Technical Aid Packet

Evaluation & Accountability
Related to Mental Health in Schools
(Revised 2015)

Evaluation & Accountability Related to Mental Health in Schools

Preface

Increased concern about evaluation in psychology and education has advanced the way the topic is conceived. At the same time, widespread demands for accountability have narrowed the way professionals, clients, policy makers, and the general public think about evaluation. In particular, contemporary social and political forces have reshaped the whole enterprise of program evaluation.

The prevailing cry is for specific evidence of efficacy – usually in terms of readily measured immediate benefits – and for cost containment. The evaluation problem involves more than determining the efficacy of current interventions and more than finding better ways to evaluate efficacy. Broadly stated, it encompasses concerns about how to expand the focus of evaluation, not only to contribute to improving practice, but also in advancing basic knowledge about interventions. Intervention evaluation can aid efforts to (a) make decisions about whether to undertake, continue, modify, or stop an intervention and (b) advance knowledge about interventions in ways that can advance understanding of and improve practices, training, and theory.

We have formatted this Technical Aid Packet around questions frequently asked by mental health in school practitioners. The packet addresses multiple levels of intervention: student outcomes, program effectiveness, system change, overall impact on a school and community.

If you are just beginning to learn about evaluating your mental health in school's interventions, it may help to begin with the responses to the first two questions in this packet: (A) *What's being done to evaluate the impact of mental health in schools on students?* and (B) *How can we evaluate the prevention and early intervention programs for mental health in schools?* Also, see Part III C for "Tips, Tools, and Planning Worksheet Example."

If you are at a stage where you are ready to broaden your evaluation, you will want to read Part III A "Mental Health in Schools: Quality Control, Evaluation of Outcomes, and Getting Credit for All You Do" and the responses to the third and fourth questions in this packet: (C) *How do others evaluate progress in building and sustaining a learning support component that embeds mental health in schools?* and (D) *How can we evaluate the impact of school-based case- and resource-oriented teams?*

Those concerned with enhancing and sustaining programs should find the responses to the fifth and sixth questions relevant: (E) *What accountability data (e.g., academic, behavioral, and emotional) can we use to evaluate the school-wide and community impact of mental health in schools?* and (F) *How can we integrate data from various evaluations to advocate for mental health in schools and establishment of a learning support component?*

> For those interested in a broad overview introduction to evaluation related to intervention in schools, see the Center's Introductory Packet *Evaluation and Accountability: Getting Credit for All You Do!*
>   http://smhp.psych.ucla.edu/pdfdocs/evaluation/evaluation.pdf

To truly ensure that no child is left behind, every school and community need to work together to enhance efforts to increase the number of students who arrive each day ready and able to learn what the teacher has planned to teach. This involves helping significant numbers of students and their families to overcome barriers to development and learning.

In doing this, schools potentially are a major public health resource. They can offer a unified, comprehensive, and equitable system of student and learning supports designed to promote healthy development, prevent problems, provide support and follow up when there is an early indication of problems, and play a significant role in caring for those with mental health problems.

News about Evaluation and Accountability for Schools (August, 2015)

>*Testing Doesn't Measure Up for Americans: Americans look beyond testing when they evaluate schools* – http://pdkpoll2015.pdkintl.org/wp-content/uploads/2015/08/pdkpoll47_2015.pdf

This report of results from the Phi Delta Kappa and Gallup 47th Annual Poll of the Public's Attitudes Toward the Public Schools (PDF) indicates that two-thirds of the American public believes there is too much emphasis on standardized testing in public schools.

Despite the public pushback against testing, fewer than half (41 percent) of those surveyed believe all parents with children in public school should be allowed to excuse their child from taking one or more standardized tests. And only 31 percent of public school parents expressed that they would excuse their child from taking a test. Similarly, 31 percent of parents state that their child complains about taking too many standardized tests.

When asked what approach would provide the most accurate picture of a public school student's academic progress, respondents of every demographic-Republican, Democrat, independent, black, Hispanic, white-selected "examples of student work" more frequently than written observations or grades provided by the teacher. "Scores on standardized achievement tests" was the least selected approach among all demographics.

>*States Gaining a Say on School Accountability* – http://www.edweek.org/ew/articles/2015/08/19/states-gaining-a-say-on-school-accountability.html

At this time, Congress is working to replace the No Child Left Behind Act (NCLB), and the bills passed by both the House and Senate both stress ending the federal law's stringent accountability system. And because states have already experienced some accountability freedoms through the administration's NCLB waivers, a few pioneering states are using that flexibility to pilot holistic approaches to accountability-a trend that is sure to grow as more educators, parents, and policymakers push back on standardized testing. Some of these new systems try to capture the noncognitive factors that testing does not measure.

>*Stakes for "High-stakes" Tests Are Actually Pretty Low* – http://hechingerreport.org/stakes-for-high-stakes-tests-are-actually-pretty-low/

This Hechinger Report article examines how states use results from the tests. It reports that the majority of states are not tying test results to student promotion or teacher evaluation this year. As states are beginning to report preliminary results from their Common Core standards-aligned tests, the results are fairly positive. Because many states administered these tests for the first time this past spring, true comparisons to the previous year's tests aren't possible. But students are performing better than projected despite the increased rigor of the new tests. They conclude that, despite all the controversy, few students or teachers will be much affected by the result of this spring's Common Core-aligned tests.

Introduction

For many years, our Center's policy analyses have stressed that all narrow agenda for student and learning supports, including endeavors to expand mental health in schools, need to be embedded into a unified, comprehensive, and equitable system of student and learning supports. Accomplishing this requires transforming current student and learning supports in ways that will end the marginalization, fragmentation, and redundancy that characterizes the whole enterprise, and the resultant counterproductive competition among pupil personnel professions as they vie for sparse resources.

From this perspective, we take a expanded view in framing and discussing evaluation and accountability for mental health in schools. See the Center's Introductory Packet *Evaluation and Accountability: Getting Credit for All You Do!*

> http://smhp.psych.ucla.edu/pdfdocs/evaluation/evaluation.pdf

This technical aid packet is meant as a resource for systematic evaluation planning. Such planning requires decisions about

- the focus of evaluation (e.g., person or environment, immediate objectives vs. long-range aims),

- whose perspective (e.g., client, intervener, program underwriter) is to determine the evaluation focus, methods, and standards used, and

- the best way to proceed in gathering, analyzing, and interpreting information (e.g., specific measures, design).

In making such decisions, concerns arise because what can be evaluated currently is far less than what a program may intend to accomplish.

One negative effect of the push toward behavioral and criterion-referenced outcomes as ways to improve accountability has been a shift away from a program's long-range aims toward a limited set of immediately measurable objectives. Comprehensive evaluation should stress the full scope of desired intervention aims. That is, even when certain processes and outcomes are not easily measured, they still must be evaluated as well as is possible and kept in the forefront of discussions about a program's worth. As schools adopt new standards (e.g., Common Core State Standards or versions thereof), these are prominent concerns.

With specific respect to mental health, the tendency has to focus mainly on mental disorders in practice and in evaluation discussions. A broad definition of mental health calls for expanding the focus to include promotion of healthy development, prevention of problems, and addressing a wide range of precursors to mental disorders. It also calls for understanding that the differences when discussing the "gold standard" for interventions and the "gold standard" for evaluations (see the Exhibit on the next page).

Exhibit

Mismatch Between the "Gold Standard" Associated with Interventions and the "Gold Standard" Associated with Evaluations

[From the work of Lisbeth B. Schorr, Project on Effective Interventions at Harvard University, PathwaysToOutcomes.org, 2009 –
   http://www.communitysolutionsva.org/files/Session_1-Mismatch_Gold_Standard_Chart1.pdf]

As illustrated below, Lizbeth Schorr has stressed we must be careful to understand the mismatch between the "Gold Standard" of Interventions and the "Gold Standard" of Evaluations

ATTRIBUTES OF EFFECTIVE COMPLEX INTERVENTIONS	ATTRIBUTES ASSOCIATED WITH "GOLD STANDARD" EVALUATIONS
Significant front-line flexibility exists within established quality standards	Intervention is standardized, discretion minimized
Intervention evolves in response to experience and changing conditions	Intervention remains constant over time
Intervention/program design reflects local strengths, needs, preferences	Intervention is centrally designed and uniform across sites
Intake/recruitment into program falls under local control, within broad parameters	Intake is centrally designed to permit random assignment
Multiple components respond to children in family, peer, and neighborhood contexts	Single-factor, single-sector interventions
Interactive components take into account the interrelationships among health, social, educational needs	Components are clearly separable
Training and setting emphasize continuing, respectful relationships and other hard-to-measure attributes	Focus on readily measured inputs
Implementers *believe in* the intervention and go beyond their job description to respond to clients	Implementation is value-free

I. Six Frequently Asked Questions and Center Responses

A. What's being done to evaluate the impact of mental health in schools on students?

Question: *I need help with structured assessments to be used as pre and post measurements that can be used by school staff and/or school mental health professionals. What measurements are being used now in other school mental health programs?*

Response: Since evaluating mental health interventions is difficult and evaluating mental health in schools adds more complexity, our response to this begins with offering some basics to guide gathering broadly-focused impact evaluation data.

