KidsMatter: the Australian Primary Schools Mental Health Initiative is developed in collaboration by the Australian Government Department of Health and Ageing, beyondblue: the national depression initiative, the Australian Psychological Society, Principals Australia, with support by Australian Rotary Health.

KidsMatter information and resources (including electronic copies of this report) are available from www.kidsmatter.edu.au. Hard copies of this report can be ordered from www.beyondblue.org.au (click Get Information).

Suggested Reference:


© Copyright Beyond Blue Limited December 2009

Foreword

I am pleased to be writing the foreword to this report on the evaluation of the national pilot of KidsMatter: the Australian Primary Schools Mental Health Initiative. The evaluation shows this initiative has worked wonderfully well - and I’m thrilled that it will be extended to more primary schools and adapted for pre-school children Australia wide.

In participating schools, the number of mental health difficulties in students diminished and overall, children experienced improved mental health and well-being.

These findings – together with the positive response KidsMatter has received from school communities across Australia – has convinced both the Australian Government and beyondblue of the need to continue to support this valuable initiative.

Our children are our future. By focusing on their well-being in pre-schools and primary schools, as they’re growing up, they’ll understand that good mental health is just as important as good physical health.

We know KidsMatter in schools helps to make kids resilient and gives them the tools they need to deal with problems. We hope they can build on this strong foundation through adolescence and into adulthood.

Children who feel good about themselves and who have good mental health are in a better position to enjoy and benefit from friendships, family relationships and learning opportunities.

On the other hand, children who don't feel good about themselves can have a hard time at school in both the playground and the classroom. If the children's problems aren't addressed early and the problems persist – this could lead to them having ongoing difficulties and fewer opportunities as they mature. The good news is these children can be helped, particularly if we recognise and address their problems early.

KidsMatter was developed to support the mental health and well-being of Australian children by helping schools to implement evidence-based mental health promotion, prevention and early-intervention strategies.

KidsMatter was strengthened by a very successful collaboration between beyondblue: the national depression initiative, the Australian Government Department of Health and Ageing, the Australian Psychological Society, Principals Australia, and Australian Rotary Health.

I commend the authors of this report from the Evaluation consortium led by the Centre for the Analysis of Educational Futures at Flinders University, which included staff from The University of South Australia and the Department of Education and Children's Services, South Australia.

Most of all, my congratulations and thanks go to the children, parents and staff of the 101 schools who participated in the KidsMatter pilot.

This is a fantastic initiative – a world-first by Australia – for which I thank everyone involved and I urge all states and territories to invest in their kids’ futures by embracing KidsMatter.

The Hon. Jeff Kennett AC
Chairman
beyondblue: the national depression initiative
November 2009
5 October 2009

KIDSMATTER MENTAL HEALTH PROJECT RECEIVES EXTRA FUNDING

An innovative primary school mental health promotion project is to receive additional funding.

The KidsMatter Primary initiative, which aims to promote mental health, prevent mental illness and initiate early intervention where necessary among primary school students, is being funded with $12.2 million so that its initial pilot roll-out at 101 schools can be extended.

In addition, the Rudd Government is committing $6.5 million over three years to develop and pilot a KidsMatter project for the early childhood sector.

I am pleased to be able to make this announcement at the beginning of Mental Health Week for 2009.

KidsMatter Primary and KidsMatter Early Childhood are being conducted in collaboration between beyondblue: the national depression initiative, which is contributing funding of $3.5 million, the Australian Psychological Society, Principals Australia and Early Childhood Australia.

KidsMatter is a key initiative of the Rudd Government’s approach to the promotion of good mental health, the prevention of mental illness and early intervention where problems arise.

It requires a whole-of-school approach and has four key components – a positive school community; social and emotional learning for students; parenting support and education and early intervention for students with mental health difficulties.

Based on approaches already tested by the World Health Organization and the American Collaborative for Academic, Social and Emotional Learning, it has been adapted to suit Australian conditions.

The initial trial began in 2007 with 50 schools across Australia. A further 50 were added last year. An evaluation of this pilot program, funded by beyondblue and carried out independently by researchers at Flinders University, has found very positive results in terms of educational and mental health outcomes.

During the 2009 and 2010 school years, the Department of Health and Ageing and the KidsMatter Primary partners will progress the implementation of KidsMatter Primary in up to 400 schools nationwide.
Contents

List of Tables v
List of Figures vi
Acknowledgements vii
KidsMatter Executive Summary viii

The KidsMatter Initiative viii
KidsMatter impact overview viii
Background to the KidsMatter Evaluation viii
Impact of KidsMatter on schools and teachers ix
Impact of KidsMatter on family context x
Impact of KidsMatter on student competencies xi
Impact of KidsMatter on student mental health xi
Conclusions xiii
Recommendations xiii

Chapter 1 Development and Background to KidsMatter 1

1.1 What is KidsMatter? 1
1.2 Who developed KidsMatter? 1
1.3 The KidsMatter framework 1
1.4 Who conducted the evaluation? 4
1.5 The KidsMatter Pilot Phase 4
1.6 What is contained in this report? 4

Chapter 2 Evaluating KidsMatter: Method and Participants 5

2.1 The three-pronged approach to the evaluation 5
2.2 Specific areas of evaluation 6
2.3 Overview of the evaluation design and participants 7
2.4 Design of the Whole Cohort Longitudinal Questionnaire study 9
2.5 Design of the Stakeholder and Student Voice studies 9
2.6 KidsMatter Project Officer Reports: An external school perspective 10
2.7 School Leadership Executive Summaries: A perspective from leadership 10
2.8 Summary of all data collected 11
2.9 Analysing and reporting the results 11
2.10 Chapter summary 13

Chapter 3 Engagement with KidsMatter and the Implementation Process: Whole Cohort Study and Project Officers 14

3.1 Teacher perspectives on engagement with the four KidsMatter components 14
3.2 Teacher perspectives on use of the 7-Step implementation process 15
3.3 Parent perspectives of KidsMatter implementation 16
3.4 Evidence about implementation of KidsMatter from the Project Officer Reports 17
3.5 Professional development as an element in KidsMatter implementation 19
3.6 General engagement with students' mental health and wellbeing 19
3.7 Chapter summary 21

Chapter 4 An Implementation Index 22

4.1 An implementation framework 22
4.2 School profiles on the Implementation Index 25
4.3 Implementation quality and meeting the needs of students with mental health difficulties 26
4.4 Chapter summary 27

Chapter 5 Engagement with KidsMatter and the Implementation Process: Stakeholder and Student Voice Studies 28

5.1 Key themes from the Stakeholder and Student Voice studies 28
5.2 Possibilities for sustainability 30
5.3 Chapter summary 32

Chapter 6 Positive School Community: Implementation, Engagement and Impact on Schools 34

6.1 Engagement with and implementation of Positive school community 34
6.2 Impact on Positive school community: Whole cohort study 35
6.3 Impact on Positive school community: Stakeholder interview and focus groups 37
6.4 Impact on Positive school community: Parent questionnaire responses 38
6.5 Chapter summary 38
Chapter 7  Social and Emotional Learning: Implementation, Engagement and Impact on Schools 39

7.1 Engagement with and implementation of Social and Emotional Learning: Whole cohort study 39
7.2 Engagement with and implementation of Social and Emotional Learning: Stakeholder and Student Voice studies 40
7.3 Impact on schools' provision of Social and Emotional Learning: Whole cohort study 41
7.4 Chapter summary 45

Chapter 8  Parenting Support and Education: Implementation, Engagement and Impact on Schools 46

8.1 Engagement with and implementation of Parenting support and education 46
8.2 Impact on Parenting support and education: Whole cohort study 47
8.3 Impact on Parenting support and education: Stakeholder responses 50
8.4 Chapter summary 52

Chapter 9  Early Intervention for Students Experiencing Mental Health Difficulties: Implementation, Engagement and Impact on Schools 53

9.1 Engagement with and implementation of Early intervention for students experiencing mental health difficulties 53
9.2 Impact on Early intervention: Whole cohort study 54
9.3 Project Officer reports: Links with external agencies 56
9.4 Impact on Early intervention: Stakeholder responses 57
9.5 Chapter summary 59

Chapter 10  KidsMatter Impact on Teachers 60

10.1 Teacher competencies 60
10.2 Impact of the professional development 65
10.3 Impact on teachers from the Stakeholder interviews 65
10.4 Chapter summary 66

Chapter 11  KidsMatter Impact on Family Context 67

11.1 Parenting knowledge 68
11.2 Parenting style 68
11.3 Overall effectiveness as a parent 68
11.4 Impact on parents' awareness of children's social and emotional needs 69
11.5 Parent interview responses about the impact of KidsMatter 69
11.6 Chapter summary 70

Chapter 12  KidsMatter Impact on Student Competencies 71

12.1 Impact on student social and emotional competencies 71
12.2 Impact on student schoolwork 74
12.3 Chapter summary 75

Chapter 13  KidsMatter Impact on Student Mental Health 76

13.1 The Strengths and Difficulties Questionnaire 77
13.2 Student mental health difficulties: An alternative measure 82
13.3 Student mental health strengths 83
13.4 Two dimensions of mental health: Difficulties and strengths 84
13.5 Chapter summary 85

Chapter 14  KidsMatter in Perspective 87

14.1 School based interventions: International perspectives 87
14.2 Promotion, prevention and early intervention 88
14.3 Working with four components 88
14.4 The change process 89
14.5 The KidsMatter conceptual model 89
14.6 Dimensions of student mental health 90
14.7 Sustaining KidsMatter 90
14.8 Portrait of a successful KidsMatter implementation 90
14.9 Considerations for further initiatives and research 92

Chapter 15  Conclusions and Recommendations 93

15.1 Conclusions 93
15.2 Recommendations 94

Glossary of Key Terms 95

Methodological Notes and Limitations of the Evaluation 97

Related Publications and Presentations 99

References 100
List of Tables

Table 1. Background characteristics of Project Officers, schools, teachers and students involved in the KidsMatter evaluation 8
Table 2. Summary of all data collected in the KidsMatter evaluation 11
Table 3. KidsMatter Engagement (T) 14
Table 4. KidsMatter Implementation (T) 15
Table 5. KidsMatter Implementation (P) 16
Table 6. School engagement with students’ mental health and wellbeing 20
Table 7. The KidsMatter Implementation Index framework 23
Table 8. Items in the KidsMatter Implementation Index 23
Table 9. KidsMatter Impact on child’s needs 26
Table 10. Facilitators and barriers to school reform 29
Table 11. The importance of the KidsMatter organising framework 30
Table 12. Suggestions for sustaining KidsMatter 30
Table 13. Questionnaire items about Positive school community 36
Table 14. Issues that teachers considered regarding Social and Emotional Learning programs 41
Table 15. Teacher ratings of Component 2: Social and Emotional Learning 41
Table 16. Most used programs used in 61 KidsMatter schools 43
Table 17. Exemplars of student learning as a result of KidsMatter 45
Table 18. Component 3: Parenting support and education 48
Table 19. KidsMatter impact on parent involvement with school 50
Table 20. Component 4: Early intervention 55
Table 21. Addressing staff awareness, knowledge and skills about mental health 57
Table 22. Teachers’ attitudes, knowledge, competence and confidence (self-efficacy) towards teaching social and emotional competencies 61
Table 23. Teacher ratings about the impact of PD on teacher knowledge, commitment and practice 65
Table 24. Staff perceptions of the impact of KidsMatter 65
Table 25. Parents’ knowledge and parenting style 67
Table 26. Parent ratings of learning from KidsMatter 69
Table 27. Parents’ perceptions of the impact of KidsMatter 70
Table 28. Child social and emotional competencies 71
Table 29. Students’ perceptions of their social and emotional competencies, coping strategies and behaviour 73
Table 30. Percentage of students rated as having difficulties in five dimensions of mental health 79
Table 31. Student mental health outcomes according to different criteria 85
List of Figures

