An Evaluation of a School-based Behavioral Health Initiative in Three Rural Counties

Bianca Anderson

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ABSTRACT

AN EVALUATION OF A SCHOOL-BASED BEHAVIORAL HEALTH INITIATIVE IN THREE RURAL COUNTIES.

By

Bianca S. Anderson

April 20, 2017

INTRODUCTION: In the United States, one in five children will experience a mental or behavioral health disorder in their lifetime. Of these children, only approximately half receive mental health services and support (Moon, Williford, & Mendenhall, 2017). School-based behavioral health services are identified as one way to increase access to behavioral health services, particularly for youth in rural areas where services are sparse (Moon et al., 2017).

AIM: The purpose of this evaluation is to examine the effectiveness of a school-based behavioral health initiative designed to improve behavioral health outcomes among school-aged children living in three rural counties.

METHODS: This report describes a mixed method evaluation consisting of satisfaction surveys (e.g., from referral personnel/consortia members), behavioral health questionnaires from students, and pre-post knowledge quizzes and qualitative interviews from staff who received training on youth mental health. Therapeutic treatment fidelity was measured using a treatment fidelity checklist completed by school-based mental health therapists after each therapy session.

RESULTS: The evaluation data are presented in both narrative and infographic formats. The report concludes with a description of the implications for public health and recommendations for the organization implementing the program.
AN EVALUATION OF A SCHOOL-BASED BEHAVIORAL HEALTH INITIATIVE IN THREE RURAL COUNTIES.

by

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B.A., UNIVERSITY OF MICHIGAN- DEARBORN

A Capstone Submitted to the Graduate Faculty of Georgia State University in Partial Fulfillment of the Requirements for the Degree

MASTER OF PUBLIC HEALTH

ATLANTA, GEORGIA
30303
AN EVALUATION OF A SCHOOL-BASED BEHAVIORAL HEALTH INITIATIVE IN THREE RURAL COUNTIES.

by

BIANCA S. ANDERSON

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April 20, 2017
Date
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Bianca S. Anderson
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Executive Summary

A School-Based Behavioral Health Consortium is working to combat mental and behavioral health concerns among approximately 22,000 youth living in three rural communities in a southeastern state. Through use of school-based intervention teams, referral personnel, and community involvement, the consortium has embarked on a behavioral health initiative designed to: (1) identify and respond to emotional and psychological distress at onset, (2) expand school-based mental health intervention services and support, (3) promote and recommend professional and self-help strategies, and (4) reduce mental health stigma.

An evaluation of the program has suggested that among 198 rural students receiving school-based behavioral health services, common mental and behavioral health concerns (e.g. anxiety, depression) are identified. Referrals to inpatient care, partial-hospitalization, and outside agencies have been made for 165 students, and participating students have been assessed for suicidal ideations and behaviors, and care planning needs. In support of the consortium’s goals, unique community partners have contributed representatives across meetings and trainings, and 130 first aiders have been taught the signs and symptoms of psychiatric illnesses and basic tools used to assess and assist during mental health crises.

This report evaluates the effectiveness of the consortia and its components, examines community satisfaction with the grant activities, identifies knowledge and skill-based changes relative to the established behavioral health training, and tracks improvements in student outcomes, academic performance, and school climate among participating rural students and K-12 public schools. This report also recommends further steps needed in order to continue to improve community health among youth populations and the community at large.
Introduction

Characterized as abnormal and/or altered mood, thinking, and behavior, mental or behavioral health represents an important public health problem (Reeves, Lin, & Nater, 2013). Costing the United States over 300 billion dollars annually in disability benefits, lost wages, and healthcare expenditure, mental illness accounts for more disability burden than any other chronic condition amongst developed countries, and is associated with other disease comorbidities (Reeves et al., 2013).

Among children in the United States, one in five will experience one or more behavioral health disorders during their lifetime; as adolescence is the onset of many psychological conditions (Moon, Williford, & Mendenhall, 2017). Of these youth, more than half are identified as having severe and persistent mental health concerns (Kelly, Mithen, Fischer, Kitchener, Jorm, Lowe, & Scanlan, 2011; Star, Campbell, & Herrick, 2002). Data from studies, such as the Methodology for Epidemiology of Mental Disorders in Children and Adolescents study, indicate that anxiety, disruptive, mood, and substance abuse disorders are the most common behavioral health conditions found in children and adolescents. Research also identifies youth indicators of behavioral health issues as risk behaviors such as episodic drinking, excessive drug use, and suicide (Satcher, 2004).

Of all children with a diagnosable psychological condition or mental health need, only half go on to receive appropriate care (Moon et al., 2017). Contributing to the fragmented utilization of mental health resources are service availability, accessibility, and delivery challenges existent within many behavioral health care systems across both urban and rural settings (Moon et al., 2017). With many youth mental health needs going unmet, youth are placed at a greater risk for poor behavioral health outcomes, poor academic performance, poor
attendance, low graduation rates, disrupted psychosocial development, and other health impairments (Moon et al., 2017). Many barriers exist prohibiting the use of mental health services and resources among children and adolescents. These barriers include, but are not limited to, low socioeconomic status, race and ethnicity, a lack of transportation, negative and stigmatizing attitudes relative to mental illness, the misidentification of psychological illness by trained practitioners, a lack of mental health literacy and awareness, and living in rural counties (Little & McLennan, 2010; Pullmann, VanHooser, Hoffman, & Heflinger, 2010).

Of U.S. children and adolescents, approximately one in five reside in rural areas (Pullmann et al., 2010). Rural children presenting with mental health concerns are faced with greater challenges relative to resource and service availability, accessibility and delivery; of which result from the geographic location of their residence, and a lack of mental health practitioners and other support services (Moon et al., 2017; Pullmann et al., 2010). Rural children are also disproportionately exposed to risk factors associated with the development of youth behavioral health issues such as poverty, few employment opportunities, and familial and household disruptions (Pullmann et al., 2010). Specific barriers limiting the use of mental health services and resources among rural children include being uninsured or under-insured, lacking adequate services, rising medical care costs, and rural hospital closures (“The Mental and Behavioral,” n.d.; Star et al., 2002).

With access and cost barriers threatening the mental and emotional well-being of children residing in both urban and rural geographic areas, schools are identified as the ideal gateways and entry points to children receiving the behavioral health care and services that they need (Moon et al., 2017). More specifically, schools have been targeted given the significant amount
of time children spend at school, and the ability to reach large numbers of youth in a single setting (Moon et al., 2017; Weist, Mellen, Chambers, Lever, Haber, & Blaber, 2012).

**School-Based Behavioral Health Services (SBBHS)**

When addressing youth mental health needs, pediatricians and other primary care providers may not have the training to address the needs of the patients in which they service (Satcher, 2004). Many lack the specialized training, assessments, and time required to appropriately identify and assess emotional and psychological distress and the extent of its symptomology (Satcher, 2004). Hence, many youth behavioral health illnesses go unrecognized, undiagnosed or misdiagnosed, and untreated alike (Satcher, 2004). To expand and provide all specific services needed by children and their families, collaborative efforts and service coordination are suggested through partnerships between community mental health agencies and schools equipped to provide behavioral health services and referrals (Powers, Swick, Wegmann, & Watkins, 2015).

In recent years, SBBHS have evolved as a strategy to ameliorate the public health problem of delayed mental health care, and to improve the access to and coordination of care and services (Masia-Warner, Nangle, & Hansen, 2006). SBBHS and interventions commonly utilize several therapeutic techniques including but not limited to individual, family, and group therapy formats, Cognitive Behavioral Therapy (CBT), and Play Therapy (Powers et al., 2015). With most care being provided by guidance counselors, social workers, school psychologists, and school-intervention teams, some schools have established school-based health clinics (SBHCs) where services are delivered; of which approximately 2,315 presently operate (Paulus, Ohmann, & Popow, 2016; “2013-14 Digital,” n.d.).
Supported by more than 75% of pediatricians, SBBHS offer both prevention and intervention strategies, and can be categorized by a three-tier model of services and needs (Paulus et al., 2016). Tier one of the model incorporates prevention programs that focus on building resistance, reducing exposure to risk factors, and ensuring that students have access to community and family supports (Paulus et al., 2016). In tier two, students who function well in social and academic arenas but present with one or more psychiatric conditions are targeted. Tier two activities include individual and group therapy, as well as individualized education programs (IEPs). Lastly, tier three targets students who have more significant mental health concerns. Activities comprising this tier include intensive forms of therapy, pharmacology, and special education services (Paulus et al., 2016).

With the coordination of services with outside mental health professionals, confidentiality concerns, and the integration of mental health services into the school environment all posing as challenges to school-based mental health services, several advantages exist in support of these school-based programs (Paulus et al., 2016). One advantage is that SBBHS attract hard to reach populations such as minorities (“Benefits,” n.d.). A second advantage is that schools provide familiar settings for both students and their families that promote comfort and foster known support (Masia-Warner et al., 2006; “Engaging Youth,” 2014.). Another advantage is the elimination of transportation needs to outside facilities. With the ease of accessibility, it is expected that more children will be serviced at onset, and that parents will be more likely to keep appointments and be involved in their child’s treatment (Masia-Warner et al., 2006; Guo, Wade, Pan, & Keller, 2010). A final advantage is the promotion and creation of a healthy and safe school climate that is brought about through the establishment of school-based mental health services. With these advantages to SBBHS being
evident, it is hoped that students and their families will possess a long-term commitment of following the recommended treatment plan (Satcher, 2004). It is also hoped that these services will result in improved identification and diagnosis of psychiatric illness among school-aged children, increased monitoring of care, and progress assessment (Satcher, 2004).

The United States’ Surgeon General calls for the development of evidence-based SBBHS and interventions, and the examination of their methodology, implementation, and outcomes to determine their effectiveness (Masia-Warner et al., 2006). A rural health system in a southeastern state has embarked on a project to enhance the mental health of the youth serviced by its many facilities. To combat poor mental health outcomes, the health system has established a behavioral health initiative focused on the early identification, diagnosis, and treatment of youth mental health concerns, and improved mental health literacy among parents, educators, care providers, and other adults. Further, the health system has presently begun to evaluate the effectiveness of its behavioral health efforts among school-aged pupils, school systems, and surrounding communities.
A School-Based Behavioral Health Consortium

Since access to effective behavioral health services and support in rural communities is limited, there is an increased likelihood that untreated youth mental health concerns will emerge within classrooms (“West Georgia,” 2016). Hence, educators and other school staff are placed in a position requiring them to accurately and effectively identify and respond to behavioral health issues. Unfortunately, many school personnel are not trained to do so; as many do not possess the knowledge, skills, and resources necessary to respond to emotional and psychological concerns (“West Georgia,” 2016).

