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ABSTRACT

This packet introduces some concepts in evaluation and accountability for mental health professionals in schools. The first section presents two briefs from the Clearinghouse of the Center for Mental Health in Schools. The first, "Mental Health in Schools: Quality Control, Evaluating Outcomes, and Getting Credit for All You Do," highlights the importance of planning evaluation to measure outcomes and enhance the quality of intervention and student benefits. The second brief, "Evaluation, Accountability, and Mental Health in Schools," focuses on accountability indicators and how to gather data related to such indicators. The second section of the packet provides "A Quick Overview of Some Basic Resources," including 22 selected references, a list of 5 guidebooks and models, a list of 8 agencies and Web sites for technical assistance, and a list of experts from the Center's consultation cadre. An evaluation flow chart and some accompanying material from a guide created by the National Institute on Drug Abuse form the third section. The final section contains two reports from the Center for School Mental Health Assistance, "Quality Assurance" and "Documenting Effectiveness of School Mental Health Programs." (SLD)

*From the Center's Clearinghouse ...**

An introductory packet on

Evaluation and Accountability: Getting Credit for All You Do!

* The Center is co-directed by Howard Adelman and Linda Taylor and operates under the auspices of the School Mental Health Project, Dept. of Psychology, UCLA, Los Angeles, CA 90095-1563 -- Phone: (310) 825-3634.

Support comes in part from the Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health.

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UCLA CENTER FOR MENTAL HEALTH IN SCHOOLS*

Under the auspices of the School Mental Health Project in the Department of Psychology at UCLA, our center approaches mental health and psychosocial concerns from the broad perspective of addressing barriers to learning and promoting healthy development. Specific attention is given policies and strategies that can counter fragmentation and enhance collaboration between school and community programs.

MISSION: ***To improve outcomes for young people by enhancing policies, programs, and practices relevant to mental health in schools.***

Through collaboration, the center will

- **enhance practitioner roles, functions and competence**
- **interface with systemic reform movements to strengthen mental health in schools**
- **assist localities in building and maintaining their own infrastructure for training, support, and continuing education that fosters integration of mental health in schools**

Consultation Cadre ***Clearinghouse***

Newsletter ***National & Regional Meetings***

Electronic Networking

Guidebooks ***Policy Analyses***

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*In 1996, two national training and technical assistance centers focused on mental health in schools were established with partial support from the U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health. As indicated, one center is located at UCLA; the other is at the University of Maryland at Baltimore and can be contacted toll free at 1-(888) 706-0980.

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(1/98)

What is the Center's Clearinghouse?

The scope of the Center's Clearinghouse reflects the School Mental Health Project's mission -- to enhance the ability of schools and their surrounding communities to address mental health and psychosocial barriers to student learning and promote healthy development. Those of you working so hard to address these concerns need ready access to resource materials. The Center's Clearinghouse is your link to specialized resources, materials, and information. The staff supplements, compiles. and disseminates resources on topics fundamental to our mission. As we identify what is available across the country, we are building systems to connect you with a wide variety of resources. Whether your focus is on an individual, a family, a classroom, a school, or a school system, we intend to be of service to you. Our evolving catalogue is available on request; eventually it will be accessible electronically over the Internet.

What kinds of resources, materials, and information are available?

We can provide or direct you to a variety of resources, materials, and information that we have categorized under three areas of concern:

- Specific psychosocial problems
- Programs and processes
- System and policy concerns

Among the various ways we package resources are our *Introductory Packets, Resource Aid Packets, special reports, guidebooks*, and *continuing education units*. These encompass overview discussions of major topics, descriptions of model programs, references to publications, access information to other relevant centers, organizations, advocacy groups. and Internet links, and specific tools that can guide and assist with training activity and student/family interventions (such as outlines, checklists, instruments, and other resources that can be copied and used as information handouts and aids for practice).

Accessing the Clearinghouse

- E-mail us at **smhp@ucla.edu**
- FAX us at (310) 206-8716
- Phone (310) 825-3634
- Write School Mental Health Project/Center for Mental Health in Schools, Dept. of Psychology, Los Angeles, CA 90095-1563

Check out recent additions to the Clearinghouse on our Web site
http://smhp.psych.ucla.edu

All materials from the Center's Clearinghouse are available for a minimal fee to cover the cost of copying, handling, and postage. Eventually, we plan to have some of this material and other Clearinghouse documents available, at no-cost, on-line for those with Internet access.

If you know of something we should have in the clearinghouse, let us know.

Evaluation and Accountability

Systematic evaluation is increasingly sought to guide operations, to assure legislators and planners that they are proceeding on sound lines, and to make services responsive to their publics.
Lee Cronbach and colleagues

This introductory packet contains:

I. Two Clearinghouse Briefs from our Center:

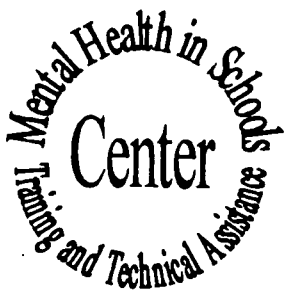
- Mental Health in Schools: Quality Control, Evaluating Outcomes, and Getting Credit for All You Do.
- Evaluation, Accountability, and Mental Health in Schools

II. A Quick Overview of Some Basic Resources

- Selected References
- Guidebooks and Models
- Agencies and Websites for Technical Assistance
- Consultation Cadre

III. An Evaluation Flow Chart and some accompanying material from the guide by the National Institute of Drug Abuse

IV. Two reports from Center for School Mental Health Assistance based on Critical Issue Planning Sessions
- *I: Quality Assurance*
- *II: Documenting Effectiveness of School Mental Health Programs*



A BRIEF DISCUSSION OF:

MENTAL HEALTH IN SCHOOLS: QUALITY CONTROL, EVALUATING OUTCOMES, AND GETTING CREDIT FOR ALL YOU DO

We approach mental health activity in schools as one facet of a comprehensive, integrated approach to addressing barriers to learning and enhancing healthy development. The intent of all such activity, of course, is to enhance outcomes for children and adolescents. However, enhancing outcomes for the large number of those in need of help usually involves addressing the systems that determine such outcomes (e.g., families, education support programs, school-based health centers, off-site services, the community at large). Moreover, it is important to proceed with a holistic perspective (e.g., viewing children in the context of families and communities). Such a perspective fosters appreciation of relationships among individuals, specific aspects of systems, and the system as a whole. Given this comprehensive orientation to mental health, it is evident that evaluation involves more than measuring outcomes for individuals served.

Broadly stated, evaluation should be planned and implemented in ways that measure outcomes and much more with a view to enhancing the quality of intervention efforts and the long-term benefits for students and society. The following sections highlight a few ideas along these lines.

Evaluation that Fosters Quality Improvement

One purpose of outcome evaluation is to provide feedback on efficacy so processes can be revised and fine-tuned. Such *formative* evaluation also includes information on participants, approaches, resources, implementation strategies, program organization, staffing, operational policies and practices. It also should include data on the characteristics of the system's "clients" -- who they are, what they want and need, how they differ from those in other locales -- as a prerequisite for effective planning and as another basis for interpreting the appropriateness of observed processes and outcomes. (That is, it is essential to understand the status of clients before an intervention is implemented, not only to be aware of their needs but ultimately to make appropriate judgments about intervention outcome efficacy.)

Thus, formative evaluation includes data gathering and analyses focused on such matters as

- needs and assets, goals and desired outcomes, resources, and activities
- challenges and barriers to mental health intervention and the integration of such interventions with other activity designed to address barriers to learning, as well as with the instructional and management components of schools and communities
- characteristics of families and children in each locale, with special focus on targeted groups
- initial outcomes.

Formative evaluation data may be gathered on and from samples of all parties who have a stake in the intervention (e.g., school staff, students and their families, other stakeholders, community agencies, and so forth). The information is used to judge the "fit" of prerequisite conditions and processes. Methods used include review of documents and records, checklists, surveys, semi-structured interviews, focus group discussions, observations, and direct assessment of clientele. A well-designed information management system can be a major aid (e.g., providing data on identified needs and current status of individuals and resources). In this respect, an advanced technology can play a major role (e.g., a computerized system that is properly designed can provide access to information in other computer-based data systems containing relevant information on clients and processes).

To be maximally useful, a data set should allow for baseline and subgroup comparisons and include multiple variables so that findings can be disaggregated during analysis Of particular interest are data differentiating clients in terms of demographics, initial levels of motivation and development, and type, severity, and pervasiveness of problems. With respect to process, it is useful to have data differentiating stages of program development and differences in program quality.

Optimally, the date gathered should allow for formative-leading-to-summative evaluations. Designing s formative evaluation system that over time yields summative findings facilitates ongoing planning in ways that improve processes and thus outcomes. At the same time, such an approach builds a system for validating interventions.

Evaluation Focused on Results

To begin with, it will help to clarify our definition of some terms that are used throughout this section. *Aims* are extremely abstract statements of intended outcomes that encompass many goals and objectives; this usually means an aim can only be accomplished over an extensive time period (e.g., many years). *Goals* are somewhat less abstract statements encompassing many objectives; thus, a goal usually requires a somewhat extended period of time to accomplish. *Objectives* are meant to be less abstract and more immediately accomplishable than the goal that encompasses them. A *standard* is defined as a statement about what is valued. Standards are used to (a) judge and promote quality, (b) clarify goals, and (c) promote change. In evaluating efficacy, standards are operationalized in terms of specific *criteria* upon which judgments of immediate and potential long-term efficacy can be made. *Indicators of efficacy* are measurable variables that can be accessed from various sources through use of specific data gathering strategies and tools.

As emphasized above, while the intent of mental health activity in schools is to enhance outcomes for students, the effort must also address the systems that determine such outcomes. Thus, the following discussion outlines intended impact not only on students, but on families and community, and on programs and systems.

Student Outcomes

Efforts to address mental health concerns and other barriers to learning include enhancing receptivity to instruction through facilitating positive academic, social, emotional, and physical development. In this section, we focus first on outcomes related to facilitating such development; then, the emphasis shifts to prevention and correction of emotional, behavioral, learning, and health problems.

(1) *Outcomes reflecting enhanced receptivity to instruction.* Teaching and learning are transactional. Students (and teachers) bring certain capacities and attitudes (abilities, expectations, values) accumulated and established over time. These provide the foundation upon which teaching tries to build. Students also come with current physiological and psychological states of being that can facilitate or inhibit learning at any given time. Efforts to enhance receptivity to instruction focus on ensuring there is a good instructional match with the student's capacities, attitudes and current state of being. While this is especially necessary for those manifesting serious problems, it is a fundamental concern related to all learners.

The *aim* of enhancing receptivity to instruction involves ensuring that students have the opportunity to acquire the types of basic abilities, expectations, and values that enable learning. The aim also encompasses the need for schools to respond appropriately to variations in students' current states of being (e.g., ensuring the opportunity to learn by providing breakfast and lunch programs to combat hunger, responding to personal problems and crises with support and guidance).

As is highlighted by the goals and objectives outlined in Exhibit A, the ultimate aim is to ensure that students develop effective levels of functionality -- academically, socially, emotionally, and physically. (With respect to social-emotional functioning, aims are sometimes referred to as personal qualities, interpersonal functioning, the affective domain, and so forth. Physical functioning often is discussed as

physical and health education.) From a developmental perspective, the aim encompasses concerns for ensuring a "healthy start," a safe school environment, preparation (readiness) for school, facilitating continued positive development in all areas, facilitating progress with respect to developmental tasks at each stage of development, enhancing areas of personal interest and strength, and fostering a psychological sense of community. As with all curricular goals, desired outcomes in these areas reflect (a) intended uses (communication, reasoning, problem solving, making relationships and connections, and creativity) and (b) factors related to intrinsic motivation (personal valuing and expectations of efficacy -- including confidence in one's abilities).

