Realizing the Promise

of the Whole-School Approach to Children's Mental Health: A Practical Guide for Schools

SAMHSA-funded National Center for Mental Health Promotion and Youth Violence Prevention
Education Development Center, Inc., Health and Human Development Division

The National Center for Mental Health Promotion and Youth Violence Prevention at Education Development Center, Inc. (EDC), in partnership with American Institutes for Research (AIR), provides technical assistance and training to Safe Schools/Healthy Students (SS/HS) grantees. See the Center's website for more information and resources: **http://www.promoteprevent.org/**.

The SS/HS Initiative is a unique collaboration between three agencies:

- U.S. Department of Justice
- U.S. Department of Education
- U.S. Department of Health and Human Services

Since 1999, the SS/HS Initiative has spread to 49 states. SS/HS grants have been awarded to 365 Local Education Agencies (LEAs) in urban, suburban, rural, and tribal communities with funding from the U.S. Departments of Education and Justice, as well as the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services.

To ensure a comprehensive approach to violence prevention, SS/HS grantees address the following core elements:

- Safe school environments and violence prevention activities
- Alcohol, tobacco, and other drug prevention activities
- Student behavioral, social, and emotional supports
- Mental health services
- Early childhood social and emotional learning programs

(The completed guide is available electronically on the National Center for Mental Health Promotion and Youth Violence Prevention's website, **http://promoteprevent.org/Publications/**)

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Introduction

Purpose of This Guide

This guide offers a practical, research-based approach to implementing mental health promotion programs in elementary and middle schools—from promotion and prevention to early intervention and treatment.

The information and resources contained in this guide are designed to help school and community professionals (e.g., practitioners, administrators, educators) and families come together to create programs that promote the healthy social and emotional development of all elementary and middle school children, recognize when children are at risk for or are experiencing mental health problems, and intervene early and appropriately.

While many publications address elements of school mental health, to date there is no single user-friendly guide that integrates *all* the key elements into a coordinated whole-school approach for educators and practitioners. *Realizing the Promise of the Whole-School Approach to Children's Mental Health: A Practical Guide for Schools* bridges the gaps among existing resources by providing a comprehensive, practical approach to promoting children's mental health in schools.

No one would deny that mental health is an essential ingredient of every adult's and child's overall well-being. We want all children and adolescents to grow into healthy, caring, and productive members of their families and communities. Attending to children's mental health is an essential component of this process. According to Jellinek, Patel, and Froehle (2002), mentally healthy children and adolescents exhibit the following:

- The ability to experience a range of emotions (including joy, connectedness, sadness, and anger) in appropriate and constructive ways
- Positive self-esteem
- Respect for others
- A deep sense of security and trust in themselves and the world
- The ability to function in developmentally appropriate ways in the contexts of self, family, peers, school, and community
- The ability to initiate and maintain meaningful relationships (love) and learn to function productively in the world (work)

Children's mental health is not just the province of mental health experts—it is the concern of every member of society. Schools in particular are an ideal setting for mental health promotion. In the United States, more than 52 million children attend school, spending close to 30 hours each week in the school setting, surrounded by caring professionals.

A major challenge in the promotion of children's mental health is to prepare community-based mental health providers (e.g., clinical social workers, clinical and counseling psychologists) and systems to work effectively with schools and to prepare schools to integrate mental health providers into their ongoing daily functions. *Realizing the Promise* provides the tools to enable school staff and community-based practitioners to overcome turf issues and to join together to promote mental health for elementary and middle school children in every community across the United States.

> *"Those who lead mental health programs in school systems are often faced with the challenge of helping school and community leaders understand the role [that] mental health plays in children's academic success. This guide provides compelling evidence that can be shared with school and community stakeholders to illustrate the value of investing in children's mental health."*
>
> — Brenda Hummell, Director of ACCESS (Austin Community Collaboration to Enhance Student Success—A Safe Schools/Healthy Students' Initiative), Austin (Texas) Independent School District

Children's Mental Health and Academic Outcomes

> *As public schools . . . are expected to meet higher performance standards, expanding school mental health programs is vital to helping schools to carry out their mission to educate our young children.*
>
> — John Staup, Executive Director, Butler County (Ohio) Mental Health Board

Considerable research demonstrates that mentally healthy children learn better (Wang, Haertel, & Walberg, 1997) and are less likely to engage in the problem behaviors that interfere with learning (e.g., violence, delinquency, heavy alcohol use, risky sexual behaviors) (Hawkins, Catalano, Kosterman, Abbott, & Hill, 1999; Zins, Weissberg, Wang, & Walberg, 2004):

- Students who can manage their emotions are more able to focus on learning, as anxiety reduces the working memory that is necessary for most learning. Students who meet academic expectations feel better about themselves and more connected to school, which is a protective factor against antisocial behavior.
- School-based *risk prevention programs* have been shown to reduce the incidence of many problem behaviors, including delinquency, alcohol and drug use, truancy, dropout, and conduct problems (Battistch, Schaps, & Wilson, 2004; Wilson, Gottfredson, & Najaka, 2001).
- *Social and emotional learning (SEL) interventions* affect academic skills and students' attitudes towards school, improve positive social behaviors and academic performance, and reduce conduct problems and emotional distress. Research on SEL programs shows that they have a positive effect on students' statewide test scores, GPAs, and class grades (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, in press).
- Studies of *school-based behavioral interventions* have shown a reduction in off-task behavior and aggressive and disruptive behaviors (Epstein, Atkins, Cullinan, Kutash, & Weaver, 2008).
- Many *school mental health programs*, when effectively implemented, not only enhance students' social competencies (e.g., assertiveness, communication, self-confidence) but also boost their academic achievement (Greenberg et al., 2003).
- A recent study suggests that *comprehensive schoolwide prevention programs* can have a significant effect on preventing problem behaviors. Fifth graders who had received the program were about half as likely to engage in substance abuse, violent behavior, and voluntary sexual activity (Beets et al., 2009).

Between 14 and 20 percent of U.S. children and adolescents have an emotional disturbance or mental illness that can be a barrier to learning (National Research Council & Institute of Medicine [NRC & IOM], 2009; U.S. Public Health Service, 1999). Since half of all lifetime cases of mental illness are diagnosable by age 14 (Kessler et al., 2005), it is essential to intervene early with school-age children to bolster their healthy mental development and identify and treat those with mental disorders.

When youth with mental health problems do not receive treatment, the long-term results can be negative and far-reaching. For example, we know that adolescents with emotional problems are four times more likely than their peers to be dependent on illicit drugs, and that the dropout rate for youth with serious emotional disturbance is almost two times that of youth with other disabilities (U.S. Department of Education, 2007).

Because many school leaders and staff may not fully appreciate the connection between children's mental health and academic outcomes or make it a priority when faced with difficult budget cuts, advocates of the whole-school approach to children's mental health promotion must make their case clearly and convincingly.

Garnering Support for Mental Health Promotion in Schools

School administrators are most likely to support a whole-school approach to mental health promotion and prevention when they understand how such an approach can help to meet their school's needs and mission. Demonstrating how the whole-school approach aligns with federal, state, and local accountability measures and standards for school improvement can be the factor that propels administrators to endorse it. Weare and Murray (2004) argue that mental health promotion and prevention efforts are key in meeting the following education priorities:

- Promoting learning for all students
- Supporting the professional development of teachers
- Addressing behavioral problems among students (e.g., aggression, bullying, attention problems, depression, withdrawal) that disrupt or are barriers to classroom learning
- Tackling widespread under-achievement and raising standards—especially among boys, poorer children, and ethnic minorities

(For more information and resources on making the case for integrating mental health promotion into schools, see UCLA's Center for Mental Health in Schools, **http://smhp.psych.ucla.edu/**, and the University of Maryland School of Medicine's Center for School Mental Health, **http://csmh.umaryland.edu/resources.html/index.html**.)

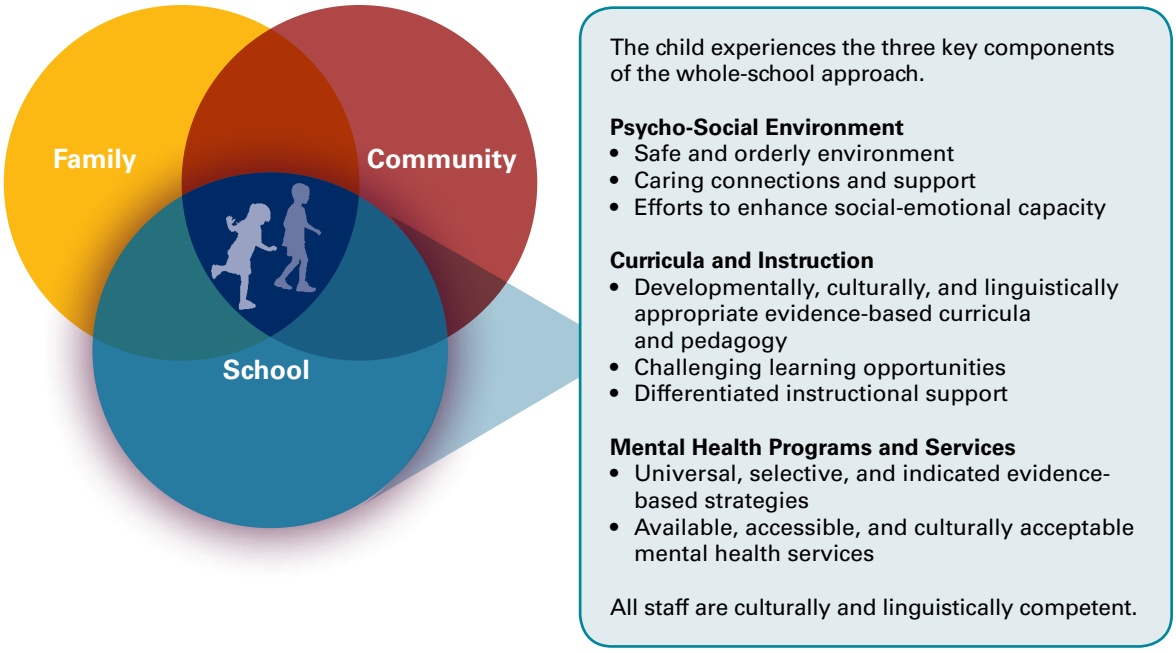
The Power of the Whole-School Approach

The Importance of Positive School, Family, and Community Interactions

> *"Parents and other caregivers are a child's first and foremost teachers. Promotion and prevention programs that address issues of parents and other caregivers increase the potential of positive outcomes. Family members and caregivers should be equal partners, along with school and community leaders, in selecting, implementing, evaluating, and sustaining programs."*
>
> — Substance Abuse and Mental Health Services Administration (SAMHSA) (2007, p. 3)

Figure 1 illustrates the conceptual model for the whole-school approach to enhancing children's mental health.

Figure 1: The Whole-School Approach for Enhancing Children's Mental Health



Children are at the center of this model. However, mental health resides not only within the child but also within the influential web of interactions surrounding the child, including the family, the school, and the neighborhood and community in which the child lives (Kellam, Ensmiger, & Branch, 1975), as illustrated by the tri-colored circles. Both research and practice have shown that these interactions can either support or undermine a child's healthy development (U.S. Public Health Service, 1999) and impact the child's vulnerability to mental health problems.

The relationship between families and schools in particular is critical, as it affects both mental health and academic outcomes (Osher, Osher, & Blau, 2008). The family is paramount in the development of a child's sense of self and his or her ability to form relationships with others.

The interaction between the child and the community is also important. Communities that value children and youth provide a myriad of youth- and child-focused development opportunities, activities, and services. However, the effectiveness of these offerings depends on a clear understanding of the diverse needs of the families within the community and how to best to address them.

The whole-school approach to children's mental health recognizes the entire web of interactions between the child and his or her family, school, and community.

Mental Health Protective and Risk Factors

Children can be helped by supportive *protective factors* within their families, schools, and communities. Some of these protective factors, such as having social and conflict management skills and warm, supportive parent-child relationships, can be strengthened and taught to children, as well as their family members and other caregivers.

Risk factors that affect children's mental health include living in poverty, being a victim of abuse, having poor social skills, having reading disabilities, and living in a family that uses inconsistent or harsh discipline practices. Nearly half the children entering kindergarten in the United States experience at least one risk factor. While some of these risk factors, such as poverty, cannot be modified by a mental health program, others, such as poor social skills or reading disabilities, can be successfully addressed.

definitions

Protective factors: Individual characteristics or peer, family, community, or societal conditions that have been shown by research to reduce the impact of risk factors and/or to decrease the likelihood of a problem behavior and promote positive mental health. Examples of protective factors are having a strong sense of connectedness to school, having a meaningful relationship with an adult, and having conflict management skills.

Risk factors: Individual characteristics or peer, family, community, or societal conditions that have been shown by research to increase the likelihood of a problem behavior. Examples of risk factors are having poor social skills and being a victim of abuse.

The Three Critical Components of the Whole-School Approach

The box to the right of Figure 1 illustrates the three critical components of the whole-school approach:

- Psycho-social environment
- Curricula and instruction
- Mental health programs and services

Although the three components appear as distinct functions, in reality they are highly interdependent and mutually reinforcing. Bringing together these diverse components requires the entire school community to work together in new and collaborative ways, and encourages a coordinated and comprehensive approach to the planning and delivery of mental health programs and services.

The Psycho-Social Environment

A positive psycho-social environment supports the well-being and healthy mental development of the greater school community (students, staff, and families) and provides the foundation for a safe learning environment. Students in positive school environments feel more connected to one another, to their teachers, and to their schools. They are also more likely to adopt the prosocial and pro-academic norms promoted by these individuals and settings. In addition, students in a positive school climate have better academic performance and attendance, as well as significantly lower rates of emotional distress, violence, delinquency, substance abuse, and sexual activity (Collaborative for Academic, Social, and Emotional Learning [CASEL], 2008).

> *"School climate encompasses the physical attributes of a school as well as levels of order, satisfaction, and productivity. It includes how students, staff, and community interact and what approaches are used to solve school problems. Climate reflects whether students and families feel they belong at the school and how school rules are determined, expressed, understood, and enforced."*
>
> —Minneapolis Public Schools (n.d.)

A Positive Psycho-Social School Environment

The *critical characteristics of positive learning environments* include the following (CASEL, 2008; Minneapolis Public Schools, n.d.[1]):

- *Caring teacher-student relationships* that promote respect for teachers and for students as individuals; that respect ethnic, cultural, and racial groups; and that establish strong student connections with the school
- *High expectations for all students* that are motivational and age-appropriate
- *Schoolwide standards* that are clearly written and consistently implemented
- Instructional and classroom management *strategies that address students' social and emotional needs*
- *Effective strategies and interventions to support student learning at all levels*; the range and intensity of these efforts is driven by students' needs
- *Psychological and physical safety* for students and staff

[1] For an in-depth resource on school climate, see *Creating a Positive School Climate for Learning*, a tool kit created by the Minneapolis Public Schools: http://sss.mpls.k12.mn.us/Positive_School_Climate_Tool_Kit.html.

Positive Behavioral Interventions and Supports

One example of an evidence-based program that promotes safe and healthy school environments is Positive Behavioral Interventions and Supports (PBIS), a systemwide approach to preventing and improving problem behaviors in classrooms and schools. PBIS does not single out "problem students" for punishment, but rather involves the entire school population in promoting and rewarding positive behaviors, while preventing negative or risky behaviors, in order to create a safe, supportive learning environment for all. PBIS does not simply seek to "fix" a problem; it also addresses the circumstances that led to the problem behavior, and creates sustained positive change in the school environment. For more information, see the *PBIS Guide* and other related resources at The National Center for Mental Health Promotion and Youth Violence Prevention's website, **http://promoteprevent.org/Publications/PBISguide/index.htm**.

The psycho-social environment of the school—as well as the curricula and services—should be framed within and responsive to the culture and ethnicity of the children, youth, and families in the community. In fact, culture plays an important role in one's mental health. It affects how people define *mental health* and *mental illness*, their coping styles and social supports, how they exhibit mental health problems, and whether and where they seek help for problems.

One way that culture interacts with mental health is through the absence or presence of stigma associated with mental health promotion and prevention. The Surgeon General identified the stigma surrounding mental illness as one of the primary reasons that individuals and families don't seek help (U.S. Public Health Service, 1999). Almost two-thirds of all people with mental illness do not seek treatment. For centuries, the public's understanding of mental illness has been shrouded in misunderstanding and fear, resulting in many individuals' unwillingness to seek professional help when mental health problems arise.

Cultural competence requires a clear and comprehensive understanding of the diverse characteristics and needs of one's community. The need to address ethnic and cultural diversity through mental health programs grows increasingly important as the U.S. population becomes more culturally and linguistically diverse. According to the U.S. Department of Education (2004), more than 5.5 million students in U.S. schools are English-language learners (ELLs) who among them speak more than 400 different languages; ELLs are expected to comprise more than 40 percent of elementary and secondary school students by 2030 (Thomas & Collier, 2002). The selection of services and interventions, professional development for staff, and program adaptations should be driven by and designed to meet these diverse cultural and linguistic needs.

> *A culturally competent mental health provider is knowledgeable in understanding, approaching, and treating the problems of culturally diverse groups. [These providers] have an awareness of the assumptions and values they hold that influence their work with students and are able to provide effective services that are respectful of the student's race, ethnicity, social class, religion or faith, and sexual orientation.*"
>
> — Dana Cunningham, Metin Ozdemir, Julian Summers, and Aya Ghunney (2006, p. 2)

Equipped with such a foundation, a school can develop a supportive psycho-social environment and put together a full menu of culturally and linguistically (in terms of both literacy levels and primary languages) appropriate services, interventions, and activities that meet children and families where they are, with service providers who understand their needs and are able to fulfill them. *Understanding students' and families' values, beliefs, and norms is an essential step in developing an effective whole-school approach to children's mental health.*

> *Many in the mental health field consider cultural competence to be essential to ensure quality of care, responsiveness of services, and renewed hope for recovery among ethnic and racial minorities.*"
>
> — President's New Freedom Commission on Mental Health (2003, p. 52)

Curricula and Instruction

The last decade has seen a blossoming of evidence-based interventions (EBIs) in schools that focus on promoting children's mental health or preventing or treating mental illness (Kutash, Duchnowski, & Lynn, 2006). In essence, EBIs are conceptually sound programs and strategies that are linked to reliable research, have been rigorously evaluated and replicated, and offer effective methods for addressing specific risk or protective factors.

- Selecting appropriate EBIs for a given school setting involves matching the school's needs, assets, and resources to the EBIs that are available and appropriate for the target population.
- EBIs should be tailored to the cultural and linguistic diversity of the school and its community.
- Recent analyses of mental health prevention and promotion EBIs for children and youth found that the reduction in the costs of crime alone offered *significant* economic benefits. For example, Functional Family Therapy (FFT)[2] produces benefit-to-cost ratios that *exceed 20 to 1*. In other words, every dollar spent on implementing FFT today can be expected to return *20 or more dollars* in the years ahead (Aos, Leib, Mayfield, Miller, & Pennucci, 2004). In general, EBIs more than pay for themselves over time in two key ways:
  - By strengthening children's resilience
  - By reversing the trajectory of developmental challenges that often results in school failure, delinquency, substance abuse, and other negative consequences

[2] An empirically grounded, well-documented, and highly successful family intervention for at-risk and juvenile justice-involved youth. For more information, see http://www.fftinc.com/.

> *The prevention of even a small percentage of mental and behavior problems will result in substantial cost savings and improved quality of life for children, families, and communities. Conversely, failure to increase needed access to proven programs will continue to exact a heavy personal toll and a heavy financial burden on workplaces; [on] the educational, welfare, and justice systems; and in State and national economies.*
>
> —SAMHSA (2007, p. 30)

The increased use of EBIs in schools promises significant protection against the risk factors that threaten children's mental health, while simultaneously strengthening the protective factors that promote mental health.

Integrating Mental Health Into the School Curriculum

EBIs are just one way to integrate mental health into a school's existing educational curriculum. Health education is another obvious venue. One excellent resource is CDC's Health Education Curriculum Analysis Tool (HECAT), which can assess health education curriculum for its mental health content. HECAT is available at **http://www.cdc.gov/HealthyYouth/HECAT/index.htm**.

In the state of Illinois, SEL standards have been developed to integrate SEL into the entire curriculum. For more information, see **http://www.isbe.state.il.us/ils/social_emotional/standards.htm**.

Mental Health Programs and Services

The whole-school approach to children's mental health involves implementing strategies along a continuum—focusing on promotion and universal, selective, and indicated prevention—to enhance all students' mental health (NRC & IOM, 2009). These strategies include the following:

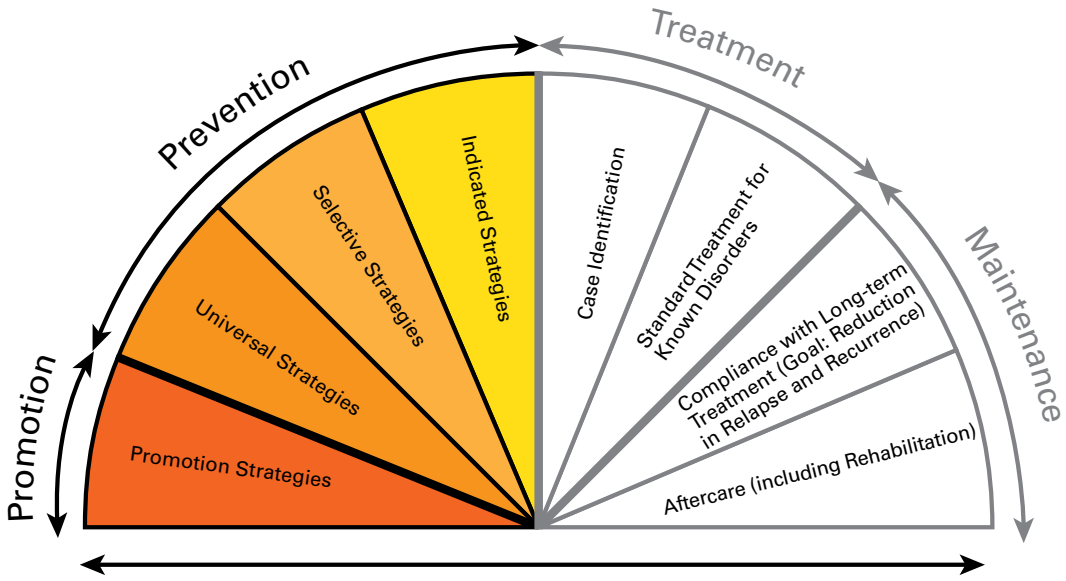
- Strengthening mental health and social and emotional well-being (rather than focusing on prevention of illness or disorder) through *mental health promotion strategies* for either the general public or a whole population.
  Example: School- and community-based programs that promote emotional and social competence and the ability to cope with adversity
- Supporting the positive development of all children and youth and enhancing protective factors for mental health through *universal prevention strategies*.
  Examples: Schoolwide programs, such as bullying prevention, or workshops for parents to teach the skills to communicate with their children about resisting substance use

» Providing interventions to subgroups of children and youth who share a significant risk factor for mental health problems through *selective prevention strategies*.
Example: Support groups for children who have experienced the death of a loved one or a divorce

» Delivering interventions to individual children and youth who have significant symptoms of a mental health problem (which is not severe enough to be a diagnosed disorder) through *indicated prevention strategies*.
Example: Early intervention for children showing high rates of aggressive behavior problems

Figure 2 (adapted from NRC and IOM [2009]) illustrates the continuum of mental health strategies. No matter where an individual falls along this continuum, school and community efforts should promote a more positive level of mental health.

Figure 2: The Continuum of Mental Health Strategies



The highlighted portion of the figure emphasizes the critical role that schools can play in promoting positive mental health and preventing disorders by combining promotion and prevention strategies. Early intervention via mental health promotion or universal prevention strategies has the cheapest per unit cost, while selective group interventions for children who are at risk for mental health problems are less expensive than individualized indicated strategies for children who show signs of a mental health problem.

definitions

Mental health promotion: Efforts that enhance individuals' ability to achieve developmentally appropriate tasks (competence); give them a positive sense of self-esteem, mastery, well-being, and social inclusion; and strengthen their ability to cope with adversity. In practice, there is often considerable overlap between prevention and promotion efforts, as mental health programs may both reduce problems and increase the positive aspects of development (NRC & IOM, 2009).

Prevention of mental health problems: Interventions that occur before the onset of a problem, as well as interventions that prevent relapse, disability, and the consequences of severe mental illness. Prevention efforts often modify or reduce risks related to mental health problems or strengthen protective factors in the home, school, and community that contribute to mental health (SAMHSA 2007).

Mental health interventions: Strategies conducted with individuals or groups who are at risk and who demonstrate a moderate need for specialized services (Kutash et al., 2006). Early intervention involves proactively taking action against factors that put individuals at risk. If the warning signs for mental health problems are detected, early intervention can help children get better in less time and can prevent problems from getting worse.

Using The Public Health Approach to Children's Mental Health

Leaders in the field of school-based mental health are increasingly advocating the use of the public health approach (Strein, Hoagwood, & Cohn, 2003). The *Report of the Surgeon General on Mental Health* (U.S. Public Health Service, 1999), for example, highlights the need for a public health approach that focuses on risk and protective factors, applying intervention research, and using a developmental perspective to understand and treat mental health disorders in children.