Recognizing this need, the rural health system has established a School-Based Behavioral Health Consortium to reduce poor behavioral health outcomes among school-aged children living in three de-identified rural counties; County C, County H, and County X (“West Georgia,” 2016). Dedicated to the early detection and treatment of behavioral health issues among school-aged children, this consortium of stakeholders’ purpose is to form and strengthen SBBHS and support through interdisciplinary collaboration (“West Georgia,” 2016). These services and supports include school intervention teams and referral personnel. The consortium has also provided a rural Youth Mental Health First Aid (YMHFA) program to educate and improve the mental health literacy of adults who support and engage in daily interaction with rural children (“West Georgia,” 2016).

In all, the School-Based Behavioral Health Consortium aims to improve child and adolescent behavioral health among rural school children by expanding SBBHS and support to promote healthy development, respond to behavioral health concerns soon after onset, and provide intensive and effective care (“West Georgia,” 2016).

Participating Schools
A total of ten K-12 public schools from the three counties (Table 1) have partnered with the health system to provide school-based mental health services to its student body. For this report, the names of the participating schools have been de-identified.

<table>
<thead>
<tr>
<th>County C Schools</th>
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<tbody>
<tr>
<td>Bow Elementary</td>
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<tr>
<td>Mt. Everett Elementary</td>
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<tr>
<td>Center Middle</td>
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<tr>
<th>County H Schools</th>
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<tbody>
<tr>
<td>Tailgate Primary School</td>
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<tr>
<td>H County High</td>
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<tr>
<td>H County Middle</td>
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<th>County X Schools</th>
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<tbody>
<tr>
<td>Central Elementary</td>
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<tr>
<td>East Elementary</td>
</tr>
<tr>
<td>X Elementary</td>
</tr>
<tr>
<td>X County High</td>
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**Invested Stakeholders**

The consortium has key stakeholders with special interests in the behavioral health efforts. These stakeholders possess specific expectations and needs, of which the consortium are aiming to address. Here, a brief list of stakeholders is presented along with their respective interests in the behavioral health initiative.

- Parents and Caregivers of School-aged Children (K-12): Adults who are interested in the impact of the project on the behavioral health outcomes of the children in which they come into daily contact with.
• Community Members: Residents from Counties C, H, and X who are interested in learning about the impact of the project on the well-being of their community (“West Georgia,” 2016).

• District-level Personnel: School administrators, counselors, and educators invested in learning about the impact of SBBHS and support on student outcomes and school climate (“West Georgia,” 2016).

• Health System Personnel: Staff providing support services to participating students, and working to identify and address the strengths and areas of needed improvement of the grant activities (“West Georgia,” 2016).

• Consortia Members: Consortium stakeholders interested in the impact of the grant activities on behavioral health services in the community (“West Georgia,” 2016).

• Behavioral Health Care Services and Support Providers: Healthcare providers working to alleviate behavioral health issues among school-aged children, and to improve behavioral health outcomes within schools and the community.

• Community Organizations: Agencies, such as the Division of Family and Children Services and Department of Juvenile Justice, who are interested in healthy and supported youth, and who contribute representatives across meetings and trainings.
Community Mental Health Needs

As a comprehensive healthcare provider, the health system has serviced state residents for over 65 years (Higgins General Hospital, 2016; Tanner Medical Center/Carrollton, 2016). Committed to advancing the health of the community and recognizing the need for community health improvement, the health system works to protect the health of underserved communities, and to ensure quality of life of neighboring populaces (Higgins General Hospital, 2016; Tanner Medical Center/Carrollton, 2016). The health system also works to address the overlooked mental and behavioral health disparities amongst seekers of health care services. As shown in Table 2, community mental health data are presented for the three counties, the state, and the United States (Higgins General Hospital, 2016; Tanner Medical Center/Carrollton, 2016).

<table>
<thead>
<tr>
<th>Table 2</th>
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<tr>
<td><strong>Community Mental Health Data across the Three Counties, the State, and the United States</strong></td>
</tr>
<tr>
<td>Population</td>
</tr>
<tr>
<td>Population</td>
</tr>
<tr>
<td>Patient to Mental Health Provider Ratio</td>
</tr>
<tr>
<td>Av. Number of Poor Mental Health Days</td>
</tr>
<tr>
<td>Mental &amp; Behavioral Health ED visits</td>
</tr>
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per 100,000 population (2010-14)

Needs Assessment Data

To identify the health needs of rural residents serviced by the health system, a 26-item needs assessment survey was administered amongst community members in February and March of 2016. These individuals, consisting of educators, organizational leaders, and regular laypersons, represented diverse groups of people with a common agenda of improving and advancing community health. From the community needs assessment, three priority health areas were identified: (1) Access to health services, (2) Chronic disease education, prevention, and
management, and (3) Mental and behavioral health (Higgins General Hospital, 2016; Tanner Medical Center/Carrollton, 2016).

For this needs assessment, residents from County C and County X (N=484) were surveyed together. Of survey respondents, 11.57% identify mental health and depression as one of three health issues faced by members of their community; joining the ranks of other chronic conditions such as obesity and heart disease. (Tanner Medical Center/Carrollton, 2016). Although viewed as a health issue among community members, only 3.55% of surveyed individuals (n=479) recognize mental health and depression as community health issues (Tanner Medical Center/Carrollton, 2016). As suggested by surveyed residents, services that the health system could provide to the community and its healthcare recipients include support programs, health screenings, and education and literacy outlets. Of the health issues warranting additional educational resources, 28.94% of persons indicate wanting to receive education on stress reduction, 21.70% on sleep problems, 14.04% on mental health and depression, 5.53% on eating disorders, 2.13% on substance abuse, and 1.91% on suicide prevention (Tanner Medical Center/Carrollton, 2016).

Of 477 individuals, 17.19% and 9.01% identify mental health, and drug and alcohol abuse services as resources needed to improve the health of their families and neighbors correspondingly (Tanner Medical Center/Carrollton, 2016). Moreover, among 481 persons asked to indicate the type of health screenings needed to advance the health of their families and neighbors, stress reduction (27.23%), mental health and depression (24.95%), drug and alcohol (16.22%), sleep problems (15.59%), eating disorders (8.94%), and suicide prevention (5.20%) screenings are specified (Tanner Medical Center/Carrollton, 2016).
Of survey respondents from County H (N=102), 13.73% identify mental health and depression as one of three health issues faced by members of their community (Higgins General Hospital, 2016). Although viewed as a health issue among community members, only 1.06% of surveyed individuals (n=94) recognized mental health and depression as community health issues (Higgins General Hospital, 2016). As specified by survey respondents, suggested services that the health system could provide to the community and its healthcare recipients include support programs, health screenings, and education and literacy resources. Of the health issues warranting further educational resources, 24.24% of persons (n=99) indicated wanting to receive education on sleep problems, 23.23% on stress reduction, 10.10% on mental health and depression, 5.05% on eating disorders, and 1.01% on substance abuse (Higgins General Hospital, 2016).

Additionally, of 96 individuals, 15.63% and 13.54% identify mental health, and drug and alcohol abuse services as resources needed to improve the health of their families and neighbors respectively (Higgins General Hospital, 2016). Moreover, among 100 persons asked to indicate the type of health screenings needed to advance the health of their families and neighbors, mental health and depression (23.00%), sleep problems (19.00%), stress reduction (18.00%), drug and alcohol (11.00%), eating disorders (8.00%), and suicide prevention (2.00%) screenings are indicated (Higgins General Hospital, 2016).

Focus Group and Listening Session Data

In 2016, a total of 106 residents from County C and County X participated in two focus groups and one community listening session. From these sessions, youth are identified as a priority population, and the top health concern by life stage is drug and substance abuse among teens. Of the top five concerns needing to be addressed to improve the health and well-being of
community members, substance abuse and mental health rank number one and number four respectively (Tanner Medical Center/Carrollton, 2016). Specific concerns among community members include poverty, transportation barriers, and mental health concerns such as the lack of recognition by adults and/or youth, the lack of available counseling services, and stigma and negative attitudes associated with mental health diagnoses (Tanner Medical Center/Carrollton, 2016). Another concern is a lack of education and literacy among adults and parents. Lastly, as specified by surveyed community members, community resources needed to accomplish community health improvements include more health education and information sessions targeted towards young parents, as well as mental health screenings (Tanner Medical Center/Carrollton, 2016).

Among the 14 County C focus group attendees, an issue of great concern associated with improving community health is the provision of adequate mental and behavioral health services, such as support and substance abuse services (Tanner Medical Center/Carrollton, 2016). Furthermore, perceived barriers potentially prohibiting the achievement of optimal mental and emotional health among County C residents are a lack of mental health awareness, and the presence of stigma and negative attitudes (Tanner Medical Center/Carrollton, 2016). A specific concern among the nine focus group members from County X is a lack of accessible mental and behavioral health services (Tanner Medical Center/Carrollton, 2016). As indicated by participants in the focus group, the area once had a full time behavioral health facility. Presently, however, a practitioner is only available once a month. For clients in immediate crisis, they must either wait for care, or travel to a neighboring facility (Tanner Medical Center/Carrollton, 2016). A group suggestion proposed by the group is to focus on healthy youth and families by focusing
on health education and promotion in schools, and ensuring the availability of mental health services and counseling (Tanner Medical Center/Carrollton, 2016).

Also in 2016, ninety-seven area residents from County H participated in one community listening session and one focus group. Again, from these sessions, youth are identified as a priority population with a health concern of drug and substance abuse (Higgins General Hospital, 2016). Of the top five concerns needing to be addressed to improve the health and well-being among the community, substance abuse and mental health rank numbers one and four respectively; like their rankings in County C and County X. Here too, of specific concern is poverty, transportation to services, and mental health concerns such as a lack of recognition by adults and/or youth, a lack of counseling and support services, and stigma associated with mental health diagnoses (Higgins General Hospital, 2016). Among the six County H focus group attendees, specific concerns include education and awareness, substance abuse among adults and youth, and a lack of available mental health services (Higgins General Hospital, 2016). Another concern is a lack of literacy among adults and parents. Additionally, health education and informational sessions for young parents and screening for mental health concerns are identified by County H residents as resources needed within the community (Higgins General Hospital, 2016).
School District Data

Presented by the Governor’s Office of Student Achievement, school academic data are obtainable for all of the state’s elementary, middle and high schools for past and present academic school years. These data consist of student enrollment, attendance records, student achievement, and school climate (“Attendance,” n.d.; “Student,” n.d.). Here, 2015-16 enrollment (see Table 3) and attendance (see Table 4) data are presented on each county of focus and the state.