Figure 1. Conceptual framework for KidsMatter (2006) 2
Figure 2. Overview of evaluation design and data collection 7
Figure 3. Average teacher perspectives on Engagement with the four KidsMatter components 15
Figure 4. Average teacher responses to school implementation of KidsMatter using the 7-Step implementation process 16
Figure 5. Average parent responses to school implementation of KidsMatter (note that Time 2 data was not collected) 17
Figure 6. Averaged progress through the 7-Step implementation process on KidsMatter four components according to Project Officers’ report 18
Figure 7. Proportion of schools completing the step of implementing’ plans for each component within two years according to Project Officers’ reports 18
Figure 8. Teacher responses to “The quality of the professional development for KidsMatter has been…” 19
Figure 9. Teacher and parent ratings of school engagement with students’ mental health and wellbeing 21
Figure 10. School profiles on the items of the Implementation Index 25
Figure 11. Change in teacher and parent perceptions about the impact of KidsMatter on the child’s needs in school 27
Figure 12. Project Officer responses to how welcomed they felt by school leadership and staff 31
Figure 13. Teacher responses about implementation and engagement with Positive school community 35
Figure 14. Teacher and parent ratings of Positive school community 37
Figure 15. Teacher responses about implementation and engagement with Social and Emotional Learning 40
Figure 16. Teacher ratings of Social and Emotional Learning 42
Figure 17. Teacher and parent mean percentages for students participating in SEL programs 42
Figure 18. Vignette used in the Student Voice study 44
Figure 19. Teacher responses about implementation and engagement with Parenting support and education 47
Figure 20. Teacher and parent reports of Parenting support and education from the school 48
Figure 21. Teacher and parent reports of Parenting support and education from the staff 49
Figure 22. Parent responses to the impact of KidsMatter on their involvement with school 50
Figure 23. Teacher responses about implementation and engagement with Early intervention 54
Figure 24. Teacher and parent ratings of school provision of Early intervention 56
Figure 25. Project Officer responses: Has KidsMatter resulted in improved links with external agencies? 56
Figure 26. Project Officer responses to the number of referrals and the time taken to access them 57
Figure 27. Staff approach to Social and Emotional Learning 62
Figure 28. Staff attitudes to Social and Emotional Learning 62
Figure 29. Teacher knowledge about Social and Emotional Learning 63
Figure 30. Teacher SEL programs and resources 64
Figure 31. Teacher self-efficacy 64
Figure 32. The impact of PD teacher competencies 65
Figure 33. Parent ratings about parenting knowledge 68
Figure 34. Parent ratings of parenting style 68
Figure 35. Change in parent perceptions about the impact of KidsMatter on parenting learning 69
Figure 36. Child social and emotional competencies 72
Figure 37. Change over time in teacher and parent ratings about the impact of KidsMatter on students’ learning outcomes 75
Figure 38. Change over time in Total SDQ Difficulties for all students 77
Figure 39. Change over time in Total SDQ Difficulties for students’ in the normal, borderline and abnormal ranges 78
Figure 40. Change over time in teacher and parent ratings about students’ emotional symptoms 79
Figure 41. Change over time in teacher and parent ratings about students’ conduct problems 80
Figure 42. Change over time in teacher and parent ratings about students’ hyperactivity 81
Figure 43. Change over time in teacher and parent ratings about students’ peer problems 81
Figure 44. Change over time in teacher and parent ratings about students’ prosocial behaviour 82
Figure 45. Change over time in teacher and parent ratings about students’ mental health difficulties 83
Figure 46. Change over time in teacher and parent ratings about students’ mental health strengths 84
Acknowledgements

beyondblue: the national depression initiative

This evaluation was commissioned and funded by beyondblue: the national depression initiative. The evaluation consortium wishes to thank and acknowledge beyondblue for their ongoing support throughout the evaluation. In particular, we would like to acknowledge Brian Graetz who at all times was a facilitative and readily accessible guide in the evaluation.

Australian Psychological Society, Principals Australia, and Australian Rotary Health Research Fund

The commitment and support of the Australian Psychological Society for their feedback and expertise regarding the development of the evaluation measures was appreciated by the evaluation consortium. The dedicated support provided by Principals Australia and the Australian Rotary Health Research Fund is also acknowledged.

John P. Keeves AM

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.

Mignon Souter

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

KidsMatter Personnel

The Flinders consortium would also like to extend their gratitude and thanks to:

- The KM Project Officers: Caroline Buckley, Michael Hardie, Cate Engelbrecht, Alexandra Petersen, Claire Cowen, Lana Jankowiak, Helen Barrett, Judanne Young, Michele Oliphant and Heidi Erickson who, at all times, were good humoured and facilitative in their support of the evaluation and assistance with data collection
- Chris Champion and Kaye Johnson who were an integral part of the KM team and who welcomed and made available to the evaluation team the resources and personnel of their very professional team.

School Communities

The Flinders University Evaluation Consortium received sustained cooperation and support from principals, teachers, parents and students in the schools who participated in the trial. This was present for the questionnaire data collection, stakeholder and student voice studies and executive summaries. We thank all these communities for their efforts, without which the evaluation could not have proceeded.
KidsMatter 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 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.” Counsellor School 9

The KidsMatter Initiative

KidsMatter (KM) is an Australian national primary school mental health promotion, prevention and early intervention initiative. KM 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, and was supported by the Australian Rotary Health Research Fund.

KidsMatter uses a whole-school approach. It provides schools with a framework, an implementation process, and key resources to develop and implement evidence-based mental health promotion, prevention and early intervention strategies. The KM framework consists of four key areas, designated as the KM components:

1. Positive school community
2. Social and Emotional Learning for students
3. Parenting support and education
4. Early intervention for students experiencing mental health difficulties.

KidsMatter aims to:

• improve the mental health and well-being of primary school students
• reduce mental health difficulties amongst students
• achieve greater support for students experiencing mental health difficulties.

KidsMatter impact overview

“[KidsMatter] 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

There were positive changes to schools, teachers, parents/caregivers1, and children associated with KM over the two year trial.

• There was evidence of change related to all four components of the KM framework.
• KidsMatter was associated with statistically and practically significant2 improvement in students’ measured mental health, in terms of both reduced mental health difficulties and increased mental health strengths.
• The impact of KM was more apparent for students who were rated as having higher levels of mental health difficulties at the start of the trial.
• There was substantial similarity in the findings for schools formally involved in KM for one year and for schools formally involved over two years. However, there were some measures that showed stronger effects in the schools involved in KM for two years.

Background to the KidsMatter Evaluation

A Pilot Phase of KM was trialled in 1003 schools across Australia during 2007-2008. Fifty of the schools ran KM during the 2007 and 2008 school years. The remaining schools undertook KM during the 2008 school year. A consortium based in the Centre for Analysis of Educational Futures at Flinders University undertook an evaluation of the two-year trial.

---

1  For simplicity, the term ‘parent’ rather than ‘parent or caregiver’ is used throughout this report, but is intended to be inclusive of both parents and caregivers.
2  The more rigorous significance level of 0.01 was chosen, to take into account multiple comparisons. Effect size was based on a regression coefficient equivalent to a part correlation with 0.10, 0.24, and 0.37 as indicative of the cut points between very small, small, medium and large, respectively (Kirk, 1996). Small, medium and large effect sizes indicate changes that are of practical significance. In each case these reported practical effect sizes were associated with statistical significance.
3  The trial of KM was originally intended for 101 schools, but one school did not participate in the evaluation due to the challenges of a high proportion of transient students in a longitudinal study.
The evaluation examined the impact of KM on schools, teachers, parents and students. Teachers and parents of students (target age of 10 years) were surveyed during 2007 and 2008. Most items on the questionnaire required responses on a 7-point Likert scale from ‘strongly disagree’ (1) to ‘strongly agree’ (7). Special emphasis was placed on the impact of KM on student mental health. Mental health was measured to include both strengths and difficulties, with the main measure being the internationally used Strengths and Difficulties Questionnaire (SDQ), designed by Goodman (2005).

The surveys covered student mental health, engagement with, and implementation of KM, and influences on schools, teachers, parents and students. Survey responses were gathered on four occasions from teachers and on three occasions from parents, for up to 76 students per school. The first survey was completed by the parents and teachers of 4980 students.

The information available in the evaluation also included qualitative data provided in:

- reports from KM Project Officers who worked with each of the Pilot schools in the implementation of KM
- interviews and focus group discussions conducted with school leaders, teachers, parents and students in 10 schools in the latter part of the KM trial
- summaries of the processes and effects of KM within their schools provided by principals and KM action team leaders at the end of the trial.

Statements about impact and change over time generated from the surveys are based on quantitative analyses and refer to results that are statistically significant and also of practical significance. Findings from the analysis of qualitative data following analysis in relation to the main themes and requirements of the evaluation are also presented at relevant points.

**Impact of KidsMatter on schools and teachers**

In general, schools adopted KM and actively worked at its implementation.

- Schools, teachers and parents increasingly became engaged with KM. This increased engagement was statistically significant and represented a large practical effect size. The increased engagement is illustrated by the fact that, at the start of the evaluation 35% of teachers strongly agreed (scored 6 or 7) that schools were engaged with KM, whereas by the end of the evaluation, 57% of teachers made such ratings. That is, 22% more teachers strongly agreed.

- By the end of the evaluation, 26% more teachers strongly agreed that schools were using the ‘7-Step’ implementation process.

- Over the course of the trial, most progress was made on implementing Component 2: Social and Emotional Learning for students, and least progress was made on Component 3: Parenting Support and Education and Component 4: Early intervention for students.

