

EXECUTIVE SUMMARY

Why was the Early Mental Health Initiative created?

In 1991, the California Legislature signed into law the School-Based Early Mental Health Intervention and Prevention Services for Children Act (Assembly Bill 1650, Chapter 757). This legislation was amended on two different occasions, first by Senate Bill 485, Chapter 722, Statutes of 1992, and later by Assembly Bill 442, Chapter 1161, Statutes of 2002.

The text of the law states: *"It is in California's best interest, both in economic and human terms, to identify and treat minor difficulties that our children are experiencing before those difficulties become major barriers to later success"* (Welfare and Institutions Code, Section 4371.e). This Act is better known as the Early Mental Health Initiative (EMHI). It is under EMHI that the California Department of Mental Health (CDMH) receives a state budget appropriation to award matching grants to county offices of education, school districts, and state special schools. These grants fund prevention and early intervention programs for students experiencing mild-to-moderate school adjustment difficulty. Services are provided to kindergarten through third grade students in California's publicly-funded elementary schools.

What kinds of programs and services does EMHI fund?

The programs funded by EMHI are required to provide short-term, 12-15 week, research-based prevention and early intervention services, which are designed to address the following goals:

- To enhance the social and emotional development of young students.
- To increase the likelihood that students experiencing mild-to-moderate school adjustment difficulty will succeed in school.
- To increase personal competencies related to life success.
- To minimize the need for more intensive and costly services as students grow older.

More specifically, grant funding is provided for three types of program models, as described below.

Primary Intervention Programs

The Primary Intervention Program (PIP) grants fund one-to-one services delivered by a carefully trained child aide under the close supervision of a credentialed school-based mental health professional to selected students using non-directive play sessions. Ideally, the PIP program model is designed to provide each participant with one 30-to-40-minute individual session per week over a 12-to-15 week period.

Other Model Programs

The Other Model grants fund direct services (other than PIP or in addition to PIP) which research has shown to be effective in meeting the key elements and overall goals of EMHI. Direct non-PIP services for Other Model programs are typically delivered in a small group format (generally two to four students) for a short, specified amount of time (usually once a week for 12-to-15 weeks). Services to small groups may use curricula to address social skills, anger management, friendship groups, or topic-specific issues such as bullying or divorce. Some Other Model programs also provide individual services using the PIP model as a second form of direct service. These programs are called Other Model with PIP.

Enhancement Programs

The EMHI Enhancement grants fund programs that include indirect support service components such as parent services, teacher in-services, classroom curricula, or other supportive activities designed to complement grant- or locally-funded direct services. Programs that provide indirect services in support of a PIP direct service model are classified as Enhanced PIP. Programs that offer indirect services in support of direct services other than PIP are classified as Enhanced Other Model. Lastly, some enhancement programs include PIP in addition to a second type of direct service. These programs are classified as Enhanced Other Model with PIP.

How are students selected to receive EMHI-funded services?

The use of a systematic process to select students who are most likely to benefit from program intervention is a requirement for all EMHI-funded programs. The Walker Survey Instrument (WSI) is a 19-item survey that is used as an aid in the student selection process. The use of this instrument is required at first grade, and is optional for use in kindergarten and grades two and three. Teachers complete the WSI for all students in their classrooms shortly after the start of the school year (mid-year for kindergartners) and the findings are considered, along with other risk factors, in determining which students would benefit most from entering the program. The teachers, parents, and/or school staff may also refer students based on an assortment of reasons including situational stressors not necessarily measured by the WSI (e.g., change of school or grief or divorce issues affecting the child). School-based mental health professionals work with school administrators, teachers, and/or others with first-hand knowledge of students and their social competence and school adjustment issues to make the final selection decisions. Past experience has shown that students with mild-to-moderate school adjustment difficulty respond well to the types of interventions funded by EMHI.

The analysis of the 2007/08 WSI data confirmed that local programs were successful in selecting students who were experiencing appropriate levels of school adjustment difficulty. The overall average WSI score for participants was within the 10th-to-25th percentile range that EMHI uses to define their target population (i.e., students experiencing "mild-to-moderate" levels of school adjustment difficulty). The fact that WSI data were submitted for 82 percent of the participants signifies that systematic selection processes were used to select students to receive services.

Do participating students show improvements in social competence and school adjustment outcomes as a result of EMHI-funded services?