**Table 3**

<table>
<thead>
<tr>
<th>2015-16 School Enrollment Data across the Three Counties and the State</th>
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<tbody>
<tr>
<td><strong>Count</strong></td>
</tr>
<tr>
<td>Number of Students Enrolled</td>
</tr>
<tr>
<td>% Enrolled in Early Intervention Program</td>
</tr>
<tr>
<td>% Enrolled in Remedial Education</td>
</tr>
<tr>
<td>– Grades 6 to 8</td>
</tr>
<tr>
<td>% Enrolled in Remedial Education</td>
</tr>
<tr>
<td>– Grades 9 to 12</td>
</tr>
<tr>
<td>% Enrolled in Special Education</td>
</tr>
<tr>
<td>– PK</td>
</tr>
<tr>
<td>% Enrolled in Special Education K-12</td>
</tr>
<tr>
<td>% Enrolled in Alternative Program</td>
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<tr>
<td>– K-12</td>
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**Table 4**

<table>
<thead>
<tr>
<th>2015-16 School Attendance Data across the Three Counties and the State</th>
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<tbody>
<tr>
<td><strong>Count</strong></td>
</tr>
<tr>
<td>Number of Students Enrolled</td>
</tr>
<tr>
<td>% Absent &lt; 5 days</td>
</tr>
<tr>
<td>% Absent 6 to 15 days</td>
</tr>
<tr>
<td>% Absent &gt; 15 days</td>
</tr>
<tr>
<td>Number of Enrolled Students Considered</td>
</tr>
<tr>
<td>% Absent &lt; 5 days</td>
</tr>
<tr>
<td>% Absent 5 to 15 days</td>
</tr>
<tr>
<td>% Absent &gt; 15 days</td>
</tr>
<tr>
<td>% of Student Eligible for Free Lunch</td>
</tr>
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Student Health Data

Per the state’s Department of Education (DOE), school climate refers to the quality of school life (“Georgia Student,” n.d.). With a positive school climate comes improved academic performance and student outcomes; all of which are indicators of a school’s character and its ability to prepare its students for future academic success (“Georgia Student,” n.d.). As a national leader in the collection of school climate data, the DOE implements a Student Health Survey 2.0 (SHS 2.0) to identify safety and health-related issues within schools that can impact student achievement and school life (“Georgia Student,” n.d.). With the self-reported survey being distributed annually and anonymously, SHS 2.0 data are available at the district, school and state levels. Elementary students are surveyed solely on school climate and school safety (“Georgia Student,” n.d.). Students in middle and high school, however, are surveyed on a variety of topics, including but not limited to school climate and safety, drug and alcohol use, graduation, and bullying and harassment. Using this data, grant funding and the development of prevention and intervention strategies are made possible (“Georgia Student,” n.d.). Here, SHS 2.0 data are presented among students enrolled in the County C, County H, and County X school districts during the 2015-16 academic school year.

As shown in Table 5, SHS 2.0 data are presented for elementary school students in County C, County H, and County X (“Carroll County - Elementary,” 2016; Haralson County – Elementary,” 2016; Heard County – Elementary,” 2016).

<table>
<thead>
<tr>
<th>Table 5</th>
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<tbody>
<tr>
<td>2015-16 Student Health Survey 2.0 Data among Elementary School Students</td>
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<tr>
<td></td>
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<tr>
<td>Total Sample</td>
</tr>
<tr>
<td>Feel Safe at School (%)</td>
</tr>
<tr>
<td>Have an Adult at School Who Helps (%)</td>
</tr>
</tbody>
</table>
Among middle and high school students across the three counties, the following SHS 2.0 data are presented (see Tables 6 and 7). For County C middle school students contemplating self-harm and suicide, engaging in self-harm, or attempting suicide, familial issues, victimization perpetrated by a bully, and reasons specified as “other” are identified as contributing factors (“Carroll County,” 2016). As indicated by the County H middle and high school students, familial issues, school demands, and unspecified reasons are influencing factors contributing to the contemplation of self-harm (“Haralson County,” 2016). Additionally, being bullied, familial conflict, and reasons specified as “other” are identified as influencing factors among students contemplating suicide, engaging in self-injurious behaviors, and committing non-fatal suicide attempts (“Haralson County,” 2016). Lastly, while identified factors contributing to the contemplation of and engagement in self-harm among County X middle and high school students include peer conflict, familial pressures, and unspecified factors, factors influencing the occurrence of suicidal ideations and unsuccessful attempts of suicide include familial conflict, bully victimization, and reasons specified as “other” (“Heard County,” 2016).

<table>
<thead>
<tr>
<th>Table 6</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2015-16 Student Health Survey 2.0 Data among Middle School Students</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Total Sample</td>
</tr>
<tr>
<td>Feel Safe at School (%)</td>
</tr>
<tr>
<td>Have an Adult at School Who Helps (%)</td>
</tr>
<tr>
<td>Experienced Sadness/Withdrawal (%) on 1-2 occasions in last 30 days</td>
</tr>
<tr>
<td>Experienced Intense Worry/Fear (%) on 1-2 occasions in last 30 days</td>
</tr>
<tr>
<td>Considered Self-harm on 1-2 (%) occasions in last 12 months</td>
</tr>
<tr>
<td>Considered suicide on 1-2 (%) occasions in last 12 months</td>
</tr>
<tr>
<td>Engaged in Self-harm on 1-2 (%) occasions in last 12 months</td>
</tr>
</tbody>
</table>
Table 7

2015-16 Student Health Survey 2.0 Data among High School Students

<table>
<thead>
<tr>
<th></th>
<th>County C</th>
<th>County H</th>
<th>County X</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Sample</td>
<td>3,070</td>
<td>765</td>
<td>454</td>
</tr>
<tr>
<td>Feel Safe at School (%)</td>
<td>31.2</td>
<td>28.6</td>
<td>54.8</td>
</tr>
<tr>
<td>Have an Adult at School Who Helps (%)</td>
<td>40.5</td>
<td>39.7</td>
<td>56.4</td>
</tr>
<tr>
<td>Experienced Sadness/Withdrawal (%)</td>
<td>15.1</td>
<td>14.1</td>
<td>15.9</td>
</tr>
<tr>
<td>on 1-2 occasions in last 30 days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experienced Intense Worry/Fear (%)</td>
<td>8.8</td>
<td>7.3</td>
<td>7.0</td>
</tr>
<tr>
<td>on 1-2 occasions in last 30 days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Considered Self-harm on 1-2 (%)</td>
<td>7.6</td>
<td>7.5</td>
<td>5.1</td>
</tr>
<tr>
<td>occasions in last 12 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Considered suicide on 1-2 (%)</td>
<td>6.8</td>
<td>6.1</td>
<td>4.6</td>
</tr>
<tr>
<td>occasions in last 12 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engaged in Self-harm on 1-2 (%)</td>
<td>5.3</td>
<td>5.5</td>
<td>4.7</td>
</tr>
<tr>
<td>occasions in last 12 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-fatal Suicide Attempt on 1-2 (%)</td>
<td>4.2</td>
<td>3.0</td>
<td>2.0</td>
</tr>
<tr>
<td>occasions in last 12 months</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Evaluation Questions**

The proposed evaluation examines the impact of the school-based behavioral health (SBBH) initiative on the students, families, and communities that it serves. Specifically, this evaluation examines the effectiveness of the consortia and its components, community satisfaction with the grant activities, knowledge and skill-based changes relative to the established behavioral health training, and improvements in student outcomes and school climate. The following evaluation questions have been posed and are addressed in further detail.

**Process Evaluation Questions**

1. Were the program activities completed as originally intended? Did the SBBH program reach the number expected in the timeframe proposed?
2. Were the program activities implemented with fidelity?
3. What are the strengths and weaknesses of the school-based referral process?
4. What are the strengths and weaknesses of the district-level consortia?

**Outcome Evaluation Questions**

1. Do the project activities impact referrals and access to services?
2. Does access to services relate to improved student outcomes?
3. Does access to services relate to improved school climate?
4. Do staff/teachers report knowledge, skill, and attitude change after participating in the project trainings and technical assistance?
5. What is the staff reported satisfaction level with project trainings and technical assistance?
**Data Collection**

This report utilizes a mixed method evaluation approach. Therapeutic treatment fidelity was measured using a treatment fidelity checklist completed by school-based mental health therapists upon the completion of each therapy session. Stakeholder satisfaction was measured using satisfaction surveys (e.g., from referral personnel/consortia members). Student outcomes were measured using behavioral health questionnaires, and pre-post knowledge quizzes and qualitative interviews from staff were used to measure knowledge and skill-based changes among participants in the stigma reducing behavioral health training.
Data Analysis and Dissemination

Qualitative Data Analysis

Using the Qualitative Framework Approach, all interviews are transcribed focusing primarily on information directly relevant to the interview questions. Using Microsoft Excel spreadsheets, survey and interview questions are analyzed by identifying domains, core ideas, and themes relative to the questions asked.

Quantitative Data Analysis

Quantitative data analysis for this project is conducted primarily using Statistical Analysis System (SAS). Descriptive statistics, for this project, include but are not limited to frequencies, means, medians, ranges, and standard deviations. Additionally, comparative analyses between two samples are conducted using paired t-tests.

Data Dissemination

All data will be disseminated as a formal report and/or infographics to key stakeholders to aid in the improvement of community health among rural dwellers including parents, teachers, school system personnel, healthcare providers, community members, and other stakeholders.
**Process Evaluation**

*Were the program activities completed as originally intended? Did the SBBH program reach the number expected in the timeframe proposed?*

**Unique Partners.** Presently, there are a total of 33 unique community partners (e.g. school systems, Department Juvenile Justice) collaborating with the health system and participating in grant activities across the three rural counties. This collaboration has resulted in these partners contributing representatives across grant-related trainings and meetings. To date, there are 10 unique partners from County C (see Appendix A), 20 partners from County H (see Appendix B), and 9 unique partners from County X (see Appendix C).

