**Friendship Edison Public Charter Schools
and
Center for Student Support Services
Washington, DC**

Elementary and Secondary School Counseling Program

YEAR II ANNUAL REPORT
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The Friendship Edison Public Charter School (FEPCS)-*Elementary and Secondary School Counseling Program* System is in the second year of a three-year grant from the Department of Education. The Counseling Program, implemented in three DC Public Charter Elementary Schools (Friendship Edison PCS-Woodridge Campus; Capital City PCS, and Ideal Academy PCS), was designed to enable educational agencies and communities to establish and/or expand counseling programs in schools with students deemed at risk for poor social and academic achievement. As part of the Safe and Drug Free Schools program, the program is part of a larger initiative within the Federal Government to support violence and substance abuse prevention activities that promote the health and well-being of all students.

The goals of the FEPCS Counseling Grant program are to: 1) identify children early who may need special education or pull-out programs; and 2) develop individual, classroom-based and family involvement interventions that meet student needs. These goals are accomplished through implementation of prevention and early intervention programs that promote effective counseling practices, foster and expand in-service training and skills development, and encourage greater parent and community involvement in school support services. In order to address these key elements, Friendship Edison Charter Schools subcontracted with the Center for Student Support Services (CSSS) to support the implementation and management of the Elementary and Secondary School Counseling Grant program. CSSS is a non-profit organization dedicated to providing charter schools in Washington DC with linkages to community-based organizations that can provide wrap-around services to students and families and promote better overall functioning.

The purpose of this report is to highlight program achievements during Year II of the Counseling Grant program and to make recommendations for Year III.

History and Background

The Counseling Grant Program is, in large part, an extension of the experiences gained by the DC Public Charter Schools and CSSS through the Safe Schools/Healthy Students (SS/HS) Initiative, and more recently the Building Mentally Healthy Communities (BMHC) project. The need for the project was evident in evaluation findings from these earlier projects, which detailed the severity of risk factors present in the DC Charter School student population and the trend for resiliency to decrease and for risk factors to increase with age. California Healthy Kids Survey (CHKS) results revealed that alcohol is indeed a gateway drug, its use expanding during middle school to include cigarettes and marijuana, with overall ATOD use peaking in high school. With 25% of charter school elementary, 21% of middle, and 52% of high school students reporting alcohol use and research findings correlating such usage with other illicit drug use, the significance of the current ATOD problem cannot be understated. These results were aligned with national findings on the 2002 National Survey on Drug Use and Health, sponsored by SAMHSA, which found that illicit drug use among youth tends to increase with age, with 12% of youth ages 12-17 reporting current drug use. SAMHSA results also indicated that illicit drug use in middle and high school-aged youth is approximately eight times higher among those who smoke cigarettes and 12 times higher in those who drink alcohol.

The prevalence of violent behaviors, particularly bullying, is a growing concern across the nation. Research has shown that bullying not only foreshadows crime and violence in the perpetrator, but can also produce depression, loneliness, and suicidal ideation, as well as aggression and violence, in its victims. CHKS results confirmed the extent of the problem in the DC Public Charter Schools surveyed. Over 50% of charter school elementary students reported being victims of bullying behavior. While bullying and harassment are significant issues for elementary students, such aggressive behavior manifests itself with more intensity as students enter adolescence, where approximately 50% of middle school and 33% of high school students report participating in physical fighting, and as many as 18% of middle school and 15% of high school students report carrying knives to school. Additionally, at the high school level, forced sex was reported by 15% of students. The predicted pattern of aggressive behavior appears to be substantiated by CHKS results as bullying behaviors demonstrated by students in elementary school escalate to physical fighting in middle school, and weapons and sexual coercion in high school.

Of even greater importance are the CHKS results that revealed mental health as an area warranting attention in implementing early intervention services. The SS/HS study found that 26% of middle school and 33% of high school students have experienced feelings of depression, and that 11% of middle school and 13% of high school students have, in fact, attempted suicide. On a positive note, results also confirmed the higher level of resiliency and the permeability of elementary school age children to prevention. For example, approximately 90% of elementary students perceive ATOD use as detrimental to a person's health and demonstrate adequate to high resiliency skills. For this reason, the Counseling Program focused on three public charter elementary schools that have comparable high-risk student populations, but had no prevention or early intervention mental health services.

Program Description

The project design of the Counseling Program was largely based on the expanded mental health model used in the DC Charter Schools' Safe Schools/Healthy Students (SS/HS) initiative. Developed in collaboration with Dr. Olga Acosta of the DC Department of Mental Health, this model represents an integration of the Adelman and Taylor *School-based Mental Health Center* framework (1998), with Weist's *Expanded School Mental Health (ESMH)* (2001). Model components include Early Intervention Teams (EIT) for early identification and referrals for comprehensive services, school-wide and classroom-based prevention activities and programming, early intervention mental health counseling, and staff training and technical assistance. Particular emphasis is placed on building a sustainable mental health services infrastructure.

As part of the grant, a clinician is placed in each school. His/her role is to provide direct services to individual students, classrooms, school, teachers, and families; and to develop school-wide infrastructure through the development of procedures, protocols, data collection, training, and referral linkages. Direct services are comprised of both Primary and Secondary Prevention activities as described below.

Primary Prevention

At each school, one of the primary roles of the Mental Health Clinician is to take the lead in building a school climate conducive to reinforcing students' mentally healthy behaviors and resiliency skills. By conducting classroom and school-wide activities, as well as consulting regularly with teachers, clinicians can access the entire student population both directly and indirectly. They use this opportunity to introduce important social and emotional topics to students through engaging activities and materials. Primary prevention activities target broad topics, such as cultural diversity, peer relationships and safety, as well as specific issues, such as manners, following rules, and managing emotions. Such activities are designed to promote positive behaviors, increase resiliency, and reduce the risk of mental health problems among the entire student population. Primary prevention activities are conducted as often as needed, reflecting sensitivity to individual school needs, as well as specific grade level needs.

In serving as a resource for teachers, clinicians also hold training workshops designed to help teachers develop strategies for behavior management, understand child development, and identify student behaviors that may signal more serious mental health concerns. Clinicians also extend their expertise to parents through parent education workshops, as well as individual consultation.

Secondary Prevention and Early Intervention Activities

Students who are identified as "at-risk" and in need of more intensive mental health support are able to access services at varying levels and intensities. Based on recommendations from the Early Intervention Team (*see below*), students are enrolled in topical support groups with students with similar issues (i.e., grief/loss, anger management, etc.), or individual, family, or group counseling sessions. The level, intensity, and course of treatment is guided by the results of assessments conducted by the clinicians; students with the most severe problems receive clinical services and/or referrals to community mental health agencies. Ongoing consultation with classroom teachers ensures coordination of intervention strategies in the school setting, while regular contact with parents engages them in the treatment process.

The Early Intervention Team (EIT) plays a pivotal role in ensuring that individual students who are referred for discussion are given appropriate interdisciplinary interventions. If efforts by the classroom teacher to meet a specific student's needs are insufficient following consultation with grade level colleagues, the student is referred to the EIT for discussion. Members of the team are charged with reviewing referrals and developing intervention plans for students identified as at-risk for poor social and academic outcomes. These plans are tailored to each student and are intended to coordinate mental health services with existing programming and resources in the schools, at home, and in the community. While open to all students in the schools, particular interest is directed toward reducing the number of unnecessary referrals for special education services, while ensuring special education students receive appropriate early supports if needed. The EIT is composed of various professionals whose expertise is used in constructing appropriate intervention plans. Recommended membership includes the schools' Principal (or designee), general and special education teachers, the school counselor, and mental health clinician, as well as parents of referred students. Student progress is monitored and discussed at follow-up meetings.

While reduced federal funding made it impossible to hire a Parent Community Involvement Coordinator under the Counseling Grant, the school-based clinicians make every effort to link students and families in need to existing community supports. Such referrals help ensure that efforts achieved through mental health services in the schools are sustained through a variety of outside means.

METHOD

The overarching goal of the Counseling Grant program is to build resiliency and reduce risk among the children and youth attending the three participating schools through prevention and early intervention mental health activities. Program objectives focus on improving youth social/behavioral and academic skills; increasing healthy behaviors; and improving teachers' knowledge and skill in developing social-emotional competency in students. To clearly link program components and activities to anticipated intermediate and long-term outcomes, a logic model was developed, which provides a useful framework for conceptualizing the program model and evaluation. *(See Appendix A – CSSS Counseling Grant Logic Model/Assessment Plan)*.

The evaluation plan developed for the Counseling Grant program addresses the impact of mental health services and activities on student well-being and school climate primarily through the collection and analysis of baseline data on youth risk and resiliency and the documentation of program implementation. To accomplish this, the plan consists of three discrete evaluation components. *Process Evaluation* documents the evolution and implementation of the program in order to provide feedback to administrators, to interpret mediating influences on outcomes, and for program replication. Support of the process evaluation includes quantitative data on participant referrals, service utilization, staffing, and administration of program components. If permissible, youth and family demographics are gathered from school and program records as supporting documentation. This data is complemented by qualitative data methodology, including program observations, collection and review of relevant program documents and surveys completed by program participants, students, and staff.

While *Process Evaluation* examines and assesses program implementation, *Outcome Evaluation* examines the impact and the effectiveness of program activities on participants and progress towards meeting stated goals and objectives. Data on the California Healthy Kids Survey (CHKS) is used to measure school-wide outcomes and impact of services, while SAT-9 scores provide an additional index of school functioning. Over the course of the three-year grant, CHKS and academic data will be compared across program years to assess and document rate of change across key variables.

Lastly, *Informal Feedback* is provided on an ongoing basis through regular meetings with CSSS leadership and direct service staff. Structured interviews and administration of the CHKS provide an opportunity to assess school climate and discuss program function, which are critical perspectives to have when working with staff on the evolution of the program and the evaluation.

The intended methodology represents a comprehensive evaluation, which can most effectively link program activities to specific outcomes, while providing sufficient detail for replication.

Goals and Objectives

The primary goal of the Counseling Grant program is to develop sustainable mental health prevention and early intervention services for schools serving predominantly low-income, at-risk children so as to minimize the need for special education and pull-out programming while building social and emotional resiliency. Objectives supporting this primary goal reflect multiple levels (i.e., student, teachers, family, and school) and a variety of domains (i.e., social, academic, programmatic). Program objectives include:

I.   Improving social and behavioral skills
II.   Increasing the use of healthy behaviors
III.   Improving academic performance
IV.   Increasing teachers' knowledge of mental health issues
V.   Creating a lasting infrastructure for mental health and student support services

Although an additional objective in the grant proposal, *"To Improve Parental Involvement,"* was eliminated due to funding reductions, the program remained committed to its holistic approach by offering family counseling and workshops.

Data Sources and Types

Government Performance and Results Act (GPRA) core client outcomes are assessed using standardized measures of both social/ behavioral and academic change. School-wide Stanford Achievement Test (SAT-9*)* and California Healthy Kids Survey (CHKS) scores are collected for this purpose. Additionally, improvements in student behavior are measured by school attendance and behavioral incidents collected at the conclusion of the school year. Data sources include:

1) *School records and reports*: Project and evaluation staff collect aggregated school and student information, including school-wide performance ratings on the SAT-9. Information collected from participating schools will be organized under the following broad categories: student demographics, academics, attendance, and behavior incidences.
2) *Service provider notes and records*: In accordance with professional standards and ethics, project staff will collect and maintain reports, records, and notes of contacts and services provided to students, teachers, and other agencies or institutions in the course of service provision (i.e. mental health monthly status reports).
3) *School and Program Staff Surveys*: A sampling of staff, parents and students will complete project developed questionnaires and/or structured interviews.
4) *Standardized measures*: School-wide data on the Stanford Achievement Test-9th Edition and CHKS data on students in Grades 3-5 will be collected annually.

Stanford-9 Achievement Test Series, Ninth Edition (SAT-9*)* is the newest edition of the standardized and nationally recognized achievement test. Based on state curricula and national standards, the test uses grade-appropriate, relevant content, designed by experienced teachers and content experts. Mathematics items concentrate on developing mathematical power, while reading selections are written and illustrated by well-known authors and illustrators of children's literature. Grade levels, standard scores, percentiles, and NCE scores are provided.

The California Healthy Kids Survey (CHKS), normed for use with 3rd - 12th graders, is a survey of student risk behaviors, as well as youth assets and resilience traits that have been found to prevent such involvement and promote success. The survey addresses ATOD use, violence and safety, mental and physical health, and external/internal resilience. Collection of CHKS data across program years helps identify changes in youth risk and resiliency over the course of the program. Select grades will be tracked enabling cohort effects to be examined between program years.

Procedure

In May 2004, the California Healthy Kids Survey (CHKS) was administered to 264 third, fourth, and fifth grade students at Ideal Academy, Capital City Public Charter School, and the Woodridge Campus of Friendship-Edison Public Charter Schools, who participated in the National Counseling Grant initiative during the 2003-04 school year. To prepare for the administration, evaluators met with project staff, coordinated test schedules with the schools, ordered materials, and prepared test packets for students, proctors, and classroom teachers. The surveys were administered in classrooms and took approximately 45 minutes. Students were informed that the survey is confidential, and were asked not to write their names on their answer sheets. No one but the respondent should know what responses are given. Students were also told that there are no right or wrong answers to the survey questions; the best answer is the one that is 'truest' for the individual student. Students followed along in their Survey question booklets as questions were read aloud by proctors and they recorded their answers on "scantron" (bubble format) answer sheets. Most questions allow a choice of 3-4 scaled answers; for example, A) *No, never,* B) *Yes, some of the time,* C) *Yes, most of the time,* or D) *Yes, all of the time.* Quality assurance was conducted on all scantrons before sending them to the publisher for scoring. Once the datasets and technical reports were received from the publisher, evaluators conducted independent analyses of the data and produced a comprehensive report on the findings, as well as separate brief reports for each school.

In addition to the administration of the CHKS surveys, evaluators attended several weekly clinical meetings and discussed program implementation issues. At the conclusion of Year I, evaluators also conducted interviews with the clinicians and the project director, collected staff surveys, compiled school-wide demographics, behavior and SAT-9 data on each school, and collected program staff service records. Due to scheduling conflicts, no formal observations were completed this past school year.

Program Implementation

Year II of the Counseling Grant project witnessed growth and development of the program in all three participating elementary schools. Clinicians expanded individual and group-based mental health service opportunities, introduced additional evidence-based programs (i.e., PATHS) into student activities, and developed classroom presentations that specifically addressed student and teacher needs. Needs assessments and interviews conducted with project staff in Year I revealed students to be in need of social skill development, anger management, and grief and loss coping strategies. Prevention activities implemented in Year II continued to build on these themes, with clinicians designing and implementing classroom-based activities that build interpersonal skills and explore effective means of conflict resolution. Smaller group sessions remained focused on grief and loss and personal aspects of building friendships, but grew to include self-image and team-building. Also in Year II, clinicians advanced school collaborative efforts and developed and implemented new parent and teacher trainings and workshops to broaden the reach and scope of the initiative. Early Intervention Teams (EIT) flourished and partnerships were established with local agencies and universities, while teacher workshop topics ranged from tips for test administration to proper identification and reporting of child abuse. Parent involvement was evident in their attendance at workshops and school health fairs.

The growth and diversity of programming helped promote the viability and visibility of the project in Year II. While overall efforts of project staff continued to focus on implementation of mental health service provision and prevention programming in the schools, discrete activities and focus of services varied greatly in response to differing school needs, attitudes about mental health programming, and perspectives on school culture. Implementation profiles were created to capture these differences and highlight the successes attained by project staff in tailoring quality services to respond to unique school climates and settings.

Implementation Profiles

Capital City. The Capital City Public Charter School is located in the Northwest quadrant of Washington, DC and serves children from pre-kindergarten through eighth grade. Capital City opened its doors in 2000 with a mission "to enable a diverse group of children to meet high expectations, develop creativity, critical thinking, and problem-solving skills, and achieve deep understanding of complex subjects, while acquiring a love of learning and a strong sense of community and character." Compared to the other participating schools, the student body at Capital City is a more representative blend of African-American (46%), Hispanic (23%) and Caucasian (26%) students. Many (54%) are considered low-income and qualify for the federal Free and Reduced Meals (FARM) program. Moreover, 8% have limited English proficiency (LEP). Capital City maintains a small student-teacher ratio (9:1). Like Ideal and Woodridge, students at Capital City have shown significant improvements in their Standford-9 (SAT-9) test scores. Specifically, students at Capital City increased the school's overall reading performance

rating by 3.6 points and math performance rating by 9.2 points in 2003. These accomplishments are significant; as noted in the DC Public Charter School Board's 2002-2003 School Performance Report, Capital City was the only charter school to achieve all six measures related to academic progress and excellence on the SAT-9. Enrollment during the 2003-2004 academic year included 227 students. This is especially remarkable as the school is located in an area identified by the DC Department of Mental Health as being a "hot spot" high crime area in the city.

Mental health services and programming grew substantially at Capital City during Year II of the project as evidenced by development of new support groups and growth of the Early Intervention Team (EIT). Specifically, the clinician was able to use his role in the school in a proactive way to address institutional barriers by implementing evidence-based programming (e.g., PATHS social skills training to 3rd and 4th grade students in Year II; 1-2-3 Magic! for teachers and parents in English and Spanish) and instituting anger management sessions with all upper elementary students. The result was an increased understanding on the part of school administrators of the purpose and potential of the project. In addition to these enhancements and the provision of individual and family therapy, mental health services were optimized by the development of multiple support groups for students and adults including:

Girl Power – Starting as a support group for girls with single parents, *Girl Power* grew over the course of the year to include almost all 3rd and 4th grade girls. It has since become an empowerment group for attendees and serves as a forum in which to discuss and strategize ways to effect personal change. A highlight of the group this year was a successful bargaining for a more equitable distribution of lunch items. Lacking space and equipment, the school lunch is catered everyday at Capital City. With the upper grade students eating first, however, not all lunch items were available for the 3rd and 4th grade students. With the clinician's guidance and Martin Luther King, Jr. as inspiration, the members solicited suggestions and feedback from teachers and the upper grade students on ways to make lunch distribution more equitable for all. In doing so, the group members achieved change in the lunch procedures, and learned the value of assertiveness and collaboration.

Good Sports Club – The *Good Sports Club* is timed to coincide with other after-school club activities. Through games, the club teaches impulse control and sportsmanship to younger students. Team work and dealing with failure are highlighted. Each week, a proud participant is awarded a "Good Sport" certificate for showing improvement in these areas. This group was so popular among the students that the clinician agreed to double the number of children allowed to participate, and created a role for older students to participate as leaders.

All Smiles Group – This energetic group certainly earned its name. The students participating have all been identified as having impulse control difficulties and smiled throughout. Based largely on needs expressed by teachers for better classroom behavior, this group focused weekly on building better self control within the students.

Social Skills Group (6th grade): This ongoing therapy group of 6th graders has proven to be invaluable to the social integration and self-esteem of its members. The students participating in this group began the school year socially isolated from their classmates and polarized from

each other. Through the year, they have developed their social skill repertoires, they have learned to accept each other, and through their acceptance of each other, they have learned to better accept themselves.

Anger Management (3/4th grade) - This group began at the request of teachers who had identified students that had difficulty expressing their anger appropriately. Although this population often resists becoming invested in the process of mental health services, it became so popular that numerous other students requested to be a part of it. The participants of this group learned Cognitive-Behavioral techniques to identify their escalating anger and how to manage it more effectively. This lively group used many real life classroom examples to rehearse techniques learned.

Anger Management / Social Skills (6th grade) - Decreasing volatility among the 6th grade population became a priority during this school year. Children in this age group are extremely concerned with their social status and how they are viewed by their peers. Unfortunately, the 6th grade student population, as a whole, used negative techniques to increase their status within the group. Daily, students were angered by other students using "put downs" and threats. However, through participation in this voluntary group, over ½ of the class learned ways to increase their social integration and success in the classroom without victimizing others. Group members changed from expressing feelings of avoidance toward the classroom to expressing their friendships with each other. Along the way, new classroom protocols for expressing disagreement in an assertive, but non-aggressive way were developed and adopted.

3/4th Grade Social Skills Classes-As part of their regular schedule this year, every 3/4th grader attended weekly social skills classes. Taking a cue from the culture of the school and its Expeditionary Learning focus, the clinician focused on various skills needed to excel in a social realm. The year began with team building among the students in each group of 14. During this period they learned about the concept of consensus and were able to develop such on various large group projects. The next, and longest phase, of the classes focused on integrating lessons and exercises from the well-researched PATHS social skills and resiliency training program. The culmination of the "expedition" found the group learning about children across the world, and becoming "pen-pals" with their peers on the island of Saipan. The concept of world peace was discussed as possibly the ultimate example of social skills.

"Handling Misbehavior in Children"- This two part seminar series focused on helping parents and teachers learn well established techniques to decrease negative behaviors in school aged children. Participants first learned "pillars of discipline," which are concepts that multiple parenting/discipline approaches have in common, such as using a calm voice, making sure to make one instruction at a time, etc. The largest portion of the training however focused on the widely used and endorsed "1-2-3 Magic! method, developed by Dr. Thomas Phelan. To ensure the development of real life application of skills, discussion throughout centered on how participants could adapt methods to use in their particular situations. This two part series was offered twice in English and once in Spanish.

"Helping Children to Manage Anger" - This didactic workshop helped parents and teachers understand the dynamics of anger and ways to help children manage it more effectively.

Participants were taught cognitive-behavioral constructs and concrete techniques to address the often daunting issue of anger.

In addition to the development of quality small groups, the clinician was able to build a successful Early Intervention Team (EIT) in Year II. Fragmented and inconsistently scheduled during Year I, the EIT at Capital City has become a model for all intervention teams. There are three EIT "cluster" teams (Pre K – 2nd, 3-5 grades, 6-8 grades) that each meet once a month. The last week of every month is reserved, should a team need to meet again or if a meeting was missed due to holidays or other scheduling problems. All teachers in a given "cluster" attend, along with a special education representative, a person from Arts department, and a representative from the administration. The mental health clinician is present at all meetings. To ensure that meetings are purposeful and effective, only one student profile is discussed per session. According to the clinician, this approach increases teachers' investment and overall satisfaction because meetings include time in which to develop an action plan for the student and to discuss the teacher's role and needs. The clinician has worked hard to ensure that action plans reflect the efforts of teachers and that mental health issues are promoted. The collaboration that this requires has resulted in a strong support system among teachers, increasing the likelihood that teachers and school administrators will sustain the EIT after the end of the project.

Over the course of Year II, the clinician worked hard with school administrators to solidify his role and establish classroom- and group-based prevention programming and activities that respond to needs of students and teachers. While the principal has indicated reluctance to becoming "dependent" on mental health services, the clinician has integrated evidence-based programming into activities with 3rd and 4th grade students. Moreover, the EIT has been able to re-center its focus onto student academic and behavioral needs, not only those in special education. Teachers have grown increasingly empowered and more proficient in the use of mental health terminology and identification of mental health issues.

Efforts in Year III will continue to focus on clarifying the role of the clinician, address potential scheduling conflicts, and develop stronger programming for upper students (6th – 8th grade). Plans for sustainability and oversight of programming for lower students will also be introduced and incorporated into existing support service structures.

Ideal Academy. Ideal Academy, located in Northwest, Washington DC, opened its doors in September 1999 to a predominantly African-American student population (97%). The mission of Ideal is "to empower its students to become academically excellent, personally fulfilled, interdependent contributors to society." The school places emphasis on mathematics, science and technology skills, which are supported by computer classes and activities. Ideal serves children from ages three to fourteen in grades ranging from pre-kindergarten to eighth grade. In 2003, enrollment at Ideal included 201 students. Compared to the other schools participating in the project, Ideal has more children (69%) who qualify for free or reduced meals. Ideal also has a relatively small student-teacher ratio (15:1). Profiles of student academic success are supported by ratings on the Stanford Achievement Test (SAT-9). In 2003, reading performance scores rose 6.7 points, while math performance scores increased 1.2 points.

In Year I of the project, the mental health clinician provided direct services to students and staff, including counseling, crisis intervention services, and prevention programming in classrooms. During Year II of the project, the clinician at Ideal expanded the mental health services program in ways that aligned with the existing school culture and its focus on collective learning. Specifically, she conducted outreach to community resources for students and families, introduced evidence-based programming (e.g., PATHS) into services, and coordinated staff development seminars on topics ranging from test administration to child abuse detection and reporting. Partnerships with the Georgetown University Nursing program and the Walter Reed Medical Center supplied additional health education classes to students, while linkages to the local YMCA provided access to information on summer camps. Portions of, the Botvin's Life Skills Training program were used to introduce drug-resistance and personal management skills to 3rd grade students. Seminars targeting child abuse and neglect, testing strategies for students, and test administration were conducted with teachers and school administrators. Such efforts have facilitated the development of a multifaceted, multidimensional mental health program at Ideal.

One of the most significant accomplishments of Year II was the coordination of two school-wide health fairs, which were open to students, teachers and staff, and parents. The purpose of the health fairs was to provide attendees with the opportunity to learn about physical and mental well-being through activities, guest presentations, and interactive materials. Health fairs centered around three topics, including:

o Physical Health – Nurses from the Georgetown University Nursing program held presentations on dental health and hygiene, nutrition and obesity, and the effects of smoking on the body for elementary and middle school students. Screenings for blood pressure, height, weight, vision, and scoliosis were provided.
o Safety – A Fire Inspector conducted presentations on fire safety with preschool and kindergarten students.
o Mental Health – The school-based clinician talked with all students about the effects of depression, anxiety, disaster recovery, and divorce on mental health.

Posters and videos highlighted important tips and strategies for maintaining good health and safety, while handouts provided additional information to parents on ways to ensure optimal child development. Over 200 students, parents, and staff members attended each day-long event. Plans for the establishment of an annual health fair are in development.