1. *Focus*. Minimally, there are two areas of focus in gathering impact data related to mental health in schools – the student and the school.[1]

Regarding the **Student,** the focus is on indicators of

>symptom reduction
>positive development (capabilities and attitudes)
>improved behavior at school (reduced misbehavior and tardiness, increased attendance)
>academic improvement

Regarding the **School,** the focus is on indicators of

>how many are doing better behaviorally and academically and to what degree
    (with respect to disaggregated subgroups)
>fewer inappropriate referrals for special assistance/special education
>fewer suspensions, expulsions, dropouts
>improved school/classroom climate
>increased family involvement (with child, with schooling)
>cost-effectiveness

2. *Sources of Data*. The most common sources are:
    >Student
    >Special intervener(s)
    >Parent /Family
    >Teachers/Staff
    >Peers
    >School Records

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[1]Descriptors of the student (e.g., demographics, referral information, diagnosis if applicable), characteristics of services provided (type of intervention, number of visits, and provider, fees, payer), and anything about the school that makes it different from others (low performing, urban, rural, etc.) all are needed for various purposes. These include planning, reporting, billing, and accountability, and carrying out such functions with disaggregated data.

3. *Pre and post measures.* Finding established instruments for gathering some facets of desired data.

To find specific measures and read reviews about them, go to Buros Center for Testing online at http://marketplace.unl.edu/buros/ and search by type of measure, For example, use the following categories (we have listed a couple of examples of what you can find):

• **Client satisfaction (youngster; family)**

> Youth Satisfaction Questionnaires
> (e.g., see http://www.dmh.cahwnet.gov/RPOD/child-posi.asp)
> Vanderbilt Satisfaction Questionnaire (R.L. Oliver (1997). *Satisfaction: A Behavioral Perspective on the Consumer*, New York: Irwin/McGraw-Hill.

• **Reduction in Youngster's Symptoms/Problem Behaviors**

> Child Behavior Checklist (Achenbach & Edelbrock; see
> http://buros.unl.edu/buros/jsp/reviews.jsp?item=13191584)
> Child and Adolescent Functional Assessment Scale (Hodges; see
> http://buros.unl.edu/buros/jsp/reviews.jsp?item=06000977)

• **Increases in Positive Functioning**

> Family Environment Scale (Moos; see
> http://www.docdatabase.net/more-family-environment-scale-third-edition-231902.html)
> Family Adaptability and Cohesion Scale (Olson; see http://facesiv.com/)

• **Classroom/School Measures**

Try this category on the Buros site to see the range of available meaures

Note: Also of value are data from functional assessments (increasingly being done when students are referred for behavior problems).

Approaching evaluation from this broad perspective trains staff to think in terms of an expanded focus when pursuing mental health in schools.

To provide more on this important topic, we continuously solicit responses from specific members of the Center's Consultation Cadre, researchers, and school based practitioners enmeshed in the process.

Following are two examples we received in response to the question when it was initially raised:

"We have learned that there is a real distinction between research supported evaluation projects, where structured pre-post measurement is possible, and the reality of working in the schools, where doing so is very difficult. In general, our evaluation focuses on evaluating changes in student grades, attendance, lateness, and discipline problems from before (e.g. 1st quarter) to after (e.g. 3rd quarter) intervention. In most of our schools this approach leads to positive findings, but these are clearly evaluation not research data. We use some brief measures for pre-post assessment (or weekly, bi-weekly, monthly assessment) for use with youth presenting specific disorders, e.g.,

>>The Children's Depression Inventory (Kovacs)
   Published by Multi-Health Systems, Inc. 800-268-6011.
>>Reynolds Adolescent Depression Scale (http://www.parinc.com)
>>Revised Children's Manifest Anxiety Scale (http://www.wpspublish.com)
>>Conners Rating Scales (for ADHD)
   (http://www.harcourt-uk.com/SearchResults.aspx?Search=Conners%20Rating%20Scales)

We have also looked into Michael Epstein's Behavioral and Emotional Rating Scale: A Strength based Approach to Assessment. (http://www.eric.ed.gov/ERICWebPortal/custom/portlets/recordDetails/detailmini.jsp?_nfpb=true&_&ERICExtSearch_SearchValue_0=EJ629365&ERICExtSearch_SearchType_0=eric_accno&accno=EJ629365)

Also, exploring the Strengths and Difficulties Questionnaire which is being used internationally to assess problems and strengths and is brief (http://sdqinfo.com)

In addition to these areas, we believe in a continuum of evaluation from qualitative (e.g., stories, focus groups, satisfaction surveys) to the more quantitative measures reviewed above."

"For starters, all NM SBHCs use the New Mexico School-Based Health Pro (SBHC-Pro), which is a clinical database created by NMDOH to track treatment activities at all funded SBHCs. It includes registration and billing information (including age, gender, race/ethnicity, primary care provider, insurance, school) and visit data (including age and grade at visit, date, parent contact, primary ICD9 code, provider type and referral information).

The primary tool that clinicians within and outside of SBHCs use here in NM is the Children's Functional Assessment Rating Scale (CFARS). This is a clinician rating scale that provides problem severity ratings on sixteen dimensions of functioning. These include depression, anxiety, hyperactivity, cognitive function, traumatic stress, substance use, ADL functioning, interpersonal, home, school and legal functioning, danger to self and/or others and security/management needs. Earlier versions were used extensively for over fifteen years for monitoring changes in functioning in child mental health and substance abuse populations in Colorado, New York, and Arizona (Saunders et al., n.d.). The current version adds the Global Assessment of Functioning (GAF) as an overall measure of functioning, questions to assess positive and negative aspects of functioning, and changed some wording to make the instrument more age appropriate. It is administered at initiation of treatment and at 90-day intervals. This tool is currently required for use by the New Mexico Medicaid program and the State Children, Youth and Families Department (CYFD) to measure clinical improvement from mental health treatment. Pilot studies showed acceptable levels of inter-rater reliability (.5 or greater) (Saunders et al., n.d.). See (http://cfars.fmhi.usf.edu)

We are also piloting the Behavioral Healthcare Rating of Satisfaction (BHRS) at some of our sites. This tool was developed at the Mental Health Institute at the University of South Florida to provide a standardized assessment of consumer satisfaction for adolescents with severe mental illness or substance abuse problems. The 29-item survey assesses general consumer satisfaction, perceptions of staff, and perceived outcomes. It has demonstrated validity and reliability (Saunders et al., n.d.)." (See http://outcomes.fmhi.usf.edu/)

To add to the above, it was noted that also used in various places are:

>Teacher Rating of Student Adjustment – http://www.fasttrackproject.org/techrept/t/tsa/

>Youth Outcome Questionnaire – http://www.oqmeasures.com/

Here's another way we have been asked about this matter:

Question: *With the end of the year approaching our staff are bringing counseling sessions for many students and families to a close. We are collecting data on outcomes, including feedback from the students and families. Do you know of any client satisfaction surveys we could use?*

Response: With tight budgets and increased focused on accountability in schools, it is more important than ever to be able to document the value of programs that provide learning support. Client satisfaction surveys are one facet (see below).

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**Examples of Client Satisfaction Surveys
Some High School-based Health Centers Have Reported as Useful**

>Client Satisfaction Questionnaire (CSQ Scales)
http://www.csqscales.com/pdfs/Brief%20Summary%20of%20the%20Client%20Satisfaction%20Questionnaire%20(CSQ%20Scales).pdf

>Service Satisfaction Scale (SSS) http://www.csqscales.com/sss.htm

Focuses on matters such as:
   1. How would you rate the quality of service you have received?
   2. Did you get the kind of service you wanted?
   3. To what extent has our program met your needs?
   4. If a friend were in need of similar help, would you recommend our program to him/her?
   5. How satisfied are you with the amount of help you have received?
   6. Have the services you received helped you deal more effectively with your problems?
   7. In an overall, general sense, how satisfied are you with the service you have received?
   8. If you were to seek help again, would you come back to our program?

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Remember, however: there are a number of ways outcomes from counseling/therapy can and should be measured and this means going beyond client satisfaction.

Feedback from teachers, parents, and students is important in documenting (1) decreases in the symptoms/problems for which the student was referred and (2) increases in prosocial behaviors, etc. These may be measured by rating scales, standardized tests used at intake and at the end of the intervention, and indicators from school records.

For broad-based (e.g., universal) programs, it is relevant to gather and aggregate pre-post data to evaluate school wide changes. If only a targeted group of students participated in the program, it is essential to gather and disaggregate data on their behaviors and, whenever feasible, compare the data to similar students who did not participate in the program. And, of course, everyone is always hoping to show connections to academic progress, so it is important to include data on test performance and grades.

This packet and the Center's Introductory Packet entitled *Evaluation and Accountability: Getting Credit for All You Do!* are good starting places to learn more about these matters. Links to other resources can be found by going to the Cednter's Quick Find topic: *Evaluation of Programs Addressing Barriers to Learning* – http://smhp.psych.ucla.edu/qf/evaluation.htm .

B. How can we evaluate prevention and early intervention programs for mental health in schools?

Question: *It seems easier to evaluate interventions when there is a problem and you show that you can reduce the problem. With prevention we have to show we kept a problem from happening. Do you have any suggestions on how to do this?*

Response:. There are a number of promising analyses of prevention and early intervention programs. Reviewing the criteria they use provides a good basis for future evaluations. The Center has compiled an "Annotated list of lists" of empirically supported/evidence based interventions for school aged children and adolescents (e.g., see Part II A) and has a Quick Find on *Empirically-Supported/Evidence-Based Interventions* – http://smhp.psych.ucla.edu/qf/ests.htm.