**Behavioral Health Trainees.** Across the three rural counties, 130 trainees (first aiders) have participated in behavioral health trainings; manualized instruction and coursework designed to increase mental health awareness and decrease mental health stigma. Of these trainees, 87 are from County C, 10 are from County H, and 9 are from County X.

**Students Serviced.** A total of 198 students have received mental health and intervention services from the rural health system; of which 83 are from County C, 67 are from County H, and 48 are from County X.

*Were the program activities implemented with fidelity?*

The fidelity of the behavioral health services provided as part of the consortia’s grant activities is assessed using the Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Brief Practice Checklist (PRACTICE). TF-CBT is a short-term psychosocial therapeutic approach that uses flexible components to address unique family and individual needs. This model, originally intended to address sexual abuse trauma experienced by children and adolescents, has been
expanded to assist children who have experienced an array of traumatic childhood experiences ("How to Implement," 2004). Summarized using the acronym PRACTICE, TF-CBT is comprised of the following components: psychoeducation, parenting skills, relaxation management skills, affect identification and modulation skills, cognitive triangle components, trauma narratives, in-vivo desensitization, conjoint youth-parent sessions, and safety and communication skills ("How to Implement," 2004; Cohen, Mannarino, Kliethermes, & Murray, 2012).

In sessions in which a therapist provides psychoeducation, children and their caregivers are given information relative to trauma reminders and the impact of the trauma (Cohen et al., 2012). In parenting skill sessions, a therapist works with the child and caregiver to build a relationship that is built upon trust, understanding, and mutual respect (Cohen et al., 2012). In sessions in which a therapist teaches relaxation skills, children are taught effective coping strategies, and in affect identification and modulation skill sessions, the therapist models appropriate affect expression to help youth identify their feelings and develop a vocabulary that can be used to express such feelings (Cohen et al., 2012).

Cognitive triangle sessions help students identify the relationship between the thoughts, feelings, and behaviors associated with the traumatic experience, and youth trauma narrative sessions address trauma processing by exposing children to traumatic memories that they may want to avoid (Cohen et al., 2012). In sessions in which in-vivo desensitization is provided, a therapist gradually exposes youth to specific feared stimuli and/or trauma reminders that provoke avoidance (Cohen et al., 2012). In conjoint parent-child sessions, youth share and discuss their trauma narratives with a caregiver with the goal of establishing shared confidence and supportive communication (Cohen et al., 2012). Lastly, in personal safety and communication skill sessions,
a therapist works to enhance the youth’s sense of safety through the development of safe relationships within immediate and external environments (Cohen et al., 2012).

Through the successful implementation of TF-CBT by therapists and other trained clinicians, children have experienced reduced symptoms of depression, anxiety, and post-traumatic stress disorder in as few as 12 sessions (“How to Implement,” 2004; Cohen et al., 2012). During the implementation of TF-CBT, therapists are encouraged to carry out treatment activities in the sequence in which PRACTICE is described and presented. While not all TF-CBT components are needed in the therapeutic process for some children and families, it is encouraged that all PRACTICE components must be applied (“How to Implement,” 2004). To ensure the complete application of the PRACTICE components, the PRACTICE checklist is utilized.

To date, fidelity data are provided for 151 students; 84 students from County C, 44 from County H, and 23 from County X. The collection of fidelity data is ongoing, and will continuously be tracked throughout the course of the proposed grant. Table 8 identifies the number of TF-CBT PRACTICE components provided by school-based therapists. Across the three counties, therapists have provided a range of 1 to 20 session to County C students (see Appendix D), 1 to 42 sessions to County H students (see Appendix E), and 1 to 18 sessions to County X students (see Appendix F).

| Table 8 |

| Number of TF-CBT Components or Sessions Provided to Children across the Three Counties |
|---------------------------------|---------|---------|---------|
|                                 | County C | County H | County X |
| P- Psychoeducation              | 118      | 151      | 44       |
| P- Parenting Skills             | 19       | 76       | 6        |
| R- Individualized Relaxation Skills | 132      | 124      | 21       |
| A- Affect Identification & Modulation | 178      | 106      | 32       |
| C- Cognitive Triangle           | 54       | 108      | 6        |
What are the strengths and weaknesses of the school-based referral process?

Referral personnel, as established through grant activities, provide children and families with referrals when a need for counseling and intervention services is specified. Using a six-item survey (see Appendix G), referral personnel were surveyed to identify the strengths and weaknesses of the referral process. One indicated strength of the referral process is the presence of health system representatives at student panel and conduct hearings. With representatives from the health system being present at panel hearings for truancy and other matters, a referral is provided efficiently and immediately. Weaknesses of the school-based referral process include the inability to obtain parental consent and maintain familial contact, and patient insurance barriers (e.g. being uninsured or insurance not being accepted by providers). The collection of data relative to this evaluation question is ongoing.

What are the strengths and weaknesses of the district-level consortia?

The School-Based Behavioral Health Consortium works to effectively connect children and families, using recommendations and referrals, to providers and community resources that best fit their unique needs. The goal of the consortia is to empower children and families to be self-sufficient, and help them achieve stability and overall functioning. Using a nine-item questionnaire (see Appendix H), the strengths of the consortium are identified as: (1) the amount of expertise represented within the consortia, (2) the collaboration between different organizations to provide services to children and families in need, and (3) the ability to identify

<table>
<thead>
<tr>
<th>T- Youth Trauma Narratives</th>
<th>7</th>
<th>34</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>I- In-vivo Desensitization</td>
<td>-</td>
<td>26</td>
<td>-</td>
</tr>
<tr>
<td>C- Conjoint Parent-Child Sessions</td>
<td>-</td>
<td>44</td>
<td>8</td>
</tr>
<tr>
<td>E- Personal Safety &amp; Communication Skills</td>
<td>-</td>
<td>104</td>
<td>44</td>
</tr>
</tbody>
</table>
and recommend community resources to children and their families. Three weaknesses of the consortium include the lack of a resource book listing available resources, a limited number of services available to students in need of care, and the inability of the consortia members to track the continuation of care among students receiving services. The collection of district-level consortia data is ongoing and will continue throughout the grant.
Outcome Evaluation

Do the project activities impact referrals and access to services?

**Referrals.** To improve the behavioral health outcomes among students from schools participating in the grant activities, the consortium has established a network of referral personnel entrusted to make referrals to the health system and other outside agencies for added care and support. From August 2016 to February 2017, referrals to school-based mental health services were made to 58 students enrolled in County C’s three participating K-12 public schools (see Appendix I). Of these students, eleven were referred to the health system for partial hospitalization and one was referred to health system for inpatient services. The remaining 46 students did not require further behavioral health referrals. In County H, from September 2016 to February 2017, 49 students from participating schools received referrals to school-based mental health services (see Appendix J). Of these students, 42 did not require additional referrals, five were referred to the health system for partial hospitalization, and two were referred to an outside agency for behavioral health services and other support. Lastly, from September 2016 to February 2017, 58 County X students from participating schools received referrals to SBBHS (see Appendix K). Of these students, 52 students did not require additional referrals, five students were referred to the health system for partial hospitalization, and one student was referred to the health system for inpatient care.

**School-based Services.** Using a ten-item questionnaire (See Appendix L), members of school intervention teams identified individual counseling, group services, crisis interventions, family support services, medication management, referrals to community-based services, and case management as services needed by their students. Of these services, the intervention teams
report that their students have received individual and group counseling, and family and community support resources.

**Access to Services.** Through school-based mental and behavioral health services, rural school-aged children from participating schools are assessed for behavioral health concerns. Presently, 198 students have received school-based mental health and intervention services. Of these students, 83 are identified as County C residents (see Appendix M), 67 reside in County H (see Appendix N), and 48 are County X residents (see Appendix O). As shown in Table 9, common mental health concerns and presenting problems among serviced students across the three counties are presented. As evident by the data, common concerns among children receiving SBBHS are anxiety, conduct/behavioral issues, and depression.

<table>
<thead>
<tr>
<th>Table 9</th>
<th>Percent of Students across the Three Counties Experiencing Common Mental Health Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>County C</td>
</tr>
<tr>
<td>Abuse</td>
<td>18.1</td>
</tr>
<tr>
<td>Anxiety</td>
<td>42.2</td>
</tr>
<tr>
<td>Conduct/Behavioral Issues</td>
<td>63.9</td>
</tr>
<tr>
<td>Depression</td>
<td>42.2</td>
</tr>
<tr>
<td>Emotional Lability</td>
<td>12.1</td>
</tr>
<tr>
<td>Grief/Loss</td>
<td>32.1</td>
</tr>
<tr>
<td>Self-Injurious Behaviors</td>
<td>15.7</td>
</tr>
<tr>
<td>Suicidal Threats</td>
<td>15.7</td>
</tr>
</tbody>
</table>

Does access to services relate to improved student outcomes?

**Student Needs.** As a multipurpose tool developed to identify the service needs of children and adolescents, the Child and Adolescent Needs and Strengths Assessment (CANS) incorporates the needs and strengths of the youth into care decision-making, support planning, and the monitoring of service outcomes (“What is CANS?”). Using this data as a guide towards
improved student outcomes, this data suggests the prevention and intervention needs of students receiving school-based mental health services as part of the grant activities. For this evaluation, CANS data are reported at baseline (30 Day) and at a six-month follow-up for students in each county.

At baseline, County C students participating in the grant and receiving care possessed a high need for prevention and intervention services (see Table 10 and Appendix I). At the six-month follow-up, the data indicates that students required only watchful monitoring. The collection of follow-up data is ongoing and will continue throughout the course of the grant.

| Table 10 |
|---|---|---|---|
| **Baseline (30 Day) and 6 Month Follow Up CANS Percentages for County C Students** |
| | 30 Day | 6 Month Follow Up |
| Total Sample | 79 | 16 |
| Watchful Monitoring for Psychosis (%) | 36.4 | 12.5 |
| Need for Action to Address Psychosis (%) | ----- | ----- |
| Watchful Monitoring for Depression (%) | 62.3 | 50.0 |
| Need for Action to Address Depression (%) | 27.3 | ----- |
| Watchful Monitoring for Anxiety (%) | 50.7 | 75.0 |
| Need for Action to Address Anxiety (%) | 24.7 | ----- |

As shown in Table 11, serviced County H students also possessed a high need for services at baseline and six-month follow-up (see Appendix J). Follow-up data collection is ongoing and will continue throughout the course of the grant.

| Table 11 |
|---|---|---|---|
| **Baseline (30 Day) and 6 Month Follow Up CANS Percentages for County H Students** |
| | 30 Day | 6 Month Follow Up |
| Total Sample | 55 | 8 |
| Watchful Monitoring for Psychosis (%) | 18.5 | ----- |
| Need for Action to Address Psychosis (%) | ----- | ----- |
| Watchful Monitoring for Depression (%) | 10.9 | 50.0 |
| Need for Action to Address Depression (%) | 70.9 | 50.0 |
Lastly, among serviced County X students, there was a high need of services at baseline (see Table 12). These students also possessed a high need for services at follow-up (see Appendix K). The collection of follow-up data is on-going and will continue throughout the course of the grant.

