mental Health Program (SMHP) is to maximize the potential for students to become successful learners and responsible citizens by fostering resilience and reducing the barriers to learning. The SMHP will actively

collaborate with key stakeholders—students, families, District of Columbia Public and Public Charter Schools, core service agencies, public and private community agencies, and the faith community—to enhance the system of care’s ability to deliver culturally competent and developmentally appropriate services to school-aged children and their families.

2.3. Types of Programs and Services Offered

The services provided by the D.C. SMHP are primarily preventive and are available to all students attending selected DC public and public charter schools. Early intervention and treatment services are available to students who are assessed as needing these services, however, mental health services provided through the SMHP are not intended to satisfy requirements for mandatory special education services.

Based on examples of successful programs in other regions, the DMH SMHP designed a set of services consisting of the three levels of care described in Table 3; primary prevention, early intervention, and less intensive treatment services. Figure 2 (in Appendix B) provides a visual reference for these three levels of service and the proposed allocation of time clinician’s spend per service category. However the actual content and amount of time dedicated to these principle components and associated programmatic activities at each school is determined through an initial needs assessment process that engages multiple stakeholders (parents, students, teachers, administrators, etc.).

Table 3. Three Levels of Care: Prevention, Early Intervention, and Less Intensive Treatment Services.

- **Primary Prevention (also known as Universal Prevention Services).** Prevention services available to the entire student body, the school staff, or parents/guardians (depending on the target audience for a particular intervention). The aim is to prevent the development of serious mental health problems and to promote positive development among children and youth. Program examples included staff professional development, mental health educational workshops for parents/guardians, school staff, or students, and evidence-based or promising school-wide or classroom-based substance abuse and violence prevention programs. At least 10 hours per week are dedicated to developing or implementing activities aimed at preventing the development of serious mental health problems and promoting positive development among children and youth.
- **Early Intervention (also known as Selective, Secondary Prevention or Targeted Services).** Students identified at elevated risk for developing a mental health problem are offered one of a number of early intervention services. The aim is to prevent the escalation of identified risks and development of more serious mental health problems. These interventions could include involvement in support groups, focused skills training groups, dropout prevention programs, and training or consultation for families and teachers who work with identified children. Depending on school needs and enrollment size, there are several targeted interventions conducted each week (constituting at least 10 hours per week) for students who have been identified by a referral source for mental health intervention.

Table 3. Three Levels of Care: Prevention, Early Intervention, and Less Intensive Treatment Services.

- ***Less Intensive Treatment Services (also known as Tertiary or Indicated Prevention Services).*** Students with more intense or chronic problems who need more targeted support are offered a number of less intensive treatment services. The aim is to minimize the impact of the problem and help restore the child or adolescent to a higher level of functioning. Examples of these clinical services included individual and family counseling, and therapeutic groups (i.e., grief and loss groups). In all schools there is a need for more intensive services for children and youth that are experiencing more intense or chronic problems and at least 30% of clinical time (approximately 12 hours per week) is dedicated to providing care for children, youth and their families with more serious needs. Students needing more intensive services may be referred for community mental health services.

To address the primary prevention, early intervention, and less intensive treatment needs in each school, DMH offers training in an array of evidence-based programs from which the SMHP clinicians can choose depending on needs identified at the beginning of, or experiences encountered during, each school year. A listing of DMH SMHP approved evidence-based programs during SY2005-06 and 2006-07 is shown in Appendix B, Table 8. Five new nationally recognized evidence-based programs were introduced during SY2006-07: Connect with Kids, Botvin's Life Skills program, Too Good for Violence, Cognitive Behavioral Intervention for Trauma in Schools (CBITS), and Taking Action-Cognitive Behavioral Intervention for Depression.

2.4. SMHP Operational Characteristics

The SMHP is housed within the D.C. Department of Mental Health, Child and Youth Services Division. The SMHP assigns one qualified mental health provider to selected public schools and public charter schools to work collaboratively with school-hired mental health providers to offer prevention and early intervention services and less intensive outpatient treatment for students and their families. SMHP evaluation and program administrators and staff at the DMH oversee all aspects of the SMHP operations, train and supervise SMHP staff assigned to each school, and monitor program delivery and utilization characteristics, and evaluate the program's success in achieving SMHP goals and objectives.

The DMH SMHP school mental health clinicians assigned to each school represent several different professional disciplines. Each clinician has a training background in child mental health, and the majority are licensed to provide treatment services to children, youth, and

families, and have had some previous experience working with schools. The DMH SMHP has three supervisors who are available to provide supervision to the SMHP staff in schools.

Table 7 in Appendix B provides a listing of the schools participating in the SMHP program during SY2004-05, 2005-06 and 2006-07. There were a total of 31 SMHP schools in SY2004-05. During the 2005-06 academic year, the SMHP expanded into 34 schools, and by 2006-07 the SMHP was operating in a total of 42 public and public charter schools⁶. This represents a 32% increase in SMHP schools over SY2004-05. Proportionate to number of schools at each grade level, the greatest increase was seen in elementary schools (from 14 to 16 and then 21 schools by SY2006-07), followed by middle/junior high schools (increasing from 8 to 12 and then 14 by 2006-07). High schools remained relatively constant across the three years (7, 6 and 9 respectively). Most SMHP program schools continued to participate across all three years, demonstrating the programs' acceptability and sustainability. Unfortunately, eight clinicians resigned in SY2006-07 resulting in vacancies in some schools during a part of the year.

2.5. School Characteristics

The SMHP is located in a range of D.C. public and public charter schools, and appears to be serving youth with demonstrated need. Over 15,000 youth in SY2005-06 and 17,600 youth in 2006-07 attended a D.C. public or charter school served by the SMHP. Table 1 in Appendix A presents the DCPS enrollment data for the 1999-2007 academic years by racial and ethnic group. Table 9 in Appendix B compares average student enrollment per school during SY2005-06 and SY2006-07, and the percentage of students eligible for the free/reduced lunch program, a widely used indicator of household poverty, in schools with and without an SMHP clinician. In both 2005-06 and 2006-07, SMHP was located in charter schools that were on average larger than the non-SMHP charter schools. In SY2006-07 SMHP also tended to be located in middle and junior high schools that were larger, on average, than the non-SMHP middle/junior high schools (Appendix B, Table 9). The SMHP's in SY2005-06 were located in schools with families experiencing higher poverty levels (average higher percent of students receiving free/reduced price lunch) than the schools without a SMHP. This difference was found among DC Public

⁶ The DMH SMHP program in SY2006-07 placed clinicians in 42 schools. Over the course of the year, due to staffing and school requirement changes, two of the original schools were removed from the program and two new schools were added. In the end, 44 individual schools participated in the DMH SMHP but only 42 at any given time.

Schools that were part of the SMHP; there was no difference in the poverty level among children in charter schools. In both school years, schools overall and the DC public schools with a SMHP in particular contained a higher percent of African-American students than those comparison schools that were not part of the SMHP (Table 10, Appendix B). SMHP clinicians in SY2005-06 and 2006-07 were placed in schools where attendance rates were equivalent to all other DCPS public and charter schools (Table 11, Appendix B). In fact, there was no change in attendance rates across the two school years. SMHP schools were ones in which reading and math scores in both years were significantly lower compared to non-SMHP schools. In SY2005-06, these differences were found in D.C. middle and junior high schools, whereas in SY2006-07, they were apparent in elementary schools (Table 12, Appendix B).

III. EVALUATION OF SCHOOL MENTAL HEALTH PROGRAM SERVICES

3.1 Overview of the SMHP Evaluation Framework

The original goals of the SMHP program evaluation were to assess the program's effect across its three core program components (e.g., Primary Prevention, Early Intervention, and Less Intensive Treatment Services). Of interest were changes in relation to the following indicators:

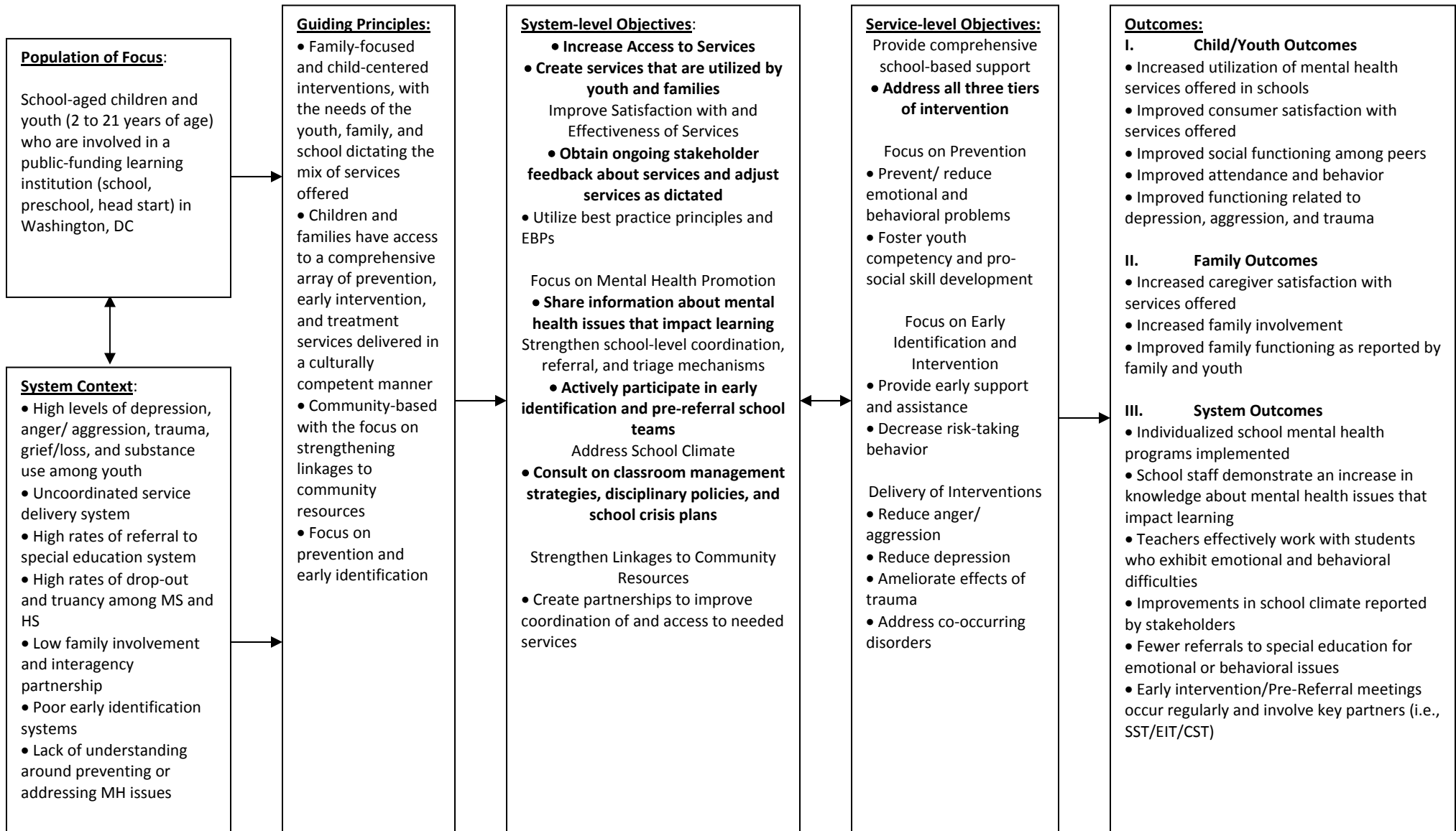
- Prevention and early intervention of emotional/behavioral problems
- Reduction in risk-taking behavior
- Improvement of social functioning
- Reduction of anger/aggressive behavior
- Reduction of levels of depression

A logic model was created to better delineate a refined set of goals and to outline service- and system-level objectives for the SMHP in order to evaluate relevant SMHP impacts and outcomes (see Figure 1 below). Service level objectives included: provision of comprehensive services at all three levels of care (prevention, early intervention, and less intensive treatment services), an emphasis on prevention, early identification and intervention, and interventions to address mental health problems. System level objectives included: increased access to services, improved satisfaction with services, training for school staff related to mental health, improved service coordination within schools, improved school climate, and linkages with community partners. Outcomes were defined at three levels: child/youth outcomes (such as service utilization, improved individual and social functioning), family level outcomes (such as caregiver satisfaction, parent involvement, and improved family functioning), and system-level outcomes (e.g. improved staff handling of mental health issues, fewer referrals to special education for emotional or behavioral issues, and improved school climate).