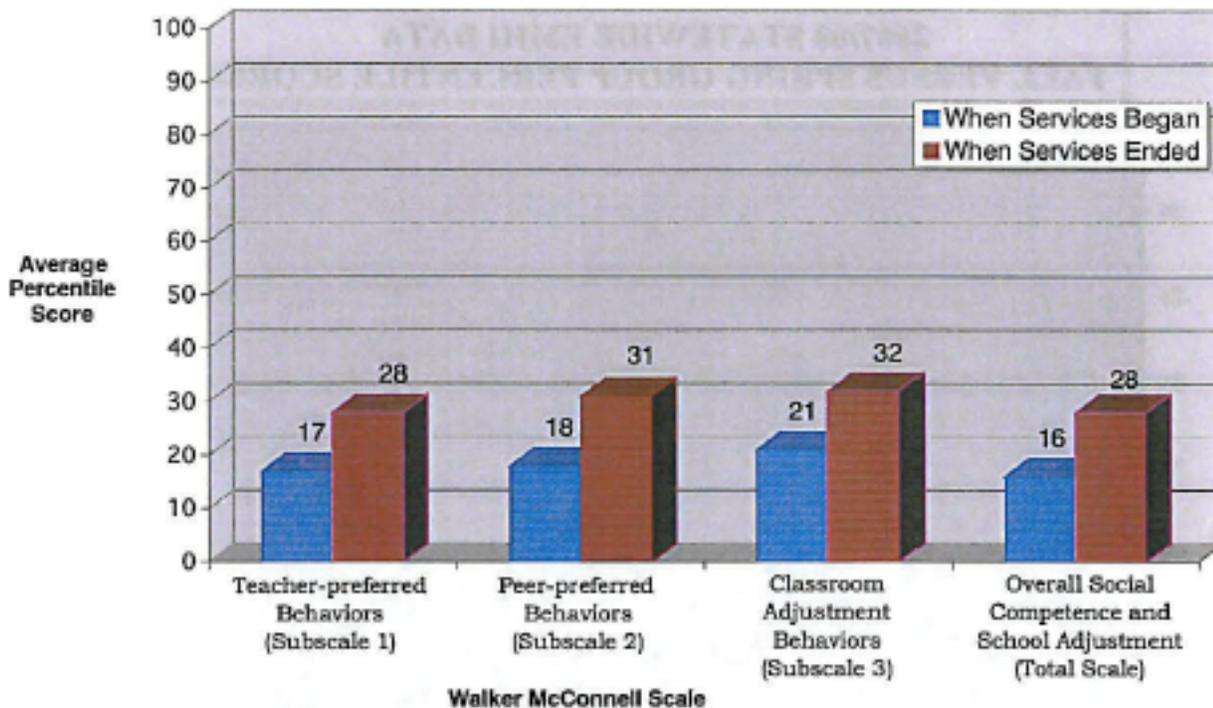
The evaluation findings provide credible evidence through several different analytical approaches that participating students made meaningful improvements in social competence and school adjustment-related behaviors, and that these improvements were directly attributable to participation in EMHI -funded services.

Classroom teachers complete the 43-item Walker-McConnell Scale of Social Competence and School Adjustment (WMS) for each student participating in the program both before and after the provision of EMHI services. The instrument contains three subscales, each of which offers insight into different student behaviors. The three subscales are *Teacher-preferred Social Behavior*, *Peer-preferred Social Behavior*, and *Classroom Adjustment Behavior*. One of the strengths of this standardized instrument is that the items ask about the frequency with which students exhibit positive, observable behaviors. Teachers only have to rate how frequently certain behaviors occur; they are not asked to judge the student or make assessments about students' inner thoughts, self-esteem, self-concept, or other

esoteric characteristics. The structure of the instrument is such that there will be no change in scale scores over time, unless due to changes in child behavior.

Several evaluation design strategies have been incorporated in the analyses to determine whether positive changes in these scores can confidently be attributed to the intervention and not to other factors. The first analysis presented is for pre-and post-participation differences in the WMS total and subscale scores, providing a measurement of the impact of EMHI-funded services on student behaviors over the period of time the intervention was delivered.

