To the Graduate Council:

I am submitting herewith a dissertation written by Jama M. McDonald entitled "An Evaluation of Project B.A.S.I.C." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Education.

Jerry J. Bellon, Major Professor

We have read this dissertation and recommend its acceptance:

Robert Z. Williams

Donald J. Dickinson

R N. Laudyn

Accepted for the Council:

Associate Vice Chancellor and
Dean of The Graduate School

AN EVALUATION OF PROJECT B.A.S.I.C.

A Dissertation

Presented for the

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Degree

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Jama M. McDonald

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ABSTRACT

The purpose of this study was to evaluate Project B.A.S.I.C., a school-based prevention/mental health promotion program which serves K-3rd grade students. The Child Development Specialist (CDS) conducts the program in the assigned school and is responsible for mental health education, early intervention, teacher consultation, and school climate enhancement. The program has been in the state of Tennessee since 1985, serves 16 schools, and has not been subjected to a formal evaluation.

The program evaluation used both qualitative and quantitative data collection methods. The qualitative data collection were conducted through semi-structured interviews. The data sources for the qualitative data collection were 30 interviews with teachers and principals from 6 schools served by Project B.A.S.I.C. Also, data were collected from 8 interviews with 6 CDSs and 2 program administrators. The information from the interviews was subjected to a content analysis to determine any themes. The quantitative data collection consisted of 3rd and 4th grade teacher-ratings of students from 6 schools served by Project B.A.S.I.C. and 5 schools not served by Project B.A.S.I.C. The teachers were asked to rate the students on measures of coping, school

problems, student competencies, achievement, behavior, and social skills. The quantitative data were subjected to a MANOVA to determine any significant difference between the experimental and control groups. Within the experimental group, students who received individual program services versus those students who did not, and 3rd and 4th grade students were also subjected to a MANOVA to determine any significant differences.

Qualitative results described the program's purposes, resources, activities, outcomes, and changes needed. The findings were fairly consistent with the program's stated goals and objectives. Quantitative results showed significant differences between the experimental and control groups in skills related to coping, shy and anxious behavior, frustration tolerance, assertiveness, and peer relations. Differences were also demonstrated for students who received individual services. No difference was demonstrated between 3rd and 4th grade students.

A conclusion drawn from the findings was that Project B.A.S.I.C. is having an impact but some modification of the goals is suggested. Other conclusions regarded accounting for any biases, continuing program evaluations, and facing challenges.

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CHAPTER ONE

INTRODUCTION

Introduction

Step One: What Is the Problem?

Often reported on television, in newspapers, on radio broadcasts, or through other media sources are the problems facing today's society. Unemployment, poverty, homelessness, violence, and drug abuse are a few of the terms that are being used to paint the dark picture of the issues presently troubling U. S. citizens.

Sadly, society is finding that the persons committing crimes are not subject to any age limitations. People seem to be coping with life situations at various ages by inflicting harm to others or themselves. For instance, a pre-adolescent shoots and kills a peer because he demonstrates disrespect toward him, a young mother kills her children so that she can continue a relationship with her lover, a man commits suicide eight years after a heroic and successful rescue of a child when he expresses concern and empathy toward rescue workers in a national tragedy, and the list continues.

In each of these cases the persons inflicting harm showed signs of needing help long before the last crisis occurred. Evidently, if support was given, it was neither timely nor effective. More often than not, the background of such persons

is tainted with a history of abuse, neglect, violence, and substance abuse, which are the issues concerning today's citizens. The present presidential administration promises to address these issues and concerns and have a positive impact on society through an emphasis on health care reform.

Step Two: What Can Be Done About It?

A reform in health care pledges to address the ails of society and offer treatment to those in need. This revolution is taking place and is capturing the attention and picking the pockets of many Americans. Not only can one hear health care discussed on news shows throughout the day but people on the city park bench and in the neighborhood beauty shops are also talking of the changes taking place.

The proposed changes are resulting in rejoicing as well as serious concern, because everyone will probably be affected by these changes. The health care providers seem to be showing the greatest concern, afraid that they are going to be taken advantage of financially and overrun with business. The everyday "Joe" and "Jane" are not exactly jumping out of their boots with joy over the changes, but their attention is captured and they are glad to see that some form of action is coming. Their hopes are that they will feel satisfied paying the expenses billed to them, because it will have gone toward quality care. Both recipients and providers just wish for things

to become more secure and certain, while leaving the confusion and uncertainty behind.

What Else Can Be Done?

Another promised emphasis included in health care is the concept of prevention. According to *The Tormont Webster's Encyclopedic Dictionary*, prevention means "a hindrance; an obstacle," which applied to health care would mean hindering or preventing problems from occurring.

During the Clinton administration, the public has watched and listened to President Clinton address the nation and give a general overview of the health care plan. Applause is generally heard when prevention is proposed to become a part of the long-term plan. Prevention appears to be something that everyone agrees is a solution to remaining healthy, but it seems to always be an afterthought in policy rather than a forethought.

Benjamin Franklin once said that "an ounce of prevention was worth a pound of cure." Apparently, he was aware of prevention's power even in the 18th century. And now, nearly three centuries later, prevention is again in the spotlight. Prevention could be the answer or a viable solution to problems of today's youth and families, especially in the area of mental health.

Mental health is often the "runt of the litter" when dealing with health care issues, because it is usually pushed aside or lowered on the list of priorities. Advocates of mental health support the inclusion of mental health in health care reform. The health care plan's provision of mental health services is seen as a positive step in restoring a healthy and vital nation.

Mental health linked with programs in prevention could have an impact on a vast number of aspects of any American's life. Physical health, productivity, kindness, and general wellness could all develop in a positive direction if accompanied by an individual's solid mental health. Prevention in mental health, through efforts to teach and build coping strategies, problem solving skills, and personal empowerment could have an impact on the psychological wellness of children and their families.

Past Experience

Roberts and Peterson (1984) report that prevention has been discussed in mental health since the 1920's, following public health's disease prevention emphasis since before the mid 19th century. Prevention has a history of being discussed and proposed in mental health, but it has rarely been taken seriously. In 1963, President Kennedy requested that prevention become a major part of the mental health field.

Community mental health centers however took the request lightly and lumped prevention under other nontreatment low priority mental health services (Roberts et al., 1984). Little funding, lack of reimbursement for preventive services, and lack of proof of its effectiveness also contributed to the inattention to the request.

Similarly, President Jimmy Carter recognized the value of prevention and the lack of involvement by the mental health field in few, if any, preventive efforts. Unfortunately, following the Carter administration, the threat of cutbacks in mental health programs further eroded the commitment of mental health centers to prevention. Even with the incorporation of various preventive methods from different fields, federal funding for prevention programs and prevention leaders are seriously limited (Price, Bader, & Ketterer, 1980). Implemented prevention programs usually lack support from the state, are in constant jeopardy in relation to funding issues and year to year continuation, and often fail because of these problems.

Preventive efforts are often viewed as temporary, placed as a low priority, and are consequently easily sacrificed to meet the demands for reactive, treatment-oriented, and clinical services. George Albee, an important researcher on prevention, calls attention to the fact that the number of persons with

psychological problems is greater than the number of persons receiving treatment (Roberts et al., 1984). Children, for instance, are greatly underserved in this population and are not identified until the problems have manifested. Prevention presents hope for these problems.

Step Three: Pick the Best Choice

A few of the numerous problems being faced by children and families today are spouse abuse, child abuse, drug and alcohol abuse, the lack of safety in their own homes or neighborhoods, developmental disabilities, mental illness, poverty, health problems, and other stressors present in family life. Most often these problems are linked to lower socioeconomic levels where limited finances produce feelings of helplessness, which serve as a catalyst for the outlook of other family members. When it is a common viewpoint that any effort is fruitless, adding more to the feelings of helplessness and hopelessness, depression often enters into the picture. Depression is likely for persons who have had a long history of life difficulties or have had a severe loss. They do not know how to deal with the situation or they deal with it in an unhealthy manner leading to treatment or rehabilitation. Severe depression is a mental illness that could be lessened through preventive efforts.

Prevention directed toward any mental illness aims to empower these persons as well as other individuals who are facing life struggles and to give them some sense of control over their lives, which is a positive link to physical and emotional well-being. Prevention also strives to show these individuals how to take notice of opportunities that signify when to take control and when to ask for help. Prevention in mental health is a positive alternative to the reactive orientation of mental health care which has "failed to resolve the serious human and societal problems it intended to address" according to Cowen, Hightower, Pedro-Carroll, and Work (1989).

Step Four: Try It Out

To be most effective, primary prevention should be targeted toward young children to build a base for them to grow and develop ways to deal with the problems they will face throughout their lives. The child who learns self-control, self-efficacy, coping abilities, awareness of others' feelings, and perceived autonomy is a child who will be able to deal with life changes and will continue to grow into a responsible well-adjusted adult. Cowen et al. (1989) recommend targeting young children for preventive programs because they are flexible, adaptable, and can be easily reached through the established educational institution of the public schools.

Currently, many fields are targeting schools for preventive campaigns toward drugs, pregnancy, violence, and high school drop outs rates. However, schools often find that there are many different persons coming into their schools for each of these efforts, which results in a lack of coordination, overlap of services, and often contradictory information. When asked, the prevention specialists who implement the programs express their wishes for more program coordination, funding, and job security to enhance their programs effectiveness. Not surprisingly, evaluation of these services is rarely done.

Step Five: See How It Works (The Missing Step)

What makes a good prevention program in the area of mental health? Berman and McLaughlin (1978) state that the amount of information available from research in the areas of developmental and community psychology gives substantial information to build programs that will benefit children. The problem arises, however, when the theory behind the idea is strong but the implementation of the prevention program is weak.

Often the persons carrying out the prevention program are more focused on just presenting the material than on making sure that the program is working. An agency gets the funding and the program is carried out by the "try it and hope" method assuming that the program, while supported by

research, will generalize to all contexts and situations with few modifications (Stolz, 1984). Implementing a solid prevention program depends not only on the validity of the material, but also on the parent and receiving organizations' functioning (Schmuck, Runkel, Arends, & Arends, 1977), program planning, and evaluation for successful implementation (Hall & Hord, 1987).

Through a perusal of the literature, one finds that the theory of prevention research is plentiful; however, the research directed toward formal evaluation procedures of successful prevention programs appears to be lacking, although evaluation is always recommended. This is a problem that can be measured by counting the number of so called "prevention programs" that have been short-lived, discontinued, or are suddenly without funding. According to Elias and Weissberg (1989), monitoring of a successful prevention program's goals over time is a necessary component for the development, replication, and continuity in the field of primary prevention. Successful and long-lasting prevention programs appear to be those that include methods for program evaluation within the implementation.

Statement of the Problem

In the state of Tennessee, several prevention or early intervention programs under the Children's Plan were implemented in 1991 to decrease the numbers of children in state custody, to prevent inappropriate placement, and to prevent juvenile delinquency. Wraparound services, such as Home Ties, Assessment, Care, and Coordination Teams (ACCT), and Intensive Case Managers are programs provided within the past few years in the Children's Plan through the Family Preservation Act.

Although these programs seem beneficial and worthwhile, their efforts (while called preventive) can be considered as early intervention or secondary-tertiary prevention, because they are made available when a problem has escalated to the point that the child is at-risk for immediate removal from the home and subject to an alternative placement. Informal interviews with persons who work under these wraparound services have revealed that the process and coordination between these related services is not clear to the workers and that the services are frequently renamed and reorganized (which is typical for these types of programs).

Many of these programs are currently in jeopardy because of the increase of children being identified with

problems. It also seems that the children and families become dependent on the crisis intervention and are not committed to following the program recommendations. In the long run, these programs promise to intervene before serious problems arise and thus to save tax payer money, but presently the problems are shown to be on the increase. Instead of dismissing the programs and creating new plans, attempts should be made to to evaluate and strengthen the prevention/intervention programs that are currently in place. A comprehensive and collaborative reorganization of the agencies involved in Children's Plan that aims to do this was announced at the end of July 1995.

Since 1985, the state of Tennessee has implemented a prevention/mental health promotion program entitled Project B.A.S.I.C. (Better Attitudes and Skills In Children) in attempt to decrease the number of adolescents and adults suffering from the many forms of mental illness. The program is directly based on the Child Development Specialist Program implemented in school systems from the Oregon Department of Education (Sheldon & Morgan, 1984). The stated goals and objectives of the program deal with promotion of a supportive environment, reduction of future mental health problems, education about mental health needs, coordination of services, and enhancement of coping skills (see Appendix A).

Project B.A.S.I.C. brings trained graduate level mental health professionals employed through community mental health centers to a school setting. These mental health professionals are called Child Development Specialists (CDSs) and are responsible for promoting mental health in the school setting and the community.

The CDS's responsibilities and activities include mental health education with K-3rd grades, early intervention, teacher/parent consultation, and school climate enhancement. The CDS works not only with the students but also with the principal, parents, teachers, or other persons affiliated with the school environment. As a liaison to the resources within the community, such as mental health services, health care providers, human services, and educational services, the CDS takes a collaborative approach to meeting the school's and student's mental health needs.

In the beginning, Project B.A.S.I.C. served schools in the rural areas of West Tennessee. Now, after nearly a decade, the program services 16 schools across the state through 8 community mental health centers and has direct contact in the classroom with over 4,600 students on a bi-weekly basis. In each school, the mental health professional provides the school with mental health education, school climate enhancement, parent/teacher consultation, and linkage to outside agencies.

Over its ten-year history, Project B.A.S.I.C. has gained state-wide recognition as being a worthwhile and beneficial program for the children and families of Tennessee. Unfortunately, however, as Project B.A.S.I.C. has continued to expand across the state to include Middle and East Tennessee, little has been done to formally evaluate the extent to which the program is meeting its intended impact. Children, schools, the communities, and service providers continue to see the merit of Project B.A.S.I.C. but are without documented support for its validation.

In order for Project B.A.S.I.C. to be a truly successful program that continues to expand and to change itself to meet the needs of the state's children, the actual impact of the program must be addressed. Since the program's beginning in 1985, informal site evaluations have been conducted by the state coordinator through interviews and surveys filled out by staff, principals, teachers, and parents, and the numbers of persons served by the program have been compiled. Even though this information has been recorded and compiled, Project B.A.S.I.C. has never been subject to a formal evaluation.

Purpose of the Study

The purpose of this study is to determine through formal research to what extent Project B.A.S.I.C. is making the intended impact. Specifically, the study addressed the following questions:

1) Do the stated goals of Project B.A.S.I.C. give direction to program implementation?

2) Are the resources sufficient to carry out the goals and objectives of Project B.A.S.I.C.?

3) Are the day-to-day operations consistent with the goals and objectives of Project B.A.S.I.C.?

4) What outcomes are being achieved through Project B.A.S.I.C.? Are the outcomes consistent with the goals and objectives of Project B.A.S.I.C?

5) What recommendations can be made to increase the impact of Project B.A.S.I.C.?

Significance of the Study

Since prevention has been proposed to be an alternative in helping the youth and families of today's society, it would be helpful to know if it actually does have the intended impact. To determine the impact of prevention, to make it cost effective, and to ensure quality programs, program evaluation must become a part of the implemented prevention program.

Because Project B.A.S.I.C. has not had a thorough evaluation in its history, results of this study can illustrate what the program is doing. With 16 schools across the state receiving Project B.A.S.I.C. services, it would ease minds and pockets to know that resources have been spent wisely. Persons who work with the program and the program participants suspect that Project B.A.S.I.C. is a strong program, but, sadly, the knowledge is based only on intuition. Informal annual evaluations also report the productivity of each site, but such is not adequate because it has been done on only an informal basis. A thorough and overall program evaluation will not only provide solid evidence of the programs capabilities, but it will also point out program strengths and weaknesses. Feedback regarding the program's strengths and weakness can be used to modify, refine, and direct program improvement as well as to solidify program impact.

On a broader level, this study is expected to add to the body of general literature, which is lacking in regard to prevention and evaluation. By being a part of the research, this study's evaluation format and findings may be used and included in other similar prevention programs that have relied on intuition and wishful thinking to guide and validate their renewal.

Finally, this study, which attempts to build a model for other prevention programs and to ensure their success, makes an endeavor to bring recognition and attention to prevention programs that are generally overlooked and unappreciated. With the changes before us in health care and the crying needs of society, prevention is a national hope and concern.

Methods and Procedures

Process

The study was conducted using quantitative and qualitative methods in a descriptive approach. This eclectic evaluation method is based on the Bellon framework (Bellon & Bellon, 1993). The Bellon framework follows a six step process, which provides a comprehensive, systematic, and formative evaluation approach. The first stage of the framework aims to gain an understanding of the ecological influences that can affect a program. The second stage is a focus on the governing plan that provides overall guidance through the goals and

objectives of the program. The third stage evaluates the minimum requirements necessary to implement the program. The human, physical, and fiscal resources to put the program in place are the target area of this stage.

The fourth stage takes the evaluation of the resources a step further by looking at how they are put into place to operate the program. Specifically, day-to-day activities to implement the program are objectively observed and described. The fifth stage of the Bellon framework attempts to answer the question of what impact the program is having on its targeted population. The sixth stage combines the information gathered from all the stages and provides feedback and recommendations to the program supervisor, showing what can be done to strengthen the program.

Subjects

The participants in this study were past and present administrative staff of Project B.A.S.I.C., principals and teachers (in grade levels K through 4) from 6 schools served by Project B.A.S.I.C., and 6 Child Development Specialists who work in these schools. Also a random sampling of 5 students from each 3rd and 4th grade classroom from 6 schools served and 6 schools not served by Project B.A.S.I.C. acted as experimental and control groups.

Data Sources

Following this systemized process of program evaluation, each of the proposed research questions required data sources which are interdependent of the other research questions; thus, the research used a formative approach. As a result, the data were collected in two parts. The first part focused on the program's attainment of goals and objectives addressed in the guiding research questions one, two, three, and four. As the Bellon framework suggests, the information was descriptive and eclectic in nature.

The information provided through interviews were taped and subjected to a content analysis to look for present themes. A committee was formed to perform a content analysis and to establish inter-rater reliability. The second part of data collection addresses the fourth question, which deals with program outcomes through a between-subjects design. This phase was more objective in nature and included a random sampling of 5 students in each third and fourth grade classroom of 6 schools served by Project B.A.S.I.C. and 5 students from each third and fourth grade classroom from 5 control schools. The sample for each group was approximately 150. Teacher-administered measures of behavior were used to assess possible differences between experimental and control groups to determine outcomes.

Data Collection

The following paragraphs describe the data needed to address each question.

Qualitative

Beginning with the qualitative data collection, data to answer the 5 research questions were obtained through a semi-structured interview process. Interviews with 38 participants including teachers, principals, CDSs, and program administration were conducted to gather information regarding Project B.A.S.I.C. goals and objectives, resources, day-to-day operations, outcomes, and recommendations.

Quantitative

For the second phase of data collection, which addresses the program outcomes, the approach shifted to quantitative methods. The multiple sources of data were obtained through standardized measures of student problems, competencies, and coping styles. More specifically, data to address this question were obtained through the use of a Student Information Sheet, the Academic and Social Coping Inventory (ASCI) (Cupp, 1993), and the Teacher-Child Rating Scale (T-CRS) (Hightower, 1989). These instruments used by 3rd and 4th grade teachers provide student information, rate randomly selected students on coping strategies (ASCI), competencies, and problem behaviors (T-CRS) from schools served and not served by Project B.A.S.I.C.

The two main instruments used to measure the outcomes of the program were the ASCI (Cupp, 1993) and the T-CRS (Hightower, 1989). Brief scale descriptions are included in the following paragraphs.

The ACSI is teacher rating scale used to assess student adaptive and maladaptive coping skills for academic and social situations. The scale is made up of 10 situation questions regarding academic coping strategies and 10 situation questions regarding social coping strategies. The ASCI has demonstrated validity and reliability.

The T-CRS is a teacher rating scale that measures problem and competency behaviors of children. The one page scale includes 18 teacher ratings dealing with problem behaviors and 20 teacher ratings of competency behaviors. The T-CRS has demonstrated validity and reliability.

In order to assess the program outcomes through the use of the the ASCI, T-CRS, and Student Information Sheet, the following hypotheses (based on the null hypothesis) were offered:

1. There will be no significant difference between experimental and control groups on numbers relating to gender, free lunch, type of household, and special education.

2. There will be no significant difference between experimental and control groups in adaptive and maladaptive

coping domains in academic and social situations as measured by the ASCI.

3. There will be no significant difference between experimental and control groups in socially acceptable and socially unacceptable coping styles in academic and social situations as measured by the ASCI.

4. There will be no significant difference between experimental and control groups in Acting Out, Shy Anxious, and Learning Skills as measured by Part I (problem behaviors) of the T-CRS.

5. There will be no significant difference between experimental and control groups in Frustration Tolerance, Assertive Social Skills, Task Orientation, and Peer Social Skills as measured by Part II (student competencies) of the T-CRS.

6. There will be no significant difference between experimental and control groups in Achievement, Social Skills, and Behavioral Skills as measured by ratings from the Student Information Sheet.

7. There will be no significant difference within the experimental group between students who have received individual B.A.S.I.C. services versus those who have not received individual B.A.S.I.C. services on the ASCI, T-CRS, and ratings on the Student Information Sheet.

8. There will be no significant difference within the experimental group between 3rd and 4th grade students on the ASCI, T-CRS, and ratings on the Student Information Sheet.

Synthesis of the Information

And lastly, the final research question, which addresses the recommendations to increase program impact, was answered through a synthesis of the overall data collection and the gathered information. Using a between-subjects design, the outcome information gathered from program (experimental) and nonprogram (control) schools determines the effectiveness of the program. This information highlights the strengths and weaknesses of the program and can be used to design a plan toward program improvement and refinement.

Organization of the Study

Chapter One contains: the statement of the problem; purpose of the study or research questions; the significance of the study; an overview of methods and procedures; and the organization of the study.

Chapter Two presents a review of related literature and issues connected to prevention in mental health.

Chapter Three contains the specific methods and procedures for data collection and data analysis.

Chapter Four includes the results of data analysis.

Chapter Five contains a summary of the findings, other findings, conclusions, relationship with previous research, limitations of the study, recommendations for future research, and reflections of the researcher.

CHAPTER TWO

REVIEW OF THE LITERATURE

Introduction

Tennessee's Project B.A.S.I.C aims to prevent potential psychological problems and contribute to the development of mentally healthy individuals through a school-based prevention program. Along with Tennessee showing interest in preventing maladaptive development, the United States has also made efforts toward building a nation of more capable individuals. For instance, in 1990 the United States formulated the well-known goals for schools to meet through *Goals 2000: Educate America Act* in order to bring the national educational system into the twenty-first century (Elias & Clabby, 1992; USDE, 1991). Following the setting of the educational Goals 2000, in 1991 the United States focused on health promotion and disease prevention with *Healthy People 2000* (USDHHS, 1990), which set specific goals and objectives for prevention, intervention, and treatment program accomplishments (Winett, 1995; Elias & Clabby, 1992).

Because the nation is placing importance on prevention and intervention strategies to enhance and promote a healthier society, it would be beneficial to become more aware of the overall concept of prevention. The following review of the literature is concerned with these areas of prevention:

definition of prevention, background of prevention, elements of successful prevention programs, and examples of prevention programs.

Definition of Prevention

What is prevention? Bloom (1981) found in a review of dictionaries in psychology, sociology, and other related areas no mention of the term "prevention." The lay meaning, Bloom (1981) discovered, stemmed from public health's concept of prevention relating to disease inoculation, which appears to be the most accepted definition. Not surprisingly, by the health-related definitions, the main emphasis of prevention is directed toward disease without mentioning well-being or mental health (Bloom, 1981). Inasmuch as he had difficult time defining the concept and found that positive mental health development was overlooked, Bloom (1981) formulated this cynical but accurate definition of prevention:

> Primary prevention deals with problems that don't exist, with people who don't want to be bothered, with methods that probably haven't been demonstrated as efficacious, in problems that are multidisciplinary, multifaceted, and multigenerational, involving complex longitudinal research design in which clear cut results are expected immediately for political and economic reasons unrelated to the task in question. (p. 8)

This definition is accurate due to the fact that prevention is usually seen as nonessential activity. As a result, prevention efforts are often lacking in coordination, fail to show immediate measurable results, and require a commitment for monitoring program effectiveness.

After taking a cynical viewpoint of prevention, Bloom (1981) presented a more interdisciplinary focus and offered a working definition of prevention that cuts across the related fields:

> Prevention involves activities directed toward obviating potentially harmful configurations of bio-social-physical events and simultaneously promoting beneficial configurations in any identifiable population/person at risk or with potential who is currently functioning in an adequate manner, using whatever theories, strategies, and techniques are feasible, ethical, and demonstrably efficacious by means of concomitant evaluation. (p. 28)

Bloom's working definition clarifies many of the misconceptions of prevention presented in the cynical viewpoint. Through the working definition he shows that prevention has an aim of not only decreasing potential problems but also promoting survival skills to weather the resurfacing of the problem. The definition also shows that prevention efforts are not a canned approach and are modified to reflect new information.

Just as Bloom demonstrated in his working definition, the definitions and importance of prevention vary among occupational fields such as health, environmental engineering, psychology, social work, law enforcement, counseling, school counseling, and education. However, the pervasive theme of prevention appears to be the avoidance of potential problems early in development or minimizing any negative effects while promoting positive adaptability to any presenting life situations (Bloom, 1981; Price, Bader, & Ketterer, 1980; Roberts & Peterson, 1984).

Themes/Orientations in Prevention

If the definitions of prevention vary across fields, then one hopes the themes or orientations of prevention will be more universal or at least related. Price et al. (1980) describe three common distinctions in the public health field concerning prevention: primary prevention focusing on the normal but "at risk" targets; secondary prevention focusing on targets showing early signs of problem development; and tertiary prevention focusing more on target treatment of manifested effects. These three levels of prevention appear to be common in public health and mental health; however, differences do occur in preventive situations between the two areas.

Price et al. (1980) explain that in the area of public health, the preventive focus is on the specific cause of disease

or the source of etiology. In mental health, on the other hand, having a preventive focus on the specific cause of the disorder or maladjustment is difficult or nearly impossible because the specific cause is often unknown and therefore cannot be traced (Price et al., 1980). The mental health field adapts to these unknown causal factors by primarily focusing on precipitating events or antecedents that may serve as triggers (Bloom, 1979). Further, Bloom (1979) states that the personal effects of a specific stressful event (the trigger) vary individually and may range from a harmless day missed from work to harmful violence toward others or self.

Different approaches to prevention that relate to the point of intervention have been categorized by Roberts et al. (1984). The first approach is the milestone approach, where the preventive effort is implemented at a critical point in development or transition, such as prenatal development or the beginning of middle school. A problem-focused approach, which is also included in preventive efforts (Roberts et al., 1984), deals with persons who are at higher risk or persons in circumstances of higher risk. Examples of a problem-focused approach would be programs dealing with children of alcoholics or grieving families. The final approach described by Roberts et al. (1984) is the population-wide approach where the goal is to aim preventive efforts at large numbers of persons.

Preventive programs through the schools or community mental health centers are examples of population-wide approaches.

Themes or dimensions in prevention are also presented by Bloom (1980). Bloom examined many prevention strategies and found that themes across most preventive efforts centered on causation, time dimension, targets, actions, active/passive orientations, or program evaluation.

As the reader can see by the many concepts of prevention, the definition of prevention is varied but centers around a central theme of the avoidance of potential or developing problems. Likewise, the described themes and dimensions of prevention are numerous with different levels, focuses, and areas of importance, yet are overlapping and depend on the overall purpose or aim of the preventive effort.

