Healthy Minds, Healthy Learners, Healthy Schools
Final Project Report
September 30, 2009

1. Provide the status of project objectives/deliverables as described in corresponding Attachment of the Agreement.

The Executive Project Management Team, which meets monthly, and the Interdisciplinary Management Team, which meets quarterly, have continued to monitor the status of the Healthy Minds project and members provide ongoing feedback and ideas to improve project implementation. The Steering Committee met in September 2008 and January 2009. The Steering Committee meeting scheduled for April 2009 was cancelled due to time constraints of participating members, as well as the closing status of the project (no new implementation in planning). This group of cross-systems stakeholders from around the state assists the Healthy Minds project by disseminating outcomes information state-wide, connecting Healthy Minds to state initiatives and programs, and championing the cause of school mental health among key state leaders and policy makers. Of interest is the fact that members of the Steering Committee are interested in continuing to meet as a group in order to collaborate on the systemic issues that impact children’s health, well-being, and success. Thus, this project has met a need not currently being addressed through other inter-agency efforts.

Unintended Finding #1: This project highlighted a need for an interdisciplinary stakeholder group in Missouri, broad in scope and geographical representation, to coalesce and integrate the multiple initiatives and programs throughout the state that impact children’s health, well-being, and success.

In coordination with the efforts of the Missouri Student Success Network (MSSN), the consultation process has proven to be very successful. In September 2008 three school mental health consultants (advanced doctoral school psychology candidates) began working on a systematic approach to providing teachers with support for working with students exhibiting mental health concerns. The consultation process is primarily an indirect method of service delivery, and has the advantage of increasing teacher skills through a coaching model of professional development. Instead of whole-school professional development sessions, teachers receive the information they need “just in time” and are able to immediately apply new knowledge and skills within their classroom. In addition, skills learned to address problem behaviors can be generalized across groups of students. Finally, teachers are learning to distinguish between typical behavior problems and behavior problems associated with mental health issues, and are seeing how their role as the teacher can be critical to promoting mental health in all students. In January 2009 two additional consultants were added to the Moberly site in order to address the early childhood and the middle school expansion. Therefore, we had one part-time consultant in each building pre-K through grade 8 as a part of the Healthy Minds Initiative. Overall indicators of success include the following:

- CARE Teams (student support team or SST) in place at all Moberly elementary buildings
- CTs are meeting on a consistent basis
- CT members are actively participating
- Teachers report forms are not a problem to use
- Forms only take 15 minutes to complete
- Fewer referrals for special education evaluation reported
- Fewer referrals to community inter-agency team reported
- Process of referral to school psychologist and/or CT is working efficiently
- Strong central office administrative support for process
- Involving community agency supports at the CT level
- Seamless process for referral to special education for evaluation
• More accountability for teachers to ensure early intervention
• Teachers and CT members see as a valuable process

Specific early indicators of success in Moberly include a **dramatic decline in referrals for special education services** in the K-2 buildings (North Park and South Park). The consultation process allows teachers to access help early and ameliorate problems before students are referred to the Student Support Team (SST). MSSN has provided training and guidance so that once referred to the SST, interventions are implemented, documented, and evaluated in a repetitive cycle until the child’s needs are met or until a determination is made to refer to special education for evaluation. At both K-2 buildings in Moberly, the number of referrals in the 2008-2009 school year in comparison to the same time period in the 2007-2008 school year decreased by approximately 50%. (Gratz Brown’s referral rate increased by 6%, perhaps due to the large percent of teacher turnover between the two school years in comparison to the other buildings.) In addition, the SST at South Park received additional training to increase efficiency, and this building showed improvement in the number of referrals that resulted in a decision to evaluate for special education. [See Exhibits A1 and A2].

**Unintended Finding #2: Additional training with the SST (follow-ups or “booster” trainings) may reduce the number of inappropriate referrals that are made to the special education system, which presumably demonstrates an improvement in early identification intervention.**

New for Summer 2009 was the pilot implementation of the “Healthy Minds Transition Program” in Moberly, which involved consultants working with children transitioning into kindergarten who screened and intervened for both academic and social-emotional-behavioral difficulties. As this was not initially a planned feature of the project, Moberly Public Schools assisted with additional payments made to university consultants. Positive findings of the pilot suggest that providing a brief, systematic intervention prior to kindergarten entry is feasible, cost-effective, and important to establishing the foundation for school success (see Exhibit B).

