2009

KIDSMATTER EVALUATION

FINAL REPORT

KidsMatter is an Australian primary schools mental health initiative

Phillip T. Slee, Michael J. Lawson, Alan Russell,
Helen Askell-Williams, Katherine L. Dix,
Laurence Owens, Grace Skrzypiec, Barbara Spears

THE CENTRE FOR ANALYSIS OF EDUCATIONAL FUTURES
FLINDERS UNIVERSITY

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Foreword

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Acknowledgements

Professor John P. Keeves

The Flinders University KidsMatter Evaluation consortium deeply acknowledges and wishes to thank Professor John Keeves for the substantial time, effort and intellectual rigour that he brought to the statistical analysis of the data collected for this evaluation. His ready availability and willingness to lead the team in the analysis has contributed significantly to the outcomes of this evaluation.

Ms Mignon Souter

From the very beginning of this project Mignon gave unstintingly of her time and enthusiasm to the KidsMatter Initiative. Her passion and obvious commitment to the understanding and betterment of young children's wellbeing was greatly appreciated by the evaluation team.

Executive Summary

> What KidsMatter does is it actually introduces the notion that social and mental health wellbeing is important at the school level. It actually says to teachers and staff at schools ... that .... you can actually do it, and this is how you go about it. This is a model for you to be able to do this and you'll be able to have some input into it and be able to participate. So KidsMatter, I think the importance of it is the changing the thinking of teachers – that they actually have a role to play in children's social and emotional wellbeing ....Although they might not be a trained mental health professional, with the resources that KidsMatter provide, they are able to provide guidance as to where they may get that information. *School Counsellor* (School 10)

What is contained in this report?

This is the report of the two-year evaluation of the KidsMatter Initiative Stage 1 Pilot Phase 2007-2008. This report presents the data collected, analyses conducted, conclusions drawn and recommendations for policy and practice resulting from the Evaluation of the KidsMatter Initiative 2007-2008.

The KidsMatter Initiative

Mental health is a matter of concern during the primary school years. It is estimated that about 10 per cent of children will display significant mental health difficulties at some time during their development (KidsMatter, 2006, p.1). To assist teachers and parents/caregivers to address these difficulties, a mental health promotion, prevention and early intervention initiative, named the KidsMatter Initiative Stage 1 Pilot Phase, was developed specifically for Australian primary schools.

KidsMatter was developed in collaboration with the Australian Government Department of Health and Ageing, *beyondblue: the national depression initiative*, the Australian Psychological Society and Principals Australia. It was also supported by the Australian Rotary Health Research Fund.

The KidsMatter Initiative Pilot Phase (KMI) was trialled in 101 schools across Australia during 2007-2008. One school did not participate in the evaluation due to the transient nature of its students, making a longitudinal evaluation design unworkable. The KMI Pilot proceeded in two stages. Fifty of the schools (Round 1 schools) ran the KMI during the 2007 and 2008 school years. The remaining 50 schools (Round 2 schools) undertook the KMI during the 2008 school year. The schools were selected from a larger pool of applicants in a way that recognised their State, location (metropolitan, rural or remote), size and sector type, in order to ensure a diverse sample. Details of the KidsMatter Initiative Pilot Phase are provided on the KidsMatter website: http://www.KidsMatter.edu.au/

The evaluation of the KidsMatter Stage 1 Pilot Phase

Areas for evaluation

The evaluation of KidsMatter Initiative Stage 1 Pilot Phase was formally specified to cover the impact of the KidsMatter Initiative in eight broad areas, namely

- School engagement with the KidsMatter Initiative,
- Parent/caregiver and family engagement with the KidsMatter Initiative,
- School staff knowledge, competence and confidence in working towards improved mental health for students,
- Parent/caregiver knowledge, competence and confidence in supporting the mental health needs of their children,
- Protective factors targeted by the KidsMatter Initiative,
- Student mental health outcome,
- Educational outcomes, and
- Final review.

Design of the evaluation

The initial KMI Pilot Phase was based upon a conceptual model relating three major elements: (1) factors and strategies associated with implementation of the intervention; (2) sets of risk and protective factors related to the school, the family and the child; and (3) student mental health outcomes. In brief, the model proposed that the implementation of the KMI would impact on risk and protective factors, which would in turn impact on student mental health outcomes. In particular, KidsMatter specified four core components that were targeted for intervention at the school level: positive school community; social and emotional learning, parenting education and support, and early intervention for students experiencing social, emotional or behavioural difficulties.

The evaluation used the KidsMatter Pilot Phase conceptual model as a guiding framework. Within this framework, the evaluation proceeded in a manner consistent with Ellis and Hogard's (2006) three-pronged approach to evaluation, emphasising (a) the definition and measurement of outcomes, (b) the description and analysis of process, especially the implementation process, and (c) the sampling of multiple stakeholder perspectives.

The measurement and representation of change across time in factors relating to the areas of the evaluation are a major focus in this report. The staged implementation of the Initiative, with 50 schools beginning in 2007 and the remaining 50 schools in 2008 provided the evaluation with both an element of delayed control, and an element of replication.

With respect to element (3) of the conceptual model, student mental health outcomes, we reviewed the ways that student mental health outcomes are conceptualised. Several streams of argument give support to the perspective taken by the World Health Organisation (2004) that

> Mental Health is not simply the absence of mental disorder or illness, but also includes a positive state of mental well-being. (World Health Organisation, 2004)

In the evaluation, both dimensions of mental health were used in the specification of student mental health outcomes.

The evaluation contract required the surveying of teachers and parents/caregivers in the Pilot schools across the years 2007 and 2008. Survey instruments were designed by the evaluators, including purpose designed and existing measures as proposed by clients (such as the SDQ Goodman, 2005), to address the key areas for evaluation. The surveys were completed by teachers on four occasions, and by parents/caregivers on three occasions across the Pilot Phase. In this report, the questionnaire study is referred to as the 'Whole cohort longitudinal study". Questionnaires were completed by the parents/caregivers and teachers of a stratified random selection of up to 76 students in each of the Pilot schools. The sampling design included provision for inclusion of students who were judged by the school staff to be at risk of social, emotional or behavioural difficulties. Of the 7114 students randomly selected from the 100 schools, data were received at Time 1 from parents/caregivers and teachers of 4980 students, resulting in an initial response rate of 70 per cent. Of these students, 76 per cent were present for data collection on all occasions.

Regular reports on the implementation of the KMI were provided by KidsMatter Project Officers who worked with each of the Pilot schools providing Professional Development and ongoing support for the implementation of the KidsMatter Initiative. Five sets of reports from Project Officers were available at the end of the pilot phase.

Toward the end of the pilot phase, school Principals and KMI Action Team leaders within the schools were asked to provide leadership executive summaries about the processes and effects of KidsMatter within their school. Completion of the Leadership Executive Summary was voluntary and 62 schools provided these statements.

The final element of the evaluation design was the Stakeholder and Student Voice Studies that were conducted within 10 of the Round 1 schools. These studies involved interviews and focus group meetings with school leaders, teachers, parents and students. The studies involved 64 interviews and 44 focus groups with school principals, teachers, parent/caregivers, students and other school staff, in Round 1 KidsMatter schools

Ethics Approvals

Ethics applications were submitted, and approvals received, from the Flinders University Social and behavioural Research Ethics Committee (Approval Number SBREC3744), and also from all school, jurisdiction and departmental bodies for all studies in all Australian states and Territories.

Preliminary investigation of the conceptual foundations of the KidsMatter Initiative

A first focus of the Evaluation was an examination of the KMI conceptual model by investigating relationships between risk and protective factors at the school, family and child levels and student mental health. This analysis was undertaken on the cross-sectional data collected at the beginning of the evaluation (Time 1). Canonical models suggested that School risk and protective factors, as well as the Family and Child protective factors, were related to lower levels of student mental health difficulties. These findings are consistent with the conceptual foundations of the KidsMatter Initiative.

Implementation and engagement with the KidsMatter Initiative: Whole Cohort study

Averaged over the whole participant sample, participants reported that Pilot schools actively worked at implementing the Initiative.

For Round 1 schools, the ratings for implementation from both parents/caregivers and teachers started above the neutral point on the scale and showed positive increases across time. The situation was slightly different for Round 2 schools, which started from a lower position, but showed, from both parent/caregiver and teacher reports, steeper rates of increase.

The pattern is similar for teacher ratings of engagement with the KMI. Again, these ratings for Round 1 schools began well above the neutral point and showed a positive increase throughout the trial. The ratings for engagement from Teachers in Round 2 schools began at about the neutral point and showed a steeper level of increase, being at a similar level to Round 1 schools by Time 4.

Implementation: Progress on the four components

Information on progress on the four components of the KMI was provided in Project Officer reports. This indicated that most progress was made on Component 2 (Social and Emotional Learning) and least progress was made on Component 4 (Early intervention). Round 1 schools began at a relatively high level for each of the components and maintained that level across the period of the Intervention. In Round 2 schools, that began the KMI in 2008, there was little progress during 2007 as expected, but the rate of progress increased rapidly when they joined the initiative in 2008.

An Implementation Index

As an innovative facet of the evaluation, an Implementation Index was created to better understand key questions relating to differences in Implementing KidsMatter across schools. The Implementation Index used information related to three features of implementation: fidelity, dosage and quality of delivery.

The Implementation Index showed substantial differences in the quality of implementation of the KMI between schools. These differences were prominent in Project Officers' perspectives of the success that schools had in addressing each of the steps in the seven-step implementation process, and in the level of involvement of all stakeholders in the KMI, including the active involvement of the school leadership team.

Implementation and engagement: Findings from the Stakeholder and Student Voice Studies

The findings from the qualitative element of the evaluation suggested KidsMatter facilitated the placement of mental health as an issue onto schools' agenda, provided a conceptual framework for considering mental health issues, and provided a common language that enabled school communities to work on these issues. As a result, schools were challenged to create space within the school program for change to occur, and to be prepared to enact change around the structures, personnel and mind-sets within school settings.

The Stakeholder study demonstrated that schools made significant efforts to engage parents/caregivers throughout the initiative. However, parent/caregiver engagement was seen as the most challenging task for schools.

For some schools, barriers to implementing the four components revolved around issues of timetabling and planning, while for others the competing agendas of national priorities, such as literacy and numeracy programs, drew their attention away from the KMI. Some schools found that only doing one, of the four, KidsMatter components did not engender sufficient momentum, While other schools reported that they needed to raise the skill levels of staff before embarking on all components of the KMI.

Perceptions of the Impact of the KidsMatter Initiative

Respondents were asked their views about whether they believed that KidsMatter had had an impact upon their attitudes, behaviours, social networks and so on. Questions about respondents' perceptions of impacts encompassed many aspects of the KMI and therefore covered the broad impact of the KMI. This type of evidence came from both the Stakeholder and Student voice studies and from the Whole Cohort questionnaire analysis.

The KMI was seen to make an impact on school culture, facilitating the raising of issues related to mental health and child development. Teachers acknowledged the value of the resources that gave them entrée to the sometimes difficult area of mental health and reported specific impacts on their teaching. The parents/caregivers interviewed valued the information provided and the strategies the KMI gave them for handling issues related to mental health. However, some parents/caregivers felt less affected by the KMI. Students showed explicit knowledge of strategies that were the focus of teaching about social and emotional learning in the KMI and reported use of this knowledge.

The parent/caregiver and teacher responses to questionnaire items that focussed on broad impact suggested that both groups perceived the KMI to have had generally positive effects. This was evident in parent/caregiver ratings for Engagement with school, Parenting Learning, and Impact on the Child's Needs. The pattern of responses of teachers for the Impact on the Child's Needs showed a similar pattern of positive change.

Perceptions of Professional development

Teachers were generally positive about the professional development delivered in the KMI. The teachers in Round 1 schools showed a slight increase in rating of professional development, having started from an already relatively high initial response. A steeper rate of increase for teachers' ratings in Round 2 schools brought them close to the Round 1 teachers' ratings at Time 4.

Change in risk and protective factors associated with the School

With respect to engagement of schools with general initiatives in promoting positive mental health, there is evidence of a small positive change on this indicator in the ratings by teachers. Although the parent/caregiver ratings on this indicator were at a similar level through the trial, they did not show evidence of change.

The interview and focus group data suggested that schools started the Initiative with, and maintained, a focus upon building a sense of belonging and connectedness for members of

school communities. Respondents' ratings on Component 1, Positive School Community, remained relatively high and showed little evidence of significant change in level throughout the Pilot Phase.

For each of the remaining three components, teaching of SEL, Parenting Support by the School (but not Parenting Support by Staff), and Early Intervention, the ratings of teachers showed evidence of positive change across time. Parent/caregiver ratings showed a generally similar pattern on this set of indicators, with the exception that there was no evidence of change in their ratings on Early Intervention, which remained moderate throughout the trial. This is consistent with data collected from the Stakeholder study, which indicated that schools prioritised their abilities to work with each of the four components, and that component 4: Early Intervention appeared to be the last component that received attention.

Change in risk and protective factors associated with teacher, family and child competencies

Whereas the initial KMI model proposed the school, the family, and the psychological world of the child as the three mediators to child mental health, teachers' knowledge, competence and confidence emerges as a potential fourth mediator for student mental health outcomes.

The analysis of change in the ratings by teachers and parents/caregivers on indicators of teacher, family and child competencies showed a mixed pattern of effects.

The ratings by teachers of their knowledge, competence and confidence that were relevant to their teaching about mental health did show evidence of positive change. There was no evidence of change in the ratings on the Teacher Attitude scale, which was already relatively high.

With regard to the protective factor of student competencies related to Social and Emotional competencies, parents/caregivers' ratings showed positive change across time for Round 1 and Round 2 schools. For teachers, such change was evident only in ratings of social and emotional competencies for students in Round 1 schools.

On scales related to Parenting Knowledge and Approach, there was no evidence of change in level of ratings across time. Throughout the trial, parents/caregivers held strong efficacy about their parenting knowledge and approach.

Perceptions of the impact of KidsMatter on students' schoolwork

Teachers reported consistent and strongly-felt attitudes towards the importance of teaching social and emotional skills to students, with 90 per cent of teachers across all schools strongly agreeing (scoring 6 or 7), that students who are socially and emotionally competent learn more at school.

Teachers' ratings of the impact of the KMI on students' schoolwork showed evidence of positive change across the pilot phase for both Round 1 and Round 2 schools. The ratings of parents/caregivers in Round 2 schools showed a similar pattern of change, but there was no evidence of change in the ratings of parents/caregivers in Round 1 schools.

Impact on student mental health

With respect to the influence of the KMI on students' mental health, the findings of the evaluation indicated an improvement in student mental health and well-being, and a decrease in mental health difficulties. These changes were evidenced by reduced SDQ (difficulties) scores,

decreases on the mental health difficulties scale, and increases on the mental health strengths scale.

Using Hierarchical Linear Modelling, with data averaged across all students in the sample involved in the evaluation, changes in mental health showed trivial to small effect sizes, with more evidence of small effects in Round 1 schools. The small effect size changes were of practical significance and are worthy of attention given the broad nature of the KidsMatter Initiative.

To further examine the changes in student mental health, two further analyses were conducted, using Latent Class Analysis to categorise students into the three mental health status groups of normal, abnormal and borderline (Goodman, 2005), based upon the Composite Student Mental Health Status measure.

The first analysis showed that in both Round 1 and Round 2 schools the percentage of students classified into the normal mental health status group increased by the end of the pilot phase, whilst the percentage of students classified in the borderline mental health status group declined. There appeared to be little change in the percentage of students classified into the abnormal mental health status group.

The next analysis investigated changes in student mental health trajectories for students with abnormal, borderline and normal mental health status at data collection Time 1. It seemed possible, for example, that while there was a consistent proportion of about 10 per cent of students in the abnormal mental health status group, that the mental health scores on the individual scales for these students could nevertheless improve, although this improvement might not have been large enough to change their overall status to ‘borderline’. This analysis, therefore, examined changes in mental health scores based on the students’ existing mental health status at Time 1.

Using Hierarchical Linear Modelling, when changes across the Pilot Phase were examined, the analysis revealed small effect sizes for changes in the mental health status of the borderline group, and medium to large effect sizes for the abnormal group. Effect sizes for the normal mental health status group were mostly trivial, with two small negative effect sizes in Round 2 schools where the KMI had been in operation for a shorter period of time. A possible explanation for these effects in the normal group is the developmental changes arising from the transition of sample students from middle childhood to pre-adolescence during the period of the KMI.

The analyses support a conclusion that, using teacher and parent/caregiver reports, the KMI had an impact on measured student mental health and that this impact appeared greater for students with a mental health status of borderline and abnormal.

Characteristics of Schools Performing Well in Implementing the KidsMatter Initiative: A Portrait

The KidsMatter Initiative is a package. We present a portrait that demonstrates the importance of collaborative leadership that encourages collegial ownership and bottom-up staff involvement, as well as professional development, long term planning for sustainability, and a whole school commitment to the KidsMatter initiative. It also emphasises the need for school and parent/caregiver partnerships which sanction parent/caregiver support of the school community. A strategic approach with a targeted, embedded program across the school, which focuses on identifying and intervening early with children at risk, is also highlighted. The portrait is not

meant as a script or formula to be followed to achieve a "successful" KidsMatter implementation, but rather, it offers suggestions for schools that might use KidsMatter Initiative resources in the future.

Methodological Notes and Limitations of the Evaluation

The report includes discussion of a range of limitations that need to be kept in mind when interpreting the findings. Limitations arise from collecting data in real world settings such as schools. This evaluation is not, and was not designed to be, a strict randomly controlled trial. Because the sample is not a true random sample, caution should be taken if generalising findings to other students and other primary schools in Australia.

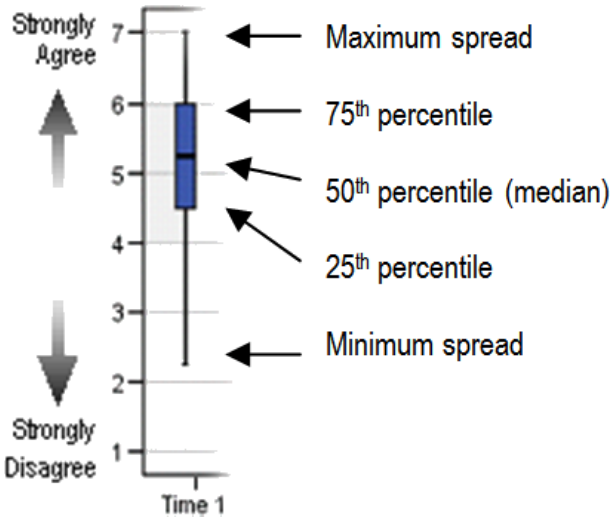
Recommendations

This section specifies recommendations for future action in the area of school-based mental health promotion and the national roll out of KidsMatter.

Glossary of Key Terms

Interpreting a box plot

A box plot (also known as a box and whisker plot) is an efficient method for displaying a five-number data summary, namely, the median score, the inter-quartiles, and the minimum and maximum scores (Lane, 2007). For ease of interpretation, outliers and extreme cases have been removed. The vertical axis reflects the response scale of, in this case, strongly disagree (1) to strongly agree (7) where a score of 4 is neutral.



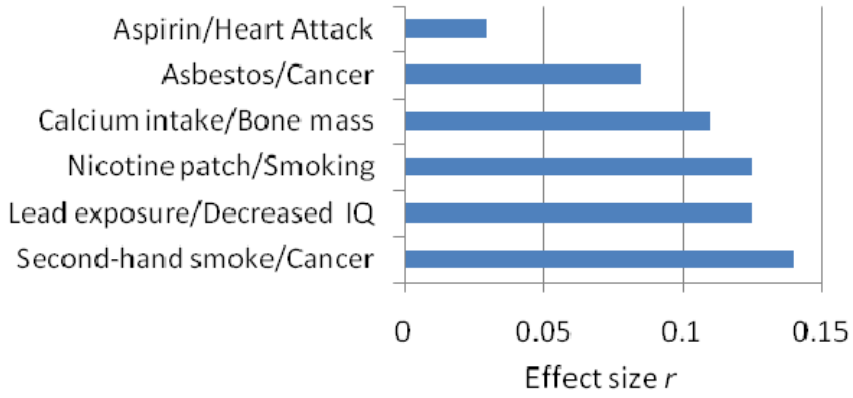
Statistical Significance and Effect Size

Statistical significance testing provides both a measure of uncertainty of a result (such as $p < 0.05$) and an indication of the magnitude of the relations between variables. A common way to express this magnitude is as an effect size. An effect size can be seen as guide to the practical significance of a result, a guide as to "whether the result is useful in the real world" (Kirk, 1996). In this evaluation statistical significance is reported, however, the discussion focuses upon effect sizes, because effect sizes give a better indication about whether an effect is of practical benefit (See Appendix A).

Effect sizes can be calculated in a number of ways. Two common methods are Cohen's *d* and the correlation coefficient *r*. In this report we used the correlation coefficient *r* for reporting all effect sizes. In statistics, correlation simply means the strength and direction of a linear relationship. We use correlations of 0.10, 0.24, and 0.37 as indicative of small, medium and large effects, respectively.

Hattie (2009) suggested that attention should be mostly given to medium and large effects. However, small effect sizes may also be important. For example, Rosenthal and DiMatteo (2001 cited in Hattie 2009) showed that the effect size of taking low dose aspirin in preventing heart attack was (Cohen's) $d = 0.07$ (trivial), indicating that less than one-eighth of one percent of the variance in heart attacks was accounted for by using aspirin. This translates into 34 people in every 1000 being saved from a heart attack if they used low dose aspirin on a regular basis. And small effects that work incrementally over time can be extremely important. For example, a kindergarten compensatory educational intervention might shift slightly the group mean in the intervention group but also may shift the learning curve itself and thus the rate at which children learn throughout their entire educational careers. Thus, the cumulative impacts of small changes over time may be huge, even when the initial impacts seem small! And there may be moderators to effect sizes. For example, Hattie (2009) reports an overall effect size of $d = 0.29$ for the influence of homework on students' academic achievement. However, when student age is taken into account, primary age students gain least from homework ($d = 0.15$) whilst secondary students gain more ($d = 0.64$).

Comparative effect sizes are provided by Anderson and Bushman (2002) as follows,



As with the effect sizes reported by Anderson and Bushman, it is important to consider the variability of educational contexts, where different schools, with different teachers, and different children interact. A fundamental approach of the KMI was that Mental Health Promotion and Early Intervention programs would not be externally imposed, but rather, that KMI would work within schools' existing contexts to support KidsMatter Initiatives. Fidelity to intervention programs and dosage are not strongly controlled in such a delivery model, and this variability would be expected to influence the ability of broad scale interventions to demonstrate substantial effects over the short term.

The 7-step implementation process

The KidsMatter Initiative employed a step-by-step Implementation Model. The seven steps of the model are:

1: Define the issues by writing a summary statement to describe the school's current situation related to each component
2: Set goals based on each summary statement
3: Identify any concerns in achieving the goals
4: Develop a broad range of options/strategies to address concerns and achieve goals
5: Evaluate feasibility of each option/strategy
6: Formalise the component plan
7: Implement the plan and review

The four KidsMatter Pilot Phase school-based components

Target areas	KidsMatter objectives
Positive school community	
1. Sense of belonging and inclusion within the school community	**a.** Caring and supportive relationships are encouraged within the school community: • Between staff • Between staff and students • Between staff and parents/families **b.** School communications and activities are inclusive and accessible to all students and families **c.** School addresses inclusion and belonging at a whole school level through specific policies and practices
2. Welcoming and friendly school environment	**a.** School staff are welcoming to families **b.** School environment (displays, artwork, facilities etc) reflects the varied cultures, family-types and needs of families at the school
3. Collaborative involvement of students, staff, families and the community in the school	**a.** Students, staff, families and the community are provided with opportunities to become involved in a range of school activities **b.** Students, staff, families and the community are encouraged to share their views and contribute to school decisions
Social and Emotional learning	
1. Effective social and emotional learning curriculum taught to all students	**a.** Curriculum is taught that: • covers the five core social and emotional competencies • has research evidence of effectiveness (or at least an identified theoretical framework) **b.** Curriculum is taught: • formally (structured sessions that adhere to the program manual) • regularly • in a coordinated and supported way throughout the school **c.** Teachers have the knowledge, skills and commitment to effectively deliver SEL curriculum
2. Opportunities for students to practise and generalise SEL skills	**a.** Opportunities are regularly provided for students to generalise their SEL skills in the classroom, school and wider community
Parenting education & support	
1. Effective parent-teacher relationships	**a.** Teachers have the skills, confidence and commitment to form collaborative working relationships with parents
2. Provision of parenting information and education	**a.** Effective information is provided to parents on parenting practices, child development and children's mental health **b.** Parents are supported to access parenting education programs
3. Opportunities for families to develop support networks	**a.** Opportunities are provided for parents to get together in a supportive environment **b.** Community resources to support parents and carers are identified and promoted
Early intervention	
1. Promotion of early intervention for mental health difficulties	**a.** School staff understand the importance of early intervention and convey this to students and families
2. Attitudes towards mental health difficulties	**a.** School community aims to destigmatise mental health difficulties
3. Processes for addressing the needs of students experiencing mental health difficulties	**a.** All school staff are educated about how to identify students experiencing mental health difficulties **b.** There are processes in the school to identify and assist students who are experiencing mental health difficulties **c.** Appropriate interventions, including referral pathways, are identified and planned for students experiencing mental health difficulties **d.** Students and families are supported to access interventions

Definitions of the scales used in the Whole Cohort Longitudinal study questionnaire

KMI Engagement	(T)	Teacher (T) ratings of school engagement with the KidsMatter Initiative on the four Components.
KMI Implementation	(T)	Teacher ratings of the KidsMatter Seven-step Implementation process.
KMI Implementation	(P)	Parent/caregiver (P) ratings of their involvement with the KidsMatter Initiative as a measure of the level of implementation.
General Engagement	(P&T)	Teacher and parent/caregiver ratings of their school's engagement with mental health initiatives, in general, with a focus on social and emotional learning.
C1: Positive School Community	(P&T)	A measure of Component 1. Teacher and parent/caregiver ratings of their school community, how welcomed they feel and their sense of belonging.
C2: Social and Emotional Learning	(T)	A measure of Component 2. Teacher ratings of the school's provision of social and emotional learning in the curriculum, support for professional development opportunities, and level of appropriate resources.
C3a: Parenting Support by School	(P&T)	A measure of Component 3. Teacher and parent/caregiver ratings of education and support provided by the school for parents/caregivers.
C3b: Parenting Support by Staff	(P&T)	A measure of Component 3. Teacher and parent/caregiver ratings of how accessible, informative and supportive staff are for providing parenting education and support.
C4: Early Intervention	(P&T)	A measure of Component 4. Teacher and parent/caregiver ratings of how effective their school is at supporting students who are experiencing emotional or social or behaviour difficulties.
SEL Attitude	(T)	Teacher ratings of their attitude to teaching social and emotional learning skills, a protective factor residing in teachers.
Staff Approach	(T)	Teacher ratings of general staff approach to helping students to develop social and emotional skill, a teacher protective factor.
SEL Knowledge	(T)	Teacher ratings of their knowledge and ability to help students to develop social and emotional awareness and skills, a protective factor residing in teachers.
SEL Actions	(T)	Teacher ratings of their teaching program and resources to help students to develop social and emotional awareness and skills, a protective factor residing in teachers.
Self-Efficacy	(T)	Teacher ratings of their self-efficacy to foster a sense of belonging in others, provide effective support to parent/caregivers, and identify early signs of social and emotional difficulties in students, a protective factor residing in teachers
Parenting Knowledge	(P)	Parent/caregiver ratings of their knowledge of how to help their child foster friendships, provide emotional comfort, and recognise when their child is having difficulties, a protective factor residing in families.
Parenting Approach	(P)	Parent/caregiver ratings of their relationship with their child and their effectiveness as a parent/caregiver overall, a protective factor residing in families.

Child Social and Emotional Competencies (P&T)	Teacher and parent/caregiver ratings of the child's ability to maintain positive relationships, solve problems, consider others, and make responsible decisions, a protective factor residing in the child.
KMI Professional Development (T)	Teacher ratings of the impact of the KidsMatter professional development on teacher and school capacities. This is a measure of the perceived impact of the KidsMatter Initiative on school and teacher processes.
KMI Engagement with School (P)	Parent/caregiver ratings of the impact of KidsMatter on their involvement with support networks, school and community. This is a measure of the perceived impact of the KidsMatter Initiative on family processes.
KMI Parenting Learning (P)	Parent/caregiver ratings of the parenting skills that KidsMatter has helped them to learn. This is a measure of the perceived impact of the KidsMatter Initiative on family processes.
KMI Impact on Child (T&P)	Teacher and parent/caregiver ratings of how well KidsMatter has provided for the child's needs at school, especially their socio-emotional needs. This is a measure of the perceived impact of the KidsMatter Initiative on child processes.
Mental Health Difficulties (T&P)	Teacher and parent/caregiver ratings of the child's negative mental health in terms of poor behaviour, anxiety and depression. This is a measure of student mental health outcomes.
Mental Health Strengths (T&P)	Teacher and parent/caregiver ratings of the child's positive mental health in terms of optimism and coping skills. This is a measure of student mental health outcomes.
Total Strengths and Difficulties (SDQ) (T&P)	Teacher and parent/caregiver ratings of the child's negative mental health in terms of hyperactivity, conduct problems, emotional symptoms and peer problems. This is a measure of student mental health outcomes.
Composite Student Mental Health Status (T&P)	Composite of four scales (SDQ, Mental health strengths, mental health difficulties, social and emotional competencies) was used to allocate students into categories of normal, borderline and abnormal mental health status.
Implementation Index (T, P, Project Officers)	Uses information related to three features of implementation, namely, fidelity, dosage and quality of delivery, to rank and categorise schools based on the extent to which KidsMatter has been implemented.

Chapter 1.
Development and Evaluation of the KidsMatter Initiative

1.1 Who developed the KidsMatter Initiative?

The KidsMatter Initiative (KMI) Stage I Pilot Phase was developed through a collaboration involving the Australian Psychological Society, Principals Australia, *beyondblue: the national depression initiative* and the Australian Government Department of Health and Ageing and was supported by the Australian Rotary Health Research Fund.

1.2 Who conducted the Evaluation of the Initiative?

Beyondblue contracted Flinders University to undertake the evaluation of the KidsMatter Initiative Pilot Phase, based on a consortium that was established in the Centre for the Analysis of Education Futures at Flinders University, Adelaide, South Australia. The consortium included the Centre for the Analysis of Educational Futures at Flinders University; the Conflict Management Research Group and Hawke Research Institute for Sustainable Societies at the University of South Australia; and Child Health and Education Support Services, Department of Education and Children's Services South Australia.

A key contributor to the operation of the evaluation was the establishment of strong working relationships between the Evaluation team and key KMI staff responsible for managing the national Pilot Phase. In addition, the evaluation depended critically on the support of teachers and school leaders and KidsMatter Project Officers. These essential working relationships were facilitated by the establishment of an Evaluation website, to keep stakeholders up-to-date with the progress and requirements of the evaluation, and the dedicated work of members of each school Action Team, who managed the delivery and return of evaluation instruments.

1.3 What is contained in this report?

This report presents the evaluation design, the data collected, analyses conducted, conclusions drawn and recommendations for policy and practice resulting from the evaluation of the KidsMatter Initiative.

Chapter 2.
Background to the KidsMatter Initiative in Schools

> "I think it's [KidsMatter] to do with the kids learning how to deal with their emotions – what they feel isn't always wrong – it's just the way you feel … and it's OK to feel whatever you want to feel – you feel bad about something doesn't mean it's wrong – just learning to deal with stuff …mental wellbeing which I think is all included in that … I think it's good that they're getting started now in primary school …. Letting them know now that all these feelings are going to come and go" *Parent* (School 9)

2.1 What is the KidsMatter Initiative?

Mental health is a matter of concern during the primary school years. It is estimated that about 10 percent of children will display significant mental health difficulties at some time during their development (KidsMatter, 2006 p.1). To assist teachers and parents/caregivers address these difficulties, a mental health promotion, prevention and early intervention initiative named KidsMatter has been developed specifically for Australian primary schools.

KidsMatter takes a whole-school approach to addressing children's mental health and aims to:

- Improve the mental health and well-being of primary school students
- Reduce mental health problems among students (eg., anxiety, depression and behavioural problems)
- Achieve greater support and assistance for students experiencing mental health problems. (KidsMatter, 2006)

During 2007 and 2008 the KidsMatter Initiative Pilot Phase was trialed in 101 primary schools across Australia. Requests for expressions of interest to take part in the KidsMatter Initiative Pilot Phase were sent to all Australian primary schools in 2006. The Pilot Phase included provision of support to each school by a project officer, targeted professional development, and resources that supported each component of the Initiative. Each school selected for the Pilot Phase also received a grant from the Australian Rotary Health Research Fund.

Inclusion in the Pilot Phase required schools to participate in an evaluation project that ran across the two years. The 101 schools that were selected from the pool of applicants were chosen on the basis of a sampling design that took into account the schools' State, location (metropolitan, rural or remote), size, and sector type (government, independent, Catholic). One selected school did not participate in the evaluation due to the transient nature of its students, making a longitudinal evaluation design unworkable.

2.2 Conceptual foundations of the KidsMatter Initiative

The KidsMatter Initiative was based upon a conceptual model, shown in Figure 1. In brief the conceptual model proposes that the strategies implemented by schools in the broad area of mental health impact on a range of risk and protective factors associated with the school, the family and the students themselves, which in turn, impact on student mental health outcomes.

The implementation design of the KMI focused on four components of school based activity, as follows:

Component 1: A positive school community: This component encourages schools to engender a sense of belonging and inclusion in members of their communities, by providing a welcoming and friendly school environment, and a collaborative sense of involvement of students, staff, families and the local community.

Component 2: Social and emotional learning for students: This component is designed to help schools select and enact a clearly structured social and emotional learning curriculum for all students covering the five core social and emotional competencies as identified by the Collaborative for Academic, Social and Emotional Learning (CASEL, 2006): self-awareness, social awareness, self-management, relationship skills, and responsible decision making.

Component 3: Parenting support and education: This component focuses on the school as an access point for families to learn about parenting, child development and children's mental health in order to assist parent/caregivers with their child rearing and parenting skills.

Component 4: Early intervention for students experiencing mental health difficulties: The final component is designed to assist schools to support children showing early signs of mental health difficulties, as well as those children identified as having ongoing mental health problems. Teachers and schools can support these students by referring them for assistance, monitoring their function at school, and closely liaising with parent/caregivers and support services.

Within the framework of the KidsMatter Conceptual Model, attention to these four components is predicted to make an impact on student mental health outcomes. The provision of a program of targeted professional development based around the four components, and the provision of support for parents/caregivers is predicted to change the levels of knowledge and skills of teachers, parents/caregivers and students, which in turn are expected to be reflected in improvements in student mental health outcomes.

For example, the regular teaching about social and emotional competencies within a structured program for all students is designed to have a direct impact upon the students' social and emotional capabilities for self-awareness; self-management; social awareness; relationship skills; and responsible decision making (CASEL, 2006). Such increased capabilities are expected to enable students to more effectively address social, emotional and behavioural difficulties that might arise in their daily lives. Similarly, provision of parenting information and support is designed to positively impact on parenting capabilities, and focussed professional development

for teachers and staff is designed to better equip school staff to act quickly in identifying, and supporting, students experiencing mental health difficulties.