Background for Prevention

Prevention has woven a long history tracing back to Benjamin Franklin's adage "an ounce of prevention is worth a pound of cure" (Roberts et al., 1984) or Greek mythology's tales of the daughters of Aesculapius, Panacea (cure-oriented) and Hygeia (prevention and health promotion-oriented). As expected from a long record, many individuals have been instrumental and critical in contributing to its development and growth. Roberts et al. (1984) include a list of contributors that is by no means all-inclusive but gives recognition to those

persons who are instrumental in the field of prevention. Included in this review are Gerald Caplan, Emory Cowen, George Albee, Bernard Bloom, and Joseph Matarazzo. National leaders have also played a role in prevention's history.

Gerald Caplan is credited for adapting public health concepts into a mental health orientation of prevention. Caplan is the prevention specialist who first described the primary, secondary, and tertiary levels of prevention (Roberts et al., 1984). Caplan (1964) explains the different orientation of prevention by stating that primary prevention is more community- or population-based than individual-based, which is traditional psychology's usual focus of treatment.

Emory Cowen and his colleagues are credited for the development of a model prevention program (Primary Mental Health Project: PMHP), as well as for evaluation projects, community psychology movement, and the training of other prevention specialists (Roberts et al., 1984). The PMHP, which aims to promote early detection and intervention of school adjustment problems, serves as a model prevention program because of its emphasis on service as well as research (Cowen & Hightower, 1989; Cowen & Hightower, 1990; Cowen, Hightower, Pedro-Carroll, & Work, 1989). Cowen (1982) is critical of many programs that are called prevention because they are often lacking in empirical evidence of their effect and

are labeled as prevention based only on the programmer's choice.

Another major contributor in prevention according to Roberts et al. (1984) is George Albee, who served as chair on the Task Panel on Prevention (1978) commissioned by President Carter. Albee believes that preventive efforts aimed at only the physical aspect of disturbances will serve little if any purpose. Instead, he suggests that intervention at many levels including organic factors, stress reduction, self-esteem, and support groups is more beneficial (Albee, 1982).

Using the public health model of epidemiology, another major contributor, Bernard Bloom (Roberts et al., 1984) suggested preventive intervention at any of the three levels of host, environment, or agent (Bloom, 1977). The host, according to Bloom, represents the individual or population; the environment represents the surroundings; and the agent represents the source or process to problem development. Bloom (1977) contends that prevention is often focused on the incidence of the problem, which is the number of new cases, or the duration of the problem, which is the time from diagnosis to the end. He further explains the levels of prevention, stating that primary prevention attempts to impact on incidence, while secondary and tertiary efforts strive to impact duration.

The last contributor described by Roberts et al., (1984) is Joseph Matarazzo, who has been instrumental in the development of behavioral health or health psychology. Matarazzo (1982) presents a challenge to psychology and related fields to maintain and promote health while preventing maladjustment. Matarazzo (1982) emphasizes that an individual's behavior and lifestyle are both modifiable by health professionals and suitable targets for preventive intervention.

National leaders such as John F. Kennedy, and Jimmy Carter have been instrumental to prevention by publicly expressing interest in the potential benefits of prevention (Roberts et al., 1984). After the Community Mental Health Center Act of 1963, community agencies emerged into the spotlight to bringing services to the communities including children, the elderly, former institutionalized mental clients, minorities, and other underserved populations (Bloom, 1975; Price et al., 1980; Swift, 1980). The new emphasis of community mental health centers (CMHCs) was understood to have more of a focus on prevention activities geared toward mental retardation and psychopathology than previously established mental health practices (Price et al., 1980). In 1963, John F. Kennedy demonstrated his support of CMHCs and their role of prevention in the area of mental health by stating:

> Prevention is far more desirable for all concerned. It is more economical and it is far more likely to be successful. Prevention will require both selected specific programs directed especially at known causes, and the general strengthening of our fundamental community, social welfare, and educational programs which can do much to eliminate or correct the harsh environmental conditions which often are associated with mental retardation and mental illness. (Kennedy, 1963, p.2)

Nearly twenty years later, the Carter administration expressed concerns toward the growing frustrations of society and the need for services (Roberts et al., 1984). To address these concerns the President's Commission on Mental Health (1979) reported:

> At present our efforts to prevent mental illness or to promote mental health are unstructured, unfocused, and uncoordinated. They command few dollars, limited personnel, and little interest at levels where resources are sufficient to achieve results. If we are to change this state of affairs, as we believe we must, the prevention of mental illness and the promotion of mental health must become part of national policy. (Report to the President, 1978, p.53)

Inasmuch as prevention has been verbally supported by top officials, developed by experts, and is in demand by the general public, one would expect that prevention has been warmly welcomed in the helping professions, especially mental health. Unfortunately, although the history of prevention is of

long duration, throughout its development and maturity (even at the present), prevention has experienced many challenges to its acceptance.

Variable Acceptance of Prevention

Interest directed toward prevention has existed as far back as the mid 19th century (Caplan, 1969; Spaulding, & Balch, 1983). Historians have found that in the 1800's superintendents of asylums considered the advantages of preventive efforts because they were aware that certain populations were at higher risk for the development of psychopathology (Caplan, 1969).

In the late twentieth century, prevention has had many turning points. One of the most recent and maybe most important occurred in the 1970's from the President's Commission on Mental Health Final Report in 1978 (Bloom, 1981; Plaut, 1980; Price et al., 1980; Price, Cowen, Lorion, and Ramos-McKay, 1988; Swift, 1980; Zins, Coyne, & Ponti, 1988). As a result of the report, recommendations were made to establish a center for prevention in the National Institute of Mental Health (NIMH), to make primary prevention a major priority, to devote 10 percent of the NIMH budget to prevention within ten years, and to target mainly children and families, (Plaut, 1980; Swift, 1980).

A few years earlier in 1976 a pilot conference on primary prevention was another turning point. The Director of the NIMH commented at the time regarding the importance of primary prevention:

> The lack of a sophisticated and comprehensive primary prevention program in mental health stands today as a major barrier between our present knowledge and resources and attainment of the goals this country has established for its mental health system (Klein, & Goldston, 1976, p. iii).

The concerns about prevention in this statement may have been a catalyst to the actions taken by NIMH and the President's Commission on Mental Health two years later.

Interestingly, according to Swift (1980), the earliest turning point for prevention was a part of the legislation in 1963 that established CMHCs and that dealt with the assignment of prevention roles within the required consultation and education units (C & E) of CMHCs. The U. S. Department of Health, Education, and Welfare (1966) stated:

> Four of the five essential elements of service required of a comprehensive community mental health center focus on new methods of treatment and care. The fifth, consultation and education to community agencies and professionals, is concerned with the prevention of illness and the promotion of mental health. (Swift, 1980, p.214)

However, even though federally-funded CMHCs were required to participate in prevention activities through C&E units, CMHCs lacked commitment. It seems that an average of only 4.1% of CMHCs total service hours were provided through C&E units over a five-year period (1973-1977) (NIMH Survey and Reports Branch, 1978). And, as grants and funds declined from other areas, CMHCs often repackaged and relabeled C&E activities in order to receive reimbursement, which was not normally received for preventive activities (Swift, 1980).

Other unintended outcomes that resulted from prevention activities by CMHCs included a large number of persons participating in the C&E activities being processed through the clinical system and receiving diagnoses rather than just attending classes. Diagnoses serve little purpose in true preventive services especially if the efforts are directed to groups and are educational. Further, the staff time devoted to these C&E activities was often prorated as a clinical service and the fees collected were credited to clinical services rather than to preventive services (Swift, 1980).

Problems Concerning acceptance

Since the principles of prevention are to decrease contributors to harmful outcomes (Catalano et al., 1980), they cut costs for health care spending (Plaut, 1980), save lives and improve the quality of life (Surgeon General's Report on Health

Promotion and Disease Prevention, 1979), and promote social-competence into the 21st century (Elias et al., 1992). These goals are essential and are more accepted by human service providers than ever before (Swift, 1980). However, this support cannot be interpreted as either guaranteeing the success or the overall welcoming of prevention programs (Goldston, 1977; Klerman, 1979; Surgeon General's Report, 1979; Swift, 1980). Realistically, prevention faces problems dealing with the acceptance of the concept, the actual practice of prevention, program implementation, and program expectations.

One of the basic problems faced by prevention is the overall concept of prevention. Historically, prevention is rooted in the field of public health; however, when the three levels of prevention (primary, secondary, and tertiary) based on the public health model are applied to mental health, the fit is awkward (Bloom, 1981; Broskowski, & Baker, 1974; Henderson, 1975; Lamb, & Zusman, 1979; Mariner, 1980; Price et al., 1988; Swift, 1980; Wagenfeld, 1972; Zusman, & Lamb, 1977).

Traditionally, mental health provides services to persons at the secondary and tertiary levels (shortly before/shortly after problem development), which is more like public health's definition of prevention (Price et al., 1980). Considering the three levels, all mental health services could be called

prevention (Broskowski et al., 1974). Actually, however, tertiary prevention is not prevention but rehabilitation (Price et al., 1980), because the treatment is focused on correcting or diminishing the effects of a developed problem.

For instance, looking at the relationship between mental health and law, VandenBos and Miller (1980) describe delinquency prevention programs labeled as secondary efforts. These "diversion" programs, which attempt to change the behavior of youth after contact with juvenile court, are also called rehabilitative (tertiary) by the authors, showing the confusion with the definition of prevention. Not surprisingly, these prevention/diversion programs receive fluctuating support of their overall value and effectiveness (Bullington, Sprowls, Katkin, & Phillips, 1978; Klein, 1975, 1976; Lundman, 1976; Lundman, McFarlane, & Scarpitti, 1976; Rutherford, & McDermott, 1976; Scari, & Hassenfeld, 1976; Vinter, 1976).

Another problem with the concept of prevention in mental health that is not found in public health is the lack of target specificity. In mental health, the prevention target is often a problem with unknown causes (Plaut, 1980; Price et al., 1980) and the intervention boundaries must expand from traditionally serviced individuals to populations (Bloom, 1975; Catalano et al., 1980; Plaut, 1980). This lack of specificity about what is actually being prevented by mental health services,

unlike public health, leads to doubts about program justification issues that negatively influence other areas in prevention.

Another problem for prevention is the actual practice of prevention in the mental health field. Prevention theories have been drawn from various areas in human service fields; however, when these theories are applied to mental health, knowledge is often limited about actual prevention services, showing a gap between the theory and practice of prevention (Price et al., 1980).

Similarly, a pilot conference on prevention in 1976 found that the knowledge base about prevention is lacking and the former leaders (and critics) of prevention in psychiatry and psychology are moving away from their traditional practice (Klein et al., 1977; Plaut, 1980). Further recommendations about the practice of prevention from the conference included the need for more conferences in reference to prevention, more information dissemination from the top decision or policy makers down to the active preventionists, centralized coordination of prevention efforts, and a national stance on prevention (Klein et al., 1976).

Bloom (1981) states that all helping professions, such as teachers, researchers, and practitioners, have been trained in exclusively interventive-rehabilitive orientation methods, have

practiced this way throughout their professional careers, and therefore are hard to convince of the importance of preventive care. Also, the settings for preventive efforts, such as schools, typically use diagnostic and classification systems from a medical model centering around IQ and serve students remedially rather than shifting toward earlier preventive strategies (Mercer, 1989). In addition, training in effective prevention program implementation is offered in neither clinical/school psychology nor in the training given to school personnel (Elias et al., 1992).

Leadership is needed in graduate education, professional training, supervision, educational administration, policy making, and credentialing in order for the practice of prevention to be strengthened (Elias et al., 1992). As a result of the lack of practitioners in prevention, professionals ". . .who see themselves as 'working in the trenches' tend to ignore prevention because they view it, in part, as a luxury for those with surplus time and money" (Price et al., 1988, p. 3).

Regarding the implementation of prevention programs, needs usually win over demands because clinical service needs, readily visible and growing, are regularly prioritized (with support and allocations) over any prevention program efforts (Plaut, 1980; Price et al., 1980; Price et al., 1988). Prevention programs are required federally by each state; however, states

have been slow to develop support (Price et al., 1980) and lack in prevention expertise (Swift, 1980). On the federal level, the nation provides central leadership for prevention, but the funding is often limited and undependable (Price et al., 1980), allocated only to prevention research facilities in universities or hospitals (Swift, 1980), or the government promises programs but not the professionals or staff to carry them out (Swift, 1980).

Within CMHCs, prevention programs are often tied in with treatment, desired by consumers but seen by CMHCs as a dispensable nonreimbursable activity (Swift, 1980) and "seen as irrelevant and existing only because of federal mandates" (Cooper, 1980, p. 259). The governing boards of CMHCs respond positively to prevention programming, but leave mental health professionals responsible for implementation of the program. In turn, prevention programming is often staffed by the least senior personnel and becomes a part of the C&E unit which is the smallest and least funded division of the agency (Cooper, 1980).

The effects of the agency's minimal commitment is often seen in targeted schools where the prevention staff are not knowledgeable about the school culture. This results in an emphasis on external prevention programs that prove to be costly and incompatible, with little impact on the school

environment (Meyers, 1989). Meyers explains that without more collaboration between the school and agency in program implementation, staffing, and appropriateness, ". . .we may unwittingly 'prevent' the primary prevention of psychopathology in schools" (p. 416).

Often in the implementation of prevention programs "turf wars" are experienced where the existence of programs with the same basic content (but different purposes) is determined by who gets there first (Cooper, 1980). On the other hand, Elias et al. (1992) state that schools can also be subject to a multitude of specialized prevention programs that are independent of one another, resulting in a "jumbled confusion." Ironically, the targets of these programs, the children "at risk" who are already having problems functioning, are expected to integrate the information from pregnancy prevention, substance abuse prevention, violence prevention, and other prevention programs into understandable and applicable information (Elias et al., 1992).

Professionals' program expectations for prevention appear to be critical in the overall acceptance of prevention programs. In 1974, Broskowski and Baker stated their doubts:

> At the present time, however, we must face the critical fact that there is a lack of any clear and salient body of valid research that can be readily used to justify

> empirically any particular form of widescale intervention at the level of primary prevention (p. 715).

Only four years later the Task Panel on Prevention (1978) claimed that there was evidence showing emphasis toward primary prevention and cited training studies of Spivack and Shure; Stone, Hands, and Schmidt; Allen, Chemsky, Larsen, Lochman, and Selinger; Gesten, Flores de Apodaca, Rains, Weissberg, and Cowen; Elardo, and Cooper; Heber, Gottfried, Horrowitz and Paden; and Jason (Forgays, 1978; Bloom, 1981). The Research Task Panel suggested that, although prevention research existed, prevention should be dealt with cautiously and more research should be done before "promising the country more than we are able to deliver" (President's Commission on Mental Health, 1978:IV, 1820).

Program expectations are also discrepant between prevention and clinical treatment. Plaut (1980) suggests that a double standard exists, because there is a higher demand for effectiveness of prevention than for traditional clinical treatment. Cooper (1989) states that "problems faced by a prevention practitioner may be infinitely greater than those faced by the clinician, since over the years clinicians have rarely been put to the test of accountability in any clear cut fashion" (p. 261).

Assessment and evaluation of prevention programs are deemed important in order to provide variables linked with health and well-being, give practical ideas for improvement, as well as establish accountability (Price et al., 1980). Although supporters of prevention all agree on evaluation efforts, little progress has been made (Plaut, 1980; Price et al., 1980; Tableman, 1980). Difficulties in evaluation have stemmed not only from the process of accurate documentation (Cooper, 1980; Tableman, 1980) but also from the lack of both fiscal and administrative commitment (Cooper, 1980).

Prevention promises to give relief to the overwhelming need for clinical services, while promoting individual competencies. The acceptance of prevention by the governing agencies, however, is conditional and cannot be separated from the lack of funding, resulting in minimal commitment and low quality representations of preventive services.

Elements of Successful Prevention Programs

Although prevention varies in acceptance, a recipe for strong and effective prevention services can be concocted with the right ingredients. Traditionally, prevention programs are centered around only one focal area such as alcohol, pregnancy, stereotypes, self-esteem, drugs, or abuse (Elias et al., 1992; Price et al., 1988). Often these programs are selected and implemented due to their easy use and their requirement of

little training for the practitioner. The practitioner in turn is relieved assuming that the prevention program has been developed with the appropriate research because he/she is preoccupied with regular clinical service demands (Price et al., 1988).

Surprisingly but characteristically, Price et al. finds through a review of over 300 prevention programs that two-thirds were lacking any type of systematic evaluation, program manuals, or documentation. Another weakness exists with program implementation (Elias et al., 1984), which shows that the knowledge base exists to design beneficial programs for children and adolescents; however, shortcomings in specific implementation issues often account for failure in establishing a beneficial school-based prevention program (Berman et al., 1978).

The primary question is then what does make a good prevention program? Many prevention experts have ideas to contribute regarding the elements of successful prevention programs. Barrios and Schigetomi (1980) suggest that a successful program must be available to a large population, be efficient, cost-wise, and acceptable to the community, have a significant impact leading toward the desirable outcomes, and have few negative side effects.

Important programming issues according to Newton (1992) are specifying the intended client group, administering correct implementation, attending to quality issues, and proving the service has had impact. Price et al. (1988) suggest that the prevention practitioner must beware, as many prevention programs are not true prevention and may be in fact only education-based or tertiary-oriented. Prevention practitioners should make a priority not only of appropriateness and easy administration but also of the quality of research, the specificity of target groups, the nature of the intervention, and the demonstration of expected outcomes (Price et al., 1988).

Bloom (1981) suggests that a gap exists between theory and practice in prevention. In order to narrow the gap, a sound prevention strategy would include awareness of the preventable problem (or promotable goal), access to the "at risk population," cooperation and acceptance with the population, specific preventive tactics, and evaluation of the process and outcome. Characteristics of sound prevention programs found by the American Psychological Association Task Force on Prevention included being targeted to specific risks and problems, being aimed at long-term change, giving new skills for coping, strengthening support networks, and having a collection of rigorous research to document success (Price et al.,

1988). (Not surprisingly, out of 300 programs submitted to the APA Task Force for review, only 14 were determined to be examples of good prevention programs.)

Attention to the details of the actual prevention programming are critical elements contributing to the success of a prevention program (Newton, 1992). For instance, Elias et al. (1992) suggest that a common framework can unify the different potential problem areas and can provide a prevention strategy to be used across many areas. By building a foundation, the prevention strategy can be used and modified at all age levels and used at home as well as at school.

Elias et al. (1992) give foundation building examples of reading and driving to illustrate their point. For instance, people are taught one strategy to read or drive. However, the one strategy is applied in a variety of situations, such as typing a letter or going from a one way street to a highway.

The researchers suggest that prevention strategies could be presented in a similar way instead of the typical method of multiple program fragmentation. Usually, many programs are implemented in the same setting independently, even though the programs may provide the similar information. Elias et al. (1992) suggest that prevention programs should be curriculum-based and centralized around a global theme that allows for structure and guided practice throughout the day.

The prevention program should also be sensitive and adaptable to the developmental level of the audience to insure maximal learning (Elias et al., 1992).

Another critical detail in prevention programming is the actual teaching. Incorporating a variety of teaching methods with a range of activities (including both active and passive) is important for transfer and generalization of the information (Elias et al., 1992; Stolz, 1984). Stolz (1984) also suggests operationalizing what is being prevented or promoted so that it is possible to measure the effectiveness of the preventive effort.

Details that are important, although often overlooked, are implementation plans and data on a program's effectiveness (Stolz, 1984). Surprisingly, little research is found on actual program planning, which is often based only on the theories supporting it (Durlak & Jason, 1984; Masterpasqua & Swift, 1984; Stolz, 1980). Stolz (1981) refers to this as the "publish and hope" or "train and hope" method of implementation. Not only is the implementation plan overlooked, but research regarding the program's effectiveness appears to be in debate (Stolz, 1984). Programs seem to be used regardless of whether they have yielded good data, bad data, or no data at all (Stolz, 1984).

In contrast, Elias and Clabby (1992) base their social competence program on the action research model that places a strong emphasis after implementation on monitoring, evaluation feedback, curriculum feedback, and consumer satisfaction. Constant feedback gives valuable information for precise tuning and adaptation for special needs. Proof of the service through evaluation is important to Newton (1992), because it allows for continuous refinement and because it documents who is or is not receiving services. However, evaluation is difficult in prevention because of the difficulty of showing causal links between intervention and developments that have not occurred or showing benefits that may appear in the distant future (Newton, 1992).

Building an effective prevention program requires the elements discussed, such as paying attention to the details of prevention programming, specifying targets, and conducting program evaluations. More importantly, however, effective prevention programs require an extensive time commitment from the agency and staff members, ongoing collaboration among the service population and service providers, and sensitivity to the ecological realities of the population at hand (Elias et al., 1989). In other words, "T'ain't what you do, it's the way you do it" (Kelly, 1979 p. 244).

Examples of Popular Prevention Programs

Although prevention is often lacking in support both administratively, financially, and empirically, prevention programs are often administered regardless of any support (Stolz, 1984). Many commercially popular prevention programs aimed at affective education are familiar to the elementary school setting (Durlak et al., 1984). *The Causal Approach* (Ojemann, 1958), *Human Development Program* (Bessell & Palomares, 1970), *Developing Understanding of Self and Others* (DUSO) (Dinkmeyer, 1970), *Schools Without Failure* (Glasser, 1969), *Teacher Effectiveness Training*, (Gordon, 1974), and *Interpersonal Problem Solving Training* (Spivack & Shure, 1974) are programs that have goals and materials available for teachers, school counselors, or community volunteers to enhance students skills in emotional and social cognitive development and promote behavior change (Durlak et al., 1984). According to the researchers, outcomes of evaluation studies of these programs produce data that at first seems positive; however, through critical analysis, it is found that the studies often have weak experimental designs, nonrandom subject assignments, lack of genuine controls, and measures with questionable reliability and validity (Durlak et al., 1984).

Another popular prevention program is *Drug Abuse Resistance Education* (DARE), which is the most widely used

drug use prevention program in the United States (Ennett, Tobler, Ringwalt, & Flewelling, 1994). DARE has been evaluated in numerous studies that were subjected to a meta-analysis by Ennett et al. (1994). The meta-analysis showed that DARE's greatest effect was on drug knowledge and social skills, while the least effect was demonstrated on actual drug use. The researchers further compared DARE with other interactive and noninteractive drug use programs, and the results showed that DARE had a smaller effect size in drug use than interactive programs but was similar in effect size with noninteractive programs. Meanwhile, even though not proven to be effective toward drug use, DARE has been adopted by 50% of school districts nationwide and receives public funding (Ennett et al., 1994).

Examples of Successful and Effective Prevention Programs

The following is an overview of successful and effective prevention programs that are included by or have characteristics similar to the programs studied by the APA Task Force on Promotion, Prevention, and Intervention Alternatives in Psychology (Price et al., 1988). The characteristics include targeting risks or problems, aiming at long term change, detailing program implementation, giving new skills for coping, strengthening support systems, and collecting research to document success. This overview

presents examples of programs for prenatal/early childhood, adults and the elderly, and children and youth. The last part of this section provides a review on the prevention program on which Project B.A.S.I.C. is based.

Prevention programs targeted toward reducing the health and psychological risks of infants, young children, and their families provide individual support for the parents, link them to available services, and often teach the skills necessary for competent parenting (Price et al., 1988). Many programs begin during pregnancy or early infancy, provide early educational opportunities, and follow the family until the child enters school (Price et al., 1988). Examples of these prevention programs include *The Prenatal/Early Infancy Project* (Olds, 1988), *Brookline Early Education Program* (Pierson, 1988), *The Carolina Early Intervention Program* (Ramey, Bryant, Campbell, Sparling, & Wasik, 1988), *Houston Parent-Child Development Program* (Johnson, 1988; Zigler, Taussig, & Black, 1992), *High/Scope Perry Preschool Program* (Schweinhart & Weikart, 1988; Wiekart, 1989; Zigler et al., 1992), and *Syracuse University Family Development Research Program* (Zigler et al., 1992).

Evaluation results from these prevention programs demonstrate increases in parental involvement and better caregiving habits (Olds, 1988; Pierson, 1988; Zigler et al., 1992),

educational and occupational achievements/aspirations (Johnson, 1988; Olds, 1988; Pierson, 1988; Zigler et al., 1992), as well as increases in children's attitudes toward school and appropriate school behavior (Johnson & Walker, 1987; Pierson, 1988; Ramey et al., 1988; Schweinhart et al., 1988; Wiekart, 1989; Zigler et al., 1992). Also, these programs reported decreases in welfare use (Olds, 1988; Zigler et al., 1992), cognitive and academic delays (Person, 1988; Ramey et al., 1988; Zigler et al., 1992), antisocial behavior, and juvenile delinquency (Johnson et al., 1987; Seitz, 1990; Zigler et al., 1992).

The focus of prevention programs provided for adults and the elderly often center on major life transitions such as childbirth, divorce, loss of a loved one, and health risk as a result of aging (Price et al., 1988). The programs such as the *Yale Child Welfare Research Program* (Zigler et al., 1992), *Perceived Personal Control Program* (Tadmor, 1988), *The Colorado Separation and Divorce Program* (Bloom & Hodges, 1988), *Stanford Heart Disease Prevention Program* (Maccoby & Altman, 1988) and *Widow-to-Widow* (Silverman, 1988) provide adults with the support and the skills necessary to cope with the life transitions and to prevent possible adjustment difficulties. Results of evaluative studies show quicker physical and psychological recovery (Bloom et al.,

1988; Silverman, 1988; Tadmor, 1988), better adjustment in new life situations (Bloom et al., 1988; Silverman, 1988; Tadmor, 1988), and a decrease in behavioral and psychological risk factors (Bloom et al., 1988; Maccoby et al., 1988; Silverman, 1988; Tadmor, 1988; Zigler et al., 1992).

The most popular and logical targets of prevention programs are children and youth who are often accessible through school settings (Cowen et al., 1989). Students in grades K-12 may be provided with programs to prevent drug use, pregnancy, problem behaviors, academic failures, school absenteeism, drop outs, aggressiveness, and juvenile delinquency (Elias et al., 1992; Price et al., 1988). Most programs, while preventing problems, intend to enhance students' assertiveness, social skills, competence, anger control, coping skills, and overall adjustment (Price et al., 1988).

Examples of these programs include *I'm Special Program* (Kim, McLeod, & Palmgren, 1989), *Assertiveness-Training Program* (Rotheram-Borus, 1988), *Interpersonal-Cognitive Problem Solving* (Hawkins, Von Cleve, & Catalano, 1991; Shure & Spivack, 1988), *Life Skills Training* (Botvin & Tortu, 1988), *The School Transition Environment Project* (Felner & Adan, 1988), *Adolescent Diversion Project* (Davidson & Redner, 1988), *Violence Prevention Prevention Curriculum for Adolescents* (Larsen, 1994; Prothrow-Stith, 1987), *Aggression Replacement*

Training (Goldstein, Glick, Reiner, Zimmerman & Coultry, 1985; Larsen, 1994), *Social Problem Solving* (Elias et al., 1992; Elias et al., 1989), a comprehensive intervention program (Battistich, Solomon, Watson, Solomon, & Schaps, 1989), *Project Achieve* (Knoff & Batsche, 1993) and the *Primary Mental Health Project* (Cowen et al., 1989, 1990).