The public health approach to children's mental health comprises the following:

- Identifying problems, underlying influences, and relevant risk and protective factors
- Considering these issues across the whole student population
- Strategically applying and implementing appropriate best practice preventive interventions
- Evaluating the effectiveness of these interventions for the whole student population

The whole-school approach uses the public health model as the mechanism to promote positive mental health for all children.

Embracing the public health model for children's mental health requires schools to expand their efforts beyond individual students' mental health issues toward a systematic assessment of a variety of factors that influence the mental health of the entire student population, such as school policies and school climate.

Currently, the vast majority of professionals who manage school mental health programs are counselors and psychologists, whose training has generally focused on selective and indicated strategies for individual students. The public health approach requires many mental health professionals to undergo a paradigm shift that emphasizes schoolwide interventions (universal prevention strategies) designed to optimize *all* children's positive mental health and to provide effective selective and indicated interventions as early as possible for children in need. This process encompasses the essence of the whole-school approach to children's mental health.

Our ultimate goal is to help all children, including those with mental health problems, reach their optimal level of health. Promoting children's mental health, preventing mental illness, and intervening with those at increased risk for mental health problems are three distinct but highly complementary functions. When schools make use of research-based approaches and EBIs to promote mental health and prevent mental disorders, they find that fewer and fewer students are in need of the higher level, more resource-intensive interventions (Durlak & Wells, 1997; Weisz, Sandler, Durlak, & Anton, 2005).

Using the Public Health Approach to Implement School Mental Health Programs[3]

The public health approach involves four steps to strategically implement programs that enhance the mental health of all children in a community.

1. ***Collect data at the community level: What is the problem?***
Use systematic data collection to identify the specific mental health challenges in the community. (*See Phase 2 of this guide.*)

2. ***Identify the community's risk and protective factors related to mental health: What are the underlying causes of the problem?***
Relate the data collected to specific risk and protective factors for mental health. (*See Phase 2 of this guide.*)

3. ***Select effective EBIs that focus on strengthening preventive factors: What works and for whom and in what contexts?***
Choose EBIs that target a community's priority challenges and risk and protective factors for mental health. (*See Phase 3 of this guide.*)

4. ***Evaluate the effectiveness of interventions for the entire population: Are the interventions meeting the intended needs?***
Monitor the effectiveness of program implementation and measure the program's impact. (*See Phases 3 and 5 of this guide.*)

[3] Adapted from Kutash et al. (2006, p. 75)

The public health approach offers a number of benefits (Strein et al., 2003):

- Focusing on the largest possible groups of people
- Emphasizing preventive approaches that decrease the number of individuals needing treatment services
- Identifying and addressing risk factors that increase the probability of illness, and protective factors that reduce risk
- Employing EBIs (e.g., prevention programs, mental health services) that have been scientifically proven to be effective
- Focusing on strengthening positive protective factors rather than decreasing problem behaviors
- Coordinating and integrating services (e.g., within the school and across the community)
- Evaluating the effectiveness of interventions on the entire target population (e.g., by looking at attendance, disciplinary referrals, suspensions and expulsions, grade retention, performance on standardized tests)

Building from Best Practices

Much work has been done to identify and document best practices in school mental health for children. Table 1 presents the key best practices for the whole-school approach to children's mental health.

Table 1: Best Practices for the Whole-School Approach to Children's Mental Health[4]

Best Practice 1:	Evidence-based school mental health programs, practices, and policies are implemented to address students' needs and strengthen their assets.
Best Practice 2:	Students, families, school staff, and community mental health providers are actively involved in the program's development, oversight, evaluation, and continuous improvement.
Best Practice 3:	School mental health programs, practices, and policies focus on reducing barriers to children's development and learning, are accessible to all, and are student- and family-friendly.
Best Practice 4:	Staff competently address cultural differences among students, families, and one another.
Best Practice 5:	Staff work collaboratively within the school to promote students' mental health and build strong relationships with students and mental health and health care providers.
Best Practice 6:	Staff are well-trained, hold to high ethical standards (including confidentiality), are committed to children and families, and display a flexible, responsive, and proactive style in their work.

In Phase 1 of this guide, you will use an assessment tool titled **Best Practice Mental Health Assessment** (p. T-2) for assessing these best practices in your school or school district.

[4] Adapted from Weist, Stephan, Lever, Moore, and Lewis (2006)

Implementing the Whole-School Approach in Rural and Urban Communities

Rural and urban communities will likely face different challenges around implementing mental health promotion, depending on their populations.

Rural Communities

There is not one homogeneous "rural America." In fact, less than 10 percent of the U.S. rural population now live on farms. Rural communities are characterized by low population density, limited access to cities, fewer economic opportunities, lower socioeconomic status, working poverty (i.e., income that falls below the poverty threshold despite one or more adults working multiple jobs), greater child poverty, individuals who often travel long distances to get to school or their workplace, many families without health insurance, and, in many rural areas, increasing diversity—over the past 10 years, there has been a 55 percent increase in rural minority students (Health Resources and Services Administration, 2006; Johnson, Strange, & Rural Trust, 2007).

However, the relative isolation of rural communities also leads to strengths that generally include self-reliance and a greater sense of community, as demonstrated by connectedness and loyalty among the members. Community members are likely to know and have direct access to the school board, the school superintendent, and other school staff.

The prevalence of mental health problems in rural communities is the same as in urban areas (except for suicide rates, which tend to be higher in rural areas). The difference between the two populations is their experience in seeking mental health services—the *accessibility*, *availability*, and *acceptability* of these services in rural areas (President's New Freedom Commission on Mental Health, 2004).

Rural communities face a number of challenges around accessing mental health services:

- Resources and organizational support for these services are generally limited.
- Fewer licensed mental health providers are available in rural areas, and these communities find it difficult to attract and retain mental health professionals.
- Families often have to travel long distances to access mental health services.
- If services are provided locally, people face the "fishbowl effect" of small communities—the lack of anonymity that heightens the stigma of receiving mental health services, and the concern that getting help could affect their personal and work lives (Slama, 2004).
- The strong ethic of self-reliance in rural communities contributes to the sense that people should be able to deal with mental health issues by themselves.

Because of these accessibility, availability, and acceptability issues, the rural population tends to wait longer to receive mental health services, and thus individuals are likely to have more serious conditions when they do receive treatment.

Because many rural school districts often have difficulty finding local area mental health providers to work in the schools, they need to develop the capacity of existing school staff (e.g., school psychologists, social workers, counselors) to provide mental health services. In addition, because rural area mental health providers are often long distances away, schools need to have trained providers who are located onsite or nearby and can help students or families in the event of a crisis situation.

One Rural Community's Mental Health Approach

The Safe Schools/Healthy Students (SS/HS) project director of St. Lawrence–Lewis Boards of Cooperative Educational Services (BOCES) in upstate New York says, "In a rural, high-poverty area, having mental health counselors [in this case, Licensed Clinical Social Workers] in the school buildings makes a huge difference in terms of both ease of assessment and access to services."

The project's mental health counselors work with students in grades pre-K through 12. In one case, a counselor works with three elementary schools and has established a good rapport with teachers. When a teacher tells her about a student who may be in need of mental health intervention (e.g., is having trouble academically and behaviorally, and educational assessments have not pinpointed the problem), the mental health counselor goes into the classroom to observe (i.e., to conduct an informal pre-screening). If she thinks that there is a possibility of a more serious issue, she then contacts the parents and asks for permission for the child to participate in a more intensive assessment. Any assessment and/or therapy that follows takes place within the school building, which makes it more accessible for families who may not have transportation and/or health insurance to cover outpatient psychological services. Parents also are more likely to accept services that do not require regularly losing time from work to drive their child to sessions.

School-based services overcome the barrier of accessing services from outside or off-site agencies. In addition to providing one-on-one services, the mental health counselor also returns to the classroom and models strategies for the teacher to use when working with kids who have particular issues. The counselor also meets weekly with a supervisor from the county mental health clinic for case review. These strategies ensure appropriate coordination and targeted delivery of services.

Urban Communities

Urban, low-income communities have experienced a dramatic rise in community violence, poverty, and substance abuse, all of which place youth at high risk of becoming perpetrators and/or victims of crimes and may affect their mental health. Children in low-income urban settings are exposed to violent crime at rates 4 to 10 times greater than the national average (Atkins, Frazier, Adil, & Talbott, 2003). Urban children often experience violence simply walking to and from their neighborhood schools. In addition, urban immigrant families may have experienced poverty, crime, social upheaval, war, or other traumatic events that can put them and their children at risk for mental health problems (Stein et al., 2003).

Disruptive behavior among children in urban low-income communities is almost three times as prevalent as the national estimates, making these behaviors a significant mental health problem. Low-income urban families also face extraordinary pressure, because of diminishing mental health services and community-based resources, as well as concrete obstacles, such as inaccessible locations, lack of information about available services, and lack of social support (Atkins et al., 2003). Although mental health services are often more available in urban than in rural communities, urban families might not feel comfortable accessing services if the service providers are not in their own neighborhoods.

Low-income, urban, minority families may not avail themselves of school-based mental health services for a variety of reasons, the most common being the stigma associated with mental disorders in certain communities and cultures, a feeling of disconnectedness from the school, previous negative experiences with the school, and concerns around confidentiality. Low participation rates of urban, minority parents at school activities is an ongoing concern for educators and school-based mental health providers, as family involvement in children's academic and behavioral performance, both in school and at home, is crucial to the success of academic and mental health programs (Atkins et al., 2003). According to Atkins et al. (2003, p. 170), these families remain "a largely untapped resource for addressing the academic and mental health needs of urban children."

Immigrant families often experience additional barriers, including a lack of understanding of the U.S. mental health system, inadequate or no health insurance, and a shortage of culturally sensitive bilingual mental health clinicians (Stein et al., 2003).

Urban school districts face unique challenges. Although school mental health programs and services may be available, the complex bureaucracies of large urban districts may make coordination of the continuum of mental health programs and services difficult. And because of the great number of schools, each may have different procedures for screening, assessment, and decision-making about referrals for mental health services and for collecting and tracking data, which makes the coordination between elementary and middle schools, for example, even more difficult. To counteract this, some urban SS/HS sites are creating more local advisory groups within the school district to coordinate and track mental health program efforts in schools.

Milwaukee, Wisconsin: Working Smarter, Not Harder

Milwaukee has the fourth highest poverty rate in the United States, which puts Milwaukee children at risk for increased violence and mental health issues in their lives. Milwaukee Public Schools is a large, urban district of 85,000 students in 200 schools—a mix of traditional, charter, alternative, and partnership, with many different configurations (e.g., K–5, K–8, 6–8, 6–12, 9–12). The size of the district has often meant that staff don't know what other mental health programs or services are being offered in the district.

The SS/HS Initiative has been a catalyst for monthly internal meetings of school district directors (i.e., MPS Departments or Divisions of Early Childhood, Guidance, Nursing, Student Services, Title I, Professional Development, Research and Assessment, School Safety, Social Work, Psychology, Special Education, Violence Prevention, and Wellness and Prevention). These regular meetings have enhanced communication and information-sharing across school service systems; directors are now aware of what others are doing and can work together to address mental health issues. As one director put it, "We were all doing our own thing. Now we sit at the table together to collaborate and are able to create systemic change."

Another issue in this large district is that there are so many different mental health providers, it is difficult to ensure program quality. The SS/HS mental health partner, Milwaukee County Behavioral Health, has helped greatly with the process of identifying, vetting, supervising, and assessing quality providers.

Milwaukee's powerful teachers union was at first resistant to using outside mental health providers, concerned that this would result in job losses for the school mental health providers (i.e., social workers and school psychologists). In response, SS/HS crafted an inclusive process of strong collaborative support teams who work with school-based providers to identify their needs, concerns, and fears and their hopes for the children, and to consider how additional mental health providers could benefit their students. SS/HS has also started a pilot intervention program in which outside providers help address children's needs, and is collecting data to determine program outcomes.

Miami-Dade County: Screening Thousands of Sixth Graders

Miami-Dade County Public Schools is an extremely large urban district of approximately 350,000 students, whose size and complexity is reflected in its 25-page organizational chart. With its SS/HS grant, the district decided to conduct a comprehensive mental health screening of all sixth graders. However, with an urban district this size, the challenges of the task were magnified. SS/HS sent a passive-consent form for the screening to the families of the almost 27,000 sixth graders—a complex process that took a considerable amount of time. Once the screening was completed, the approximately 10 percent of sixth graders (almost 3,000 students) identified with mental health issues then needed follow-up from the school district caseworkers. This tremendous extra workload required building increased capacity to address student needs.

Ultimately, the SS/HS grantee built a partnership with a local university to use social work graduate student interns to add the needed capacity to address the school's needs for referrals. The lesson learned is that large, urban sites might begin with a smaller scope of work to fit their existing capacity and then scale up their efforts as capacity increases.

Using this Guide

There are many frameworks for implementing comprehensive mental health programs (Devaney, Utne O'Brien, Resnik, Keister, & Weissber, 2006; Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Glasgow, Klesges, Dzewaltowski, Estabrooks, & Vogt, 2006; Hawkins, Catalano, & Miller, 1992; Osher, Dwyer, & Jackson, 2004; SAMHSA, 2007), and the whole-school approach to mental health incorporates aspects of many of them. While these frameworks differ in some regards, they share the following common phases of development:

- A *planning* or *pre-implementation phase*, in which organizations or communities collect and review data to assess needs, organizational readiness and capacity, infrastructure, and culture, and then create a plan of action appropriate for addressing the identified needs
- An *implementation phase*, in which the plan of action is operationalized and evaluated, and evaluation findings are used for program improvement

When schools and communities take a more structured approach, regardless of the specific framework chosen, the programs and practices are typically more effective than when implementation is informal and unstructured (Cooper & Edgett, 1999; Sandler, Ayers, & Dawson-McClure, 2005). The results of an informal implementation approach are likely to be fragmented, duplicative, and unresponsive to the needs of the children and families being served. For example, schools that don't engage in a careful planning process are likely to find that their efforts in the areas of mental health promotion, prevention, early intervention, and treatment are disconnected and heavily skewed toward early intervention and treatment.

This guide describes seven sequential phases for developing and implementing a whole-school approach to children's mental health that uses the public health approach and incorporates the six best practices outlined in Table 1 on page 15.

Seven Implementation Phases: An Overview

Phase 1: Convene a School and Community Coalition

- Secure support from school leadership and staff for a whole-school approach by making a strong case for the link between children's mental health and academic success.
- Expand to a broader coalition, representing key community members invested in children's mental health who recognize the importance of enhancing children's mental health in the school setting.
- Conduct an initial assessment of your school's best practices for children's mental health.
- Develop a shared vision that mobilizes the school and community to promote and protect children's mental health.

Phase 2: Assess Mental Health Problems, Needs, and Resources

- Conduct a comprehensive assessment of mental health problems and concerns in the school and community and the existing policies and resources to meet these needs.
- Use the public health approach; focus on the larger school population to maximize the program's effectiveness.
- Use existing data to identify problems, analyze related risk and protective factors in the school and community, and determine the gaps between the current situation and the coalition's vision for a whole-school approach.
- Share results with the community, proposing recommendations that build on community strengths and resources.

Phase 3: Develop an Implementation Plan

- Develop program goals, objectives, and outcomes to address the priority mental health needs and enhance the strengths that have been identified.
- Review and select EBIs to help address identified needs and achieve desired goals and outcomes.
- Determine strategies and training to support and enhance the EBIs selected and then develop an action plan that includes specifics and timelines for achieving the goals.
- Determine an evaluation plan to monitor program implementation and outcomes.

Phase 4: Secure Financial Resources

- Develop a budget for the implementation plan.
- Identify existing and potential sources of funding, including public and private sources.
- Involve school district officials and community members in pursuing and securing the financial resources needed to support the plan.

Phase 5: Monitor and Address Challenges

- Prepare staff and carry out the implementation plan.
- Carefully monitor the effectiveness of program implementation to identify and address in a timely manner such challenges as resistance, cultural competence issues, stigma, turf issues, and confidentiality concerns.

Phase 6: Create and Carry Out a Communications Plan

- Conduct a situation analysis to identify communications goals, target audiences and their characteristics, and the available assets for creating and implementing the communications plan.
- Create communications messages that define both the problems and how the program's efforts address them.
- Select the best communications strategies to convey your messages.
- Identify channels, such as local cable stations and school newsletters, that will help reach diverse audiences in the community.
- Evaluate your efforts to determine how to refine your communications plan in order to reach your goals.

Phase 7: Build Sustainability

- Identify and prioritize the practices and activities that are that most effective and that will require support beyond the current funding.
- Identify the key functions of these practices and activities (e.g., screening and assessment of high-risk children).
- Use a variety of strategies, such as strategic planning, partnerships and collaboration, and capacity-building, to sustain these functions in a way that ensures positive outcomes.

It is recommended that school staff use the **Best Practice Mental Health Assessment: The Whole-School Approach to Children's Mental Health** in Phase 1 (see p. 1-6) to determine the best point in the process to begin. For example, if a school has already created a broad coalition and assessed problems, needs, and resources, it is ready for Phase 3: Develop an implementation plan. If the school is trying to create an implementation plan and has not built a broad coalition nor adequately assessed the situation, the stakeholders will need to complete Phases 1 and 2 before moving to Phase 3.

Mental health programs in schools fall somewhere on the continuum of program development, from the early stages of recognizing the need for a whole-school approach to the later stages of refining and integrating evidence-based practices to meet the needs of all students. Schools in the early stages may find it helpful to follow the phased approach outlined in this section of the guide. Schools with more elements of their program in place may prefer to focus on the phases of program implementation that they haven't yet addressed and/or phases they want to revisit to fine-tune their efforts.

> *. . . Implementation amounts to mutual adaptation in which both the innovation (program) and the organization change in important ways.*
>
> —Everett Rogers (1995, p. 372)

Phase 1: Convene a School and Community Coalition

Getting Started with the Whole-School Approach

How and why do schools and communities commit to a whole-school approach to children's mental health? The catalyst for this decision varies. It can be an impassioned administrator with a vision for supporting the needs of the whole child. Other times it's an outside influence, such as a partnership with a local social services agency or university. Sometimes the catalyst is a traumatic event, such as school violence. And frequently, it's the recognition by one or more school staff that the school needs to coordinate and intensify its efforts to break down social and cultural barriers to learning.

Initial steps to get a program off the ground also vary, but once the principal's support has been secured, it is important to draw on other key players within the school who will be involved in the effort. While parents and community organizations are absolutely critical to the success of mental health promotion, it is important to begin by establishing a core team of committed school and district staff and getting their buy-in before reaching out to families and community partners. These efforts will help build the support and commitment that a school mental health program needs to succeed in the school environment.

The most effective coalitions for school mental health include school and district staff, parents, and members of community organizations, who bring different viewpoints and perspectives to the task at hand. Educators bring insights into students' motivations and behaviors. Parents and families can provide a deeper understanding of their children's needs and strengths and help to ensure that programs and services are culturally competent. Community partners can provide access to resources and help to create an integrated effort that doesn't duplicate or waste resources. The broader coalition can forge a shared vision of a mental health system that meets the needs of all children so they can succeed. Through the combined efforts and resources of its members, the coalition can maximize its power to effect change and achieve this vision.

> *"The welfare of students is a shared responsibility. The health of students and their families is the responsibility of the entire community of which the school is a part. . . . By working together, [schools and communities] leverage their resources and identify new resources."*
>
> —Centers for Disease Control and Prevention (CDC) (2003, p. 22)

The active participation of school staff, families, and community partners in the coalition contributes to building the larger community's awareness of students' mental health needs, and helps in mobilizing the community to take action.

Steps to Take to Convene a Coalition

Step 1: Secure Support from School Leadership

While the principal may not be the initiator of mental health programs in the school, gaining his or her trust and support is a key first step for the success of the whole-school approach. Principals can galvanize staff support for new initiatives and can serve as champions and spokespeople for the power of school efforts to promote and protect children's mental health.

> *A 10-year study of whole-school reform by the Rand Corporation found that 'the single biggest predictor of implementation quality was principal leadership.'*
>
> —Devaney et al. (2006, p. 27)

School administrators typically have many demands on their time, so you should be prepared to summarize clearly and convincingly for the principal how the whole-school approach to children's mental health dovetails with the mission of the school, for example:

- It increases students' ability to be focused and attentive.
- It helps to improve their academic performance.
- It decreases the amount of instructional time spent managing disruptive behavior.
- It leads to improved graduation rates.

It is important to ask the principal to be involved in and supportive of the initiative and to make your request as specific as possible. For example, you might ask the principal to introduce the effort at the first meeting of interested school staff. If a nearby school has successfully implemented the whole-school approach, invite the principal and two or three key staff members to visit with that school's leaders.

> *The principal is the school's gatekeeper, establishing the school's priorities and controlling allocations of staff, space, and fiscal resources. Where programs succeed, principals are actively engaged.*
>
> —CDC (2003, p. 21)

Step 2: Identify and Convene Interested School Staff

Once the principal is on board, your next step is to draw on other key players within the school to create a core team of committed school and district staff.

The group should comprise school staff with relevant knowledge and expertise, for example:

» The principal
» A district administrator
» Health educators
» Classroom teachers
» The school nurse and other health services staff
» Counseling, psychology, and social services staff
» Special Education staff
» Prevention coordinators
» Family and community involvement staff
» A representative of the teacher-school employee union
» Other interested staff

To ensure effective functioning, the schoolwide group should be no smaller than 5 and no larger than 12, as other members will be added to the coalition. Group members should be committed to the school's role in promoting and protecting children's mental health, able to work as a team, and capable of making a long-term commitment to the initiative.

The first few meetings of the schoolwide group should focus on preparing a rationale to present to a broader community coalition, including local data whenever possible:

» Briefly review the connection between students' mental health and academic achievement, reinforcing the critical role that schools play in children's mental health
» Identify students' mental health needs, such as behavioral referrals or bullying incidents in the school
» Discuss the three components of the whole-school approach to children's mental health (described on p. 6) and how this approach can benefit students and families

Step 3: Identify and Recruit Members of a Broader Coalition

The next step is to expand the group to a broader coalition of students, parents, and community organizations. It is particularly important that the coalition include key stakeholders from all the systems that influence and can strengthen children's mental health. The schoolwide group can help identify potential members who are invested in children's mental health and who recognize the importance of a collaborative approach, for example:

» Students
» Parents and other caregivers of students of a variety of ages
» Members of parent groups
» Day care and early childhood educators
» High school educators
» Community mental health agency staff
» Social services agency staff
» Law enforcement and juvenile justice agency staff
» Members of organizations serving children
» Civic and religious leaders
» Individuals with political power in the community
» Business leaders with an interest in children's health and well-being

Be sure that coalition members represent the diverse characteristics of students and their families and can link the school to the larger school district, from pre-elementary to high school.

You might also consider merging with an appropriate existing group if one already exists.

> *. . . Successful advocacy for mental health programs in schools requires collaboration between the mental health and the education fields. . . . The best advocacy efforts are the product of communitywide coalitions and careful collaboration between multiple constituencies.*
>
> —HoganBruen, Clauss-Ehlers, Nelson, & Faenza (2003, p. 48)

A letter inviting individuals to an initial meeting of the coalition could include the following:

- The link between children's mental health and academic performance
- The promise and goals of the whole-school approach
- The purpose of the coalition
- The roles of individuals invited to participate in the coalition
- An invitation to attend a coalition meeting at a specific time and place
- A contact name and phone number
- A promise to follow up with them by phone to discuss their interest in participating

Step 4: Convene the Broader Coalition

At the first few meetings of the broader community coalition, you will need to do the following:

- ***Present the rationale for school mental health***. Review the connection between students' mental health and academic achievement, describe the critical role that schools play in children's mental health, and use local data to describe the need for mental health promotion and prevention.
- ***Explain what the whole-school approach is***. Discuss the three components and how the approach can benefit students and families.
- ***Designate a coordinator for the mental health coalition***.
- ***Discuss coalition members' recommendations for sharing leadership and create a decision-making structure*** that provides leadership roles for each constituent group.

» ***Establish clear roles and responsibilities*** for each member, for example, meeting facilitator, meeting recorder, and timekeeper. In particular, identify who will perform the following functions to support the group:

- Schedule meetings
- Facilitate meetings
- Record and distribute notes or minutes from meetings
- Serve as liaison with administrators and other school staff

Note that members can have multiple roles and responsibilities and that these roles can rotate among members. (See **Team Responsibilities** on p. T-6 for additional roles and responsibilities.)

» ***Define the group's goals and objectives*** together to create clarity and focus. For example, the coalition might have the following objectives:

- Identify the critical mental health needs of young children in the community
- Identify existing resources and the resources needed (for example, research-based programs that can reduce risk factors and increase protective factors in the lives of the target population)
- Create and implement an action plan
- Monitor and communicate the effectiveness of the mental health program

» ***Emphasize each member's responsibility*** to the coalition as a whole and to meeting the group's goals and objectives while building on each partner's strengths.

» ***Determine a meeting schedule*** that is convenient for all members, and schedule regular meetings at mutually agreed-on times.

» ***Focus on developing trust and respect*** among team members.

> *"Participants [in coordinated school health programs] need time to develop relationships, understand each other's disciplines, overcome turf issues, and agree upon roles. Incorporating their activities into institutional practice is a continuing process."*
>
> —CDC (2003, p. 25)

» ***Handle conflicts and turf issues openly*** by working through problems together, always keeping the coalition's goals in mind.

» ***Have fun together!*** Humor can increase members' sense of belonging and commitment.

