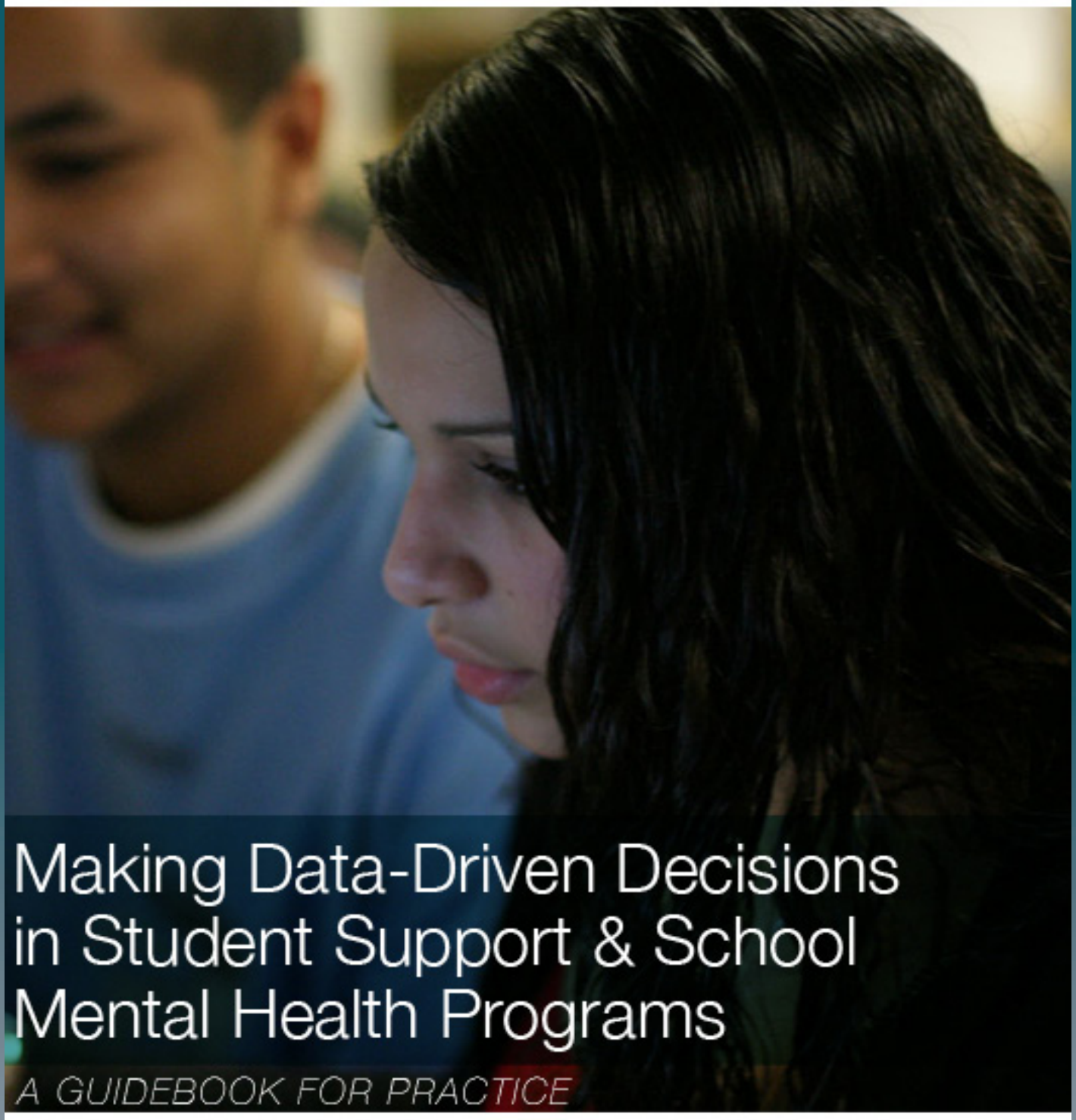
school climate health & learning

CALIFORNIA SURVEY SYSTEM



Making Data-Driven Decisions in Student Support & School Mental Health Programs

A GUIDEBOOK FOR PRACTICE

2011/2012

California Department of EDUCATION

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PREFACE

This Guidebook was developed by WestEd under contract CN100346 from the California Department of Education (CDE) for the Educational Options, Student Support, and American Indian Education Office (EOSSAIEO), with funding from the state Mental Health Services Act (MHSA) of 2004. It is designed to support schools in achieving the goals set forth in the MHSA and the *California Strategic Plan on Suicide Prevention* (California Department of Mental Health 2008). The MHSA calls for implementing comprehensive community–based mental health services and supports in California. More specifically, its purpose is to:

- Define serious mental illness among California residents, including pre–kindergarten through twelfth-grade students;
- Reduce the long–term negative effects on individuals, families, and state and local budgets that result when mental health issues are not addressed or treated;
- Expand successful, innovative services that have demonstrated their effectiveness in providing outreach and integrated services; and
- Provide state and local funds to adequately meet the mental health needs of Californians, including prevention and early intervention.

Neighborhood schools play a critically important role in reaching these goals. School–based prevention and intervention efforts are key to achieving positive long–term mental health outcomes for children and youth. They are also essential if schools are to reach their goal of graduating *all* students with the academic and social–emotional skills necessary to experience success in careers, college, and adulthood. Central to these efforts is the need for schools to foster school climates that are safe, caring, and supportive of the needs of all school community members, students and staff.

To guide these efforts, all schools regularly need to assess the mental–health status of their students and staff, the related supports provided by the school environment, as well as to identify and monitor local community resources related to mental health services. School–site councils, school safety planning committees, student success teams, and other stakeholders need data for planning, implementing, and monitoring community or school–based mental health (CSBMH) and school climate improvement efforts. A school and district goal of continual improvement of mental health services, or the creation of needed resources where none exist, must be driven by data.

This guidebook is designed to aid California schools in using the data from their California Healthy Kids Survey (CHKS), and its companion California School Climate Survey (CSCS), to identify and address the mental health needs of students and school staff. Along with the new California School Parent Survey (CSPS), these surveys constitute the California School Climate, Health, and Learning Survey System (Cal–SCHLS). The Cal–SCHLS suite of surveys provides a broad spectrum of data to help implement and improve comprehensive community or school–based mental health programs, as called for by the MHSA, and the school climates that support them.

Following an introductory overview to the importance of CSBMH programs and a summary of survey data, the guidebook reviews the significance of the survey questions most relevant to promoting mental health wellness and academic achievement. More detailed information about each question is available in the CHKS and CSCS *Guidebooks to Survey Content*, which may be downloaded from the survey websites (chks.wested.org and cscs.wested.org).

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1 INTRODUCTION

The American Academy of Pediatrics (2004) estimates that more than 20% of children and adolescents have mental health needs.[1] Serious mental illness affects an estimated 5% to 9% of California children and youth.[2] Media reports of bullying-related youth suicides are tragic testimony to the challenges that today's youth experience to their healthy social and emotional development and learning.

Schools must take an active role in providing mental health supports that promote the wellbeing of the students and staff. They must work together with community agencies to create a comprehensive system of mental health services and supports for children and youth, as called for by the state Mental Health Services Act (MHSA) of 2004.[3] Unfortunately, mental health programs have typically been marginalized within schools, viewed apart from the school's education mission and subject to the vagaries of funding. Due to the lack of guiding policy and coordination, those mental health services that are available have often been flawed by gaps and redundancies.[4] School reform efforts have almost exclusively focused on curriculum, instruction, and governance, with little attention paid to how the social and emotional health of students and staff affect their ability to bring about significant change in academic outcomes.[5] The goals of the MHSA and school reform are complementary and inter-related. The promotion of mental health wellness among students and staff will help improve:

- Student attendance, academic performance and graduation rates; and their preparation for college, career, and adulthood;
- Teacher and other staff job satisfaction, performance, and retention, reducing burnout.

The CDE seeks to foster a comprehensive community or school-based mental health (CSBMH) approach through evidence-based programs and positive school climates that promote learning, positive youth development, and resilience. High-quality assessments of school conditions and the mental health needs of students and staff are necessary to guide the implementation of effective school programs, policies, and practices. This guidebook is meant to help schools implement data-driven improvements in CSBMH efforts through an examination of the results from their students' answers on the CDE's California Healthy Kids Survey (CHKS) and their staff members' answers on the California School Climate Survey (CSCS).

These surveys provide a broad spectrum of critical data to guide implementation of comprehensive CSBMH programs, as called for by the MHSA, and the fostering of positive school climates that support these programs. They help identify specific mental health needs (i.e., positive and negative indicators) of youth, as well as risk and protective factors that influence these needs, with special attention paid to school climate. The surveys provide data on whether schools have conditions in place that promote positive mental health, such as a sense of safety, caring relationships, and connectedness, as well as programs and services that meet students' needs.

The purpose of this guidebook is to assist schools in understanding and using their CHKS/CSCS results to inform their decisions in creating a web of supports that foster mental wellbeing among all students and staff. Outlined within are the survey questions most relevant to the promotion of mental wellness. More broadly, this tool is intended to help foster expanded programmatic efforts in schools by raising awareness of the links between mental health and student attendance, academic achievement, and graduation. More detailed discussions of all the survey questions can be found in the CHKS and CSCS Survey Content Guidebooks.[6]

This guidebook is particularly designed for use by collaborative teams of school personnel in their efforts to provide student support services related to mental health. As illustrated in Figure 1, collaborative teams within schools may include, but are not limited to, members from the following personnel groups: counselors and psychologists, social workers, nurses, prevention specialists, school resource officers, student success teams, administrators, and, of course, teachers.

This guidebook is *not* intended to be a comprehensive resource for understanding best practices. The *California Results-based School Counseling and Student Support Guidelines* (California Department of Education, 2007) provides guidance on programs and strategies that school teams may implement in order to meet the needs identified by the surveys. Section 2 of this guidebook, however, does discuss several initial action steps.

1 Similarly, researchers have estimated that almost 21% of youth ages 6–17 suffer a diagnosable mental health problem or addictive disorder that impairs their functioning, including academic achievement (Shaffer et al., 1996). Others estimate that between 20% and 38% of youth in the United States need mental health intervention, and 9–13% have serious disturbances (Goodman et al., 1997; Grunbaum et al., 2004; Marsh, 2004).

2 California Mental Health Services Act of 2004.

3 See the Preface for an outline of the specific goals of the MHSA.

4 Factors that have contributed to this piecemeal approach include the diverse professional disciplines, state and federal agencies and programs, and categorical funding streams related to mental health.