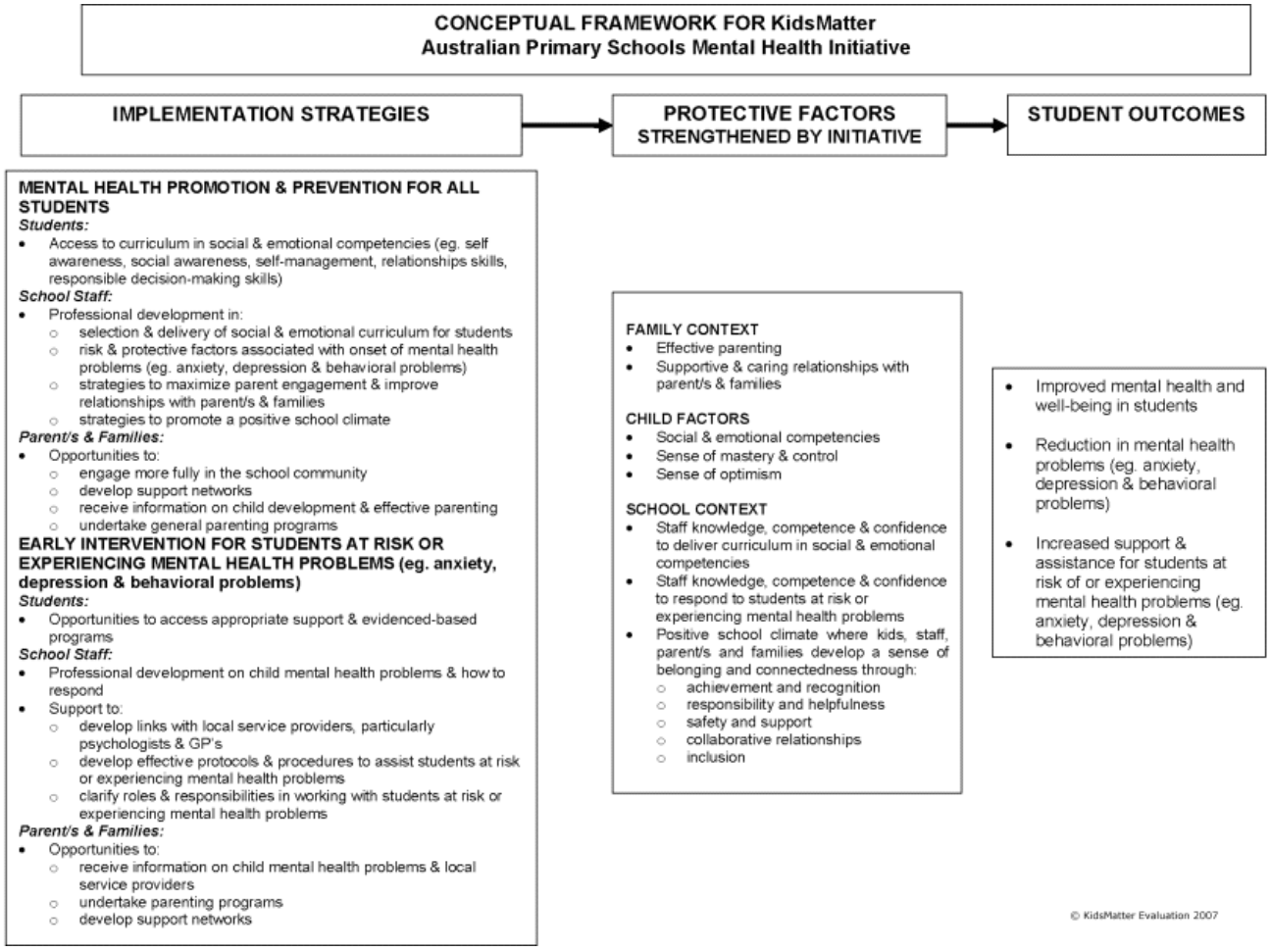


Figure 1. Conceptual framework for the KidsMatter Initiative (KidsMatter, 2006)

Key resources provided to schools involved in the KidsMatter Initiative Pilot Phase included detailed manuals and annotated guides. The plan for the implementation of the Initiative started with a comprehensive audit by the schools of their current situations.

2.3 What were the aims of the Evaluation?

The evaluation of KidsMatter was formally specified to cover the impact of the KidsMatter Initiative in eight broad areas, namely

1. School engagement with the KidsMatter Initiative
2. Parent/Caregiver and family engagement with the KidsMatter Initiative
3. School staff knowledge, competence and confidence in working towards improved mental health for students
4. Parent/caregivers' knowledge, competence and confidence in supporting the mental health needs of their children
5. Protective factors targeted by the KidsMatter Initiative.
6. Student mental health outcomes
7. Educational outcomes
8. Final review

Areas 1 to 6 can be related directly to the KidsMatter Conceptual model in Figure 1. Although it was anticipated that student information related to educational outcomes would be available as part of the evaluation, this proved not to be the case. However, indirect indicators of impact on educational outcomes were generated and are discussed in Chapter **Error! Reference source not found.**. Area 8 is concerned with recommendations that are of relevance to a wider rollout of the KidsMatter Initiative.

2.4 Evaluation principles and approach

The evaluation was a substantial undertaking for all involved in the KidsMatter Pilot Phase. The evaluation team worked closely with the KidsMatter Initiative client group throughout the period of the evaluation, addressing such issues as sampling, survey design, and a wide range of practical matters that arose in a project that involved such widespread activity involving large numbers of participants. Regular contact was also maintained with the KidsMatter Initiative Project Officers, whose reports provided an important source of information for the evaluation. However, perhaps the most substantial load was borne by the school communities, the principals, action team leaders, teachers and parents/caregivers who responded to the multiple surveys. Members of 10 school communities also participated in interviews and focus groups during the latter part of the evaluation. The deep level of engagement of all these groups enabled the evaluation team to assemble a very large and rich set of information that could be used to inform the findings of the evaluation.

The analyses conducted for the evaluation drew on four major sources of information:

- Large scale surveys completed by teachers on four occasions and by parents/caregivers on three occasions.
- Regular reports of KidsMatter Initiative activity provided by the Project Officers in each State.
- Interviews and focus groups conducted with school staff, parents/caregivers and students in 10 selected schools during the middle of the second year of the Pilot Phase, referred to here as the Stakeholder and Student Voice Studies.
- An Executive Summary provided by school principals and KidsMatter action team leaders in the final stages of the Pilot Phase.

Descriptions of each of these sources and their associated documents are provided in the following chapter and in the KidsMatter Technical Report.

An extended discussion of the approach taken to the evaluation is provided in Askell-Williams et al. (2008). In the following section we briefly identify key features of the evaluation design and significant decisions that shaped it.

The conceptual model underlying the design of the KMI provided the overarching framework for the design of the Evaluation of the outcomes of the national KMI Pilot Phase. Within this frame the evaluation proceeded in a manner consistent with Ellis and Hogard's (2006) three-pronged approach to evaluation, emphasising (a) the definition and measurement of outcomes, (b) the description and analysis of process, especially the implementation process, and (c) the sampling of multiple stakeholder perspectives.

2.4.1 Outcomes

With respect to outcomes, two broad issues were of concern. The first issue related to change. The KMI is a program designed to engender change in schools. Our task was to measure and

identify factors associated with any change. The measurement and representation of change across time in measures relating to participating teachers, parents/caregivers and students is therefore a major focus in this report. Change at the level of school processes is also a major interest in the Initiative, and so the current literature about educational reform has been drawn upon in representing and interpreting this element of change. It is apparent in the structure of Figure 1 that the processes of change in the left-hand and middle panels are seen to be critical influences on student mental health outcomes.

The second issue that arose concerning outcomes related to the ways that student mental health outcomes are to be conceptualised. Several streams of argument give support to the perspective taken by the World Health Organisation (2004) that

> Mental Health is not simply the absence of mental disorder or illness, but also includes a positive state of mental well-being. (World Health Organisation, 2004)

This position reflected views such as those of Kazdin (1993) and Roeser, Eccles and Strobel (1998), which conceptualised mental health as consisting of two dimensions, namely a) the absence of dysfunction (impairment) in psychological, emotional, behavioural and social spheres, and b) the presence of optimal functioning in psychological and social domains. The two related dimensions are represented in the outcomes on the right-hand side of the KMI conceptual model (Figure 1).

This raised the issue of defining the outcome measures of student mental health. We were advised by our clients that there was some interest in using the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 2005). The stated purposes of the SDQ are more for clinical screening applications, rather than as a whole school measure of student mental health (Youth in Mind, 2004). However, we were also aware that the SDQ had been used in other large scale studies in Australia and internationally, such the *Every Family* study (Sanders et al., 2005). The possibility of making comparisons between the data collected for the KMI evaluation and other studies convinced us to include the SDQ as one of our evaluation instruments. The SDQ provides one important outcome measure of students' wellbeing for the longitudinal analysis.

However, we were also aware that typically the SDQ is used to represent just one of the domains of mental health: the difficulties domain. The typical use of the SDQ in mental health research uses the difficulties' subscales in order to calculate a total mental health difficulties score, and excludes the pro-social scale of the SDQ. This ignores the second dimension of mental health, the positive expression of mental health strengths. Therefore we developed a small set of items that asked teachers and parents/caregivers to rate students in terms of general Mental Health Strengths. In addition teachers and parents/caregivers were asked for general ratings of the level of students' Mental Health Difficulties. These latter two sets of items were represented on a seven-point scale in order to provide ratings that were distinct from the more limited three-point SDQ scales.

2.4.2 Processes

The second of Ellis and Hogard's (2006) three-pronged approach to evaluation is concerned with the description and analysis of process, especially the implementation process. The process of implementation therefore became a major focus of the evaluation. Information related to this process was generated from the school staff and parents/caregivers directly involved in the Initiative and from the KidsMatter Project Officers who worked in each of the schools. The multiple sources of information related to implementation enabled the development and use of an index of implementation quality that is described in Chapter **Error! Reference source not found.**.

2.4.3 Multiple stakeholder perspectives

Seeking the views of the key stakeholders was a central element of our evaluation strategy. At the level of management of the evaluation across the three year period, from its initial planning until final reporting, an important concern was to develop and manage effective relationships with our clients, who were responsible for the design and implementation of the KidsMatter Initiative. With regard to sources of information, the surveys designed for the evaluation provided information from teacher and parent/caregiver informants. The regular reports from KidsMatter Project Officers provided a third source of information, and the final executive summaries completed by principals and action team leaders gave us access to the views of other members of the school communities. Finally the Stakeholder and Student Voice studies enabled direct exploration of the areas of the evaluation with teachers, parents/caregivers and students in 10% of the Pilot Phase schools.

2.5 Specific areas of evaluation

Using the KidsMatter conceptual model and the formal specification for the evaluation, the following areas were the focal points for the generation of information that would inform the analyses.

- School Implementation of KMI
- Perceived KMI Impact
- School Engagement with Mental Health Initiatives in General
- School Risk and Protective Factors
- Teacher Risk and Protective Factors
- Family Risk and Protective Factors
- Child Risk and Protective Factors
- Student Mental Health Outcomes

The areas in this list provided the specific framework for the design of the KidsMatter questionnaires completed by teachers and parents/caregivers (see Table 27), and also guided the design of the instruments developed for completion by Project Officers and the questions used in the interviews and focus groups conducted in the Stakeholder and Student Voice studies.

In order to meaningfully relate these specific areas of the evaluation to the conceptual model underpinning the KidsMatter Initiative, the analysis and reporting of the findings have been organised to address the areas to be covered in the evaluation under four main sections, namely, a) The processes of the KidsMatter Implementation (incorporating school engagement as well as parent/caregiver and family engagement), b) the Impact of KidsMatter on school-level risk and protective factors in terms of changes associated with the four components, c) the Impact of KidsMatter risk and protective factors associated with teacher, child and family competencies (including teachers' and parent/caregivers' knowledge, competence and confidence as well as changes to student competencies), and d) Impact of KidsMatter on student mental health outcomes.

Chapter 3.
Method and Participants

"…from what I've seen around the table we've got different age groups; we've got different agendas; we've got different experiences with principals; grandparenting. I think we've got a good cross-section here." *Evaluator describing participants of one parent/caregiver focus group*

3.1 Who were the participants in the evaluation of the KidsMatter Initiative?

Data for the evaluation were collected between February 2007 and December 2008. Data included purpose-designed questionnaires, interviews and focus groups, reports from school leaders and collections of school artefacts. Figure 2 presents an overview of the research design and the data collected.

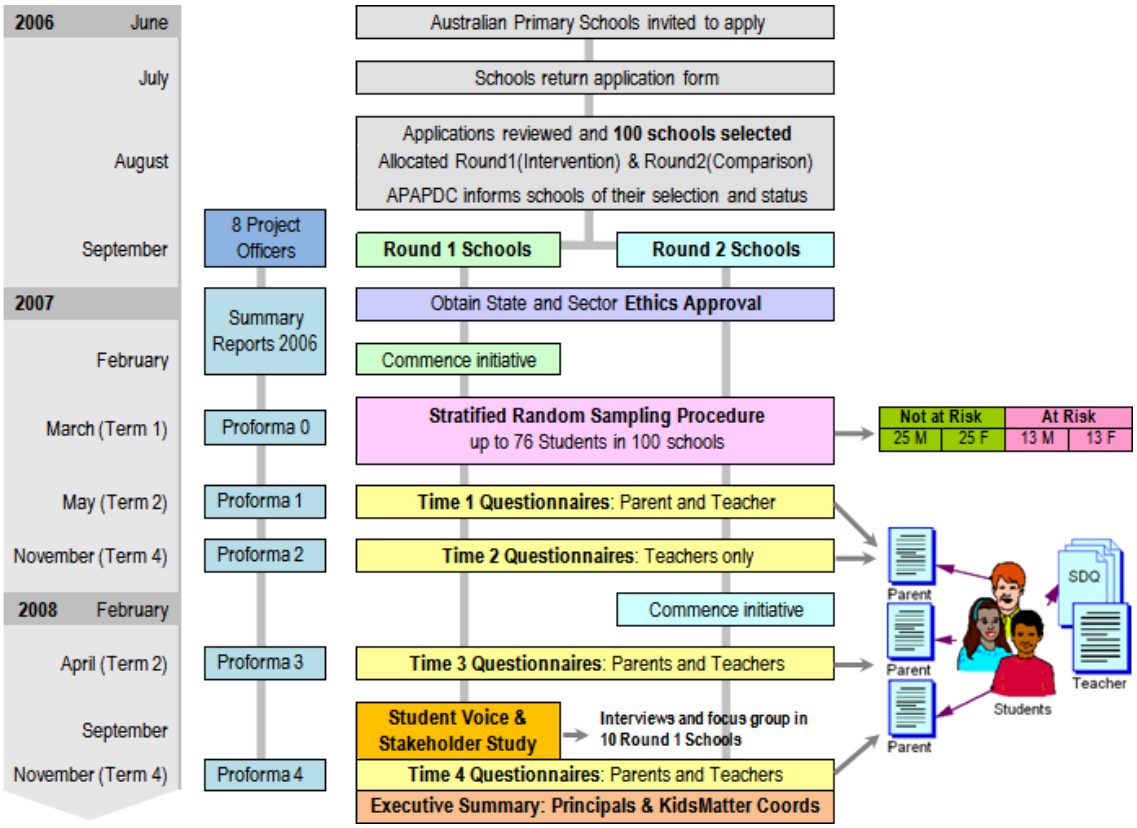


Figure 2. Overview of research design and data collection

3.1.1 The KidsMatter schools

Schools across Australia applied to take part in the KidsMatter Initiative. The KidsMatter Initiative was designed to accommodate 101 schools selected from the larger pool of applicants based on their State, location (metropolitan, rural or remote), size and sector type, in order to ensure a diverse sample. Distribution of schools across States and Territories was approximately proportional to State size, so large States like Victoria had 20 schools, while Tasmania, the Northern Territory and the Australian Capital Territory each had six schools. Geographically similar schools were assigned to a KidsMatter Project Officer to support schools in implementing the KidsMatter Initiative and provide professional development.

The selected schools ranged in size from 11 students with one staff member, to 1085 students with 100 staff. In terms of language background, schools ranged from those that had no students with English as a Second Language (ESL), to a school with 94 per cent ESL students. Some schools had no Aboriginal or Torres Straight Island (ATSI) students, and some had more than 75 per cent ATSI students. One school did not participate in the evaluation due to the transient nature of its students, making a longitudinal evaluation design unworkable.

3.1.2 Participants in the whole cohort longitudinal questionnaire study

School enrolment lists provided the sampling frame from which up to 76 students were randomly selected from each of the 100 KidsMatter schools. Originally we selected up to 25 boys and 25 girls, aged 10 in 2006, to provide a sufficient sample size (allowing for attrition) to conduct meaningful statistical analyses for the evaluation. In addition, we recognised that the technique of stratified random sampling might not, through pure chance, include students of particular interest to the KidsMatter Initiative. We therefore over-sampled up to 13 boys and 13 girls per school to ensure students nominated by school staff as being ‘at risk’ of social, emotional or behaviour problems were included in the sample. More details about the sampling frame are contained in the KidsMatter Technical Report.

The parents/caregivers and teachers of the selected students were invited to complete the initial questionnaires during Term 2, 2007. A parent/caregiver response rate of 70 per cent yielded a sample of 4980 primary school students. A parallel set of responses was provided by the 812 teachers of the target children, on the first data collection occasion (Time 1), and by a total of 1319 teachers by the last data collection occasion (Time 4). (Note that over the two year period most students changed Year level and thus changed their class teacher. Therefore, by the end of Year 2 of the KMI we collected reports on each student from their 2007 teacher and from their 2008 teacher).

Our strategy to maintain an equal gender balance, target 10-year-old students, with up to an additional 26 students per school in order to ensure that students identified as being ‘at risk’ were included, was successful.

Since schools were encouraged to select replacement students for those parents/caregivers not wishing to participate in the evaluation, in addition to the KidsMatter schools forming a voluntary sample of schools rather than a random sample, school or student weights have not been applied when conducting statistical analyses. Because the sample is not a true random sample, caution should be taken if generalising findings to other students and other primary schools in Australia.

3.1.3 Participants in the stakeholder and student voice studies

At the end of 2008, as part of the stakeholder and student voice studies, 10 KidsMatter Round 1 schools were invited to contribute to interviews and focus groups involving students, staff, leadership and parents/caregivers. These schools were drawn from nearly all states and territories and covered the full socio-demographic range. The interviews and focus groups were designed to access the lived realities of the participants as they were experiencing the implementation of KidsMatter, and to provide opportunities for case study analysis and detailed insight into participants' perceptions of the KMI.

3.1.4 Participants in the Project Officer Questionnaire study

Purpose designed questionnaires seeking information about the Implementation of KidsMatter were delivered to KidsMatter Project Officers on five occasions over the duration of the KMI.

3.1.5 Participants in the School Leadership Executive Summaries Study

A request was sent to school leadership, at the end of the two-year evaluation period, for responses (in writing) to a set of focus questions about key components of the KidsMatter Initiative. This was an additional data collection activity, not included in the original tender or evaluation design. As such, school leadership participation in this activity was voluntary.

It is these qualitative and quantitative data sources that provide the foundations of the analyses used in this evaluation. Characteristics of the KidsMatter schools, teachers and students are presented in Table 1.

Table 1. Background characteristics of Project Officers, schools, teachers and students involved in the KidsMatter Initiative

Project Officers	**N=8**	**Male**	**Female**	**Total**
	Gender	1	7	8
Schools	**N=100**	**Government**	**Catholic**	**Independent**
	Metro	36	20	4
	Rural	24	9	2
	Remote	5	0	0
	School-wide Characteristics	**Round 1 Schools**		**Round 2 Schools**
	Male Teachers	15.6%		16.1%
	Full-Time Teachers	58%		56.1%
	Support Teachers	35.5%		23.6%
	Students with Special Needs	9.9%		9.0%
	ATSI	8.3%		5.6%
	ESL	16.7%		13.2%
Teachers	**N=1393**	**Male**	**Female**	**Total**
	Gender	14.9%	85.1%	100.0%
	Mean Teaching Experience (SD)	14.6 (10.8)	15.2 (10.8)	
Students	**N=4980**			
	Gender	47.8%	52.2%	100.0%
	Mean Age (SD)	9.6 (1.6)	9.7 (1.6)	
	At Risk Status	14.7%	12.3%	27.0%
	ATSI	1.5%	1.9%	3.4%
	ESL	7.2%	8.1%	15.2%
	Intact Family	35.9%	39.3%	75.3%

Teachers show typical characteristics, such as a predominance of female teachers and the indication of an aging population reflected by the average years of teaching experience. Student characteristics reflect the sampling procedure used. Students considered to be 'at risk' of experiencing social, emotional or behaviour problems were identified using non-clinical assessment by their teacher or school counsellor. Other demographic characteristics include Aboriginal or Torres Strait Island (ATSI) background, English as a second language (ESL) background, and the percentage of children who live with both parents in an intact family. Round 1 and Round 2 schools have similar demographic profiles.

3.2 Ethics Approvals

Ethics applications were submitted, and approvals received, from the Flinders University Social and Behavioural Research Ethics Committee (Approval Number SBREC3744), and also from all school, jurisdiction and departmental bodies for all studies in all Australian states and Territories. The goodwill shown by over 30 ethics jurisdictions to process the complex ethics applications associated with the quantitative and qualitative data collection in the KMI evaluation is testament to the wide ranging support for the evaluation of the KidsMatter Pilot Phase.

3.3 Conceptual Foundations of the Whole Cohort Longitudinal Questionnaire Study

The first component of the evaluation consisted of the design and delivery of a questionnaire, on four occasions (Time 1, 2, 3, and 4) during 2007-2008, to the parents/caregivers and teachers of a stratified random sample of up to 76 students in each of the 100 KidsMatter Pilot Phase schools across the two-years of the KidsMatter Initiative. Following the longitudinal design, questionnaire data were collected according to the schedule detailed in Figure 2. Questionnaire completion was a major undertaking, therefore to avoid impacting upon parent/caregiver goodwill towards KidsMatter, questionnaires were collected on three occasions from parents/caregivers.

A conceptual framework was developed that covered the evaluation requirements and the KidsMatter initial conceptual model to ensure that all aspects of the evaluation were represented in the teacher and parent/caregiver questionnaires. Figure 3 presents the framework used for the design of the questionnaire. Figure 3 lists the constructs used for the design of the questionnaires and shows how they are organised into an overall evaluation framework. It can be seen that the constructs are grouped into process and impact categories, which in turn cover implementation and engagement with the KMI, school, teacher, family and child risk and protective factors, perceived impact, and measures of student mental health. Figure 3 also provides information on whether the construct was addressed in the evaluation questionnaires for teachers, parents/givers or both teachers and parents/givers.

For each of the constructs listed in Figure 3, a collection of individual questionnaire items was developed in order to measure that construct. The items were sourced from the identified aims and outcomes presented in the KidsMatter Manual (2006), from the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 2005), from the five core groups of social and emotional competencies recommended by CASEL (2006), from a search of relevant literature (e.g. Levitt et al., 2007), and from our own research and practical experiences with schooling, families, and student wellbeing (e.g. Russell et al., 2003; Russell in press). A total of 112 items, addressing the key areas of school, family, child, and student mental health outcomes, were presented as attitudinal or belief statements and generally required participants to respond using seven-point

Likert-type response options of Strongly Disagree (1) to Strongly Agree (7). Three-point response options of Not True (0), Somewhat True (1) and Certainly True (2) were used for the SDQ. As noted above, while many items in the Parent/Caregiver and Teacher Questionnaires were in common, this was not appropriate for some items. For example, items pertaining to school-based social and emotional learning (SEL) programs were only present in the teacher version, while items about parenting were only present in the parent/caregiver version.

Following data collection, the items included in each construct were subjected to confirmatory factor analysis for asymptotically distribution-free data (CFA-ADF) using AMOS (in SPSS) to determine the factor structure of the groups of items (Tabachnick & Fidell, 2001 Garson, 2009). Further detail about the factor analysis is contained in the technical manual that accompanies this report. The analysis confirmed the grouping of the items into the initial constructs and thereby supported the formation of scales based on the items and constructs set out in Figure 3. The emphasis in reporting the evaluation is on the scales, rather than the individual items. A definition of each of the scales is provided below in Table 2 and the individual items in each scale can be found in the KidsMatter Technical Manual.

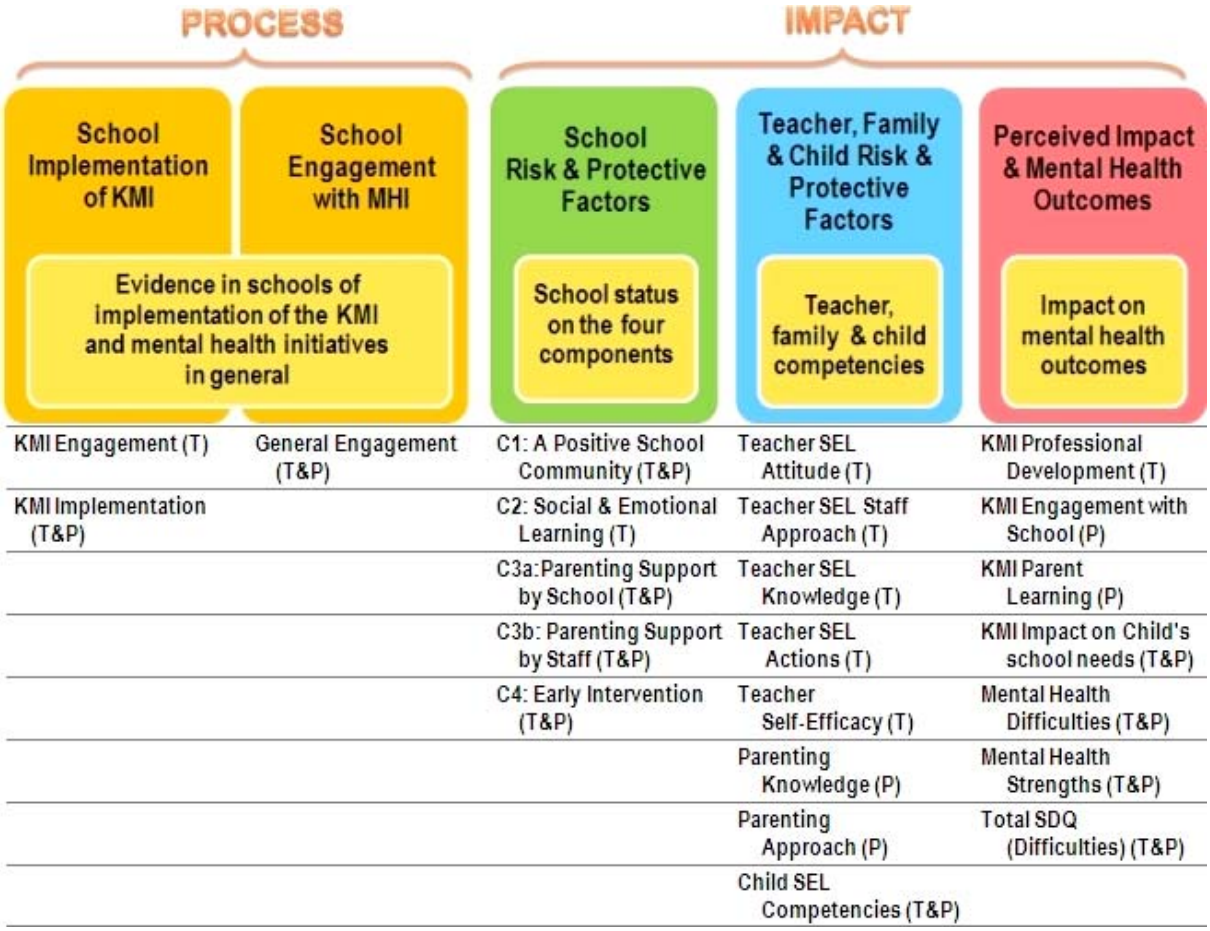


Figure 3. Variables used in the KidsMatter evaluation questionnaires for teachers (T) and parents/caregivers (P)

To introduce the data, Table 2 provides a description of each of the scales in the Evaluation Questionnaire, and Figure 4 sets out parent/caregivers' and teachers' median responses at data collection Time 1, to each of those scales (For this initial display we use the Median, with the bar within the box representing upper and lower quartiles. The median is a more meaningful measure of central tendency than the mean when data are skewed, as these data are.)

Table 2. Definition of the scales used in the whole cohort longitudinal questionnaire

Scale Name	(Rater)	Definition
KMI Engagement	(T)	Teacher (T) ratings of school engagement with the KidsMatter Initiative on the four Components.
KMI Implementation	(T)	Teacher ratings of the KidsMatter Seven-step Implementation process.
KMI Implementation	(P)	Parent/caregiver (P) ratings of their involvement with the KidsMatter Initiative as a measure of the level of implementation.
General Engagement	(P&T)	Teacher and parent/caregiver ratings of their school's engagement with mental health initiatives, in general, with a focus on social and emotional learning.
C1: Positive School Community	(P&T)	A measure of Component 1. Teacher and parent/caregiver ratings of their school community, how welcomed they feel and their sense of belonging.
C2: Social and Emotional Learning	(T)	A measure of Component 2. Teacher ratings of the school's provision of social and emotional learning in the curriculum, support for professional development opportunities, and level of appropriate resources.
C3a: Parenting Support by School	(P&T)	A measure of Component 3. Teacher and parent/caregiver ratings of education and support provided by the school for parents/caregivers.
C3b: Parenting Support by Staff	(P&T)	A measure of Component 3. Teacher and parent/caregiver ratings of how accessible, informative and supportive staff are for providing parenting education and support.
C4: Early Intervention	(P&T)	A measure of Component 4. Teacher and parent/caregiver ratings of how effective their school is at supporting students who are experiencing, emotional or social or behaviour difficulties.
SEL Attitude	(T)	Teacher ratings of their attitude to teaching social and emotional learning skills, a protective factor residing in teachers.
Staff Approach	(T)	Teacher ratings of general staff approach to helping students to develop social and emotional skill, a teacher protective factor.
SEL Knowledge	(T)	Teacher ratings of their knowledge and ability to help students to develop social and emotional awareness and skills, a protective factor residing in teachers.
SEL Actions	(T)	Teacher ratings of their teaching program and resources to help students to develop social and emotional awareness and skills, a protective factor residing in teachers.
Self-Efficacy	(T)	Teacher ratings of their self-efficacy to foster a sense of belonging in others, provide effective support to parent/caregivers, and identify early signs of social and emotional difficulties in students, a protective factor residing in teachers
Parenting Knowledge	(P)	Parent/caregiver ratings of their knowledge of how to help their child foster friendships, provide emotional comfort, and recognise when their child is having difficulties, a protective factor residing in families.

Parenting Approach	(P)	Parent/caregiver ratings of their relationship with their child and their effectiveness as a parent/caregiver overall, a protective factor residing in families.
Child Social and Emotional Competencies	(P&T)	Teacher and parent/caregiver ratings of the child's ability to maintain positive relationships, solve problems, consider others, and make responsible decisions, a protective factor residing in the child.
KMI Professional Development	(T)	Teacher ratings of the impact of the KidsMatter professional development on teacher and school capacities. This is a measure of the perceived impact of the KidsMatter Initiative on school and teacher processes.
KMI Engagement with School	(P)	Parent/caregiver ratings of the impact of KidsMatter on their involvement with support networks, school and community. This is a measure of the perceived impact of the KidsMatter Initiative on family processes.
KMI Parenting Learning	(P)	Parent/caregiver ratings of the parenting skills that KidsMatter has helped them to learn. This is a measure of the perceived impact of the KidsMatter Initiative on family processes.
KMI Impact on Child	(T&P)	Teacher and parent/caregiver ratings of how well KidsMatter has provided for the child's needs at school, especially their socio-emotional needs. This is a measure of the perceived impact of the KidsMatter Initiative on child processes.
Mental Health Difficulties	(T&P)	Teacher and parent/caregiver ratings of the child's negative mental health in terms of poor behaviour, anxiety and depression. This is a measure of student mental health outcomes.
Mental Health Strengths	(T&P)	Teacher and parent/caregiver ratings of the child's positive mental health in terms of optimism and coping skills. This is a measure of student mental health outcomes.
Total Strengths and Difficulties (SDQ)	(T&P)	Teacher and parent/caregiver ratings of the child's negative mental health in terms of hyperactivity, conduct problems, emotional symptoms and peer problems. This is a measure of student mental health outcomes.

In Figure 4, the majority of scales are displayed on the original Likert response options of Strongly Disagree (1) to Strongly Agree (7), while the SDQ (difficulties) is positioned on its total difficulties scale score interpreted as Not at Risk (0) to At Risk (40). It can be seen that most of the scales about KidsMatter, schools and the risk and protective factors, had medians on the positive side of the Likert scales. As well, it is evident that there was a reasonable variation in medians for each of the evaluation scales. Median scores for the SDQ were towards the "not at risk" end, but again with a reasonable variation in medians.

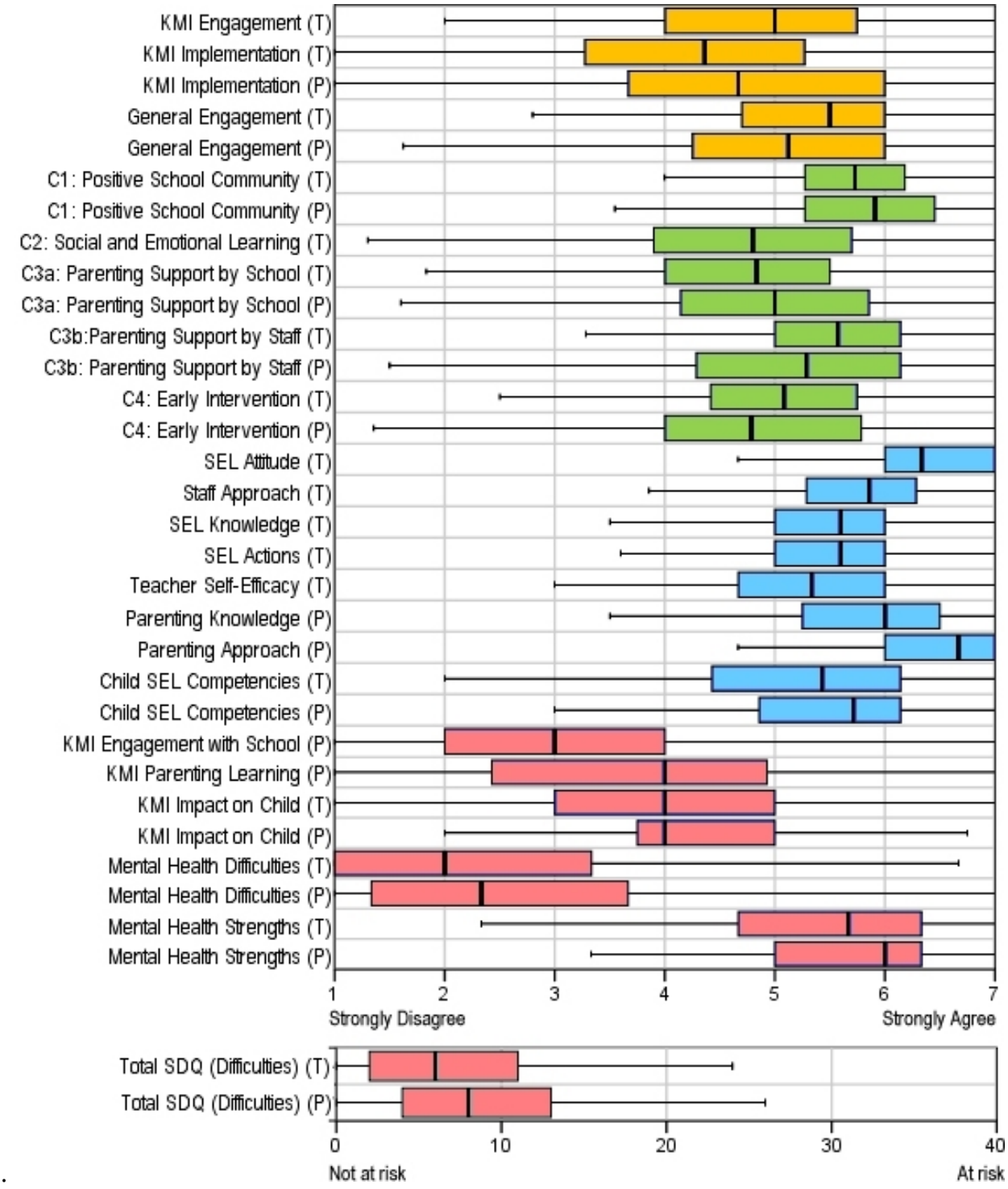


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Figure 4. Box plots showing median scores on each of the scales in the Evaluation questionnaire

3.4 Conceptual foundations of the Stakeholder and Student Voice studies

The second component of the evaluation consisted of the design and administration of focus groups and interviews with principals, teachers, students and parents/caregivers in 10 schools. This aspect of the evaluation not only drew on the individual's experiences during the KMI, but also the central, core themes which were common across the schools.