> *". . . you should spend time in the beginning developing a collaborative process, building trust, identifying individuals' strengths and weaknesses, and establishing working relationships."*
>
> —Devaney et al. (2006, p. 69)

Early on, it's also a good idea to meet with leaders of other school mental health advisory or planning groups to determine areas of intersection and areas for possible collaboration.

Effective Coalitions

According to Abt Associates, Inc. (2007), effective coalitions share a number of ***characteristics***. They:

- address important needs
- are broad and deep
- are inclusive
- involve community leaders and policymakers
- reflect the cultural, economic, racial, and religious diversity of the school community
- reflect diverse opinions

Rappaport et al. (2003) found that effective coalitions engage in four ***tasks***:

- "Define mutually agreed upon goals that provide incentive for the investment of effort in the collaborative process.
- "Decide on an overall strategy that integrates services and accepts shared responsibilities for designated activities.
- "Create a working environment that fosters accountability and outcomes.
- "Where possible, shift from separate funding sources to viable integrated mechanisms for the allocation of financial resources to support collaborative strategies" (p. 108).

Forming and maintaining coalitions over time does present ***challenges***, for example:

- Supporting members to have a role in decision-making
- Sustaining active involvement of members
- Addressing divergent agendas, competing priorities, and possible turf issues (Abt Associates Inc., 2007)

To be successful, groups need to attend to these issues early on and revisit them often.

Step 5: Conduct an Initial Best Practice Assessment

To familiarize the coalition with the best practices of the whole-school approach to children's mental health, conduct the **Best Practice Mental Health Assessment** (p. T-2). First, ask individuals to rate the school or district. Then convene the group to discuss its ratings for each best practice and identify needs for improvement.

You should plan to revisit this assessment at regular intervals (e.g., every 12 to 18 months).

Step 6: Develop a Shared Vision

The coalition's next task is to create a vision statement that describes the future the school aspires to—one in which children's mental health needs are met, and all students are successful. This shared vision will guide your school mental health program planning and implementation efforts.

> *"The collaborative vision you create will serve as a rallying call throughout the implementation process. It is the "Big Idea"—your hopes and dreams of what you want for your students."*
>
> —Devaney et al. (2006, p. 72)

Since all coalition members will commit to this vision, you'll need to determine the best way to get input from each key stakeholder.

Here are some guiding questions for developing your vision statement (adapted from Devaney et al., 2006, p. 71):

1. What does success mean for our students? What qualities and skills will they have when they leave our school?
2. What are our school's core values, and how will they be represented in our efforts?
3. What do we envision that our ideal school will look like in 10 years? What is the school culture and climate we want to create?
4. What mental health assets, issues, and needs do we want to address in this mental health program?

The results of your **Best Practice Mental Health Assessment** are also a good source of input for your vision statement.

Vision Statement Checklist

Is it:

- ☐ concise (fewer than 100 words)?
- ☐ powerful enough to inspire positive, effective action, despite barriers?
- ☐ written in meaningful language that is concrete enough to paint a picture of the desired future? (The more richly detailed, the more compelling it will be.)
- ☐ consistent with the school- and district-level visions?

Does it:

- ☐ include roles for the school, family, and community in helping children become healthy?

Once it's completed, your vision statement should be publicized within the greater school community. (See *Phase 6: Create and Carry Out a Communications Plan* for effective communications strategies.)

Engaging Stakeholders—Creating a Broad Coalition

The Vail School District, 30 miles southeast of Tucson, consists of 432 square miles of isolated rural pockets of homes, with no social services, medical facilities, parks, libraries, public transportation, or recreational facilities. Since the early 1990s, the district has experienced steady, unprecedented growth, including a 48 percent increase in student population in just three years, and has struggled to systematically unify a diverse and geographically challenged population. Despite the population increase, services for families remain dismally lacking—and because Vail is unincorporated, there is no local government or elected representatives to advocate for the community's needs.

The Vail CARES SS/HS Initiative addressed the need for stakeholder involvement and empowerment by creating a Community Action Board (CAB) to be the "voice of the community." To create this group, a committee that included the SS/HS project director, the assistant superintendent, the CAB director, an early childhood specialist, and a mental health provider first identified strong voices in a broad spectrum of the Vail population. This included business owners, sports organizations, parents, teachers, law enforcement, college faculty and staff, retirees, youth activity leaders, faith-based leaders, long-time residents, new arrivals, and representatives from each area of the community. The committee wrote letters, sent e-mails, and made phone calls to invite more than 250 people to a luncheon to discuss the assets and needs of the Vail community.

After the 130 participants discussed the community's strengths and priority needs in small groups, participants were asked if they would like to serve on a CAB that would function as a driving force for positive change in the community. Over 60 people sent resumes to be considered for the 20 community positions on the CAB (joining 8–10 SS/HS staff members). CAB members represent a broad spectrum of expertise and reflect Vail's diversity. The CAB began by developing bylaws and creating three subcommittees to address Vail's priority areas:

» **Behavioral Health**: Advocates for behavioral health services within the Vail community through needs assessment and resource development.

» **Youth and Out-of-School Time**: Provides information to families about out-of-school opportunities and works to create new programs to meet the needs of students and parents.

» **Early Childhood**: Strives to connect all child-care providers and preschool programs in the district and support the development of quality early care and education.

SS/HS staff facilitated the development of the CAB, with the intent of transitioning this role and ownership to the community members over time. At first, the SS/HS grant-paid CAB director worked with the subcommittees, each of which was co-chaired by a staff person and a community member. Later on, the community member assumed the chair role, supported by the staff member. Ultimately, the staff members withdrew completely to enable community members to govern the CAB by themselves. This transition in leadership has been an important element in sustaining the CAB beyond the life of the SS/HS grant.

Although the SS/HS project has ended, the CAB continues to thrive, and has partnered with the United Way of Southern Arizona to fund its activities. In addition, the Behavioral Health subcommittee successfully petitioned the School Governing Board and the superintendent to fund five new behavioral specialist positions.

> *If a deep, authentic effort is effective at gaining buy-in, the following phases have the possibility of successful completion. However, if this first phase doesn't really hit the mark, the last six phases might be futile.*"
>
> —Brenda Hummel, director of ACCESS (Austin Community Collaboration to Enhance Student Success), Austin (Texas) Independent School District

Print and Internet Resources on Convening a School and Community Coalition

Engaging School Administrators: A Guide for Safe Schools/Healthy Students Project Directors. National Center for Mental Health Promotion and Youth Violence Prevention, 2007. Available at **http://www.promoteprevent.org/Publications/pp-guides/engaging-school-administrators**.

Guidelines for School-Community Partnerships. Illinois Children's Mental Health Partnership, 2005. Available at **http://www.icmhp.org/icmhpproducts/gdlnsclcmnty.html**.

Research on the Relationship Between Mental Health and Academic Achievement. National Association of School Psychologists, 2008. Available at **http://www.nasponline.org/advocacy/Academic-MentalHealthLinks.pdf**.

Safe, Supportive, and Successful Schools: Step by Step. David Osher, Kevin Dwyer, and Stephanie Jackson. Longmont, CO: Sopris West, 2004.

Step by Step to Health Promoting Schools. Joyce V. Fetro. Santa Cruz, CA: ETR Associates, 1998.

Sustainable Schoolwide Social and Emotional Learning (SEL). [Implementation Guide.] Elizabeth Devaney, Mary Utne O'Brien, Hank Resnik, Susan Keister, and Roger P. Weissberg. Chicago, IL: Collaborative for Academic, Social, and Emotional Learning, 2006. [See in particular "A Sample Vision Statement," p. 73.]

Sustainable Schoolwide Social and Emotional Learning (SEL). [Toolkit.]

- "Tool 2: PowerPoint Presentation on SEL and Academics" can be used as talking points to convince administrators and staff of the needs and benefits of SEL.
- "Tool 10: SEL Steering Committee: Stages of Group Development" is a leaders guide for facilitating effective groups.

Tools Related to Phase 1: Convene a School and Community Coalition

» **Best Practice Mental Health Assessment (T-2)**, an assessment tool for mental health best practices in the school or district

» **Team Responsibilities (T-6)**, a list of responsibilities for each constituency of a community coalition for children's mental health

Checklist for Phase 1: Convene a School and Community Coalition

1. Secure support from school leadership
   - ☐ Meet with the school principal to explain how the whole-school approach to children's mental health dovetails with the mission of the school.
   - ☐ Ask the principal to be involved in and supportive of the initiative, and suggest a specific role for him or her.

2. Identify and convene interested school staff
   - ☐ Make a list of school staff with relevant mental health knowledge and expertise.
   - ☐ Identify a small group of individuals who are committed to the school's role in promoting and protecting children's mental health, can work well in teams, and will make a long-term commitment to the initiative.
   - ☐ Set a meeting date for the schoolwide group.
   - ☐ Prepare a rationale about the importance of promoting mental health for students within the school.

3. Identify and recruit members of a broader coalition
   - ☐ Identify potential members of a community coalition, including students, parents, and community organizations invested in children's mental health.
   - ☐ Write a letter inviting potential participants to an initial meeting of the coalition.

4. Convene the broader coalition
   - ☐ Present a rationale for the importance of promoting mental health for students within the school.
   - ☐ Define roles, responsibilities, and the decision-making process.
   - ☐ Determine goals and objectives.
   - ☐ Set a schedule for future meetings.

5. Conduct an initial best practice assessment
   - ☐ Conduct the **Best Practice Mental Health Assessment** to better understand the school's or district's assets and needs in addressing children's mental health.

6. Develop a shared vision
   - ☐ Get input from key stakeholders.
   - ☐ Write a concise vision statement.
   - ☐ Publicize the vision statement.

Phase 2: Assess Mental Health Problems, Needs, and Resources

The Benefits of Assessment[5]

The initial **Best Practice Mental Health Assessment** conducted in Phase 1 summarizes coalition members' assessment of the strengths and challenges of your school or district's approach to children's mental health. As a next step, it is important to round out this information with current data from students, the school district, and the community about risk and protective factors, school climate and policy issues, and existing resources. A comprehensive assessment is a critical component of the program implementation process. Each school has its own needs and concerns regarding children's mental health and draws on different assets to support and protect its children. What works for one school may not be appropriate for or produce positive outcomes in your school. When the coalition has a clear picture of the target population's mental health needs and risk and protective factors, it can focus programs, policies, and resources in ways that are appropriate and most likely to be effective, thereby saving valuable time and money.

Assessment also helps to gauge how ready the school and community are to move forward with effective promotion efforts. Some schools and communities may already be actively applying research-based strategies to prevent and reduce mental health problems in young people. Others may be wedded to programs that are popular but have limited effectiveness. And still others may not be aware of the scope and nature of children's mental health problems.

When the school and community appear unaware of problems or are not ready to move forward with mental health promotion efforts, data on a particular issue can be a mobilizing force. For example, one school district found that the suspension rate was higher in kindergarten than in the middle school and was surprised and spurred to action by this data. Facts presented well make a compelling argument to school and community leaders, parents, educators, and other community decision-makers for adopting a program strategy to address children's mental health needs. In addition, assessment data often serve as baseline information against which the effectiveness of a given EBI can be measured.

An effective assessment can do the following:

- Identify the nature and extent of mental health problems in your school
- Determine what resources may be needed to address the problems you identify within the school
- Increase the likelihood of selecting appropriate and effective school solutions
- Mobilize the school and community
- Serve as a baseline for evaluation

[5] Adapted from Dash, Vince Whitman, Harding, Goddard, and Adler (2003).

Steps to Take to Complete an Assessment

Step 1: Assess School Mental Health Problems, Needs, and Resources

> *It is helpful to think of your school's vision as embodying the highest hopes and aspirations for your students, while a needs and resources assessment provides a starting point for identifying specific and measurable goals.*
>
> —Devaney et al. (2006, p. 72)

The coalition's first assessment task is to identify the gaps between the shared vision for mental health and the current situation. You have begun this process by conducting the **Best Practice Mental Health Assessment** to determine the coalition's sense of which best practices are already in place in the school and community and which are lacking. Now, to ensure that the approach that is implemented is responsive to the specific mental health needs of the young people in the school or district, you need to assess those needs, as well as the mental health resources available for children. This is an important first step of the public health model. The entire coalition might play a role in this assessment, or it might appoint a task force to oversee the process.

Data collection on school mental health problems should aim to describe the scope, characteristics, and consequences of the problem. A needs assessment can help the coalition answer six key questions (adapted from Devaney et al., 2006):

- What is the school already doing to address students' mental health needs?
- What parts of these efforts may need strengthening?
- What needs or problems in schools are not being successfully addressed?
- What are students' most pressing mental health needs?
- What are the underlying causes of these problems or needs?
- How healthy is the school environment for students and adults?

Fortunately, you don't have to collect all of these data yourself. Others at the federal, state, and local levels have spent much time collecting and compiling information that could be helpful in defining the school community's needs and assets and shaping prevention efforts. Good sources of local data are the school district, the census (city/town or county), and the local or county health departments. In addition, the state and local school Youth Risk Behavior Survey, which is conducted biennially among national probability samples of ninth and twelfth graders from public and private schools, provides unique health-behavior information about various groups of adolescents in the United States. Information is gathered regarding weapons, fights, thoughts of suicide, drugs, AIDS, sexual activity, dieting, and exercise—valuable data on the ages at which students are most likely to initiate risk behaviors.

By collecting local data and comparing it to state or national demographic data and/or to local data collected over time, you can gauge the scope of the problem and the availability and use of mental health services. You may also identify areas in which efforts need to be enhanced, and areas that are functioning well.

Before beginning the needs assessment:

- Identify existing databases and mental health-related reports in the school and district.
- Decide which data will be used in planning. There is an overwhelming amount of data available; don't collect data that already exists or that will not be used.
- Plan to collect data related to family, school, and community risk and protective factors for mental health. (Figure 3: Youth Mental Health Indicators Related to Risk Factors and Figure 4: Youth Mental Health Indicators Related to Protective Risk Factors provide examples of risk and protective factors and related indicator sources.)

The **Assessment Planning Tool** on p. T-8 can help to design and implement the needs assessment and summarize the results.

Special Considerations for Collecting Available Data[6]

- ☑ Use indicator data that is closely related to the mental health risk and protective factors for the population of interest. For example, an indicator for low commitment to school (a school risk factor) might be the school dropout rate, while an indicator for high commitment could be engagement in school clubs or organized sports. (For more details on matching indicator data to risk and protective factors, see Figures 3 and 4.)
- ☑ Observe trend data that illustrates problems over time. Indicator (or other) data collected at only one point in time does not reveal whether the problem has remained unchanged for several years, has worsened, or has improved.
- ☑ Obtain background information on the sources of indicator data to understand what the numbers mean. If possible, ascertain the method and frequency of data collection to determine reliability.

[6] Dash et al. (2003).

Figure 3: Youth Mental Health Indicators Related to Risk Factors

Risk Factors	Related Data Indicators[7]	Possible Data Sources
Individual-Level Risk Factors		
Substance use	• Early initiation of tobacco, alcohol, and other drug use • Past year and "current" (past 30-day) use • Early initiation of substance use	• Self-reported data from student surveys (e.g., CDC's *Youth Risk Behavior Survey*) • School district data on violent incidents
Violence	• Physical fighting • Weapon carrying	
Depression and suicide	• Feeling sad/hopeless • Suicidal ideation and attempts	
Family-Level Risk Factors		
Family violence	• Domestic violence arrests • Reported child abuse • Divorce rate	• Social services agencies • Census data (http://www.census.gov) • State and local health departments, state office of vital statistics • City/town records
Marital discord Family management problems	• Children living in foster care or away from parents • Reported neglect cases	
Family history of alcoholism, drug use, and/or mental illness	• Adults in alcohol, other drug, or mental health treatment programs • Availability and usage of mental health programs	
School-Level Risk Factors		
Antisocial and aggressive behavior	• Referrals to social services or counseling • Placements for children with emotional or behavioral disorders	• School-based health center • Community health center • Local hospitals • Social services agencies • School district data on student achievement (e.g., test scores, "School Report Cards"), attendance and dropout, and disciplinary actions
Academic failure	• Grade retention • Percentage of students reading below grade level	
Delinquent school culture Low attachment to school	• Suspensions/expulsions • Average daily absenteeism/ truancy • Dropout rates • Vandalism, theft, property damage • Teacher/faculty attendance	
Violence/bullying	• Violence on school property (including physical fighting, weapon carrying, and bullying, including electronic bullying)	
Substance use	• Substance use violations on school property, at school events (possession, consumption)	

[7] Related data indicators are measures that indicate the prevalence of specific risk factors in the community (Dash et al., 2003).

Risk Factors	Related Data Indicators[1]	Possible Data Sources
Community-Level Risk Factors		
Economic deprivation	• Unemployment rates • Free lunch program participants • Aid to Families with Dependent Children recipients • Food stamp recipients • Adults without high school diplomas • Single female head of household as percentage of all households	• Census data • Social services agencies • Local police department • Court records • Department of Juvenile Justice • Local hospitals and community health centers • League of Women Voters • State Department of Corrections • School district data on free and reduced price school meals
Neighborhood violence and crime	• Youth offenses and arrests for violence, substance use violations, property damage/ vandalism, and theft • Arrests for violent crimes and homicides	
Community mental health	• Number of youth admitted to in-patient mental health settings • Number of youth receiving out-patient mental health treatment • Hospitalizations due to self-injury	
Community disorganization and low neighborhood attachment	• Voter registration/voting rates • Prisoners in state or local correctional systems	

Figure 4: Youth Mental Health Indicators Related to Protective Factors

Protective Factors	Related Data Indicators	Possible Data Sources
Individual-Level Protective Factors		
Healthy sense of self, healthy social engagement	• Participation in sports, clubs, other extracurricular activities	• Student surveys • School district
Family-Level Protective Factors		
Positive relationships with adults	• Supportive/caring relationship with a parent or other adult	• Student surveys • Social services agencies • State office of vital statistics
Stable households	• Two-parent households • High employment	
School-Level Protective Factors		
Student motivation Positive expectations Optimism for the future	• Plans to graduate high school • Plans to pursue education beyond high school/number of students going on to post-secondary education	• Student surveys • School district • School climate survey (see *School Climate*, below) • School district data on disciplinary actions
Positive relationships with adults and peers	• Supportive/caring relationship with an adult at school • Engagement in school clubs, organized sports, other school activities	
Positive school climate; strong school connection	• Sense of connectedness to school • Perception of school as a positive, safe environment (see *School Climate*, below)	
School policies that support safety	• Discipline referrals for violence, bullying	
Community-Level Protective Factors		
Health status	• Proportion of youth receiving routine medical and dental care, including well-visits	• Community health centers, hospitals • Social services agencies • Religious organizations
Community engagement Social networks	• Religious participation • Community service participation • Presence of active and welcoming community centers	

Assessing School Climate. As the psychosocial environment is an essential component of the whole-school approach to children's mental health, it is useful to conduct a school climate survey to get a clearer picture of whether your school does the following (adapted from Osher et al., 2004, pp. 25–26):

- Involve families in meaningful ways, so that they feel welcome at school
- Emphasize and foster positive relationships among and between students and staff
- Treat all students fairly, equally, and with respect
- Create ways for students to share their concerns
- Help students feel safe expressing their feelings
- Promote positive mental health and socially responsible behavior
- Identify problems and monitor progress toward solutions
- Support students in making transitions
- Provide culturally and linguistically competent services, activities, and interventions

(A good resource for school climate assessment is the Minneapolis School District's school climate tool kit; see *Print and Internet Resources on Assessing Mental Health Problems, Needs, and Resources* on p. 2-11 for details.)

Assessing School Policies. Policies are a driving force of schools. Without supportive policies that are consistently enforced, whole-school mental health programs cannot be successfully implemented or sustained. School and district policies related to mental health issues can have a significant impact on the school's mental health program in a number of ways:

- Creating a supportive context for the coalition's work
- Contributing to positive school climate (for example, policies for addressing bullying incidents or requiring services for students with depression)
- Legitimizing the importance of addressing children's mental health in the school
- Focusing the coalition's work (for example, policies may require using evidence-based programs or teaching SEL in elementary school)
- Determining the availability of resources to support students' mental health (O'Brien, 2007)

School policies related to mental health generally include the following:

- Student learning standards for social and emotional development in curricula
- Bullying and violence prevention and protocols for handling incidents
- Substance use
- School climate guidelines; collection and use of school climate data
- Student Assistance Programs available to all students
- Screening of incoming kindergarten students for mental health issues
- Referral and triage policies

» Privacy and confidentiality
» Coordination with community mental health agencies
» Inclusion of families
» Cultural competence of staff

As part of the needs assessment, it is important to identify the school and district policies that support students' mental health and whether these policies are consistently enforced.

Identifying Existing Resources. Another significant piece of the assessment is to identify available resources that are already or could be devoted to mental health programs and services. For example:

» Staff training on indicators of mental health problems, behavior intervention, and strategies for classroom interventions for mental health disorders
» Staff cultural and linguistic competency
» Available school and community staff and services for mental health
» Level of readiness and/or expertise of school and community staff
» Effectiveness of current programs and teaching materials and supplies
» Time available for mental health programs and services in the school schedule
» Community resources beyond school programs, such as community-based programs offered by youth groups and other community agencies (Kane, 1993)

Additional Assessment Tools

» Use "asset mapping" to learn about community strengths and resources related to children's mental health. (See *Print and Internet Resources on Assessing Mental Health Problems, Needs, and Resources* on p. 2-11 for details.) Interview key people—members of the school and community who are knowledgeable about mental health assets or problems or have an interest or stake in prevention efforts. These individuals can help to obtain a better understanding of what is going on in the community as well as gauge opinions about what needs to be done. Be sure that the interviewees reflect the diversity of the community.
» Use the **Mental Health Services Infrastructure Assessment** on p. T-13 to determine the school and community infrastructure for mental health services (e.g., the availability of mental health programs and services, and the referral processes for these services).
» To systematically assess and improve the quality of mental health services delivered within school settings, use the "Mental Health Planning and Evaluation Template" (MHPET) developed by the National Assembly on School-Based Health Care (see *Print and Internet Resources on Assessing Mental Health Problems, Needs, and Resources* on p. 2-12 for details).

Step 2: Analyze Results and Develop Recommendations[8]

The next step is to set priorities. Meet with the coalition to discuss the data collected:

- What school and community strengths are revealed?
- What do the data reveal about specific school mental health issues that might be targeted (e.g., bullying at school, disruptive behavior at school, academic failure)?
- How do the school-related problems that have been identified relate to the underlying risk factors for mental health (see Figure 3)? Which are the priority risk factors, and how could they be addressed?
- Which school and community protective factors are most lacking (see Figure 4)? How can these protective factors be strengthened?
- Where do disagreements exist among school personnel, parents, and students? What do these differences mean?
- What resources are available across the district or in the community to support the school's efforts? What additional resources and capacity will have to be developed?

Based on the coalition's answers to these questions, the coalition should then decide where to focus its efforts:

- Which findings stand out?
- In terms of mental health, what changes would you like to see for the student population?
- What changes would you like to see for the faculty, staff, parents, and school administrators?
- What are the priorities?

Initially, many areas will emerge that need to be addressed. Team members from different community sectors may have different or competing priorities. It is helpful to address these differences directly, to try to understand each member's viewpoint, and to refer the group back to the shared vision statement if necessary.

After discussing the range of findings, the coalition should come to a consensus on which issues to address first.

[8] Adapted from Dash et al. (2003).

Survey Reveals a Great Need for Services

In one small rural community, parents had to drive more than an hour to obtain mental health services for their children. As a result, only six students in the community were receiving mental health services. A local elementary school principal knew that the number of students who came into his office with problems was far greater than those who were accessing services.

The principal met with several local organizations to develop a community survey to determine parents' perception of the community's needs, including several questions that addressed mental health needs. Sixty-five percent of respondents indicated that they would obtain mental health and alcohol, tobacco, and other drug (ATOD) services for their children if they were easily accessible. The principal shared the results with the community mental health center director, and requested that a full-time mental health counselor be located in the elementary school. The principal offered to provide a small contract for the services through the school's budget. The mental health center director agreed. As a result, more than 100 students and parents received mental health services on site at school during the following school year.

Step 3: Share Assessment Results and Recommendations

The next task is to share the assessment results with other school and community members who will be involved in program planning and implementation. Here are some suggestions for how to proceed:[9]

» Plan how to frame and phrase the priority issue. State the issue clearly in a way that is likely to attract positive attention in the school, and support it with data, as in the following example:

> Many of our students believe that aggression is a solution to social problems. Last year, for example, nearly 50 percent of students reported that they think fighting is warranted in some situations. These attitudes were also demonstrated by the high number of school-related fighting incidents at recess reported during the past school year. Our assessment also noted a high number of reported bullying incidents in school and on school grounds. Currently, we have no anti-bullying curriculum in place, and enforcement of our bullying policy is inconsistent. Therefore, our top priority for the coming school year is *to reduce fighting and bullying incidents at school.*

» Make the presentation at a public forum at which police, clergy, school personnel, health providers, politicians, businesspeople, and others are present to discuss the data and the community's past and future response to mental health issues. Make sure that those who provided the baseline data support sharing the data in a public forum.

» Be sure that outreach efforts include a linguistically and culturally diverse cross-section of the community.

[9] Adapted from Dash et al. (2003).

- Emphasize that the problems are community-wide—they are not school problems exclusively. Use information about risk and protective factors to support your case.
- Keep the presentation short! People can only absorb small amounts of data at a time.
- Prepare to defend (to the extent that it is appropriate) the accuracy and validity of the data. Acknowledge any shortcomings up front.
- Prepare a written press release on the data to help ensure that the news media are able to present the issues in a complete and balanced way. (See *Phase 6: Create and Carry Out a Communications Plan* for more information on effective communications strategies.)