<table>
<thead>
<tr>
<th></th>
<th>30 Day</th>
<th>6 Month Follow Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Sample</td>
<td>44</td>
<td>13</td>
</tr>
<tr>
<td>Watchful Monitoring for Psychosis (%)</td>
<td>11.6</td>
<td>-----</td>
</tr>
<tr>
<td>Need for Action to Address Psychosis (%)</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Watchful Monitoring for Depression (%)</td>
<td>53.5</td>
<td>58.3</td>
</tr>
<tr>
<td>Need for Action to Address Depression (%)</td>
<td>34.9</td>
<td>25.0</td>
</tr>
<tr>
<td>Watchful Monitoring for Anxiety (%)</td>
<td>51.2</td>
<td>75.0</td>
</tr>
<tr>
<td>Need for Action to Address Anxiety (%)</td>
<td>39.5</td>
<td>16.7</td>
</tr>
</tbody>
</table>

**Suicide Risk.** Assessing the risk of suicide, the Columbia Suicide Severity Rating Scale (C-SSRS) examines the lifetime and monthly prevalence of suicidal thoughts and behaviors among students receiving behavioral health support and intervention services ("About," n.d.). Presented here are baseline C-SSRS data for serviced students across the three counties. The collection of follow-up or C-SSRS “Since Last Visit” data is forthcoming and will continue throughout the remainder of the grant.

As evident by the data in Table 13, serviced County C students express a high lifetime prevalence of the following suicidal ideations: wishing to be dead, non-specific suicidal thoughts, and active suicidal thoughts with no plan on intent to act (see Appendix I).
### Table 13

**C-SSRS Percentages Among Serviced County C Students (N=84)**

<table>
<thead>
<tr>
<th>Suicidal Ideations</th>
<th>Lifetime</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wish to be dead</td>
<td>31.0%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Non-specific suicidal thoughts</td>
<td>21.4%</td>
<td>8.3%</td>
</tr>
<tr>
<td>Active suicidal thoughts, no plan or no intent to act</td>
<td>18.1%</td>
<td>6.9%</td>
</tr>
<tr>
<td>Active suicidal thoughts, no plan but some intent to act</td>
<td>6.9%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Active suicidal thoughts, with a specific plan and intent to act</td>
<td>2.8%</td>
<td>2.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Suicidal Behaviors</th>
<th>Lifetime</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparatory acts or behavior</td>
<td>4.0%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Self-interrupted Attempt</td>
<td>3.9%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Interrupted Attempt</td>
<td>1.3%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Non-fatal Attempt</td>
<td>8.0%</td>
<td>2.7%</td>
</tr>
</tbody>
</table>

Among County H students receiving services (see Table 14 and Appendix J), a high lifetime and monthly prevalence is reported for the following ideations: wishing to be dead and non-specific suicidal thoughts. These students also express a high lifetime prevalence for active suicidal thoughts with varying levels on intent, and non-fatal and interrupted suicide attempts.

### Table 14

**C-SSRS Percentages Among Serviced County H Students (N=64)**

<table>
<thead>
<tr>
<th>Suicidal Ideations</th>
<th>Lifetime</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wish to be dead</td>
<td>31.8%</td>
<td>17.5%</td>
</tr>
<tr>
<td>Non-specific suicidal thoughts</td>
<td>27.0%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Active suicidal thoughts, no plan or no intent to act</td>
<td>23.4%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Active suicidal thoughts, no plan but some intent to act</td>
<td>26.7%</td>
<td>4.4%</td>
</tr>
<tr>
<td>Active suicidal thoughts, with a specific plan and intent to act</td>
<td>17.4%</td>
<td>6.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Suicidal Behaviors</th>
<th>Lifetime</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparatory acts or behavior</td>
<td>7.0%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Self-interrupted Attempt</td>
<td>7.0%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Interrupted Attempt</td>
<td>15.9%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Non-fatal Attempt</td>
<td>17.8%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>
Additionally, a high lifetime prevalence of suicidal ideations is indicated by serviced County X students (see Table 15 and Appendix K). Specifically, these students express a lifetime prevalence for wishing to be dead, non-specific suicidal thoughts, and active suicidal thoughts with no intent and some intent to act.

### Table 15

*C-SSRS Percentages Among Serviced County X Students (N=47)*

<table>
<thead>
<tr>
<th>Suicidal Ideations</th>
<th>Lifetime</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wish to be dead</td>
<td>27.8%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Non-specific suicidal thoughts</td>
<td>21.3%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Active suicidal thoughts, no plan or no intent to act</td>
<td>19.2%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Active suicidal thoughts, no plan but some intent to act</td>
<td>14.9%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Active suicidal thoughts, with a specific plan and intent to act</td>
<td>6.4%</td>
<td>2.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Suicidal Behaviors</th>
<th>Lifetime</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparatory acts or behavior</td>
<td>4.3%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Self-interrupted Attempt</td>
<td>2.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Interrupted Attempt</td>
<td>8.5%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Non-fatal Attempt</td>
<td>6.4%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

**Academic Achievement.** As an indicator of student achievement, academic preparedness, and college and career readiness, the College and Career Ready Performance Index (CCRPI) is used annually as a tool to assess how well the school district, its schools, and the state are preparing students for their next educational endeavors (“Accountability,” n.d.). This score, which is calculated out of 100 points, is used by community members, educators, and parents as a guide towards the promotion and improvement of college and career readiness. Components of the score consist of achievement, achievement gap, progress, and challenging points (“Accountability,” n.d.).

In 2015, the overall CCRPI scores for County C’s elementary, middle, and high schools were 75.8, 71, and 76.5 correspondingly (“2015 College,” n.d.). Further, the collective 2016
CCRPI scores for this county’s elementary, middle, and high schools were 82.7, 74.6, and 75.8; an indication of an increase in scores among the county’s elementary and middle schools (“2016 College,” n.d.). While it is difficult to determine an association between grant activities and changes in CCRPI scores, the following 2015 and 2016 scores for County C have been reported during the grant period (see Table 16). Of these schools, County C’s Mt. Everett Elementary School showed significant gains in student achievement (“2015 College,” n.d.; “2016 College,” n.d.) (see Appendix P).

<table>
<thead>
<tr>
<th>School Name</th>
<th>2015 CCRPI Score</th>
<th>2016 CCRPI Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bow Elementary</td>
<td>79.1</td>
<td>76.2</td>
</tr>
<tr>
<td>Center Middle</td>
<td>80.4</td>
<td>77.9</td>
</tr>
<tr>
<td>Mt. Everett Elementary</td>
<td>65.7</td>
<td>83.4</td>
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</table>

In County H, the overall CCRPI scores given to it’s elementary, middle, and high schools in 2015 were 69.8, 80.3, and 71.8 correspondingly (“2015 College,” n.d.). In the following year, the reported 2016 scores for the county’s elementary, middle, and high schools were 72.8, 83.9, and 72; an indication of an increase in the overall academic achievement amongst County H students (“2016 College,” n.d.). While it is difficult to determine an association between grant activities and changes in CCRPI scores, the following 2015 and 2016 scores presented in Table 17 have been reported for County H participating schools. Presently, there is no CCRPI data available for Tailgate Primary School, and H County High and Middle Schools have experienced increases in their CCRPI scores (“2015 College,” n.d.; “2016 College,” n.d.) (see Appendix Q).
Lastly, in 2015, the CCRPI scores for County X’s elementary, middle, and high schools were 84.2, 90.2, and 84.4 respectively. Additionally, the 2016 CCPRI scores for the county’s elementary, middle and high schools were 88.0, 92.4, and 84.7 (“2015 College,” n.d.; “2016 College,” n.d.). For serviced County X schools, the following 2015 and 2016 CCRPI scores are reported in Table 18. Although it is difficult to determine an association between grant activities and CCRPI scores, East Elementary and X County High School experienced increases in their CCRPI scores from 2015 to 2016 (“2015 College,” n.d.; “2016 College,” n.d.) (see Appendix R).

<table>
<thead>
<tr>
<th>School Name</th>
<th>2015 CCRPI Score</th>
<th>2016 CCRPI Score</th>
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</thead>
<tbody>
<tr>
<td>H County High</td>
<td>72.3</td>
<td>72.5</td>
</tr>
<tr>
<td>H County Middle</td>
<td>80.8</td>
<td>84.9</td>
</tr>
<tr>
<td>Tailgate Primary</td>
<td>No Data</td>
<td>No Data</td>
</tr>
</tbody>
</table>

Table 17

<table>
<thead>
<tr>
<th>School Name</th>
<th>2015 CCRPI Score</th>
<th>2016 CCRPI Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Elementary</td>
<td>94.1</td>
<td>92.5</td>
</tr>
<tr>
<td>East Elementary</td>
<td>94.3</td>
<td>98.0</td>
</tr>
<tr>
<td>X County High</td>
<td>84.4</td>
<td>84.7</td>
</tr>
<tr>
<td>X Elementary</td>
<td>80.2</td>
<td>77.6</td>
</tr>
</tbody>
</table>

Table 18

**Academic Growth and Performance.** Utilizing school CCRPI scores to determine award eligibility, the Single Statewide Accountability System (SSAS) Award is presented to schools with high school academic performance and growth (“Single Statewide,” n.d.). To be eligible to receive the award, schools must have CCRPI scores within the 93rd percentile of the state’s overall score during three consecutive years. More specifically, the bronze award is given to schools within the 93rd percentile, and the silver award is given to schools within the 95th.
percentile. Recipients of these awards are schools with a minimum CCRPI score of 80 during three consecutive years ("Single Statewide," n.d.). Gold and platinum award recipients are those schools with a consecutive minimum CCPRI of 90, and those who rank within the 97th and 99th percentiles of the state’s overall score correspondingly ("Single Statewide," n.d.).