Stakeholder interviews conducted with the mental health clinician provide unique perspective on the ways in which school climate and culture influence program implementation. The culture at Ideal is strikingly different from the other participating schools. Teachers are referred to as 'Mama' or 'Baba' to reflect a family-centered approach to learning, and programming encourages strong racial identity and pride among students. It is within the framework of this culture that mental health services are utilized. For example, the family-centered approach is designed to encourage students to think about and respond to the needs of others. To that end, individual and group therapy for students is not strongly encouraged at Ideal because staff and administration want to minimize any potential for stigma or jealousy that may arise for students receiving special services. The school-based clinician has therefore increased

the focus on classroom-based programming and coordinated school-wide events such as the health fairs to ensure a successful fit of programming to school culture. Teachers have responded positively to the clinician's classroom- and school-based activities since they provide them the opportunity to see their students interact with each other in a different context.

Adapting Ideal's mental health program to fit the existing school culture has also been a challenge for the clinician, as she focused on developing more universal programming rather than working with students individually or in small groups. Although this approach did not lend itself to identifying existing social and emotional problems among students or the impact of the prevention activities on individual students, working with the student body as a whole has largely been successful. Prevention programming has been well received by the younger students, who enjoyed working with the clinician and participating in the class discussions that stem from classroom prevention presentations (e.g., health and safety) and *Stop, Think and Go lessons adapted from the Botvins Life Skills Curriculum*. Efforts in Year III will continue to focus on strengthening relationships with teachers and providing programming that fits their needs. Opportunities to introduce evidence-based programming on bullying and violence prevention will also be explored.

Woodridge. The Woodridge Campus of the Friendship Public Charter School system opened in September 1998 to serve residents in the Northeast quadrant of Washington, DC. The mission of Woodridge is "to prepare a diverse cross section of children for success as students, workers, and citizens by providing them with a world-class education." As with the other schools in the Friendship-Edison Community, Woodridge promotes the 'core values' of education and emphasizes the role of technology in education. Woodridge serves students in kindergarten through fifth grade. The student body at Woodridge is exclusively African-American, the majority of which is comprised of low-income families. Nearly 50% of students qualified for free or reduced meals (FARM) program during the 2003-2004 school year. The largest of the three schools, Woodridge served 409 students in 2003-2004, which is more than both Capital City and Ideal combined. As such, they also maintain a higher student-teacher ratio (19:1) compared to the other schools. The mission and core values remain supported by performance on academic tests. Since 1999, Woodridge test scores have risen 23% in reading and 28% in math, serving as proof of Woodridge's progress in creating a challenging, results-driven curriculum and school climate.

Programming efforts during Year II at Woodridge focused heavily on individual and group therapy. Clinicians working for the school, along with the support of a doctoral graduate student, introduced group therapy topics ranging from drug use and violent behavior to responsibility, while individual therapy sessions focused largely on grief and loss. Year II also saw an increased focus on family sessions and classroom observations. These efforts were largely sustained by the doctoral graduate student, who assumed primary responsibility for implementation of the mental health program during a period of staff turnover.

In addition, Peaceful Schools Program (PSP) methodology was made available to Woodridge. As a school-wide approach designed to prevent substance abuse and violence, PSP creates a respectful school and community environment in which students and adults could feel safe, respected, and supported, and where students learn life skills that promote resiliency,

problem-solving, empathy, and self-discipline. PSP accomplishes these through extensive teacher training in pedagogy and classroom management techniques, as well as through coaching for administrators in discipline plan review and revision. The Woodridge clinician and representatives from the PSP developers, Educators for Social responsibility (ESR), conducted *Building Instructional Leadership* workshops for mentor teachers at Woodridge, CAPCS Elementary, and Chamberlain. The Building Instructional Leadership workshops were offered to lead teachers, mentor teachers, curriculum coordinators, and instructional coaches to help them refine the practice of mentoring new teachers while developing a collaborative learning community where adults work and learn together. These workshops gave teachers the tools necessary to support a new teacher through their first years of teaching while simultaneously raising student achievement by helping them improve their instructional skills.

The high staff turnover, both within the school administration and the direct service staff, made it increasingly difficult to generate momentum and build sustainable infrastructure for mental health programming at Woodridge. Since the start of the project in 2002, there have been three school principals and three mental health clinicians working in the school. The newest principal started during Fall 2003, and the newest clinician started in March 2004 after a three-month moratorium. The ability to implement classroom- and school-based prevention programs was somewhat compromised, as was the ability to participate on Woodridge's FASST team (the equivalent to the EIT). However, both the graduate student extern and the new clinician have spent the last part of Year II working together to establish consistent programming, and conduct regularly scheduled group sessions, which have been well received by teachers and students.

Stakeholder interviews revealed challenges to building and sustaining an identity for the mental health program at Woodridge that are likely the result of the new administration's efforts to develop school-wide discipline policies and procedures. As in the establishment of any new system, there were inconsistencies its implementation through the school year. Occasionally, therefore, teachers were uncertain as to how to deal with specific discipline matters. This, in turn, impacted the clinician's level of engagement with students and teachers, as well as her ability to be proactive in addressing student social/ emotional and behavioral incidents. Although in the past year, the school principal set parameters for the clinician's level of involvement in changing the school climate and the extent of student level interaction, it is likely that as the school-wide discipline infrastructure becomes more stabilized, a more collaborative process will be emerge in implementing the Counseling Program activities.

Nonetheless, teachers have been receptive and welcoming, and have praised the efforts of the graduate student extern. The new clinician has established a good rapport with the Student Support Manager. As the new clinician settles into her position, efforts in Year III will include new group sessions, parent outreach, and a co-constructed needs assessment with the school principal. Efforts will also be directed toward ways in which to better define the mental health clinician role, so as to be more effective for students, staff and school administration in designing and implementing prevention programming.

Support Role of Center for Student Support Services (CSSS)

The ability of project staff to be effective in their roles was dependent largely upon the internal capacity and infrastructure of CSSS to provide needed management, training and clinical

supervision. Stakeholder interviews conducted during Years I and II indicated significant improvement was made in the development of a supportive infrastructure. During Year I, staff members felt uncertain about the future of the project, the vision of CSSS, and about how to navigate the relationship between CSSS and the schools. In Year II, however, project staff found CSSS management to be more responsive to their needs. The Extern program, established by the CSSS Project Director, helped relieve some of the programmatic and administrative burden on clinicians. In addition, program decisions were more balanced and purposeful, and efforts to correspond more regularly with staff improved. Clinicians noted the willingness of leadership staff to build quality relationships and appreciate their efforts to improve the stability of the agency in ways that promote more effective program implementation.

Improvement in supportive infrastructure is most widely recognized through weekly case management meetings. In Year II meetings became more formalized and useful than in the previous year. The Project Director introduced a didactic component, in which the clinicians presented cases, trained each other, and discussed current challenges as they relate to theory and research. This process facilitated consensus among project staff and CSSS management on implementation issues (e.g., training, case management), and information sharing on strategies that inform clinical practice. Weekly meetings also included the regular attendance of a consulting psychiatrist and a Medicaid Reimbursement consultant. The meetings, case presentations, and the discussion they generated, reflected a growing maturity of staff and the project itself.

Staffing

Initial staffing problems in Year I due to funding shortages and delays in implementation led to an intensified effort to find and retain quality project staff that could support the growth and development of the project. Strategies implemented by the Project Director in Year II resulted in the hiring of strong candidates who successfully strengthened role identification among primary project staff, but also the programming and services offered. In Fall 2003, the Project Director instituted an Extern/Practicum program to support school-based clinicians in their daily tasks and duties. Two doctoral students from Argosy University were placed in participating charter schools (one at Capital City and one at Woodridge) and worked alongside Clinicians to develop treatment plans for students, present prevention programming in classrooms, and conduct group therapy sessions. By all accounts, this new program was tremendously successful. According to the Project Director, school-based clinicians valued the extra help, felt programming was stronger as a result, and enjoyed the opportunity to cultivate their management and supervisory skills. That the externs were well received by students and school administrators served as confirmation of the success of the program. The program will expand in Year III to include up to three Externs at Capital City alone. Late in Year II, the Project Director also conducted an extensive search to find a clinician that would be an appropriate match for Woodridge. Within three months, the newly hired clinician had immersed herself in school activities and played an instrumental role in coordinating efforts for administration of the California Healthy Kids Survey (CHKS) for the project. These efforts go a long way toward rectifying early disruptions and promote internal capacity building in the agency.

With the addition of the Extern program and the hiring of a well-matched clinician at Woodridge, the seven-member Counseling Grant team reflects quality in training and experience (*see Appendix B - Staff Tenure and Qualifications*). Leadership staff (i.e., Project Director; Consulting Medical Director) hold doctorates in clinical psychology and medicine, respectively, while the three clinicians hold advanced degrees in social work and education. Perhaps most importantly, all three clinicians possess prior experience in school-based mental health settings. The two externs are in the process of acquiring their doctoral degrees. With this training and experience, staff was able to broaden the scope of the project in Year II. This is most readily demonstrated through their sensitivity to cultural differences among students and school staff, which continues to be a tremendous strength of the project. The staff's cultural competence is evident in the programming that consistently reflects their understanding of and immersion into their respective schools' cultures. Parent groups for Hispanic/Latino parents were conducted in Spanish, and group therapy sessions responded directly to students' unique experiences at school and at home. In addition, clinicians continually worked with parents and caregivers to de-stigmatize mental health services and promote family well-being.

Staff Development and Training

A key factor in the development of a quality program is a continued interest in and focus on staff professional development. Trainings and educational opportunities provide clinicians with the latest mental health and clinical practice research and techniques to be incorporated into program activities, thereby strengthening staff's existing skills and program quality. Staff training remained a top priority for CSSS leadership staff in Year II. Please see a complete list of trainings offered through CSSS, schools, and a variety of partners in *Appendix C - Staff Trainings-Year II*. As in Year I, project staff was encouraged to participate in training events designed to increase existing knowledge and promote systems reform. Partnerships with the DC Department of Mental Health (DMH), and the Addiction, Prevention and Recovery Administration (APRA) provided access to a broad array of trainings and focus group sessions. At the same time, while weekly team meetings introduced topics specific to project staff, trainings ranged in focus and scope, as outlined below.

Program Support

As in Year I, most staff development and training sessions targeted increased skill (e.g., diagnostic assessment) and competency in service delivery (e.g., working with deaf and hard of hearing communities). Trainings for project staff included *De-escalation Techniques for Aggressive Behavior* and *Diagnostic Assessment Techniques of Children and Adolescents of Color*. Competency trainings focused on building collaboration (e.g., *Community Decision-Making Process*) and management skills (e.g., *Leadership Development in a Diverse Work Setting*, *Managing Staff Burnout and Compassion Fatigue*). Grants development and management training was also sponsored by DMH, for which all project staff were encouraged to attend. In-house trainings targeted school-based interventions for youth gang violence.

Clinical Issues

The majority of DMH-sponsored trainings target discrete mental health issues of children and adolescents and ways to educate and train clinicians for improved service delivery. Project staff attended sessions like *Autism Issues for Families and Youth*, *Attention-Deficit/Hyperactivity Disorder*, and *Youth who Bully*. Other trainings focused on clinical management,

including *Introduction to Mental Health Rehabilitation Services* and *Principles for Recovery for Mental Health.* Weekly team meetings focused intensely on case management and the unique clinical challenges facing project staff, including suicide assessment and intervention.

Policies and Procedures

Staff also participated in trainings designed to introduce and/or enhance policies and procedures affecting clinical practice in the District of Columbia. DMH sponsored several of these trainings, including *Overview of DC Mental Health Information Act* and *Usual Incident Reporting System*. Weekly team meetings also continued to focus on development of policies and procedures related to incorporating fee-for-service structures into existing service delivery systems in the interests of building a sustainable model of service delivery in the schools served by the grant. While often considered to be tedious work by most of the project staff, the Project Director recognized the importance of training project staff to be proficient at documentation for audit and compliance.

Service Utilization

Clinicians worked to provide quality mental health services to students to improve social and academic functioning by working closely with teachers and school administrators to identify, define, and respond to school needs. To be effective, services and programs must be broad in scope and flexible enough to adapt to individualized school climates and cultures. A brief description of services offered by clinicians is listed below:

o Direct Clinical Services – Direct services include individual, family, or group therapy. Services are focused on clinical and behavioral assessments and can include crisis management planning and response.
o Primary Prevention Activities – Primary Prevention Activities highlight school-wide and classroom-based interventions. Staff professional development and parent workshops are also considered primary prevention programming.
o Secondary Prevention Activities – Secondary Prevention Activities are conducted for students who have been identified as "at risk" for developing mental health problems because of certain life experiences. Services are delivered in a preventive manner, before a more serious (i.e., diagnosable) mental health problem develops. These interventions may include training or interventions aimed at families or the teachers who work with these children, such as grief and loss groups, support groups, targeted social skills training groups, classroom and functional assessments, one-on-one teacher consultations, drop-out prevention programs, and parent training groups.

Referrals

The Monthly Report Forms submitted by clinicians track referrals, service utilization and modality, and engagement with school staff. Students in need of clinical intervention are referred to clinicians for individual or group therapy within the context of the Early Intervention Team (EIT) or in the case of Woodridge, the FASST team. The EIT/FASST teams at each school serve as the main tributary through which referrals travel, except in the case of family initiated referrals, which may go directly to the clinician. The issues discussed by the family with the clinician are handled confidentially within this process. **Tables 1 and 2** highlight referral sources and reasons for referral, as itemized on Monthly Report Forms. As can be seen in **Table**

1, referral patterns for direct clinical services (individual or group therapy) differ dramatically across schools and reflect overall difference in school culture and need. For example, referrals for such services decreased substantially at Ideal Academy in Year II, while at Capital City, referrals flourished. Without Woodridge data from Year I, a referral profile is difficult to establish. Overall, in Year II, classroom teachers served as the primary source of referrals (n=38), followed by Special Education teachers (n=10), guidance counselors (n=7), and administrators (n=7). Family referrals were few.

Table 1. Mental Health Services Referral Information Year II – Referral Source

Referral Source	Ideal (School B)		Capital City (School A)		Woodridge (School C)	
	Yr I	Yr II	Yr I	Yr II	Yr I*	Yr II
Teachers	1	1	4	8		29
Administrators		1				6
Family	11	1		1		
IEP/ Special Ed				9		1
Students	1					
Self	1					
Guidance Counselor						7
Mental Health Team						1
School Team	1					

* Referral data reporting format not quantifiable for Woodridge in Year I of project

Reasons cited most often for referral are reflected in **Table 2.** Because many students are referred for multiple reasons, totals are greater than those presented in the referral sources table. A total of 101 presenting problems are documented for the 65 students represented above. The most frequently cited reasons for referral include disruptive/hostile/unusual behavior, along with hyperactivity and impulsivity. To a lesser degree, poor peer relationships and poor academic performance were also noted in students referred for services.

Table 2. Mental Health Services Referral Information Year II – Presenting Problem

Reason for Referral	Ideal (School B)	Capital City (School A)	Woodridge (School C)
Disruptive/ Hostile/ Unusual Behavior	2	8	29
Hyperactive/ Impulsive		4	19
Poor Academic Performance/ Academic Concerns		2	8
Family Problems	2		6
Poor Peer Relations			8
Depressed, Withdrawn		2	4
Attendance Problems		1	2
Anxious/ Nervous		2	
Conflict with Staff			
Suicide Issues			2
Physical/ Sexual Abuse			

Of the 101 total documented presenting problems, over one-third (38%; n=39) were disruptive, hostile or unusual behaviors. An additional 23 instances of hyperactivity/impulsivity (23%) were also documented. **Figure 1** below shows the distribution of presenting problems recorded on Year II Monthly Reporting Forms.

Figure 1. School-Based Mental Health Services: Presenting Problems
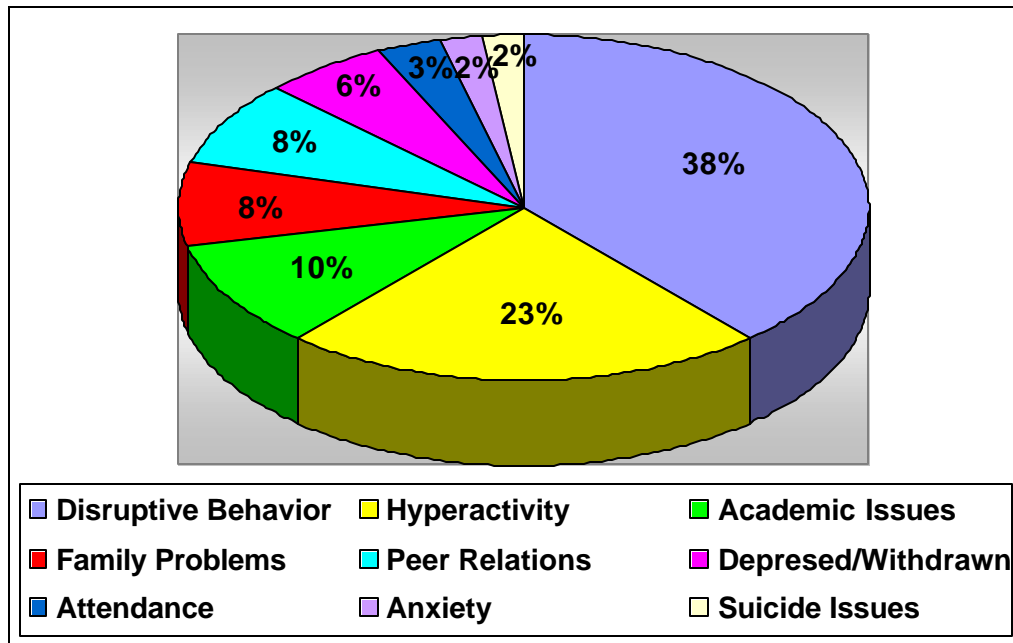
A comprehensive profile of service dosage for each of the three schools is presented in **Table 3**. Compared to Year I of the project, the number of prevention activities increased substantially across all three schools in response to individual school needs. A total of 341 individual therapy sessions were conducted in Year II (a 241% increase over Year I), along with 65 group sessions. Not surprisingly, direct clinical services were more prominent at Capital City and Woodridge than at Ideal, where individualized therapy is less of a priority. Prevention activities focusing on social skills, health, anger management, peer relationships, and risk behavior were conducted across 234 sessions (a 200% increase over Year I) with over 2,500 students. In this case, programming was more frequently featured at Ideal and Capital City than at Woodridge. It is likely that staff turnover at Woodridge may have impacted the ability of school-based clinicians to define and respond to unique student or classroom needs.

Staff training and development activities were unique features at Ideal in Year II. However, consultations with teachers on student behavior or classroom dynamics were uniformly high for all three schools, totaling 560 for the year (a 115% increase over Year I). Perhaps most importantly, clinicians spent a total of 172 hours participating in school team (e.g., EIT) meetings (a 38% increase over Year I). Taken together, these numbers reflect increased activity among all clinicians to enhance programming for students, build better relationships with school staff, and collaborate on ways to improve school infrastructure to respond to student social and emotional functioning.

Table 3. Service Utilization and Dosage – Years I & II

Family	Ideal ACADEMY*		CAPITAL CITY**		WOODRIDGE***	
	YR I	YR II	YR I	YR II	YR I	YR II
Therapy						
Number of Individual Therapy Sessions:	79	45	21	181	NONE	124
Number of Group Therapy Sessions:	55	NONE	NONE	35	12	30
Number of Family Sessions:	NONE	NONE	NONE	1	4	11
Prevention Services						
Number of Student Prevention Sessions:	47	98	15	124	15	12
Student Population Served (duplicated):	593	1,413	96	1,250	111	503
Focus of Student Prevention Sessions:	- Social Skills (Manners, Sharing, Friendship/Getting Along with Others, Following Rules) - Introduction to MH Services - Holiday Fun and Safety - Cultural Diversity - Transitioning Grades in School (Be Successful, Following Directions)	- Social Skills (Getting Along with Others, Listening and Following Rules) - Introduction to MH Services - Health - Cultural Diversity - Transitions - Home to School - Grades in School	- Friendship - Self-Control and Impulsivity - Social Skills (Managing Emotions, Appropriate Group Behavior)	- Social Skills - Leadership - Anger Management - Art Therapy - "Girl Power" - "Good Sports" - "All Smiles"	- Impulsivity/Inattentativness - Handling Conflict and Getting Along with Others - Making and Keeping "Good" Friends - Positive Peer Relations	- Responsibility - Violence and Drugs - Teasing – "Using Assertive Language"
Number of Parent Consultations:		48		NONE		NONE
Number of Parent Trainings:		NONE		1		NONE
School						
Teacher Services						
Number of Teacher Sessions:		7		NONE		NONE

	Col1	Col2	Col3	Col4	Col5	Col6
Teachers Served (unduplicated):		94		N/A		N/A
Focus of Teacher Sessions:		- Child Abuse and Reporting Requirements - Testing Strategies for Students - SAT-9 Test Administration - Health Fairs		N/A		N/A
Number of Teacher Consultations:	203	148	27	230	25	186
Number of Classroom Observations:	26	27	8	23	15	44
School-wide Services						
Hours Spent on School Team Meetings:	70	79	33	56.5	22	36.5
Hours Spent Coordinating Outreach Activities:		69		4		60
Hours Spent in Case Management:		41		1		36.5
Number of Crisis Incidents:	1	5	22	12	1	5
Type of Crisis Incidents:	- Report of sexual abuse	- Report of sexual abuse to CPS - *Health concerns* - *Response to school vandalism* - School evacuation for fire alarm	- Despondency - Physical aggression - Defiance - Rage - Thoughts of self-harm - Extreme disruptive behavior	- Harassment - Physical aggression - Defiance - Student/Parent rage	- Parent involved in drive-by shooting	- Death in family - Suicidal ideation

*   *Statistics reflect activities of one Mental Health Clinician*
**   *Statistics reflect activities of Mental Health Clinician and Graduate Student Extern*
*** *Statistics reflect activities of two Mental Health Clinicians and one Graduate Student Extern*

Satisfaction Surveys

Satisfaction surveys are distributed annually to project staff to solicit input and feedback on issues relating to program implementation and job satisfaction. Such data helps inform implementation at the school level and guides strategies for program improvements and future activities. In order to establish a more comprehensive profile of the project, surveys were also distributed to students and teachers in Year II. Key findings for each target group are presented below.

Staff

As in Year I, staff satisfaction surveys were distributed to the direct service staff, including the mental health clinicians and student extern participating in the Counseling Grant project. The 24-question survey was designed to ascertain impressions of the program's effectiveness, as well as their level of job satisfaction. Due to the staff turnover at Woodridge, the graduate student Extern placed there was invited to complete the survey. All four staff returned the survey for analysis.

Services. In the first part of the survey, clinicians were asked to respond to each of 9 statements assessing various dimensions of the program by marking "Agree," "Disagree," or "Don't Know." **Table 4** below shows the number of responses for each item.

Table 4. Staff Survey – Services (n=4)

Services	Agree	Disagree	Do Not Know
1. I understand the goals and objectives of the mental health services program.	3		1
2. I receive an adequate amount of supervision to help me get my job done in a quality manner.	4		
3. The program's goal is to build resiliency and reduce risk among the youth through prevention and early intervention activities.	4		
4. The program is responsive to the needs of staff.	1	2	1
5. The program is responsive to the needs of children and their families.	4		
6. I have participated in training that adequately prepared me for my position.	3	1	
7. The program documents and materials are adequately designed.		4	
8. I am encouraged by CSSS leadership to make systematic and/or procedural change suggestions to improve programming.	2	1	1
9. The program adequately coordinates with the school staff and handles informing school administration and families of available services.	4		

As seen in the Table, five statements drew universal agreement from staff. Four of these five statements targeting clinical supervision, stated program goals, perceived program responsiveness, and collaboration with school staff were considered strengths of the project. Only one statement regarding the design of the project documents and materials received unanimous *negative* support. This item also was negatively rated last year, where two out of three staff members disagreed that the materials are adequately designed. All respondents agreed that the goal of the project is to build resiliency and reduce risk among the students, and three out of four respondents understand the goals and objectives of the program. As in Year I, responses to questions reflecting quality of interaction with CSSS management (e.g., level of responsiveness, support in programmatic changes) suggest dissatisfaction among staff that warrants further consideration.

Job Satisfaction. Project staff were then asked to comment on 11 statements designed to probe aspects of job satisfaction. As with the previous set of questions, response choices included "Agree," "Disagree," or "Don't Know." **Table 5** indicates that respondents feel good about their work and position. All report that they enjoy their work, find it worthwhile, and that their work utilizes their skills. All clinicians also report believing that their work has had a positive impact on students and their families, and most report having a good working relationship with their host schools. Discrepancies in responses were noted on statements reflecting perceived appreciation by CSSS leadership staff, as well as compensation. General satisfaction with the position was supported by three out of four respondents.

Table 5. Staff Survey – Job Satisfaction

Job Satisfaction	Agree	Disagree	Do Not Know
1. I enjoy my work.	4		
2. I find my work worthwhile.	4		
3. I find the work that I do is hard.	1	2	1
4. I find my work boring.		4	
5. The work I do uses my skills.	4		
6. I am satisfied with my position.	3	1	
7. I am appropriately compensated for my position.	2	2	
8. I feel appreciated by CSSS leadership for the work I do for the program.	2	2	
9. I believe I have made a positive impact on the children and families I work with.	4		
10. I have the CSSS leadership support and encouragement to work with my clients in ways tailored to meet each child/family's specific circumstances.*	3		
11. I feel welcomed and have a collegial relationship with the host school(s) with whom I work.	3	1	

* 3 total responses

At the end of the survey, staff members were asked to respond to two open-ended questions. The first question asked project staff to consider those areas of the Counseling Grant project that are particularly strong. Only one staff member chose to respond to this question. Whereas Year I comments focused on the fact that services were provided within the schools, current responses cite more specifically, the prevention, consultation and counseling services as strengths of the project. In addition, coordination between CSSS leadership staff appears to be improving. The other open-ended question asked project staff to consider those areas of the Counseling Grant project in need of improvement. Two staff members responded to this question. For one staff member, the biggest need for improvement centered on role delineation and responsibility, and was expressed by recommending that additional steps be taken to ensure that schools truly understand what services will be provided before schools agree to participant in the project. Other areas for improvement included staff training (e.g., increased focus on content and mission of project) and oversight (e.g., annual timelines distributed to project staff containing key dates for training, test administration, etc…).