Evaluation studies of these programs demonstrate decreases in problem behaviors (Cowen et al., 1989, 1990; Elias et al., 1989; Hawkins et al., 1990; Kim et al., 1989; Knoff et al., 1993; Larsen, 1994; Rotheram-Borus et al., 1988; Shure et al., 1988), aggressiveness (Hawkins et al., 1990; Larsen, 1994; Shure et al., 1988), drug use (Botvin et al., 1988; Hawkins et al., 1990; Kim et al., 1989; Shure et al., 1988), social anxiety (Botvin et al., 1988; Cowen et al., 1989, 1990; Elias et al., 1989), dropouts/truancy (Cowen et al., 1989, 1990; Felner et al., 1988; Kim et al., 1989), delinquent behavior/police contacts (Davidson & Redner, 1988; Kim et al., 1989; Larsen, 1994), violence (Larsen, 1994), grade retention (Knoff et al., 1993), and school maladjustment (Cowen et al., 1989, 1990; Elias et al., 1989; Felner et al., 1988). The program evaluations reported increases in assertiveness (Botvin et al., 1988; Cowen et al., 1989, 1990; Hawkins et al., 1990; Rotheram-Borus et al., 1988; Shure et al., 1988); social skills, problem solving, and independence (Battistich et al., 1989; Botvin et al., 1988; Cowen

et al., 1989, 1990; Elias et al., 1992; Elias et al., 1989; Hawkins et al., 1990; Larsen, 1994; Rotheram-Borus et al., 1988; Shure et al., 1988); psychosocial knowledge (Botvin et al., 1988; Cowen et al., 1989, 1990; Hawkins et al., 1990; Larsen, 1994; Shure et al., 1988), adjustment (Cowen et al., 1989, 1990; Elias et al., 1992; Elias et al., 1989; Felner et al., 1988); and academic progress (Cowen et al., 1989, 1990; Felner et al., 1988; Rotheram-Borus et al., 1988).

The *Child Development Specialist (CDS) Program* developed for the Oregon public schools in 1973 (Sheldon et al., 1984) for the prevention of personal and learning problems is the model program used for the design of Project B. A. S. I. C. which is the central focus of this study. The activities in the CDS program include regularly scheduled affective teaching (K-5), assessment/screening, student monitoring, parent education/consultation, staff development/consultation, and a liaison and referral source between outside agencies and the school. A longitudinal study at the 4 year mark (Ryan, 1982) demonstrated higher student self-concepts, which were greatest with early program exposure and appeared to be maintained over subsequent grades. The impact on student achievement was demonstrated but was not statistically significant. Parent reports yielded high rates of satisfaction and indicated positive effects on their children (Ryan, 1982;

Sheldon et al., 1984). Over twenty years later, the CDS program has expanded its reach to older and younger children and continues as a regular service of the Oregon public schools.

Summary

Prevention was first defined and put to use in the area of public health to intervene and combat the effects of disease formation. Mental health researchers, administrators, and the general public have expressed interest in prevention but have found that the public health model of prevention needs some modification to apply to mental health endeavors. The awkward fit in mental health aspects, mainly because of the nonspecified causal triggers, has been a contributor to prevention's variable support. As a result CMHCs, even though federally mandated, do not make a priority of investing time or money in preventive efforts. Preventive efforts when conducted are weak in knowledge about prevention, experience, coordination, program implementation, and program expectations. These flawed efforts are often without proof of success; and as a result, the agencies or sponsors of prevention programs often lack commitment to them and view prevention as a frivolity or "fluff" in true mental health services.

The literature does report that effective prevention programs are possible with the inclusion of the correct

elements to sustain, strengthen, and adapt the programs to different environments. One of the most important elements, the inclusion of an evaluation process, is often absent. But examples of strong programs exist and demonstrate proof of their effectiveness. Unfortunately, however, service agencies overlook these elements and examples and are reluctant to sacrifice any amount of investment required for successful programming over the demand for treatment services.

As a solution to the mounting societal problems that exist today, preventive services are a possible alternative. Quality preventive programs show promise for developing and maintaining responsible adults and contributing members of society. However, the literature indicates that higher standards of preventive implementation, consistent support of the programs, realistic expectations, and the criteria to attain and maintain their effectiveness are requirements of prevention programs that can be neither forgotten, overlooked, nor dismissed.

CHAPTER THREE

METHODS AND PROCEDURE

Introduction

The purpose of this study was to describe the impact of Project B.A.S.I.C. The study was conducted using a program evaluation format incorporating both qualitative and quantitative methods. The qualitative data collection used the within-subjects research design, where the data gathered in the semi-structured interviews was used to measure the perceptions of persons involved with Project B.A.S.I.C. In the quantitative data collection the outcome data on students in experimental and control schools represented the between-subjects research design. The quantitative data were used to demonstrate any significant differences in behaviors/competencies between the two groups. For the purpose of clarity, this chapter has been divided into two sections in order to distinguish between the qualitative and quantitative methods.

Qualitative

Sources of Data

The sources of qualitative data collection were the participants in 38 interviews. The participants in the interviews included two subjects representing past and present Project B.A.S.I.C. administration, six subjects representing Child

Development Specialists (CDS) positions, and 30 subjects representing school staff from six schools (24 K-3 classroom teachers and six principals). The six schools from which the school staff were recruited have housed Project B.A.S.I.C. for at least three years with the same CDS and were distributed geographically across the state (East, Middle, and West). All school staff (teachers and principals) had opportunity for contact with the Project B.A.S.I.C. program in their school. The six CDSs represented the Project B.A.S.I.C. staff assigned to the six schools.

The past and present Project B.A.S.I.C. administrators represented the leadership of the program from conception to the present. All participants indicated a willingness to participate and signed a Form of Informed Consent allowing them to withdraw from the interview at any time.

Techniques for Data Collection

Measures for the perceptions of persons involved with Project B.A.S.I.C. were conducted through a semi-structured interview process. Questions for the interviews were based on the Bellon framework (1993) and were modified into three forms: School Staff, CDS, and Administration (see Appendix B-D).

A semi-structured interview format was selected because it is reasonably objective, in depth, and because it provides

valuable data not always obtained by other methods; yet it is adaptable to many situations (especially education settings) because it allows the interviewer to explore responses and ask questions for clarity (Borg & Gall, 1973; Mason & Bramble, 1978). Further, interviews give insight to a person's knowledge, experiences, values, attitudes, and beliefs (Tuckman, 1972). Also, interviews can be used to test hypotheses, identify new variables, and relationships (Cohen and Manion, 1980). Disadvantages of using interviews include possible response bias and timeliness (Borg & Gall, 1973; Cohen & Manion, 1980).

Pilot interviews were conducted by the interviewer with two teachers and one CDS not participating in the actual study. After the experiences with the pilot interviews, which were manually recorded or taped, the questions were modified to enhance respondent understanding and ease in interview administration.

The interview questions were developed from the research questions guiding this study, which were derived from the Bellon Framework (1993). In order to obtain the specific information needed to answer each research question, each was broken down into further inquiries that were also derived from the Bellon Framework (1993). Every respondent, whether school staff, CDS, or administration, was asked these

questions, which served as the basic structure for all interviews.

To acquire information regarding the first research question (Do the stated goals of Project B.A.S.I.C. give direction to program implementation?), these questions were asked:

- What do you see as the goals of Project B.A.S.I.C. in your school? Objectives?
- Are there goals in Project B.A.S.I.C. that you feel are up to date and worthwhile? Objectives?
- In your opinion, are these goals based on the school's or society's needs and expectations? What is there needed more of in Project B.A.S.I.C.? Less?

For the second research question (Are the resources sufficient to carry out the goals and objectives of Project B.A.S.I.C.?), the information was obtained through the questions:

- Do you feel that the resources (room, space, etc.) in this/these school(s) are adequate for carrying out Project B.A.S.I.C.?
- Do you feel that the Child Development Specialist has the skills, competencies, and knowledge to carry out the program's responsibilities?

The third research question (Are the day-to-day operations consistent with goals and objectives of Project B.A.S.I.C.?) derived information from these questions:

- Do you feel that the Project B.A.S.I.C. material presented and available is adequate for the carrying out of Project B.A.S.I.C.? Is the overall school set-up adequate?

Answers for the fourth research question (What outcomes are being achieved through Project B.A.S.I.C.? Are the outcomes consistent with the goals and objectives of Project B.A.S.I.C.?) related to these questions:

- What do you believe are some of the unexpected outcomes as a result of Project B.A.S.I.C.?
- How has the total school (students, staff, community) been influenced by any unexpected outcomes?
- How has Project B.A.S.I.C. changed or influenced the students and their behavior? Anyone else?
- If your job was to measure the influence of Project B.A.S.I.C., how would you go about it? What resources would you use?
- In your opinion what is the level of satisfaction with all aspects of Project B.A.S.I.C.?

- What do you see as the long term effect of Project B.A.S.I.C. on the total school environment (students, staff, community)?

Information regarding the fifth and final research question (What recommendations can be made to increase the impact of Project B.A.S.I.C.?) was obtained with this question:

- If you were to redesign Project B.A.S.I.C. from scratch, how would you do it as compared to the way it is currently done?

The 13 interview questions served as the entire interview process for the 30 school staff persons because of time limitations (approximately 30 minutes) and appropriateness. The CDS and administration interviews also contained these questions but included more specific questions regarding program philosophy, development, implementation, program assessment, resources, and agency regulations which would have been inappropriate for the school staff. All interviews began with warm-up questions regarding the respondent's experiences with education and Project B.A.S.I.C.

Procedure for Data Collection

Permission was received from each school system's superintendent or designee before any contact was made in the schools. Following permission, letters were sent to each CDS to recruit willing participants from teachers representing each

grade in K to 3 and the school principal within the Project B.A.S.I.C. school. Forms of Informed Consent were signed and copied for the individuals before the interviews took place. The CDS was responsible for scheduling all interviews and interview settings. Before beginning the interviews, participants were told about this interviewer and the general aim of the research study. Permission was also obtained to tape record the interviews. The respondents were instructed to answer the interview questions in the best way possible, to refrain from worry about the correctness of their answers, and to base their answers on their own perceptions of the program. The participants were told that the information obtained was considered confidential and would be recorded without identifying the school or persons involved. All school staff were individually interviewed in the school setting with each interview being completed in approximately 30 minutes.

CDS and administrator interviews were conducted in the same manner; however, because of the length of the interview (1.5 to 3.0 hours) the process was broken up in parts and administered in a variety of settings including cars, offices, and individual homes. One CDS interview was not completed because of time and geographic constraints, but the information gathered was included in the data analysis.

Information gathered from the semi-structured interviews was documented by note taking and audio tape. The audio tapes were transcribed with the help of the notes into written documents. Qualitative data collection through the semi-structured interview process was conducted from December 1994 to April 1995.

Techniques for Data Analysis

A content analysis was used to analyze the transcribed data from the interviews. Content analysis converts communication, especially with interview material, into objective, systematic, and quantitative descriptions (Berelson, 1952). A three person committee, including the interviewer, was formed to review the interview documents looking for themes relating to the research questions and to establish inter-rater reliability.

Quantitative

Sources of Data

Twelve schools were asked to participate in the quantitative portion of this research process (6 experimental and 6 control). The same schools, which house Project B.A.S.I.C. used in the qualitative data collection, serve as the experimental schools. They represent the three geographic regions of Tennessee (West, Middle, and East) and were chosen on the basis of at least 2 years maturity of the program with

the same CDS, along with the willingness to be included in the evaluation process. The six control schools were selected because of an approximate match with an experimental school, willingness to participate, geographic location, enrollment size, and percentage of students on free or reduced lunch.

Approximately 410 students (210 experimental and 200 control) in the 3rd and 4th grades were asked to be rated by a total of 82 teachers on measures of coping abilities, competencies, and problem behaviors. The students represent 3rd and 4th grade students from experimental and control schools. For each 3rd or 4th grade teacher, 5 students to be rated were chosen through a random selection process from each classroom. Names remained absent from any information sheet or measurement to assure anonymity. The only requirements of the students was that he/she must have been continually enrolled in the school for at least 2 previous academic school years (assuring maximal exposure to Project B.A.S.I.C. in the experimental schools and the present school environment in the control schools).

Techniques for Data Collection

Measures directed at the research question related to outcomes for Project B.A.S.I.C. included sets of teacher answered student forms to be completed by third and fourth grade teachers in experimental and control schools. Each set of

forms included a Student Information Sheet, the Academic and Social Coping Inventory, and the Teacher-Child Rating Scale.

Student Information Sheet

The Student Information Sheet is a one page form providing demographic information on each student. Along with providing background information, the form asks teachers to rate the performance level for each student on a 5-point scale regarding Achievement, Social skills, and Behavioral skills. The final questions on the form, which were modified to fit either the experimental (Appendix E) or control schools (Appendix F), related to any support services received by the students.

Academic and Social Coping Inventory (ASCI)

The ASCI is a teacher rating scale used to assess student adaptive and maladaptive coping styles for academic and social situations (see Appendix H). The maladaptive coping style is further broken down into socially acceptable and unacceptable coping strategies. During the development of the ASCI, evidence of its concurrent validity with the Coping Inventory (Zeitlin, 1980) was demonstrated by having coefficients of significant positive correlations to the ASCI adaptive scores and significant negative correlations to the ASCI maladaptive scores (Cupp, 1993). The test-retest reliability over a four week period yielded a range from .71 to .98 (with the exception of

one correlation being .42) and all correlations were significant at the $p < .001$ level. Split-half reliability based on odd and even numbered items yielded significant and strong correlations ranging from . 96 to .99. At the present time the primary research done with the ASCI has been on students in grades two through five in a school system in Middle Tennessee. The ASCI presents 10 academic situations and 10 social situations in which the teacher is asked to rate (on a scale of 1 to 5) to what extent the student engages in the given behavior.

Teacher-Child Rating Scale (T-CRS)

The T-CRS is a teacher rating scale which measures behaviorally-oriented school problems and children's strengths (Hightower, Spinell, & Lotyczewski, 1989; Hightower et al., 1986) (see Appendix G). The T-CRS was developed from efforts by the Primary Mental Health Project (PMHP) which uses this instrument in the evaluation of its programs. The T-CRS was created to make the measurement of problem behaviors and competencies more teacher-efficient; and, therefore, it is a combination of two scales previously used by the PMHP, the Classroom Adjustment Rating Scale (CARS) (Lorion, Cowen, & Caldwell, 1975; Weissberg, Cowen, Lotyczewski, & Gesten, 1983) and the Health Resources Inventory (HRI) (Gesten, 1976; Weissberg et al., 1983). Since the T-CRS parallels these two

scales, it is divided into Part I and Part II, which are reflective of the former problem and competency behavior rating scales. Part I (school problems) is divided in to three subscales that include Acting Out, Shy Anxious, and Learning Skills. Part II (student strengths or competencies) is divided into four subscales that include Frustration Tolerance, Assertive Social Skills, Task Orientation, and Peer Social Skills. Pearson correlations of the T-CRS Acting-Out, Shy-Anxious, and Learning scales to similar CARS scales ranged from .72 to .89. The T-CRS competency scales do not correspond exactly with the scales on the HRI; however, the correlations were highest (r=.56 to .82) between the T-CRS and the HRI scales from which they were drawn. Cronbach's Alphas for the T-CRS across many samples ranged from reliability coefficients of .85 to .95. Test-Retest reliability coefficients collected after a 20-week period range from .61 to .91. The six subscales of the T-CRS correlated with measures of achievement, anxiety, parent perception, self-control, and grades yielded 66 out of 78 possible correlations significant at the $p < .05$ level. The T-CRS is normed for urban, suburban, and rural males and females in Kindergarten through the sixth grade in the state of New York. The T-CRS is a one page form requesting teachers to rate (on a scale of 1 to 5) a student on 18 items related to problem behaviors and 20 items related to competencies.

Procedure for Data Collection

Permission for this study was obtained from both experimental and control school systems' superintendents and school principals. After permission was received, contact was made with either the CDS or school principal to describe the process, to answer questions, and to obtain teacher and classroom numbers. Packets were assembled and sent to the teachers through the school principal or CDS who served as the school coordinator. Each teacher received a packet which included an information letter, Form of Informed Consent, and five sets of teacher-rating forms. Students were chosen from each classroom through a random number drawing based on the number of eligible students. The randomly drawn numbers were provided for the teachers to correspond with names alphabetized on the teacher's classroom roll (which was for the teacher's reference only). For research purposes on the teacher rating measures, code numbers were assigned to students to take place of names. A set of forms was completed on each student who was randomly selected.

Third and fourth grade teachers in the experimental and control schools were asked to provide general information about the students and to rate these randomly selected students from their classes using the measures of academic coping, social coping, school problem behaviors, and student

competencies. Instructions included to read over and review both rating forms, as well as to observe the students for approximately two weeks prior to completing the rating forms. The teachers were suggested to complete one set per day for five days and were reminded not to include any identifying information (besides the assigned code number). The sets were completed based on the teacher observations, collected by the school coordinator, and mailed back to the experimenter. The response rate for the data collection was 80%; one school and two teachers from the control group refused participation, as well as two teachers from the experimental group. A total of 327 sets of rating forms were returned however many sets were not complete, but included at least one complete form. Data collection for the second phase was conducted in May 1995.

Techniques for Data Analysis

The data collected were subjected to a Chi Square to determine homogeneity between experimental and control groups based on the numbers of free/reduced lunch and special education students as well as gender and type of household.

Further data analysis was conducted to either support or reject these hypotheses:

1. There will be no significant difference between experimental and control groups in adaptive and maladaptive coping domains in academic and social situations as measured by the ASCI.

2. There will be no significant difference between experimental and control groups in socially acceptable and socially unacceptable coping styles in academic and social situations as measured by the ASCI.

3. There will be no significant difference between experimental and control groups in Acting Out, Shy Anxious, and Learning Skills as measured by Part I (problem behaviors) of the T-CRS.

4. There will be no significant difference between experimental and control groups in Frustration Tolerance, Assertive Social Skills, Task Orientation, and Peer Social Skills as measured by Part II (student competencies) of the T-CRS.

5. There will be no significant difference between experimental and control groups in Achievement, Social Skills, and Behavioral Skills as measured by ratings from the Student Information Sheet.

6. There will be no significant difference within the experimental group between students who have received individual B.A.S.I.C. services versus those who have not

received individual B.A.S.I.C. services on the ASCI, T-CRS, and ratings on the Student Information Sheet.

7. There will be no significant difference within the experimental group between 3rd and 4th grade students on the ASCI, T-CRS, and ratings on the Student Information Sheet.

For all of the above hypotheses, a multivariate analysis of variance (MANOVA) for repeated measures was used to determine any significant difference between the experimental and control group means on the ASCI, T-CRS, and teacher ratings of achievement, social skills, and behavioral skills. With this information, the decision was made to accept or reject the null hypothesis. If the null hypothesis was rejected, the data were subjected to a follow-up univariate F-test to confirm the influence of the experimental condition.

Summary

Using both qualitative and quantitative methods for program evaluation provided eclectic and extensive data to answer the research questions guiding this study. The data gathered provided descriptive information to assess the effectiveness of the program and provide recommendations for program refinements and modifications.

For the qualitative portion, semi-structured interviews with persons directly involved with the program (school staff, CDSs, and program administrators) provided information on

overall program perceptions. Interview questions addressing program goals and objectives, program implementation, perceived outcomes, and program satisfaction gave information relating to program effectiveness. Also, information gathered in the interview process was used for identifying program strengths and weaknesses as well as points for program refinement. The interview material has undergone analysis to pinpoint themes relating to the research questions.

For the quantitative portion, descriptive student information and data from teacher ratings of coping, competencies, and problem behaviors provided information to assess possible program outcomes. By comparing quantitative information between control schools and experimental schools, this study pointed out any significant differences that may be attributed to the effectiveness the prevention program.

CHAPTER FOUR

ANALYSIS OF DATA

Introduction

The purpose of this study was to evaluate Project B.A.S.I.C., a school-based prevention/mental health promotion program. Data were collected using both qualitative and quantitative methods. For the qualitative data collection semi-structured interviews were conducted with 30 persons representing teachers and principals of six schools which receive Project B.A.S.I.C. services, six Project B.A.S.I.C. Child Development Specialists (CDSs), and two Project B.A.S.I.C. administrators (both past and present positions). The quantitative data collection consisted of acquiring sets of teacher-rating forms on randomly selected third and fourth grade students in six schools receiving Project B.A.S.I.C. services and five schools without Project B.A.S.I.C. services. As in previous chapters, this chapter has been divided into two sections to present the results from both sets of data analysis.

Qualitative Analysis

The qualitative data collected from the 38 semi-structured interviews were subjected to a content analysis. Each person interviewed was asked a core set of 13 questions. The Project B.A.S.I.C. staff persons (CDSs and past and present program administrators) were asked the same set of 13

questions, as well as 15 to 19 other questions more specific to job roles involved with the program.

Suitable inter-rater reliability was attempted but not established, by a three person committee. The committee members included this researcher, and two persons with advanced degrees in education who were objective by having no knowledge of Project B.A.S.I.C. Meetings were held to familiarize the members with the coding process and to allow practice before rating the information independently. During two meetings the coding process was refined and mastered to some extent, but complications continued to arise regarding the other members being unfamiliar with details about Project B.A.S.I.C. After several attempts at reliability establishment, the process was discontinued due to this complication and because of time constraints. The range of inter-rater reliability with the committee from 52 to 56%.

The information gathered from the interviews was subjected to a content analysis which categorized the responses as stated by school staff or program staff. The analysis yielded four primary themes regarding: Program Aims or Purposes, Program Resources, Program Activities, Program Outcomes, and Program Changes Needed. Examples of responses have also been included.

Program Aims or Purposes

Five areas emerged from the interviews related to the program aims or purposes. Responses were coded in this area if reference was made to the program "hoping to," "trying to," or "teaching" in a general manner. Most items coded in this manner were responses made about the program in the present or future tense. The areas found were promoting future mental health, psycho-social skill development, meeting the needs of the school and children, providing something positive for the school environment, and educating society about mental health needs and services. The frequency of responses relating to program purposes can be seen in Table 1a.

A school staff member explained the purpose of Project B.A.S.I.C. by stating:

> . . . the program teaches to look on the inside and that's what counts. It's not so much of what you're wearing now and they try to fix it where if they see a need.. "hey, how can we help this child look better", or "how can we help this child feel good about themselves". And with this concentration you change the mode of thinking within the child, and if you start now then you don't have to worry about the drop-outs. . .you don't have to worry about those with behavior problems when they get older because you're starting now and you try to tell them that "you're the one that can make a difference."

Table 1a
Frequency of Responses for Program Purposes

Theme	School Staff	Prog. Staff	Total
Promote future mental health	63	47	110
Enhance Psycho-social skills:			
Self Esteem, self confidence	50	8	58
Coping with feelings/emotions	29	12	41
Responsibility/decision	27	24	51
Having health body and mind	4	6	10
Getting along with others	33	15	48
Problem solving	7	8	15
Values	12	NM	12
Meet needs of:			
School	27	22	49
Children	50	14	64
Providing a positive influence	25	6	31
Educate about mental health needs	5	25	30

NM=not mentioned

A Project B.A.S.I.C. staff person described the program with many aims by commenting

> . . . it targets the school community, it targets behavior problems, teacher needs, parent needs, mental health issues, academic issues, behavior issues, and also focuses on improving the community's view of mental health and mental health services because I've found that some families are not aware of all the services we can provide or just the fact that we can refer them to other providers. . .

Another program staff person explained the purpose of the program through this description:

> To assist children in having some better choices to make as they're growing up. Getting them to realize that there are people in the county in the schools that do care for them, and that there are other people that are there for them. They don't have to feel like that everything is lost or there is no hope for them. I'm hoping that the children are realizing that, as they grow up, they may not always have to live the way that they are living now.

Promoting Future Mental Health

Interviewees indicated that one of the purposes of the program was to impact children by preventing future mental health problems into adolescence and adulthood. By starting at a young age, the hopes of the program were described as being to enhance the development of these children into productive adult citizens. References made about children as adults or

adolescence, as well as mention of the possibilities for the future were coded in this category. School staff persons gave 63 responses, while Project B.A.S.I.C. staff persons gave 47 responses relating to the program's attempts toward future mental health promotion or prevention.

A school staff person commented about the preventive aspect of Project B.A.S.I.C. by saying:

> Anytime a child is having problems, it's going to go off into the classroom. If B.A.S.I.C. is helping that child then they're helping the teacher. If there's not any disruption in that class because of the problems and B.A.S.I.C. can help that problem, then the teacher is not going to have problems. If the teacher's not going to have any problems, it's going to manifest itself throughout the school. There's not going to be any problems. So I think B.A.S.I.C., overall is a plus for the classroom, the school, and the community. If that child is not helped and the problem grows, then it grows for the school, it probably grows for the community. So I think it's kind of like at the grass root. . .if you get to it first and take care of it then it won't get any bigger.

Another school staff person when asked about any long term preventive effects of the program commented:

> Any time you're making a healthier individual you're giving society a person who can function, a person who can function within a group of people whether it is their peers, their family, and you're giving that other individual freedom to be able to live their life without dragging all those problems with them for the next 20-30 years before, you know, it's an intervention. Trying to

> stop problems from getting any worse and taking control of a child's life. Hopefully, for some it will mean the difference between whether they drink and do a great deal of drugs in high school. If they can deal with the problems when they are younger rather than looking for ways out. Running away. Teenage pregnancy. You think those things start when they're 16, 17, and 20? They start when they're 4, 5, and 6.

Commenting about prevention programs, a school staff person said:

> . . . I think that through taking the preventive approach, we prevent as opposed to try to put a band-aid on at some point down the road. The preventive avenue is a far better approach in my opinion than to try to go back and fix that that's broken and the counseling and to point out what is the right avenue, what is the right path and decide what should be done in a given situation so that the children have better tools, better knowledge, better equipped to make wise choices, make good decisions, academically, behaviorally, emotionally--in any capacity or any fact.

Developing Psycho-social Skills

Another identified purpose of the program was to impact on children's psycho-social skill development. References to specific skill development such as self-confidence, decision making, social skills or responsibility were coded in this category. The 30 school staff persons pointed out these skills in 162 responses, while the 10 program staff persons indicated

these skills in 73 responses. The specific skills described and the frequency of responses are documented in Table 1a.

Meeting Needs

Another purpose of the program indicated was meeting the needs of the school and children. When the recorded responses directly referred to the program meeting the needs of the school or of the children, the response was coded in this category. Meeting the needs of the school was described in 27 school staff responses and 22 Project B.A.S.I.C. staff responses. Meeting the needs of children was indicated in 50 school staff responses and 14 program staff responses.

Giving a Positive Influence

Just giving the schools and students something positive was another identified program purpose. Reference to the program providing a positive for the school or children was coded in this category. Providing a positive influence was referred to in 25 school staff responses and 6 program staff responses.

Educating Society About Mental Health

Educating society (including specifically parents and teachers) about mental health needs and services was another described purpose. Increasing awareness and educating persons about mental health needs and services were responses typical for this category. Project B.A.S.I.C.'s role in

informing society about mental health needs and services was described in 5 school staff responses and 25 program staff responses.

Program Resources

The main resources pointed out as themes referred to overall for Project B.A.S.I.C. were human resources (including the CDS), space, materials, and time. Other resources indicated by only program staff included trainings, commitment, and funding. The frequency of the responses are displayed in Table 1b.

Human Resources

The main human resource provided to the school through of Project B.A.S.I.C. is the CDS. The CDS was described with many characteristics. References made about the CDS and how she handles the program in the school were coded in this category. The CDS was described as competent, professional, flexible, adaptable, heavily involved, and/or caring in 194 school staff responses and 49 program staff responses. Program staff also indicated the CDS as frustrated or overwhelmed in 9 responses, while only 2 responses from school staff addressed this issue. The specific characteristics and frequency of responses are displayed in Table 1b. Other characteristics described by school and program staff but not constituting themes were being relaxed and open, having a

Table 1b
Frequency of Responses for Program Resources

Theme	School Staff	Prog. Staff	Total
Human Resources - CDS Characteristics:			
Competent/professional	93	25	118
Heavily Involved	55	13	68
Flexible/Adaptable	23	9	32
Caring	23	2	25
Frustrated/Overwhelmed	2	9	11
Other Human Resources			
Adequate	NM	1	1
Inadequate	NM	14	14
Space			
Adequate	18	10	28
Inadequate	30	27	57
Materials			
Adequate	34	21	55
Inadequate	3	12	15
Time			
Adequate	NM	NM	NM
Inadequate	25	9	34
Training opportunities			
Adequate	NM	9	9
Inadequate	NM	10	10
Investment by School or Mental Health			
Adequate	NM	NM	NM
Inadequate	NM	10	10
Funding			
Adequate	NM	2	2
Inadequate	NM	7	7

NM=not mentioned

sense of humor, being experienced, possessing certain personality characteristics to fit the role, willingness to learn, and feeling inadequate.