A closer examination of the data revealed differences in the degree of implementation across schools. According to Project Officers’ reports, high implementation schools:

- paid more attention to the prescribed 7-Step implementation process
- displayed a higher level of involvement of all stakeholders, including the active involvement of the school leadership team.

Although there were some difficulties and barriers to the implementation of KM, such as lack of available time in school timetables, there were positive reports about the impact of KM from stakeholders, including effects such as:

- facilitating the placement of mental health as an issue onto schools’ agenda
- providing a conceptual framework for considering mental health issues
- providing a common language that enabled school communities to work on these issues
- making an impact on school culture, which facilitated the raising of issues related to mental health and child development.

**KidsMatter professional development**

Teachers were generally positive about the professional development delivered in KM. The effectiveness of the PD assessed at the end of the trial was highlighted by the finding that 60% of the teachers strongly agreed that the professional development had increased their commitment to promoting student wellbeing, and better equipped the school to address the four components.

**The four KidsMatter Components**

A major emphasis in KM was on the four components of the framework as the foundation for effecting change in student mental health. There was evidence of improvement in schools’ performance associated with each component, although not all components improved to the same extent. There was more evidence of positive change in the ratings from teachers than in the ratings from parents.
Component 1: Positive school community. Parents and teachers provided high ratings for their school's performance on Component 1 at the start of KM, and there was little evidence of significant change in ratings for this component over the two years. At the start of the trial, approximately 63% of parents and teachers strongly agreed that their school was committed to developing a sense of belonging and connectedness for members of the school community. This level of rating for school commitment was maintained throughout the two years.

However, the interview and focus group data showed that the KM emphasis on positive school community appeared to strengthen and reinvigorate this component in the schools:

“Where I wanted to bring this focus in terms of parent and community was very much creating opportunities for parents and carers to come into our school for a variety of reasons. The most powerful way to do that was to invite them to come and work alongside their children in an activity linked strongly to curriculum … The parents and carers are invited into our school for a variety of different reasons, all of them connected to KidsMatter in some way.” Principal School 1

Component 2: Social emotional learning (SEL). Over the two years of KM, 19% more teachers strongly agreed that their school was performing well on the teaching of social and emotional skills for students.

Component 3: Parenting support and education. Compared with ratings at Time 1, by the end of the trial 7% more parents strongly agreed that KM had an effect upon their school's performance in providing parenting support and education. The comparable figure for teacher ratings was higher, with 22% more teachers strongly agreeing at the end of the trial that the school provided parenting support and education.

Component 4: Early intervention for students experiencing mental health difficulties. Parents' and teachers' views differed with respect to this component. The number of parents who strongly agreed to the school's level of early intervention (namely how effective their school was at supporting students who were experiencing mental health difficulties) did not change across the two year trial. However, by the end of the trial, 10% more teachers strongly agreed that their school was effective in providing early intervention. Data collected from the interviews indicated that schools prioritised their work on the four components, and that Component 4 appeared to be the last that received attention.

Teachers' knowledge, competence and confidence

Across the two-year trial there were increases in the teachers' ratings of their knowledge, competence and confidence with respect to teaching students about social and emotional competencies. From questionnaires collected at Time 4, compared to Time 1:

- 14% more teachers strongly agreed that they knew how to help their students to develop social and emotional competencies
- 8% more teachers strongly agreed that the school staff, as a whole, acted to help students to develop social and emotional competencies
- 16% more teachers strongly agreed that their teaching programs helped students to develop social and emotional competencies.

In addition, 11% more teachers strongly agreed that they felt effective in dealing with issues surrounding the mental health of students, such as being capable of identifying students experiencing social and emotional difficulties, and helping others to develop a sense of belonging in the school community.

Teacher attitudes about the importance of teaching students about social and emotional competencies were high at the start of KM and changed little over the course of the trial.

Impact of KidsMatter on family context

Interviews with parents revealed that they valued both the information provided by their school as part of Component 3: Parent support and education, and the strategies this information gave them for handling issues related to their children's mental health.

From Time 1 to Time 4, the surveys showed an increase in the number of parents who strongly agreed that:

- they had become more involved with the school as a result of KM (7% more parents strongly agreed)
- they had increased their capacity to help their children with social and emotional issues as a result of KM (11% more parents strongly agreed).

In addition, 10% more parents strongly agreed that, as a result of KM, the school's capacity to cater for their child's needs had improved. Furthermore, 22% more teachers strongly agreed with this statement.

However, findings from the parent questionnaire related to parenting knowledge and parenting styles show no evidence of change as a result of KM. In the first administration of surveys at the start of KM in 2007, parents already held strong efficacy beliefs about their parenting knowledge and gave high ratings to their use of positive parenting strategies. Their beliefs and ratings of positive parenting remained strong for the duration of KM.
Impact of KidsMatter on student competencies

Three kinds of impact on children were examined in the evaluation. The first concerned impact on student social and emotional competencies, the second was about schoolwork, and the third related to measures of student mental health.

Student social and emotional competencies

At the start of KM, 54% of parents and teachers indicated that students were performing well in areas of social and emotional competence, such as the ability of students to solve personal and social problems. By the end of the KM trial, there were 7% more parents and teachers who strongly agreed about the positive nature of students' social and emotional competencies.

Students' schoolwork

- During the two years of KM, over 90% of teachers consistently strongly agreed that “students who are socially and emotionally competent learn more at school”.
- Teachers' ratings of the positive impact of KM on students' schoolwork increased across the period of KM, with 14% more teachers strongly agreeing with the statement “KidsMatter has led to improvements in this student's school work” by the end of KM.

Impact of KidsMatter on student mental health

The central purpose of KM was to improve student mental health and well-being and to reduce mental health difficulties. The principal measure of student mental health difficulties used in the evaluation was the Total SDQ Difficulties score (Goodman, 2005) using parent and teacher ratings of the targeted students (up to 76) in each KM school. This total difficulties measure is the sum of scores on the SDQ subscales of Emotional Symptoms, Conduct Problems, Peer Problems and Hyperactivity. At the start of KM, the average Total SDQ Difficulties scores were low, being around a rating of 7 by teachers and a rating of 9 by parents. These scores are well within the range of normal mental health on the SDQ scale, with a possible total score of 40 (high level of difficulties).

Reduction in Total SDQ Difficulties

On average across all students, the Total SDQ Difficulties score declined significantly over the period of KM, equivalent to a small effect size. This decline represents a practically significant overall reduction in mental health difficulties associated with the implementation of KM.

Reduction in SDQ difficulties for students in the normal, borderline and abnormal ranges

A further examination of changes in student mental health was based on Goodman's (2005) recommended cut-off points for categorising students into 'normal', 'borderline', and 'abnormal' ranges according to their Total SDQ Difficulties scores (using both parent and teacher ratings). Previous research suggested that about 80% of students score in the normal range, with about 10% of students scoring in each of the borderline and abnormal ranges respectively (Hayes, 2007). At the start of KM, 25% of the sampled students were classified within the borderline or abnormal ranges by teachers, and 23% by parents. Change over time in SDQ Difficulties (Total score and subscale scores) was examined for students who were classified within the normal, borderline or abnormal ranges at the start of the trial. It was found that:

- For students in the abnormal range, there were medium to large effect sizes associated with reductions in the mean scores for the SDQ subscales of Emotional Symptoms, Conduct Problems, Peer Problems and Hyperactivity.

---

4 The higher percentage of students in the borderline and abnormal ranges in this evaluation reflects the sampling strategy of intentionally targeting students who may be exhibiting social, emotional or behavioural difficulties.

5 The plotted trajectories represent the results of hierarchical linear modeling analysis based on the student within schools regression line fitted to the available data across the four occasions.
For students in the borderline range, there was a medium effect size for a reduction in the mean score for Hyperactivity, and small effect sizes for reductions for the other three subscales.

**Improved mental health strengths**

In addition to reductions in mental health difficulties on the SDQ and its subscales, students in the abnormal and borderline ranges showed significant improvements over the period of the KM trial on a scale designed to measure Mental Health Strengths. There were medium effect sizes for Mental Health Strengths for students in the abnormal range, and small effect sizes for students in the borderline range, as displayed in the following figure.

![Mental health strengths of students identified at Time 1 in the:](image)

Furthermore, students in the abnormal and borderline ranges also improved significantly on a purpose-designed measure of social and emotional competencies over the period of the trial (abnormal group: medium and large effect sizes for improvement) (borderline group: small and medium effect sizes for improvement).

**Change in the proportion of students in the normal, borderline and abnormal ranges**

As an alternative way of considering changes in student mental health at the population level, the proportion of students who were identified within the normal, borderline or abnormal ranges according to the SDQ cut-off points was calculated for each of the four times of data collection. An improvement in overall student mental health would be indicated by a decrease in the proportion of students who were classified within either the abnormal or borderline ranges, and a corresponding increase in the proportion of students classified within the normal range. Based only on the Total SDQ Difficulties scores, and keeping parent and teacher reports separate, this analysis showed that the proportion of students scoring within the abnormal and borderline ranges was reduced by 4.5% according to ratings by teachers, and by 5.8% according to ratings by parents, across the period of KM. This reduction of students within the abnormal and borderline ranges was associated with a 5% increase in the proportion of students classified as being in the normal range. This represents a positive change for approximately 1 in 5 of the students who were originally in the abnormal and borderline ranges.

**Classifying students using both mental health strengths and difficulties**

“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 order to take into account students’ mental health strengths as well as difficulties, and by bringing together parent and teacher reports, an expanded set of criteria were used to classify students into normal, borderline and abnormal ranges. The score ranges for these groups were formed from parent and teacher ratings of students on the Total SDQ Difficulties score, as well as from parent and teacher ratings of students on two purpose-designed measures, namely the Mental Health Strengths and the Mental Health Difficulties scales. The profile of each group according to their score on the three measures showed, as expected, that:

- students within the abnormal range were rated higher on difficulties and lower on strengths
- students within the normal range, were rated lower on difficulties and higher on strengths
- students within the borderline range displayed a profile that included some difficulties but also some strengths.

This alternative method of classification showed that at the start of KM 34% of students were classified into the borderline or abnormal ranges. By the end of the trial, this figure had reduced to 24%. As a consequence, 10% more students were classified into the normal range by the end of the trial. This represents a positive change for approximately 1 in 3 of the students who were originally in the abnormal and borderline ranges. One possible interpretation of this finding is that KM was associated with improved mental health scores of more students than suggested by the analysis that used the Total SDQ Difficulties classifications alone.

---

6 Students were classified based on the measures of mental health using Latent Class Analysis. This alternative method of classification was undertaken using Goodman’s SDQ cut-off points applied to each measure and therefore Goodman’s classification labels of normal, borderline and abnormal were retained to maintain consistency of wording in this report.
In particular, the classification of students using the expanded criteria showed a larger impact on students who were in the borderline range than suggested in the SDQ Difficulties analysis, possibly because KM was able to build upon students’ existing strengths as well as reducing difficulties.