By constant comparison of the individual voices of participants to the emerging themes and categories which resulted from examining the multiple realities of those experiencing the KMI, it was possible to gain greater understanding about the actual "lived" experiences and perceptions of the stakeholders and students in the KidsMatter schools as it was being implemented.

A preliminary study was undertaken at a local school to trial the focus group and interview questions and research design with the target groups. The preliminary study was successful, confirming our selection of questions and the evaluation design.

The 10 schools were selected to provide diverse representation of different geographical areas, and also, to represent schools who, on preliminary analysis of data, appeared either to be going well, or were finding difficulties, with implementing the KidsMatter Initiative. This is consistent with maximum variation sampling, a purposive strategy which involves selecting a wide range of variation on several dimensions of interest. For consistency of approach, one evaluation researcher collected data from all of the 10 schools. For cross-checking of perceptions and methods, the researcher was accompanied by a second researcher on five occasions.

3.5 Interviews and focus groups

Audio-taped transcripts (over 80 hours) were collected during September and October 2008. This involved 64 interviews and 44 focus groups with school principals, teachers, parent/caregivers, students and other school staff, in Round 1 KidsMatter schools. All of the principals and at least two teaching staff from each of the 10 schools spoke to the evaluator(s) about the KidsMatter initiative. The schools also organised parents/caregivers and students to attend focus group discussions led by the evaluator.

The parent/caregiver focus groups, which ranged in size from 4 to 10 participants, focused on the four KidsMatter components and asked parents/caregivers to consider any changes they had noticed since KidsMatter was introduced into the school, particularly with regard to the school culture and their children's behaviour, confidence, mental health and general wellbeing.

The student focus groups, which generally comprised 5 to 8 girls and boys of approximately 10 years of age, commenced with a scenario about a child named Cris, which acted as an ice-breaker and prompted the children to think about situations in which someone is feeling sad and discouraged. The scenario then led to a general discussion about feelings, which provided the opportunity for the students to discuss what they could recall about teaching and learning about feelings, friendships and related mental health topics.

3.6 Artefacts

In addition, during the school visits various artefacts, including a CD of student songs and KidsMatter articles published in school newsletters, were collected by the evaluator. These served to orient the evaluators to the contextual nature of the school culture and environment of the KMI.

3.7 Legitimacy and trustworthiness of interview and focus group data

Interview and focus group data require some assessment of dependability and consistency (reliability) and accuracy and trustworthiness (validity) (Miles and Huberman, 1994*)*, to address whether the experiences of the participants, their perceptions and understandings, legitimately capture the lived reality of the phenomenon under question.

Individual responses, whilst providing information-rich and intense personal experiences, can sometimes be considered a limitation, because each individual reality may be quite different from another. This heterogeneity is expected, however, when gathering interview and focus group data, as each voice represents a unique, subjective and contextual view of the issue under consideration, which in this case was the actual, lived reality of the participants experiencing the KMI in each of these 10 schools.

However, (Patton, 1990 p. 172) reported that multiple voices provided by a maximum variation sampling strategy, such as the one employed in this evaluation of 10 selected schools, turn that possible limitation into a strength: lending credibility to the individual experiences; providing a coherent picture across all schools; and verification and confirmation of the core messages, common patterns and issues of central importance that emerged from the data.

Triangulation across settings and previous studies provided a means of verifying the accuracy and trustworthiness of the data. A process of inter-coder agreement was developed for identifying key themes across all data sets (Miles & Huberman, 1994). This entailed independently reading the transcripts of participants, noting ideas, concepts and issues, and then determining a level of agreement across four evaluators (See Technical report).

3.8 An external perspective of what happened in schools: The KidsMatter Project Officer Questionnaire

We designed a Project Officer Questionnaire which was completed by KidsMatter Project Officers on five occasions, as detailed in Figure 2, during the KidsMatter Initiative in 2007-2008. The Project Officer questionnaire, delivered via online survey software, collected contextual and event data from the eight state-based KidsMatter Project Officers. The Questionnaire contained multiple-choice and open-response questions that enabled the Project Officers to provide details of, and insightful reflections about, the rollout of the KidsMatter initiative in their respective schools.

In addition, members of the Flinders evaluation team attended Project Officer Cluster meetings to better understand the issues that Project Officers faced in their work in KidsMatter schools, and to further understand some of the rich contextual data that the Project Officers provided about the wide range of settings of the KidsMatter schools.

3.9 A perspective from leadership: The School Leadership Executive Summaries

An additional source of qualitative information was sought from all KidsMatter school principals and KidsMatter action team members at the end of the KidsMatter Initiative in 2008. We developed a “Leadership Executive Summary” to gain an overall picture of the social and emotional health programs delivered in schools, and to gain perspectives about “A day in the life of KidsMatter” at the respective schools. The purpose of this additional data collection was to

generate a "leadership" perspective of KidsMatter, in order to complement the other sources of data listed above. The potential of such an Executive Summary was realised as the Evaluation developed, and was additional to our tender brief. As the Leadership Executive Summary had not been introduced to the School Principals as part of their commitment to KidsMatter, completion of the Executive Summary was voluntary. As detailed in Table 3, 62 schools provided Leadership Executive Summaries.

3.10 Summary of all data collected

Table 3 presents an overview of all of the data collected for the Evaluation of the KidsMatter Initiative. In summary, of the 7114 students randomly selected from the 100 schools, data were received at Time 1 from parents/caregivers and teachers of 4980 students, resulting in an initial response rate of 70 per cent. Of these students, 76 per cent were present for data collection on all four occasions. Accordingly, the sample size and composition, together with the response rates, are considered appropriate for reliability, validity, and the statistical analyses undertaken in the evaluation.

All of the KidsMatter Project Officer Questionnaires were received, resulting in a 100 per cent response rate. For the voluntary Leadership Executive Summary, 62 per cent of schools responded. In addition, there were 10 case study schools, yielding over 80 hours of interview and focus group recordings. These involved 64 Stakeholder interviews (principals, KidsMatter Action Team, counsellors and teachers), 20 parent/caregiver focus groups and 20 Student Voice focus groups.

Table 3. Summary of all data collected in the evaluation

Year	**2006**	**2007**				**2008**					
School Term/Quarter	4	1	2	3	4	1	2	3	4		
Data Collection Time		**0**	**1**		**2**		**3**		**4**		
Student Enrolment Lists		28205								Final returns	
Teachers										1397	
Student Sample Lists (B)			7114		4980		4810		4435	3762	
Parent/caregiver Questionnaire (D)			4346				2995		2404		
Teacher Supplement (E)			4793		4592		3866		3587		
Teacher Questionnaire (F)			812		802		928		716	53%	of original 7114 students
Response Rate at each return			70%		97%		92%		85%	76%	of partic. 4980 students
School Profile	100		100		99		100		97		
Project officer Qn Round 1 Schools	50	50	50		50		50		50		
Project officer Qn Round 2 Schools					50		50		50		
Leadership Executive Summary									53	62%	School response rate
Coordinator Executive Summary									61		
Principal and Staff Interviews									64		
Parent/caregiver Focus Groups									19		
Student Focus Groups									20		

We would like to note here that the feedback, high response, and cooperation received from staff and parents/caregivers in KidsMatter schools for the processes of the evaluation was overwhelmingly positive.

KidsMatter was rolled out in two phases. In 2007 it began with 50 schools (Round 1 schools), and in 2008 it began in the next 50 schools (Round 2 schools). This staged implementation provided the evaluation with a group of 50 schools that acted as a delayed control, and an element of replication.

In this report, we present results separately for Round 1 and Round 2 schools. There are two reasons for this approach. First, the staggered start time of the KMI in Round 1 and Round 2 schools means that for Round 1 schools no data could be collected prior to the commencement of the KMI, whereas for Round 2 schools, the first year provided information largely prior to the introduction of the KMI. Second, the implementation processes experienced in Round 2 schools differed substantially from Round 1 schools due to the experience and knowledge gained in the first 12 months of the Initiative: This developing expertise for implementation over the first 12 months can be predicted to change how the Initiative was rolled out on Round 2 schools.

The main attention in the evaluation is on changes over time in both Round 1 and Round 2 schools. The emphasis on Round 1 schools is on whether sustained and systematic changes were associated with the KMI over the two years of school involvement. In contrast, the attention in Round 2 schools is mainly on whether and how changes occurred in the second year following the introduction of the KMI.

3.11 Chapter Summary

In this Chapter we presented the overall evaluation design. The individual studies were described and justified. The emphasis of the evaluation was on a multi-method, multi-informant design, with a strong longitudinal component. The design matched the needs of the evaluation and the conceptual model underpinning the KidsMatter Initiative. Priority was placed on methodological soundness and conformity to current principles of evaluation.

Chapter 4.
A Preliminary Investigation of the Conceptual Foundations of the KidsMatter Initiative

> "I think it's a wonderful concept that we talk about children learning things that maybe they're not learning which will help them not harass each other; be aware of other people's feelings and that type of stuff." *Parent* (School 1)

The KidsMatter Initiative's intervention design was based on assumptions (set out in the conceptual model, Figure 1, and described in the Implementation Manual) that student mental health is causally related to the four school-based components. For example, that student mental health will be better when schools provide more parenting education and support (Component 3). In turn, the conceptual model assumes that the effects of these four components (conceived as school risk and protective factors) on student mental health are mediated through Family and Child risk and protective factors. The KidsMatter Initiative is an intervention designed to produce changes in the four school-based components, which are then assumed to lead to changes in the risk and protective factors, and finally to changes in student mental health.

As a foundation to the intervention and evaluation, it is important, in the first instance, that the School risk and protective factors as well as the Family and Child risk and protective factors can indeed be shown to be related to student mental health. For example, if it can be shown that Child mental health is better in schools with a more positive school community (Component 1), this supports the assumption that intervening to create a more positive school community should improve student mental health. Similarly, if parenting behaviour, as a component of Family, is related to student mental health, this supports intervention efforts to improve parenting behaviour as a strategy to improve student mental health.

4.1 Cross-sectional relationships

In order to provide a preliminary investigation of the conceptual foundations of the Initiative, data from Time 1 (Term 2, 2007) for the whole cohort longitudinal study were used to examine relationships between (a) School risk and protective factors in terms of the four components, together with Family and Child risk and protective factors, and (b) student mental health measured using the SDQ (difficulties scales). These data are contemporaneous/cross-sectional, meaning they were collected at the same time. They use questionnaire responses from parents/caregivers and teachers of over 4000 students in the 100 schools. Any relationships between the risk and protective factors and student mental health do not show causation, but they

are consistent with the conceptual model underpinning KidsMatter and would support the Initiative's design and conceptualisation. There also would be justification to proceed with the examination of whether **changes** in schools, parents/caregivers and students led to **changes** in student mental health.

This preliminary analysis of the conceptual model used the following scales to measure the school risk and protective factor (see Table 2 for a definition of the individual scales): positive school community, social and emotional learning, parent support by school, parent support by teachers, and early intervention. In addition, the scale of "general engagement" was included because it measured the school's engagement with mental health initiatives in general. The following scales were used to measure the Family risk and protective factor: parenting knowledge and parenting approach. To measure the child risk and protective factor, the scale of child social and emotional competencies was used.

4.2 Visual representations of relationships

An initial inspection of the relationships between the School, Family and Child risk and protective factors and student mental health was conducted using simple scatter plots. Figure 5 presents averaged responses for the factors School, Family and Child, each plotted against student mental health. The measure of student mental health was derived from the difficulties sub-scales of Goodman's (2005) Strength and Difficulties Questionnaire (SDQ), which places 'normal' mental health at the low end of the scale (score 0) and 'abnormal' mental health at the high end of the scale (score 40). The protective factors presented on the vertical axis are positioned on the original Likert response options of strongly disagree (1) to strongly agree (7) and can be interpreted, respectively, as the prevalence of the protective factor being low or high. In other words, a preferred relationship exists if as the protective factor increases, the SDQ (difficulties) decreases. Figure 5 suggests that there is a weak relationship between School and mental health, a moderate relationship between Family and mental health and a strong relationship between Child and mental health. The direction of the relationships shown in the scatter plots are as predicted, when considering influences on student mental health.

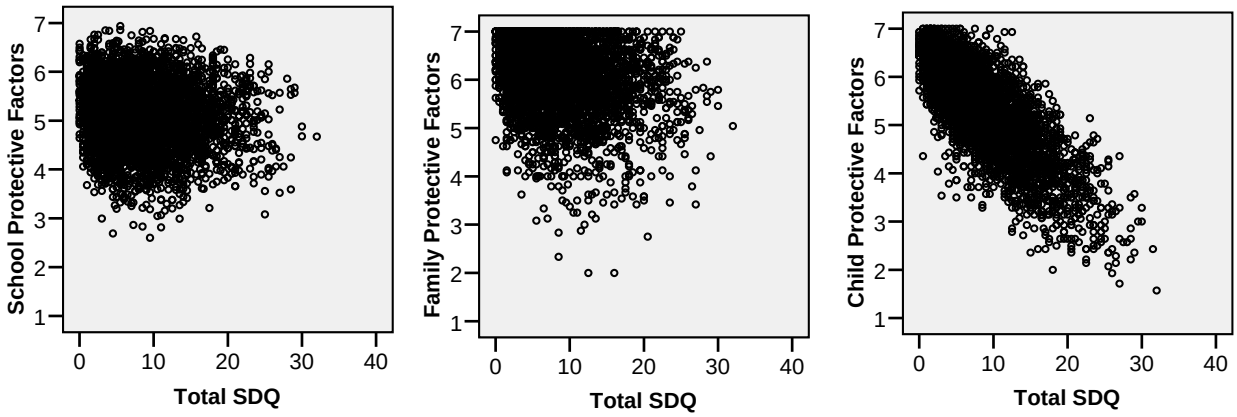


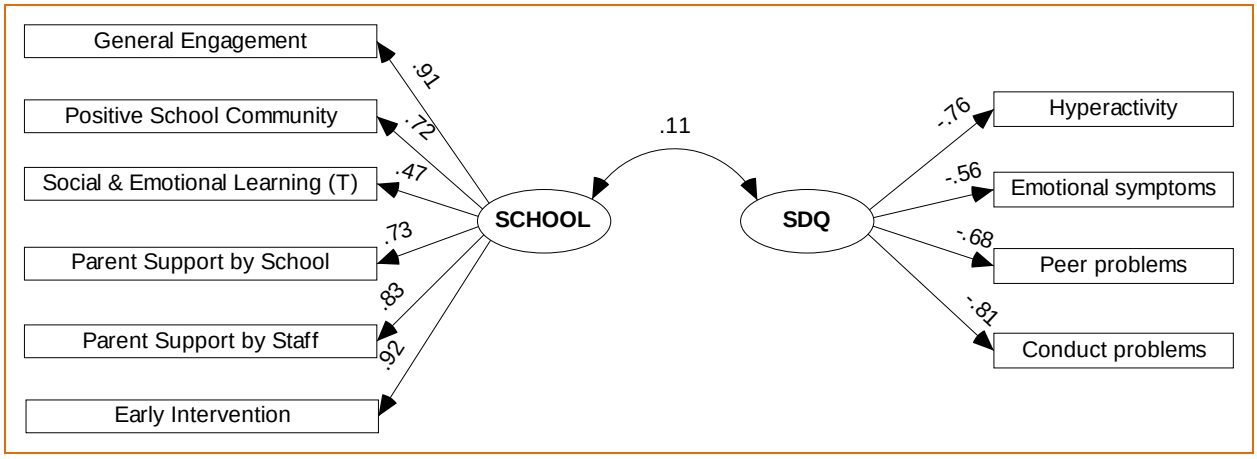
Figure 5. The relationships of School, Family and Child protective factors with the Strengths and Difficulties Questionnaire

4.3 Canonical Analysis of relationships

To further investigate the KidsMatter conceptual model, a form of structural equation modelling called canonical correlation was used (Garson, 2008). This technique considers more completely the complexity of relationships than does a simple correlation. Given the skewed distributions of the questionnaire data and the large sample size it was appropriate to use asymptotically

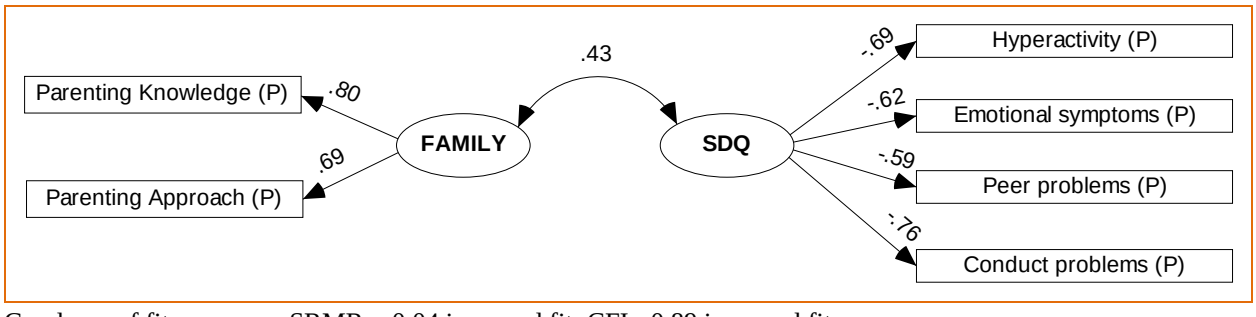
distribution-free (ADF) estimation for each canonical model (Browne, 1984; Garson, 2009; Hox & Bechger, 1998). The School, Family and Child Models showed reasonable indices of fit. The School, Family and Child canonical models were tested for goodness of fit using the Standardised Root Mean Square Residual (SRMR Steiger & Lind, 1980) and the Comparative Fit Index (CFI Bentler, 1990). The smaller the SRMR, the better the model fit (Garson, 2009). Conversely, the closer CFI is to one, the better the fit. These indices were selected as they perform better than other indices under non-parametric conditions and are less sensitive to sample size (Fan, Thompson, & Wang, 1999; Lei & Lomax, 2005; Marsh, Balla, & McDonald, 1988; Schumacker & Lomax, 2004). A full discussion of these models is presented in the Technical Report.

Figure 6, Figure 7 and Figure 8 respectively, present the canonical models for the separate relationships between School, Family and Child with student mental health. Improved mental health, according to the difficulties scales of the SDQ, is reflected by reductions in emotional symptoms, conduct problems, hyperactivity and peer problems, shown in the following figures as negative values. Moreover, both parents/caregivers and teachers were asked to complete questionnaires, for which many of the items, including the SDQ, were in common. In order to present simple relationships, scales common to both parents/caregiver and teacher questionnaires are presented as the averaged response, while scales unique to parents/caregiver or teacher questionnaires are followed by (P) or (T), respectively.



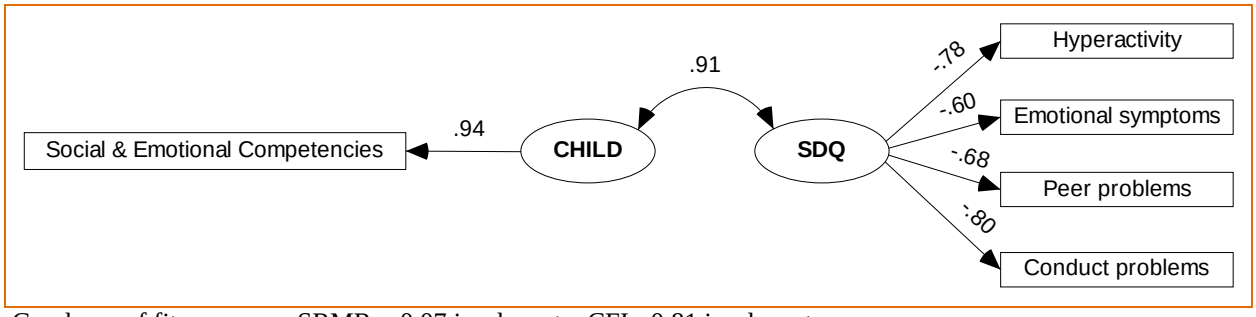
Goodness of fit measures: SRMR = 0.05 is a good fit; CFI = 0.78 is a poor fit.

Figure 6. Canonical model of the School Protective Factors with the SDQ



Goodness of fit measures: SRMR = 0.04 is a good fit; CFI =0.89 is a good fit.

Figure 7. Canonical model of the Family Protective Factors with the SDQ



Goodness of fit measures: SRMR = 0.07 is adequate; CFI =0.81 is adequate

Figure 8. Canonical model of the Child Protective Factor with the SDQ

The relationship between school protective factors and the SDQ (difficulties) shows a canonical correlation of 0.11, as shown in Figure 6. While all of the outer path loadings are highly significant and strong, general school engagement with mental health initiatives (0.91) and early intervention (0.92) are more closely linked to the behavioural aspects of student mental health, namely, hyperactivity (-0.76) and conduct problems (-0.81). The least influential school protective factor, at this early stage in the KidsMatter Initiative, is the regular teaching-learning of social and emotional competencies (0.47).

Figure 7 shows a medium canonical correlation of 0.43 between parenting and scores on the SDQ (difficulties). It suggests that higher levels of parenting knowledge (0.80) and parenting approach (0.69) are linked to lower levels of student mental health difficulties, such as conduct problems (-0.76) and emotional symptoms (-0.62). Showing the greatest level of association in the scatter plots, Figure 8 confirms that a child's social and emotional competencies are strongly linked to the reported SDQ (difficulties) scores, with a canonical correlation of 0.91. It suggests that, averaged over the whole data set, students with strong social and emotional competencies are likely to have fewer mental health difficulties.

4.4 Chapter Summary

The canonical models presented in this chapter suggest that School risk and protective factors, mainly in terms of the four components, as well as Family and Child risk and protective factors, are related to lower levels of student mental health difficulties. Therefore, the preliminary analyses reported here are consistent with the conceptual foundations of the KidsMatter Initiative. Although the canonical correlation between School and SDQ (difficulties) is relatively low, this must be interpreted in terms of the wide variation in school contexts, the broad nature of the measurement instruments, and the fact that that Time 1 measurement is a single snapshot of data. Nevertheless, the broad relationships are as predicted by the KidsMatter conceptual foundations and the assumptions of the Initiative. As the KidsMatter Initiative and the evaluation are longitudinal, there is the possibility of examining whether changes in schools, families, and children are associated with changes in student mental health. Interventions, and the examination of changes that occur following those interventions, provide scope for drawing causal conclusions about influences on student mental health.

Chapter 5.
Implementation and Engagement with the KidsMatter Initiative: Whole Cohort Study

> "KidsMatter for us has brought everything into closer focus again and a lot of what we do now … all the time refers back to KidsMatter. The welcoming community, the parents, the actual social emotional learning, and also then that early intervention – the four components, have really given us clear direction for how to work with the children." *Principal* (School 5)

Following the consideration of the relationships between the hypothesised risk and protective factors and student mental health outcomes, the next task for the Evaluation was to examine whether and how schools implemented and became engaged with the KMI. This is a fundamental question, because actually engaging with the Initiative is a necessary first step in achieving outcomes. A variety of data sources were used to investigate implementation, including the questionnaire-based whole cohort longitudinal study, the stakeholder and student voice study, project officer questionnaires, and the leadership executive summaries. The findings that are detailed in this chapter show that, averaged over the whole participant sample, participants reported that KidsMatter schools did actively work at implementing the Initiative.

5.1 Evidence from parents/caregivers and teachers responses in the evaluation questionnaires

An important aspect of the Evaluation was to gauge from parents/caregivers and teachers the extent of the implementation of KidsMatter. The following section discusses implementation and engagement with the KidsMatter Initiative in terms of parent/caregivers' views, teachers' views and the seven-step implementation process.

5.1.1 Parents/caregiver views of KidsMatter Implementation

Three questions in the Evaluation questionnaire addressed parents/caregivers' perceptions of the general level of implementation of the KMI. For example, parents/caregivers were asked to respond, on a 7-point Likert Scale of Strongly Disagree to Strongly Agree, to the question, *I have heard about KidsMatter*. At data collection Time 4, 59 per cent of parents/caregivers in Round 1 schools, and 62 per cent in Round 2 schools selected scores 6 or 7 (Strongly Agree) in response to the Implementation of the KMI questions.

Table 4 shows that effect sizes for change from Time 1 to Time 4 data collection for the group of KMI Implementation questions for parents/caregivers were medium (r = 0.27) in Round 1 schools and large (r = 0.66) in Round 2 schools. Although it appears that the effect in Round 1 schools was lower than in Round 2 schools, it is reasonable to suggest that this is an artefact of

the timing of the data collection, reflecting the fact that the data collected at Time 1 occurred in Term 2, 2007. By this time, Round 1 schools were already advanced in the implementation of the KMI, whereas Round 2 schools had received little exposure to the KMI. This difference in the "start-up" characteristics of Round 1 and Round 2 schools at Time 1 carries through to the calculated differences between the Means calculated for Time 1 and Time 4 data. Therefore, Round 2 schools, with lower Time 1 means, show a larger effect size. Overall, the medium and large effect sizes indicate that parents/caregivers, on average, were increasingly involved with the KidsMatter Initiative during the two year Implementation period. The mean responses at Time 4 provide evidence for substantial implementation of the KMI from the perspectives of parents/caregivers.

Table 4. Implementation and engagement with the KMI

Variable Names		Total	Round 1 Schools					Round 2 Schools				
School Implementation of KMI		N	Time 1 Mean	Time 4 Mean	p[b] sig.	r correlation	Effect[c] Size	Time 1 Mean	Time 4 Mean	p[b] sig.	r correlation	Effect[c] Size
KMI Implementation	(P)	9,625	4.99	5.43	**0.000**	0.27	medium	4.14	5.34	**0.000**	0.66	large
KMI Implementation	(T)	2,837	4.77	5.35	**0.000**	0.31	medium	3.94	4.95	**0.000**	0.44	large
KMI Engagement	(T)	2,871	5.06	5.53	**0.000**	0.26	medium	3.53	4.93	**0.000**	0.51	large

[a] Parent/Caregiver (P); Teacher (T). [b] Significant levels ($p<0.01$) of slope are shown in bold.
[c] Interpretation of the correlation coefficient, r, as an effect size, according to Kirk (1996).

5.1.2 Teacher perspectives of the 7-step Implementation process

A set of 11 questions, specifically relating to the KMI 7-Step Implementation process, was used as a measure of teachers' perspectives of the KMI Implementation. Sample questions included *Our school has defined issues related to the four KidsMatter components* and *Our school has developed coherent plans for early intervention for students who are at risk or are experiencing social, emotional or behaviour difficulties*. At Time 4, 55 per cent of teachers in Round 1 schools, and 46 per cent in Round 2 schools nominated scores 6 or 7 (Strongly Agree) in response to questions about the Implementation of the KMI. The effect sizes reported in Table 4 demonstrate the relatively rapid Implementation in the Round 2 schools, with medium (Round 1 $r = 0.31$) and large (Round 2 $r = 0.44$) effect sizes.

5.1.3 Teacher perspectives of KMI Engagement with the four components

The third group of items about Implementation included questions which asked teachers to rate the extent to which their school had worked on each of the four components on a 7-point scale, from 'Not at all' to 'A great deal'. At Time 4, 65 per cent of teachers in Round 1 schools, and 56 per cent in Round 2 schools nominated scores 6 or 7 for each of the four components. Table 4 shows medium (Round 1 $r = 0.26$) and large (Round 2 $r = 0.51$) effect sizes for changes from Time 1 to Time 4.

A summary of the results for Implementation and Engagement is found in Figure 9, which is a graph of the mean scores for Round 1 and Round 2 schools at each data collection point, showing the positive trend in implementation and engagement, and especially, the more rapid increase for Round 2 school parents/caregivers.

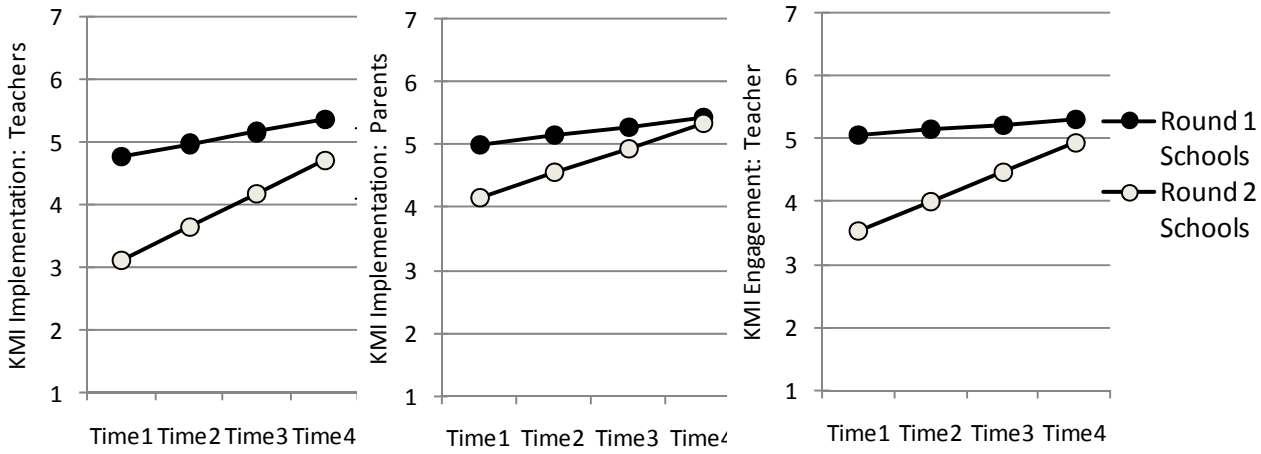


Figure 9. Implementation and engagement with KidsMatter, average responses from parents/caregivers and teachers

5.2 Evidence about Implementation of the KidsMatter Initiative from the Project Officer Questionnaires

Information about schools' progress through the seven-steps of implementation on each of the four components was also available from the KMI Project Officer Questionnaires.

5.2.1 Progress on the 7-step implementation process on each of the four components

Figure 10 provides an indication, from Project Officers' perspectives, of the progress that Round 1 and Round 2 schools made through the seven steps on each of the four components. It suggests that most progress was made on Component 2 (Social and Emotional Learning) and least progress was made on Component 4 (Early intervention). Data were not available on Time 1, but shows that on the remaining three occasions, progress was made across all components in Round 2 schools, while in Round 1 schools progress was maintained. Figure 10 shows that, on average, schools did not achieve the seventh step of implementation for any of the components, by Project Officers' accounts.

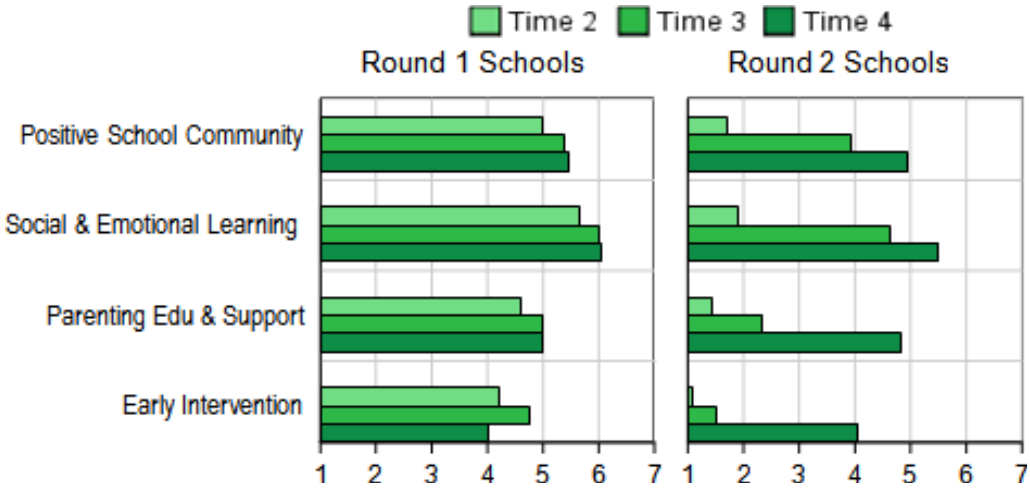


Figure 10. Averaged progress on the 7-step implementation process on the KMI four components

5.2.2 Which Component is a current priority in the school?

From Project Officer reports, Figure 11 shows that, in Round 1 schools, although Component 2 (SEL) was a higher priority during Time 2, schools gave sustained attention to all components. Round 2 schools focused on the first two components and sustained that focus during Times 3 and 4. Round 2 schools gave greater attention to Component 3 during Time 4 and increased their attention to Component 4.

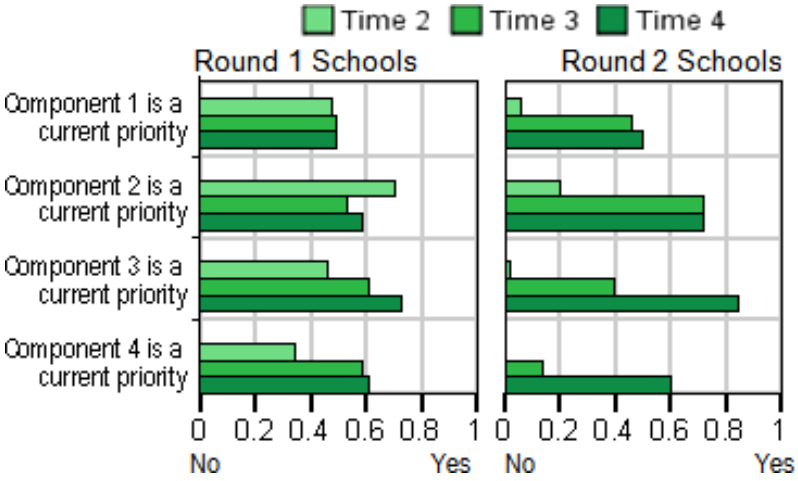


Figure 11. Priorities for the four KMI components

5.3 Chapter Summary

For Round 1 schools the ratings for implementation from both parents/caregivers and teachers started above the neutral point and showed positive increases across time. The picture is slightly different for Round 2 schools, which began at a lower level, but showed, from both parent/caregiver & teacher reports, steeper rates of increase. The pattern is similar for teacher ratings of engagement with the KMI. Again, these ratings for Round 1 schools began well above the neutral point and showed a positive increase throughout the Pilot Phase. The ratings for engagement from teachers in Round 2 schools began at about the neutral point and showed a steeper level of increase, and drew level with Round 1 schools by Time 4.

Most progress was made on Component 2 (Social and Emotional Learning) and least progress was made on Component 4 (Early intervention). Round 1 schools began at a relatively high level for each of the components and maintained that across the period of the Intervention. For the Round 2 schools, initial progress, in 2007, was low, but this rapidly increased when they joined the initiative in 2008.

Chapter 6.
An Implementation Index

> "Implementation quality is the discrepancy between what is planned and what is actually delivered when an intervention is conducted." (Domitrovich, 2008 p. 64)

In this chapter we examine questions about variations among schools in the level and manner of implementation more closely through the development of an Implementation Index based upon three principles of fidelity, dosage and quality of delivery.

