D.C. Department of Mental Health
School Mental Health Program
SY 07-08 Report

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Executive Summary

The DC School Mental Health Program (SMHP) is located within the Office of Programs and Policy in the DC Department of Mental Health. The SMHP promotes social and emotional development and addresses psycho-social and mental health problems that become barriers to learning by providing prevention, early intervention, and treatment services to youth, families, teachers and school staff. Services are individualized to the needs of the school and may include screening, behavioral and emotional assessments, school-wide or classroom based interventions, psycho-educational groups, consultation with parents and teachers, crisis intervention, as well as individual, family and group treatment. During SY 07-08 the SMHP serviced 37 DC Public Schools and 11 DC Public Charter Schools.

The following report summarizes the evaluation findings for the SMHP during SY 07-08. A brief summary of the findings related to utilization of services, outcomes and satisfaction data are described below.

SMHP Program Characteristics, Delivery & Utilization of Services

- Mental health referrals remain high within the SMHP. In SY 07-08, 1173 students were referred for clinical services. Approximately 83% (968) of these students met with a clinician, were triaged and directed to the appropriate level of care within a month of referral.

- Clinical intakes were conducted and cases were opened for 592 students who participated in individual, group, and/or family therapy.

- SMHP clinicians reached a large number of students, families, teachers and staff through the implementation of prevention and early intervention services. Approximately 2524 prevention sessions (e.g., Signs of Suicide, Too Good for Violence or social skills presentations) and 1885 conflict resolutions sessions were conducted by SMHP clinicians.

- The SMHP places a strong emphasis on implementing Evidence-Based Programs (EBP). Approximately, 1635 students participated in Good Touch Bad Touch, 649 students in Connect with Kids, 316 students in Botvin's LifeSkills, and 181 students in Too Good for Violence.

- Approximately 505 students were screened for depression and other emotional problems using the Columbia Health Screen.

- SMHP clinicians provide clinical services in the aftermath of traumatic events which impact the school population. In conjunction with DCPS staff, clinicians responded to 28 crises and provided intervention for approximately 4,600 students.

Prevention and Early Intervention

- Students participating in Good Touch Bad Touch displayed significant improvements in knowledge acquisition of skills used to prevent or interrupt abuse.

- Students participating in Connect with Kids reported a slight increase in prosocial behaviors; however, the change was not statistically significant.

Clinical Treatment Outcomes

- Students and their parents reported significantly more hopefulness and well-being by the end of treatment.

- Students, their parents and clinicians reported that everyday functioning significantly improved after treatment.

- Students, their parents and clinicians reported significantly fewer behavioral and emotional symptoms after treatment.

- Students and their parents reported high satisfaction with treatment services and felt included in the clinical decision making process.

- The number of students who met criteria for psychiatric disorders decreased after treatment, and demonstrated a significant improvement in global functioning as assessed by the Global Assessment Scale.

- Treatment clients exceeded the program performance benchmark: Greater than 40% of clients demonstrated measured improvement on the Ohio Scales. Improvement rates ranged from 44 to 52% for Problem Severity and from 48 to 55% for Functioning.

Satisfaction with SMHP Services

- Overall levels of satisfaction measured across various stakeholders remained high; actual levels met or exceeded 90% for children, youth, parents, teachers, staff and administrators.

Assessment of School Climate & School Level Outcomes

- The majority of school administrators reported that the SMHP clinician helped contribute to the school's positive environment.

Overall, clinicians in the SMHP program provided a wide range of prevention, early intervention, and treatment services and were well utilized by students, parents, teachers and staff. The data revealed an increase in knowledge and skill sets for students participating in a sexual abuse prevention program, as well as significant improvements in everyday functioning and feelings of hopefulness, and a decrease in problems for students receiving treatment services. While the data suggested that the mental health services provided by the SMHP clinicians were effective, moving forward, it will be important for DMH to place a greater emphasis on assessing the impact of its prevention programs. This will better assist DMH when making programmatic decisions for the future.

Purpose of Report and Limitations:

Since the SMHP program was initiated, it has placed an emphasis on data-driven decision making and maintaining ongoing collaboration and accountability to the various stakeholders associated with the program. The infrastructure and methods to collect and report program data have continued to evolve in order to support transparent program functioning and high quality service.

The purpose of the current report is to:

- inform stakeholders regarding program activities during SY 07-08
- assess program performance relative to pre-established benchmarks
- provide data to SMHP managers to support program refinement

Data were collected to address the following guiding questions:

- What are the program activities of the SMHP clinicians and how many of these services do they provide?
- Do prevention programs result in enhancing a participating student's well-being?
- Are mental health treatment services helping to reduce the problems or symptoms that students experience and do they enhance their overall functioning?
- Are program participants (students, parents, teachers, administrators and staff) satisfied with SMHP services?

In addition, the data contained in the report will be used to inform the process of establishing future program performance goals.

While the methods used to analyze and report the data represent the appropriate use of statistical techniques when they could be applied, controlled comparisons were not utilized due to the restrictions imposed by current resources. While causation is assumed to relate to the prevention, early intervention, and treatment interventions applied, current methods do not allow causal interpretations to be made with certainty. Furthermore, this report was written to provide information to a wide variety of stakeholders, technical explanations and jargon were minimized in the body of the document- greater detail on analysis and results was included in the Appendix. More information on the limitations are integrated into specific report sections.

Program Overview:

The DMH 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 37 D.C. public schools and 11 public charter schools and their families (see Table 1 for detailed description).

During SY 2007-08, one qualified mental health professional was assigned by the SMHP to each participating school. SMHP clinicians offer an array of prevention, early intervention and 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 care coordination.

Table 1. Three Levels of Care: Prevention, Early Intervention, and Treatment Services.
• ***Primary Prevention (also known as Universal Prevention Services).*** Prevention services are 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 informed school-wide or classroom-based substance abuse and violence prevention programs.
• ***Early Intervention (also known as Secondary, Selective 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, skill building groups, 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 for students who have been identified by a referral source for mental health intervention.
• ***Treatment Services (also known as Tertiary Prevention or Indicated Prevention Services).*** Students in the general education population with an identified mental health concern resulting in disruption of academic and/or social-emotional functioning are offered a number of 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). Students needing more intensive services may be referred for community mental health services.

Table 2. Utilization Data		
	2006-2007	2007-2008
	Total for All SMHP Schools N=42	Total for All SMHP Schools N=48
Student Referrals	1017	1173
Student Referrals Seen	753	968
Student Involved Outside Agency	78	58
Students on Clinical Caseload	577	592
Individual Therapy Sessions	5691	5106
Group Therapy Sessions	636	514
Family Therapy Sessions	358	442

SMHP Program Characteristics, Delivery & Utilization of Services

The SMHP expanded into six additional schools staffed by clinicians from two Core Service Agencies (CSAs), First Home Care and Family and Child Services of Washington DC, Inc. for a total of 48 schools (37 Public and 11 Charter). Performance benchmarks were established assuming the added service of the six additional clinicians; however, due to, staff turnover, the shifting of schools, and the clinicians from the contract agencies beginning mid year, the average number of clinicians available to provide service per month remained relatively static (i.e., average of 37.54 Full Time Employees (FTEs) in SY 06-07 vs. 39.54 FTEs in SY 07-08). Even though the number of clinicians providing service per month remained relatively constant nearly all performance benchmarks were achieved. Information on each benchmark is detailed below.