Using Data to "Sell" the Program

Because mental health services are generally less available in rural communities, and community members may be more hesitant to use these services, rural communities may be less aware of the relationship between students' mental health and academic success. One rural SS/HS project director described having to convince the community that implementing school mental health programs would reduce discipline problems and create a better climate for learning, resulting in improved academic outcomes. She found it essential to use relevant data, such as discipline, attendance, and bullying data, to make the connection between mental health, positive school climate, and academic success.

Print and Internet Resources on Assessing Mental Health Problems, Needs, and Resources

Applying Effective Strategies for School Violence and Substance Abuse Prevention. Kim Dash, Cheryl Vince Whitman, Wayne Harding, Chelsey Goddard, and Melanie Adler. Newton, MA: Education Development Center, Inc., 2003.

Asset Mapping. UCLA Center for Health Policy Research. Available at **http://www.healthpolicy.ucla.edu/healthdata/ttt_prog21.pdf**.

Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets. John P. Kretzmann and John L. McKnight. Evanston, IL: Institute for Policy Research, 1993. Available at **http://www.northwestern.edu/ipr/publications/community/introd-building.html**.

Creating a Positive School Climate for Learning. Minneapolis Public Schools. Available at **http://sss.mpls.k12.mn.us/Positive_School_Climate_Tool_Kit.html**.

Enhancing Student Connectedness to Schools. Catharine L. Weiss, Dana L. Cunningham, Charla P. Lewis, and Michelle G. Clark. Baltimore, MD: Center for School Mental Health Analysis and Action, Department of Psychiatry, University of Maryland School of Medicine, December 2005. Available at **http://csmh.umaryland.edu/resources.html/caring%20connectedness%20brief.pdf**.

Getting to Outcomes 2004: Promoting Accountability Through Methods and Tools for Planning, Implementation and Evaluation. Matthew Chinman, Pamela Imm, and Abraham Wanderman. Santa Monica, CA: Rand Health, 2004. Available at **http://www.rand.org/pubs/technical_reports/TR101/**.

Identifying and Selecting Evidence-Based Interventions for Substance Abuse Prevention: Revised Document for the Strategic Prevention Framework State Incentive Grant Program. HHS Pub. No. (SMA)09-4205. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2009.

Mental Health Planning and Evaluation Template. National Assembly on School-Based Health Care. Available at **http://www.nasbhc.org/MHPET**.

Reducing Problem Behaviors in the Elementary School Classroom: A Practice Guide (NCEE #2008-012). Michael Epstein, Marc Atkins, Douglas Cullinan, Krista Kutash, and Robin Weaver. Washington, DC: National Center for Education Evaluation and Regional Assistance, Institute of Education Sciences, U.S. Department of Education, 2008. Available at **http://ies.ed.gov/ncee/wwc/pdf/practiceguides/behavior_pg_092308.pdf**.

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School-Based Mental Health: An Empirical Guide for Decision-Makers. Krista Kutash, Albert Duchnowski, and Nancy Lynn. Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child and Family Studies, 2006. Available at **http://rtckids.fmhi.usf.edu/rtcpubs/study04/SBMHfull.pdf**.

SchoolMentalHealth.org. [School mental health resources for clinicians, educators, administrators, parents/caregivers, families, and students, with an emphasis on practical information and skills, based on current research, and lessons learned from local, state, and national initiatives.] Available at **http://www.schoolmentalhealth.org/index.html**.

Stories from the Field: Lessons Learned About Building Coordinated School Health Programs. Atlanta, GA: Centers for Disease Control and Prevention, 2003.

Sustainable Schoolwide Social and Emotional Learning (SEL) [Implementation Guide and Toolkit]. Elizabeth Devaney, Mary Utne O'Brien, Hank Resnik, Susan Keister, and Roger P. Weissberg. Chicago, IL: Collaborative for Academic, Social, and Emotional Learning, 2006.

Tools Related to Phase 2: Assess Mental Health Problems, Needs, and Resources

- **Assessment Planning Tool (T-8)**, a worksheet for identifying and organizing possible sources of data and prioritizing findings
- **Mental Health Services Infrastructure Assessment (T-13)**, a worksheet for assessing the school and community infrastructure for providing mental health services, including capacity, procedures, and existing mental health programs and services

Checklist for Phase 2: Assess Mental Health Problems, Needs, and Resources

1. Assess school mental health problems, needs, and resources
   - ☐ Determine data collection needs related to mental health.
   - ☐ Identify existing local and state databases.
   - ☐ Collect data about community and school mental health problems, needs, school climate, policies, community readiness, and available resources, including capacity.
   - ☐ Meet with leaders of existing advisory groups to identify areas of collaboration.

2. Analyze results and develop recommendations
   - ☐ Identify school and community strengths and problems related to mental health.
   - ☐ Relate the problems to school and community risk factors.
   - ☐ Determine which risk factors can be addressed by and which protective factors can be strengthened by EBIs.
   - ☐ Compare data to the vision statement to identify gaps between the current situation and hopes for the future.
   - ☐ Determine available resources to support school mental health.
   - ☐ Develop recommendations about priorities.

3. Share assessment results and recommendations
   - ☐ Prepare a short presentation that highlights significant data, frames problems as community-wide rather than just school-based, explains risk and protective factors, proposes solutions and makes recommendations, and builds on community strengths and resources.
   - ☐ Identify and schedule presentations at appropriate public forums.

Phase 3: Develop an Implementation Plan

The Benefits of Developing an Implementation Plan

The next step is to implement a program to address the school mental health priorities that were identified through the assessment. To ensure the most effective use of resources, you will need an implementation plan, which will help the coalition do the following:

- Focus clearly on desired outcomes and how to achieve them
- Successfully match EBIs to the priority needs
- Gather the school and community resources needed to implement EBIs and monitor their success
- Determine the appropriate professional development and other supports needed to make the program successful
- Consider how to align the implementation plan with other school or district plans

A well thought out, detailed plan provides a clearly defined direction to guide decisions about implementation and evaluation and keeps the focus on the goals and vision. A clear roadmap will also enhance your ability to garner support and resources from key stakeholders in the community to implement the program.

What to Include in the Implementation Plan

At a minimum, a school mental health program implementation plan should include the following:

- Program goals and objectives
- Selected EBIs
- Supporting strategies
- Action steps and a timeline
- An evaluation plan

> *Schools that skip critical planning activities may get an initial jump on implementation, but often run into problems down the road that are detrimental to the programming effort.*
>
> —Devaney et al. (2006, p. 51)

Steps to Take to Develop an Implementation Plan

Step 1: Develop Program Goals, Objectives, and Outcomes to Address Priority Mental Health Needs

The coalition needs to use the findings from the assessment of the school's needs, issues, and resources to develop program goals, objectives, and desired outcomes. Answer these questions:

- What mental health problems or concerns identified in the assessment do we most want to address in our school?
  Example: Fighting and bullying in school and the high number of disciplinary actions and suspensions
- What broad goals do we have related to those concerns? To which risk factors are these goals related?
  Example: The broad goals are to reduce students' aggressive behavior and to create an environment where all students feel safe. These goals are related to the risk factors of antisocial and aggressive behavior, violence and bullying at the school level, and violence at the individual level.
- What outcomes do we want to see?
  Example: School staff will consistently enforce the policy for dealing with bullying and fighting.
- What specific measurable objectives will help us achieve these outcomes?
  Example: Fully implement the EBI Second Step in the school. (Second Step teaches social skills and socio-emotional skills aimed at reducing impulsive and aggressive behavior while increasing children's social competence.) Additionally, reduce the number of bullying incidents by 80 percent in the coming year.

Use the **Program Planning Tool** on p. T-21 to guide implementation planning efforts.

Understanding how the mental health program supports the school's academic goals will help staff understand the value of devoting instructional time to mental health promotion and prevention and will increase their engagement and commitment. Clarify how the whole-school approach to mental health helps to achieve the school's goals, whether the goals are to improve academic performance, to create a safer and more supportive learning environment, or to decrease instructional time managing disruptive behavior. For example, systemic mental health supports can help overcome barriers to learning by saving instructional time that would be lost to disruptive behavior in the classroom or by eliminating bullying that undermines the mental health of children with depression or anxiety.

Implementation Plan Logic Model. Work with the coalition to create a Logic Model of the implementation plan. A Logic Model is a systematic, visual way to represent the major components of the implementation plan and their relationship to one another. It can also help to ensure that activities and strategies are linked to goals and outcomes, and help to create an evaluation plan. See Figure 5 and the **Logic Model Worksheet** on p. T-20.

Using a Logic Model to Coordinate Services

In order to provide good coordination of treatment services, the Lexington/Richland School District Five SS/HS Initiative in South Carolina developed a Logic Model that included all of the community partners (social workers and mental health, juvenile justice, and ATOD prevention professionals) and determined how the partners would interface to provide treatment to students and their families. The partners met weekly to coordinate treatment and services with the school and to avoid service duplication. Team members found it valuable to project the Logic Model on a screen to focus their discussion and activities. The team also met quarterly with the project evaluator, who shared outcome data from the database to which each partner had contributed. At these meetings, the team also used the Logic Model to compare its expected results to the actual outcomes. When desired outcomes were reached, team members would continue to implement existing strategies. When the outcomes were not reached, the team would revise the Logic Model accordingly. The project documented several positive student outcomes, and the team continues to meet regularly (although the SS/HS grant has been completed), using the Logic Model to guide coordinated treatment efforts and to ensure a common vision and focus among team members.

Figure 5 provides an example of a school's half-completed Logic Model for addressing the problem of bullying. (The school still needs to identify and select the EBIs and other strategies it will use to accomplish its goals and objectives.)

Figure 5: Sample Logic Model Worksheet

Problems/Needs	Goals and Objectives	Activities/Strategies	Process and Outcome Evaluation
• What are the underlying needs or problems that must be addressed (e.g., risk factors that can be changed)? *–Schoolwide survey shows that 60 percent of students believed that bullying is a problem in school.* *–75 students were sent to the office in the first semester for aggressive or bullying behaviors toward peers and/or staff.*	• What broad goals and long-term objectives are you trying to achieve? *Goal: A supportive learning environment where all students feel safe.* *Objective: Reduce bullying in the school by 80 percent in the next year.*	• Which EBIs will you use? • What strategies and resources (e.g., staffing, staff development, materials, partners, policies, procedures) will you need to support and enhance effective implementation of these programs?	*Process* (Formative): • Was the intervention implemented as planned? • Was the target population reached? • Were implementation goals and objectives attained? *Outcome* (Summative): • Is the program having the expected effect on the population?

Planned Work → Intended Results

Step 2: Identify and Select EBIs

The coalition, or possibly a subcommittee that includes representatives of those who will implement the EBIs, needs to be actively engaged in the process of reviewing and selecting EBIs. This process also needs to include ongoing collaboration with community partners.

To guide this selection, the group should address two key questions:

- What process will we use to choose school-based strategies, including EBIs, to help to achieve the goals, objectives, and outcomes we desire?
- What capacities are needed to implement these strategies (e.g., staff, training, time, materials)?

The first step in selecting EBIs is to see what's available:

- Identify sources of appropriate mental health-related EBIs. (See *Print and Internet Resources on Developing an Implementation Plan* on p. 3-15 for suggestions.)

Next, review the EBIs you've identified as possibilities, narrow the choice to a group of 5–10, and select among them. Be sure that the EBIs you're considering:

- address the school's priority issues and identified risk factors
- are likely to deliver the expected outcomes
- are suitable for students' age range, developmental needs, ethnicity, and gender(s)

Selecting EBIs Across the Mental Health Continuum

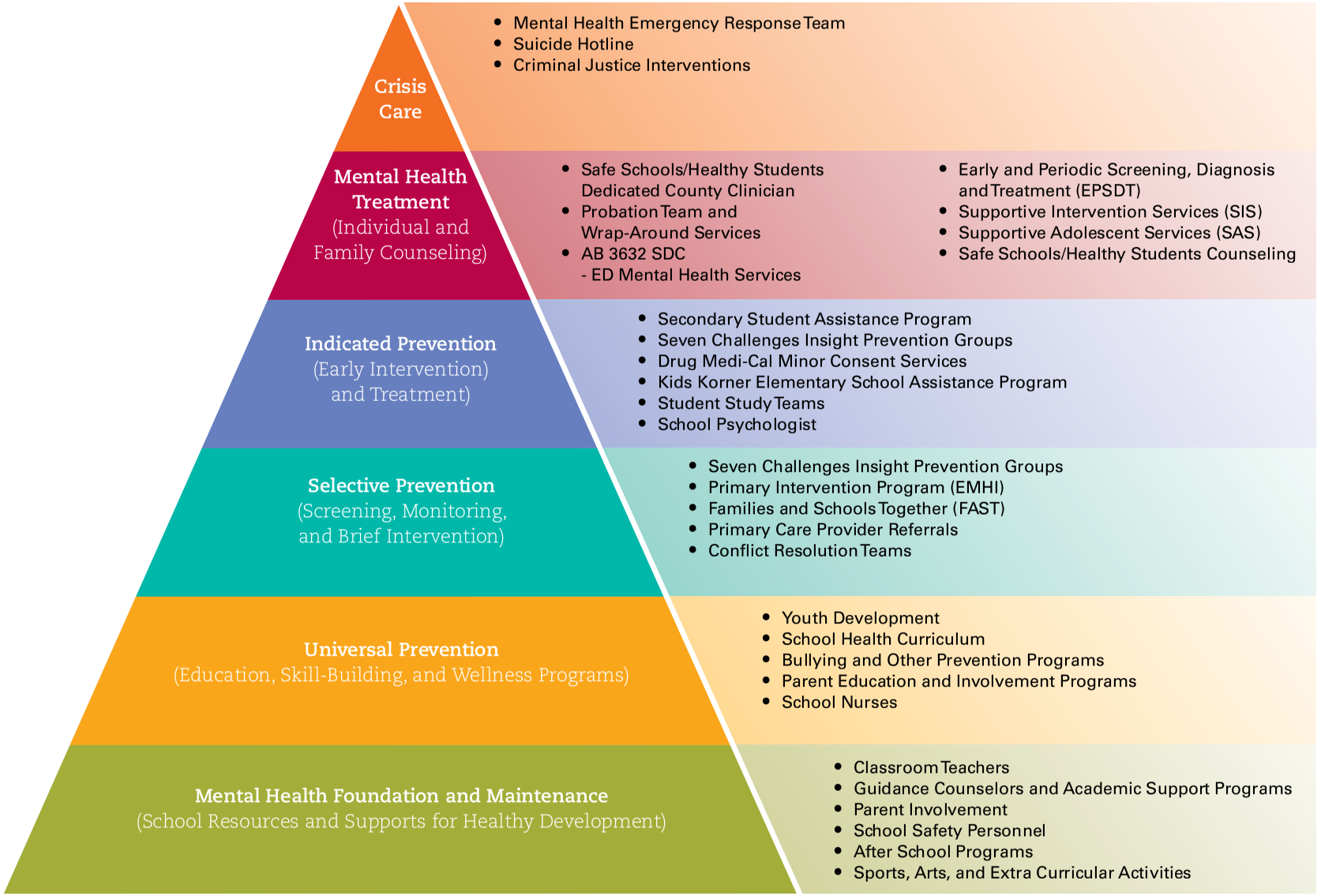
Evidence-based mental health programs and practices in schools need to address identified student needs across the mental health continuum by providing *universal*, *selective*, and *indicated* strategies (as discussed on pp. 10–11):

- *Universal interventions* provided in schools systemwide promote healthier mental functioning and outcomes for all students. EBI examples include PBIS, Second Step, and Too Good For Drugs/Violence.
- *Selective interventions* promote healthier mental functioning for students with at-risk behaviors and emotional difficulties. EBI examples include Life Skills Training, Strengthening Families, I Can Problem Solve, and Restorative Justice.
- *Indicated interventions* aim to promote healthier mental functioning for students with significant symptoms of a mental health problem (short of a mental health disorder diagnosis). EBI examples include therapeutic strategies, such as Functional Family Therapy and Aggression Replacement Training.

More examples of universal, selective, and indicated interventions can be found under "Evidence-Based Intervention Fact Sheets" on the National Center for Mental Health Promotion and Youth Violence Prevention's website, **http://promoteprevent.org/Publications/EBI-factsheets/**. Figure 6 demonstrates how one school district integrated programs across the mental health continuum.

Figure 6: Pajaro Valley Unified School District Integrated Mental Health Services

Linda Perez, project director of the Pajaro Valley (California) Unified School District, a 2005 SS/HS grantee, developed a tiered process for school mental health promotion and prevention that includes universal, selective, and indicated interventions to establish the behavioral and social supports needed to help all students achieve social, emotional, and academic success.



> *Children and adolescents with serious emotional disorders (SED) and their families often get left out of a school's culture, either because the child's disorder is too difficult to be addressed by school staff and/or the child qualifies for Special Education services, so that "the problem" is not viewed as belonging to the rest of the school.*
>
> *If you want to really make a difference for the families and the children with SED, the "whole school approach" needs to work on interventions that improve schools' capacity to deal with SED kids and their families in a competent and compassionate manner. This means improving coordination between the mental health and educational systems; development of alternative learning approaches that integrate academic and emotional development taught by qualified staff; and implementation of and financing for effective group and individual interventions led by clinical staff working closely with the educational leaders and supervisors."*
>
> —Michael Cohen, MA, CAGS, Executive Director, NH NAMI

Use the **EBI Feasibility Checklist** on p. T-19 to assess the fit of the 5–10 EBIs the coalition is considering in terms of resources required, target population, school climate, community climate, evaluability, and future sustainability.

For each EBI that matches the initial criteria, the group should answer the following:

- Is there evidence that this program has worked in similar schools and communities?
- Are any issues raised by the program that are not in keeping with the norms and policies of our community? Does the EBI fit our school culture?
- What can be added or changed to make the program more appropriate for the diverse needs of students, parents, school personnel, and community members? (See *Adapting Programs to Meet the Needs of Diverse Students*, below.)
- Will additional staff or training be required? What is the cost of other materials required?
- Can we identify a source of funding to pay for training and materials? (See *Phase 4: Secure Financial Resources*.)
- Is external support available? How much will it cost?
- Does the EBI align with other planned mental health interventions?

There are a number of strategies for getting additional information on an EBI:[10]

- Visit the program's website for the latest information on new developments, professional development packages, etc.
- Call the program developers to discuss possible options that might fit your school's needs.
- Review sample program materials—many program developers will loan sample lessons or even the entire program for review.

[10] *Sustainable Schoolwide SEL: Toolkit*, Tool 18: Selecting an Evidence-Based SEL Program, Devaney et al. (2006).

» Read any journal articles about the effectiveness of the program.

» Ask for contacts in other schools that have used the program, and talk to them about their implementation experiences.

Once the group has completed its in-depth review, select two or three EBIs that meet your criteria, and present them to other key stakeholders in the final selection process.

Here are some possible strategies for making the final selection:[11]

» Ask staff members to review the final two or three program options, perhaps even try out a lesson or two to see how it works with their students.

» Bring a team from the school, including staff who will implement the program, to visit a school that is currently using it.

» Hold a coalition or an all-school meeting to review the final two or three program options. Have program developers present their EBI package and answer any questions.

Fidelity and Adaptation of EBIs

"When looking to implement an effective prevention program in your community, your priority should be to replicate with fidelity a research-based program that has been proven effective through rigorous evaluation. Fidelity of implementation or replication with fidelity means implementing a given program in the same manner as the program was implemented when it was proven to be effective, inclusive of all components of the program or strategy that the developer and evaluator consider to be key, unique, and necessary features. While replication provides many advantages, you should also be aware that there are some challenges you should consider. These include the following:

» "The program you select may have been designed, implemented, and evaluated with populations and in settings different than your own.

» "The program may not meet the needs you have identified as priorities for the population you serve.

» "The program, if composed of multiple strategies, may have some strategies that work better than others for achieving desired outcomes.

» "The program may be too expensive to implement as intended" (Dash et al., 2003, p. 87).

When you replicate an evidence-based program, remember that there is no guarantee of effectiveness unless the program retains the *core elements* of the original intervention. You cannot pick and choose parts of an EBI and expect to achieve the same outcomes. The National Institute of Drug Abuse (1997) defines these core elements as the program's basic *structure*, *content*, and *delivery*:

[11] *Sustainable Schoolwide SEL: Toolkit*, Tool 18: Selecting an Evidence-Based SEL Program, Devaney et al. (2006).

- **Structure:** How the program is organized and constructed—e.g., the necessary number, length, frequency, and sequence of sessions and boosters; the critical age or description of the target audience (elementary or middle school students; parents); the setting in which the program is offered (e.g., class, after-school, home, community center).
- **Content:** The most important informational and/or educational components of the program—e.g., inclusion of social problem-solving skills in curricula, inclusion of family communications training in family programs, use of program materials.
- **Delivery:** How the program is given to and received by the audience—e.g., if implementing the EBI requires training, will your teachers be able to receive this training, be monitored, and be provided with assistance as needed to maintain fidelity to the program's core elements?

When you base your program on a strategy (or a combination of strategies) that rigorous evaluation has proven to be effective, you increase the likelihood that the program will be effective. You assume greater risk when adapting a program or designing your own program than you do when replicating another. So, how do you increase the likelihood that an EBI will succeed if you adapt it?

Adapting Programs to Meet the Needs of Diverse Students. The ultimate goal of program adaptation is to create a program that respects and responds to the needs of all members of the target population (Dash et al., 2003). It is very important to consider the diverse needs of the student population before adapting any program. When examining the literature on effective mental health promotion programming, pay special attention to the populations with whom the strategies were tested. Ask:[12]

- How are the students described in the intervention similar to or different from students in our school?
- Are our students (in terms of their ethnicity, sex, age, sexual orientation, physical ability, economic condition, geographic setting, and values) reflected in the materials?
- Are the materials written in language and at a reading level that is appropriate for our students, parents, and other community members?
- How can this program be adapted to meet the needs of our students?

Here are some strategies to address these questions:

- Draw on the expertise of the coalition.
- Ask the EBI developer about other, similar communities that have made adaptations to the EBI.
- Solicit recommendations from the EBI developer for adapting the program to your school's population.

[12] Dash et al (2003).

EBIs Adapted for Different Communities

- Kalihi Valley (Honolulu, Hawaii) chose the Second Step curriculum because of its effectiveness in preventing violence and the ease of adapting the curriculum to Hawaii's diverse ethnic populations. The scenarios used to reinforce each lesson were rewritten in local terms, using places and activities that were familiar to students (e.g., surfing instead of soccer).
- The Red Cliff Head Start Early Childhood Center, which serves the Lake Superior Chippewa, learned through experience that the entire family needed to be involved in efforts to support children's development. The center worked with a cultural mentor and the developer of the EBI Touchpoints to integrate the Red Cliff Anishinable culture into Touchpoints, which brings parents and providers together around critical points in young children's development. According to Project Director Dawn Nixon, through this process, the program "weaves a new kind of fabric, where the warp is made of traditional values and teachings and the weft is made of 'Western' knowledge and understanding." This collaborative effort with the developer enabled the center to emphasize the positive, strength-based aspects of the community, while addressing important mental health concerns.
- The Washington County Commission on Children and Families (WCCC) in Hillsboro, Oregon, identified the need for mental health services for young children beginning school who were at risk for behavioral and social problems that could affect their school careers. WCCC implemented the EBI First Step to Success, designed for children who show early signs of emerging antisocial behavior as they enter school. In the original intervention, the classroom was the focal point. Washington County learned that engaging and supporting parents to work with their children was critical to the project's success, so they strengthened the home-based component by adding more parent training.
- When conducting the Strengthening Families program in Spanish at a sports-focused community center, Waukesha (Wisconsin) UW Extension program staff used physical fitness as a vehicle for parents and children to strengthen their self-image and family communication skills, all while participating in sessions designed to reduce risk factors for substance abuse, violence and aggression, delinquency, and school failure.
- A rural community that lacked the staff to implement an in-home EBI decided to piggyback with another program that complemented the EBI and was currently being implemented in the community. Staff were trained to incorporate the new EBI into what they were already doing with families. The programs are now working well together.

Step 3: Identify Strategies that Support or Enhance and Can Sustain EBIs

After the group has selected the EBIs to be implemented, the coalition should answer these questions:

- How will the EBIs be incorporated into the school's core curriculum?
- What will we need to do to prepare and support staff for the effective implementation of the EBIs (for example, provide ongoing opportunities for teams of implementers to meet and problem-solve, use data to make mid-course corrections)?
- Which strategies will help to ensure sustainability of the EBIs (for example, conduct a training-of-trainers to build capacity, offer coaching and mentoring training, provide training to new staff on an ongoing basis, engage community partners to build ownership and secure funding)?
- Which community partners might we want to collaborate with to implement the EBIs?

Determine Professional Development and Ongoing Support Needed for Staff. New programs often require staff to develop new skills and knowledge. Staff development needs to be ongoing, not a one-time event. The Concerns-Based Adoption Model (a model for individual change) identifies different levels of needs and concerns that individuals have when initiating, implementing, and sustaining new programs. For example, during initiation, staff will want to know how implementing the programs will affect their other work, how and why the new programs work, how they work in a classroom, what kind of training will be available, when training will be offered, and what other support they will receive. Staff may also need additional cultural competence training to deliver the EBIs to a diverse student population. Effective implementation at later stages may require coaching from a more experienced implementer, ongoing collaborative learning and problem solving with colleagues, and booster sessions to renew skills and address new concerns (Osher et al., 2004).