Furthermore, it is possible that the classification using the expanded criteria resulted in a more targeted recognition of students in the abnormal range. These students have an overall profile of high difficulties and low strengths based on the reports of both parents and teachers. It is expected that it is relatively more difficult to effect change in students with this type of profile.

Conclusions

“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 the 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. . . . I think that there has been a fairly profound effect and one of the best parts of KidsMatter I think it’s changed culture and focus within the school community.” Principal School 9

KidsMatter appears to have impacted upon schools in multiple ways, being associated with a systematic pattern of changes to schools, teachers, parents and students. These included changes associated with school culture and approaches to mental health difficulties, as well changes that served to strengthen protective factors within the school, family and child. Importantly, KM was associated with improvements in students’ measured mental health, especially for students with higher existing levels of mental health difficulties.

“We’ve given a much stronger focus to our community, students and parents, being able to articulate emotions and stretch their language so they really have an understanding that there’s things much deeper than happy and sad, and that’s where we were before. So you hear a lot of people talking a lot more – and a lot more deeply – about where they are, how they’re feeling, how people’s actions affect their actions.” Principal School 9

It needs to be remembered that KM was a multi-faceted, population-based initiative using a whole-school approach. It was based on a conceptual framework, a prescribed implementation process and provision of key resources. Any explanation of possible changes in student mental health must consider all aspects of KM and its approach. It is most likely that the obtained changes in student mental health are due to KM rather than other factors such as student maturation.

The outcomes of the KM trial are consistent with an emerging body of national and international literature that a ‘whole school’ approach can be protective for students, promoting a positive shift in mental health for the whole school population, and helping to enhance academic and social competencies through more positive interactions between all members of the school community.

However, although there is evidence from the evaluation of the successful implementation of KM and of associated positive changes, the observed impacts varied in size and were not evident in all aspects of KM. Furthermore, evidence of potential limitations and of possibilities for increasing the effectiveness of KM also emerged. In particular:

- Stakeholders highlighted the importance of leadership in generating change – particularly transformative leadership which brings about change in attitudes, beliefs and behaviour in the school community.
- It was challenging for schools to find space for all four KM components in an already crowded curriculum. However, the fact that KM opened a niche in school timetables for issues related to student mental health is considered to be a key factor in the success of KM.
- As with all curriculum innovations, the sustainability of KM was raised as an issue, and as one School Principal noted, “we need to have really strong structures – the sustainable structures in place so that it continues, but time is a real factor”. In particular, it was argued that the maintenance of the support and resources provided to schools is necessary to ensure that KM is sustainable and continues to be effective.
- It was also apparent that the implementation of Components 3 and 4 presented challenges for many schools.

Although there were some variations in the pattern of findings for schools involved in KM for one year, and for schools involved over two years, the nature of the intervention makes it difficult to interpret or explain the variations. However, one clearly apparent factor was the development of expertise of the KM team in general and the KM Project officers in particular, during the first year. This meant that the roll-out of KM in Round 2 schools during 2008 benefited strongly, in terms of being able to access an expanding base of available knowledge and of resources generated from KM activities in Round 1 schools in 2007.

Recommendations

“This is not an initiative for poor schools with disadvantaged families, it’s an initiative for all children in primary schools and all types of schools.” Principal School 5

Taking account of the evaluation findings and subject to the recommendations below, the main recommendation is that the broad framework, processes and resources of KidsMatter be maintained as the basis for a national roll-out.
Note that we have interpreted the effects of KM as a total package, and have no basis for drawing conclusions if parts of the package were to be delivered independently.

The evaluation suggested a number of ways for improving the efficacy of KM. As a consequence, it is recommended that, inter alia, future development of KM:

1. Provide guidelines to schools that will enable them to enhance the quality of the KM implementation in a structured and sustained way. These might include procedures for sharing best practice about the ways exemplary schools have implemented KM and how common problems, such as changes in key staff can be addressed.

2. Examine the conceptual model and the interactions of the elements upon which KM is based. There is a need to specify further the nature of the risk and protective factors under the headings of School, Family and Child. In particular, the positioning of the broad concept of School, and within ‘School’, teachers’ knowledge, competence and confidence, as risk or protective factors for student mental health, needs further clarification and elaboration.

3. Give further consideration to ways in which schools can increase the effectiveness of Component 3 (Parenting support and education). This could include further research into effective models of delivery for parenting support and education within population-based mental health interventions. The gathering of knowledge from schools about exemplary practice related to this Component is also recommended.

4. Strengthen Component 4 (Early intervention for students with mental health difficulties), through further professional development for teachers on this component, and further consideration of ways of building of stronger connections between external agencies and schools. This could include:
   - supplementing the existing professional development with respect to teachers’ knowledge, competence and confidence for identifying students at risk
   - investigating the perspectives of both schools and external agencies about the difficulties schools experience in instigating and accessing referrals to such external agencies.

5. Consider ways to further support the commitment to, and active involvement of, school leaders in developing and maintaining KM in their school setting.

6. Consider how the professional development can be enhanced to better prepare schools and teachers to implement and engage with Components 3 and 4.

7. Attend to the differing manifestations of students’ mental health in home and school settings, and the consequences of these setting-based differences for students, teachers and parents. This might include supplementing existing advice about ways for parents and teachers to share their concerns and strategies for assisting students at risk of, or experiencing mental health difficulties, so that compatible approaches can be implemented in home and school settings.

8. Consider how KidsMatter can be productively linked with other mental health initiatives in schools, such as the mandated National Safe Schools Framework or the Council of Australian Governments National Action Plan for Mental Health 2006-2011.
1.1 What is KidsMatter?

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

KidsMatter uses a whole-school approach to addressing students’ mental health (Graetz, et al., 2008). It provides schools with a framework, an implementation process, and key resources to develop and implement evidence-based mental health promotion, prevention and early intervention strategies. The KM framework consists of four key areas, designated as the KM Components:

1. Positive school community
2. Social and Emotional Learning
3. Parenting support and education
4. Early intervention for students experiencing mental health difficulties.

KidsMatter aims to improve the mental health and well-being of primary school students, reduce mental health problems among students, and achieve greater support and assistance for students experiencing mental health problems (KidsMatter, 2006).

1.2 Who developed KidsMatter?

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

1.3 The KidsMatter framework

KidsMatter is based on a social-ecological approach that recognises the influences of parents, families and schools (Graetz et al., 2008). The framework comprises four school-based components delivered using a whole-school approach. In each of the components, schools are provided with target areas and objectives for change, together with resources and strategies for achieving such change. In turn, the framework draws upon an overall model of risk and protective factors that are assumed to be central influences on student mental health. The initial conceptual framework for KM is shown in Figure 1.
Conceptual framework for KidsMatter
Australian Primary Schools Mental Health Initiative

Implementation Strategies

Mental health promotion and prevention for all students
Students:
- Access to curriculum in social and emotional competencies (e.g., self-awareness, social awareness, self-management, relationships, skills, responsible decision-making skills)

School Staff:
- Professional development in:
  - Selection and delivery of social and emotional curriculum for students
  - Risk and protective factors associated with onset of mental health problems (e.g., anxiety, depression, and behavioral problems)
  - Strategies to maximize parent engagement and improve relationships with parent/s and families
- Strategies:
  - Responsibility and helpfulness

Parent/s and Families:
- Opportunities to:
  - Engage more fully in the school community
  - Develop support networks
  - Receive information on child development and effective parenting
  - Undertake general parenting programs

Early intervention for students at risk or experiencing mental health problems (e.g., anxiety, depression, and behavioral problems)
Students:
- Opportunities to access appropriate support and evidence-based programs

School Staff:
- Professional development on child mental health problems and how to respond
- Support to:
  - Develop links with local service providers, particularly psychologists and GPs
  - Develop effective protocols and procedures to assist students at risk or experiencing mental health problems
  - Clarify roles and responsibilities in working with students at risk or experiencing mental health problems

Parent/s and Families:
- Opportunities to:
  - Receive information on child mental health problems and local service providers
  - Undertake parenting programs
  - Develop support networks

Protective factors strengthened by initiative

Family Context
- Effective parenting
- Supportive and caring relationships with parents and families

Child factors
- Social and emotional competencies
- Sense of mastery and control
- Sense of optimism

School context
- Staff knowledge, competence, and confidence to deliver curriculum in social and emotional competencies
- Staff knowledge, competence, and confidence to respond to students at risk or experiencing mental health problems
- Positive school climate where kids, staff, parent/s and families develop a sense of belonging and connectedness through:
  - Achievement and recognition
  - Responsibility and helpfulness
  - Safety and support
  - Collaborative relationships
  - Inclusion

Student outcomes
- Improve mental health and well-being in students
- Reduction in mental health problems (e.g., anxiety, depression, and behavioral problems)
- Increased support and assistance for students at risk of experiencing mental health problems (e.g., anxiety, depression, and behavioral problems)
In brief, the conceptual model, set out in Figure 1, proposes that the strategies implemented by schools in each of the components 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 four components of school-based activity are as follows:

**Component 1: 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 parents 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 parents and support services.

The provision of a program of targeted professional development based around the four components, and the provision of support for parents is predicted to change the levels of knowledge and skills of teachers, parents and students, which also in turn are expected to be reflected in improvements in student mental health outcomes. The KM framework and conceptual model assumes a set of mutually dependent processes, with multiple outcomes. This means that the components are expected to interact to positively influence risk and protective factors. The mutually dependent processes associated with the components are assumed to have multiple outcomes. These outcomes are expected to include changes in both levels of risk and protective factors and student mental health.

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). This may decrease the need for early intervention and as well as contribute to a more positive school community. The increased student capabilities are expected to enable students to more effectively address social, emotional and behavioural difficulties that might arise in their daily lives, and therefore have an impact on student mental health. Similarly, provision of parenting information and support is designed to positively impact on parenting capabilities, which could also assist student competencies and mental health.

The evaluation team was informed that key features of the implementation of KM included the following:

- Participating schools were informed that KM required a planned and coordinated whole school approach.
- School principals were to ensure school staff and parents were adequately briefed and that the majority supported participation.
- A school-based KM Action Team of at least three people that included the principal or nominee and ideally a parent representative was to be formed.
- The Action Team would plan and coordinate the implementation of KM within the school and attend a two-day national leadership briefing prior to implementation.
- KidsMatter Project Officers would provide both implementation support (i.e. meeting with Action Teams approximately 1½ hours every five weeks), and whole staff professional learning for each of the four KM components (3 hours per component).

During the KM trial, additional resources provided to schools included:

- an Implementation Manual outlining the rationale and implementation processes
- an annotated Programs Guide providing evaluative information on over 70 school-based mental health programs
- information sheets for parents on more than 30 topics
- resource packs for parents and school staff intended to provide comprehensive information on children’s mental health and wellbeing needs.
1.4 Who conducted the evaluation?