The goals and objectives outlined in Exhibit A provide a frame of reference for designing programmatic activity to facilitate development related to enhancing receptivity to instruction through facilitating positive academic, social, emotional, and physical development. It is clear that attending to such functioning is basic to preventing, treating, and remedying problems. Moreover, the goals and objectives provide direction for daily program planning and for evaluation.

The assumption in pursuing goals and objectives is that optimal processes (comprehensive and integrated programs) will be used to create a match that enhances positive attitudes, growth, and learning. This applies to the full range of support available to students and families -- including specialized programs at the site, home, and community. Until a comprehensive, integrated continuum of programs and services are in place, steps must be taken to address the less than optimal conditions. From this perspective, evaluation focuses on (a) individual student outcomes (related to the goals and objectives set forth in Exhibit A) and (b) outcomes for all children in the catchment area (e.g., community indicators of improved health, safety and survival, emotional health, and positive social connections). In addition, there can be a focus on outcomes reflecting significant changes in support systems (e.g., measures of enhanced home involvement in schooling; indicators of enhanced integration of center and community health, social, and mental health services -- including related data on financial savings).

Furthermore, in pursuing goals and objectives related to instructional receptivity and social-emotional and physical development, it is essential to do so in ways that value and foster rather than devalue and inhibit appropriate diversity among students. This is especially important given the diversity students bring with regard to ethnic background, gender, interests, and capabilities. Thus, another focus for evaluation is on these concerns (especially in assessing for negative outcomes). In particular, efforts should be made to measure (a) movement toward inappropriate conformity in thinking and behaving in areas where diversity is desired and (b) trends toward increased levels of other-directedness and excessive dependency.

(2) ***Outcomes related to preventing and correcting emotional, behavioral, learning, and health problems.*** In addition to the above goals and objectives, student goals and objectives are formulated in connection with specialized programs designed to prevent and correct emotional, behavioral, learning, and health problems. These objectives relate to the efforts of such programs to remove barriers and enable students to pursue the above goals.

It is important to emphasize that problems become of concern because they are reflected in the student's functioning; however, the primary source of the problem often is environmental. Environmentally based problems are an especially important focus for prevention programs. Such programs are targeted to designated at-risk populations (e.g., students with older siblings in gangs, immigrant and highly mobile families who have major transition and school adjustment needs, students who experience a crisis event).

In general, then, immediate objectives in working to address emotional and behavioral problems with a view to enabling student progress often include activity designed to reduce specified barriers to school attendance and functioning. Thus, attending to mental health concerns often requires addressing practical deterrents such as health problems, lack of adequate clothing, problems in the home, working with home to increase support for student improvement, dealing with student's physical or sexual abuse, dealing with student's substance abuse, dealing with gang involvement, provisions for pregnant minors and minor parents, dropout outreach and recovery, teaching student to use compensatory strategies for learning, and so forth. And, based on the discussion to this point, hopefully it is clear that the first indicators of progress may be fewer problems related to learning, behavior, and affect. See Exhibit A for examples of key

intervention goals and objectives and potential indicators of efficacy. The goals and objectives listed in Exhibit A represent individual student outcomes that can be measured as indicators of the impact of specialized programs. Positive "side effect" outcomes worth measuring are significant changes related to (a) all children in the catchment area (e.g., community indicators of improved health, safety and survival, emotional health, and positive social connections) and (b) support systems (e.g., enhanced home involvement in schooling; enhanced integration of a school-based health center and community health, social, and mental health services -- including related data on financial savings). Of course, additional student outcomes can be delineated and measured with respect to efforts to prevent specific types of problems. This is usually accomplished by fostering positive functioning through activities designed to enhance knowledge, skills, attitudes, and action related to healthy physical and mental development. Some of these efforts are carried out in special settings, such as school-based health centers and family resource centers. Whether or not there is a special setting, these efforts include specialized programs focused on

- home involvement to enhance social-emotional development
- peer-to-peer interventions designed to enhance social-emotional development
- early education for prenatally drug-exposed children and their families
- substance abuse prevention
- suicide prevention
- physical and sexual abuse prevention
- violence prevention
- dropout prevention and school re-entry
- STD/AIDS prevention
- pregnancy prevention
- prenatal care of pregnant minors and minor parent education
- crisis intervention and emergency responses to prevent long-term impact (e.g., PTSD) and to prevent subsequent emergencies

Intended Impact on Families and Community

Aims related to families encompass promotion of positive family development and functioning and enhanced home involvement in schooling. Aims for the community encompass promotion of positive community development and functioning and related reform of community agencies (with particular emphasis on reducing problems related to health and safety). See Exhibit B for examples of key intervention goals and objectives and potential indicators of efficacy.

Intended Impact on Programs and Systems

Major aims with respect to the school-site are to promote and support (a) a major restructuring of school support services, (b) integration of school support services with other school-based/linked support programs, teams, and special projects (in both the regular and special education arenas), (c) outreach to enhance linkages and collaborations with community resources (e.g., health, social, recreational programs; involvement of volunteers and local businesses), and (d) integration of all activity designed to address barriers to learning with the instructional and school management components. See Exhibit C for examples of key goals and objectives and of potential indicators of efficacy.

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Exhibit A

Intervention Impact on Students

Aims	Examples of Goals/Objectives	Examples of Indicators of Efficacy	Standards/Criteria Immediate -- Long-term
Enhance receptivity to instruction	Increase knowledge, skills, & attitudes to enhance •acceptance of responsibility (including attending, following directions & agreed upon rules/laws) •self-esteem & integrity •social & working relationships •self-evaluation & self-direction/regulation •physical functioning •health maintenance •safe behavior	Ratings by staff, family, peers Self-reports by students Performance indices (focus is on: •readiness/prerequisites/ survival skills •attendance •tardies •distractibility/ daydreaming/overactivity •dependence on others in pursuing tasks and controlling behavior •misbehavior •symptoms •negative attitudes toward self, teachers, school, peers, family, society)	TO BE DETERMINED BY SITE
Prevent and correct emotional, behavior, learning, & health problems	Reduce barriers to school attendance and functioning by addressing problems related to •health •lack of adequate clothing •dysfunctional families •lack of home support for student improvement •physical/sexual abuse •substance abuse •gang involvement •pregnant/parenting minors •dropouts •need for compensatory learning strategies	(Ultimately, of course, a major focus is on grades and achievement test scores.)	

Exhibit B

Intervention Impact on Families and Communities

Aims	Examples of Goals/Objectives	Examples of Indicators of Efficacy	Standards/Criteria Immediate -- Long-term
Promotion of positive family development & functioning	Increase social and emotional support for families	Parents rate satisfaction with school & community programs & services designed to enhance family functioning & provide assistance	TO BE DETERMINED BY SITE
	Increase family access to special assistance		
Enhanced home involvement in schooling	Increase family ability to reduce child risk factors that can be barriers to learning	Staff rates functioning of families	
	Increase bilingual ability and literacy of parents	Frequency counts of services/ programs in operation; Performance indices	
	Increase family ability to support schooling	Staff rates functioning of families	
	Increase positive attitudes about schooling	Family self-reports	
	Increase home (family/parent) participation at school	Frequency counts of areas of participation and number of participants	

Exhibit B (cont.)

Intervention Impact on Families and Communities

Aims	Examples of Goals/Objectives	Examples of Indicators of Efficacy	Standards/Criteria Immediate -- Long-term
Promotion of positive community development and functioning (including influencing restructuring of community agencies)	Enhance positive attitudes toward school and community Increase community participation in school activities Increase perception of the school as a hub of community activities Increase partnerships designed to enhance education & service availability in community Enhance coordination & collaboration between community agencies and school programs & services Enhance focus on agency outreach to meet family needs Increase psychological sense of community	Self-reports of community residents Frequency counts of areas of participation and number of participants Self-reports of community residents Existence of partnership agreements & shared decision making mechanisms Staff rates quality of coordination mechanisms & working relationships Frequency counts of students and families using programs and services Self-reports of community residents Data from records on (a) violent acts (b) nonviolent crime (c) public health problems	TO BE DETERMINED BY SITE

Exhibit C

Intervention Impact on Programs and Systems

Aims	Examples of Goals/Objectives	Examples of Indicators of Efficacy	Standards/Criteria Immediate -- Long-term
Promote and support restructuring of support services (including integration with instruction & management)	Enhance processes by which staff and families learn about available programs and services and how to access those they need	Frequency counts of students and families using programs and services	TO BE DETERMINED BY SITE
	Increase coordination among services and programs	Staff rates quality of coordination mechanisms	
	Increase the degree to which staff work collaboratively and programmatically	Supervisors and staff rate how staff spends time	
	Increase services/programs at school site	Frequency counts of services/ programs in operation	
Promote and support outreach to community resources & their integration with school programs & services	Increase amount of school and community collaboration	Existence of interagency agreements & shared decision making mechanisms	
	Increase quality of services and programs by improving systems for requesting, accessing, and managing assistance for students and families (including overcoming inappropriate barriers to confidentiality)	Staff rates quality of (a) systems for triage, referral, case monitoring & management; (b) staff development Users rate satisfaction	
	Establish a long-term financial base	Data from financial records	

Mental Health in Schools Center
Training and Technical Assistance

A Brief Discussion of:

Evaluation, Accountability, and Mental Health in Schools

How effective is the intervention?

Do you have data to support that approach?

Where's your proof?

The questions are so logical and simple to ask, *and* they can be so devastating in their impact. The problem is that such questions imply that relevant data are easy to gather, and so if data aren't available, the intervention must be ineffective or else those in charge are irresponsible. Usually ignored by the questioners are the many complexities associated with valid and ethical evaluation of major mental health and psychosocial problems.

Every mental health practitioner is aware of the importance of having data on *results.* All interveners want to be accountable for their actions and outcomes. But *it is* complicated.

Fundamental dilemmas stem from the limited validity and focus of available measures and the tendency for those demanding accountability to have inappropriate expectations that there can be rapid improvement even though youngsters and their families are experiencing severe and pervasive problems. Most widely sanctioned evaluation instruments are quite fallible. Moreover, they are designed to measure results that require a lengthy course of intervention, thereby giving short shrift to immediate benefits (benchmarks) that are essential precursors of longer-range improvements. Ironically, demands for accountability tend not to take responsibility for the negative consequences that formal assessment has on some clients. Accountability pressures increasingly require the gathering of a significant amount of data during the first session with a client; many practitioners note that this practice interferes with building positive relationships and contributes to what is already too high an intervention dropout rate.

What are practitioners and program leaders to do?

Well, not surprisingly, they often look for assistance. The topics of evaluation, accountability, and quality improvement are among the most frequent requests for technical assistance and continuing education. As a result, the number of publications and technical assistance resources in the area has increased at an exponential rate. And, there are endless lists of measures (many that have not been appropriately validated). Unfortunately, the volume of materials and other resources is not an indication that fundamental evaluation concerns have been effectively addressed. The complications remain unresolved, the status quo remains unsatisfactory; and all that any of us can do at this point is to develop aids, guidelines, and standards for practice that strive for appropriate accountability while doing the least harm to youngsters and their families.

As an aid to those involved with mental health in schools, our intent here is to support evaluative efforts by highlighting a broad range of accountability indicators and outlining ways data related to such indicators currently can be gathered. In doing so, we differentiate three different areas for accountability (i.e., accountability to the society, to an institution such as schooling, and to youngsters and their families).