An example of the personal characteristics of a CDS as stated by a school staff person would be:

> Caring people. . .not just anybody can deal with this kind of job. . .who has insight to human needs. This is something that cannot be taught in in a school. This is something that you grab it and it grabs on to you through years of experience and you must love what you do and that reflects also back on how it effects those that you are trying to reach within the program.

Another school staff person described the CDS in this manner:

> It's, it's not just something to do. It's not just a job. It's something (CDS's name) feels deep within herself. It's a genuine concern and feeling for our kids and we call them our kids because we claim them as ours. But it's a genuine, very genuine kind of concern and care that she has for the children and far more giving of herself above and beyond that which is required to help promote the total school program. Being willing to reach out and to offer her time and talents in any way that we feel will benefit the school or have a positive impact. Taking on more responsibility than is required, analyzing the situation and seeing what she has to offer to make it better. Taking the extra time to go the extra mile.

A program staff person described the qualities of a CDS to an extensive degree:

> There are certain personal characteristics that I think drive an individual to being effective as a CDS. One is a prevention orientation which is not always the case. Some clinicians have a real problem making the transition or not being able to achieve transition because they cannot get out of the clinical mind set. A community orientation, a willingness. . .to become a member of another community. . .sensitive to the issue of community membership are real essential. There have been some people that have had some difficulty in that regard. I guess an attitude of a demure crusader is perhaps a good way to describe it. . .The white knight syndrome is real bad for anyone in this position. If you feel like you're coming in and doing something to this community, this child, these groups of people, that is somehow benevolent and beneficent to them then you're not the right person for this position. If you feel like you can come in and work cooperatively with these folks and to achieve some contribution to their health status and probably your own health status along the way, then you're better equipped. . . So there are some inherent characteristics that I think we can choose from and then if that person has the basic equipment of the human service professional. . . the more equipment they have the easier the transition as someone that can be trained in this position. . . It's basically an on-the-job process.

Other human resources involved with Project B.A.S.I.C. were pointed out by only the program staff. Human resources such as referral agencies and support staff were coded in this

category. One response suggested that the human resources were adequate, while 14 responses referred to a lack in human resources.

The other human resources were described by a program staff person in this manner:

> . . .they try to do their best but they're overwhelmed. they can only take so many referrals . . .like a human resource available to me is if I need help from the Department of Human Services and I go to Human Services to get help for a child and they try to make a recommendation to have that child placed in Home Ties, for example, well if Home Ties is full and cannot take that child and when that child needs that help within the next 24 hours, there's only so much that they can do. . .

Space

The availability of work space for the CDS in the school received mixed responses. Direct reference to the available space was coded in this category. Eighteen responses of school staff referred to adequacy of work space, while 10 responses of program staff referred to adequacy of work space. On the other hand, 30 school staff responses referred to the lack of available work space for the CDS, while 27 program staff responses referred to the lack of available work space.

A fortunate program staff person made this statement about her space assignment:

> What I have here is adequate. It's better, much better, than some areas from what I've heard. The teachers here and the principal are very supportive. They've allowed me to have first choice many times in the area for me to use and allow me to move around freely. They've been very supportive in giving me that space.

Another program staff person described a former space assignment in this manner:

> Down there with the garbage. Awful. Awful. I'd sit with garbage and I could always count on the floor buffer but in most cases could not count on a table or a chair and I'm talking a student sized first grade chair and a pathetic looking, it did not qualify for a table that would barely fit the size of the DUSO kit. We couldn't even spread out materials. It was ridiculous for the setting to be that way. We've worked, not just me, but everybody worked too hard to have that kind of setting.

Another program staff person described the limited space for everyone in this manner:

> . . . Every school is crowed and crowded to the point that some of our folks are just taking a little piece of the hallway or one's using a tent. . . I've got to give our folks credit for just being real inventive in coming up with ideas and ways to make space. And I laugh about one CDS and her boiler room going outside, having to go outside the building down underneath the building and taking just a little section of the boiler room and making a little room that she can use. . .It hasn't slowed anybody down that I know of. We've got three people that are

> just set up in the hall right now. Of course one of those people has been promised her own office as soon as they have a building program in process. . . I mean we've got people in ticket booths and all those kinds of things.

Materials

Reference to the materials available to the CDS was coded in this category. The adequacy of materials to conduct Project B.A.S.I.C. was supported by 34 school staff responses and 21 program staff responses. The lack of material for the program was referred to in 3 school staff responses and 12 program staff responses.

Time

References to the amount of time available to the CDS and for the school were coded in this category. The lack of time to conduct the program was referred to in 25 school staff responses and 9 program staff responses.

An example of a school staff response related to the lack of time was expressed by this comment:

> But I think all too often somebody like (CDS) is put in a situation where there is not enough time. . .enough hands, so to speak. There is one of her and too many of us.

Other Resources

Other resources were mentioned by only the program staff persons. Regarding training opportunities, the program staff felt the opportunities were adequate (9 responses) or

lacking (10 responses). A program staff person explained situations regarding training opportunities in this manner:

> The center has allowed me to attend a couple of seminars but it's getting harder and harder to get that approved and just recently, I really felt let down because we were told to target SED children that would benefit our program. . .Those children need our help. There was an opportunity for some of us to go to a seminar on working with children with severe emotional problems but I wasn't allowed to go. It wasn't approved by my team leader.

Another staff person explained that training specific for the CDS was lacking because:

> There is no specific preparation. . .there is no one training mental health preventionists . . . And this program . . . would have worked most effectively with a trained mental health preventionist coming into the program. . . but there just aren't any out there or very few of them out there.

A lack of investment or commitment by the school was referred to in 5 responses and by the sponsoring mental health agency in 5 responses. Funding was referred to as adequate in 2 responses and as inadequate in 7 responses. Other areas mentioned but not constituting themes were a lack of public relations, lack of standardization, and evaluation information.

Program Activities

The specifics of the program's implementation were described through a variety of activities. The items coded in this category were responses that made direct statements or references regarding the activities of the CDS, such as she comes in the classroom, she keeps me informed, or she works with this child with problems. The activities of the CDS centered around the perceived themes of classroom activities/lessons, intervention, working with the school, liaising, providing a resource, school climate enhancement, establishing relationships, and other activities (see Table 1c).

Presenting Classroom Activities/Lessons

Classroom activities in the responses were coded when reference was made regarding the CDS coming into the classroom, referring to a specific lesson, or describing the teaching methods. Classroom activities or specific lessons related to the CDS conducting mental health education was pointed out in 52 school staff responses and 37 Project B.A.S.I.C. staff responses. The variety and appropriateness of the classroom activities was described in 33 school staff responses and 4 program staff responses. The classroom activities taught by the CDS were described as reinforcing what was taught in the regular classroom or filling in for what the

Table 1c

Frequency of Responses for Program Activities

Theme	School Staff	Prog. Staff	Total
Classroom lessons	85	41	126
Reinforces regular classroom	40	2	42
Intervention	114	36	150
Deal with children/family problems of:			
Broken homes	32	4	36
Deprived	38	12	50
Behavior Problems	25	8	33
Home life issues	12	13	25
Abuse	11	5	16
Death in family	4	4	8
Transitions	4	3	7
Vulnerability	4	1	5
Self-esteem	13	NM	13
At-risk	12	NM	12
School/learning issues	12	NM	12
Work with the school			
Teachers	52	24	76
General school	28	11	39
Principal	6	8	14
Liaising			
Parents/guardians	52	17	69
Other agencies (DHS, MH, etc.)	28	38	66
Community	13	16	29
Resource used by/for			
Teachers	57	12	69
Principal	11	4	15
Parents	22	4	26
Students	15	2	17
General	14	7	21
School Climate Enhancement	22	23	45
Establishes relationships with others	53	23	76
Implementation decisions	NM	16	16

NM=not mentioned

classroom teacher lacked was mentioned in 32 school staff responses and 2 program staff responses.

A school staff person provided this example regarding the CDS filling in gaps for the teacher:

> I think getting to share and talk with someone different besides the teacher who doesn't have the way of thinking "Oh my gosh, I need to be teaching time. I need to be teaching them to count. I need to be doing this. . ." that can just come in and kind of sit down or walk around the room in a more relaxed environment and just let the children stand up and talk about what's happening or what they just drew on their paper. That kind of thing is helpful.

Another school staff person commented regarding the situation in this manner:

> . . . I just feel like our school has been so fortunate to have this program because I think we have a higher percentage of children with problems and I think that this program really address a lot of things that as teachers, you know, we can't cover.

Intervening

The CDS was frequently referred to as working either individually or in small groups with children who have problems. The CDSs were described as working to help these children by discovering or diagnosing the problems. Intervening with problem children was mentioned in 114

responses by school staff and 36 responses by program staff. Characteristic problems of the children and their families also became evident through 167 school staff responses and 50 program staff responses. The main types of problems faced by children and subject to Project B.A.S.I.C. intervention were stated as broken home issues, deprivation of means or parental involvement, behavioral problems, home life issues, abuse, death in family, transitions, and vulnerability. Children's problems dealt with through CDS intervention mentioned by only school staff included self-esteem issues, at-riskness, and school/learning issues. Details of the frequency of responses about children's problems are located in Table 1c. Other problems mentioned by either school staff or program staff which did not constitute themes included dealing with family secrets and long term problems.

Working with the School

Another activity of Project B.A.S.I.C. conducted by the CDS was working with the persons involved in the school environment. Responses were coded in this category when the CDS was referred to as working with teachers, the school principal, or the whole school in general. Working specifically with teachers was referred to in 52 school staff responses and 24 Project B.A.S.I.C. staff responses. Working with the principal was referred to in 6 school staff responses and 8 program staff

responses. Working with the overall school was indicated in 28 school staff responses and 11 program staff responses.

Examples given by school staff persons explaining how Project B.A.S.I.C. works with the school and its staff were described in this manner:

> We are working together. . .we are a unit. . .one can't do without the other.
>
> She pitches right in there with us, and it is a team effort. I really appreciate that, because B.A.S.I.C. could be a program completely apart, but instead it has been a very integral part of our curriculum and our total school program.
>
> I haven't found anything that she won't hunt or find or didn't know that I've asked. So she either finds out or know it or looks it up and has more than shared with me for my own children at home as well my children at school and any time it's psychological she can explain things on some of that stuff better than the explanation I get from the school psychologist.
>
> . . . it would have to be a positive effect in that just by virtue of having another outlet for some of these children, it takes a lot of pressure off of us as teachers. I think there's less pressure in our jobs knowing that more children are receiving help for some of these really bizarre behaviors that we're seeing now. . .

Liaising

As well as working within the school environment, the CDS was also referred to as making contacts outside the school

through parents, outside agencies, and the community. Responses mentioning these activities were coded for this category. Working specifically with the parents or guardians of the students was referred to in 52 school staff responses, and 17 program staff responses. The CDS referring to or working with outside agencies such as mental health service providers, Department of Human Services, or the Juvenile Justice System was pointed out in 28 school staff responses and 38 program staff responses. The CDS working with the general community was described in 13 school staff responses and 16 program staff responses.

A school staff person responded to the CDS acting in a liaising role by stating:

> Well, (CDS's name) and I talked some and I think her main objective is to help the child first, but she reaches a little farther than that even to families. Helping families with problems they may have that interfere with learning, self-esteem, and that kind of thing. She works with parents as well as children. Also, it's a good person to facilitate a child getting services from other organizations that might could help the child. I'll go to her quickly if I need an outside organization. She can tap into that as quick or quicker than I can.

Another school staff person described the CDS's role in the school and community by commenting:

> I think she kind of serves like a bridge between the community services, and us, and parents. So she's kind of in between all of us.

Providing a Resource

Project B.A.S.I.C. providing a resource for teachers, principals, parents, and students was also identified as an activity of the CDS. Responses pointing out the CDS as a resource or referencing the CDS as being used by others were coded in this category. Providing a resource or being used as a resource specifically for teachers was mentioned in 57 responses by school staff and 12 responses by program staff.

One school staff person stated:

> As, individual teachers, we have talked with her quite a lot about individual students who had serious problems, and she has followed through with that as much or more than any guidance personnel or that sort of thing we have access to.

Another school staff person commented:

> Actually I feel more comfortable turning to (CDS's name) about problems with the kids than I do our own guidance counselor. . .So it's wonderful to be able to have another resource because if not, we would be left just standing there trying to work it out ourselves. . .

A program staff person described the program providing a resource in this manner:

> Just having a resource person who is not part of their system. Who isn't caught up in the school's politics and that's real surprising to them that we can care so much about a place that we are not employed by, and in a way, I think it makes us each have more impact on the parents and on the students and the teachers as well.

Providing a resource or being used as a resource specifically for principals was referred to in 11 school staff responses and 4 program staff responses.

A school staff person described the CDS as acting as a resource for the principal in this manner:

> If I have a problem that I think (the CDS) needs to see about, I can call her at home or I can call at (the other school) and say, "Look, I have a problem." She'll work with the principal at (the other school) so she can come over here. The day that she's supposed to be here, she will go back and be over there. But (the CDS) puts in more time than I think the program actually calls for, for the benefit of the kids.

Providing a resource or being used as a resource for parents was described in 22 schools staff responses and 4 program staff responses. Providing a resource for students was identified in 15 school staff responses and 2 program staff responses. Just providing a general resource was referred to in 14 school staff responses and 7 program staff responses.

Enhancing School Climate

The CDS conducting special programs or school climate enhancement activities was also described as an activity of

Project B.A.S.I.C. Special programs or school enhancement activities mentioned were coded in this category and included examples such as Academic Pep Rallies, Birthday Boards, Attendance Programs, and Student of the Week. School climate enhancement activities were mentioned in 22 school staff responses and 23 program staff responses.

Establishing Relationships

Another activity of the CDS included establishing, building, or maintaining relationships with various individuals or groups in and around the school environment. Responses referring to the CDS establishing relationships, being a friend, or showing evidence of a relationship such as "The children just love her!" were coded in this category. Establishing or maintaining a relationship with the students, teachers/principals, or parents was described in 53 school staff responses. Program staff referred to establishing relationships with students, teachers, parents, or the sponsoring agency was included in 23 responses.

Other Activities

Another activity of the CDS identified by program staff was the CDS's involvement in making specific implementation decisions for the individual schools (16 responses). Various other activities referred to by school and program staff but not constituting themes were sending out parent/teacher feedback

forms, being asked to do other things outside of Project B.A.S.I.C. responsibilities, attending trainings and meetings, and keeping the program diverse and flexible.

Program Outcomes

Any changes or results of the program in persons or environments were coded in this category (see Table 1d). Outcomes as a result of Project B.A.S.I.C. were described as being in the areas of cooperation, children, school staff, classroom/school, and parents/community. Other outcomes such as obstacles of the program, benefits of the program, support of the program, and satisfaction with the program were also identified.

Cooperation

Working together or getting along better was an outcome reported by the respondents. References to students, staff, parents, or community agencies cooperating more or getting along better were coded in this category. The school staff indicated more cooperation with the home, teachers, or the students in 16 responses. The program staff referred to more cooperation between home, teachers, students, or outside agencies in 7 responses.

Children

The main response to program outcomes focused on the impact on the students. Changes described in students such as

Table 1d

Frequency of Responses for Program Outcomes

Theme	School Staff	Prog. Staff	Total
More cooperation btwn others (Students, teachers, parents, agencies)	44	7	51
Impact on children's:			
self-concept/attitude	27	NM	27
behavior	33	6	39
decisions/responsibility	16	7	23
coping/handling stress	13	3	16
opening up/know s'mone cares	29	9	38
remembered/learned lessons	19	11	30
overall positive change	45	17	62
Changes in teachers/principal/staff	42	15	57
Changes in classroom/school	33	3	36
Changes in parents/community	26	15	41
Obstacles	5	8	13
Benefits of Program (Students, teachers, parents, community)	21	NM	21
Demonstrate program satisfaction	100	14	114
Demonstrations of support by teachers, school, guidance counselors, parents, community, mental health, program staff:			
Positive	17	27	44
Negative	23	33	56

NM=not mentioned

feeling better about themselves, coming out of their shells, or trying harder were coded in this category. Improvements in children were referred to by school staff in 182 responses and program staff in 53 responses. The specific categories and frequency of the responses are contained in Table 1d.

An example of the impact Project B.A.S.I.C. has had on a child is described by a school staff member who stated:

> Another child last year, he was having problems with his lessons when he got home. He was a slow learner. . .had comprehension problems. . .angry all the time. I sent him down here to be counseled. Come to find out it was a home problem. Mama wasn't there. Mama couldn't read. . . and grand-mama was too old to help with anything. . .daddy was on a county road. . .the aunt was trying to do what she could. . .so that was self-esteem, that was anger. . .I can't voice so I'm gonna voice it in any way that I can! We got the mama in here, sat down and talked to her and told her about these adult programs. .. It's alright. . .you can't read now but you can make the change. . .your child needs you! You see this gets interpersonal. That baby began to come in. . . he'd be frustrated. . .but he began to try a little harder. And what told it all. . .we had a play. . .he was never one to do anything. . .and he was chosen for this part to do in the play. This little guy. . .7:00 at night the program was supposed to begin. . .mama's still irresponsible. . .but, wait a minute. . .he took it upon himself, yet it was dangerous, to walk from where he lived back over here to the school to show that he was responsible enough to do his part and be happy about it! He's in third grade now. . . You need to see him!

A Project B.A.S.I.C. staff person made this statement:

> . . . I truly can say we have been able to help some children who may have not gotten that help until later on when the problem would have only increased and maybe have become severe. So we've been able to prevent some serious problems within families, within the school, within that student, and hopefully those families and children will share some of the things that we've taught them and that they've learned.

Teachers/Principal/School Staff

Results of Project B.A.S.I.C. related to the school personnel were referred to in a positive manner. References to teachers or any school staff person changing were coded in this category. Forty-two responses from school staff and 15 responses from program staff reported positive changes seen in teachers or principals.

A school staff member commented on the impact upon teachers by stating:

> I think there are a few teachers who are now more aware of how emotional upset can really hurt a child in the classroom, teachers that, you know, didn't receive a lot of training along those lines in college, some of our newer teachers, made them more aware that you need to deal with these kid's problems get them some help. And then it would help your classroom, make your job easier.

A school staff person responded from personal experience by commenting:

> I think it's given me a lift as a teacher. It motivates me and wants me to try to touch on those things more than I have in the past.

Another school staff person admitted to being surprised by responding:

> I did not expect the support for myself as a teacher. I knew the program was going to be supportive to the students and I was not aware when the program started, the materials and things available to the community. She also meets at (Club name) meetings and I just assumed when they said, "You're going to have Project B.A.S.I.C.", she would come into my classroom one every two weeks. I did not know that if I had problems or anything else that she was willing to help me with those problems. . .not only school problems but anything that I needed help with.

Another school staff person described a personal outcome by stating:

> It gave me some perspective and some views and angles to take from that I had not thought of and, you know, to me that's long-term effect when you get into how that's focusing and helping and all those things.

A program staff person describes changes seen in the teachers with this explanation:

> Some of the teachers have been changed. When I first started here, a few of them were making referrals or coming in asking me for information for assistance and referrals as far as resources. I've had a few that have come to me just wanting to talk about some individual problem that they have. That was not so when I first started.

Classroom/School Environment

References to changes in the classroom or overall school environment were coded in this category. Positive changes observed in the classroom or school environment were described in 33 school staff responses and 3 program staff responses.

Parents/Community

Any observed impact or change in parents or the community as a result of Project B.A.S.I.C. was coded in this category. Impact on parents or persons in the community was referred to in 26 school staff responses and 15 program staff responses.

When asked about any impact Project B.A.S.I.C. had on parents, a school staff person responded:

> I know of a couple of situations where it, I know of one particular situation where it got a parent in counseling. I know another situation where it, a couple come to mind, where it has given parents some parenting skills. I think definitely influenced and changed a few parents, not a lot, but still, even if you just reach one that's great.

Another school staff person expressed dismay regarding this situation:

> Well, I'm surprised that every parent that we mention this program to was not eager to take advantage of it. As a parent I'm surprised that here is this wonderful resource that's available to them and they choose not to participate.

Other Outcomes

Respondents also referred to situations where Project B.A.S.I.C. may have run into obstacles which hinder any impact the program may have on a child. Five school staff responses mentioned little-to-no impact because of potential obstacles as well as 8 responses of program staff persons.

A Project B.A.S.I.C. staff person described a situation in this manner:

> An unexpected outcome I think for me is sometimes how angry parents can get when they try to provide assistance or intervention. . .because some people perceive mental health personnel as being very threatening, very intrusive, and they are somewhat fearful and paranoid about that. . . We have to have parental permission before we engage in a counseling relationship with a child and without that permission the child who truly needs our intervention may not receive it.

Regarding the same situation, the program staff person continued by stating:

> It hasn't effected the whole community it's just maybe after the initial assessment they became very angry that I saw the child. . . There's only one long-reaching effect of that and in one family that child is now involved in mental health intervention. So I guess something negative turned into something positive after all.

Another program staff person responded:

> If I know there's a student and I've talked with them and I've become friends with them and I know they're having problems with something or something has happened that they are not able to deal with I can't just call a parent and recommend therapeutic counseling and if that parent says "Well, I'm sorry, I don't have the time" or whatever excuse that parent gives. . . I can't just not see that student again. I try to do the best I can do to help them deal with this.

A program staff person had this to say regarding obstacles:

> I wish that we did not have to have a parent's permission to see a child. I understand the importance of that, but I wish we didn't have to. There are some children that would like to talk, and parents say no. I've had that to happen in three circumstances, which is not very many. I feel like that those three have probably lost out by not having someone to talk with.

Another program staff person described different obstacles faced:

> . . . there is not a one of us that is not going to respond in the best way that we can to a child who is in fear of crisis and when you are talking about waiting lists at centers and you're talking about unresponsive parents or if they

> are in such a state of denial or if you cannot get DHS to move. . .with all the barriers that the children will have to face, we're just not going to turn our backs on them.

Other outcomes referred to by school staff persons which did not constitute themes include preventing potential problems by educating school staff, removal of children from detrimental home situations, few if any short term changes, and surprise that Project B.A.S.I.C. continues.

An example given by a school staff person related to the removal of a child from the home was stated in this manner:

> Sometimes the outcome, as a result of Project B.A.S.I.C., is not what we would like to have happen. If the child has to be hospitalized or removed from home or something because of the CDS's tenacity, it's not always the desired outcome but I think you have to expect things like that if you have someone who's working hard to solve problems.

A school staff person provided an example relating to problems in measuring short term effects:

> . . . a lot of the benefits received from the program are not necessarily readily visible as far as being something that's tangible or immediate. Often times the impact that you have just as a classroom teacher, is not readily identifiable and I think that there's not a true measurement that you can make as far as the positive impact of it because you don't always know how you touch a child or how what you're saying will effect them in making better decisions. Often times it is readily identifiable and you can observe changes in the children's

> behavior or see that they're adapting better socially, see that they're making wiser choices, wiser decisions, see that parents have their children on a regular basis, see that there's an improvement in parenting skills but you don't always measure that because it could be the child might not have encountered a given situation they could just say no to or have a need to just say no but further down the road might have an experience where they could think back, yes, (CDS's name) told me what I should do in this particular setting when you find yourself at odds with another classmate or whatever and it might not be this year but it might be next when the child could look back and say hey, I learned what to do. (CDS's name) told me what I need to do when I was facing a situation such as this. What action shall I take? How should I respond? What's my best choice? What's the best approach in a given situation so it may not be immediate but certainly a positive impact at some point in time. . .

Another school staff person responded to feedback given as a result of the program:

> . . . we get a lot of feedback that we might not see otherwise working with the children ourselves and you can sit back and look at a different person and hear their responses. Sometimes you find out things about that child that helps you and I know that's not really an expectation of the program but that's helpful kind of aside. . .it helps the teacher work better with that child. It sometimes gives insight into a family situation that the teacher may need to get involved, in order to help that child, so that it would help you know family/community both.

Another school staff person described prevention of problems with parents through this outcome:

> I've used (CDS's name) as a sounding board in dealing with parents, you know I mean, it's definitely helped me to approach things in a different perspective and from a different standpoint to where that, you know, it's helped prevent problems in dealing with the parents and I think I can say that will continue to happen as far as having her for that in that any time we can prevent a problem with parents that's definitely what we need to do. . .

A school staff person expressing surprise at the longevity of the program stated:

> . . . I couldn't imagine this wonderful gift from heaven for more than one year at a time and I've been real surprised that it's been going on for three years and that the funding has continued with the turmoil and government and powers that be. There's people that like those checks for this type thing. That was a pleasant outcome.

Other outcomes as seen by the program staff but did not contribute to a theme included building upon the program year after year leading to more long term benefits than short term benefits, increase in the number of referrals, students not receiving help developing more serious problems, and a change in attitude about mental health services.

Who Benefits

Only responses that stated direct benefits of the program were coded in this category. School staff identified children,

teachers, teachers, or the school as being benefitted by the program in 21 responses.

Program Satisfaction

Questions regarding the overall perception of program satisfaction were responded to by both school staff and Project B.A.S.I.C. staff. Expressions of satisfaction were coded in this category. The school staff reported program satisfaction in 100 responses, while program staff reported program satisfaction in 14 responses.

One school staff person responded honestly by saying:

> Well, I don't think every program meets the needs of every child. I'm sure that there are few that fall through the cracks and just misses with them but, on the majority, on the whole, but I think that as far as addressing important topics and at least giving them all a taste of some of the lessons, I think it does, Project B.A.S.I.C. does a good job.

A program staff person described evidence of support through this report:

> What is the level of satisfaction? Gosh, that depends because I have had a variety of reactions that has stemmed from a fifth grade teacher who has made me the scapegoat of all mental health centers' activities to. . . I would say the kindergarten through third grade teachers come to me all the time and now even some of the fourth grade teachers have come to me (I've worked with some of their kids now) and said how they are

> really thankful Project B.A.S.I.C. is there in the school. . . I think on the whole they are more than satisfied with the program really. I think they would fight to keep it there, put it that way. I guess it's all in the teachers having realistic expectations that I can't cure these children, I can just offer suggestions to help them manage them.

Support

School staff and program staff reported both positive and negative support of Project B.A.S.I.C. Support was coded when the response contained examples or demonstrations of positive regard for the program or negative regard for the program. School staff referred to positive demonstrations of support by teachers, parents, students, or community in 17 responses.

A school staff person demonstrated positive support of the program by responding:

> You never see anything in the papers from the State about Project B.A.S.I.C. other than maybe from the school because I think it's the best kept secret in town to tell you the truth. I think it needs to be advertised on a higher level on what the job responsibilities and duties are.

Another school staff person expressed positive support by stating:

> I think Project B.A.S.I.C. is really filling a strong need that we have here within the school and in society. . . we are just adamant about doing whatever we can do to keep it in our system. . . if there's anyway we could and if it

> comes to the time when picketers are needed for the funding, just call me!

Project B.A.S.I.C. staff referred to demonstrations of support by teachers, the school, other program staff, the sponsoring mental health agency, parents, or the community in 27 responses.

Conflict, lack of participation, uneasiness, or any controversies were coded as negative support of Project B.A.S.I.C. School staff reported negative support by parents, teachers, or the community in 23 responses.

An example of negative support from parents was expressed by a school staff person in this manner:

> . . . Parents sometimes seem a little resistant or a little hesitant about having someone talk with their children and I don't, you know, and this is not even circumstances where I think they have anything to hide or that there's problems at home that they don't want shared. I don't know whether it's just as a general thing in society that if you have to go to someone to talk that you're crazy or, you know, that kind of perception of things or what. I just feel like if somebody's there that's a resource that we can use, then we need to use them.