<p align="center">**A Sample of Reviews Evaluating Prevention and**
Early Intervention Programs Relevant to Mental Health in Schools</p>

Safe and Sound. An Educational Leader's Guide to Evidence-Based Social & Emotional Learning Programs by the Collaborative for Academic, Social, and Emotional Learning (http://www.casel.org). One set of criteria used was evidence of effectiveness. This included: pretest and post test assessment; a comparison group; measures of students behavior change (not just changes in student attitudes or knowledge); behavioral impacts replicated in different sites and sustained over time

*Positive Youth Development in the United States: Research Findings of Evaluations of Positive Youth Development Programs,*Social Development Research Group, Univ. of Washington (http://ann.sagepub.com/cgi/content/refs/591/1/98). Covers programs to promote bonding; foster resilience; promote social, emotional, cognitive, behavior, and moral competence; foster self-determination; foster spirituality; foster self-efficacy; foster clear and positive identity; foster belief in the future; provide recognition for positive behavior and opportunities for prosocial involvement; foster prosocial norms (healthy standards for behavior). One set of criteria used was enhancement of positive outcomes and/or reduction of negative outcomes.

Blueprints for Violence Prevention, Center for the Study and Prevention of Violence, Institute of Behavioral Science, University of Colorado, Boulder (http://www.colorado.edu/cspv/blueprints/). Criteria include deterrence for delinquency (including childhood aggression and conduct disorder), drug use, and/or violence and that deterrence sustained for one year post treatment as evidence of effectiveness.

Exemplary Substance Abuse Prevention Programs. Center for Substance Abuse Prevention – http://www.nationalfamilies.org/parents/pipp_booklet/model_sapps.html

World Health Organization. (2004). *Prevention of Mental Disorders: Effective Interventions and Policy Options, Summary Report*. A report of the World Health Organization in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht. Geneva, Switzerland. http://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf

Institute of Medicine. (2009). *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities.* M.E. O'Connell, T. Boat, & K.E. Warner, (Eds.), Board on Children, Youth, and Families,Division of Behavioral and Social Sciences and Education. Washington, DC: National Academy Press. http://www.nap.edu/catalog.php?record_id=12480

Promoting healthy development, well-being, and a value-based life are important ends unto themselves and are keys to preventing mental health and psychosocial problems.

**A Sampling of Outcome Findings for Prevention and Early Intervention Programs
Relevant to Addressing Barriers to Learning**

For an in-depth look at a range of evaluated programs for prevention and early intervention
see the Center resource entitled *A Sampling of Outcome Findings for Interventions Relevant
to Addressing Barriers to Learning* online at http://smhp.psych.ucla.edu. Each program
included provides a resource for understanding how outcomes were evaluated.

The programs included are organized into the six major facets of a comprehensive approach
to addressing barriers to learning. This exemplifies the value of not just focusing on one or
two programs, but organizing and contextualizing evaluation to indicate what a "critical
mass" of activity can accomplish in terms of outcomes. The Packet includes information
related to

1. *Classroom-focused Enabling*, focusing on
   • Small Classes/Small Schools
   • Prereferral Intervention Efforts
   • Tutoring
   • Alternative Schools
   • Health/Mental Health Education a. social emotional development,
     enhancing protective factors and assets building b. promoting physical
     health

2. *Support for Transitions,* focusing on
   • Readiness to Learn/Early Childhood Programs
   • Before and After School Programs
   • Grade Articulation Programs
   • Welcoming and Social Support Programs
   • To and From Special Education
   • School-to-Career Programs

3. *Student and Family Assistance Programs and Services*, focusing on
   • School-Owned and/or School-Based Support Programs
   • School-Linked Projects and Services (including health and human services
     and therapies; substance abuse programs)

4. *Crisis Response and Prevention*, focusing on
   • Crisis Team Response and Aftermath Intervention
   • School Environment Changes And Safety Strategies
   • Curriculum Approaches to Preventing Crisis Events – social & personal,
     including violence prevention; suicide prevention; physical/sexual abuse
     prevention

5. *Home Involvement in Schooling*, focusing on
   • Parenting Education
   • Adult Education and Family Literacy
   • Mobilizing the Home to Address Students' Basic Needs

6. *Community Outreach for Involvement and Support*, focusing on
   • Mentor/Volunteer Programs
   • School-Community Partnerships
   • Economic Development/Community Rebuilding

C. How do others evaluate progress in building and sustaining a learning support component that embeds mental health in schools?

One major approach to embedding mental health in schools is to promote and support a major rethinking of student/school support services. This includes a focus on integrating all activity designed to address barriers to student learning and teaching (e.g., integrating traditional pupil support services with other school-based/linked support programs, teams, and special projects in both the regular and special education arenas). It also encompasses outreach efforts to enhance linkages and collaborations with community resources (e.g., health, social, recreational programs; involvement of volunteers and local businesses). And, it involves full integration of all activity designed to address barriers to learning with the instructional and school management components. See the Center's Introductory Packet *Evaluation and Accountability: Getting Credit for All You Do!* for specific examples of aims, goals/objectives, and indicators of efficacy for evaluating this approach.

Also think about making the case for such an approach by using existing compilations of research findings such as the one mentioned on the preceding page and the various reviews cited in Section III D-2.

Advancing mental health in school is about much more than expanding services and creating full service schools. It is about unifying existing student and learning supports and then developing a comprehensive and equitable system that strengthens students, families, schools, and neighborhoods and does so in ways that maximize learning, caring, and well-being for all students.

All policy to enhance mental health in schools must interface with school improvement policy or it will be marginalized in daily practice at schools.

D. How can we evaluate the impact of school-based case- and system development-oriented teams?

Response: First, be certain to everyone knows the difference between these two types of teams (see exhibit below).

Exhibit. Contrasting Team Functions

A Case-Oriented Team	A Leadership Team for System Development
Focuses on specific *individuals* and discrete *services* to address barriers to learning	Focuses on developing a unified & comprehensive system of supports to address barriers to learning for all students
Sometimes called:	Possibly called: • Learning Supports Resource Team • Learning Supports Component Team • Learning Supports Component Development Team
• Child Study Team • Student Study Team • Student Success Team • Student Assistance Team • Teacher Assistance Team • IEP Team	
EXAMPLES OF FUNCTIONS:	EXAMPLES OF FUNCTIONS: >aggregating data across students and from teachers to analyze school needs >mapping resources in school and community >analyzing resources >identifying the most pressing program development needs at the school >coordinating and integrating school resources & connecting with community resources >establishing priorities for strengthening programs and developing new ones >planning and facilitating ways to strengthen and develop new programs and systems >recommending how resources should be deployed and redeployed >developing strategies for enhancing resources >social "marketing"
>triage >referral >case monitoring/management >case progress review >case reassessment	

For discussions of the different functions of case- and system development-oriented teams and how to establish effective teams, see *Key Leadership Mechanisms for Enhancing student & Learning Supports* – http://smhp.psych.ucla.edu/pdfdocs/report/resource_oriented_teams.pdf

Developmental benchmarks provide an invaluable guide in evaluating the impact of teams. Minimally, it is essential to consider phase of development as a basis for establishing standards for judging degree of impact (e.g., What are appropriate expectations?).
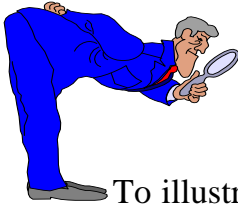
To illustrate the point, see the example highlighting the *Benchmark Checklist for Monitoring and Reviewing Progress in Developing a Comprehensive System to Address Barriers to Learning and Teaching*
– http://smhp.psych.ucla.edu/pdfdocs/studentsupport/toolkit/benchmarktool.pdf
The items can be used for purposes of both formative and summative evaluation.

Also see the Center's System Development Toolkit for other resources relevant to evaluating infrastructure mechanisms that can promote and support mental health in schools – http://smhp.psych.ucla.edu/summit2002/resourceaids.htm .
See for example, *Leadership Infrastructure: Is What We Have What We Need?* A tool outlining a four step process that can be used by planners and decision makers to map and analyze current infrastructure – http://smhp.psych.ucla.edu/summit2002/tool%20infrastructure.pdf .

E. Question: What accountability data (e.g., academic, behavioral, and emotional) can we use to evaluate the school-wide and community impact of mental health in schools?

Response: The following resources help address this matter:

>"Effects of school-based mental health programs on mental health service use by adolescents at school and in the community" (2002) by E. P. Slade, in *Mental Health Services Research* 4, 151-166. (See the summary at: http://www.ncbi.nlm.nih.gov/pubmed/12385568)

>"Effectiveness of School Based Mental Health Services for Children – A 10 year research review" (1997) by K. Hoagwood and H. Erwin in *Journal of Child and Family Studies, 6*, 435-451. The authors looked at studies using standardized outcome measures. They point out that most studies focus only on changes in symptoms or functioning. Good tools need to look at all these areas and while some standardized assessment as available, school-based clinicians are developing data sets that begin to show the broader impact of their work, and making sure that these measures are included in databases for school accountability. They describe an interactional model of outcomes that includes evaluation of
1. Symptoms (e.g., impulsivity depression)
2. Functioning (e.g. capacity to adapt to the demands of home, school neighborhood)
3. Consumer perspectives (satisfaction with care, impact on family)
4. Environments (stability of primary environments at home, school or neighborhood
5. Systems (level, type or costs of services).

>*The Effectiveness of Universal School-Based Programs for the Prevention of Violent and Aggressive Behavior* – From CDC's MMWR
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5607a1.htm
Summary: During 2004--2006, the Task Force on Community Preventive Services conducted a systematic review of published scientific evidence concerning the effectiveness of universal school-based programs to reduce or prevent violent behavior. The results provide evidence that universal school-based programs decrease rates of violence and aggressive behavior among school-aged children. Program effects were demonstrated at all grade levels. An independent meta-analysis of school-based programs confirmed and supplemented these findings.