Australian school students spend over 6 hours per day in school and various authors have noted that this provides an important opportunity to provide a range of school-based services including mental health programs (Domitrovich, 2008). There is no doubt that schools are complex organisations providing significant challenges for the delivery of intervention programs. A range of publications as reviewed in Payne (2009) have pointed to the nature of such challenges associated with effectively implementing research-based school intervention and prevention programs. In a review of the literature, Domitrovich argued that outside of highly controlled research studies, that generally, prevention programs are not well implemented in schools given the complexity of the school environment in which they are delivered. What is clear from research is that lower-quality implementation leads to poorer program effectiveness. The fidelity of an implementation, broadly described as whether a program was delivered in a comparable manner to all participants true to its underlying theory, is a significant, if under-researched, component of intervention programs. Lee and colleagues (2008) noted that only a minority of intervention studies have attended to the issue of implementation fidelity. Traditionally research has paid more attention to other key methodological issues (such as experimental design, reliability of measurements, and statistical power) with the assumption that the participants received the intervention(s) they were supposed to receive as designed. The literature makes a distinction between Program versus Process or Intervention versus Support System fidelity. This distinction needs to be recognised in the KidsMatter Initiative, because while we have very little information on program(s) fidelity, we do have data on process or support system fidelity as part of the implementation. In this chapter, consideration is given to the quality of the KMI implementation assessed in relation to the key parameters of 'fidelity', 'dosage' and 'quality of delivery'.

A series of indicators were collated from all of the various data sources collected in the evaluation to create an Implementation Index, suitable for classifying KidsMatter schools according to the quality of their implementation of the KMI. Our interest lies in identifying the particular features of schools categorised into the "performing well group", in order to report indicators of exemplary practice.

In order to identify schools as being low or high implementers of the KidsMatter Initiative, a framework was developed based on Domitrovich's (2008) recommendations to ensure that aspects of fidelity, dosage and quality of delivery were gauged by those implementing the

intervention and those providing the support. The framework is presented in Table 5, followed by the items selected to 'measure' the quality of intervention and quality of support, in Table 6.

In developing this Implementation Index, a large number of items from Parent/Caregiver, Teacher and Project Officer Questionnaires, that might provide useful discriminants of school implementation, were selected and arranged into the framework. We decided that items specifically about the four components would not give a clear indication of fidelity since schools could choose in which order to implement the components and the ranking of schools was based only on data collected from Time 4.

Table 5. The KidsMatter Quality of Implementation framework

	INTERVENTION	SUPPORT SYSTEM
FIDELITY Degree to which an intervention is conducted as planned	School views of progress Seven Step Implementation Process, SEL curriculum	Project Officer views of progress Seven Step Implementation Process
DOSAGE Specific units of an intervention and support system	In-school activities Time allocated to planning and implementation, Principal participation, Amount of professional development	Project Officer activities Contact with school leadership, Parent/caregiver events and information dissemination
QUALITY OF DELIVERY Affective engagement with the process & support responsiveness	School and leadership views Quality of PD, Parent/caregiver and Teacher engagement	PO views Leadership and staff and parent/caregiver encouragement and involvement

Next, we used Latent Class Analysis (in MPlus 5.2) to identify the questionnaire items that best discriminated between schools. Items that were shown by the Latent Class Analysis to be poor indicators of implementation were systematically removed from the analysis, resulting in the final selection of 37 items, with balanced representation in each section of the Implementation Framework. Table 6 details the items and their scores. A maximum score of 226 indicates a high level of implementation, while a minimum score of 42 indicates a low level of implementation.

Using the response scores, shown in Table 6, to each item, a total index score was calculated for each school. Missing values were below 5 per cent and were replaced with the local median. Schools ranged from a low score of 89 to a high score of 205 (see Table 6). The total index score was ranked to establish that those schools with high scores were identified as the 'high implementation' class, while those schools with low scores fell in the 'low implementation' group. This translates to a low-high cut-point of 160 in the Round 1 schools and 170 in Round 2 schools. In Round 1 schools, more schools were identified as being high implementers (56%), compared to Round 2 schools, in which 46 per cent of schools were identified as high implementers. Given that Round 1 schools had a one year head start, this is an expected outcome.

Table 6. Items in the KidsMatter Quality of Implementation Index

	INTERVENTION	Max Score
FIDELITY (Teacher)	From your own experience, rate the extent to which you disagree or agree with the following statements: 1= SD, 7= SA	
	Step 1: Our school has defined issues related to the four KidsMatter components	7
	Step 2: Our school has set goals for the four components	7
	Step 3: Our school has identified difficulties in achieving our goals	7
	Step 4: Our school has developed strategies for achieving our goals for the four components	7
	Step 5: Our school has evaluated strategies for addressing the four components	7
	Step 6: Our school has developed and implemented coherent plans for the four components	7
	Step 7: Our school has reviewed and adjusted plans for the four KidsMatter components	7
	The school teaches social and emotional skills to students in formally structured sessions that adhere to a program manual	7
	Sub Total	56
DOSAGE (Teacher)	Principal attends most KidsMatter meetings? No=1, yes=2	2
	On average, how much: 1= under 5 mins, 2= under an hour, 3= more than an hour	
	a) formal time per week does the Action team allocate to planning & implementing KidsMatter?	3
	b) time in staff meetings is formally allocated to KidsMatter?	3
	Teachers attend professional development associated with the KidsMatter Initiative 1=SD, 7=SA	7
	Sub Total	15
QUALITY OF DELIVERY (Parent/caregiver)	The following questions ask you to consider the ways in which you have been involved with KidsMatter: 1= SD, 7= SA	
	a) I feel positively about KidsMatter	7
	b) I am encouraged to participate in the KidsMatter Initiative	7
	c) I have formed more support networks with other parents/caregivers since KidsMatter	7
	d) I have been more involved with the school since KidsMatter	7
	e) I feel that the school community is more positive since KidsMatter	7
(Teacher)	In general, the quality of the Professional Development for the KidsMatter Initiative has been: 1=Poor, 7=Excellent	7
	Sub Total	42
	SUPPORT SYSTEM	
FIDELITY (Project Officer)	This section is designed to measure how effective the school has been in undertaking the Seven-Step Implementation process SINCE COMMENCEMENT of the KidsMatter Initiative. It is not about the components, but rather the implementation process of the whole KidsMatter Initiative. This school has: 1= SD, 7= SA	
	Step 1: Defined the issues related to the components they worked on.	7
	Step 2: Set goals for the components they worked on.	7
	Step 3: Identified difficulties for achieving goals for the components they worked on.	7
	Step 4: Developed strategies for achieving goals for the components they worked on.	7
	Step 5: Evaluated strategies for addressing the components they worked on.	7
	Step 6: Developed and implemented plans for the components they worked on.	7
	Step 7: Reviewed and adjusted plans for the components they worked on.	7
	The KidsMatter Initiative is well implemented in this school.	7
	Sub Total	56
DOSAGE (Project Officer)	For this section, consider what this school has done SINCE THE LAST REPORT. From your discussions with school leadership, did the school provide opportunities for parents/caregivers to meet with each other? How many times? 1= no, none; 2 = once, …7 = six or more times	7
	From your discussions with school leadership, did the school: no=1, yes=2	
	a) Send newsletters containing information about parenting home to families?	2
	b) Send tip sheets containing information about parenting home to families?	2
	c) Send KidsMatter Information sheets home to parents/caregivers?	2
	Did you have contact with the Deputy Principal? No=1, yes=2	2
	Sub Total	15
QUALITY OF DELIVERY (Project Officer)	Consider what this school has done since the last report. Please rate the extent to which you agree with the following statements by selecting the best response. 1= SD, 7= SA	
	The school leadership encourages staff to become actively involved with KidsMatter.	7
	Staff are actively involved with the KidsMatter Initiative.	7
	The school leadership team is actively involved with the KidsMatter Initiative.	7
	Parents in this school are encouraged to participate in the KidsMatter Initiative.	7
	The whole staff are involved in the planning of KidsMatter?	7
	The whole staff are involved in the implementation of KidsMatter?	7
	Sub Total	42
	Total Index Score	226

6.1 School profiles on the Implementation Index

Figure 12 shows profiles across the different items, for schools rated low and high on the Implementation Index.

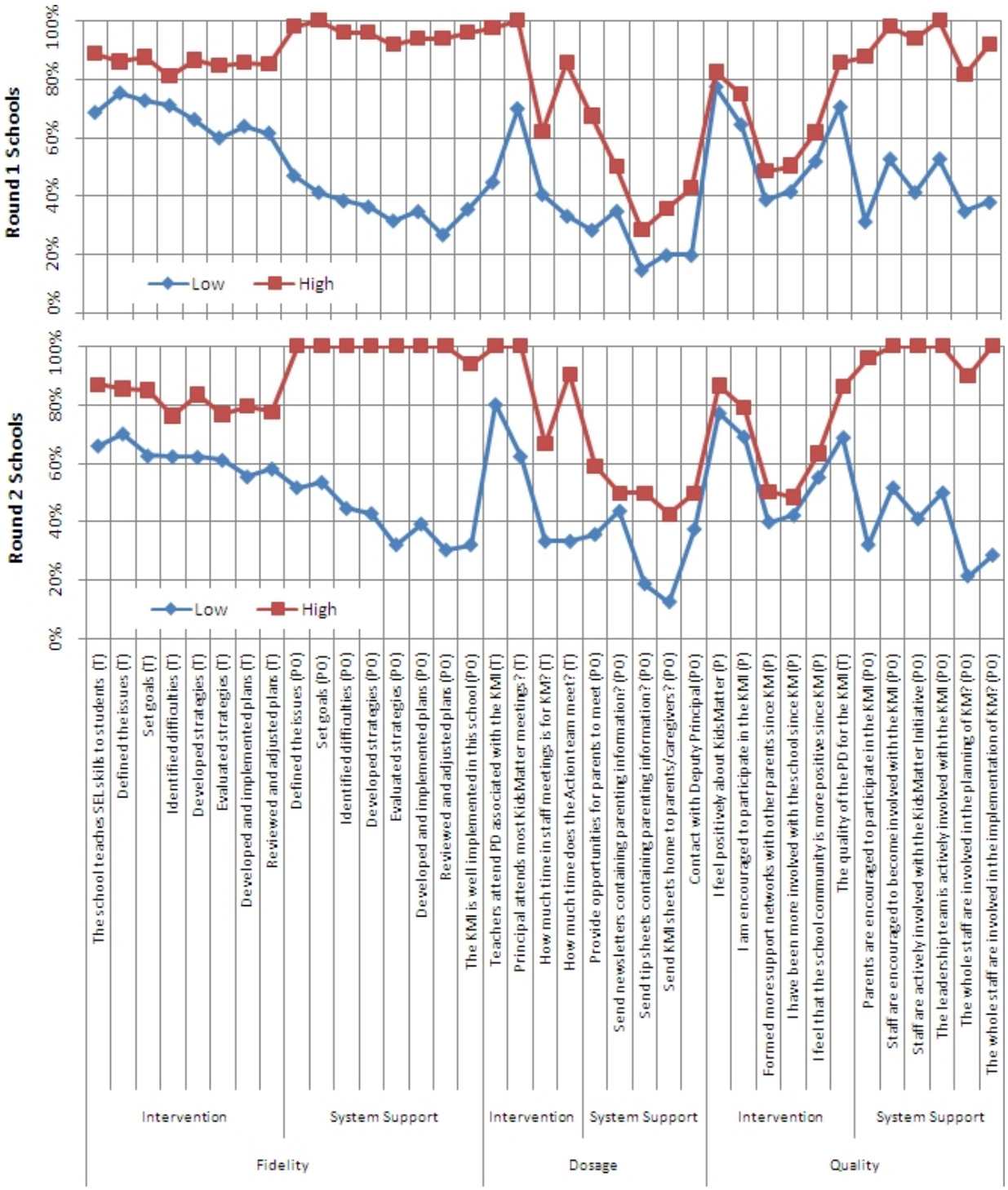


Figure 12. School profiles on the items of the Implementation Index

It can be seen that for the first eight items located on the left side of the chart, which are teachers' reports about teaching social and emotional competencies and the seven-step implementation process, there is not a great deal of difference in Implementation Scores between the schools. However, the KidsMatter Project Officer reports about the seven-step process,

which are reflected in the next eight items, do clearly differentiate between the schools. For example, there is a substantial difference between Project Officers' reports for low implementing and high implementing schools on the item, *Reviewed and adjusted plans*. This suggests a critical difference between schools at the end stage of the 7-step implementation process, for which a number of explanations are possible, including lack of time to reach the review stage, and possible lack of capabilities to engage in reflective review. Time spent by the KidsMatter Action Teams (whether actual or perceived by respondents) is another point of difference between high and low implementing schools.

The next main area of difference between the schools lies in the last six variables to the right hand end of the chart. These variables deal with the involvement of parents/caregivers, staff and leadership with the KidsMatter Initiative. For example, there is a substantial difference between low and high implementing schools on the item, *Whole staff are involved in the planning*. This variable speaks to the importance of a whole school approach if general health promotion initiatives such as KidsMatter are to be successfully embedded within schools.

6.2 Chapter Summary

The implementation Index showed substantial difference in the quality of implementation of the KMI, in particular in Project Officers' perspectives of the success that schools had in addressing each of the steps in the 7-step process, and in the level of involvement of all stakeholders including the active involvement of the leadership team.

Chapter 7.
Implementation and Engagement with the KidsMatter Initiative: Stakeholder and Student Voice Studies

> "I think it's been a good thing in a whole range of ways. It's given some people opportunities to do really interesting things – it's given opportunities for staff to be leaders – it's been an opportunity for staff to own and feel that they manage something and to actually bring about change that's not just top driven. It's given parents and committee members the opportunity to be part of decision making and then actually make a decision and then follow it through. I think for the kids, it's given mental health a priority where before it probably didn't have one at all." *Principal* (School 8)

Differences between schools in the level of implementation and engagement with the Initiative, together with factors contributing to those differences, were also evident from data collected from the Stakeholder and Student Voice studies.

7.1 Key themes from the Stakeholder and Student Voice studies

School principals, Project Officers, students, parents/caregivers, action team leaders and teachers have contributed to our understanding of the implementation and their engagement with the KMI through interviews and focus groups. Participants' core experiences of how the KMI was implemented were identified and are reported in this chapter.

7.1.1 Normal school life and change

There are many well-recognised factors in the international literature which are known to facilitate, contribute to, or hinder change and reform in schools generally (Fullan, 2007). Factors that facilitate school reform include: creating knowledge and awareness; adequate time and commitment; establishing facilitating structures in the school such as meetings and communication processes; collaborative or distributive leadership style and engagement in decision-making (Shields, cited in Credaro, n.d.). Barriers to school reform include: organisational structures and cultures which impede implementation; leadership style; lack of time; perceptions of stakeholders which do not see the need for change; lack of commitment and absence of follow-up (Fullan, 1997; Hargreaves & Fink, 2004). In considering the data collected from the Stakeholder and Student Voice studies, we were informed by the key themes that emerged from the literature on educational change. In addition, particular themes emerged from the collected data. Therefore, we adopted a theory driven and data driven approach to extract meaning from the data, and report this thematic analysis in the section that follows.

Principals and action team members from the Stakeholder study indicated that facilitators and barriers to implementation were present in some form as part of their everyday school life. For example, where adequate time was allocated, this facilitated the implementation process. Where inadequate time was allocated, implementation was impeded. The themes identified are consistent with what is known from previous studies on school change (see Fullan, 2007). The themes consistently identified by participants are represented in Table 7, emerging as either facilitators or barriers, depending upon the context.

Table 7. Facilitators and barriers to school reform

Facilitators and Barriers	Exemplar statement	Source
Adequate time	"like with everything, time is a major element. Within the last 2 years we've had … so many other things that impinge on a school, …so that's been hard I suppose – the management of that."	*Principal* (School 7)
Resources	"I think just getting the staff all on board at once and getting them to have ownership of the program…."	*Principal* (School 9)
Staff change	"We turned over a large percentage of our staff, and this is going to happen … and so suddenly the pre-work that was done the year before wasn't necessarily carried over."	*Principal* (School 9)
Leadership	"the challenge for me then would be to make sure that the staff that come up now who haven't been through the KidsMatter training,…. That I actually do something about that."	*Principal* (School 10)
Ongoing support	"I think it's really important to have a team of people keen on promoting a change. It's more difficult if it's just … top down stuff rarely works … It has to come from within the organisation and for them to see the reason for it."	*Principal* (School 4)
Leadership change	"while I was away, the person who was taking my role obviously was trying to cope with all sorts of things, so KidsMatter was not one of the balls he was able to keep up in the air."	*Principal* (School 5)
Leaders' priorities	'coming in as a new principal with new focus and staff saying we need to have time on the new English curriculum, we need the time on the new numeracy … We've just had to say that's what we will do…"	*Principal* (School 7)

Schools are dynamic systems – not static places: staff come and go; leadership changes; resources fluctuate; curricula are crowded; additional demands impinge on time available; and perceptions of support vary.

School leadership is implicated in all of the above themes, and therefore emerged as a fundamental factor for implementation and engagement with the KMI. As an agent of change a principal is responsible for the overall direction of the school community and the resourcing available (Hargreaves & Goodson, 2006). It was clearly identified from the various sources of qualitative data that principals who were committed to the Initiative demonstrated their commitment through their leadership style. Successful leaders remained closely involved with the KMI, either personally, or through using strategies such as delegating responsibilities for KMI to Action Team leaders (displaying trust and a distributive leadership style), and demonstrating an interpersonal and collaborative style (encouraging ownership across the staff), thereby ensuring that others became or remained engaged with the Initiative:

> "make sure that teachers are engaged, and maintain it from a collaborative point of view, because if it's not done collaboratively, it won't work." *Principal* (School 6)

7.1.2 KidsMatter Initiative: Implementing the four components

From the qualitative data it was evident that the four components were not undertaken simultaneously or equally across the 10 schools in the Stakeholder and Student Voice studies.

> "We had 3 components last year, spaced across the year and then we've done one component this year. I think the one component this year from doing that, …that was the parent component,…. That lost all momentum." Principal (School 7)

> "I just think that it would've been more beneficial to run with all of the components really early and then select one or two that we were really going to focus on and have a definite plan – we didn't necessarily have that definite plan around that." *Principal* (School 7).

Schools are constantly dealing with a crowded curriculum which impacts on their ability to do everything they want to do, and it appeared that the issue of embracing all four components was a significant task for several reasons.

> "…making sure that all the pressures that we're under for a crowded curriculum…that KidsMatter doesn't become swallowed up and just pushed to one side as it easily could." *Principal* (School 5).

For some schools, barriers to implementing the four components revolved around issues of timetabling, while for others the competing agendas of national priorities, such as literacy and numeracy programs, drew their attention away from the KMI. Other schools found that only doing one component did not engender sufficient momentum. For still others, the strategy was to upskill staff before embarking on anything else, as captured in the following statement from the Principal of school 9.

> "I think you can only take in a small amount of those components, or maybe even one component and just focus and build on that. I think I'd do it differently…Really hone it down and just be more realistic." *Principal* (School 9).

7.1.3 Building a positive school community (KMI Component 1)

The first component, positive school community, focussed upon building a sense of belonging and connectedness for all members of school communities. A school that is welcoming, and that encourages students and families to belong, provides a necessary, (but not sufficient) condition for the success of other initiatives to promote mental health. It must be recognised that many schools already have positive school communities, programs and philosophies which support student wellbeing. The KMI provided opportunities to do further work in this area:

> "Where I wanted to bring this focus in terms of parent and community...was very much creating opportunities for parents and carers to come to our school for a variety of reasons...and all of them connected to KidsMatter in some way" (*Principal)* (School 1).

As one example of efforts to build a positive school community around the KMI, schools specifically addressed communication with parents/caregivers through various media and made changes to the physical environment of the school:

> "It's certainly helped to develop that idea that parents are with us in this process, that we've got to work together, and that while that can be challenging, we just have to meet it." *Principal* (School 5)

Others used creative strategies to generate a collaborative sense of involvement, such as:

> "We were really aware that our assemblies weren't well attended, so we looked at how we could actually celebrate more and get more parents into the school…so…every week we have merit certificates for kids from each class …and we put them in the newsletter … so that all the parents of those kids would come…sometimes we would have 40 parents, from having nothing" *Principal (*School 5).

In spite of the changes made by schools, however, some parent/caregiver communities did not always perceive that they were welcomed or belonged.

> "there is a lot of disruption between the parents at this school and that makes the school community difficult at its foundations and its roots, because our children all come here together and they need to feel that we are all being supported … I don't think that's happening." *Parent* (School 1)

Clearly, the importance of leadership style was also raised, along with the need for schools to model by example:

> "maybe if we were encouraged by *leadership* [parent's emphasis] to have more of a school *community* [parent's emphasis] then perhaps the children would be able to benefit … by us setting an example… a) us setting an example and b) using the language that they learn in KidsMatter, because they know that we are on the same page as them … at the moment they're not knowing that." *Parent* (School 1)

Some schools also endeavoured to provide a parents' room or similar meeting place, where parents/caregivers could go before or after school to meet and chat and to welcome new parents/caregivers to the community. The provision of parent rooms proved both successful and unsuccessful, with some suggestion that it was how the parent rooms were established, resourced and managed, that contributed to their success:

> "That (parents' room) has not been successful. Initially it was highly popular, but what it did was become a haven for cliques and gossip and it created quite a dysfunction within the school from that." *Principal* (School 7).

> "We'll have one mum who was just in tears, she just needed to get out. She needed to be around people that weren't going to judge her. None of us are trained in anything whatsoever. I can pour fantastic beers, but I'm not trained in this sort of thing. I can only talk to other parents from my own – how I've dealt with things and then they've come with me with how they've dealt with things. So it's not just about our children. It's just about being able to talk to another human being. It's a very important room." *Parent* (School 6)

The Stakeholder study demonstrated that schools made significant efforts to build or enhance their existing positive school communities and to engage parents/caregivers throughout the initiative. As the quotation below reveals, parent/caregiver engagement was seen as the most challenging outreach for schools:

> "I think that you'll find that across any intervention that you look at whole school, whether it be for this, whether it be other mental health interventions done in the United States or any bullying interventions …the parent factor is always the weakest one. It's just the way it is." *School Counsellor* (School 10)

7.1.4 Social and emotional learning for all students (KMI Component 2)

A key theme that arose from the Stakeholder and Student Voice studies concerned issues that teachers considered when making decisions regarding the selection, implementation of, and engagement with, Social and Emotional Learning programs. For example, these included

Integration with the curriculum

> "Once you start implementing programs like that … I mean that program – there's literacy in it, it's got science stuff in it, it's got PD health in it, there's creative arts in it, this is what I mean about the integration of things …" *Principal* (School 3)

> "if it becomes part of the curriculum…it just becomes part of ... like maths and spelling and everything else… then I think it's definitely going to be beneficial ..if it's learnt from reception *Parent* (School 1).

Tailoring programs to the school needs or context

> "Don't just take a program and run with the program…personalise it. Make it about your school and the needs of your school …Don't just grab something off the shelf…make it fit your school because the needs of your kids are all different *Principal* (School 7).

Consistency

> "it's not just a lesson they're teaching. It's all day, everyday … it should be instilled in them …they're trying to teach them those things that will help them, which I think will help them in later life. *Parent* (School 1)

Involving parents/caregivers

> "we did have a KidsMatter forum where we talked about the program and we had a pretty good turn up of parents...and had a really…quite a powerful discussion about bullying and cyber bullying and phone bullying…with some input from two local GP's who have children here…We got really positive feedback from that …." *Principal* (School 4)

Whole school approach

> "having the same program …the X program as our core program…has given us something that we can talk …as a staff … that we're all going to do the bit on bullying or the bit on friendship, so that we can be consistent. We've tried to do that as a sort of school wide thing to develop a common understanding and for teachers to support each other and that sort of thing… *Principal* (School 4).

Developing a common language and shared values

Schools were keen to locate a social and emotional learning program which would serve to unify the community through providing a common language and consistent messages. Furthermore, integrating the SEL program they had chosen throughout the curriculum raised awareness and community understanding:

> "I suppose the core of it...is to develop a common language and to make sure that children in all classes are having regular learning experiences around the emotional and social skills stuff so that builds across the school." *Principal* (School 4)

> "You have to have a community that's got common values, common thinking about the importance of the social emotional learning and mental health…otherwise it's just one of those other things you do." *Principal* (School 5).

7.1.5 Parenting support and education (KMI Component 3)

Typically, schools in the Stakeholder and Student voice studies instituted strategies to promote the school as an access point for families to learn about parenting, child development and children's mental health by offering parenting education and support through various means. This ranged from making space available in the school for parents/caregivers to meet; offering pamphlets and information on child development; regular contributions in newsletters and open forums with experts. However, these strategies for engaging parents/caregivers with support and education were often not straightforward. A common difficulty concerned the discrepancy between what the school thought it was communicating or offering, and what was of interest or benefit to parents/caregivers:

> "When I write about KidsMatter in the newsletter, I know that a lot of the families who might benefit from the advice don't read it, for all sorts of reasons. So it is hard to reach the ones you want to reach." Principal (School 4)

> "Even if they have tried to explain to us what it's about, it's a 3 page letter. I'm sorry, but we're busy women. We're not going to sit down and read a 3 page letter." *Parent* (School 1)

This discrepancy impacted on parent/caregiver connections with the KMI, and with the school's perception that parents/caregivers could be difficult to engage:

> "… promotion with parents is challenging – getting them engaged in it; excited about it; understanding what it's about." *Principal* (School 9)

Supporting parents/caregivers to understand the link between mental health and learning outcomes was another aspect that schools endeavoured to provide:

> "one of the things that I've had to say to parents has been around well, until we sort this anxiety out with "Sally", we really can't hope to impact on her literacy scores…and getting that message across…and the parent just wants to focus on the literacy scores…" *Principal* (School 10)

Some parents/caregivers just didn't see the relevance for their child:

> "It is a bit daunting for parents because they think "oh there's nothing wrong with my child. I don't have an emotional problem. There's nothing mentally wrong with my child". *Parent* (School 6)

Regardless of whether parents/caregivers engaged or not in the parenting education and support component at the individual level, on the whole they were supportive of what the school was trying to do for the benefit of their children and themselves:

> "Parents understand not only what it is we're doing, but why we're doing it. I think prior to being on board with KidsMatter, it wasn't as clear as to why we were doing things." Principal (School 7)

> "This school being the school that it is, we're more than welcome; very accepted …We've got our own room and everyone's welcome here." Parent (School 6)

> "The parents that are involved here come to me, or come to other committee members, and tell them how this program has assisted their understanding of their child." *Principal* (School 6).

7.1.6 Early intervention for students experiencing social, emotional and behavioural difficulties (KMI Component 4)

Whilst schools recognised the importance of addressing Component 4, Early intervention for students experiencing social, emotional and behavioural difficulties, the demands of addressing all components created the need for establishing priorities in implementing the KMI. In particular, schools were advised, if selecting only one component to address, to start with Component 2, social and emotional learning. This meant that Component 4 was often left until later in the two year period of the initiative:

> "the other thing that we haven't got to yet in our planning is that early intervention. I mean, it is something that we're doing, but it hasn't been something that we've put under the KidsMatter umbrella, because we've been focused on other sections, other components." *Principal* (School 5)

Whilst implementing the SEL program was at the forefront of teachers' focus, the professional development they received around early intervention and positive mental health promotion did enable them to recognise students at risk even though the planning for this component was delayed in some schools. One of the barriers to the implementation of the early intervention component was the need to address staff awareness, knowledge and skills around mental health, in particular the need to demystify mental health and to challenge commonly held taboos. The statements in Table 8 illustrate this challenge.

Another factor which influenced how well early intervention progressed in schools concerned the inter-agency support that schools received. In some schools a good collaborative partnership with external agencies facilitated the process of early intervention and enhanced confidence amongst school staff that help was available for students identified as needing assistance. These

connections also provided staff with strategies for dealing with difficult situations. In the words on one principal at a school where inter-agency services were readily available:

> "I think our referral of kids with needs is really fantastic in where we can go and who we can access and the agencies that we work with are just fabulous … and we do have a lot of agencies that we work with …. If I need help, I just ring somebody out there that I know in one of the agencies and say I need help with this, and they'll go "I can't help you but ring this person, because they will". So it is like a village out there, where everybody talks to everybody else." *Principal* (School 2)

Table 8. Addressing staff awareness, knowledge and skills about mental health

Theme	Exemplar Statements	Sources
Identifying gaps in knowledge	"The aspect of it that I suppose we're still understanding and coming to terms with is how to ensure that those children we identify as at risk, who are demonstrating some significant issues in their mental health – how to support parents and carers and families to be able to access specialist services."	*Principal* (School 1)
Developing Awareness	"I think it's demystifying and de-stigmatising mental health, because I think mental health – it's mental – you know mental it's got a bad label. *Mental!* But it was never talked about. It's like fitness or a cold. It's ok to talk about it and I really am enjoying being in a school where that is so open."	*Teacher* (School 9)
Generating Knowledge	"I suppose through KidsMatter I've shifted some thinking. I have a much deeper understanding about the mental health issues, what it is we're dealing with."	*Principal* (School 7)
Skills Development	"It's made us much more aware because we've been up-skilled in what are the danger signs to look at and particularly in the younger years ... Our staff have become much more confident in making those calls"	*Principal* (School 5)

A barrier to early intervention however, was created where there was a lack of inter-agency support. In these cases, staff were put-off making referrals as they knew they would not be acted upon. This is illustrated by the statement made by the following principal:

> "the capacity of schools to be able to work in an interagency capacity with other service providers is never been more poorly resourced, in my teaching career. So, I find that very, very difficult and very frustrating within our environment … So, it doesn't matter how good we are. It doesn't matter the quality of the work that we do here, if we can't get the intervention at that level or with that particular specialised service, we have to continually re-evaluate how we can use this within our school to improve learning and achievement. It's continually reframing because of the lack of support services outside of us." *Principal* (School 2)

It is envisaged that with the increase in awareness, knowledge and skills, that Component 4 will achieve greater focus for staff and that schools' capacities to address the issues associated with early intervention and support will develop.

7.2 Other key messages about implementation, engagement and sustainability

In addition, KidsMatter provided a framework that supported what schools were already doing, and extended schools' existing efforts for addressing the aims of the Initiative. Table 9 displays stakeholders' comments that reflect upon these themes.

The final message in this section is important: that the process of implementation and the engagement with KMI by the stakeholders was empowering in the main, but that it will take time and adequate resourcing to sustain it. However, implementation and engagement are only the first steps towards school cultural change.

Table 9. The broader contribution that KidsMatter has made to schools

Theme	Exemplar Statements	Sources
A conceptual framework	"If you've got a principal who's struggling or a newly appointed one or someone who's going through a low patch themselves … if there's a framework for them to hang onto – to guide how they're managing their school – that's a really valuable thing to have, because otherwise it would just slide away and rather than just go into survival mode and just deal with what you have to deal with, there's a framework to hang things on."	*Principal* (School 10)
Permission to change	"I think because we're doing KidsMatter, we're more understanding of some of the broader emotional issues that children are bringing to school, so taking a different approach in the classroom has been supported probably a bit more than it may have been… it's ***OK*** to do things differently "	*Teacher* (School 3)
Impact of change	"Its got massive potential. I couldn't say that I have seen a lot of change [yet], but if KidsMatter as a concept is injected into all parts of schooling, then it can have an enormous effect on kids.	*Parent* (School 1)

It is evident that stakeholders were sufficiently engaged to begin thinking about sustainability. Participants in the stakeholder study indicated that achieving sustainability will come from the range of issues detailed in Table 10.

Table 10. Sustaining KidsMatter

Theme	Exemplar Statements	Sources
Teacher beliefs in it	"should just be an integral part of what the teachers do in daily life…rather than , oh, I have to do a KidsMatter thing….It's got to come from what you believe. Your beliefs are what you fell your rights are, your responsibilities and then your values."	*Principal* (School 3)
Not an "add-on" to their workload	"they're not discrete lessons…they are ways of being…"	*Principal* (School 1)
that PD is ongoing	"So next year for argument's sake, if we don't redo the PD, we're going to lose it, because there's so many new staff"	*Principal* (School 6)
part of the school's strategic plan	"I think one of the biggest things is that it has to be included as part of the whole school planning. If it's not, it's doomed to failure.	*Principal* (School 6)
and part of the whole school and leadership commitment	"You have to get that whole school commitment and you do that by making sure that everyone is involved, that it comes up at *every* staff meeting, that you get feedback from people as to things that don't work	*Principal* (School 6)
Resource allocation	"You need to get the structure right…No matter what happens in the staffing change, your resource allocation into this needs to be set and you need to look at people that are really going to feel comfortable in this area and be able to drive it	*Principal* (School 9)
School ownership	"It's all contextual, so what works for us in our context is going to be completely different in a different area…they need to think carefully about what is achievable in their school setting and then they need to be serious about their resource allocation to achieve those outcomes and work in teams….and ensure they allow the staff plenty of time to process what the program [KMI] is all about, so they take ownership….	*Principal* (School 9)
Long term commitment	"Schools need to make a strong commitment and there needs to be a commitment over a period of time…a commitment that's going to manifest itself in whole school change…It can't be owned by just one or two people….but it needs to be led by people who believe in it.	*Principal* (School 8)

7.2.1 The Student Voice study: Students and KMI Implementation and Engagement

Whereas stakeholders such as staff and Project Officers were asked directly about the KidsMatter Initiative by the evaluators, students were not directly involved in the evaluation of the KMI. However, changes to students' attitudes, knowledge and behaviours were the targeted outcomes of the programs adopted by each school. KidsMatter happened around the students: in the classrooms and through curriculum. From this immersion in KidsMatter, it would be expected that students would be able to report on their awareness of, and ways they had been working on, such issues as: Self-awareness, Self-management, Social awareness, Relationship skills and Responsible decision-making (CASEL, 2006).

Through the Student Voice Study students were able to provide insight into their understanding of KidsMatter, as well as providing a platform for them to express what they may have learnt from the Initiative overall. Students were also asked about the specific Social Emotional Program the school had chosen to implement as part of Component 2: Social and Emotional Learning for Students. Furthermore, students' ability to discuss the introductory vignette about a student called "Cris" (used at the beginning of the student focus groups), and to express what had been happening in their school and classrooms, reflects students' social and emotional competencies.

It appeared that all students who participated in the Student Voice Study had some knowledge of KidsMatter. This could reflect that KidsMatter was visible throughout the schools as posters, lanyards, pins/broaches and related artefacts, as well as the teaching and learning about social and emotional learning that occurred in classrooms.

Some students could explain a simple understanding of KidsMatter, such as,

> "Children that matter…children's wellbeing…[being] mentally healthy…physically healthy." *Student* (School 1)

Other children presented a more in-depth understanding of KidsMatter, including issues such as, *social awareness and relationship skills, self awareness, self management and responsible decision-making*. For these children, KidsMatter meant

> "It helps kids that…doesn't [sic] have…like..people to play with…or helps people out ..when you're sick…or not fitting in very well...or not having a lot of fun or they're depressed about how the other kids are treating them *Student* (School 4)

> "its about getting along with your people in the classroom and school….you've got to be responsible for everything you do *Student* (School 7)

> "helping kids take control of their-self [sic]...control of their work and the way they act and how they're doing it…behaviour, responsibility." *Student* (School 7)

> "it's to...help kids express themselves…to help them…cheer them up if they're upset…to stop bullying." *Student* (School 6)

> "[it's about making] a good decision…. Is to walk away from something bad and no matter if someone teases you because you're not going to do something bad." *Student* (School 7)

Students' ability to articulate the components of the specific social and emotional learning program they had been learning about indicated that programs were being actively implemented:

> "it's about the five keys: organisation, confidence, resilience, persistence ...the 5 key to …be happy." *Student* (School 5)

> "Bouncing Back…it's about when you're not feeling too well and you're just angry - it's going back to your normal self, not being the sulking around person…"*Student* (School 4)

"in class…we have activities on it, about caring…yeah…harmony, patience." *Student* (School 6)

Furthermore, students' comments indicated that what they were doing in those programs helped to promote positive relationships:

"We do pictures and writing…our teacher reads out cards…you make up a pocket and they go and write something…after lunch you've got lots of nice messages in there….We've done posters and we have to write friendship or loyalty...and then you draw pictures and written stuff down" *Student* (School 6)

"We've got a booklet about the 5 keys and each term we work on one. First terms was getting along…this one is resilience...last terms was organisation *Student* (School 5)

"We have done things that have been trying to involve everybody ..and trying to make sure everybody is safe…doing group things…read books where a dog felt lonely ..and he felt depressed and unhappy because he didn't know anyone…We were also talking about empathy, feeling what other people were feeling" …*Student* (School 4).