Mental health referrals remain high within the SMHP. The number of students referred and seen exceeded the program performance benchmark of a 10% increase from SY 06-07.

In SY 07-08, 1173 students were referred for clinical services. Of these students, approximately 83% (968) met with a clinician, were triaged and directed to the appropriate level of care within one month of referral (see Table 2). The actual percentage of students served exceeded the benchmark, representing a 29% increase over the 06-07 school year.

Teachers (34%) continue to be the main referral source for students, but administrators (15%) and family members (10%) provided a significant number of referrals as well. Of the students referred, approximately half were male (49%) and half were female (51%). The top five presenting problems were: Anger/Aggression, Disruptive Behavior, Family Problems, Grief/Loss, and Poor Peer Relations. Of the students referred, 58 were known to be involved with an outside agency (e.g., Child and Family Services Agency, Department of Youth Rehabilitation Services, etc.) and 219 students were referred to an outside mental health provider for more intensive services.

While there was a 3% increase in the number of students receiving treatment services in SY 07-08, the program performance benchmark of a 10% increase was not met.

Clinical intakes were conducted and cases were opened for 592 students who participated in individual, group, and/or family therapy. The number of students on the caseload increased in SY 07-08; however, the number of individual and group therapy sessions decreased while the number of family sessions increased (see Table 2). While the cause of these changes remain unclear, not meeting the benchmark may be due to transition and staff turnover rates within the SMHP. In addition, some clinicians have acknowledged more difficulty accessing students due to the increased emphasis on structured academic blocks in their schools.

SMHP clinicians reached a large number of students, families, teachers and staff through the implementation of prevention and early intervention services.

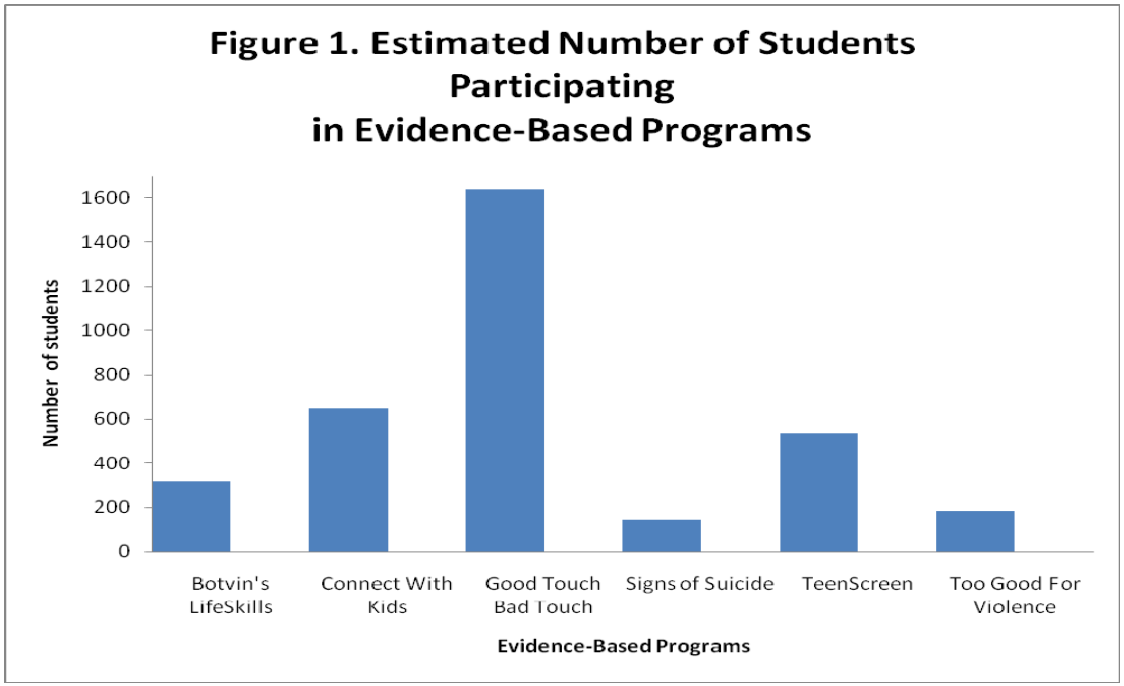
During SY 07-08, 2524 prevention sessions (e.g., Signs of Suicide, Too Good for Violence or social skills presentations) were conducted by SMHP clinicians (see Table 3).

Table 3. Prevention and Early Intervention Data	**2007-2008**
Prevention Sessions	2524
Walk-ins	3366
Conflict Resolution Sessions	1885
Classroom Observations	1823
Parent Consultations	1878
Teacher Consultations	3834
Other Staff Consultations	3691
Referrals Made for Outside MH Services	219
Presentations, Workshop, and Conferences	365

SMHP clinicians conducted 1885 conflict resolution sessions and there were 3366 recorded encounters when students walked in for services. Clinicians also provided consultations with parents, teachers, and staff regarding students at the schools. SMHP clinicians provided 365 workshops, presentations or staff developments to school personnel, parents and individuals in the community.

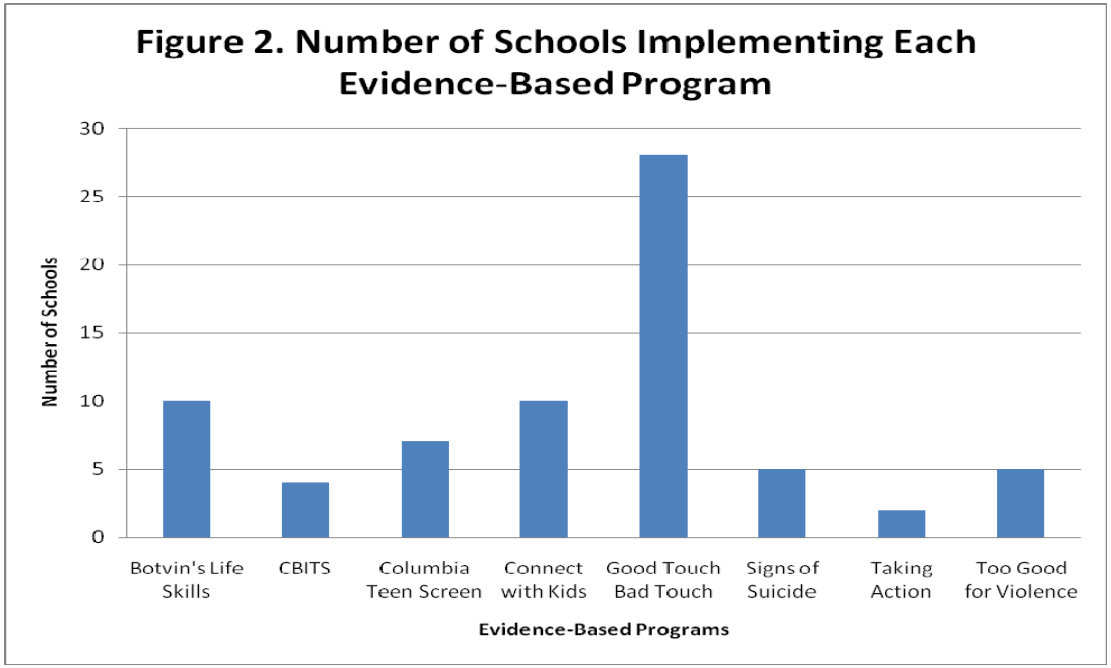
The SMHP places a strong emphasis on implementing Evidence-Based Programs (EBP). The number of students participating in an EBP exceeded the SMHP performance benchmark established for each program: Good Touch Bad Touch (1000), Connect with Kids (550), Botvin's LifeSkills (300), Too Good for Violence (150).