A final question on the survey asked staff to rate how stressful they find their jobs, choosing from options ranging from always and usually stressful to sometimes, rarely, or never stressful. Overall, a slightly higher level of stress is evident in Year II as compared to previous results. Whereas most Year I respondents characterized their jobs as "Sometimes stressful," Year II respondents were evenly divided on ratings of job stress, with two respondents characterizing their jobs as "sometimes stressful," and the remaining two characterizing their jobs as "usually stressful."

Students

New in Year II, youth satisfaction surveys were distributed to students participating in individual or group therapy at participating schools. The 10-item survey was designed to assess students' impressions about the quality of care they receive and identify perceptions about the quality of their relationship with the school-based clinician. A total of 13 (6 Woodridge, 5 Capital City, and 2 Ideal) surveys were completed and returned for analysis. For ease in interpretation, items on the survey have been assigned to one of three general areas. The first, *Participation levels*, includes items that track information about students' utilization of services. The second, *Session Quality*, includes items that capture students' perceived relationship with the clinician and the quality of that relationship. The third area, *Session Outcomes*, includes items that reflect students' perceived benefits of participation in counseling sessions. Each area is described in turn.

Participation levels. The first three questions on the survey target duration and frequency of services. Parents arranged for participation in mental health services for the majority of students (n=8, 67%). Over half of students (54%) reported seeing the clinician for individual therapy, with 38% (n=5) reporting participation in group therapy. One student reported seeing the clinician as part of family therapy. Nearly all students (92%) reported seeing the clinician more than five times over the course of the school year.

Session Quality. The next four questions target students' perceptions about the quality of their relationship with the clinician. A strong connection was noted by nearly every student (92%), who reported feeling able to talk to the clinician about most things because the clinician "would

not tell anyone" and because "[the clinician] is a person that I and my mom can talk to." Similarly, 92% of respondents reported feeling that their clinician understands them and that the clinician makes them feel like he/she "went through the same thing." Clinicians' respect of confidentiality and efforts to build a connection were significant to respondents. All (100%) reported that time spent with their clinician was either just right or that they wished for even more time. That the majority of respondents (92%) were aware that the clinician had been in touch with their parents did not seem to minimize their trust and rapport. Clearly, boundaries and trust so critical in a clinical setting had been established.

Session Outcomes. The last section on the survey targeted respondents' perceptions of progress toward goals and the impact of therapy on their social functioning. Twelve students (92%) responded that their clinician had helped them set goals for themselves. Of these, nine (75%) felt they had made a lot of progress toward achieving them. As a follow-up, students were asked to rate the impact of therapy sessions on various social/emotional or behavioral outcomes. The scale ranged from a strong NO! (has not helped at all) to a strong YES! (has helped a lot). **Table 6** below illustrates the combined responses to this series of questions.

Table 6. Student Survey –Impact of Mental Health Services on Functioning (n=12).

	YES!	Yes	No	NO!
Helped you solve problems that brought you to him/her in the first place?	85%	15%		
Helped you learn how to make better decisions?	62%	38%		
Helped you feel better about yourself?	77%	23%		
Taught you new things about yourself?	46%	23%	23%	8%
Helped you get along better with other kids?	69%	31%		
Helped you do better in school?	69%	31%		
Helped you to like school more?	76%	8%	8%	8%
Helped you get along better with adults?*	58%	25%	17%	

As reflected in the Table, there was strong consensus among most students regarding perceived benefits of therapy. All respondents reported feeling better about themselves. With ten of the 13 students (77%) expressing a strong feeling of having a more positive self-perception. The majority of participants also reported doing better in school, even liking school more, and getting along better with others. While students may be too young to verbalize ways in which mental health services have taught them something new about themselves, all of them (100%) recognize that therapy helped them address the problems that initially brought them to the clinician. The strong, positive opinions expressed here serve as testimony to the critical need for, and inherent value in, quality mental health services to improve social functioning in youth.

Teachers
Also new in Year II, teacher satisfaction surveys were distributed to school staff who worked directly with the clinicians in providing services to students. The 13-item survey was designed to assess perceived value of mental health services for at-risk students and determine the impact of service delivery on increased school staff detection and identification of poor social and emotional functioning. A total of n=13 surveys were completed and returned for analysis (5

Capital City, 5 Ideal, and 3 Woodridge). For ease of interpretation, items on the survey have been assigned to one of three general areas. The first, *Service Activities*, includes items that identify frequency of interaction with the clinician and the range of topics covered in prevention activities. The second, *Support and Interaction*, includes items that capture teachers' perceived relationship with the clinician and sense of collaboration. The third area, *Value*, includes items that assess teachers' perceptions about the value of school-based services in helping teachers identify and detect mental health problems among students and promoting a better school climate. Each area is described in turn.

Service Activities. The first four questions on the survey ask respondents to comment on the frequency with which they worked with the school-based clinician, the focus of those activities, and the perceived benefit of such activities for students. One respondent did not work with the clinician in a classroom setting; therefore, results in this section are based on an n=12. According to teachers' reports, clinicians were available on an "as needed" basis to conduct classroom activities. A little over half of teachers (n=7, 54%) reported working with the school-based clinician once or twice a week. Three (23%) reported working with the clinician on an "as needed" basis. One teacher reported working with the clinician daily, while the two remaining teachers did not know. The focus of prevention activities was diverse. **Figure 2** highlights the topics covered by school-based clinicians when working in classroom settings as reported by teachers.

Figure 2. Teacher Survey - Focus of Prevention Activities (n=12)
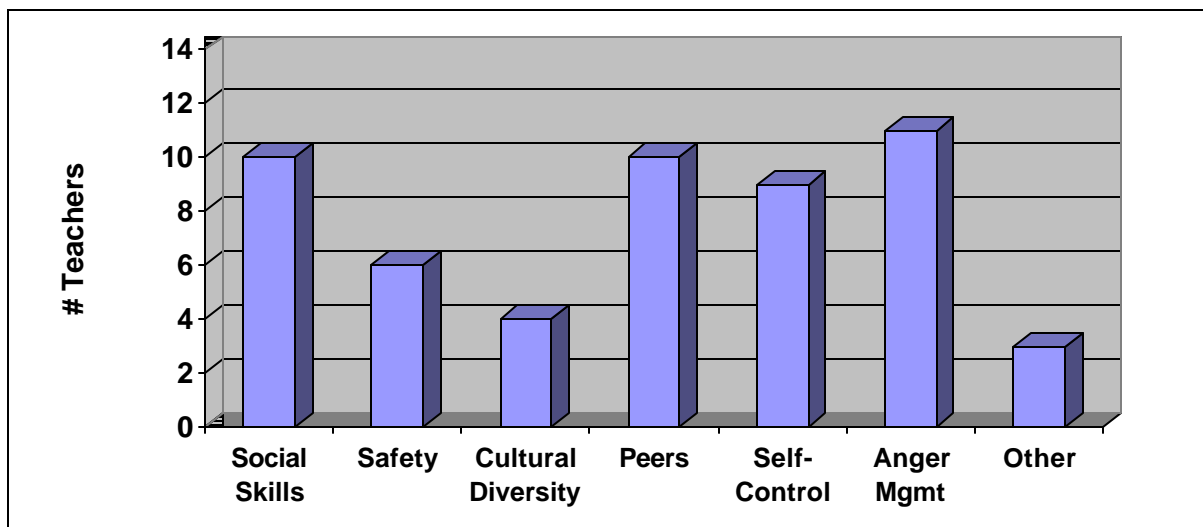
As seen in **Figure 2**, activities centering on interpersonal relationships (e.g., anger management, peers, social skills) were most frequently presented. Less focus was directed to issues like safety and cultural diversity. Other topics included substance abuse and appropriate classroom behavior. All respondents (100%) reported feeling that participation in classroom activities was beneficial for students. Eight teachers elaborated on how the students have benefited from the activities. Several focused on the students' positive perceptions of their time spent with the clinicians. Comments included, *"Students are always looking forward to doing the activities with enthusiasm," "[the students] are always so attentive and able to air their*

feelings," and *"What's great is how much [the students] look forward to being with [the clinician]."* Teachers also responded that working with the clinician gave students the opportunity to "bounce ideas off someone who is experienced" and to "learn and grow." Several also noted that the clinician's consistency and flexibility have helped in tailoring the activities to the specific needs of the students, that they are *"learning to be good caring citizens,"* and that the clinician provided much-needed social skills training. Eleven of the 12 teachers responded to a question asking whether they felt that services and programming available to students were culturally sensitive. All 11 (100%) felt that activities were indeed culturally sensitive, with one teacher adding that the activities are conducted in such a way that *"students are sensitive and aware of the diversity in our school and city."*

Support and Interaction. The next several questions on the survey explored teachers' relationships with the school-based clinician and general perceptions about clinicians' interactions with school staff. As shown below in **Table 7**, when teachers were asked to indicate specific areas in which they have sought help from the clinicians, "Assistance with a particular student" (n=11) was the most frequently cited, followed by "Reporting emergency situations" (n=8) and "Strategies for classroom discipline" (n=7). Only a few teachers (n=3) reported working with the clinician to gather information on community resources. Overall, nine of 11 respondents (82%) felt that clinicians were "very" helpful when addressing teachers' areas of concern, and two felt that clinicians were "somewhat" helpful.

Table 7. Areas of Support Sought by Teachers (n=13)

Area of Support	# Teachers
Assistance with a particular student	11
Reporting emergency situations	8
Discussing personal strategies for classroom discipline	7
General consultation on classroom function	6
Help in working with/contacting a parent	4
Information on community resources	3
Other (please specify:) (*Social skills advice for the after-school program*)	1

Teachers were asked to rate their experiences with the school-based mental health services provided to them and their students by indicating their level of agreement with a series of seven statements. Overall, respondents were extremely positive about the relationships clinicians had established school wide. **Table 8** shows the aggregate ratings reported by the teachers. All respondents felt that clinicians worked very hard to engage students in a professional manner and felt the same effort was directed toward teachers and staff. (One respondent indicated N/A due to having no experience with classroom-based activities) In addition, 12 out of 13 respondents felt very strongly that clinicians welcomed questions and concerns from staff, shared pertinent information regarding students when appropriate, and felt that staff were able to provide adequate information regarding student behavioral or developmental issues. Three respondents felt that teachers and clinicians did not always work together to resolve academic and/or discipline issues.

Table 8. Teacher Ratings on Experiences with School-Based Mental Health Staff (n=13)

Statement	1 (very untrue)	2 (somewhat untrue)	3 (neither true nor untrue)	4 (somewhat true)	5 (very true)	N/A
The clinical staff engage with students in a professional and respectful manner					13	
The clinical staff engage with teachers in a professional and respectful manner				1	12	
The clinical staff greet me and my students in a welcoming and friendly manner					12	1
The clinical staff share pertinent information with me regarding my students, as appropriate				1	12	
The clinical staff welcome my questions and concerns				1	12	
The clinical staff and teachers work together to resolve academic and discipline issues		1		2	10	
The clinical staff provide adequate information when I have a specific concern about a behavioral or developmental issue regarding my student(s)*				1	11	

* 12 total responses

Value. The next four questions on the survey targeted teacher impressions regarding the extent to which working with the school-based clinician improved their ability to recognize mental health problems in students, make more accurate referrals for services, and whether mental health services in the school were vital to the school infrastructure. Nine of 12 respondents (75%) reported that working with the clinician increased their knowledge of mental health issues facing young children. When asked how, teachers reported that they now know *"how to help children when basic needs are not met,"* have *"a better understanding of the issues and strategies that might help" students,"* and are *"more aware of all mental health issues."* To a lesser degree, only 5 of 11 respondents (45%) felt that working with the school-based clinician increased their capacity to identify and detect mental health problems in their students. Four teachers offered comments to further explain, one of whom said that *"I don't feel comfortable identifying, but feel support when just raising a concern."* Other comments included, *"I have become aware of 'red flags' that otherwise go unnoticed," "I am learning ways to detect and be aware of my students who are having personal problems,"* and *"Sometimes, others can open doors that I do not see."* Nine of 11 teachers (82%) felt better able to make the appropriate student referrals for services as a result of working with the clinician. All 13 respondents (100%) felt that mental health services were vital to the overall infrastructure of their schools.

As seen in **Figure 3** below, when asked to rate their overall experience with the mental health services program in their school on a four-point scale with ratings of poor, average, very

good, and excellent. No respondents rated the program average or poor. Instead, 100% of respondents reported services to be 'Excellent' (n=7) or "Good" (n=6).

Figure 3. Overall Teacher Ratings of School-Based Mental Health Program (n=13)
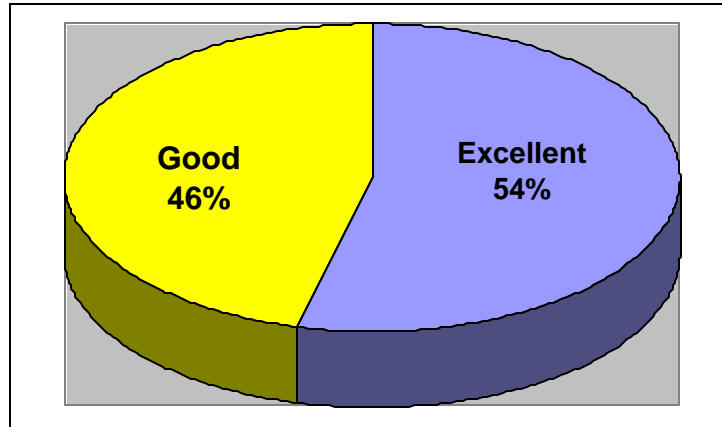
Several teachers also provided additional comments, noting their desire for more time with clinicians, more clinicians in the schools, and additional workshops for parents, indicating a growing recognition of the mental health needs of their school population and the benefits afforded by the expanded mental health services model.

Summary of Program Implementation

Program Implementation was examined across schools using qualitative data analysis methods. Through a careful review of presentation materials and interviews with CSSS leadership and project staff, as well as data itemized on monthly report forms, detailed descriptions of each program component for all schools were constructed. A five-point rating scale (1=not implemented or unsuccessful; 2=somewhat or marginally successful; 3=moderately successful; 4=successfully implemented; 5=highly successful implementation) was applied that signified the degree to which each program component was successfully implemented at each school **(See Table 9-Program Implementation Ratings by Components and School).**   Since staff turnover within schools could significantly impact implementation, these factors are included in the table below also.

School A had the most success implementing the range of program components. The one component not successfully implemented in School A , *Linkages and Referrals*, was a deliberate choice by the school who preferred to offer all its services in-house and not refer out. The implementation at Schools B and C were comparable in terms of number of components successfully implemented. However, there were distinct differences in the reasons why certain components were not successful. For example, School B made a deliberate choice not to implement individual or group therapy, while turnover in leadership at School C weakened the overall implementation of several components. Secondary Prevention, which was comprised of topical support groups (i.e., social skills; grief and loss), was the one project component to be successfully implemented by all schools, while parent involvement was the least.

Table 9. Year II Program Component Implementation: Ratings Within and Across Schools

School Code	National Counseling Grant Primary Program Components								Turnover		# Successful Components Implemented By School
	1=not implemented/unsuccessful; 2=somewhat/marginally successful; 3=moderately successful; 4=successfully implemented; 5=highly successful										
	Indiv. Therapy	Group Therapy	Primary Prevention	Secondary Prevention	EIT	Staff Training/ Consult	Parent Involve	Linkages/ Referrals/ Outreach	# Principal	# Clinician	
A	4	5	5**	5	5	4	4	1****	1	1	7
B*	1*	1*	5	5	3	5	3	5	1	1	4
C	4	4	2	5	4***	2	3	4	3	3	5
# Schools with Successful Implementation	2	2	2	3	2	2	1	2			

*Only Primary and Secondary Prevention activities implemented at this school

*Clinician brought in the PATHS curriculum for 3rd and 4th graders.

***This school was very successful in using their pre-existing student support services referral system (FASST), and did not require CSSS consultation on the development of this program component.

****This school preferred to offer its interventions and support in-house, and was reluctant to use outside referral sources.

Secondary Prevention-for example Social Skills Groups, Grief and Loss Groups

Progress Toward Goals and Objectives

The Counseling Grant program made great strides during Year II in providing quality school-based mental health prevention and early intervention services. The range of components that comprise the mental health services model were implemented with varying levels of fidelity and intensity that reflected the individual schools' needs, culture and challenges. The impact of these services on student outcomes and the success of the program in developing a sustainable mental health services infrastructure were examined by individual school and across schools. Preliminary findings suggest success in sustaining youth resiliency, decreasing youth violence, increasing teachers' knowledge and awareness of mental health issues and ability to identify problems early, building sustainable infrastructure and increasing parental involvement.

Objective 1. Improving social and behavioral skills; and
Objective 2. Increasing the use of healthy behaviors

In May 2004, the California Healthy Kids Survey (CHKS) was administered to 264 third, fourth, and fifth grade students at Ideal Academy, Capital City Public Charter School, and the Woodridge Campus of Friendship-Edison Public Charter Schools, who participated in the second year of the National Counseling Grant initiative during the 2003-04 school year. The survey is designed to assess youth health risk and resilience, as well as the factors that influence them.

Resilience Assessment

In assessing youth resilience, two types of developmental assets are examined: **External Assets** and **Internal Assets.**

External Assets refer to environmental or external supports and opportunities that are linked to the development of innate resilience in youth. Research has shown that three principles are essential in healthy youth development: *Caring Relationships, High Expectations,* and *Meaningful Participation.* The CHKS measures students' perceptions of these principles in two environments: the school and the home.
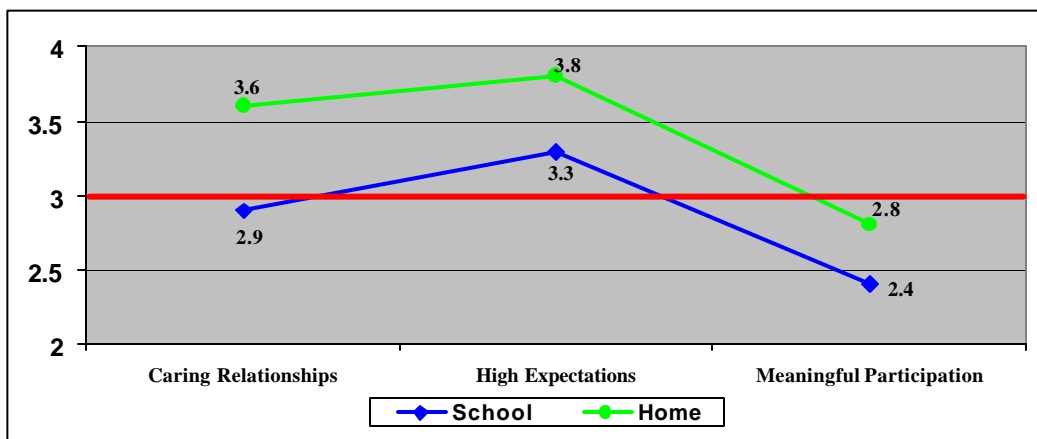
o *Caring Relationships*: These are defined as a student's supportive connections to others who are role models of healthy development and well-being. Research has consistently shown caring relationships to be the most critical factor in successful child development.
o *High Expectations*: These are messages relayed both directly and indirectly by adults that communicate their belief that the student can and will succeed responsibly. These are at the core of caring relationships and reflect the adult's and friend's trust in the youth's resilience and ability to learn. High expectations have been shown to be a key protective factor in the environments of youth who have refrained from involvement in risk behaviors.
o *Meaningful Participation*: Meaningful participation refers to the involvement of the student in relevant, engaging, and interesting activities with opportunities for responsibility and contribution. Research has shown that when youth are given valued responsibilities, planning and decision-making opportunities, and chances to contribute and help others, positive developmental health/academic outcomes are achieved.

The following categories are used to group scores: *High* (average item response score above 3), *Moderate* (average item response score of at least 2 and no more than 3), and *Low* (average item response score below 2).

Although the individual profiles of Schools A, B, and C vary somewhat with regard to students' resiliency traits health-risk behaviors and as measured on the CHKS, the overall trends that emerge from these results are presented below.

Year II **External Asset** scores do not differ significantly from those achieved in Year I. As in Year I, students at all three schools appear to have adequate *Caring Relationships* and *High Expectations* both at home and school. However, as shown in **Figure 4** below, current results continue to highlight the striking difference in scores in the two environments, which indicate that these resilience factors are appreciably stronger in the home environment. In this domain, all schools maintained mean scores in the *High* range in *Caring Relationships*, suggesting that students have strong connective bonds with adults at home. Scores in *High Expectations* particularly, both at school and in the home, are consistently the highest scores for all three schools. Also as in Year I, the majority of students at each school (91% to 94%) scored *High* in *High Expectations* in the home, indicating that they feel they are viewed as valued participants. On the other hand, only 17% to 26% scored *High* in *Meaningful Participation*, suggesting that most students continue to perceive infrequent opportunities to contribute meaningfully to the life of the family. With *Meaningful Participation* scores both at school and at home continuing to be relatively low across all schools, it remains essential that students be encouraged to participate actively and be provided with opportunities to contribute their talents and abilities in both environments.

*Figure 4. Year II External Assets – Comparison of School and Home Environments*

The CHKS also provides information on three **Internal Assets** associated with resiliency: *Empathy, Problem Solving,* and *Goals and Aspirations*. These traits are considered outcomes of the developmental process and can be seen as indicators as to whether critical environmental supports and opportunities are in place. They are, therefore, the individual qualities associated with environments rich in caring relationships, high expectations, and meaningful participation.

- *Empathy*: The Empathy asset refers to understanding and caring about the feelings of others. The lack of empathy is associated with behaviors such as bullying, harassment, and other forms of violence.
- *Problem solving*: Problem solving includes the ability to plan, to be resourceful, to think critically, and examine multiple perspectives before making a decision or acting. Research has identified the presence of strong problem solving skills in successful adults.
- *Goals and Aspirations*: Having goals and aspirations requires the ability to look to the future and have expectations and hope for one's self. Children who have goals and aspirations develop a sense of connectedness to their world.

Overall mean scores for the **Internal Assets** of *Empathy* and *Problem Solving* fell slightly. These scores represent decreases for two of the three schools, while one school showed increased its mean scores. With evidence of the association between lack of empathy and bullying behaviors being documented in current research, the system-wide implementation of comprehensive programs that aim both at preventing and/or reducing bullying behavior through strategies that develop empathic skills should be investigated. *Goals and Aspirations* scores for all schools have been consistently in the *High* range, suggesting the presence of students' intrinsic motivation to look to the future and make plans for success (see **Figure 5**).

Figure 5. Internal Assets: Aggregate Means-Year I and II
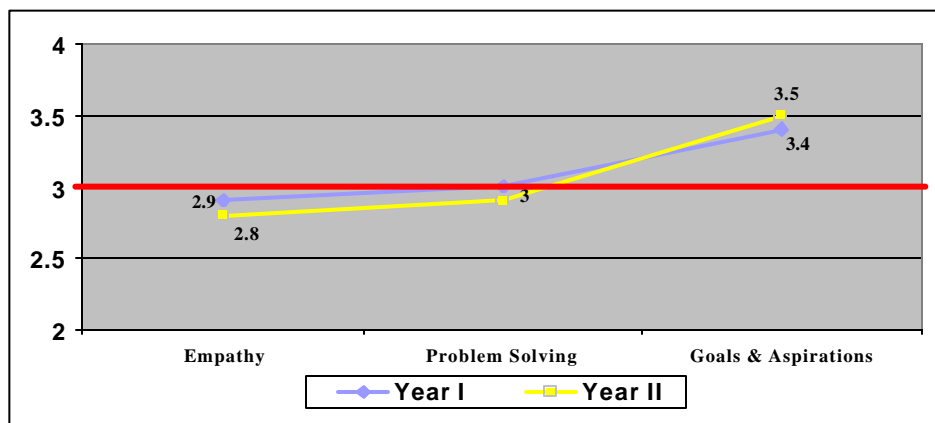
Risk Assessment

ATOD

Although national statistics on risk behavior are not available for elementary students, results of the Center for Disease Control's 2003 Youth Risk Behavior Surveillance System (YRBS), administered to middle and high school youth, can be used for limited comparison. The YRBS is a national survey conducted every two years to assess the health risk behaviors of young people, and from which selected CHKS items were derived.

According to the 2002 National Survey on Drug Use and Health, sponsored by the Substance Abuse and Mental Health Administration (SAMHSA), illicit drug use among youth tends to increase with age, with 12% of youth ages 12-17 reporting current drug use, peaking at 23% among 18-20 year-olds. Mirroring these findings, Year II CHKS results show that, with the exception of inhalant use, ATOD use was reported with more frequency as grade levels

increased. Specifically, as shown in **Figure 6** below, reports of alcohol use by both the 3rd and 4th grade cohorts increased by an average of 7 percentage points between Years I and II. Interestingly, the highest percentage of students (36%) that reported having used alcohol is in the current 3rd grade class.

These findings appear to reflect national YRBS data, which indicates that 28% of students had their first drink of alcohol, other than a few sips, before age 13.