BeyondBlue contracted Flinders University to undertake the evaluation of the KM Pilot Phase, based on a consortium lead by 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 in the 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 the principal KM staff responsible for managing the national Pilot Phase. In addition, the evaluation depended critically on the support of teachers, school leaders and KM Project Officers. These essential working relationships were facilitated by the establishment of an Evaluation website (caef.flinders.edu.au/kidsmatter), 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.

1.5 The KidsMatter Pilot Phase

During 2007 and 2008 the KM Pilot Phase was intended to be trialed in 101 primary schools across Australia. Requests for expressions of interest to take part in KM 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 trial also received a grant from the Australian Rotary Health Research Fund.

Inclusion in KM required schools to participate in an evaluation project that ran across the two years. The 101 schools that were selected from the pool of 260 applicants, were chosen on the basis of a sampling design that took into account the schools' State or Territory, location (metropolitan, rural or remote), size, and sector type (government, independent, Catholic).

1.6 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 two-year evaluation of the KidsMatter Initiative. For further information about the statistical analyses presented in this report, please refer to the KidsMatter Technical Report.
Chapter 2

Evaluating KidsMatter: Method and Participants

The evaluation was a substantial undertaking for all involved in KM. The evaluation team worked closely with the KM client group, 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 KM Project Officers, whose reports provided an important source of evaluation data. However, perhaps the most substantial load was borne by the school communities, the principals, action team leaders, teachers and parents who responded to the multiple evaluation questionnaires. 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 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 on three occasions.
- Regular reports of KM activity provided by the Project Officers responsible for KM schools in each State and Territory.
- Interviews and focus groups conducted with school staff, parents and students in 10 selected Round 1 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 KM Action Team leaders in the final stages of the trial.

More detailed descriptions of each of these sources and their associated documents are provided in the KidsMatter Technical Report.

An extended discussion of the conceptual approaches taken to the design of 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.

2.1 The three-pronged approach to the evaluation

The KM framework and initial conceptual model provided an overarching guiding structure for the design of the Evaluation of the national KM Pilot Phase. 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. Each of these three prongs is now considered in turn.

2.1.1 KidsMatter outcomes

With respect to outcomes from KM, there were two broad underlying issues. The first issue related to change. KM was designed to engender change in schools. Our task was to examine change in key areas associated with KM and to comment on that change. The measurement and representation of change across time in measures relating to participating teachers, parents and students is therefore a major focus in this report. Change at the level of school processes is also a significant interest in KM. We consulted extant literature about educational reform in representing and interpreting this element of change.
The second issue is related to 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)

This position reflects 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 KM conceptual model, shown in Figure 1 (see Chapter 1).

This raised the issue of defining the outcome measures of student mental health. We were advised by our clients that there was strong 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 KM 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' mental health for the evaluation.

However, we were also aware that 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 Prosocial scale of the SDQ. This overlooks the second dimension of mental health, the positive expression of mental health strengths. Therefore, we developed a set of items that asked teachers and parents to rate students in terms of general Mental Health Strengths. In addition, teachers and parents were asked for general ratings of the level of students' Mental Health Difficulties. These latter two sets of items were represented on 7-point scales in order to provide ratings that were more discriminatory than the more limited 3-point SDQ scales.

2.1.2 KidsMatter 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 directly involved in KM, and from the KM 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 4.

2.1.3 Multiple stakeholder perspectives

Seeking the views of the key stakeholders was a central element of our evaluation strategy. The evaluation surveys provided information from teacher and parent informants. The regular reports from KM Project Officers provided a third source of information, and the leadership 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 focus group and interview studies enabled direct exploration of the areas of the evaluation with teachers, parents and students in 10% of the KM schools.

2.2 Specific areas of evaluation

Using the KM conceptual framework and the formal specification for the evaluation, the following areas were the focal points for the generation of information that informed the analyses and the structure of the present report.

- School engagement with, and implementation of, KM in general
- School engagement with, and implementation of, each of the four components
- Impact of KM on schools through changes to their level of performance on each of the four components
- Impact of KM on teachers
- Impact of KM on family context
- Impact of KM on student competencies
- Impact of KM on student mental health

The areas in this list provided the specific framework for the design of the KM questionnaires completed by teachers and parents, 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.
2.3 Overview of the evaluation design and participants

Data for the evaluation were collected from 100 schools between February 2007 and December 2008. Data sources included purpose-designed questionnaires, interviews and focus groups, reports from school leaders and collections of school artefacts. Figure 2 presents an overview of the evaluation design, the participants and the timeline for collection of the various forms of data.

2.3.1 The KidsMatter schools

Over 260 schools across Australia applied to take part in the initiative. KM 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 representative 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. Schools were assigned a State-based KM Project Officer to support schools in implementing KM and provide professional development. One school did not participate in the evaluation due to the transient nature of its students, making a longitudinal evaluation design unworkable, thereby reducing the final sample to 100 schools. Figure 2 shows that even though the 50 Round 1 schools commenced KM in 2007 and the remaining 50 Round 2 schools commenced in 2008, all schools participated in the questionnaires over the two year period.

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 who were culturally and linguistically diverse (ESL/CALD), to a school with 94% ESL/CALD students. Some schools had no Aboriginal or Torres Strait Islander students, and some had more than 75% Aboriginal or Torres Strait Islander students.

Figure 2. Overview of evaluation design and data collection
2.3.2 Participants in the evaluation

With schools selected, the next step in the evaluation was to select a representative sample of students from KM schools, as it was not feasible to survey every child in every school. School enrolment lists provided the sampling frame from which up to 76 target students were randomly selected from each of the 100 KM schools (see Figure 2). Initially, we selected up to 25 boys and 25 girls, aged 10 in 2007 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, by chance, include students of particular interest to KM. 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.

It should be noted that KM schools were a voluntary sample of schools selected from a large sample rather than a random sample. Furthermore, schools were encouraged to select replacement participants for parents not wishing to participate in the evaluation. Therefore, school and 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.

The parents and teachers of the selected students were invited to complete the initial questionnaires during Term 2, 2007. A parent response rate of 70% yielded a sample of questionnaires that reported on 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 KM, we had collected reports on each student from their 2007 teacher and from their 2008 teacher.

A summary of the characteristics of the participants in the KM evaluation is provided in Table 1.

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

<table>
<thead>
<tr>
<th>Schools</th>
<th>N = 100</th>
<th>Government</th>
<th>Catholic</th>
<th>Independent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metro</td>
<td>36</td>
<td>20</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>24</td>
<td>9</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Remote</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>School-wide Characteristics</td>
<td>Round 1 Schools</td>
<td>Round 2 Schools</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male Teachers</td>
<td>15.6%</td>
<td>16.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-Time Teachers</td>
<td>58%</td>
<td>56.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support Teachers</td>
<td>35.5%</td>
<td>23.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Students with Special Needs</td>
<td>9.9%</td>
<td>9.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal or Torres Strait Islander</td>
<td>8.3%</td>
<td>5.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ESL/CALD</td>
<td>16.7%</td>
<td>13.2%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Project Officers</th>
<th>N = 8</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>1</td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Teachers</th>
<th>N = 1393</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>14.9%</td>
<td>85.1%</td>
<td></td>
</tr>
<tr>
<td>Mean Teaching Experience (SD)</td>
<td>14.6 (10.8)</td>
<td>15.2 (10.8)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Students</th>
<th>N = 4980</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>47.8%</td>
<td>52.2%</td>
<td></td>
</tr>
<tr>
<td>Mean Age (SD)</td>
<td>9.6 (1.6)</td>
<td>9.7 (1.6)</td>
<td></td>
</tr>
<tr>
<td>At Risk Status</td>
<td>14.7%</td>
<td>12.3%</td>
<td></td>
</tr>
<tr>
<td>Aboriginal or Torres Strait Islander</td>
<td>1.5%</td>
<td>1.9%</td>
<td></td>
</tr>
<tr>
<td>ESL/CALD</td>
<td>7.2%</td>
<td>8.1%</td>
<td></td>
</tr>
</tbody>
</table>

Teachers show typical characteristics of the Australian teacher population, such as a predominance of female teachers and the indication of an ageing 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 Islander background, and culturally and linguistically diverse background. Round 1 and Round 2 schools have similar demographic profiles. Table 1 shows that our sampling strategy to maintain an equal gender balance, and to 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.
2.3.3 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 (see Figure 2). The goodwill shown by over 30 ethics jurisdictions to process the complex ethics applications associated with the quantitative and qualitative data collection in KM evaluation is testament to the wide ranging support for the evaluation.

2.4 Design of the Whole Cohort Longitudinal Questionnaire study

The first element 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 and teachers of a stratified random sample of up to 76 students in each of the 100 KM schools across the two-years of the pilot. Questionnaire data were collected according to the schedule detailed in Figure 2. Questionnaire completion was a major undertaking. To avoid impacting upon parent goodwill towards KM, questionnaires were collected on three occasions from parents, and on all four occasions from teachers.

The design of the questionnaire was guided by the KM framework, the KM initial conceptual model and the evaluation requirements. This ensured that all aspects of the evaluation were represented in the teacher and parent questionnaires. In addition, individual questions, or items, were sourced from the target areas and objectives set out 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 (for example, Levitt et al., 2007), and from our own research and practical experiences with schooling, families, and student wellbeing (for example, Murray-Harvey and Slee, 2007; Russell et al., 2003; Russell in press; Slee and Murray-Harvey, 2007). A total of 112 items were presented as attitudinal or belief statements and generally required participants to respond using 7-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) are used in the SDQ. While many items in the Parent 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 version.

Overall, the questionnaire was designed to cover a number of broad constructs that pertain to either process or impact, as follows:

Processes of:
- Implementation of KM through the 7-Step process and implementation of each of the four KM components
- Engagement with KM, including engagement with each of the four KM components

Impact on:
- Component 1 (Positive school community)
- Component 2 (Social and Emotional Learning)
- Component 3 (Parenting support and education)
- Component 4 (Early intervention for students experiencing mental health difficulties)
- Staff and teachers
- Family context
- Student competencies
- Student mental health

In addition to these process and impact constructs, the questionnaire also investigated the impact of the professional development delivered in association with KM. The initial set of items developed for the questionnaire were trialled in a non-KM school and adjustment made based on feedback from that trial.

Collections of individual items were designed to encompass each of the constructs listed above. In turn, the items were organised into scales to measure each construct. Throughout the evaluation report, the scales and their individual items are described. A summary and broad definition of each of the scales is set out in the glossary.