The main area for engagement with KidsMatter for students was with the social and emotional learning programs and through the learning that occurred through this component. Students were able to demonstrate insights into:

anger management strategies:

"You have to say what's bugging you … and then you have to see if you can deal with it and try your hardest and if you can't then you always have other options, but always try to explain to the person who's hurting you." Student (School 6)

building peer relationships and positive friendships:

"You just try and make friends with them…but first you need to know more about them…then you can make friends with them." Student (School 5)

managing bullying:

"If I was being bullied, I'd rather walk away or I'd go and tell the teacher so that it can be fixed." Student (School 4)

Table 11 shows themed examples of the learning that the students demonstrated.

Table 11. Exemplars of students' engagement with KidsMatter

Theme	Exemplar Statements	Sources
Express their feelings	"We say it's alright to feel sad sometimes and if you do feel sad you know you've always sometimes got your friends there to help you and cheer you up."	*Student* (School 1)
	"in our classroom we've got like …an emotions chart and there's happy and all the words happy and sad. For sad there's words like misery, disappointing, angry …for happy there's words like fantastic."	*Student* (School 5)
	"empathy means putting yourself in someone else's shoes…thinking of how it would be like if you're in that situation."	*Student* (School 4)
Demonstrate problem solving strategies	"They could ring up the teacher and say he's having a hard time…they could have a meeting with the teacher…his mum and dad could sit him down and talk about all that…they could send him to a psychiatrist…they could tell him to share his feelings with them."	*Student* (School 5)
	"Tell the teacher he was having problems…have a quiet chat wit someone he knows and someone he feels safe with."	*Student* (School 4)
Discuss coping strategies	"he should talk to someone because you can't let it build up inside."	*Student* (School 5)
	"Breathe deeply and just try and calm down for a few minutes …go and talk to someone about why you're sad and they could probably help you."	*Student* (School 7)
	"Sometimes its good to be angry ...but not to take it out on other people ….just to walk away if you feel the urge to abuse someone."	*Student* (School 1)

7.2.2 Students' reports about specific KMI activities to build social and emotional competencies

Some unique initiatives were employed to engage the children with the KMI across the school, which simultaneously served to build relationships across the different age cohorts. For example, one group of students became KMI "ambassadors" and, after some training engaged in cross age-tutoring around the notions of KM:

> "we've been running workshops with junior primary classes...and now we're heading up to middle-primary….we've been asking if they recognise the logos…and doing "t" people [from KidsMatter logo] so they can colour them in…We gave them a crown task where you put on a crown and you're queen or king what would you change for children in the world…" *Student* (School X)

And in one school, students spoke favourably about a peer support program especially in the school yard:

> "they come and ask…like their friends aren't playing…and we can help sort it out…" *Student* (School 2)

This peer leadership strategy, of training young people to work with others in a peer support capacity around the key messages of the KMI, is one worthy of consideration, as it was evident in this school that these young people had an explicit understanding of mental health, due to the training they had been given:

> "Mental health is not all about sickness…Its about being mentally healthy…like happy inside…and knowing your feelings….knowing how to express them without going over the top…" *Student* (School 1)

7.3 Chapter Summary

Patterson (1997) stated that systemic change happens only when the people inside the school critically examine their beliefs and change their instructional practices to fit these revised precepts. Implementation and engagement with the KMI was a critical factor in the successful conduct of the Initiative. Change is a slow process requiring skilful leadership to provide the right conditions including the creation of adequate time and resources, and which helps the school community cope with any sudden changes, for example those arising out of leadership change. Shifts in core beliefs, attitudes and knowledge require time to occur. Critical elements in the engagement and change process involved active participation and involvement of parents/caregivers and staff, leadership and whole school planning. As was evident from the evaluation of the KMI, the school change process is a dynamic and complex mix that must consider the nature and availability of the resources available to undertake the 4 components. The findings from this evaluation suggested that factors that help to promote changes include the provision of a conceptual framework, creating the space for change to occur, and being prepared for the extent of change that might be engendered. It was found that schools made practical organisational decisions regarding how many of, when and where, the 4 components would be addressed. A significant element of implementation and engagement is planning for sustainability and this was found to require forethought and planning.

Chapter 8.
Perceptions of the Impact of the KidsMatter Initiative

> "It has changed school culture, I think. It's changed the way the school views mental health. It's given a greater awareness, but it's also changed the way, I think, people relate to one another, particularly the students, and the way the classrooms operate." *Principal* (School 9)

Following evidence about the Implementation of the KMI presented in the preceding chapter, the next step in reporting results from the evaluation is to turn to evidence of impact and outcomes. In this chapter we report on a number of broad judgements about the impact of the KMI. The first set of reports are derived from interviews and focus groups conducted as part of the Stakeholder and Student Voice studies. These are judgements made by participants in a subset of the schools. Then we report on a set of broad judgements made in questionnaire responses by respondents in the whole cohort longitudinal study.

8.1 Perceptions of KMI impact: Evidence from the Stakeholder and Student Voice Study

> "KidsMatter's not a curriculum...it's not a document. We don't deliver it…we don't teach it…It's a way of thinking …of doing." *Teacher (School 3)*

It was evident in the Stakeholder and Student Voice studies that the KMI was perceived to have had a broad positive impact overall, in spite of some initial reservations from staff who were fearful that adopting the KMI may have contributed to additional workload, to their already "crowded curriculum".

> "I think there has been some resistance from some staff, purely because it's another thing that we've had to add in to our programs…to a busy curriculum…now they are realizing…well, it's actually a different way of integrating. Teacher (School 2).

Beyond this initial reserve, however, the KMI was seen to give permission to staff and parents/caregivers to raise and address mental health issues, to challenge taboos and demystify mental health.

> "I think that *anything that's going to deal with mental health issues in the community couldn't possibly be a bad thing*. It's good to be aware of what's happening out there. It's good to know what's happening to some of those children. Because when we find out what's happening…then we can actually start to say...'Well now I know why that child isn't learning this' ..or 'now I know why that child is continually getting into fights and problems in the playground…or has some difficulties with other children…"*Teacher (School 3)*

It was also reported that the KMI has promoted understanding and inclusivity, where families and children at risk no longer appear marginalised, on the periphery of the school community, but squarely placed within it.

> "It was quite a humbling experience for myself…actually knowing what some of the children have been through in their very young lives…" *Teacher (School 3)*

> "Once you start the circle of sharing and a sense of trust…and it's ok...people will go for it. Because, really...our society gets sick at the edge, where this is denied. That's where we get the stressed out, the anxious, the depressed. *As soon as you open it up and people start sharing, ...all those things diminish and people start feeling better*…So we're inviting that…" *Counsellor* (School 9).

> "he [student] can talk to all the other kids and they all talk with respect about his situation..not putting him down. I think if we didn't have KidsMatter we wouldn't have had those sorts of results. *Principal* (School 5)

An examination of the subgroups of participants involved demonstrated the breadth of the impact of the KMI across all stakeholders' perceptions.

8.1.1 The perspective of the school principals

Taken together, the comments of the principals pointed to a positive, empowering impact of the KMI. These comments, overviewed in Table 12, focussed around the impact of the Initiative on various issues.

Table 12. Principals' perceptions of the impact of KidsMatter in relation to a variety of issues

Theme	Exemplar Statements	Sources
School culture	…"Look...it really works…It *can change school culture*, which changes the way kids relate...It really does. By having that focus and by really thinking about how kids relate to one another…how staff relate to the children and teaching them a set of relationship skills to help them cope…You can really make a profound difference in your school and in those children's lives.	*Principal* (School 9)
	It wasn't just something as an add-on, it was actually making a difference to the way we all worked. And so it was fantastic…and it really did…and has felt good being part of that.	*Principal* (School 5)
Parent/caregiver understanding of children and their development	…"I think it's been a very rewarding and positive program … the parents that are involved here come to me or come to other committee members and tell them how this program *has assisted their understanding of their child*…	*Principal* (School 6)
Children's language and play	…" Once *we could see the changes* in the kids and the *kids were using the language* and *using the ideas in their play* and resolution thinking, I think everyone got a sense that this was a successful thing.	*Principal* (School 5)
Parent/caregiver involvement and engagement	…" It's given parents and committee members the *opportunity to be part of decision making* and then actually make a decision and follow it through. I think for the kids, it's given mental health a priority, where before it probably didn't have one at all.	*Principal* (School 8)
Impact on student behaviour	…"*Our school data is very clear that the incidence of issues around violence/conflict in our playground has reduced significantly*…So that leads me to connect KidsMatter really strongly around the kind of learning that's happening in the classroom here. That *social and emotional curriculum is actually starting to make a difference for the way students perceive themselves and others around them*…so that when they go outside to play *they're actually able to negotiate rules* in a far more appropriate and powerful way for themselves and we're not having the conflicts.	*Principal* (School 1)

Theme	Exemplar Statements	Sources
Interaction with parents/caregivers about mental health	…" *the parent support part is difficult*. There's that sort of tension between the idea of providing advice to parents ..without sounding like I'm the know-it-all teacher.	*Principal* (School 4)
	…one of the things that I've had to say to parents has been around..well..until we sort this anxiety out with 'Sally', we really can't hope to impact on her literacy scores…and getting that message across…..and *the parent just wants to focus on the literacy scores.*	*Principal* (School 10)

That the principals witnessed and commented on the empowering, positive impact of the KMI on various aspects of parents/caregivers', staff and students' interactions, serves to highlight the importance of communication, relationships and the dynamic nature of the school community for the principal. This has implications for leadership style and how change is managed. Leaders in school communities undergoing change need to manage transitions in school culture; in student behaviour, language and play; and in parent/caregiver interactions and engagement. The dynamic nature of schools as systems is evident here, and as such, principals must be flexible and responsive to the change that is occurring if the initiative is to become embedded and sustained.

8.1.2 Views from staff

In the interviews with staff, comments were made about the impact of the KMI from the perspectives of the teachers, on their teaching, and on their interactions with parents/caregivers, as summarised in Table 13. The themes highlighted the challenges associated with the KMI, particularly in relation to assessing the nature and extent of the impact.

Table 13. Staff perceptions of the impact of KidsMatter in a variety of areas

Theme	Exemplar Statements	Sources
Teacher attitudes, knowledge and awareness	…" Number 1, I suppose is *de-stigmatising mental health*…because I think people still think mental health means you are mentally ill.	*Counsellor* (School 8)
School initiatives to reach and include parents	…" it's building staff's knowledge and awareness *..it's drawing parents in closer*…it's making the kids more empowered…it's brilliant	*Teacher* (School 4)
	…"*They're [parents] feeling more welcomed and more accepted* and they're starting to value that aspect of it… I think that's the biggest change we've seen this year	*Teacher* (School 3)
Difficulties knowing the impact on parents/caregivers:	…" Every week there's something that goes home and it's translated..to help our Chinese parents, our Vietnamese parents, our Sudanese parents. We have members of staff who are able to translate and make phone calls…All of these things happen. We have a parent room. We have parent meetings…*but it's very difficult to measure the impact we're having.* Everything is being done, but…we don't know.	*Teacher* (School 2)
Positive impact of KMI on teaching:	…" *now teachers are feeling that it's OK for them to seek help if* they don't feel confident…we're all in this thing together, along with student services and the psychologists ….so everybody's more relaxed	*Counsellor* (School 9)

It is clear that the KMI impacted broadly on teachers' perceptions of their knowledge, attitudes and their teaching. Shifting teacher attitudes and raising awareness about mental health and changing teaching practices with regards to social and emotional learning are important steps in moving from the implementation phase of a new initiative, towards adopting and

sustaining the lasting change that is achieved through teachers' beliefs and commitment. Staff also noted, however, that in spite of making the effort, not knowing exactly what the impact was on parents/caregivers presented them with ongoing challenges.

8.1.3 Parents/caregivers' views

In the interviews, a key focus was to seek information from parents/caregivers regarding the perceived impact of KMI (Table 14). The themes identified included the need of parents/caregivers to feel welcomed and valued in the school, and their need for mental health information where it was relevant to their situation.

Table 14. Parent/caregivers' perceptions of the impact of KidsMatter in a variety of areas

Theme	Exemplar Statements	Sources
Perceived relevance of KMI	It's a bit daunting for parents because they think…*"Oh there's nothing wrong with my child*..I don't have an emotional problem. There's nothing mentally wrong with my child…*Parent* (School 6).	
Positive personal impact	…" I'm still learning where my breaking point is... I hope I never have to find out where it is…I've certainly come close a lot of times, *but I've found so many strategies from this room.*	*Parent* (School 6)
	…*"My son was talked to by the Principal* that runs this….to see if he was OK…That's where that KidsMatter came into it...It was like…*your wellbeing is very important*…you can't…don't...sit back. You have to come and tell us and that's good in a way.	*Parent* (School 1)
	…"Then we got told we had *our parent room*. I was like, alright this is perfect. I threw myself into everything – all the books. We've got lots and lots of books… We've got leaflets and books on everything – losing families; losing parents; losing mother, fathers, grandparents…. As parents if we're struggling with our children in certain areas, we can then come in here, get the information; we can talk to any of the teachers.	*Parent* (School 6)
Staff commitment had an impact	… *you can't have KidsMatter in half a dozen teachers.* There's 40 teachers in this school and they all need to be on board. They all need to be speaking the same language	*Parent* (School 6)

The broad impact of the KMI on parents/caregivers was related to their specific needs. If a need to engage with the KMI was perceived, then the impact was perceived as broadly positive. If parents/caregivers did not believe that they or their child warranted any contact with KidsMatter, then impact was less apparent.

8.1.4 Effective parent-teacher relationships

Discussions with teachers in the Stakeholder and Student Voice studies suggested that some changes in parent-teacher relationships occurred as a result of schools' efforts to increase parent/caregiver involvement. The parenting education component of the KMI provided a process for improving parent-teacher communication. At one school, the action team leader explained the effect of a parent/caregiver forum she had organised where a partnership of learning between parents/caregivers and teachers was being encouraged:

> "the [parent] forum that I ran last term, it showed that we want to work with them. We can say this is a partnership of learning … they [parents] said it was so nice to get to talk to the teachers … that's important, because if you're a prep mum, you've only seen the prep person and they don't know what I'm like or Mr P." *Action Team Leader* (School 4).

Encouraging parents/caregivers to attend assemblies, or inviting them to a free barbeque made parents/caregivers feel welcome and more at ease about engaging with the school:

> "We've already had a few events this year where the whole community has been invited to come during school, after school and they've gone done fairly well … We had an excursion and we had to knock back parents because so many volunteered to come. Now I don't think previous… I think they were really appreciative that they were invited to come along and be involved. I think some of those things have happened because of KidsMatter." *Teacher* (School 3).

Some teachers made a special effort to provide positive avenues for communication with parents/caregivers. This is illustrated in the words of one teacher who explained the value of improved relationships with parents/caregivers for her students:

> "I've tried to get to know most of the parents, even just on a 'hi, how you going?' basis outside the classroom of an afternoon; not rushing off and closing the doors… If the children think that "my mum is happy to speak to my teacher; is happy to come up to the office and speak to the principal; wants to be involved in doing things … has a nice conversation with at the end of the day, even if it's only for a few minutes; then those children [are] …less fearful and anxious … they can talk to us … and we might be able to help in some way." *Teacher* (School 3).

While teachers acknowledged changes in their attitudes to students, there was also some evidence that for some teachers there had also been changes in their attitudes towards parents/caregivers. In one focus group, a parent praised the changes made by one teacher with whom she now felt collaboration, which she attributed to KidsMatter:

> "L [teacher] and I are working together and I think she's brilliant for what she's done. We had our issues at the start of the year – but now I can't recommend her enough … when you sent that newsletter home about teachers going to that thing about KidsMatter – I actually laughed at it and I said what a joke that was. But after she [teacher] done that course she's actually done a whole 360. She went to that course and she done a whole 360 … She actually came up after that course and we apologised to each other." *Parent* (school 6)

8.1.5 Students' perceptions

In the Student Voice Study we asked students to reflect on the impact that KidsMatter had for them. The responses of the students ranged across general impacts on their behaviour, impact on the different parts of their lives, and strategies that they had developed for coping with difficulties. The broad impact of the KMI is shown to extend across home and school and relate strongly to the development of self efficacy and self management skills. Students' comments illustrative of certain themes are shown in Table 15.

Clearly, the KMI has impacted broadly across schooling and home contexts, with students recognising changes in behaviours in both settings. They also indicated that they have become empowered to express their feelings and to problem-solve and generate alternate ways of coping when situations were difficult or confronting.

This was apparent in the general discussions about the vignette that was used about Cris, a student who was not coping well at school. Students were able to describe how Cris was feeling:

> "sad…depressed…he's feeling angry ….lonely…upset…annoyed…unhappy…angry at his friend…anxious" Student (School 4)

and were aware of productive strategies

> "he could tell a friend" Student (School 4)

Table 15. Students' perceptions of the impact of KidsMatter in a variety of areas

Theme	Exemplar Statements	Sources
Changes in the behaviours	"There's *not as many fights*…they're more considerate of each other…there's less people coming up to you."	*Student* (School 1)
	"I only used to have one or two friends….I never used to be very good at making friends…until this year…because *I can express my feelings* and stuff...so I have made loads more friends."	*Student* (School 6)
	"in the last year *we've talked about what to do, being resilient* and all the 5 keys…I feel like we're older and know more things…responsible…yeah..responsible."	*Student* (School 5)
	"I used to be really mean and bad…but *I've got a bit better now."*	*Student* (School 5)
At school…	"I'd probably say that *it's made kids think* about if they do this…how will it affect the other child… *given them an understanding* of how each person is unique in their own way."	*Student* (School 1)
	"Sometimes you might have to deal with things in life. You're not going to get along with everyone…and *you just have to deal with it…*"	*Student* (School 1)
	"Yeah..Last term [I learnt] ..like you should rest…*not always take it out on something or anyone…just try and rest it.*…just like stand there , count to 3..take a deep breath and clam down…then go and have fun and play and forget about it."	*Student* (School 6)
	"*I feel a lot more comfortable* coming to school in the morning knowing that I am going to have fun at lunch and recess."	*Student* (School 6)
	"*Less fighting*…we used to have people in our school that used to bully everyone and think that they were in charge of the school…and our biggest bully at school ..now she's been out of school trying to make friends."	*Student* (School 7)
At home	"It's helped me a lot because sometimes my sister can be really annoying so *I just talk to my parents.*..Yeah you would talk to somebody you actually know…I had to help sort out a problem with two year 1s. …so I had to say to them " I know you won't be friends, but be calm and just say sorry to each other."	*Student* (School 5)
	"I have learnt from the story that *life isn't going to be as easy as it always seems.* You're going to go up and down and up and down etc...and once you're up there you'll learn how to stay up there…and not come back down…I learnt about life…and just do things that you think would be best and *just take your own road to happiness."*	*Student* (School 4)
Coping when feeling everything is wrong….	"I *tell a teacher* and *tell my parents*….I speak to *family members and relatives* and friends and that…I *turn to my friends* and they support me heaps."	*Student* (School 4)
	"go to my room…play Play Station..makes me feel better…*do something to make me calm down, to take your mind off it.*..If someone's being mean to you, you go and play with someone that you like and try and forget about it…or go outside and play with my dog."	*Student* (School 6)
	"think of happy things…of Christmas or something that's happening in your life that you really had fun with…*think about the good stuff that has happened* like winning a race or something"	*Student* (School 6)
	"When he [Cris] gets stressed they could let him onto the computer..or go outside and cool down."	*Student* (School 7)
	"You could *get someone like a… really professional… a person* who deals with the feelings about people – talk to you about feelings."	*Student* (School 4)
Expressing feelings	"We say *it's alright to feel sad* sometimes and if you do feel sad you know you've always sometimes got your friends there to help you and cheer you up."	*Student* (School 1)
	"in our classroom we've got like...*an emotions chart* and there's happy and all the words happy and sad. For sad there's words like misery, disappointing, angry…for happy there's words like fantastic"	*Student* (School 5)

In the focus groups students also discussed anger management strategies, ways of building positive friendships and peer relationships; and managing bullying approaches.

> "Sometimes its good to be angry ..but not to take it out on other people ….just to walk away if you feel the urge to abuse someone." *Student* (School 1).
>
> "It's good to have a friend there for you because if you're hurt or something and you don't know what to do about it…they might be able to suggest something for you to do." *Student* (School 6)
>
> "When I get angry and I need to cool down I've got a card that I can write on with a white board marker that can rub off…and every time I write on it. Like 'X room , reading area or Close to the Principal's Office…I just write where I'm going for 10 minutes." *Student* (School 7).
>
> "We used to have people in our school that used to bully everyone..and think that they were in charge of the school…and our biggest bully at school…now she's been out of school trying to make friends with people." *Student* (School 7)

In summary, the Stakeholder and Student Voice studies revealed that the KMI had a broad impact across participants which variously changed behaviours, attitudes and awareness levels. This breadth and depth of impact occurring simultaneously, across different participants at different times, contributed to the change in school culture that the principals were reporting. Whilst not all stakeholders were impacted by the KMI, there was enough evidence to indicate that, across the 10 schools, positive change was occurring in the school communities concerning knowledge, understanding and awareness of mental health.

8.2 Perceptions of KMI impact: Evidence from the questionnaire study

Respondents' perceptions about the impact of KMI was also gathered by the evaluation questionnaires. We asked parents/caregivers and teachers a set of four questions that inquired specifically about the impact of the KMI on each of the four components. A sample question is *KidsMatter has helped the school to focus on my (this) child's emotional or social or behavioural needs.* A further three questions were related to the impact of KMI on parent/caregivers' engagement with the school, such as *I have been more involved with the school since KidsMatter*. Finally, in this cluster, we asked parents/caregivers a set of 10 questions about their perceptions about the impact of KMI on their parenting capabilities, such as *KidsMatter has helped me to learn how to identify if my child is showing emotional or social or behaviour difficulties* and *KidsMatter has helped me to learn how to help my child to make responsible decisions.*

Change in parent/caregivers perceptions about the impact of KMI on their engagement with school and on their learning, over the four occasions, are presented in Figure 13 and Figure 14, respectively. Figure 15 shows change in teacher and parent/caregiver perceptions about the impact of KMI on a child's need in school.

In Table 16, the medium and large effect sizes for the perceptions of KMI impact on parent/caregiver Engagement with School, for Parenting Learning, and for Impact on the Child's needs, reported from the perspectives of parents/caregivers, indicates that parents/caregivers generally found increased benefit from the presence of the KMI in their schools in these targeted areas of the KMI. Note that the parent/caregiver responses on these scales at Time 1 was around the neutral point of the scale. One hypothesis for the larger effects in the Round 2 schools is that the Time 1 responses of parents/caregivers in Round 1 schools were initially at a higher level because these schools had already begun their involvement with the KMI. Although the responses of these Round 1 parents/caregivers did show an increase on these scales, they started from higher levels.

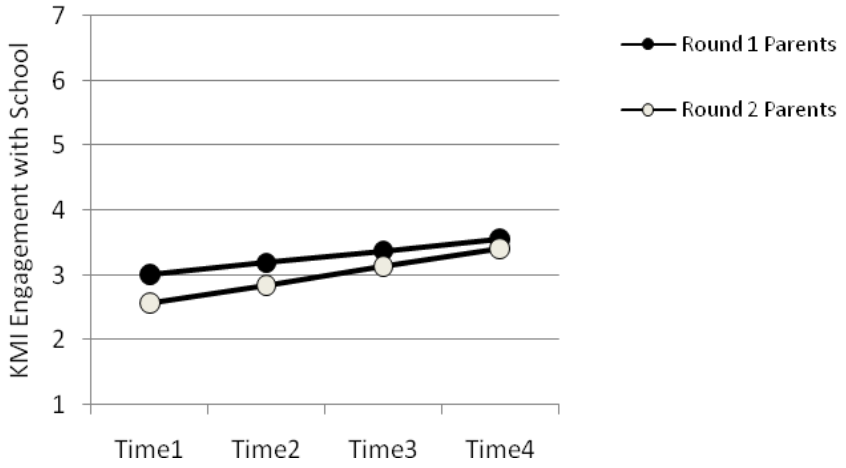


Figure 13. Change in parent/caregiver perceptions of the impact of KMI on their engagement with school

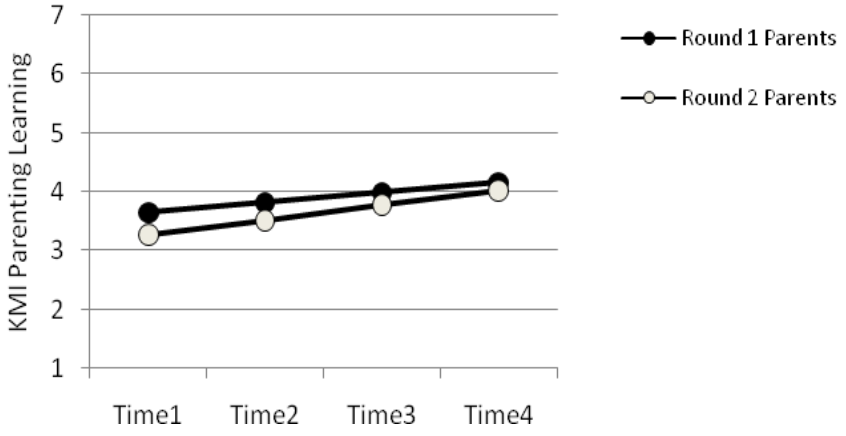


Figure 14. Change in parent/caregiver perceptions about the impact of KMI on parenting learning

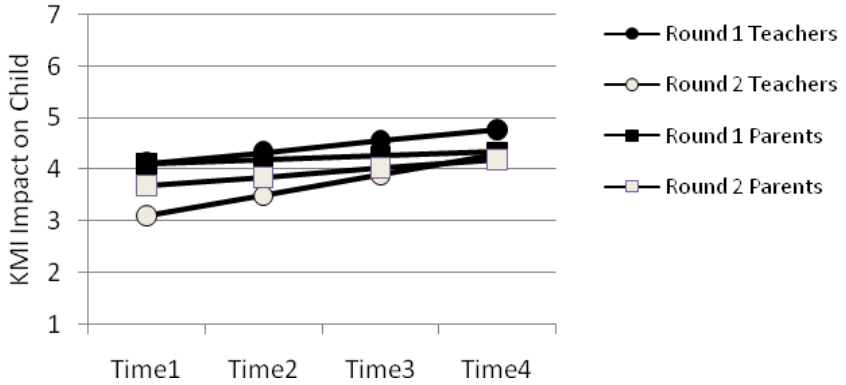


Figure 15. Change in teacher and parent/caregiver perceptions about the impact of KMI on the child's needs in school

The pattern of responses of teachers for the Impact on the Child's needs is similar to that of the parents/caregivers. Thus on this broad indicator of KMI impact the parents/caregivers and teacher questionnaire responses suggest that both groups perceived the KMI to have had a broad positive impact, equivalent to a medium effect size.

Table 16. Perceptions of KMI impact: Questionnaire responses

Variable Names		Total	Round 1 Schools					Round 2 Schools				
Perceived KMI Impact		N	Time 1 Mean	Time 4 Mean	*p*[b] sig.	*r* correlation	Effect[c] Size	Time 1 Mean	Time 4 Mean	*p*[b] sig.	*r* correlation	Effect[c] Size
KMI Engagement with School	(P)	9,119	3.00	3.56	**0.000**	0.30	medium	2.56	3.41	**0.000**	0.49	large
KMI Parent Learning	(P)	8,716	3.65	4.15	**0.000**	0.27	medium	3.27	4.01	**0.000**	0.41	large
KMI Impact on Child's needs	(T)	3,035	4.12	4.77	**0.000**	0.26	medium	3.11	4.28	**0.000**	0.46	large
KMI Impact on Child's needs	(P)	8,521	4.12	4.34	**0.005**	0.13	small	3.68	4.19	**0.000**	0.32	medium

[a] Parent/Caregiver (P); Teacher (T). [b] Significant levels ($p<0.01$) of slope are shown in bold.
[c] Interpretation of the correlation coefficient, *r*, as an effect size, according to Kirk (1996).

8.3 Chapter Summary

Both sets of indicators of broad level impact discussed in this section suggest that the KMI was perceived to have a positive impact. The interviews with parents/caregivers, teachers and students in the Stakeholder and Student Voice studies suggested that these participants did perceive an overall positive impact of the KMI that related to the components of the KMI. The KMI was perceived to make an impact on school culture, facilitating the raising of issues related to mental health and child development. Teachers acknowledged the value of the resources that gave them entrée to the sometimes difficult area of mental health, and reported specific impacts on their teaching. The parents/caregivers who were interviewed valued the information provided and the strategies the KMI gave them for handling issues related to mental health. However, it was also evident in the responses of principals, teachers and parents/caregivers, that some parents/caregivers felt less affected by the KMI. It appears that it is a challenge for schools is to address the needs of parents/caregivers in relation to mental health. In their interviews, students showed explicit knowledge of strategies that were the focus of teaching about social and emotional learning in the KMI, and reported use of this knowledge. The parent/caregiver and teacher responses to questionnaire items focussed on broad impact suggest that both groups perceived the KMI to have had generally positive effects, reflected in the increasing slopes of ratings for indicators of broad impact.

Chapter 9.
The KMI Professional Development

Another perspective on the broad impact of the KMI is to consider the perceptions of the teachers on the key processes for delivering the content of the Initiative, namely, the programs of professional development. The evaluation questionnaire contained nine questions related to professional development, including, *The Professional Development related to the KidsMatter Initiative has: Enhanced my knowledge about students' mental health* and *The Professional Development related to the KidsMatter Initiative has Helped me to foster student wellbeing through my practices as a teacher.*

Table 17 indicates that teachers' responses to these items about professional development show a small effect size (r = 0.1) for change over time for Round 1 schools, and a large effect size (r = 0.46) for change over time in Round 2 schools.

Table 17. Broad impact of KidsMatter professional development

Variable Names		Total	Round 1 Schools					Round 2 Schools				
Perceived KMI Impact		N	Time 1 Mean	Time 4 Mean	p[b] sig.	r correlation	Effect[c] Size	Time 1 Mean	Time 4 Mean	p[b] sig.	r correlation	Effect[c] Size
KMI Professional Development	(T)	2,098	5.35	5.53	0.150	0.10	small	4.00	5.14	**0.000**	0.46	large

[a] Parent/Caregiver (P); Teacher (T). [b] Significant levels (p<0.01) of slope are shown in bold.
[c] Interpretation of the correlation coefficient, r, as an effect size, according to Kirk (1996).

Figure 16 shows that the teachers in Round 1 schools showed a slight increase in rating of PD, having started from an already relatively high initial response. This would seem to reflect the 'head start' these teachers had at Time 1, with the KMI being first discussed in their schools, and the KMI "start-up" days in late 2006. The steeper rate of increase for teachers in Round 2 schools brought them close to the Round 1 teachers at Time 4.

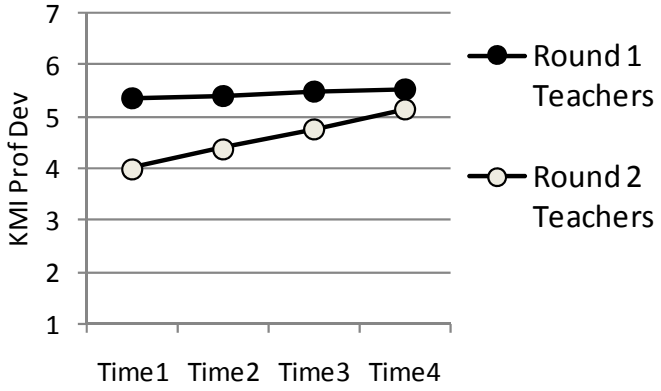


Figure 16. Teacher ratings of KidsMatter professional development

One hypothesis for this rapid catch-up in the impact of the KMI professional development is that it is associated with a difference in the level of expertise and preparedness developed by the KMI Project Officers. Arguably, at the beginning of the KMI, in early 2007, the Project Officers would have been at very early stages in identifying school and teacher needs and developing appropriate programs. By the time the Round 2 schools came on board in 2008, the Project Officers were perhaps more experienced, and were able to work effectively in schools to shorten the start-up time required to see gains in teacher expertise. This finding, and interpretation, argues for the ongoing maintenance of personnel with expertise in the area of developing student mental health.

The questionnaire for teachers also contained one marker question that requested an overall rating of the KMI professional development, namely, *In general, the quality of the Professional Development for the KidsMatter Initiative has been…*Likert scale Poor (1) to Excellent (7).

Table 18 details teachers' responses, showing that 52 per cent of teachers in Round 1 schools and 60 per cent of teachers in Round 2 schools rated selected scores 6 or 7 (excellent) for this marker question about professional development. Only 6 per cent (Round 1) and 5 per cent (Round 2) of teachers nominated scores below the neutral level for the quality of the KidsMatter Professional Development. Note that these responses about professional development were generated in a context separate from the professional development itself, (unlike typical course feedback questionnaires), and thus have the potential to indicate teachers' considered reflections related to the impact of the Professional Development on their subsequent teaching actions.

Table 18. Teachers' rating of the KidsMatter professional development

	Round 1 Schools			Round 2 Schools		
	Time 2%	Time 3%	Time 4%	Time 2%	Time 3%	Time 4%
Poor 1	0.5	1.4	1.2	13.2	0.8	1.2
2	2.1	0.9	0.9	7.9	1.7	1.5
3	3.1	2.8	3.5	4.9	4.8	1.8
Neutral 4	12.3	16.2	14.0	30.5	16.9	11.2
5	30.8	33.0	28.3	21.4	31.6	24.7
6	36.0	30.5	30.6	15.8	27.1	35.6
Excellent 7	15.1	15.1	21.6	6.4	16.9	24.1

9.1 Chapter Summary

The teachers in Round 1 schools showed a slight increase in ratings of professional development, having started from a relatively high initial response. A steeper rate of increase for teachers in Round 2 schools brought their ratings close to the Round 1 teachers at Time 4. Overall ratings of KMI professional development were relatively high.

Chapter 10.
Change in Risk and Protective Factors Associated with Schools

> "we … get together and we talk about okay, how do we help these children? That's when all the others, student counsellor, all those other people then the teachers put in referral forms for them and we try and look at how we can up-skill those children and give them different strategies for coping. It may be just the anger, it may be lack of organisation, it may be all those sorts of things and we're looking at ways then of helping those children develop. So by having this KidsMatter focus we're no longer just focused on the behaviours themselves, it's more focused on the child and the child's needs." *Principal* (School 5)

The KidsMatter conceptual model hypothesised that risk and protective factors for positive mental health reside within schools, families and the psychological world of each child. KidsMatter therefore focussed upon increasing schools' capacities in four components of school based influence upon those risk and protective factors, namely:

- Creation of a positive school community
- Regularly teaching social and emotional competencies to all students
- Providing parenting information and support
- Early intervention for students at risk

The Evaluation questionnaires for parents/caregivers and teachers contained items to measure these four components of school based influence. The data from the stakeholder and student voice studies adds richness to our interpretations of changes in the four components.

10.1 Changes in general engagement with Mental Health Initiatives

Schools are increasingly viewed as one of the most effective settings to provide support to students with mental health and wellbeing issues (De Jong & Griffiths, 2008).

The Evaluation team recognised that Pilot Phase schools would already be substantially involved with activities related to students' mental health. In particular, we recognised that schools may already be delivering social, emotional and behavioural intervention programs. For this reason questionnaire items were designed to gather information about the activities that KidsMatter schools were undertaking related to general engagement with activities supporting positive social, emotional and behavioural capabilities. The longitudinal data collection design enabled us to investigate whether these activities increased during the KidsMatter initiative period. In the design of the KidsMatter Evaluation Questionnaire this level of engagement with mental health

initiatives in general was seen as being distinct from the specific impact of the KidsMatter Initiative.

This observation that schools would already, to varying degrees, be engaging with mental health initiatives is important in interpreting the impact of the KidsMatter Initiative. It might be expected that one outcome of the KMI would be that schools' general engagement with mental health initiatives would increase over time. Here we will investigate this prediction at the relatively simple level of change in engagement with mental health initiatives in general (General Engagement) over the two years of the initiative.