5 Adelman & Taylor, 2006a; Adelman & Taylor, 2006b; Klem & Connell, 2004; Honig, Kahne, & McLaughlin, 2001; Zins, Weissberg, Wang, & Walberg, 2004.

6 *Guidebook for the California Healthy Kids Survey, Part 2: Survey Content* (chks.wested.org/training_support) and *Guidebook for the California School Climate Survey, Part 2: Survey Content* (cscs.wested.org/training_support).

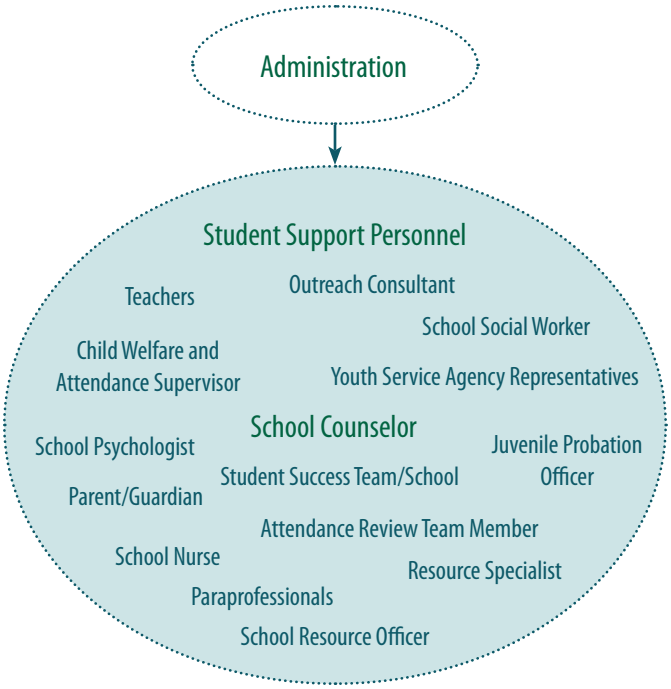
ORGANIZATION

Section 2 provides: (1) a framework for understanding the importance of data–driven promotion of school mental health wellness; and (2) recommendations for actions that schools should take. Section 3 contains a summary of CHKS/CSCS data illustrating the extent of the mental health needs of California secondary students and the services schools provide related to these needs. The relevance of specific CHKS/CSCS questions to implementing this framework is then discussed in the following sections:

- Physical & Social-Emotional Safety (Section 4)
- Substance Use (Section 5)
- Risk of Depression & Suicide (Section 6)
- School Connectedness (Section 7)
- Student Developmental Supports & Internal Strengths (Section 8)
- Student Services & Staff Supports (Section 9)

Appendix A lists each indicator as well as the related survey report table where results can be found. Appendix B provides resources for implementing programs.

Figure 1. Types of Student Support Personnel



2 PROMOTING MENTAL HEALTH WELLNESS IN SCHOOLS

What do we mean by mental health? According to the US Surgeon General (1999), mental health "is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity." *Mental health, like physical health, exists on a continuum or spectrum of states, from healthy living to chronic illness*, from temporary responses to painful events to more debilitating and permanent conditions. Youth may suffer one condition at a time or simultaneous co–occurring conditions. They can move through problems in a developmental sequence with varying levels of severity.

In the past, concerns over youth mental health were focused on psychological disorders, such as depression, anxiety, and conduct disorder. Mental health was generally understood to be the absence of these disorders (i.e., the lack of mental illness). The mental health needs of vulnerable children and youth who did not have symptoms of psychopathology were largely overlooked.[7]

7 Evans, Mullett, Weist, & Franz, 2005; Suldo & Shaffer, 2008.

In recent years, a growing number of scholars and practitioners have recognized that a more comprehensive approach is needed that aims to foster a complete state of positive social–emotional wellbeing among all children and youth. Such a comprehensive system of care includes not only supports for addressing the individual mental health needs of youth, but also for reducing risk factors such as substance use, bullying, and violence that may both contribute to and reflect mental health issues. What is more, it involves creating conditions that promote resilience and amplify youth protective factors that mitigate against risk.

Figure 2 illustrates five basic components of a comprehensive mental health wellness system.[8]

I. *Universal health promotion and prevention programs* are implemented schoolwide to prevent the onset of psychosocial difficulties for all students. Health promotion strategies seek to enhance strengths and protective factors and increase the likelihood of positive development and resilience. Key among them is providing caring relationships within supportive school environments.

II. *Selective or secondary prevention programs* such as early warning systems target *groups* of students with similar risk

8 Weist & Evans, 2005; California Department of Mental Health, 2008. These five basic components align with the three–tiered pyramidal prevention models advocated for use in Response to Intervention (Fox, Carta, Strain, Dunlap, & Hemmeter, 2009), and public health promotion.

factors and are aimed at preventing the onset of behavioral or emotional problems.

III. *Early intervention or indicated prevention* programs that address the needs of *individual* youth displaying symptoms of a disorder, but not at the diagnosable level requiring treatment. These programs can provide case management, behavior modification, or brief intervention.

IV. *Treatment interventions* generally target those individuals who have high symptom levels or diagnosable disorders at the current time. These programs often require referrals to agencies outside the school and careful monitoring.

V. Finally, for those who have undergone treatment interventions, *recovery supports* — such as peer support groups — are needed.

THE ROLE OF SCHOOLS IN MEETING THE CHALLENGE

Addressing mental health risks early in life is essential. Failure to do so is extremely costly to both individuals and society. Childhood mental health disorders persist into adulthood and often worsen if left untreated, thereby increasing the length and associated direct cost of treatment.[9] Individual costs include increased risk of school dropout, underemployment, incarceration, substance use, co-morbid illness, and shorter life span. Societal costs include the heavy burden placed on both local and state systems of health care, welfare, education, business, industry, justice, and public safety.

Unfortunately, evidence suggests that among youth, the great majority of mental health needs are not being met. It has been estimated that as few as one-sixth to one-third of youth with diagnosable disorders receive any treatment, and, of those who do, far less than half receive adequate treatment.[10] That schools must play a larger role in filling this gap has become increasingly apparent because (a) schools are central for identifying and addressing youth mental health needs within a comprehensive delivery system; and (b) failure to do so comes at a high cost to schools in terms of both academic outcomes and financial resources.

IDENTIFYING AND ADDRESSING STUDENT MENTAL HEALTH NEEDS

School staff are in a unique position to identify and address the mental health needs of children and youth. As central neighborhood hubs for youth and their families, schools are uniquely suited to provide identification, prevention, and early intervention services, as well as referrals to treatment.[11] In fact, one study showed that 70% to 80% of youth who receive mental health services accessed them through the education sector.[12] These powerful data led to

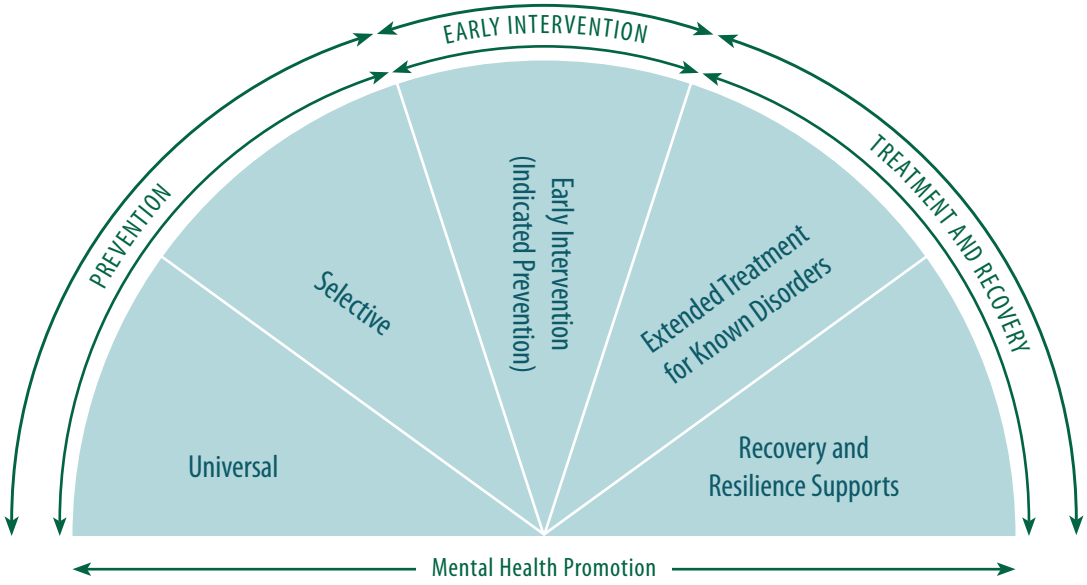
9 Approximately one-half of adults with mental illness experience symptoms prior to age 14 (Kessler et al., 2005). In one study, 74% of 21-year-olds with mental disorders reported experiencing symptoms as a child (U.S. Surgeon General, 1999). See also: Hurwitz & Weston, 2010; Wade, Mansour, Guo, Huentelman, Line, & Keller, 2008.

10 Burns et al., 1995; Leaf et al., 1996; Weisz, 2004. Kataoka, Zhang, & Wells (2002) report that 80% of youth between 6 and 17 years of age did not receive the mental health services they needed.

11 An American Academy of Pediatrics *Policy Statement on School-Based Mental Health Services*, concluded in 2004 that "school-based programs offer the promise of improving access to diagnosis of and treatment for the mental health problems of children and adolescents" (p. 1). See also Brener, Kann, McManus, Stevenson, & Wooley, 2004; Weist & Evans, 2005; Weist & Paternite 2006.

12 Burns et al., 1995.

Figure 2. Mental Health Intervention Spectrum Diagram



Source: Adapted from California Department of Mental Health. *California Strategic Plan on Suicide Prevention*, 2008.

then President Bush's New Freedom Commission on Mental Health to call for the expansion and improvement of school–based mental health programs toward the larger goal of transforming mental health care in America.

IMPROVING EDUCATIONAL OUTCOMES

Mental health is strongly connected to school–related outcomes, including attendance, academic performance, and graduation, as summarized in Table 1. Schools with climates and services that promote the well-being of all students and staff show improvements in multiple educational outcomes, including:

- Improved school attendance;[13]
- More positive staff–student relationships and perceptions;[14]
- Increased student connectedness, engagement, attitudes toward learning, and in prosocial attitudes and behaviors (e.g., autonomy, efficacy, democratic values, conflict resolution skills);[15]
- Reduced risk–taking and violent behaviors;[16]
- Fewer discipline referrals and school suspensions;[17]
- Increases in feelings of safety at school and willingness to report potential threats to safety;[18] and
- Increases in scores on measures of academic achievement — including tests in language, reading and math, and overall grade point average.[19]

Student mental health issues can adversely impact schools. For example, students with mental health issues are more likely to miss school; thus reducing Average Daily Attendance (ADA), which is the basis for a majority of school district funding. Chronically absent students are deprived of essential instruction. What is more, chronic absenteeism reduces teacher effectiveness and contributes to teachers leaving the profession. Chronic absenteeism can also be related to an unhealthy school climate, costs the school time and money in reducing and training new teachers, and undermines the quality of instruction. A model school attendance review board (SARB) can help schools discover when mental health issues or unhealthy school climates are impacting school attendance.