Figure 6. Aggregate Cohort Effects from Year I to Year II – Alcohol
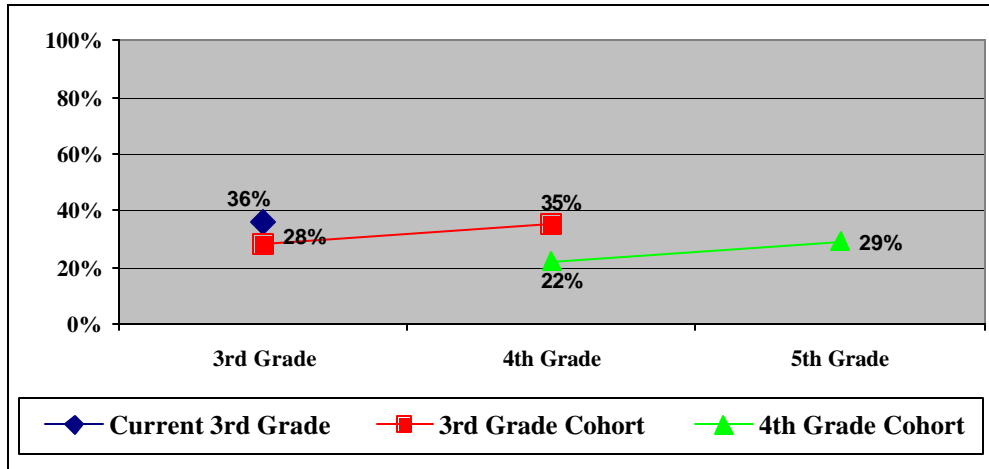
In addition to increased alcohol usage reported by both cohorts, students also reported tobacco use with increased frequency. As seen in **Figure 7**, the number of 3rd graders who reported having smoked at least part of a cigarette increased from 5% (n=5/92) in Year I to 13% (n=11/88) in Year II. Reports by the 4th grade cohort increased from 9% (n=8/92) to 15% (n=12/82). These figures are only slightly lower than national YRBS data, in that the CDC found that 18% of students have smoked a whole cigarette before the age of 13.

Figure 7. Aggregate Cohort Effects from Year I to Year II – Tobacco
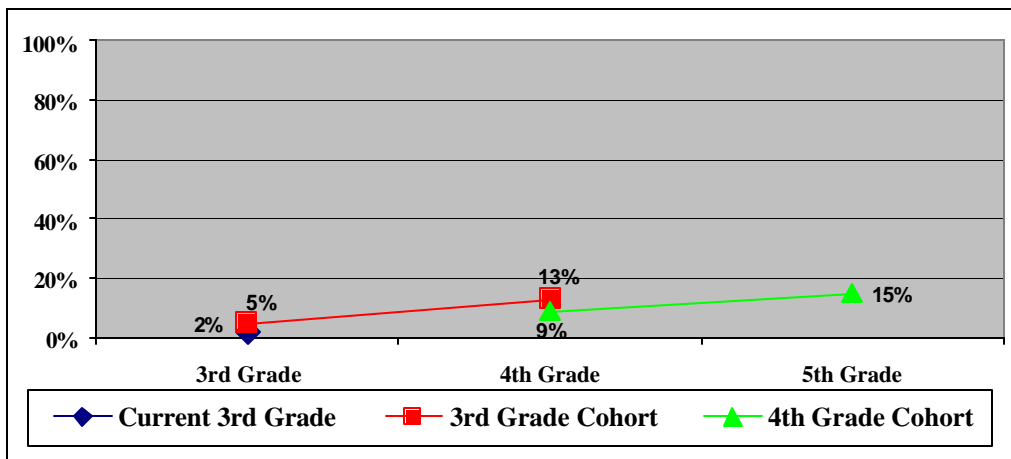
Although used about half as frequently as tobacco, marijuana was a third substance that was reported to have been used by up to 7% of students. Moreover, the trend toward increased usage with increased age is evident, even if slight, as seen in **Figure 8**.

Figure 8. Aggregate Cohort Effects from Year I to Year II – Marijuana
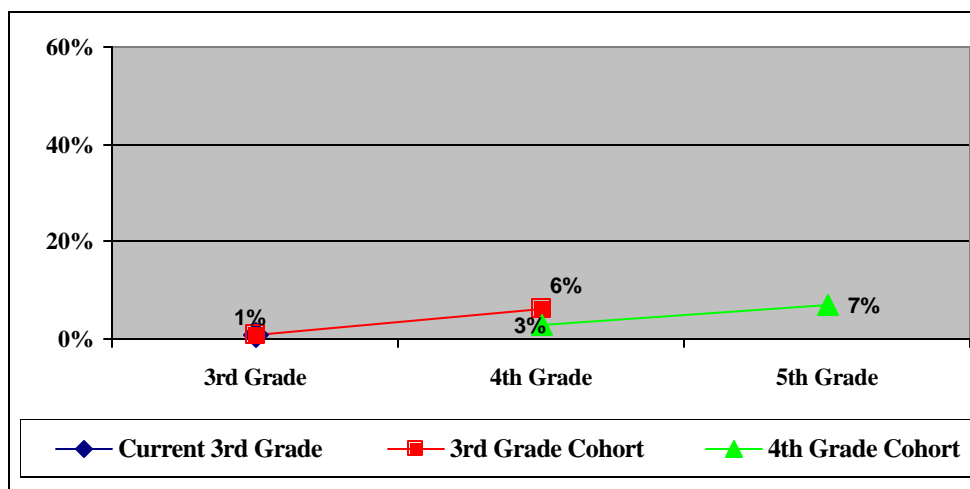
According to the 2002 National Survey on Drug Use and Health, sponsored by the Substance Abuse and Mental Health Administration (SAMHSA), illicit drug use among youth tends to increase with age, with 12% of youth ages 12-17 reporting current drug use, peaking at 23% among 18-20 year-olds. Further, in examining the correlation between substances used, results indicate that illicit drug use in 12-17 year-olds is approximately eight times higher among those who smoke cigarettes and 12 times higher in those who drink alcohol. In light of the fact that CHKS results indicate that alcohol and tobacco are the two most frequently used substances, with evidence of a trend toward increased usage with increased age, these findings underscore the critical need for the implementation of effective prevention programs in early elementary grades.

Violence

Bullying behavior at all three schools continues to be reported by over half of the students surveyed. While it remains the most frequently reported negative behavior at all three schools, overall reports of bullying victimization actually decreased from 69% in Year I to 63% in Year II. Moreover, at one school, the percentage of students who reported being hit or pushed by others during the past year dropped from 73% to 60%, a decrease of 13 percentage points. However, results of bullying behavior by grade revealed that between 70% and 79% of current 3rd graders report that they have been hit or pushed by other students in the past year. This represents individual school increases of between 9 and 18 percentage points over last year's 3rd graders.

On indices related to weapons, overall decreases were also noted, both in reports of carrying weapons to school and in seeing others with weapons. Only one school, however, showed decreases in both areas (from 10% to 3% in carrying weapons and from 43% to 27% in

witnessing). Conversely, perceived safety at school has increased across schools as reports of weapons carrying decreased (see **Figure 9**)

Figure 9. Aggregate Violence-Related Behaviors and Experience – Years I and II
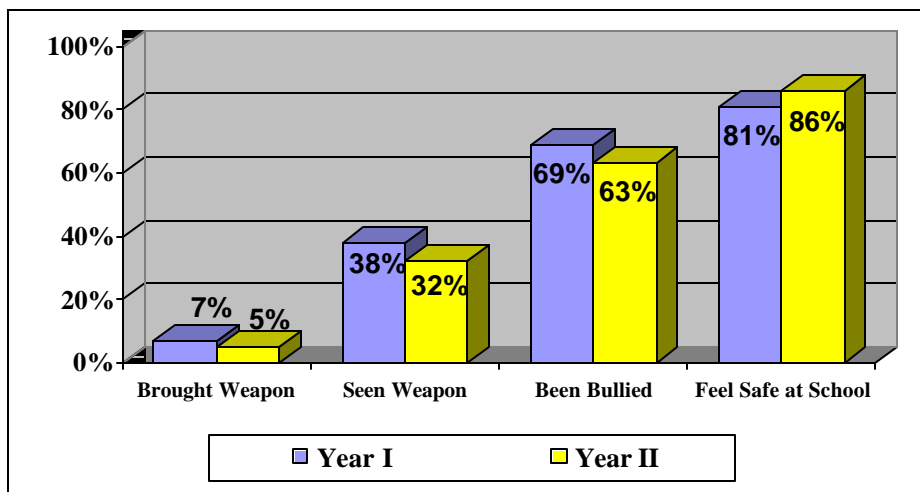
While documented decreases in bullying behavior are encouraging and may be suggestive of the effectiveness of school-wide efforts in this area, the number of students experiencing bullying behavior (63%) continues to exceed national trends. The 2003 YRBS results indicate that 45% of middle school students report that they have been hit, pushed, or shoved within the 12 months prior to survey completion. A report released on September 4, 2003, by Fight Crime: Invest in Kids[1] adds that 60% of boys identified as "bullies" in grades 6 through 9 were later convicted of at least one crime by the age of 24. Continued efforts, therefore, at addressing bullying behavior and its consequences for both the bullies and the victims in the lower elementary grades are critical.

Objective 3. Improving academic performance

An underlying assumption of the Counseling Grant is that academic success in students is inextricably tied to their physical and emotional well-being. As a result, clinicians have focused their efforts on the development of a positive and safe school climate and the reduction of barriers to learning. In addition to direct counseling with students, classroom presentations, and topical support groups, clinicians also provide support to teachers in the areas of instructional quality and classroom management.

As the newest edition of the standardized and nationally recognized achievement test, the Stanford-9 Achievement Test Series, Ninth Edition (SAT-9) is used school-wide to measure student academic performance in math and reading. SAT-9 testing is done annually during the Spring, and schools receive individual and aggregate performance scores and ratings during the Summer.

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[1] Fox, J., Elliott, D., Kerlikowske, R., Ne wman, S., & Christeson, W. (2003) *Bullying Prevention Is Crime Prevention: A Report by Fight Crime: Invest in Kids.*

At the time of this reporting, SAT-9 NCE scores were not yet available from participating schools. However, it is expected that the 2004 school performance scores will be available by September 2004. At that time student academic progress can be assessed and an addendum added to this report.

Objective 4. Increasing teachers' knowledge of mental health issues

During Year II of the Counseling Grant project, clinicians continued to utilize a variety of methods to broaden teacher and staff knowledge and understanding of youth mental health issues and early identification. As highlighted earlier in this report, the clinician at Ideal conducted several teacher trainings and workshops on child abuse detection and reporting. In addition, the clinician at Capital City helped broaden and deepen the scope of the EIT and generated interest and enthusiasm among teachers. Lastly, clinicians at all three schools conducted a total of 560 teacher consultations, a 115% increase over Year I. These activities are designed not only to increase teachers' knowledge and skill in identification and management of youth behaviors, but also to encourage meaningful communication among staff on the importance and value of early detection. These activities also help teachers understand the connection between classroom policies, practices, and expectations and student social/emotional functioning and academic performance.

The teachers recognized the impact of these activities on their increased knowledge of mental health issues, as evidenced by their ratings on the Teacher Satisfaction Surveys collected at the conclusion of Year II. Several questions on the survey targeted teacher impressions regarding the extent to which working with the school-based clinician improved their ability to recognize mental health problems in students, make more accurate referrals for services, and whether mental health services in the school were vital to the school infrastructure. Nine of 12 respondents (75%) reported that working with the clinician increased their knowledge of mental health issues facing young children. When asked how, teachers reported that they now know *"how to help children when basic needs are not met,"* have *"a better understanding of the issues and strategies that might help" students,"* and are *"more aware of all mental health issues."* To a lesser degree, only 5 of 11 respondents (45%) felt that working with the school-based clinician increased their capacity to identify and detect mental health problems in their students. Four teachers offered comments to further explain, one of whom said that *"I don't feel comfortable identifying, but feel support when just raising a concern."* Other comments included, *"I have become aware of 'red flags' that otherwise go unnoticed," "I am learning ways to detect and be aware of my students who are having personal problems,"* and *"Sometimes, others can open doors that I do not see."* Nine of 11 teachers (82%) felt better able to make the appropriate student referrals for services as a result of working with the clinician. All 13 respondents (100%) felt that mental health services were vital to the overall infrastructure of their schools.

Objective 5. Creating a lasting infrastructure for mental health services

The foundations of a sustainable mental health services infrastructure were established in Year I with the placement of a clinician at each school, the initiation of prevention and early intervention services, the creation of Early Intervention Teams (EITs), teacher training, the establishment of a Grant Oversight Committee and community partnerships, and the completion of an application to receive Medicaid reimbursement for mental health services. These

significant accomplishments of Year I were extended and strengthened during Year II through the introduction of additional evidenced-based programming, extensive program staff development, the expansion of school-wide and classroom based prevention activities, topical support groups that addressed school specific needs, teacher trainings and parent education workshops, extending community linkages and partnerships, and a strong focus on the central role of the EIT interdisciplinary team in identifying and developing intervention plans for at-risk students. In addition to these extensive accomplishments in Year II, the Counseling Program, with leadership from CSSS, successfully completed the Medicaid reimbursement application process. This significant achievement provides a solid foundation for sustainability.

Objective 6. Improve Parental Involvement

At the initiation of the Counseling Grant project, the parental involvement component was eliminated due to decreased funding by the Department of Education. Nonetheless, over the past two years, project staff remained committed to engaging parents on any level, through various prevention activities and learning opportunities. As mentioned earlier in this report, the clinician at Ideal Academy conducted nearly 50 consultations with parents and was able to interest parents in the two school-wide health fairs offered during Year II. In addition, the clinician at Capital City was able to establish after-school parent sessions that covered a range of special topics, including social skills development. The curriculum was also made available in Spanish so as to extend participation to as many parents as possible. Project staff aim to maintain if not expand opportunities to engage parents in mental health programming in Year III.

SUMMARY

The Friendship Edison Public Charter School (FEPCS)-*Elementary and Secondary School Counseling Program* System is in the second year of a three-year grant from the Department of Education. The Counseling Program, implemented in three DC Public Charter Elementary Schools (Friendship Edison PCS-Woodridge Campus; Capital City PCS, and Ideal Academy PCS), was designed to identify at-risk children early and develop interventions that meet their individual needs. Through prevention and early intervention services, effective counseling, teacher and parent training and skills development, parent and community involvement, and linkages for support services, the Counseling Program aims to reduce risk and increase resiliency among DC Public Charter School students. The Comprehensive School-Based Mental Health Services Model is comprised of multi-level components that include: Early Intervention Teams (EIT) for early identification and referrals for comprehensive services; school-wide and classroom-based prevention activities and programming; early intervention mental health counseling; and staff training and technical assistance. Particular emphasis is placed on building a sustainable mental health services infrastructure.

The mediating role that an individual school's culture and context play in program implementation and model replication was evident in the qualitative analysis. For example, individual and small group student therapy was less a focus at Ideal, where school administrators opted for programming that was more collective in its approach. In contrast, clinicians at Capital City and Woodridge used individual and small group therapy to expand and/or sustain their programs and establish connections with staff. At the same time, clinicians at Capital City and Woodridge found success working independently with teachers through consultation and observation, while the clinician at Ideal utilized administrative support and involvement to implement staff development trainings and coordinate a school-wide health fair. Despite differences, each school achieved success in implementing multiple program components. Secondary Prevention, which was comprised of topical support groups (i.e., social skills; grief and loss), was the one project component to be successfully implemented by all schools, while parent involvement was the least successful.

In addition to successes in achieving implementation objectives, the Counseling Program received positive feedback from staff, students and teachers regarding the value and impact of its services. Project staff noted the latitude given to them to intervene at multiple levels and to be responsive to the individual student and school needs as they arise. All staff felt project was effectively delivering services to students and their families, but recommended improved program materials. Student survey responses indicated an increased sense of self, better outlook toward school, and improved relationships with peers as a result of time with working with the clinician. Teacher reports indicated strong relationships between school-based clinicians and the school staff.

The impact of the Counseling Grant services on student outcomes and the success of the program in developing a sustainable mental health services infrastructure were examined by individual school and across schools. Preliminary findings suggest success in sustaining youth

resiliency, decreasing youth violence, increasing teachers' knowledge and awareness of mental health issues and ability to identify problems early, building sustainable infrastructure and increasing parental involvement.

Of particular interest are the findings of the California Healthy Kids Surveys, which were administered to 264 third, fourth, and fifth grade students at Ideal Academy, Capital City Public Charter School, and the Woodridge Campus of Friendship-Edison Public Charter Schools. The survey is designed to assess youth health risk and resilience, as well as the factors that influence them. The overall profiles of the schools (coded School A, B, and C) vary somewhat with regard to students' health-risk behaviors and resiliency factors as measured on the CHKS. Sixty-two percent (n=163) of the 264 students who completed the survey were from School C. Twenty-five percent (n=66) of the total group surveyed was from School A, with the smallest cohort (13%; n=35) completing surveys at School B. Key findings include:

o   As in Year I, students at all three schools appear to have adequate *Caring Relationships* and *High Expectations* both at home and school, with results continuing to indicate that these resilience factors are stronger in the home environment. Scores in *High Expectations* particularly, both at school and in the home, are consistently the highest scores for all three schools. When Year II mean scores for the individual schools are compared with their respective Year I scores, Schools A and B show slight increases in at least one area. More significantly, however, were the increased percentages of individual students who achieved High scores compared to Year I. Specifically, the number of students at School A who scored High in *all* External Assets in the School Environment rose by 7% to 13%. *Meaningful Participation* scores continued to be lower for all schools and in both environments, although .1 mean increases were achieved by Schools B and C.

o   In the Home domain, all schools maintained mean scores in the High range in Caring Relationships, suggesting that students have strong connective bonds with adults at home. Moreover, these scores increased for both Schools A and B (by .1 and .2, respectively), while School C retained its same score. The number of high scorers also increased School A and at School B. As in Year I, the majority of students at each school (91% to 94%) scored high in *High Expectations* in the home, indicating that they feel they are viewed as valued participants. On the other hand, only 17% to 26% scored high in Meaningful Participation, suggesting that most students continue to perceive infrequent opportunities to *contribute meaningfully* to the life of the family. Impressively, however, increases in both mean scores and number of students with high scores in *all* areas of the home environment were realized by School B. In addition to increases in all mean scores in this domain, more School B students scored in the High range in Year II as compared to Year I. With Meaningful Participation scores both at school and at home continuing to be relatively low across all schools, it remains essential that students be encouraged to participate actively and be provided with opportunities to contribute their talents and abilities in both environments.

o   Mean Empathy and Problem Solving scores for Schools A and C fall in the Moderate range, with each school's score remaining the same as Year I or decreasing slightly. Interestingly, while School A's decreased Empathy scores may correlate with increased rates of bullying,

the same relationship cannot be assumed at School C, where bullying decreased by 13 percentage points and coexists with a .2 decrease in Empathy.

o The most significant Internal Assets gains in both mean scores and in students scoring high were realized by School B. Mean score gains were made by School B in each internal asset (+.2 in Empathy and Problem Solving to +.3 in Goals and Aspirations) Moreover, the number of high scorers increased by 2 percentage points in Problem Solving, 8 percentage points in Empathy, and most impressively, by 31 percentage points in Goals and Aspirations.

o Results for Lifetime ATOD Usage revealed that the percentages of students reporting experimentation remained static or decreased at Schools A and B, with significant declines in tobacco (-15percentage points) and inhalant (-17percentage points) rates at School B. Increased usage of all four substances was reported by students at School C, where Year II rates rose an average of 8 percentage points over Year I rates (from a 5 point increase in Inhalant use to a 13 point increase in alcohol rates). Cohort effects at both Schools B and C show increased alcohol usage in the 3rd grade cohort, where more students reported drinking alcohol as 4th graders (+8 percentage points at School B; +14 percentage points at School C). Interestingly, current 3rd graders at all three schools reported having tried alcohol with almost as much (School A) or more frequency (Schools B, C) as last year's 3rd graders.

o Bullying behavior at all three schools continues to be reported by over half of the students surveyed. However, while it remains the most frequently reported negative behavior at all three schools, reports of bullying victimization actually decreased at School C, where a 13 percentage point decrease was noted in students who reported being hit or pushed by others during the past year with (from 73% in Year I to 60% in Year II).

o Results across schools by grade reveal that between 70% and 79% of current 3rd graders report that they have been hit or pushed by other students in the past year. This represents an 18 percentage point increase over last year's 3rd graders at School A and a 15percentage point increase at School C. A 9 point decrease was noted at School B.

o The 3rd grade cohort (current 4th graders) at each school, however, showed an average decrease of 8percentage points in reports of victimization of such behavior. More variability, however, was noted in the 4th grade cohorts, where reports remained essentially the same at School A (55% in Year I to 54% in Year II), increased by 21percentage points at School B (from 46% in Year I to 67% in Year II), and substantially decreased by 23 percentage points at School C (from 80% in Year I to 57% in Year II).

o On indices related to weapons, overall decreases were also noted, both in reports of carrying weapons to school and in seeing others with weapons. Only one school, however, showed decreases in both areas (from 10% to 3% in carrying weapons and from 43% to 27% in witnessing). Conversely, perceived safety at school has increased across schools as reports of weapons carrying decreased

CSSS COUNSELING GRANT-LOGIC MODEL/ASSESSMENT PLAN

PROGRAM GOALS/	ACTIVITIES	OUTCOMES	MEASURES	TARGET DATE
Goal - To develop mental health prevention and early intervention services.				
Individual Level				
A. Youth				
Objective 1 o To improve social/ behavioral skills	o Mental Health early intervention/prevention services in school-based/non-clinical setting o Individual and/or group therapy	o Enhanced resilience as evidenced through improved social and behavioral skills o Reduced suspensions/ expulsions/aggressive behaviors/ fighting incidents	o Behavioral and Emotional Rating Scale (BERS) o Observations o School records o Post surveys	o Jan/June '03 o March '03 o July '03 o June/Oct '03
Objective 2 o To increase the use of healthy behaviors	o Psycho-educational groups o Topical prevention groups	o Increased use of healthy behaviors	o Program records (i.e., Monthly Rpts)	o July/Sept '03
Objective 3 o To improve academic performance	o Teacher consultations o Psycho-educational groups	o Improved grades/academic performance o Increased attendance	o School records o Stanford –9	o July '03

School Level				
B. Teachers				
Objective 1 o To increase teachers' knowledge of mental health issues	o Workshops/seminars on youth mental health issues (depression, stress) o Consultation on student mental health issues	o Increased knowledge and skill in developing socio-emotional competency in students	o Surveys o Training documentation	o Sept '03
Objective 2 o To create lasting infrastructure for mental health and case management services	o School mental health assessment	o Increased incorporation of prevention best practices into classrooms and clinical interventions	o Assessment documentation o Surveys	o Sept '03

APPENDIX B

CSSS – National Counseling Grant Project

Staff Tenure and Qualifications

2003 – 2004

NAME	TITLE	QUALIFICATIONS	START DATE	EXIT DATE
Leadership Staff				
Leila Bakry-Becker	Clinical Director Project Director, Counseling Grant Project *CSSS*	Psy.D., Clinical Psychology	Aug 2002	
T. Allen Gore	Medical Director *CSSS*	MD	Feb 2004	
Service Staff				
Wayne Dunn	Mental Health Clinician *Capital City*	MSW	April 2003	
Sharon Murphy	Mental Health Clinician *Ideal Academy*	Ph.D. Social Work	Dec 2002	
Anise Walker	Mental Health Clinician *Woodridge*	M.Ed.	March 2004	
Erik Hansen	Extern *Woodridge*	Doctoral candidate (Psy.D.)	Sept 2003	June 2004
Elaine Hurson	Extern *Capital City*	Doctoral candidate (Psy.D.)	Oct 2003	June 2004

Former Staff

NAME	TITLE	QUALIFICATIONS	START DATE	EXIT DATE
Mezeline Lindor-Carty	Mental Health Clinician *Woodridge*	MA	March 2003	Dec 2003
Diane Hanek	Clinical Supervisor *CSSS*	LiCSW	Aug 2002	Dec 2003

APPENDIX C

CSSS Mandatory Trainings

Training Name	Date	Offered by	Number of CSSS staff who attended *
CALOCUS-Children and Adolescent Levels of Care Utilization System	5/17/04	DMH	CSSS Team Attended
Unusual Incident Reporting System	6/1/04	DMH	CSSS Team Attended
De-Escalating Techniques for Aggressive Behavior	6/11/04	DMH	CSSS Team Attended
Co-Morbidity Factors for Incarcerated Youth	5/27/04	DMH	CSSS Team Attended
Youth Gang Culture (CC)	6/8/04	DMH	CSSS Team Attended
Diagnostic Assessment Techniques of Children and Adolescents of Color	6/11/04	DMH	CSSS Team Attended
Stages of Development	3/03	Howard University	CSSS Team Attended
Behavior Modification	4/03	Howard University	CSSS Team Attended
Classroom Management Techniques	5/03	Howard University	CSSS Team Attended
Special Education Laws	6/03	Howard University	CSSS Team Attended
Confidentiality	1/03	CSSS	CSSS Team Attended
Making a report to Childe Protective Services	4/03	CSSS	CSSS Team Attended
Attention Deficit Hyperactivity Disorder	4/03	CSSS	CSSS Team Attended
Grief & Loss	4/03	CSSS	CSSS Team Attended
Social Skills Activities for Youth	4/03	CSSS	CSSS Team Attended
Stress Management	4/03	CSSS	CSSS Team Attended
Monthly Reporting Documentation	5/03	CSSS	CSSS Team Attended
How to conduct a Home Visit	6/03	CSSS	CSSS Team Attended
Play Therapy	7/03	CSSS	CSSS Team Attended
Autistic Spectrum Disorders	08/03	CSSS	CSSS Team Attended
Peer Mediation Part I	8/03	CSSS	CSSS Team Attended
Peer Mediation Part II	8/03	CSSS	CSSS Team Attended

CSSS Recommended Trainings

Training Name	Date	Offered By:	Number of CSSS staff who attended *
Principles of Mental Health Recovery for Youth Providers and Family Members	5/6/04	DMH	
Principles of Mental Health Recovery for Youth Providers and Family Members	5/6/04	DMH	
Spirituality and Mental Health Treatment for African-Americans	5/6/04	DMH	
DC Medication Access Project: An Overview	5/11/04	DMH	
The Culture of Youth Gangs (CC)	5/12/04	DMH	
Medication Management for Children	5/19/04	DMH	

and Adolescents			
Children As Witnesses to Domestic Violence	5/20/04	DMH	
Children As Witnesses to Domestic Violence	5/20/04	DMH	
Youth Gang Culture **(CC)**	6/8/04	DMH	
Principles of Mental Health Recovery: Providers for Adult Consumers	6/17/04	DMH	
Principles of Mental Health Recovery for Youth Providers	6/17/04	DMH	
Principles of Mental Health Recovery for Youth Providers and Family Members	5/6/04	DMH	
Principles of Mental Health Recovery for Youth Providers and Family Members	5/6/04	DMH	
Spirituality and Mental Health Treatment for African-Americans	5/6/04	DMH	
DC Medication Access Project: An Overview	5/11/04	DMH	**2**
The Culture of Youth Gangs **(CC)**	5/12/04	DMH	**2**
Medication Management for Children and Adolescents	5/19/04	DMH	
Children As Witnesses to Domestic Violence	5/20/04	DMH	
Children As Witnesses to Domestic Violence	5/20/04	DMH	
Principles of Mental Health Recovery: Providers for Adult Consumers	6/17/04	DMH	

* Blank cells do not indicate that no staff attended, some or all of staff could have attended but that information was unavailable.