Figure 1. highlights the estimated number of students who participated in each evidence-based program. Approximately, 1635 students participated in Good Touch Bad Touch, a program which teaches children the skills needed to prevent or interrupt abuse, and 649 students received Connect with Kids, a character education program that helps improve student behavior and reduce violence. Approximately 316 students participated in Botvin's LifeSkills, a substance abuse prevention program. One hundred and eighty-one students participated in Too Good for Violence which focuses on reducing aggression by emphasizing conflict resolution, anger management and effective communication skills.



Two evidence-based treatment programs, Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) and Stark's Cognitive-Behavioral Therapy for Depression - Taking Action, were used less frequently (18 students received services). The low numbers may be indicative of the Taking Action training being provided late in the academic year, as well as some clinicians requesting additional support and supervision prior to implementing CBITS. Further training and support for these programs was added for SY 08-09.

Current SMHP data collection methods count the number of students present at each intervention, but do not document the specific students served. As a result, it is difficult to report the number of individuals served because of duplicate entries for each student.



For this report the number of students receiving each intervention was estimated by examining aggregate data for each program by school.

While only estimates for the number of students served may be derived with current data collection methods, the total number of schools implementing a program may provide a more accurate representation of evidence-based program utilization. Figure 2 displays the number of schools that implemented each EBP. Overall, Good Touch Bad Touch was implemented in the most schools, followed by Connect with Kids and Botvin's LifeSkills.

505 students were screened for depression and other emotional problems.

Clinicians in the SMHP assisted the STOP Suicide Project, a SAMHSA grant funded program, with screening students for depression and low mood, substance abuse and anxiety or worry using the Columbia Health Screen (CHS), a component of the Columbia Teen Screen. During SY 07-08, 505 students were screened for depression and other emotional problems using the CHS and 143 were referred for further evaluation. The benchmark of 525 students was set high to encourage persistent pursuit of the goal; however, it was narrowly missed due to the considerable difficulty of achieving informed consent from parents. While this program is being phased out, due to the grant coming to an end, an evidence-based suicide prevention program called Signs of Suicide (SOS) will be implemented by SMHP clinicians. This program teaches students how to respond if they or a friend experience symptoms of depression. During SY 07-08, 143 students participated in SOS.

SMHP clinicians provide clinical services in the aftermath of traumatic events which impact the school population.

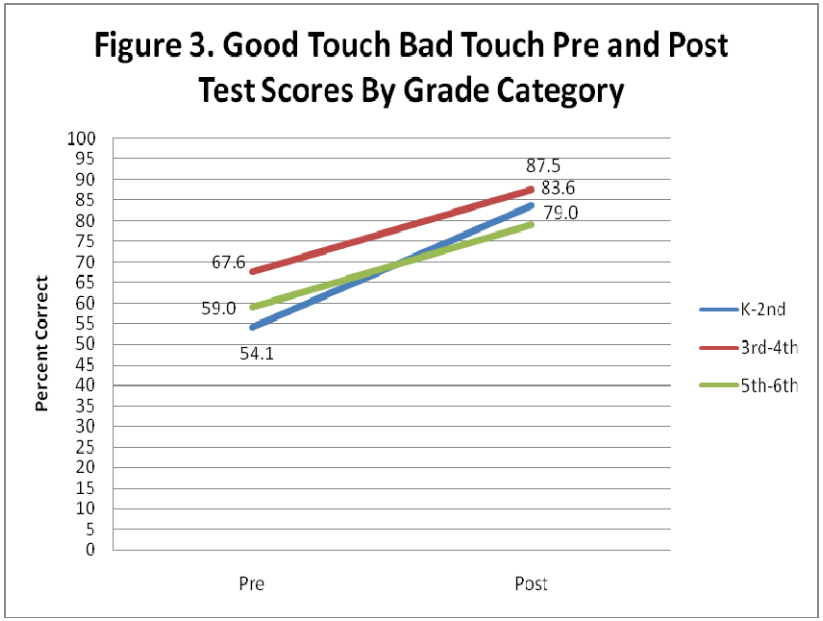
Trained SMHP clinicians working in collaboration with DCPS staff, responded to 28 crises and provided services to approximately 4,600 students. Interventions are provided for urgent school and community situations resulting in significant distress. One crisis response involved helping a school and family cope when a 6-year-old student was killed in a hit and run vehicle accident. While the specific interventions implemented varied across crises, classroom presentations were utilized the most followed by individual, supportive counseling sessions.

Prevention and Early Intervention

Primary prevention and early intervention activities and programs help to prevent or intervene at the first occurrence of emotional, behavioral, or social concerns and may include activities such as: classroom-based presentations, small psycho-educational sessions or groups, staff development, parent presentations, and teacher and staff consultations. Although a more comprehensive effort to assess the impact of all of the primary prevention services continues to evolve, during SY 07-08, clinicians collected pre and post data on the Good Touch Bad Touch and Connect with Kids programs.

Students participating in Good Touch Bad Touch displayed significant improvements in knowledge acquisition used to prevent or interrupt abuse.

Good Touch Bad Touch is an evidence-based primary prevention program that teaches children the skills needed to prevent or interrupt abuse. One thousand four hundred sixty questionnaires were completed by students measuring their awareness of sexual abuse and the knowledge of the skills needed to protect themselves should it occur. However, due to problems encountered in data collection, only 914 questionnaires could be matched leaving 546 questionnaires unmatched. Pre-post survey responses were converted to a percent of



the total knowledge of questions answered correctly. Paired t-tests were used to calculated the difference between the percent correct at pre-test as compared to at post-test. The results of the matched data are presented separately based on 3 grade level categories: Kindergarten-2nd grade, 3rd-4th grade, and 5th-6th grade. See Figure 3.