2.5 Design of the Stakeholder and Student Voice studies

The second component of the evaluation consisted of focus groups and interviews with principals, teachers, students and parents in 10 diverse schools. This aspect of the evaluation drew on individual experiences during KM, and enabled elaboration of core themes that were common across the schools. By constant comparison of the individual voices of participants to the themes that emerged during the analysis it was possible to gain greater understanding of the perceptions of stakeholders in KM schools.
A preliminary study was undertaken at a local school to trial the focus group and interview questions and research design of the stakeholder and student voice studies. 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 that, on preliminary analysis of data, appeared either to be going well, or were finding difficulties, with implementing KM. 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 evaluator collected data from all of the 10 schools. For cross-checking of perceptions and methods, the evaluator was accompanied by a second evaluator on five occasions.

### 2.5.1 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, parents, students and other school staff in Round 1 KM schools. All of the principals and at least two teaching staff from each of the 10 schools spoke to the evaluator(s) about KM.

The parent focus groups, which ranged in size from 4 to 10 participants, focused on the four KM components and asked parents to consider any changes they had noticed since KM 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 five to eight girls and boys of approximately 10 years of age, commenced with a scenario about a child named Cris. This scenario acted as an ice-breaker for the discussions, 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.

### 2.5.2 Legitimacy and trustworthiness of interview and focus group data

Interview and focus group data require assessment of dependability, consistency (reliability), accuracy and trustworthiness (validity) (Miles and Huberman, 1994), to address whether the experiences of the participants, their perceptions and understandings, legitimately capture the phenomenon under question. Heterogeneity of participants' views is expected when gathering interview and focus group data. However, (Patton, 1990) reported that multiple voices provided by a maximum variation sampling strategy, such as employed in this evaluation, provides important advantages: lending credibility to the individual experiences; providing a coherent picture across all schools; and indicating the consistency of messages, common patterns and issues of central importance that emerged from the data.

Triangulation across settings 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 (further detail about the processes of qualitative data interpretation is contained in the KidsMatter Technical Report).

### 2.6 KidsMatter Project Officer Reports: An external school perspective

We designed a Project Officer Report form that was completed by the eight Project Officers on five occasions for their Round 1 schools and on three occasions for their Round 2 schools during 2007-2008, as indicated in Figure 2. The Project Officer Report was completed online and collected contextual and event data. It contained multiple-choice and open-response questions that enabled the Project Officers to provide details of, and reflections about, the roll-out of KM in their respective schools.

In addition, members of the Flinders evaluation team attended KM Cluster meetings in order to better understand the issues and contexts that Project Officers experienced in their work with staff in KM schools.

### 2.7 School Leadership Executive Summaries: A perspective from leadership

An additional source of qualitative information was sought from all KM school principals and action team members at the end of KM in 2008, using the Leadership Executive Summary. This was designed 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.” The potential benefits of a Leadership Executive Summary was realised as the evaluation developed and was not in the original design, so completion of the Executive Summary was voluntary. Nevertheless, 61 schools provided Leadership Executive Summaries.
2.8 Summary of all data collected

Table 2 presents an overview of all of the data collected for the KM evaluation. In summary, of the 7114 students identified in the 100 schools, data were received at Time 1 from parents and teachers of 4980 students, resulting in an initial response rate of 70%. Of these students, 76% were present for data collection on all four occasions. Accordingly, the sample size and composition, together with the response rates, are considered appropriate for the statistical analyses undertaken in the evaluation.

All of the KM Project Officer Reports were received, resulting in a 100% response rate. For the voluntary Leadership Executive Summary, 62% of schools responded. In addition, the 10 case study schools yielded over 80 hours of interview and focus group recordings. These involved 64 Stakeholder interviews (principals, KM Action Team, counsellors and teachers), 19 parent focus groups and 20 Student Voice focus groups.

We would like to note here that the feedback, high response rate, and cooperation received from staff and parents in KM schools for the processes of the evaluation were overwhelmingly positive.

Table 2. Summary of all data collected in the KidsMatter evaluation

<table>
<thead>
<tr>
<th>Year</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Final returns</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Time 1</td>
<td>Time 2</td>
</tr>
<tr>
<td>School Term/Quarter</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Data Collection Time</td>
<td>28205</td>
<td></td>
</tr>
<tr>
<td>Student Enrolment Lists</td>
<td></td>
<td>1397</td>
</tr>
<tr>
<td>Teachers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student Sample Lists (B)</td>
<td>7114</td>
<td>4980</td>
</tr>
<tr>
<td>Parent Questionnaire (D)</td>
<td>4346</td>
<td>2995</td>
</tr>
<tr>
<td>Teacher Supplement (E)</td>
<td>4793</td>
<td>4592</td>
</tr>
<tr>
<td>Teacher Questionnaire (F)</td>
<td>812</td>
<td>802</td>
</tr>
<tr>
<td>Response Rate at each return</td>
<td>70%</td>
<td>97%</td>
</tr>
<tr>
<td>School Profile</td>
<td>100</td>
<td>99</td>
</tr>
<tr>
<td>Project Officer Rpt Round 1 Schools</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Project Officer Rpt Round 2 Schools</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Leadership Executive Summary</td>
<td>53</td>
<td>62% School response rate</td>
</tr>
<tr>
<td>Coordinator Executive Summary</td>
<td>61</td>
<td></td>
</tr>
<tr>
<td>Principal and Staff Interviews</td>
<td>64</td>
<td></td>
</tr>
<tr>
<td>Parent Focus Groups</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Student Focus Groups</td>
<td>20</td>
<td></td>
</tr>
</tbody>
</table>

2.9 Analysing and reporting the results

The remaining chapters of this report are focused upon the presentation and interpretation of results structured around the specific areas of the evaluation detailed at the start of this chapter. Given the wealth of data collected from multiple informants in multiple contexts on multiple occasions using multiple methods, a number of key decisions were made towards developing a consistent approach to the presentation of results.

2.9.1 Round 1 and Round 2 schools

The KM trial was rolled out in two phases. In 2007 it began in the Round 1 schools, and in 2008 it began in the 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 KM in Round 1 and Round 2 schools means that for Round 1 schools no data could be collected prior to the commencement of KM, whereas for Round 2 schools, the first year provided information largely prior to the introduction of KM. 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 KM. This developing expertise for implementation over the first 12 months can be predicted to have changed how the KM was rolled out in Round 2 schools.
Effect sizes can be calculated in a number of ways. Two common methods are Cohen’s $d$ and the correlation coefficient. In this report we use correlations of 0.10, 0.24, and 0.37 as indicative of small, medium and large effects, respectively. In the cases when there is limited practical significance, that is $r < .10$, we do not report an effect size, even if there is still statistical significance.

---

2.9.2 Confirming the scales

In the questionnaires, each conceptual construct being assessed (for example, mental health difficulties) was underpinned by a number of items. The theoretical basis for the grouping of items was then tested to ensure that there was good agreement amongst items. Accordingly, the items included in each construct were subjected to confirmatory factor analysis using asymptotically distribution-free (CFA-ADF) methods available in AMOS in order to confirm the factor structure of the groups of items (Tabachnick & Fidell, 2001; Garson, 2009). With scale reliability and validity confirmed using methods sensitive to highly skewed data, item scores were averaged to provide a final score for each scale construct. The main emphasis in reporting the evaluation findings is based upon these averaged item scores, rather than the individual items, though the items are also presented. Further detail about the confirmatory factor analysis is contained in the KidsMatter Technical Manual.

2.9.3 Measuring change over the time of KidsMatter

A major focus in the evaluation was on changes over time in both Round 1 and Round 2 schools. The main interest was whether or not the questionnaires gathered at the four different times showed evidence of change that could be associated with KM. To assess this evidence we used a form of analysis known under various labels, such as multilevel modelling, or hierarchical linear modelling (HLM) (Bryk & Raudenbush, 1992). Version 5 of the HLM program was used in preference to more recent versions since it had greater capacity to handle missing data.

HLM has specific advantages for analysing complex longitudinal nested data such as that gathered in this evaluation by developing and testing models that examine change within schools. It provides information about the slope or gradient of change across time, which enables an assessment of whether the line summarising the trajectory of change across time goes up, or down, or stays at much the same level.

For example, in this evaluation, one question we were interested in was the way that the mean responses of teachers on items about their knowledge about Social and Emotional Learning changed across the four data collection occasions. HLM models examining change between teachers within schools allowed us to estimate whether the slope of that change was in a positive or negative direction, and whether that change was statistically significant.

In the results presented in the following chapters we provide information generated from analyses using HLM, and the mean levels of teacher and parent responses on the various measures (scales) used in the evaluation. This information is shown in tables and in figures that present the HLM slopes associated with the multiple occasions of data gathering. In addition to reporting HLM means at Time 1 and Time 4, the statistical significance, $p$, is also reported at three levels, where *** is equivalent to $p < .000$, ** is given for $p < .001$, * is presented as $p < .01$, and not significant (ns) is $p > .01$.

In addition to the analysis of change through the use of HLM, this report also contains a more descriptive approach in the form of percentages. Teacher and parent responses to the individual questionnaire items were on a 7-point Likert scale with anchor points of ‘strongly disagree’ and ‘strongly agree’. A special focus in the report has been placed on the percentage of parents and teachers who reported that they strongly agreed on particular items. ‘Strongly agreed’ was taken as the highest two levels of the response scale (i.e., scored 6 or 7 on the Likert scale). The percentage of respondents who strongly agreed is used in this report in two ways. First, it is used to provide an indication of performance at the end of KM (Time 4). For example, if 80% of teachers strongly agreed that the school had worked on implementing Social and Emotional Learning, this is used as evidence of this component having been implemented. Second, change in the proportion of respondents who strongly agreed is used as supporting evidence of change in association with KM.

2.9.4 Statistical significance and effect size

Statistical significance testing provides both a measure of uncertainty of a result (such as $p < .05$) 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 a guide to the practical significance of a statistically significant result, a guide as to ‘whether the result is useful in the real world’ (Kirk, 1996, p.746). In this evaluation statistical significance is reported. However, the discussion of the outcomes of the statistical analysis focuses upon effect sizes, because these give a better indication about whether an outcome is of practical benefit.

Effect sizes can be calculated in a number of ways. Two common methods are Cohen’s $d$ and the correlation coefficient. In this report we used the part-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. In the cases when there is limited practical significance, that is $r < .10$, we do not report an effect size, even if there is still statistical significance.

---

7 The effect sizes were calculated using a simple formula that relates the part-correlation coefficient, $r$, and the slope of a regression line, $b$, expressed in deviation-score form (Ferguson, 1971, p.113).
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) $d = .07$, indicating that less than one-eighth of one per cent 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. Furthermore, small effects that work incrementally over time can be extremely important because they eventually result in substantial change. There may also be influences that act as moderators to effect sizes. For example, Hattie reported an overall effect size of $d = .29$ for the influence of homework on students’ academic achievement. However, when student age is taken into account, primary age students gain least from homework ($d = .15$) whilst secondary students gain more ($d = .64$).