Figure 1. SMHP Theory of Change Logic Model

Vision: The SMHP assures that all students learn in a safe, supportive and responsive environment

Mission: To maximize the potential for students to become successful learners and responsible citizens by reducing the barriers to learning and fostering



3.2 Summary of SMHP Evaluation Measures

It is the responsibility of the SMHP clinical staff in each of the participating schools to administer evaluation measures to staff, parents and students, to store collected data in a safe, confidential location and maintain up-to-date clinical documentation of services provided. A complete listing of the assessment measures is included in Appendix C, Table 13. Briefly, the SMHP has included the following evaluation components as a requirement for all SMHP clinicians:

- Needs assessments must be conducted at the beginning of each school year. Plans for programs and services to be implemented during the school year are to be derived from this assessment based on the schools individual needs.
- SMHP are required to monitor all staff referrals, and the programs and services delivered and utilized on a monthly basis. These monthly reports are reviewed by DMH SMHP staff to ensure continuous quality improvement of services, to align operations, curriculum and programs to achieve desired outcomes in a cost-constrained environment.
- Workshops and training programs offered by SMHP staff in participating schools are evaluated using a workshop evaluation forms specific to the population served. Two workshop evaluation forms exist; one for children and youth and the other for adults (e.g., parents, school staff, etc.)
- Evaluation measures are available for two of the SMHP approved Evidence-Based Programs to assess pre-to-post benefits of participation: the Good Touch Bad Touch classroom-based program, which is designed to prevent sexual abuse among elementary school-age children, and the G-TREM trauma recovery group-based program, which is designed for older girls who are trauma victims. Pre-post assessments are conducted to determine knowledge gains among Good Touch Bad Touch program participants, and reductions of trauma symptoms among G-TREM program participants.
- A standardized battery of assessments is administered to all students who receive SMHP clinical services at the beginning and end of treatment, or the end of the school year, whichever comes first. Participation is based upon parental consent, or youth consent if a child is of legal age. Assessments are tailored to child or adolescent age and focused on evaluating improvement in functioning in three primary areas: depression, anger/aggression, and disruptive behaviors. These measures were pilot-tested during SY 2004-2005, and implemented SMHP-wide for the first time in SY2005-06.
- DMH has begun to pilot and plans to adopt the Ohio Youth Problem, Functioning, and Satisfaction Scales (“Ohio Scales”; Ogles, Melendez, Davis, & Lunnen, 1999). The scales identify student problems, guide treatment planning and track progress for students receiving services, while measuring problem severity, functioning, hopefulness, and satisfaction among students being treated as well as their caregivers and their mental health providers. When used to screen for problems, students demonstrating high scores on particular subscales of the tool can then receive a second round of screening for depression, anger and aggression using other validated measures currently used in the SMHP.

- At the end of each school year, SMHP clinicians are required to assess stakeholder satisfaction with the clinical services provided in each participating school. Students and parents/caregivers who receive clinical services, teachers/other staff members who refer students for clinical services, and school administrators are asked to complete satisfaction surveys.
- Administrators in each participating SMHP school are additionally asked to complete a school climate survey to assess their perceptions of changes in school-level outcomes relative to the prior school year on issues such as school improvement, safety, organization, fighting, attendance, suspensions and expulsions, and referrals to Special Education for emotional disturbance.

IV. EVALUATION RESULTS FOR THE 2005-06 & 2006-07 SCHOOL YEARS

4.1 SMHP Service Utilization & Delivery Results

The Monthly Report Form has been the primary method of collecting and reporting data for the SMHP. Since its inception, a Monthly Report Form has been used in each SMHP school to capture data about service utilization and delivery, referral sources, caseloads and participation in various primary prevention, early intervention, and less intensive treatment activities. This form represents essentially a tally of activities initiated and completed over the course of each month. Monthly report data were received from all of the SMHP schools SY2005-2006 (n=34) and SY2006-2007 (n=42)⁷. A total of 14,769 and 17,656 students were enrolled in these schools respectively during each year. Although the SMHP placed a full time clinician in each SMHP school in both years, unexpected departures and delays in filling positions resulted in the SMHP activities being undertaken by 28.3 FTEs (84% of full staffing) in SY2005-2006 and 38.4 FTEs (87% of full staffing) in SY2006-07 (Appendix D, Table 17). Nonetheless, the total numbers of students and families served across these two years with a range of clinical programs and services was substantial (Table 4).

Table 4. Average SMHP Clinician Activities & Populations Served Per Month.				
Primary Prevention, Early Intervention, and Less Intensive Treatment Services	2005-06		2006-07	
	Average for All SMHP Schools N=34	Average Per SMHP School	Average for All SMHP Schools N=42	Average Per SMHP School
Average Numbers of Clinical Cases Served Per Month				
Student Referrals	44	1.3	63	1.4
Student Walk-Ins	350	10.3	444	10.3
Students on Clinical Caseload	263	7.7	314	7.1
Number on Caseload Receiving Conflict Resolution	136	4.0	170	3.9
Average Number of Clinical Sessions Per Month				
Individual Therapy Sessions	355.0	10.4	480.2	10.9

⁷ Over the course of the 2006-07 school year, two clinicians shifted placements so the actual number of schools that provided data in this section reflects n=44 schools.

Table 4. Average SMHP Clinician Activities & Populations Served Per Month.

Primary Prevention, Early Intervention, and Less Intensive Treatment Services	2005-06		2006-07	
	Average for All SMHP Schools N=34	Average Per SMHP School	Average for All SMHP Schools N=42	Average Per SMHP School
Group Therapy Sessions	45.8	1.3	53.0	1.2
Family Therapy Sessions	19.8	0.6	29.6	0.7
Average Numbers of Primary Prevention or Early Intervention Program Participants Per Month				
Evidence-Based Program Participants (all types)	913	28.6	772	17.9
Group Therapy/Counseling Participants (all types)	148	4.6	93	2.2
Primary Prevention Program Participants (all types)	1943	60.9	1413	32.9
Average Numbers of Primary Prevention or Early Intervention Program Sessions & Activities Per Month				
Evidence-Based Program Sessions	109	3.2	122	2.8
Early Intervention Group Counseling Sessions	31	0.9	32	0.75
Primary Prevention Sessions	196	5.7	178	3.9

** Reflects the average numbers of participants and activities per month (September through June) in all schools.*

SMHP clinical services (tertiary prevention) are offered to students who are (1) newly referred, (2) walk in for services without referral, or (3) who are already officially on the caseload after receiving parent/guardian consent. Referrals are received from varied sources, and can include self-referrals. A total of 674 students were referred to SMHP clinicians in SY2005-06. With the increase in the number of SMHP schools and clinicians and the increased maturity of the program, 1,013 students were referred in SY2006-07. This represents, on average, approximately 5-7% of the student population enrolled in SMHP schools each year (Table 5). It is difficult to compare changes over time in SMHP schools to previous years without similar school population denominators; averaging the number of referrals per year per school suggests that there may have been increases of approximately 3-4 students per year per school.

Table 5. Mean Percent of Enrolled Male & Female Students Referred to SMHP Clinicians for Services. *

	2005-06					2006-07				
	Overall	ES	MS/ JHS	MS/H S	SHS	Overall	ES	MS/ JHS	MS/H S	SHS
Mean % of male students referred	5.2	4.9	3.7	10.0	8.8	7.0	6.6	9.5	5.1	3.8
Mean % of female students referred	6.8	3.3	6.1	10.2	19.0	6.1	4.0	9.1	5.5	6.8

* Reflects the average number of male and female students enrolled in SMHP schools who were referred to the SMHP Clinicians each year.

The top three referral sources both years were teachers, family members and school administrators; self-referrals were a close fourth. Teachers, followed by family members, were the most common referral sources for Elementary and Middle school students, whereas administrators followed by teachers were more common referral sources for High School students (Appendix D, Table 21). Nearly 80% of the referrals both years were seen by the SMHP clinician within the same month of referral, highlighting the responsiveness of SMHP clinicians to school and student needs. At referral, 74 (14% for 2005-06) and 106 (10% for 2006-07) students were already being served by other community agencies; most often by other mental health agencies, the Child & Family Services Administration or Youth Services Administration (Appendix D, Table 22).

While referrals are a more formal process, walk-ins constitute a more spontaneous visit by a student to see a clinician. After three visits within a month, clinicians request parental consent and student assent to conduct a formal intake assessment so that a treatment plan can be developed. Approximately 350 walk-ins were counted on average per month across all SMHP schools in SY2005-06, and 444 walk-ins in SY2006-07 (Appendix D, Table 23). Although reasons for referrals or walk-ins are not captured by the monthly reporting system, SMHP clinicians do rate their impressions of the presenting problems. The six primary presenting issues in both years were anger management or aggression, family problems, depression, grief or unresolved loss, peer relations or social skills, and disruptive behavior/attention seeking (Appendix D, Table 24).⁸

⁸ In 2005-06 the monthly report did not distinguish between referrals and walk-ins, whereas in 2006-07 SMHP clinicians were asked to exclude walk ins.

Students who are counted as being on a SMHP clinician's caseload are those for whom formal consent has been obtained. Because the same people can be on a caseload over multiple months it is not possible to sum the numbers carried on a caseload across months to determine the overall size of the caseload managed. Therefore, an average monthly determination is more appropriate. On average, across all SMHP schools, 263 students per month in 34 schools during SY2005-06 (September through June), and 314 students per month in the 42 schools in SY2006-2007, were clients of the program (Appendix D, Table 25). Males and females were equally represented. This reflects an average caseload per month per school of 7.7 in SY2005-06 and 7.5 in 2006-07. It also reflects a further decrease over the last three years of the 2000-05 retrospective report; when the clinical caseloads were consecutively 14, 11, and 10 students per month per school.

SMHP clinicians provide therapy, counseling, and conflict resolution sessions to students on their caseload. The total numbers of sessions across all youth and schools were substantial; approximately 5,000 total therapy sessions of all types (individual, group, and family) were held in SY2005-06, and 6,700 in SY2006-07 (Appendix D, Table 26). Two-thirds of these students in SY2005-06 and three-fourths in SY2006-07 were seen predominantly in individual therapy sessions. Approximately one-quarter of these students were seen in group sessions each year, and fewer received family sessions (Appendix D, Table 26). Conflict resolution sessions were calculated separately. On average, 136 students during SY2005-06 and 170 in SY2006-2007 were seen in any given month for conflict resolution support. When compared to the sessions offered each year since SY2001-02, there was a general decline in the average number of therapy sessions offered per SMHP school, per year (not the total). The numbers of conflict resolution sessions per school per month (annualized) appeared comparable to numbers presented in the 2000-05 report (based on a per school, per year average).

SMHP clinicians address numerous other pressing issues and service needs in schools. The SMHP clinicians consult with teachers and other school staff, as well as parents. They conduct classroom observations and home visits, handle case management activities, attend SST/EIT/CST meetings, and conduct professional development in-service activities. In SY2005-06, 9,954 of these other clinical service activities were collectively reported (approximately 292.7 per school per year), and this number increased to 13,645 in SY2006-07 with the addition of more clinicians and schools (approximately 324.9 per school per year). The figures below show the distribution of these other activities (see Figure 2 and Figure 3). Teacher, staff and

parent consultations together with classroom observations make up vast majority of these activities; 82% in SY2005-06 and 83% in 2006-07.

Figure 2. Distribution of SMHP Clinician Time in Other School Activities: 2005-06

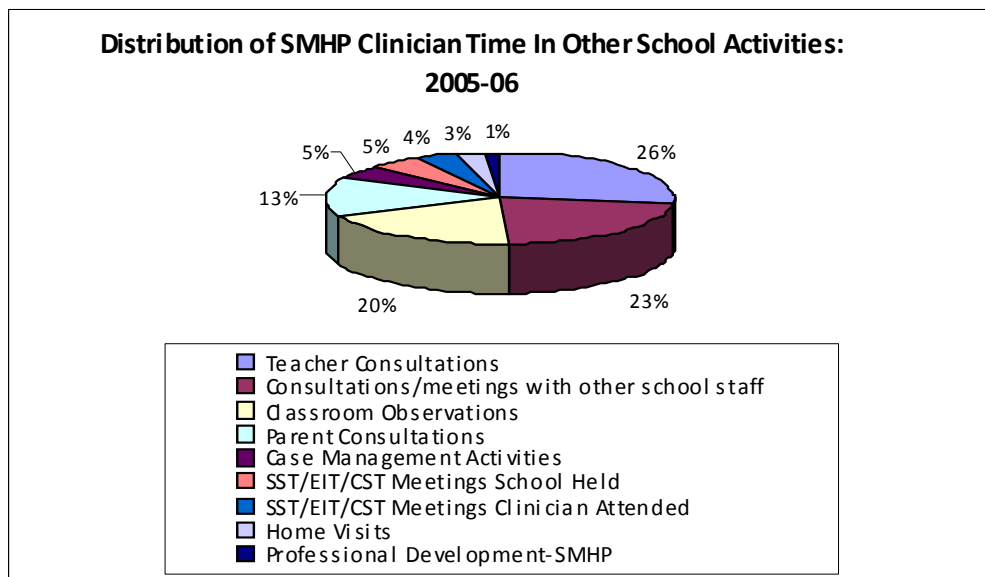
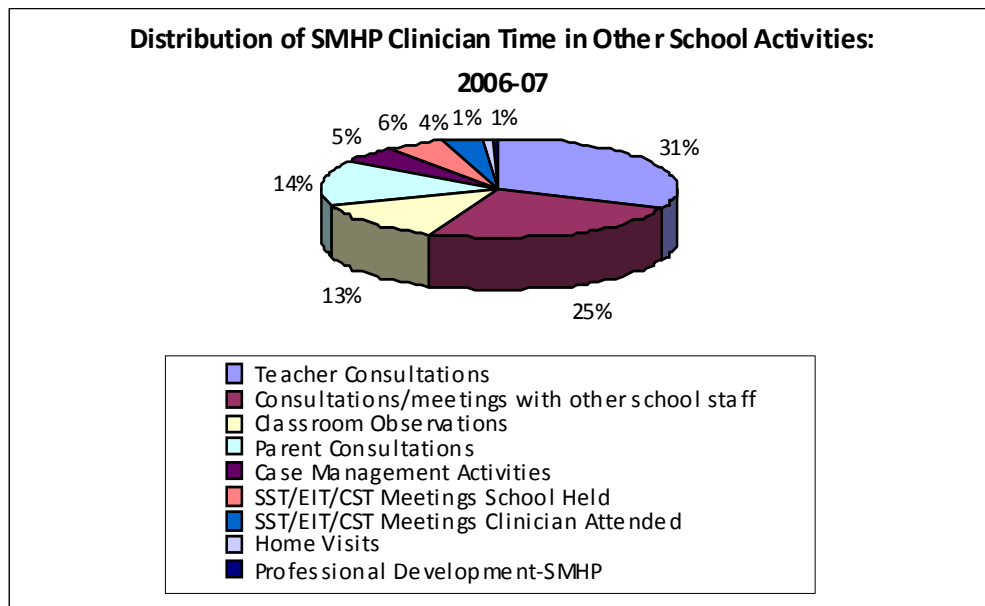