Project B.A.S.I.C. staff reported demonstrations of negative support by the sponsoring mental health agency, parents, guidance counselors, the community, or teachers in 33 responses.

Support in a negative manner by the sponsoring mental health agency was indicated by a program staff person who stated:

> . . . From the amount of grant money and then how much the center was allowed to use towards office space and office machines. . .what was left over after that, there was money there. When my past supervisor and I sat down and worked on a budget, there was money to increase travel, there was money there to increase supplies, there was money there so that I could go to seminars. . .We wrote out a budget for an increase in pay and then when the changes were made that have been made now, I'm being told by my team leader "it's different now" and I'm not clear as to how it's working. . .

Another response by a program staff person demonstrates negative support from the sponsoring agency by describing:

> Up until this year there hasn't been that much of a problem because I was satisfied pretty much because I was on a school-based schedule, 9 month contract. I was off 2 1/2 months during the summer and 2 weeks for Christmas and as far as pay compared to a teachers pay, no, it's not comparable. . . but now, they are trying to have me work 12 months for the same pay . . .

Another staff person described her frustration in this manner:

> . . .I know (State Coordinator) knows what we do because she's already done it and she can truly appreciate the frustration of being an outsider at school and being an outsider at the center.

As an example of parental support in a negative manner, a program staff person describes:

> One negative unexpected outcome for me was when I more aligned myself with the mental health center, some of the phone calls from parents were really agitated and "didn't want that crazy doctor seeing" their son or daughter or whatever, so I've had to tone that down and send out permission forms on school stationery and kind of be real subtle with my affiliation with the mental health center. . .But at the same time maybe that will help the relationship between the mental health center. . . if they feel that I'm doing a good job maybe they'll feel better about the mental health center.

Both school staff and program staff referred to other issues related to support that could not be fit neatly into either category. Items such as dealing with uneasiness of school administration and teachers in program beginnings, differing requirements for the CDS between the school and sponsoring mental health agency, long standing conflict between the school and mental health agency, and program staff being taken advantage of by both the school and mental health agency were also present.

Program Changes Needed

Respondents had many recommendations to refine Project B.A.S.I.C. (see Table 1e). The main areas targeted for change were towards time, materials, space, communication,

Table 1e

Frequency of Responses for Program Changes Needed

Theme	School Staff	Prog. Staff	Total
Increase time/staff	92	10	102
Update, expand materials	34	24	58
More of different space	39	10	49
More communication (w/ teachers and parents)	30	7	37
Increase/reorganize funding (+ stability and expansion)	24	20	44
Lessen program requirements	9	8	17
Increase training opportunities	3	16	19
Increase referral resources	3	6	9
Increase investment and commitment (schools and sponsoring agencies)	NM	10	10
Change MH's view of program	NM	9	9

NM= not mentioned

and funding. Other changes suggested included program requirements, trainings, and resources. Changes in the investment from the schools and mental health agency, along with changes in mental health's view of the program were mentioned by only program staff.

Time

The time allotted for the CDS in the school whether full time or half-time, was a popular item pointed out by the respondents. Wishes regarding the amount of time allotted were coded in this category. School staff referred to increasing the amount of time allowed or increasing the staff in 92 responses. Program staff referred to increasing the time in 10 responses.

A school staff person suggesting a change in the amount of time allotted to Project B.A.S.I.C. made this remark:

> If anything, I would like to see maybe more people in the field. I'd like to have (CDS's name) full time. .. I'm sure that (principal name) at (school name) would like to have her full time. . .to be there so I wouldn't have to call if I needed her. I think more time in the school if anything. But the program itself, I think, is sound. I think the purposes are sound. There wouldn't be a whole lot of change except having her a little more often.

A program staff person wishing for changes in time explained:

> . . . I wish that I had co-workers doing the same thing that I am doing and in the same school system or. . .

> something that we could work more closely as a team so that I wouldn't feel so spread out. I mean there are days I can't even get down the hall, you know my classes one after another. Say a teacher for the fourth or fifth grade or even one of the grades that I'm in needs to talk to me. . . . that puts me behind and it takes away from the time that I should be with the next class, so it gets really hard sometimes to meet your goals and expectations of that day just because someone's having an emergency.

Materials

Suggestions regarding updating, expanding, or standardizing materials were also addressed as a point of change, and were coded in this category. School staff referred to changes in materials in 34 responses, and program staff referred to changes in materials in 24 responses. A school staff person suggested:

> Just something in general maybe would be when they're doing the group sessions in our classroom, maybe if it were some lessons that were designed to focus in and talk about family problem and broken homes and, you know divorce, just the things the children are facing today, maybe even death, and you know that maybe something that as people who are trained with guidance in that kind of thing say, "Oh, you don't want to have that discussed with a group", you know, I mean there again, that's not my area of expertise but that would be the only thing as far as what she does in the classroom.

Space

Changes related to the space assigned to the CDS in each school were also recommended, and were coded in this category. Giving the CDS more space or a different space was mentioned in 39 school staff responses and 10 program staff responses.

Communication

Better communication or involvement between the CDS and teachers or parents was also suggested to be a worthwhile change, and was coded for this category. School staff stated a wish to see better communication between the CDS and teachers or parents in 30 responses. Program staff expressed wishes for better communication between CDSs and teachers or parents in 7 responses.

Funding

Increasing or reorganizing funding was also an area suggested for modification, and any responses regarding these changes were coded in this category. Increasing funding also was coded as related to wishes regarding program stability and program expansion. School staff gave 24 responses related to increasing funding, program stability, or program expansion. Program staff gave 20 responses related to funding, program stability or program expansion.

A school staff person commented about changes needed in program funding by stating:

> I know there is always a question as to whether or not Project B.A.S.I.C. is going to survive budget cuts and things like that leave a little uneasiness about the program. It would be really nice if this were perceived as a very integral part of a school, and as a way to unite the community and the schools. This is something we keep talking about and this is one way that it could actually happen in a very concrete way, but it's going to require a lot of funding from the state in order to get this done.

Wishes for the program to extend its services both to earlier ages and later ages as well as to expand to more schools was suggested by the respondents. A school staff person commented regarding program expansion:

> Project B.A.S.I.C. here in this county works with only grades K through 3 so maybe back in that other question what we need more of is more flexibility as far as grade wise because she only works with K through 3.

Another school staff person stated:

> I am a big advocate for these interventions for children. I don't think we get them early enough. I would like to see some kind of program like this in the preschools, particularly in the housing projects. We may have some that I am just not aware of. If we could get the children even sooner at age three, then I think we would see a greater gain by the time we get to Kindergarten.

Program Requirements

The paperwork and program requirements were also targeted for change, and were recorded in this category. Freeing the CDS from paperwork and meetings was suggested by school staff (9 responses) and program staff (8 responses) in order to allow the CDS more time.

Training

Making changes regarding the amount of training made available and allowed for the CDS was coded in this category. Allowing the CDS to attend more trainings was suggested by 3 school staff responses and 16 program staff responses. A program staff person stated:

> I wish that they would make it more available to me. The experience and knowledge gained from things that we are allowed to attend and from the seminars and things like that are as important to me as salary. I feel like I want to do my job adequately and I want to go home at night and be able to think that I was qualified to have worked with that child with that problem. . . If I'm not allowed to go to seminars to learn things and to become more knowledgeable of what's being taught. . . then I'm just having to go on my own personal experience.

Another program staff person described:

> I wish that there were a state requirement to the centers with a grant that they send down for a certain percentage of that to go to training. Just like there is a percentage that goes for having internal coordination and a

> percentage of the money that goes for state coordination. Maybe they can't require the centers to do it. . . they need to reduce the grant and take such a small piece from each pie and have one chunk do group in-service and put somebody in for something that would be real helpful to us.

Resources

The availability of human resources was another area targeted for change. Responses regarding changes in the availability of human resources, such as referral agencies, were coded in this category. More resources were suggested by 3 school staff responses and 6 program staff responses. A program staff person stated:

> I wish that we were more in tune, and I don't know necessarily know that anybody is, with community agencies and knowing what's going on and actually being able to access services a little bit better. However, just calling agencies within the state, they don't even know what their parameters or limitations are and find it hard to to give us requirements or a set of criteria that we can use so that we know who to refer and who not to and how to access their services.

Other Areas in Need of Change

Project B.A.S.I.C. staff suggested other areas also in need of change. More investment or commitment from the schools or the sponsoring mental health agencies was referred to in 10 program staff responses.

A program staff person commented about more investment in the program from schools, mental health agencies, and the state department by stating:

> I think a broader base of investment. . . A lot of people are getting an awful lot for free. For instance I can only speak of certain schools, for the project the problem we always had was the schools welcome the project almost universal, were supportive in a general sense of the word, but a sense of investment wasn't there or even a reality of investment. . . To a certain extent I feel there's been a loss in investment on the part of the mental health centers themselves. That's in part because there is little incentive financially, or politically to pursue prevention services right now and that's been declining for some time. . . There is a certain lack of investment on the part of the State decision-makers. . . there is a failure to really endorse the concept of mental health prevention or mental health promotion as a primary service responsibility of the State program. . . It has to be a natural part of operations and it doesn't exist for anyone. It always remains a special project. It has never become, it has always been fairly permanent, I mean it's been in existence for ten years now and with other locations as well. . . it's still been on a kind of year-to-year base. So I think a broader base of investment needs to be there.

Changes in the sponsoring mental health agency's view of Project B.A.S.I.C. was mentioned in 9 program staff responses. A program staff person commented regarding the sponsoring agency's view of the program:

> . . . Our staff people deserve more respect in and amongst the mental health community and in and amongst their local offices. Prevention is not looked upon

> as profitable in the short fall. . . it's not looked upon as profit producing type of program, therefore the powers that be amongst the community mental health centers often do not view it as a valid part of their system and prevention is very much a part of their system. It's an important part of their system and it should be a major dedication on the part of the community mental health centers for the benefit of the community not just for the benefit of the severely and consistently mentally ill persons. . .We know now that so many of the problems that adults have can be linked to things that happened in their childhood and if we can identify those needs in childhood, we can alleviate a lot of those problems in adulthood and by doing so the bottom line is not only lives saved, and minds saved, and bodies saved, but money saved.

Other areas mentioned for change but not constituting themes were for more evaluation techniques, more public relations, more program flexibility, and more support and cooperation from parents and guidance counselors.

Summary of the Qualitative Analysis

The qualitative information provided input from teachers, principals, CDSs, and program administrators regarding their view of the program's purposes, resources, activities, outcomes, and changes needed. The results are summarized below:

- The purposes of the program were described to be the promoting future mental health, psycho-social skill development, meeting the needs of schools and children,

providing a positive influence in the school environment, and educating society about mental health needs and services.

- The resources of the program included the CDS, other human resources, space, materials, and time. Other resources indicated by the program staff were training, commitment, and funding.
- The program activities described by the respondents were classroom lessons, intervention, working with the school, liaising, providing a resource, school climate enhancement, establishing relationships, and making implementation decisions.
- The outcomes of the program were indicated to be mainly in cooperation, children, school staff, classroom/school, and parents/community. Other outcomes were reported to be benefits of the program, support of the program, and satisfaction with the program.
- The changes needed in the program or recommendations were pointed out to be regarding time, materials, space, communication and funding. Changes were also referred to in program requirements, training, resources, as well as investment.

Quantitative Analysis

The data were collected from six experimental schools and five control schools. Third and fourth grade teachers from

each school were asked to rate five randomly selected students from their classrooms on measures of coping, student problems and strengths, achievement, behavior and social skills, as well as fill out a student information sheet.

Comparisons Between Experimental and Control Groups

The experimental and control groups were subjected to a Chi square to determine any differences between the two groups due to any variables (besides the dependent variable) which might have influence on the results. The Chi square indicated that the experimental and control groups did not differ on numbers relating to gender (X^2 [1, n=326]=.02, p>.05), free lunch (X^2 [1, n=312]= 1.88, p>.05), types of household (X^2 [2, n=323]=2.58, p>.05), or special education (X^2 [1, n=317]=.02, p>.05).

A MANOVA was chosen because of multiple dependent variables present in each hypothesis and to reduce the likelihood of Type I error. As a result of the MANOVA, multivariate over univariate tests were selected due to the determined significance of Bartlett's Test of Sphericity. According to Schutz and Gessaroli, ". . .multivariate repeated measure (RM) designs require ANOVA test statistics (if the RM assumptions are met) or MANOVA test statistics (if the sphericity assumption is not met) on the RM factors, and at the same time, uses true multivariate procedures for the multiple

dependent variables" (Schutz & Gessaroli, 1987, p. 136) Normal distribution with equal variation within the groups was assumed. To support or reject each hypothesis, a multivariate F-test (Wilk's lambda) was conducted to determine any significant differences. Follow-up was conducted through univariate F-tests. The significance levels for the univariate F-tests were adjusted to control for Type I error. The standard alpha of .05 was divided by the number of tests run (ie. .05/4=.0125 and .05/3=.017). Each set of data related to a hypothesis was analyzed with these statistical procedures. Group means and standard deviations for experimental and control groups, students receiving individual B.A.S.I.C. Services and no individual B.A.S.I.C. services, and third and fourth grade students are displayed in Tables 2a to 2f.

The first hypothesis was that there would be no difference between the experimental and control groups in adaptive and maladaptive coping domains in academic and social situations as measured by the ASCI. A significant difference was determined between the two groups by a multivariate F-test (Wilk's Lambda) [F (3, 315)=3.678, $p<.05$]; therefore, the null hypothesis was rejected. Results from the follow-up univariate F-test (Table 3) show that the control group received significantly higher occurrence rates of Adaptive Coping Styles for Academic and Social

Table 2a
Descriptive Statistics
Experimental Group (N=182)

	Mean	SD
ASCI		
AAdapt	1.997	.482
AMalad	1.975	.479
SAdapt	1.890	.519
SMalad	1.898	.517
ASocAcc	1.984	.588
ASocUna	1.535	.710
SSocAcc	1.887	.597
SSocUna	1.618	.735
T-CRS		
ActOut	1.759	.987
ShyAnx	1.491	.631
LearnSk	2.125	1.224
FrusTol	3.322	1.0118
AsserSk	2.772	.456
TaskOrt	3.293	1.272
PeerSkl	3.799	1.037
Student Info		
Achieve	3.183	1.381
SocSkill	3.414	1.240
Behave	3.403	1.248

Table 2b
Descriptive Statistics
Control Group (N=135)

	Mean	SD
ASCI		
AAdapt	2.141	.480
AMalad	2.126	.481
SAdapt	2.094	.550
SMalad	2.100	.547
ASocAcc	2.187	.552
ASocUna	1.731	.822
SSocAcc	2.117	.631
SSocUna	1.895	.803
T-CRS		
ActOut	1.832	.930
ShyAnx	1.701	.750
LearnSk	2.207	1.083
FrusTol	2.978	.868
AsserSk	2.590	.435
TaskOrt	3.012	1.022
PeerSkl	3.496	.982
Student Info		
Achieve	3.090	1.223
SocSkill	3.157	1.068
Behave	3.276	1.146

Table 2c

Descriptive Statistics

Students Receiving Individual B.A.S.I.C. Services within the Experimental Group (N=34)

	Mean	SD
ASCI		
AAdapt	2.092	.554
AMalad	2.083	.549
SAdapt	2.016	.531
SMalad	2.035	.528
ASocAcc	2.130	.720
ASocUna	1.934	.893
SSocAcc	2.124	.645
SSocUna	2.007	.855
T-CRS		
ActOut	2.476	1.206
ShyAnx	1.943	.916
LearnSk	2.543	1.231
FrusTol	2.560	.850
AsserSk	2.737	.408
TaskOrt	2.691	1.140
PeerSkl	3.417	.962
Student Info		
Achieve	2.946	1.332
SocSkill	3.135	1.227
Behave	2.946	1.268

Table 2d

Descriptive Statistics

Students Receiving No Individual B.A.S.I.C. Services within the Experimental Group (N=148)

	Mean	SD
ASCI		
AAdapt	1.975	.463
AMalad	1.950	.461
SAdapt	1.861	.514
SMalad	1.867	.511
ASocAcc	1.913	.548
ASocUna	1.443	.630
SSocAcc	1.833	.574
SSocUna	1.529	.677
T-CRS		
ActOut	1.592	.849
ShyAnx	1.386	.491
LearnSk	2.028	1.205
FrusTol	3.500	.973
AsserSk	2.780	.467
TaskOrt	3.433	1.264
PeerSkl	3.888	1.037
Student Info		
Achieve	3.240	1.391
SocSkill	3.481	1.227
Behave	3.513	1.222

Table 2e

Descriptive Statistics

3rd Grade Students within the Experimental Group (N=100)

	Mean	SD
ASCI		
AAdapt	2.014	.537
AMalad	1.996	.532
SAdapt	1.927	.522
SMalad	1.940	.522
ASocAcc	1.920	.647
ASocUna	1.600	.754
SSocAcc	1.896	.596
SSocUna	1.681	.768
T-CRS		
ActOut	1.856	1.034
ShyAnx	1.500	.660
LearnSk	2.085	1.237
FrusTol	3.321	1.035
AsserSk	2.819	.493
TaskOrt	3.344	1.276
PeerSkl	3.821	1.102
Student Info		
Achieve	3.324	1.404
SocSkill	3.400	1.153
Behave	3.343	1.254

Table 2f

Descriptive Statistics

4th Grade Students within the Experimental Group (N=82)

	Mean	SD
ASCI		
AAdapt	1.976	.407
AMalad	1.949	.408
SAdapt	1.846	.515
SMalad	1.847	.511
ASocAcc	1.995	.508
ASocUna	1.456	.648
SSocAcc	1.876	.601
SSocUna	1.541	.690
T-CRS		
ActOut	1.636	.914
ShyAnx	1.479	.596
LearnSk	2.177	1.212
FrusTol	3.323	1.002
AsserSk	2.711	.399
TaskOrt	3.227	1.284
PeerSkl	3.770	.954
Student Info		
Achieve	3.012	1.342
SocSkill	3.430	1.153
Behave	3.477	1.244

Table 3

Univariate F-test for
Experimental and Control Groups

Variable	Hypoth. SS	Error SS	Hypoth. MS	Error MS	F	Sig. of F
ASCI						
AAdapt	1.61791	72.91192	1.61791	.23147	6.98981	.009*
AMaldt	1.76245	72.60852	1.76245	.23050	7.64612	.006*
SAdapt	3.21579	89.36508	3.21579	.28370	11.33525	.001**
SMaldt	3.16014	88.59176	3.16014	.28124	11.23631	.001**
ASocAc	4.20429	103.43037	4.20429	.32835	12.80429	.000**
ASocUn	2.96206	181.75239	2.96206	.57699	5.13363	.024
SSocAc	4.11291	117.81460	4.11291	.37401	10.99666	.001**
SSocUn	5.96861	197.77187	5.96861	.62785	9.50647	.002*
T-CRS						
ActOut	.41181	295.01796	.41181	.92773	.44389	.506
ShyAnx	3.44986	148.76811	3.44986	.46782	7.37426	.007*
LrnSkls	.52712	432.48599	.52712	1.36002	.38758	.534
FrusTol	9.25641	291.49247	9.25641	.91664	10.09816	.002*
Assert	2.59268	63.63932	2.59268	.20012	12.95539	.000**
TaskOr	6.16797	437.90190	6.16797	1.37705	4.47912	.035
PeerSk	7.14757	327.30793	7.14757	1.02927	6.94431	.009*
Student Information Sheet						
Achieve	.69132	561.51176	.69132	1.73843	.39767	.529
SocSkills	5.19721	444.03356	5.19721	1.37472	3.78057	.053
Behavior	1.27061	470.74170	1.27061	1.45750	.87183	.351

*p<.01; **p≤.005

situations than the experimental group. For Maladaptive Coping Styles, the control group also achieved significantly higher occurrence rates than the experimental group in both Academic and Social Situations.

The second hypothesis was that there would be no significant difference between experimental and control groups in Socially Acceptable and Socially Unacceptable Coping Strategies in academic and social situations as measured by the ASCI. A significant difference was determined between the two groups by a multivariate F-test (Wilk's Lambda) [$F(3,314)=4.491$, $p<.05$]; therefore, the null hypothesis was rejected. Results from the follow-up univariate F-test (Table 3) show that for Socially Acceptable Coping Strategies, the control group's occurrence rates were significantly higher than the experimental group in both Academic and Social Situations. Also, Socially Unacceptable Coping Strategies were more likely to be used by the control group to a significant degree in mainly Social Situations.

The third hypothesis was that there would be no difference between experimental and control groups in Acting Out, Shy Anxious, and Learning Skills as measured by Part I (problem behaviors) of the T-CRS. A significant difference was determined between the two

groups by a multivariate F-test (Wilk's Lambda) [F(2, 317)=2.666, p<.05]; therefore, the null hypothesis was rejected. Results from the follow-up univariate F-test (Table 3) show that the experimental group was rated as having fewer school problems relating to Acting Out and Learning Skills than the control schools, but only Shy Anxious was significant.

The fourth hypothesis was that there would be no significant difference between experimental and control groups in Frustration Tolerance, Assertive Social Skills, Task Orientation, and Peer Social Skills as measured by Part II (student competencies) of the T-CRS. A significant difference was determined between the two groups by a multivariate F-test (Wilk's Lambda) [F(3, 316) =4.271, p<.05]. Results from the follow-up univariate F-test (Table 3) show that on the T-CRS, the experimental group was rated significantly better with Frustration Tolerance, Assertive Social Skills, and Peer Social Skills than the control group.

The fifth hypothesis was that there would be no significant difference between the experimental and control groups in Achievement, Social Skills, and Behavioral Skills as measured by ratings on the Student Information Sheet. No significant difference was determined between the two groups by the multivariate F-Test (Wilk's Lambda) [F(2, 323)=1.916, p=.13]; therefore, the null

hypothesis was accepted. On these ratings, the experimental group did received higher ratings than the control group on Achievement, Social Skills, and Behavioral Skills; however the differences were not significant (see Table 3).

Comparisons Between Students Receiving Individual B.A.S.I.C. Services and Other Students Receiving No Individual Services within the Experimental Group

The sixth hypothesis was that there would be no significant difference within the experimental group between students who have received individual B.A.S.I.C. services versus those students who have not received individual B.A.S.I.C. services, on the ASCI, T-CRS, and ratings from the Student Information Sheet. (The same data analyses used between the experimental and control groups, were used between students who received individual B.A.S.I.C. services and those that did not receive individual B.A.S.I.C. services.) (All information from univariate tests is displayed in Table 4)

For Adaptive versus Maladaptive Coping Styles on the ASCI, a significant difference was determined by the multivariate F-test (Wilk's Lambda) [$F(3, 178)=3.028$, $p<.05$]. Results from the follow-up univariate F-test show that students receiving B.A.S.I.C. services engaged more often in the Adaptive Coping Style for both academic and social situations, the

Table 4

Univariate F-test for
Students Receiving Individual B.A.S.I.C. Service and Other Students Receiving No Service

Variable	Hypoth. SS	Error SS	Hypoth. MS	Error MS	F	Sig. of F
ASCI						
AAdapt	.37585	41.67361	.37585	.23152	1.62342	.204
AMaldt	.48654	41.12602	.48654	.22848	2.12947	.146
SAdapt	.66429	48.11237	.66429	.26729	2.48528	.117
SMaldt	.78204	47.65580	.78204	.26475	2.95385	.087
ASocAc	1.29772	61.24749	1.29772	.34026	3.81386	.052
ASocUn	6.66008	84.62013	6.66008	.47011	14.16702	.000**
SSocAc	2.33908	62.08130	2.33908	.34490	6.78200	.010*
SSocUn	6.32283	91.48161	6.32283	.50823	12.44085	.001**
T-CRS						
ActOut	22.17486	156.92664	22.17486	.85752	25.85921	.000**
ShyAnx	8.81390	64.50442	8.81390	.35248	25.00517	.000**
LrnSkls	7.52898	267.93108	7.52898	1.46410	5.14238	.025
FrusTol	25.07514	165.56400	25.07514	.90472	27.71587	.000**
Assert	.05212	38.20171	.05212	.20875	.24969	.618
TaskOr	15.62010	282.30076	15.62010	1.54263	10.12565	.002*
PeerSk	6.29167	191.74811	6.29167	1.04780	6.00462	.015
Student Information Sheet						
Achieve	2.58411	360.00228	2.58411	1.90477	1.35665	.246
SocSkills	3.55872	288.76588	3.55872	1.52786	2.32922	.129
Behavior	9.59220	286.36592	9.59220	1.51516	6.33080	.013*

*p<.01; **p<.005

difference was not significant. Also, students receiving B.A.S.I.C. services were shown to engage in the Maladaptive Coping Style more often than the other students, but again the difference was not significant.

The multivariate F-test (Wilk's Lambda) determined a significant difference between students receiving individual services and the other students not receiving services in the Socially Acceptable and Socially Unacceptable Coping Strategies [$F(3,178)=4.349$, $p<.05$]. Results of the follow-up univariate F-test show that students receiving individual services were rated as more likely to engage in Socially Acceptable Coping Strategies in both Academic and Social situations, but only Socially Acceptable Coping Strategies in Social situations was significant. Students receiving B.A.S.I.C. services were also rated to a significant degree as more likely than the other students to engage in Socially Unacceptable Coping Strategies in both Academic and Social situations.

The multivariate F-test (Wilk's Lambda) showed a significant difference between students receiving individual B.A.S.I.C. services versus those that do not with school problems of Acting Out, Shy Anxious, and Learning Skills on Part I of the T-CRS [$F(2,182)=17.393$, $p<.05$]. Results of the follow-up univariate F-tests, show that school problem behaviors as measured by the T-CRS were higher for students

receiving B.A.S.I.C. services than for other students, especially on Acting Out and Shy Anxious which were significant.

The multivariate F-test (Wilk's Lambda) showed a significant difference between students receiving individual B.A.S.I.C. services versus those that do not on student strengths of Frustration Tolerance, Assertive Social Skills, Task Orientation, and Peer Social Skills on Part II of the T-CRS [$F(3, 181)=9.196$, $p<.05$]. Results on the follow-up univariate F-test show that the students' receiving B.A.S.I.C. services were rated as significantly weaker than the other students on strengths related to Frustration Tolerance and Task Orientation. Although Peer Skills were rated as weaker for student's receiving individual services, the difference between the groups only was not significant. Both sets of students were rated similarly on abilities with Assertive Social Skills.

The multivariate F-test (Wilk's Lambda) was not significant between students receiving B.A.S.I.C. services and those that did not on ratings of Achievement, Social Skills, and Behavioral Skills [$F(2,189)=2.591$, $p=.054$]. Results from the follow-up univariate F-test showed that students receiving individual B.A.S.I.C. services were rated as having lower skills in Achievement, Social Skills, and Behavior, but the differences were not significant.

Due to the multivariate F-tests finding significant differences on several variables between the students receiving individual B.A.S.I.C. services and the other students receiving no individual services, the null hypothesis was rejected.

Comparisons Between Third and Fourth Grade Students within the Experimental Group

The final hypothesis was that there was no significant difference within the experimental group between third and fourth grade students on the ASCI, T-CRS, and ratings on the Student Information Sheet. Using the same types of data analysis as used above, no significant differences were found within the experimental group between students in the third and fourth grades on all measures (see Table 5); therefore, the null hypothesis was accepted.