Eight questions in the parent/caregiver questionnaire, and ten questions in the teacher questionnaire, were grouped to form scales of school general engagement with mental health initiatives in general. Examples of questions include, *The school has good links with professionals who can assist students with emotional or social or behaviour difficulties (such as social workers, psychologists, nurses and doctors)* and *All teaching staff support the teaching of social and emotional skills to students.*

The results of the multilevel modelling of change in General Engagement are shown in Figure 17 and in Table 19. The means of the Pilot Phase schools' engagement with mental health initiatives in general, for both teachers' and parents/caregivers' ratings, began well above the neutral point on the 7-point Likert response options. The teachers' ratings showed a small positive trend in both Round 1 and Round 2 schools. The parent/caregiver ratings for this scale showed little change in both sets of schools. One explanation for the difference between parent/caregiver and teacher reports on this scale is that teachers would be expected to have more information at hand about the mental health initiatives (such as programs, referrals) undertaken by their school. Another explanation, and one confirmed by comments from the stakeholder studies, is that parents/caregivers often did not take much interest in school-based mental health issues if they felt that such issues were not relevant to their own child (children).

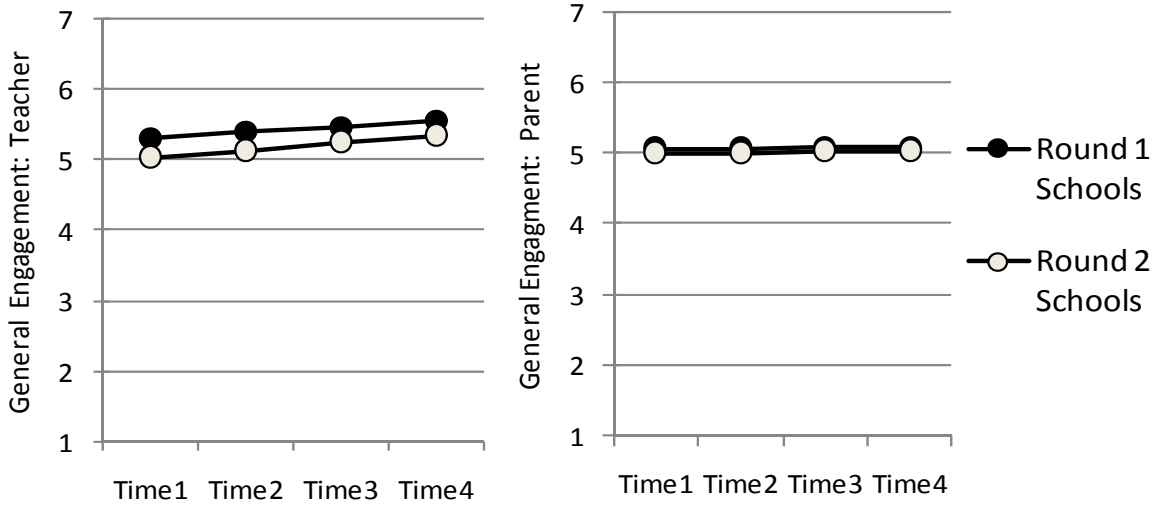


Figure 17. Teacher and parent/caregiver views of school engagement with mental health initiatives in general

At Time 4 data collection, 61 per cent of teachers and 42 per cent of parents/caregivers in Round 1 schools, and 57 per cent of teachers and 43 per cent of parents/caregivers in Round 2 responded strongly agree to questions about their schools' engagement with mental health initiatives in general (scores of 6-7).

Table 19. School engagement with mental health initiatives in general

Variable Names	Total	Round 1 Schools	Round 2 Schools

School Engagement with Mental Health Initiatives in General		N	Time 1 Mean	Time 4 Mean	p^b sig.	*r* correlation	Effect[c] Size	Time 1 Mean	Time 4 Mean	p^b sig.	*r* correlation	Effect[c] Size
General Engagement	(T)	3,047	5.31	5.56	**0.002**	0.17	small	5.03	5.35	**0.001**	0.20	small
General Engagement	(P)	9,577	5.08	5.09	0.871	0.01	trivial	5.01	5.04	0.342	0.03	trivial

[a] Parent/Caregiver (P); Teacher (T). [b] Significant levels (p<0.01) of slope are shown in bold.
[c] Interpretation of the correlation coefficient, *r*, as an effect size, according to Kirk (1996).

10.2 Changes in the four components

Table 20 presents the results of analyses of multilevel modelling of changes in teacher and parent/caregiver ratings for scales developed to gauge changes on the four KidsMatter Components of, A Positive School Community; Social and Emotional Learning; Parenting Education and Support; and Early Intervention. Again it is apparent that the Time 1 ratings for both teachers and parents/caregivers on these scales were quite positive. Even so there were some changes in a positive direction that were of practical significance, as indexed by the effect sizes. The following section discusses each component.

Table 20. The four KidsMatter Components

Variable Names		Total	Round 1 Schools					Round 2 Schools				
School Risk and Protective Factors		N	Time 1 Mean	Time 4 Mean	p^b sig.	*r* correlation	Effect[c] Size	Time 1 Mean	Time 4 Mean	p^b sig.	*r* correlation	Effect[c] Size
C1: A Positive School Community	(T)	3,051	5.61	5.71	0.216	0.07	trivial	5.67	5.60	0.299	-0.05	trivial
C1: A Positive School Community	(P)	9,680	5.81	5.74	0.043	-0.07	trivial	5.76	5.68	**0.007**	-0.08	trivial
C2: Social and Emotional Learning	(T)	3,017	4.97	5.45	**0.000**	0.25	medium	3.10	4.70	**0.000**	0.64	large
C3a:Parenting Support by School	(T)	3,025	4.43	5.20	**0.000**	0.39	large	4.36	4.94	**0.000**	0.25	medium
C3a: Parenting Support by School	(P)	9,716	4.84	5.01	**0.001**	0.13	small	4.82	5.01	**0.000**	0.15	small
C3b: Parenting Support by Staff	(T)	3,025	5.35	5.68	**0.000**	0.19	small	5.35	5.46	0.172	0.06	trivial
C3b: Parenting Support by Staff	(P)	9,716	5.11	5.18	0.254	0.04	trivial	5.12	5.12	0.963	0.00	trivial
C4: Early Intervention	(T)	3,045	4.89	5.32	**0.000**	0.25	medium	4.83	5.07	**0.009**	0.13	small
C4: Early Intervention	(P)	9,613	4.80	4.84	0.460	0.03	trivial	4.71	4.80	0.057	0.06	trivial

[a] Parent/Caregiver (P); Teacher (T). [b] Significant levels (p<0.01) of slope are shown in bold.
[c] Interpretation of the correlation coefficient, *r*, as an effect size, according to Kirk (1996).

10.2.1 Component 1: Building a positive school community

The parent/caregiver and teacher questionnaires each contained 11 questions that made up the scale of Positive School Community. Examples of questions in this section include, *The school is welcoming to families,* and *The school encourages parents/caregivers to have a say about school matters.* The changes across time in ratings related to this scale are shown in Figure 18. The ratings of both teachers and parents/caregivers were relatively high throughout the KMI Pilot Phase and showed very little change. This suggests that KidsMatter schools had accorded this component a high priority and continued this throughout the Pilot Phase.

At Time 4 data collection, 67 per cent of teachers and 66 per cent of parents/caregivers in Round 1 schools, and 60 per cent of teachers and 64 per cent of parents/caregivers in Round 2 schools allocated strongly agree scores to questions about positive school community (scores of 6 or 7).

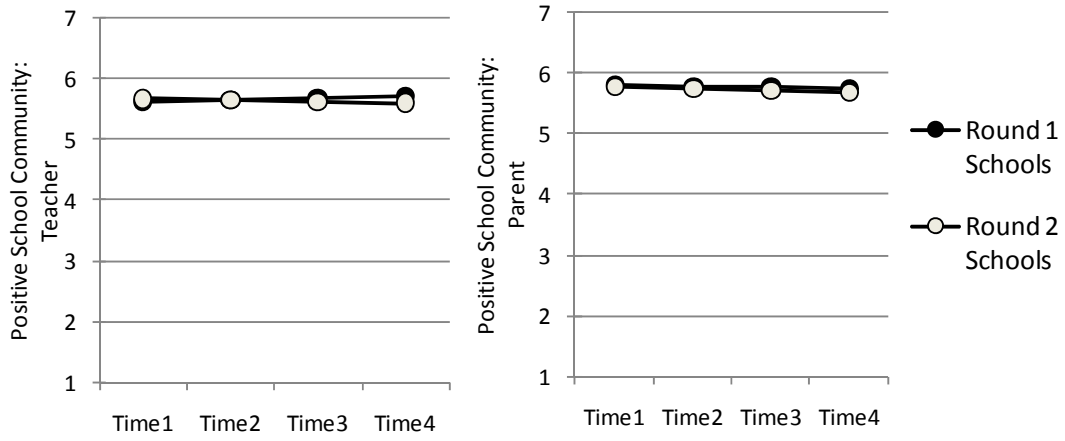


Figure 18. Teacher and parent/caregiver views of positive school community

One question in the Evaluation questionnaire acts as a "marker" of parents/caregivers' overall perceptions of the impact of KidsMatter on the school community, namely, *I feel that the school community is more positive since KidsMatter*.

Table 21 shows that the proportion of parents/caregivers responding at the low end of the scale at Time 1 was relatively high, as expected since KidsMatter had barely commenced in schools. By Time 4, responses at the neutral level (score 4) stabilised at just below one third of all respondents, while scores of 6 and 7, combined, showed that approximately one quarter of parents/caregivers Strongly Agreed with the marker statement about the school community being more positive since KidsMatter.

Table 21. Parents/caregivers' perceptions of the overall impact of KidsMatter on the school community

	Round 1 Schools			Round 2 Schools		
	Time 1%	Time 3%	Time 4%	Time 1%	Time 3%	Time 4%
Strongly Disagree 1	15.1	8.4	8.1	22.8	10.1	7.9
2	8.9	8.6	7.5	13.4	9.1	6.2
3	9.7	10.1	8.4	9.8	10.8	8.8
4	38.9	31.4	31.9	37.8	34.4	31.5
5	12.4	18.9	18.4	7.3	17.9	21.5
6	8.7	14.1	16.7	5.5	11.0	15.4
Strongly Agree 7	6.3	8.7	9.0	3.4	6.6	8.6

10.2.2 Component 2: Social and emotional learning for all students

Ten questions in the teacher questionnaire were designed to measure the teaching of social and emotional skills in KMI schools. This section of the questionnaire included questions such as, *The school teaches social and emotional skills regularly to all students (at least once per week), The school supports professional development about teaching social and emotional skills,* and *The school's resources for teaching social and emotional skills meet the needs of our students.*

The findings (Row C2) in Table 20 show that the ratings for the Social and Emotional learning scale showed positive change across the period of the KMI Pilot Phase in both Round 1 and Round 2 schools. The effect sizes for these indicate that these changes were of practical significance, being medium (r = 0.25) for Round 1 and large (r = 0.64) for Round 2 schools. These effects parallel those noted in national and international literature indicating that increasing students' social and emotional capabilities is a key direction for positive mental health

(e.g. CASEL, 2006; Jennings & Greenberg, 2009). Figure 19 shows the slopes of increase of the Round 1 and Round 2 teachers, and the somewhat steeper rate of increase for Round 2 group, who, once they began the KMI, appeared to move toward the level of the schools in Round 1. It is also appears that at Time 1 the teachers in the Round 1 schools rated this component more strongly, perhaps as a result of already being involved in the KMI.

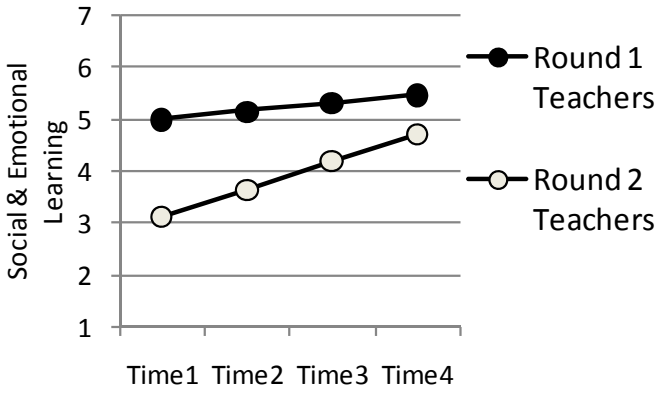


Figure 19. Teacher views of social and emotional learning in Round 1 and Round 2 schools

At data collection Time 4, scores of 6 and 7 were allocated by 58 per cent (Round 1) and 51 per cent (Round 2) of teachers to these questions about their schools' social and emotional learning programs for students.

10.2.3 Student participation in SEL programs

In addition to the scale related to the teaching of social and emotional competencies just discussed, the questionnaires for teachers and parents/caregivers, and the Leadership Executive Summaries provided by schools toward the end of the Pilot Phase, provided information related to this component of the KidsMatter Initiative.

The parents/caregivers and teachers of each child involved in the KidsMatter Pilot Phase Evaluation were asked to respond Yes or No to whether their child participated in a program teaching social and emotional skills during the previous semester. The pattern of responses to this question, shown in Figure 20 suggests that only approximately half of the parents/caregivers knew that their child was participating in SEL programs.

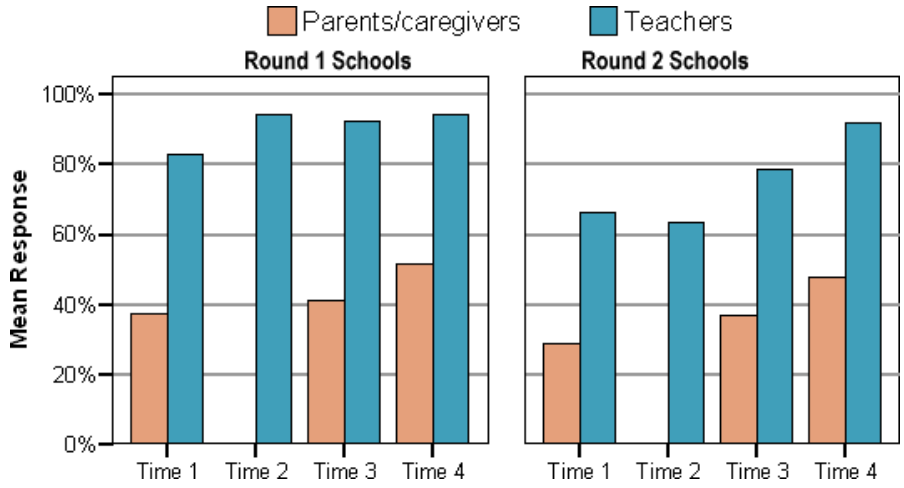


Figure 20. Parent/caregiver and teacher mean score responses to student participation in SEL programs

Parent/caregiver responses contrast strongly to the teachers' reports which indicate that more than 80 per cent of students in Round 1 Schools were exposed to SEL programs, at Time 1, rising to 90 per cent over Times 2, 3 and 4. For Round 2 schools, the teachers' responses indicate a lower start, at approximately 65 per cent of students, rising to over 90 per cent at Time 4. Recall that Round 2 schools did not start the KidsMatter Initiative until after Time 2. The teacher reports suggest that over 90 per cent of students were involved in SEL programs in a sustained way. The comparable figures for Round 2 schools show that by Time 4, they were also achieving the involvement of 90 per cent of students in this component of the Initiative. The Figure also shows that, in both schools, parents/caregivers became more aware of their child's SEL education as time progressed.

One resource provided to KidsMatter schools was a programs guide, which was based upon the evidence base for the effectiveness of the program, the mode of delivery, and the availability of specific professional development to support school implementation. Schools were able to refer to the programs guide to assist in their selection of social and emotional learning curriculum materials. As part of the data collection via the Leadership Executive Summary, we asked school leadership to identify all of the Social and Emotional Learning (SEL) programs used in their school. The 15 most frequently used programs based on responses from 62 schools, in order of most frequent to least frequent, are listed in Table 22. An indication of whether the program is reviewed in the programs guide is included.

Table 22. Most popular programs used in KidsMatter schools

Popularity	Program	Reviewed in Programs guide	Component
24%	The BOUNCE Back!	yes	Social & Emotional Learning
16%	Program Achieve (3rd Edition)	yes	Social & Emotional Learning
15%	Friendly Kids, Friendly Classrooms	yes	Social & Emotional Learning
10%	Protective Behaviours: A personal safety program	no	
6%	Friendly Schools and Families Program	yes	Social & Emotional Learning
6%	FRIENDS for Life	yes	Social & Emotional Learning
6%	Seasons for Growth	no	
6%	Stop Think Do Social Skills Training	yes	Social & Emotional Learning
5%	Peer Support Program (Peer Support Foundation)	yes	Positive school community
5%	Resilience Education and Drug Information (REDI)	no	
3%	Cool Kids (School Version)	yes	Early intervention
3%	1-2-3 Magic Parenting Program	yes	Parenting education & support
3%	Tribes Learning Communities - Tribes TLC	yes	Positive school community
2%	AusParenting	yes	Parenting education & support
2%	Being Me: ABC health series	yes	Social & Emotional Learning

10.2.4 Component 3: Parenting education and support

The parent/caregiver and teacher questionnaires contained a group of 14 questions that addressed whether the school (7 questions) and staff (7 questions) provided parents/caregivers with education and support for parenting. Sample questions for Parent Support by the School were more general, such as, *Information about parenting practices is available at school.* The items for Parent Support by Staff were more specific, such as *Parents/caregivers feel able to discuss their child's emotional or social or behaviour difficulties with school staff*. The outcomes of the analyses of the four sets of ratings are shown in the C3a and C3b rows in Table 20, and are represented in Figure 21 and Figure 22.

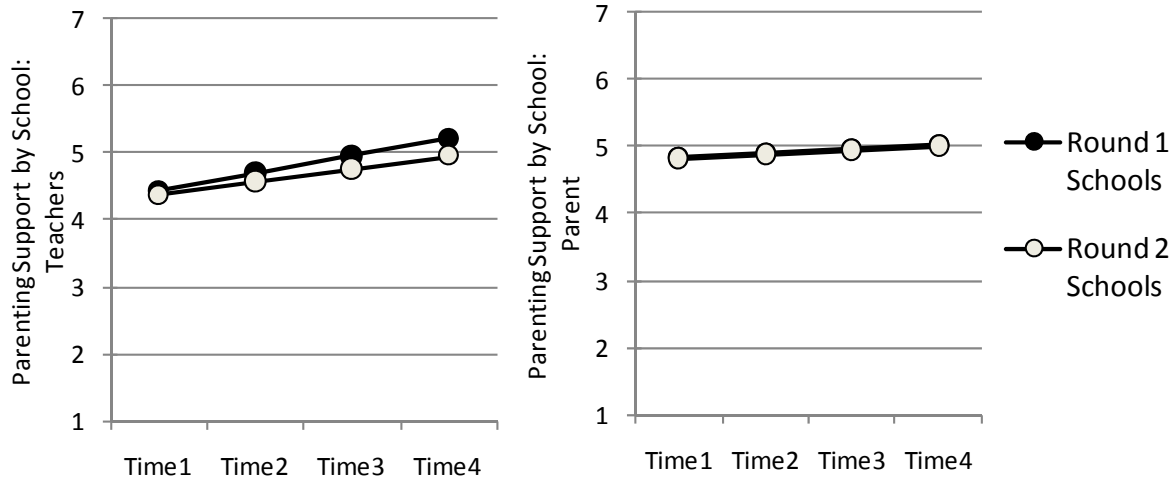


Figure 21. Component 3a: Parenting education and support by school

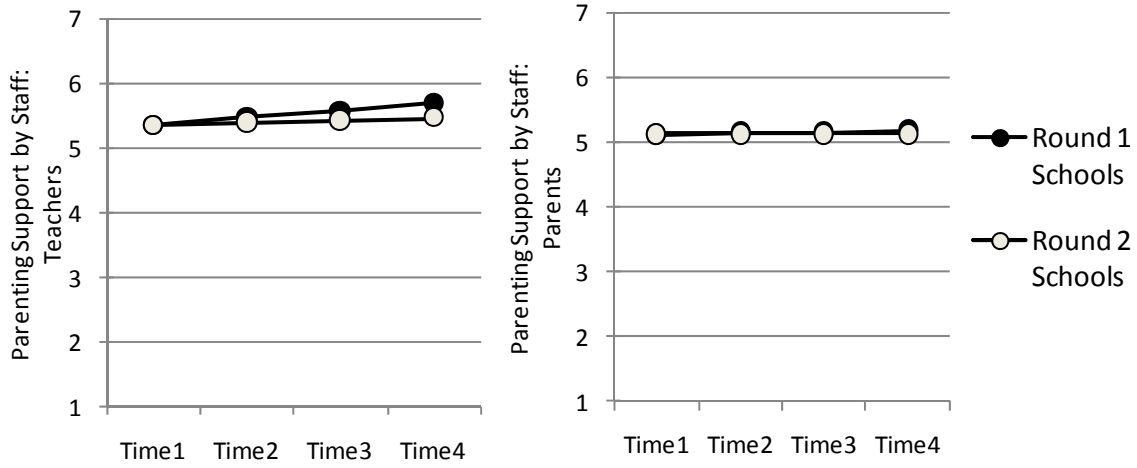


Figure 22. Component 3b: Parenting education support by staff

These findings suggest somewhat different levels of impact for the two sets of items, there being a more positive rate of change across time in the ratings for Parenting Support provided by the School than was the case for the Parenting Support provided by Staff. The difference is reflected in the more substantial effect sizes for Parenting Support by the School.

The findings show positive impact for the level of education and support provided to parents/caregivers by the school. This is the case in the ratings of both parents/caregivers and teachers, and again these ratings are at reasonably high levels. For the parent/caregiver ratings, the pattern of findings is very similar in Round 1 and Round 2 schools. In the case of the teacher ratings there is a slightly increased rate of change for the Round 1 schools. These findings suggest that both teachers and parents/caregivers were aware of efforts being made at the whole school level to provide education and support to parents/caregivers.

For the items tapping more specific levels of support, the ratings by the teachers do show a small practically significant effect for Round 1 schools. On these items the ratings by the parents/caregivers show little evidence of change across the period of the Pilot Phase. However the ratings by both teachers and parents/caregivers remain relatively high across the Pilot Phase. At Time 4 data collection, approximately 52 to 67 per cent of teachers, and 38 to 46 per cent of parents/caregivers allocated strongly agree scores to questions about the school providing parenting education and support (scores of 6-7).

An alternative perspective about the provision of parenting information is provided by information contained in the KMI Project Officer questionnaires. From Figure 23 it can be seen that the provision of parenting tip-sheets, newsletters and KMI information was recorded by KMI Project Officers to have occurred in most schools across the duration of the KMI. Although the level of provision of the various sources of information was not uniform across time, there is evidence of consistent provision of information through newsletters in both Round 1 and Round 2 schools across the period of the Pilot Phase, with a somewhat lower use of KidsMatter information sheets in a majority of schools.

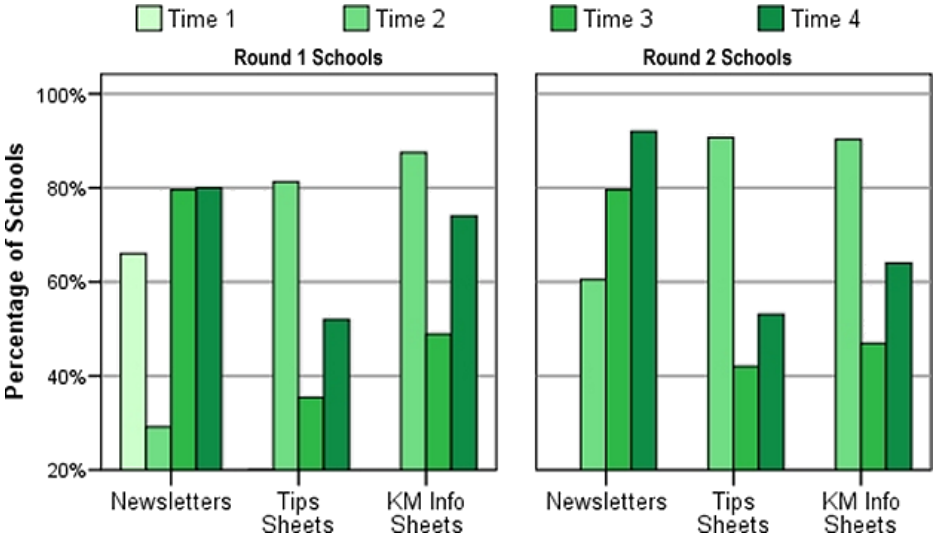


Figure 23. KMI Project Officer reports about the provision of parenting information in Round 1 and Round 2 Schools

10.2.5 Component 4: Early intervention and support for students experiencing social, emotional and behavioural difficulties

Teachers were asked 14 questions, and parents/caregivers were asked 12 questions, about provisions that their school makes for early intervention and support for students who might be considered to be at risk of social, emotional or behavioural difficulties. Sample questions included, *The school acts quickly if a child has emotional (eg. sad, depressed or anxious) or social or behaviour difficulties,* and *School staff are respectful and sensitive towards people experiencing emotional or social or behaviour difficulties.* The findings related to this final component are shown in the C4 row in Table 20 and are represented in Figure 24.

The mean ratings for both teachers and parents/caregivers are at a moderate level throughout the Pilot Phase. Parent/caregiver ratings remain at similar levels throughout, with very similar patterns of ratings for Round 1 and Round 2 schools.

The ratings of teachers show more positive rates of increase across the Pilot Phase, the slope for the Round 1 schools being slightly steeper than for the Round 2 schools. The effect sizes suggest that these changes in slope are of practical significance. The pattern of teacher ratings suggests that the Early Intervention component was seen as more prominent as the Pilot Phase progressed.

This is consistent with data collected from the Stakeholder study, which indicated that schools prioritised their abilities to work with each of the four components, and that component 4: Early Intervention, appears to be, in many situations, the last component to receive focussed attention. Given that Round 2 schools engaged with the KMI for one year, many Round 2 schools, and even some of the Round 1 schools, did not progress to giving focussed attention to Component 4.

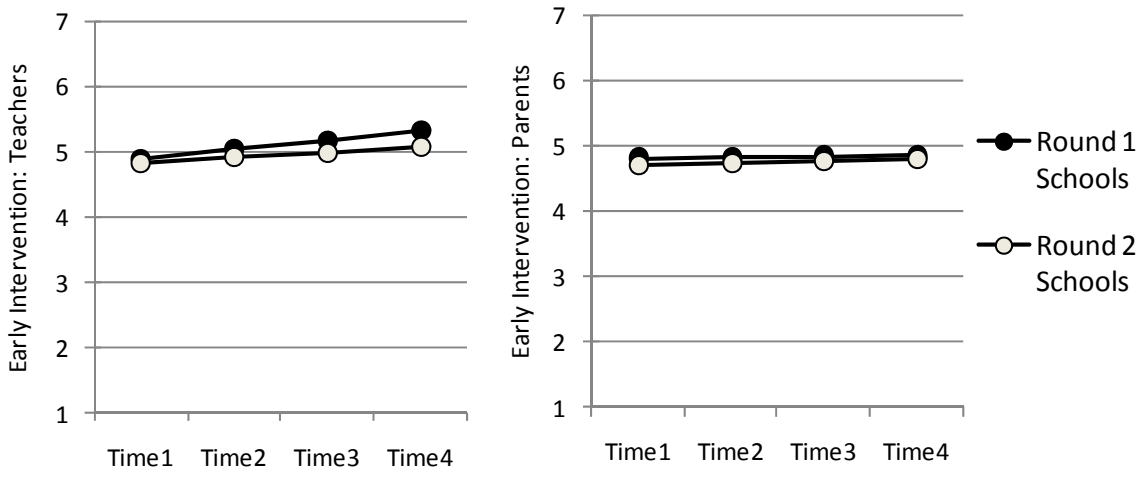


Figure 24. Early intervention and support for students at risk

At data collection Time 4, 35 per cent (Round 1) and 33 per cent (Round 2) of parents/caregivers, and 50 per cent (Round 1) and 45 per cent (Round 2) of parents/caregivers selected scores 6 or score 7 (strongly agree) overall to questions relating to early intervention and support for students experiencing difficulties

10.3 Links with external agencies

One of the focal points of the fourth component was concerned with the use by schools of appropriate external agencies who could provide assistance with students experiencing social, behavioural or emotional difficulties. On the last three data collection occasions, Project Officers were asked to provide information related to whether KidsMatter resulted in improved links with external agencies.

In their responses the Project Officers could select from Not at all (score 1) to Highly improved (score 7) in response to the statement: *To what extent do you agree that KidsMatter has resulted in improved links with external agencies that support children experiencing mental health difficulties and their parents and carers*. Figure 25 shows that the median score for reports about Round 1 Schools began at the neutral point and remained neutral over the duration of KidsMatter. However, while at Time 2, Project Officers felt that 13 per cent of Round 1 schools had improved or highly improved on this item (scored 6 or 7), this figure had increased to 26 per cent at Time 4.

In comparison, Round 2 schools began at a much lower point and showed a clear increase, but still with an overall median of neutral at Time 4. However, for the Round 2 schools, Project Officers reported high improvement with 27 per cent at Time 4, a level very close to that reported for the Round 1 schools.

Project Officers reported approximately the same percentage (mid 20%) of “high improvement” (scores 6 & 7) for links with external agencies in Round 1 and Round 2 schools by the end of the Initiative, reflecting the trend in this project of Round 2 schools catching up to Round 1 schools, with explanations such as readiness and developed experience of their support systems (e.g. the Project Officers themselves).

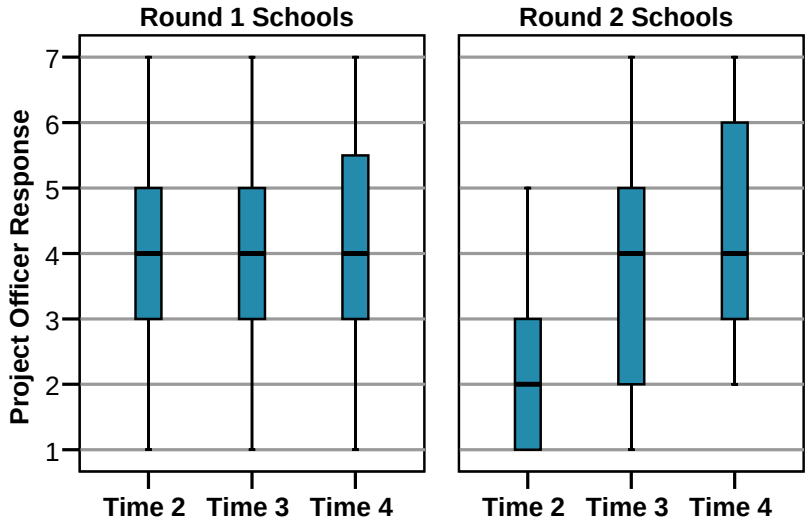


Figure 25. Project Officer responses: *Has KidsMatter resulted in improved links with external agencies?*

Included in the Project Officer questionnaires were questions that sought specific information about referrals, such as:

> *How many external referrals have been made for students experiencing social or emotional or behavioural problems?*
>
> *How much time, on average, has been taken to access these referrals?*

Figure 26 suggests that R1 schools were more often taking longer to access these referrals, but that Round 2 schools improved in the time taken. In both schools it suggests, in a general sense, that some referrals were quick and some were not, as expected. Figure 26 indicates that there does not seem to be any clear trend about the change in the number of referrals over time although there may have been an increase in both Round 1 and Round 2 schools as the impact of KidsMatter was beginning to be felt, perhaps with this impact flowing through to teacher awareness of student mental health issues. (Note that Time 1 data for Round 2 Schools was not collected).

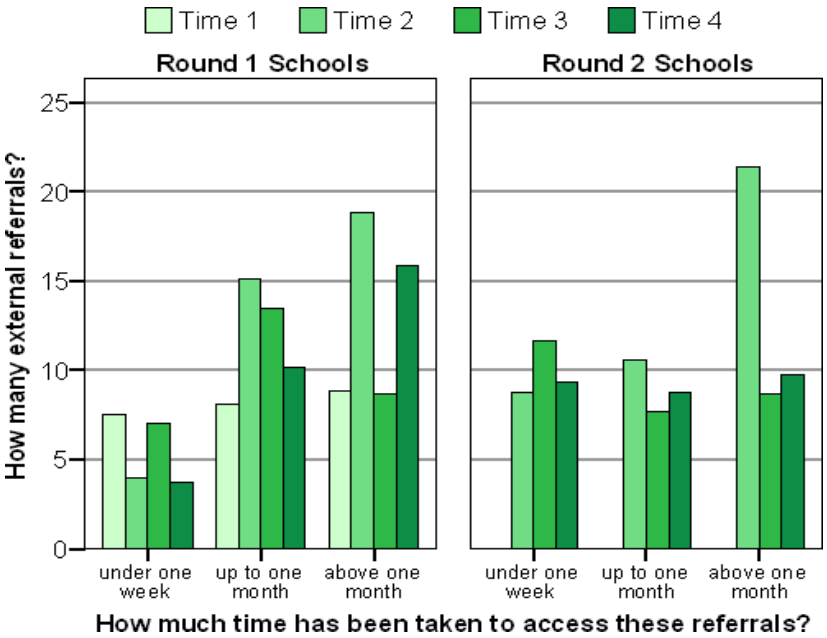


Figure 26. Project Officer responses to the number of referrals and the time taken to access them

10.4 Chapter Summary

With respect to engagement of schools with general initiatives in mental health, there is evidence of a small positive change on this indicator in the ratings of teachers. Although the parent/caregiver ratings on this indicator were at a similarly high level through the Pilot Phase they did not show evidence of change.

The results of analysis of change for the ratings on Component 1, Positive School Community, remained high and stable throughout the Pilot Phase. For each of the remaining three components, teaching of SEL, Parent Support and Early Intervention, the ratings of teachers showed evidence of positive change across time. In each case, the effect sizes for change were substantial.

The pattern of parent/caregiver ratings was more mixed. Parent/caregiver ratings showed a positive increase for Parenting Education and Support from the school, but not for Parenting Education and Support from Staff, and there was no change in the level of parent/caregiver ratings on Early Intervention for students experiencing emotional, social or behavioural difficulties.

The reports from the Project Officers on referrals to external agencies did not show strong evidence of consistent change in the Round 1 schools, either in terms of the level of referrals or in the time taken to access these referrals. Although there was an increase in the number of referrals in the second year of the Pilot Phase in Round 2 schools, the time taken to access referrals remained quite long for both sets of schools. It must be recognised that this access time was strongly influenced by matters beyond the control of the schools.

Chapter 11.
Change in Risk and Protective Factors Associated with Teacher, Family and Child Competencies

> "the parents that are involved here come to me, or come to other committee members, and tell them how this program has assisted their understanding of their child." *Principal* (School 6)

11.1 Changes in teacher knowledge, competence and confidence with mental health initiatives

We incorporated items in the teacher questionnaires about teachers' knowledge, competence and confidence in the area of providing positive mental health initiatives for students. Whereas the initial KMI model proposed the School, the Family and the psychological world of the Child as the three mediators to child mental health, teachers' knowledge, competence and confidence emerges as a potential fourth mediator for student mental health outcomes. This influence is consistent with findings in the educational literature of the influence of teachers on student learning outcomes in general, for the importance of positive teacher/student relationships, and for (under-researched) interactions between relationships, mental health and achievement (Roeser et al., 1998).

Teachers were asked 23 questions about their attitudes, knowledge, competence and confidence (self-efficacy) towards teaching social and emotional competencies. Teacher attitude was assessed with questions such as, *Students can be taught social and emotional skills*. Staff approach to teaching social and emotional skills was assessed with questions such as, *Staff help students develop skills for establishing healthy relationships with other children*. The cluster of questions for teacher knowledge about teaching social and emotional learning included items such as, *I know how to help students to develop skills to establish healthy relationships with other children*, whilst questions about teacher actions included, *My teaching programs and resources help students to develop skills to make responsible decisions.* Finally, the teacher efficacy items included three questions about efficacy for the KidsMatter components, such as, *I can help people to develop a sense of belonging within the school community*.