As the coalition begins to plan for staff development, consider the following issues:

- Who should participate in training for the EBIs (e.g., classroom teachers, counselors, administrators, community partners, families)?
- How will you communicate information about the EBIs to families and other community stakeholders?
- Are there facilitation skills or program content that are not part of the EBI training that need to be included in staff development?
- Can staff be given credits toward state and/or district certification for participating in training?

List all the professional development, technical assistance, and ongoing consultation needed to implement the plan of action.

Challenges Related to Training in Rural Communities

Effective implementation of EBIs requires training. However, rural communities often have less access to certified EBI trainers—and without effective networking, school districts may not even know what is available in their region. For example, one community did not know that a certified Olweus bullying program trainer was available in a nearby regional training center, and had planned to send staff fairly far away to be trained. Some rural SS/HS sites send staff to trainings-of-trainers for the EBIs they are implementing so that their district can build capacity to sustain the programs beyond the grant period.

Create Collaborative Relationships with Other Organizations to Support the EBIs. If possible, tap into district, community, or state resources identified in the assessment to address staff and professional development needs. You may identify members of the broad coalition, such as mental health providers, who can assist with implementing an EBI or providing related training. Mental health service providers might be willing to come to a rural area to provide services to families. Other partners, such as businesses, might provide funding for materials or training, or even offer services at an after-school program. (See *Phase 4: Secure Financial Resources* for more on funding sources.)

Involving community partners in supporting implementation of EBIs is also important for promoting the mental health programs in the greater community. The more that community members feel ownership of the programs and understand the impact of mental health promotion efforts in children's lives, the greater their support will be.

> Effective collaboration at all levels of implementation forms the foundation for the ultimate success of school mental health programs.

Supporting Change

Readiness can be a major factor in whether a school mental health program will be well-implemented and supported by the community. Some schools may have committed leadership and staff, but lack experience in implementing a particular program. Others may have staff who do not see the urgency of the program and are resistant to change. To successfully implement new programs, six factors are necessary (Abt Associates, Inc., 2007, pp. 42–43):

- School and community awareness of students' mental health needs
- Access to new knowledge and programs
- Credible evidence that the new program will lead to improved mental health outcomes
- The resources—including curricula, time, materials, space, staff, training, and staff planning and process time—needed to implement the program
- Mechanisms for keeping district staff and other key stakeholder groups (e.g., teacher unions, district parent groups) aware of and involved in initiatives
- The ability to address the evolving concerns and needs of staff and community members as the intervention is implemented

Step 4: Develop Action Steps and Timeline

Based on goals, objectives, EBIs selected, and the strategies needed to enhance and support their implementation, the coalition's next task is to develop a set of action steps and a timeline. Identify:

- The specific steps needed to carry out the strategies
- Who will carry out the steps
- A realistic target date for accomplishing each action step
- The indicators to be used to monitor implementation fidelity and assess progress along the way

The action plan will be your guide. Use the list of activities and strategies from your Logic Model, and then list action steps for each activity/strategy in the **Action Plan Worksheet** on p. T-18. A sample action planning worksheet is provided in Figure 7.

Figure 7: Sample Action Plan Worksheet

Strategy #1: *Implement EBI X*

Action Steps	Person Responsible	Target Date for Completion	How You Know You Have Achieved This (Indicators—Process Measure)	Progress and Comments
1. Order program materials	*Steve*	*6/12*	*Materials will arrive*	*Purchase order in process*
2. Train two staff members to implement EBI				
3. Identify partners to provide referral services related to EBI				

Step 5: Develop a Plan for Program Evaluation[13]

There are many reasons to evaluate your school's mental health program efforts. Perhaps the most important is to determine how the program is working and what outcomes it is producing.

Other reasons to conduct an evaluation:

- To learn whether the program has been implemented as planned
- To improve the effectiveness or efficiency of program components
- To learn how to divide resources among prevention/promotion strategies in the future

[13] Dash et al (2003).

It's important to remember that evaluation is a way of documenting progress. You are not likely to see significant changes in the first year or two of program implementation, but you will still need to determine whether things are going as planned along the way—and if so, why, and if not, why not.

When using an EBI, it is especially important to determine whether the program is being implemented with fidelity (i.e., faithfulness to the original model), particularly in regard to its core elements—the components of the program that contribute to its effectiveness.

There are two major types of evaluations—*process evaluation* and *outcome evaluation*:

» *Process evaluation* asks:

- Was the intervention implemented as planned, was the target population reached, and were the goals and objectives attained? Process measures document implementation and include, for example, the number of teachers trained to deliver a curriculum, the number of classrooms receiving a bullying prevention program, the number of sessions delivered per classroom, and measures of program fidelity (National Center for Mental Health Promotion and Youth Violence Prevention, 2007d).

» *Outcome evaluation* asks:

- Did the intervention have the anticipated effect on the target population? For example, an *outcome measure* for a universal bullying intervention might be for the incidence of bullying to be reduced by a specific percentage, as described in the "Goals and Objectives" column of your Logic Model. Selective and indicated interventions also have functional outcomes for students. For example, as a result of an anger management intervention, a student with anger and aggression problems may be expected to have an increased ability to manage his or her anger and behave appropriately with peers and adults.
- What impact, if any, did the program have on the system at large (e.g., family, school, community)?

Your Logic Model serves as a guide to designing an evaluation plan that includes process and outcome measures, which will be included in the "Process and Outcome Evaluation" column of the model.

The evaluation plan should include the following (Dash et al., 2003):

» **Outcomes:** What are you expecting to change? How do these outcomes relate to the underlying risk factors for mental health? (See Figure 3, p. 2-4.) For example, you might decide to measure students' rates of suspension, the incidence of bullying at school, or students' perception of safety in school. How will you collect data about these changes? Possibilities: Survey all students or a sample of students, consult available indicator data, conduct observations, and conduct focus groups.

» **Data:** Review existing data that will serve as a baseline; determine the additional data that are needed and how they will be collected.

- **Data collection methods:** What instruments/tools will be used to measure outcomes? What do these instruments measure? How often will information be collected? Who will collect the information? How accurate are the data being collected?
- **Data analysis:** What descriptive information should be reported? For example, you might look at differences in students' attitudes about bullying before, during, and after implementing the EBI. How will these relationships be analyzed? What will constitute statistically significant results?
- **Evaluation report:** How will the evaluation results be communicated to the school and greater community? Using as many visuals as needed, the report should describe the problem and how it is being addressed, the evaluation results and their meaning, and what should be done, given the results. (See *Phase 6: Create and Carry Out a Communications Plan* for suggested communications strategies.)

Working with an Evaluator[14]

The evaluation needs to be designed during the planning phase and should be an integral part of implementation. The community coalition might form an evaluation committee comprising individuals with experience in evaluation or data collection. Another option is to hire a consultant to design and conduct the evaluation and ensure dissemination and use of the evaluation findings. Many states have Intermediate School Districts or Educational Service Agencies with Measurement and Evaluation experts whom you could consult. In addition, consider incorporating the evaluation into any existing school and community structures that collect and use data—such as school resource management teams and school improvement teams.

It is important to involve the evaluator in planning the evaluation. An experienced, unbiased evaluator can do the following:

- Assist in identifying and collecting the appropriate data to assess problems, needs, resources, and outcomes
- Measure the selected outcomes in a timely and cost-efficient way
- Provide realistic guidance on the level of change that can be expected from the chosen program, based on experience with other communities that have implemented the same EBI
- Monitor the quality of implementation
- Guide the coalition in using evaluation findings to improve the program

[14] Abt Associates, Inc. (2007, p.54).

Print and Internet Resources on Developing an Implementation Plan

Applying Effective Strategies for School Violence and Substance Abuse Prevention. Kim Dash, Cheryl Vince Whitman, Wayne Harding, Chelsey Goddard, and Melanie Adler. Newton, MA: Education Development Center, Inc., 2003.

Center for the Study and Prevention of Violence. *Blueprints for Violence Prevention.* Institute of Behavioral Science, University of Colorado at Boulder. Available at **http://www.colorado.edu/cspv/blueprints/index.html**.

Logic Model Development Guide: Using Logic Models to Bring Together Planning, Evaluation, and Action. Battle Creek, MI: W.K. Kellogg Foundation, 2004. Available at **http://www.wkkf.org/knowledge-center/resources/2010/Logic-Model-Development-Guide.aspx**.

National Center for Mental Health Promotion and Youth Violence Prevention. S*S/HS Evaluation Toolkit.* Newton, MA: Education Development Center, Inc. Available at **http://www.promoteprevent.org/implementing/evaluation**.

Safe and Sound: An Educational Leader's Guide to Evidence-Based Social and Emotional (SEL) Programs. Chicago, IL: Collaborative for Academic, Social, and Emotional Learning, 2003.

Safe, Supportive, and Successful Schools: Step by Step. David Osher, Kevin Dwyer, and Stephanie Jackson. Longmont, CO: Sopris West, 2004.

SAMHSA's National Registry of Evidence-Based Programs and Practices. Available at **http://www.nrepp.samhsa.gov**.

Stories from the Field: Lessons Learned About Building Coordinated School Health Programs. Atlanta, GA: Centers for Disease Control and Prevention, 2003.

Sustainable Schoolwide Social and Emotional Learning (SEL): Toolkit. Elizabeth Devaney, Mary Utne O'Brien, Hank Resnik, Susan Keister, and Roger P. Weissberg. Chicago, IL: Collaborative for Academic, Social, and Emotional Learning, 2006. ("Tool 18: Selecting an Evidence-Based SEL Program" lays out a step-by-step process for choosing an EBI that is a good fit for the school.)

Tools Related to Phase 3: Develop an Implementation Plan

Action Plan Worksheet (T-18), which can help you determine strategies and the steps to achieve them

EBI Feasibility Checklist (T-19), which can help you assess the fit of an EBI to your community

Logic Model Worksheet (T-20), a graphic way to represent major components of the action plan and their relationship to one another

Program Planning Tool (T-21), a step-by-step guide to developing an implementation plan

Checklist for Phase 3: Develop an Implementation Plan

1. Develop program goals, objectives, and outcomes to address priority mental health needs
   - ☐ Identify the school's priority mental health problems or concerns to be addressed.
   - ☐ Determine broad goals related to the mental health needs and risk factors.
   - ☐ Align the mental health program's goals with the school's goals.
   - ☐ Determine desired outcomes.
   - ☐ Create measurable objectives to help achieve outcomes.
   - ☐ Create a Logic Model to show how the components of the plan interrelate.
   - ☐ Determine indicators of progress.

2. Identify and select EBIs
   - ☐ Determine a process for selecting EBIs to address needs and reach goals.
   - ☐ Review and select appropriate EBIs for the desired outcomes and target population.
   - ☐ Identify the capacity and professional development needed to implement EBIs.
   - ☐ If necessary, adapt EBIs to the population but retain the core elements.

3. Identify strategies to support, enhance, and sustain EBIs
   - ☐ Identify all professional development, technical assistance, and consultation needed to effectively implement the plan of action and EBIs.
   - ☐ Create collaborative relationships with community partners to support the EBIs.

4. Develop action steps and a timeline
   - ☐ Determine specific activities needed to implement the EBIs, persons responsible, timeline, and indicators of progress.

5. Develop a plan for program evaluation
   - ☐ Decide whether to use an internal or external evaluator.
   - ☐ Select the evaluator.
   - ☐ Identify existing data to use as a baseline.
   - ☐ Determine additional data needed and how to collect them.
   - ☐ Plan and conduct process evaluation of selected EBIs.
   - ☐ Determine outcomes to be measured.
   - ☐ Collect, analyze, and report outcome data related to the EBIs.
   - ☐ Report results to the school and community.

Phase 4: Secure Financial Resources

The Challenge of Securing Financial Resources

The practice of promoting comprehensive mental health in schools may be new territory in many communities. Many schools also face shrinking budgets and competing priorities. Consequently, one of the biggest challenges of implementing a school mental health program may be to secure adequate funding.

> *"Although a range of funding options exists to finance school mental health efforts, none of these options fully meet the long-term fiscal needs of school mental health interventions. Identifying sustainable and flexible funding sources for these programs is extremely important and will most likely require major reform to the health care financing system."*
>
> —Hunter et al. (2005, p. 20)

Steps to Take to Secure Financial Resources

Step 1: Develop a Budget

The action plan for the school mental health program that the coalition created in Phase 3 will also serve as a comprehensive list of to-dos that will help determine necessary budget items:

- Staff (consider existing staff, such as classroom teachers who could be trained to deliver EBIs, and pupil services personnel who could deliver other programs; community mental health providers might be needed for more specialized EBIs, such as Multisystemic Therapy[15])
- Curriculum materials
- Supporting materials (optional or mandatory), such as DVDs or student booklets
- Office supplies
- Special equipment (e.g., LCD projector, laptop computer, DVD player)
- Staff training for facilitators
- Consultants
- Teacher release time (substitutes or extra pay)
- Professional development for staff implementing EBIs
- Cultural competency training for mental health providers

[15] An intensive, family-based treatment for youth with serious behavioral problems. For more information, see www.mstservices.com.

- Travel expenses
- Community education/communications materials to reach diverse audiences
- Funding for language services, such as translation of program materials or interpreters for a linguistically diverse population
- Program evaluation (evaluator fees, data collection and analysis expenses)

Since the first year of a program is often the most expensive, due to materials and training, develop a two-year budget to project the costs needed to sustain the program. The **Budget Summary for Program Implementation** on p. T-31 will be very useful for this purpose.

Step 2: Identify Existing and Potential Sources of Funding

Securing financial resources may involve several steps (adapted from Osher et al., 2004, p. 41):

- Reallocate existing public funds to support new programs
- Combine funding from different sources to coordinate and maximize services
- Find additional funding to purchase materials and services and to provide training

> *Approaching school change as an add-on to existing school programs is likely to be more expensive and less effective than an integrated approach that blends, braids, or otherwise aligns existing resources and new funding.*
>
> —Osher et al. (2004, p. 41)

Reallocate Existing Public Funds. A first task is to identify existing funding that might be used more effectively to support implementation of EBIs and related tasks. This may require eliminating ineffective programs and/or shifting funding along the continuum of mental health strategies—from expensive indicated interventions to more cost-effective early intervention and prevention efforts. Another possibility is to combine resources in ways that enhance the efficiency and effectiveness of program efforts. Ask coalition members about possible community partners to collaborate with to maximize funding. Some options to consider (Osher et al., 2004):

- Aligning and coordinating categorical funds to improve efficiency (for example, Safe and Drug-Free Schools [SDFS], Title I, and Special Education funds)
- Pooling funds across agencies and programs to collaborate on a shared goal related to the mental health program (for example, a Boys and Girls Club pays for space, local businesses provide mentors by allowing employees paid time off, and a mental health clinician trains and supervises the mentors)
- Braiding funds in such a way that agencies can track and retain their identities and funding requirements, while the monies fund one Integrated Service Plan that offers coordinated and comprehensive services (for example, combining separate categorical community and program funding streams into one source that supports individual components of unified services)

» Capturing and reinvesting the funds saved through reducing mental health program costs (e.g., when fewer referrals for costly services are made) (for example, relocating alternative education programs within existing school buildings, and reinvesting transportation costs in enhanced mental health services for students)

If the decision is made to reallocate funds, be sure that your timeline notes both when the funds will be allocated and when you'll need them for the mental health program.

Reallocating Existing Public Funds

South Carolina SS/HS sites have been able to reallocate existing public funds to sustain portions of their programs beyond the grant. While prevention and early intervention services in schools cannot be funded through Medicaid, school funds from other sources (e.g., Individuals with Disabilities Education Act [IDEA], Title I, IV, and V funds, SDFS) can be used to provide school-based prevention programs as long as they address the population designated by the funding source. So, for example, mental health counselors are able to provide therapeutic and preventive groups in classrooms for students who receive Special Education and in drug awareness and intervention groups for at-risk students.

Combining and Maximizing Public Funding.[16] Another strategy is to maximize resources by accessing available public funds in new ways. Medicaid—a federal and state health program that is administered by states—is one such source of funding. Under the mandate of Early and Periodic Screening, Diagnosis, and Treatment, all states must screen and diagnose all eligible children and then provide appropriate medically necessary treatment to "correct or ameliorate defects and physical and mental illness and conditions discovered by the screening" (Osher et al., 2004, p. 50). This screening can be a formal check-up for physical or mental health issues, or it can be any contact with a health care professional for an assessment of health issues. These assessments entitle children to any services necessary to treat the diagnosed problem. Most states allow Medicaid reimbursement for school mental health services provided by school psychologists, school social workers, and licensed clinical providers.

There are three ways to maximize Medicaid funding:

» **Fee-for-service claiming:** Medicaid payments are available for services provided. If your school doesn't yet provide such services, Medicaid reimbursement may allow that. (To find out about your state, see the list of State Medicaid Directors at **http://www.nasmd.org/links/State_Medicaid_links.asp.**)

» **Administrative claiming:** This requires less documentation and uses a formula to determine time spent and the number of individuals involved.

» **Leveraged funds:** Two or more agencies create a formal partnership to leverage new or additional Medicaid funding.

[16] Osher et al. (2004).

Los Angeles Unified School District—Partnering with the Department of Mental Health

For years, the Los Angeles (LA) Unified School District spent its general funds and state and locally generated funds on mandated mental health services for children, without accessing Medicaid funding. In 1992, LA Unified became a contract agency and certified Medicaid provider. This allowed the school district to claim Medicaid reimbursement for many of the services previously supported by general funds. In turn, the school district is now able to use its general funds to provide services to children who are not Medicaid-eligible. This allows the LA County Department of Mental Health to extend its services to an underserved population. The result is a win-win situation for both organizations, with expanded resources to provide increased services to a larger number of children (Osher et al., 2004, p. 48).

Finding Additional Funding. Once you have identified existing funding, the coalition will probably also need to seek additional funding from such sources as the federal and state government, local agencies, and foundations.

> *"In seeking new funding for schoolwide improvement projects, schools should determine whether (1) the district already receives funds that could support new or expanded initiatives; (2) the district is eligible for such funds; (3) the district makes allocations to schools; and (4) the school is free to pursue additional funding independently."*
>
> —Fetro (1998a, p. 31)

Federal programs related to school mental health include the following:

- **Healthy Schools, Healthy Communities** (funded by the U.S. Department of Health and Human Services): Supports the development and operation of school-based health centers—important providers of mental health interventions in schools.
- **IDEA** (funded by the U.S. Department of Education): Supports development of an Individualized Education Program (IEP) for students with emotional disabilities that interfere with educational achievement, and provides appropriate related services, including psychological counseling and social work services, when they're part of an IEP.
- **SS/HS Initiative** (funded by SAMHSA): Supports youth violence prevention; alcohol, tobacco, and other drug prevention; school and community mental health programs; and early childhood psycho-social and emotional development services.

Survey of Funding Streams Most Often Used for School Mental Health Services

The first national survey of school mental health services, conducted by SAMHSA in 2002–03, found this distribution of funding sources used by school districts (Foster, Rollefson, Doksum, Noonan, & Robinson, 2005):

- 37% IDEA
- 32% state Special Education funds
- 43% local funds
- 39% state general funds
- 20% Medicaid
- 57% Title IV (prevention resources)
- 22% Title I
- 22% SS/HS Initiative

Existing Federal Programs that Provide Support for School Mental Health Services

- Elementary and Secondary School Counseling Program
- Grants for the Integration of Schools and Mental Health Systems
- IDEA
- SS/HS
- Systems of Care

State Funding. States may provide Special Education and mental health funds that can contribute to supporting mental health programs and services. States can also use federal block grants to fund school mental health interventions (Evans et al., 2003). To find sources of funding for your state, see "School Grants" in *Print and Internet Resources on Securing Financial Resources* on p. 4-7.

Local Funding. Local funding (i.e., county, city, town, or school district) varies greatly from district to district and is often targeted for more basic school services. The best strategy for accessing these funds is to show how preventing mental health problems aligns with the school's goals for learning.

Private Funding. Some schools tap national and local foundations, both public and corporate, to fund school health programs. According to the School Mental Health Alliance, "Several foundations (i.e., Robert Wood Johnson, and W.K. Kellogg) have a specific interest in supporting school mental health efforts. Unfortunately, support from private foundations is typically time-limited and cannot maintain a project indefinitely" (Hunter et al., 2005, p. 20). Organizations such as PTOs and PTAs may also be a source of funding.

Seeking Funding from Foundations

You should learn as much as possible about potential funders by checking their websites and reviewing annual reports to identify the foundations' missions, their priorities and eligibility requirements, and the groups they currently fund. Try to meet with representatives from the foundation to get their reactions to and input on your program plan. Follow their guidelines in submitting a proposal.

At a minimum, expect that your proposal should include clear, persuasive statements about the following (Marx & Northrop, 1995):

- How your proposal addresses the goals of the foundation
- Why your program is needed (data on the problem, costs of the problem, and the target population)
- Who in the community supports the program, including letters of support from key organizations and individuals
- The program's appropriateness for the school or district's population, size, staffing, and previous involvement
- The specific school or district need (e.g., "We need $3,000 to purchase . . . ")
- Feasible and measurable objectives
- A program evaluation plan
- Prospects that the activities will continue and grow beyond the plan

Step 3: Pursue Relevant Sources

Once you have identified the most appropriate sources of funding, you will need to work with the school district and the coalition to pursue the likeliest possibilities. Working with the broad mental health coalition will continue to build a sense of community among the group—and the group members could provide access to expertise, experience, and financial support that might not otherwise be available, especially in regard to seeking funding from foundations.

Print and Internet Resources on Securing Financial Resources

Center for Mental Health in Schools at UCLA. *Financial strategies to aid in addressing barriers to learning* (2007 Revision). Los Angeles, CA: Author. Available at **http://smhp.psych.ucla.edu/pdfdocs/Financial/fund2000.pdf**.

Center for Mental Health in Schools at UCLA. *Financing mental health for children and adolescents (Report).* Los Angeles, CA: Author. Available at **http://smhp.psych.ucla.edu/pdfdocs/briefs/FinanceBrief.pdf**.

Financing Behavioral Health Services and Supports for Children, Youth and Families in the Child Welfare System. Jan McCarthy and Lan Le. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health, November 2008. Available at **http://www.napcwa.org/home/docs/financingstrategiesreport.pdf.**

Foundation Center. [Provides information on foundations, corporate giving, and related subjects, and publishes the *Philanthropy News Digest*, a weekly listing of requests for proposals from U.S. grant makers.] Available at **http://fdncenter.org/**.

Judge David L. Bazelon Center for Mental Health Law. [Provides principles and examples of successful funding strategies.] Available at **http://www.bazelon.org/News-Publications/Publications/CategoryID/20/List/1/Level/a/ProductID/41.aspx?SortField=ProductNumber,ProductNumber**.

Maximizing Medicaid Funding to Support Health and Mental Health Services for School-Age Children and Youth: Strategy Brief, Volume 1, No. 7, October 2000. Washington, DC: The Finance Project. Available at **http://76.12.61.196/publications/Brief5.pdf**.

The National Center for Mental Health Promotion and Violence Prevention. [Offers a variety of tools for financing mental health.] Available at **http://sshs.promoteprevent.org/implementing/sustainability/legacy-wheel**.

Safe, Supportive, and Successful Schools: Step by Step. David Osher, Kevin Dwyer, and Stephanie Jackson. Longmont, CO: Sopris West, 2004.

SchoolGrants. [Posts all types of grants for schools, teachers, and students and provides links to federal and state agencies and foundations.] Available at **http://www.schoolgrants.org**.

Step by Step to Health Promoting Schools. Joyce V. Fetro. Santa Cruz, CA: ETR Associates, 1998b.

Towards Better Behavioral Health for Children, Youth and their Families: Financing that Supports Knowledge. Janice L. Cooper. New York: National Center for Children in Poverty, Columbia University, January 2008. Available at **http://www.nccp.org/publications/pdf/text_804.pdf**.

Working Together to Promote Academic Performance, Social and Emotional Learning, and Mental Health for All Children: A Position Paper of the School Mental Health Alliance. Lisa Hunter, Kimberly Hoagwood, Steve Evans, Mark Weist, Carl Smith, Carl Paternite, Rob Horner, David Osher, Peter Jensen, & the School Mental Health Alliance. New York: Center for the Advancement of Children's Mental Health at Columbia University, 2005. Available at **http://www.thereachinstitute.org/school-mental-health-alliance.html**.

Tools Related to Phase 4: Secure Financial Resources

Budget Summary for Program Implementation (T-31), worksheet for identifying first- and second-year program implementation costs

Checklist for Phase 4: Secure Financial Resources

1. Develop a budget
   - ☐ Identify costs for each step of the school mental health program action plan, including staff, materials, training, teacher release time, communications materials, and program evaluation.
   - ☐ Develop a two-year budget, as start-up costs are usually higher.

2. Identify existing and potential sources of funding
   - ☐ Determine if the district already receives funds that could support new or expanded mental health initiatives.
   - ☐ Find out the district's policy on the school independently seeking funding.
   - ☐ Ask coalition members about possible community partners to collaborate with to maximize funding.
   - ☐ Research existing funds, such as Medicaid, that could provide reimbursement for mental health services.
   - ☐ Seek additional federal, state, and local funds that could support school mental health programs and services.
   - ☐ Research relevant foundations that could provide additional funding.