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Accountability to Who?

In a seminal article on the evaluation of therapeutic outcomes, Strupp and Hadley (1977) stress how different the expectations of society and its institutions often are from those of individual clients.[1] Thus, it is imperative to understand accountability from the perspective of the various parties who have special interest in the results of interventions that are meant to address mental health and psychosocial concerns. For our purposes here, the focus is on (a) the *society* in general and the *institution of schooling* in particular and (b) those specific *youngsters and their families* who are the direct focus of intervention efforts.

Accountability to Society and to the Institution of Schooling

Society looks at the following general indicators to evaluate whether efforts related to psychosocial and mental health concerns are paying appropriate dividends:

Increases in youth employment (ages 16-19)
Reductions in
- student mobility
- youth pregnancy
- sexually transmitted diseases
- child abuse/neglect
- youth arrest/citation
- youth probation violations

Reductions in
- youth emergency room use for mental health and psychosocial related events
- foster care placements
- homeless youth
- youth suicide rates
- youth death rates

In addition, those responsible for schools are required to demonstrate effective fulfillment of their specific mission -- which is to educate the young in ways that meet society's needs. The primary indicators currently demanded by social policy are those that reflect academic achievement at a standard that is competitive with other major countries. Thus, the emphasis on increases

at all grades with respect to
- achievement test scores
- grades
- other indicators of progress in academics (analyses of work)

at high school level with respect to
- number graduating (with a related reduction in the number dropping out)
- number taking SATs
- number continuing with post-secondary educ.

Because many youngsters are experiencing barriers to learning and performing at school, programs and services to address such barriers are increasingly essential to the ability of schools to accomplish their mission. Some major indicators for accountability related to these enabling or learning support programs are

Reductions in
- unexcused absences
- tardies
- suspensions/expulsions
- referrals for misbehavior
- referrals for learning problems

Increases in
- attendance
- cooperation & work habits
- fluency in English as Second Language

Reduction in numbers designated as Learning Disabled or Emotionally Disturbed

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[1] As these writers state: "*Society* is primarily concerned with the maintenance of social relations, institutions, and prevailing standards of sanctioned conduct. Society and its agents thus tend to define mental health in terms of behavioral stability, predictability, and conformity to the social code. ... The *individual client* ... wishes first and foremost to be happy, to feel content [and] thus defines mental health in terms of highly subjective feelings of well-being ... (p. 188). Strupp, H.H. & Hadley, S.M. (1977). A tripartite model for mental health and therapeutic outcomes with special reference to negative effects in psychotherapy. *American Psychologist, 32*, 187-196.

Data for Accountability to Society and the Institution of Schooling

Data related to most of the above indicators are available from the records at school sites, school districts, and city/county agencies. Some schools also are involved in administering the Youth Risk Behavior Surveillance System (sponsored by the Centers for Disease Control and Prevention) which contains relevant indicators for use in monitoring changes over time. (Many communities and child advocacy groups are gathering local and statewide data on child well-being and publishing it as "Report Cards.") If data are not available, then efforts are needed to ensure relevant indicators are gathered and made accessible. And, appropriate steps should be taken to ensure that data can be disaggregated with respect to specific subgroups.

Accountability to Specific Youngsters and Families

Those who work in school districts to provide programs and services related to psychosocial and mental health concerns also are accountable to the specific individuals they help. Such accountability certainly can be seen as encompassing the indicators listed above. However, for individuals who must deal with major barriers, many of the above realistically are only good indicators of progress after a lengthy period of multifaceted, comprehensive, integrated intervention. More immediate accountability indicators are needed to demonstrate progress related to objectives that are the current and direct focus of psychosocial and mental health interventions (e.g., reductions in symptoms; enhanced motivation and psychological and physical well-being). Because data on such specific objectives are not readily available, the problem of *generating* relevant data arises -- as do some serious dilemmas. Efforts to answer the following questions lead to an appreciation of the many problems and issues.

What are the right indicators?

Endless arguments arise over indicators when they are discussed in highly *specific* and *concrete* terms. At a more abstract level, there is considerable agreement around three general categories: (1) client satisfaction (the youngster; the family), (2) reduction in the youngster's symptoms/problem behaviors, and (3) increases in positive functioning (the youngster; the family).

*How can appropriate **specific** and **concrete** indicators be identified for particular clients?*

The dilemmas that arise here reflect the problem of "Who is the client?" -- the youngster? the family? a teacher who made the referral? Additional dilemmas arise because the various involved parties often have different perspectives regarding what problems should be addressed. (And , of course, the intervener may have even another perspective.) A reasonable compromise is to gather evaluative data related to (1) the specific symptoms and behavior problems that led to the referral, (2) any objectives that the client wants help in achieving, and (3) specific objectives that the intervener believes are warranted and that the client consents to add.

How should the deficiencies associated with existing measures be accounted for?

Although some measures are better than others and some are designated the best that exist, best should not be equated with good or good enough. All instruments we rely on currently have limited reliability and validity; also quite limited are the normative data for various subgroups. These limitations (1) call for using formal instruments only when they are necessary, (2) require full disclosure of limitations in reporting findings, and (3) warrant making extreme efforts to look for disconfirming evidence whenever findings suggest significant pathology.

How can the negative impact of gathering the data be minimized to an appropriate degree?

All evaluation has the potential to produce major negative consequences. The ethical obligation is to maximize benefits and minimize costs to clients. Putting aside the financial costs, it is clear that use of any formal measure can increase a client's distress and produce psychological reactance. It is likely that the high dropout rate among clients, in part, is a reaction to too much formal assessment during the first encounters with an intervener. Accountability requirements that mandate administration of formal measures before counseling is initiated may well be contributing to the low rate of youngsters who stay in counseling long enough to reap significant benefits. From the perspective of sound standards for practice, (1) no formal measures should be administered until the intervener judges that the relationship with the client is strong enough to mediate any distress and (2) measures should be personalized to assess only the specific and concrete indicators that are relevant to a particular client.

Accountability: Is it Becoming a Mantra?

Accountability should not simply be a mantra. It is an invaluable facet of effective practice; but it is just one facet and only makes sense when the other facets are properly planned and implemented.

Measures Relevant for Accountability to Specific Youngsters and Families

Below are listed a sample of promising instruments. Unless otherwise noted, the measure cited is reviewed in *Evaluating the Outcome of Children's Mental Health Services: A Guide for the use of Available Child and Family Outcome Measures* (1995) -- prepared by T.P. Cross & E. McDonald for the Technical Assistance Center for the Evaluation of Children's Mental Health Services.[2]

It is essential that interveners review and choose measures that minimize negative impact on clients. Proper personalization of assessment in the best interests of the client may even call for not using a measure in its entirety or in the way the developer prescribes. We recognize that this violates standardization of administration and makes interpretation more difficult, but just as empirically supported therapeutic strategies must be adapted to ensure a good fit with a client, so must assessment practices. In both instances, empirical support for prevailing practices is not so strong as to warrant rigid implementation. Also of value are data from functional assessments (increasingly being done when students are referred for behavior problems). Finally, some interveners use projective procedures and selected items from other measures (e.g., sentence completion, drawings and related stories, Childrens Depression Inventory) as a stimulus for discussion with clients. Client responses early and near the end of the period of intervention may be useful as supplementary evaluation data.

(1) Client Satisfaction (youngster; family)

Client Satisfaction Questionnaire (CSQ -- Larsen, et al. -- Portland State U. Version)

Youth Satisfaction Questionnaire (YSQ -- Portland State U.)

Vanderbilt Satisfaction Scales -- parents/caregivers and/or adolescent self-report

(2) Reduction in Youngster's Symptoms/Problem Behaviors

Child Behavior Checklist (CBCL -- Achenbach & Colleagues)
There are versions to be filled out by parents-caregivers, teachers, and youth self-report, as well as a direct observation form.

Child Assessment Schedule (CAS -- Hodges) -- self-reports from child and/or parents-caregivers

(3) Increases in Positive Functioning (youngster; family).

Child and Adolescent Functional Assessment Scale (CAFAS -- Hodges) -- intervener rating

Preschool and Early Childhood Functional Assessment (Hodges) -- intervener rating

Quality of Well-Being Scale[3] (QWB) -- client self-report

Family Environment Scale (Moos) -- family self-report

Family Empowerment Scale (Portland State U.) -- family self-report

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[2]Other instruments are reviewed in the guidebook; those included here seem most useful for practitioners concerned with mental health in schools. The guidebook is available by contacting the TA Center for the Evaluation of Children's Mental health Services at Judge Baker Children's Center, 295 Longwood Ave., Boston, MA 02115 (617) 232-8390.

[3]Reviewed in W.H. Hargreaves, M. Shumway, T. Hu, & B. Cuffel (1998). *Cost-Outcome Methods for Mental Health*. San Diego: Academic Press.

Sampling of Indicators with Respect to Different Accountability Demands

As should be evident from the preceding discussion, it can be extremely costly and time consuming to be accountable to all parties (see also Figure 1) with interests in the productivity of an intervention. In most situations, the reality is that only a sample of data can be gathered (see Figure 2).

With respect to individual clients, the data sample should begin with assessment that has direct and immediate relevance to the specific objectives an intervener and client have agreed to pursue. Then, in response to accountability demands and in keeping with ethical and feasible practice, a subset of standardized items can be administered to stratified samples of clients. The particular subsets of items chosen should reflect matters of greatest concern to those demanding accountability. If the pool of items is large, then different subsets of items can be administered over time and later combined to provide a full picture of outcomes.

With respect to societal and institutional accountability, the data sample initially consists of that which can be readily gathered on a regular basis. Subsequently, again reflecting matters of greatest concern to those demanding accountability, step by step strategies can be developed to establish systems for amassing regular findings related to key variables and specific population subgroups.

Clearly, sampling requires considerable planning and careful implementation. A systematic evaluation plan must be developed, and there must be appropriate budgeting for its implementation. Many programs will require specific consultation in developing an appropriate sampling strategies.