The results of the analyses of changes across time in the teachers' ratings on these scales are shown in Table 23. For all scales except Teacher Attitude there is evidence of positive change across the period of the KMI. The mean level of ratings on Staff Attitudes were already very high in both Round 1 and Round 2 schools, with mean scores above six. These ratings remained stable across time, and did not show evidence of significant change.

For Staff Approaches, which also showed quite high mean levels at Time 1 in both Round 1 and Round 2 schools, there was positive change over time with small effect sizes (r = 0.17 and r =

0.13 respectively). The pattern for Teachers' Knowledge and Teachers' Actions showed similar patterns of positive increases, with medium effect sizes in Round 1 schools (r = 0.29 and r = 0.26) and small effect sizes in Round 2 schools (r = 0.13 and r = 0.19). Finally, teachers' self-efficacy showed a positive change, with small effect sizes (r = 0.23 and r=0.10).

Table 23. Teacher knowledge, competence and confidence

Variable Names		Total	Round 1 Schools					Round 2 Schools				
Teacher Risk and Protective Factors		N	Time 1 Mean	Time 4 Mean	p[b] sig.	r correlation	Effect[c] Size	Time 1 Mean	Time 4 Mean	p[b] sig.	r correlation	Effect[c] Size
SEL Attitude	(T)	3,049	6.24	6.35	0.051	0.08	trivial	6.25	6.30	0.480	0.03	trivial
SEL Staff Approach	(T)	3,061	5.75	6.01	**0.000**	0.17	small	5.64	5.85	**0.005**	0.13	small
SEL Knowledge	(T)	3,059	5.41	5.84	**0.000**	0.29	medium	5.39	5.62	**0.005**	0.13	small
SEL Actions	(T)	3,055	5.47	5.86	**0.000**	0.26	medium	5.33	5.64	**0.000**	0.19	small
Self-Efficacy	(T)	3,058	5.18	5.55	**0.000**	0.23	small	5.20	5.38	0.013	0.10	small

[a] Parent/Caregiver (P); Teacher (T). [b] Significant levels (p<0.01) of slope are shown in bold.
[c] Interpretation of the correlation coefficient, r, as an effect size, according to Kirk (1996).

The presence of the small to medium effect sizes among this cluster of indicators, points to a positive change in this teacher protective factor.

At Time 4 data collection, a high percentages of teachers (69% and above) nominated scores 6 and 7 (strongly agree) to the questions in these groups of items. The percentages for self-efficacy were slightly lower, nevertheless, more than 50 per cent of teachers self-rated highly on self-efficacy for working with mental health initiatives.

11.2 Changes in parent/caregiver knowledge, competence and confidence in supporting the mental health needs of their children

We asked parents/caregivers eight questions directed at parenting knowledge and approach. For example, *I know how to calm my child if he/she is angry or upset* was directed at parenting knowledge, and *I am affectionate with my child* was directed at parenting approach.

From Table 24 it can be seen that parents/caregivers responded positively to these sets of questions with relatively high mean scores at both Time 1 and Time 4. These results indicate that, on average, parents/caregivers hold strong efficacy about their parenting knowledge and approach. Indeed, for parenting knowledge, 76 per cent (Round 1) and 74 per cent (Round 2) of parents/caregivers selected strongly agree (scores 6 & 7) about their positive parenting knowledge, and 91 per cent (Round 1) and 90 per cent (Round 2) of parents/caregivers selected scores six and seven for positive parenting approach.

Table 24. Parenting knowledge and approach

Variable Names		Total	Round 1 Schools					Round 2 Schools				
Family Risk and Protective Factors		N	Time 1 Mean	Time 4 Mean	p[b] sig.	r correlation	Effect[c] Size	Time 1 Mean	Time 4 Mean	p[b] sig.	r correlation	Effect[c] Size
Parenting Knowledge	(P)	9,611	5.83	5.83	0.361	0.00	trivial	5.76	5.81	0.152	0.05	trivial
Parenting Approach	(P)	9,657	6.40	6.31	**0.002**	-0.09	trivial	6.37	6.36	0.571	-0.02	trivial

[a] Parent/Caregiver (P); Teacher (T). [b] Significant levels (p<0.01) of slope are shown in bold.
[c] Interpretation of the correlation coefficient, r, as an effect size, according to Kirk (1996).

The analysis of change across time in these ratings for Parenting Knowledge and Parenting Approach did not show evidence of positive change. Effect sizes for change on these scales were trivial.

11.3 Changes in student social and emotional competencies

Parents/caregivers and teachers were asked seven questions about students' social and emotional competencies. The competencies that were the focus of these questions were sourced from the five areas suggested by CASEL (2006) and included questions such as, *On average over the last month, this student has shown that he/she can solve personal and social problems.*

Table 25 presents the result of the analysis of change across time for the ratings of teachers and parents/caregivers on this scale. As was common for other scales, the mean levels of both teacher and parent/caregiver ratings were quite strongly positive at Time 1. The multilevel modelling analysis indicated that there was evidence of positive change in the ratings of both parents/caregivers and teachers for the Round 1 schools, with small effect sizes (r = 0.13; r = 0.16). In Round 2 schools, although a similar pattern of change was present in the parent/caregivers' ratings (r = 0.16), there was a trivial effect in teachers' ratings.

Table 25. Child social and emotional competencies

Variable Names	Total	Round 1 Schools					Round 2 Schools				
Child Risk and Protective Factors	N	Time 1 Mean	Time 4 Mean	p[b] sig.	r correlation	Effect[c] Size	Time 1 Mean	Time 4 Mean	p[b] sig.	r correlation	Effect[c] Size
Social and Emotional Competencies (T)	3,035	5.22	5.50	**0.000**	0.16	small	5.24	5.40	**0.007**	0.09	trivial
Social and Emotional Competencies (P)	9,470	5.47	5.61	**0.000**	0.13	small	5.39	5.56	**0.000**	0.16	small

[a] Parent/Caregiver (P); Teacher (T). [b] Significant levels ($p<0.01$) of slope are shown in bold.
[c] Interpretation of the correlation coefficient, r, as an effect size, according to Kirk (1996).

At Time 4 data collection, in Round 1 schools, 64 per cent of parents/caregivers and 60 per cent of parents/caregivers selected scores 6 or 7 (Strongly agree), and in Round 2 schools, 63 per cent of parents/caregivers and 56 per cent of teachers selected scores 6 or 7 when rating students' social and emotional competencies.

11.4 Chapter Summary

The analysis of change in the ratings by teachers and parents/caregivers on this group of indicators showed a mixed pattern of effects. The ratings by teachers of their knowledge, competence and confidence that were relevant to their teaching about mental health did show evidence of positive change. This effect was consistent for Round 1 schools and evident for Round 2 schools on each scale except for Teacher Efficacy. However, there was not evidence of change in the ratings on the Teacher Attitude scale. With regard to the protective factor of student competencies related to Social and Emotional Learning, parents/caregivers' ratings showed positive change across time for both sets of schools. For teachers, such change was evident only in ratings for Round 1 schools. The major divergence from the above pattern of results was for the scales related to Parenting Knowledge and Approach, on which there was no evidence of change in level of ratings across time.

Chapter 12.
Perceptions of the Impact of KidsMatter on Students' Schoolwork

> "if children aren't socially and emotionally together, their learning is going to be disjointed. We just feel if you're going to put the cart before the horse, you're going to have a no-win situation. We found that happy kids, and contented kids and kids who know how to interact better with one another, are much better learners. So we see things going together very much hand in glove." *Principal* (School 5)

Teachers reported consistent and strongly-felt attitudes towards the importance of teaching social and emotional skills to students, with 90 per cent of teachers across all schools strongly agreeing (scoring 6 or 7), that students who are socially and emotionally competent learn more at school. This response from teachers is consistent with findings in the research literature, as reported by Roeser, Eccles and Strobel (1998), who strongly argued that academic and emotional difficulties are reciprocally related over the course of a child's development. For example, Roeser et al. reported that early problems such as grade retention, declining academic performance and poor motivation for academic learning, predict the later emergence of social and emotional difficulties such as drug abuse, delinquency, teenage pregnancy and failure to complete secondary school. Reciprocally, emotional difficulties can interfere with children's abilities to engage with learning. Figure 27 shows the high level of responses from teachers in KidsMatter schools regarding their beliefs about the links between learning and social and emotional competencies, in response to the statement, *Students who are socially and emotionally competent learn more at school*.

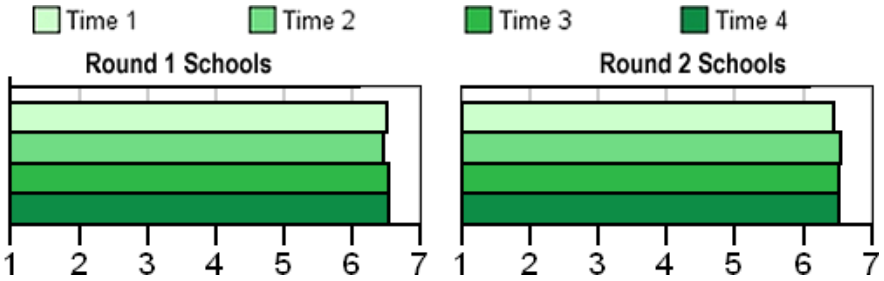


Figure 27. Teacher beliefs about, Stu*dents who are socially and emotionally competent learn more at school,* over the four occasions (1=Strongly disagree, 7=Strongly agree)

Not only did staff believe that it was important: to teach social and emotional skills to students; that students can be taught those skills; and that students who operate more competently and effectively socially and emotionally learn more at school, but principals and staff considered the connections between academic outcomes and social and emotional difficulties:

> "I think there's an extra focus. So some children I think, that may be having difficulty with learning are now being looked at from the perspective of 'OK is that because of mental health issues *as well as* learning difficulties?' " *Principal* (School 6)

Also, classroom readiness was an issue for some principals:

> "We can't attend to the learning of our kids if we don't have the right social emotional balance with our kids in the classroom. That's probably something we've seen a huge change in. Last year, and prior to that, we had huge numbers of kids who would come to school, just not ready to be in a classroom, and we're not getting that now" *Principal* (School 7).

The link with Literacy and Numeracy (LAN) results was also articulated:

> "[Interviewer: Do you think KidsMatter has a role to play in terms of LAN results?] Principal: " I believe that happy, healthy schools get good results…and that's about the combination…methodology, pedagogy...all wrapped together…" *Principal* (School 8)

The sense that the KMI had an impact over time in relation to teachers' beliefs about the links between social and emotional competencies and student learning is evidenced in the following principals' comments:

> "now we have discussions quite often based on mental health, rather than based on a child struggling in a learning area because of learning difficulties." *Principal* (School 6)

> "I think our teachers have come to accept that if they go back a step and look at their relationship with the kids and the kids are wanting to do for them and they understand and respect each other, then your classroom environment is a much better one in terms of learning. The kids are often much more willing and ready to learn as a result of being comfortable in the class … So yeah, I think it's made a big difference" *Principal* (School 5)

12.1 Change in perceptions of student work

Hierarchical Linear Modeling was employed to investigate teachers' and parent/caregivers' perceptions of the impact of KMI on change in students' learning over time, as reported in response to the statement: *KidsMatter has led to improvements in my child's (this student's) school work.* The results, shown in Figure 28, suggest the following:

- Below the neutral score of four on the 7-point scale (only a section is shown), which corresponds to disagreeing to the statement, at Time 1, parents/caregivers and teachers disagreed that the KMI had improved student work. This result was expected, given that students had not been exposed to the KMI.
- In Round 1 schools there was no significant change (effect size was trivial) in parents/caregivers' ratings that the KMI had improved their child's school work. However, in Round 2 schools parents/caregivers ratings showed evidence of positive change (small effect size).
- In Round 1 schools teachers held similar views to parents/caregivers at Time 1 (both starting at the same score) and showed positive change by Time 4 (effect size was small/medium).
- The lower Time 1 starting score in Round 2 schools reflects their later KidsMatter starting date 2008.
- Responses from parents/caregivers (small effect size) and teachers (medium effect size) in Round 2 schools, showed positive change over time in respondents perceptions about the impact of KidsMatter on students' school work.

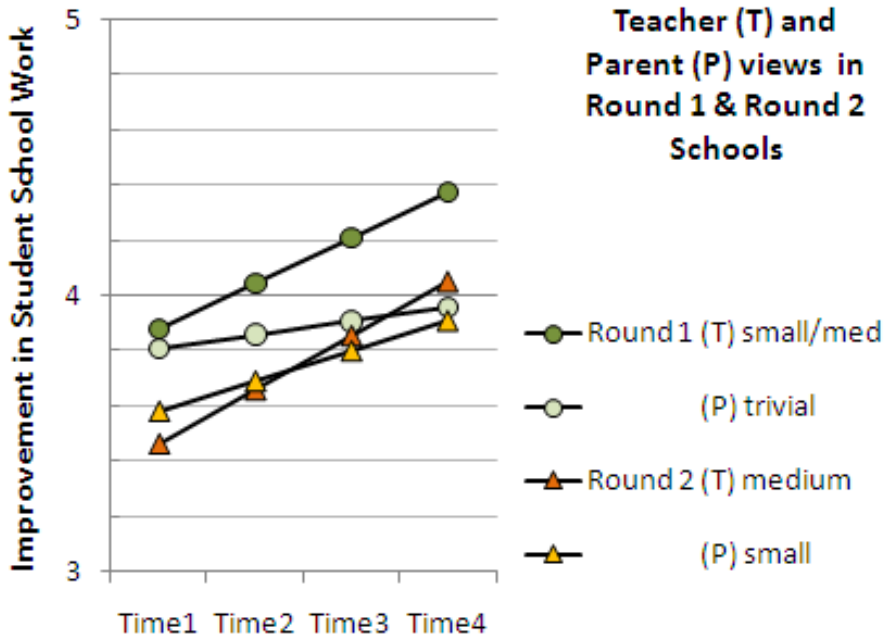


Figure 28. Change over time in teacher and parent/caregiver beliefs about the impact of KMI on students' learning outcomes

To illustrate how one school responded to the issue of mental health and student learning the following practical strategy was described by a principal:

> "the X room was really set up for those kids that would arrive at school un-medicated, huge fights, mum's still in bed, hasn't had breakfast …all those sorts of things ..And couldn't be in the classroom, couldn't engage in learning, so how can we attend to them? The X room really started to exist because of that. But now we're lucky if we get, we might get 2 a week that come in. A big part of that is the work that's done in classrooms. A big part of that is the community feel within the classroom – the culture that's developed within that classroom. A big part of that is the KidsMatter work. The kids are developing their self-esteem. They're feeling confident" *Principal* (School 7)

Clearly, the use of a dedicated space for students initially provided somewhere for students to go if they were unable, or not ready, to be in class. The decline in usage of such spaces was deemed to be related to the positive changes which occurred in the classrooms, and extended to the community, around social and emotional learning. The anticipated outcome was improvement in engagement with learning.

12.2 Chapter Summary

The findings suggested that over time teachers and parents/caregivers perceived that the KMI had a positive impact on students' schoolwork. Teachers recognised, throughout the initiative, that there are strong links between students' social and emotional capabilities and their learning capabilities. The impact of student mental health on factors such as school retention and academic achievement amongst students is well documented in the international research literature.

Chapter 13.
Changes in Student Mental Health

> It's been *weeks*, which is *weeks*, which is fantastic, since the 2 hottest boys have blown up. One was running away regularly from school and the other one was throwing stuff regularly in his classroom … Their mental health is improving. It is. The lower incidence of swearing at the teacher and throwing things at the teacher and running away from school. It's been weeks since it's happened and it was happening *all* the time. … I regularly run into them and they are, they're brighter, they're happier - they are more open to conversation. They see me coming and give me a big cheery wave. I know that their teachers are seeing differences in their behaviour and in their demeanours as well. So it does take time. This is not an overnight thing, this is been all year. We're in term 3 and these boys have been a hell of a job this year and we're just getting there now and if we continue along this same path I can just see by the time they get to year 6 that they are going to be so much more mentally stable and healthy. *Teacher* (School 9)

In this chapter, the question of changes to student mental health over the period of the KidsMatter Initiative is examined in detail. In reporting first on implementation and impact in this report, it is assumed that the changes in student mental health arose from the associated changes to schools, teachers, parents/caregivers and children.

The primary aim of the KidsMatter Initiative was to improve the mental health and well-being of primary school students and reduce mental health difficulties among these students. In the evaluation, therefore, the principal outcome measures pertained to student mental health. As set out in Chapter Chapter 3, the evaluation used three scales to measure student mental health. Each one was based on teacher and parent/caregiver reports. First, we administered Goodman's (2005) Strengths and Difficulties Questionnaire (SDQ) (parent/caregiver or teacher informant versions) for the targeted students' parents/caregivers and teachers to complete. The SDQ contains questions about students' strengths and difficulties. However, in accordance with Goodman's instructions about scoring the SDQ, only the questions about difficulties were summed to give a total difficulties score (i.e. the pro-social "strengths" items in the SDQ were omitted from calculations of the SDQ score). Low scores on the SDQ 40 point scale indicate low mental health difficulties. Included in the SDQ score are ratings of hyperactivity, conduct problems, emotional symptoms and peer problems.

The second student mental health scale was designed for the Evaluation to measure mental health difficulties, with three items about poor behavior, anxiety and depression. For example, *On average over the last month, my child is often sad or depressed.* The third student mental health scale was designed for the Evaluation to measure mental health strengths, with three items about optimism and coping skills. For example, *On average over the last month, this student has shown that he/she is able to cope with life overall.*

To examine and report on changes in student mental health we use three strategies. The first strategy is to follow the procedure for the other scales in the evaluation and examine changes in

the means for all students over the four time periods and calculate the effect sizes for those changes for teacher- and parent-reports in Round 1 and Round 2 schools.

13.1 Change over time in student mental health

The results for mean change over time are presented in Table 26. It can be seen in Table 26 that there was a positive change for each of the measures over the course of the evaluation. The effect sizes for these changes were trivial to small.

An examination of the data showed that on average, parents/caregivers and teachers provided ratings indicating low scores on mental health difficulties and relatively high scores for mental health strengths. It can be seen in Table 26 that the mean ratings for mental health difficulties were below the neutral point (of 4) and for the mental health strengths the mean ratings were above the neutral point. Also in Table 26 it can be seen that the mean SDQ difficulties score for students on the 40 point scale revealed a low mean level of mental health difficulties.

Results showed that at Time 4 data collection, in Round 1 schools, 71 per cent of parents/caregivers and 62 per cent of teachers selected scores 6 or 7 (strongly agree), and in Round 2 schools, 68 per cent of parents/caregivers and 58 per cent of teachers selected ratings of 6 or 7 for the mental health strengths of students. Overall, low scores (ratings of one and two) for student mental health difficulties were selected by both parents/caregivers and teachers (2% to 4%).

Table 26. Mental health strengths and difficulties

Variable Names		Total	Round 1 Schools					Round 2 Schools				
		N	Time 1 Mean	Time 4 Mean	*p*[b] sig.	*r* correlation	Effect[c] Size	Time 1 Mean	Time 4 Mean	*p*[b] sig.	*r* correlation	Effect[c] Size
Student Mental Health Outcomes												
Mental Health Difficulties	(T)	3,032	2.33	2.22	0.057	0.05	trivial	2.41	2.32	0.046	0.04	trivial
Mental Health Difficulties	(P)	9,500	2.69	2.53	**0.001**	0.09	trivial	2.71	2.55	**0.003**	0.09	trivial
Mental Health Strengths	(T)	3,025	5.35	5.56	**0.001**	0.11	small	5.39	5.48	0.152	0.04	trivial
Mental Health Strengths	(P)	9,427	5.55	5.72	**0.000**	0.14	small	5.47	5.65	**0.000**	0.14	small
Total SDQ	(T)	3,039	7.53	6.51	**0.000**	0.12	small	7.59	6.98	**0.007**	0.07	trivial
Total SDQ	(P)	9,434	8.90	8.29	**0.000**	0.11	small	9.57	8.43	**0.000**	0.21	small

[a] Parent/Caregiver (P); Teacher (T). [b] Significant levels ($p<0.01$) of slope are shown in bold.
[c] Interpretation of the correlation coefficient, *r*, as an effect size, according to Kirk (1996).

The results in Table 26 show that at a general level, in terms of the mean score for all students, there was evidence of positive changes in student mental health. This occurred in terms of both a reduction in mental health difficulties and an increase in mental health strengths. Some of the effect sizes were classified as small and are therefore of practical significance.

Following this evidence of some general changes in student mental health it is important to examine how the KMI affected particular groups of students. One reason is that it would be expected that the KMI should have limited impact on students within the normal range of the SDQ (having low levels of existing mental health difficulties). On the other hand, for example, it would be expected that the KMI should have more impact on students with abnormal levels of mental health difficulties. In short, the changes in mean scores need to be further examined to determine whether change was differentially evident according to the existing level of mental health difficulties.

13.2 Abnormal, borderline and normal student mental health status

The second and third strategies to examine changes in student mental health involved the classification of students into the three groups that are recommended for use with the SDQ: namely, students are classified, according to pre-determined cut-off points, as belonging to 'normal', 'borderline', or 'abnormal' categories of Mental Health difficulties. Students in the normal group had few mental health difficulties and score high on mental health strengths, with the reverse for students in the abnormal group. The borderline group is intermediate in terms of difficulties and strengths. The classification of students into these three groups was undertaken using combined reports from parents/caregivers and teachers to form a Composite Mental Health Status from the Child social and emotional competencies scale plus the three student mental health scales, namely, the SDQ, Mental Health Strengths, and Mental Health Difficulties. The classification procedure used Latent Class Analysis (MPlus). A full discussion of the analysis procedure is presented in the KidsMatter Technical Report.

13.3 Changes in the proportion of students with abnormal, borderline and normal mental health status

The classification of students in the groups of abnormal, borderline and normal mental health status allows for a further examination of changes in mental health. Our second strategy to examine change in student mental health involved the examination of the proportion of students in each of the three mental health status groups over the course of the evaluation. Because parent/caregiver data were not collected at Time 2, the analysis of proportions in each group was calculated for Time 1, Time 3 and Time 4. The results are presented in Figure 29 and Figure 30 for Round 1 and Round 2 schools, respectively. It can be seen that, in both Round 1 and Round 2 schools, the percentages of students classified as 'normal' mental health status showed an increase over time, whilst the percentages of students classified as 'borderline' mental health status declined. There appeared to be little change in the numbers of students classified the 'abnormal' mental health status group. These results suggest a tendency for some students to achieve a change in mental health status arising from the KMI, with about a 10 per cent change in the percentages of students in the borderline and normal mental health status groups over the two year period.

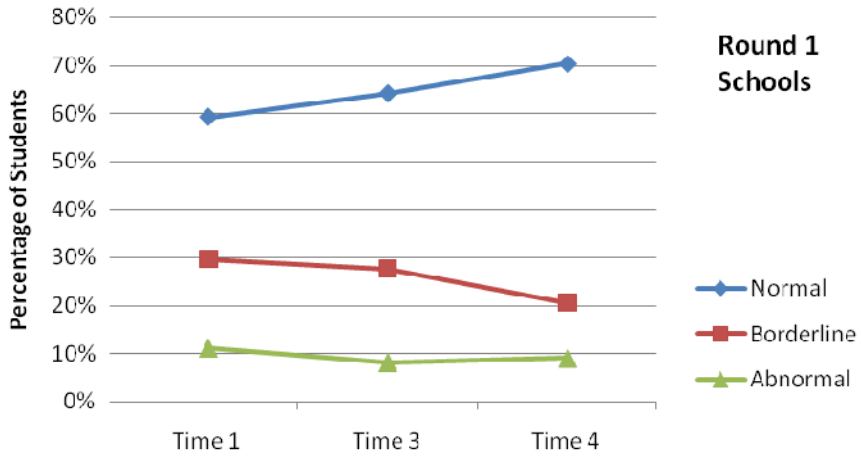


Figure 29. Changes in percentage of students' classified as normal, borderline, or abnormal mental health status over the two years of the KidsMatter Initiative in Round 1 schools

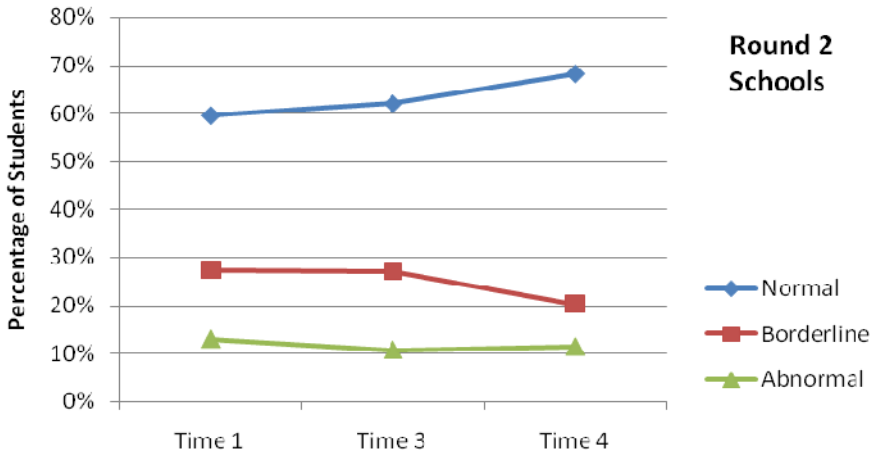


Figure 30. Changes in percentage of students' classified as normal, borderline, or abnormal mental health status over the two years of the KidsMatter Initiative in Round 2 schools

13.4 Change trajectories for students identified with abnormal, borderline and normal mental health status at Time 1

The final strategy used to investigate changes in student mental health focused on the change trajectories for students with abnormal, borderline and normal mental health status at Time 1. It seemed possible, for example, that while there was a consistent proportion of about 10 per cent of students in the abnormal mental health status group, that the mental health scores on the individual scales for these students could nevertheless improve, although this improvement might not have been large enough to change their overall status to 'borderline'. The final analysis, therefore, examined trajectories of change in mental health scores based on the students' existing mental health status at Time 1. As noted above, it was expected that more change over time would be evident in students within the abnormal and borderline status groups than in the normal group.

For the examination of change trajectories based on mental health status at Time 1, separate analyses were done for Round 1 and Round 2 schools, and for teacher and parent/caregiver ratings, and for three of the components of the composite student mental health index (the SDQ (Difficulties), Mental Health Difficulties and Mental Health Strengths). In addition to determining the change trajectories, effect sizes were also calculated in order to gauge the practical significance of any change. The results of these analyses are presented in Figure 31, Figure 32, and Figure 33.

Figure 31 presents teacher (dark) and parent/caregiver (light) ratings on the SDQ (difficulties) for the normal (lower cluster), borderline (middle cluster), and abnormal (upper cluster) status groups, along with the effect sizes in Round 1 and Round 2 schools. Figure 32 and Figure 33 respectively present teacher (dark) and parent (light) ratings of Mental Health Difficulties and Mental Health Strengths for the normal (lower cluster), borderline (middle cluster), and abnormal (upper cluster) status groups, along with the effect sizes in Round 1 and Round 2 schools. To interpret these figures, remember that for the SDQ (difficulties) and the Mental Health Difficulties scales, lower scores reflect better mental health. For the Mental Health Strengths scale, however, higher scores reflect better mental health.

Firstly, we can see that teachers consistently reported better mental health scores for students than did the students' parents/caregivers. Goodman (1997) recognised this in his analysis of

SDQ data, and compensated for it by recommending different cut points, according to respondent, for allocating students to normal, borderline or abnormal categories. We have also adopted these different cut points for grouping the SDQ (difficulties) data prior to conducting the Latent Class Analysis. The results in Figure 31 to Figure 33 show the positioning of the respective groups, with students in the normal group located at the low end, while students in the abnormal group are at the high end of the respective scales. Most importantly, these Figures present change over time in the students' scores, as represented by the slope of each line. The greater the slope the more significant is the change in student mental health. Accordingly, the following interpretations can be made:

- Students who were identified as being of 'normal' mental health status at the beginning of the KidsMatter Initiative showed trivial to small effect sizes for changes over time. On the SDQ(difficulties) scale, the changes were all trivial. However, for the teacher-reported measures of Mental Health Difficulties and Mental Health Strengths there were changes in a non-preferred direction in Round 2 schools that yielded small effect sizes. These changes suggest a small deterioration in mental health strengths and a small increase in mental health difficulties for the normal status group in Round 2 schools, where the KMI had been in operation for a shorter period of time. A possible explanation for these effects in the normal status group is the developmental changes arising from the transition of sample students from middle childhood to pre-adolescence during the period of the KMI.

- Students who were identified as being of 'borderline' mental health status at Time 1, were generally reported as improving in their mental health over the two years by two units on the SDQ (difficulties), equivalent to a small effect. This is equivalent to a 4 per cent reduction in social, emotional and behavioural difficulties on the SDQ.

- Students who were identified as being of 'abnormal' mental health status at Time 1, were generally reported as improving in their mental health, according to both parents/caregivers (medium effect size), and teachers (large effect size). This is equivalent to a 10 per cent reduction in social, emotional and behavioural difficulties together with an equivalent increase in mental health strengths.

- Regardless of the differences between teachers' and parent/caregivers' ratings, it appears that students with poorer mental health status were reported to have improved the most over the two years.

- For the Mental Health Difficulties scale and the Mental Health Strength scale, the effect sizes were greater for the teacher reports than for the parent/caregiver reports. It is difficult to interpret this finding, but one possibility is that the KMI had more impact on the indicators of student mental health that are evidenced in school contexts, compared to difficulties evidenced in home contexts.

- The results in Figure 31 to Figure 33 suggest that most of the changes to student mental health status occurred during the second year of the Initiative, with this pattern common to both Round 1 and Round 2 schools.

- The results suggest little difference in the size of the changes on the mental health scales according to whether the students were in Round 1 or Round 2 schools.

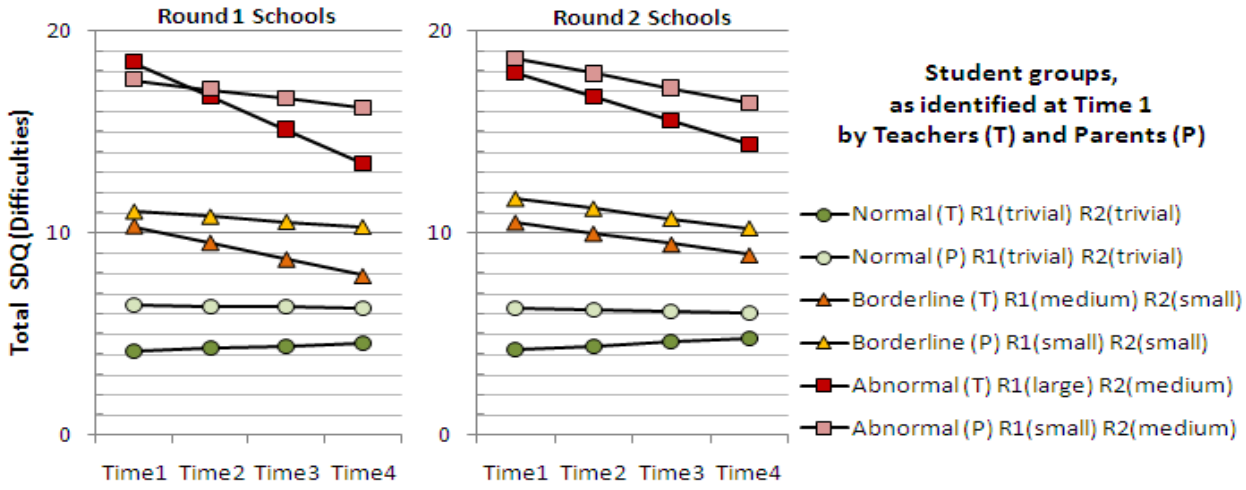


Figure 31. Change trajectories in student SDQ (Difficulties) scores in Round 1 and Round 2 schools for the three mental health status groups

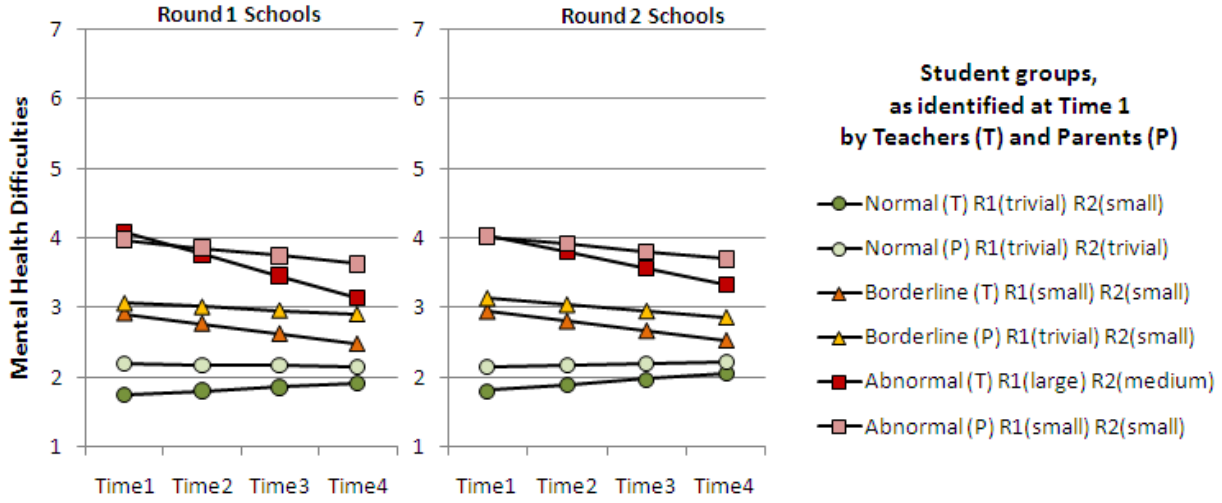


Figure 32. Change trajectories in student Mental Health Difficulties scores in Round 1 and Round 2 schools for the three mental health status groups

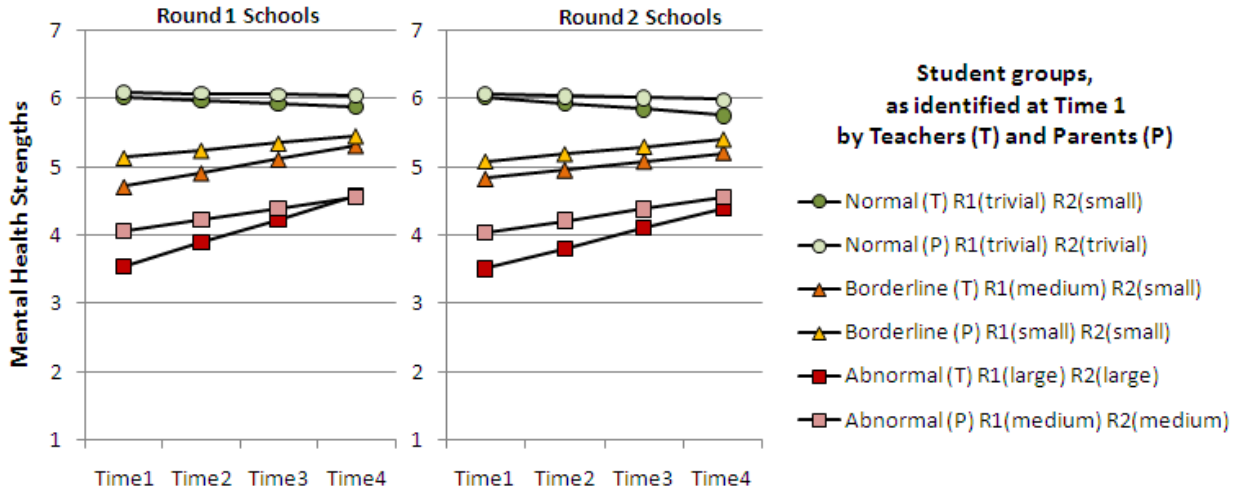


Figure 33. Change trajectories in student Mental Health Strengths scores in Round 1 and Round 2 schools for the three mental health status groups

- The pattern of results for Round 1 and Round 2 schools might suggest that Round 2 schools began to focus on student mental health in the year prior to formally joining the KidsMatter Initiative. Or, it could imply a greater efficiency and effectiveness when Round 2 schools fully participated in the Initiative in the second year.