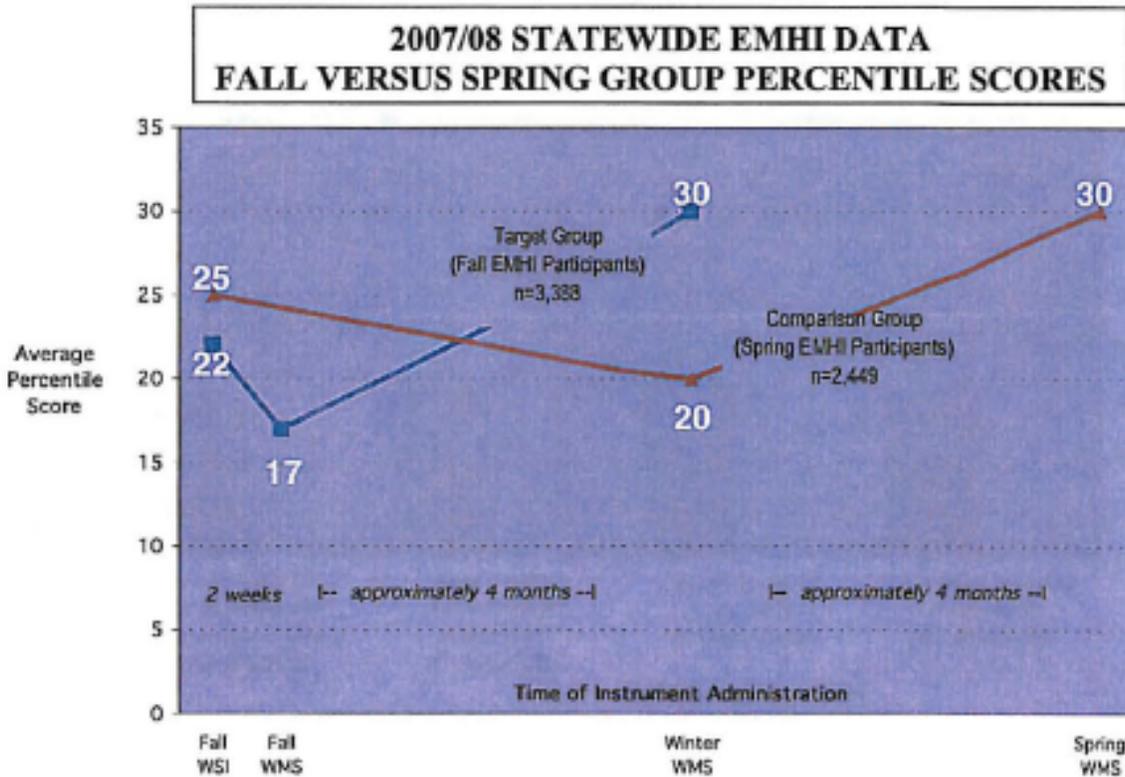
PARTICIPANT PRE-POST WMS SUBSCALE AND TOTAL SCALE SCORES



The evaluation found that participants experienced an average gain of 12 percentile points on the WMS total scale, a dramatic improvement of social and behavioral school adjustment-related behaviors. The corresponding statistical effect size of .59 represents a moderately large magnitude of change, especially considering the relatively short-term nature of the intervention. Participants also made similar improvements on all three WMS sub-scales. They improved an average of 13 percentile points on the Peer-preferred Social Behaviors subscale, which measures social behaviors that are highly valued by peers in terms of peer dynamics and social relations in free-play settings. Participants improved an average of 11 percentile points on the Teacher-preferred Social Behaviors subscale, which measures social behaviors that are highly valued by teachers during non-instructional interactions with students, such as sensitivity, empathy, cooperation, self-control, and social maturity. The third sub-scale measures Classroom Adjustment Behaviors, which are adaptive social-behavioral competencies that are highly valued by teachers in classroom instructional contexts, such as student study habits, listening skills, participation, responsiveness, and quality of work. These scores increased an average of 11 percentile points.

An additional analysis compared changes in school-adjustment behaviors of EMHI participants (target group) to a similar comparison group of students who did not receive EMHI services, and is

summarized in the chart below'. The comparison group was selected using the same approach as that for the target group, so these were similarly "at-risk" children. Target participants received EMHI services in the fall of 2007, shown in the chart below by the blue line. The measured improvements for the target group were large and statistically significant, while the comparison group (red line) experienced a modest decline during this same time period. The Comparison group then received EMHI services in spring 2008, and during that time made WMS gains that were very similar to those of the target group. This analysis strongly supports the conclusion that participation in EMHI -funded services improves social behavior and school adjustment-related behavior.