Standards for Comparison

Whatever data are collected will be imperfect and only rarely will be easily interpreted. For accountability to be rationale, there must be a reasonable set of standards for comparison. In asking how good an intervention is, the question must be answered in terms of *Compared to what?*

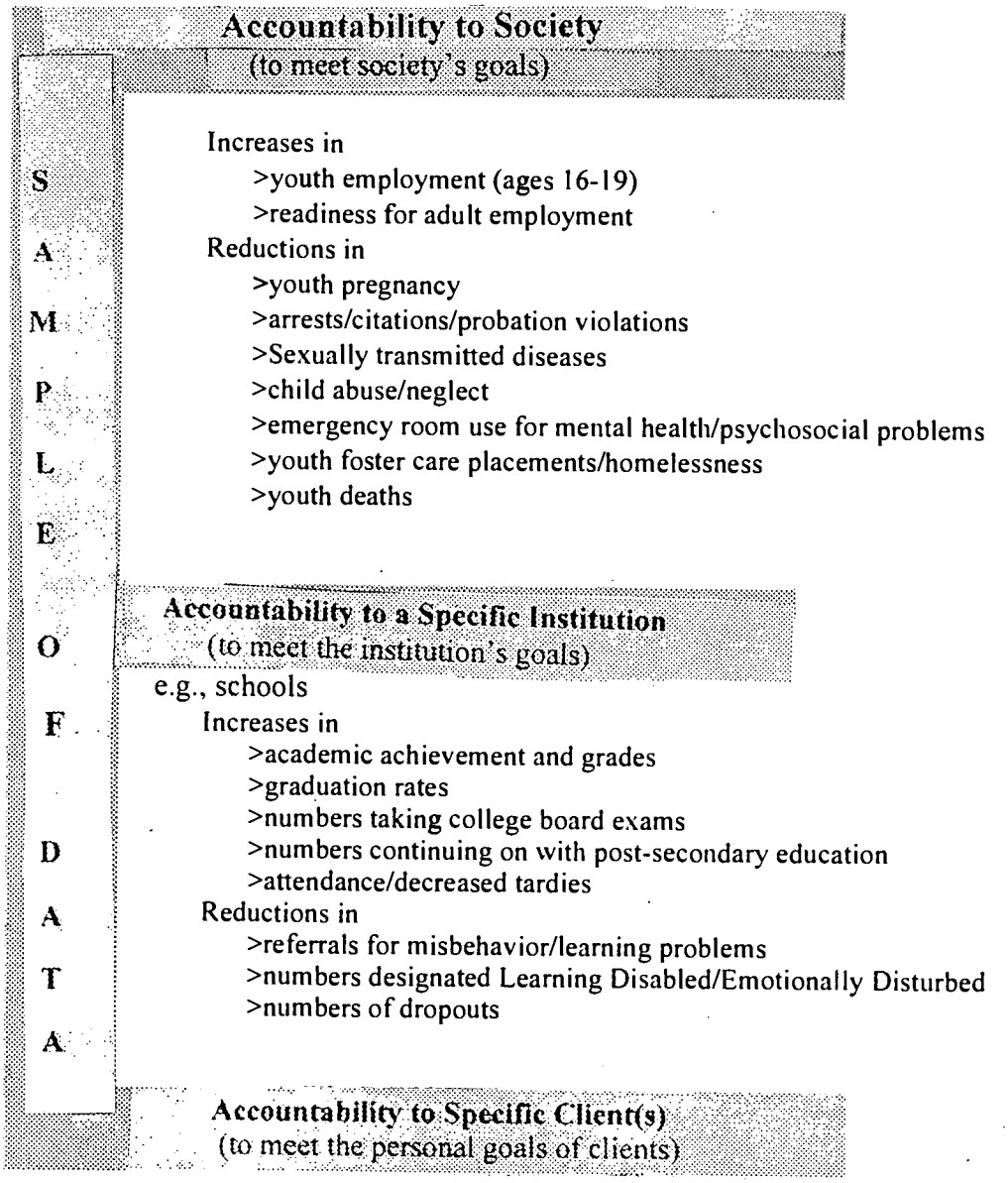
When it comes to mental health in the schools, the best comparisons are (a) data on the previous results of intervention efforts with comparable students and their families, (b) data on similar students/families at a school who have not yet been served (e.g., appropriate waiting list samples), or (c) data from a very similar school that does not have the programs being evaluated. The first approach calls for gathering a "baseline" of data before or in the early stages when an intervention is being developed. The latter approaches call for being able to gather the same data with nonserved groups. Again, the matters of systematic planning and appropriate budgeting are central considerations.

> Finding out if interventions are any good is a necessity. But in doing so, it is wise to recognize that evaluation is not simply a technical process. Evaluation involves decisions about what, how, and when to measure, and these decisions are based in great part on values and beliefs. As a result, limited knowledge, bias, vested interests, and ethical issues are constantly influencing evaluation processes and the decisions made with respect to accountability.

Figure 1. Accountability as related to differing intervention goals.

Purpose of Intervention	***Accountability to Who?***	***Sampling of Objectives/Goals***
To meet *society's goals*	Accountable to society	Data are gathered on indicators that reflect society's purposes in financing the institution
To meet an *institution's goals*	Accountable to a specific institution	Data are gathered on indicators that reflect the institution's purposes
To meet the *personal goals of specific clients*	Accountable to specific clients	Data are gathered on indicators that reflect individual client's purposes in participating in an intervention
To meet some combination of society, institution, and individual goals	Combination of the above	Combination of the above

Figure 2. Evaluation/accountability/results: Sampling indicators with respect to different accountability demands.



Note: Not included here are indicators of negative effects that may accrue for individuals, interveners, institutions, and the society (e.g., the many psychological, social, and economic costs). Clearly, data on these matters is essential -- although they tend to be ignored in many so-called *results*-oriented demands for accountability.

II. A Quick Overview of Some Basic Resources

A. Selected References

1. Developing Your Rationale

Evaluator's Handbook: Vol.1 9160 pgs.), In *Program Evaluation Kit.*
J.L. Herman, L.L. Morries, & C.T.Fitz-Gibbon (1987). Thousand Oaks, CA: Sage. (Phone: 805/499-9774).

New Approaches to Evaluating Community Initiatives -- Concepts, Methods and Contexts.
J.P. Connell, A.C. Kubisch, L.B. Schorr, & C.H. Weiss (Eds.). Washington, DC: The Aspen Institute, 1995.

On Understanding Intervention in Psychology and Education. H.S. Adelman & L. Taylor. Westport, CT: Praeger, 1994. See section on "The Evaluation Problem".

Multi-Stage Evaluation for a Community Mental Health System for Change.
K. Kutash, A. Duchnowski, M. Johnson, & D. Rugs (1993). *Administration and Policy in Mental Health, 20,* 311-322.

An Interorganizational Network Approach to Evaluating Children's Mental Health Service Systems.
J.P. Morrissey (1992). *New Directions for Program Evaluation, 54,* 85-99.

The Process Study Components of Mental Health Evaluation.
R.D. Perry, B.H. Hoff, & D.S. Gaither (1994). *Evaluation and Program Planning, 17,* 43-46.

What Works for Whom: The Design and Evaluation of Children's Mental Health Services.
M. Armstrong, S. Huz, & M. Evans (1992). *Social Work Research & Abstract, 28,* 35-41.

Child and Adolescent Mental Health Services: Evaluation Challenges.
L. Bickman & D.J. Rog (1992). *Evaluating Mental Health Services for Children, 54,* 5-16.

Quality, Quality Assessment, and Quality Assurance: Considerations for Maternal and Child Health Populations and Practitioners.
H. Grason& B. Guyer(1995). Baltimore: The Child and Adolescent Health Policy Center, The Johns Hopkins University.

2. Specific Topics

Evaluating Children's Mental Health Systems: An analysis of Critical Behaviors and Events. D. Rugs & K. Kutash (1994). *Journal of Child and Family Studies, 3*, 249-262.

Scales to Assess Child and Adolescent Depression: Checklists, Screens and Nets. E.J. Costello & A. Angold (1988). *Journal of American Academic Child and Adolescent Psychiatry,* 27, 726-737.

Structured Interview for Assessing Children. K. Hodges (1993). *Journal of Child Psychology and Psychiatry, 34*, 49-68.

Improving Accountability in a Service Delivery System in Children's Mental Health. J.D. Burchard (1992). *Clinical Psychology Review, 12*, 867-882.

Assessing Mental Health Outcome Measurement Techniques. J. A. Ciarlo, T.R. Brown, D.W. Edwards, T.J. Kiresuk, & F.L. Newman (1986). National Institute of Mental Health. Series FN No. DHHS Pub. No. (ADM) 86-1301. Washington, DC: Supt. of Docs., U.S. Govt. Printing Office.

Assessing Outcomes for Sufferers of Severe Mental Disorder: A Conceptual Framework and Review. A. Rosenblatt & C.C. Attkinsson (1993). *Evaluation and Program Planning, 16,* 3347-3363.

Measuring Treatment Outcome and Client Satisfaction Among Children and Families. Special Section: Outcomes research. T.G. Plante, C.E. Couchman, & A.R. Diaz (1995). *Journal of Mental Health Administration, 22*, 261-269.

Cost-Outcome Methods for Mental Health. (242 pp.) W. Hargreaves, M. Shumway, T. Hu, & B. Cuffel (1998). San Diego, CA: Academic Press.

Integrating Systems of Care in California for Youth with Severe Emotional Disturbance (Two reports from the California AB377 Evaluation Project). A. Rosenblatt & C.C. Attkinsson (1992). *Journal of Child and Family Studies, 1*, 93-113; 263-286.

Use of Structured Assessment Tools in Clinical Practice. M.D. Weist, & M. Baker (1995). Paper presented at the 1995 annual meeting of the American Society for Adolescent Psychiatry.

Analyzing Costs, Procedures, Processes, and Outcomes in Human Services. B.T. Yates (1996). Thousand Oaks, CA: Sage. (161 pp.)

Outcomes and Evaluation: System, Program and Clinician Level Measures. S. Essock & H. Goldman (1997). In K. Minkoff & D. Pollack (Eds.), Managed Mental Health Care in the Public Sector: A Survival Manual. Singapore: Harwood Academic Publishers. (pp. 295-307).

Evaluating Family Programs. (556 pp.)
H.B. Weiss, & F. H. Jacobs (1988). Hawthorne, NY: Aldine de Gruyter.

B. Guidebooks and Models

Evaluating the Outcome of Children's Mental Health Services: A Guide for the Use of Available Child and Family Outcome Measures (1995) -- by T.P. Cross & E. McDonald

Discusses ways to use available standardized child and family outcome measures in the development of an outcome measurement plan. Describes the process used to select a standard instrument; discusses criteria used as the basis for instrument selection; presents basic information on a selected set of instruments suitable for use in measuring child and family outcomes.

To order a copy of this guide, contact:

The Technical Assistance Center for the Evaluation of Children's Mental Health Systems/ Judge Baker Children's Center; 295 Longwood Ave., Boston, MA 02115
Phone: (617) 232-8390/ Fax: (617) 232-4125.

Center for the Study of Evaluation: Program Evaluation Kit (1987)

This nine volume kit offers a step-by-step guide to planning and conducting program evaluations. Titles include: *Evaluator's handbook, How to focus on evaluation, How to design a program evaluation, How to use qualitative methods in evaluation, How to assess program implementation, How to measure attitudes, How to measure performance and use tests, How to analyze data, and How to communicate evaluation findings.*

Contact: Sage Publications, Inc., P.O. Box 5084, Thousand Oaks CA 91359-9924
Telephone: (805) 499-9774; Fax: (805) 499-0871; Internet: order@sagepub.com

National Institute on Drug Abuse
How Good is Your Drug Abuse Treatment Program? A Guide to Evaluation (1993) -- by the National Institute on Drug Abuse (NCADI #BKD104)

This guide is highlighted in Section IV of this Introductory Packet. The guide outlines a 52 week evaluation plan, and the steps necessary to meet each week's goals. This model encompasses developing a program plan, with concrete objectives and goals; organizing resources; operationalizing measures; developing a research design; collecting and analyzing data; and finally reporting and using the findings. Also outlined is how to use the developments from earlier steps as stepping stones to later ones. Although this model pertains to drug treatment programs, the basic strategies can be applied to various intervention programs.

Contact: The National Technical Information Service order desk, 5285 Port Royal Road
Springfield, VA 22161. Phone: 703-487-4650; FAX: 703-321-8547 (To verify receipt of your fax, call 703-487-4679). For RUSH service: 1-800-553-NTIS

A. Rosenblatt & C. C. Attkinsson (1993). **Assessing Outcomes for Sufferers of Severe Mental Disorder: A conceptual Framework and Review.** *Evaluation and Program Planning, Vol. 16*, pp. 347-363.

A brief summary of this framework is presented in a box on the next page. This article presents a conceptual framework to classify the outcomes of services (and thus outcome measures). The classification framework integrates three dimensions: 1) respondent type, which reflects a range of social perspectives: client, family, social, clinician, and scientist; 2) social context of measurement, which states that measures must be taken in the context of all areas of functioning: individual/self, family, work/school, community; 3) treatment outcomes, is based on the need for multiple measures and approaches to measuring outcomes for persons suffering from severe mental disorders.