CSSS Optional Trainings

Training Name	Date	Offered By:	Number of CSSS staff who attended *
Beyond Stereotypes: Sensitivity Training for Human Services Providers about Commercial Sex Workers Consumers	6-14/04	DMH	2
Domestic Violence Treatment and Research Implications	11-14-03	DMH	2
Diagnostic Assessment with Youth of Color	11/03	DMH	2
Principles of Mental Health Recovery	11/03	DMH	1
Adolescents Who Hate School	4/03	Psychiatric Institute of Washington	2
Changing the Behavior of Large Groups of Adolescents	6/03	DMH	1
Pediatric Obsessive Compulsive	6/03	DMH	1

Disorders			
Developing MHRS Policies and Procedures	12/02	DMH	2
Certification Readiness Issues	12/02	DMH	1
Clinical Documentation and Medicaid Compliance	12/02	DMH	1
Individualized Plan of Care	12/02	DMH	1
A Review of Quality Improvement Methods	12/02	DMH	1
Youth Substance Abuse Treatment Forum	9/10/03	Department of Health	1
Diagnostic Assessment Techniques: Children and Adolescents of Color	11/17/03	DMH	2
An overview of the Gay, Lesbian, Bi-Sexual, Transgender communities	6/03	DMH	2
Adolescents Who Hate School II: Helping the Adolescent to Succeed Academically	4/11/2003	DMH	1
Disaster and Terrorism Update: Mental Health Issues	9/11/03	Georgetown University	2
DC Mental Health Information Act: An Overview of Consumer Privacy Issues and Concerns	10/03	DMH	1

* Blank cells do not indicate that no staff attended, some or all of staff could have attended but that information was unavailable.

APPENDIX D

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CSSS – Counseling Grant
California Healthy Kids Survey Report
Year II

Prepared by
Donna D. Klagholz, Ph.D. & Associates, LLC

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Introduction

In May 2004, the California Healthy Kids Survey (CHKS) was administered to 264 third, fourth, and fifth grade students at Ideal Academy, Capital City Public Charter School, and the Woodridge Campus of Friendship-Edison Public Charter Schools, who participated in the second year of the National Counseling Grant initiative during the 2003-04 school year. The survey is designed to assess youth health risk and resilience, as well as the factors that influence them. Information from the CHKS Technical Report[2] discussion section is used throughout this report to provide context and meaning to the results presented. Schools are coded for confidentiality and participant protection purposes.

Population

CHKS results presented here highlight findings from the May 2004 CHKS follow-up administration at the three participating schools and compare current outcomes to those identified during Year I. Comparative data analysis allows for the tracking of changes in student risk and resiliency over time. Participation rates by grade are included in **Table 1** below. As can be seen in the Table, a 5th Grade cohort was added in Year II in order to follow those 4th grade students who participated in the 2003 baseline CHKS administration. A new 3rd grade cohort was added at each school to provide baseline data on that cohort in Year III.

Table 1. CHKS Participation Rates by Grade and Year

	School A		School B		School C	
Grade	**Year I (n=41)**	**Year II (n=66)**	**Year I (n=25)**	**Year II (n=35)**	**Year I (n=124)**	**Year II (n=163)**
3rd Grade	19	24	14	15	61	51
4th Grade	22	20	11	11	63	59
5th Grade		22		9		53

Of the 264 students surveyed, gender information was available on 262. The group was evenly split, with 131 males and 131 females. The male/female ratio at Schools A and C was similarly split, while the group from School B was comprised of 54% males (n=19/35) and 46%

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[2] Technical Report: Elementary CHKS. A report by WestEd, Los Alamitos, CA. CHKS is copyrighted and funded by the California Department of Education, Healthy Kids Program Office.

females (n=16/35). Data on age (n=263) reveals that students ranged from 7 to 13 years old, with a mean age of 9.6.

Alcohol, Tobacco, and Other Drug Use

In order to determine the nature and extent of youth drug involvement in the schools and surrounding communities, as well as approximate age of onset, the CHKS assesses the overall lifetime prevalence of the four most popular psychoactive substances among preadolescents: alcohol, tobacco, marijuana, inhalants. Research has shown that when children experiment with even small amounts of substances at a young age, they are more at risk for later involvement. According to the 2002 National Survey on Drug Use and Health, sponsored by the Substance Abuse and Mental Health Administratio n (SAMHSA), illicit drug use among youth tends to increase with age, with 12% of youth ages 12-17 reporting current drug use, peaking at 23% among 18-20 year-olds. Further, in examining the correlation between substances used, results indicate that illicit drug use in 12-17 year-olds is approximately eight times higher among those who smoke cigarettes and 12 times higher in those who drink alcohol. These findings underscore the critical need for the implementation of effective prevention programs in our nation's elementary schools.

Data on ATOD use among students at each of the three schools is presented in **Figures 1 - 7**. Occasionally, not all students responded to a specific question. In such instances, where the number of respondents is less than the total surveyed at each school, the correct ratio (# out of # respondents) is indicated. Also, because the Year II sample size at each school is larger than that of Year I, it is important to note the *n*'s represented in each graph, as lower percentages may actually represent a higher number of students.

Alcohol

As seen in **Figure 1**, the number of students at School A who reported having taken *at least* sips of alcohol at some point in their lives decreased from 43% in Year I to 39% in Year II. The percentage of students at School B increased slightly (from 24% to 26%), while there was a more significant increase in students reporting the same at School C (from 20% to 33%).

Figure 1. Lifetime Alcohol Use – Years I and II: Comparative Data
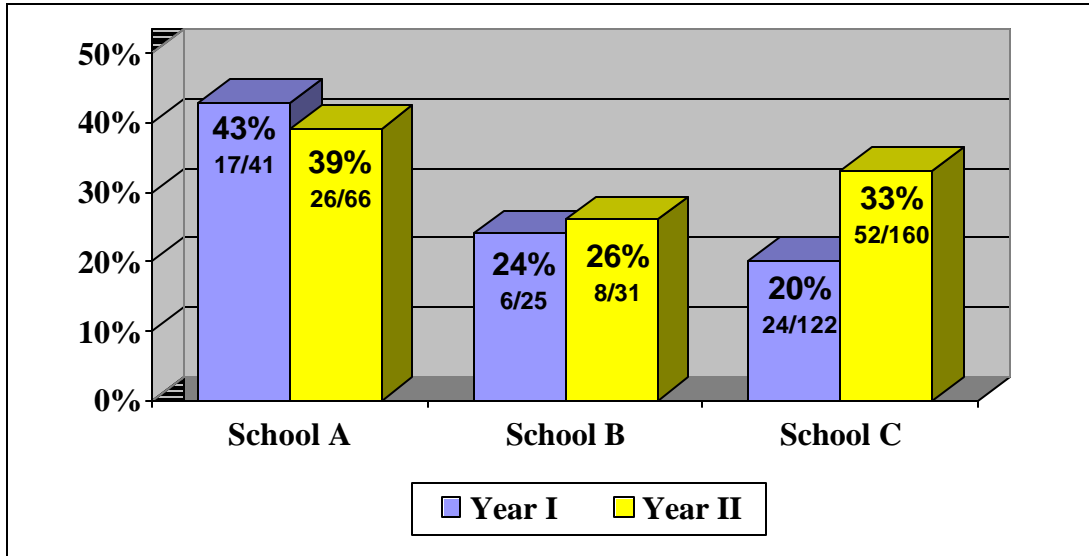
Given that alcohol is the most widely used substance across both program years, each school's data was analyzed for cohort effects. This data represents findings on the 3rd grade cohort (3rd graders in Year I who were re-administered the CHKS as 4th graders in Year II), the 4th grade cohort (last year's 4th graders who completed the CHKS as 5th graders in Year II) and the current 3rd grade group, who were administered the CHKS for the first time and whose results serve as baseline data for follow-up analysis in Year III. **Figure 2** below reveals a decline in alcohol use across the 3rd grade cohort at School A, where reported use decreased by 18 percentage points in 2004. The rate for the 4th grade cohort remained static. The current 3rd graders reported having had alcohol at approximately the same rate as last year's 3rd graders (50% vs. 53%).

Figure 2. Cohort Effects – Alcohol Use: School A
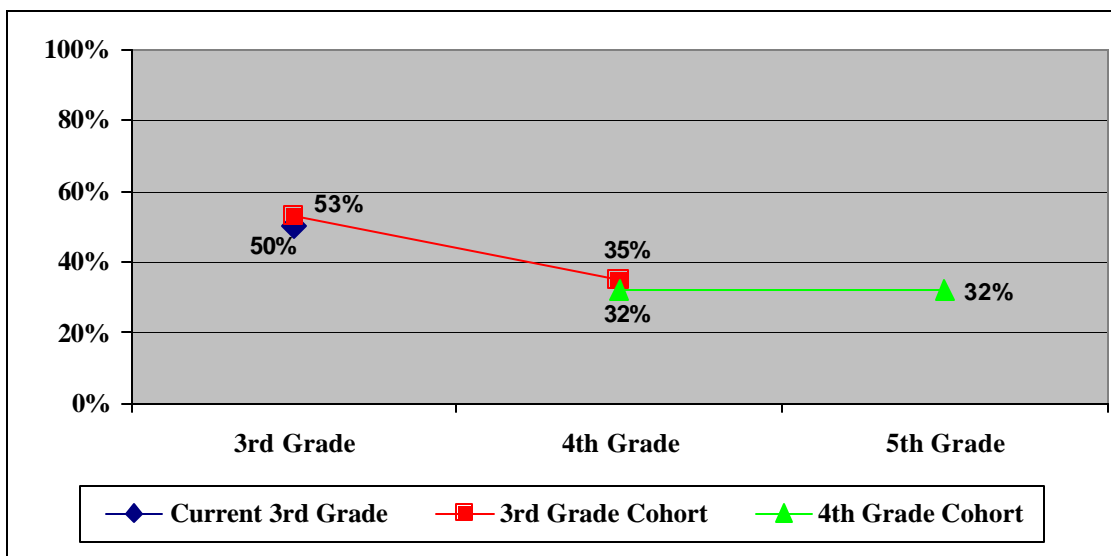
As seen in **Figure 3**, results at School B reveal that the 3rd grade cohort's rate of alcohol use increased by eight percentage points as 4th graders. A slight increase was noted in the 4th grade cohort, as well. A higher percentage of the current 3rd grade cohort (21%) report having had some alcohol, compared to last year's 3rd graders.

Figure 3. Cohort Effects – Alcohol Use: School B
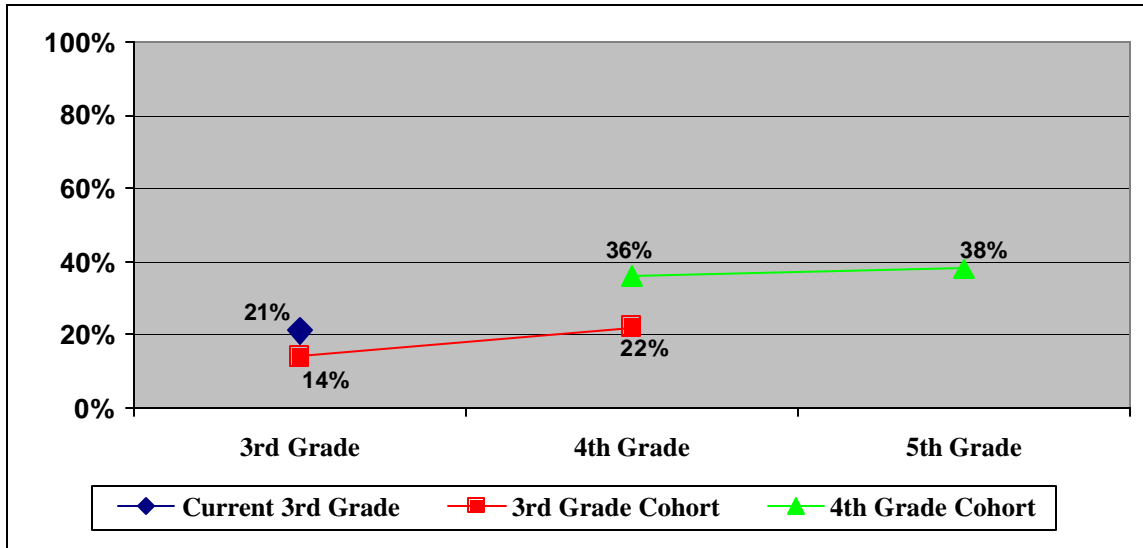
As seen in **Figure 4**, the 3rd grade cohort at School C reported a higher rate of alcohol use than the 4th grade in Year I. With increases in both cohorts' rates in Year II, the 3rd grade cohort's rate as current 4th graders exceeds the 4th grade cohort by 10 percentage points. The current 3rd graders' rate for alcohol use was found to be 33%, 10 percentage points higher than last year's 3rd graders.

Figure 4. Cohort Effects – Alcohol Use: School C
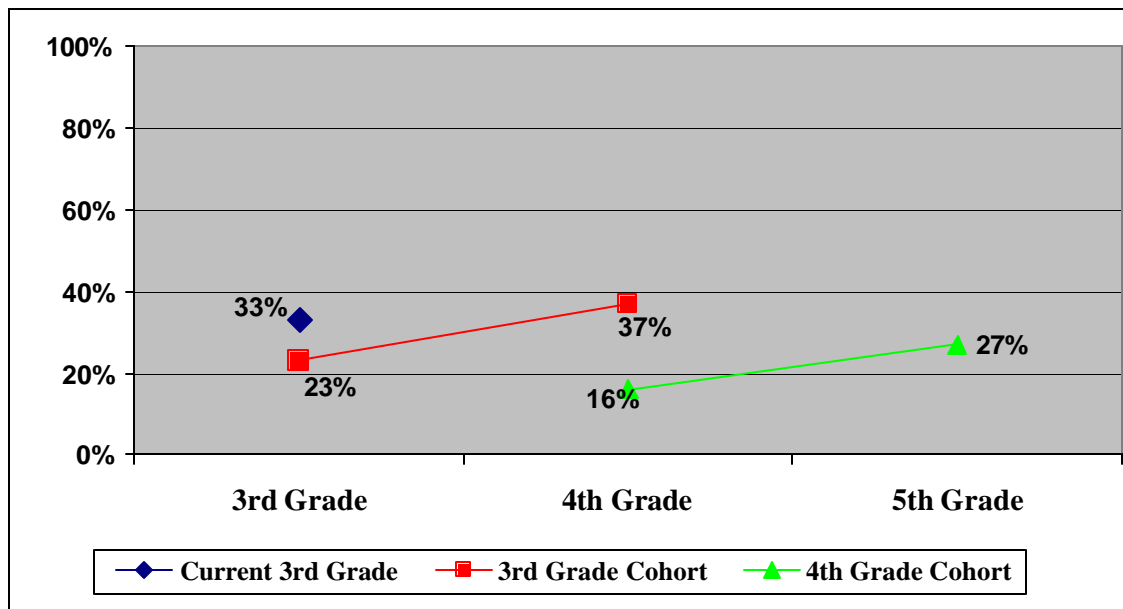
Tobacco

Figure 5 shows variance in comparative lifetime tobacco use. While only School B showed a significant decrease in the percentage of students who have tried at least a few puffs of a cigarette (from 24% to 9%), rates at School A remained the same, while School C had a 57% increase in students reporting smoking behavior from Year I to Year II. Of those 19 students at School C, eight were 4th graders (42%) and nine were 5th graders (47%).

Figure 5. Lifetime Cigarette Smoking – Years I and II: Comparative Data
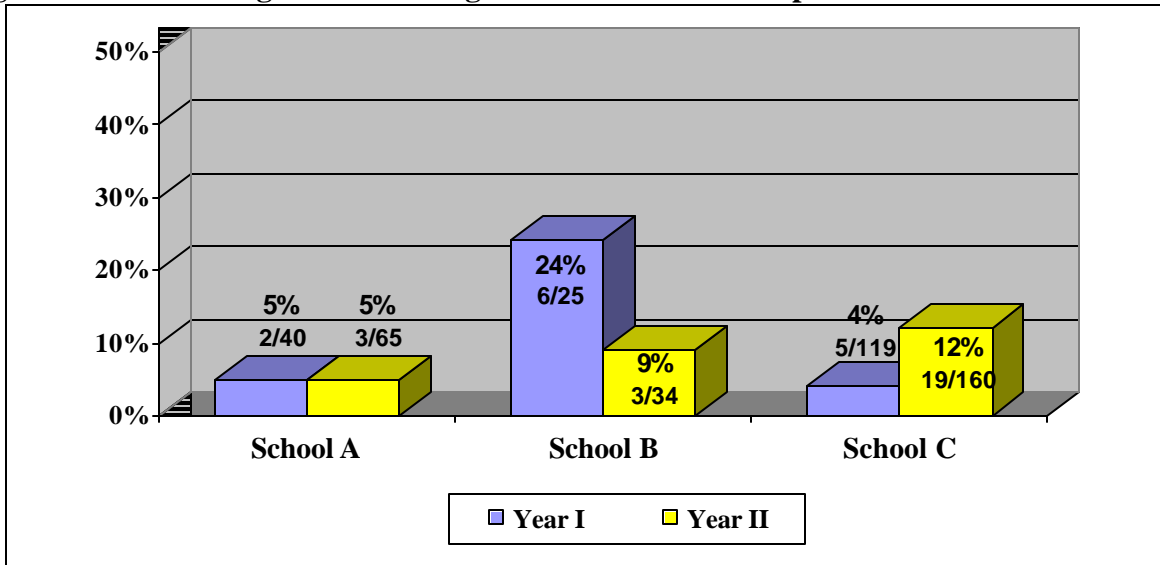
Inhalants

Comparative results for Years I and II on reported use of inhalants mirror those for tobacco usage. **Figure 6** shows that rates have remained static for School A, while a slight increase was found at School C (from 4% to 9%). A significant decrease was again noted at School B, where 72% fewer students reported this behavior. Interestingly, the greatest number of students who reported inhalant use at School C were the youngest. Of the 15 students who responded positively to the question, "Have you ever sniffed something through your nose to get high?" seven (46%) were 3rd graders and six (40%) were 4th graders.

Figure 6. Lifetime Inhalant Use – Years I and II: Comparative Data
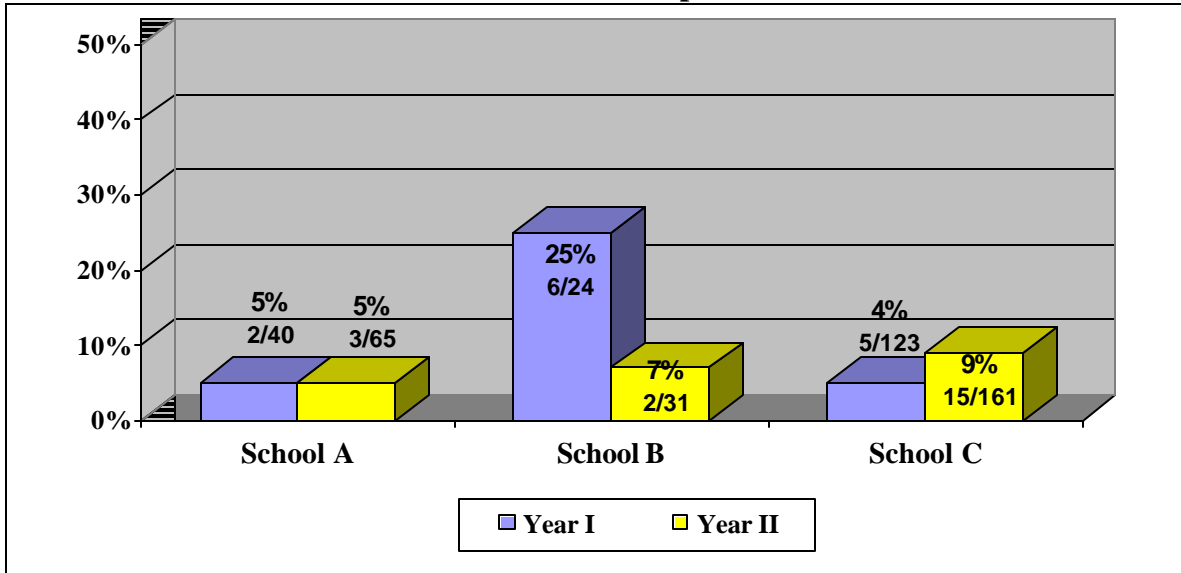
Marijuana

While only one student at each of Schools A and B reported experimenting with marijuana in Year I, current results show that no students at either school report such use. As seen in **Figure 7**, however, results indicate a 6 percentage point increase in students at School C who report trying marijuana (from 2% to 8%).

Figure 7. Lifetime Marijuana – Years I and II: Comparative Data
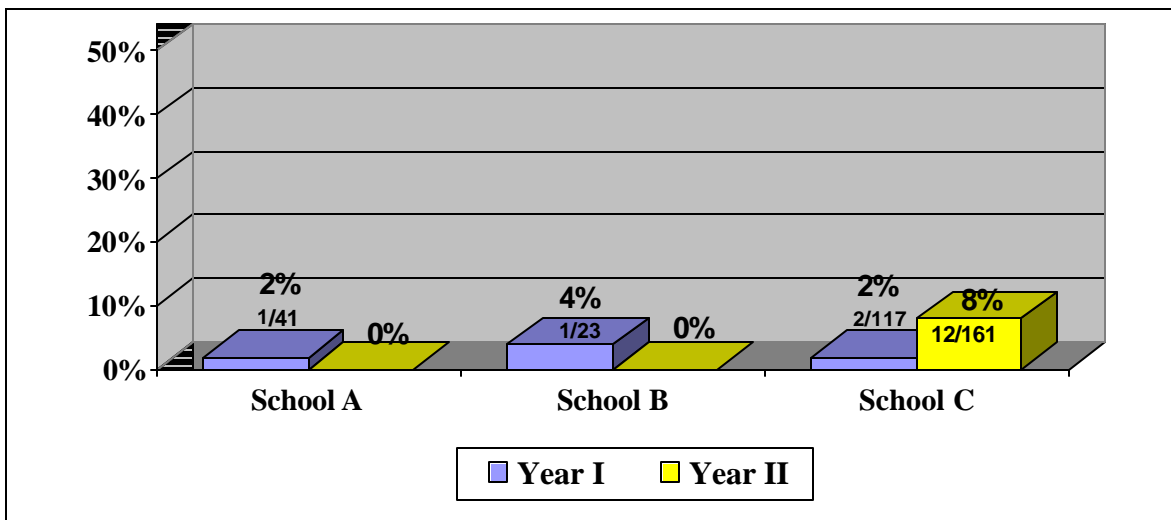
Perception of ATOD Risk

A student's perception that drug use is a high-risk activity, especially as students advance through secondary school, is associated with lower rates of usage. As such, items on the CHKS target students' perception of risk of use for alcohol, tobacco and other drugs. As can be seen in **Figure 8** below, a decrease in perception of risk associated with alcohol use was found at School

A. Conversely, an increase was noted at School C, as well as a more substantial increase at School B, where rates rose from 77% to 91%.

Figure 8. Perception of Health Risk from Alcohol Use
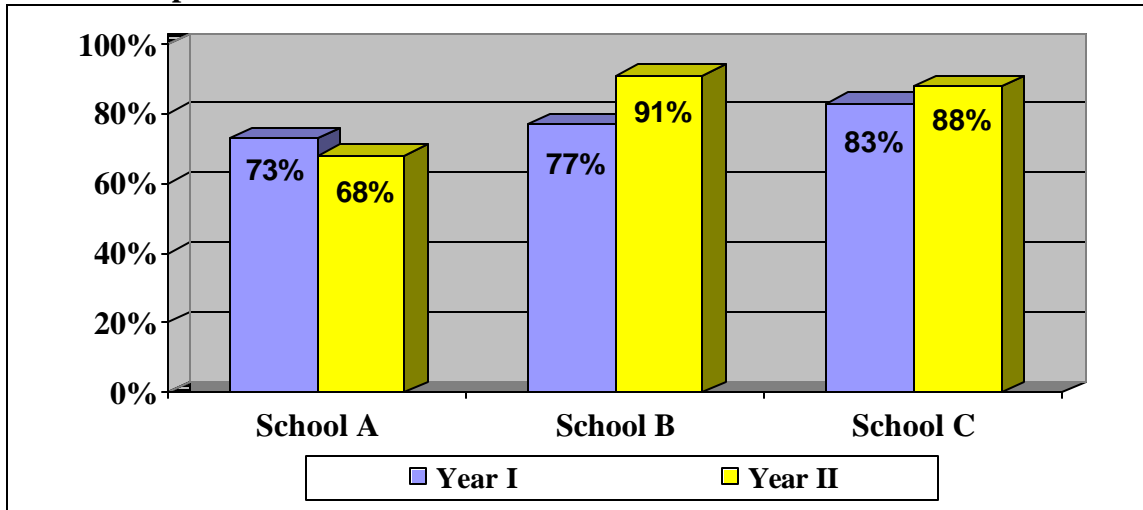
The substance perceived to carry the most risk and, indeed the only substance associated with an increase in risk perception across all schools was tobacco. As shown in **Figure 9**, 100% of respondents at School B, consider smoking cigarettes to be very harmful, along with 99% of those at School A. A 2% increase at School C was found, where the rate rose to 89%.