Figure 3. Distribution of SMHP Clinician Time in Other School Activities: 2006-07



Consistent with the growing programmatic emphasis on prevention and early intervention services and the interest in reaching the largest number of students possible, SMHP clinicians

also provide a range of primary prevention and early intervention programs to students, staff, and parents. Most notable are those that are evidence-based since there is research available demonstrating their efficacy in preventing or impacting mental health problems (Appendix D, Table 27). On average, 913 staff, students, and parents were enrolled in evidence based programs (EBPs) across all SMHP schools on a monthly basis in SY2005-06 (about 28.5 participants per school per month), and a slightly lower average of 772 was reported in SY2006-07 (reflecting about 17.9 participants per school per month). The average number of EBP sessions held per month across schools was 109 and 122 each year respectively; about 2-3 sessions per school each month. The majority of the EBP programs appear to have been delivered in elementary schools, since this is where the largest numbers of sessions and participants were reported – possibly due to broader use of *Good Touch/Bad Touch*. Most participants were students, followed by staff, and relatively few parents attended. Unfortunately, no data on the numbers of EBPs delivered, or which ones, were collected on the monthly reports because of limitations related to the monthly report data collection process.

Other early intervention (or secondary prevention) treatment/counseling groups are also offered in SMHP schools which are not considered evidence-based programs but may be promising or data-driven programs (Appendix D, Table 28). These groups focus on issues such as anger management, grief and loss, social skills, or substance abuse prevention, and they are offered to students at increased risk who may or may not be on the SMHP clinician caseload. On average, 148 (in SY2005-06) and 93 (SY2006-07) students and parents were enrolled in these groups per month across all SMHP schools (reflecting about 4.7 and 2.2 total persons per school per month each year). About 30 such sessions were offered on a monthly basis both years across all schools, again more so in elementary than at higher grade levels (reflecting about 0.97 and 0.72 total sessions per school per month each year respectively). Groups, however, were only offered by 27 (79%) and 38 (90%) of SMHP schools each year respectively.

The delivery of primary prevention activities is also required of SMHP clinicians. Non-evidence based primary prevention activities can be classroom-based or offered school-wide. They are open to all interested students, parents and staff, and they do not target any particular population subgroups. On average in any given month, 196 primary prevention sessions were held during SY2005-06, and 168 during SY2006-07 (Appendix D, Table 29); this translates into about 6.1 sessions per month in SY2005-06, but only 3.9 sessions per month in SY2006-07 (Appendix D, Table 30). Large numbers of students, staff and parents participated in primary

prevention sessions. On average, 1,943 (SY2005-06) and 1,413 (SY2006-07) participants were reported per month across all schools (reflecting about 60.7 and 32.9 participants per school per month). These decreases in number of prevention activities and participants may actually reflect a coding change in how this information was tracked in SY2006-2007. More female than male students participated, on average, both school years. The proportions represented each year were essentially the same. Ninety percent of participants in SY2005-06 and 93% in SY2006-07 were students; school staff represented 7% and 6%, and parents 3% and 1% of the totals respectively each year.

Unfortunately, the various types of primary prevention and early intervention programs being delivered were not well documented prior to SY2005-06 since SMHP clinicians were just being trained to deliver programs, and several were first being pilot-tested. Data in the 2000-05 evaluation report identified an increasing number of SMHP clinician hours being spent on “prevention” activities per month per school; from 8 hours in SY2003-04, to 11 hours in SY2004-05. Summing across the numbers of evidence-based, early intervention and prevention sessions delivered in SY2005-06 and 2006-07, did not suggest any further increases across these two years in delivery of such programs; approximately 10 prevention sessions were offered per month per school respectively.

4.2 Clinical Services Evaluation Results

4.2.1 Clinical Outcome Evaluation Results

Students referred for individual, group or family therapy are asked to complete a standardized battery of clinical scales at intake following referral, and at a follow-up point either at the end of the school year or treatment (whichever comes first). Depression, disruptive behavior, anger, and aggression, which represented the major presenting problems reported by SMHP clinicians in the monthly reports in prior years, were the primary clinical domains measured in SY2005-06 and 2006-07 to assess treatment success. Younger children completed the following assessments: the Reynolds Child Depression Scale (RCDS), the Beck Disruptive Behavior Inventory for Youth (BDBI-Y), and the Beck Anger Inventory for Youth (BANI-Y). Older youth completed the following scales: the Reynolds Adolescent Depression Scale – Second Edition (RADs-2) and the Aggression Questionnaire (AQ). In 2006-07, the Child Inventory of Anger (ChIA) was also completed by children and adolescents (ages 6-16) to assess

situations that may generate anger. See Appendix C, Table 14 for further details on each of these assessment instruments.

Twenty-five (74%) out of 34 schools in SY2005-06, and 39 (93%) out of 42 SMHP schools in SY2006-07 collected data and submitted it to DMH using one or more of these clinical scales from a total of n=324 children and adolescents during SY2005-06, and n=347 students during 2006-07. These data were collected at all school levels and in charter and non-charter schools (see Table 32, Appendix D). This represents a significant increase in the number of assessments completed over the first pilot year of implementation, when there were only thirty-three children between the ages of six and twelve who completed the clinical assessments.

As is shown in Table 33, Appendix D, the average age of students completing one or more clinical scales in SY2005-06 and 2006-07 was 12.4 and 12.3, and the average grade level was 6.8 and 6.4 respectively. There were slightly more females than males completing any clinical scales in SY2005-06 (59.6 vs. 40.4%), but females and males were equally represented in SY2006-07 (49.6% vs. 50.4%). The majority of respondents were African American in both years (80.7% and 92% respectively). Slightly more older youth (ages 13+) in SY2005-06 (55.8%) and SY2006-07 (51.5%) completed either the pre or posttest assessments than children ages 6-12 (44.2% and 48.5% respectively). On average, across all clinical scales, 93% to 96% of the students completing these clinical forms were within the valid age range (Table 35, Appendix D).. However, far fewer completed both the pre and posttests. On average, only 46% of the students in 2005-06, and 39% in 2006-07, had both the pre- and post-treatment clinical data scores (Table 36, Appendix D).

To determine whether there were significant pre-to-post treatment differences, only students with matched pair data who were within the valid age range for each scale were included. Paired t-tests were conducted to assess pre-to-post mean differences. For analysis of categorical variables, McNemar and Kappa test statistics were calculated to determine whether pre-to-post treatment scores were likely to change in one direction over another or remained essentially the same. Results from the paired t-tests of the overall T-scores for all scales are presented in Table 6. Direction of change scores over time are presented in Table 7. Other results from each clinical scale, associated subscales, and the categorical variable analyses are discussed briefly below. (Results from more detailed data analyses are included in Appendix D, Tables 37-39).

Table 6. Pre-Posttest Mean Differences in Clinical Scale Total Scores among Matched Pairs Within Appropriate Scale Age Range: 2005-06 & 2006-07. *

	2005-06						2006-07					
	Pre-test Scores			Post-test Scores			Pre-test Scores			Post-test Scores		
	N	Mean	SD	Mean	SD	P-value	N	Mean	SD	Mean	SD	P-value
Young Children												
BANI-Y (ages 7-14)	48	56.3	14.1	52.5	13.3	0.03	70	56.0	10.4	52.3	10.7	0.01
BDBI-Y (ages 7-14)	57	53.1	10.6	51.6	12.3	0.28	75	54.8	12.8	55.3	11.1	0.77
RCDS (ages 8-12)	56	57.3	11.7	55.1	13.4	0.22	66	59.0	12.4	56.6	13.5	0.16
Older Children												
AQ (ages 9-88)	62	52.7	8.7	50.7	9.6	0.03	32	54.8	10.5	52.6	9.2	0.17
RADS-2 (ages 11-20)	76	52.5	10.9	47.3	8.8	0.000	31	54.1	11.8	52.0	10.0	0.29
Across-Ages												
ChIA (ages 6-16)**	--	--	--	--	--	--	66	48.9	1.3	45.1	1.2	0.01

* This table reflects only the total score from each clinical scale. Other details are provided in the Appendix for each.

** The ChIA was only administered in 2006-07.

Table 7. Direction of Change of Scores in the Clinical Range Among Matched Pairs within the Scale Age Range: 2005-06 & 2006-07.

	BANI		BDBI		RCDS		AQ		RADS	
Direction of Change Scores	n	%	n	%	n	%	n	%	n	%
2005-06										
Started Non-Clinical & Went to Clinical	2	4.2	5	8.8	5	8.9	4	6.5	1	1.3
Started & Stayed in Clinical Range	9	18.8	8	14	1	1.8	8	12.9	5	6.6
Started & Stayed in Non-Clinical Range	31	64.6	36	63.2	46	82.1	41	66.1	57	75.0
Started Clinical & Went to Non-Clinical	6	12.5	8	14.0	4	7.1	9	14.5	13	17.1
Total	48	100	57	100	56	100	62	100.0	76	100
2006-07										
Started Non-Clinical & Went to Clinical	9	12.9	17	22.7	5	7.6	2	6.3	2	6.5
Started & Stayed in Clinical Range	9	12.9	12	16	4	6.1	4	12.5	4	12.9
Started & Stayed in Non-Clinical Range	40	57.1	37	49.3	53	80.3	20	62.5	20	64.5
Started Clinical & Went to Non-Clinical	12	17.1	9	12.0	4	6.1	6	18.8	5	16.1
Total	70	100	75	100	66	100	32	100.0	31	100

Note: Where direction of change is defined as remaining at the same level (clinical vs. non-clinical) or shifting above or below the clinical range for each scale from pre-to-post treatment.

Younger Child Outcomes

Anger (BANI-Y) (ages 7-14). The Beck Anger Inventory for Youth (BANI-Y) assesses both angry affect and cognitions associated with anger in children. Clinical evidence suggests that the higher the level of anger, the more likely a child will act out behaviorally.

- Forty-eight children in SY2005-06, and n=70 in SY2006-07, completed the Beck Anger Inventory for Youth (BANI-Y) pre-and-post treatment within the valid age range.
- As is shown in Table 6, significant improvements pre-to-post treatment were found in mean BANI-Y scores suggestive of a reduction in levels of anger and cognitions associated with anger from a *mildly elevated* range (a T-score of 55-59) to an *average* range (a T-score of <55) in both years ($p<.05$). These findings differ from results reported during SY2004-05 where no significant differences in anger pre-to-post treatment were observed.
- Two categorical variables reflecting anger elevation levels on the BANI-Y were created: a four-level variable ranging from *average* (<55), to *mildly elevated* (55-59), *moderately elevated* (60-69), and *extremely elevated* (70+), and a 2-level variable reflecting scores that fell within a clinically significant range (60+) or not (<60). During SY2005-06, 31% (n=15) and 22.9% (n=11) of children pre-and-post treatment respectively had scores that fell within the clinical range (T-Score ≥ 60). In SY2006-07; 30% (n=21) had scores within the clinical range before receiving services compared to 25.7% (n=18) post-treatment. Categorical comparisons suggested that anger elevation levels among children remained essentially the same pre-to-post treatment (Table 41, Appendix D).
- As is shown in Table 7, the majority of younger students started and stayed in the non-clinical range pre-to-post treatment in SY2005-06 (65%) and 2006-07 (65%); 13% and 17% improved each year respectively moving from the clinical to non-clinical range for levels of anger.

Disruptive Behavior (BDBI-Y) (ages 7-14). The Beck Disruptive Behavior Inventory for Youth (BDBI-Y) assesses the level of disruptive behavior in children. In the school setting, this instrument can be used to identify students who are likely to develop difficulties, which may in turn impair their ability to function in the school setting (Beck, et al. 2001, p.13).

- Fifty-seven children in SY2005-06, and n=75 in SY2006-07, completed the Beck Disruptive Behavior Inventory for Youth (BDBI-Y) pre-and-post treatment in the valid age range.
- As shown in Table 6, no significant differences were found pre-to-post treatment in mean levels of disruptive behavior in either year. In SY2005-06, mean disruptive behavior levels were within the *average* range (a T-score of <55) pre-and-post treatment, whereas in SY2006-07, the scores were within the *mildly elevated* range (a T-score of 55-59) at both time points. These findings were consistent with results reported during the SY2004-05 school year.
- During SY2005-06, 28.1% (n=16) and 22.8% (n=13) of the children at pre-and-post treatment respectively had scores within the clinical range (T-Score ≥ 60). In SY2006-07, 28% (n=21) had scores within the clinical range prior to receiving services, whereas 38.7% (n=29) had scores in the clinical range post-treatment. Categorical comparisons suggested the levels of disruptive behavior among children remained essentially the same before and after treatment (Table 41, Appendix D).
- As is shown in Table 7, the majority of younger students started and stayed in the non-clinical range pre-to-post treatment in SY2005-06 (63%), although less so in 2006-07 (49%); 14% and 12% improved each year respectively moving from the clinical to non-

clinical range for levels of disruptive behavior. A larger percentage of students moved from non-clinical to clinical range on disruptive behaviors pre-to-post treatment in SY2006-07 than in 2005-06 (23% vs. 9%).