Paired t-tests revealed significant improvements in knowledge acquisition for each grade category as well as the overall sample. Specifically, the overall scores showed an improvement from M=55.9 to M=83.8 (n=457, p<.000, two-tailed). Similar gains were noted for students in K-2nd grade (M=54.1 to M=83.6, n=385, p<.000, two-tailed). Students in 3rd-4th grade (M=67.6 to M=87.5, n=51, p<.000, two-tailed), and 5th-6th grade (M=59.0 to M=79.0, n=21, p<.001, two-tailed) made significant, but less robust gains.

Students participating in Connect with Kids reported a slight increase in prosocial behaviors.

Connect with Kids is an evidence-informed prevention program intended to improve student behavior. The character trait series focuses on topics such as: teasing and bullying, cheating and lying, respecting teachers and classmates, violence prevention and academic perseverance. Two hundred and three pre and post test questionnaires were completed by students; however, only 67 questionnaires could be matched due to problems encountered in data collection. While students reported a slight increase in prosocial behavior from the pre to post test, a paired t-test revealed the increase was not statistically significant (M=3.31 to M=3.41, n=67, p>.05, two-tailed).

Clinical Treatment Outcomes

Background and Overview of Methods and Instruments

The SMHP has placed an emphasis on providing, high quality, family centered treatment services since it began in the summer of 2000. Clinical outcome data has been collected for students receiving treatment services since the SY 2004-2005, when instruments were chosen based on students' major presenting problems: depression, disruptive behavior, anger, and aggression. Treatment interventions resulted in significant reductions in several of the measured clinical domains (see SY 2005-2007 SMHP Evaluation Report). During SY 2007, the program moved towards refining the clinical measurement process. Decisions were made to place an emphasis on methods useful for program evaluation while simultaneously enhancing the clinical utility of the data.

The Ohio Scales are a treatment outcome instrument with established reliability and validity (Ogles, Dowell, Hatfield, Melendez & Carlston, 2004; Ogles, Melendez, Davis, Lunnen, 2001). There are three parallel forms completed from the perspective of: the primary caregiver (Parent Form), the client (Youth Form- for clients 12 years and above) and the therapist (Worker Form). The Ohio Scales

Table 4.
Demographic Characteristics of the Sample of Students in Treatment: 2007-2008

N=458	N	**%**
Grade Level of Student		
PK-2nd Grade	84	18.7%
Grades 3-4	67	14.9%
Grades 5-6	93	20.7%
Grades 7-8	129	28.7%
Grades 9-12	77	17.1%
Total	450	100.0%
Sex		
Male	212	46.2%
Female	245	53.8%
Total	457	100.0%
Age (mean, SD)	11.4	3.2
Age Range (Min/Max)	4	21
Age		
4-5 years	23	5.00%
6-10 years	151	33.2%
11-13 years	155	34.1%
14+ years	126	27.7%
Total	455	100.0%
Race/Ethnicity		
Black	409	89.9%
Hispanic	40	8.8%
Other	6	1.30%
Total	455	100.0%

Note: All data reflect numbers and percent except were specified.

consist of two primary indices measured across all three respondents: Problem Severity and Functioning. Two additional subscales, Hopefulness and Satisfaction, are included on the Youth and Parent forms.

Clinicians were instructed to administer the Ohio Scales to students (12 years old and above) and their parents who consented and agreed to participate in individual, group or family treatment services. Though completing the Ohio Scales was encouraged for both parents and youth, clinicians respected their clients' right to refuse completing a form but still participate in treatment. Clinicians completed the Worker form of the Ohio Scales after the intake assessment but prior to formulating the initial treatment plan. After the intake process was complete, clinicians were asked to administer the Ohio Scales at three month intervals and upon discharge, if three sessions had elapsed since the last administration. Also at discharge, clinicians were asked to complete a discharge summary form to provide additional data describing the intervention. (See Appendix A for more information on the instruments and analysis).

Sample

A total of 1912 valid Ohio Scale forms were submitted over the course of the school year with 458 of 592 (77%) of clients represented with at least one valid form. Forms that contained missing data that could not be prorated based on the Ohio Scales scoring criteria were considered invalid and excluded from all analyses. Discharge summary forms were completed for 370 of the students in treatment which represented 65% of the cases closed during that period.

Student Treatment Demographics

As shown in Table 4, the majority of the sample of students receiving mental health treatment services through the SMHP were African American (89.9%), with slightly more females than males (53.8 % vs. 46.2%). Hispanic students represented 8.8% of the sample, while the "other" category accounted for only 1.3%. Students were almost evenly distributed through grade levels though there were slightly more students in the 7th and 8th grades.

Characteristics of Treatment

Based on the sample of the 370 completed and submitted discharge summaries, the majority of students in treatment services attended individual sessions with their therapist (81%, Mean (M) =14 sessions). Forty-eight percent (M=8.6 sessions) attended group therapy and 18% (M= 3.4 sessions) saw their therapist with their family. Of the 300 students receiving individual therapy, 112 (37%) participated in group treatment and 65 (22%) also had family sessions. Over the course of the school year, students participated in an average of 16.44 (SD 14.31) sessions of any combination of individual, group or family treatment.

Therapists reported in discharge summaries the treatments or combinations of treatments that were selected for each student. (Note: treatment type categories were not mutually exclusive; percentages represented the total number of endorsements for each category). Cognitive behavioral treatment methods were reported for the majority of students (64%) followed by play therapy (27%). In addition, therapists reported solution-focused therapy (17%), psychodynamic therapy (17%) and other methods (19%). More than half (55%) of the students enrolled in treatment also participated in prevention programming.

The majority of students in the discharge summary sample met criteria for a DSM-IV-TR mental health diagnosis when entering treatment (59%). The five most prevalent diagnostic categories were: Disruptive Behavioral Disorders (n=69), Mood Disorders (n=55), Bereavement (n=45), Attention- Deficit Disorders (15) and Anxiety Disorders (including PTSD) (n= 13). The average Global Assessment of Functioning (GAF) Score was 61.22 (n=215, SD= 10.35) indicating that the typical student's symptoms and functioning were on the border of mild to moderate. Scores of 70 and above on the GAF indicate few or no symptoms and represent optimal levels of functioning.