Figure 9. Perception of Health Risk from Cigarette Smoking
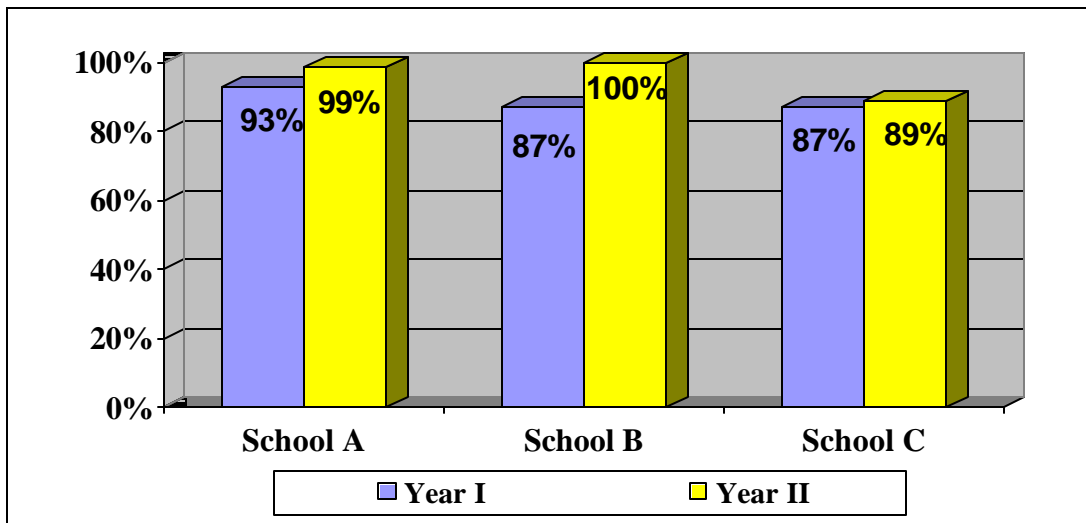
With the exception of School A, where alcohol is perceived to carry the least amount of risk, students consider marijuana the least risky substance of all three most commonly used by youth. Interestingly, the increased perception of alcohol risk at School B was somewhat tempered by a decreased perception of marijuana risk. As seen in **Figure 10**, rates for School C remain the lowest, at a consistent 70%.

Figure 10. Perception of Health Risk from Marijuana
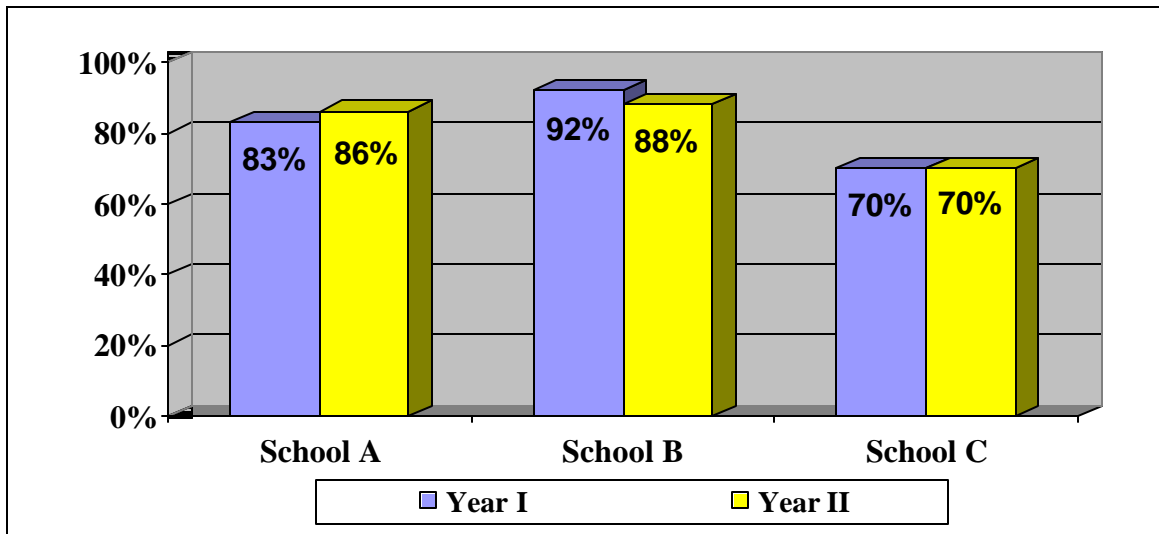
Violence and Safety

The prevalence of aggressive behaviors in youth, particularly bullying, is a growing concern across the nation. According to a study published in the April 2001 Journal of the American Medical Association[3], more than 16% of US students reported being victims of bullying during the current school year, with the frequency of such behavior being highest among 6th to 8th grade students. Further, a report released on September 4, 2003, by Fight Crime: Invest in Kids[4] adds that 60% of boys identified as "bullies" in grades 6 through 9 were later convicted of at least one crime by the age of 24. Efforts, therefore, at addressing bullying behavior and its consequences for both the bullies and the victims in the lower elementary grades are critical.

Figure 11 below illustrates School A students' responses to questions involving violence at school. Students were asked if they had brought a gun or knife to school in the year prior to completing the survey, and whether they had seen other students with weapons at school within the same time period. In Year II, the rates for carrying weapons and for witnessing others with weapons decreased, by 70% and 37% respectively. On the other hand, bullying behavior increased slightly (10%) in Year II. Overall, however, almost all respondents feel safe in the school environment.

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[3] Nansel, T., Overpeck, M., Pilla, R., Ruan, W., Simons-Morton, B., & Scheidt, P. (2001) Bullying behaviors among US youth: Prevalence and association with psychosocial adjustment. *Journal of the American Medical Association*, (285) 16, 2094-2100.
[4] Fox, J., Elliott, D., Kerlikowske, R., Newman, S., & Christeson, W. (2003) *Bullying Prevention Is Crime Prevention: A Report by Fight Crime: Invest in Kids.*

Figure 11. Violence Related Behaviors and Experiences – School A
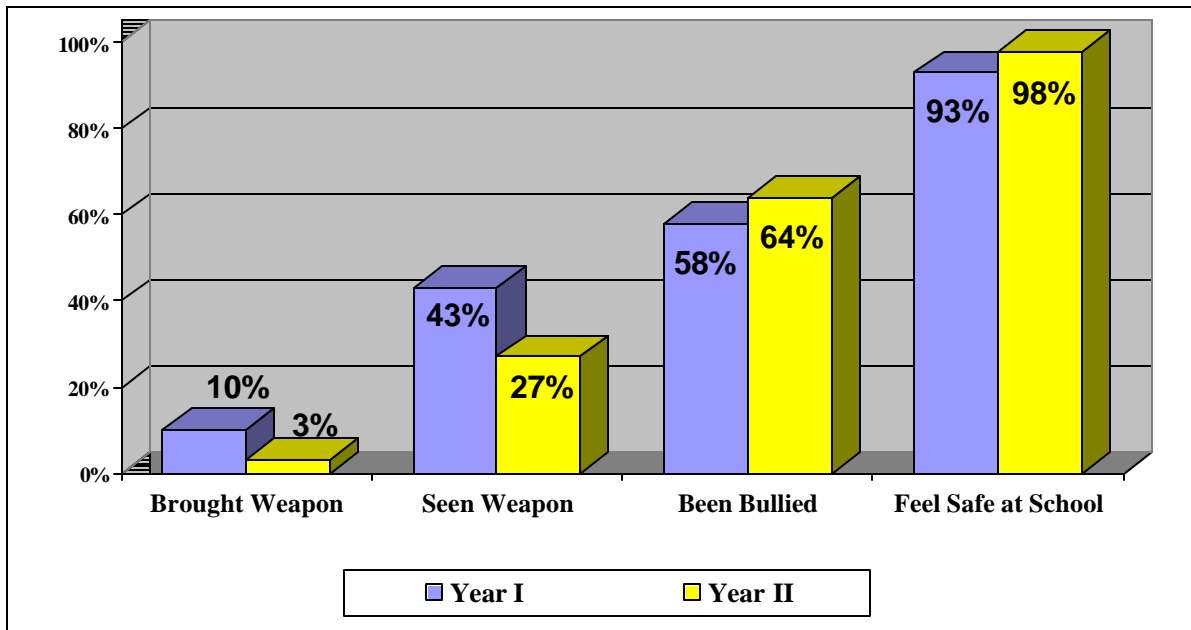
In light of the pervasive nature of bullying at participating schools, as well as in schools across the country, data on this behavior was also analyzed for cohort effects. **Figure 12** below reveals a decline in reported bullying behavior across both the 3rd and 4th grade cohorts at School A. The overall 10% increase in the school's bullying rate is heavily weighted, however, by the 79% of current 3rd graders reporting that they have been hit or pushed by others at least some of the time.

Figure 12. Cohort Effects – Victimization of Bullying: School A
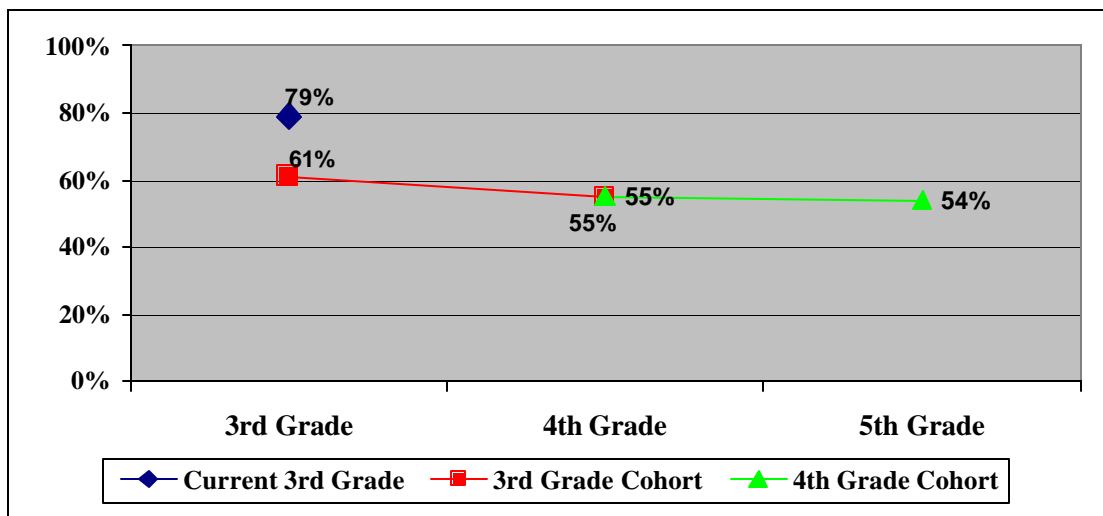
Cohort decreases in other violent behaviors and experiences were also found. Specifically, a 100% decrease in current 4th graders' reports of bringing weapons to school was found (from 11% in Year I as 3rd graders to 0% in Year II). The 4th grade cohort remained static

at 9%. Additionally, the 3rd grade cohort reported 39% fewer instances of witnessing weapons at school (from 33% as 3rd graders in Year I to 20% as 4th graders in Year II). Similarly, the 4th grade cohort reported 20% fewer instances in Year II (from 50% in Year I to 40% as 5th graders in Year II). Both the 3rd and 4th grade cohorts also showed gains in reports of feeling safe at school. No current 3rd graders reported bringing a weapon to school in the past year; however, 21% (n=5/24) reported witnessing other who did so.

Figure 13 below illustrates School B students' responses to questions relating to violence at school. Although the rate for carrying a gun or knife to school is down from 12% to 7%, rates for witnessing others with weapons increased by 4 percentage points (from 13% to 17%). Additionally, a rise in bullying behavior was found, from 68% in Year I to 74% in Year II. Interestingly, however, the largest increase (11 percentage points) was found in students reporting feeling safe at school, where 87% of students in Year II reported feeling safe some, most, or all the time, as compared to 76% of Year I students.

Figure 13. Violence Related Behaviors and Experiences – School B
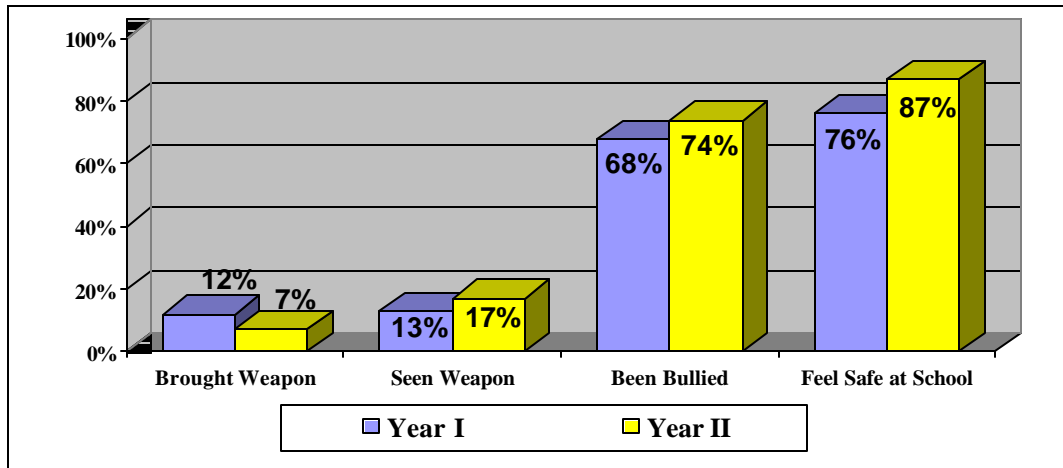
Figure 14 shows that when bullying behavior at School B was examined for cohort effects, data revealed a decrease in the 3rd grade cohort (from 86% in Year I to 78% as 4th graders in Year II). On the other hand, the 4th grade cohort showed a 46% increase in student reports of bullying victimization, as this group's rate went from 46% in Year I to 67% in Year II. High rates of victimization were also reported by the current 3rd grade (77%).

Figure 14. Cohort Effects – Victimization of Bullying: School B
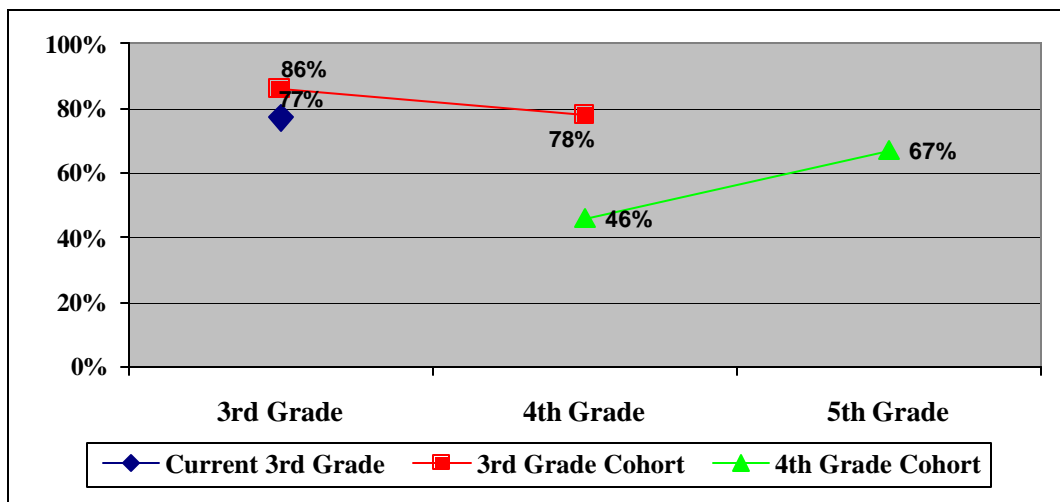
Cohort decreases in other violent behaviors and experiences were also found at School B, particularly with the 4th grade cohort. Specifically, a 100% decrease in current 5th graders' reports of bringing weapons to school was found (from 27% in Year I as 4th graders to 0% in Year II). Additionally, the 4th grade cohort's rate for witnessing others with weapons dropped from 20% in Year I to 13% in Year II. Conversely, increases in both bringing and witnessing weapons were noted with the 3rd grade cohort. Whereas this group had no students report carrying a gun or knife to school in Year I, 11% reported such behavior in Year II. Additionally, reports of witnessing other students with weapons at school rose from 8% in Year I to 33% as current 4th graders, an increase of 25 percentage points. This increase in reported presence of weapons is reflected in a decrease in this cohort's reports of feeling safe at school, where the rate went from 79% in Year I to 75% in Year II. The 4th grade cohort, on the other hand, showed a 37% increase in perceived safety at school, from 73% to 100%. One current 3rd grader (8%) reported bringing a weapon to school.

Figure 15 below illustrates violence-related behavior rates for School C. Across years, rates remained comparable for reports of carrying a gun or knife to school (4% vs. 5%). A decrease, however, was found in witnessing weapons at school (from 41% to 37%) and, more significantly, in reported instances of bullying victimization, where the rate decreased by 13 percentage points (from 73% to 60%). A slight increase was found in the number of students reporting feeling safe at school some, most, or all the time.

**Figure 15. Violence Related Behaviors and Experiences – School C**
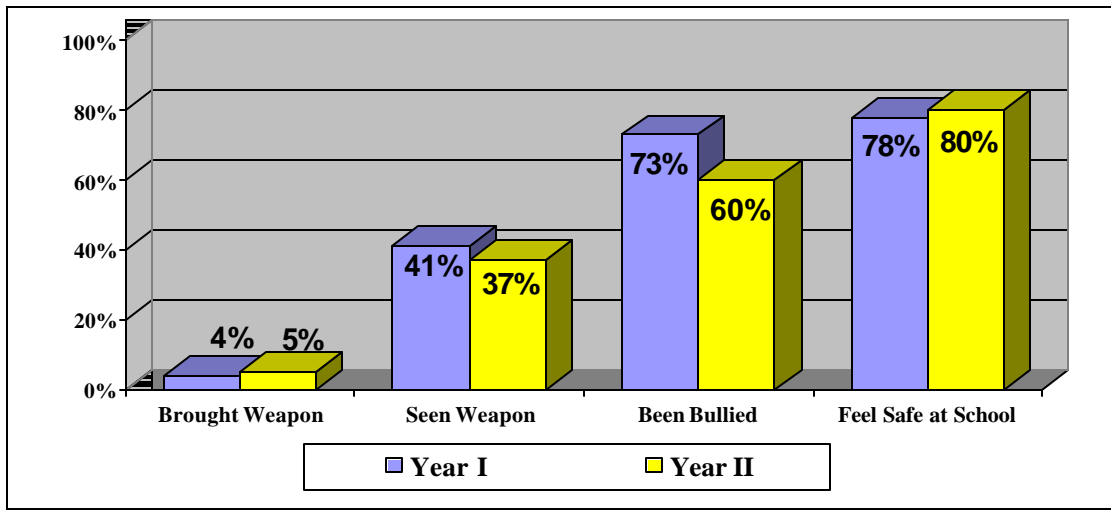
Figure 16 shows that at School C, bullying behavior for each cohort decreased across years. A 14% decrease was found in the 3rd grade cohort (from 65% to 54%) while a more substantial drop (29%) was noted in the 4th grade cohort, where the Year I rate of 80% decreased to 57% in Year II. Seventy percent of the current 3rd graders reported that they had been victims of bullying behavior in the past year.

Figure 16. Cohort Effects – Victimization of Bullying: School C
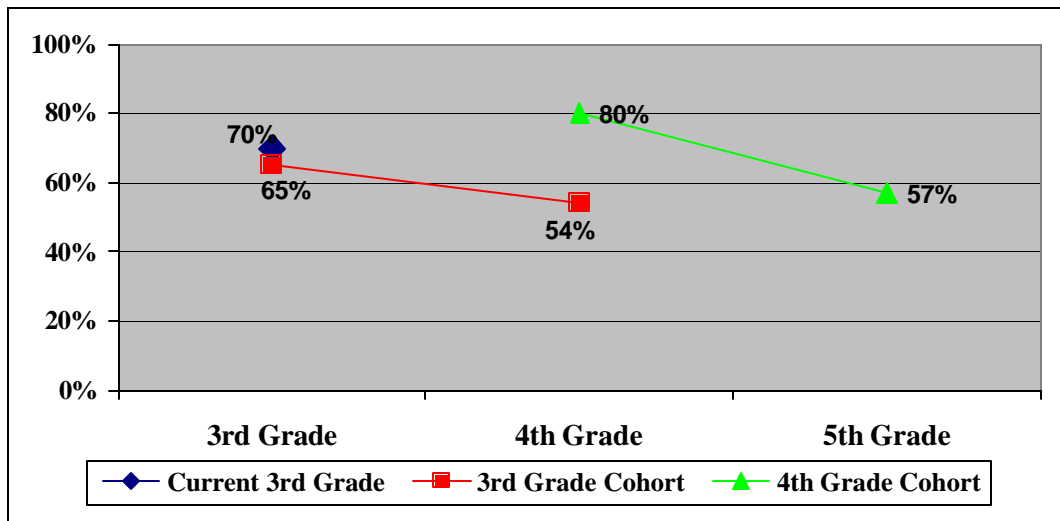
School C's Year II data on the indices related to weapons shows increased reports from the 3rd grade cohort, while the 4th grade cohort shows declines. Specifically more students in the 3rd grade cohort report bringing a gun or knife to school during the past year (up from 2% in Year I to 9% in Year II as 4th graders), while an increase (from 31% to 39%) report witnessing others who have. In the 4th grade cohort, a slight decrease was found in reports of carrying weapons on school property, while a 31% decrease (51% to 35%) was found in that cohort's reports of seeing others at school with weapons. No current 3rd graders reported bringing a

weapon to school; however, 36% (n=17/47) reported seeing other students at school who had done so in the past year.

Resiliency Factors

A. External Assets

External assets refer to environmental or external supports and opportunities that are linked to the development of innate resilience in youth. Research has shown that three principles are essential in healthy youth development: *Caring Relationships, High Expectations,* and *Opportunities for Meaningful Participation.* The CHKS measures students' perceptions of these principles in two environments: the school and the home.

Caring Relationships: These are defined as a student's supportive connections to others who are role models of healthy development and well-being. Research has consistently shown caring relationships to be the most critical factor in successful child development.

High Expectations: These are messages relayed both directly and indirectly by adults that communicate their belief that the student can and will succeed responsibly. These are at the core of caring relationships and reflect the adult's and friend's trust in the youth's resilience and ability to learn. High expectations have been shown to be a key protective factor in the environments of youth who have refrained from involvement in risk behaviors.

Meaningful Participation: Meaningful participation refers to the involvement of the student in relevant, engaging, and interesting activities with opportunities for responsibility and contribution. Research has shown that when youth are given valued responsibilities, planning and decision-making opportunities, and chances to contribute and help others, positive developmental health/academic outcomes are achieved.

The following categories are used to group scores: **High** (average item response above 3), **Moderate** (average item response of at least 2 and no more than 3), and **Low** (average item response below 2).

1.   External Assets: School Environment

Figure 17 presents the mean scores for students at School A in External Assets in the school environment. Scores above 3, categorized as *High*, indicate the presence of strong external supports and opportunities for positive outcomes. In the area of **Caring Relationships**, School A's mean score continues to fall in the *High* range, suggesting that students have strong supportive connections with teachers and other adults at school. A caring relationship with teachers is considered to be one of the strongest motivations for academic success. Additionally, *High* scores in *Caring Adults in the School* are generally indicative of a school staff that is receiving support and care themselves.

School A's scores in the area of **High Expectations** remained in the *High* range. Like positive student-teacher relationships, high expectations on the part of school staff have a direct

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impact on the quality of students' academic performance. Results clearly show that students at School A are perceiving that the adults at school convey high expectation messages as well as demonstrate belief in their ability to succeed.

Meaningful Participation in the school environment continues to fall in the *Moderate* range. This may suggest that students feel they have infrequent involvement and opportunity for responsibility and contribution. The school may want to explore ways of providing students with increased opportunities to assume responsibility and contribute to the school community. Research has documented positive developmental outcomes when teaching activities are based on reciprocity and collaboration with students rather than authoritative control.