**Unintended Finding #3: The use of teacher consultation, screening, and brief interventions prior to kindergarten entry may provide an exceptionally cost-effective and feasible means for schools to prevent long-term academic and social-emotional-behavioral difficulties that impede student success.**

Additional analysis comparing baseline data (2007-2008) to Time 1 data (2008-2009) indicate that the Healthy Minds approach is promising:

A. **Statistically significant increases were seen across schools in the measurement of teachers’ perceptions of collective efficacy, the school climate, students’ prosocial behaviors, available supports for students at-risk, parents’ support of education, and colleague support** (see Exhibit C).

B. On measures of parent perceptions, **there was a statistically significant increase in how parents view their child’s school experiences.** Sample questions in this factor include, “My child feels safe at school”, “My child is respected by adults at the school”, and “My child is respected by other students in the school.” Although no other statistically significant changes were found on the remaining parent factors, it should be noted that parents overall perceptions of the Moberly schools were high at baseline (see Exhibit D).

C. Analysis of the comprehensive student data collection proved to be more difficult. Data was analyzed according to cohorts: students were assigned codes and Grade 3 students were compared to themselves in Grade 4, while Grade 4 students were compared to themselves in Grade 5. This follow-along approach has strengths in terms of investigating the project impact on specific groups of students, but weaknesses in terms of developmental impacts as students age (e.g., less positive attitudes toward school). Also, follow-up studies cannot control for factors related to differences in teaching, curriculum, and classroom environments from year to year. Therefore, continued study of methodologies that might lead to a more sophisticated and targeted analysis is needed. For now, project evaluators examined the progress of students...
who were classified by self-report of their overall mental health functioning into low, average, and high functioning subgroups. Of most interest to project evaluators is the low functioning group, who potentially are in most need of interaction within the school mental health promotion system. For this group, the only statistically significant finding was in the area of office referrals, with a significant decrease in minor office referrals and total office referrals (minor and major), but no significant decrease in major office referrals (see Exhibit E). The results from the student data comparison (baseline to Time 1) raise more questions than are answered. For example, many research studies indicate that new initiative implementation, particularly when requiring system change as this project does, will not evidence changes or improvements for three to five years. It is possible that further follow-up would clarify whether or not the Healthy Minds project was a success. However, with the current evidence demonstrating a clear success in terms of the impact on student problem behaviors, it could be possible that such an intensive effort is not needed; perhaps a well-implemented system of positive behavioral supports is all that is needed. Only further study with more sophisticated methodology will answer important questions related to the effectiveness of school mental health promotion initiatives. Although during the three years of this project there has been an increase in the number of researchers who have been successful in developing investigative methods related evaluating such multifaceted initiatives, they comprise a relatively small group of experts and the literature base is still relatively small.

Unintended Finding #4: The task of evaluating comprehensive school mental health initiatives is enormously complex, and there is a need in the field for researchers to research evaluation methodology (as opposed to only researching project outcomes) and publish their results. Coinciding with this is the need for funders to allow evaluation costs that will extend project findings beyond “does it work?” to “how do we best prove what specific aspects of the project work/don’t work and why they work/don’t work?”

2. Describe any issues encountered with the project.

At the time of the last annual report (September 2008), we had identified an alternative urban pilot site (Hancock Place School District) because the previously identified Wellston School District proved to have too many barriers to implementation. Hancock Place is similar to Wellston in that it has many challenges due to the high number of students from lower socio-economic levels and the close proximity to the city core of St. Louis. The Healthy Minds project leadership has been engaging this school district in the initial phases of the implementation process. We have had limited success in Hancock Place, however, but the “starts and stops” we have experienced this year have provided invaluable lessons, most notably the following:

- **The importance of an “engagement phase,” as developed in Project Year 2, cannot be underestimated.** A period of time to establish trusting relationships prior to implementation is critical. Beginning a “partial” implementation with the thought of increasing the level of implementation over time does not work. School leaders need time to understand the implications of school mental health promotion efforts, to see the connections to student academic success, and utilize their new knowledge to generate self-commitment to leading such an effort. They can then create buy-in among staff, as well as lead the effort to map existing resources, look for gaps, and set goals so that all stakeholders have a clear idea of where the project is heading. Also, it is imperative that the school leader has time to lay the groundwork for integration of the project processes into existing school initiatives as well as into the existing school improvement processes. Embedded within the engagement phase, therefore, is a need for the establishment of clear indices of district, school, and even community “readiness.”

- **The “school fit” of a mental health consultant is key.** School mental health consultants, even if highly experienced in working with children who have mental health concerns, may not be effective in the school environment unless they are open to adapting to the culture of the school. Again, this process takes time, and the mental health consultant must make a significant effort to establish positive relationships with teachers and staff before student issues are addressed. If this immersion into the school culture doesn’t take place, then the
consultant is relegated to “putting out fires” and helping only a few students—s/he will not become part of the Healthy Minds process which depends on the close collaboration between school leaders, school-employed health and mental health professionals, and “outside” health and mental health professionals.

- A comprehensive model (promotion, prevention, early intervention, and treatment) will not be attainable unless considerable effort is made to develop the student support processes within schools (i.e., the SST). In addition, schools need to create partnerships with families and community members if they are to be successful in supporting the health and mental health needs of all students. Ideally, a district-level or community team will operate to provide assistance to the SSTs on difficult cases, as well as to wrestle with the systemic changes that need to take place so that a comprehensive array of services and supports can be implemented.

It should be noted that despite our difficulties in Hancock Place, the school leadership remains committed to the project. From January through July 2009, Project Director Karen Weston visited monthly to re-build relationships and assist the elementary school in correctly identifying needs and integrating mental health promotion into existing school initiatives (full engagement period). Hancock Place will receive additional support from MSSN for the development of their student support teams and associated processes in the 2009-2010 school year.

The only other setback during the project was in regard to the prevention/early intervention program, First Steps to Success, which was implemented in the initial pilot year in Moberly grades K-2. School counselors could not find time to implement the initial phase (about 15-20 minutes per day per child for the first 6 days). Although this evidence-based intervention is one that is thought to be “low-intensity” in terms of time, schools that are stretched for resources (and perhaps not using all resources effectively) may be unable to sustain even this small amount of required effort. As Healthy Minds project leadership is committed to a comprehensive framework that includes prevention and early intervention, we piloted the evidence-based “Good Behavior Game” (GBG) in Moberly grades K-5 in April 2009. This is a whole class intervention within which specific children or groups of children can be targeted. It is free (although curriculum can be purchased) and can fit easily into existing behavior support systems. The drawback is that this game primarily targets externalizing behaviors, leaving a clear need to develop processes for students who experience difficulties along the internalizing behavior continuum. This brief implementation was investigated for feasibility, so no data was collected in regard to student impact. Of the three buildings where GBG was voluntarily implemented by teachers (though all teachers received equal training), only one building was observed to have widespread implementation. Investigation revealed that in this building the principal expressed strong support for GBG and a strong desire to see all teachers implement their training. Thus, even when a “low-load intervention” (not time-consuming, not difficult to learn to implement, and not difficult to integrate into daily practice) was provided, teachers without overt principal support were not as likely to voluntarily implement the intervention. Further investigation is needed to delineate factors that contribute to “teacher readiness” for implementation of interventions. In addition, research is needed to examine approaches that can move teachers from seeing the need for mental health promotion but expecting others to do this job, to seeing the need and feeling confident that they can be effective mental health promotion agents in their own classrooms.

| Unintended Finding #5: Implementing a school mental health promotion initiative that is comprehensive (promotion, prevention, early intervention, treatment) is difficult when the majority of schools are struggling with an enormous number of children who exhibit serious mental health problems that impede social, behavioral, and academic success in school. |