Depression (RCDS) (ages 8-12). The Reynolds Child Depression Scale (RCDS) consists of an overall Total score, a Total Percentage Score, and six Critical Items which tend to discriminate between clinically depressed and non-depressed children.

- Fifty-six children in SY2005-06, and n=66 in SY2006-07, completed the Reynolds Child Depression Scale (RCDS) pre-and-post treatment within the valid age range.
- As shown in Table 6, no significant pre-to-post treatment differences were found in mean depression levels in either year. Mean depression levels were well below the clinical range (T-score ≥ 74) in both years, suggesting that relatively few referred children were clinically depressed either before or after treatment. Overall, the majority of children were not clinically depressed prior to receiving services and they remained non-depressed at end of treatment. These findings were consistent with results reported during SY2004-05. Additionally, no significant differences were found on either the mean percentage score or the mean number of critical items endorsed pre-to-post treatment (see Table 43 in Appendix D).
- Relatively few students scored within the clinical range for depression (T-score ≥ 74) pre- or post-treatment in SY2005-06 (8.9% and 10.7% respectively) or SY2006-07 (12.1% and 13.6% respectively). The percent of students endorsing one or more Critical Items pre-and-post treatment was higher in SY2005-06 (25.5% and 19.6%) and 2006-07 (42.4% to 35.9%). Categorical comparisons suggested that depression elevation levels among children remained essentially the same pre-to-post treatment (see Table 44 in Appendix D).
- As is shown in Table 7, the majority of younger students started and stayed in the non-clinical range for depression pre-to-post treatment in SY2005-06 (82%) and 2006-07 (80%); 7% and 6% improved respectively each year moving from the clinical to non-clinical range.

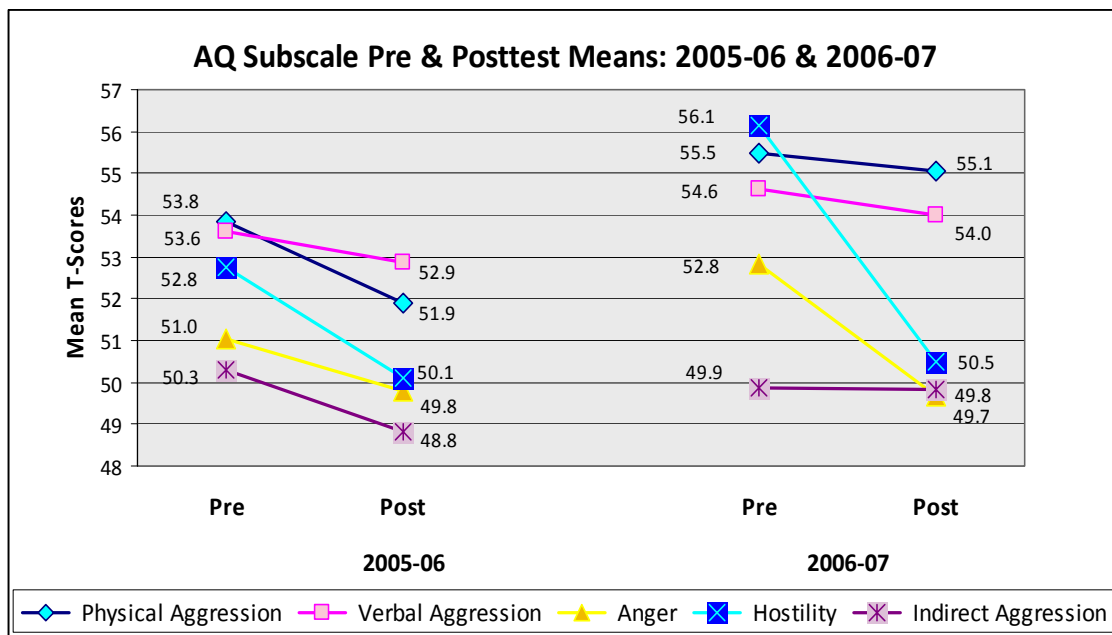
Older Youth Outcomes

Aggression (AQ) (ages 9 and older). The Aggression Questionnaire (AQ) assesses both anger and aggression, and consists of an overall T-score, plus five subscale T-scores (i.e., Physical Aggression, Verbal Aggression, Anger, Hostility, and Indirect Aggression), and an Inconsistent Response Index.

- Sixty-two youth in SY2005-06, and n=32 in SY2006-07, completed the Aggression Questionnaire (AQ) pre-and-post treatment within the valid age range.
- Table 6 shows significant improvements pre-to-post treatment in overall AQ aggression scores suggestive of a reduction in both anger and aggression among adolescents in SY2005-06 ($p < .05$), but not in SY2006-07 ($p = .17$). Mean aggressive behavior levels on the overall AQ score were within the *average* range (a T-score of 40-59) at pre-and-post treatment in both years. These findings were consistent with results reported during the 2004-05 school year.

- As shown in Figure 4 (and in Table 47, Appendix D), mean differences pre-to-post treatment were also observed on several AQ subscales: on the Physical Aggression subscale (which reflects tendencies to use physical force) in SY2005-06 only ($p<.05$), the Anger subscale which reflects irritability and mood swings in SY2006-07 only ($p<.05$), and the Hostility subscale which reflects bitterness, alienation and social maladjustment in both SY2005-06 ($p<.05$) and SY2006-07 ($p<.01$). Similar reductions in aggression subscale scores were found in SY2004-05.
- Substantial numbers of adolescents scored within a *high* (T-score 60-69) or *very high* (T-score 70+) range indicative of clinical levels of aggression pre-treatment in both years (27.4% and 31.3% respectively), and these proportions were reduced post-treatment both years (19.4% and 18.7% respectively). Categorical comparisons for the total and subscale scores, when able to be calculated, suggested that aggression elevation levels remained essentially the same (Table 48 in Appendix D).
- As is shown in Table 7, the majority of adolescents started and stayed in the non-clinical range for aggressive behavior pre-to-post treatment in SY2005-06 (66%) and 2006-07 (63%); 15% and 19% improved respectively each year moving from the clinical to non-clinical range.
- Caution should be however exercised since youth may have been inconsistent in their responses either stemming from carelessness or lack of attention. In SY2005-06, 27.4% ($n=17$) had elevated inconsistent response (INC) scores both pre-and-post treatment. In SY2006-07, 37.5% ($n=12$) of youth had elevated INC scores at pretest, and 34.4% ($n=11$) had scores within this same range post-treatment. These proportions did not differ remarkably from pre-to-post treatment suggesting that adolescents responded consistently at both time points (Table 48 in Appendix D).

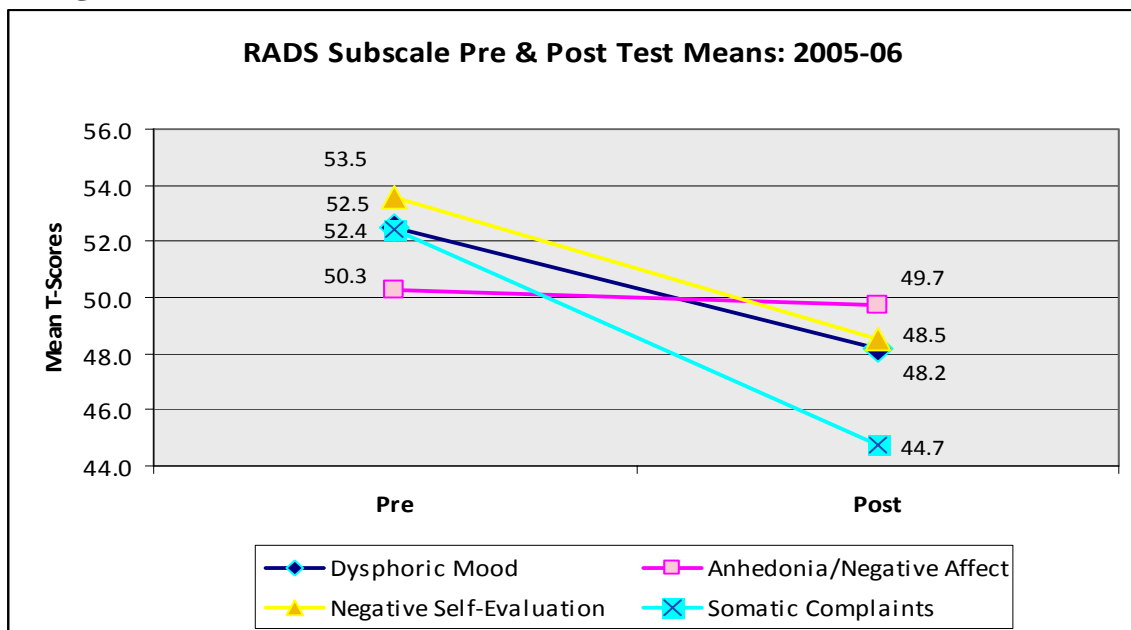
Figure 4. Pre- & Posttest Means on the Aggression Questionnaire (AQ) Subscales: 2005-06 & 2006-07



Depression (RADS-2) (ages 11-20). The Reynolds Adolescent Depression Scale – Second Edition (RADS-2) consists of an overall T-score, plus 4 subscales (Dysphoric mood, Anhedonia/Negative Affect, Negative Self-Evaluation, and Somatic Complaints), and six Critical Items which tend to discriminate between depressed and non-depressed children.

- Seventy-six children and adolescents in SY2005-06, and n=31 in SY2006-07, completed the pre-and-post treatment RADS-2 scale within the valid age range.
- Table 6 indicates significant improvements in pre-to-post treatment scores reflecting overall depression levels on the RADS overall T-score during SY2005-2006 ($p<.0000$), but not in SY2006-07. Mean depression scores declined from 52.5 at pre-test to 47.3 at posttest in 2005-06. Mean depression levels on the overall RADS T-score were within the *normal* range (a T-score <61) at pre-and-post treatment in both years. Improvements in depression levels pre-to-post treatment in SY2005-06 were consistent with results reported during SY2004-05.
- Significant pre-to-post treatment improvements were also observed on most of the RADS-2 depression subscale means in SY2005-06, but not in SY2006-07 (see Table 50 Appendix D). Figure 5 displays the clinical subscale mean scores pre-to-post treatment for SY2005-06. Significant improvements ($p<.001$) on all except the Anhedonia/Negative Affect subscale are evident. All of these mean subscale T-scores (at pre-and-post treatment) were also below the clinically significant range (<61) in both academic years. Similar changes pre-to-post-treatment were found on depression subscale scores during SY2004-05.

Figure 5. RADS Pre & Posttest Subscale Score Means: 2005-06



- Six categorical variables were created to assess changes in depression elevation levels among adolescents; five, 4-level variables, and one, 2-level variable. The direction of change for two of these variables was indicative of clinical improvement pre-to-post-

treatment in SY2005-06, but not in SY2006-07. The percent of students scoring within the clinical range for depression (T-score ≥ 60) declined pre-to-post-treatment in SY2005-06 (24% to 8% McNemar, $p < .01$; Kappa, $p < .0001$), but not in SY2006-07 (29% and 19% respectively; McNemar, $p = .45$; Kappa, $p < .05$). The only other significant change in depression elevation levels was observed on the Negative Self-Evaluation subscale (McNemar, $p < .05$) in SY2005-06, where a larger percentage of adolescents' scores fell within the *normal* range post-treatment (88.2%, $n=67$) than prior to receiving services (76.3%, $n=58$). Categorical comparisons for other variables were not able to be calculated or it was found that depression levels remained essentially the same before and after treatment (Table 51, Appendix D).