Figure 17: External Assets in the School Environment – Mean Scores: School A
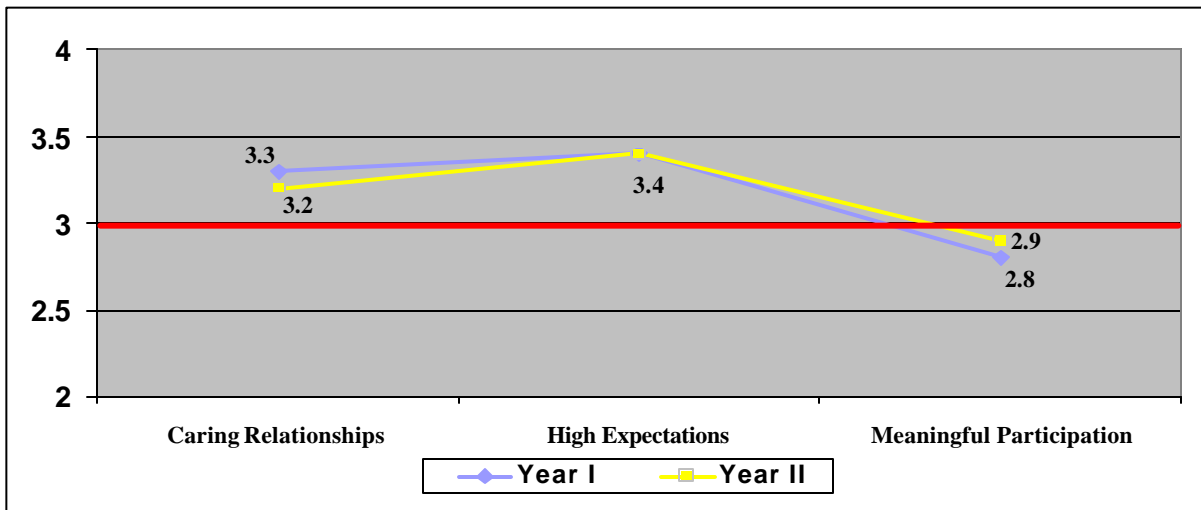
Whereas School A's comparative mean scores indicate that External Assets have remained relatively constant over the two years, individual student scores denote increased numbers of students who scored in the High range in all three assets. As shown in **Figure 18**, the most significant increase is in the area of *High Expectations*, where the percentage of students earning *High* scores rose from 63% in Year I to 76% in Year II, a 21% increase.

Figure 18. External Assets in the School Environment - High Scorers: School A
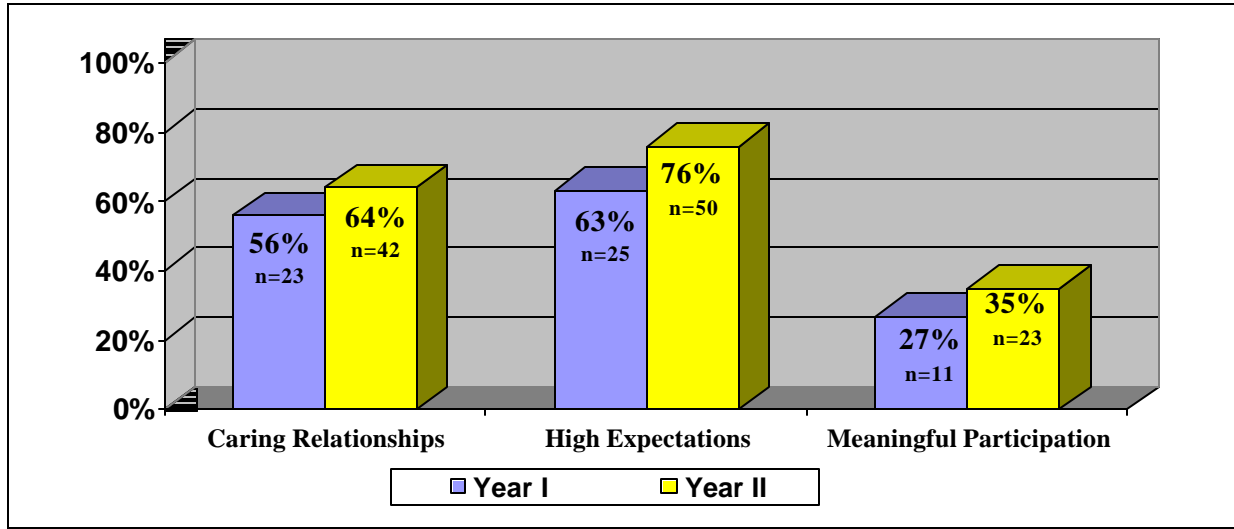
The External Asset mean scores for School B indicate that High Expectations is the one area that has been consistently in the High range. This is suggestive of a student body that clearly perceives the faculty and staff at school to have confidence in their ability to succeed   A .3 increase in the mean score for Caring Relationships places this score in the High range, as well. Scores in Meaningful Participation remain in the lower end of the Moderate range, suggesting that administrators at School B may also want to investigate strategies to provide students with increased opportunities to assume responsibility and contribute to the school community.

Figure 18: External Assets in the School Environment – Mean Scores: School B
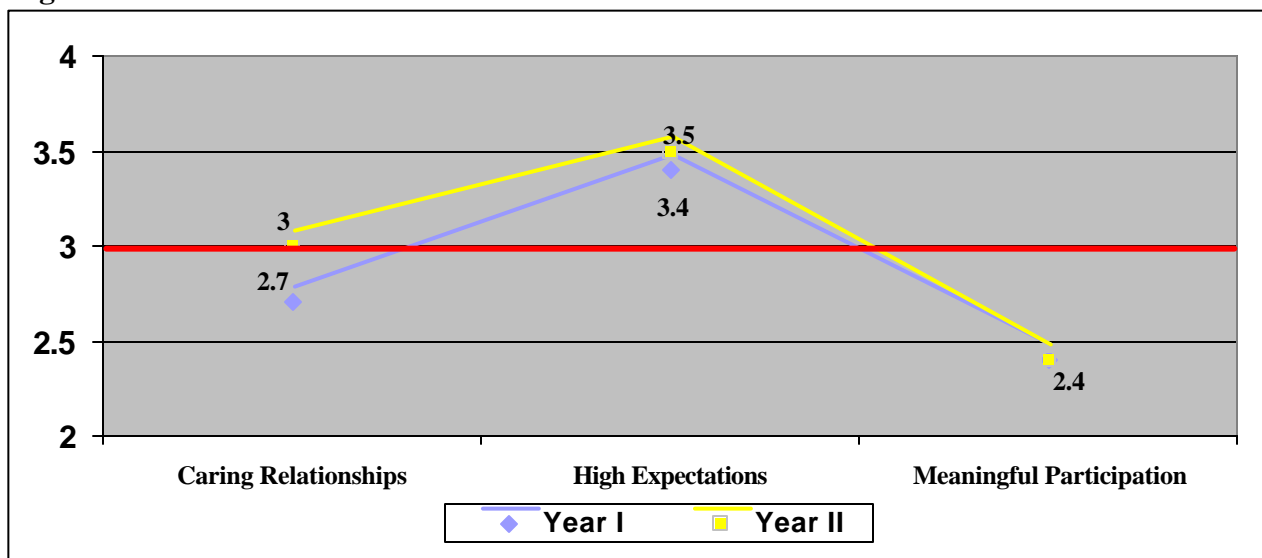
Figure 19 shows the percentages of Year I and Year II students who scored in the High range at School B. Although the mean score for *Caring Relationships* increased in Year II, the

number of students with scores in the High range slightly decreased in Year II. On the other hand, the modest .1 gain in the *High Expectations* mean reflects a 5 percentage point increase in *High* scoring students. Whereas the *Meaningful Participation* score remained static, fewer students scored in the High range, from 13% in Year I to 5% in Year II.

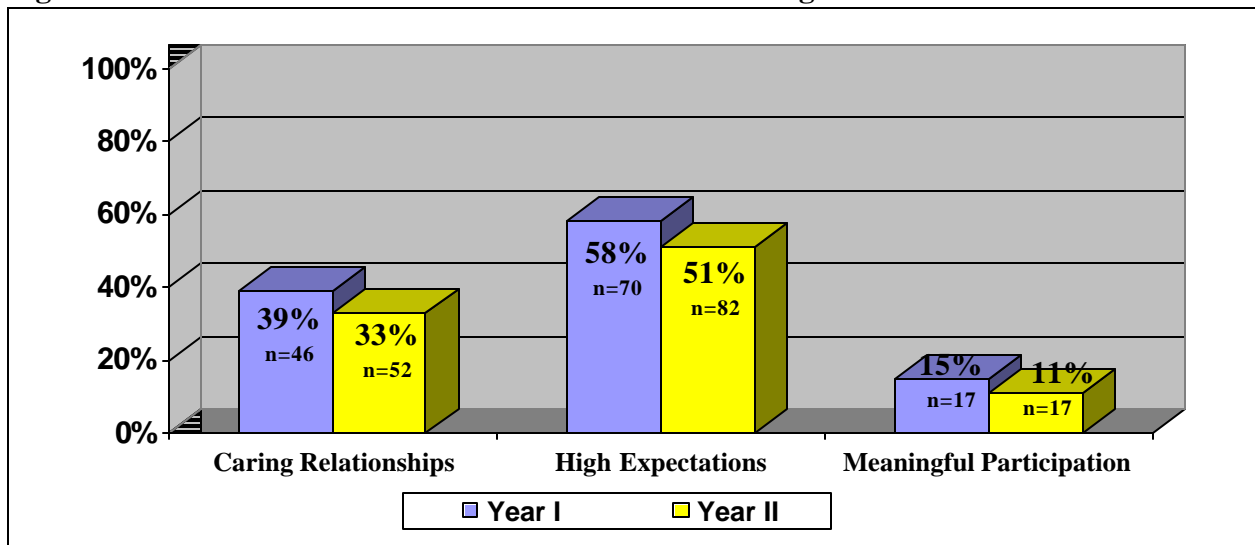**Figure 19. External Assets in the School Environment - High Scorers: School B**
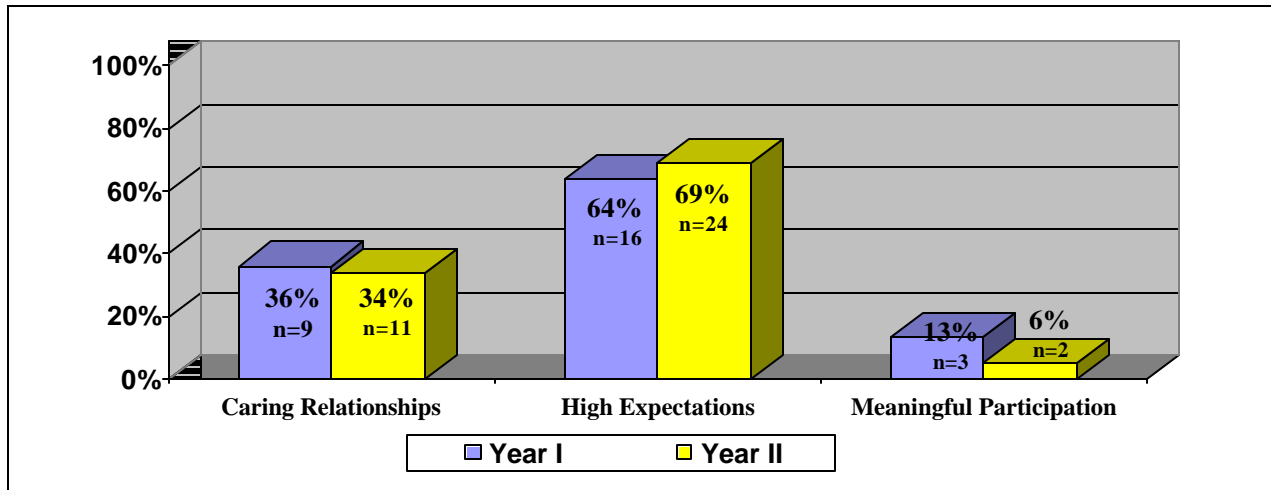
Unlike Schools A and B, School C maintained the same *Moderate* range mean in Caring Relationships. School C may want to explore ways to foster student-teacher relationships through activities that build supportive connections and encourage increased collaboration between teachers and students. Because relationships with teachers so strongly impact student motivation for academic success, focusing on cultivating student-teacher bonds will yield multi-faceted benefits. Like Schools A and B, the mean score for High Expectations continues to be in the High range, indicating that students realize that the adults at school believe in their ability to succeed. Meaningful Participation scores in the lower end of the Moderate range imply that the students could benefit from increased opportunity to contribute to the school community and to assume responsibility for their learning.

Figure 20: External Assets in the School Environment – School C
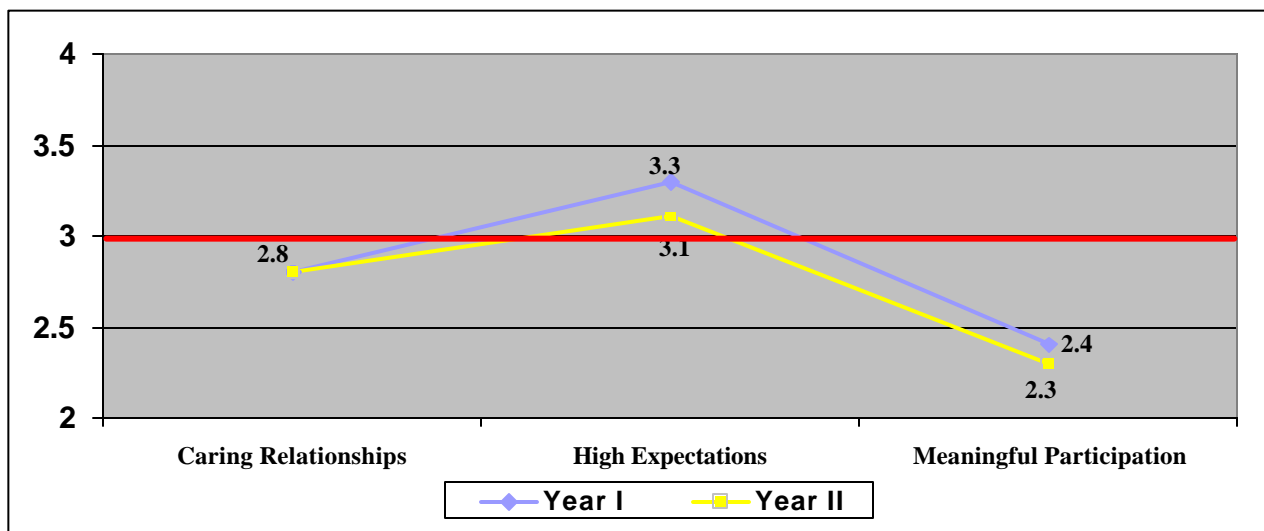
As seen below in **Figure 21**, the percentage of students earning High scores at School C decreased in Year II by 4% to 7% in all three external assets in the school environment. School C may want to intensify its efforts to bolster these essential supports in order to maximize the development of innate resilience in its students.

Figure 21. External Assets in the School Environment - High Scorers: School C

Several strategies that schools can implement in improving the quality of assets in all three domains are provided in technical reports to the schools.

2.   External Assets: Home Environment

When the school and home environments are compared, results for Schools A, B, and C indicate that scores in all three domains are higher in the home environment. Findings at all schools also continue to mirror those of the school environment in that the highest scores were earned in the area of *High Expectations*, while scores were lowest in *Meaningful Participation*. However, unlike those in the school environment, all schools' *Caring Relationships* means for the home environment fall solidly in the High range. This is a clear indication that students at all three schools perceive strong supportive connections and involvement from adults in the home. These positive findings, along with consistently higher mean scores in *High Expectations*, indicate that students at all three schools demonstrate the presence of two critical factors necessary in promoting resilience. These provide a strong foundation on which schools can develop family involvement programs that encourage participation by all family members.

Meaningful participation, while slightly higher than that in school, continues to earn the lowest scores in the home environment. Schools can work on educating parents in their role in providing their children with opportunities to participate and contribute to family life as frequently as possible. Research has shown that when children are given responsibilities in the home and can participate in family decision-making activities, they are also building self-management skills.

Figure 22 shows that at School A, mean scores for *Caring Relationships* and *High Expectations* remained essentially the same as in Year I, in the *High* range. The slight .2 decrease in *Meaningful Participation*, while not a significant drop, may be an incentive for the school to play a more active role in providing family involvement programs that model collaborative parent-child decision making skills.

Figure 22: External Assets in the Home Environment – Mean Scores: School A
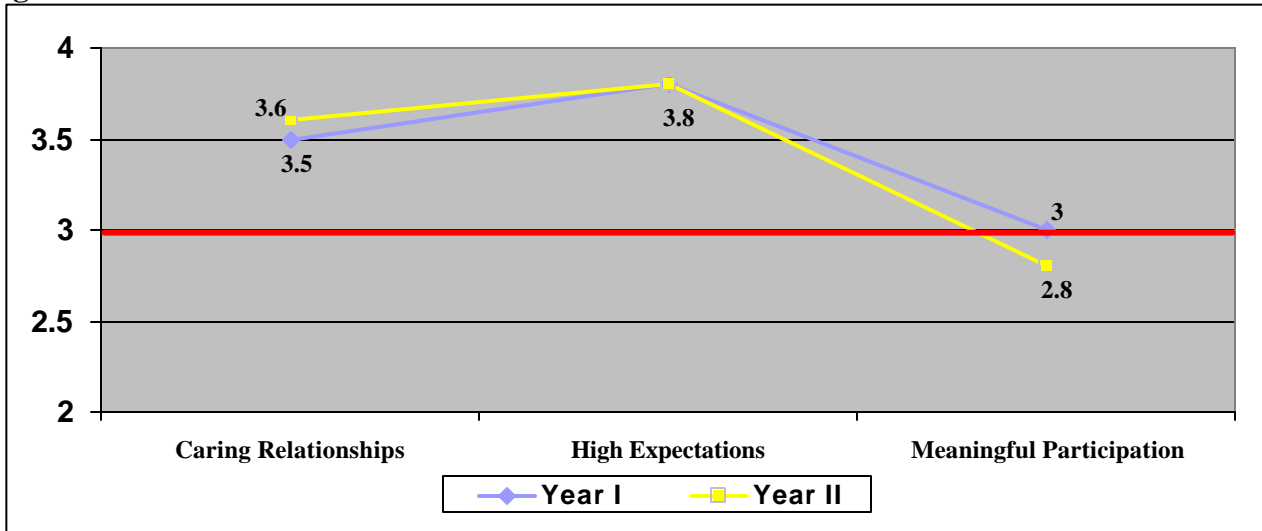
Individual student scores at School A mirror the mean scores in that the percentages of students who scored in the *High* range in the first two home assets were similar across years. With more than three-quarters of students scoring in the *High* range in perceived caring from the adults in their home, the families at School A appear to be providing positive caregiving and are involved in their children's school lives. Similarly, most students perceive high parental expectations which, when coupled with support and love, are strongly associated with academic and life success. As shown in **Figure 23**, a decrease in the number of students who scored *High* in *Meaningful Participation* underscores the need for increased efforts on the part of the school to assist families in this indicator.

Figure 23. External Assets in the Home Environment - High Scorers: School A
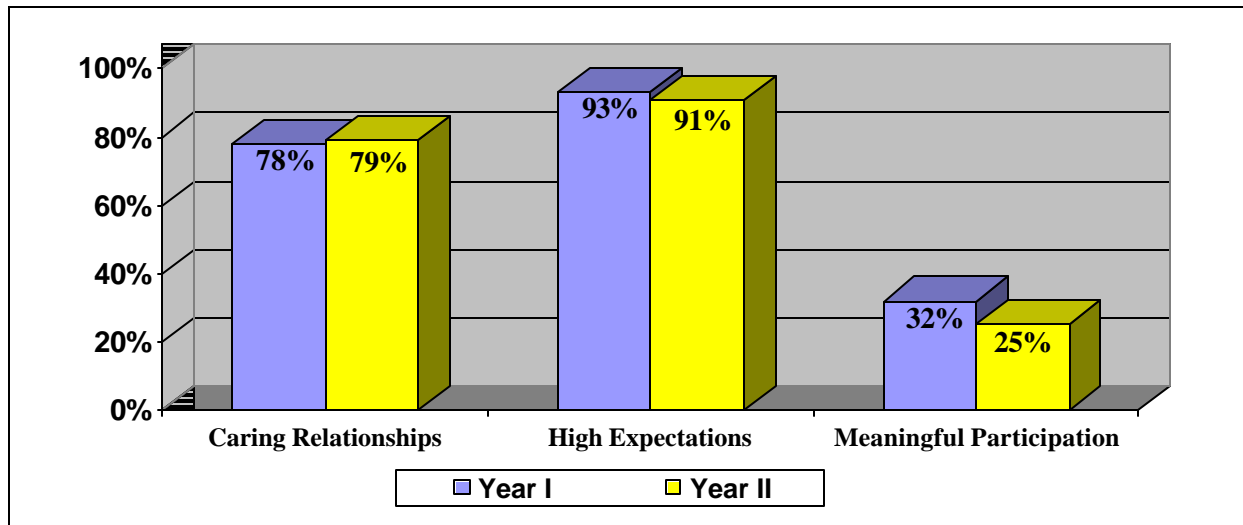
As shown in **Figure 24**, the home environment mean scores for School B reveal increases in all three domains. *Caring Relationships* and *High Expectations* scores, solidly in the *High* range in Year I, were even higher in Year II, each asset showing a gain of .2. These students clearly recognize the strong support they receive from the adults at home, as well as an awareness that these adults believe in their ability to succeed. While the *Meaningful Participation* mean remains in the *Moderate* range, the modest .1 gain indicates a trend toward increased opportunities for development of self-management skills.

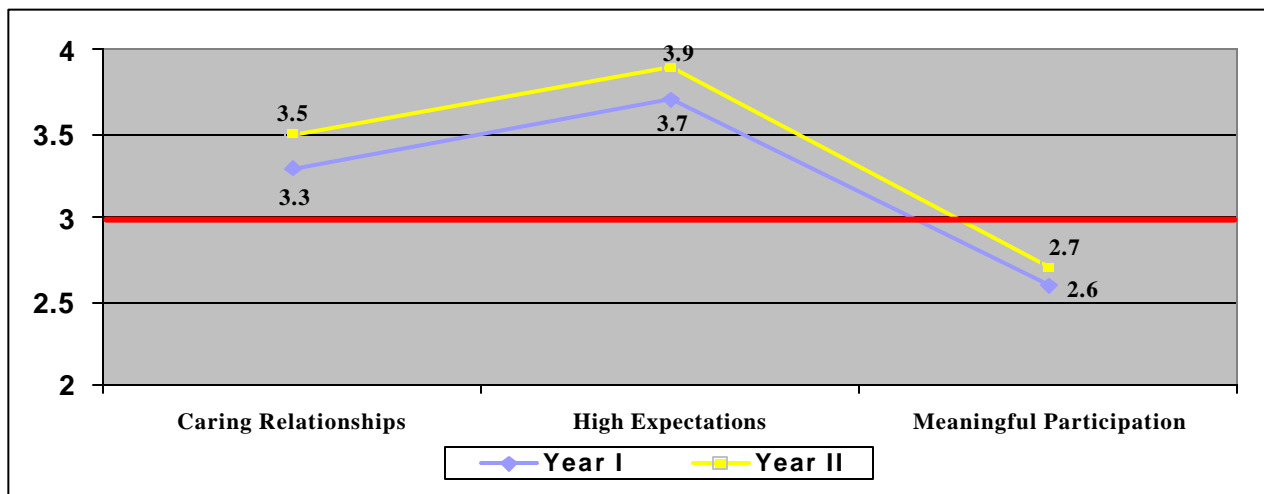**Figure 24: External Assets in the Home Environment – Mean Scores: School B**

Figure 25 shows the comparative percentages of Year I and Year II students who scored in the *High* range. The overall growth in all three home assets represented by the mean scores is paralleled in the individual students' scores. The percentages of students who attained *High* scores in the home environment increased in each domain. Twelve percent more students scored *High* in *Caring Relationships* in Year II (from 63% to 71%) and 12% more scored *High* in *High Expectations* (from 84% to 94%). An additional increase in high scorers in *Meaningful*

Participation, 31% from Year I to Year II, supports the trend toward students being afforded increased opportunity to assume responsibility and contribute meaningfully to their family life.

Figure 25. External Assets in the Home Environment - High Scorers: School B
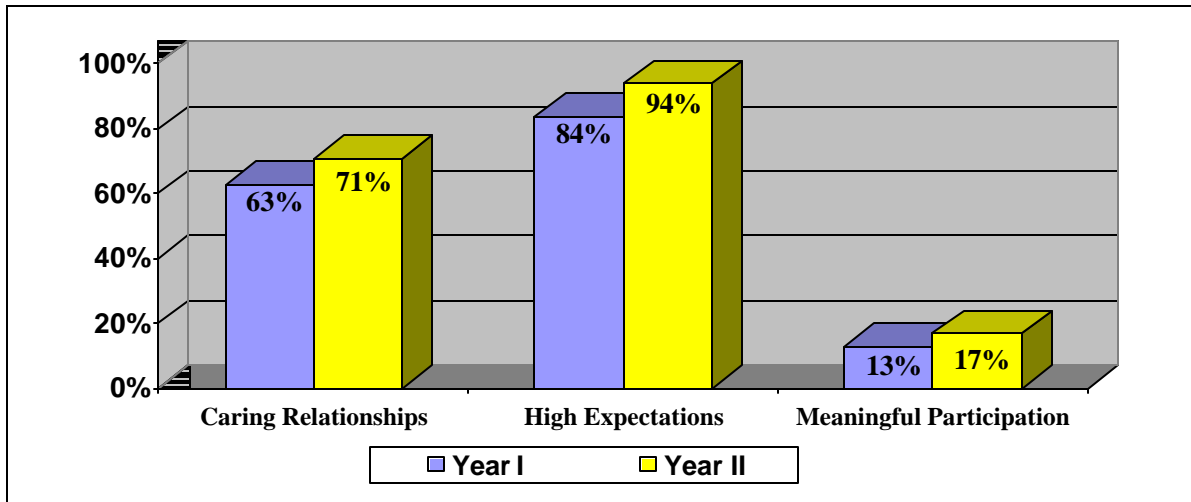
School C's Year II mean scores in the home environment are essentially the same as those in Year I. As shown in **Figure 26**, continued *High* range *Caring Relationships* and *High Expectations* scores suggest that these students, like their peers in Schools A and B, acknowledge the support they receive from the adults at home, and demonstrate an appreciation for these adults' confidence in their capabilities. Just as with School B, the slight increase in *Meaningful Participation* indicates a trend toward increased opportunities for development of self-management skills

Figure 26: External Assets in the Home Environment – School C
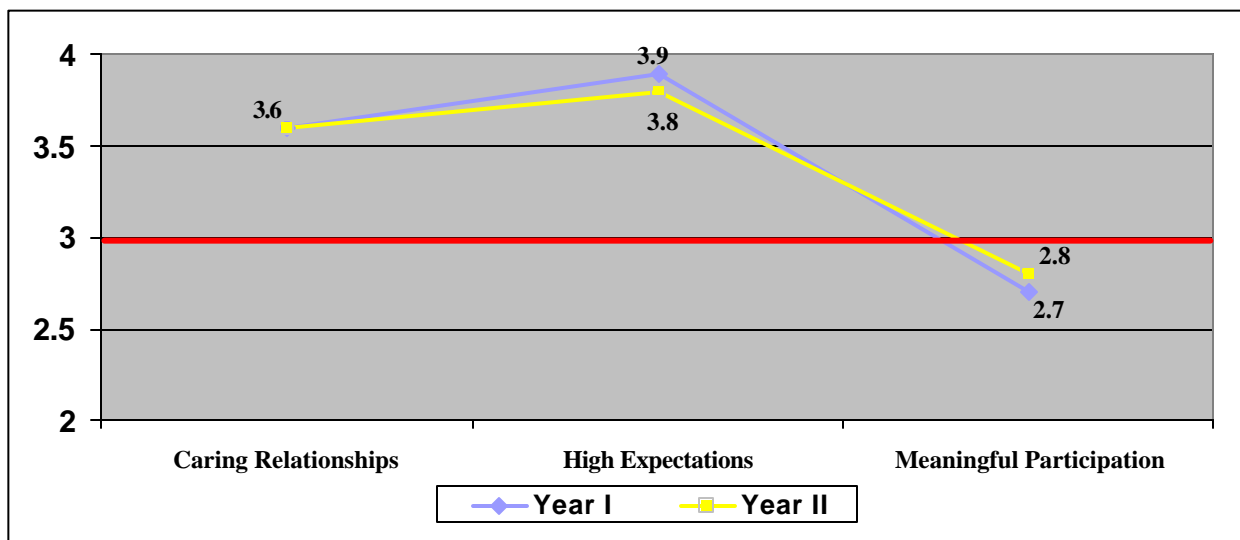
The percentages of students earning High scores in home assets, as presented in **Figure 27**, remained essentially the same in Year II as in Year I. Just as with School A, the large percentages of students at School C who consistently scored *High* in the first two assets indicate

the presence of critical factors that can serve as a foundation on which the school can develop appropriate resiliency programming. Like Schools A and B, School C may want to initiate family involvement programs that model collaborative parent-child decision making skills.