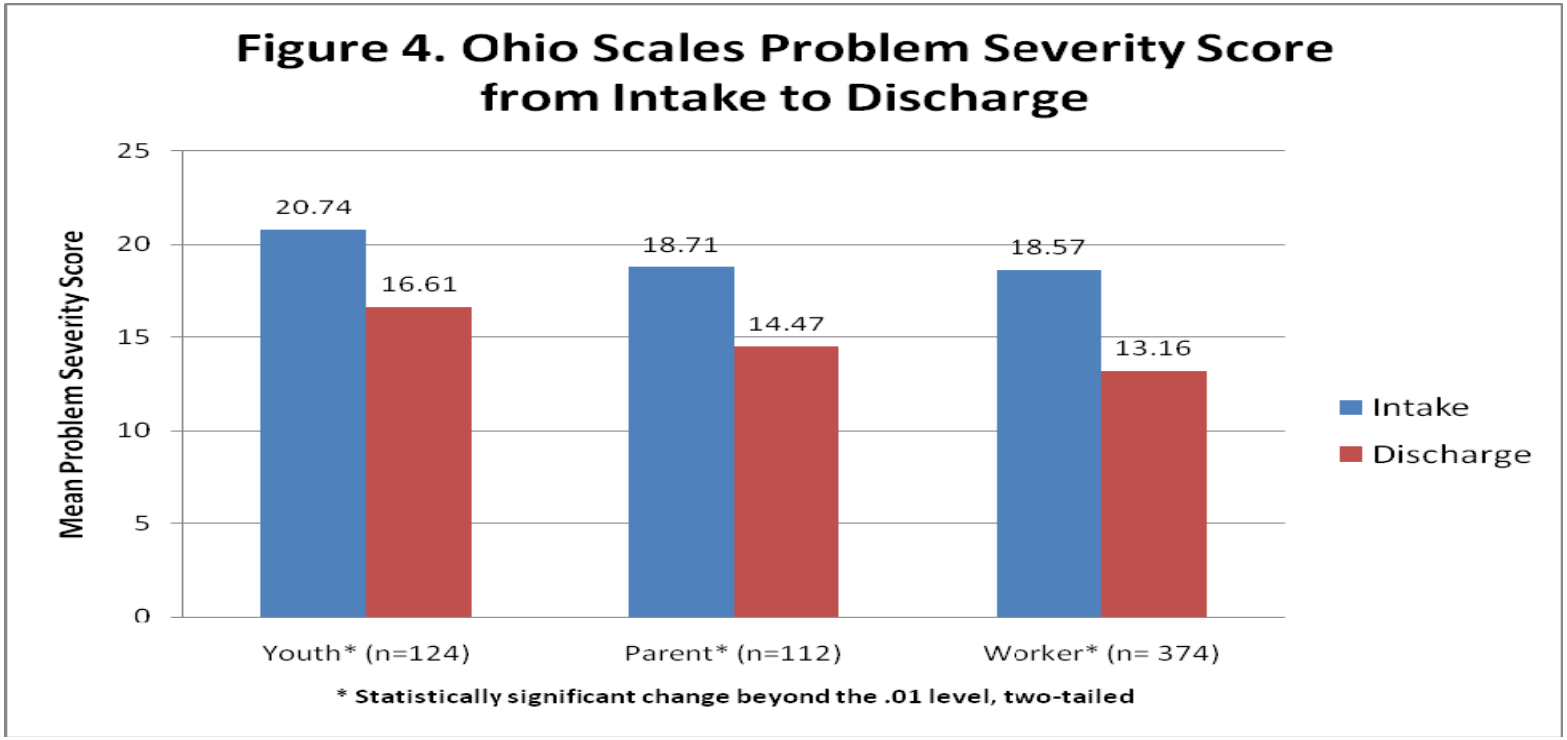
Students and their parents report significantly more hopefulness and well-being by the end of treatment.

Treatment Outcomes

The overall scores for the Youth Ohio Scales Hopefulness Subscale showed an improvement from M=10.07 to M = 8.87 (n=115, $p < .01$, two-tailed). Similar gains were also noted for the Hopefulness Subscale for parents, M= 9.38 to M = 8.06) (n=95, $p < .01$, two-tailed). Increases in hopefulness may indicate enhanced resiliency, specifically, a sense of purpose. Hopelessness is associated with increased risk taking, depression, and poor academic achievement.

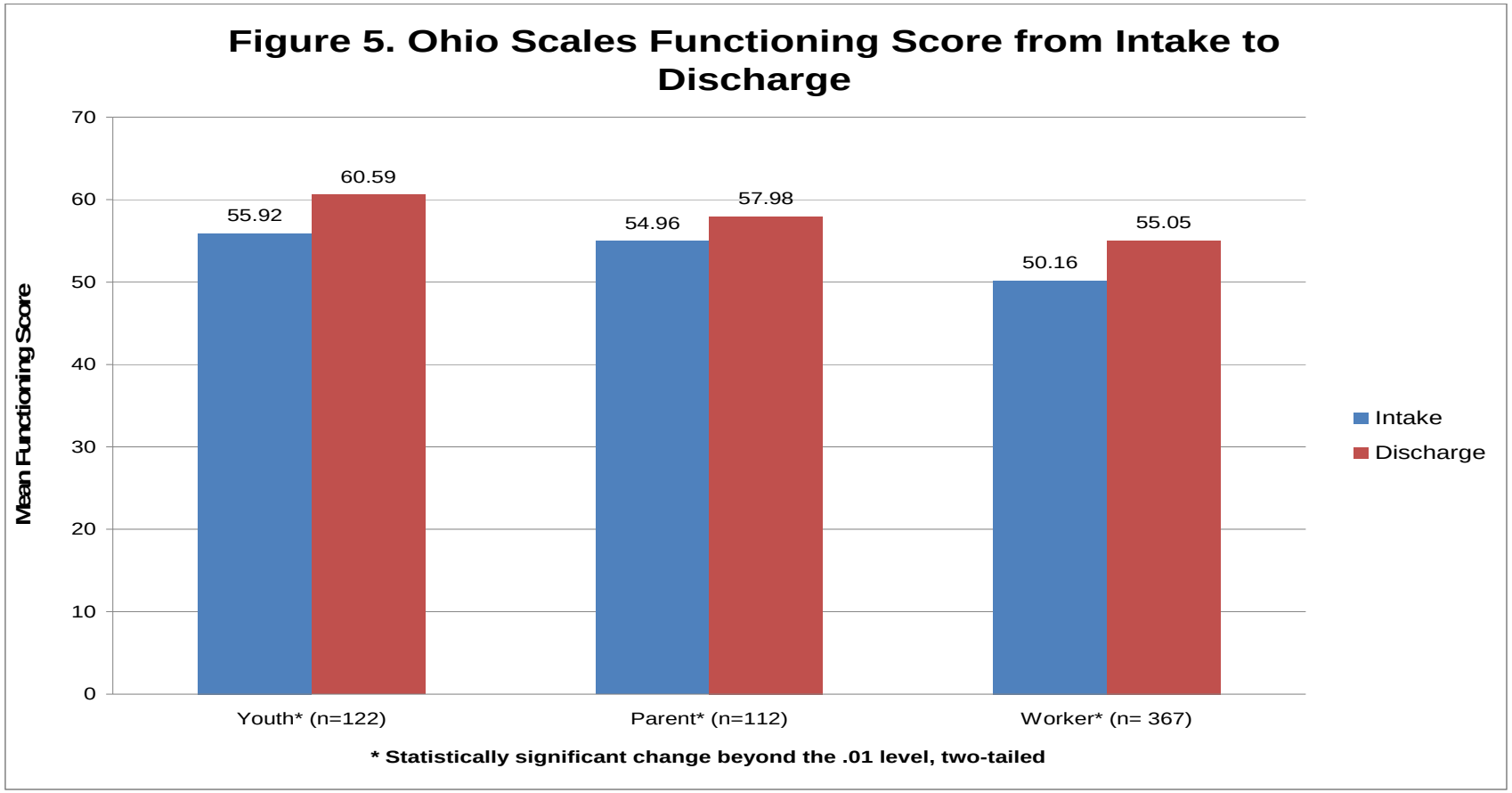
Students, their parents and clinicians report significantly fewer behavioral and emotional symptoms after treatment.