Again, while it is difficult to determine an association between grant activities and the awarding of the SSAS award to participating K-12 public schools, the academic performance of schools involved in the behavioral health initiative will continue to be tracked throughout the duration of the grant. Of the schools involved in the behavioral health initiative, two schools located in County X have been awarded the SSAS award. Specifically, in 2015 and 2016, Central and East Elementary Schools were awarded the Platinum SSAS Award for greatest gains ("Single Statewide," n.d.; "2015 Single," 2016; "2016 Single," 2017).

**Does access to services relate to improved school climate?**

Based on the patterns of student, school personnel, and parental experiences, school climate refers to the appeal and quality of school life ("School Climate," n.d.). Influenced by norms, values, and interpersonal relationships, school climate predicts the academic success and failure of its student body, as well as student attendance and safety ("School Climate," n.d.). Specifically, while positive school climates consist of high test scores and graduation rates, and promote students who feel safe and socially accepted, schools with low or negative school climates are comprised of students with poor academic performances, high rates of absenteeism, and unsafe school environments ("School Climate," n.d.).

**School Climate Ratings.** As a diagnostic tool, the School Climate Rating is utilized by the state as an early indicator of student academic achievement, and college and career readiness.
This rating, on a scale of one to five, is used to determine if the schools are making the appropriate progress towards school improvement, and it helps to pin-point areas needing additional attention ("School Climate," n.d.). To calculate these ratings, four components are considered; (1) Student and school staff attendance, (2) Student discipline, (3) A safe and substance-free school environment as determined by the number of school incidents, reported school victimization and bullying, and student use of illegal substances, and (4) Student and staff perceptions of the school’s climate as reported in the Health Survey ("School Climate,” n.d.).

Among County C participating schools, the reported 2015 and 2016 school climate ratings are presented as shown in Table 19. While it is difficult to determine an association between grant activities and changes in school climate ratings, the following ratings have been reported during the grant period. Noteworthy, the school climate ratings of Mt. Everett Elementary and Center Middle School remained consistent from one reporting period to the next, while Bow Elementary experienced a decrease in its climate rating ("2015 CCRPI,” 2016; “2016 CCRPI,” 2017) (see Appendix S).

Table 19

<table>
<thead>
<tr>
<th>School Name</th>
<th>2015 Climate Ratings</th>
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</thead>
<tbody>
<tr>
<td>Bow Elementary</td>
<td>4</td>
<td>3</td>
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<tr>
<td>Center Middle</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Mt. Everett Elementary</td>
<td>3</td>
<td>3</td>
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</table>

Again, while it is difficult to determine a direct association between grant activities and changes in school climate ratings, the following 2015 and 2016 ratings for participating County H schools have been reported during the grant period (see Table 20). As indicated by the data, while the school climate rating for H County High School increased from one reporting period to
the next, the climate ratings for H County Middle and Tailgate Primary School remained consistent from 2015 to 2016 (“2015 CCRPI,” 2016; “2016 CCRPI,” 2017) (see Appendix T).

Lastly, for participating schools in County X, the school climate ratings for 2015 and 2016 are presented in Table 21. Although it is difficult to determine a direct association between grant activities and changes in school climate ratings, East Elementary experienced an increase in its climate rating, X Elementary suffered a decrease in its rating, and the climate ratings for Central Elementary and X County High School remained consistent (“2015 CCRPI,” 2016; “2016 CCRPI,” 2017) (see Appendix U).

<table>
<thead>
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<th>Table 20</th>
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<tbody>
<tr>
<td>2015 &amp; 2016 School Climate Ratings for Participating County H Schools (N=3)</td>
</tr>
<tr>
<td>School Name</td>
</tr>
<tr>
<td>------------</td>
</tr>
<tr>
<td>H County High</td>
</tr>
<tr>
<td>H County Middle</td>
</tr>
<tr>
<td>Tailgate Primary</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 21</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015 &amp; 2016 School Climate Ratings for Participating County X Schools (N=4)</td>
</tr>
<tr>
<td>School Name</td>
</tr>
<tr>
<td>------------</td>
</tr>
<tr>
<td>Central Elementary</td>
</tr>
<tr>
<td>East Elementary</td>
</tr>
<tr>
<td>X County High</td>
</tr>
<tr>
<td>X Elementary</td>
</tr>
</tbody>
</table>

Do staff/teachers report knowledge, skill, and attitude change after participating in the project trainings and technical assistance?

Defined as accurate knowledge and beliefs about the recognition, prevention, and response to mental health concerns, mental health literacy is a stepping stone to improved community health efforts (Aakre, Lucksted, & Browning-McNee, 2016). When there is
improved mental health literacy among community members, greater access to appropriate care, encouragement to seek professional help, and increased support results (Aakre et al., 2016; Kelly et al., 2011). While children and adolescents are less likely to seek and receive professional psychiatric care on their own, literacy programs have begun to target the adults who assist and come into daily contact with these youths. These programs have been designed to teach parents, and other adults about the warning signs of psychological conditions common among youth populations, reduce mental health stigma, and teach effective intervention strategies that can be implemented until a successful hand-off to a trained behavioral health specialist can occur (Aakre et al., 2016; Kelly et al., 2011). One such program, Youth Mental Health First Aid (YMHFA), is a skill-based manualized modification of the Mental Health First Aid training (Aakre et al., 2016; Kelly et al., 2011).

Determined to educate parents, educators, health care workers, and other community members about mental and behavioral health concerns common among youth populations, the health system and consortium are presently providing an eight-hour YMHFA course to interested adults from the three rural counties. Using an analysis of training participant’s pre-and post-opinion quiz scores, and in-person and telephone qualitative interviews, an investigation of first aider perceptions, and attitude, knowledge, and skill-based changes post participation in the course has been conducted.

**Pre- and Post-Opinion Quiz Procedures and Results.** At the beginning of each YMHFA training, the instructor(s) of the course distributed a Pre-Opinion Quiz to each participant to measure their knowledge and beliefs of mental health topics. These quizzes remained in the possession of the trainee until the end of the course. After the course, a Post-Opinion Quiz, utilizing the same questions presented on the Pre-Opinion Quiz, was distributed to
the first aiders to identify their knowledge and beliefs post participation in the YMHFA course. As each first aider went to collect their certificates of course completion, they were asked to place both the pre- and post-opinion quizzes on a nearby table so that they could be collected by the course instructor.

A paired t-test was conducted to compare the average number of questions correct on the Pre- and Post-Opinion Quiz among 130 first aiders. There was a significant difference in the Pre-Opinion quiz scores (M= 7.97, SD= 2.45) and Post-Opinion quiz scores (M= 10.92, SD= 2.02); t(129)= -13.08, p= 0.001. These results suggest that first aiders report a higher number of questions correct after completing the YMHFA course than at the baseline.

![Figure 1. Average Number of Questions Correct on the Pre- and Post-Opinion Quiz.](image-url)

**Interview Procedures and Results.** Fifteen minute open-ended interviews were conducted using a set of eleven questions (see Appendix V). To recruit interview participants, a member of the evaluation team attended YMHFA training sessions during the last 30 minutes of instruction while course participants were completing their evaluation forms. This team member addressed the first aiders by describing the evaluation project and interview process. Persons interested in participating in the interviews were given the opportunity to sign-up by providing
their name, email address, telephone number, and preferred interview method; in-person or telephone. Participants were also allowed to choose a convenient interview time and date.

Since completing the training, seven out of eleven interview participants describe an increase in their knowledge of mental health topics. The first aiders express that they have acquired a better understanding of youth mental health statistics, and behaviors, and can identify the signs and symptoms of psychological distress. Three trainees describe the YMHFA training as a refresher course that allowed them to “get back to the basics,” and suggests that the course would be a great starting point for persons with no understanding of mental illness among youth groups. Influencing the way in which the first aiders relate to and feel in regards to persons experiencing a mental health concern, two first aiders explain that the training helps trainees better understand each disorder presented. Through this new-found understanding, first aiders report feeling more empathetic, compassionate, and sensitive towards persons experiencing a mental health crises, and being less likely to judge; as one can never know what a person is experiencing or has experienced, nor what they need if one has never taken the time to ask. Noteworthy, three participants indicate that since they work in the mental health field, the course does not change how they feel or relate to their patients and clients. If anything, it reaffirms their desire to help people in need, and that they are in the right field of work.

While the purpose of the course is not to teach participants how to diagnose youth who are experiencing a mental health concern, the course improves the ability of first aiders to help youth in need. More specifically, as one participant explains, trainees are more confident and inclined to talk with youth in crisis, and less likely to ignore the signs of distress. First aiders also report being more likely to listen and assess a child or adolescent’s situation; thus, suggesting further professional or self-help. Additionally, the training builds the confidence to ask questions
such as, “Are you experiencing suicidal thoughts?” Although a scary question to ask and situation to be placed in, as one first aider describes an incident where she asked a woman at a conference who indicated the loss of several friends to suicide, it is a question that must be asked directly to prevent potentially fatal consequences.

**What is the staff reported satisfaction level with project trainings and technical assistance?**

**Behavioral Health Trainings.** All interviewed first aiders (N=11) report high satisfaction with the YMHFA training overall. The common factor contributing to course satisfaction is the interactive nature of the course material and exercises. Identified as a strength of the course, the different activities promote engagement and the sharing of expertise, opinions, ideas, and personal experiences amongst the entire group and within smaller group sections. Four participants identify a need to restructure instruction time to take into consideration the amount of content being provided, with three participants suggesting that the course be broken into multi-day sessions. In consensus, all interviewed first aiders see the need to make YMHFA trainings, and other behavioral health trainings alike, mandatory in all organizational, workplace, and community settings; especially in those involving child-adult interaction (e.g. schools).
Implications for Public Health

Prevention

Of children possessing behavioral health needs, only half receive mental health interventions, services, and support (Moon et al, 2017). With availability, accessibility, and cost barriers threatening the mental well-being of children, and influencing the rates in which they receive care, schools are recognized as ideal gateways and entry points to children receiving needed psychosocial services (Moon et al., 2017). With students spending more time in school than at home, schools can play a key role in establishing health promotion and prevention programs that build resistance, reduce the exposure to risk factors associated with mental illness, and increase access to supports. Such factors are key in preventing or delaying the onset of psychological conditions among youth.