Figure 27. External Assets in the Home Environment - High Scorers: School C
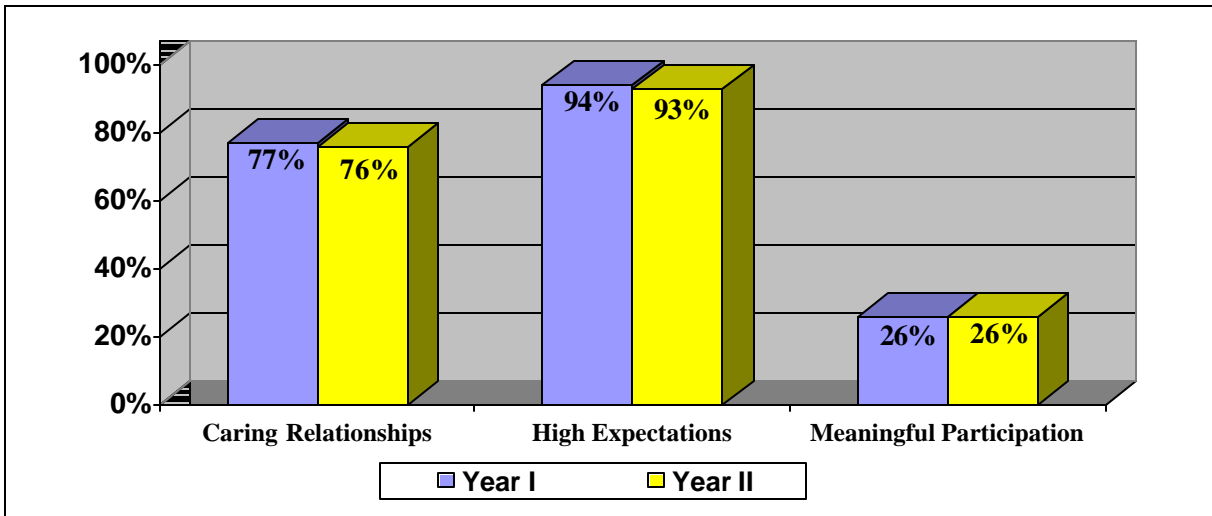
Strategies that schools can implement in engaging and forming partnerships with the home in order to strengthen assets in all three domains are provided in technical reports to the school.

B. Internal Assets

The CHKS also provides information on three internal assets associated with resiliency: Empathy, Problem Solving, and Goals and Aspirations. These traits are considered outcomes of the developmental process and can be seen as indicators as to whether critical environmental supports and opportunities are in place. They are, therefore, the individual qualities associated with environments rich in caring relationships, high expectations, and meaningful participation.

Empathy: The Empathy asset refers to understanding and caring about the feelings of others. The lack of empathy is associated with behaviors such as bullying, harassment, and other forms of violence.

Problem solving: Problem solving includes the ability to plan, to be resourceful, to think critically, and examine multiple perspectives before making a decision or acting. Research has identified the presence of strong problem solving skills in successful adults.

Goals and Aspirations: Having goals and aspirations requires the ability to look to the future and have expectations and hope for one's self. Children who have goals and aspirations develop a sense of connectedness to their world.

Figure 28 shows the mean Internal Assets scores of ***Empathy, Problem Solving***, and ***Goals and Aspirations*** across both years for School A. Goals and Aspirations scores have been

consistently in the High range, with a slight increase noted in Year II. This is indicative of a student body that has the ability to look to the future and work toward achieving personal goals. The .2 decrease in the Empathy mean score appears to be reflected in the 10% increase noted earlier in bullying behavior at School A. Programs aimed at bullying prevention should, therefore, incorporate strategies that develop empathy and model positive individual behaviors, such as consideration, kindness, and compassion.

Figure 28. Comparative Internal Assets – Years I and II: School A
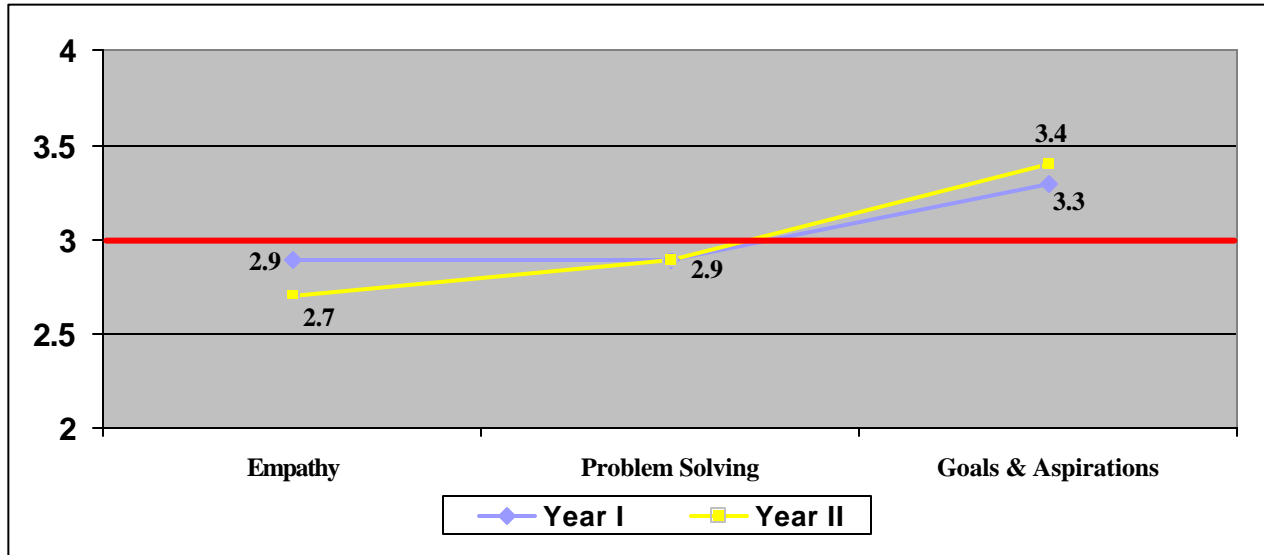
As seen in **Figure 29**, Goals and Aspirations was the only area in which there was an increase in the percentage of students earning high scores.

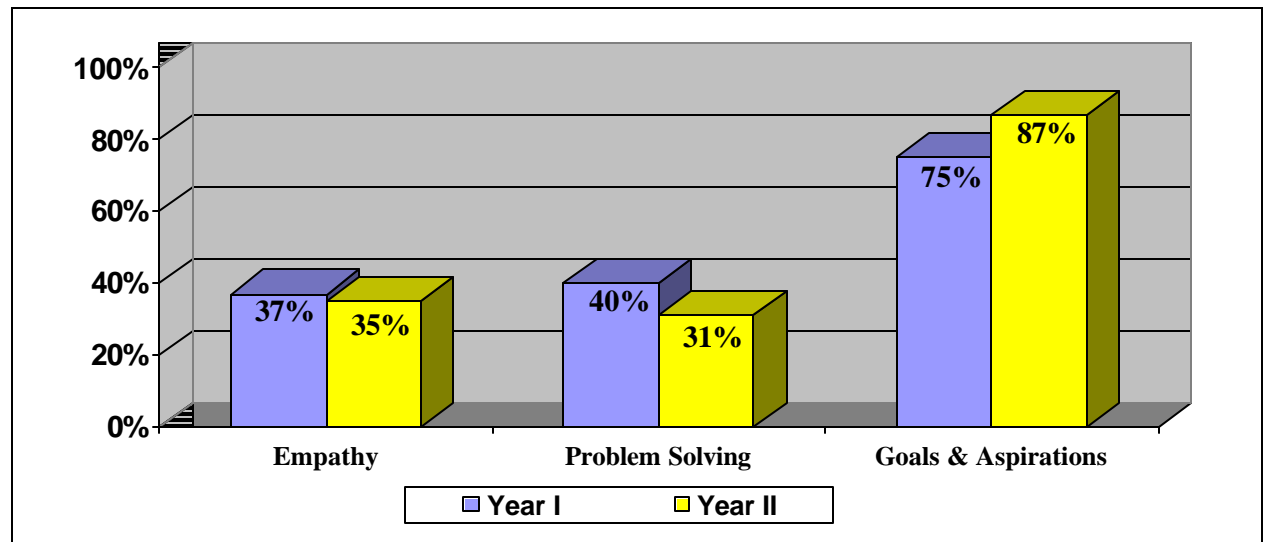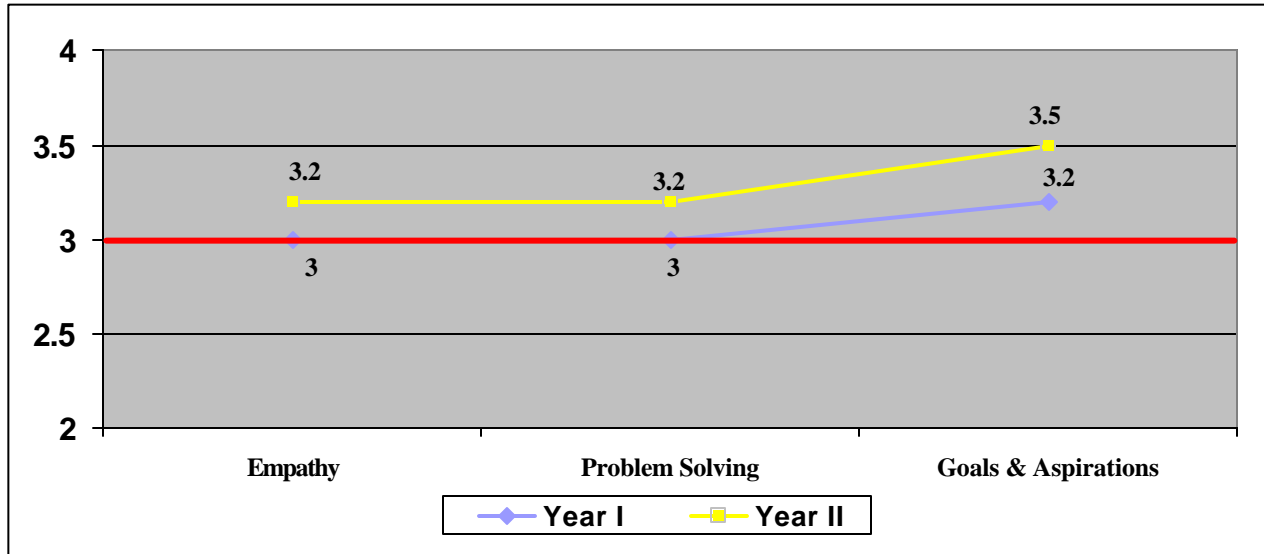**Figure 29. Internal Assets – High Scorers: School A**

Figure 30 shows the mean scores across both years for School B. Just as with School B's scores in External Assets in the home environment, Internal Asset results reveal increases in each domain, placing *all* mean scores solidly in the *High* range. *Goals and Aspirations* scores have been consistently in the *High* range, suggesting the presence of students' intrinsic motivation to look to the future and make plans for success.

Figure 30. Comparative Internal Assets – Years I and II: School B

As shown in **Figure 31**, the percentages of students at School B who scored *High* in Internal Assets increased across years in all three areas, particularly in *Goals and Aspirations*, where 54% more students earned *High* scores.

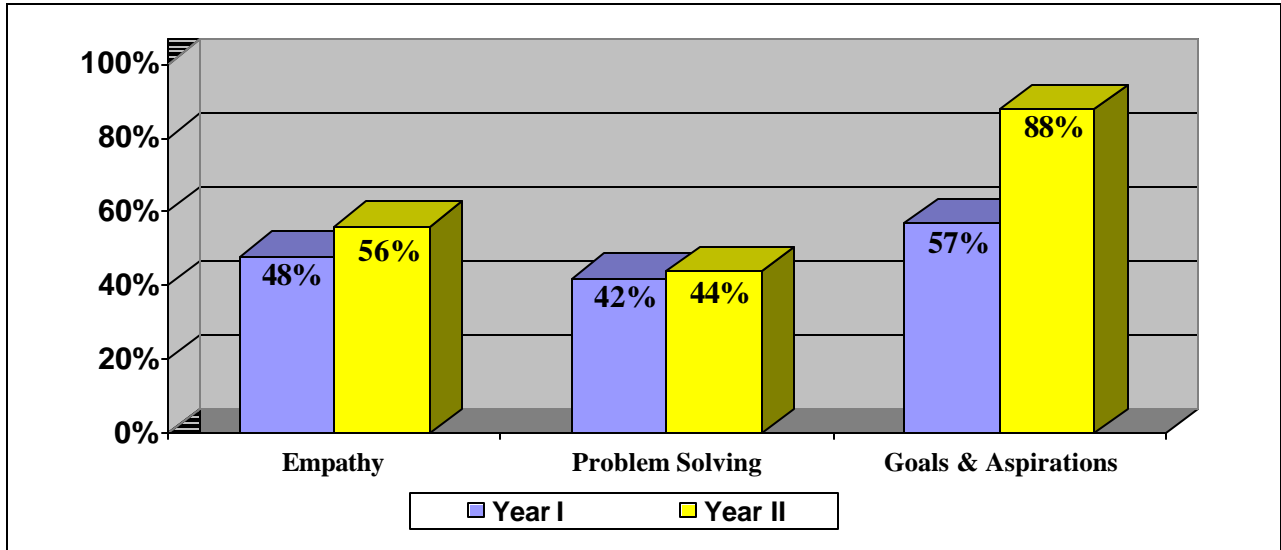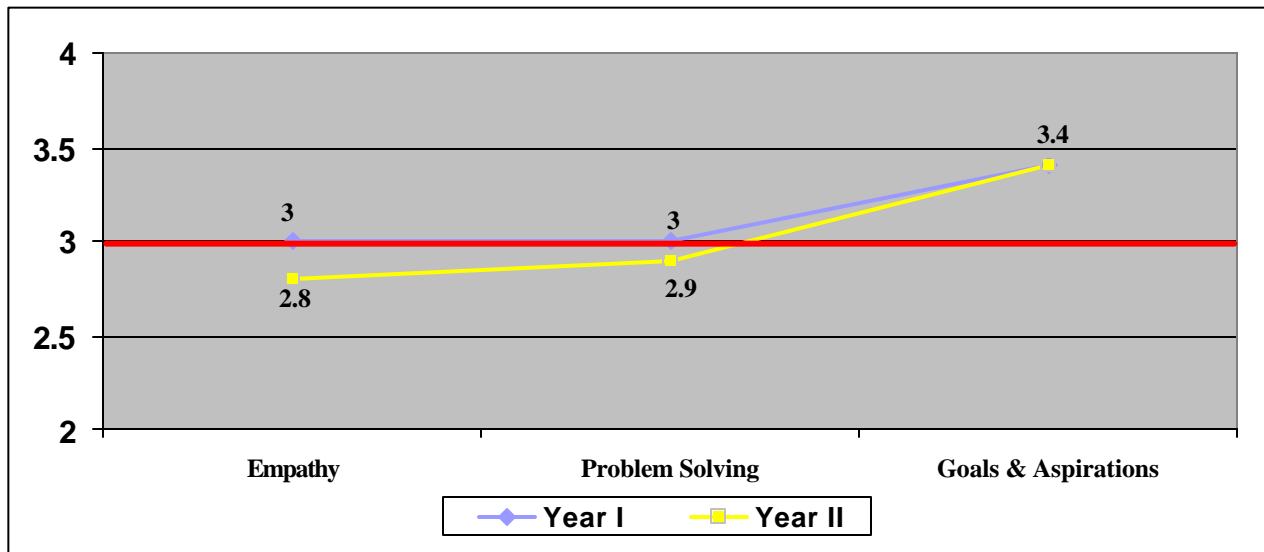**Figure 31. Internal Assets – High Scorers: School B**

Bar chart showing Internal Assets High Scorers for School B. Empathy: Year I 48%, Year II 56%. Problem Solving: Year I 42%, Year II 44%. Goals & Aspirations: Year I 57%, Year II 88%. Legend: Year I (purple), Year II (yellow).

Figure 32 shows the mean Internal Assets scores across both years for School C. Whereas *Empathy* and *Problem Solving* mean scores fell just into in the *High* range in Year I, slight decreases in Year II place these two assets into the *Moderate* range. Just as with Schools A and B, *Goals and Aspirations* scores have been consistently in the *High* range.

Figure 32. Comparative Internal Assets – Years I and II: School C

Line chart showing Comparative Internal Assets for School C. Empathy: Year I 3, Year II 2.8. Problem Solving: Year I 3, Year II 2.9. Goals & Aspirations: Year II 3.4. Legend: Year I (purple), Year II (yellow).

As shown in **Figure 33**, slight decreases in mean scores for the first two assets also reflect in lower percentages of *High* scorers in those same assets. A slight increase was noted in high scorers for Goals and Aspirations.

Figure 33. Internal Assets – High Scorers: School C
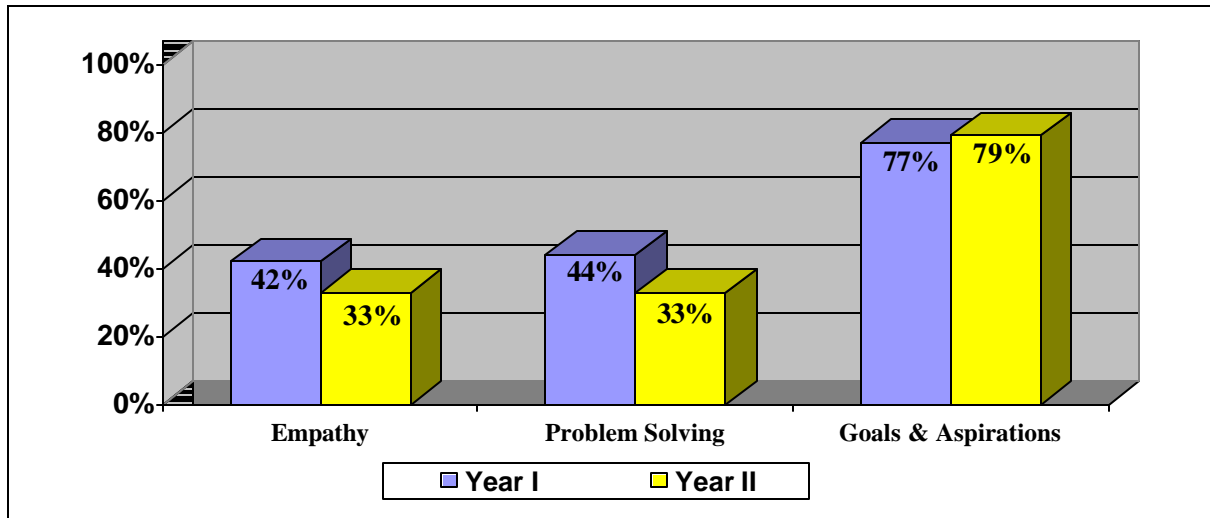
Strategies that schools can implement to internal resiliency are provided in ***Appendix C: Sample Strategies to Promote Internal Resilience Traits.***

Summary

The overall profiles of Schools A, B, and C vary somewhat with regard to students' health-risk behaviors and resiliency factors as measured on the CHKS. Sixty-two percent (n=163) of the 264 students who completed the survey were from School C. Twenty-five percent (n=66) of the total group surveyed were from School A, with the smallest cohort (13%; n=35) completing surveys at School B. Key findings include:

o   As in Year I, students at all three schools appear to have adequate *Caring Relationships* and *High Expectations* both at home and school, with results continuing to indicate that these resilience factors are stronger in the home environment. Scores in *High Expectations* particularly, both at school and in the home, are consistently the highest scores for all three schools. When Year II mean scores for the individual schools are compared with their respective Year I scores, Schools A and B show slight increases in at least one area. More significantly, however, were the increased percentages of individual students who achieved High scores compared to Year I. Specifically, the number of students at School A who scored High in *all* External Assets in the School Environment rose by 7% to 13%. *Meaningful Participation* scores continued to be lower for all schools and in both environments, although .1 mean increases were achieved by Schools B and C.

o   In the Home domain, all schools maintained mean scores in the High range in Caring Relationships, suggesting that students have strong connective bonds with adults at home. Moreover, these scores increased for both Schools A and B (by .1 and .2, respectively), while School C retained its same score. The number of high scorers also increased School A and at School B. As in Year I, the majority of students at each school (91% to 94%) scored high in

High Expectations in the home, indicating that they feel they are viewed as valued participants. On the other hand, only 17% to 26% scored high in Meaningful Participation, suggesting that most students continue to perceive infrequent opportunities to *contribute meaningfully* to the life of the family. Impressively, however, increases in both mean scores and number of students with high scores in *all* areas of the home environment were realized by School B. In addition to increases in all mean scores in this domain, more School B students scored in the High range in Year II as compared to Year I. With Meaningful Participation scores both at school and at home continuing to be relatively low across all schools, it remains essential that students be encouraged to participate actively and be provided with opportunities to contribute their talents and abilities in both environments.

o   Mean Empathy and Problem Solving scores for Schools A and C fall in the Moderate range, with each school's score remaining the same as Year I or decreasing slightly. Interestingly, while School A's decreased Empathy scores may correlate with increased rates of bullying, the same relationship cannot be assumed at School C, where bullying decreased by 13 percentage points and coexists with a .2 decrease in Empathy.

o   The most significant Internal Assets gains in both mean scores and in students scoring high were realized by School B. Mean score gains were made by School B in each internal asset (+.2 in Empathy and Problem Solving to +.3 in Goals and Aspirations) Moreover, the number of high scorers increased by 2 percentage points in Problem Solving, 8 percentage points in Empathy, and most impressively, by 31 percentage points in Goals and Aspirations.

o   Results for Lifetime ATOD Usage revealed that the percentages of students reporting experimentation remained static or decreased at Schools A and B, with significant declines in tobacco (-15 percentage points) and inhalant (-17 percentage points) rates at School B. Increased usage of all four substances was reported by students at School C, where Year II rates rose an average of 8 percentage points over Year I rates (from a 5 point increase in Inhalant use to a 13 point increase in alcohol rates). Cohort effects at both Schools B and C show increased alcohol usage in the 3rd grade cohort, where more students reported drinking alcohol as 4th graders (+8 percentage points at School B; +14 percentage points at School C). Interestingly, current 3rd graders at all three schools reported having tried alcohol with almost as much (School A) or more frequency (Schools B, C) as last year's 3rd graders.

o   Bullying behavior at all three schools continues to be reported by over half of the students surveyed. However, while it remains the most frequently reported negative behavior at all three schools, reports of bullying victimization actually decreased at School C, where a 13 percentage point decrease was noted in students who reported being hit or pushed by others during the past year with (from 73% in Year I to 60% in Year II).

o   Results across schools by grade reveal that between 70% and 79% of current 3rd graders report that they have been hit or pushed by other students in the past year. This represents an 18 percentage point increase over last year's 3rd graders at School A and a 15 percentage point increase at School C. A 9 point decrease was noted at School B.

- The 3rd grade cohort (current 4th graders) at each school, however, showed an average decrease of 8percentage points in reports of victimization of such behavior.   More variability, however, was noted in the 4th grade cohorts, where reports remained essentially the same at School A (55% in Year I to 54% in Year II), increased by 21percentage points at School B (from 46% in Year I to 67% in Year II), and substantially decreased by 23 percentage points at School C (from 80% in Year I to 57% in Year II).

- On indices related to weapons, overall decreases were also noted, both in reports of carrying weapons to school and in seeing others with weapons. Only one school, however, showed decreases in both areas (from 10% to 3% in carrying weapons and from 43% to 27% in witnessing). Conversely, perceived safety at school has increased across schools as reports of weapons carrying decreased