K. Hoagwood, P.S. Jensen, T. Petti, & B.J. Burns (1996). **Outcomes of Mental Health Care for Children and Adolescents: I. A Comprehensive Conceptual Model.** *Journal of the American Academy of Child and Adolescent Psychiatry, 35.*

Outlines a dynamic and interactional model of outcomes that braodens the range of intended consequences of care. It comprises five domains: Symptoms, functioning, consumer perspectives, environmental contexts and systems. The model reflects the changeable interaction between children's evolving capacities and their primary environments (home, school, and community).

C. Agencies and Website for Technical Assistance

In addition to our Center and the Center for School Mental Health Assistance (University of Maryland at Baltimore) -- which provide technical assistance support and put out a variety of publications -- the following agencies can also be of assistance.

ERIC -- Clearinghouse on Assessment and Evaluation

The Educational Resources Information Center (ERIC) is a national information system. One of its divisions focuses on assessment and evaluation, providing access to technical assistance services as well as documents and reports, test banks, and more. Their web site provides links to relevant sites, and information on many other ERIC programs and services.

Contact: O'Boyle Hall, Department of Education, The Catholic University of America
Washington, DC 20064; Website: http://www.cua.edu/www/eric_ae/MAIN.HTM

Harvard Family Research Project

Focuses on family support programs and policies; provides technical assistance to a nationwide network of practitioners, policy makers, and educators. Publishes "The Evaluation Exchange," a quarterly newsletter; their website links to agencies, foundations and think tanks involved in child and family issues and research.

Contact: Harvard Family Research Project, 38 Concord Avenue, Cambridge, MA 02138
Phone: (617) 495-9108 Email: hfrp@hugse1.harvard.edu
Website: http://hugse1.harvard.edu/~hfrp/

National Center for Educational Outcomes (NCEO)

Specializes in the identification of outcomes, indicators, and assessments to monitor educational results for all students including students with disabilities. Has an extensive publication list, a directory of assessment projects, a national network of technical assistance providers.

Contact: University of Minnesota, 350 Elliott Hall, 75 East River Road
Minneapolis, MN 55455 Phone: (612) 626-1530 Fax: (612) 624-0879
Website: http://www.coled.umn.edu/nceo/

Technical Assistance Center for the Evaluation of Children's Mental Health Systems

This center is highlighted on the next page. Located at Judge Baker Children's Center, this agency provides consultation and has a library of measures, manuals, and articles, including *Evaluating the Outcome of Children's Mental Health Services: A Guide for the Use of Available Child and Family Outcome Measures.*

Contact: Christina Crowe, Director, 295 Longwood Ave., Boston, MA 02115
Phone: 617/232-4125 or (800) 779-8390 Fax: 617/232-4125
Website: http://tac.pie.org/T3632

Internet websites can be goldmines of information. They have reports, publications, online resources (e.g., catalogs, technical assistance), model programs, and links to other resources.

Assessment and Evaluation on the Internet
Website: http://ericae2.educ.cua.edu/intbod.stm#AA

Developed by The Educational Resources Information Center (ERIC) to provide online services and documents pertaining to assessment and evaluation; contains information on special issues in evaluation, test descriptions, lists of online test publishers, and much more.

The Evaluation Clearinghouse
Website: http://www3.sympatico.ca/gpic/evalweb.htm

Specializes in linking to useful information and organizations related to evaluation and assessment, has online documents, information discussion groups, links to relevant evaluation organizations and think tanks, and more.

Measuring Mental Health Outcomes

A Brief Highlight from Assessing Outcomes for Sufferers of Severe Mental Disorder: A Conceptual Framework and Review, by A. Rosenblatt and C.C. Attkisson, *Evaluation and Program Planning*, Vol. 16, pp. 347-363, 1993.

In light of the challenges facing the field of outcome research related mental health services, a conceptual framework is presented to classify the outcomes of services for sufferers of severe mental disorders. This classification framework integrates three dimensions: (a) the respondent type, (b) the social context, and (c) the domain of treatment outcomes based on the need for multiple measures and approaches to measuring outcomes for persons suffering from severe mental disorders.

The conceptual framework consists of five respondent types (who), four behavioral/social contexts of measurement (where), and four domains of treatment outcomes (what) which are graphically represented in Figure 1:

Respondent types -
measures of outcomes must reflect a range of social perspectives:client, family, social, clinician, and scientist

Behavioral/social contexts of measurement - measures must be taken in the context of all areas of functioning: individual/self, family, work/school, community

Domains of treatment outcomes -
measures should cover all domains: clinical status, functional status, life satisfaction & fulfillment, safety & welfare

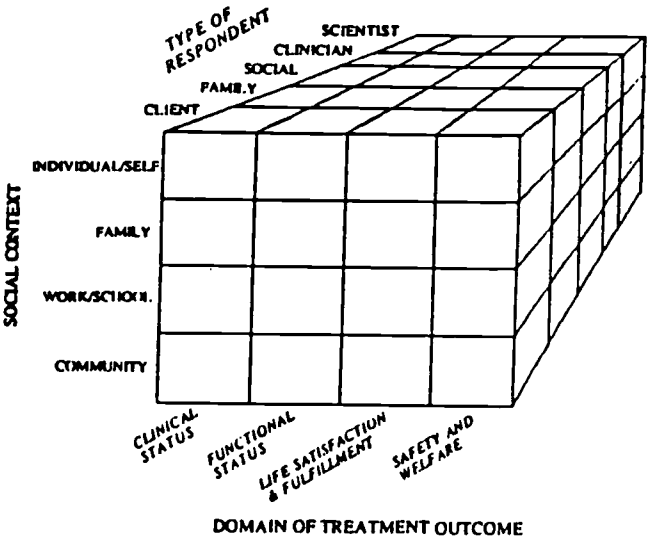


Figure 1. A model of the dimensions of outcome measurement for mental health services research.

This conceptual framework is useful in classifying and evaluating the usefulness of outcome measures, for example, who provides the data for the measure, what is the relevant social context, and what is the domain of treatment outcome?

A Highlighted Resource

Technical Assistance Center for the Evaluation of Children's Mental Health Systems (located at the Judge Baker Children's Center in Boston, 295 Longwood Ave., Boston, MA 02115). This is a premier resource for information on specific measures; the Center provides consultation and has a library of measures, manuals, and related articles: Phone (800) 779-8390, ext. 2139. Website -- http://tac.pie.org/T3632.

Among the measures they cite are:

- Parenting Stress Index
- Child Behavior Checklist
- Early Childhood Assessment Tool
- Family Evaluation Scale
- Self-esteem measures
- Cultural Competence Instrument
- Diagnostic Interview Schedule for Children
- Adaptive Social Behavior Inventory
- Adaptive Functioning Measure
- Youth Satisfaction Questionnaire

In reviewing measures, they provide detailed information on various instruments. Examples include:

1) Hodges' **Child and Adolescent Functional Assessment Scale (CAFAS)** which they indicate measures client functioning in general and in each of six psychosocial areas: "Role Performance (includes legal problems), Thinking, Behavior Toward Others/Self, Moods/Emotions, and Substance Abuse. For each subscale, service providers are asked to rate the client at the most severe level of dysfunction that has occurred at anytime in the last month. In addition, two scales have been added to assess resources of caregivers' capacity to provide for a) basic needs and b) family/social support."

2) Achenbach's **Child Behavior Checklist** which measures Externalizing behavior (directed outward -- poor behavior control, etc.) and Internalizing behavior (directed inward -- anxiety, depression, etc.). Scores for problem areas distinguish a) withdrawn behavior, b) somatic complaints, c) anxious/depressed, d) social problems, e) thought problems, f) attention problems, g) delinquent behavior, h) aggressive behavior, and i) sex problems. Scores for Social Competence distinguish school, social, and activities.

3) DeChillo's **Client Satisfaction Questionnaire (CSQ)** which is an 8-item scale that yields an overall satisfaction score and specific items that might help with quality improvement of services.

Each review also provides technical information on the psychometric properties of the instrument and discusses other relevant matters.

D. CONSULTATION CADRE

Professionals across the country volunteer to network with others to share what they know. Some cadre members run programs; many work directly with youngsters in a variety of settings and focus on a wide range of psychosocial problems. Others are ready to share their expertise on policy, funding, and major system concerns. The group encompasses professionals working in schools, agencies, community organizations, family resource centers, clinics and health centers, teaching hospitals, universities, and so forth.

People ask how we screen cadre members. We don't! It's not our role to endorse anyone. We think it's wonderful that so many professionals want to help their colleagues, and our role is to facilitate the networking. If you are willing to offer informal consultation at no charge to colleagues trying to improve sytems, programs, and services for addressing barriers to learning, let us know. Our list is growing each day; the following are those currently on file related to this topic. Note: the list is alphabetized by Region and State as an aid in finding a nearby resource.

Central States

Minnesota
Gordon Wrobel
Mental Health Consultant
Minnesota Dept of Children, Families & Learning
830 Capitol Square Building
St. Paul, MN 55101
Phone: 612/297-1641
Fax: 612/297-7368
Email: gordon.wrobel@state.mn.us

Missouri
Sandra Nichols
Missouri Dept. of Elementary
Secondary Education
P.O. Box 480
Jefferson City, MO 65202

East

District of Columbia
Ronda Talley
425 Eighth Street, NW, #645
Washington, DC 20004
Phone: 202/393-0658
Fax: 202/393-5864
Email: rct.apa@email.apa.org

Maryland
Kristin Langlykke
Maternal and Child Health Bureau
Office of Adol. Health
5600 Fisher Lane
Rockville, MD 20857
Phone: 301/443-4026
Email: ncemch01@gumedlib.dml.georgetown.edu

Maine
Ellen Bowman
LCPC-Clinical Counselor
Maranacook Community School-Student
P.O. Box 177
Readfield, ME 04355
Phone: 207/685-3041

New York
Christopher Cinton
Project Director
Bronx-Lebanon Hospital Center
1650 Grand Concourse
Bronx, NY 10457
Phone: 718/960-1328
Fax: 718/583-0460

Pennsylvania
Patricia Welle
Student Services Coordinator
School District of the City of Allentown
31 South Penn Street
P.O. Box 328
Alllentown, PA 18105
Phone: 610/821-2619
Fax: 610/821-2618

Rhode Island
Robert F. Wooler
Executive Director
RI Youth Guidance Center, Inc.
82 Pond Street
Pawtucket, RI 02860
Phone: 401/725-0450

Southeast

Alabama

Deborah Cleckley
Director, Quality Assurance/Education
Jefferson County Department of Health
1400 6th Avenue, South
Birmingham, AL 35233-2468
Phone: 205/930-1401
Fax: 205/930-1979

Florida

Howard Knoff
Professor and Director
School Psychology Program
University of South Florida
4202 East Fowler Avenue, FAO 100U
Tampa, FL 33620-7750
Phone: 813/974-9498
Fax: 813/974-5814
Email: knoff@tempest.coedu.usf.edu

Georgia

Peter A. Cortese
Chief Program Development and Services Branch
Center for Disease Control and Prevention
Division of Adolescent and School Health
4770 Buford Highway, N.E., MS-K31
Atlanta, GA 30341-3724
Phone: 404/488-5365
Fax: 404/488-5972
Email: pac2@ccdash1.em.cdc.gov

Louisiana

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Medical and Health Services Department
820 Girod St.
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Fax: 504/592-8378

North Carolina

Bill Hussey
Section Chief
Dept. of Public Instruction
301 N. Wilmington St.
Raleigh, NC 27601-2825
Phone: 919/715-1576
Fax: 919/715-1569
Email: bhussy@dpi.state.nc.us

William Trant
Director Exceptional Programs
New Hanover County Schools
1802 South 15th Street
Wilmington, NC 28401
Phone: 910/815-6935
Fax: 910/815-6929
Email: nhcsswrt@uncwil.edu

Virginia

Sally McConnell
Director of Government Relations
National Association of Elementary School Principals
1615 Duke Street
Alexandria, VA 22314
Phone: 703/518-6263
Fax: 703/548-6021
Email: sallymac@ix.netcom.com

Southwest

California

Frank Binch
Department of Health Services County of Los Angeles
1200 N. State St.
Los Angeles, CA 90033
Phone: 213/226-8326
Fax: 213/226-8320
Email: 73267.2635@compuserve.com

Howard Blonsky
Coordinator, Beacon Schools
San Francisco Unified School District
1512 Golden Gate Avenue
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Fax: 415/749-3420

Southwest (cont.)