Paired t-tests revealed statistically significant reductions in problem severity (symptoms expressed by the youth and as observed by parents and clinicians). See Figure 4 and Table 5 (Appendix B).



Students, their parents and clinicians report that everyday functioning significantly improved after treatment.

Paired t-tests revealed statistically significant improvements in students' self-reported functioning as well as that observed by their parents and clinicians. Improvements in functioning, how well a student does in school or relates to peers and family, may be more evident after problems have diminished and hope has increased (Howard, Lueger, Maling & Martinovich, 1993). See Figure 5 and Table 5 (Appendix B).



Students and their parents reported high satisfaction with treatment services and felt included in the clinical decision making process.

The satisfaction scale ranges from 4 (most satisfied and included) to 24 (least satisfied and included). Students (n=131, M=7.64, SD=3.66) and parents (n=116, M=6.72, SD=3.89) reported relatively high scores on satisfaction. Scores in this range suggest a collaborative approach toward the development of a treatment plan and overall satisfaction with the services provided.

The number of students who met criteria for psychiatric disorders decreased after treatment, and demonstrated a significant improvement in global functioning as assessed by the Global Assessment Scale.

Of the 220 students who met the criteria for a DSM IV-TR mental health diagnosis at the initiation of treatment, 169 still met criteria at the end of treatment (a 23% improvement). Furthermore, a statistically significant improvement on the Global Assessment Scale (a measure that combines symptom severity and functioning) was noted. The overall mean of 61.3 at intake improved to 70.0 at discharge ($n=208$, $p< .01$, two-tailed). These findings appear to suggest that those students with a diagnosable mental health condition at the beginning of treatment were functioning at a higher level at the end of treatment. Scores above 70 indicate generally symptom free patterns and optimal functioning.

Treatment clients exceeded the program performance benchmark: Greater than 40% of clients demonstrated measured improvement on the Ohio Scales. Improvement rates ranged from 44% to 52% for Problem Severity and from 48 to 55% for Functioning.

Expected rates of clinically significant improvement for the average psychotherapy consumer (child and adult) range from 40 to 50% while 5 to 10 % are expected to deteriorate or have symptoms escalate during the course of an intervention. The remaining clients may respond to the treatment intervention, but the magnitude of that change may not be sufficient to statistically rule out measurement error or other factors (Ogles, Lambert, & Fields, 2002). The treatment program performance benchmarks were generated earlier in the year based on the research literature: that greater than 40% of students would demonstrate measured improvement in response to treatment.

Separate analyses were completed for problem severity and functioning on the Ohio Scale data for the Youth, Parent and Worker forms. Overall, results indicated that when all improvement categories were included (see Appendix B for information regarding Reliable Change Index), each form exceeded the established performance benchmark of 40 % measured improvement (see Table 8 in Appendix C). Improvement rates ranged from 44 to 52% for Problem Severity and from 48 to 55% for Functioning depending on the respondent.

Satisfaction with SMHP Services

Satisfaction surveys were collected from children and youth receiving prevention, early intervention, and treatment services. Forms were provided to potential respondents and collected by the clinicians. While over 900 surveys were collected, several limitations

exist due to challenges with data collection methodology. The exact number of surveys administered is unknown because clinicians disseminate and collect surveys making it challenging to provide a confidential process and to determine the return rate. In order to understand the possible influence of nonresponse bias on the results (i.e., results skewed towards those who completed the survey and possibly under representing those who did not complete the survey), the SMHP has revised the satisfaction data collection methods in the 08-09 SY.

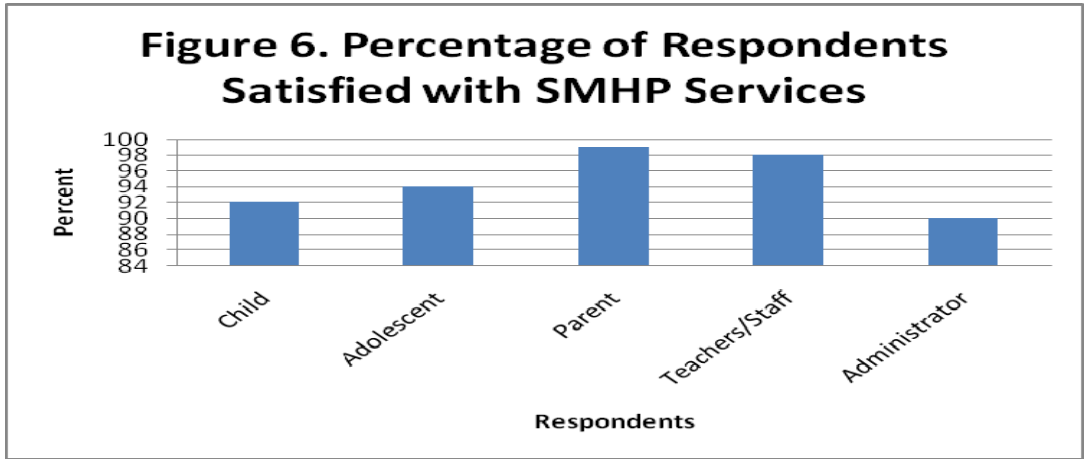
While the current limitations exist, more surveys were collected from children, parents and teachers/staff in SY 07-08 than in SY 06-07. Fewer youth completed surveys in SY 07-08 (see Table 6).

Survey questions focused on whether the children and youth were satisfied with services and inquired whether they felt better, got along better with their classmates and families, would recommend the SMHP clinician to a friend who needed help, and whether or not they would return for services if they needed help again. Parents, teachers and school staff were also encouraged to complete satisfaction surveys.

Overall levels of satisfaction measured across various stakeholders remained high and exceeded the benchmark. Actual levels met or exceeded 90% for all groups (see Figure 6).

Table 6. Number of Satisfaction Surveys Collected

	SY06-07	SY 07-08
Child	325	399
Youth	242	177
Parent	42	69
Teacher/Staff	212	273



Child Satisfaction

Specifically, 95% of children reported that the SMHP clinician helped them feel better, 89% reported that the clinician helped them get along better with their peers, and 93% reported they would come back if they needed help again.

Youth Satisfaction

Youth also rated their experience as positive. Approximately 85% of the youth stated that what they talked about with the clinician helped them to make better decisions, 86% reported they would recommend the clinician to someone who needed help, and 84% reported that what they talked about would help them in the future.

Parent Satisfaction

Nearly all of the parents who completed surveys (99%) reported that they felt comfortable talking with the clinician, would recommend the clinician to other parents, and would return to talk to the clinician again if they needed help. Over 85% of the parents reported what the clinician and the parents talked about helped to improve communication in their family, their children's behavior and attitude, and taught them better ways to work with their child.