Summary of the Quantitative Analysis

The quantitative information provides information regarding the students receiving Project B.A.S.I.C. as compared to students who do not receive Project B.A.S.I.C. as a part of their school program. Students' coping skills, problem behaviors, and competencies were measured via teacher ratings and yielded significant differences between groups. Significant differences were found between the experimental

Table 5

Univariate F-test for
3rd and 4th Grade Students

Variable	Hypoth. SS	Error SS	Hypoth. MS	Error MS	F	Sig. of F
ASCI						
AAdapt	.06417	41.98529	.06417	.23325	.27510	.601
AMaldt	.09940	41.51315	.09940	.23063	.43099	.512
SAdapt	.29651	48.48015	.29651	.26933	1.10091	.295
SMaldt	.38580	48.05205	.38580	.26696	1.44517	.231
ASocAc	.25649	62.28872	.25649	.34605	.74121	.390
ASocUn	.94089	90.33932	.94089	.50189	1.87471	.173
SSocAc	.01916	64.40123	.01916	.35778	.05354	.817
SSocUn	.88323	96.92122	.88323	.53845	1.64031	.202
T-CRS						
ActOut	2.20323	176.89827	2.20323	.96666	2.27923	.133
ShyAnx	.01928	73.29904	.01928	.40054	.04813	.827
LrnSkls	.38557	275.07449	.38557	1.50314	.25651	.613
FrusTol	.00024	190.63889	.00024	1.04174	.00023	.988
Assert	.53230	37.72154	.53230	.20613	2.58237	.110
TaskOr	.62408	297.29679	.62408	1.62457	.38415	.536
PeerSk	.11743	197.92235	.11743	1.08154	.10858	.742
Student Information Sheet						
Achieve	4.60754	357.97885	4.60754	1.89407	2.4362	.121
SocSkills	.04321	292.28140	.04321	1.54646	.02794	.867
Behavior	.84748	295.11063	.84748	1.56143	.54276	.462

*p<.01; **p≤.005

and control groups with coping behaviors, shy anxious behaviors, frustration tolerance, assertive social skills, and peer skills. Significant differences were also found between students receiving individual services versus those that do not in regards to coping behaviors, acting out, shy/anxious behaviors, frustration tolerance, and task orientation. There were no apparent differences between students in the third and fourth grade in Project B.A.S.I.C. schools.

Using the information obtained from both the qualitative and quantitative data collection the following chapter attempts to answer the related research questions regarding Project B.A.S.I.C.'s direction for implementation, resources, day to day operations, outcomes, as well as recommendations for program refinement.

CHAPTER FIVE

SUMMARY, FINDINGS, CONCLUSIONS, RELATIONSHIP WITH PREVIOUS RESEARCH, LIMITATIONS OF THE STUDY, RECOMMENDATIONS FOR FURTHUR RESEARCH, AND REFLECTIONS OF THE RESEARCHER

Summary

As the end of the twentieth-century approaches and the beginning of the twenty-first draws near, society as we know it is displaying more and more signs of unrest. Violence whether occurring between strangers or between family members is not uncommon, the numbers of the homeless are increasing daily, drug use is becoming a welcome escape, and more children than ever are living below the poverty line. Promises for help are coming from all sides of the political arena. However, regardless of party affiliation, the pledges seem to consume more cerebral energy to be verbally expressed than to be put into action.

The concept of prevention/health promotion has existed as far back as the practice of medicine and has been proven effective in the health related field, especially with immunization and other disease precautionary tactics. Prevention/health promotion in the mental health field would seem to be a logical assumption in assisting Americans to develop healthy bodies as well as healthy minds, as proposed

in the goals of *Healthy People 2000.* However, historically (as well as presently), in the mental health field, prevention/mental health promotion is typically placed at a much lower priority than other treatment-oriented reactive financially-producing clinical services.

As an example of the unrest seen in everyday America, this researcher just received a call from a friend who works in a local high school in East Tennessee, where a stabbing just occurred between two "good students". Incidences just as this seem to occur frequently and confirm other indications of the lack of effective coping in situations of emotional distress. Families are dealing with poverty, unemployment, spouse abuse, child abuse, lack of safety within their own neighborhoods, substance abuse, health problems and mental illness. Without the appropriate skills and a support network to weather these life situations, problems become more severe and escalate into an eternal cycle of doubt and frustration.

Prevention or mental health promotion programs can offer individuals "tools for their tool box" in order to enhance the development of more effective skills to handle stressful situations. Through skill development or linkage with the appropriate resources, preventive methods can impact the development of the problems and decrease their severity. Often if a problem is allowed to fester to the point of crisis, the

reactive orientations of mental health services serve only as a temporary band-aid until the next crisis occurs.

Not just any effort in prevention/mental health promotion will suffice. Many programs that are defined as preventive have weaknesses that lead to their downfall as well as contribute ammunition for the skeptics of any proactive field. Beginning early with skill enhancement (such as with children), planning towards conscientious program implementation, and developing effective strategies for program evaluation are essential activities of successful prevention/health promotion programs. More often than not, program evaluation is the activity that is most likely forgotten or half-way done in a prevention/health promotion program's implementation.

The Problem

Project B.A.S.I.C. is a prevention/mental health promotion program in existence for 10 years in the state of Tennessee. This school-based program (targeted for K - 3rd grade students) attempts to decrease the amount of adolescent and adult mental health problems through skill development, linkage to services, and enhancement of supportive environments.

Project B.A.S.I.C. provides schools with trained graduate level mental health professionals (CDSs) employed through

local community mental health agencies. In the school the CDS facilitates mental health education, early intervention, teacher consultation, and school climate enhancement. The CDS works with all persons involved in the school environment and serves as a liaison to community agencies, such as mental health, human services, health care, and the legal system. Working as an instrumental portion of the school and as a part of community service providers, Project B.A.S.I.C. aims to meet the needs of both the school and its students.

Existing in several schools spanning across the state from east to west, Project B.A.S.I.C. has become an essential part of the school environment. Like other prevention programs, Project B.A.S.I.C. is in constant financial jeopardy and continues only on a year-to-year basis, raising the anxiety level of the persons involved. Since 1985, only informal site evaluations based on surveys completed by staff, teachers, principals, and parents, as well as compilations of the numbers of persons served have been conducted. Unfortunately, a formal evaluation could make a valuable contribution toward Project B.A.S.I.C.'s refinement and chance for permanence has not been done.

The Purpose of the Study

The purpose of the study was to conduct a program evaluation to determine to what extent Project B.A.S.I.C. is

making its intended impact. The study was based on obtaining information to answer the following questions:

1) Do the stated goals of Project B.A.S.I.C. give direction to program implementation?

2) Are the resources sufficient to carry out the goals and objectives of Project B.A.S.I.C.?

3) Are the day-to-day operations consistent with the goals and objectives of Project B.A.S.I.C.?

4) What outcomes are being achieved through Project B.A.S.I.C.? Are the outcomes consistent with the goals and objectives of Project B.A.S.I.C?

5) What recommendations can be made to increase the impact of Project B.A.S.I.C.?

Procedures

The study was conducted using both qualitative and quantitative methods, both of which provided descriptive information. This method was based on the Bellon program evaluation framework (Bellon & Bellon, 1993).

For the qualitative portion, semi-structured interviews were conducted with 30 school staff members from 6 schools served by Project B.A.S.I.C., 6 CDSs, and 2 program administrators. The questions included in the interviews were generated from the research questions guiding this study. The information from the interviews was subject to a content analysis to determine the most important themes.

For the quantitative portion (which was primarily related to the research question dealing with outcomes), information was obtained about third and fourth grade students from 6 schools served by Project B.A.S.I.C., and 5 matched schools not served by Project B.A.S.I.C. Teachers were asked to rate 5 randomly selected students from their classrooms on the ASCI, T-CRS, and the Student Information Sheet. The information on 192 students from the experimental group and 135 students from the control group was subjected to a MANOVA to determine any significant differences between the groups. Information from within the experimental group, dealing with receiving individual/group program services, and third or fourth grade status was also subjected to a MANOVA to determine any significant differences.

The results of the qualitative data analysis are discussed in detail in Chapter Four and the themes and frequency of the responses are displayed in Table 1a-1e. Specific results of the

quantitative data analysis and tables (Tables 2-5) regarding the obtained information are also found detailed in the preceding chapter. The findings of the study have been compared to Project B.A.S.I.C.'s stated goals, objectives, and activities which can be found in Appendix A.

Findings

Research Question 1: Do the stated goals of Project B.A.S.I.C. give direction to program implementation?

Teachers, principals, CDSs, and program administrators gave their ideas regarding the direction in which the program was working, or in other words, the overall purposes of the program. The purposes were identified to be preventing future mental health problems, enhancing psycho-social skills, meeting the needs of the school and the children, bringing a positive influence to the school environment, and educating others about mental health needs and services. The perceived purposes were compared with Project B.A.S.I.C.'s stated goals.

One main purpose was seen by the respondents as attempting to impact children's futures through prevention/ mental health promotion. Respondents described the preventive efforts both in short-term and long-term timelines. In the short-term, respondents referred to helping decrease incidences of problems with the persons involved in the school environment. In the long-term, respondents referred to

preventing the severity of problems, as well as enhancing healthier and more productive development of future adult citizens. This perceived direction, especially in long-term concepts, is a good match with the stated goal of the reduction of adolescent and adult mental health problems.

Another main purpose of the program as explained by the respondents was the development of children's psycho-social skills. Dealing with feelings, making good decisions, feeling good about yourself, being responsible, and getting along with others were all identified areas addressed through Project B.A.S.I.C. Enhancement of these skills was stated to be necessary in order for children to have the "tools" available to appropriately handle stressful situations. This perceived direction appears to be most closely related to the stated goal of providing schools assistance with students' academic and developmental effectiveness.

Another purpose of the program as seen by the interviewees was meeting the needs for the school and children through Project B.A.S.I.C.'s various activities. The program was described as being individualized to each school and adapting to fit whatever areas were in need of fulfillment. Also, the program was referred to as being committed to helping children and working to provide what was needed for the child and his/her family. This perceived direction seems to also be

related to the stated goal of providing schools assistance with academic and developmental effectiveness of students.

Another purpose indicated by the respondents for Project B.A.S.I.C. was giving the schools a general positive to enrich the school environment and its inhabitants. This purpose is a close match with the stated goal of promotion of a supportive environment for the development of children's mental health.

The final purpose of the program pointed out (by only the program staff) was increasing awareness about mental health needs and the services available to address those needs. Through the education of teachers and parents, as well as other community members, the program staff expressed the program's hopes for informing persons in the lives of children regarding how to get help when help is needed. This perceived purpose is related to both stated goals of promoting a supportive school environment and assisting the schools in the development of student effectiveness.

Differences in the responses existed between the school staff and program staff. The school staff described the primary purpose of the program to be the development of psycho-social skills, whereas the program staff described the primary purpose to be the focus of prevention/mental health promotion. Another area of difference between the school and program staff was in the area of educating others about mental

health needs and services, which was only mentioned by the program staff.

The stated goals of Project B.A.S.I.C.. appear to give direction to program implementation. Using the perceptions and observations of the program in action, the respondents defined the purposes of the program consistently with the stated program goals. The importance of the purposes and their matched goals as defined by the number of responses by school and program staff varied but covered the documented goals of the program to some extent.

Research Question 2: Are the resources sufficient to carry out the goals and objectives of Project B.A.S.I.C.?

The main resource themes described by the teachers, principals, CDSs, and program administrators included human resources, space, materials, and time. Other resource themes pointed out by only program staff included trainings, commitment by the school or mental health center, and funding.

The primary human resource of Project B.A.S.I.C. is the CDS. Respondents described the main characteristics of the CDS as being: competent, knowledgeable, and professional; flexible and adaptable; heavily involved and conscientious; and caring. In general all information about the CDS was positive. Another

description of the CDS used primarily by the program staff was being frustrated.

The status of other human resources such as referral service agencies were mentioned only by program staff. The responses mainly indicated that the human resources available to the CDS were either lacking or the services were limited.

Another resource theme dealt with the space available for the program. The majority of responses suggested that the space such as the assigned office space of the CDS was not adequate. Support for the adequacy of the space was demonstrated but did not match the magnitude of the respondents feeling otherwise.

Another subject regarding resource themes was the availability of materials for Project B.A.S.I.C. The majority of respondents expressed satisfaction regarding the adequacy of the materials for educational purposes. Some responses, mainly from the programs staff, demonstrated dissatisfaction with the material made available.

Time was another resource pointed out by the respondents. Most respondents, especially school staff, referred to the lack of time available to carry out the program's responsibilities.

Other resource themes were pointed out only by the program staff. Some felt that training opportunities were

adequate, while others felt that the training opportunities were lacking. A lack of commitment by the school and the sponsoring mental health agency was indicated by the program staff respondents. Also, inadequate funding resources were referred to more frequently by the respondents than adequate funding resources.

Using this information to answer the proposed research question regarding adequacy of the resources to carry out the goals and objectives of Project B.A.S.I.C., the responses were mixed depending on what resource was being discussed and who was being interviewed. Support for sufficiency of a resource was demonstrated overall in the area of the CDS as the main human resource for Project B.A.S.I.C. However, insufficient human resources such as the limitations of referral agencies were expressed by only the program staff. Respondents were divided on the issue of adequacy versus inadequacy in relation to space and materials, but they leaned more toward sufficiency for materials and insufficiency of space. Time was viewed as inadequate by all respondents.

The program staff identified themes not indicated by the school staff. The views of the program staff were divided on training and funding issues, but were more frequently described as lacking. Also, an inadequate degree of commitment by the school and mental health centers was

expressed by the program staff. In sum, the CDS and educational materials were determined to be sufficient, while other human resources, space, time, training opportunities, and funding were most frequently responded to as insufficient. Although many resources were described as inadequate most responses indicated that some form of the resources was available and adaptations were made to make up for any deficiencies.

Research Question 3: Are the day-to-day operations consistent with the goals and objectives of Project B.A.S.I.C.?

Several themes related to the operations or activities of Project B.A.S.I.C. were mentioned by respondents. The main activities mentioned included classroom lessons, intervention, working with the school, liaising, providing a resource, school climate enhancement, establishing relationships, and making implementation decisions. These observed activities have been matched with the stated program activities. Also, these activities have been compared with the stated goals and objectives of the program.

The classroom lessons which are consistent with the Project B.A.S.I.C.'s stated activity of *mental health education* were described to be appropriate, as well as varied in teaching methods. The lessons were also referred to as reinforcing or

supplementing what was being taught in the regular classroom. In relation to the stated program goals and objectives, the classroom activities/lessons appear to be consistent with the goal of assisting schools in developing student effectiveness and the objective of assisting children with coping skills.

Another activity frequently indicated in the responses was early intervention either individually or in small groups with children. The CDS working with children who are exhibiting problems is consistent with the stated activity of *early intervention services.* Descriptions of typical problems for children subject to intervention included: broken home lives, deprived of means or parental support, behavioral problems, dysfunctional home lives, abused, grieving, in transition, and vulnerable. School staff also included childhood issues dealing with self-esteem, at-riskness, and school/learning issues. This observed activity, due to the targeting of children with problems, is most closely related to the stated goal dealing with the reduction of future mental health problems. The stated objectives related to this activity include assisting schools with students' "on task" behaviors and assisting children with the development of effective coping skills.

Another activity constituting a theme referred to the CDS working with the school and the persons involved. Working

directly with the teachers, the principal, and the overall school were frequently described program activities. The documented activity in Project B.A.S.I.C. most closely related would be *teacher consultation.* The stated goals most closely related would be the ones dealing with promotion of a supportive environment and assistance to the schools in student effectiveness. The stated objective most consistent with this information is the enhancement of awareness and capacity for response of school personnel to the mental health needs of children.

Working within the school environment and serving as a liaison to parents, outside agencies, and the community was another theme emerging from the responses. Project B.A.S.I.C.'s stated activity matching this theme occurs with services involved with *early intervention.* Respondents described the CDS as working with parents, referring or working with outside agencies such as the court system or human services, and working with the general community. The stated goal most closely related is the promotion of a supportive environment for children's mental health. Promoting cooperation and coordination of efforts between the schools and community service providers, and providing schools, families, and students linkage with community networks are the stated objectives most consistent with the observed activities.

Providing an extra resource in the school was also a frequent theme developed from the responses. Project B.A.S.I.C. was described as being a resource available to and used by teachers, principals, parents, students, as well as providing a general resource. Providing a resource is most closely related to the documented activities involved in *mental health education, early intervention,* and *teacher consultation.* The stated goals most consistent with this theme are promotion of a supportive environment and assistance to schools in student effectiveness. The matching objectives related to providing a resource are enhancing awareness and capacity for school personnel to children's mental health needs, promoting cooperation and coordination between the schools and outside agencies, and assisting children in the development of effective coping skills.

Another activity emerging from the responses was school climate enhancement which is a match with the required Project B.A.S.I.C. activity of *school climate enhancement.* Special programs coordinated by the CDS which benefit the entire school were detailed by the respondents. The stated goal most closely related to school climate enhancement is the promotion of a supportive environment. No clear relationship appears to exist between the theme of school climate enhancement and the stated objectives.

Establishing, maintaining, and building relationships developed as a theme from the respondent information. No apparent relationship appears between establishing relationships and the program's required activities. Relationships were described as forming between the CDS and students, teachers, parents, and mental health agencies (which was only mentioned by program staff). The stated goal most consistent with relationship establishment deals with the promotion of a supportive environment. Promoting cooperation and coordination of efforts between schools and community service providers is the stated objective most closely related to this theme.

A final activity, reported by program staff only, dealt with the CDS making implementation decisions for the individual school. No required activity is a close match for this theme. Project B.A.S.I.C. was described as allowing the CDS to make implementation decisions based on the needs of the individual school. No stated goals or objectives appear to be related to this theme.

The day-to-day operations of Project B.A.S.I.C. appear to be consistent with the stated goals and objectives. To some extent every stated goal and objective was consistent with the described activities of classroom lessons, intervention, working with the school, liaising, providing a resource, and establishing

relationships. The activity of school climate enhancement appeared to relate to a documented goal, but did not appear to have a relationship with the stated objectives. There was not a clear relationship between the stated goals and objectives and the theme of making implementation decisions.

Research Question 4: What outcomes are being achieved through Project B.A.S.I.C.? Are the outcomes consistent with the goals and objectives of Project B.A.S.I.C?

Information from qualitative and quantitative data collections were be used to answer this question regarding program outcomes. According to the respondents in the qualitative information, outcomes being achieved through Project B.A.S.I.C. were related to cooperation, children, school staff, classroom/school, and parents/community. Also, outcomes regarding obstacles of the program, benefits of the program, support of the program, and satisfaction with the program were identified. Quantitative information showed significant differences between experimental and control groups, which may be attributed to the influence of Project B.A.S.I.C.

Qualitative Findings

Increased cooperation between the home and school was a theme pointed out by the respondents as a result of the

program. Also, better working relationships among school staff persons, between the school and outside agencies, as well as, improved relationships among the children was credited to the efforts of the program. This cooperative outcome is most consistent with the stated goals of promoting a supportive environment and assisting schools in enhancing student effectiveness. The objectives of promoting cooperation and coordination between schools and community providers, and assisting children in the development of effective coping skills are most closely related to the increased cooperation theme.

The impact of the program on children was an outcome supported by frequent responses. Results of the program were referred to as making a general positive change in children, improving their behavior, allowing them to open up, learning new skills, increasing decision making and responsible behavior, and improving the children's abilities in handling stressful situations. Improvements in children's attitude or self-concept was described by only the school staff. The goals related to these outcomes are assisting the schools in the development of student effectiveness and possibly the reduction of future mental health problems. The objectives most consistent with the impact on children are assisting schools in students' "on task" behaviors and assisting children in the development of effective coping skills.

Changes were also described in the staff of participating schools. Positive changes and influences as a result of the program, especially in teachers, were reported in many responses. The documented goals related to this outcome are the promotion of a supportive environment and reduction in the incidences of adult mental health problems. Enhancing awareness and capacity of school personnel to mental health needs of children is the most consistent objective related to this theme.

Positive changes in the classroom or school environment as a result of Project B.A.S.I.C. were also reported. The stated goal most related would be promotion of a supportive environment. There were no clear consistencies between the positive changes identified in the school environment and the documented objectives of the program.

Outcomes of the program regarding parents and the community were also pointed out by the respondents. Parents were referred to as being affected positively by the program. Through the program's efforts, the parents were described to be able to access services and to develop skills to enhance their skills as a parents. The goal most consistent with this outcome is the promotion of a supportive environment. Providing schools, families, and students with linkage to other services is

the stated objective most closely related to the influence upon parents and the community.

Outcomes related to obstacles which hinder the impact of the program were also discussed. Little to no impact of the program was a result of parents feeling threatened, or refusing program recommendations or services, leading to limitations of what the CDS can do to help the child. No documented goals or objectives are consistent with this outcome.

Beneficiaries of the program as referred to by the respondents was also categorized as an outcome. Mainly the school staff reported benefits of the program for children, teachers, the school, and parents. A related goal is the promotion of a supportive environment. Enhancing awareness and capacity for response of school personnel, and providing schools, families, and students with linkage to community services are the objectives most consistent with the identified beneficiaries of the program.

Program satisfaction, which was categorized as an outcome, was expressed by both school and program personnel. School staff referred to program satisfaction in a much greater magnitude than the program staff. This outcome does not exhibit a clear relationship with the program's stated goals and objectives.

Another outcome emerged from the respondents describing support of the program in both positive and negative terms. School personnel referred to demonstrations of support in a positive manner by teachers, parents, the community, and students. Program staff also indicated demonstrations of support in a positive manner by teachers, overall school, parents, community, the sponsoring agency, and other program staff. The stated goal most consistent with support in a positive orientation is the promotion of a supportive environment. Promoting cooperation and coordination of efforts would be the objective most closely related to this theme.

Demonstrations of support in a negative manner, such as evidenced by conflicts, controversies or lack of support, were reported by both school and program staff persons. School staff persons described a lack of program support by teachers, parents, and the community. The program staff described negative feelings about the program demonstrated by teachers, parents, guidance counselors, the community, and the sponsoring mental health agencies. Not surprisingly, negative reactions or lack of support are inconsistent with the stated goals and objectives.

The outcomes as a result of Project B.A.S.I.C. as indicated in the qualitative information were increases in cooperation

from home, between teachers, among children, and from agencies; improvements in children; and influences on school staff, the school environment, and parents. Outcomes also emerged from descriptions regarding obstacles of program impact, beneficiaries of the program, satisfaction with the program, and demonstrations of support. All stated goals and/or objectives appear to closely match the outcomes of increased cooperation, improvements in children, influences on school staff, the school environment, parents, program beneficiaries, and positive support of the program. The goals and objectives do not appear to have a direct relationship with obstacles of the program, demonstrations of program satisfaction, or support of the program in a negative manner.

Quantitative Findings

The quantitative information from the teacher ratings of third and fourth grade students from schools receiving Project B.A.S.I.C. services and those schools without program services showed significant differences between the experimental and control groups in several situations. The students were rated on measures of coping, problem behaviors, and competencies, as well as achievement, behavioral skills, and social skills. Other comparisons were also made within the experimental group including students receiving individual B.A.S.I.C. services,

those students in the school who do not receive them, and third and fourth grade students.

After establishing that there was no difference between the two groups on any variables besides the dependent variable, the data were subjected to analyses to determine any significant differences. On measures of coping, the control group appeared to use more adaptive coping strategies than the experimental group in academic and social situations Also, the control group appeared to engage in more maladaptive coping methods than the experimental group in both situations. The control group was also more active in acceptable coping strategies and unacceptable coping strategies than the experimental group in both academic and social situations. In relation to coping, the control group appeared to be more active with appropriate or inappropriate coping behaviors regardless of the situation.

Ratings regarding school problem behaviors also showed evidence of significant differences between the two groups. The students with Project B.A.S.I.C. services appeared to have less of a problem with shy and anxious behaviors than the control group students. The problem behaviors of acting out and learning skills were found to be nearly similar between the two groups. Therefore, shy anxious behaviors appear to be

more of a problem with children from schools without access to the program than those children with access to Project B.A.S.I.C.

Differences between experimental and control groups regarding student competencies were also determined. The children from Project B.A.S.I.C. schools appeared have better skills for dealing with frustration tolerance, assertiveness, and peers than the control group. The experimental group's skills in task orientation failed to demonstrate any significant difference from the control.

On general ratings of achievement, behavior, and social skills the experimental and control groups appear to be the nearly the same. As a result, students from Project B.A.S.I.C. schools and those from control schools are basically similar with general achievement, behavior, and social skills.

Comparing students in the experimental group who have received individual services from Project B.A.S.I.C. to those who have not, the same analyses as between the experimental and control groups for were conducted on ratings of coping, problem behaviors, competencies, and general ratings of achievement, behavior, and social skills. Differences did not appear to be present for either adaptive or maladaptive coping strategies. However, students receiving B.A.S.I.C. services were found to be more likely to use acceptable coping strategies in predominantly social situations. Socially acceptable coping in

academic situations by students receiving individual services failed to differ from the other students in the schools. Students receiving individual B.A.S.I.C. services were shown to use socially unacceptable coping strategies in both academic and social situations to a greater degree than the other students.

Students receiving individual services had more problems with acting out and shy/anxious behaviors (to a significant degree), as compared to other students in their schools. The competencies of frustration tolerance, and task orientation were also weaker for those students receiving individual program services. Social skills related to peers were also rated as weaker for the students receiving individual services, but the difference was not significant. Assertive social skills were shown to be similar between the students. On general ratings of achievement, behavior, and social skills, the children receiving individual program services were rated as similar to the other students but the difference in regards to behavior skills which was the greatest was not significant.

The final analysis compared the third and fourth grade students from the schools with Project B.A.S.I.C. Ratings of coping, problem behaviors, competencies, and general achievement, social skills, and behavior were found to be relatively the same between students in the third and fourth grades.

The quantitative data provide specific information to address what outcomes are being achieved as a result of Project B.A.S.I.C., and if they are consistent with the stated goals and objectives. One outcome in regards to coping skills has shown that students who have access to the program engage in fewer adaptive and maladaptive coping strategies, and fewer socially acceptable and unacceptable coping strategies. This outcome is related to the stated goal of assisting children in the development of coping skills, but it is mixed in its support.

Another outcome achieved suggests that students involved with Project B.A.S.I.C. have less of a problem with shy and anxious behaviors, and have better developed skills for frustration tolerance, assertiveness, and peer relations. The stated goal associated with these outcomes is assisting the schools in student effectiveness. The objective most consistent is assisting children in the development of coping skills.

Another outcome, which gives characteristics of students receiving individual services from the program, showed that these students are not different from the other students in coping strategies, except for engaging in acceptable coping in social situations, and engaging in unacceptable coping in both academic and social situations. Students who receive individual services were demonstrated to have more problems

with acting out, shy anxious behaviors, frustration tolerance, and task orientation. Their assertiveness skills and peer skills were not found to be different than the other students, as also were their achievement and social skills. On the other hand, the students receiving individual services appeared to have slightly weaker behavioral skills than the other students. Because of the evidence of problems existing within these students receiving individual services, the goal most related is the reduction in the incidence of future mental health problems. The objectives most consistent with this outcome are assisting the schools in the maintenance of "on task" behavior and in the development of effective coping skills.

The final outcome from the quantitative data suggests that in schools served by Project B.A.S.I.C. third and fourth grade students are not different in relation to skills in coping, problem behaviors, competencies, and general skills with achievement, social relations, and behavior. Since the effects of the program do not appear to fade within a year's time, the goal most consistent with this outcome is assisting the schools in student effectiveness. The objectives most closely related are assisting schools with "on task" behavior and assisting children with effective coping skills.

Research Question 5: What recommendations can be made to increase the impact of Project B.A.S.I.C.?

The respondents indicated need for change in the main areas of time, space, materials, communications, and funding or stability. Changes were also referred to for resources and program requirements.

All school staff persons had a CDS assigned to their school through Project B.A.S.I.C. either on a part-time or full-time basis. The respondents recommended that the CDS's time be either increased or suggested adding another program staff person.

The space assigned the the CDS was also targeted for change. Both school staff and program staff recommended that the CDS be given more private space or moved to a different location.

School staff and program staff also saw a need for changes in the materials offered through Project B.A.S.I.C. Changes such as updating, expanding, and standardizing the materials were recommended by the respondents.