California (cont.)

Jim Bouquin
Executive Director
New Connections
1760 Clayton Rd.
Concord, CA 94520
Phone: 510/676-1601

June Cichowicz
Community Relations Director
Crisis and Suicide Intervention of Contra Costa
P.O. Box 4852
Walnut Creek, CA 94596
Phone: 510/939-1916
Fax: 510/939-1933

Lois Coleman-Lang
Coordinator of Health Services / Tracy Public Schools
315 East 11th Street
Tracy, CA 95376
Phone: 209/831-5036
Fax: 209/836-3689

Georgiana Coray
CA Assoc. for School-Based &
School Linked-Health Centers
7956 Grape St.
La Mesa, CA 91941
Phone: 619/464-3988

Alfredo Crespo
Psychologist
San Fernando Valley Child Guidance Clinic
9650 Zelzah Ave.
Northridge, CA 91325
Phone: 818/506-1348
Fax: 818/998-2726

Kimberly Dark
Community Program Coordinator
Reachout to Families
South Bay Union School District
610 Elm Avenue
Imperial Beach, CA 91932
Phone: 619/575-5917
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Sylvia Dean
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Los Angeles School District
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California (cont.)

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Children and Youth Services Bureau
L.A. County Dept. of Mental Health, C&FSB
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Susan Lordi
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9300 Imperial Highway, Room 210
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A PERSPECTIVE ON ACCOUNTING FOR DIFFERENCES AND DISABILITIES IN ASSESSING STUDENTS

The following are issues covered in our Center's Introductory Packet on *Assessing to Address Barriers to Learning* (available at cost from the Center's Clearinghouse).

In gathering data related to intervention effectiveness, it is important to remember that some interventions are meant to change the school, classroom, home, and so forth. When interventions are designed to alter environments, then sound accountability focuses not just on assessing students but also evaluating environmental changes. Often, the primary need is to assess how well external barriers to learning have been addressed.

- When it is clear that student data are needed, the next consideration is whether the information already is in accessible, existing records

- If the desired information is not available and direct assessment of the student is appropriate, then concerns about the assessor's ability to gather valid information arise. When all is said and done, these concerns are reflected in three question:

  Are there valid procedures for gathering the information?
  (e.g., culturally appropriate instruments)

  Can the assessor establish a positive working relationship with the student?

  Relatedly, is the student motivated to provide the desired information?

Concerns about cultural differences, disabilities, and other ***group differences*** *resolve down to the problem of* ***individual differences*** *when it comes to assessing a given individual*

III. An Evaluation Flow Chart and Some Accompanying Material from a Resource Published by the National Institute on Drug Abuse (Rockville, MD) entitled

How Good is Your Drug Abuse Treatment Program? A Guide to Evaluation.

Although the work stresses evaluation of drug treatment, the flow chart and related materials can be readily adapted to meet many program evaluation needs.

Exhibit III-1: Flowchart of a 52 Week Evaluation Process

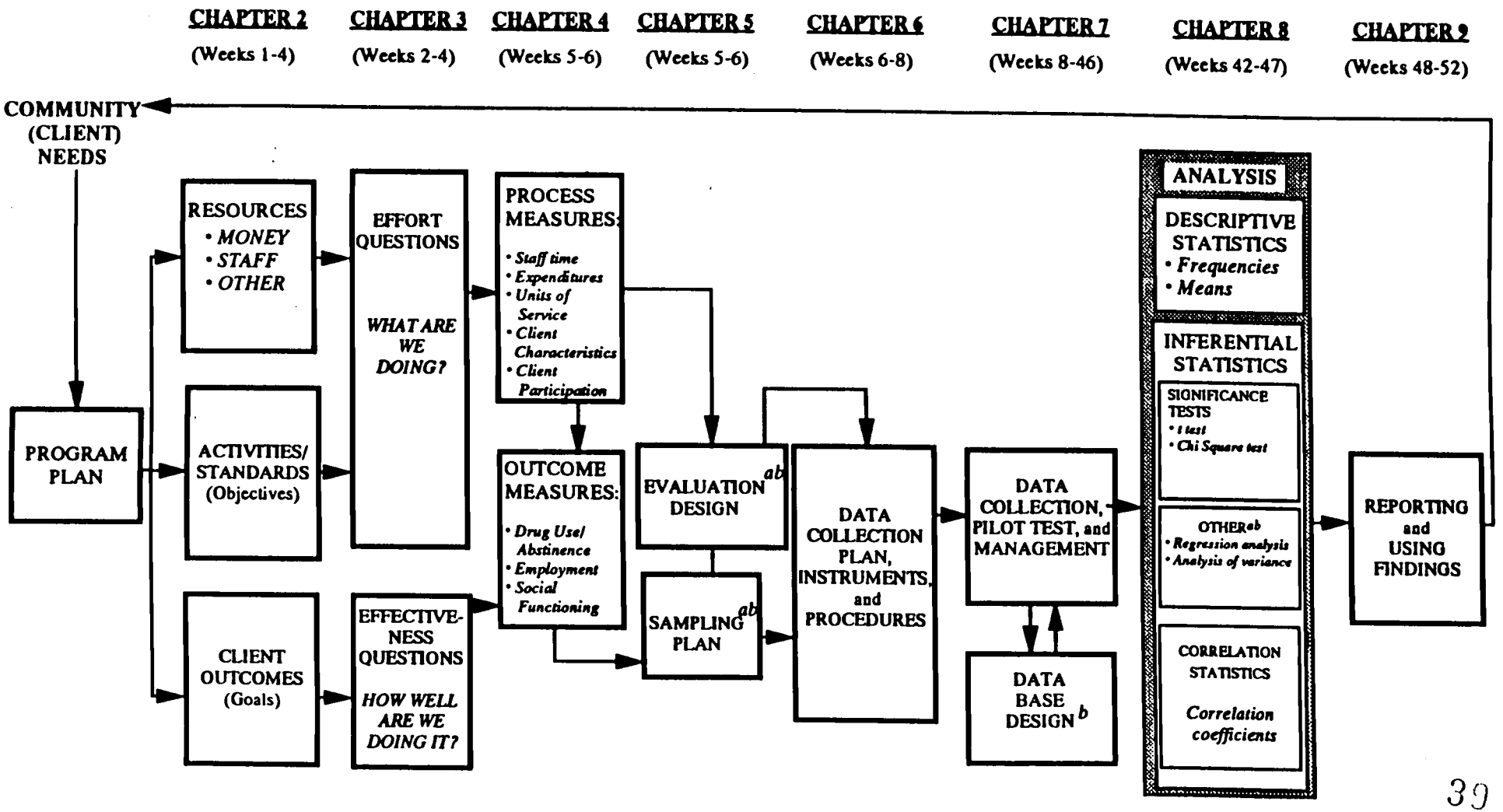

Exhibit III-2: Examples of Program Objectives

Goal: Cygnus clients will develop a lifestyle that supports abstinence and enables them to provide healthy home environments for their children.

Objectives:

(1) Eighty percent of clients, before leaving treatment, will have completed a 6-week employment skills program that covers job search skills, interviewing skills, and basic work skills.

(2) Eighty percent of clients with husbands or significant others, before leaving treatment, will have completed 12 weeks of couples counseling.

(3) Eighty percent of clients will have completed a 6-week parenting skills program of 2 hourly meetings per week before leaving treatment.

(4) Eighty percent of clients will have completed a 3-part workshop on self-esteem within 45 days after entering treatment.

(5) Eighty percent of clients will have completed a relapse prevention program within 6 months of completing primary treatment.

Exhibit III-3: Eight Threats to Internal Validity

1. HISTORY: Unplanned events that occur between the first and second measurements. Examples include changes in local drug use patterns, drug supply interruptions, changes in treatment approach, and seasonal drug use patterns. In general, the more time that elapses between measurements, the greater the threat from historical effects.

2. MATURATION: Developmental changes that naturally occur in clients. Growing older, more experienced, or more independent may be especially important maturation effects with adolescent client populations. Other maturation effects raise particular concerns in samples from special populations in transition, such as pregnant women, HIV positive clients, and ex-offenders re-entering society from prison.

3. TESTING: Effects of taking a measurement on the results of subsequent measurement. Repeated urine tests for drug use tend to discourage later drug use, for example, while repeated ability tests tend to raise scores as subjects practice their test-taking skills, even if no real increase in ability occurs.

4. INSTRUMENTATION: Effects of changes in a measurement instrument, or in criteria for recording behavior, during the course of an evaluation. Common examples are a change in the cutoff point for a "drug positive" determination by a urinalysis laboratory or a change in police criteria for making arrests (for example, during a neighborhood crackdown).

5. STATISTICAL REGRESSION: Effects of selecting samples on the basis of extreme behavior—over time, their behavior tends to "regress" toward the overall group average. In drug treatment program evaluation, prodrug attitudes in an extremely prodrug sample, heroin consumption in a sample selected during periods of heavy use, and self-esteem in a sample selected on the basis of low self-esteem, will all tend to be less extreme on a second measurement.

6. SELECTION: Effects of unmeasured difficulties between a group receiving treatment and a nonequivalent group not receiving treatment. Common examples of unmeasured difficulties include clients' motivation to seek treatment, family and social support structures, and expectations about future drug use. The problem tends to arise when treatment is given to volunteers and withheld from nonvolunteers, instead of assigning volunteers randomly to treatment.

7. ATTRITION: Effects of unequal dropout rates among different subgroups in the sample. In drug treatment program evaluation, common examples include differences between those who receive treatment and those who do not, between heavier drug users and lighter users, or between more and less satisfied clients.

8. HAWTHORNE EFFECT: Effect of changes which are due to the fact of being included in an evaluation.

IV. Two Reports from the Center for School Mental Health Assistance (Prepared by Mark Weist, Ph.D.)

Critical Issue Planning Session:

- Quality Assurance
- Documenting Effectiveness of School Mental Health Programs

Center for School Mental Health Assistance
Critical Issue Planning Session: Quality Assurance
March 26, 1996
Baltimore, Maryland

Meeting Overview

One of the seven major objectives of the Center for School Mental Health Assistance (CSMHA) is to provide direction in addressing issues critical to the advancement of school mental health (SMH) services. In year 1 of the project, three issues have been targeted as the most important: 1) Developing mechanisms to assure the quality of SMH services, 2) documenting the effectiveness of SMH services, and 3) developing stable funding mechanisms. To begin to formulate strategies to address these pressing issues, the CSMHA will convene analysis and planning sessions with national experts. The first in our series of these meetings focused on Quality Assurance, and was held on March 26, 1996. The meeting included national experts representing providers and planners of school health and mental health services (Paula Armbruster, MSW; Lois Flaherty, MD; Ellen Garrison, Ph.D.; Marcia Glass-Siegel, LCSW-C; Bernice Rosenthal, M.P.H.; Beth Warner, Ph.D., Mark Weist, Ph.D.), leading academicians (Stan Friedman, M.D.; Phil Leaf, Ph.D), representatives from local and state agencies and governments (Art Cohen, J.D.; Bonnie Peet, MSN; Tom Merrick, M.A.), leaders in managed care organizations (Kirk Griffith, Ph.D., Donna Horsey, R.N.), family members of youth with emotional and behavioral disorders (Susan Tager, B.A.), quality assurance officers (Eileen Hastings, LCSW-C; Patrick Myers, M.S., Julie Tyler, R.N.) and others (Patrice Davis-Rose).