>*A New Wave of Evidence: The impact of school, family, and community connections on student achievement*. (http://www.sedl.org/pubs/catalog/items/fam33.html) This document from the Southwest Educational Development Laboratory, National Center for Family & Community Connections with Schools reviews 51 studies. It has relevance for school based mental health programs that engage families in the intervention process. The studies are identified by general topic, by age/grade level, and by design. On page 32 there are tables showing the grade point average difference based on teacher support, parent involvement, and student sense of belonging.

>A *Sampling of Outcome Findings from Interventions Relevant to Addressing Barriers to Learning*. This Technical Aid Packet prepared by the Center amasses data on school based intervention in six areas (classroom, transitions, special assistance, crisis, home involvement, and community support). There is a table in each section related to the target population, focus of change outcomes, and nature of academic improvement. Where the table indicates strong outcomes, you can pursue the original source document which is listed in the appendices.
http://smhp.psych.ucla.edu/qf/crisis_tt/samplingofoutcomefindings.pdf

>School-based mental health program evaluation: Children's school outcomes and acute mental health service use. (2013). Kang-Yi, C.D.1., Mandell, D.S., & Hadley, T. Journal of School Health, 83, 463-472. http://onlinelibrary.wiley.com/doi/10.1111/josh.12053/abstract;jsessionid=191834C55B2B06F358891B70B9411388.f01t03

Abstract: A multilevel analysis examined the relative effects of SBMHs on children's absence, suspension, grade promotion, use of acute mental health services, as well as the association of child and school-level factors on the outcomes of interest. Little change in average number of days absent per month and no significant change in the use of acute mental health services were found. The mean number of days suspended per month out-of-school decreased from 0.100 to 0.003 days (p < .001). The percentage of children promoted to the next grade increased almost 13% after program enrollment (p < .01). Program type did not predict outcome changes except grade promotion. Despite the positive effect of school-based mental health programs on some school outcomes, the lack of difference between programs suggests the need to identify active mechanisms associated with outcome to make the delivery of care more efficient.

With respect to methodological considerations, see:

>*Achieving and Measuring Community Outcomes: Challenges, Issues, Some Approaches* (United Way of America, 1999). http://national.unitedway.org/outcomes/library/interven.cfm .

The authors identify the following challenges: (1) selecting appropriate outcomes to achieve, (2) developing a strategy for achieving the intended outcomes, (3) creating and implementing an action play, (4) identifying indicators of success, (5) measuring the selected indicators, and (6) Linking program outcomes to community outcomes

>"How shall we study comprehensive, collaborative services for children and families?" *Educational Researcher* (1995). Michael Knapp points to five sets of issues confronting researchers and evaluators wishing to make sense of comprehensive, collaborative services for children and families. These issues are present to some degree in studying many complex interventions, but they are demonstrably acute in this case.

1. Engaging divergent participants' perspectives. For whom and with whom are we undertaking research on comprehensive, collaborative services? How should the perspectives of different research and service disciplines, professionals and consumers, and diverse agencies be reflected in the design, conduct, and interpretation of studies?

2. Characterizing (and measuring) the elusive independent variables: What exactly is it that we are studying?

3. Locating (and measuring) the bottom line: What would indicate that delivering human services in a comprehensive, collaborative form had achieved some desirable ends? What ends would be included in such an evaluation - health, education, welfare, the reform of human service systems, or all of the above?

4. Attributing results to influences: Given so many possible influences, what is to be taken as the result of what?

5. Studying sensitive processes and outcomes: How do we capture what is going on without intruding on the subtle (and often confidential) interaction between service providers and consumers of services?

Further discussion of accountability indicators is offered in the Center's Introductory Packet on *Evaluation and Accountability: Getting Credit for All You do!*.

I. Six Frequently Asked Questions and Center Responses (cont)

F. Question: How can we integrate data from various evaluations to advocate for enhancing mental health in schools and establishment of a learning support component?

Response: We understand that everyone wants outcome/result/impact data. Decision makers are asking for it with every proposal. However, what they are asking for represents quite a morass and is an emerging issue in the field these days.

Unfortunately, particularly with respect to enhancing the field, the question is being asked too simplistically and in many ways is scientifically naive and premature. Indeed, as federal agencies increasingly have argued for using science-based approaches (empirically supported interventions), it is becoming painfully clear the focus is on very narrow approaches. Moreover, the demand for positive impact evidence is being used often to argue against the value of many types of pupil personnel and is leading to lay offs. This type of use is what is being labeled as "using science for political purposes" rather than advancing knowledge and practice.

Our sense is that the way to counter all this is to pursue a twofold strategy: (1) start emphasizing the data that underscore the necessity of developing (and then gathering evaluative data) on the need for enhancing the field (which usually means pursuing new directions) and (2) underscore the promising analyses of current programs but do so within a comprehensive framework that suggests the potential of moving in new directions.

(1) With respect to the first point, for example, we stress data pointing to the shortcomings of current school improvement efforts
- high student dropout rates,
- high teacher dropout rates,
- the continuing achievement gap,
- the plateau effect related to efforts to improve achievement test performance*
- the growing list of schools designated as low performing,
- the degree to which high stakes testing is taking a toll on students

   *Evidence is growing that when test score gains are achieved, they mainly occur for young students, are related to noncomplex skills, and tend to plateau after a district shows modest gains over a three year period.

See:
> *Data Related to the Need for New Directions for School Improvement* –
   http://smhp.psych.ucla.edu/summit2002/data.pdf

>*Data on the Plateau or Leveling Off Effect of Achievement Test Scores* –
   http://smhp.psych.ucla.edu/pdfdocs/plateau.pdf

(2) In underscoring the promising analyses of current programs within a comprehensive framework that suggests the potential of moving in new directions, we have amassed *A Sampling of Outcome Findings for Prevention and Early Intervention Programs Relevant to Addressing Barriers to Learning* – http://smhp.psych.ucla.edu/pdfdocs/Sampler/Outcome/outcome.pdf .

This work has been condensed for decision makers into a brief entitled: *Addressing Barriers to Student Learning & Promoting Healthy Development: A Usable Research-Base"* – http://smhp.psych.ucla.edu/pdfdocs/briefs/BarriersBrief.pdf

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We also have been trying to highlight places where efforts are underway. The section on our website about *Where it's Happening* describes major examples of trail blazing and pioneering efforts that are playing a role in designing new directions for student support. This pioneering work is being carried out at school, district, state, and national levels. Some places are involved in or are planning broad-based systemic changes, and others have tried some form of interesting innovation. Other examples are added as soon as they are identified and relevant descriptive materials are gathered.

http://smhp.psych.ucla.edu/summit2002/trailblazing.htm

In general, we are somewhat cautious about claims that narrow-band mental health interventions alone can produce the type of behavior changes the field is asked to document. The need is to put in place the type of unified, comprehensive, and equitable system that can actually produce major outcomes.

> *And, whatever the focus, it is essential to disaggregate data (e.g., with respect to populations, intervention purposes, and severity, pervasiveness, and chronicity of problems).*

A couple of other points we usually make about this matter are:

- The body of promising data is growing. Everyday there are new published studies that look at correlations between psychosocial and mental health interventions and improved school attendance and performance, reduced delinquency, reduced out of home placement, and client/family satisfaction. Too often, however, the data are not disaggregated (e.g., with respect to populations, intervention purposes, and severity, pervasiveness, and chronicity of problems). Correlational findings, of course, do not clarify cause and effect; but they are a useful step along the way and can be even more useful when disaggregated.

- For the future, those involved in addressing mental health concerns in schools should weave accountability demands into ongoing data collection processes (e.g., related to planning and decision making). This helps make outcome accountability part of the process of improving interventions. At the same time, mental health providers need to expand their understanding of and involvement in collecting a broader range of data – eliciting ongoing info from clients, families, and school related to behavior changes (e.g., school attendance and performance, delinquency, etc.).

On the following page is an example of how one school-based mental health program developed an accountability evaluation plan.