The CDS's communication with parents and teachers was another area of change pointed out by the respondents. Better communication between the CDS and the parents which may result in greater parental involvement was recommended. Also, better communication between the CDS and teachers in relation to things such as classroom activities was recommended.

The funding of Project B.A.S.I.C. was also an area addressed by primarily the program staff as needing modification. The respondents recommended an increase in funding or a reorganization of funding for the program. With an increase or a reorganization in funding, the program could be expanded and program stability established which were also recommendations of the respondents.

Other recommendations included allowing the staff to attend more trainings, have less paperwork and program requirements, and have more accessible human resources. Also, more commitment from the schools and from the sponsoring mental health agency, as well as changing the sponsoring agencies view of prevention services, were recommendations suggested by only the program staff.

Other Findings

From the data collection, other information regarding knowledge about Project B.A.S.I.C. and school and teacher constraints emerged but did not fit with the main themes regarding Project B.A.S.I.C.

Regarding knowledge about the program, school staff members were divided about having overall knowledge of the program, its activities, responsibilities, and history in the school. Of course program staff demonstrated the most overall knowledge about the program. Uncertainty about details of the

program or confusion/comparisons with other school programs such as school guidance programs were referred to by both school and program staff. School staff persons reported in several indications that they relied on the CDS assigned to their school more often than the school guidance counselor. Concern about losing the program or other funding issues were also pointed out by the respondents. Another reference of the respondents dealt with parents lack of knowledge about Project B.A.S.I.C. Program staff also referred to the sponsoring mental health agencies lack of knowledge about the program.

Respondents frequently referred to the constraints existing in schools and for teachers. Predominantly the school staff described the lack of space in the schools, expectations of the schools to take up for what's lacking in society, excessive demands and pressures on the teacher for student performance records, and the lack of time in a school day to cover everything.

Another finding resulted from the document review related to Project B.A.S.I.C.'s development. As reported in the first few chapters of this study, the idea for Project B.A.S.I.C. was derived from the Child Development Specialist (CDS) Program in Oregon schools (Sheldon & Morgan, 1984). In the Project B.A.S.I.C. archives, the document describing the details of the CDS program's 10 year follow-up study at the 4 year

mark as described by Sheldon and Morgan (1984) was found. Further investigation about the 10 year follow-up study after the 4 year mark proved surprising. It seems that the 10 year follow-up study stopped at the 4 year mark because the funding was cut, so therefore the study was never completed. In fact this researcher was requested to send a copy of the 4 year evaluation study results to the CDS program administrator from the Oregon Department of Education. As discussed in Chapter 2, the CDS program in the state of Oregon, has been expanded and continues to be a part of Oregon school systems.

Summary of the Findings in Relation to the Stated Goals and Objectives

The current stated goals and objectives of Project B.A.S.I.C. are supported to some extent through this study's findings and are described in the following information (see Appendix A for a complete list of the program's stated goals, objectives, and activities).

Promotion of a supportive environment for the development of children's mental health, which is the first goal, was supported through the respondents' themes regarding the program purposes, activities, and outcomes. Examples include providing a positive influence in the school environment, providing an extra resource, increasing cooperation, and producing change in the school environment.

Another goal, *Assistance to schools in the enhancement of academic and developmental effectiveness of its students*, was supported through themes identified for program purposes, activities, and outcomes. The outcomes identified from the teacher ratings of student behaviors relating to skills with shyness and anxiety, assertiveness, and peers were also supportive of this goal. The ratings of coping behaviors were mixed in their support.

Reduction in the incidence of adolescent and adult mental health problems, which is the final goal, was supported through themes described for program purposes and activities. Examples of themes include mental health promotion and early intervention. Although related outcome themes were identified, such as helping adults to access services, and evidence of carryover to the fourth grade was demonstrated, there were no documented outcomes to strongly support this goal.

The five objectives of Project B.A.S.I.C. were also supported to some extent by the findings.

To enhance awareness and capacity for response of school personnel to the mental health needs of children was supported in themes related to program activities and outcomes. Examples include working with school staff

members, acting as a resource, and changing the attitudes of school staff members

To promote cooperation and coordination of effort between schools and community mental health service providers toward the mutual interest of healthy children was supported in response themes about program activities and outcomes. Examples include liaising between service providers, acting as a resource, establishing relationships with the community, and increasing cooperation.

To assist schools in the maintenance of "on task" behavior of students was supported by the descriptions of program activities and outcomes, such as early intervention and changes seen in children, as well as the behavioral data related to children receiving individual B.A.S.I.C. services and third and fourth grade students.

To assist children in the development of effective coping skills for response to normative developmental crises and mental health risk factors was supported by themes describing program activities and outcomes. Behavioral data from the Project B.A.S.I.C. schools regarding shy and anxious behaviors, frustration tolerance, assertiveness, and peer skills also support this objective, however the data about coping skills were mixed. Information about the behavior of students receiving

individual services and third and fourth grade students was supportive of this objective as well.

The final objective, *To provide schools, families, and students with linkage to the community network for mental health and other services*, was supported by themes related to program activities and outcomes. Examples include acting as a liaison, changing parents attitudes, and benefitting the persons involved.

Conclusions

The following conclusions have been generated from the study's findings:

- Looking at program outcomes and their relation to the program purposes, resources, and activities, the only way to change the outcomes of Project B.A.S.I.C. is to modify the program's goals and objectives or the program activities. Specifically the goal, *The reduction of the incidence of adolescent and adult mental health problems*, was not addressed by the outcome data due to the fact that any true evidence requires long term follow-up. Therefore, in order to have impact on the program outcomes, either this goal or the program activities related to this goal need to be modified.
- The information gained about Project B.A.S.I.C. through this program evaluation was based on perceptions from school staff or program staff who were willing to

participate in the interviews or from third and fourth grade teachers requested to rate students in their classrooms. The outcome findings were mixed and at times contradictory from both the qualitative and quantitative data. Therefore, readers need to be aware that the information regarding outcomes may be biased depending on the perceptions of the respondents.

- Evaluating a prevention program like Project B.A.S.I.C. is difficult because impact is not always measurable. Program evaluations such as this one are usually conducted on a short term basis even though prevention/mental health promotion programs aim for long term change. In sum, this program evaluation may only be representative of Project B.A.S.I.C. in the school year 1994-1995. Therefore, the program implementation plan should include efforts for a continuous evaluation improvement process.

- Prevention/mental health promotion programs such as Project B.A.S.I.C. take more than a canned approach for implementation. Even with the most highly developed goals, objectives and plans for implementation, the program can still face challenges. Resources, as seen in this study, may be available but be perceived as a challenge to the program. Realistically, modifying the resources is near to impossible. Other obstacles for the program may exist as well, but are also not amenable to change. The program should remain flexible

to account for any obstacles or challenges. If change is needed to increase the impact of Project B.A.S.I.C., the main areas which can be targeted are the program's purposes and activities.

Relationship with Previous Research

This study regarding Project B.A.S.I.C. is supported by other research about prevention/mental health promotion programs. The program demonstrated elements of good prevention programs by detailing its implementation (Newton, 1992), being non-problem specific by making its efforts generalizable (Elias et al., 1992), and using a variety of teaching methods and strategies to increase learning (Elias et al., 1992; Stolz, 1984). But just as with other prevention programs described by Price et al. (1988), Project B.A.S.I.C. lacked a process for documentation of the program's effect for reasons such as lack of time, money, or appropriate measures.

Information from this study also compared with the research regarding prevention/mental health promotion facing many challenges. Persons referring to Project B.A.S.I.C. described problems with funding (Plaut, 1980; Price et al., 1980; Price et al., 1988) and the lack of support from mental health (Meyers, 1989: Price et al., 1988). Responses in the study also discussed the problems with the lack of training in the specialty of prevention (Elias et al., 1992; Swift, 1980).

On a recent note, Project B.A.S.I.C. seems to be similar to the school programs suggested and supported by Goleman (1995) which address the enhancement of emotional intelligence. Emotional intelligence deals with skills such as how to deal with the feelings of oneself and of others. Goleman (1995) suggests that high emotional intelligence is a better predictor of life success than a high IQ. But unlike IQ, emotional intelligence is something that can be learned and developed through out life. Therefore, he suggests that schools should include emotional skills along with reading, writing, and arithmetic to help society increase its emotional literacy.

Limitations of the Study

In the overall evaluation of Project B.A.S.I.C. some limitations existed, such as the recruitment of representative participants and the adequacy of the dependent measures.

Finding school staff members who were willing to participate proved to be challenging. For the semi-structured interview process, some CDSs recruited the teachers to be interviewed, while in other schools the principals selected the teachers. The teachers who were willing to participate may have been the teachers who most favored the program and consequently were not representative of all K-3rd grade teachers.

The data collection from the student behavior ratings by the teachers also proved to be challenging. As reported by the CDSs, some third and especially fourth grade teachers were not pleased with the request for their involvement. Complaints focused on the time required to fill out the forms and the time of year for the data collection. As a result some teachers refused to fill out the forms, sent them back incomplete, or filled them out inaccurately. However, most teachers were observed to be conscientious in their efforts to respond.

The purposes of the three dependent measures used in the quantitative data collection appeared to be reflective of behaviors proposed through Project B.A.S.I.C. All sets of forms returned by the control schools were complete, while the sets returned by the experimental schools varied in their completeness.

The Student Information Sheet which requested mainly factual information and general ratings of achievement, social skills, and behavior was the form with the greatest return and completion rate. However, the general ratings of achievement, social skills, and behavior did not appear to be discriminant between the students.

The return and completion rate for the T-CRS was also very good. This scale appeared to distinguish school problems and strengths for the students being rated.

On the other hand, the rate of return and completion of the ASCI was noticeably lower than the other scales. Small to large portions of the ASCI were often left out by the teachers. One main difference between the ASCI and the other scales was that it is three times longer than the other forms, which may have been a critical investment factor for the teachers.

Also, the ASCI was observed to have been completed but filled out inaccurately, as several forms claimed that the typical social and academic coping situations "never occurred" with the student. With frequent ratings of "never occurs" (which is the lowest rating), the results from the ASCI may be invalid and may not be an accurate representation of the students coping behaviors. Therefore, in an attempt to make the coping results more reflective of the students, a data analysis eliminating inaccurate ratings has been conducted and the results are included in an Addendum at the end of this study.

Recommendations for Further Research

Several suggestions regarding future research emerged from this study's findings and conclusions:

1) Future studies should include the perspective of all the persons involved with the program for the evaluation. A variety of methods and measures backed by research is also suggested. Information from parents as well as students should be added to the teacher and program staff input to

provide a comprehensive picture of the program and to compensate for any predominant biases. Input from the sponsoring agency, and from other referral agencies would also provide valuable insight to the program. Ideally, information from persons who have conflict with the program is also suggested. Investigation into the conflicts would clarify whether the problem was within the specific program, the sponsoring agency, or attitude about receiving mental health services.

2) Future research is also suggested to include pre and post measures on school climate, teacher attitudes, children's behavior, parental involvement, knowledge about mental health issues, etc.

3) A longitudinal study is suggested to follow children into adolescence to determine if the impact of Project B.A.S.I.C. continues or fades into the more turbulent years. This information would be especially valuable for those children who received early intervention services.

Reflections of the Researcher

The findings of this study about Project B.A.S.I.C. are not surprising to me. I know first hand of the program purposes, resources, activities, outcomes, changes needed, and challenges, because I have worked with Project B.A.S.I.C. as a CDS for the

past 3 1/2 years. I am glad to finally see evidence of what the program is doing and how it is viewed by others.

Since the data were collected some changes have occurred in the program. Three of the CDSs interviewed have left their positions to retire or take a better paying job, and one school has lost the program's services due to the sponsoring mental health center's decision. Also, one CDS who responded to opportunities for training as adequate was recently told by her mental health center's administration that training would no longer be approved.

As a CDS, I have experienced many ups and downs in the program. Ups could be the hundreds of hugs, smiles, and waves I receive as I walk out to recess and the downs could be the struggles I face trying to get children the help that they need. The ups are what keep me going; the downs make me question if the effort is really worth it.

The challenges of the program as described in the study exist and are faced by the CDS weekly and are ever present in my mind. From my personal experience one example of a challenge is from parents who do not follow through with recommendations for mental health services even though their six year old is binding up stuffed rabbits at nap time, drawing gory pictures of things that make her special, or seeing aliens in the room with the CDS. As the parents usually state loudly,

"I'm not going to that counseling place, 'cause there ain't nothing wrong with my child!" Another example of a challenge is referral services who are on a 48 hour crisis requirement suggesting you call back in two weeks because their slots are filled so they do not have room for the child you are working with who just held a knife to his throat. Therapists who overlook your access to a child in the school, agency administration denying you training opportunities, the mental health agency receptionists questioning whether you are an employee when parents call for you, and the annual anxiety that comes from wondering if the program will be renewed for the next year, are a few of the many challenges faced in my position.

Despite the challenges and frustrations, I truly enjoy my job and I believe in the purposes of Project B.A.S.I.C., which is one of the reasons I conducted this study. Not surprisingly though, Project B.A.S.I.C. is far from perfect and has a lot of room for improvement and refinement.

Realistically, even with the improvements and refinements which may come from this study, Project B.A.S.I.C. existence will still be in question. The biggest determinants to the programs existence are not if the recipients centering around the school feel as if it is worthwhile or even if it is proven in its effectiveness. The biggest determinants of its

existence are based on persons in the political and financial arena who are indifferent to Project B.A.S.I.C.'s purposes, resources, activities, or outcomes.

Not only Project B.A.S.I.C., but other so called prevention programs are left standing on unstable ground for many reasons, including money issues and ineffective efforts. A main reason for the ineffective efforts (which is tied to the money issues) is that many prevention programs go about their tasks in a backwards manner. Prevention is a term that is loosely used and is a label put on things such as midnight basketball leagues, an increase in the numbers of police officers, and an expansion of penal institutions. Just what is trying to be prevented here and what skills are people going to learn from these services? Not much and not many I say. Many prevention programs for children have their services based on helping families when the child is in immediate risk of being removed from the home and/or are not accessible until the child is involved with the court system. Those of us who work with children know that these children showed signs of needing help long before they ever reached this current point. Unfortunately, nothing is typically done or can be done for the child until the problems have manifested in severity and people are forced to do something about it.

I hope I am getting the point across that prevention/

mental health promotion programs are a worthwhile investment. Does this mean that the state or nation should spend all its money toward preventive efforts? No. Prevention/mental health promotion is an involved process that cannot be carried out without a conscientious effort toward quality services. Plans for implementation, selection of the right staff, integration and acceptance within the environment, and designs for a program evaluation are a few of the essential elements of a quality prevention/mental health promotion program.

A recent topic discussed in the media is the concept of the Emotional Quotient (EQ). These discussions center around the book entitled, *Emotional Intelligence: Why it can matter more than IQ* by Daniel Goleman, which came out in October, 1995. Persons with high EQs and modest IQs are found to be in higher paying jobs and better positions than persons with higher IQs. Schools typically have more of an orientation toward IQ enhancement, but now suggestions are being made to include an EQ orientation as well. It seems that Project B.A.S.I.C. has had the right idea all along. Let's just hope that there are instrumental persons who are listening and are willing to support the purpose of building a more emotionally health society.

ADDENDUM

Subsequent Analysis of Data

Data from the ASCI was subjected to further analysis in attempt to be more reflective of the students' behaviors. Individual ASCIs were eliminated (approximately 30) from both the experimental and control schools if a student received over 90% "never occurs" ratings. As originally done, the data was subjected to a MANOVA with follow-up through univariate F-tests. The related hypotheses to be tested were the first, second, sixth, and seventh. Group means and standard deviations are portrayed in Table 6a-6c.

The first hypothesis was that there will be no significant difference between experimental and control groups in adaptive and maladaptive coping domains in academic and social situations as measured by the ASCI. No significant difference was determined between the two groups by a multivariate F-test (Wilk's Lambda) [F (3, 284)=2.340, p>.05]; therefore, the null hypothesis was accepted. Results from the follow-up univariate F-tests are displayed in Table 7.

The second hypothesis was that there will be no significant difference between experimental and control groups in socially acceptable and socially unacceptable coping styles in academic and social

Table 6a

Descriptive Statistics for Additional Data Analysis

Experimental and Control Groups

	Mean	SD
ASCI (Experimental. N=159)		
AAadapt	2.097	.421
AMalad	2.027	.417
SAdapt	2.007	.445
SMalad	2.015	.441
ASocAcc	2.043	.568
ASocUna	1.597	.736
SSocAcc	2.003	.544
SSocUna	1.689	.753
ASCI (Control, N=128)		
AAdapt	2.183	.452
AMalap	2.168	.453
SAdapt	2.141	.525
SMalad	2.147	.522
ASocAcc	2.229	.531
ASocUna	1.765	.830
SSocAcc	2.164	.613
SSocUna	1.932	.871

Table 6b

Descriptive Statistics for Additional Data Analysis
Students Receiving Individual B.A.S.I.C. Services
and Students Receiving No Individual B.A.S.I.C. Services

	Mean	SD
ASCI (Students Receiving Individual B.A.S.I.C. Services, N=32)		
AAdapt	2.157	.503
AMalad	2.148	.497
SAdapt	2.058	.514
SMalad	2.075	.512
ASocAcc	2.191	.696
ASocUna	1.991	.891
SSocAcc	2.161	.639
SSocUna	2.025	.865
ASCI (Students Receiving No Individual B.A.S.I.C. Services, N=127)		
AAdapt	2.083	.398
AMalad	2.058	.395
SAdapt	1.994	.427
SMalad	2.000	.422
ASocAcc	2.006	.527
ASocUna	1.498	.659
SSocAcc	1.963	.513
SSocUna	1.605	.701

Table 6c

Descriptive Statistics for Additional Data Analysis

3rd and 4th Grade Students

	Mean	SD
ASCI (3rd Grade Students, N=89)		
AAdapt	2.117	.474
AMalad	2.098	.469
SAdapt	2.098	.457
SMalad	2.041	.455
ASocAcc	2.012	.622
ASocUna	1.661	.775
SSocAcc	1.990	.556
SocUna	1.742	.782
ASCI (4th Grade Students, N=70)		
AAdapt	2.073	.344
AMalad	2.049	.341
SAdapt	1.980	.429
SMalad	1.982	.423
ASocAcc	2.083	.491
ASocUna	1.516	.679
SSocAcc	2.018	.533
SSocUna	1.623	.715

Table 7

Subsequent Univariate F-tests for

Experimental and Control Groups

Variable	Hypoth. SS	Error SS	Hypoth. MS	Error MS	F	Sig. of F
ASCI						
AAdapt	.51438	53.97275	.51438	.18938	2.71616	.100
AMaldt	.59304	53.61150	.59304	.18811	3.15261	.077
SAdapt	1.27823	66.20427	1.27823	.23230	5.50261	.020
SMaldt	1.24077	65.30604	1.24077	.22914	5.41482	.021
ASocAc	2.46140	86.71601	2.46140	.30427	8.08962	.005**
ASocUn	2.00705	172.93975	2.00705	.60681	3.30756	.070
SSocAc	1.85638	94.46166	1.85638	.33144	5.60088	.019
SSocUn	4.15735	186.05464	4.15735	.65282	6.36826	.012*

*p<.01; **p≤.005

situations as measured by the ASCI. A significant difference was determined between the two groups by a multivariate F-test (Wilk's Lambda) [F (3, 284)=3.015, p<.05]; therefore the null hypothesis was rejected. Results from the follow-up univariate F-test (see Table 7) show that for Socially Acceptable Coping Strategies, the experimental group was significantly lower than the control group in academic situations. Also, the experimental group was significantly lower than the control group for Socially Unacceptable Coping Strategies in social situations.

The sixth hypothesis was that there will be no significant difference within the experimental group between students who have received individual B.A.S.I.C. services versus those who have not received individual B.A.S.I.C. services on the ASCI. . . . For Adaptive versus Maladaptive Coping Styles, no significant difference was determine by the multivariate F-test (Wilk's Lambda) [F (3, 156)=2.092, p>.05]. Results of the follow-up univariate F-test are displayed in Table 8.

For Socially Acceptable and Socially Unacceptable Coping Strategies, a significant difference was determined by the multivariate F-test (Wilk's Lambda) [F (3,156)=3.714, p<.05]. Follow-up univariate F-tests (see Table 8) show that Socially Acceptable and Unacceptable Coping Strategies were used more

Table 8

Subsequent Univariate F-tests for

Students Receiving Individual B.A.S.I.C. Service and Other Students Receiving No Service

Variable	Hypoth. SS	Error SS	Hypoth. MS	Error MS	F	Sig. of F
ASCI						
AAdapt	.13978	27.83862	.13978	.17732	.78833	.376
AMaldt	.20483	27.29795	.20483	.17387	1.17807	.279
SAdapt	.10491	31.12617	.10491	.19826	.52919	.468
SMaldt	.14407	30.59228	.14407	.19486	.73937	.391
ASocAc	.87988	50.2578	.87988	.31864	2.76140	.099
ASocUn	6.20903	79.29642	6.20903	.50507	12.29334	.001**
SSocAc	1.00558	45.78816	1.00558	.29164	3.44798	.065
SSocUn	4.51162	85.10093	4.51162	.54204	8.32334	.004**

*p<.01; **p≤.005

frequently by students receiving individual B.A.S.I.C. services than the other students in both academic and social situations. Only the Socially Unacceptable Coping Strategies for academic and social situations were significantly greater for the students receiving individual services.

Since a significant difference was determined between students receiving individual services versus those students who do not receive individual services, the null hypothesis was rejected.

The final hypothesis was that there will be no significant difference within the experimental group between 3rd and 4th grade students on the ASCI. . . No significant differences were found between third and fourth grade students on coping strategies as measured by the ASCI (see Table 9); therefore the null hypothesis was accepted.

Summary

In an attempt to be more reflective of student behavior, several ASCIs from the quantitative data collection were determined invalid due to inaccurate ratings ("never occurs">90%). This subsequent analysis shows that the experimental group does not differ from the control group with Adaptive and Maladaptive Coping Strategies in Academic and Social Situations. In Socially Acceptable Coping Strategies in academic situations the experimental group

Table 9

Subsequent Univariate F-tests for

Third and Fourth Grade Students

Variable	Hypoth. SS	Error SS	Hypoth. MS	Error MS	F	Sig. of F
ASCI						
AAdapt	.07464	27.90376	.07464	.17773	.41997	.518
AMaldt	.09454	27.40824	.09454	.17457	.54153	.463
SAdapt	.08816	31.14292	.08816	.19836	.44444	.506
SMaldt	.13397	30.60238	.13397	.19492	.68731	.408
ASocAc	.19782	50.70784	.19782	.32298	.61249	.435
ASocUn	.82288	84.68257	.82288	.53938	1.52561	.219
SSocAc	.02961	46.76414	.02961	.29786	.09941	.753
SSocUn	.55410	89.05845	.55410	.56725	.97681	.325

*p<.01; **p≤.005

ratings were significantly lower than the control group. Also in Socially Unacceptable Coping Strategies for social situations, the experimental group was rated significantly lower than the control group.

Students receiving individual B.A.S.I.C. services did not differ from the other students with Adaptive versus Maladaptive Coping Strategies in both academic and social situations. However, ratings of students receiving individual services were significantly greater than ratings of the other students in using Socially Unacceptable Coping Strategies for both academic and social situations.

No significant differences in coping strategies were found between third and fourth grade students.

In this additional analysis the findings regarding the outcomes related to coping are somewhat clearer than in the previous analysis. However, even with the elimination of several inaccurate and extremely low ratings, the experimental group coping means continued to be consistently lower than the control group means.

Although two groups (experimental vs. control and B.A.S.I.C. services vs. no B.A.S.I.C. services) differed between Acceptable and Unacceptable Coping Strategies, the importance of no significant differences between Adaptive and

Maladaptive Coping is not reduced. In this regard, overall coping skills between the groups do not appear to be different.

In conclusion, the classroom activities and early intervention services of Project B.A.S.I.C. attempt to impact children's mental health and coping skills for school, home, and personal crisis situations. The ASCI, which measures only typical school situations, has demonstrated reliability and validity, but may not have been a good match for coping as influenced through Project B.A.S.I.C. Therefore, it may be determined that in relation to coping skills, the experimental group did not participate in coping as much as the control group, the teacher ratings were not accurate, and/or the ASCI may not have measured the type of coping targeted for the students in Project B.A.S.I.C. schools.

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Appendices

Appendix A

GOALS AND OUTCOME OBJECTIVES

The current goals for Project B.A.S.I.C. are:

1. Promotion of a supportive environment for the development of children's mental health.

2. Assistance to schools in the enhancement of academic and developmental effectiveness of its students

3. Reduction in the incidence of adolescent and adult mental health problems.

The project utilizes and adaptation of the "Health Analysis and Planning for Preventive Services" model for management. This model recognizes program goals and outcome objectives as "directions" for project development and basis for statement of impact objectives (short-term changes in the service population's health status or health related behavior) and process objectives (operations necessary to achieve impact). Impact and process objectives are subject to revision as result of a "positive feedback loop", the results of program evaluation.

B.A.S.I.C.'s outcome objectives are:

1. To enhance awareness and capacity for response of school personnel to the mental health needs of children.

2. To promote cooperation and coordination of effort between schools and community mental health service providers toward the mutual interest of healthy children.

3. To assist schools in the maintenance of "on task" behavior of students.

4. To assist children in the development of effective coping skills for response to normative developmental crises and mental health risk factors.

5. To provide schools, families, and students with linkage to the community network for mental health and other services.

SERVICES

Activities are conducted in four areas:

Mental Health Education

- **B.A.S.I.C. Classroom Programming-** presentations are made in every K-3 Classroom of a participating school. The presentations are based on project curriculum guidelines and focus on the development of positive self-concept and related skills
- **Other Classroom Programming-** in response to teacher/school request, other presentations on mental health topics are provided; available to any elementary grade in a participating school. Recent areas have included refusal skills, personal safety, and self-care.
- **Parent Information/Education-** includes formal and informal efforts to assist parents to develop their knowledge and skills in regard to child development and children's mental health issues.

Early Intervention Services

- **Assessment**- identification of children at significant risk of mental health problems an development of intervention plans for risk control.
- **Referral**- informing students and their parents about availability of community services and providers when a needs is identified during assessment, and assistance for acquisition of services.
- **Resource Networking**- identification of sources for health and psychosocial support services for children and families, and maintenance of effective liaison with providers of these services.
- **Service Coaching**- counsel/support/motivation of parents in the decision to use a community service and effective participation in its delivery.
- **Individual/Group Support**- services to assist students with development of specific skills for control of identified risk factors and support/motivation to utilize these skills. Clear distinction is maintained between this process and a school's guidance counseling program or the sponsoring agency's treatment program. Functionally, the activities are psychoeducational with the additional capacity for individualized coaching of skills.
- **Adjunct Services to Students in Mental Health Treatment**-includes support to the individual, observation, and participation in a primary clinician's case management for students of a participating school who are in treatment with the

sponsoring agency. The intention is to increase the effectiveness of the student's participation in treatment, as well as associated risk control. Technically a secondary prevention process, the unique position of the Project B.A.S.I.C. prevention specialist as member of the agency staff and member of the school community allows this specialty service.

Teacher Consultation

- **Case Consultation-** assistance to an educator in identification of children at risk in regard to their mental health and planning the most effective response.
- **Program Consultation-** assistance to the teacher or administrator toward the promotion of a supportive environment for healthy child development, awareness of children's mental health needs, and accomplishment of risk control in the classroom and other program areas.
- **Personal Consultation-** assistance to school staff members in identification of their own mental health needs and response to those needs; the service recognizes that the educator, activated toward her/his mental health, is a more effective participant in the promotion of student health.