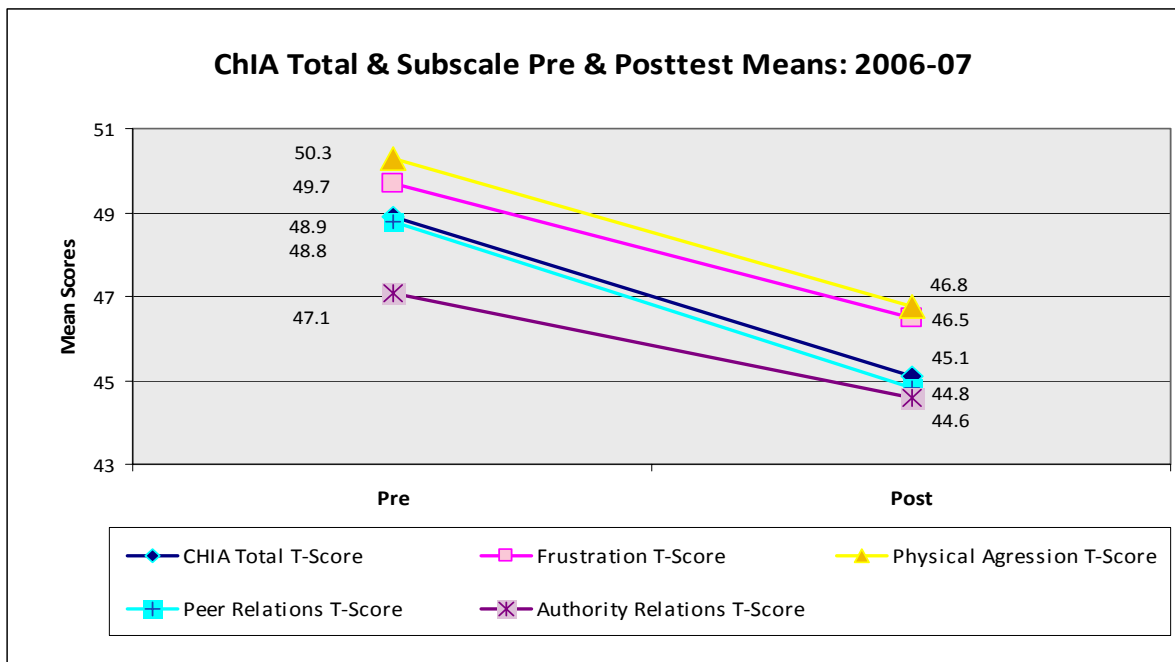
- As is shown in Table 7, the majority of adolescents started and stayed in the non-clinical range for depression pre-to-post treatment in SY2005-06 (75%) and 2006-07 (65%); 17% and 16% improved respectively each year moving from the clinical to non-clinical range.
- Similar to the RCDS, there are six “critical items” on the RADS-2 that are clinically relevant. Mean differences on a critical item count score pretest ($M=0.63$, $SD=.94$) versus post-treatment ($M=0.20$, $SD=.52$) were statistically significant in SY2005-06 ($p < .0001$), but not in SY2006-07. Several of the individual critical items were similarly significant in SY2005-06 (see Table 50, Appendix D), but were unavailable in SY2006-07. The critical item count score was also converted to a categorical variable (any vs. no critical items endorsed). Categorical comparisons were only significant in SY2006-07 (see Table 51, Appendix D); 39.5% of adolescents endorsed no critical items at pretest compared to 14.5% post-treatment (McNemar, $p < .001$).

Children & Adolescents

Anger (ChIA). The Children’s Inventory of Anger (ChIA) has a total T-score, as well as four subscale T-scores (e.g., Frustration, Physical Aggression, Peer Relations, and Authority Relations).

- Sixty-six children in SY2006-07 completed Children’s Inventory of Anger (ChIA) pre-and-post treatment within the valid age range (ages 6-16). Of these, $n=38$ were 6-10 years old, and $n=28$ were ages 11-13. The ChIA was not administered in SY2005-2006.
- Significant improvements pre-to-post treatment were found in mean ChIA anger scores suggestive of a reduction in situations that provoke anger and in the intensity of anger responses (Table 6). This was also true on the on all of the ChIA anger subscales (as shown in Figure 6, and in Table 54, Appendix D), except the Authority Relations T-Score ($p < .10$). Results suggest that children’s anger symptoms, frustration and aggression levels, as well as relationships with peers improved over time.
- Categorical versions of the ChIA Total T-test score, and the four subscale scores were also created, but did not change from pre-to-post treatment (see Table 55, Appendix D).

Figure 6. ChIA Pre & Posttest Subscale Score Means: 2006-07



4.2.2. Client & Customer Satisfaction with SMHP Services

Satisfaction surveys were distributed to five constituency groups to assess the level of satisfaction with SMHP clinical services. The groups included direct clients (youth as well as their parents/guardians), the staff and teachers that the SMHP clinicians worked with in each school as well as the administrator of that school. Clinicians were asked to distribute satisfaction surveys after they had provided clinical services or professional assistance (in the case of teachers/staff). They were also asked to distribute a survey to their school's administrator at the end of the school year.

The number of satisfaction surveys completed and returned has increased over time. Parent and Teacher/Staff satisfaction surveys, which were introduced in SY2004-05, doubled between the second and third year of their distribution. The total number of satisfaction surveys collected in SY2006-07 is almost double that of SY2005-06 (Table 8). Surveys were collected from 28 of 34 (82%) of the SMHP schools in SY2005-06 and 34 of 42 (81%) schools in SY2006-07. In 2006-07, 5 SMHP schools only provided an administrator survey; that is, they did not submit any student, parent or staff satisfaction surveys.

Table 8. Satisfaction Survey Respondent Distributions by Type, School Level & Type of School.

	2005-06		2006-07	
	N	%	N	%
Respondents				
Child	176	36.6	325	39.4
Youth	144	29.9	242	29.4
Teacher/Staff	118	24.5	215	25.7
Parent/Guardian	19	4.0	42	5.1
Administrator	24	5.0	34	0.4
Total	481	100	858	100
School Level *				
Elementary	267	55.5	569	69.1
Middle	79	16.4	130	15.8
Jr. High	45	9.4	49	6.0
High School	90	18.7	75	9.1
Total	481	100	823	100
Charter School *				
No	340	70.7	732	88.8
Yes	141	29.3	92	11.2
Total	481	100	824	100

Notes:

* For 2006-07, not all surveys included information on school level or chartered school status. In particular, the n=34 administrator surveys did not include school name information.

Irrespective of the type of respondent, the overwhelming majority reported being highly satisfied with SMHP clinical services. There has, in essence been no change between SY2005-06 and 2006-07 in levels of satisfaction, but this is because there was little opportunity for change because of the high scores both years. As Table 9 shows, parents and teachers/staff on average *strongly agreed* across all satisfaction questions asked across both school years, as did administrators in SY2005-06. Over 80% of children said that they were satisfied on all five of the survey questions that were asked in both school years. Youth *agreed* that they were satisfied in both school years as did Administrators in SY2006-07. Summaries of selected individual items and ratings of overall experiences with the school SMHP clinician are summarized below.

Table 9. Average Satisfaction Survey Ratings Across All Items by Respondent Type. *				
	2005-2006		2006 – 2007	
	Mean	SD	Mean	SD
Child Satisfaction Rating (5 items) **	86.9	0.3	81.2	0.4
Youth Satisfaction Rating (11 items)	4.3	0.5	3.7	0.4
Parent Satisfaction Rating (13 items)	4.8	0.3	4.6	0.3
Teacher/Staff Satisfaction Rating (9 items)	4.7	0.4	4.6	0.5
Administrator Satisfaction Rating (9 items) ***	4.7	0.4	4.4	--

Notes:

* For all respondents except children, this score represents the average score across all available items similar each year rated on the following scale: 1=Strongly Disagree, 2=Disagree, 3= Neutral, 4=Agree, 5=Strongly Agree.

** All children rated their satisfaction on a "yes" vs. "no" format. These data reflect the average percent of children who said "yes" on 5-items.

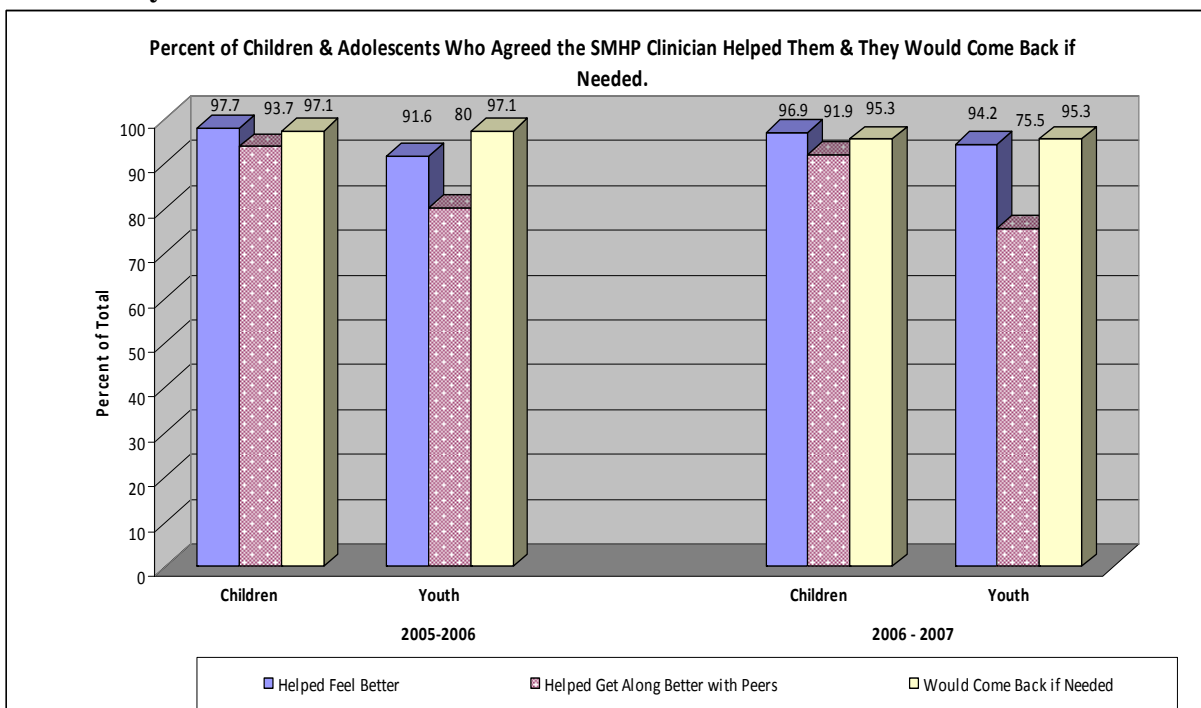
*** Data from administrators in 2006-07 were aggregated, and standard deviations could not be calculated.

Child Satisfaction Surveys. While there were 176 child respondents in SY2005-06 and 325 in SY2006-07, the results from the satisfaction surveys were completely consistent; child respondents, based on these results, were extremely satisfied with the clinical services being delivered by their SMHP clinician (Appendix D, Table 61). Approximately 95% of children in both years said that they would come back to see the clinician if they needed help (Figure 7). This is consistent with the affirmation by 97% or more of respondents that the clinician helped them feel better. Important not only for the respondent, but for the greater school environment, 92-94% indicated that the clinician helped them to get along better with their classmates.

Youth Satisfaction Surveys. The numbers of youth satisfaction surveys similarly increased from SY2005-06 to SY2006-07 (144 to 242), a number comparable to the 269 satisfaction forms collected in SY2004-05. Overall, youth in both years rated their experiences with their SMHP clinician as *excellent* (Appendix D, Table 63); where 4=excellent and 5=outstanding). They *agreed* (Appendix D, Table 63; where 4=agree and 5=strongly agree), on average, that they were satisfied with the services they received from the SMHP clinician. Youth responses were consistent across the two school years. They, on average, *strongly agreed* that their interactions with the clinician helped them feel better, make better decisions, and will help them in the future. They, on average, *agreed* that interactions with their clinician helped them relate better to their peers and family. Approximately 95% or more of adolescents in both years said that they would come back to see the clinician if they needed help (Figure 7). The results

indicate that youth are highly satisfied with core aspects of the program – and, even in areas where satisfaction was not as strong, that the program is still very successful.

Figure 7. Percent of Children & Adolescents who Agreed the SMHP Clinician was Helpful & That They Would Come Back



Parents/Guardian Satisfaction Surveys. While the number of parents/guardians completing satisfaction surveys in SY2005-06 decreased from the 43 collected in SY2004-05 to 19, 42 were collected in SY2006-07. Parents/guardians felt that, on average, their experience with the clinician in SY2005-06 was *outstanding*; in SY2006-07 the increased number of respondents rated it *excellent* (Appendix D, Table 65); where 4=excellent and 5=outstanding). There was little variation in the responses of parents/guardians on the SY2005-06 survey – and with a doubling of respondents came greater variation in responses in SY2006-07 (See Appendix D, Table 65).

Even with this increase in respondents, parents in both school years *strongly agreed* that the clinician worked with teachers and staff to better support their child in the classroom and, perhaps more importantly, that the clinician had taught them better ways to work with their child at home. While parents *strongly agreed* in SY2005-06 that the SMHP clinicians helped improve communications within the family, as well as the child’s behavior and attitudes, parents, on

average, only *agreed* in SY2006-07 that clinicians had done so. Despite the decline in scores over time, the low number of respondents in SY2005-06 potentially yielded a false picture – and the level of satisfaction in SY2006-07 is well above the midpoint.

Teacher/Staff Satisfaction Surveys. The number of teachers and other school staff completing satisfaction surveys increased in SY2006-07 from the 2004-05 school year when 147 teachers/staff returned satisfaction surveys; 118 and 215 surveys were returned for SY2005-06 and SY2006-07 respectively. Also consistent with the prior year, the majority of teachers and other staff who completed the surveys were highly satisfied with the performance of the SMHP clinician assigned to their school. In both years, on average, teachers/staff who returned the survey characterized their overall experience with the SMHP clinician as *outstanding* (Appendix D, Table 67). On average, across all satisfaction questions asked of this group about the SMHP clinician, the respondents *strongly agreed* that the clinician was making a positive difference in the lives of students, as well as on the school and its mental health program. Teachers/staff *strongly agreed* that the clinicians were active participants during school meetings, providing valuable input on mental health interventions to support students. Teachers/staff viewed the SMHP clinician as a collaborative partner, helping to support students both individually as well as collectively.