Intervention

Through the use of school intervention teams (e.g. therapists), similar to those established by the grant, youth can be assessed to identify psychological distress and symptomology. Using these behavioral health assessments completed with students, youth mental health concerns can be detected and treated early through SBBHS, in order to minimize their consequences and their appearance within classrooms. From here, referrals to additional services (e.g. outside agencies, inpatient care) can be made as needed. Thus, it is important to have school personnel who can effectively assess and respond to mental health crises. This professional development can be established through the implementation of behavioral health trainings such as YMHFA.

Student Outcomes

SBBHS may help reduce the symptoms and severity of many mental health conditions (e.g. through therapy). Through the use of therapeutic interventions and services provided by
SBBHS, students may require fewer needs for action to address mental health concerns such as psychosis, depression, and anxiety. With reduced symptomology and fewer needs for action to address mental health issues, this may result in improved academic performance, improved school climate, and healthy and supported youth.
Recommendations

Through detection and screening efforts, the consortium has identified common concerns, the risk of suicide and self-injurious behaviors, and the care planning needs among rural school-aged children living in three rural counties. Targeted rural students have been serviced through school-based and community behavioral health services and supports, and the consortium continues its efforts of reducing mental health stigma. Further consortia and grant efforts are needed to:

1. Establish ways to track common concerns among students throughout treatment. Prior to receiving SBBHS, students are assessed to identify common mental health concerns (e.g. abuse/depression). There is a need to continue to track the prevalence of these concerns throughout treatment. To implement this recommendation, a supplemental behavioral health survey is needed.

2. Identify ways to link mental health and education records to better track the long-term outcomes of all children for whom the health system provides services. Specifically, there is a need to track the grades and attendance records of each student receiving SBBHS to examine associations between receiving services and academic outcomes.

3. Create a resource book that can be shared across counties. Using this resource book, referral personnel and consortia members can identify the type of services available, determine their location relative to the patient’s location, and provide a variety of services and support across counties. With this book, the consortium can further establish ways to provide all services needed by students as specified by school intervention teams.

4. Provide a feedback loop to referral personnel on students referred to outside agencies, partial hospitalization, and inpatient care. Using these data, referral personnel can
monitor the continuation of care and use this data track student progress. Referral personnel can also use the data to determine the effectiveness of the treatment and make additional referrals as needed.

5. Encourage behavioral health assessments and help-seeking among parents and children. To do so, the health system and consortium, through the support of county school districts, should offer an eight-hour conjoint parent-child YMHFA course to teach about the prevalence of youth mental illness, address parent and child perceptions of mental health, and help identify a need for care and support.

6. Implement a mandatory YMHFA training for school district personnel from participating schools. By offering a mandatory course, teachers will possess the knowledge and skills necessary to identify the signs of emotional and psychological distress among youth, assess harm, and ensure the success of school-based mental and behavioral health services by aiding school-intervention teams.

7. Increase the scope and reach of professional development within the schools. By conducting a needs assessment on educator professional development needs (e.g. school-based mental health, social/emotional concerns), the data can be used to inform the search for evidence-based trainings on content identified by the educators.
Works Cited


Policy/Policy/Documents/2016%20Star%20Ratings%20and%20CCRPI%20scores.pdf


Benefits of School-Based Health Centers. (n.d.). Retrieved April 17, 2017, from National Assembly on School-Based Health Care website: [http://ww2.nasbhc.org/RoadMap/Communications/Benefits%20of%20SBHC%20Investment%20NASBHC.pdf](http://ww2.nasbhc.org/RoadMap/Communications/Benefits%20of%20SBHC%20Investment%20NASBHC.pdf)


Appendix A

Unique Partner Contributions to the Behavioral Health Initiative

Total Number of Unique Community Partners Participating in Grant Activities

Number of Unique Partners in County C Contributing Representatives Across Different Meetings.

Organizations and Agencies Involved in the Grant Activities

- County Health Department
- Department of Behavioral Health and Developmental Disabilities
- Department of Human Services
- Department of Juvenile Justice
- Division of Family and Child Services
- State University
- Pathways
- Phoenix Recovery
- Health System

Shared Ideas & Expertise + Shared Resources = Shared Outcomed

Number of Representatives by Meeting Type

- Champion: 13
- Consortium: 17
- Planning: 28
- Training: 117
Appendix B

Unique Partner Contributions to the Behavioral Health Initiative

Total Number of Unique Community Partners Participating in Grant Activities

Number of Unique Partners in County H Contributing Representatives Across Different Meetings.

Shared Ideas & Expertise + Shared Resources = Shared Outcomes

Number of Representatives by Meeting Type

- Champion: 6
- LIPT: 43
- Planning: 36
- Training: 124

Organizations and Agencies Involved in the Grant Activities:

- County Health Department
- Department of Behavioral Health and Developmental Disabilities
- Department of Human Services
- Department of Juvenile Justice
- Division of Family and Child Services
- State University
- Pathways
- Phoenix Recovery
- Health System
Appendix C

Unique Partner Contributions to the Behavioral Health Initiative

Total Number of Unique Community Partners Participating in Grant Activities

Number of Unique Partners in County X Contributing Representatives Across Different Meetings.

Shared Ideas & Expertise

Shared Resources

Shared Outcomes

Organizations and Agencies Involved in the Grant Activities

- County Health Department
- Department of Behavioral Health and Developmental Disabilities
- Department of Human Services
- Department of Juvenile Justice
- Division of Family and Child Services
- State University
- Pathways
- Phoenix Recovery
- Health System

Number of Representatives by Meeting Type

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<thead>
<tr>
<th>Meeting Type</th>
<th>Count</th>
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<tr>
<td>Champion</td>
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</tr>
<tr>
<td>Consortium</td>
<td>9</td>
</tr>
<tr>
<td>Planning</td>
<td>46</td>
</tr>
<tr>
<td>Training</td>
<td>7</td>
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</table>
Therapeutic TREATMENT FIDELITY

Psychoeducation
Therapists provided 118 psychoeducation sessions.

Individualized Relaxation
Therapists taught 132 sessions focused on individualized relaxation skills.

Parenting Skills
Therapists provided 19 parenting skill sessions.

Affect Identification
Therapists provided 178 sessions that included affect identification and modulation skill development.

Cognitive Triangle
Therapists provided 54 cognitive triangle training sessions to County C students.

Trauma Narratives
Therapists provided 7 sessions during which clients were guided through youth trauma narratives.

Treatment fidelity data is reported on 84 County C students receiving therapeutic interventions. These students have received between 1 and 20 therapeutic sessions.
Appendix E

**TREATMENT FIDELITY**

- **Psychoeducation**
  Therapists provided 151 psychoeducation sessions.

- **Individualized Relaxation**
  Therapists taught 124 sessions focused on individualized relaxation skills.

- **Cognitive Triangle**
  Therapists provided 108 cognitive triangle training sessions to County H students.

- **In-vivo Desensitization**
  Therapists taught 26 in-vivo desensitization components.

- **Personal Safety and Assertive Communication**
  Therapists provided 104 personal safety skill and assertive communication components to students.

- **Parenting Skills**
  Therapists provided 76 parenting skill sessions.

- **Affect Identification**
  Therapists provided 106 sessions that included affect identification and modulation skill development.

- **Trauma Narratives**
  Therapists provided 34 sessions during which clients were guided through youth trauma narratives.

- **Conjoint Youth-Parent Sessions**
  Therapists held 44 conjoint youth-parent sessions.

**Treatment fidelity data is reported on 44 County H students receiving therapeutic interventions. These students have received between 1 and 42 therapeutic sessions.**
Appendix F

**Therapeutic TREATMENT FIDELITY**

**Psychoeducation**
Therapists provided 44 psychoeducation sessions.

**Parenting Skills**
Therapists provided 6 parenting skill sessions.

**Individualized Relaxation**
Therapists taught 21 sessions focused on individualized relaxation skills.

**Cognitive Triangle**
Therapists provided 8 cognitive triangle training sessions to County X students.

**Affect Identification**
Therapists provided 32 sessions that included affect identification and modulation skill development.

**Trauma Narratives**
Therapists provided 12 sessions during which clients were guided through youth trauma narratives.

**Conjoint Youth-Parent Sessions**
Therapists held 8 conjoint youth-parent sessions.

**Personal Safety and Assertive Communication**
Therapists provided 44 personal safety skill and assertive communication components.

Treatment fidelity data is reported on 23 County X students receiving therapeutic interventions. These students have received between 1 and 18 therapeutic sessions.
Appendix G

Name: ____________________________
Date: ____________________________
Organization: ____________________
Title: ____________________________

Referral Person Survey

1. Are you one of the staff members at your school who is responsible for making referrals to health system clinicians? Have you ever worked in the capacity of a referral person?
   a. Yes (continue completing the survey)
   b. No (stop completing the survey)

2. Describe your role as the referral person for the mental health grant.

3. What have been the strengths of the referral process?

4. What can be done to build upon these strengths?

5. What are the weaknesses of the referral process?

6. What can be done to improve the referral process?
Appendix H

Name: _______________________________
Date: ______________________________
Organization: _________________________
Title: ______________________________

Consortium Member Survey

1. What led you to join the consortia?

2. If you were asked to join the consortia, by whom were you asked?
   a. A colleague
   b. A supervisor and/or manager
   c. A family member
   d. A friend
   e. Other (Please specify ________________________)
   f. Not applicable

3. Have you ever worked on a consortium like this one before?
   a. Yes
   b. No

4. What is the long-term vision of the consortium?

5. Is the consortium working towards this long-term vision thorough its activities?
   a. Yes
   b. No
   c. Other (Please specify ________________________)
   d. Not applicable
6. What does the consortia do for students with mental health concerns?

7. What is your role as a member of the consortia?

8. What are the strengths of the consortia?

9. What could the consortium do more of or do differently?
Appendix J

Student Outcomes
Service Access, Need, Well-being, & Academic Performance

From September 2016 to February 2017, 49 County H students received referrals to school-based mental health services.

- Of these students, 42 did not require additional referrals.
- 5 students were referred to Partial-Hospitalization.
- 2 students were referred to an outside agency.