Section 3 of this guidebook summarizes key findings related to mental health reported by California students and school staff on the CHKS and CSCS, including a Student Mental Health Scorecard. Subsequent sections outline in more depth how these survey indicators relate to mental health and educational outcomes. To briefly summarize:

- Schools that are unsafe emotionally or physically, wherein students experience and/or witness acts of aggression and violence, can contribute to poor school attendance and academic performance, in part by the stress and anxiety that result (Section 4).
- Heavy substance use can be both a reflection of, and a contributing variable to, mental health issues as well as a major learning and attendance barrier (Section 5).
- Youth who are depressed, anxious, or stressed do not have optimal learning outcomes or attendance (Section 6).
- The degree to which students feel connected to their schools is related to their physical and mental well–being (including lower rate of stress, substance use, and violence), as well as to positive educational outcomes (Section 7).
- Developmentally supportive school climates — characterized by caring relationships, high expectation messages, and opportunities for meaningful participation — enhance school connectedness, internal strengths (e.g., social skills), and positive academic and social–emotional student outcomes (Section 8).
- Schools also need to be sensitive to the mental health needs of staff both in terms of: (1) the contribution of the unmet mental health needs of students to staff stress, poor performance, and low job retention; and (2) the truism that staff cannot meet the mental health needs of students if their own needs are not being met (Section 9).

WHAT SCHOOLS CAN DO

The responsibility for addressing all the mental health risks that students experience cannot be held solely by schools. School–family–community collaboration is at the heart of the MHSA and effective programmatic efforts. Nevertheless, there is much that schools can and *must* do.[20] Research clearly demonstrates that schools must begin by overcoming the current state of programmatic marginalization and fragmentation by adopting a comprehensive approach to identifying and addressing the needs of all students and staff that is integrated within overall school improvement efforts (as illustrated in Figure 2).

Within the school, it is essential to communicate the prioritization of mental health promotion efforts by including them in comprehensive school improvement plans. As noted above (see Figure 1), a collaborative team needs to be formed to guide these integrated efforts, drawing from counselors and psychologists, school social workers, nurses, prevention specialists, school resource officers, student success teams, administrators, and, of course, teachers. Membership on this team should be integrated with membership in other school improvement and student service teams. For example, *California Education Code* Section 48321 has

13 Suldo & Shaffer, 2008.

14 Ludwig & Warren, 2009; Zimmerman, Bingenheimer, & Notaro, 2002.

15 Battistich, Solomon, Watson, & Schaps, 1995; Brand et al., 2003; Klem & Connell, 2004; Henrich, Brookmeyer, & Shahar, 2005; Roeser, Eccles, & Sameroff, 2000; Ryan & Patrick, 2001; Waters et al., 2009.

16 Resnick et al., 1997.

17 Nelson, Martella, & Marchand–Martella, 2002; Welsh, 2000.

18 Ozer & Weinstein, 2004; Syvertsen, Flanagan, & Stout, 2009; Welsh, 2000.

19 Brand et al., 2003; Wilms & Somer, 2001.

20 Hogenbruen, Clauss–Ehlers, Nelson, & Faenza, 2003.

been amended to include a mental health representative on student attendance review boards (SARBs), which meet with persistently absent students and their parents. This mental health expertise on the panel can be crucial in any plan to improve graduation rates. Emphasis should be on finding appropriate resources for students with mental health needs.

In developing such a comprehensive approach, research underscores four areas in which to begin: improving school climates, establishing early warning and intervention systems, professional development, and data-driven decision making.

IMPROVE SCHOOL CLIMATES

As part of universal health promotion and prevention efforts (the first tier of the comprehensive approach in Figure 2), schools must begin by ensuring safe, caring, challenging, and participatory environments that foster school connectedness for all students. They need to provide supportive and healthy learning conditions characterized by opportunities for meaningful engagement for both staff and students, positive relationships between and among staff and students, and high levels of emotional and physical safety (see especially Sections 4, 7 and 8). These conditions are the cornerstones of a positive school climate. When universally applied, they can help prevent many mental health issues from arising and lay the foundations for school connectedness and academic success. School environments are powerful for promoting healthy social and emotional adjustment in youth as well as academic success.

IMPLEMENT EARLY IDENTIFICATION AND REFERRAL

In addition, schools need to provide early identification of students at risk of school failure, dependency, and other social–emotional problems and then target intervention systems for students who already need help, including referrals to services outside of school. Early warning systems that identify chronically absent students can be a critical tool for both preventing school failure and the escalation of mental health needs.[21] Students who miss ten percent or more of school days should be screened by a school team for possible interventions, including mental health interventions. As part of these efforts, a school needs to map the resources available in the community to provide students help. Very few schools provide mental health services directly, but they should create an inventory of resources and a referral process to improve access to mental health services.

One strategy to achieve these goals is the Student Assistance Program (SAP), a school–based integrated approach to identify and link students to behavioral health education, programs, and services in the community to address barriers to learning due to social, behavioral, emotional, and/or mental health issues.[22] In the most common SAP model, a Core Team of staff who have respon-

21 In California, a chronic absentee is defined in Education Code Section 60901(c)(1).

22 According to the California Department of Education's Local Educational Agency (LEA) Plan database for 2003–04, only 353 of 1298 LEA's report having a SAP. Even this number is probably an over–estimation as considerable confusion exists over the use of this term.

Table 1. Summary of Research on the Relationship of Student Mental Health on School Attendance and Performance

FINDING	SOURCE
Compared with typically developing peers, students with mental health challenges usually display moderate to severe academic deficits. They earn lower grades across all academic subjects, have higher course failure rates, and are more likely to drop out of school than any other disability group.	U.S. Department of Education, 1994; Greenbaum et al., 1998; Reid, Gonzalez, Nordness, Trout, & Epstein, 2004; Woodruff et al., 1999
Academic deficits among students with mental health challenges appear early in life.	Kauffman, 2001
Depression among youth is associated with lower academic achievement and school performance.	Försterling & Binser, 2002; Kumpulainen, Rasanen, & Henttonen, 1999; Marmorstein & Iacono, 2001; Slap, Goodman, & Huang, 2001
Rates of absenteeism and tardiness are much higher for students with untreated mental health disturbances than those who are receiving treatment or those without such disturbances.	Gall, Pagano, Desmong, Perrin, & Murphy, 2000; Engberg & Morral, 2006; Woodruff et al., 1999
Less than 25% of children with emotional or behavioral disorders graduate from high school.	California Little Hoover Commission, 2001
Students with serious emotional disturbance or a diagnosable psychological illness are more likely to drop out and not complete high school.	Stoep, Weiss, Kuo, Cheney, & Cohen, 2003; Woodruff et al., 1999
An estimated 46% of failure to complete school is attributable to psychiatric disorder.	Stoep et al., 2003

sibilities for student health, attendance, and learning determine student needs, provide referrals to services in the school and community (including treatment and family support), and monitor progress. If school–based programs have limited capacity, students may also be referred to district–level interventions, including a School Attendance Review Board (SARB). Monitoring of these students by a SAP, SARB, or other team that deals with intensive interventions is essential.

SAP's do not treat students so much as motivate them to seek help and provide a bridge to systems that provide that help. It is important that students are aware that help exists, know how to access it, and feel no stigma in seeking help from any school mental health program. In doing this, an effective SAP and SMH program in itself communicates that the school is caring and supportive and helps build school connectedness.

ADDRESS PROFESSIONAL DEVELOPMENT NEEDS

On the CSCS, half of teachers in all grade levels report that they need professional development in meeting the social, emotional, and developmental needs of youth. Roughly 30%–40% of teachers needed help in knowing how to create a positive school climate. Schools should take steps to build capacity within their school walls. Professional development around identifying indicators of risk is important for teachers and other school staff, who may have never received formal education around youth mental health. Often, teachers do not know that there is a mental health disorder underlying problematic student behavior, and students are thus labeled a discipline or behavior problem without the underlying mental health need being addressed. Teachers and school staff must be taught to recognize risk factors and they must have access to a referral system that is responsive and effective for meeting the needs of the students in their care.

USE DATA TO GUIDE PROGRAM DECISION MAKING

Outlined in the sections that follow are the essential CHKS and CSCS items that may be used to inform system–level and program–level improvement decisions around the mental health needs of students. Copies of individual school district CHKS/CSCS results may be downloaded from the survey websites (chks.wested.org and cscs.wested.org). School reports, as well as complete datasets for analysis, may be ordered from the Cal–SCHLS regional centers by calling toll–free 888.841.7536. Examining school–specific results is necessary in determining how and where to allocate often–limited resources that address the needs of students within schools in a district that may vary significantly.

The CHKS *Guidebook to Data Use and Dissemination* provides step–by–step directions for effectively reviewing, disseminating, and using survey results to guide program decision–making (download at chks.wested.org/publications).[23] As it details, seven action–steps are essential:

1. *Review results with school–community stakeholders.* First, school leaders, staff, students, parents, and community stakeholders must all be engaged in the process of reviewing the survey results and determining key findings, as well as discussing their implications for district–level policy and practice. These teams should include staff responsible for health and prevention programs, counseling services, safety, and school improvement. Student voice is also essential. Students provide insight into the meaning of the CHKS results and how to address the identified needs. Community representatives — parents, extended family members, community and agency leaders, among other stakeholders — are especially important for providing insight into nonschool issues that affect students and the local resources that may help the school achieve short– and long–term goals. Including students and local community members communicates that they are meaningful members of the school community, with an active and important role in leadership and decision–making. Together, team members should be encouraged to review areas for intervention and discrepancies between student and staff data. If staff perceptions are not aligned with student survey or other data (e.g., chronic absenteeism, violent incidents), it is important to explore why.
2. *Assess other types of data.* Reconciling CHKS/CSCS data with other available data, such as rates of suspension and expulsion, chronic absenteeism, and graduation, is important for understanding the scope of the school's needs. For information on other valuable data sources, consult the *California Results–Based School Counseling and Student Support Guidelines*. [24]
3. *Identify high–risk groups.* In order to inform the allocation of resources, additional analysis of results should be undertaken to determine if there are specific groups of students with mental health needs that should be targeted with interventions as part of a continuum of care. For example, analyses of CHKS data have shown that foster youth and youth who are harassed because of their sexual orientation or disability are at high risk of both depression and substance use. The survey demographic indicators provide a means to identify subgroups by race/ethnicity and living conditions. The *California Strategic Plan on Suicide Prevention* discusses several groups that are at elevated risk to guide these analyses.