These positive findings were also corroborated by information from the Participant Data Instrument (PDI). The PDI is completed at program exit by program staff for each participant. This form documents demographic information, service participation (types, frequency, and duration), and exit ratings. School-based mental health professionals use this instrument to rate participants on a variety of school adjustment characteristics using a scale much different from the WMS. Analyses of these ratings revealed that most participants improved in various school adjustment-related skill areas during the period of time they received EMHI-funded services. Of participants experiencing problems with school attendance or discipline at the start of the program, attendance improved for 56 percent and school discipline improved for 68 percent over the course of the intervention. School-based mental health professionals also indicated that referrals for other services at program exit were needed for only five percent of the participants.

Do participants maintain these improvements over longer periods?

An analysis of the longitudinal evaluation data found that participants maintained improvements in social competence and school adjustment one year following the year that they received EMHI-funded services. The average score for students who did not receive EMHI services remained about the same during this same period. This evidence of longer-term program impact and maintenance of outcomes should be considered as strong support for continued or expanded funding for EMHI.

How many students were served and what are their demographic characteristics?

Complete evaluation data sets (pre-WMS, post-WMS, and PDI) were available for 16,386 participants, or 96 percent of all participants. Students were located in 432 elementary schools across 71 school districts. The following trends were apparent based on the demographic variables that were collected for participants using the PDI.

Gender

Male students were more likely to have received EMHI services than female students (60 percent versus 40 percent, respectively). This matches the gender proportions scoring in the mild-to-moderate range on the WSI. It was found that female participants showed slightly larger improvements than male participants, particularly on the Peer-preferred Social Behavior and Classroom Adjustment subscales.

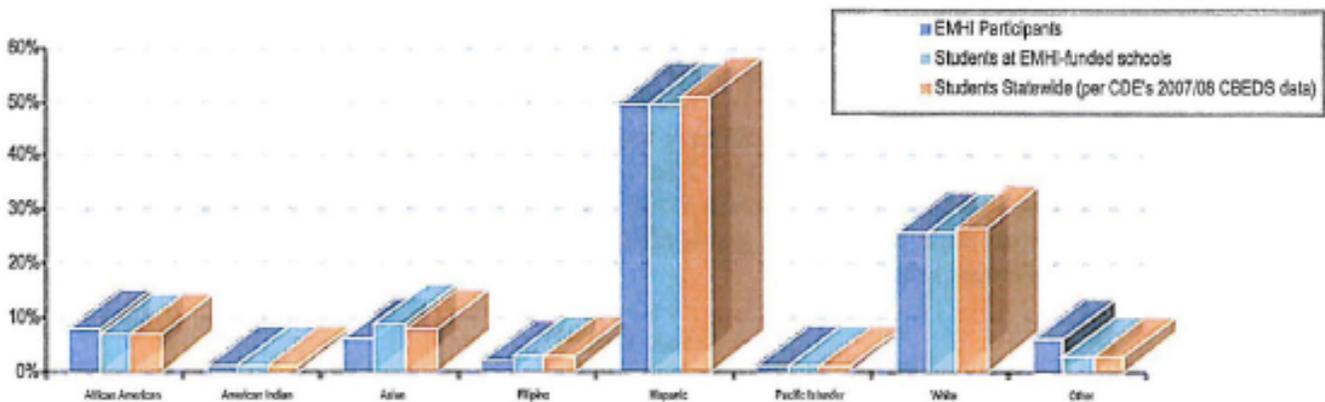
Grade Level

EMHI-funded programs served a higher percentage of first grade students (31 percent) compared to the percentages of kindergarten, second, and third graders (18, 26, and 25 percent respectively). Considering that kindergartners only receive services during the second half of the school year and the high percentage of 1st graders served, EMHI -funded programs appeared to target service to students early in their school experience. Outcome data also revealed that kindergarten and first grade students experienced slightly larger improvements than the older students.

Ethnicity

The ethnicity of participants in EMHI -funded programs resembled the California school population in general, and the ethnic distribution at EMHI-funded school sites in particular. Of the students served, eight percent were African American, six percent were Asian, two percent were Filipino, 50 percent were Hispanic, 26 percent were White, six percent selected the "Other" category, and the categories of American Indian! Alaskan and Pacific Islander comprised one percent or less. Differences in the levels of improvement in social competence and school adjustment-related behavior were fairly consistent across ethnic groups.

**BREAKOUT OF ETHNICITY
BY EMHI PARTICIPANTS, EMHI-FUNDED SCHOOLS
AND STATEWIDE SCHOOLS**



Risk Factors

Data regarding several risk factors were also collected and used in the evaluation, including mobility, socio-economic status, out-of-home status, and grade level retention.