3. Pursue relevant sources
   - ☐ Ask members of the mental health coalition to participate in the pursuit of funding, especially those who have grant-writing expertise.

Phase 5: Monitor and Address Challenges

The Value of a Monitoring System

Effectively implementing the whole-school approach to children's mental health involves anticipating or identifying problems and challenges and responding to them before they affect the desired outcomes. A *monitoring system* is a systematic process for tracking and measuring the progress of your implementation efforts.

In many cases, process measures (described in your evaluation plan and Logic Model) can be used to assess program implementation, measuring such issues as staff preparation and support, practitioner-to-student ratios, location of service provision, completion of training, what portion of the EBI curriculum or treatment approach was implemented, and length of treatment. The monitoring system should also provide data about how different subgroups within the target populations are participating in given activities. In addition, rather than merely reporting a problem (e.g., identifying a shortfall in trained teachers after scheduled trainings are completed), a monitoring system should warn of potential problems early on (e.g., identifying the shortfall early enough to recruit additional teachers to be trained).

Steps to Take to Monitor and Address Challenges

Step 1: Carry Out and Monitor Implementation Plan

The **Action Plan Worksheet** completed in Phase 3 provides a comprehensive to-do list, including recruiting and hiring the appropriate staff and conducting professional development. Ideally, the plan will describe who should be trained, supplied with curricula, and provided with the materials and resources needed to carry out particular tasks.

Professional development is key to the success of implementing a whole-school approach to mental health. Staff must be adequately trained to deliver programs and services effectively. When implementing an EBI, the best way to ensure high-quality and uniform training is to involve the program's developers.

It is also important to provide ongoing staff support—technical assistance, materials, advice and guidance, and additional training, mentoring, and coaching. These supports will also need to be monitored.

A good monitoring practice is to appoint one or more coalition members to take responsibility for regularly contacting the people carrying out the work to see how things are going and to identify any concerns before they become major problems.

It is essential for the principal and other school or district leaders to provide ongoing support to the people carrying out the activities, especially if these activities are expected to complement one another and form part of a comprehensive schoolwide approach to mental health.

Monitoring Program Implementation

- Is the necessary technical assistance, coaching, and other support being provided to the people carrying out the activities and to other participants who are critical to the success of the mental health program?
- Do staff have a regular channel of communication to alert others when they need additional support?
- Is a monitoring system built into each activity to provide corrective and constructive feedback (such as self-reports of staff effectiveness, or peer observations of staff implementation)?
- Does the monitoring system assist implementers and others critical to the success of the program in identifying and solving problems?
- Does the monitoring system provide timely, useful, and complete information?
- Does the monitoring system have a mechanism for measuring fidelity if adaptations are made to the program? (National Center for Mental Health Promotion and Youth Violence Prevention, 2007d)

Step 2: Identify and Address Challenges

Careful planning can minimize many challenges. If a concerted effort has been made to involve diverse representatives from the school and community in decisions, procure necessary resources, and provide staff with quality professional development so they feel prepared, the coalition will have gone a long way toward minimizing the difficulties that can undermine successful implementation. However, even the best planning cannot totally eliminate challenges.

Teachers, school staff, and community mental health program staff, for example, may pose the following issues:

- Staff are not adequately trained or supported during implementation, or not enough staff are trained to implement EBIs
- Staff need cultural competence training
- Due to staff turnover, new staff are not adequately trained, are not coached by experienced implementers, or are not as committed as the "founding" staff members
- Teachers are not implementing the EBI as recommended
- Teachers are impatient with the amount of time and perseverance required to effect change

- Teachers are resistant to mental health programs—they see neither the benefits nor how the programs link to academics
- There are turf issues between teachers, school staff, and community mental health program staff
- Community mental health staff and school staff have different confidentiality guidelines
- Community-based providers do not feel welcome in the school
- School staff are resentful that money is spent on mental health programs rather than academic programs

Students and families may pose the following challenges:

- Students do not respond to the program (e.g., they don't like it or relate to it, it is not culturally appropriate for them, teachers are not teaching it well)
- The stigma related to mental health is preventing students from learning, and keeping families from accessing services
- It's too difficult for families to access services
- Families don't feel connected to the school
- Community outreach efforts are not culturally competent and/or don't reach children and parents/guardians

Challenges may also arise related to the program's **logistics, facilities, equipment, or materials**, for example:

- The schedule doesn't allow teachers and other staff time to plan and implement EBIs appropriately
- Materials are not available in a timely manner or are missing altogether
- Turf issues arise over office space for community staff members

Other dynamics that challenge implementation, and some strategies to address them, are described below.

Impatience and Frustration. Implementing change requires ongoing support and resources, and it takes time. It's easy to get discouraged when you don't see immediate results. Michael Fullan (2001), a leader in educational reform, notes that the process of implementing change is often most difficult in the first six months, no matter how well you plan.

Addressing Impatience and Frustration. It's important to have realistic expectations about the time it will take to see significant progress and to make sure that other stakeholders in the community understand this as well. To sustain momentum, be sure to identify and celebrate successes and recognize staff for their role in each accomplishment. Using communications and marketing to inform the community about the program's goals and successes is a good way to create momentum and maintain a base of support for the program. (See Phase 6: Create and Carry Out a Communications Plan for effective ways to communicate the program's progress.)

Resistance. Despite your program's best efforts, you are likely to face resistance at some point—and some of it will be beyond the program's control, as not all resistance is program-related. However, resistance may reflect legitimate concerns or needs of staff, community partners, students, and families that are not being met through staff development, support, logistics, or clear communication. Resistance may be evident in people's behavior—for example, not attending meetings, not following through on assigned tasks, or criticizing the program and undermining support.

Addressing Resistance. Provide informal and formal opportunities for people to voice their needs and concerns in a timely manner. Pay attention to, acknowledge, and address needs and concerns before they turn into resistance.

> *"Reframing the legitimate basis of most forms of resistance will allow us to get a more productive start and to isolate the real problems of improvement."*
>
> —Fullan & Miles, 1992, cited in Osher et al. (2004, p. 36)

To minimize resistance, it's important to make a strong case for the link between mental health programs and students' academic and life success, include key stakeholders in decisions and the coalition, provide quality staff development and ongoing support for EBI implementation, monitor and address implementers' concerns, use data to demonstrate program successes, and maintain ongoing communications with the community about the success of the program.

> *"Advocates must demonstrate that school-based mental health programs achieve specific goals that policymakers and society value. At the school or local level, school-based programs must be presented as an integral part of the school and the community, fully compatible with the education mission)."*
>
> —HoganBruen et al. (2003, p. 48)

Program Effectiveness Counters Initial Resistance

The Newport–Mesa (California) Unified School District's SS/HS Initiative, Project ASK, targeted older students with the most at-risk behaviors: truancy, suspension, expulsion, and/or low academic achievement. Outreach advocates contacted families, offering to help modify students' behaviors by providing services and a skills program for parents. While more affluent families in the district did not accept the school district's help, many in lower-income communities embraced the offer. Project ASK began by focusing on those mostly Latino communities and chose an EBI parenting program, Parenting Wisely, offered in Spanish and English at a vocabulary level that was friendly to families with limited education. The Family Outreach leader, a well-respected Hispanic woman, said that the most important elements in working with the community were being a good listener to families, being respectful and compassionate, and learning from them: "Even though I am Hispanic, I do not know more about their reality than they do."

As the parenting program was implemented, the district collected data about the program's effectiveness to correlate changes in student behavior with the parents who completed the program. After the first six months, the district began seeing results: improvements in student attendance, discipline, and social behaviors. Truancy decreased by almost half. By the end of the first semester, there were improvements in students' academic achievement, and the number of referrals to mental health professionals greatly increased. Word started spreading within the community about the benefits of participating in the program. Individuals began telling others about how the program helped to improve their family's communication. Fathers who had participated began to see positive results at work as well. After the first year, more affluent families began to join the program, and the program had to create a waiting list.

Stigma. Simply making mental health services available is often not sufficient. It is also important to address the issues of stigma related to mental illness and concerns about confidentiality.

> *"Stigma—negative labels, thoughts, and attitudes toward individuals with mental illness—results in barriers to appropriate and adequate mental health services . . . [that] might make parents loathe to seek services for fear they will be blamed for their child's difficulties . . . [and that] might make youth feel embarrassed about the prospect of treatment and may lead them to avoid seeking services."*
>
> —HoganBruen et al. (2003, p. 45)

Depending on their cultural, historical, or ethnic background, some staff, students, and parents may be resistant to mental health promotion, prevention, and intervention programs. The Surgeon General's report on mental health identified stigma as a major barrier that keeps the parents of children and adolescents with serious emotional disorders from seeking treatment for their child (U.S. Public Health Service, 1999). Children are especially sensitive to discrimination and stigma, which can greatly impact their self-esteem.

Addressing Stigma. Effective outreach to students, parents, and the community is key:

- To overcome parents' resistance, explain the nature and benefits of mental health promotion in terms that are understandable and acceptable to them.
- Consider logistical issues, such as transportation, flexible operating hours, a sliding fee schedule, and offering services in a variety of languages, with translation and interpreters as needed, to ensure access to and usability of mental health services.
- Provide professional development opportunities for staff about diversity, mental health issues, and fostering an inclusive school environment.
- Provide strength-based mental health services that affirm children's competencies and build on the resources of the school, family, and community.
- Avoid deficit-oriented approaches that perpetuate negative stereotypes of children and families and reinforce the stigma associated with mental health programs.
- Foster positive attitudes about mental health service providers.

> *Reducing stigma requires community education and willingness among individuals to challenge others when discrimination occurs, or when negative stereotypes are used to describe those who have mental illness.*
>
> —Commonwealth of Australia (2005, p. 5)

- Challenge any disrespectful terms used to refer to people with a mental illness, or related words used as terms of derision, such as "psycho," "lunatic," or "schizo."
- Use "people first" language. For example, say "a person with schizophrenia" instead of "a schizophrenic."
- Use facts to challenge people's misconceptions about mental illness. Stress that mental illness is quite common, that it is in fact an *illness* rather than a character flaw, that recovery and management are possible, and that people are not to blame for their illness.
- Post positive messages about wellness.
- Include mental illness in discussions about acceptance of diversity, just as you would discuss cultural and religious diversity, physical or intellectual disabilities, etc.
- Invite a school counselor to visit a class or school assembly to dispel myths, break down stigma, and encourage students to seek help for mental health problems.
- Invite a health professional, or a person who has had mental illness, to talk to students about mental health issues, stigma, and their community.

(From Commonwealth of Australia, 2005; HoganBruen et al., 2003.)

Using Data to Decrease Stigma

In one rural SS/HS site, Allamakee (Iowa) Community School District, very few families were accessing mental health services. The SS/HS Initiative's goal was to destigmatize mental health services. To do this, they launched a campaign using data that showed that students with attendance and discipline problems who received mental health services did better than students who didn't. Once the word got out, the number of mental health referrals soared. The campaign increased the acceptability of getting services and provided ways for family to access services.

Reframe Services to Lessen Stigma

At the inception of a multi-school district SS/HS Initiative in Bradley County, Tennessee, four Behavioral Intervention/Prevention Specialists (BIPS) were hired to assist classroom teachers to handle disruptive student behaviors. The BIPS conducted observations in the classrooms where teachers were concerned about disruptive behaviors, talked with the teacher, and often followed up with parents. If it was determined that a student's disruptive behaviors were based on social-emotional issues, the student was referred to a school-based mental health counselor. In planning for sustainability of the BIPS, the SS/HS project director proposed to the county Boards of Education and Directors of Schools that the BIPS be called Learning Support Specialists. This new title lessened the stigma of receiving help for families and sent a clear message to parents, teachers, and administrators that the district was serious about addressing learning barriers that hinder students' academic achievement. All four renamed positions were sustained in both districts.

Turf Issues. When school- and community-based providers collaborate to promote mental health in schools, "turf issues" (strong feelings of territoriality) often arise. There are a number of reasons this occurs, including differing goals for the program, different approaches to school mental health, an overlap in responsibilities, job insecurity, conflicts over the use of space, confidentiality issues, liability issues, and the degree to which school staff and community mental health providers have opportunities to become better acquainted, both personally and professionally. To avoid competition for scarce resources, fragmentation of services, needless duplication of effort, and the potential isolation of service providers, successful collaboration is critical (Rappaport et al., 2003; Weist, Steigler, & Lever, 2008).

Addressing Turf Issues. Interdisciplinary collaboration depends on appreciating and building on the competencies of the various disciplines involved. Early in the collaborative process, the leaders of the program should devote time to clarifying each participant's role and professional paradigm and then communicate this to all participants (Rappaport et al., 2003).

Another prerequisite to successful collaboration is making sure that school-employed mental health professionals—school psychologists, counselors, social workers—and collaborating community mental health professionals—clinical and counseling psychologists, clinical social workers—have equal status, especially in regard to authority and access to resources (Rappaport et al., 2003).

Keep in mind, though, that while these "equal standing" consultative relationships are essential, they may be particularly challenging for mental health professionals, whose professional training often advocates the hierarchical "expert-consultee" model and a proprietary attitude toward discipline-specific mental health expertise (Weist, Paternite, & Adelsheim, 2005). Community mental health providers need opportunities to become oriented to the school culture and its daily routines and to observe students and talk with school personnel. It is important that community mental health professionals

view educators as *valued customers and colleagues* by acknowledging and building on their individual competencies and respecting the unique perspective they bring to understanding students' strengths and difficulties (Rappaport et al., 2003).

Successful Resolution of Turf Issues

As part of its SS/HS grant, Springfield (Missouri) Public Schools integrated school-based clinicians (SBCs)—licensed mental health professionals—into its schools. A unique feature of this model was that the SBCs were hired and paid by the district's community mental health partner, Burrell Behavioral Health, but were housed in the schools, which created the potential for turf issues. To ensure a good match between the SBC's and each school's culture, school personnel were active in the hiring process. To prevent overlapping job responsibilities with school counselors, the SBCs' role was clearly defined as "providing services to students identified by school personnel as most in need of intensive mental health services." In addition, the SBCs were hired to work 12 rather than 9 months a year, to allow for the ongoing provision of services to at-risk families and students.

A key to the success of this project was that both the schools and the mental health agency designated one administrator to work on developing and implementing the grant. The administrators served as advocates, cheerleaders, and point people for solving problems that arose among the staff. Their first tasks were to identify and resolve existing problems between the schools and mental health agency, discuss turf issues, identify the cultural differences between the two organizations, and clarify each organization's concerns related to space, paperwork, accounting procedures, and accountability. The administrators' success was based on open and honest communication; knowledge of policies, procedures, and politics within their respective organization; respect and credibility within their organization; and tenacity and commitment to the success of the project.

The SBCs' training was critical to their successful integration into the school setting. The training included information about school climate and procedures and openly addressed potential barriers to collaboration (including school staff's limited office space, equipment, and resources; educators' perceptions of the freedom of mental health workers; misunderstanding of roles; potential conflicts with Special Education processes; and possible turf conflicts with school counselors).

Trainings were also held for school principals and counselors to inform them about the roles and responsibilities of the SBCs. These meetings included open discussion of participants' concerns, which led to some adjustments to the project plan.

As a testament to the model's success:

- 96 percent of school administrators reported that having SBCs allowed school counselors more time to work with additional students
- 97 percent of school administrators would like to have SBCs become a permanent part of their schools

Confidentiality Concerns. School-based mental health professionals operate under different rules and regulations regarding student records than do mental health professionals from community agencies (Weist et al., 2008):

- Under the Family Educational Rights and Privacy Act (FERPA), which states that student records may be accessed by family and relevant school staff, professional staff in the school have open access to student records.
- In contrast, community mental health professionals adhere to the standards of the Health Insurance Portability and Accountability Act (HIPAA), which does not allow access to a child's mental health records without a release signed by the parent or guardian.

> *"Since expanded school mental health providers are located within, but are not necessarily employed by, the school, they must navigate a difficult course through professional ethics codes, state and federal mandates (both health and education), local school board policies, and the policies of their employing agencies. Addressing such issues as client confidentiality and parental consent within the school setting, while maintaining collaborative relationships with the school staff, for example, can be very challenging."*
>
> —Prodente, Sander, Grabill, Rubin, & Schwab (2003 p. 363)

Collaboration can be impaired by both sets of rules and regulations; for example, FERPA may limit the ability of collaborating community mental health professionals to participate in IEP meetings, and HIPAA can limit what community staff can share with school staff who need to know critical information about individual students (Prodente, et al., 2003).

Addressing Confidentiality Issues. Both school- and community-based mental health providers must be explicit about their organization's confidentiality policies and must communicate these policies to school administrators, parents, and students in order for therapeutic relationships with students to be sustained. Community mental health providers may encourage students to allow information to be shared with educators and/or parents when it can help the school make critical decisions beneficial to the student (Rappaport et al., 2003).

> *"In areas where current law and policy are either inadequate or in need of revision or clarification, it may be useful for expanded school mental health programs to initiate a dialogue with administrators, mental health professionals, [and] school community stakeholders to identify and problem-solve about the merging of legal and ethical concerns."*
>
> —Prodente et al. (2003, p. 372)

To avoid breaching confidentiality while still providing useful information to school staff, community mental health providers can offer school staff training or coaching on working with children with specific mental health needs—such as ADHD, depression, anger control issues, or anxiety—while not revealing confidential information about any particular student.

Two Sets of Legal Concerns, One Common Agreement

The Springfield (Missouri) SS/HS Initiative had to research and resolve many legal issues in preparation for allowing its SBCs, employees of an outside agency, to provide mental health services in the school setting. Satisfying FERPA requirements for schools and HIPPA requirements for the mental health agency required consultation with the legal counsels of both agencies and the development of procedures to respond to the concerns of each. Here is what they agreed on:

- The School-Based Services record is separate from the child's educational record. The school system owns the child's educational record, while Burrell Behavioral Services owns the School-Based Services record. School district staff do not have access to the School-Based Services record without a signed authorization.
- The School-Based Services record is housed in the school building in which services are provided. Burrell staff are responsible for safeguarding the confidentiality and protecting the information in the record against loss, defacement, tampering, and/or unauthorized access.
- SBCs may have one contact with a student before written parental permission is required.
- Signed consent by a student's legal guardian is required before mental health treatment may be provided by an SBC to a student in a school setting.
- SBCs will follow all of the operational guidelines of Burrell Behavioral Health when providing mental health services.
- Parental permission forms include notification that students' information will be shared with school staff on a "need-to-know" basis, similar to FERPA guidelines for confidentiality.
- All Burrell Behavioral Health employees who provide services in the school district's buildings or in or around students must comply with the Springfield Public School Board's policies.

Print and Internet Resources on Monitoring and Addressing Challenges

Cultural and Linguistic Competence [Resources on cultural competence]. National Center for Mental Health Promotion and Youth Violence Prevention. Available at **http://learn.aero.und.edu/links.asp?LinkID=15486**.

Cultural Competence. Dana L. Cunningham, Metin Ozdemir, Julian Summers, and Ava Ghunney. Baltimore, MD: Center for School Mental Health Analysis and Action, Department of Psychiatry, University of Maryland School of Medicine, August 2006. Available at **http://csmh.umaryland.edu/resources.html/CulturalCompetenceIB-CSMHA.pdf.**

Culturally Competent Mental Health Services in the Schools: Tips for Teachers. Barbara Bole Williams. Bethesda, MD: National Association for School Psychologists, 2006. Available at **www.nasponline.org/resources/culturalcompetence/cultcompmhservices.pdf**.

NASP Toolkit: School-Based Mental Health. Bethesda, MD: National Association of School Psychologists. Available at **www.nasponline.org/publications/booksproducts/mhtoolkit.aspx**.

National Center for Cultural Competence. Washington, DC: Georgetown University Center for Child and Human Development. Available at **http://www11.georgetown.edu/research/gucchd/nccc/**.

SchoolMentalHealth.org [School mental health resources for clinicians, educators, administrators, parents/caregivers, families, and students, with an emphasis on practical information and skills, based on current research, and lessons learned from local, state, and national initiatives]. Available at **http://www.schoolmentalhealth.org/index.html**.

The Substance Abuse and Mental Health Services Administration's Resource Center to Promote Acceptance, Dignity, and Social Inclusion Associated with Mental Illness. (2008). *ADS Center Brochure.* [Resource about reducing stigma about mental illness.] Available at **http://www.stopstigma.samhsa.gov/default.aspx**.

Tools Related to Phase 5: Monitor and Address Challenges

Action Plan Worksheet (T-18) (completed in Phase 3), a comprehensive list of action items to monitor

Checklist for Phase 5: Monitor and Address Challenges

1. Carry out and monitor implementation plan
   - ☐ Hire staff.
   - ☐ Conduct professional development on EBIs and cultural competency.
   - ☐ Create and use a monitoring system to detect problems and/or concerns related to implementation.

2. Identify and address challenges
   - ☐ Determine sources of impatience, frustration, and resistance and address areas of concern and needs.
   - ☐ Identify issues related to cultural competence and stigma and address them.
   - ☐ Identify issues related to turf and confidentiality and address them.
   - ☐ Acknowledge and celebrate successes.

Phase 6: Create and Carry Out a Communications Plan

The Value of a Communications Plan

School leaders, staff, and community members may dismiss the need for a whole-school approach to mental health, believing that mental health is not the province of schools or simply not understanding the relationship between students' mental health and their academic performance. Effectively employing communications strategies can help to overcome this barrier to mental health promotion in schools. Communicating clearly and frequently with school leaders and staff, parents, and the community during a program's start-up and implementation stages can also expand support for program activities and set the stage for sustaining the program in the future. Taking the time to create a communications plan enables a coalition to focus its efforts and avoid wasting resources.

> The Communication and Social Marketing Center provides communications technical assistance and training to SS/HS grantees. The center's website (**http://www.sshs.samhsa.gov/communications/login/login.aspx**), accessible only to SS/HS grantees, offers a wealth of information on communications, including templates, to aid in planning and implementation efforts.

An effective communications plan is grounded in a firm understanding of the concerns and motivations of the target audience. Below is a brief overview of communications planning and actions.

Steps to Take to Create and Carry Out a Communications Plan[17]

Step 1: Conduct a Situation Analysis

Situation analysis, the starting point for a communications plan, identifies communications goals, target audiences, an analysis of each audience's characteristics, and assets available for creating and implementing the plan.

Coalition members from different target groups should participate in the situation analysis. You may also want to conduct focus groups—small-group interviews led by a

[17] This section was adapted from Project LAUNCH's *Communications Toolkit: Creating and Implementing a Communications Plan*, available on the National Center for Mental Health Promotion and Youth Violence Prevention website, http://projectlaunch.promoteprevent.org/commtoolkit01/.

moderator in a comfortable atmosphere that allows participants to share their views. In addition, coalition members can conduct one-on-one interviews with key informants to get more in-depth information and insights for the situation analysis (see *Print and Internet Resources on Communications* on p. 6-8 for more details).

Communications Goals. The first task in conducting a situation analysis is to identify communications goals for the program.

Questions to consider:

» What do we want to accomplish with a communications strategy?

» What actions do we want people to take after they hear our messages?

For example, consider the following potential goals:

» To raise community awareness of the benefits of the whole-school approach to mental health and gain greater parent participation.
Possible resulting actions: More parents attend meetings and access mental health services.

» To increase support from school administrators.
Possible resulting action: More school resources are devoted to mental health programs and services.

Target Audience. The next task is to identify the target audiences to be reached. Your program may have a primary audience—the one you most want to reach—and a secondary audience who would also benefit and may be able to influence the primary audience. Some possible audiences:

» Program participants—this could include parents and/or students (if the latter, parents may be the target audience if they need to give permission)

» Key stakeholders, including community and political leaders, staff, superintendents, school board members, and PTAs

» Collaborators, such as mental-health providers, teachers, and community agencies

» Funders, for example, foundations, local and federal government agencies, and business leaders

Audience Analysis. The next step is to better understand the audience and what motivates them in order to tailor communications messages to achieve the intended response. Your program's messages will also have a greater impact if the audience can relate to them. Audience analysis should include the following:

» The demographics of the audience (age range, gender, ethnic/cultural background, etc.)

» Language and vocabulary issues (the primary languages spoken and the vocabulary the audience will best understand)

- The motivations underlying the audience's attitudes and behaviors (such as greater academic success for their children, evidence-based findings, emotional responses, cost-benefit analyses)
- The prevailing attitudes, knowledge, and beliefs in the school and community regarding school mental health
- The audience's readiness to take the desired action

Assets. The final task is to determine the assets the program has for developing and implementing the communications plan. For example:

- *Staff and consultants:* Does your school or district have staff who can plan and implement communications strategies, or will you need to hire a professional firm or interns from a local university? Will staff require special training?
- *Time:* How long do you have to plan and implement the strategy?
- *Budget:* Have funds been set aside to implement the communications plan? If there is no or limited money, can you broker in-kind donations?
- *Coalition:* Does the mental health coalition include representatives of the target audience or people with connections to the target audience?
- *Shared vision or goals:* Do staff, coalition members, and/or collaborating partners share the program's vision and goals?

Step 2: Create the Program's Communications Message(s)

The program's communications message must rise above the clamor of all the messages your audience hears on a daily basis. To do this, you must draw on what the target audience already knows and believes, and what will appeal to them.