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Exhibit

An Example of One School-based Mental Health Program's Accountability Evaluation Plan

I. Intervention Impact on Students

Aim: Prevent and correct emotional, behavior, learning and health problems which are
barriers to learning

Goal I: To institute a Learning Support Component at each school to enable children
to function to their full capacity.
Expected Short Term Outcomes: (e.g., access to supportive services to prevent problems;
restructure student support teams; community resources accessed)
Formative (Process) Data: (e.g., weekly team meetings; policies and procedures manual; referral
process; learning support center established in each school)
Expected Long Term Outcomes (after 3 years):(e.g., more children successful in school; more
complete high school; attendance increased by 20%; fewer students labeled SED)
Specific Indicators used to monitor progress: (e.g., school attendance, mobility, suspensions,
expulsions, grades, dropout rates)

Goal 2: To implement prevention/early intervention programs that effectively help students build
resiliency assets to have healthier lives and reduce barriers to learning.
Expected Short-Term Outcomes: (e.g., review current prevention programs for consistent
delivery and fidelity to program guidelines; evaluate gaps in prevention programs; introduce
research-based prevention programs)
Formative (Process) Data: (e.g., completion of prevention program matrix; evaluation report of
current program implementation; report recommending promising practices to fill gaps; staff training
to improve fidelity of implementation)
Expected Long-Term Outcomes: (e.g., improved fidelity of prevention programs; learning support
centers used by students and staff as resource centers)
Specific Indicators used to monitor progress: (e.g., violence and substance abuse reduced by 10%; class
cutting reduced by 20%; attendance increased; 75% of program participants self-report better
knowledge of problems solving and positive changes in behavior)

II Intervention Impact on Programs and Systems

Aim: Promote and support restructuring of support services (including integration with instruction and
management components)
Goal: To create infrastructure that supports systemic change to create a true learning environment for
children, school staff, and families.
Expected Short Term Outcomes: (e.g., school improvement teams include student support
component; parents involved in school improvement teams; resource coordinating council for the
feeder pattern of schools)
Formative (Process) Data: (e.g., training for school improvement teams on barriers to learning; a
subgroup on each school improvement team to focus on barriers to learning; regular meetings of
resource coordinating council with district involvement; funding analysis completed; resource sharing
framework designed with ongoing monitoring; teacher training in student support)
Expected Long Term Outcomes (after 3 years): (e.g., resource coordinating councils will link all
schools for students ages 5 - 18; district resource coordinating council will reallocate funding for at
risk students to sustain the infrastructure established)
Specific Indicators to monitor progress: (e.g., school climate change measures; District
reallocated 10% of funding for at risk students to maintain the Learning Support Component)

III. Intervention Impact on Families and Communities

Aim: Promotion of positive family development and functioning
Goal: To increase parent involvement in child' learning at home and school
Expected Short-Term Outcomes: (e.g., parent education classes)
Formative (Process Data): (e.g., parent education curriculum identified; outreach to parents;
parent "ambassadors" training to link families with schools)
Expected Long Term Outcomes (after 3 years): (e.g., family ability to reduce barriers to learning;
families involved in children's learning and healthy development; schools actively promote family
involvement)
Specific Indicators used to monitor progress: (e.g., 80% of family who participate using positive
approaches with their children; 60% of families participating with have "schoolmarm homes" as
defined by Parents on Board curricula; family knowledge, behavior change, and satisfaction ratings).

In order to understand the complex politics of ... evaluation research, it is necessary to recognize the difference between two very different pursuits of knowledge: *knowledge for understanding* and *knowledge for advocacy.*

Knowledge for understanding is typically referred to as scholarship or science. Its primary purpose [as applied to intervention efforts] is to disentangle the complicated dynamics of human development and elucidate the multiple influences on selected outcomes. Generally speaking, this type of research is a fascinating but relatively low-stakes enterprise that is engaged in an impartial search for "truth." In its purest form, it is cautious, conservative, and focused on what we *don't know.*

Knowledge for advocacy is what some people call lobbying. Its primary aim is to use data to influence the formulation of a particular policy or the delivery of a specific service. In most circumstances, this type of pursuit is a challenging and relatively high-stakes enterprise that is engaged in a dedicated campaign to prove a point. In its most common form, it is bold, assertive, and focused on how much we *do know.*
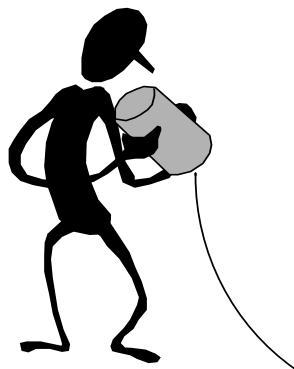
<div align="right">

Jack Shonkoff (2004)
In *The Evaluation Exchange*
from the Harvard Family Research Project
(www.gse.harvard.edu/hfrp.eval/issue26/)

</div>

Many people define intervention as providing help to someone.

Yes, but the dictionary says it's *an interference into the affairs of others!*

II. A Bit More About Empirically Supported Interventions

Question: *"I am a coordinator working under a federal grant for the local school district. I am charged by the federal grant to implement research-based prevention programs -- even though doing so means giving up on what we have been doing which seems to be working well for us. Where do I find information on accepted research-based programs?*

Response: This is a conundrum facing many schools -- giving up what they know well and believe works in their community and adopting a new program that has published research support but is not guaranteed to work for a particular school or district. (Sometime the question is asked: *Why is it appropriate/necessary for local schools to have to give up on endeavors that seem to work and adopt something from a list of federally approved programs?*)

There are many issues here, not the least of which is that the field is a long way from having an adequate body of sound research for dealing with the complex problems faced at schools and the complexity of schools as intervention settings for addressing such problems. The overarching need is to build truly comprehensive, multifaceted, and cohesive approaches that match the complexity of the problems students and schools experience daily, rather than continuing to pursue a fragmented set of empirically supported or unsupported practices.

For now, however, where it is required to indicate the science-base, the information needed can come from a variety of sources:

(1) If a school is using a program that seems to be working, the developers of the program may have research evidence on its efficacy. If the program isn't on a list of programs that have been reviewed and determined promising, you may be able to convince the funder there is an adequate research-base. (If not, you may want to consider ways to sustain what you value and integrate it with a listed program.)

(2) For more on evidence based programs, see the Center documents entitled:

>*Annotated Lists of Empirically Supported/evidence Based Interventions for School-aged Children and Adolescents –*
http://smhp.psych.ucla.edu/pdfdocs/aboutmh/annotatedlist.pdf

>*About Empirically Supported Therapy Relationships –*
http://smhp.psych.ucla.edu/pdfdocs/aboutmh/therapyrelationships.pdf

For links to other resources on these matters, see the Center's Quick Find on:

>*Empirically Supported Interventions for Children's Mental Health –*
http://smhp.psych.ucla.edu/qf/ests.htm

(3) For more detailed information on a broad range of programs with outcome data, you may want to see the Center's document entitled: *A Sampling of Outcome Findings for Prevention and Early Intervention Programs Relevant to Addressing Barriers to Learning –* http://smhp.psych.ucla.edu/qf/crisis_tt/samplingofoutcomefindings.pdf .

BUT THE NEEDS OF SCHOOLS ARE MORE COMPLEX!

Currently, there are about 91,000 public schools in about 15,000 districts. Over the years, most (but obviously not all) schools have instituted programs designed with a range of behavior, emotional, and learning, problems in mind. School-based and school-linked programs have been developed for purposes of early intervention, crisis intervention and prevention, treatment, and promotion of positive social and emotional development. Some programs are provided throughout a district, others are carried out at or linked to targeted schools. The interventions may be offered to all students in a school, to those in specified grades, or to those identified as "at risk." The activities may be implemented in regular or special education classrooms or as "pull out" programs and may be designed for an entire class, groups, or individuals. There also may be a focus on primary prevention and enhancement of healthy development through use of health education, health services, guidance, and so forth – though relatively few resources usually are allocated for such activity.

There is a large body of research supporting the promise of specific facets of this activity. However, no one has yet designed a study to evaluate the impact of the type of comprehensive, multifaceted approach needed to deal with the complex range of problems confronting schools.

SAMHSA is focusing on this by highlighting evidence-based programs (see http://www.samhsa.gov/data/evidence-based-programs-nrepp)

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It is either naive or irresponsible to ignore the connection between children's performance in school and their experiences with malnutrition, homelessness, lack of medical care, inadequate housing, racial and cultural discrimination, and other burdens . . . .
Harold Howe II
****

. . . consider the American penchant for ignoring the structural causes of problems. We prefer the simplicity and satisfaction of holding individuals responsible for whatever happens: crime, poverty, school failure, what have you. Thus, even when one school crisis is followed by another, we concentrate on the particular people involved – their values, their character, their personal failings – rather than asking whether something about the system in which these students find themselves might also need to be addressed.
Alfie Kohn
****

What the best and wisest parent wants for (her)/his own child that must the community want for all of its children. Any other idea . . . is narrow and unlovely.
John Dewey
****

III. Other Resources

A. Mental Health in Schools: Quality Control, Evaluation of Outcomes, and Getting Credit for All You Do – a brief discussion with examples of evaluation indicators

B. Guidelines for Mental Health in Schools

C. Tips, Tools, and Planning Worksheet Example

D. Sample of Current Resources and Recent References
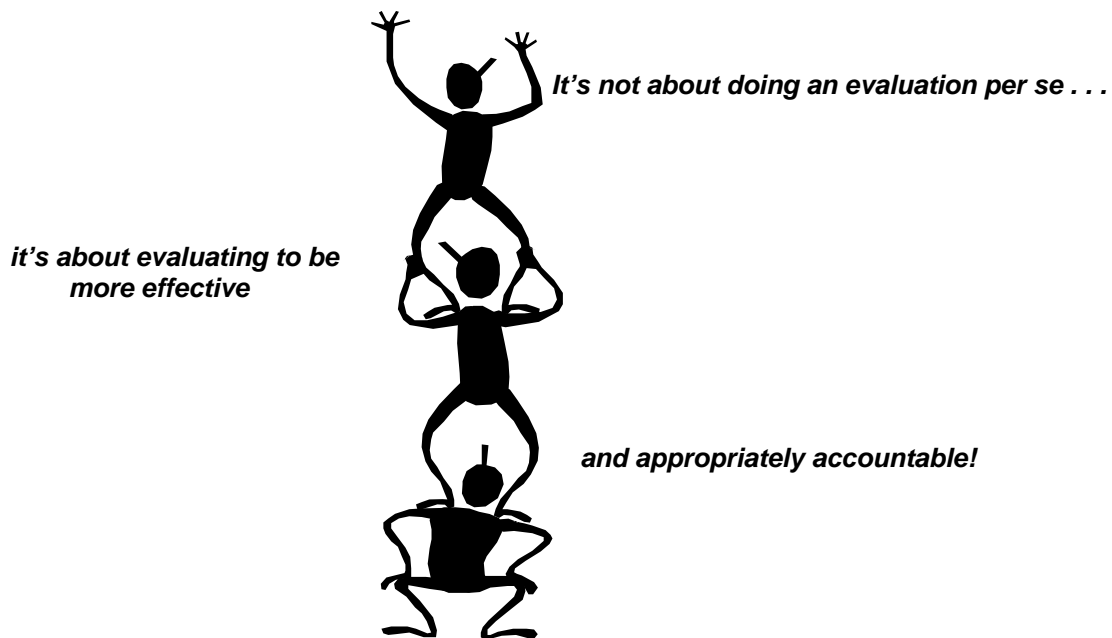
It's not about doing an evaluation per se . . .

it's about evaluating to be more effective

and appropriately accountable!