Mobility: A total of 28 percent of participants had experienced at least one school transfer since starting kindergarten. The EMHI-funded services had an equally positive impact on students who had transferred schools and on those that had transferred even more frequently.

Socio-Economic Status: Participating schools were classified into one of the four statewide quartile groups based on the percentage of students receiving free and/or reduced meals. The distribution of schools with EMHI -funded services was very similar to the distribution of schools statewide. The student outcomes were consistent regardless of socioeconomic status

Out-of-Home Status: Four percent of the participants were not living with one or more biological and adoptive parent. As a group, these students experienced improvements in social competence and school adjustment-related behaviors that were similar to students that live with their parents.

Grade Level Retention: Seven percent of the participants had been retained at grade level at least once since starting kindergarten. Although their average pre-and post-WMS scores were lower than students who had not been retained, the size of their improvement from pre to post on the WMS was greater. That is, while they represented a group with more severe social and school adjustment issues at pre-assessment, they experienced more growth due to the program than did those students who had not been retained.

How did outcomes differ by program type?

The three EMHI program models described earlier are comprised of either individual or group services, or a combination of both. On average, participants who received individual services completed 11 sessions, which lasted an average of 30 minutes each. Participants who received group services completed an average of 11, 36-minute, sessions. Sixty-eight percent of the participants received individual services and 39 percent received group services. These services total more than 100% because nearly seven percent of the participants received both types of services and therefore are counted in both categories.

Participant outcomes were virtually identical across the three EMHI program models. This is a key finding, because the three different program models have evolved to help match the particular needs of local schools. These findings demonstrate that schools can select the program model that best fits their needs with the confidence that all three provide similar, positive outcomes for their children.

However, the amount of service received by students was key: the evaluation data revealed that 12-to-15 individual and/or group sessions was the ideal level of service relative to positive outcomes. These EMHI-funded services filled a void by providing support to many students experiencing school adjustment difficulty; especially considering only five percent of the students received counseling services during program participation.

What conclusions can be drawn from the evaluation data?

The pre-to-post WMS changes for all scales were statistically significant and represented a moderately large magnitude of improvement in functioning in response to this relatively short-term, school-based intervention service. Overall the 2007/08 statewide program evaluation found that 77% of the students participating in EMHI-funded services exhibited positive social competence and school adjustment behaviors more frequently after completing services. This included social behaviors that were highly valued by peers, such as a desire to help others, ability to make friends, leadership, perceptiveness, communications, and sharing with others. Participants also demonstrated positive social behaviors that were highly valued by teachers during non-instructional interactions on a more frequent basis. Examples of these behaviors included sensitivity, empathy, cooperation, self-control, and social maturity.

Substantial improvements were also found in social-behavioral competencies that were highly valued by teachers in classroom instructional contexts. These behaviors included student study habits, listening skills, participation, responsiveness, and quality of work. Improvements in these areas should translate into better academic performance, given the importance of social interactions in the school setting, particularly in regards to improved functioning in the classroom during instructional activities.

Additional analyses document that EMHI-funded services were directly responsible for these improvements in social competence and school adjustment-related behaviors among participants, and that those improvements were maintained one year following the intervention. These evaluation data provide substantial and justifiable evidence that EMHI-funded services help many thousands of students exhibit positive behaviors more frequently at school and in the classroom.

The evaluation reveals an unmet demand for EMHI-funded services at participating school sites. Only 38 percent of the students that scored in the mild-to-moderate school adjustment difficulty range were selected for EMHI-funded services during FY 2007/08 due to program capacity and funding constraints. In addition and more importantly, only about eight percent of the elementary schools in California receive EMHI funding. Since EMHI-funded school sites appear to be representative of all

public elementary schools in California in terms of free and reduced meal program participation rates and ethnicity, similar positive results would be expected at schools not currently receiving EMHI grants.

Does the program meet legislative requirements?

The authorizing Legislation that created the EMHI program requires the reporting of the number of eligible pupils served by the program. Reports provided to DMH by the individual grantees indicate that 16,506 students were served in the 2007-2008 school year. The legislation also specified the circumstances under which the program would be "deemed successful." The criterion for success was that " ... at least 75 percent of the children who complete the program [will] show an improvement in at least one of the four following areas: learning behaviors, attendance, school adjustment, (or) school-related competencies." The WMS addresses both of the last two areas on this list, and the evaluation has shown that 77 percent of students made improvements on the scale. It can therefore be concluded that the EMHI program has met legislative requirements.