Teacher and Staff Satisfaction

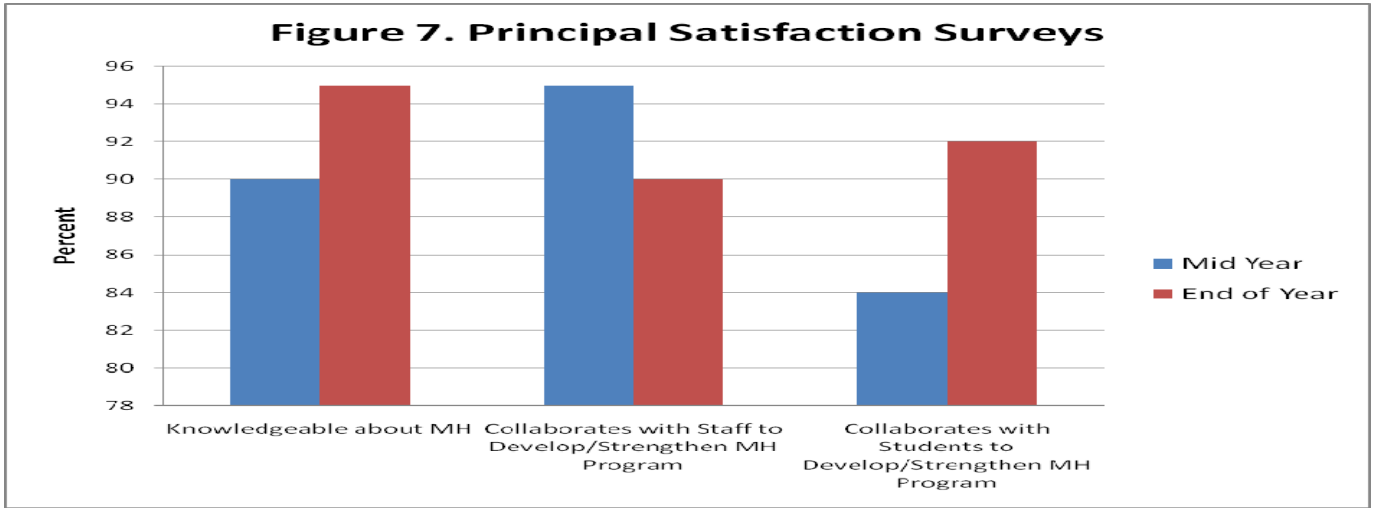
Teachers and school staff also completed satisfaction surveys at the end of the school year. A total of 273 staff surveys were collected in SY 07-08 as compared to 212 in SY 06-07. Overall, teachers and staff reported that their experience with the SMHP clinician was outstanding. Specifically, 95% of teachers and staff reported that the SMHP clinician was knowledgeable about mental health issues pertaining to the students at the school, were flexible or responsive to see students and their families during times of crisis, and were willing to work collaboratively with staff to develop/strengthen the mental health program at the school.

Principal Satisfaction

Prior to SY 07-08 principal satisfaction data was collected only at the end of the year; however, in SY 07-08, a mid year survey was added to identify existing problems with services delivery prior to the end of the year. At mid year, 36 surveys were distributed and 19 (53%) were completed and returned to the SMHP. Ten administers were not required to complete the mid year satisfaction surveys, either because the clinician placed at their school had only recently begun providing services (i.e., 6 contract clinicians began during January 2008) or there was a vacancy.

At the end of the year 45 surveys were distributed to school administrators and 38 surveys (84%) were completed and returned to the SMHP. Administrators at 5 schools were not asked to complete an end of the year evaluation, either because no clinician was currently placed in the school or the clinician had been providing services at the school for less than 2 months.

Overall, the data from the mid year and the end of the year satisfaction surveys were positive and administrators were satisfied with the SMHP services. Figure 7 summarizes the satisfaction survey data collected over the year. Principals reported clinicians were knowledgeable about mental health issues of students at the school, and collaborated with staff, students, and parents to develop and/or strengthen the mental health program at the school. In addition, clinicians attended and provided valuable input during team meetings. The majority of principals reported they would like the SMHP clinician to continue providing mental health services in their school.



When comparing the feedback from the mid year and the end of the year surveys, principals reported an increase in the amount of communication between the SMHP clinicians and the school staff. Specifically, 87% of administrators (as compared to 74% at mid year) reported that clinicians communicated effective strategies for how to work with students experiencing mental health concerns in their classroom. In addition, 89% of administrators (as compared to 74% at mid year) reported that clinicians were able to communicate relevant mental health information about students effectively to others.

Principals also noted an improvement with clinician's responsiveness and flexibility during times of crisis. Ninety percent of administrators reported at the end of the year as compared to 79% at mid year, that clinicians assisted families during crisis.

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 were asked to rate their perceptions of a variety of factors within their schools. When comparing SY 07-08 to SY 06-07, the majority of principals reported a decrease in the number disciplinary referrals, Level 1 and Level 2 suspensions, and the number of fights, while the number of students attending class on a daily basis increased. Principals perceived their schools to be safer, more organized, and indicated that the relationship between the staff and students had improved since SY 06-07.

SMHP clinicians exceeded the program performance benchmark: Greater than 50% of principals reported that the SMHP clinician contributed to the schools' positive environment.

The majority of administrators (92%) responding to the survey reported that the SMHP clinician helped contribute to the school's positive environment. Administrators perceived the factors as most influential in contributing to the positive environment as: providing individual or group mental health services (87%), collaborating with parents (70%), collaborating with staff (65%) and implementing school-wide or classroom-wide interventions (60%).

While the data from the satisfaction surveys is valuable and extremely positive, it will be helpful in the future to conduct focus groups to gain additional information and specific feedback regarding topics such as communication between SMHP clinicians and staff, implementation of services, and how clinicians play a role in improving the school's positive environment.

Workshop Satisfaction

SMHP clinicians provide a variety of workshops such as classroom management, signs and symptoms of childhood disorders, impact of trauma on student functioning, etc. to various groups throughout the year (e.g., teachers, parents, students, community members, etc). Following the workshop, satisfaction forms are provided to potential respondents and collected by the clinicians. In SY 07-08, 392 surveys were completed and returned to the SMHP. Data from the majority of respondents was positive indicating that the workshop was useful and relevant, and most individuals stated they would apply the skills or techniques learned in the workshop at school or at home.

Conclusion

Overall results reveal SMHP clinicians provided effective prevention, early intervention, and treatment services during SY 07-08. The SMHP met nearly all of the program performance benchmarks and in most cases exceeded the thresholds. That is, referrals remained high, students were screened for depression and other emotional problems and referred to appropriate services, a large number of students participated in evidence-based prevention and early intervention programs, and students in treatment were more hopeful, functioned better and reported fewer problems after treatment. Overall levels of satisfaction measured across various stakeholders remained high and the majority of principals reported that SMHP clinicians contribute to the school's positive environment. While the number of students receiving treatment services increased, the amount did not meet the anticipated benchmark. This may be due to transition and turnover rates within the SMHP.