Administrator Satisfaction Survey. School leaders from all schools participating in the SMHP were asked to complete an evaluation of their assigned SMHP clinician. Satisfaction surveys completed in SY2005-06 and 2006-07 indicated that school principals continued to feel very positively about the SMHP. Eighty percent of administrators in SY2005-06, and approximately the same percent (79%) in 2006-07, responded to the survey. The vast majority of principals felt that SMHP clinicians were extremely competent, professional, and that they had successfully helped families, youth, and staff understand and address mental health issues (Appendix D, Table 68).

With the expansion of the SMHP over time, satisfaction responses have tempered, but are still strongly positive; overall, on average in SY2005-06, administrators *strongly agreed* (mean=4.6 of 5) that they were satisfied with a range of SMHP clinician services and relationships while in SY2006-07 they *agreed* (mean=4.4 of 5) that they were. Similar to previous years, school administrators on average *agreed* that the SMHP clinician was

knowledgeable about mental health issues relevant to students enrolled at their school. In terms of their work with key stakeholders, school administrators reported that SMHP clinicians worked collaboratively with school staff, and with students and parents/guardians to develop/strengthen the mental health program at the school. The vast majority of school administrators in both SY2005-06 and SY2006-07 stated that they wanted the SMHP clinician to return to their school the following year. Reflecting the general trend displayed in responses by administrators across all questions, these percents declined slightly between the two years (92% in SY2005-06 vs. 85% in SY2006-07).

4.3 Primary Prevention & Early Intervention Evaluation Results

Based upon needs assessments completed at the beginning of each school year, and/or experiences during the school year, SMHP clinicians provide mental health-related training and workshops to youth, parents, teachers/staff and other school or community members. Evidence-based programs to address identified primary prevention, early intervention, or less intensive treatment needs are similarly offered to youth as part of the DMH SMHP program and service delivery efforts.

4.3.1 Evidence-Based Program Evaluation Results

During SY2005-06 and 2006-07, one evidence-based program was evaluated in SMHP schools. The evaluation design used to evaluate this program was quasi-experimental. Pre-post data were only collected from program participants, and logistical challenges prevented the use of a comparison or control group for these analyses. Findings from this pre-post evaluation are summarized below.

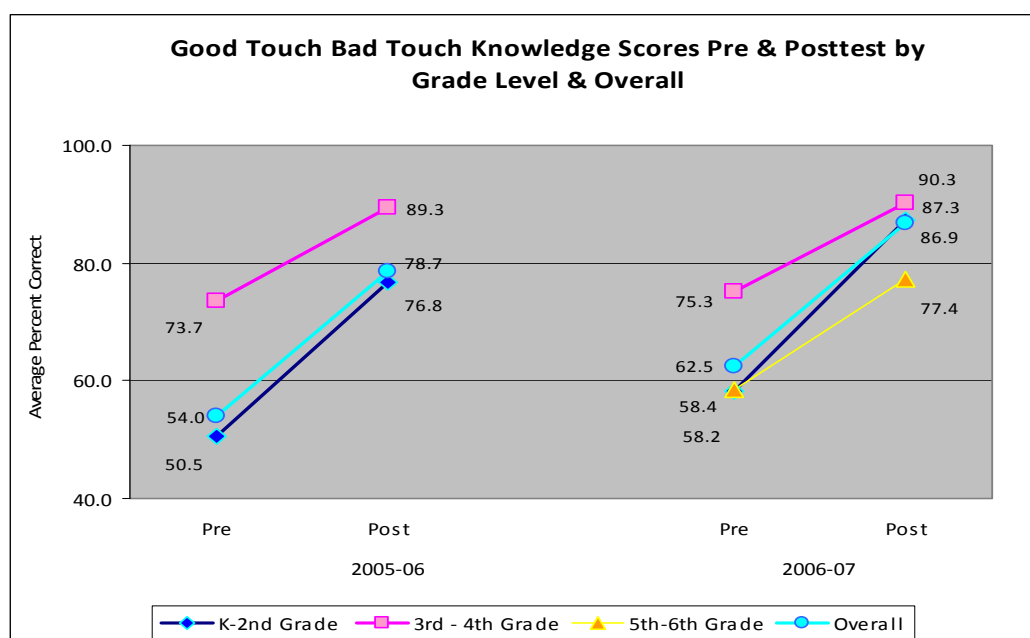
In order to reduce the rates of sexual abuse, Child Help USA offers a training program and curriculum entitled “Good Touch/Bad Touch (GTBT),” to teach children about ways to prevent and/or interrupt sexual abuse. GTBT is age appropriate for children in grades K-6, taught in three one-hour sessions, and designed to inform and enhance children’s coping skills to prevent or interrupt child abuse. Program goals include: giving children language and information that is positive, non-threatening, and practical; teaching children that their body is their own; affirming the fact that sexual abuse is never the child’s fault; and, giving children the opportunity to practice skills learned.

SMHP clinicians have delivered the GTBT curriculum since SY2003-04. Pre and post program questionnaires are collected to assess the amount of knowledge children possessed prior to and following participation in the program. The evaluation results are presented separately based upon the three grade level forms available for students to complete; PK-2nd grade, grades 3-4, and 5-6.

During SY2005-06, data were collected from a total of n=199 students at pretest and n=194 students at posttest in n=5 SMHP schools; representing 31.3% of the 16 elementary schools with an SMHP at the time. None of these data were able to be matched due to problems encountered in data collection. During the 2006-07 school year, n=195 pretest forms and n=174 posttest forms were collected; of those, n=157 pre-post forms could be matched. These data were collected by n=6 schools; representing 28.6% of the 21 elementary schools with an SMHP at the time. Most respondents in both years were in grades K-2 (85% in 2005-06 and 64% in 2006-07), followed by grades 3-4 (15% and 24% respectively), and the fewest were in grades 5-6 (0% and 11% respectively).

Pre-post survey responses were converted to a single summary score reflecting the percent of the total knowledge questions answered correctly. In SY2005-06, independent t-tests were calculated, whereas in 2006-07, paired t-tests were used to assess changes pre-to-post. As is shown in Figure 8 below, pre-posttest results from both years suggest that participants learned new information about ways to protect themselves from sexual abuse. The findings were significant overall, and for each grade level in both years (see Table 70, Appendix D); consistent with results obtained SY2003-2004 and 2004-2005.

Figure 8. Pre-Posttest results from GTBT Analyses



Notes: Data presented for 2005-06 reflect Independent groups t-tests, whereas those for 2006-07 were based on matched pairs t-test analyses.

4.3.2 Training & Workshop Evaluation Results

The SMHP scope of work requires that clinicians provide at least two in-service/professional development trainings to school staff per academic year. These presentations are intended to inform school staff members about relevant mental health topics and to address specific student, school staff, or school community needs. Clinicians identify topics that might be of the greatest benefit by utilizing teacher surveys and a school needs assessment conducted at the start of the year. SMHP clinicians deliver these workshops themselves, or invite outside experts in to provide training or workshops. Because SMHP clinicians are required to maintain and develop new professional skills and competencies, some of the workshops delivered each year also include SMHP clinicians as respondent group.

Standardized workshop evaluation forms were used starting in SY2005-06. At the end of each workshop presentation, participants are asked to complete a workshop evaluation form that contains questions about the quality and content of the presentations, as well as the extent to which any knowledge or skills gained will be applied afterwards. Forms contain both closed and open-ended questions. Ratings for the closed-ended questions are asked on a scale ranging from 1 to 5; where 1=Strongly Disagree and 5=Strongly Agree. As shown in Appendix D, Table 71, similar questions are asked of both youth and adults. Results from workshop evaluation forms

are intended to be used for SMHP program improvement. Each SMHP clinician tallies the evaluation results and uses them to assess participant reception to the presentation and whether any modifications may need to be considered for future presentations.

During SY2005-06, evaluation surveys from 20 different workshops were collected (Table 10). This number more than doubled in SY2006-07 when evaluation forms from 43 workshops were submitted. Workshop evaluation forms for SY2006-07 were centrally received at DMH from approximately 30% of the SMHP schools; thus, the workshop evaluation information presented here likely reflects a sub-sample of the total number of workshops held during these two years. Nonetheless, the number of workshop participants reported about almost doubled in this two year period – from 547 in SY2005-06 to 961 in SY2006-07. Distinctly important is that this reflects increases in workshop evaluations received from teachers, parents, school staff, and SMHP clinicians (see Table 72, Appendix D).

Table 10. Overview of Workshop Participant Types and Average Overall Workshop Scores *

	2005-06		2006-07	
	#	Avg Overall Score**	#	Avg Overall Score**
Types of Participants & Average Workshop Ratings				
Children/Youth	400	4.1	535	4.2
Teachers	34	4.6	129	4.6
SMHP Clinicians	15	4.7	112	4.5
Other	6	5.0	107	4.4
Security Personnel/Public Safety Officers	37	4.4	46	4.0
Parents	9	4.8	19	4.8
School Staff	--	--	13	4.2
Community Mental Health Workers	41	4.2	--	--
Unknown	5	4.8	--	--
Total Numbers of Participants & Workshops				
Number of Participants	547	4.3	961	4.3
Number of Workshops	20	--	43	--
Number & Percent of Participants in Evidence-Based Programs ***	39	7.2%	150	15.7%
Number & Percent of Evidence-Based Workshops ***	3	15.0%	9	20.9%
Number & Percent of Schools in SMHP ****	--	--	13	30.0%

* Of those workshops where an evaluation sheet was completed

** Average scores reflect means for item #'s 1-6 where 1 = Strongly Disagree; 2 = Disagree; 3 = No Opinion; 4 = Agree; 5 = Strongly Agree.

*** Workshop title suggested that this was an Evidence-Based, Evidence-Informed or Promising Practice Programs.

**** The number of schools represented by the SY2005-06 data is not known.

Workshops, irrespective of participant group, were evaluated as being valuable. Table 10 reflects the average evaluation scores by audience and topic. On average and across all participant types, respondents *agreed* (4.3 of 5) with the statements affirming the workshops' usefulness, relevance and their intentions to use what was learned. No workshop from which forms were received had an average score of under 4.0 of 5. In sum, workshops appear to be well conducted and valued contributions to participating SMHP schools and constituencies.

Since workshops are designed to reflect the needs and interests of the individual school communities and varied respondent groups, there were therefore a broad range of workshops delivered and these differed by year (Table 73, Appendix D). Topics included anger and stress management, child development, mental health, bullying prevention, child abuse and reporting laws, and how to avoid joining a gang. They also included workshops in evidenced-based or promising programs such as Second Step, Botvin's Life Skills, Too Good for Violence, and Good Touch Bad Touch. Fifteen percent of workshops held in SY2005-06, and 20% in SY2006-07, were associated with these highly valuable programs. The percent of evidence-based program participants doubled between SY2005-06 (7.2%) and SY2006-07 (15.7%). These are clearly positive trends in SMHP schools since evidence-based programs have been demonstrated to be effective in improving mental health outcomes among participating children, adolescents and families.

4.4 School Level Outcome Results

DMH collects data from the principal of each SMHP school on their perceptions of changes in school climate and selected behavioral outcomes each year as compared to the previous year. Twenty-two SMHP school administrators returned the climate survey forms in SY2005-06 and twenty-eight responded during 2006-07 reflecting a response rate of 65% and 67% of the of 34 and 42 SMHP schools respectively. It also reflects a significant decline in administrator response rates over previous years, where 29 of 31 (94%) school leaders in SY2003-04 and 26 of 31 (84%) school leaders in SY2004-05 responded.

Principals rated school improvement, safety and organization (improved, stayed the same or worsened), and changes in key indicators relative to the prior year (increased, stayed the same, decreased or not applicable). Indicators included attendance, repeating a grade, fighting, suspensions and expulsions, disciplinary referrals, and SPED referrals for emotional disturbance.

Not applicable responses, which were removed from analysis, were higher than anticipated on several indicators in both years: repeating a grade (5% and 8%) fighting (9% and 15%), expulsions (12% and 10%), and SPED referrals (0% and 15%).

Figure 9 presents school administrator responses regarding school improvement, safety, and organization. More principals in SY2006-07, than in SY2005-06 indicated that the school had improved (52% vs. 45%) and was more organized (57% vs. 41%). The majority of the remaining balance felt the school had remained the same overall. In contrast, more administrators in SY2005-06 (59%) than SY2006-07 (48%) felt their school was safer than the prior year suggesting a decline in perceived safety across years. Data presented from SY2003-04 (77%) and SY2004-05 (69%) in the 2000-2005 SMHP retrospective evaluation report tended to confirm this trend.