A message will have the most "traction" if three key things are clear:

- What *difference* your program makes
- *Who* should care
- *Why* they should care

Communications messages should contain, at most, three points. For example, a general message might succinctly answer the following three questions:

- *What is the problem the program addresses?* Very briefly explain the problem the mental health program is addressing, using demographics and the data collected in Phase 3. Paint a picture that tells the audience why they should care.
- *How is the program addressing the problem?* Briefly explain one or two things that the program is doing to solve the problem.

» *What outcomes are expected from the program? Or: What evidence is there that the program is succeeding? Or: What more needs to be accomplished, and what action can the audience take to support the program?* Use outcome, and/or cost-benefit data to describe the program's accomplishments and impacts. You might also ask the audience for funding, volunteers, or to advocate for a change in mental health-related policy.

Communications message(s) must be simple; a message that's too complex will be tuned out. It should strike a chord with the audience, and it should be repeated frequently.

Here are some tips for making a communications message more accessible:

» Use specific examples culled from the program's experience to "paint a picture" for your audience that reinforces the key points.

» Break down data so that it's easy for the audience to connect with. Use colorful words and "social math" (presenting the data in a real-life, familiar context) to illustrate your points and make the intangible more tangible. For example:

- Before the Second Step program was implemented, two out of four kids reported being bullied in the hall as they passed between classes.
- Kids spend more money on violent video games than books.

» Start communicating from a point of consensus—begin with what the audience knows and believes.

» Avoid jargon. Using the jargon of social science, psychology, and education is a sure-fire way to lose the audience's attention. Test the program's communication message on a neighbor. If your neighbor doesn't understand the point you're making, it's likely that the target audience won't either.

Step 3: Select One or More Communications Strategies

What are the best strategies to communicate your program's message to the target audience? Of the many possible strategies, which ones you use and whether you use them alone or in combination depends greatly on the program's communications goals. Four strategies are most commonly used to communicate a message to an audience:

» Community outreach (used to increase program participation or enlist businesses or policymakers)

» Social marketing (used to change the behavior of individuals)

» Media advocacy (used to change policy)

» Media relations (used to inform or persuade)

Your program can use one or more strategies to reach its communications goals. For example, to raise awareness, you could choose a combination of media relations and community outreach. To change behavior, you might choose social marketing. (Since you are most likely to use community outreach to promote your mental health program, this

strategy is described in detail here. For more information on each strategy, see *Print and Internet Resources on Communications* on p. 6-8 and **Working with the News Media** on p. T-32.)

Step 4: Identify Channels for Getting the Message(s) to School and Community Audiences

How will the audience get your program's communications message(s)? A *channel* is the vehicle that transmits a message from the source to the receiver (i.e., the audience).

Outreach Channels. There are a number of ways to reach an audience to increase participation:

- Public meetings, for example, School Board meetings, PTA meetings, meetings of faith-based organizations, town meetings
- Printed materials, such as brochures, flyers, direct mail, and newsletters
- Mass media, for example, radio public service announcements, cable TV, local newspapers (for more on this, see **Working with the News Media** on p. T-32)
- Other Web-based media, for example, the Internet, e-mail distribution lists, social networking websites

Determine where and how the target audience regularly receives information and how your program can tap into that channel. Whatever form your program's communications take, they should take into account the educational and literacy levels of and the languages spoken by the intended audience. Questions to consider:

- Through which channel(s) does your program's audience receive this type of information?
- Will the audience perceive this channel to be a credible source of information?
- Given funding, staffing, and the amount of time available, is it feasible to use this channel?
- Is there any evidence that this channel will successfully reach the audience?

Although all members of the coalition can and should advocate for the program in the community, it can be helpful to designate specific members to be program "champions" who act as the designated voice and face of the program.

Rural Area Poses Communications Challenges

In a rural, high-poverty area in upstate New York, communications channels have proved challenging for the SS/HS-funded St. Lawrence–Lewis BOCES. Although public libraries offer Internet access, many families lack Internet access in their homes. Even television does not reach all families in this rural area. The SS/HS project director found that using the local radio stations to communicate about SS/HS work has been surprisingly effective. The project has had students develop public service announcements about the SS/HS Initiative, which have been played on local stations. In addition, two radio stations recorded a press conference with the SS/HS partners and replayed segments that were designed to introduce the community to the work of SS/HS and attract new community partners to the initiative. The SS/HS Initiative has also used school newsletters and the weekly community newspaper to communicate key messages. The weekly paper subsequently developed a free public-access website, which has also become a useful communications vehicle.

Step 5: Evaluate the Program's Communications Efforts

To determine whether the communications plan is effective, it's necessary to evaluate its implementation. The findings from the evaluation will help to determine whether the coalition needs to refine or rework the communications plan. Questions that the evaluation should answer include the following:

- Which communications strategies worked well and which did not? How do you know?
- Do the messages resonate with the intended audience?
- Is it time to modify the program's communications goal or messages?
- Does the program need to reach out to a new audience?

Measurement of the effectiveness of communications strategies depends on your program's communications goal. Here are some possible measures:

- Participant outreach: Did your program meet its target number of participants? Did participants stay for the entire "dose"? Were those who participated (parents, children, youth) the audience you originally targeted?
- Referrals: Was there an increase in referrals to or use of mental health services? Did more parents ask to have their children enrolled in a mental health program?
- Community attitudes: Have you experienced (or can you measure) a change in attitudes toward the program? Did community norms (regarding, for example, the value of mental health programs in schools) change? How do you know?
- Stakeholder support: Was the desired outcome reached, for example, a next meeting? the beginnings of a relationship? policy consideration? budget consideration? budget approval?
- Funding: Has new funding been secured? Did your program attract the attention of new funders?

Other ways to measure success:

- Number of requests for materials or information
- Number of Web visitors (both unique and repeat visitors)
- Number of positive news stories or stories promoting your program's communications message
- Verbal or written feedback, negative or positive
- New volunteers, members, or partner organizations
- New funders and/or increased funding levels from existing funders

In addition to assessing the effectiveness of the communications plan, you should document the process of implementing the plan and identify successes and challenges. This will help to make the case for continuing the work, identify potential improvements or modifications, and allow others to learn from your program's experiences. Questions to consider:

- What were the goals of the plan, and what activities were carried out to accomplish them?
- Were the communications strategies implemented as planned? If not, what changes were made and why?
- What problems, if any, did the program encounter when carrying out the plan, and how were they addressed?
- What elements of the plan worked well?
- What changes to the plan should be made?
- Is there a need to reach out to a new audience to broaden or deepen the program's impact?

Print and Internet Resources on Communications

Communication & Social Marketing Center. [Provides communications technical assistance and training to SS/HS grantees.] Available (to SS/HS grantees only) at **http://www.sshs.samhsa.gov/communications/login/login.aspx**.

Building Business Support for School Health Programs: An Action Guide. Arlington, VA: National Association of State Boards of Education, 1999. Available at **http://store.nasbe.org/merchant2/merchant.mvc?**.

Communicating Public Health Information Effectively: A Guide for Practitioners. David E. Nelson, Ross C. Brownson, Patrick L. Remington, and Claudia Parvanta. Washington, DC: American Public Health Association, December 2002.

Communicators' Guide: For Federal, State, Regional and Local Communicators. Federal Communicators Network, revised December 2001. Available at **http://www.publicforuminstitute.org/activities/2002/fcn/commguid.pdf**.

The Community Toolbox. A service of the Work Group for Community Health and Development, University of Kansas, copyright 2009. Available at **http://ctb.ku.edu/en/**.

Generating Family-School Partnerships Through Social Marketing. Sylvia Sensiper. Cambridge, MA: Harvard Family Research Project, 1999. Available at **http://www.hfrp.org/publications-resources/browse-our-publications/generating-family-school-partnerships-through-social-marketing**.

How to Communicate Evaluation Findings. Lynn Lyons Morris, Carol T. Fitz-Gibbon, and Marie E. Freeman. Newbury Park, CA: SAGE Publications, 1997. **http://library.promoteprevent.org/item.php?id=118772**.

Now Hear This: The Nine Laws of Successful Advocacy Communications (with Words of Wisdom from More than 25 Leading Experts). Washington, DC: Fenton Communications, 2001. Available at **http://www.fenton.com/FENTON_IndustryGuide_NowHearThis.pdf**.

Project Launch: Communications Toolkit: Creating and Implementing a Communications Plan [Includes worksheets and recommendations for creating a communications plan; developing a situation analysis; conducting focus groups and key informant interviews; identifying messages, strategies, and channels; and evaluating efforts.] National Center for Mental Health Promotion and Youth Violence Prevention. Available at **http://projectlaunch.promoteprevent.org/communication/communications-toolkit/**.

Tools Related to Phase 6: Create and Carry Out a Communications Plan

Working with the News Media (T-32), tips for working with broadcast media, including interview questions and strategies for responding

Checklist for Phase 6: Create and Carry Out a Communications Plan

1. Conduct a situation analysis
   - ☐ Identify communications goals for the program.
   - ☐ Identify the target audience for the program's communications messages.
   - ☐ Conduct an audience analysis to better understand the target audience.
   - ☐ Identify the assets your program has for developing and implementing a communications plan.

2. Create the program's communications message(s)
   - ☐ Create communications messages that focus on the problem your program addresses, how the program addresses the problem, what outcomes are expected, evidence that the program is succeeding, and actions the audience can take to support the program.

3. Select one or more communications strategies
   - ☐ Determine which of the four most common communications strategies your program will use to reach its audience.

4. Identify channels for getting communications message(s) to school and community audiences
   - ☐ Determine the channels to be used to transmit communications messages.

5. Evaluate communications efforts
   - ☐ Evaluate the effectiveness of the communications plan in reaching your program's communications goals.

Phase 7: Build Sustainability

The Benefits of Building Sustainability

Substantial human, fiscal, and technical resources are usually invested in the implementation of school mental health programs. Start-up costs, including materials and staff training, are often the most significant expenses. For a program to end before its full benefits are realized—which happens all too often, unfortunately—is wasteful, undesirable, and demoralizing to those involved. When programs end prematurely, communities may become more reluctant to implement other new programs in the future (Abt Associates, Inc., 2007, p. 56).

> *A common tendency is for those involved in a project or the piloting of a new school program to think about their work as a time-limited demonstration. And, other school stakeholders also tend to perceive the work as temporary (e.g., "It will end when the grant runs out," or "I've seen so many reforms come and go; this too shall pass."). This mind set leads to the view that new activities will be fleeting, and it contributes to fragmented approaches and the marginalization of initiatives.*
>
> —Adelman & Taylor (2007, p. 2)

Many equate sustainability with securing continued funding for programs and services. However, a broader view of sustainability entails using a variety of strategies to build an infrastructure to maintain *all* the elements of the school mental health program that are responsible for its positive outcomes—for example, having staff in place to deliver an EBI, creating a broad coalition of mental health advocates who initiate new work that continues beyond the project, enhancing policies or procedures related to mental health in schools, or creating a referral mechanism for children with partnering organizations.

Sustainability is a dynamic process. At various points during the planning and implementation process, your program's sustainability strategies may change, depending on the program's phase, the funding cycle, and the program's goals and outcomes (National Center for Mental Health Promotion and Youth Violence Prevention, 2007e).

Steps to Take to Build Sustainability

Step 1: Identify the Program's Most Effective Practices and Activities

Use outcome evaluation data from Phase 3 to identify the program practices and activities that have been most effective in producing the outcomes that support program goals. For example, you might identify having mental health services for elementary and middle school children, a district-wide bullying policy, and an EBI on social-emotional learning implemented in grades 4–8.

Use the **Sustainability Planning Worksheet** on p. T-35 to guide and document the results.

Step 2: Determine Which Effective Practices and Activities Need Support Beyond Current Funding

Determine which of these effective practices and activities are not supported beyond current funding and will end (and stop producing positive outcomes) unless action is taken to sustain them. For example, you might identify mental health services for elementary school children and an EBI on social-emotional learning.

> *"Improved approaches are only as good as a school district's ability to develop and institutionalize them equitably in all its schools."*
>
> —Adelman & Taylor (2007, p. 2)

Step 3: Prioritize Effective Practices and Activities

Using evaluation data about school needs and outcomes, determine which effective practices and activities are the most important to continue. You can start by identifying the program elements that have proven to be most effective within the community, the elements that target the most visible and widely recognized problems, and/or the elements that lend themselves most easily to being sustained. For example, you might identify an EBI that includes a training-of-trainers, which will allow the program to train new staff indefinitely.

Step 4: Determine the Functions of These Practices and Activities

Review each effective practice and activity to identify the specific function(s) that it provides. Examples of functions include: classroom instruction using mental health prevention curricula, short-term counseling, screening and assessment of high-risk children, and referrals to mental health providers.

Step 5: Identify Strategies that Can Sustain These Functions and Positive Outcomes

Going beyond the "best practices" of implementation and sustaining the many positive outcomes of your school's mental health program often requires employing a variety of strategies to maintain the key functions of existing program activities and/or staff positions. The next task is to identify specific strategies that can sustain these functions (and thus the positive outcomes of the effective practices and activities).

Eight strategies that can develop and support your program's infrastructure for sustainability—leadership for change, partnership and collaboration, strategic planning, capacity building, evaluation, financing, public policy, and communications/marketing—are discussed in detail below.[18]

Leadership for Change. Leaders are needed to guide the implementation and institutionalization of mental health programs. Achieving lasting systemic change requires leaders with vision, group management skills, and knowledge of how to promote change within systems and communities. Individuals or coalitions in a leadership role must be able to identify and prioritize the changes that will produce positive, lasting outcomes, to plan for these changes, to provide a vision for how the program aligns with and contributes to other community initiatives, and to influence larger systems, such as policymaking groups or government units, that have the power to support the program over the long term.

But how can leadership be a sustainability strategy? The positive outcomes that the program achieves can be sustained when leaders identify infrastructure changes that institutionalize practices, such as implementing evidence-based curricula or having teachers utilize new screening procedures.

Questions to Consider

- Are school and district administrative leaders (e.g., principals and superintendent) active supporters of the program?
- Has the coalition clarified which program elements are most important to sustain?
- Does the coalition have an understanding of how change happens in an organization or community and the role of a change agent?
- Has the coalition considered the goal of systemic change as it determines which elements of the mental health program to sustain?
- Has the coalition considered that policy and infrastructure changes might need to occur to sustain the program?
- Which decision-makers in the community should be involved in the process of identifying the elements of the mental health program to sustain?

[18] This section was adapted from the National Center for Mental Health Promotion and Youth Violence Prevention (2007e, 2007f). The Center's website provides additional information on and a self-assessment for each strategy. (See http://sshs.promoteprevent.org/implementing/sustainability/legacy-wheel for the self-assessments.)

Leadership for Change

The Vail CARES SS/HS Initiative implemented PBIS in nearly all Vail schools to promote positive behavior and a caring school climate. The initiative recognized that the success of PBIS depended on principal buy-in, ongoing training for staff, and implementation fidelity.

During the course of the project period, the school district grew from 6,000 to 10,000 students. Students often changed schools, principals moved to new schools, and new teachers were hired.

Because of these transitions, Vail CARES staff realized that in order to effectively implement the EBI, the group needed a core leadership team at each site, including teachers, parents, and paraprofessionals, who were responsible for monitoring implementation of PBIS and the school's culture and climate. From these core teams, the Vail CARES Leadership Cadre was formed to ensure that this and other key grant activities would continue beyond SS/HS funding. The Leadership Cadre currently comprises 15 leaders representing schools throughout the district that are dedicated to promoting positive school climate. The Cadre meets monthly during the school year to review fidelity of PBIS implementation and project outcomes and to ensure that staff training and support continue. It has developed a formal structure, including bylaws, a vision, a mission, and goals, and created committees for Training and Development, Evaluation, and Resources. The group asked the School Governing Board to continue the Leadership Cadre beyond the grant, and has received formal approval to do so.

Partnership and Collaboration. To sustain mental health programs and services beyond initial grant funding, it is important to strengthen and maintain community partnerships and collaborations that provide support to the program, including expertise, resources, and community connections. For example, delivering mental health services to children in school settings often involves a partnership between the school and a mental health provider. To sustain these services, the partners can work together to create a service delivery system that draws on a variety of revenue streams, such as third party payments or local mental health funding.

Questions to Consider

- Has the coalition considered how strategic partners might assist in sustaining the program?
- Do coalition members have a common understanding of sustainability that focuses on maintaining the program's positive mental health outcomes?
- Has the coalition determined how to decide which tasks or components of the program to sustain?
- Do coalition meetings/agendas reflect sustainability as a goal, and do partners take responsibility for sustainability planning?
- Does the program take advantage of partners' existing activities, services, and community connections?

- Are programs aligned with the school or district's vision and priorities?
- Who outside of the coalition could provide significant support to the program?
- What local policymakers, legislators, foundations, and philanthropists should know about the program?
- Do parents have avenues to publicly support the program?

Strategic Planning. Conduct strategic planning to plot the course of the mental health program for the next year or more. Determine which program activities are most likely to achieve program goals and objectives, and the infrastructure that is needed to maintain positive outcomes over time. Decide how resources (including capital and people) will be allocated. Make sure that the plan includes program monitoring and opportunities to change or adjust program activities as needed.

Involving key stakeholders early on in strategic planning can help to generate sustainability opportunities before grant funding expires. An effective strategic planning process will help to do the following:

- Identify goals and objectives that the program and its partners share
- Identify ways that stakeholders' resources can sustain the work of the mental health program, and identify opportunities for individual partners to assume ownership of shared functions beyond grant funding
- Embed program goals and activities in the community's long-range vision for youth and families
- Inform potential supporters—such as policymakers or legislators—about the program

Questions to Consider

- Does the coalition have the tools and skills needed for strategic planning?
- Has the coalition created a strategic plan to sustain key elements of the program?
- Do coalition members actively share responsibility for creating and acting on the plan?
- Does the sustainability plan prioritize program outcomes?
- Are program activities paired with possible sustainability strategies?
- Does the plan incorporate a variety of strategies?

Capacity Building. Sustaining a mental health program requires building in-house staff capacity and expertise to implement the program beyond current funding. This may involve designing ongoing staff development, including booster sessions and coaching, and developing a training-of-trainers program for EBIs that the program uses.

Questions to Consider

- Are there internal mechanisms of support (e.g., infrastructure, policies, procedures) within the school and/or with partners that will help sustain the program?
- Are staff development activities adequate to create lasting capacity to implement the program, including EBIs? Do program activities include training-of-trainers and implementation support systems to keep EBIs in place even with changes in staff?
- Are the current supervisory and administrative structures and policies adequate to train and support staff to implement the program without new funding?
- Is there a need to modify the program to adapt to changing conditions?

Capacity Building

When Vail CARES looked closely at how the Vail School District provided behavioral health services to students, they discovered the following:

- School-based Behavior Specialists were not distributed at schools based on students' needs.
- The specialists often worked in isolation, without communication with other Behavior Specialists.
- The specialists represented a variety of backgrounds, experiences, and skill sets.
- To continually improve behavioral support across the district, Behavior Specialists needed opportunities to learn from one another, to share their experiences, and to work in teams.

Vail CARES realized that with varying levels of expertise among the Behavior Specialists, some specialists needed more training, which could be provided by more experienced specialists, and that many of the specialists had the capacity to provide high-quality consultation to the faculty and administration.

To this end, Vail CARES formed a Behavior Specialist Cadre that collaborates with principals to prioritize service needs and establish best practice standards for Behavior Specialists. The cadre meets monthly to explore best practices, share successes, and discuss professional articles and case studies. In addition, the cadre provides systematic mentoring and "five-minute check-ins with feedback" coaching. As practice standards are now clearly defined and being implemented, principals are better able to effectively supervise Behavior Specialists and assess the services they provide.

Evaluation. Program evaluation data can be instrumental in sustainability efforts. Policymakers and stakeholders need to be aware of the problem(s) the program addresses, and the evidence that the program is working. Presenting key evaluation findings can help to gain financial and other support for continuing the program.

Questions to Consider

- Is the program evaluation designed with sustainability in mind?
- Are EBIs implemented with fidelity?
- Does the evaluation plan include gathering process and outcome data to identify program successes as early as Year 2?
- Is there a process for partners and other stakeholders to review evaluation data when they become available?
- Has the coalition considered how to best select and present evaluation data to enhance sustainability efforts? (For example, are the data broken down by significant subpopulations of students and families?)
- Are any changes necessary to improve access to EBIs and/or services?

Financing. In Phase 4, the coalition identified various funding streams to support the program. Publicizing the program's positive outcomes gives you the chance to demonstrate the program's worth to new funders, including the school district, private foundations, and county boards. It may also enable the program to establish third party payment mechanisms, such as Medicaid, for a particular service.

Questions to Consider

- How is local funding for school and mental health services allocated and structured?
- Is it possible to leverage existing resources to help sustain the program?
- Is it possible to use Medicaid or comparable funding to support mental health services for students and their families?
- Are there any statewide initiatives related to children's mental health or education reform that might align well with the program? If so, how are they funded?
- Have foundations or other community organizations that might help to sustain the program been contacted?

Public Policy. Every community has a variety of formal and informal groups—local legislators, elected officials, influential community members, and school boards—that define the priorities for mental health services and influence which programs get funded. Enagaging these groups—in particular, by sharing positive program outcomes—and encouraging their involvement in the program, they are more likely to advocate for district, local, state, and federal policies and funding to institutionalize mental health programs.

Questions to Consider

- Which policymakers may be able to influence the sustainability of the mental health program?
- What are key policymaker's priorities and how might these align with sustaining the program?
- How will you communicate, involve, and educate policymakers about program successes in order to help sustain the program?
- What steps are being taken to create, update, or publicize policies that support ongoing program implementation?
- Which stakeholders need to be involved in expediting the development of these policies?

Communications/Marketing. Communicating the success of the program, as described in Phase 6, will help promote community awareness of mental health issues, engage key community members, stakeholders, and decision-makers, and build community support for the program. This may lead to other partnerships and collaborations, funding, and further contributions to the program.

Questions to Consider

- Which audiences need to be informed about the mental health program and its successes to help sustain the program? Do these audiences reflect all community stakeholders?
- Which target audiences should be matched with which communications strategies?
- Are program communications reaching important stakeholders, including families, school staff, partners, local policymakers, and potential funders?
- How is the program using initial process results to make communications more effective?

Step 6: Identify and Carry Out Action Steps for Sustainability Strategies

The coalition will need to identify action steps for each of the eight sustainability strategies. Use the **Sustainability Planning Worksheet** on p. T-35 to plan and record the program's sustainability action steps.

Print and Internet Resources on Building Sustainability

Legacy Wheel. National Center for Mental Health Promotion and Youth Violence Prevention. Available at **http://sshs.promoteprevent.org/implementing/sustainability/legacy-wheel**.

Safe Schools Healthy Students Project Resource Guide: From Start-Up to Sustainability. National Center for Mental Health Promotion and Youth Violence Prevention. Newton, MA: Education Development Center, Inc., 2007. [Helps grantees review the progress of their grant and engage partners in the leadership and management aspects of the SS/HS Initiative. Three appendices titled "Resources," "Tools," and "Management Requirements" provide a wealth of practical information, including Logic Model worksheets, communications tools, and an introduction to Government Performance and Results Act measures and federal requirements.] Available at **http://www.promoteprevent.org/publications/pp-guides/project-resource-guide.**

Sustainable Schoolwide Social and Emotional Learning (SEL) [Implementation Guide and Toolkit]. Elizabeth Devaney, Mary Utne O'Brien, Hank Resnik, Susan Keister, and Roger P. Weissberg. Chicago, IL: Collaborative for Academic, Social, and Emotional Learning, 2006.

Tools Related to Phase 7: Build Sustainability

Sustainability Planning Worksheet (T-35), a worksheet for identifying priority programs and activities and for planning the program's sustainability action steps.

Checklist for Phase 7: Build Sustainability

1. Identify the program's most effective practices and activities
   - ☐ Review outcome evaluation data to identify the practices and activities that most effectively address students' mental health needs.

2. Determine which effective practices and activities need support beyond current funding
   - ☐ Identify which of these practices and activities need additional funding to continue, and how much funding and support is required.

3. Prioritize effective practices and activities
   - ☐ Determine a process and criteria for prioritizing the practices and activities that have been identified.
   - ☐ Identify which school staff and coalition members should be involved in setting priorities.

4. Determine the functions of these practices and activities
   - ☐ Identify the specific functions provided by each practice and activity.

5. Identify strategies that can sustain these functions and positive outcomes
   - ☐ Review the eight sustainability strategies.
   - ☐ Determine which strategies will best ensure sustainability of the most effective program practices and activities.

6. Identify and carry out action steps for sustainability strategies
   - ☐ Identify action steps for each sustainability strategy.
   - ☐ Implement the action steps.

Tools

Phase 1: Convene a School and Community Coalition

- Best Practice Mental Health Assessment: The Whole-School Approach to Children's Mental Health
- Team Responsibilities

Phase 2: Assess Mental Health Problems, Needs, and Resources

- Assessment Planning Tool
- Mental Health Services Infrastructure Assessment

Phase 3: Develop an Implementation Plan

- Action Plan Worksheet
- EBI Feasibility Checklist
- Logic Model Worksheet
- Program Planning Tool

Phase 4: Secure Financial Resources

- Budget Summary for Program Implementation

Phase 6: Create and Carry Out a Communications Plan

- Working with the News Media

Phase 7: Build Sustainability

- Sustainability Planning Worksheet

[Note: Click here for a downloadable Word version of all tools.]