I. Vision for School Mental Health Services

Our initial discussion focused on the Vision for SMH services. Important points that were raised during this discussion included:

* Major dimensons of Quality Assurance (QA) are Access and Availability, the Quality of Interventions. Continuity of Care, Collaboration between Providers, Acceptability of Services to Consumers, and Reasonable Cost. Participants endorsed these dimensions as being relevant to SMH programs.

* To ensure quality, SMH services should be integrated with community health services, and reflect genuinely collaborative relationships between mental health, health, and educational staff.

* There is an important distinction between Quality Assurance (QA) and Quality Improvement (QI). QI is a gradual and progressive improvement in the process of care toward meeting long-term objectives, while QA is more of a snapshot of how an organization is functioning at a given point in time. QI never ends; instead, process is influenced by objectives, and objectives are influenced by the process in a continuing cycle of service improvement.

* A commitment to quality requires linking efforts to customers, but identifying them is a challenge. Who are the customers: students, their families, legislators? The vision will vary based on the customers.

* Any system of QI for SMH services must be centered around the significant improvements in access enabled by having them in schools. There are numerous barriers preventing youth from receiving services in traditional settings (e.g., community mental health centers, private offices). As recognition of these barriers has increased, so have activities to develop more and more primary mental health services for youth in schools. As such, QI programs should not impose barriers between youth and needed services.

* Efforts to document the effectiveness of SMH programs are actually subsumed under QI. Often education staff and community members need to be educated on the benefits of school-based mental health services (e.g., to address aggressive behavior and violence). The benefits of SMH services must be connected to outcomes pertaining to educational functioning. Efforts to document the cost savings and general community benefits (e.g., in assisting the juvenile justice system) of these programs are also critically needed.

* The degree to which SMH programs address pressing problems in their surrounding communities (e.g., teenage pregnancy, violence) is an important dimension for measuring their quality. There is no way around significant community input that comes from parents and leaders from community clubs and religious groups.

* Ideally, SMH programs should emphasize primary and secondary prevention of psychosocial adjustment problems in youth. But in many cases, there will be a need for tertiary preventive services, and the needs of youth with severe/chronic disturbances cannot be neglected. As such, SMH programs should not replicate other services in communities, but be meshed with them.

* To truly have an impact, SMH programs need to be accepted by school staff and the teachers union. One method to promote such acceptance is to highlight the benefits of SMH programs in "enabling" children's learning (from H. Adelman and L. Taylor). This connection is absolutely critical to political advocacy efforts for SMH services.

* Families need to be closely involved in all phases and aspects of planning for and providing SMH programs. Outreach efforts to families, while often frustrating, are critically important.

II. Small Group Discussions: Translating the Vision of Quality SMH Services into Operational Principles and Procedures

In the second half of our meeting we broke into discussion groups which were charged with operationalizing the vision for high quality SMH services in the major domains of: A. Goals. B. Scope of Services, and C. Quality Indices. These are reviewed here:

A. Goals for SMH Services:

* develop programs in areas where there are clear problems with access to mental health services for youth (e.g., very rural areas, inner cities),
* improve the social, familial, emotional, behavioral and educational functioning for youth who receive services,
* provide high quality yet cost-effective services,
* when possible, provide school health and mental health services in an integrated fashion,
* ensure that services are integrated with services available in the community,
* ensure that assessment and treatment services are both developmentally and culturally sensitive,
* work to reduce the stigma associated with mental health services,
* improve awareness of mental health issues for students, their families, and school staff,
* involve students in providing input on the development and delivery of mental health services,
* develop collaborative and collegial relations with other mental health staff (e.g., guidance counselors, school psychologists) to ensure the coordination of services,
* provide input into the reorganization and improvement of school "support" services,
* advocate for appropriate services for youth who are acting out and for youth who have dropped out,
* integrate the mental health program into the philosophy and life of the school,
* attend to the relevance of treatment targets and provide empirically valid services,
* provide pragmatic and effective assistance to education, related mental health, and school health staff,

B. Scope of SMH Services:

* conduct local needs assessments to ensure that services are congruent with community needs,
* emphasize preventive services, based on systems of early identification of youth in need,
* in addition to more preventive services, identify youth with mild as well as severe emotional/behavioral disturbances,
* provide services regardless of ability to pay,
* provide a full continuum of services including assessment and treatment services to youth without diagnoses, as well as to those with more severe problems (when indicated), in both regular education and special education tracks,
* provide assessment and treatment services to address substance-related issues, including drug and alcohol abuse, exposure to familial substance abuse, and drug dealing,
* provide the appropriate level of services based on utilization patterns of school- vs. community-based programs,
* conduct community outreach activities (e.g., working with neighborhood associations, parent-teacher organizations) to promote community-wide benefits of SMH services,
* assist in the development of "school-wide" services to address pressing problems (e.g., violence),

- provide mental health education and/or facilitate the development of mental health programs in educational curricula,
- develop mental health screening to facilitate mental health services for youth who use school health services at high rates,
- develop mental health programs for youth contending with chronic illness and/or special health problems.

C. Quality Indices:

- amount of time between referral of students and contact with clinicians,
- appointment keeping rate of referred students,
- percentage of referred students who are actually seen by the clinician,
- number of students who are successfully referred to appropriate services in the community (e.g., for medication),
- amount of services provided (e.g., number of students seen; number of individual, group and family therapy sessions),
- degree of family involvement (e.g., percentage of students seen with contact between the clinician and the family),
- educational and emotional/behavioral improvement in youth from pre to post intervention,
- "consumer satisfaction" ratings from youth, families and educational staff,
- number or percentage of youth referred for special education services,
- number or percentage of youth who undergo changes in intensity of special education services (e.g., from higher to lower),
- having an orientation program for new clinicians,
- "sensitivity" of mental health providers to factors important to the school setting,
- functioning of multidisciplinary teams (e.g., disciplines represented, yearly objectives accomplished),
- degree to which mental health staff become accepted by, and part of, the school milieu,
- amount of appropriate (e.g., by licensed providers) clinical supervision of the school-based therapist,
- expertise and experience of school-based clinicians,
- support provided to the SMH program by the school administration (e.g., adequacy of office space),
- compliance of the program with relevant state laws and professional guidelines.

III. Summary Discussion

In summing up the day, four "overarching goals" for SMH programs were identified: 1) Provide comprehensive direct clinical assessment and treatment services for underserved youth, 2) emphasize preventive programs that provide early identification and treatment for youth in need, 3) ensure that mental health programs have a strength or competency focus, versus an exclusive focus on reducing psychopathology, and 4) seek to maximize the impact of mental health services by involvement in collaborative efforts aimed at improving the global school ironment.

In a similar process to the above, critical SMH services were identified. At the core, SMH programs should include focused mental health evaluation, which acknowledges the influence of context (e.g., include classroom behavioral observations), and leads to referral for appropriate services in the school and/or community when indicated. Mechanisms should also be in place to track referrals to ensure that youth in fact contact needed services. At the next level of importance are: a) treatment services, including individual group and family therapy for youth in special and regular education, and b) consultative and mental health education services designed to broaden the impact of the SMH program. There was general consensus that these elements would comprise the "basic" SMH program.

m.weist
4/15/96
(revised 5/5/96)

Center for School Mental Health Assistance
Critical Issue Planning Session II
"Documenting the Effectiveness of School Mental Health Programs"
June 18 & July 23 1996
Baltimore, Maryland

Meeting Overview

On June 18, 1996, the Center for School Mental Health Assistance (CSMHA) convened a meeting of national experts in Baltimore, Maryland to explore relevant issues and methods to document the effectiveness of school mental health (SMH) services. This meeting was the second in a series of meetings designed to analyze and address critical issues confronting the movement to develop and improve SMH services nationwide, and built on concepts developed in our first meeting in March, 1996 focusing on Quality Assurance. Participants in the meeting included providers and planners of school mental health services (Paula Armbruster, MSW; Ellen Garrison, PhD; Marcia Glass-Siegel, LCSW-C; Bernice Rosenthal, MPH; Mark Weist, PhD), education administrator (Louise Fink, MEd), experts on mental health evaluation (Louis Hagopian. PhD; Pat Myers, MA; Jennifer Oppenheim, PhD) and children's mental health issues (Cheryl Alexander. PhD; Joan Dodge, PhD; Marsha Gorth, LCSW-C; Eileen Hastings, LCSW-C; Phil Leaf, PhD), and family member (Gail Johnson).

I. Open Discussion

To open the meeting, participants shared their experiences with, and thoughts about SMH evaluation. Important points raised during this discussion included:

- One benefit of managed care may be to increase pressure on SMH programs to develop systems to evaluate provided services. Managed care companies are looking for proof that the dollars they have invested are actually paying for something. Evaluations showing that SMH programs are effective should enhance the willingness of more managed care companies to fund them.

- University-based programs may have reputations of "using kids as research subjects," which may lead to resistance by schools in cooperating with evaluation plans.

- There are numerous potential obstacles to implementing formal evaluation designs. These include obtaining parental approval and consent for the project, finding and assessing a comparison group, addressing language barriers for certain students (e.g., Hispanic youth), and dealing with poor reading levels of many students.

- Need careful assessment of the importance of the particular outcome to be assessed, respondent burden to obtain measures of this outcome, and pragmatic factors in obtaining the outcome measure (e.g., Is it brief?, Will using it lead to meaningful findings that help improve the program?).

- Many programs initiate complex and labor intensive evaluation designs, collect voluminous amounts of data, then actually only use a small percentage of the data. This essentially leads to wasted efforts, which should be avoided at all costs.

- The concept of Treatment Utility is an important one which states that the evaluation process should directly contribute to positive outcomes, and definitely should not lead to negative outcomes (e.g., students dropping out due to very long assessment procedures).

- Evaluation plans need to be tailored to the individual school, as "every school has its own ecology, and every Board of Education has its own ecology."

- Community members and parents should be closely involved in the development of SMH evaluation plans.

- Should not view these evaluation plans as research; rather, they should be viewed as part of clinical assessment, which will assist in improving the quality of care. Two major functions of evaluation are to design effective programs for kids, and to document that services are beneficial for support of the program.

- For every evaluation program, a careful pre-analysis should occur which considers the goals of the evaluation and the means to accomplish the goals. As few measures as possible should be used to assess accomplishment toward goals.

II. Important Factors to Consider in Developing SMH Evaluations

The panel generated a list of principles that characterize good SMH evaluation programs. These principles included:

- Being relevant to the type of services provided and the population served,

- having an evaluation process that would be generalizable to different programs and different student populations,

- viewing evaluation as an ongoing process, which provides feedback to efforts to continuously improve services,

- attending to cultural sensitivity in evaluation processes and measures,

- involving key "stakeholders" in the evaluation process, such as students, families, school staff, and funders,

- including multiple levels of assessment, for example, measuring student grades and absenteeism, as well satisfaction of teachers with the program,

- being relatively simple and "doable,"

- focusing on factors that are likely to be affected by the program, and

- using measures that are "face valid," or make sense to those completing them.