23 As an additional resource, technical survey staff regularly hold webinars and onsite workshops on data use.

24 For information on other valuable data sources, see the California Department of Education's *California Results–Based School Counseling and Student Support Guidelines* (www.cde.ca.gov/ls/cg/re/documents/counselguidelines.pdf).

4. *Analyze the relationships between mental health indices.* It is important to analyze how different mental health risks are interrelated — for example, contemplating suicide and substance abuse — so that service providers can coordinate their work and address needs in an integrated fashion. Systematic intervention efforts reduce redundancy and improve outcomes. Datasets for analysis are available from the CHKS helpline (888.841.7536).
5. *Implement evidence-based programs and practices.* Having identified and prioritized needs, use evidence-based strategies and programs to address these needs within a comprehensive continuum of care, and evaluate those efforts on an on-going basis. Appendix B provides a summary of some helpful programmatic resources. Other useful tools include:
   - » The *California Strategic Plan on Suicide Prevention*
   - » The *California Results-Based School Counseling and Student Support Guidelines* (available at: www.cde.ca.gov)
   - » The numerous publications of the Center for Mental Health in Schools at the University of California, Los Angeles (http://smhp.psych.ucla.edu).
   - » The Healthy Kids Resource Center (www.californiahealthykids.org).
6. *Disseminate plans widely.* Widely disseminate information about the identified needs of youth in your district and/or school, as well as your team's plans for addressing the identified needs. Include special considerations for how parents and community members can support these efforts.
7. *Map resources.* Identify and disseminate information about the resources within the schools and community to help meet the identified needs of support program efforts.

3 THE NEED IN CALIFORNIA

The need for California schools to improve school climate and mental health program efforts — as well as the value of the CHKS and CSCS in assessing that need — is evidenced by the Student Mental Health Scorecard provided as Exhibits 3.1 and 3.2. CHKS data indicate that approximately 1 of every 3 secondary students is chronically sad or hopeless; 2 of every 3 do not experience high levels of caring adult relationships at school; 40% do not feel safe at school; and over 80% report low levels of opportunities for meaningful participation at school. Perhaps as a function of these experiences, over half of secondary students report feeling a weak connection to school and over one-fifth of 11th graders were drunk or high on drugs on school property in the past year. Substance use remains a chronic mental health problem, with almost one-sixth of 11th-grade experiencing two or more signs of problematic use and dependency (Exhibit 3.1).

Staff awareness of the problems posed to schools, especially high schools, by student mental health issues is evident in CSCS data. Staff members are asked to rate how much of a problem the school experienced from each of 14 potential student behaviors and conditions. Results show that school staff perceive that problem severity related to mental health increases markedly after elementary school. Moderate-to-severe problem ratings were selected by:

- » Over half of middle-school staff for harassment/bullying.
- » Over half of both middle and high school staff for disruptive student behavior.
- » Almost one-third of high school staff for depression or other mental health problems.
- » Half of high school staff for alcohol and drug use, making it the top-rated problem after disruptive behavior and truancy.

The CSCS also shows that, while the severity of problems increased from elementary to high school, the services and practices related to mental health promotion declined markedly. Only about one-fifth of high school staff strongly agreed that their schools: (1) placed an emphasis on helping with the social, emotional, and behavioral problems of students; and (2) provided effective referral services for addressing their behavioral or other problems (See Exhibit 3.2). Moreover, only about one-fifth of elementary and middle school staff, and only 14% of high school staff, report that their school fostered "a lot of" positive youth development (not shown in score card).[25] Overall, the student and staff data indicate California schools are not sufficiently addressing their students mental health needs.

25 Austin & Bailey, 2008.

Exhibit 3.1. California Student Mental Health Scorecard

CALIFORNIA HEALTHY KIDS SURVEY STATEWIDE STUDENT REPORTED INDICATORS, 2008–10	GRADE 7TH (%)	 9TH (%)	 11TH (%)
SOCIAL/EMOTIONAL WELL–BEING			
Experienced chronic sadness or hopelessness (depression risk)*	28	31	32
SCHOOL SAFETY AND VICTIMIZATION (PAST 12 MONTHS)			
Do not feel very safe or safe	37	41	38
Bullied or harassed	42	35	28
» Bias–related reasons**	32	27	23
Made fun of because of looks or way talk.	44	37	33
Had mean rumors/lies spread about you	47	39	36
Afraid of being beaten up	26	20	13
Been threatened or injured by a weapon	9	8	6
HEAVY, REGULAR, OR RISKY SUBSTANCE USE			
Binge drinking (5 or more drinks in a row, past 30 days)	6	15	22
Weekly marijuana use (3 or more past 30 days)	3	13	18
Used drugs other than marijuana, past 30 days	7	11	10
Alcohol and other drug use on school property, past 30 days	8	12	11
Ever drunk or high on drugs on school property	5	17	21
Experienced two or more problems from AOD use	n/a	10	15
» Experienced problems with emotions, nerves, or mental health from AOD use	n/a	8	10
Experienced two or more use–dependency indicators	n/a	9	15
LEARNING ENGAGEMENT AND SUPPORTS			
Low in school connectedness***	50	57	57
Truant, more than 1–2 times, past 12 months	9	17	29
Low in total school developmental supports***	66	71	66
» Caring adult relationships	65	69	62
» High expectations messages	44	53	52
» Opportunities for meaningful participation	86	87	83
PERCEIVED SEVERE–TO–MODERATE PROBLEM AT SCHOOL BY STAFF			
Student depression or other mental health issues	12	21	31
Disruptive student behavior	39	59	51
Harassment or bullying of students	26	54	35
Alcohol or other drug use	01	16	50

*Past 12 months, ever felt so sad or hopeless almost everyday for two weeks or more that you stopped doing some usual activities.

**Reasons classified as hate crimes: because of race/ethnicity, religion, gender, sexual orientation, physical or mental disability.

***For this scorecard, students were categorized as low if they were not categorized as high. This includes students who were categorized in the mid–range because the goal is to have all students fall within the high range of school connectedness and experiencing developmentally supported schools.

Exhibit 3.2. California School Mental Health Supports Scorecard

CALIFORNIA SCHOOL CLIMATE SURVEY STATEWIDE STAFF REPORTED INDICATORS, 2008–10	ES (%)	MS (%)	HS (%)
STRONGLY AGREE THAT SCHOOL...			
Is a supportive and inviting place for students to learn	57	39	36
Is a safe place for students	53	36	34
Emphasizes helping students with their social, emotional, and behavioral problems	25	23	17
Provides adequate student counseling and support services	23	30	29
Provides effective confidential support and referral services for students needing help due to substance abuse, violence, or other problems	19	24	20
AT SCHOOL...			
Nearly all adults at school really care about every student	60	38	33
A lot of youth development, resilience, or asset promotion is fostered	23	21	14
Staff need more professional development in meeting the social, emotional, and developmental needs of youth	49	56	49

Key: ES=elementary school; MS=middle school; HS=high school

4 PHYSICAL & SOCIAL–EMOTIONAL SAFETY

Fundamental to mental health is safety, a basic human need that must be met in order for youth to succeed in school and life. All schools are required to develop an annual *Comprehensive School Safety Plan* to ensure there is a safe and orderly environment conducive to learning for all students (*California Education Code* sections 32280–32289). The goal is both physical and social-emotional safety. Such safe environments enhance creativity, cooperative behavior, exploration, and positive risk–taking. Safety is also characteristic of a high–quality school, one in which students feel a sense of belonging.[26] The extent to which students feel physically and social–emotionally safe at school is highly correlated with both overall wellbeing and academic outcomes. Discussed below are the CHKS and CSCS items that report on how safe students and staff feel at school and on the conditions that affect that perception. Section 9 outlines the CSCS items that provide data on the scope and nature of measures taken by the school to promote safety and prevent bullying and violence.

STUDENT PERCEPTIONS OF SAFETY AND VICTIMIZATION CHKS TABLES 6.1–2, 5, 7, 10

The CHKS asks students how safe they feel at school (Table A6.10) and a series of questions assessing experiences and behaviors related to victimization and violence. The items are intended to shed light on the reasons why students feel unsafe or anxious; experience mental health issues; and avoid attending school. These items include the frequency in the past year that students:

- Experienced forms of verbal and physical bullying or harassment (Tables A6.1–2);
- Were involved in a physical fight (Table A6.2);
- Had property stolen or damaged (Table A6.3);
- Were threatened with a weapon or saw a weapon at school (Table A6.5); and
- Were harassed or bullied because of any of the five hate– or bias–related reasons covered by California Penal Code 628 (race/ethnicity/national origin, gender, religion, sexual orientation, a physical or mental disability) as well as for any other reason. (Table A6.7).

Students are also asked the frequency with which they personally engaged in violent or criminal acts in school by carrying a weapon or damaging school property on purpose, as reported in Tables A6.3–4.

26 Dwyer & Osher, 2000.

Chronic fear for one's safety can have devastating, long-lasting effects on young people. In addition to the risk of physical injury, experiencing violence interferes with youth's successful completion of normal social and emotional developmental processes. It also interferes with the ability to concentrate and engage successfully in school. As research has shown:

- Many youth experience difficulty coping with the stress associated with violence and may exhibit a lack of interest in academics, behavior problems in school, poor grades, low self-esteem, and a high dropout rate.[27] Emerging evidence suggests exposure to violence has lifelong effects on learning.[28]
- Youth who *witness* chronic violence, especially in school, also tend to exhibit poor concentration and a general decline in academic performance, attendance, and behavior. [29]

While the psychological effects of physical violence, such as the high profile events that are made visible by the media, are profound, similar psychological damage results from the more regularly occurring, although often under-recognized, acts of interpersonal aggression among youth.[30] Aggression in any form — physical or relational — instills a sense of vulnerability, isolation, and fear in its victims, and affects the general sense of safety at school. While the dynamics of peer victimization are complex, threats, intimidation, rumor, and ostracism have consistently been found to be related to persistent problems in functioning, including:

- Loneliness and satisfaction with social relationships;
- Emotional distress, including depression, anxiety, and withdrawal;
- Disruptive behavior problems, including aggression, hyperactivity, impulsivity, and conduct problems;
- High-risk behaviors, such as alcohol and drug use; and
- Nonsuicidal self-injurious behavior and suicidal ideation.[31]

In addition to its effects on emotional and behavioral health, experiences of persistent peer aggression have been linked to declines in school attendance, lower school connectedness (see Section 7), reduced engagement and control of cognitive and emotional resources in the academic environment, and impaired academic achievement, including class grades and standardized test scores.[32]

In sum, peer aggression results in reduced ability to organize and deploy cognitive and emotional resources in order to learn. These persistent acts of aggression between students, when ignored, create a social norm that will eventually undermine the perceived safety and school climate for *all* members of the school community, including children who are not directly involved, as well as staff and family members.