III. Other Resources

A. Mental Health in Schools: Quality Control, Evaluation of Outcomes, and Getting Credit for All You Do – a brief discussion with examples of evaluation indicators

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

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

Evaluation that Fosters Quality Improvement

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

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

- needs and assets, goals and desired outcomes, resources, and activities

- challenges and barriers to mental health intervention and the integration of such interventions with other activity designed to address barriers to learning, as well as with the instructional and management components of schools and communities

- characteristics of families and children in each locale, with special focus on targeted groups

- initial outcomes.

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

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

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

Evaluation Focused on Results

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

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

Student Outcomes

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

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

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

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

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

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

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

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

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

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

In general, then, immediate objectives in working to address emotional and behavioral problems with a view to enabling student progress often include activity designed to reduce specified barriers to school attendance and functioning. Thus, attending to mental health concerns often requires addressing practical deterrents such as health problems, lack of adequate clothing, problems in the

home, working with home to increase support for student improvement, dealing with student's physical or sexual abuse, dealing with student's substance abuse, dealing with gang involvement, provisions for pregnant minors and minor parents, dropout outreach and recovery, teaching student to use compensatory strategies for learning, and so forth. And, based on the discussion to this point, hopefully it is clear that the first indicators of progress may be fewer problems related to learning, behavior, and affect. See Exhibit A for examples of key intervention goals and objectives and potential indicators of efficacy. The goals and objectives listed in Exhibit A represent individual student outcomes that can be measured as indicators of the impact of specialized programs. Positive "side effect" outcomes worth measuring are significant changes related to (a) all children in the catchment area (e.g., community indicators of improved health, safety and survival, emotional health, and positive social connections) and (b) support systems (e.g., enhanced home involvement in schooling; enhanced integration of a school-based health center and community health, social, and mental health services -- including related data on financial savings). Of course, additional student outcomes can be delineated and measured with respect to efforts to prevent specific types of problems. This is usually accomplished by fostering positive functioning through activities designed to enhance knowledge, skills, attitudes, and action related to healthy physical and mental development. Some of these efforts are carried out in special settings, such as school-based health centers and family resource centers. Whether or not there is a special setting, these efforts include specialized programs focused on

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

Intended Impact on Families and Community

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

Intended Impact on Programs and Systems

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

Exhibit A

Intervention Impact on Students

Aims	Examples of Goals/Objectives	Examples of Indicators of Efficacy	Standards/Criteria Immediate -- Long-term
Enhance receptivity to instruction	Increase knowledge, skills, & attitudes to enhance •acceptance of responsibility (including attending, following directions & agreed upon rules/laws) •self-esteem & integrity •social & working relationships •self-evaluation & self-direction/regulation •physical functioning •health maintenance •safe behavior	Ratings by staff, family, peers Self-reports by students Performance indices (focus is on: •readiness/prerequisites/ survival skills •attendance •tardies •distractibility/ daydreaming/overactivity •dependence on others in pursuing tasks and controlling behavior •misbehavior •symptoms •negative attitudes toward self, teachers, school, peers, family, society) (Ultimately, of course, a major focus is on grades and achievement test scores.)	TO BE DETERMINED BY SITE In developing standards and criteria, it may be helpful to review the report from the Policy Leadership Cadre for Mental Health in Schools. See *Mental Health in Schools: Guidelines, Models, Resources, and Policy Considerations* online at http://smhp.psych.ucla.edu/pdfdocs/policymakers/cadreguidelines.pdf.
Prevent and correct emotional, behavior, learning, & health problems	Reduce barriers to school attendance and functioning by addressing problems related to •health •lack of adequate clothing •dysfunctional families •lack of home support for student improvement •physical/sexual abuse •substance abuse •gang involvement •pregnant/parenting minors •dropouts •need for compensatory learning strategies		

Exhibit B

Intervention Impact on Families and Communities

Aims	Examples of Goals/Objectives	Examples of Indicators of Efficacy	Standards/Criteria Immediate -- Long-term
Promotion of positive family development & functioning Enhanced home involvement in schooling	Increase social and emotional support for families Increase family access to special assistance Increase family ability to reduce child risk factors that can be barriers to learning Increase bilingual ability and literacy of parents Increase family ability to support schooling Increase positive attitudes about schooling Increase home (family/parent) participation at school	Parents rate satisfaction with school & community programs & services designed to enhance family functioning & provide assistance Staff rates functioning of families Frequency counts of services/ programs in operation; Performance indices Staff rates functioning of families Family self-reports Frequency counts of areas of participation and number of participants	TO BE DETERMINED BY SITE In developing standards and criteria, it may be helpful to review the report from the Policy Leadership Cadre for Mental Health in Schools. See *Mental Health in Schools: Guidelines, Models, Resources, and Policy Considerations* online at http://smhp.psych.ucla.edu/pdfdocs/policymakers/cadreguidelines.pdf

Intervention Impact on Families and Communities

Aims	Examples of Goals/Objectives	Examples of Indicators of Efficacy	Standards/Criteria Immediate -- Long-term
Promotion of positive community development and functioning (including influencing restructuring of community agencies)	Enhance positive attitudes toward school and community Increase community participation in school activities Increase perception of the school as a hub of community activities Increase partnerships designed to enhance education & service availability in community Enhance coordination & collaboration between community agencies and school programs & services Enhance focus on agency outreach to meet family needs Increase psychological sense of community	Self-reports of community residents Frequency counts of areas of participation and number of participants Self-reports of community residents Existence of partnership agreements & shared decision making mechanisms Staff rates quality of coordination mechanisms & working relationships Frequency counts of students and families using programs and services Self-reports of community residents Data from records on (a) violent acts (b) nonviolent crime (c) public health problems	TO BE DETERMINED BY SITE In developing standards and criteria, it may be helpful to review the report from the Policy Leadership Cadre for Mental Health in Schools. See *Mental Health in Schools: Guidelines, Models, Resources, and Policy Considerations* online at http://smhp.psych.ucla.edu/pdfdocs/policymakers/cadreguidelines.pdf

Exhibit C

Intervention Impact on Programs and Systems

Aims	Examples of Goals/Objectives	Examples of Indicators of Efficacy	Standards/Criteria Immediate -- Long-term
Promote and support restructuring of support services (including integration with instruction & management) Promote and support outreach to community resources & their integration with school programs & services	Enhance processes by which staff and families learn about available programs and services and how to access those they need Increase coordination among services and programs Increase the degree to which staff work collaboratively and programmatically Increase services/programs at school site Increase amount of school and community collaboration Increase quality of services and programs by improving systems for requesting, accessing, and managing assistance for students and families (including overcoming inappropriate barriers to confidentiality) Establish a long-term financial base	Frequency counts of students and families using programs and services Staff rates quality of coordination mechanisms Supervisors and staff rate how staff spends time Frequency counts of services/ programs in operation Existence of interagency agreements & shared decision making mechanisms Staff rates quality of (a) systems for triage, referral, case monitoring & management; (b) staff development Users rate satisfaction Data from financial records	TO BE DETERMINED BY SITE In developing standards and criteria, it may be helpful to review the report from the Policy Leadership Cadre for Mental Health in Schools. See *Mental Health in Schools: Guidelines, Models, Resources, and Policy Considerations* online at http://smhp.psych.ucla.edu/pdfdocs/policymakers/cadreguidelines.pdf

B. Guidelines for Mental Health in Schools

Based on a set of underlying principles and some generic guidelines for designing comprehensive, multifaceted, and cohesive approaches to MH in schools, the following set of guidelines was developed by the Policy Leadership Cadre for Mental Health in Schools. The Cadre's report includes rationale statements and references related to each guideline.* Clearly, no school currently offers the nature and scope of what is embodied in the outline. In a real sense, the guidelines define a vision for how MH in schools should be defined and implemented. It also provides a basis for developing standards and evaluation indicators.