III. Student-Focused Evaluation Programs

The panel discussed student characteristics and indices of functioning that are most relevant to SMH programs. These included:

- Commonly occurring "emotional" problems such as depression, anxiety, traumatization symptoms, and social withdrawal,

- commonly occurring behavioral problems such as aggression, oppositionality, classroom disruptiveness, and hyperactivity,

- school performance in terms of grades, scores on standardized tests, attendance, and discipline problems,

- family and peer relationships, and

- competencies or qualities of "resilience" such as social skills, positive self-concept, involvement in meaningful activities, participation in athletics, spirituality, coping skills and problem-solving.

There was some discussion of the fact that frequently in mental health, there is a bias toward focusing on pathology, and that positive qualities of youth are often neglected in evaluation programs. There was strong support for a focus on competency variables in SMH program evaluations.

IV. Ethics of SMH Evaluations

Over lunch. participants broke into small groups to discuss ethical issues involved in evaluations of SMH programs. Reports of these discussion groups emphasized the following points:

- Parental consent for services is essential.
- Family members should be involved in the development of SMH services, and should provide feedback on them once they are developed.
- There is an ethical requirement to provide treatment when screening programs are initiated. As such, programs should be cautious about implementing broad screening projects if they have limited resources to provide follow-up services.
- Special safeguards are necessary to protect the confidentiality of students receiving SMH services (e.g., the fact that they are receiving mental health services can usually be witnessed by other students).
- Programs need to document that youth are receiving enough from a program to justify an intensive evaluation.
- When professional staff are not involved in the collection of data, protections need to be in place to ensure its confidentiality.
- Whenever possible, programs should use reliable and valid measurement tools, versus created ones, to avoid the possibility of anomalous findings.

V. Caveats to be Aware of When Implementing SMH Evaluations

The panel reviewed pitfalls of evaluation, and problems that are encountered in evaluation efforts. These included:

- The psychotherapy outcome literature has failed to document that interventions as commonly implemented in applied settings are actually effective. When an SMH evaluation yields negative results, this information can and should be used to improve the program. However, there is a danger that if such negative results are disseminated, they could be used to justify a cut in funding.
- Many youth show up for mental health appointments in schools during crises. Overtime, these youth would do better without intervention. As such, we need to be careful to ascribe recovery from a crisis to SMH services.
- In some SMH programs, clinicians are so overwhelmed with students in need, that less than optimal services are able to be delivered to any one student. This dilutes the effect of school-based interventions, and may lead to failure of evaluations to document positive changes.
- A common failure in evaluation programs is the failure to assess the integrity of treatment services. For example, in many programs little is known about the skill level of the therapist, and what happens behind the therapy door. In structured programs to address particular student problems (e.g., anger control), clinicians have been shown to deviate from the prescribed treatment program without structure (e.g., treatment manuals) and ongoing monitoring of their performance.

- As a general rule, SMH programs are not fine-tuned interventions, which decreases the likelihood of finding positive impacts.

- Many of the instruments used in child mental health assessment basically provide information on whether the child does or does not meet criteria for a specific problem (i.e., "caseness"). These measures are commonly not sensitive to treatment effects. Similarly, there is a lot of random movement from "case" to "noncase" and caution is needed in ascribing this movement to an SMH program.

The above points highlight complexities and difficult issues involved in SMH evaluation, particularly evaluations focused on treatment outcomes. As such, programs should be cautious in attempting to document treatment impacts. However, assessment of treatment outcomes is only one aspect of program evaluation. Such broader program evaluation was the next focus of group discussion.

VI. Desired Outcomes for SMH Programs for Relevant Stakeholders

A. In this section of the meeting, participants sought to address the question: What needs to be demonstrated for SMH programs to expand? The group identified major stakeholders for SMH programs of: 1) Children and families, 2) schools, 3) community health and mental health systems, and, 4) funders. Desired outcomes for each of these stakeholders are reviewed in the following:

1. Children and Families

The group (which included family members of children with emotional/behavioral disturbances) suggested the following outcomes as being the most important. From involvement in an SMH program, children should show:

- academic success
- enhanced self-esteem
- improved social skills
- improved capacity to function independently
- more positive behaviors at home and school
- decreased levels of emotional disturbance

2. Schools

Participants (including education administrators) suggested that schools are most interested in these outcomes from SMH programs:

- academic success
- improved school attendance
- reduced school violence and aggression
- established linkages between the child and other needed services

3. Community Health/ Mental Health System:

Administrators and planners of community health and mental health services were viewed to prioritize the following outcomes for SMH programs:

- detection and treatment of emotional/behavioral problems early
- prevention of emotional and behavioral problems
- family preservation
- decreased child abuse
- decreased suicidal behavior in youth
- decreased substance abuse by youth
- fewer entries into the juvenile justice system

4. Funders

The group suggested that funders (e.g., third party payers, managed care companies) would have one major outcome desired for SMH programs:

- **reduction of high cost services such as hospitalization**

B. The panel then attempted to identify the most desired outcomes for SMH programs; that is, outcomes that cut across the various stakeholder groups. Five outcomes were determined to be the most important. These were:

1. Prevention of emotional/behavioral problems and early intervention to prevent their worsening,
2. improved school attendance,
3. decreased risk-taking behavior including substance abuse and violence by youth,
4. decreased use of high intensity services, including community health services such as hospitalization, and school services such as placement in special education, and
5. improved collaborative linkages for programs within schools, and between school-based and community-based programs.

In discussion of these outcome indicators, the panel emphasized that reduction of emotional/behavioral symptoms in youth per se, is not a priority outcome; rather, positive changes in these symptoms should impact youth functioning in other domains as above. Thus, symptom reduction should be viewed as a means to an end, versus and end in and of itself.

VII. Meeting Day Two - Open Forum

CSMHA staff presented highlights of the Day One meeting, and invited general comments from the panel, which included all but four participants from the first meeting (Paula Armbruster, Marsha Gorth, Louis Hagopian, and Jennifer Oppenheim). Noteworthy comments from the panel included:

- The design and conduct of treatment outcome studies are highly complex and fraught with problems. These problems include the general failure of the few existing studies to document significant benefits, the considerable variability that occurs in service delivery not only across, but within programs, and the generally limited resources of SMH programs to mount these kinds of studies. In essence, most SMH programs should be interested in evaluating the effectiveness of programs, not in evaluating the efficacy of particular treatments.

- In designing SMH programs, there is a need to analyze how the school-based program will affect the community. For example, a program could reduce school violence by expelling violent students, but this would likely cause problems in the community. In SMH evaluations, there needs to be attention to positive and potentially negative community impacts.

- If SMH programs strive to target "resilience factors," or variables that have been shown in the literature to promote positive psychosocial adjustment in youth under stress (e.g., family support, social skills, involvement in meaningful activities), the likelihood that these programs will show positive and meaningful impacts should be improved.

- There is a continuum of SMH programs in terms of their sophistication and resources available to them. "Cadillac" programs will have a much greater chance of documenting program benefits than smaller, more isolated programs. In essence, program planners should consider the "minimum threshold for evaluation" to avoid the worst case scenario of evaluating a small program, finding negative results, and then losing funding. Generally, the group recommended that comprehensive evaluations only be conducted for programs (i.e., not one part-time clinician in one school), that preferably have some institutional backing (e.g., from a university or community health/mental health agency).

- Evaluation should be tailored to the size and nature of the SMH program. Small programs should emphasize evaluation of the impacts for individual children, and should not undertake systems evaluations, as systems level changes will probably not be shown. Systems level evaluations should be limited to larger programs with more resources. Essentially, SMH programs should conduct a "self-evaluation process," to guide decisions about the appropriate evaluation strategy.

- One problem that has severely constrained SMH program evaluation has been the lack of funding to do this. Among participants, no one was aware of any SMH program receiving funding for evaluation. Clearly, such funding is needed to document program strengths and weaknesses. Lobbying efforts will be important to sell funders on the benefits of, and significant need for SMH program evaluation.

VIII. A Recommended Process for SMH Program Evaluation

A. CSMHA staff presented a proposal to the panel on a process for SMH program evaluation. The panel endorsed and fine-tuned this process, which follows:

1. Define the program (e.g., number of clinicians, funding, provided services).

2. Define stakeholders for the program and determin their interests and goals.

3. Develop program goals so that they reflect interests of stakeholders.

4. Develop a realistic evaluation plan, focusing on outcomes that are of interest to stakeholders, and that can be collected within the pragmatic constraints of the program.

5. Gain feedback from the stakeholders on the evaluation plan and modify the plan based on this feedback.

6. Implement the evaluation plan and monitor its implementation.

7. Organize program evaluation findings.

8. Present program evaluation findings to representative stakeholders for their feedback and input.

9. Modify and improve the program based on results of the evaluation.

B. To elaborate on such a plan with concrete examples, a subgroup of the panel agreed to develop an SMH program evaluation based on the Baltimore City experience. The goal is for this project to commence in the Fall of 1996, and to be finished in the Summer of 1997. This prototype SMH evaluation project will then be disseminated nationally in Year 3 of the CSMHA grant (beginning 10/1/97).

IX. Other Steps

In addition to the pilot SMH program evaluation project reviewed above, the CSMHA will be gathering and organizing resources on this topic. A number of participants from this meeting will assist in this process, as well as recruiting other knowledgeable people for assistance. The panel endorsed the notion of a Center developed manual for SMH program evaluation.

m.weist
8/5/96

We hope you found this to be a useful resource. There's more where this came from!

This packet has been specially prepared by our Clearinghouse. Other Introductory Packets and materials are available. Resources in the Clearinghouse are organized around the following categories.

CLEARINGHOUSE CATEGORIES

Systemic Concerns

- Policy issues related to mental health in schools
- Mechanisms and procedures for program/service coordination
  - Collaborative Teams
  - School-community service linkages
  - Cross disciplinary training and interprofessional education
- Comprehensive, integrated programmatic approaches (as contrasted with fragmented, categorical, specialist oriented services)
- Other System Topics: _____
- Issues related to working in rural, urban, and suburban areas
- Restructuring school support service
  - Systemic change strategies
  - Involving stakeholders in decisions
  - Staffing patterns
  - Financing
  - Evaluation, Quality Assurance
  - Legal Issues
- Professional standards

Programs and Process Concerns:

- Clustering activities into a cohesive, programmatic approach
  - Support for transitions
  - Mental health education to enhance healthy development & prevent problems
  - Parent/home involvement
  - Enhancing classrooms to reduce referrals (including prereferral interventions)
  - Use of volunteers/trainees
  - Outreach to community
  - Crisis response
  - Crisis and violence prevention (including safe schools)
- Staff capacity building & support
  - Cultural competence
  - Minimizing burnout
- Interventions for student and family assistance
  - Screening/Assessment
  - Enhancing triage & ref. processes
  - Least Intervention Needed
  - Short-term student counseling
  - Family counseling and support
  - Case monitoring/management
  - Confidentiality
  - Record keeping and reporting
  - School-based Clinics
- Other program and process concerns: _____

Psychosocial Problems

- Drug/alcoh. abuse
- Depression/suicide
- Grief
- Dropout prevention
- Learning Problems
- Pregnancy prevention/support
- Eating problems (anorexia, bulim.)
- Physical/Sexual Abuse
- Neglect
- Gangs
- Self-esteem
- Relationship problems
- Anxiety
- Disabilities
- Gender and sexuality
- Reactions to chronic illness

- School Adjustment (including newcomer acculturation)
- Other Psychosocial problems: _____

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