CHKS data show that about four in ten students report not feeling safe at school. From 42% of 7th graders to 28% of 9th graders report having been harassed or bullied in the past year.

The relationship between victimization and the psychological wellbeing of California students is demonstrated in CHKS Factsheets #4 and #10. As a group, harassed students consistently report lower levels of wellbeing across indicators compared to students who are not harassed. *All victims of harassment are more likely than non-harassed to experience chronic sadness/ hopelessness and to feel less safe at, and connected to, school.* The bias-harassed were more than twice as likely to report incapacitating sadness/hopelessness (46% vs. 23%). They were about 1.5 times more likely to not feel safe at school (54% vs. 36%) and almost four times more likely to fear being physically beaten at school (44% vs. 12%).[33] Consistent with these findings, the bias-harassed were less likely to score high in school connectedness (66% vs. 53%). Students who were harassed because of a *physical or mental disability* had the poorest results, followed by those harassed because of sexual orientation. [34] The *California Strategic Plan on Suicide Prevention* identifies both groups as at elevated risk of suicide.

STAFF PERCEPTIONS OF PERSONAL AND SCHOOL SAFETY CSCS TABLES 6.1–6.6

School staff report on the CSCS how much they agree that the school was safe for students as well as staff, and how great a problem the seven safety-related student behaviors (i.e., harassment or bullying, physical fighting, racial/ethnic conflict, weapons possession, gang activity, vandalism, theft) were for the school. For the purposes of comparison, these items directly correspond to student-reported behavior on CHKS items.

By far, the greatest safety-related problem reported on the CSCS by middle school staff is harassment or bullying. Half (54%) consider it a moderate-to-severe problem at their school, compared to 26% of elementary staff and 35% of high school staff. These data are consistent with those from student self-report showing bullying peaks in middle schools.

27 Landen, 1992; Lockwood, 1993; Obiakor, 1992.

28 Prothrow-Stith & Quaday, 1996.

29 Lorian & Saltzman, 1993; Bowen & Bowen, 1999.

30 Juvonen & Graham, 2001; Rigby, 2004.

31 Hanish & Guerra, 2002; Hawker & Boulton, 2000; Heilbron & Prinstein, 2010; Kochenderfer-Ladd & Ladd, 2001; Kochenderfer-Ladd & Wardrop, 2001; Paul & Cillessen, 2003; Sullivan, Farrell, & Kliewer, 2006).

32 Iyer, Kochenderfer-Ladd, Eisenberg, & Thompson, 2010, Kochenderfer & Ladd, 1996; Nakamoto & Schwartz, 2010; You et al., 2008.

33 They were also more likely to engage in violence at school: they were over twice as likely to carry a weapon at school (21% vs. 8%) and be in a physical fight at school (20% vs. 9%).

34 A survey conducted by Human Rights Watch (2001) found that teachers and administrators frequently ignore bullying and even violence against gay students. This harassment takes a serious toll on the students' emotional and physical health and on their academic studies, contributing to dropping out of school and suicide. These students spend an inordinate amount of effort figuring out how to avoid victimization and preserve their safety.

5 SUBSTANCE USE

Statewide trend data indicate that we have made little impact over the past decade on reducing the overall prevalence of alcohol and other drug (AOD) use among California secondary students, particularly levels of heavy use reported by high school students, although alcohol use did decline between 2007 and 2009. About one–tenth of 9th graders and about one–sixth of 11th graders may be AOD users who would be helped by some intervention, with one–tenth of 11th graders possibly at risk of dependence and in need of treatment or counseling.[35]

While all youth who use alcohol or drugs are not at mental health risk, frequent or heavy AOD use may be both a symptom of mental health issues and a cause of them. Students who report chronic sadness/hopelessness (see Section 6) are more likely to use substances than same–age peers who did not report these feelings. In 7th grade, they are over twice as likely (22% vs. 10%, respectively, in 2006–08). The relationship between chronic sadness and substance use may be reciprocal, as substance users are more likely than nonusers to report mental health issues, with the differences increasing with the level and frequency of use (see CHKS Factsheet #11). For some of these students, substance use may reflect an effort to self–medicate untreated mental health issues.

Heavy substance users are disproportionately responsible for a wide range of problems within schools that can interfere with the ability of other students to learn (Austin, Skager, Bailey, & Bates, 2007).

The CHKS contains a wide range of questions that help shed light on the level of heavy, regular, or high–risk patterns of substance use, and their adverse effects on the mental health and education of the individual student, as well as the overall school environment. Section 9 provides data on school services to meet the needs of substance users.

HEAVY PATTERNS OF USE
CHKS TABLES A4.3–6, 12, 18, 19

To assess the level of heavy alcohol and drug use that is currently occurring among students, pay particular attention to the following indicators:

- Current (in the past 30 days) binge drinking (five or more drinks of alcohol in a row) (Table A4.7).
- Weekly alcohol or marijuana use (in three or more of the past 30 days) (Table A4.4).
- Current use of drugs other than marijuana and polydrug use (simultaneous use of alcohol and drugs or two or more drugs) (Table A4.3).
- Lifetime frequency of being drunk or intoxicated on drugs (Tables A4.5–6).
- Liking to get drunk or usually getting very high on drugs (Tables A4.8–9).
- Current use at school and lifetime frequency of attending school high on drugs or alcohol (also an indicator of school disengagement and risk taking in general) (Tables A4.12–13).

The percentage of students who use substances on school property or attend school high/drunk is an especially important indicator as it reflects not only a high level of AOD use, but active disengagement from school and a willingness to engage in risk–taking behavior (e.g., getting caught and punished at school).

To gauge the relationship between substance use and mental health, Austin et al. (2007) analyzed the prevalence of chronic sadness/hopelessness among three groups of users: (a) heavy users (binge drinkers and high–risk drug users); (b) more conventional or occasional users of alcohol and other drugs; and (c) nonusers. Chronic sadness or hopelessness increased in a linear fashion as AOD involvement increased. For example, in 9th grade:

- Chronic sadness was reported by 61% of high–risk drug users, 36% of occasional users, and 24% of nonusers. Compared to nonusers, chronic sadness was 2.5 times higher in the high–risk group.
- Chronic sadness was reported by 51% of binge drinkers, 42% of occasional current drinkers, and 27% of nondrinkers.

According to the Center for Addiction and Substance Abuse, binge drinkers between the ages of 12 and 17 are more than twice as likely to report that they have contemplated suicide, with teen alcohol–related suicide costing an estimated $1.5 billion annually.[36]

USE–RELATED PROBLEMS AND DEPENDENCY INDICATORS
CHKS TABLES A4.18–19

To shed light on the impact of heavy use, the CHKS asks high school students whether their use of alcohol or other drugs had *ever* caused them to experience: (a) any of 11 health, legal, academic, or psychosocial problems (Table A4.18); or (b) any of 11 indicators of dependency, which were drawn from criteria established by the American Psychiatric Association (Table A4.19). These questions are particularly helpful for exploring the association between substance use and mental health and estimating intervention program need.

The use–related problem that is the second most reported by high school students (after forgetting what happened or pass–

35 Austin, Skager, Bailey, & Bates, 2007; Austin & Skager, 2008.

36 Center on Addiction and Substance Use, 2003.

ing out after use) is "problems with emotions, nerves, or mental health," by 8% of 9th graders, and 10% of 11th graders in 2008–10.

The percentage of students who report two or more problem or dependency indicators is a gauge of how many students may need immediate intervention. Although such self–report is likely an underestimation of the level of problem/dependency risk, the CHKS results statewide are still disconcerting. About 10% of 9th graders and 15% of 11th graders reported two or more use–related problems as well as two or more dependency indicators.

What is more, there is a strong correlation between these measures and mental health. Ninth graders who report chronic sadness, compared to other students, are almost three times as likely to report two or more use–related problems (17% vs. 6%) and two or more dependency indicators (16% vs. 6%).[37]

The pattern of responses further suggests that youth who are chronically sad or hopeless may be using substances in order to escape difficult thoughts and emotions. Chronically sad students were three times more likely to report they: (1) didn't like the way they felt when not high on drugs or drunk, (2) use when alone, and (3) that their use interferes with normal activities (e.g., going to school, working, or doing recreational activities or hobbies).

To help determine whether students ever took action to address concerns over the AOD use, the dependency indicators provide data on whether students talked with someone about stopping or reducing use and whether they attended counseling, a program, or group to help stop or reduce use.

37 WestEd, 2011.

CESSATION EFFORTS AND PERCEIVED NEED FOR HELP
CHKS TABLES C11–13

Schools that report a high level of heavy or problematic substance use among students should also administer the supplementary AOD Use and Violence Module to them. This module includes four questions designed to better gauge student intervention needs by providing data on:

- How many times have students tried to stop or quit using: (1) alcohol or (2) marijuana? (Tables C11–12)
- Whether students *ever* felt that they needed help (such as counseling or treatment) for (3) alcohol *or* (4) other drug use? (Table C13)

STAFF PERCEPTIONS OF ADVERSE IMPACT OF SUBSTANCE USE ON THE SCHOOL
CSCS TABLE 6.7

The level of substance use, particularly use at school, should be compared with staff perceptions of how much substance use poses a problem to the school. Not surprisingly, as substance use increases with student age, so too does the perception that it is a problem. Use of alcohol and drugs were perceived as a moderate–to–severe problem by a negligible percentage of staff in elementary schools and by only 16% of staff in middle school, but by 50% in high school. Endorsements rose again for continuation high schools, reaching 68%. For high school staff, alcohol and drug use were in the top three of fourteen potential student–related problems, exceeding all safety, violence, and victimization indicators.

6 RISK OF DEPRESSION & SUICIDE

The two items in the CHKS Core Module that most directly relate to mental health assess the prevalence of: (1) secondary students who experienced incapacitation because they felt chronically sad or hopeless; and (2) high school students who contemplated suicide. To compliment the student reports, the CSCS asks school staff how serious they believe student depression and mental health problems are at the school.