It is also important to consider the variability of educational contexts, where different schools, with different teachers, and different children interact. A fundamental approach of KM was that mental health promotion and early intervention programs would not be externally imposed, but rather, that KM would work within the schools’ existing contexts to support KM 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.

### 2.10 Chapter summary

In this chapter we presented the overall evaluation design and participants. The individual studies were described and justified. The emphasis of the evaluation was on a multi-method, multi-informant design, with a longitudinal component. The design matched the needs of the evaluation and the KM framework. Priority was placed on methodological soundness and conformity to current principles of evaluation.
“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

The first step in the evaluation was to examine whether and how schools implemented and became engaged with KM. 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 Reports, and the leadership executive summaries. In the present chapter, the emphasis is on the whole cohort longitudinal study and Project Officer Reports. The findings show that, in general, schools actively engaged with KM and worked at its implementation. Over the course of the evaluation, schools, teachers and parents increasingly became engaged with KM. One way in which this was revealed was through parent and teacher responses to the evaluation questionnaire.

3.1 Teacher perspectives on engagement with the four KidsMatter components

Teachers were asked a set of items (see Table 3) about the extent to which the school worked on each of the four components. They responded on a 7-point response scale, from ‘Not at all’ to ‘A great deal’. Evidence about the individual components is presented below in the separate chapters about each component. In this chapter, the teachers’ answers are combined across the four components to indicate the overall extent to which schools engaged with KM, with higher scores indicating greater levels of engagement. The more teachers agreed that schools worked on the four components, the more engaged they were with KM. Answers at the end of the two years provide an overall indication of how engaged schools were with the KM components. Changes in answers to these items across the two years show whether schools became increasingly engaged with KM.

Table 3. KidsMatter Engagement (T)

<table>
<thead>
<tr>
<th>Rate the extent to which your school has worked on the following four components:</th>
<th>Round 1</th>
<th>Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>A positive school community</td>
<td>71%</td>
<td>64%</td>
</tr>
<tr>
<td>Social and Emotional Learning for students</td>
<td>73%</td>
<td>63%</td>
</tr>
<tr>
<td>Parenting support and education</td>
<td>46%</td>
<td>43%</td>
</tr>
<tr>
<td>Early intervention for students who are at risk or are experiencing social, emotional or behaviour difficulties</td>
<td>54%</td>
<td>42%</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>61%</strong></td>
<td><strong>53%</strong></td>
</tr>
</tbody>
</table>

By the end of the evaluation (at Time 4), 61% of teachers in Round 1 schools, and 53% in Round 2 schools indicated that their school had worked on the four components ‘a great deal’ (scored 6 or 7). Figure 3 shows medium and large effect sizes for changes from Time 1 to Time 4, based on the lines of best fit. The graph in Figure 3 shows a greater increase in engagement for Round 2 schools, which is expected given that they did not formally commence KM until the second year. The two sets of schools reached a similar level of engagement by the end of the trial.
The findings indicate a strong agreement that teachers overall had “worked on” the four components.

3.2 Teacher perspectives on use of the 7-Step implementation process

A set of eight items for teachers specifically related to the KM 7-Step implementation process (see Glossary). These items are provided in Table 4. The eight items match the steps in the implementation process, with extra detail provided by the seventh question, which requested information about implementation of each of the four components. The results for the eight items were combined into the KM Implementation scale. Answers to these items at the end of the two years of KM provide a summary of the degree to which schools followed the implementation process. Positive changes in answers to the items over the two years would indicate that schools became increasingly involved with the implementation of KM.

At Time 4, teachers’ ‘strongly agree’ ratings for the steps in the implementation process varied between 46% to 71% in Round 1 schools, and between 36% to 66% in Round 2 schools. The graph in Figure 4 shows a greater increase in teacher-reported implementation for Round 2 schools, but a similar level of implementation by the end of the two years for Round 1 and Round 2 schools.

The teachers’ responses indicate a broad agreement that schools overall had used the steps in the recommended implementation process.

Table 4. KidsMatter Implementation (T)

<table>
<thead>
<tr>
<th>From your own experience, rate the extent to which you disagree or agree with the following statements:</th>
<th>Round 1</th>
<th>Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our school has defined issues related to the four KidsMatter components</td>
<td>60%</td>
<td>56%</td>
</tr>
<tr>
<td>Our school has set goals for the four components</td>
<td>57%</td>
<td>51%</td>
</tr>
<tr>
<td>Our school has identified difficulties in achieving our goals</td>
<td>48%</td>
<td>41%</td>
</tr>
<tr>
<td>Our school has developed strategies for achieving our goals for the four components</td>
<td>51%</td>
<td>44%</td>
</tr>
<tr>
<td>Our school has evaluated strategies for addressing the four components</td>
<td>48%</td>
<td>36%</td>
</tr>
<tr>
<td>Our school has developed coherent plans for the four components</td>
<td>46%</td>
<td>40%</td>
</tr>
<tr>
<td>Our school has implemented plans to develop</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) a positive school community</td>
<td>71%</td>
<td>66%</td>
</tr>
<tr>
<td>b) Social and Emotional Learning for students</td>
<td>53%</td>
<td>50%</td>
</tr>
<tr>
<td>c) parenting support and education</td>
<td>58%</td>
<td>47%</td>
</tr>
<tr>
<td>d) early intervention for students who are at risk or are experiencing social, emotional or behaviour difficulties</td>
<td>49%</td>
<td>37%</td>
</tr>
<tr>
<td>Our school has reviewed and adjusted plans for the four KidsMatter components</td>
<td>60%</td>
<td>56%</td>
</tr>
</tbody>
</table>

Archived at Flinders University: dspace.flinders.edu.au
3.3 Parent perspectives of KidsMatter implementation

Three items in the questionnaire addressed parents’ perceptions of the general level of implementation of KM. Parents rated the extent to which they agreed with the three items listed in Table 5. These are broad items, with greater agreement from parents taken as evidence of KM implementation in the school. These items were phrased in this broad way because it was not expected that parents would be aware of the individual KM components or the 7-Step implementation process. At Time 4, 60% of parents in Round 1 schools, and 62% in Round 2 schools ‘strongly agreed’ about the implementation of KM. This suggests that at Time 4 parents had a relatively good awareness of KM and felt engaged with it.

Figure 5 shows the pattern of change in parent ratings about implementation. The effect sizes for change from Time 1 to Time 4 for the group of KM Implementation items for parents were medium in Round 1 schools, and large in Round 2 schools, indicating that parents were increasingly aware of and involved with KM over the two years. The mean responses at Time 4 provide evidence for substantial implementation of KM from the perspectives of parents. The graph in Figure 5 shows the greater increase in parent-reported implementation for Round 2 schools, reaching a similar extent of implementation by the end of the two years for Round 1 and Round 2 schools.

Table 5. KidsMatter Implementation (Parent perspective)

<table>
<thead>
<tr>
<th>From your own experience, rate the extent to which you disagree or agree with the following statements:</th>
<th>Round 1</th>
<th>Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have heard about KidsMatter</td>
<td>72%</td>
<td>72%</td>
</tr>
<tr>
<td>I feel positively about KidsMatter</td>
<td>62%</td>
<td>64%</td>
</tr>
<tr>
<td>I am encouraged to participate in the KidsMatter Initiative</td>
<td>47%</td>
<td>52%</td>
</tr>
<tr>
<td>Average</td>
<td>60%</td>
<td>62%</td>
</tr>
</tbody>
</table>
The responses from parents indicate that the schools had implemented KidsMatter in such a way as to generally engage parents in the initiative.

### 3.4 Evidence about implementation of KidsMatter from the Project Officer Reports

The following section uses information from Project Officer Reports to examine the KM 7-Step implementation process and engagement with KM.

Figure 6 presents Project Officers' ratings of the average progress that their Round 1 and Round 2 schools made through the 7-Steps on each of the four components at Times 2, 3 and 4. Progress data was not available for Time 1. A rating of 7 indicates that the school had completed the whole implementation process. The differences between Round 1 and Round 2 schools, shown in Figure 6, illustrates that Round 1 schools achieved rapid progress, and by Time 3 were involved in sustained implementation across the four components. Meanwhile, Round 2 schools showed limited progress in the first year, as expected, and by Time 4 were achieving substantial progress on implementation. Most progress appears to have been made on Component 2 (Social and Emotional Learning) and least progress was made on Component 4 (Early intervention). It can be seen that at the end of the trial most schools were developing and implementing plans for Component 2. In contrast, for Component 4, schools mainly achieved Step 4, developing and evaluating strategies for implementing the component.

Because the results in Figure 6 are averaged across all schools, it means that some schools did achieve the final review step, but others did not. This was especially the case for the first two components, where almost half the Round 1 schools achieved the final review step according to Project Officers at Time 4.
Based on assessment by Project Officers, only eight Round 1 schools and three Round 2 schools had completed the review step for all four components by the end of the two years of KM. However, given that Round 2 schools only had one year to implement the entire KM framework, this finding is expected. A better indicator of implementation and its potential for impact, considers the step of ‘implementing’ the component plans. This is illustrated in Figure 7, which shows the proportion of schools that achieved at least up to the stage of implementing their plans by Time 4. The lower proportion of Round 2 schools completing the step of implementing plans for each component within the two years is evident, along with a greater proportion of schools implementing the first two components.

Project Officer Reports support the views of teachers that schools did give attention to each of the four components across the KidsMatter trial, and that they generally followed the recommended 7-Step implementation process.
3.5 Professional development as an element in KidsMatter implementation

A central element in the KM implementation was the provision of professional development for teachers. The professional development was provided by the KM Project Officers. In order to gauge the quality of professional development, the evaluation questionnaire asked teachers to score Poor (1) to Excellent (7) for the following statement:

*In general, the quality of the professional development for KidsMatter has been…*

Over half (52%) of the teachers in Round 1 schools, and 60% of the teachers in Round 2 schools rated the professional development as ‘excellent’ (scored 6 or 7) by the end of KM (see Figure 8). The following comment by a Principal is illustrative of this view.

“A lot of the staff … and I mean they’ve been doing KidsMatter for a while now, I think we just need a reminder. To have PO come in and say ‘OK now, these are our four components, let’s have a look at this’.” Principal School 2

![Figure 8. Teacher responses to “The quality of the professional development for KidsMatter has been…”](image)

At the same time, only 6% (Round 1) and 5% (Round 2) of teachers nominated scores below the neutral level (score 4) for the quality of the KM professional development. Note that the neutral rating at Time 2 for Round 2 schools reflects the fact that those schools had not yet received KM professional development.

The questionnaire responses about professional development were generated in a context separate from the professional development itself, and might be taken to indicate teachers’ considered reflections related to the impact of the professional development on their subsequent knowledge and actions related to mental health.