GUIDELINES FOR MENTAL HEALTH IN SCHOOLS

1. General Domains for Intervention in Addressing Students' Mental Health

  1.1 Ensuring academic success and also promoting healthy cognitive, social, and emotional development and resilience (including promoting opportunities to enhance school performance and protective factors; fostering development of assets and general wellness; enhancing responsibility and integrity, self-efficacy, social and working relationships, self-evaluation and self-direction, personal safety and safe behavior, health maintenance, effective physical functioning, careers and life roles, creativity)
  1.2 Addressing barriers to student learning and performance (including educational and psychosocial problems, external stressors, psychological disorders)
  1.3 Providing social/emotional support for students, families, and staff

2. Major Areas of Concern Related to Barriers to Student Learning

  2.1 Addressing common educational and psychosocial problems (e.g., learning problems; language difficulties; attention problems; school adjustment and other life transition problems; attendance problems and dropouts; social, interpersonal, and familial problems; conduct and behavior problems; delinquency and gang-related problems; anxiety problems; affect and mood problems; sexual and/or physical abuse; neglect; substance abuse; psychological reactions to physical status and sexual activity)
  2.2 Countering external stressors (e.g., reactions to objective or perceived stress/demands/ crises/deficits at home, school, and in the neighborhood; inadequate basic resources such as food, clothing, and a sense of security; inadequate support systems; hostile and violent conditions)
  2.3 Teaching, serving, and accommodating disorders/disabilities (e.g., Learning Disabilities; Attention Deficit Hyperactivity Disorder; School Phobia; Conduct Disorder; Depression; Suicidal or Homicidal Ideation and Behavior; Post Traumatic Stress Disorder; Anorexia and Bulimia; special education designated disorders such as Emotional Disturbance and Developmental Disabilities)

3. *Type of Functions Provided related to Individuals, Groups, and Families*

  3.1 Assessment for initial (first level) screening of problems, as well as for diagnosis and intervention planning (including a focus on needs and assets)
  3.2 Referral, triage, and monitoring/management of care

*See *Mental Health in Schools: Guidelines, Models, Resources, and Policy Considerations* online at http://smhp.psych.ucla.edu/pdfdocs/policymakers/cadreguidelines.pdf.

3.3   Direct services and instruction (e.g., primary prevention programs, including enhancement of wellness through instruction, skills development, guidance counseling, advocacy, school-wide programs to foster safe and caring climates, and liaison connections between school and home; crisis intervention and assistance, including psychological first-aid; prereferral interventions; accommodations to allow for differences and disabilities; transition and follow-up programs; short- and longer- term treatment, remediation, and rehabilitation)

3.4   Coordination, development, and leadership related to school-owned programs, services, resources, and systems – toward evolving a comprehensive, multifaceted, and integrated continuum of programs and services

3.5   Consultation, supervision, and inservice instruction with a transdisciplinary focus

3.6   Enhancing connections with and involvement of home and community resources (including but not limited to community agencies)

4.   *Timing and Nature of Problem-Oriented Interventions*

4.1   Primary prevention

4.2   Intervening early after the onset of problems

4.3   Interventions for severe, pervasive, and/or chronic problems

5. *Assuring Quality of Intervention*

5.1   Systems and interventions are monitored and improved as necessary

5.2   Programs and services constitute a comprehensive, multifaceted continuum

5.3   Interveners have appropriate knowledge and skills for their roles and functions and provide guidance for continuing professional development

5.4   School-owned programs and services are coordinated and integrated

5.5   School-owned programs and services are connected to home & community resources

5.6   Programs and services are integrated with instructional and governance/management components at schools

5.7   Program/services are available, accessible, and attractive

5.8   Empirically-supported interventions are used when applicable

5.9   Differences among students/families are appropriately accounted for (e.g., diversity, disability, developmental levels, motivational levels, strengths, weaknesses)

5.10 Legal considerations are appropriately accounted for (e.g., mandated services; mandated reporting and its consequences)

5.11 Ethical issues are appropriately accounted for (e.g., privacy & confidentiality; coercion)

5.12 Contexts for intervention are appropriate (e.g., office; clinic; classroom; home)

6. *Outcome Evaluation and Accountability*

6.1   Short-term outcome data

6.2   Long-term outcome data

6.3   Reporting to key stakeholders and using outcome data to enhance intervention quality

The preceding *Guidelines for Mental Health in Schools* have provided a basis for generating standards for a learning supports component at schools. These and an expanded framework for school accountability are included in a Center policy report entitled:

Addressing What's Missing in School Improvement Planning: Expanding Standards and Accountability to Encompass an Enabling or Learning Supports Component – http://smhp.psych.ucla.edu/pdfdocs/enabling/standards.pdf

Based on analyses and recommendations reported in School Improvement Planning: What's Missing?*, the report proposes ways to (a) reorganize school improvement guidance and (b) expand standards and accountability to encompass a component to address barriers to learning and teaching. In doing so, the work highlights the need and a focus for new directions for student support.

Specifically suggested is that school improvement guides be reorganized with two interactingdimensions in mind: One encompasses three primary and essential components of an integrated systems approach to schooling. The other stresses five key areas of concern for systemic improvement related to each component. The three components are those encompassing comprehensive, multifaceted, and cohesive efforts to (a) facilitate instruction, (b) address barriers to learning, and (c) govern, lead, and manage schools. The key areas of concern are (a) framing and delineating intervention functions, (b) reworking infrastructure, (c) enhancing resource use, (d) continuous capacity building, and (e) continuous evaluation and appropriate accountability based on delineated standards and quality indicators.

Because school improvement planning across the country is "standards-based" and accountability driven, establishing standards and expanding the current focus of accountability are important facets of ensuring high levels of attention and support for development of comprehensive, multifaceted approaches to address barriers to learning. Therefore, much of this report is devoted to delineating standards and outlining an expanded framework for school accountability for a component to address barriers. Standards are organized in terms of the five key areas of concern.

* Note: You can access *School Improvement Planning: What's Missing* at http://smhp.psych.ucla.edu/whatsmissing.htm

C. Tips, Tools, and a Planning Worksheet Example

Below and on the following pages are some resources excerpted from various works.

Nine Points to Consider When Contemplating an Evaluation

By Patty Hill for Innovation Network, Inc.*

1. Why do you want to do a program evaluation? Ask yourself: why is it important to you and your organization that you initiate an evaluation now?

2. Who is going to use the evaluation information (executive director, board, funders, staff, members, clients, etc.)? For whom are you completing the evaluation? To which person(s) will the evaluators be accountable?

3. Are you interested in evaluating how your program works, or its impact -- or both? Be specific! Which potential positive impacts do you want to know more about? Which potential negative impacts concern you?

4. How will the evaluation findings be used? What will you know after the evaluation that you don't know now? What will you be able to accomplish using the evaluation information that you can't accomplish now?

5. How will staff/board members/executive director/others be involved? How much time will they spend? Are you intending the evaluation process to have a particular effect on board, staff, or funders?

6. Are there resources/funds available to do an evaluation? Do you have individual skills, contacts, in-kind donations, creativity, and other sources of funding? Or can you include the cost of an evaluation in a program proposal?

7. What is the time frame for this evaluation? When should the evaluation begin? When should you have the final report?

8. Is an outside evaluator needed? Does this evaluator have experience with organizations and programs like yours? Does this evaluator produce useful reports?

9. What do you want included in the final report? Do you want an explanation of the underlying academic principles used by the evaluator? Do you want just conclusions and recommendations?

_____

*Innovation Network, Inc. (InnoNet) . 1001 Connecticut Ave., NW, Suite 900 . Washington, DC 20036
   Tel: (202) 728-0727 . Fax: (202) 728-0136 . www.innonet.org

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Tips for Conducting an Evaluation

1. Develop Evaluation Questions

- Clarify goals and objectives of the evaluation.
- Identify and involve key stakeholders and audiences.
- Describe the intervention to be evaluated.
- Formulate potential evaluation questions of interest to all stakeholders and audiences.
- Determine resources available.
- Prioritize and eliminate questions.

2. Match Questions with Appropriate Information-Gathering Techniques

- Select a general methodological approach.
- Determine what sources of data would provide the information needed.
- Select data collection techniques that would gather the desired information from the identified sources.

3. Collect Data

- Obtain the necessary clearances and permission.
- Consider the needs and sensitivities of the respondents.
- Make sure data collectors are adequately trained and will operate in an objective, unbiased manner.
- Cause as little disruption as possible to the ongoing effort.

4. Analyze Data

- Check raw data and prepare data for analysis.
- Conduct initial analysis based on the evaluation plan.
- Conduct additional analyses based on the initial results.
- Integrate and synthesize findings.

5. Provide Information to Interested Audiences

- Provide information to the targeted audiences.
- Deliver reports and other presentations in time to be useful.
- Customize reports and other presentations.

Overview of Evaluation Prototypes

Planning Evaluation:

A Planning Evaluation assesses the understanding of project goals, objectives, strategies and timelines.

It addresses the following types of questions:

- Why was the project developed? What is the problem or need it is attempting to address?
- Who are the stakeholders? Who are the people involved in the project? Who are the people interested in the project who may not be involved?
- What do the stakeholders want to know? What questions are most important to which stakeholders? What questions are secondary in importance? Where do concerns coincide?• Where are they in conflict?
- Who are the participants to be served?
- What are the activities and strategies that will involve the participants? What is the intervention? How will participants benefit? What are the expected outcomes?
- Where will the program be located (educational level, geographical area)?
- How many months of the school year or calendar year will the program operate? When will the program begin and end?
- How much does it cost? What is the budget for the program? What human, material, and institutional resources are needed? How much is needed for evaluation? for dissemination?
- What are the measurable outcomes? What is the expected impact of the project in the short run? the longer run?
- What arrangements have been made for data collection? What are the understandings regarding record keeping, responding to surveys, and participation in testing?

Formative Evaluation

A Formative Evaluation assesses ongoing project activities. It consists of two types: Implementation Evaluation and Progress Evaluation.

Implementation Evaluation

An Implementation Evaluation assesses whether the project is being conducted as planned. It addresses the following types of questions:

- Were the appropriate participants selected and involved in the planned activities?
- Do the activities and strategies match those described in the plan? If not, are the changes in activities justified and described?
- Were the appropriate staff members hired, and trained, and are they working in accordance with the proposed plan? Were the appropriate materials and equipment obtained?
- Were activities conducted according to the proposed timeline? by appropriate personnel?
- Was a management plan developed and followed?