Schools that experience high percentages on any of these questions should consider administering to students the supplementary follow–up questions related to suicidal behavior discussed below. Schools should also analyze the CHKS dataset to determine the characteristics of students who report these experiences to determine if specific groups are at higher risk than others. District and/or school–based Student Support Teams must explore the potential underlying causes for the data and design targeted prevention and intervention efforts.

As a further aid to CSBMH program development, statewide reports are available on the CHKS website that disaggregate all the CHKS results as reported by students who have experienced chronic sadness/hopelessness or contemplated suicide compared to students who have not reported these conditions. In addition, two CHKS factsheets (numbers 11 and 12) summarize and analyze the key results in these reports.

CHRONIC SADNESS/HOPELESSNESS
CHKS TABLE A6.8

Major Depressive Disorder is estimated to affect approximately 4% to 6% of teenagers ages 13 through 18, and 2% to 3% of youth under age 13 (Costello, Erkanli, & Angold, 2006; Hammen & Rudolph, 2003). In a large U.S. sample, 9% of adolescents reported moderate to severe depressive symptoms with females, older adolescents, and ethnic minority youths reporting higher levels of depressive symptoms than their counterparts (Rushton, Forcier, & Schectman, 2002). Early vulnerability to depression is predictive of recurring depression in adulthood with serious consequences if not detected and treated.[38]

Signs of depression change as youth move from early childhood to adolescence. Young children frequently show signs of depression through their outward appearance, including appearing disheveled and underweight, and through physical complaints such as stomachaches and headaches (Merrell, 2001). They also tend to demonstrate more disruptive and irritable behavior than adults (Kashani, Holcomb, & Orvaschel, 1986).

Adolescents with depression tend to be more withdrawn, which may include disinterest in activities that previously brought pleasure, slow physical movement, and sleep disturbances (Carlson & Kashani, 1988).

Depression interferes with normal developmental processes and functioning, including compromised educational, social, and emotional outcomes. Depressed adolescents tend to express hopelessness and have negative thoughts and attitudes (Garber, Weiss, & Shanley, 1993). Depressed youth may get into trouble with alcohol, drugs, or sex; have trouble with school or grades; or have problems maintaining relationships with family or friends. Substance abuse, eating disorders, self–injury, and suicide have been linked to childhood and adolescent depression (Fleming & Offord, 1990; Merrell, 2001). More than 60% of children and adolescents with depression have considered suicide (Kashani et al., 1987) and rates of completion have risen in the recent decade (Lubell et al., 2007).

Identification of adolescents who are at–risk of experiencing significant episodes of depression is the foundation for developing a system of appropriate referral and treatment options, including supports for social and academic performance. The *California Strategic Plan on Suicide Prevention* stresses that one of the important strategies is to address early signs of loneliness and depression.

On the CHKS, as an indicator for the risk of depression, secondary school students are asked whether, during the past 12 months, they felt so sad or hopeless almost every day for two weeks or more that it interfered with their interest in their normal activities[39] One–third of traditional secondary students in California report having experienced such chronic sadness/hopelessness. As summarized in CHKS Factsheet 11, these youth are at elevated risk for poor academic achievement, low school connectedness and perceived safety; for truancy and substance use; and for experiencing school violence and victimization. In 7th grade, they were about twice as likely to be truant (31% vs. 17%), to be low in school connectedness (17% vs. 9%), to feel unsafe at school (16% vs. 7%), to have been harassed or bullied at school (47% vs. 25%), and to be current users of alcohol (22% vs. 11%) and marijuana (9% vs. 4%).

Consistent with national reports, rates of chronic sadness among California students are higher among three groups: (1) females than males (WestEd, 2011); (2) students of color than Whites (with the exception of Asians) (CHKS Statewide Results by Race/Ethnicity, 2008–10); and (3) youth in foster care or living with a relative, compared to youth living with a parent(s) (CHKS Factsheet #6). Rates of chronic sadness are also higher among youth who have experienced harassment and bullying (CHKS Factsheets 4 and 10) and among substance users (Austin et al. 2007). Moreover, chronically sad students are much less likely than others to experience developmentally supportive school environments that promote school connectedness and positive academic outcomes (see Section 6).

STAFF PERCEPTIONS OF STUDENT MENTAL HEALTH
CSCS TABLE 5.8

The CSCS provides data on the degree to which school staff perceive that student depression or other mental health problems was a problem at the school. Statewide, the percentage of staff indicating that it is a moderate–to–severe problem rises from 13% in elementary school to 31% in high school. It jumps again to 51% in continuation schools. This item exposed one of the largest differences in problem severity rates between traditional and continuation high schools out of the 14 school–problem indicators (along with drug and tobacco use). These data underscore the urgency of the need to support mental health problems in high schools.

SUICIDE IDEATION
CHKS TABLE A6.9

In the 2009–10 school year, a question was added to the CHKS Core Module that asked high school students if they had ever seriously considered attempting suicide in the past 12 months. Alarming statistics on suicidal behavior in youth made the addition of this item compelling. For example, in 1997, 1.5 times as many people died as a result of suicide than as a result of homicide. Past history

38 Until the early 1980's childhood depression was not a recognized mental health disorder because many mental health professionals did not feel that children were emotionally mature enough to feel a true depression. Recently, childhood depression has received much attention and is believed to be so serious a problem that the World Health Organization has predicted that by the year 2020 depression will be the second leading cause of impairment in work and home life (World Health Report 2001, available at www.who.int/whr/2001/en/whr01_ch2_en.pdf).

39 This question was derived from the Center for Disease Control and Prevention's Youth Risk Behavior Survey is used nationally. Related questions ask about experiencing problems with "emotions, nerves, or mental health" or not doing usual activities because of alcohol or drug use (see Section 2.2 below).

of suicide attempts is a critical risk factor for eventually committing suicide.[40] The incidence of suicide attempts reaches a peak during mid–adolescence, with mortality from suicide increasing steadily through the teens.[41] While the suicide rate for the general population has remained stable since 1950, it has increased by more than 300% among adolescents 15 to 19 years of age. Much of this increase may have resulted from more accurate reporting of the cause of death,[42] but this does not negate the troubling reality that suicide is now the third leading cause of death among adolescents aged 15 to 19.[43]

Nationally, the annual rate of suicide contemplation among high school students is 14%, and just under half of these students (6% of total sample) actually made one or more attempts (Eaton et al., 2010). According to the National Household Survey on Drug Abuse (SAMHSA, 2000), of the nearly 3 million youth 12 to 17 years of age who engaged in suicidal ideation, 37% actually attempted suicide.

CHKS data for 2009-10 indicated that with this item 18% of secondary students in the state have seriously contemplate suicide in the past 12 months. CHKS Factsheet #12 shows that these youth are already at elevated risk of a wide range of educational, health, social, and emotional problems. These problems include lower school attendance, performance, and connectedness, and greater likelihood of substance use, having been victimized at school, and experiencing chronic sadness or loneliness, an indicator of risk of depression. These youth also report lower levels of the developmental supports that have been shown to mitigate these problems in their schools and communities — a deficit that may contribute to their problems.

SUICIDAL BEHAVIOR
CHKS TABLES C28–29

In addition to the suicide contemplation item on the Core Module, the CHKS Supplementary Module C on AOD Use and Violence includes three questions assessing the degree to which high school students moved from thinking about suicide to ever planning, attempting, or being injured in a suicide attempt in the 12 months prior to the survey.[44] Middle school students are similarly asked whether they had *ever* thought out, made a plan, or tried to kill themselves. If a student reports not just considering suicide but making a plan, the risk for suicide is much greater. The level of risk in having made a plan is similar to that of verbal communication of intent to commit suicide, one of the best predictors of attempted suicide.[45] A past history of suicide attempts is another critical risk factor for suicide completion.[46] If a high proportion of a schools' students report suicide contemplation, school–based mental health professionals must be *immediately* consulted to determine the best course of action to take.

40 Nordstroem, Asberg, Asberg–Wistedt, & Nordin, 1995.

41 U.S. Department of Health and Human Services, 1990.

42 Males,1996.

43 Hoyert, Arias, Smith, Murphy, & Kochanek, 2001.

44 These questions were derived from the Centers for Disease Control and Prevention's Youth Risk Behavior Survey.

45 Maris, 1992; Shea, 1998.

46 Nordstroem et al., 1995.

7 SCHOOL CONNECTEDNESS

CHKS TABLE A3.1; CSCS TABLE 5.1

In determining what steps schools should take to promote greater mental well–being, one of the most logical and natural is to foster higher levels of school connectedness or engagement, which the National Research Council (2004) considered a fundamental, often overlooked, challenge to school reform efforts. Children feel *connected* to school when they feel personally engaged within the school environment. Connected children feel safe, valued, respected, and supported by adults at school (Goodenow, 1993). The degree to which students feel personally connected to their schools has been linked to attendance, performance, and graduation (Loukas, Suzuki, & Horton, 2006; Wentzel 1999; Blum & Libbey, 2004), but also a wide range of health (both physical and social–emotional) outcomes:

- Lower rates of emotional distress, including symptoms of depression and anxiety, both in the short–term and long–term (Shochet, Dadds, Ham, & Montague, 2006).
- Lower rates of tobacco, alcohol, and other drug use (Bond et al., 2007) and involvement in health risk behaviors in general (Dornbusch, Erickson, Laird, & Wong, 2001; Resnick et al., 1997).
- More positive peer relationships, including the perception that peer relationships in the school are positive, supportive, and low in conflict (Loukas, Suzuki, & Horton, 2006).47

47 See also Anderman, 2002; Blum, 2005; Centers for Disease Control and Prevention, 2009.

School connectedness has also been found to buffer some of the adverse consequences of early risk factors, such as negative family functioning (Loukas, Roalson, & Herrera, 2010) and weak social skills in childhood (Ross, Shochet, & Bellair, 2010).

The CHKS reports include the percentage of students that are categorized as having high, medium, or low levels of school connectedness on a five-item scale derived from the National Longitudinal Study on Adolescent Health (Add Health). This scale assesses how close students feel to people at the school, how happy they are to be at the school, if they feel a part of it, and if teachers treat students fairly.

Less than half of California secondary students are categorized as high in school connectedness. These alarming data underscore the importance of engaging youth at school in order to promote mental health. Community-based mental health agencies also need to support children and adolescents' connection to school as a mental health promotion strategy.