Some examples from the Stakeholder and Student Voice Studies support the finding of improved mental health for some students::

A principal on a journey with a child:

> We had one mum who's been in a mental institution for the last couple of years. Her son two years ago was in hospital because he was suicidal (year 5). To see that boy now and see the journey that he is been on and go with him. … he couldn't talk to anyone about it … Once KidsMatter was on board and we were talking all the time about mental health, he began to see it in a different light. He responded personally… but he can talk to all the other kids and they all talk with respect about his situation, not putting him down. I think if we didn't have KidsMatter we wouldn't have had those sorts of results." *Principal* (School 5)

A parent acknowledging change in her son:

> "My son's had some intervention under KidsMatter last year. He was in a group dealing with emotions… it's helped his adjustment to high school … he was worrying about us dying and death – he learnt some strategies to deal with that … he still has some issues, but it did help him, yes. I think it made his adjustment to secondary school better." *Parent* (School 9)

13.5 Chapter Summary

With respect to the influence of the KMI on students' mental health, the findings of the evaluation indicated, on average, an improvement in student mental health and well-being and a decrease in mental health difficulties. These changes were evidenced by reduced SDQ (difficulties) scores, decreases on the mental health difficulties scale, and increases on the mental health strengths scale.

Using Hierarchical Linear Modelling, averaged across all students in the sample involved in the evaluation, changes in mental health showed trivial to small effect sizes, with more evidence of small effects in Round 1 schools. These changes were of practical significance and are worthy of attention given the broad nature of the KidsMatter Initiative.

To further examine the changes in student mental health, two further analyses were conducted. Latent Class Analysis was used to categorise students into the three mental health status groups of normal, abnormal and borderline (Goodman, 2005), based upon the composite student mental health status measure.

The first analysis showed that in both Round 1 and Round 2 schools the percentage of students classified into the normal mental health status group increased by the end of the pilot phase, whilst the percentages of students classified in the borderline mental health status group declined. There appeared to be little change in the percentage of students classified into the abnormal mental health status group.

The next analysis investigated changes in student mental health trajectories for students with abnormal, borderline and normal mental health status at Time 1. It seemed possible, for example, that while there was a consistent proportion of about 10 per cent of students in the abnormal mental health status group, that the mental health scores on the individual scales for these students could nevertheless improve, although this improvement might not have been large enough to change their overall status to 'borderline'. This trajectory analysis, therefore,

examined changes in mental health scores based on the students' existing mental health status at Time 1.

Using Hierarchical Linear Modelling, when changes across the Pilot Phase were examined, the analysis revealed small positive effect sizes for changes in the mental health status of the borderline group, and medium to large effect sizes for the abnormal group. Effect sizes for the normal mental health status group were mostly trivial, with two small negative effect sizes in Round 2 schools where the KMI had been in operation for a shorter period of time. A possible explanation for these effects in the normal group are the developmental changes arising from the transition of sample students from middle childhood to pre-adolescence during the period of the KMI.

The analyses support a conclusion that, using teacher and parent/caregiver reports, the KMI had an impact on measured student mental health and that this impact appeared greater for students with a mental health status of borderline and abnormal.

Throughout the report, evidence of changes to schools, teachers, parents/caregivers and children have been presented as a consequence of the KidsMatter Initiative. These changes arise from implementation of the whole package of the KMI and we have no basis for drawing conclusions about independent parts of the package. It is possible to conclude that the changes in mental health presented here are due to the Initiative and the consequent changes in schools, teachers, parents/caregivers and children.

Chapter 14.
A portrait

14.1 Characteristics of schools performing well in implementing the KidsMatter Initiative

The KidsMatter Initiative is a package. We talked to stakeholders about the ways in which they have used that package, and about the ways in which they recommended other schools would use it. In this section we distil key themes that emerged from those discussions and from our other findings about ways for making the package work effectively. The portrait demonstrates the importance of collaborative leadership that encourages collegial ownership and bottom-up staff involvement, as well as professional development, long term planning for sustainability, and a whole school commitment to the KidsMatter Initiative. It also emphasises the need for school and parent/caregiver partnerships which sanction parent/caregiver support of the school community. A strategic approach with a targeted, embedded programme across the school which focuses on identifying and intervening early with children at risk, is also highlighted. The portrait is not meant as a script or formula to be followed to achieve a "successful" implementation, but rather, it offers suggestions for schools that might use KidsMatter Initiative resources in the future.

14.2 Portrait of a successful KidsMatter Implementation

Kevin is a Year 5-6 teacher who spends some of his week-ends as an ambulance driver. Too often he has thought about how horrible it would be to be called out to a fatal incident involving one of his students. Unfortunately one day it happened and Kevin has since made it his life's mission to do whatever he could to minimise the likelihood that any of his students would ever face such mental anguish as to cause them injury or death.

When Kevin heard about KidsMatter he jumped at the chance to be involved. He spoke to his principal, Margaret, and got the OK to go ahead and make the application. Margaret at the time had given little thought to what that might mean for the school, privately thinking that the application would probably not be successful and that nothing would come of it.

Involvement of all levels of staff along with professional development

Late in 2006, after having learnt that their application had been successful, Margaret, Kevin and Larissa (the Year 3-4 teacher) travelled to Adelaide for a conference about the KidsMatter Initiative. Soon after their return, staff at the school met with their KidsMatter Project Officer (PO) to undertake professional training about mental health and the four components that comprised the KidsMatter model, namely a positive school community, social and emotional learning (SEL) for students, parenting support and education, and early intervention for students experiencing mental health difficulties.

At first, some of the staff were not enthused, saying that it was just something else that they had to do and they couldn't see the point of it, while other staff were keen to be involved. Larissa was particularly interested and she volunteered to be part of the Action Team as she had good knowledge about mental health due to a considerable amount of reading, research and personal experiences through having a daughter with a mental illness.

Collaborative leader encouraging collegial ownership and a whole school commitment

After the professional development day Margaret called a meeting of the Action Team, which now also comprised the school's wellbeing co-ordinator and the school counsellor. She had surrendered to the idea that the school would be involved and she had come to realise how important it was for the school community to participate in this new initiative. Having spoken to the PO and engaged with the KidsMatter literature, Margaret had come to see that the initiative was just affirming all that she had always known about children and how they should be treated at school. In the 25 years that she had been in education, Margaret's experiences had shown her that teachers cannot attend to the learning of their students if they do not have the right social emotional balance in the classroom. "Only when the children are feeling confident and when they've got a tummy full of breakfast and they're engaged, are they ready to get on with their literacy and numeracy", she reflected. Margaret also knew that it would flounder unless something like this was supported from the top down.

At that first meeting the team talked about a plan of action knowing that they now had all of the staff on board. It had not been difficult to get staff to agree to participate. Margaret had called a staff meeting shortly after the staff returned from an overnight team building retreat that occurred every year during Term 1. Staff generally felt more collegial and united after having spent some time away together participating in team building exercises and chatting casually over drinks, so it wasn't difficult to engage them in a discussion and then some collaborative decision making about taking on the KidsMatter Initiative. They had all agreed that no matter what they did, it would need to be consistent across the school and that time would need to be set aside for professional development and training for all the staff, including auxiliary staff.

School and Parent/caregiver partnership

The relationship between parents and caregivers and the school was relatively good and Margaret and the staff felt that KidsMatter was an ideal opportunity to strengthen that partnership. Three parents who were actively involved in the school and who were generally well known to other parents and caregivers, were asked if they would like to start a KidsMatter Parent Action Team and they were invited to participate with staff in the professional development. Jodie, a mother of two, who had experienced some depression following the birth of her youngest child, rose to the challenge.

A parents' room was made available for parents/caregivers to use one day a week and some of the Action Team members volunteered to make themselves available. Jodie set about rallying other parents and together they stocked the room with books, brochures, pamphlets and agency information on all child-raising and child development issues, ranging from bed wetting to handling teenage girls. KidsMatter posters were placed on the walls and a corner was set up as a play area for mums, dads and caregivers with pre-school children. A computer was made available for parental use so that parents could obtain further information from the internet. Jodie and her team were well aware that sometimes parent rooms could become places for gossip and took measures to avoid that happening. They agreed to stop any inappropriate discussions when they witnessed them, so that there would be a clear message to parents about the genuine purpose of the room.

The staff had agreed that they would work on the four components one at a time. One person from the Action Team spent some time talking at staff meetings about KidsMatter and collaborative decisions were made about the various tasks that would be undertaken by staff to achieve the aims of the initiative. The Action Team met weekly and selected aspects of the components that they felt were achievable. They were careful not to bite off more than they could chew.

A strategic approach with a targeted program embedded across the school

At the end of the first year staff had decided on a program that they would all implement as part of KidsMatter and that would address social and emotional learning. By that time they had come to realise that KidsMatter was not in fact an "add-on", but that embedding it into their working week was relatively easy because the program had a large English focus, especially oral language, so that it fitted easily with their teaching program. In addition, Margaret ensured that the KidsMatter program would be timetabled so that everyone in the school would spend at least one half hour at the same time each week on the program.

At the beginning of the second year the school put more of their plans into action. As staff implemented the KidsMatter program and they started to change the way they viewed children. Whereas they once would have automatically scolded a child for aggressive behaviour, they were now re-evaluating their actions and asking themselves whether something was going on with this child that they needed to be aware of and that would require a different, more empathic response. As the professional development continued through training sessions with the PO they began to gain a deeper understanding of the role that they could play in fostering positive mental health in their students. KidsMatter became embedded in everything they did during the school day, starting with saying good morning to children with a smile, to developing a trusting and safe classroom environment that facilitated respect and an openness to feelings, to being available to greet parents as students were leaving at the end of the day.

Parents/caregivers supporting the school community

The parents and caregivers made good use of the parents' room and they ensured that at least one parent was present in the room to assist any new and enquiring parents. They established a 2-page KidsMatter newsletter, containing information downloaded from the KidsMatter website, nutritious recipes and other useful parental information, that went out to parents on a regular basis, and they brain stormed ways they could encourage parents to come in and make use of the parents' room. They regularly liaised with the Action Team and shared ideas with staff, attended the professional development and rallied other parents to be involved in school community events.

A focus on identifying children at risk and intervening early

As the second year progressed the Action Team began meeting less regularly and they set up a case management team comprising of the Principal, key staff and the School Counsellor. The aim of this team was to identify children who required monitoring, support, referral and early intervention – kids who might be 'at risk'. This included children who were not only obviously troubled and in trouble, but the quiet ones too. This team met on a weekly basis to discuss the children's progress, as well as identify any new children that needed to be included.

Well into the second half of the second year the staff began to see changes in the children and their school community. The issuing of pink cards for inappropriate behaviour decreased dramatically and children began to self-regulate and control their emotions. Margaret sensed the positive impact of KidsMatter when one of the children who was considered 'at risk', shared with her his joy of getting angry, but not hitting anybody or smashing anything. Parental

attendance at school assemblies increased significantly, as parents came to witness their children in performances, sharing their work or receiving KidsMatter merit certificates.

Long term planning for sustainability

As the end of the year approached and the pilot study was drawing to a close, Margaret met with her executive to make plans for the next year. One thing was for sure, they intended to keep the KidsMatter Initiative going in their school and they carefully considered how they could sustain it in the future. They had all the resources, they thought, as well as the KidsMatter website, so all new teachers would be given some form of induction. During the last two years the Action Team had documented everything that they had done, so should any of them change schools the information would be available for the next teacher. Parents were also aware of changes to their team so they ensured that the information they carried was shared between them. The timetabling of the program was to continue and a clear place for KidsMatter was made in the school's goals.

The school's strategic planning would continue through the KidsMatter lens, with a continued focus on the four components. The only concern Margaret had was where she was going to find the support that had been provided by the KidsMatter Project Officer. This support had been so critical in up-skilling the staff and providing guidelines on how to achieve the aims of the KidsMatter model. It would still be required, Margaret thought, as they continued to embed the initiative in their school.

Chapter 15.
Methodological Notes and Limitations of the Evaluation

15.1 Nature of the intervention

The KMI Pilot Phase was not an experimental intervention. It was a naturalistic study that had strong ecological validity. The intervention involved the well-supported use by schools of evidence-based programs relevant to mental health needs of students in primary schools. Clear guidelines for use of KMI materials were agreed to by schools involved. Beyond this the Pilot Phase proceeded under the direction of the schools, using the regular support and guidance provided to each school by the KMI Project Officers. There was therefore variation in the quality of the implementation of the Initiative across the schools involved, as evidenced by the range of scores on the Implementation Index. However, there are three important strengths of the design. First, it was longitudinal and this, in a conceptual sense, provides increased confidence to interpretations that noted effects can be associated with the Initiative. Second, the design provided for staged implementation of the Initiative, with 50 schools beginning in 2007 and the remaining 50 schools in 2008. This provides both an element of delayed control and an element of replication. Third, the design has strong ecological validity in that it was based in the real life of schools and any positive impacts emerged from an intervention that varied across sites that were subject to a wide variety of competing influences.

15.2 Sampling

Schools were invited to apply for inclusion in the KMI trial and the schools involved in the Pilot Phase were selected to be involved. The final sample included in the evaluation is therefore not one that is representative of the Australian school population. This limitation is of relevance in making generalisations about the findings of the evaluation. The attained sample is, however, large and designed to provide a good representation of the Australian schools applying to be involved in the Pilot Phase.

It was found that selection probabilities for the KidsMatter participants varied greatly from unit to unit because of clustering and the over-sampling used to ensure that a representative range of students were included in the sample Moreover, because schools were directed to select replacement students for those parents/caregivers not wishing to participate in the evaluation, the problem of under-coverage arose causing further bias to estimates with respect to the population of interest. Due to this problem, coupled with self-selection for involvement, it was decided that to calculate and apply sampling weights, in order to maximise transferability of results, was not appropriate. Hence, caution should be taken if generalising findings to other students and other primary schools in Australia.

15.3 Instruments

Like all surveys, the questionnaires used in the evaluation have limitations as indicators of the constructs that are central to the conceptual basis of the KMI. In particular the Strengths and Difficulties Questionnaire (Goodman, 2005) has limitations in design. For this reason an alternative set of items related to mental health strengths and difficulties was included in the evaluation. It was not feasible for the Evaluation Team to personally administer questionnaires to the parents/caregivers and teachers of the selected 7600 students across Australia on four occasions. Accordingly, the administration of questionnaires to parents/caregivers and teachers was undertaken by school staff, and while every effort was made to provide training and clear instructions as to how best approach parents/caregivers and teachers and maximise returns, questionnaire delivery and receipt was ultimately out of the control of the Evaluation team.

15.4 Duration of the study

The KMI Pilot Phase ran for two years and was focussed, in particular, on the situations of students who might be at risk of mental health difficulties. Such difficulties are typically developed over reasonable lengths of time and have residual strength. The expectation that widespread change would be observed in such students is quite demanding. It is more realistic to expect that any changes for these students would be gradual rather than dramatic.

15.5 Participation and non-participation

An analysis of missing data was undertaken to establish any group differences so that the importance of replacing missing data could be established and decisions made about the treatment of missing data. Analysis of differences between groups of interest found that:

- *Population versus participated*: In the participant group there were fewer young students (as expected), more students identified 'at risk' (as expected), fewer male students, and fewer ATSI, than in the overall KidsMatter school population.
- *Selected versus participated*: In the participant group there were fewer male students, fewer 'at risk' students and fewer ATSI students than in the selected-but-did-not-participate group.
- *Non-participating parents/caregivers versus participating parents*: For the group of parents/caregivers that chose to participate there were fewer students nominated ‘at risk’ and fewer ATSI students.
- *Non-participating teachers versus participating teachers*: For the group of teachers that chose to participate there were fewer older students and fewer students with English as a second language (ESL).

Analysis suggests that respondents are not missing at random and missing values should be replaced to minimise potential bias. However, a conservative approach was taken and where possible, missing data was not replaced. Accordingly, this places a general caveat on the findings that they are not more broadly representative of male students, those identified as being ‘at risk,’ and those from ATSI or ESL backgrounds.

15.6 Common method variance

An issue common to many questionnaire studies, as used in the present evaluation, relates to common method variance. This occurred firstly through the use of questionnaires to report on

the main scales of measurement, and secondly, through the use of common informants (i.e. parent/caregivers and teachers). Note however, that the evaluation used multiple methods and multiple informants over the period of the Pilot Phase to address this issue. For example, in most cases more than one teacher reported on each student's mental health status (due to changes in class groups). The evaluation also collected data from Project Officers.

15.7 Scope of the analysis of change

The analysis of change undertaken in this report uses an analytical procedure known as multilevel modelling. This procedure has particular strengths in handling issues that arise from the nesting effects associated with school data. In keeping with the requirements of the evaluation, in this report the analyses focus on change observed at the individual student level. Analyses of influences on the nature of this student-level change, such as influences at the school level, have not been included.

Chapter 16.
Final Review and Recommendations

16.1 Final review

This section will be completed following final presentation to, and consultation with, the KidsMatter Evaluation Reference group.

16.2 Recommendations

16.2.1 The mental health needs of Australian children

1. Advocate for the continued development and implementation of school-based initiatives with a focus on the mental health needs of Australian children.
2. Facilitate longitudinal research to examine the nature and influence of risk and protective factors associated with student mental health in Australia.
3. Support applied research in schools to identify effective implementation strategies and conditions that enhance the effectiveness of mental health intervention initiatives in schools.
4. Recognise the importance of qualitative and quantitative data for monitoring and evaluating relationships between general mental health initiatives and changes in student mental health. This will strengthen the evidence base for future initiatives.
5. Continue to provide to all schools a framework to assist with understanding student mental health and the role of school sites in promoting positive mental health.
6. Further develop programs to encourage use of an appropriate professional vocabulary that can assist teachers, parents/caregivers and students to engage in productive conversations about mental health strengths as well as mental health difficulties.
7. Endorse a whole school approach to the implementation of initiatives, such as KidsMatter, while recognising the importance of targeted interventions for specific student groups within that whole school approach.
8. Promote a variety of types of ongoing professional development (including teacher education) to build teachers' knowledge and competence in relation to mental health strengths and difficulties, risk and protective factors for mental health difficulties, and links between positive mental health and academic achievement.
9. Support sustained interventions over the long-term in order to achieve changes in mental health risk and protective factors during the early school years.
10. Further investigate the development of critical leadership capabilities necessary for the implementation and effectiveness of mental health interventions such that all members of school communities are engaged.

11. Encourage the perception in schools and among the teaching profession that mental health is not an add-on component of schools' work but is inherent in the core purposes of schools. This should explicitly address:
    - Common misconceptions that social, emotional and behavioural difficulties act separately from engagement with academic learning.
    - The reciprocal relationship between positive mental health and academic learning.

16.2.2 The KidsMatter Initiative and its national roll out

Taking account of the evaluation findings and subject to the recommendations below, we recommend the maintenance of the broad aims and processes of the KidsMatter Initiative. Note that we have interpreted the effects of KidsMatter as a total package, and have no basis for drawing conclusions if parts of the package were to be delivered independently. This is consistent with systems theory and a settings approach to health promotion initiatives.

12. Recognise the need for funding and infrastructure support to resource the key elements of the KidsMatter Initiative, both in relation to schools and to external agencies.
13. Continue to examine the conceptual model upon which the KidsMatter Initiative is based. Further specify the elements of the risk and protective factors under the headings of School, Family and Child. In particular, the positioning of the broad concept of "School" as a risk or protective factor for mental health needs further clarification and elaboration.
14. Further clarify ways in which risk and protective factors are assumed to influence student mental health.
15. Examine the role of moderating or setting conditions in schools that enhance or impede the effectiveness of the intervention, but do not directly contribute to student mental health. Such conditions may include the extent to which there is a positive school community, and effective school leadership.
16. Provide schools with further assistance in making informed selections, using criteria detailed in the programs guide, from available programs for teaching about social, emotional and behavioural capabilities in particular, and for the other KidsMatter components.
17. Facilitate the re-examination of Component 3: Parenting education and support, in order to increase its effectiveness as part of the intervention.
    - Assist schools in the formation and implementation of strategies in this area.
    - Consider other processes, such as incorporating parent/caregiver participation in program design.
    - Conduct further research into effective models of delivery for education and support to parents/caregivers within mental health interventions.
18. Provide additional support for schools to develop effective and sustainable Professional Development and strategies in the area of Component 4: Early intervention for students who are at risk or are experiencing mental health difficulties.
19. Facilitate the building of stronger connections between external agencies and schools. This could include:
    - Investigating the difficulties schools experience in instigating and accessing referrals to external agencies.

- Seeking input from school leadership staff and external agencies about how to improve school-agency links.
- Auditing current referral processes to identify efficiencies and inefficiencies.
- Surveying referred families to identify their experiences and views on any shortcomings in referral processes.
- Considering the adequacy of current levels of funding to support effective referral processes.
- Calling upon the expertise of staff from external agencies in school-based initiatives.

20. Investigate the scope for innovative processes for delivering the KMI, such as incorporating student participation in curriculum design for mental health initiatives.
21. Attend to the differing manifestations of students' mental health in home and school settings, and the consequences of these setting-based differences for the design of the intervention.
22. Provide curriculum writing support to schools to develop new syllabi that integrate the regular curriculum with a social and emotional learning curriculum. Draw on the expertise of existing 'expert' teachers in the field of social and emotional capabilities learning to take leadership of curriculum writing and delivery.
23. Assist schools to find avenues for greater involvement of parents/caregivers in KidsMatter structures.
24. Consider further how KidsMatter can contribute to the development of mental health advocacy in school communities.
25. Review the effectiveness of the model of the seven-step implementation process in school contexts.
26. Review and evaluate how the delivery of mental health services in schools can be linked to currently existing programs e.g. the National safe schools framework, to avoid duplication.
27. Consider the scope and sequence across year levels of mental health curricula to meet students' developmental needs, to avoid duplication from year to year, and to support student transitions across year levels (especially into secondary school).
28. Establish a dedicated "sharing" website where teachers can download or upload ideas, strategies, examples, successful integrated teaching units/lessons etc around the KMI/mental health.

Chapter 17.
Publications

The evaluation team has prepared reports on aspects of the evaluation. The planning of these reports has been carried out in consultation with Dr Brian Graetz and other partners in the KidsMatter project. All of these papers focus only on baseline data and matters of psychometric and theoretical interest, and do not focus on the evaluation of the impact of the KidsMatter Initiative.

Askell-Williams H., Dix, K. L., Lawson. M. J., and Russell. A. (2008). *School characteristics, parenting and student mental health: Parent/caregivers reports from 100 Australian KidsMatter schools.* Paper presented at the World Education Forum Conference, Adelaide, June.

Askell-Williams H., Russell. A., Dix, K. L., Slee, P. T., Spears, B. A.., Lawson. M. J., Owens, L. D., & Gregory, K. (2008). Early challenges in evaluating the KidsMatter national mental health promotion initiative in Australian primary schools. *The International Journal of Mental Health Promotion, 10*, 35-44.

Dix, K. L., Askell-Williams H., Lawson. M. J. (2008). Different measures, different informants, same outcomes? Investigating multiple perspectives of primary school students' mental health. Paper presented at the Annual Conference of the Australian Association for Research in Education, Brisbane, December.

Gregory, K., Lawson, M.J., Russel, A. and Dix, K.L. (2008) Issues in measuring student mental health. Symposium: Evaluating whole school approaches to mental health promotion: transferring learning to practice. Paper presented at *From Margins to Mainstream: 5th World Conference on the Promotion of Mental Health and the Prevention of Mental and Behavioural Disorders*, 10-12 September, Melbourne. http://www.margins2mainstream.com/ppt-pdf/thu/Gregory_K_Thu_1030_H2.ppt.pdf

Slee, P., Lawson, M.J., Russell, A., Askell-Williams, H., Dix, K.L., Owens, L., Skryzpiec, G. and Spears, B. (2008) Mental Health promotion in primary schools: The KidsMatter evaluation from concept to data and beyond. Paper presented at the Learner *Wellbeing Conference 2008*, Flinders University, Adelaide. http://caef.flinders.edu.au/wellbeing_conf/

Spears, B.A. and Dix, K.L. (2008) KidsMatter Project Officers facilitating change in schools. Symposium: Evaluating whole school approaches to mental health promotion: transferring learning to practice. Paper presented at *From Margins to Mainstream: 5th World Conference on the Promotion of Mental Health and the Prevention of Mental and Behavioural Disorders*, 10-12 September, Melbourne. http://www.margins2mainstream.com/ppt-pdf/thu/Spears_B_Thu_1030_H2.ppt.pdf

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Appendix A: Summary Analysis

The KidsMatter Evaluation questionnaires involved parents/caregivers and teachers to respond (mostly on a 7-point Likert scale) to statements about various aspects of the KidsMatter Initiative. There were approximately 112 items in each of the parent/caregiver and teacher questionnaires. Those 112 items were divided into sub-groups, with each group of items dealing with different aspects of interest to the evaluation. For example, one group of items dealt with implementation, another group dealt with teachers' knowledge, and another group dealt with a positive school community, and so on. Items in each group were subjected to confirmatory factor analysis for asymptotically distribution-free data (CFA-ADF) using AMOS (in SPSS) to determine the factor structure of the groups of items (Garson, 2009; Tabachnick & Fidell, 2001). Further detail about the factor analysis is contained in the KidsMatter Technical Manual that accompanies this report. For the purposes of this descriptive analysis, note that the questionnaire items in each group reported below factor together well. This allows us to interpret and report participants' responses to groups of items rather than attempting to deal with each of the questionnaire items separately.

A total of 34 variables of interest were resolved from the Teacher and Parent/Caregiver Questionnaire items and are summarised in Table 27 across a number of measures, arranged according to the conceptual design and by school Round. Table 27 focuses on measuring significant change over time and presents mean responses on Time 1 and Time 4 along with its associated level of significant difference ($p<0.01$). The more rigorous significance level of 0.01 (rather than 0.05) was chosen to take into account multiple comparisons. In order to test for significant change over time using a technique that took into consideration the nested nature of the data and did not depend on assumptions of normality, three level hierarchical linear models (HLM) were prepared for each variable as a direct function of the occasion at which the variable was taken. Version 5 of the HLM program was used in preference to more recent versions since it had great capacity to handle missing data (Bryk & Raudenbush, 1992). For several of these measures the change is not statistically significant. In addition, Table 27 presents a measure of practical significance using an effect size. It was calculated using a simple formula that relates the correlation coefficient, *r*, and the slope of a regression line, *b*, expressed in deviation-score (*s*) form (Ferguson, 1971, p.113). A detailed discussion in presented in the Technical Manual. Since a correlation is being estimated, Kirk (1996) suggested 0.10, 0.24, and 0.37 as indicative of small, medium and large, respectively. The associated box plots are also presented to demonstrate that most measures violate the assumptions of normality (Burns, 1998). A box plot is an efficient method for displaying a five-number data summary, namely, the median score, the inter-quartiles, and the minimum and maximum scores (Lane, 2007).

Table 27. Factors from the KidsMatter Teacher (T) and Parent/Caregiver (P) Questionnaires by school Round, with change in HLM-derived means on Time 1 and Time 4, level of significant difference (*p*), and practical level of significance (*r*)

Variable Names		Total	Round 1 Schools					Round 2 Schools				
		N	Time 1 Mean	Time 4 Mean	p^b sig.	*r* correlation	Effect[c] Size	Time 1 Mean	Time 4 Mean	p^b sig.	*r* correlation	Effect[c] Size
School Implementation of KMI												
KMI Engagement	(T)	2,871	5.06	5.53	**0.000**	0.26	medium	3.53	4.93	**0.000**	0.51	large
KMI Implementation	(T)	2,837	4.77	5.35	**0.000**	0.31	medium	3.94	4.95	**0.000**	0.44	large
KMI Implementation	(P)	9,625	4.99	5.43	**0.000**	0.27	medium	4.14	5.34	**0.000**	0.66	large
School Engagement with Mental Health Initiatives in General												
General Engagement	(T)	3,047	5.31	5.56	**0.002**	0.17	small	5.03	5.35	**0.001**	0.20	small
General Engagement	(P)	9,577	5.08	5.09	0.871	0.01	trivial	5.01	5.04	0.342	0.03	trivial
School Risk and Protective Factors												
C1: A Positive School Community	(T)	3,051	5.61	5.71	0.216	0.07	trivial	5.67	5.60	0.299	-0.05	trivial
C1: A Positive School Community	(P)	9,680	5.81	5.74	0.043	-0.07	trivial	5.76	5.68	**0.007**	-0.08	trivial
C2: Social and Emotional Learning	(T)	3,017	4.97	5.45	**0.000**	0.25	medium	3.10	4.70	**0.000**	0.64	large
C3a:Parenting Support by School	(T)	3,025	4.43	5.20	**0.000**	0.39	large	4.36	4.94	**0.000**	0.25	medium
C3a: Parenting Support by School	(P)	9,716	4.84	5.01	**0.001**	0.13	small	4.82	5.01	**0.000**	0.15	small
C3b: Parenting Support by Staff	(T)	3,025	5.35	5.68	**0.000**	0.19	small	5.35	5.46	0.172	0.06	trivial
C3b: Parenting Support by Staff	(P)	9,716	5.11	5.18	0.254	0.04	trivial	5.12	5.12	0.963	0.00	trivial
C4: Early Intervention	(T)	3,045	4.89	5.32	**0.000**	0.25	medium	4.83	5.07	**0.009**	0.13	small
C4: Early Intervention	(P)	9,613	4.80	4.84	0.460	0.03	trivial	4.71	4.80	0.057	0.06	trivial
Teacher Risk and Protective Factors												
SEL Attitude	(T)	3,049	6.24	6.35	0.051	0.08	trivial	6.25	6.30	0.480	0.03	trivial
SEL Staff Approach	(T)	3,061	5.75	6.01	**0.000**	0.17	small	5.64	5.85	**0.005**	0.13	small
SEL Knowledge	(T)	3,059	5.41	5.84	**0.000**	0.29	medium	5.39	5.62	**0.005**	0.13	small
SEL Actions	(T)	3,055	5.47	5.86	**0.000**	0.26	medium	5.33	5.64	**0.000**	0.19	small
Self-Efficacy	(T)	3,058	5.18	5.55	**0.000**	0.23	small	5.20	5.38	0.013	0.10	small

[a] Parent/Caregiver (P); Teacher (T). [b] Significant levels (p<0.01) of slope are shown in bold.
[c] Interpretation of the correlation coefficient, *r*, as an effect size, according to Kirk (1996).

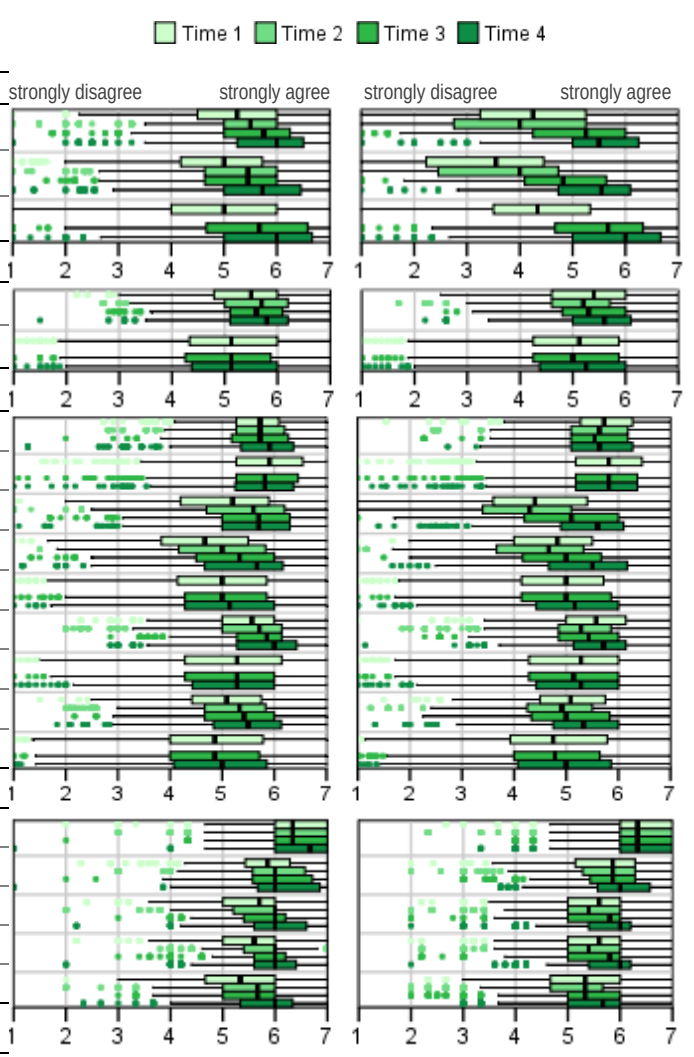

Table 27. Continued

Variable Names		Total	Round 1 Schools					Round 2 Schools				
		N	Time 1 Mean	Time 4 Mean	p^b sig.	*r* correlation	Effect[c] Size	Time 1 Mean	Time 4 Mean	p^b sig.	*r* correlation	Effect[c] Size
Family Risk and Protective Factors												
Parenting Knowledge	(P)	9,611	5.83	5.83	0.361	0.00	trivial	5.76	5.81	0.152	0.05	trivial
Parenting Approach	(P)	9,657	6.40	6.31	**0.002**	-0.09	trivial	6.37	6.36	0.571	-0.02	trivial
Child Risk and Protective Factors												
Social and Emotional Competencies	(T)	3,035	5.22	5.50	**0.000**	0.16	small	5.24	5.40	**0.007**	0.09	trivial
Social and Emotional Competencies	(P)	9,470	5.47	5.61	**0.000**	0.13	small	5.39	5.56	**0.000**	0.16	small
Perceived KMI Impact												
KMI Professional Development	(T)	2,098	5.35	5.53	0.150	0.10	small	4.00	5.14	**0.000**	0.46	large
KMI Engagement with School	(P)	9,119	3.00	3.56	**0.000**	0.30	medium	2.56	3.41	**0.000**	0.49	large
KMI Parent Learning	(P)	8,716	3.65	4.15	**0.000**	0.27	medium	3.27	4.01	**0.000**	0.41	large
KMI Impact on Child's school needs	(T)	3,035	4.12	4.77	**0.000**	0.26	medium	3.11	4.28	**0.000**	0.46	large
KMI Impact on Child's school needs	(P)	8,521	4.12	4.34	**0.005**	0.13	small	3.68	4.19	**0.000**	0.32	medium
Student Mental Health Outcomes												
Mental Health Difficulties	(T)	3,032	2.33	2.22	0.057	0.05	trivial	2.41	2.32	0.046	0.04	trivial
Mental Health Difficulties	(P)	9,500	2.69	2.53	**0.001**	0.09	trivial	2.71	2.55	**0.003**	0.09	trivial
Mental Health Strengths	(T)	3,025	5.35	5.56	**0.001**	0.11	small	5.39	5.48	0.152	0.04	trivial
Mental Health Strengths	(P)	9,427	5.55	5.72	**0.000**	0.14	small	5.47	5.65	**0.000**	0.14	small
Total SDQ	(T)	3,039	7.53	6.51	**0.000**	0.12	small	7.59	6.98	**0.007**	0.07	trivial
Total SDQ	(P)	9,434	8.90	8.29	**0.000**	0.11	small	9.57	8.43	**0.000**	0.21	small

[a] Parent/Caregiver (P); Teacher (T). [b] Significant levels (p<0.01) of slope are shown in bold.
[c] Interpretation of the correlation coefficient, *r*, as an effect size, according to Kirk (1996).