Figure 9. Administrator Perceptions of School Safety, Organization & Improvement

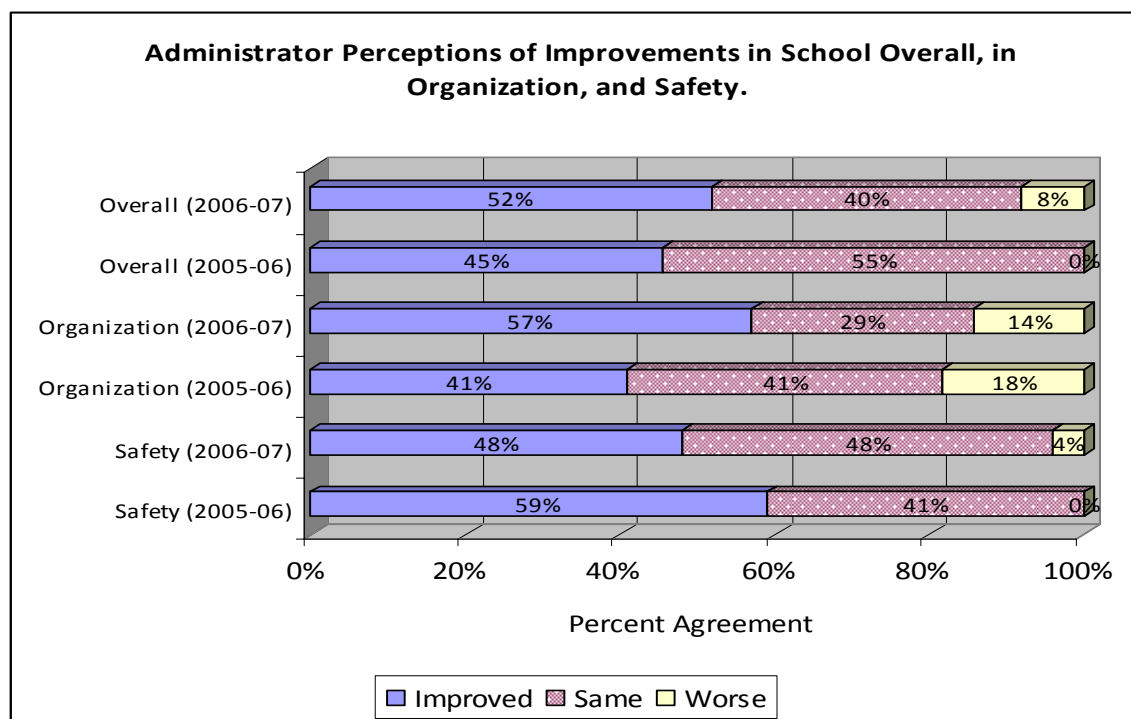


Figure 10 displays school leaders' perceptions of changes in daily class attendance and in the numbers of students having to repeat a grade. Half or fewer of the administrators in both years reported that student attendance improved (50% vs. 40%), and that numbers of students having to repeat a grade declined (48% vs. 42%). These indicators appear to be holding fairly

constant across years; ratings for student attendance in SY2003-04 and 2004-05 (24% and 48% respectively) and the number of students repeating a grade (48% and 54% respectively) were in the same general range.

Figure 10. Administrator Perceptions of Attendance and Repeating Grades

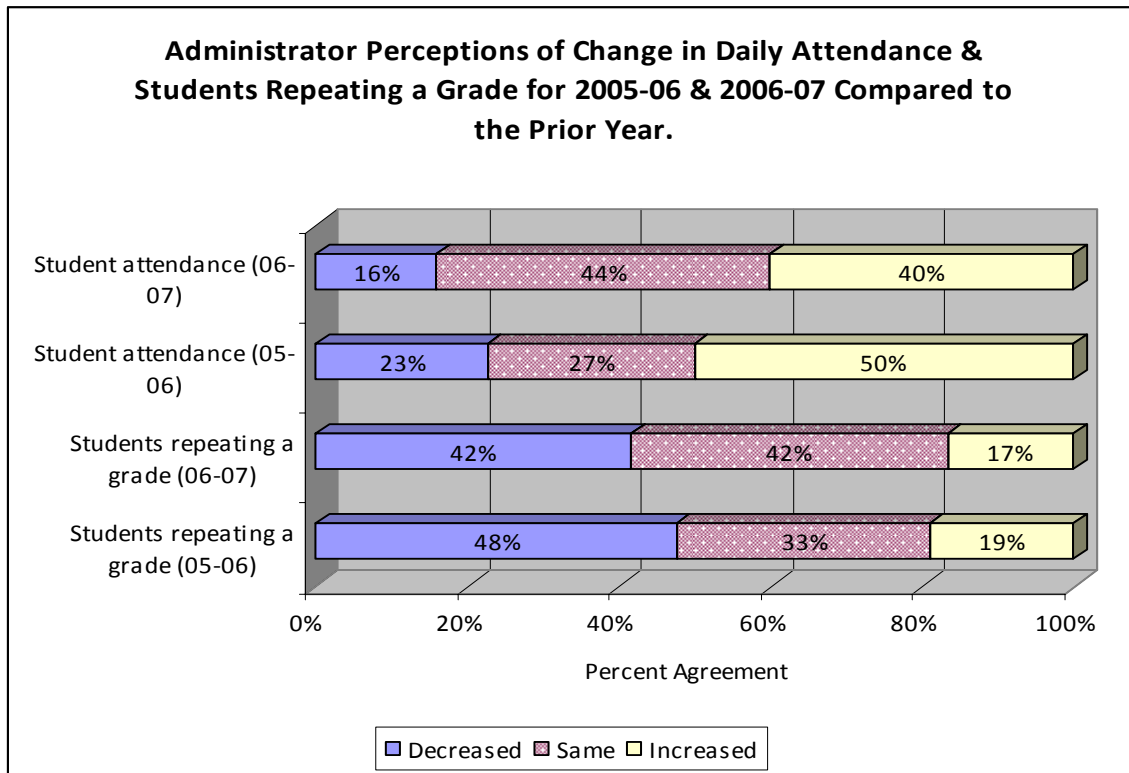


Figure 11 presents perceived changes in the number of suspensions and expulsions. In both years, the majority of administrators reported decreases over the prior year in Level 1 suspensions (57% and 46% respectively), Level 2 suspensions reflecting more serious infractions (59% and 76%), and expulsions (53% and 56%). These data suggest that the improvements found between SY2003-04 and SY2004-05 were sustained; Level 1 suspensions (39% and 53% respectively), Level 2 suspensions (35% and 71%), and expulsions (19% and 55%).

Figure 11. Administrator Perceptions of Changes in Suspensions & Expulsions

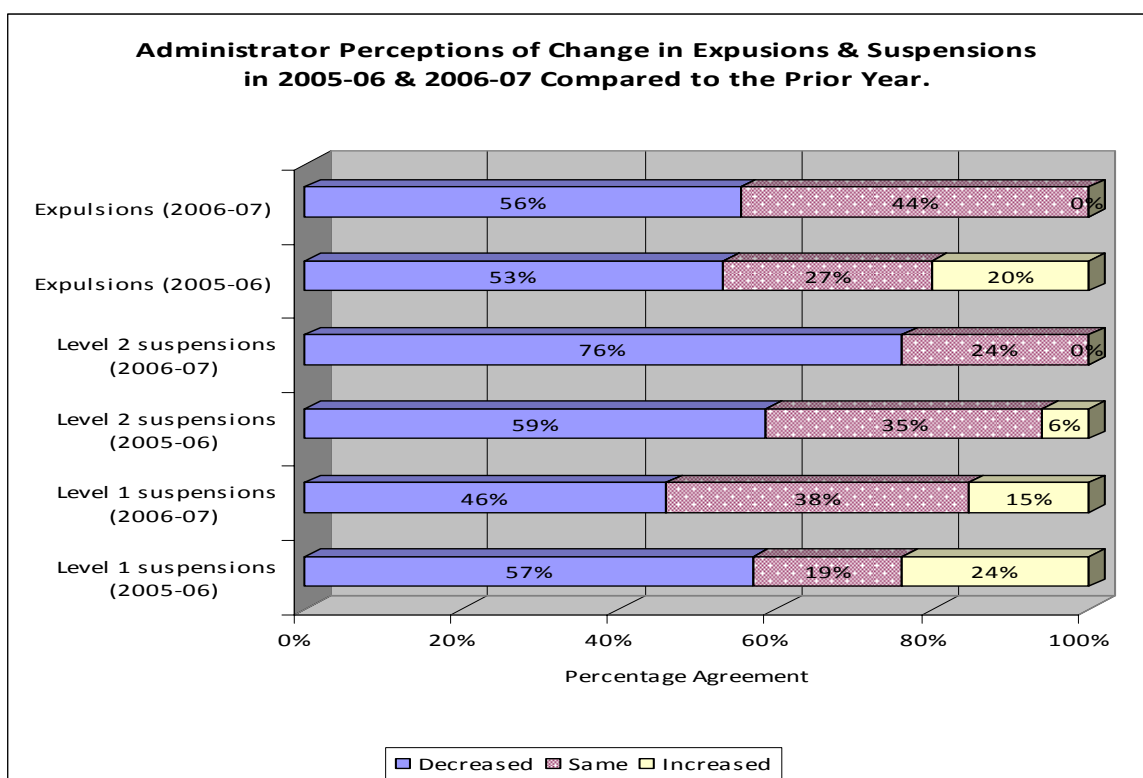
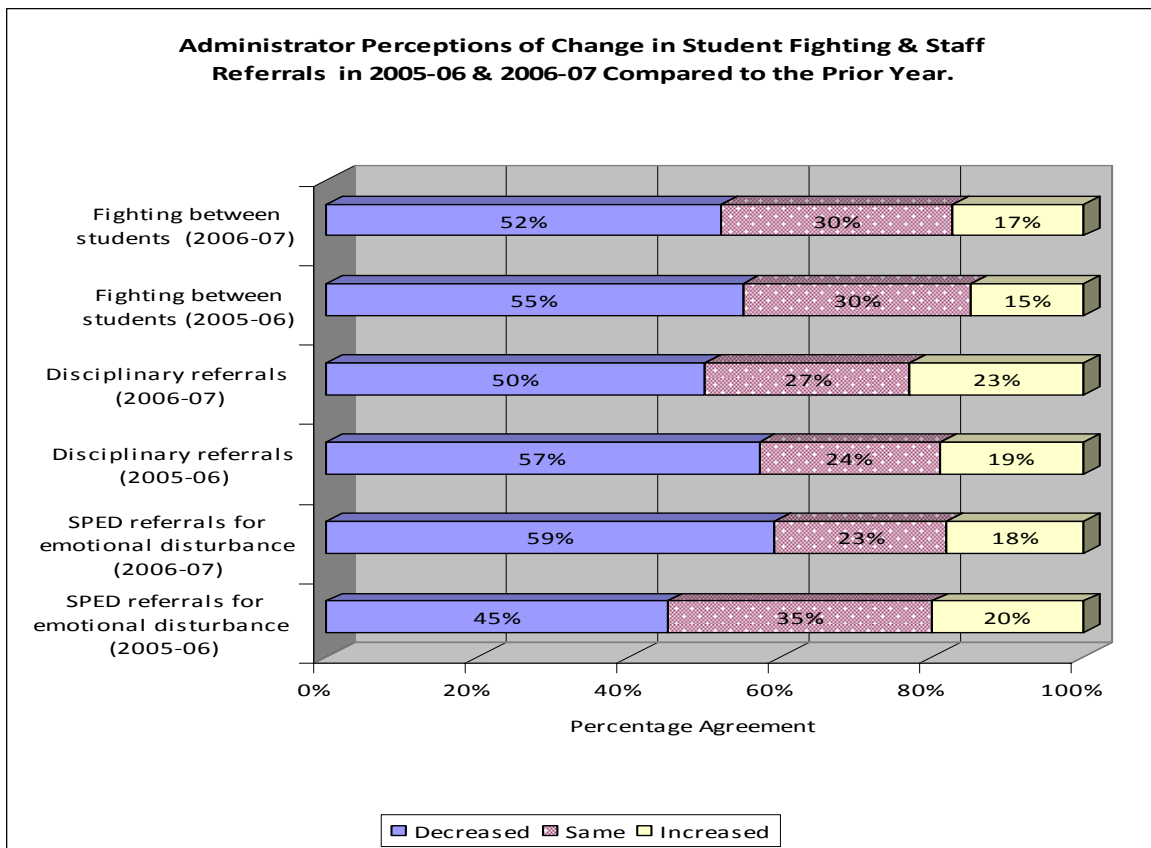


Figure 12 reflects perceived changes in the number of fights, disciplinary referrals, and referrals to special education for emotional disturbance. Just over half of the principals in SY2005-06 and 2006-07 reported declines over the previous year in student fighting (55% and 52% respectively) and disciplinary referrals (57% and 50%). More principals in 2006-07 (59%), than in SY2005-06 (45%), felt that the numbers of SPED referrals for emotional disturbance had decreased relative to the prior year. As compared to SY2003-04 and 2004-05, fewer principals are reporting reductions in student fights each year, but improvements in disciplinary referrals are being sustained, whereas improvements in SPED referrals for emotional disturbance appear more variable across years. Data from SY2003-04 and 2004-05 were as follows: student fighting (72% and 65% respectively), disciplinary referrals (52% and 60%), and SPED referrals for emotional disturbance (16% and 50%).