In addition, the CSCS asks staff how much they agree that students at their school are motivated to learn, an indicator of staff perceptions of how well connected and engaged in learning to students are at the school (CSCS Table 5.1). The percentage reporting this was true of most or nearly all students declines from 69% in elementary schools to 45% in high schools.

As discussed in Section 8, the CHKS also measures three developmental supports that help promote both school connectedness and mental well-being. These findings strongly support the need to move away from the false dichotomy between mental health promotion and school reform. Schools that create learning conditions that are safe and supportive and promote school connectedness not only improve student academic performance but also foster positive mental health. School connectedness, academic achievement, positive school climates, and mental health are all intertwined.

8 STUDENT DEVELOPMENTAL SUPPORTS & INTERNAL STRENGTHS

A major focus of both the CHKS and CSCS is measurement of the extent to which schools and communities provide students with three fundamental developmental supports that are linked to resilience and positive academic, social-emotional, and health outcomes even in the face of high-risk environmental conditions:

- caring, supportive adult relationships;
- messages that communicate high expectations for success; and
- opportunities for meaningful participation and contribution.

The CHKS Resilience and Youth Development Module (RYDM) further assesses the level to which: (1) the home and peer environment provide these supports; and (2) students possess the internal strengths that characterize youth who are resilient and who succeed in school and life. Staff are also asked about the level to which the school provides services related to youth development and their own professional development needs.

THREE PRINCIPLE DEVELOPMENTAL SUPPORTS
CHKS TABLE A3.1

School efforts to promote mental health, physical and emotional safety, and school connectedness should begin by fostering school climates rich in caring relationships, high expectations, and meaningful participation. Within the developmental supports model, the focus of intervention is on amplifying these elements in the environment, rather than "fixing" individual children. These developmental supports, each of which is supported by resilience research, are assessed within the CHKS Core Module in regard to the school and community environments. They constitute among the most effective universal health promotion and prevention strategies that a school can implement (see Figure 2), and have also been linked to school connectedness and positive academic outcomes.

Central to mental health is the trait of resilience, considered an innate capacity necessary for healthy development. In a broad sense, resilience is the ability to rebound from adversity, but it is also the ability to achieve healthy development and successful learning under any circumstance. Resilience research has shown that young people who experience school, community, home, and peer environments rich in these developmental supports are more likely to develop the individual characteristics, or internal strengths, that are associated with physical and mental health and successful learning. These youth are less likely to be involved in those risk-taking behaviors, such as substance abuse and violence, that are known barriers to learning.[48]

These three developmental supports promote a sense that adults at school are caring individuals who are invested in the success of all students. They have been associated across multiple studies with positive academic, health, and psychosocial outcomes, including that sense of deep *social connectedness* that research

48 Werner, 1993; You et al., 2008; Benard, 2004.

has identified as a powerful protective factor (see Section 7). They are central to the promotion of both mental health and school connectedness.[49] Together, these are the lynchpins of a positive school climate.

The CHKS reports the percentage of youth who are categorized as high, moderate, or low in each of these three supports. It also provides a summary Total School Supports score. Just over one-third of secondary students do *not* experience high levels of caring adult relationships or high expectations; and over half are *not* classified as high in opportunities for meaningful participation.

Regarding mental health promotion, CHKS data reveal that students who report incapacitating, chronic feelings of sadness/hopelessless are less likely to report having high levels of these developmental supports in their schools when compared to other students. Among 7th graders, 28% of sad/hopeless students had high levels of total supports in the school environment, compared to 37% of their peers. A similar gap was reported for students in the 9th grade (CHKS Factsheet #11).

DEVELOPMENTAL SUPPORTS IN THE HOME AND PEER ENVIRONMENTS
CHKS TABLE B.1

The supplementary RYDM (CHKS Supplement B) assesses these same three developmental supports in the home environment and peer group. These data can help engage parents in a discussion of what they can do to create home environments that foster mental health as well as school success. The peer-related questions help determine the degree to which youth associate with prosocial peers, an important protective factor and influence on academic performance.

STUDENT INTERNAL STRENGTHS
CHKS TABLE B.1

The supplementary RYDM also includes multi-item scales measuring six internal assets (i.e., resilience traits) that are consistently described in the literature as being associated with positive development, mental health, and successful learning. These internal strengths, described in detail in the *CHKS Survey Content Guide*, are: cooperation and communication, self-efficacy, empathy, problem solving, self-awareness, and goals and aspirations.

Children who have access to more environmental supports tend to report having more internal strengths. In fact, in 2007-2009, 94% of students classified as *high* in total school supports were also *high* in total internal strengths. Only 65% of those classified as *moderate* in school supports, and 37% of those classified as low in school supports, were *high* in internal strengths.

Positive school climates foster the development of these internal assets. Schools focusing on improving climate and student mental health should administer the full RYDM in order to assess developmental supports within the home and peer environments and to monitor progress in improving them.

STAFF PERCEPTIONS CONCERNING SCHOOL DEVELOPMENTAL SUPPORTS
CSCS TABLES 3.1–9

Drawing on the questions asked of students in the CHKS, the CSCS assesses staff perceptions of the degree to which they believe staff within their school have caring relationships with students (staff care about students, acknowledge/pay attention to them, and listen to them), and have high expectations for their success (wanting students to do their best, believing they can succeed).[50] Related to caring, staff are also asked about treating students fairly. These results can be compared to the student data to determine how consistent staff perceptions are to student experiences (Table 3.1-3.9).

CSCS staff data suggest that as students move from elementary to high school settings the relationships within school environments becomes less caring and supportive, and adults provide fewer messages that communicate expectations for success. Austin and Bailey (2008) report that the percentages of school staff endorsing that *nearly all* adults at the school had caring relations and high expectations with students declined by about half between elementary and high school. Only about one-fifth of high school staff reported that *nearly all* adults at the school treated students fairly, listened to what they had to say, or believed every student could be a success. Only about one-third reported that staff acknowledged/paid attention to students or really cared about them. Finally, less that half reported that *nearly all* adults wanted all students to do their best.

STAFF PROFESSIONAL DEVELOPMENT AND SCHOOL POLICY
CSCS TABLES 3.10, 8.4–5

The consistency of staff and student reports around developmental supports suggests a need for ongoing professional development and systemic efforts to improve youth development in schools. In fact, CSCS data suggest that staff members, particularly those working in high schools, are interested in knowing more about how to meet the social, emotional, and developmental needs of youth.

The CSCS asks staff how much they agree that the school:

- » Fosters youth development, resilience, or asset promotion (Table 8.5).
- » Emphasizes helping students with their social, emotional, and behavioral problems (Table 8.4).
- » Meets the professional development needs of staff in addressing the social, emotional, and developmental needs of youth (Table 3.10).

49 Battistich, Solomon, Watson, & Schaps, 1997; Resnick et al., 1997; Solomon, Watson, Battistich, Schaps, & Delucchi, 1996; Solomon, Battistich, Watson, Schaps, & Lewis, 2000.

50 These are the same three variables that constitute the CHKS Student Caring Adult Relationships scale and two of the three variables on the High Expectations scale.

Only 23% of elementary school staff and 14% of high school staff felt their school fostered *a lot* of youth development, resilience or asset promotion. Moreover, half of staff report they need more professional development in meeting the social, emotional and developmental needs of youth.

9 STUDENT SERVICES & STAFF SUPPORTS

The CSCS contains a wealth of other information about the supports, services, and policies that schools should implement in order to meet the mental health–related needs of students and staff. They fall largely into these areas:

- Substance use and violence prevention efforts;
- The staff working environment; and
- Special education supports.

SPECIAL EDUCATION SUPPORTS
CSCS TABLES 2.16; 8.11; 9.1–25

Two questions in the core CSCS section ask all staff to assess the level to which their school provides: (1) services for students with disabilities or other special needs (Table 8.11); and (2) meets the professional development needs of staff in serving special education students (Table 2.16). About half of staff report that they need more professional development in providing services to special education students and just over half reported their schools provided a lot of services for these students.

The survey also includes a Special Education Supports Module, which includes items to be answered by those staff members responsible for working with students with Individualized Education Programs (IEPs). These items were developed to ascertain how well the school is doing in meeting students' with special education needs, as well as the needs of the staff who serve them. Starting in 2008, schools that participate in the CSCS receive supplemental reports disaggregating all their survey results between staff who self–identified they had special education responsibilities compared to those that did not.

It is important to note that many students who are not eligible for special education supports for mental health are still eligible for accommodations as qualified handicapped persons, as that term is defined in regulations promulgated by the United States Department of Education pursuant to Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. Sec. 794). Although children with exceptional needs, as that term is defined in *California Education Code* Section 56026, have a different delivery system available to them in their IEPs, both groups of students need to have their mental health needs served. Also, students may have temporary disabilities due to mental or emotional disabilities incurred while enrolled in school which qualifies them for Home and Hospital Instruction (pursuant to *EC* Section 48206.3). A temporary disability is defined as a "physical, mental, or emotional disability incurred while a pupil is enrolled in regular classes or an alternative education program, and after which the pupil can reasonably be expected to return to day classes or the alternative education program without special intervention." Section 48206.3 also specifies: "A temporary disability shall not include a disability for which a pupil is identified as an individual with exceptional needs pursuant to Section 56026." Although it is important to recognize these types of mental health disabilities, the type of disability should not preclude a student from garnering the additional mental health support needed for his or her education.

SUBSTANCE USE AND VIOLENCE PREVENTION SERVICES
CSCS TABLES 8.2–3, 12–17, 21–24

Section 9 of the CSCS report summarizes the results for the Learning Supports Module, which assesses services and practices related to a wide range of health and well–being indicators. These items are only asked of staff who have responsibilities for prevention and health programs, safety, and/or counseling. The majority of these questions deal with the scope and nature of services and supports related to student substance use and safety, including:

- Whether the school provides confidential student referral services for problems and collaborates with the community in addressing student needs (Tables 8.2–3);
- Whether the school considers substance use prevention an important goal, has sufficient prevention resources, and provides prevention instruction (Table 8.17, 21–22); and
- The level to which the school has sufficient resources and the scope and nature of services, policies, or practices related to behavior management (discipline), safety, violence, and bullying (Tables 8.12–20, 24).

Statewide CSCS results show that while the most serious risk behaviors — especially violence and substance use — increase as students age, services and resources to address these problems stabilize or even decline. Only one–fifth of secondary staff practitioners strongly agree that their school provides effective confidential support and referral services for students needing help due to substance abuse, violence or other problems.