School Climate Enhancement- includes the entire catalog of potential activities which utilize environmental modification, systems intervention, public relations, and other macro-techniques to increase opportunities for positive transactions among members of the school

community (or reduce opportunity for negative transaction) or promote positive attitude/motivation and wellness concepts.
Recent examples include establishment of positive school rituals, "Just Say No" Clubs, and establishment of a Family Resource Center in local libraries.

All direct services are delivered by the Prevention Specialist at his/her assigned participating school(s). The Specialist receives technical assistance from the Regional Coordinator and logistical support from the Specialist's sponsoring agency. Activities related to community organization/networking are accomplished through partnerships with community agency representatives, school personnel, parents, or students.

*This information is taken from the Project B.A.S.I.C. Staff Manual

Appendix B

School Staff Interview Form

How many years have you been teaching/working in the schools?

What grade levels?

How long at this school?

How many years with Project B.A.S.I.C.?

What do you see as the goals of Project B.A.S.I.C. in your school? Objectives?

Are there goals in Project B.A.S.I.C. that you feel are up to date and worthwhile? Objectives? Explain.[1]

In your opinion, are these goals based on the school's or society's needs and expectations? Explain.[1]

a) What is there needed more of in Project B.A.S.I.C.? Less?

How well do you believe the students achieve the stated goals and objectives? [4]

What do you see as the long term effect of Project B.A.S.I.C. on the total school environment (students, staff, community)?[4]

Do you feel that the Project B.A.S.I.C. material presented and available is adequate for the carrying out of Project B.A.S.I.C.? Explain.[3]

a) Is the overall school set up adequate?

Do you feel that the resources (room, space, etc) in this/these school(s) are adequate for carrying out Project B.A.S.I.C.? Explain.[2]

Do you feel that the Child Development Specialist has the skills, competencies, and knowledge to carry out the program's responsibilities? How so?[2]

What do you believe are some of the unexpected outcomes as a result of Project B.A.S.I.C.? [4]

How has the total school (students, staff, community) been influenced by any unexpected outcomes? Give some examples.[4]

How has Project B.A.S.I.C. changed or influenced the students and their behavior? Anyone else? [4]

If your job was to measure the influence of Project B.A.S.I.C., how would you go about it? What resources would you use? [4]

In your opinion what is the level of satisfaction with all aspects of Project B.A.S.I.C.? [4]

If you were to redesign Project B.A.S.I.C. from scratch how would you do it as compared to the way it is currently done?

Appendix C

Child Development Specialist Interview Form

How many years have you been teaching/working in the schools?

What grade levels?

How long at this school?

How many years with Project B.A.S.I.C.?

What is your educational background?

What is you experience in Mental Health or Psychology?

What do you see as the goals of Project B.A.S.I.C. in your school? Objectives?

Are there goals in Project B.A.S.I.C. that you feel are up to date and worthwhile? Objectives? Explain. [1]

In your opinion, are these goals based on the school's or society's needs and expectations? Explain. [1]

a) What is there needed more of in Project B.A.S.I.C.? Less?

How well do you believe the students achieve the stated goals and objectives? [4]

What do you see as the long term effect of Project B.A.S.I.C. on the total school (students, staff, community)? [4]

Do you feel that the Project B.A.S.I.C. material presented and available is adequate for the carrying out of Project B.A.S.I.C.? Explain. [3]

a) Is the overall school set up adequate?

Do you feel that the resources (room, space, etc) in this/these school(s) are adequate for carrying out Project B.A.S.I.C.? Explain.[2]

Do you feel that the Child Development Specialist has the skills, competencies, and knowledge to carry out the program's responsibilities? How so? [2]

What do you believe are some of the unexpected outcomes as a result of Project B.A.S.I.C.? [4]

How has the total school (students, staff, community) been influenced by any unexpected outcomes? Give some examples. [4]

How has Project B.A.S.I.C. changed or influenced the students and their behavior? Anyone else? [4]

If your job was to measure the influence of Project B.A.S.I.C., how would you go about it? What resources would you use? [4]

In your opinion what is the level of satisfaction with all aspects of Project B.A.S.I.C.?

_____

Do you feel that the goals/objectives of the program are measurable? Explain. [2]

Do you feel that all of the stated program goals have been assessed in its years of existence? Which ones have or have not? [4]

Do you feel that the goals have been prioritized? Explain. [1]

In the overall program, how are the implementation decisions made? [3]

a) What about in the individual schools?

Is there a clear relationship between the implementation plan and the program goals and objectives? Explain. [3]

To your knowledge, does Project B.A.S.I.C. have a process for assessing the effectiveness of the program's implementation or how its carried out? Explain. [3]

Is there a process for reviewing and revising Project B.A.S.I.C.'s operation (or day to day) activities? Explain. [3]

Is there and ongoing formative assessment process (for improvement) to determine how well the goals and objectives are achieved? Explain. [3]

What is the predominant (common) delivery mode of Project B.A.S.I.C.? [3]

Do you feel that the human resources available to you are adequate to effectively attend to all aspects of Project B.A.S.I.C.? What is needed or not needed? [2]

Are your delivery plans consistent with Project B.A.S.I.C.'s overall program plan? Explain the similarities and differences. [3]

Are the physical facilities (rooms, space, etc) adequate and available to conduct the program? Explain. [2]

Are the rules, regulations, and policies of Project B.A.S.I.C. supportive of and consistent with the work expectations? [2]

a) What about the school/educational system? Is the school system expectation different from Project B.A.S.I.C.? Conflicts?

Are there goals that give clear direction to Project B.A.S.I.C.'s objectives and activities? [1]

Do the personnel (CDSs) clearly understand their role, authority and responsibilities to implement Project B.A.S.I.C.? Explain. [2]

Do you feel there are professional development opportunities available to strengthen and enhance program operations (daily activities)? Explain. [3]

Does the organization provide staff development and renewal programs to assist you in developing and improving the skills, competencies, and knowledge to carry out the program expectations? Explain. [2]

Do the participants (students, school staff) have access to the equipment and materials necessary to achieve the program goals? Explain. [2]

Is the funding adequate to carry out program activities? How so? [2]

If you were to redesign Project B.A.S.I.C. from scratch how would you do it as compared to the way it is currently done?

Appendix D

BASIC Administration Interview Form

How many years have you been teaching/working in the schools?

What grade levels?

How long?

How many years with Project B.A.S.I.C.?

What is your educational background?

What is you experience in Mental Health or Psychology?

What do you see as the goals of Project B.A.S.I.C. in the schools? Objectives?

Are there goals in Project B.A.S.I.C. that you feel are up to date and worthwhile? Objectives? Explain. [1]

In your opinion, are these goals based on the school's or society's needs and expectations? Explain.[1]

a) What is there needed more of in Project B.A.S.I.C.? Less?

How well do you believe the students achieve the stated goals and objectives? [4]

What do you see as the long term effect of Project B.A.S.I.C. on the total school (students, staff, community)? [4]

Do you feel that the Project B.A.S.I.C. material presented and available is adequate for the carrying out of Project B.A.S.I.C.? Explain. [3]

a) Is the overall school set up adequate?

Do you feel that the resources (room, space, etc) in the school are adequate for carrying out Project B.A.S.I.C.? Explain. [2]

Do you feel that the Child Development Specialists have the skills, competencies, and knowledge to carry out the program's responsibilities? How so? [2]

What do you believe are some of the unexpected outcomes as a result of Project B.A.S.I.C.? [4]

How has the total school (students, staff, community) been influenced by any unexpected outcomes? Give some examples.[4}

How has Project B.A.S.I.C. changed or influenced the students and their behavior? Anyone else? [4]

If your job was to measure the influence of Project B.A.S.I.C., how would you go about it? What resources would you use? [4]

In your opinion what is the level of satisfaction with all aspects of Project B.A.S.I.C.? [4]

What are the vision, mission, or philosophical statements that give direction to the program goals, objectives, and activities? Are these documented? Where? [1]

What do you see as the tie between these statements? [1]

a) Do you feel the relationship among them is clear?

To your knowledge, are there other programs which share these same or similar goals? Examples. [1]

Is there a process to review, refine, and update the goals? Explain. [1]

Who was involved in the development of Project B.A.S.I.C? [1]

a) How did it come about?

Do you feel the personnel (CDSs) clearly understand their role, authority, and responsibility to implement Project B.A.S.I.C.? Explain. [2]

Do you feel that the goals/objectives of the program are measurable?

Do you feel that all of the stated program goals have been assessed in its years of operation? Which ones have or have not? [4]

Do you feel that the goals have been prioritized? Explain the priority. [1]

In the overall program, how are the implementation decisions made?[3]

a) What about in the individual schools?

Is there a clear relationship between the plan for carrying out the program and the program's goals and objectives? Explain. [3]

Does Project B.A.S.I.C. have a process for assessing the effectiveness of the program's implementation (or how its being carried out)? Explain. [3]

Is there a process for reviewing and revising Project B.A.S.I.C.'s operation (or day to day) activities? Explain. [3]

Is there an ongoing formative assessment process (for improvement) to determine how well the goals and objectives are achieved? Explain. [3]

What is the predominant (most common)delivery mode of Project B.A.S.I.C.? [3]

If you were to redesign Project B.A.S.I.C. from scratch how would you do it as compared to the way it is currently done?

Appendix E

Student Information Sheet

1) Student Age: 7 8 9 10 11

2) Student Gender: Male Female

3) Does this student receive Free or Reduced Lunch benefits? Yes / No

4) Which best describes the student's household:
a) Two parent
b) Single Parent
c) Other_____

_____

Circle the one that best describes the performance of this student in these areas:

	Low		Average		High
5) Achievement:	1	2	3	4	5
6) Social skills:	1	2	3	4	5
7) Behavioral skills:	1	2	3	4	5

Please answer the following questions:

8) Does this student receive Special Education services? Yes / No

*9) Has this student ever been **referred** for individual or small group services to Project B.A.S.I.C.? Yes / No

*10) Has this student ever **received** individual or small group services from Project B.A.S.I.C.? Yes / No

*please check with your Project B.A.S.I.C. Child Development Specialist if you are unsure of these answers

Appendix F

Student Information Sheet

1) Student Age: 7 8 9 10 11

2) Student Gender: Male Female

3) Does this student receive Free or Reduced Lunch benefits? Yes / No

4) Which best describes the student's household:
a) Two parent
b) Single Parent
c) Other _____

Circle the one that best describes the performance of this student in these areas:

	Low		Average		High
5) Achievement:	1	2	3	4	5
6) Social skills:	1	2	3	4	5
7) Behavioral skills:	1	2	3	4	5

Please answer the following question:

8) Does this student receive Special Education services? Yes / No

9) Does this student receive any other additional support services from the school? Yes / No If yes, please describe _____

Appendix G

The Academic and Social Coping Inventory (ASCI)

Jann D. Cupp Donald J. Dickinson

Purpose

This inventory is designed to assess school-based coping skills for children in grades 1-9 In order to be as practical as possible, the items and coping styles in this inventory are taken from actual classroom situations. The ASCI measures how well children cope with academic and social problems which they encounter in the schools. The ASCI provides information on the **Academic and Social Coping** of children, including four **adaptive** and four **maladaptive** styles. The ASCI can serve as a curriculum for teaching adaptive coping as each situation (item) can be used as a hypothetical scenario to directly teach effective coping. (See the ASCI handbook for specifics on teaching coping strategies.)

Instructions

1. Read the 20 ASCI situations a week or two before rating the students. Observe the students on the 20 situations to see how the children cope.

2. It should require no longer than 15 minutes to rate the first student and no more than 10 minutes for each of the remaining students. After rating the first student, you need read only the underlined portion of the situation to recall all the item. Doing this will save you time.

3. Please rate each item by indicating the **extent** to which the student engages in the specific coping behavior. **Rate your responses on a scale of 1 to 5: 1 = never occurs, 2 = seldom occurs, 3 = occasionally occurs, 4 = frequently occurs, 5 = always occurs.** Please note that the specific coping behaviors are only examples, and the students need only do "such things as" the indicated examples.

Example:

1. **When/if the student <u>makes a mistake,</u> he/she:**
   - a.___ Isolates him/herself.
   - b.___ Cries.
   - c.___ Works on another task unrelated to the task at hand or laughs about it.
   - d.___ Blames others.
   - e ___ Asks for help with the problem or seeks support..
   - f.___ Identifies, defines, or clarifies the problem.
   - g.___ Investigates alternatives or tries new ideas to solve the problem.
   - h.___ Follows through with the plan to solve the problem and changes plan when necessary.

Simply rate each blank 1-5. For example, Johnny never isolates himself, so choice a. is marked 1. He never cries or does anything unrelated, so choice b. and c. are also 1. He frequently blames others, so d. is marked 4. He seldom asks for help so this is marked 2 ... and so on. **NOTE: If an entire item does not apply to the student at all, simply mark all items "never occurs" which is a rating of 1.**

Code Number _____

Remember: 1 = never occurs 2 = seldom occurs 3 = occasionally occurs 4 = frequently occurs 5 = always occurs

Academic Coping

1. When/if the student *makes a low score*, he/she does such things as:

____Withdraws, has nothing to do with others.
____Pouts, cries, throws temper tantrum, or refuses to do work.
____Works on another task completely unrelated to the problem (e.g., drawing instead of working math problems) or makes light of the situation.
____Blames others for his/her low score.
____Asks the teacher or peers to help find ways to improve performance on the task and/or seeks support.
____Asks what he/she did wrong.
____Develops such strategies as rereading, being prepared, or using reference material.
____Follows a plan he/she has developed to solve the problem and changes plan if necessary.

2. When/if student is asked to *make an oral reading/presentation* and is not successful because he/she is not prepared, he/she does such things as:

____Runs away or isolates him/herself.
____Cries, strikes out at peers, or makes angry statements.
____Performs some other task which has nothing to do with the oral presentation or jokes about it.
____States that his/her mistake was someone else's fault.
____Seeks advice from the teacher or peers on how he/she may improve his/her presentations in the future and/or seeks understanding.
____Asks what was wrong with the presentation.
____Considers other strategies such as note taking, practice, outlining, or focusing on the content of presentations and not on his/herself.
____Follow through with a plan for improving his/her future presentations and changes plan when appropriate.

3. When/if the student has *a large amount of work to do in short period of time*, he/she does such things as:

____Runs away from the task or becomes withdrawn and quiet.
____Acts angry, frightened, frustrated, refuses to work, or makes "smart" remarks.
____Starts working on a task/activity which has not been assigned or laughs it off.
____States that other student(s), teacher, or parents are keeping him/her from completing work on time.
____Asks the teacher or other students for ideas or assistance in completing the work on time and/or seeks support.
____Determines what has to be done and the time left to do it.
____Develops other strategies such as time management and/or developing priorities to meet the goal.
____Follows the steps of a plan to get the job done on time and corrects plan when necessary.

4. When/if faced with *an assignment that requires a novel and creative effort*, the student does such things as:

____Sits by him/herself without responding.
____Appears angry or frustrated.
____Begins tasks which are unrelated to the assignment or talks way out of assignment.
____States that someone else is keeping him/her from doing a good job or that instructions are not clear.
____Asks for advice or ideas on how to complete the assignment and/or encouragement.
____Asks for clarification of the assignment.
____Considers other strategies such as reference materials, ideas from others, or starts with a small step.
____Follows a plan to complete the tasks and changes strategy when plan does not work.

5. When/if the student is faced with an assignment that requires *independent work*, he/she does such things as:

____Withdraws from the task or daydreams.
____Cries or appears frightened, hesitant, or angry.
____Does something completely different or jokes about the situation.
____Accuses someone else of interference.
____Asks the teacher or others for advice on how best to approach the task alone and/or seeks encouragement.
____Identifies what must be done in order to work independently.
____Develops a strategy that allows the student to complete independent work (working away from others, avoiding distractions, etc.).
____Implements the plan for independent work and modifies when necessary.

6. When/if the student is *faced with repeated failure* (several assignments in a row, consistently low grades, etc.), he/she does such things as:

____Isolates him/herself from the rest of the class.
____Shows anger, frustration, or refuses to work.
____Works on tasks completely unrelated to assignments or makes the failure seem unimportant.
____Claims that others are at fault for his/her failure.
____Admits the problem and seeks advice for correcting the problem and/or seeks support.
____Determines what he/she did wrong.
____Develops strategies such as rereading, listing assignments, and checking work.
____Follows the plan designed to solve the problem and modifies when it fails.

7. When/if the student is *confronted for failing to turn in homework*, he/she does such things as:

____Avoids the teacher or peers.
____Cries or becomes angry.
____Does other work unrelated to the assignment or makes light of the situation.
____Makes up excuses (blames others, "the dog ate it," etc.).
____Seeks help from the teacher or others and/or encouragement.
____Identifies things that prevent him/her from doing homework.

Remember: 1 = never occurs 2 = seldom occurs 3 = occasionally occurs 4 = frequently occurs 5 = always occurs

___Constructs such strategies as listing homework assignments, using reminders to keep track of homework, etc.
___Follows through with a plan to solve the problem and corrects plan when necessary.

8. When/if the student *receives criticism* over an assignment from the teacher, he/she does such things as:
___Goes off by him/herself, sits alone, and refuses to talk.
___Becomes angry, acts hurt, cries, or throws a tantrum.
___Ignores the teacher and continues working on an unrelated task and jokes about the criticism.
___Blames others or the task for the problem.
___Asks for suggestions from the teacher on how to improve and/or seeks sympathy.
___Asks the teacher the reason for the criticism.
___Plans to do such things as clarifying assignments, showing neater work, or turning work in on time.
___Implements plan to avoid criticism and changes strategies when appropriate.

9. When/if the student is given an *unexpected assignment*, like a surprise test for which he/she is not prepared, he/she does such things as:
___Withdraws, tries to avoid the test quietly.
___Cries, throws a tantrum, or becomes hostile.
___Performs some other task (e.g., sharpens pencil, tries to work on other assignment) or makes fun of the assignment.
___States that he/she cannot comply due to outside interference or blames others.
___Asks the teacher for advice on how to be ready for the unexpected assignment or test and/or seeks encouragement.
___Asks teacher for clear instructions.
___Develops a plan for completing the task, such as focusing on only the first question and not the full test or first locating a question he/she can answer.
___Takes the test in a way that indicates a thought-out plan and modifies plan when not effective.

10. When/if the student is confronted with *a task he/she does not understand*, he/she does such things as:
___Withdraws from the situation.
___Cries or gets angry.
___Tries to become involved in a different task or pokes fun at the value of the task.
___ Blames others for his/her own lack of understanding.
___ Asks teacher or peers for help in understanding the task and/or seeks compassion.
___ Focuses step-by-step on what the instructions say.
___ Develops a strategy for comprehending the task, like re-reading instructions, looking up definitions, etc.
___ Follows the plan he/she has devised and modifies when appropriate.

Social Coping

1. When/if the student *fails to get his/her own way* when sharing or playing, he/she does such things as:
___Sulks, pouts, isolates him/herself, or refuses to participate.
___Throws a tantrum, cries, whines, or argues.
___Gets involved in something unrelated or different or makes light of the situation.
___Blames someone else for not being able to get his/her way.
___Asks teacher or peers for alternative ways in which he/she may participate appropriately and/or seeks support.
___Determines whether it is reasonable to have his/her own way in this situation.
___Considers other alternatives to solve the problem, such as waiting turn, focusing on positive aspects of cooperation, etc.
___Executes a plan to solve the problem and modifies plan when not effective.

2. When/if the student is *not selected for an activity* or game, he/she does such things as:
___Becomes withdrawn and sits by him/herself.
___Gets mad, breaks things, stomps, etc.
___Performs some other task or laughs it off.
___Tells others it is their fault he/she was not selected.
___Asks teacher (or others) what he/she can do to be selected and/or seeks condolence.
___Determines why he/she was not selected.
___Develops alternatives for being selected next time such as raising hand, practicing the required skills, being nice to others, etc.
___Follows through with ideas on improving chances of being selected or dealing with not being chosen and develop new plan when first plan is not effective.

3. When/if the student receives *punishment in front of others*, he/she does such things as:
___Runs off, sulks away from others, or withdraws.
___Shows anger, strikes out physically, or cries.
___Does something that makes no sense, given the situation (laughs, combs hair, etc.) or engages in an unrelated activity.
___Puts the blame on someone else (teachers, parents, peers, society, etc.).
___Seeks teacher or student advice in preventing the situation from occurring again and/or seeks sympathy.
___Clarifies why he/she received the punishment.
___Considers strategies to prevent punishment by using self-talk, planning, and environmental cues to control behavior.
___ Follows plan in preventing the situation from occurring again and modifies plan when appropriate..

4. When/if the student is *forced to work or play with other student(s) he/she clearly does not like*, he/she does such things as:
___Leaves the situation and goes off to be by him/herself.
___Fusses, complains, insults others, or throws a tantrum.
___Tries to perform some other task, associates with a different group, or makes the best of it by kidding others.
___Makes excuses or accusations as to why he/she cannot work or play with the student or blames others.
___Asks the teacher or peers for advice on how to handle this situation constructively and/or seeks support.
___Verbalizes why he/she dislikes the other student and determines whether these dislikes have a factual basis.
___Considers recognizing positive attributes of the student he/she

Go To Next Page >>>

Remember: 1= never occurs, 2= seldom occurs, 3= occasionally occurs, 4= frequently occurs, 5= always occurs

is forced to play with and considers how to deal with prejudices and to not make general statements about others, etc.

___Follows through with a plan to deal with the problem, and uses new strategy when first strategy does not work.

5. When/if the student is *placed in an embarrassing situation*, such as trips or falls down in front of others, he/she usually does such things as:

___Isolates him/herself from others, covers face, hides, etc.
___Show anger or cries.
___Says something or does something unrelated to the situation or laughs at him/herself.
___Blames someone else for the event leading to the embarrassment.
___Goes to the teacher or others to seek advice on how to handle embarrassment and/or seeks condolence.
___Determines why he/she is embarrassed and if this is normal.
___Develops a strategy to react without defensiveness or calling additional attention to the offense.
___Follows through with such strategies and changes plan when appropriate.

6. When/if the student is called a name, *teased, picked on by other student(s), or drawn into a fight*, he/she does such things as:

___Goes off by him/herself or avoids others.
___Gets angry, strikes other students, cries, or pouts.
___Performs some unrelated task (e.g., drawing, studying) or talk about other things.
___Blames others for the teasing or fighting.
___Asks the teacher for ideas to deal with the difficulty and/or seeks sympathy.
___Seeks clarification as to why he/she is being picked on or teased.
___Develops such strategies as being socially positive, remaining calm, asking the offender to stop, or getting others to help with conflict resolution.
___Follows a plan to deal with the situation and uses new strategies when first one fails.

7. When/if the student is *faced with an inconvenience*, like noise in the lunchroom, loss of recess time, wait time for computer, or long lines, he/she does such things as:

___Withdraws.
___Gets extremely upset, acts angry, or cries.
___Exhibits "silly" behavior, performs some task unrelated to the inconvenience or find humor in the situation.
___Blames the teacher or others for the inconvenience.
___Talks to others about the situation and gains ideas for dealing with the inconvenience like remaining calm, talking with the others, etc.
___Finds out why the inconvenience has happened.
___Develops a plan like starting earlier to avoid lines or asking teacher or principal for student input in solving problem etc.
___Implements a plan designed to stop or prevent the inconvenience and modifies plan when necessary.

8. When/if the student gets *his/her feelings hurt*, or is exposed to sad or disruptive experiences (such as an injury or death of a friend, unhappy life experiences, etc.) he/she does such things as:

___Becomes withdrawn and self-isolated.
___Seems inconsolable, cries excessively, or strikes out violently.
___Acts as if it really does not matter, performs unrelated tasks or changes the subject.
___Blames others (teachers, society, etc.) for the problem.
___Seeks help in finding alternatives and advice for addressing the experience, such as talking with a counselor, etc. and/or seeks compassion.
___Seeks help from others as to why the hurtful experiences are occurring.
___Develops a plan to eliminate the hurtful or disruptive experience, etc.
___Follows through with the plan to deal with the situation and modifies when necessary.

9. When/if the student has *peer pressure to do something against the school rules*, such as running in the hall, defacing school property, skipping class, using tobacco, etc. he/she:

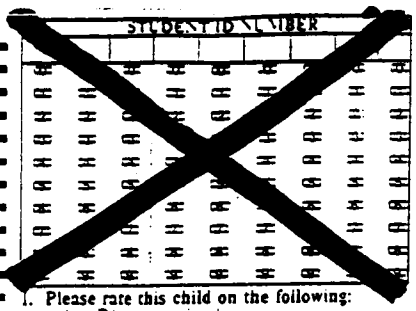
___Refuses to discuss the situation and retreats.
___Becomes aggressive or belligerent.
___Gets involved in another task or sidetracks the conversation.
___Blames others (teacher, principal, etc.), for letting such things happen or blames unfair rules.
___Asks parents, teacher, or others how to deal with peer pressure and/or seeks understanding.
___Attempts to understand the situation by asking such things as "Why/how did they pressure me?"
___Develops a plan to deal with peer pressure by saying "No" in a positive way or developing other friendships.
___Follows the plan by doing such things as being positive, yet rejecting peer pressure, and uses new plan when necessary.

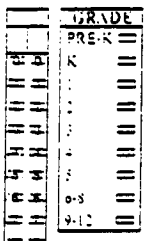
10. When/if the student is *without friends*, he/she does such things as:

___Avoids the other students.
___Insults, ridicules, or fights other students.
___Performs an unrelated task or makes light of not having friends.
___Blames others for the difficulty.
___Asks peer or others how to deal with the lack of cooperation and/or seeks support.
___Identifies whether or not the problem is with him/herself.
___Identifies ways to approach students, making eye contact, sustaining conversation by asking questions, etc.
___Follows through with the plan and modifies strategies when not effective.

End of Academic/Social Coping Inventory (Short Form)

Appendix H





Teacher-Child Rating Scale (T-CRS

Student #_____

Teacher Last Name_____

School_____ Date_____

Screening | Initial | Middle | Final

SEX

I. Please rate this child on the following:	Not a Problem	Mild	Moderate	Serious	Very Serious Problem
1. Disruptive in class					
2. Withdrawn					
3. Underachieving (not working to ability)					
4. Fidgety, difficulty sitting still					
5. Shy, timid					
6. Poor work habits					
7. Disturbs others while they are working					
8. Anxious, worried					
9. Poor concentration, limited attention span					
10. Constantly seeks attention					
11. Nervous, frightened, tense					
12. Difficulty following directions					
13. Overly aggressive to peers (fights)					
14. Does not express feelings					
15. Poorly motivated to achieve					
16. Defiant, obstinate, stubborn					
17. Unhappy, sad					
18. Learning academic subjects					

II. Please rate the following items according to how well they describe the child:	Not at All	A Little	Moderately Well	Well	Very Well
1. Accepts things not going his/her way					
2. Defends own views under group pressure					
3. Completes work					
4. Has many friends					
5. Ignores teasing					
6. Comfortable as a leader					
7. Well organized					
8. Is friendly toward peers					
9. Accepts imposed limits					
10. Participates in class discussions					
11. Functions well even with distractions					
12. Makes friends easily					
13. Copes well with failure					
14. Expresses ideas willingly					
15. Works well without adult support					
16. Classmates wish to sit near this child					
17. Tolerates frustration					
18. Questions rules that seem unfair/unclear					
19. A self-starter					
20. Well liked by classmates					

VITA

Jama M. McDonald was born in Newport, Tennessee on February 22, 1966 to James Benteen and Eunice McDonald. She attended Newport Grammar School and Cocke County High School where she graduated in May 1984. She entered Clemson University, Clemson, South Carolina, in August 1984 and graduated with a Bachelor of Arts in Psychology in May of 1988. Shortly thereafter, in August 1988, she entered the School Psychology program at the University of Tennessee, Knoxville. After completion of her internship in Summer 1992, she gained employment through Cherokee Health Systems as a Project B.A.S.I.C. Child Development Specialist in an elementary school in Cocke County Tennessee, where she currently continues the position. Jama received her doctoral degree in December, 1995.