Figure 12. Administrator Perceptions of Student Fighting, Disciplinary & SPED Referrals



V. CONCLUSIONS & RECOMMENDATIONS

5.1 Related to SMHP Programs & Services

- The SMHP clinicians remained responsive to the substantial numbers of student referrals and walk-ins, and continued to serve students and families on their caseload with more intensive mental health services. SMHP clinician caseloads and the numbers of therapy sessions being offered each year were somewhat lower than in prior years, although consultation provided to parents, teachers, and school staff increased over the two years. Additionally, the SMHP clinicians are fostering significant improvements pre-to-post treatment in clinical levels of functioning in the domains of anger and aggression for both children and adolescents, and in adolescent depression. Children's depression and disruptive behavior levels, which were within the *average* or *mildly elevated* range at initial referral, remained essentially the same pre-to-post treatment. **These are critical school mental health services that appear to be making a difference in student functioning overall and the SMHP clinicians should continue the valuable efforts.**
- Satisfaction surveys indicated high levels of satisfaction with the SMHP clinician and the clinical services offered across all respondent groups. Youth had generally lower scores than other respondent groups, although the majority concurred that services were valued. The level of satisfaction appears to have fallen slightly between years among some respondent groups, but because variability in responses is likely to increase with increases in the number of responses collected, this was not altogether surprising. Certain items on the satisfaction surveys were also rated lower than others. **The overall satisfaction levels were quite high and a testament to how well SMHP clinical services are being received by recipients in SMHP schools. Some changes in satisfaction scores observed over the two years and differences among items within the survey are worth exploring further. Clarity about the significance of these discrepancies may be accomplished through interviews with respondents and/or discussions with clinicians.**
- A diversity of evidence-based programs are approved for delivery in SMHP schools. These programs address a range of topics which include: social-emotional development, problem solving, life skills, anger management, sexual abuse prevention and trauma reduction, school bullying, harassment and violence, job-preparation and parenting. Results from pre-posttest evaluations of one of these approved evidence-based programs were extremely positive. The Good Touch/Bad Touch program increased elementary school student knowledge about ways to prevent and/or interrupt sexual abuse. Anecdotal information suggests that several of these programs are offered more often than others because they tend to be shorter and more easily delivered. **DMH should seek ways to promote broader use of a variety of the evidence-based programs that are approved and available to SMHP clinicians, especially if they have documented impact with this population of students. When selecting EBPs for approval, consideration of program length and feasibility of delivery is important to program sustainability.**
- Substantial increases in the numbers of workshops offered, as well as in the numbers and diversity of participants and workshop topics, were demonstrated during these two years. There was also an increase in the number of evidence-based program workshops offered and a doubling in participants - a highly positive and noteworthy trend. The workshops offered in

SMHP schools appear to be well received; this was true regardless of participant type. Thus, workshops appear to be well conducted and valued contributions to participating SMHP schools and constituencies. **DMH should ensure that more schools have access to workshops and helps to support this activity by sharing workshop and presentation materials in order to minimize additional burden on SMHP clinicians.**

- Substantial numbers of students, families, and school staff in these schools participated in various primary prevention, early intervention, and less intensive treatment services offered by SMHP clinicians during SY2005-06 and SY2006-07. The hours spent per month on primary prevention and early intervention activities remained approximately the same as those reported in prior evaluation years. **Parents were involved in all SMHP programs and services, although as was true in prior evaluation years and schools more generally, they were fewer parents involved. It will, therefore, be important for DMH to help SMHP clinicians increase outreach efforts to parents at all levels of program implementation and evaluation to achieve maximum effect overall.**
- Most indicators of school climate, as reported by principals, were sustained or improved across years; these indicators include attendance, repeating a grade, suspensions, expulsions, disciplinary referrals and special education referrals for emotional disturbance. However, there appears to be a downward trend in principal perceptions of safety, with fewer principals reporting improvements in school safety or reductions in student fighting each year. Principal perceptions that schools are becoming safer have steadily declined since SY2003-04 when this SMHP evaluation measure was put in place. **School climate data, as reported by principals, suggest the need for the DMH to promote expanded use of evidence-based programs designed to prevent school bullying, harassment and youth violence, to include issues related to dating violence, and the special needs of GLBTQ youth in SMHP schools.**

5.2 Related to SMHP Evaluation Activities, Measures & Data Collection

- The DMH has demonstrated responsible program management in collecting and analyzing clinical data in order to better document program successes. Without a non-treatment comparison or control group when measuring treatment outcomes, it is difficult to know whether observed changes in anger, aggression and depression are directly attributable to the clinical services being offered, or to other factors. However, collecting such data may be impractical and withholding mental health treatment would be unethical. There may be alternatives available to measure the outcomes of students who receive clinical services. These options include developing new evaluation strategies for collecting individual student outcome data from those receiving services as well as from a control group (e.g., students who are walk-ins who never receive services). Other possibilities include comparing academic achievement scores, or other indicators of school performance or social adjustment (e.g., disciplinary referrals, truancy, or fighting) for students who are referred and receive services versus those who do not receive treatment services, but who were referred. **Despite acknowledged limitations in design, it is recommended that DMH continue to collect pre-posttest data on clinical treatment outcomes and interpret them accordingly with caveats about the limitations of results obtained from evaluation designs that do not include a comparison group. Future DMH SMHP studies might consider utilizing other methods suggested that would strengthen conclusions drawn from program**

evaluation efforts, and potentially expand those assessments to other indicators such as school performance or social adjustment (e.g., disciplinary referrals, truancy, or fighting).

- Although there were a number of positive changes identified in clinical functioning among students seen for clinical services, only 46% of those receiving such services had both pre and post-treatment data collected. Results were similar to those found in SY2004-05, except that the decreases in children's anger levels were statistically significant in SY2005-06 and 2006-07, but not in SY2004-05. Changes in clinical findings across years may represent improvements in SMHP clinical services for younger children over the previous academic year and/or the ability to detect significant improvements with a larger sample. **Maintaining consistency within and across years in clinical data collection is important to the assessment of trends over time in the quality of clinical services. Because the collection of pre and post-treatment data was low, and the DMH introduced a new general screening assessment of functioning scale in SY2007-08 (i.e., the Ohio Scales), policies need to be put in place to ensure that if a student is given the new screener or a specialized scale (e.g., a depression or aggression measure) at the beginning of treatment, that same scale should be administered at the end-of-the-year or treatment – irrespective of age or general improvements identified through the Ohio Scale scores -- so that pre-to-post changes in clinical functioning can be consistently measured among all youth receiving clinical services.**
- It was difficult to know how many referred students received parental consent and child assent to complete the clinical assessments and/or to receive SMHP treatment services during the year, and whether all of the clinical assessments sent to DMH reflected all clinical cases opened that year. For example, some students may have been referred to clinicians, but never seen because parental consent or child assent was not obtained. **Thus, there may be unmet needs for mental health services that were not able to be met due to a lack of parental consent, or child assent, or needs met that were not able to be assessed. In order to demonstrate program success, it is critical that the DMH data base reflects all of the clinical assessments being undertaken, and how many clinical cases never materialized due to lack of parental consent or child assent.**
- It is important to collect satisfaction survey information from as many people touched by the SMHP clinical services as possible. Yet, as currently collected, it is difficult to know how many youth, parents, and staff were given satisfaction surveys and how many returned them, making a determination about response rates impossible. **In order to ensure that satisfaction survey information is collected from as many people as are touched by the SMHP clinical services as possible and response rates are known, a tracking system should be put into place to permit more specific information on the distribution and return of satisfaction surveys. Alternatively, it may be possible to expand collection methods by using web-based surveys that would not depend on clinician collection. Focus groups may offer more nuanced feedback to supplement data currently collected from satisfaction surveys since overall satisfaction levels are high and do not capture any dissenting views.**
- There were approximately fifteen DMH approved evidence-based programs available for use in SMHP schools. However, only two of these programs have been evaluated for cultural/ audience appropriateness or effectiveness with DCPS students; the G-TREM and Good Touch/Bad Touch programs. Evaluation results documented improvements in knowledge of

abuse and reductions in trauma symptoms among participating DCPS youth. Providing feedback to SMHP clinicians and school staff on the success of these two programs could contribute to broader use, adaptations to, and/or endorsements of these programs that might increase SMHP clinician implementation in other schools. Evaluating the process of implementation and the acceptability and effectiveness of the 13 other available evidence-based programs may similarly be helpful in promoting more widespread use. Evaluation of these programs are not as likely to be plagued by limitations in evaluation design since many of these programs are prevention and early intervention programs which apply to a broader school population. **In order to increase more widespread SMHP clinician use of the array of approved evidence-based programs, it is important for DMH to identify appropriate evaluation designs and measures to assess the process of implementation, the acceptability and/or barriers to implementation, and the pre-to-post effectiveness of each evidence-based program available, and to provide feedback on those findings to SMHP clinicians and school staff.**

- The workshop evaluation forms provide information on the training and professional development services provided by clinicians, but it was unclear whether these forms reflected all of the workshops offered and the participants who attended them. It was also difficult to determine the correspondence between the needs assessment results conducted at the beginning of the year and the types of workshops being delivered. This information is essential to DMH because stronger concordance between the needs assessments and the workshops offered could increase the impact of the overall SMHP. Clinicians should be encouraged to report on the scheduling and implementation of workshops conducted and to submit all relevant evaluation forms complete with workshop audience, title and school identifier information to the SMHP evaluation team. Additionally, they should report on the relationship between these workshops and the needs assessments conducted at the beginning of each school year. **In order to more accurately determine how many different types of workshops and sessions are delivered and the extent they address school needs, it is important that DMH ensure that SMHP clinicians are collecting workshop forms from all participants. It is also important that DMH verify that workshops are being conducted in accordance with unique SMHP school needs identified in assessments conducted at the beginning of each school year. This will increase the likelihood that limited resources are used efficiently.**
- A complete picture of the breadth and scope of SMHP clinician activities is unavailable due, in part, to the flawed methods used to capture monthly report data and count some categories of information. It is difficult to ascertain the percent of any school population (i.e., school level penetration) that was exposed to services and programs in a given school because data are not currently collected in a manner that yields an unduplicated count. Numbers of programs delivered and people seen are all impossible to determine from the data collected by SMHP clinicians, which obfuscates the work being done. Data are collected in such a fashion as to make it impossible to know how many people fall into specific categories or participate in specific interventions. Particular problem areas include information on client contacts and services, delivery of primary prevention and early intervention programs, and delivery and participation in evidence-based programs. A system permitting both unduplicated count and volume data to be stored would significantly improve the quality of findings. While an electronic data tracking system would be an ideal long-term solution, a basic spread-sheet program could be established to improve the quality of monthly report data being collected in the short-term. For example, a standard excel spreadsheet could be

established for recording all student contacts on an individual basis. Names of enrolled students could be obtained from the principals' office at the beginning of each school year, and all subsequent contacts and participation in SMHP programs could be recorded thereafter by date for each student. **Toward that end, DMH should implement a record keeping system that will permit SMHP clinicians to show how many students, staff and parents they work with, how frequently they are seen, and precisely what interventions they are providing to each person touched by the program. Specificity in reporting could be achieved by revising the monthly data collection procedures and excel worksheets, making it possible for clinicians to more fully detail what programs and services they have delivered, and the numbers of participants and sessions for each. An investment in an electronic data tracking system is recommended over the long term to improve the reliability of data collection and reduce the current burden on clinicians. Either improvement would provide a means of better understanding and interpreting results obtained by clarifying the breadth of the services and the number of participants impacted.**

- While the importance of school climate assessments is acknowledged, there may be a saturation effect in relation to the school climate forms being collected from administrators. Fewer administrators appear to be completing the forms each year, and more are indicating that several of the outcome indicators are not relevant to SMHP performance. **Consideration should be given to assuring that the school climate questions clearly measure perceptions from the perspective of school leaders. It would be helpful if DMH presented results from the overall evaluation findings each year to participating schools along with plans for improvement to address staff and administrator concerns. Doing so could serve multiple purposes: it would provide some feedback to stakeholders, it would send the message that completing the DMH assessment forms is taken seriously, that staff and administrators are being heard, and that their completion of these assessments will, in fact, influence improvements in SMHP programs iteratively. Furthermore, the discussions that accompany these presentations could be used to clarify some of the nuances of administrator and staff perceptions using actual data results. Additionally, informal discussions with school principals may be warranted to explore how school climate forms are being answered, why certain response trends were observed, and how the forms could be improved. It would also be worthwhile to evaluate the perceived impact of the SMHP from those with even greater decision-making power, such as assistant superintendents. DMH should also continue to work directly with schools to compare administrator perceptions of program impact and actual, objective data on violence, disciplinary referrals, and attendance.**
- The DMH has expressed an interest in evaluating school-level outcomes. Examples of school-level indicators of interest include school attendance and truancy, achievement scores, grade repetition, SPED and disciplinary referrals, student fighting, suspensions and expulsions, and school drop out rates. These are certainly important goals to aspire toward, however, without clear evidence of the SMHP penetration rates, these school-level outcomes may be very difficult to assess and/or achieve. And even if those penetration rates were well-known, but the program and service delivery was not highly diffused, the ability for school level outcomes to be demonstrated is not a realistic expectation. Furthermore, there are other factors, outside of the control of SMHP clinicians, either within the school, family or community that may be exerting greater influence. For example, schools vary in certain factors, such as student staff ratios, staff and administrator turnover, the quality of the

physical environment and facilities, all of which may have an influence on the desired outcomes, but over which the SMHP clinicians have little to no control. Families and neighborhoods differ in levels of stability, poverty, connectedness, violence and other factors that could influence school-level outcomes. In addition, some school level indicators, such as time since SMHP adoption (i.e., how long a clinician or SMHP services have been in a school) may account for some of the differences in school or student outcomes. Attendance and achievement test results may not be sensitive enough to use as indicators of SMHP impact and, as other researchers have concluded, mental health interventions may not actually have a direct relationship to grades or attendance, but may directly influence other factors that have a more notable effect on these school outcomes. Academic achievement may potentially be impacted among youth receiving services, but it could take time for any increases in mental health to impact readiness to learn, and even longer to be reflected in test scores. **If it is indeed the desire and intent of the SMHP to demonstrate school level changes over time, then it will be important to consider a different methodological approach to evaluating such changes and to consider the role of other mediating factors. Individual level outcomes and school climate changes may be more appropriate indicators of DMH SMPH impacts and future program evaluation efforts may be better served by concentrating on these areas.**

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