STAFF WORKING ENVIRONMENT AND SUPPORTS
CSCS TABLES 2.6–10

Nine CSCS questions are particularly relevant for gauging staff mental health and their perceptions of school climate as it relates to job satisfaction and performance:

- The level to which staff agree the school: (1) is a supportive and inviting place for staff to work; (2) promotes trust and collegiality among staff; (3) is a safe place for staff; (4) provides staff resources and professional development to do their job effectively; and (5) promotes personnel participation in decision–making that affects school practices and policies (Tables 2.6, 9, 11, 18; 9.13)?
- How many adults at the school: (1) have close professional relationships with one another; (2) support and treat each other with respect; and (3) feel a responsibility to improve the school (Tables 2.7–8, 10)?
- How serious a problem is lack of respect of staff by students at this school (Table A6.7)?

School mental health services should not be focused on students alone. Equal emphasis should be placed on efforts to foster school environments that promote the physical and mental health of the staff. Fostering a healthy, safe, caring, participatory, challenging, and supportive school environment is just as relevant to teacher motivation, performance, and retention as it is to students' (National Research Council, 2004). Systematic improvements in school environments, including improvements in mental health programs, services and professional development, can also improve conditions for teachers. Teacher perceptions of positive school climate are related to:

- Greater willingness to implement new curricula and interventions[51];
- Decreased reports of burnout[52];
- Greater levels of job satisfaction[53]; and
- Increased teacher retention.[54]

Among the host of reasons to support staff wellbeing is that California and the nation are facing a major crisis in low teacher retention. The average national teacher turnover rate is 17%, with almost half of new teachers leaving the profession within five years. In California, 22% of new teachers quit within four years. In a survey of California teachers, Futernick (2007) found that they were less concerned with compensation (though this was still important) than with a whole range of particulars about the teaching and learning environment that are related to mental health, including safety, inter–staff relationships and expectations, and participatory opportunities. Dissatisfied teachers, particularly in high–poverty schools, cited lack of support, meaningful participation, and collegiality, as well as unclean and unsafe environments as reasons for leaving the profession. Among those who stayed, the quality of staff relationships (mutual supports) and opportunities to participate in decision–making at the school were endorsed as the most important considerations for staying. In other words, the same developmental supports and school climate factors that influence student connectedness and positive academic and health outcomes also influence staff engagement in the profession.

Adding to the stress that teachers may feel in meeting academic accountability demands are feelings of frustration and perhaps helplessness when faced with the disruptions to learning and classroom discipline that often result from students' unmet mental health needs. In fact, Moir and Gless (2001) found that new teachers working in classrooms with a larger percentage of students with behavior problems are much less likely than their peers to report a good first–year teaching experience, to plan to continue teaching, and to plan to remain in the same school.[55] When barriers to instruction are removed, both students and teachers benefit. For example, effective Section 504 accommodations related to a mental health disorder benefit both the teacher and the student by removing barriers to instruction which impact academic achievement, absenteeism, and behavioral problems in the classroom.[56]

Moreover, teachers cannot be expected to effectively provide the mental health supports that students need when their own sensitive mental health needs are not being met. The foundation of a positive, health–promoting school climate for students rests on a positive, health–promoting school climate for staff.

51 Beets et al., 2008; Gregory, Henry, & Schoeny, 2007.

52 Grayson & Alvarez, 2008.

53 Lee, Dedrick, & Smith, 1991; Taylor & Tashakkori, 1995.

54 Kelly, 2004; Loeb, Darling–Hammond, & Luczak, 2005; Weiss, 1999; see Guarino, Santibanez, & Daley, 2006, for review.

55 Roeser & Midgley, 1997; Williams, Horvath, Wei, Van Dorn, & Jonson–Reid, 2007; Anderson–Butcher, 2006; Burke & Stephan, 2008; Weston, Anderson–Butcher, & Burke, 2008.

56 Section 504 of the Rehabilitation Act of 1973 is a national law that protects qualified individuals from discrimination based on their disability. The nondiscrimination requirements of the law apply to employers and organizations that receive financial assistance from any Federal department or agency. Section 504 forbids organizations and employers from excluding or denying individuals with disabilities an equal opportunity to receive program benefits and services. It defines the rights of individuals with disabilities to participate in, and have access to, program benefits and services.

10 CONCLUDING REMARKS

Building and sustaining healthy school environments that support the mental health needs of children and youth requires that collaborative teams within schools understand their CHKS/CSCS results, appropriately use their results to select targets for implementation for prevention and intervention activities, and make critical decisions about how to allocate resources. This guidebook provides essential information to guide these collaborative teams as they attempt to discern the meaning of complex student and staff data reports.

Although this guidebook was not meant to provide specific recommendations for prevention and intervention, several overarching best practices have been outlined throughout. First, schools must adopt a comprehensive approach to identifying and addressing the mental health needs of their students. To support the mental health of all students, schools must create and maintain healthy, supportive environments characterized by the absence of incivil behavior and substance use and the flourishing of positive, meaningful relationships. Furthermore, selecting target areas for prevention and intervention efforts is facilitated through the careful surveillance of student mental health-related risk behaviors and protective factors using the Cal-SCHLS suite of surveys.

For more in-depth reviews of prevention and intervention programs and curricula, please contact the CDE Educational Options, Student Support and American Indian Education Office.

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APPENDIX A. KEY CHKS ITEMS ASSESSING STUDENT MENTAL HEALTH (2010/11)

Core Module

VARIABLE	REPORT TABLE NUMBER	SURVEY ITEM NUMBER
SOCIAL/EMOTIONAL WELL–BEING		
Felt so sad or hopeless almost everyday for two weeks or more that you stopped doing some usual activities, past 12 months	A7.2	HS A123/MS A105
Seriously considered attempting suicide, past 12 months	A7.3	HS A124
SCHOOL SAFETY AND VICTIMIZATION		
Felt safe/unsafe at school	A6.10	HS A119/MS A101
Harassed or bullied, especially for bias(hate)–related reasons (i.e., race/ethnicity, religion, gender, gay/lesbian, physical or mental disability), past 12 months	A6.7	HS A113–118/ MS A.95–100
Verbally harassed (had rumors/lies spread; sexual comments etc.; made fun of because of looks/way talk)	A6.1	A103–105/ MS A85–87
Been afraid of being beaten up; Been pushed, shoved, past 12 months	A6.2	HS A100–101/MS A82–83
HEAVY, REGULAR, OR RISKY SUBSTANCE USE		
Frequent or risky current use (past 30 days): e.g., binge drinking, weekly alcohol or marijuana use (3 or more times), "hard" drug use, and polydrug use	A4.3–4, 4.7	HS A63, 65–71/MS A52,54–56:
Used at school past 30 days; ever drunk or high on drugs on school property	A412–13	HS A73–75/ MS A58–60; HS A55/MS A44:
Ever sick or drunk on alcohol	A4.5	HS A53/MS A42
Ever high from using drugs	A4.6	HS A54/MS A43
Use–related Problems: » Experienced two or more problems » Experienced problems with emotions, nerves, or mental health	A4.18	HS A90
Use–dependency Indicators: » Two or more indicators » Use of alcohol or drugs kept you from doing a usual activity (school, working, or doing recreational activities or hobbies) » Used alcohol or drugs when alone » Often didn't feel OK unless you had something to drink or used a drug	A4.19	HS A97
LEARNING ENGAGEMENT AND DEVELOPMENTAL SUPPORTS		
School Connectedness (degree feel close to people at school, happy at school, feel a part of it, and teachers treat students fairly)	A3.1	HS A11–15 MS A10–14
Truancy: Frequency skipped school or cut classes in the past 12 months	A2.7	HS A126/MS A.108
Developmental Supports and Opportunities in the School Environment: caring adult Relationships, high expectations, and opportunities for meaningful participation, plus Total School Supports. (Percentage high, medium, and low)	A3.1	HS A16–21/ MS A15–20

Supplementary Module B: Resilience and Youth Development Module

VARIABLE	REPORT TABLE NUMBER	SURVEY ITEM NUMBER
DEVELOPMENTAL SUPPORTS	B1	
Home and Peer Group		B19–33
INTERNAL RESILIENCE STRENGTHS (ASSETS)	B2	
Cooperation and collaboration		B8, 13, 14
Self–efficacy		B6, 7, 9
Empathy		B10, 11, 15
Problem solving		B14, 5, 12
Self–awareness		B16, 17, 18
Goals and aspirations		B1, 2, 3

Supplementary Module C: AOD Use and Violence

VARIABLE	REPORT TABLE NUMBER	SURVEY ITEM NUMBER
SUICIDE		
During the past 12 months, did you make a plan about how you would attempt suicide? (MS: ... make a plan about how you would like to kill yourself)	C29	HS C29 MS C15
During the past 12 months, how many times did you actually attempt suicide? (MS: Have you ever tried to kill yourself?)	C30, 32	HS C30 MS C19
If you attempted suicide during the past 12 months; did any attempt result in an injury, poisoning, or overdose that had to be treated by a doctor or nurse?	C31	HS C31

APPENDIX B. PROGRAM RESOURCES

School–based programs and services to meet the mental health needs of students range from basic support services provided by school counselors or other school personnel to specific, evidence–based, packaged programs (e.g., Second Step, Incredible Years, Reconnecting Youth, Project Success). Schools often implement a variety of strategies, programs or interventions focused at health promotion, universal, selected, and indicated levels of prevention, as well as treatment interventions. Often times these SMH programs are implemented unsystematically, as a response to environmental pressures or the availability of funding, rather than as part of a comprehensive support system. This appendix summarizes helpful resources related to identifying best practices.

Several compendia of evidence–based mental health programs and web–based resources, as well as journal articles and monographs, are available to inform mental health service providers and school district staff in their selection of programs. The following are the most frequently referenced and well–known listings, each of which provides lists of mental health programs with ratings of their scientific soundness:

- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Collaborative for Academic, Social, and Emotional Learning (CASEL)
- U.S. Department of Education (USDOE) Institute of Education Sciences: What Works Clearinghouse
- Prevention Research Center for the Promotion of Human Development at Penn State
- Center for the Study and Prevention of Violence (CSPV)
- Center for School Mental Health Assistance (CSMHA)
- UCLA Center for Mental Health in Schools

SAMHSA maintains a web–based National Registry of Evidence–based Programs and Practices (NREPP). Programs are rated by experts on 16 research criteria and classified into three categories: *Model*, *Effective*, or *Promising*. Programs listed in these compendia need to be reviewed by key stakeholders (e.g., district and school administrators, academics, parents, clinical service providers) to ascertain that the target population addressed by the program is a "good fit" with the local context and its resources. Aspects of the local context that should be considered include the specific types of presenting problems (e.g., substance abuse, violence, mental health disorders) and subgroups of students (e.g., age, ethnicity) needing services.