Percent of County H Students with a High Need of Care; 30 Day Whole (N=55)

Depression: 10.9%
Anxiety: 27.3%
Psychosis: 5.3%

Percent of County H Students with a High Need of Care; 6 Month Follow-Up (N=8)

Depression: 50%
Anxiety: 42.9%

Student Columbia-Suicide Severity Rating Scale (C-SSRS) Score Percentages

- 31.8% wished to die
- 27% had non-specific suicidal thoughts
- 23.4% had active suicidal thoughts, no intent
- 17.4% had active suicidal thoughts, some intent
- 15.9% had active suicidal thoughts, with specific intent
- 17.8% had interrupted attempts
- 17.6% had non-fatal attempts
- 11.1% had suicide attempts
- 44% had suicide ideation
- 6.5% had self-harm
- 6% had suicidal thoughts
- 0% had suicide plan
Appendix L

Name: _______________________________
Date: ________________________________
Organization: _________________________
Title: ________________________________

School-Based Behavior Intervention Team Survey

1. In what grade level are your students?
   a. Pre-Kindergarten
   b. Kindergarten
   c. Elementary School (1st to 5th grade)
   d. Middle School (6th to 8th grade)
   e. High School (9th to 12th grade)

2. What school-based mental health services that your students might need? Circle all that apply.
   a. Individual Counseling
   b. Group Services
   c. Crisis Interventions
   d. Family Support Services
   e. Case Management
   f. Medication Management
   g. Referrals to Community-Based Services
   h. Substance Abuse Prevention Programs
   i. Other (Please specify______________________)

3. What are the barriers to accessing school-based mental health services in rural districts? Circle all that apply.
   a. Inability to identify children’s need for mental health services
   b. Denial of the severity of a mental health problem
   c. Belief that the problem can be handled without treatment
   d. Parental perceptions of mental health concerns
   e. Stigma related to receiving care
   f. Lack of children’s desire to receive care
   g. Lack of available school-based mental health service
   h. Lack of available providers
   i. Long waiting lists
   j. Other (Please specify______________________
4. What school-based mental health services have your students received from the rural health system?

5. Have your students found the services from the rural health system helpful?
   a. Yes
   b. No
   c. Unsure
   d. Not applicable
   e. Other (Please specify ______________________)

6. Have the school staff found the services from the rural health system helpful to their students?
   a. Yes
   b. No
   c. Unsure
   d. Not applicable
   e. Other (Please specify ______________________)

7. What professional development have you received from the rural health system? Please list the topics covered during the professional development.

8. Did the staff find the topics covered in the professional development useful?
   a. Yes
   b. No
   c. Unsure
   d. Not applicable

9. What would you like to see the rural health system continue to do in your school during this academic year?

10. What would you like to see the rural health system do differently at your school during this academic year?
Appendix M

Students Receiving School-based Behavioral Health Services

To date, 198 students have received mental health and intervention services.

Receiving Services

Of the students receiving school-based mental health and intervention services, 83 students reside in County C.

Conduct/Behavioral Issues

63.9% of County C students experienced conduct and/or behavioral issues.

Depression

42.2% of students experienced depression.

Anxiety

42.2% of students experienced anxiety.

Grief/Loss

32.1% of students were experienced grief or loss.

Abuse

18.1% of students were victims of abuse.
Appendix N

Students Receiving School-based Behavioral Health Services

To date, 198 students have received mental health and intervention services.

- **67 County H Students**
- **62.7% Depression** (62.7% of County H Students experienced depression)
- **44.9% Emotional Lability** (44.9% of students experienced emotional lability)
- **44.9% Anxiety** (44.9% of County H students experienced anxiety)
- **43.3% Conduct/Behavioral Issues** (43.3% of students experienced conduct and/or behavioral issues)
- **32.6% Grief/Loss** (32.6% of students experienced grief and/or loss)
Appendix O

Students Receiving School-based Behavioral Health Services

To date, 198 students have received mental health and intervention services.

- **Receiving Services**
  - County X Students: 48
  - Of the students receiving school-based mental health and intervention services, 48 students reside in County X.

- **Anxiety**
  - 75.0% of serviced County X students experienced anxiety.

- **Conduct/Behavioral Issues**
  - 68.8% of County X students experienced conduct and/or behavioral issues.

- **Depression**
  - 43.8% of students experienced depression.

- **Emotional Lability**
  - 41.7% of serviced County X students were victims of abuse.

- **Grief/Loss**
  - 35.3% of students experienced grief or loss.
The CCRPI is a comprehensive school improvement, accountability, and communication tool for all educational stakeholders that promotes college and career readiness for all State public school students. While it will be difficult to make a direct connection between grant activities to immediate changes in the schools’ CCRPI scores, CCRPI data for participating County C schools will be reported during the grant period.

**Bow Elementary**

2015: 79.1

2016: 76.2

**Mt. Everett Elementary**

2015: 65.7

2016: 83.4

**Center Middle**

2015: 80.4

2016: 77.9
Appendix Q

College and Career Ready Performance Index (CCRPI)

The CCRPI is a comprehensive school improvement, accountability, and communication tool for all educational stakeholders that promotes college and career readiness for all State public school students. While it will be difficult to make a direct connection between grant activities to immediate changes in the schools’ CCRPI scores, CCRPI data for participating County H schools will be reported during the grant period.

2015

No Data

Tailgate Primary

2016

No Data

H County Middle

80.8

84.9

H County High

72.3

72.5
Appendix R

College and Career Ready Performance Index (CCRPI)

The CCRPI is a comprehensive school improvement, accountability, and communication tool for all educational stakeholders that promotes college and career readiness for all State public school students. While it will be difficult to make a direct connection between grant activities to immediate changes in the schools’ CCRPI scores, CCRPI data for participating County X schools will be reported during the grant period.

2015

94.1 ■■■■■ Central Elementary

94.3 ■■■■■ East Elementary

80.2 ■■■■■ X Elementary

84.4 ■■■■■ X County High

2016

92.5 ■■■■■

98.0 ■■■■■

77.6 ■■■■■

84.7 ■■■■■
School Climate Ratings

School climate refers to the quality and character of school life – the “culture” of a school. A sustainable, positive school climate fosters youth development and student learning, which are essential elements for academic success, career-skill improvement and overall quality of life. The School Climate Star Rating helps determine whether a school is on the right path to school improvement. While it will be difficult to make a direct connection between grant activities to immediate changes in the DOE’s school climate rating, the school climate data for County C participating schools will be tracked over the course of the grant.

2015

- Bow Elementary: 4
- Mt. Everett Elementary: 3
- Center Middle: 4

2016

- Bow Elementary: 3
- Mt. Everett Elementary: 3
- Center Middle: 4
Appendix T

School Climate Ratings

School climate refers to the quality and character of school life – the “culture” of a school. A sustainable, positive school climate fosters youth development and student learning, which are essential elements for academic success, career-skill improvement and overall quality of life. The School Climate Star Rating helps determine whether a school is on the right path to school improvement. While it will be difficult to make a direct connection between grant activities and immediate changes in the DOE’s school climate rating, the school climate data for County H participating schools will be tracked over the course of the grant.

<table>
<thead>
<tr>
<th>Year</th>
<th>Tailgate Primary</th>
<th>H County Middle</th>
<th>H County High</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>2016</td>
<td>5</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>
School Climate Ratings

School climate refers to the quality and character of school life – the “culture” of a school. A sustainable, positive school climate fosters youth development and student learning, which are essential elements for academic success, career-skill improvement and overall quality of life. The School Climate Star Rating helps determine whether a school is on the right path to school improvement. While it will be difficult to make a direct connection between grant activities to immediate changes in the DOE's school climate rating, the school climate data for County X participating schools will be tracked over the course of the grant.

2015

Central Elementary

East Elementary

X Elementary

X County High

2016

4

3

4

4

4

3

4
Appendix V

Good morning/afternoon/evening. My name is ______________ and I am a Masters of Public Health student at State University. I am completing a capstone project evaluating a rural health system’s Youth Mental Health First Aid (YMHFA) program. As part of this project, I am interested in talking to individuals like yourself who have taken the course in order to identify the benefits of participating in behavioral health initiatives such as the one the health system has established.

I want to let you know that your participation in this interview is completely voluntary, and if you do not feel comfortable answering a question or would like to discontinue with our conversation, please do not hesitate to let me know.

Also, this interview will be completely confidential and anything you say will not be shared with any persons employed by the health system. If you don't mind, I would like to tape-record our discussion so that I do not miss or forget anything that we talk about. So, is it okay for me to tape-record this interview? I want you to know that all research documents relating to our conversation will not include your name or any personal information.

I am excited to speak with you. I have a list of topics I would like to discuss, but I want this to feel more like a conversation so please feel free to bring up any topics you feel are related. I am interested in your ideas, thoughts and feelings, so please feel comfortable being honest.

Do you have any questions?

Who Are You? I have given you some brief information about myself and I would like to learn a few things about you. Please tell me about yourself and what you do for a living.

Why MHFA? I am very interested in how you became involved with the rural health system’s behavioral health efforts with school-aged children.

1. What prompted your participation in the YMHFA course?

2. Tell me about why you think it’s important that YMHFA be offered to adults in your county.

3. How do you think having YMHFA offered to adults in your county will ultimately affect youth with mental health concerns? In other words, what impact do you expect this training to have on youth with mental health concerns?

Knowledge/Attitudes/Skills: Next I would like to ask you a few questions about your understanding of mental health issues.

4. Before taking the YMHFA course, how much did you know about mental illness, and the signs and symptoms of mental disorders?
5. Since the completion of the course, how would you describe your knowledge of mental health topics?

6. Before the YMHFA course, what were your feelings about individuals with mental health concerns?

   *If negative or indifferent, please ask the following follow-up questions:*

   a) What factors, if any, contributed to your feeling about mental health concerns?

   b) How have these feelings changed since completing this course?

   c) Did the YMHFA course address any of the factors that contributed to your feelings about mental health?

   *If positive, please ask the following follow-up question:*

   a) Are there any factors or reasons that you can describe that can explain why you did not possess any strong feelings about mental health concerns?

7. How (if at all) has participating in the YMHFA course changed how you relate to or feel about person(s) experiencing a mental health disorder?

8. Using what you have learned in the YMHFA course, how would you decide your ability to help youth with a mental health disorder?

   *Follow-up Question:* How likely are you to help youth with a mental health disorder in the near future?

**Youth MHFA curriculum:** We are close to the end of this interview. My final questions pertain to your perceptions of the Youth MHFA program.

9. What were the strengths of the YMHFA training?

10. Are there any areas of the training that need improvement?

11. Is there anything else you would like to say about the MHFA course and its value to you?

I would like to take the time to thank you once again for your participation in this interview. Before we conclude, do you have any questions or concerns that I can answer? In the case that questions and concerns may arise in the future, I will send you an email with my contact information. Again, thank you for your participation in my interview today. Your input is greatly appreciated.