Data collected before and after implementation of Good Touch Bad Touch, a sexual abuse prevention program, revealed significant improvements in knowledge acquisition and skills used to prevent or interrupt abuse; however, data from Connect with Kids, a violence prevention program indicated that students did not benefit from services to the same extent. Students' prosocial behaviors improved slightly, but the improvement was not found to be significantly different. It will continue to be important for the SMHP to collect outcome data and refine the evaluation methods for all current and any new prevention, early intervention, and treatment programs implemented in the SMHP. This will allow the program to evaluate the effectiveness of all of its programs, and to assist with programmatic decision making regarding future implementation plans.

Appendices

APPENDIX A. Instruments

The Ohio Scales are a treatment outcome instrument with established reliability and validity (Ogles, Dowell, Hatfield, Melendez & Carlston, 2004; Ogles, Melendez, Davis, Lunnen, 2001). There are three parallel forms completed from the perspective of: the primary caregiver (Parent Form), the client (Youth Form- for clients 12 years and above) and the therapist (Worker Form). The Ohio Scales consist of two primary indices measured across all three respondents: Problem Severity and Functioning. Two additional scales, Hopefulness and Satisfaction, are included on the Youth and Parent forms.

- Problem Severity (0-100) consists of 20 items rated from zero (Not at All) to five (All of the Time). The scale assesses externalizing problems (e.g., fighting, lying, anger, substance use) as well as internalizing difficulties (loneliness, anxiety, suicidal ideation, depression, and eating problems). Higher scores indicate more severe problems, with a score of 20 representing the clinical threshold: Scores above 20 are more representative of youth receiving traditional outpatient or inpatient mental health services.

- Functioning (0-80) consists of 20 items ranging from zero (Extreme Troubles) to four (Doing Very Well) and rates the youth's level of functioning in several domains such as: interpersonal relationships, recreation, self-direction and motivation. Higher scores represent better levels of functioning while scores below 50 represent a clinically significant disturbance.

- Hopefulness (1-24) is rated on a six point scale and measures levels of hope (e.g., parent's level of optimism regarding child's future) and well-being for the parent or youth. Lower scores indicate higher levels of hope.

- Satisfaction (1-24) is a six point scale assessing satisfaction with and inclusion in treatment planning. Lower scores represent higher levels of satisfaction and inclusion.

Clinicians were asked to provide a discharge summary at the end of treatment. This form generally describes the course of the intervention, specifically, information such as: modality and frequency, type of therapy, DSM Diagnosis, Global Assessment of Functioning Score (GAF), presenting problems and concurrent treatment or prevention services.

APPENDIX B. Paired Samples T-Test Results

Table 5. Paired Samples T-Test Results for Ohio Scale Scores at 3 Months, 6 Months and Discharge.

	3 Months				6 Months				Discharge			
	N	Baseline Mean (SD)	Mean (SD)	*P*-value	N	Baseline Mean (SD)	Mean (SD)	*P*-Value	N	Baseline Mean (SD)	Mean (SD)	*P*-value
Problem Severity												
Youth	108	21.19 (13.56)	17.69 (12.26)	.006**	53	21.15(14.5)	16.58(14.9)	0.039*	124	20.74(13.1)	16.61(12.3)	.001**
Parent	100	19.04 (12.16)	15.21 (11.47)	.000**	32	17.13(11.5)	12.22 (8.53)	0.015*	112	18.71(11.9)	14.47(11.0)	.000**
Worker	349	18.35 (11.35)	14.35 (10.03)	.000**	189	19.71(12.8)	13.61(10.2)	.000**	374	18.57(11.5)	13.16 (9.56)	.000**
Functioning												
Youth	106	55.76 (14.55)	59.49 (12.25)	.007**	49	56.37(15.1)	63.41(11.7)	.000**	122	55.92(14.9)	60.59(12.3)	.000**
Parent	100	55.24 (13.79)	58.02 (13.92)	.016*	32	52.97(10.2)	58.03(11.8)	.041*	112	54.96(13.3)	57.98(13.6)	.004**
Worker	341	50.74 (12.91)	54.43 (11.26)	.000**	183	48.89(14.8)	53.60(11.7)	.000**	367	50.16(13.3)	55.05(11.1)	.000**

* Significant beyond the .05 level, two-tailed, * * Significant beyond the .01 level, two-tailed

APPENDIX C. Note on Analysis and the Reliable Change Index

Note on analysis:

The Ohio scales were administered at three month intervals during treatment. After receiving all of the data, a discharge category was created in order to generalize the scores for each student from the beginning of therapy until the end, regardless of duration. The last recorded scores were used as the discharge score and, in cases where complete data was not submitted, the intervention may have continued resulting in further change that could not be accounted for in this analysis. Outcomes analysis was conducted only for students who had a valid, follow-up scale that could be matched with their baseline data- sample sizes are reported for each comparison. To determine whether there were significant treatment effects, paired t-tests and a Reliable Change Index (Jacobson & Truax, 1991) were calculated.

Reliable Change Index:

The reliable change index analysis method developed by Jacobson & Truax (1991) provides a technique to determine what magnitude of change is necessary to categorize a client's response to treatment as statistically significant while also incorporating the concept of clinically significant change. Clinically significant change refers to clients who moved from the clinical to non-clinical range during treatment and had a statistically significant magnitude of change.

Tam and Healey (2007) applied the reliable change index concept to a large dataset of youth receiving outpatient services across the state of Ohio (greater than 40,000 clients). Derived from the psychometric properties of the Ohio Scales, they established the following categories for statistically significant and clinically significant change:

Improvement / Deterioration- (Problem Severity)-

For problem severity, a change of 10 points or more indicates a significant improvement or deterioration, while a change between 5 and 10 points indicates partial improvement or deterioration. Clinically significant change required movement of >10 points and crossing from the clinically significant range,>20, at the intake to <20 at discharge.

Improvement / Deterioration (Functioning)-

For the functioning category, a change of 8 is significant, while a change between 4 and 8 is considered partial improvement.

Clinically significant change required an 8 point difference and movement from <50 to >50 at discharge.

No Change-

Less than 5 points change in problem severity or <4 points difference in functioning represents no measurable change.

Table 8. Ohio Scales Reliable Change Index for Problem Severity (PS) and Functioning (F) from Intake to Discharge by Respondent

	Youth				Parent				Worker			
	PS (n=124)		F (n=122)		PS (n=111)		F (n=112)		PS (n=374)		F (n=367)	
Improvement with Clinical Significance (%)	18		16		12		12		21		22	
Improvement without Clinical Significance (%)	10	47	18	51	11	44	21	48	8	52	13	55
Partial Improvement (%)	19		17		21		15		23		20	
No Change (%)	34	34	27	27	39	39	28	28	37	37	26	26
Partial Deterioration (%)	7		11		10		12		6		8	
Deterioration without Clinical Significance (%)	6	19	8	22	3	17	6	24	2	11	8	19
Deterioration with Clinical Significance (%)	6		3		4		6		3		3	

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