(cont.)

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Overview of Evaluation Prototypes (cont.)

Progress Evaluation

A Progress Evaluation assesses the progress made by the participants in meeting the project goals. It addresses the following types of questions:

- Are the participants moving toward the anticipated goals of the project?
- Which of the activities and strategies are aiding the participants to move toward the goals?

Summative Evaluation

A Summative Evaluation assesses project success – the extent to which the completed project has met its goals. It addresses the following types of questions:

- Was the project successful?
- Did the project meet the overall goal(s)?
- Did the participants benefit from the project ?
- What components were the most effective?
- Were the results worth the project's cost?
- Is this project replicable and transportable?

From the EHR/NSF *User-Friendly Handbook for Project Evaluation*

Sources and Techniques for Collecting Evaluation Information

I. Data Collected Directly From Individuals Identified as Sources of Information

A. Self-Reports: (from participants and control group members)

1. Diaries or Anecdotal Accounts
2. Checklists or Inventories
3. Rating Scales
4. Semantic Differentials
5. Questionnaires
6. Interviews
7. Written Responses to Requests for Information (for example, letters)
8. Sociometric Devices
9. Projective Techniques

B. Products from participants:

1. Tests
   a. Supplied answer (essay, completion, short response, and problem-solving)
   b. Selected answer (multiple-choice, true-false, matching, and ranking)
2. Samples of Work

II. Data Collected by an Independent Observer

A. Written Accounts

B. Observation Forms:

1. Observation Schedules
2. Rating Scales
3. Checklists and Inventories

III. Data Collected by a Mechanical Device

A. Audiotape

B. Videotape

C. Time-Lapse Photographs

D. Other Devices:

1. Graphic Recordings of Performance Skills
2. Computer Collation of Student Responses

IV. Data Collected by Use of Unobtrusive Measures

V. Data Collected from Existing Information Resources

A. Review of Public Documents (proposals, reports, course outlines, etc.)

B. Review of Institutional or Group Files (files of student records, fiscal resources, minutes of meetings)

C. Review of Personal Files (correspondence files of individuals reviewed by permission)

D. Review of Existing Databases (statewide testing program results)

From: Worthen, B.R., Sanders, J.R., and Fitzpatrick. (1997). *Educational Evaluation*, Second Ed. White Plains, NY: Longman, Inc.

Planning a Program Evaluation: Worksheet

Focusing an Evaluation

1. What are you going to evaluate?

2. What is the purpose of the evaluation?

3. Who will use the evaluation?   How will they use it?
   _____   _____
   _____   _____
   _____   _____

   How many others will be involved in the evaluation? _____

4. What questions will the evaluation seeks to answer?
   _____
   _____
   _____
   _____
   _____

5. What information do you need to answer the questions?

      What I wish to know   *Indicators – How will I know it?*
   _____   _____
   _____   _____
   _____   _____
   _____   _____

6. When is the evaluation needed? _____

7. What resources do you need?

   a. Time available to work on evaluation: _____

   b. Money: _____

   c. People – professionals, paraprofessionals, volunteers, participants: _____
      _____
      _____
      _____
      _____

Collecting the Information

8. What sources of information will you want?

Existing Information _____

People: _____

Observations: _____

Pictorial Records: _____

9. What data collections method(s) will you use?

___ Survey	___ Document Review
___ Interview	___ Testimonials
___ Observation	___ Expert panel
___ Group techniques	___ Simulated problems or situations
___ Case study	___ Journal, log, diary
___ Test	___ Unobtrusive measures
___ Photos, videos	___ Other (list) _____

Instrumentation: What is needed to record the information?
_____
_____

10. What data collection procedures will be used?

When will you collect data for each method used?

Method	Before program	During program	Immediately after	Later
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Will a sample be used?   Yes   No

If yes, describe the procedure you will use. _____
_____
_____

Who will collect the data? _____

Using the Information

11. How will the data be analyzed?

   Data analysis methods: _____
   _____

   Who is responsible: _____

_____

12. How will the information be interpreted? by whom?

_____

_____

_____

   Who will do the summary? _____

13. How will the evaluation be communicated and shared?

To Whom	When/where/how to present
_____	_____
_____	_____
_____	_____
_____	_____

Managing the Evaluation

14. Implementation plan: timeline and responsibilities

   Management Chart

   Budget

D. Sample of Current Resources and Recent References

The evaluation literature is immense. Here are some examples. Each is a gateway to other references and resources.

A Few References

Research and Evaluation in Education and Psychology (4th ed.). D.M. Merten (2015). Thousand Oaks: Sage.

Counseling and Educational Research; Evaluation and Application (3rd ed.). Rick A. Houser (2015). Thousand Oaks: Sage.

Evaluation Theory, Models, and Applications (2nd ed.). D.L. Stufflebeam & C.L.S. Coryn (2014). San Francisco: Jossey-Bass,

Designing Evaluations 2012 Revision Washington, DC: U.S. Government Accountability Office. – http://www.gao.gov/assets/590/588146.pdf

Really New Directions in Evaluation: Young Evaluators' Perspectives: New Directions for Evaluation, Number 131. Sandra Mathison (Ed.). (2011). San Francisco: Jossey-Bass

Resource Sources

Evaluation Resources from the Institute of Museum and Library – http://www.imls.gov/research/evaluation_resources.aspx

University of Michigan – "My Environmental Education Evaluation Resource Assistant" (MEERA) is an online "evaluation consultant" created to assist with user evaluation needs. It points users to helpful resources for evaluating education programs. – http://meera.snre.umich.edu/

University of North Carolina, Greensboro – Program Evaluation Resource Center – http://erm.uncg.edu/oaers/methodology-resources/program-evaluation/

CDC's Framework for Program Evaluation in Public Health has provided a set of steps and standards for practical evaluation by programs and partners. While the focus is public health programs, the approach can be generalized to any evaluation effort. – http://www.cdc.gov/eval/framework/index.htm

CDC's list of other Evaluation Resources – http://www.cdc.gov/eval/resources/index.htm

A basic introduction to evaluation concepts – http://www.socialresearchmethods.net/kb/evaluation.php An online course on evaluation for non-researchers: http://nrepp.samhsa.gov/Courses/ProgramEvaluation/NREPP_0401_0010.html - See more at: http://arts.gov/grants-organizations/art-works/program-evaluation-resources#sthash.F6Rn3TFz.dpuf

Federal Evaluators – http://www.fedeval.net/books.htm

Basic Guide to Program Evaluation (Including Outcomes Evaluation) – http://managementhelp.org/evaluation/program-evaluation-guide.htm

On-Line Evaluation Resource Library (OERL) – http://oerl.sri.com/

Evaluation Handbook W.K. Kellogg Foundation – http://www.wkkf.org/resource-directory/resource/2010/w-k-kellogg-foundation-evaluation-handbook

Planning and Monitoring Evaluation Checklists – http://www.wmich.edu/evaluation/checklists

CIHLC Evaluation Primer: Overview of Relevant Frameworks and Tools – University of British Columbia – http://www.ipe.utoronto.ca/sites/default/files/CIHLC%20Evaluation%20Primer.pdf

Special education evaluation: an overview –
http://www.greatschools.org/gk/articles/special-education-evaluation-an-overview/

Also see the Center's Online Clearinghouse Quick Finds on:

>*Evaluation of Programs to Address Barriers to Learning* –
http://smhp.psych.ucla.edu/qf/evaluation.htm

>*Data Management Systems for Schools and Clinics* –
http://smhp.psych.ucla.edu/qf/datasystems.htm

>*Cost-Benefit Analyses Relevant to Addressing Barriers to Learning and Mental Health in Schools* –
http://smhp.psych.ucla.edu/qf/costbenefitanalysis.htm

>*Empirically Supported Interventions for Children's Mental Health* –
http://smhp.psych.ucla.edu/qf/ests.htm

A Few Centers Focusing on Evaluation

The Evaluation Center – Western Michigan University – http://www.wmich.edu/evalctr/

National Center on Educational Outcomes (NCEO) – University of Minnesota –
http://education.umn.edu/NCEO/

National Center for Education Statistics – http://nces.ed.gov/help/

The Center for the Study of Testing, Evaluation, and Educational Policy (CSTEEP) – Boston
College – http://www.csteep.bc.edu/

The National Center for Research on Evaluation, Standards, and Student Testing (CRESST)
–UCLA – http://www.cse.ucla.edu/

National Study of School Evaluation – http://www.nsse.org/

Assessment and Evaluation on the Internet –
http://www.ericfacility.net/ericdigests/ed385609.html

BJA Evaluation Website – http://www.bja.evaluationwebsite.org/html/useful_links/index.html

Resources for Methods in Evaluation and Social Research –
http://gsociology.icaap.org/methods

Buros Institute of Mental Measurement – http://www.unl.edu/buros/

For more Tools

See Section III of the Center Document:

> *Evaluation and Accountability: Getting Credit for All You Do!*
> http://smhp.psych.ucla.edu/pdfdocs/evaluation/evaluation.pdf

There you will find:

III. Tools for Evaluating Planning and Implementation

- The Program Manager's Guide to Evaluation (2nd ed)
  (From the Office of Planning, Research and Evaluation (OPRE),
    Administration for Children and Families (ACF)

- Two Sample Evaluation Checklists

- Program Evaluation Standards

- Measures Relevant for Accountability to Specific Youngsters & Families