Phase 1: Best Practice Mental Health Assessment—the Whole-School Approach to Children's Mental Health[19]

Instructions:

1. Individually review and complete this assessment. Then discuss ratings with a broad coalition that includes school leadership and staff with knowledge and expertise in student mental health issues, community mental health providers, and families.
2. Revisit this assessment periodically with your coalition to assess progress.

	Not at all in place					Fully in place	Don't know
Best Practice 1: Evidence-based school mental health programs, practices, and policies are implemented to address students' needs and strengthen their assets. (Phases 2 & 3)[20]	1	2	3	4	5	6	DK
Assessment of Needs and Strengths (Phase 2)							
1. Assessments of students' mental health risk and protective factors have been conducted.							
2. Parents, teachers, other staff including mental health professionals, and students have been involved in assessment of students' mental health needs and strengths.							
3. Existing mental health services and programs for students in the school and community have been identified.							

[19] Adapted from Weist et al. (2006), National Assembly on School-Based Health Care (n.d.), and CASEL (2008).
[20] A complete list of implementation phases can be found on pp. 22–23 of the guide.

	Not at all in place					Fully in place	Don't know
Addressing Needs and Strengths (Phase 3)	1	2	3	4	5	6	DK
4. Evidence-based programs, practices, and policies have been matched with the school's identified needs and strengths.							
5. Evidence-based programs, practices, and policies used are culturally and linguistically appropriate for the student population (or have been adapted to be culturally and linguistically appropriate).							
6. A full continuum of mental health strategies for students from promotion to prevention to early intervention and treatment is provided. (See Figure 2 in introduction.)							
Notes for Best Practice 1:							

	Not at all in place					Fully in place	Don't know
Best Practice 2: Students, families, school staff, and community mental health providers are actively involved in the program's development, oversight, evaluation, and continuous improvement. (Phases 1–7)	1	2	3	4	5	6	DK
7. School staff and families understand the rationale for a whole-school approach to children's mental health. (Phases 1, 6)							
8. A diverse coalition (including youth, families, administrators, teachers, other school staff, community mental health providers, and school and community leaders) provides input to the whole-school approach. (Phase 1)							
9. Diverse families are partners in developing and implementing the whole-school approach. (Phases1–7)							
Notes for Best Practice 2:							

	Not at all in place					Fully in place	Don't know
Best Practice 3: School mental health programs, practices, and policies focus on reducing barriers to children's development and learning, are accessible to all, and are student-and family-friendly. (Phases 1, 3, 5, 7)	1	2	3	4	5	6	DK
10. Staff actively work to improve the school environment and train students in skills that promote their mental health and academic success. (Phases 3, 5)							
11. Staff uphold and model policies and practices that support respectful behavior. (Phases 3, 5)							
12. Staff and families are aware of and regularly updated about the continuum of mental health services and programs available. (Phases 1, 3, 5, 6, 7)							
Notes for Best Practice 3:							

	Not at all in place					Fully in place	Don't know
Best Practice 4: Staff competently address cultural differences among students, families, and one another. (Phases 1, 3, 5, 7)	1	2	3	4	5	6	DK
13. Staff receive cultural competence training that reflects the diversity of the community.							
14. Mental health programs, practices, services, and policies reflect, address, and support the cultural diversity of the school and community.							
Notes for Best Practice 4:							

	Not at all in place					Fully in place	Don't know
Best Practice 5: Staff work collaboratively within the school to promote students' mental health and build strong relationships with students and mental health and health care providers. (Phases 1–3, 5, 6, 7)	1	2	3	4	5	6	DK
15. Structured opportunities for networking and collaboration between community agencies and school personnel are provided to ensure coordination of services.							
16. Staff teams that address students' social and emotional needs are expanded to include community providers when appropriate to ensure coordination across school and community.							
Notes for Best Practice 5:							

	Not at all in place					Fully in place	Don't know
Best Practice 6: Staff are well-trained, hold to high ethical standards (including confidentiality), are committed to children and families, and display a flexible, responsive, and proactive style in their work. (Phases 3, 5, 7)	1	2	3	4	5	6	DK
17. School and mental health staff receive training and ongoing support and supervision in implementing evidence-based programs, practices, and policies.							
18. Educators and school and community mental health staff receive training and ongoing support and supervision in providing strengths-based and developmentally and culturally competent services.							
19. Staff receive regular training on effectively working with students and families with a diversity of developmental, cultural, and ethnic backgrounds.							
Notes for Best Practice 6:							

Phase 1: Team Responsibilities[21]

The District Administrator

» Gives authorization to proceed, and commits to resources for the team for the long term

» Applies existing policies, secures necessary waivers for planning and implementation, and develops needed policies and interagency agreements for program implementation

The Principal

» Supports the creation of the mental health coalition

» Supports selection of coalition leadership

» Facilitates resources for coalition

» Actively participates in coalition

» Helps secure community buy-in for school mental health program

» Supports staff development for mental health program

Teachers

» Actively participate in coalition

» Participate in identifying needs, strengths, and resources for school mental health

» Help identify effective programs and strategies for addressing identified needs and behaviors

» Participate in appropriate staff development for mental health programs and cultural competency

[21] Adapted from Osher et al. (2004).

School Mental Health and Other Pupil Personnel Staff

- Actively participate in coalition
- Seek and support inclusion of community mental health partners
- Assist in designing coalition assessment of risk and protective factors
- Help identify effective programs and strategies for addressing identified behaviors
- Participate in appropriate staff development for mental health programs and cultural competency

Youth, Families, and Other Community Members

- Actively participate in assessing school and community mental health needs and strengths and in identifying mental health goals and objectives
- Provide information about youth and family perspectives and youth and family involvement
- Help ensure that mental health programs and services are culturally competent
- Identify community resources and strengths and provide information about links between school and community mental health problems and needs
- Secure community buy-in for mental health goals and objectives
- Assist in developing and securing cooperative agreements and coordinated services required to implement mental health programs and services

Phase 2: Assessment Planning Tool[22]

1. How will you gather information on mental health issues among K–8 students in your school and community?

   a. Will you collect available data? ☐ Yes ☐ No

   If *no*, skip to b.

   If *yes*, what indicators will you use? Complete the chart below, indicating which data indicators you will use and the risk factors they are related to (See Figure 3, p. 2-4), the data sources for these indicators, the person(s) responsible for collecting and analyzing the data, and your time frame for data collection and analysis.

Data Indicators and Related Risk Factors	**Data Sources**	**Data Collector and Analyzer**	**Time Frame**
Example: *Data Indicator:* Suspensions for fighting; student perceptions of safety at school *Related Risk Factor:* School violence	*Example:* District discipline data; Student Health Survey, 2007–2008 data for middle school students		

   b. Will you conduct **one-to-one interviews** with key people?

   ☐ Yes ☐ No

   If *no*, then skip to c.

   If *yes*, list key people you plan to interview.

[22] Adapted from Dash et al. (2003).

What kinds of questions do you plan to ask?

Who will conduct and analyze the interviews?

What is your time frame for conducting interviews?

c. Will you conduct **focus groups** with key people?

☐ Yes ☐ No

If *no*, skip to d.

If *yes*, which key people do you plan to include in these focus groups?

What kinds of questions do you plan to ask?

Who will conduct the focus groups?

What is your time frame for conducting focus groups?

d. Will you **survey large numbers** of students (or others)?

☐ Yes ☐ No

If *no*, skip to question 2.

If *yes*, are you:

☐ developing your own survey instrument?

☐ using a survey instrument that has already been developed and tested? If so, which one?

Who are you surveying?

How many people are you surveying?

Who will conduct the survey?

What is your time frame for conducting the survey?

2. What are the most **compelling findings** from your assessment? Write them below.

   a.

   b.

   c.

   d.

Look at your list of findings and **select the issue that you want to work on first**. Summarize that issue below. Think about how you would state this issue in a way that would mobilize support from the school and community.

3. How will you **share your results with other school and/or community members** who will be involved in program planning and implementation? Check all that apply.

☐ Community coalition meetings

☐ Staff memos in pay envelopes or teacher mailboxes

☐ Faculty and staff meetings

☐ Community newsletters and bulletins

☐ School board meetings

☐ Press release for the local media (community newspapers and cable access television)

☐ Town council meetings

☐ Community forum or panel

☐ PTA/PTO meetings

☐ Notices to parents

☐ Email

☐ On your website

☐ Other:

Phase 2: Mental Health Services Infrastructure Assessment[23]

Where Are We?
Choose your current status toward building and/or sustaining your mental health (MH) programs.

5 = Consistently Used
4 = Currently in Place
3 = Planning Now
2 = Need to Develop
1 = Not Yet Considered

I. Personnel and community awareness and MH training

School staff, parents, youth, and community are provided with . . .

1. Ongoing training to recognize:					
a. risk and protective factors impacting children/youth	5	4	3	2	1
b. actions that support the needs of children/youth	5	4	3	2	1
c. referral process for accessing MH services	5	4	3	2	1
2. System established for school and community involvement to:					
a. serve on student assistance teams or child study teams	5	4	3	2	1
b. participate in planning for student support and services	5	4	3	2	1
3. Strategies for increasing awareness of mental health, using data:					
a. needs identified	5	4	3	2	1
b. services available	5	4	3	2	1
c. outcomes realized	5	4	3	2	1
4. Strategies to reduce MH stigma and increase access	5	4	3	2	1

II. Formalized referral process is established and will continue to be used

1. Clear understanding among referral agents (staff, parents, community, etc.) regarding coordination for making referrals	5	4	3	2	1
2. Referral forms provided to all referral agents (staff, partners, other child-serving agencies, parents, youth, etc.)	5	4	3	2	1
3. Protocol for referral is understood by school personnel, community agencies, and parents/families	5	4	3	2	1
4. System of triage/process for determining where referrals go (primary, secondary, and tertiary levels)	5	4	3	2	1

[23] Developed by the National Center for Mental Health Promotion and Youth Violence Prevention (2009).

III. System sustained for functional teams to do referral and triage (coordination among the providers for children and families)

1. Collect and share information about the functions and services that each of the various MH staff provide within the three levels of intervention: universal, selective, and indicated	5	4	3	2	1
2. Framework is in place to serve the full MH continuum of care	5	4	3	2	1
3. School personnel/administrators have a clear and approved process for connecting to community MH resources and providers	5	4	3	2	1
4. Plan is in place to address gaps/barriers/overlap within all systems	5	4	3	2	1
5. Consider other providers to invite to plan sustainability	5	4	3	2	1
6. Evaluate effectiveness of referral/triage to increase service access	5	4	3	2	1

IV. Infrastructure, capacity, financing, and resource allocation and management

1. Resource management team comprising school and partner agencies meets regularly to review and address resource needs	5	4	3	2	1
2. Mapping of services within the MH continuum updated regularly	5	4	3	2	1
3. Cross-agency staff development completed and needs are regularly reviewed	5	4	3	2	1
4. Data are regularly reviewed, and plan exists for making needed adjustments	5	4	3	2	1
5. Yearly review of financing resources and coordination of funding streams	5	4	3	2	1

V. MOA and other strategies for coordination of work

1. Procedures in place to ensure confidentiality; a release exists for sharing information as appropriate (complying with HIPPA, FERPA, etc.)	5	4	3	2	1
2. School personnel/administrators have a clear and approved process for connecting to community MH resources and providers	5	4	3	2	1
3. Ongoing coordination of services among agencies within the three levels of intervention: universal, selective, and indicated	5	4	3	2	1

4. A plan is developed for reviewing and addressing barriers among agencies and community, including the following:					
a. School staff	5	4	3	2	1
b. Families	5	4	3	2	1
c. Youth	5	4	3	2	1
d. Prosecution	5	4	3	2	1
e. Law enforcement	5	4	3	2	1
f. MH and social services agencies	5	4	3	2	1
5. Data collection systems continue to be used and shared	5	4	3	2	1
6. Decision-making process is in place for considering outcome data	5	4	3	2	1
7. Plan for continuity and follow-up is in place	5	4	3	2	1

VI. MH program and services: Considerations for each level of intervention: universal (U), selective (S), and indicated (I)

Program	Service	Location	Population	Personnel / Professional Skill Needs	Referral/ Service Tracking	Funding Stream	Resources Needed to Sustain	Evaluation/ Outcome Procedures	Training / Initial & Ongoing	U	S	I

Other sustainability questions:

» Where and with whom will the above functions continue?

» What financing options will be explored?

Phase 3: Action Plan Worksheet

Strategy #___: _____

Activities/Steps	Person Responsible	Target Date for Completion	How You Know You Have Achieved This (Indicators—Process Measure)	Progress and Comments
1.				
2.				
3.				
4.				
5.				

Phase 3: EBI Feasibility Checklist

Use this tool to assess the fit of each EBI regarding resources required, target population, school climate, community climate, evaluability, and future sustainability.

For each EBI that matches the initial criteria, explore the following questions:

☐ Is there evidence that this program has worked in similar schools and communities?

☐ Are any issues raised by the program that are not in keeping with your community norms and policies? Does the EBI fit your school culture?

☐ Can something be added or changed to make the program more appropriate for the diverse needs of students, parents, school personnel, and community members?

☐ Will additional staff or training be required? What is the cost of other materials required?

☐ Can a funding source be identified to pay for training and materials?

☐ Is external support available? How much will it cost?

☐ Does the EBI align with other planned mental health interventions?

Phase 3: Logic Model Worksheet

Problems/Needs	Goals and Objectives	Activities/Strategies	Process and Outcome Evaluation
What are the underlying needs or problems that must be addressed (e.g., risk factors that can be changed)?	What broad goals and long-term objectives are you trying to achieve (e.g., Goal: A supportive learning environment where all students feel safe; Objective: Reduce bullying in school by 80 percent in the next year)?	• Which EBIs will you use? • What strategies and resources (e.g., staffing, staff development, materials, partners, policies, procedures) will you need to support and enhance effective implementation of these programs?	*Process* (Formative): • Was the intervention implemented as planned? • Was the target population reached? • Were your implementation goals and objectives attained? *Outcome* (Summative): Is the program having the expected effect on your population?

Planned Work → Intended Results

Phase 3: Program Planning Tool[24]

1. What are the specific, **measurable, long-term outcomes** related to the finding on which you want to focus your initial efforts? *Use the questions provided below to help develop your outcome statements*.

   a. Who is the target group for change (e.g., all middle school students, grades 6 to 8)?

   b. What action or change do you expect to see (e.g., a reduction in the percentage of students who report having been bullied at school)?

   c. What is your baseline or starting point (e.g., 50 percent of middle school students report being bullied on school grounds)?

   d. How much change from that baseline do you expect to see (e.g., only 10 percent of students will report being bullied on school grounds)?

   e. By when do you expect to see this change (e.g., the end of the second school year after the EBI has been implemented)?

   f. How will you measure change (e.g., school climate survey and school disciplinary data)?

[24] Adapted from Dash et al. (2003).

2. What kinds of strategies will help you meet your long-term outcomes? In other words, **what kinds of program assumptions are you making**? Use the questions below to help you select appropriate strategies.

   a. Which influences do you want to affect or change?

   b. To what risk factors is the problem(s) you've identified most closely related?

   c. Whom do you want to target?

   d. Where do you want to focus your efforts?

   e. When do you want to focus your efforts?

   f. What do you want to do to achieve your outcome(s)? Please list specific strategies:

g. What are you already doing to meet your long-term outcome(s)? Use the following matrix to record what you are already doing to promote mental health, in keeping with your long-term outcomes, and what new strategies and activities you will employ to achieve your outcomes.

Strategy	Already doing	Will do
Mental health promotion programs		
Early identification, referral, and intervention		
Alternative activities		
School-community collaboration		
School policies		
School policy enforcement		
Schoolwide communications campaigns		
Classroom restructuring		
Community policies		
Community policy enforcement		
Community communications campaigns		

h. What resources can you devote to your efforts?

i. How receptive is your community to a particular strategy?

Are there competing mental health prevention efforts or priorities in the school and community?

If so, what are they?

How might you merge your efforts with these?

Is the school resistant to change?

Do you have the buy-in of key school and community leaders?

j. How well does your effort lend itself to evaluation?

Do you have available baseline data?

If not, how do you plan to compensate?

Do you have access to program participants over time?

Do you have computers and appropriate software for data collection and analysis?

If yes, what specifically?

Do you have available staff skilled in evaluation techniques?

If yes, who?

If not, are you working with an outside evaluator?

3. What is your mission statement? Use the matrix below to list your long-term outcome statements (i.e., what you would like to achieve) and the corresponding program assumptions (i.e., those approaches you believe will help you to reach your long-term outcomes, which you defined above).

Long-term outcome statements	Program assumptions

Draft a mission statement below by combining your long-term outcomes with your program assumptions:

4. Who will help you implement your program? For each system identified in the chart below, list individuals who represent or have access to the system and who might assist or are currently assisting you in your efforts to promote mental health among young people in your community. Indicate the financial or material resources (e.g., funding, in-kind support, facilities, equipment) that these systems or individuals may provide. Also list the potential benefits of participating in your mental health coalition for the different systems and individuals. Consider:

» What are the systems where members of different ethnic, age, or other groups can be contacted (e.g., churches, social clubs, community or cultural centers, agencies or organizations serving these groups)?

» What are the organizations that represent or advocate for different groups?

» Who are the contacts or spokespersons for each of these groups? Are they represented among the members of your mental health coalition?

Systems	**People**	**Affiliation(s)**	**Assets**	**Benefits**
Education				
Public health				
Criminal justice				
Social services				
Municipal government				
Neighborhood associations				
Social clubs				
Community and cultural centers				
Faith community				
Business				
Media				
Sports and recreation				
Other:				
Other:				
Other:				
Other:				

5. What are the specific activities or steps involved in implementing the strategies you have selected? Use the ACTION PLAN WORKSHEET on p. T-18 to identify activities, people responsible, target dates, indicators, and progress.

6. What is your time frame for completing program activities?

Strategy:_____

Month

Activity	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**

7. What is your budget? Use the following as a guide to develop a budget for implementing your plan.[25]

Personnel	**Year 1**	**Year 2**
School mental health coordinator	$_____	$_____
Teachers	$_____	$_____
Other staff costs	$_____	$_____
Staff Training		
Number of staff to be trained x cost of training		
Staff ____ x $_____	$_____	$_____
Substitute teachers (# of teachers x # of days)		
_____ x _____	$_____	$_____
Per diem pay for training outside school hours		
(# of teachers x # of days x per diem rate)		
_____x ____days x per diem rate $_____	$_____	$_____
Travel	$_____	$_____
Materials		
Teacher guides		
(# of staff x cost of guides)		
_____ x $_____	$_____	$_____
Student books		
(# of students x cost of guides)		
_____ x $_____	$_____	$_____
Other materials	$_____	$_____
Equipment	$_____	$_____
Consumables	$_____	$_____
Program Evaluation		
Consultants	$_____	$_____
Other evaluation costs	$_____	$_____
TOTAL	**$**_____	**$**_____

[25] Tool adapted from Marx and Northrop (1995).

8. What are current and potential funding sources for your program efforts?

Name of Source	Dollar Amount
Federal Current: Potential:	
State Current: Potential:	
Local Current: Potential:	
Foundations Current: Potential:	
Business Current: Potential:	
Other Current: Potential:	

Phase 4: Budget Summary for Program Implementation[26]

Personnel	**Year 1**	**Year 2**
School mental health coordinator	$_____	$_____
Teachers	$_____	$_____
Other staff costs	$_____	$_____
Staff Training		
Number of staff to be trained x cost of training Staff ____ x $_____	$_____	$_____
Substitute teachers (# of teachers x # of days) _____ x _____	$_____	$_____
Per diem pay for training outside school hours (# of staff x # of days x per diem rate) _____ x _____days x per diem rate $_____	$_____	$_____
Travel	$_____	$_____
Materials		
Teacher guides (# of staff x cost of guides) _____ x $_____	$_____	$_____
Student books (# of students x cost of guides) _____ x $_____	$_____	$_____
Other materials	$_____	$_____
Equipment	$_____	$_____
Consumables	$_____	$_____
Program Evaluation		
Consultants	$_____	$_____
Other evaluation costs	$_____	$_____
TOTAL	$_____	$_____

[26] Tool adapted from Marx and Northrop (1995).

Phase 6: Working with the News Media[27]

Choose a "Face" and "Voice" for the Coalition

The coalition should select one or two spokespeople to speak to media, and ask that all other members refer media to that person.

Tips for a Successful News Media Interview

» Have a topic outline with the basics clearly noted. Have three critical main points in mind, and repeat those points often.

» Be concise—it is easy to bore an audience. Get all your key points across in the first half of the interview.

» Be concrete—use short sentences, active verbs, simple and colloquial language.

» Be colorful—use language that makes an audience sit up and listen. Paint pictures for the audience. Cite specific examples to back up general statistics.

» Develop good skills for question-and-answer sessions—they demonstrate that you can talk off the cuff.

» Practice, practice, practice. Keep perfecting, adding, tightening. Get feedback that helps you see mannerisms that harm your credibility.

Answering News Media Interview Questions

» Be relaxed, confident, and honest.

» Think ahead about how much you want to say, and devise a way to cut off discussion if you wish to (e.g., "As I've said, the school board will be acting on those issues tonight. I'll be happy to comment further after the meeting").

» Discuss only those activities and policies within your area of responsibility.

» Admit that you do not know the answer if that is the case. If you promise to provide more information, deliver.

» If the situation warrants, try to tape the interview yourself. When discussing complicated and sensitive issues, it may be valuable to have documentation of the interview.

» Do not use jargon, acronyms, or technical terms.

» Do not use speech mannerisms, such as "you know."

» Do not be rude or abrupt.

» Answer only one question at a time.

» Answer the question that is asked. Do not rephrase it in an attempt to convey other information.

» If you are asked for information that you cannot provide (because of policy, regulations, confidentiality, etc.), simply say so and move on.

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[27] Adapted from Gary Beals Advertising and Public Relations Agency, San Diego, California, in Marx and Northrop (1995).

- Do not volunteer information unless it supports a positive point you want to make.
- Make all your responses positive; do not be defensive.
- Do not let anyone put words in your mouth; agree only if a statement is true.

Working with Radio and Television Stations

The better prepared you are for the talk shows or news programs, the better the result. What you do before you meet the media is as important as what you do when you meet them. By being prepared, you are not only more confident and comfortable, you are also able to get your story across to those who count most—the viewers or listeners.

Here are a few suggestions that will help you come across to the audience as forceful yet friendly:

- Before the interview, in a courteous but firm way, ask about the reporter's background and experience in dealing with the issue at hand. This will help you understand his or her perspective and level of experience.
- Before the interview, make sure that you and the reporter(s) agree on the topic(s) to be covered. This is the only way that you or your spokesperson can prepare specific answers and positive points.
- Be yourself. Concentrate on how to get ideas and positive feelings across—not just words.
- Watch or listen to the program beforehand. Know the show's format and theme. It helps to preview several different episodes of the show, if possible, to get information on the style and philosophy of both the program and the interviewer(s).
- Know the listeners/viewers.
- Be there early, even if it is a taped program. Studios are heavily booked, and punctuality is essential. Provide the host with your sheet of suggested questions—you know your topic best!

Specific Tips for Television

- Watch what you wear: no black, no white, no distracting patterns. Make sure that your clothes, jewelry, or hairstyle will not draw extra attention. Dress in a style comparable to the host's (e.g., no open collar if the host wears a suit and tie.)
- Avoid one-word answers.
- Know what is most interesting to the public.
- Be calm. Do not let anything anger you.
- Call the host by name.
- Have a phone number or address for viewers to get more information.
- Always have humor points, no matter how serious the topic.
- Get your enthusiasm level up before you go on the air.
- Remember the two or three key points you want to get across.

Types of Interview Questions and Recommended Ways to Respond

Puffballs—The Easy Questions

» Take the opportunity to communicate a positive point.

» Do not let the chance to talk about one of your key points pass by.

Hypothetical Questions

» Remind the interviewer that no one has the ability to see into the future.

» Bridge into a key positive point.

False Facts or False Assumptions, Questions, or Comments

» Do not repeat false information, but counter it with facts.

» Discount the false facts or assumptions by bridging to a positive point.

Leading or Loaded Questions

» Do not repeat the information.

» Set the record straight, but do not dwell on the interviewer's leading or loaded question.

» Bridge into a key positive point.

Questions That Put Words in Your Mouth

» Never repeat what the interviewer has said if it is not true or you do not agree.

» Be sure not to repeat key negative words the interviewer used.

» Give a positive answer by using a key point.

Factual Questions

» Affirm and bridge to a positive point if the information is correct.

» Disagree (tactfully), if not correct, and give the correct information.

» End with a positive point.

Forced Choice Questions

» Do not agree if both choices are incorrect.

» Make the information as positive as possible.

After the Interview

» If the story or interview is good, write to the reporter and to his or her boss.

» Even if the story was just adequate, it's nice to send a note.

» Stay in touch with the reporter.

Phase 7: Sustainability Planning Worksheet[28]

Work with your coalition to answer the following questions.

1. Which programs and activities have been most effective and have produced outcomes that support your goals?	2. Which of the programs and activities in Column 1 are not currently sustained beyond the end of your federal funding?	3. Which of the programs and activities in Column 2 should be prioritized for sustainability efforts?

[28] From the National Center for Mental Health Promotion and Youth Violence Prevention (http://www.promoteprevent.org/Resources/legacy_wheel/planning.html).

4. What functions are performed by each of the programs and activities in Column 3?			
Program or activity	**Function**	**Function**	**Function**

Functions (from Columns in #4)	5. Which sustainability strategies can help preserve these functions?	6. What action steps can you take to implement these strategies?

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