In general, teachers indicated that the quality of the professional development for KidsMatter has been good.

3.6 General engagement with students’ mental health and wellbeing

The evaluation team recognised that schools would already be substantially involved with activities related to students’ mental health when they began KM. In particular, we recognised that at the time of the introduction of KM, schools may already be delivering social, emotional and behavioural intervention programs, focusing on the quality of the school community, working with parents, and undertaking efforts to intervene with students experiencing mental health difficulties. For this reason, questionnaire items were designed to gather information about the activities that KM schools were already undertaking related to general engagement with activities supporting students’ mental health and wellbeing. The longitudinal data collection design enabled us to investigate whether these activities changed during the KM period.

Eight items were included in the parent questionnaire, and ten items included in the teacher questionnaire about schools’ engagement with mental health initiatives in general. The items are given in Table 6. The items were grouped to form scales of school engagement with students’ mental health and wellbeing. Note that following extensive discussions and advice from our KM partners, in designing these items we deliberately chose to use the words ‘emotional or social or behaviour difficulties’ rather than referring to “students’ mental health”, in order to avoid stigma and to assist the understanding of parents and teachers.

At Time 4, 61% of teachers and 42% of parents in Round 1 schools, and 57% of teachers and 43% of parents in Round 2 schools strongly agreed to items about their schools’ engagement with students’ mental health and wellbeing.
The results of the multilevel modelling (HLM) of change over time in schools' general engagement with student mental health and wellbeing are presented in Figure 9. It can be seen that from both parent and teacher questionnaires, schools were rated well above the neutral point on the 7-point Likert scale in terms of this scale. The teachers' ratings showed a small positive slope in both Round 1 and Round 2 schools. The parent ratings for this scale showed little change in both sets of schools. One explanation for the difference between parent and teacher reports on this scale is that teachers would be expected to have more information at hand about their school's engagement with students' mental health and wellbeing (such as programs and referrals). Another explanation, and one supported by comments from the Stakeholder study, is that parents often did not take much interest in school-based mental health initiatives if they felt that such initiatives were not relevant to their own child.

The results for schools' engagement with students' mental health and wellbeing confirmed that, in general, schools did have a focus on these aspects of the welfare of their students throughout the trial. From teacher reports there was a statistically significant change in this engagement across time, associated with a small effect size. The initial high level of the ratings from teachers and parents, together with the broad and general nature of the items, could have been factors in the limited evidence of change over time for engagement with students' mental health and wellbeing.

Table 6. School engagement with students' mental health and wellbeing

<table>
<thead>
<tr>
<th>Parent Items</th>
<th>Round 1</th>
<th>Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>From your own experience, rate the extent to which you disagree or agree with the following statements:</td>
<td>'Strongly Agree' at Time 4</td>
<td></td>
</tr>
<tr>
<td>Staff at the school are concerned for children with emotional or social or behaviour difficulties</td>
<td>52%</td>
<td>53%</td>
</tr>
<tr>
<td>The school encourages parents to discuss their children's emotional or social or behaviour difficulties with staff.</td>
<td>48%</td>
<td>48%</td>
</tr>
<tr>
<td>The school has good links with professionals who can assist students with emotional or social or behavior difficulties (such as social workers, psychologists, nurses and doctors)</td>
<td>40%</td>
<td>38%</td>
</tr>
<tr>
<td>Parents/caregivers are involved when staff make decisions about their child's emotional or social or behaviour difficulties</td>
<td>44%</td>
<td>44%</td>
</tr>
<tr>
<td>The school is doing a good job in helping students who have emotional or social or behaviour difficulties</td>
<td>44%</td>
<td>43%</td>
</tr>
<tr>
<td>The external school support services (such as psychologists and social workers) do a good job in helping students who have emotional or social or behaviour difficulties</td>
<td>35%</td>
<td>32%</td>
</tr>
<tr>
<td>I find it easy to discuss my child's social and emotional skills with school staff</td>
<td>54%</td>
<td>55%</td>
</tr>
<tr>
<td>My child talks about ways to solve his/her emotional or social or behaviour difficulties</td>
<td>40%</td>
<td>38%</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td>45%</td>
<td>44%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Teacher Items</th>
<th>Round 1</th>
<th>Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>The school leadership team actively supports the implementation of programs to develop students' social and emotional skills</td>
<td>74%</td>
<td>69%</td>
</tr>
<tr>
<td>All teaching staff support the teaching of social and emotional skills to students</td>
<td>66%</td>
<td>63%</td>
</tr>
<tr>
<td>Parents/caregivers actively support the school's program for teaching social and emotional skills</td>
<td>50%</td>
<td>38%</td>
</tr>
<tr>
<td>Teachers attend professional development about supporting students with emotional or social or behaviour difficulties</td>
<td>55%</td>
<td>64%</td>
</tr>
<tr>
<td>Teachers discuss students' emotional or social or behaviour difficulties with the appropriate staff</td>
<td>75%</td>
<td>73%</td>
</tr>
<tr>
<td>Teachers discuss individual student's emotional or social or behaviour difficulties with the student's parents/ caregivers</td>
<td>70%</td>
<td>64%</td>
</tr>
<tr>
<td>The school has good links with professionals such as social workers, psychologists, nurses and doctors who can support students who have emotional or social or behaviour difficulties</td>
<td>47%</td>
<td>39%</td>
</tr>
<tr>
<td>Staff consult parents/caregivers about emotional or social or behaviour interventions for their children</td>
<td>60%</td>
<td>59%</td>
</tr>
<tr>
<td>Our teaching about social and emotional skills engages students’ interest</td>
<td>58%</td>
<td>54%</td>
</tr>
<tr>
<td>Parents/caregivers are positive about teaching social and emotional skills to students at school</td>
<td>56%</td>
<td>49%</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td>61%</td>
<td>57%</td>
</tr>
</tbody>
</table>

The analysis suggests that schools have maintained a relatively high level of attention to, and engagement with, students' general mental health and wellbeing across the trial period.
3.7 Chapter summary

At the commencement of KM, schools gave evidence to suggest that they had a general focus on and engagement with strategies for promoting students’ mental health and wellbeing. However, in many schools the introduction of KM provided a lens to better identify needs and led to the development of new activities and strategies in this area. The evidence was clear that schools engaged with KM and actively worked at its implementation. For Round 1 schools the ratings for implementation from both parents 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, in parent and teacher reports, steeper rates of increase. The pattern is similar for teacher ratings of engagement with KM. 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. The teacher and parent ratings for Time 4 reveal a pattern of substantial implementation and engagement with KM.

Although progress was made on all components, 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.

Not all schools were rated by the Project Officers as having reached the ‘implemented plan’ step on the implementation process by the end of the evaluation. Nevertheless, approximately 68% of schools had achieved this level for the components of Positive school community and Social and Emotional Learning.
Chapter 4

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 consider more closely the variations among schools in the level and manner of implementation of KM. For this purpose we used information from the final (Time 4) Parent, Teacher and Project Officer Questionnaires to develop an Implementation Index that was structured around the three principles of fidelity, dosage and quality of delivery (Domitrovich, 2008). This allowed consideration of particular areas of implementation where there were differences between schools that achieved high and low Implementation Index scores.

4.1 An implementation framework

Australian school students spend over six hours per day in school and various authors have noted that this presents an important opportunity to provide a range of school-based services including mental health programs (Domitrovich, 2008). It is also recognised that schools are complex organisations providing significant challenges for the delivery of new intervention programs, such as KM (Barry & Jenkins, 2007; Clift & Jensen, 2005; Payne 2009). A range of publications, as reviewed in Payne (2009), has pointed to the nature of the challenges associated with effectively implementing research-based school intervention and prevention programs (e.g. Melde, Esbensen, & Tusinski, 2006). Domitrovich argued that many school-based prevention programs were not well implemented in schools because of the complexity of school environments and that lower-quality implementation led to poorer program effectiveness.

Program fidelity, broadly described as whether a program was delivered in a comparable manner to all participants consistent with its conceptual foundations, is therefore, a significant, if under-researched, component of school-based intervention programs. Lee and colleagues (2008) noted that only a minority of intervention studies had 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, making the assumption that the participants received the intervention they were supposed to receive.

The nature of the KM intervention encouraged us to use information from our range of data sources to consider the fidelity of its implementation. A strength of KM is that it is a school-based intervention that is supported with substantial resources. These resources include teaching resources, a systematic program of professional development and the continuing support of Project Officers.

Although there are some aspects of implementation fidelity that cannot be addressed in this evaluation, such as the extent to which schools delivered the specific details of a program as intended, it is possible for us to examine information related to support fidelity of KM implementation (Bellg et al., 2004; Oshima, Cho, & Takahashi, 2004). In this chapter, consideration is given to the assessment of KM implementation in relation to the key parameters of ‘fidelity’, ‘dosage’ and ‘quality of delivery’.

In order to identify schools as being low or high implementers of KM, an Implementation Index framework was developed, based on Domitrovich’s (2008) recommendations, using information from participants who were involved in the implementation of KM within the school, and from the Project Officers who were providing the support and resources and were external to the school.

A pool of items from the Parent, Teacher and Project Officer Questionnaires, that might provide useful discriminators of school implementation, was identified. These indicators were arranged according to Domitrovich’s (2008) categories of ‘fidelity’, ‘dosage’ and ‘quality of delivery’, based on multiple points of view – those of the teachers and parents, and those of the Project Officers. The indicators were then combined to form an Implementation Index that would be suitable for classifying KM schools according to the
quality of their implementation of KM. In using this Implementation Index, our particular interests were initially in examining whether there was a positive relationship between implementation index score and student outcomes, and then in identifying the particular features of those schools in order to provide indicators of exemplary practice.

The Implementation framework is represented in the row and column headings of Table 7. In each cell of the table are the data sources selected to assess the quality of intervention and quality of support.

Table 7. The KidsMatter Implementation Index framework

<table>
<thead>
<tr>
<th></th>
<th>Participant View</th>
<th>Project Officer View</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fidelity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Degree to which an intervention is conducted as planned</td>
<td>School views of progress</td>
<td>Project Officer views of progress</td>
</tr>
<tr>
<td></td>
<td>7-Step Implementation Process</td>
<td>7-Step Implementation Process</td>
</tr>
<tr>
<td></td>
<td>SEL curriculum</td>
<td></td>
</tr>
<tr>
<td><strong>Dosage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specific units of an intervention and resources</td>
<td>In-school activities</td>
<td>Project Officer activities</td>
</tr>
<tr>
<td></td>
<td>Time allocated to planning and implementation, Principal participation</td>
<td>Contact with school leadership, Parent events and information dissemination</td>
</tr>
<tr>
<td></td>
<td>Amount of professional development</td>
<td></td>
</tr>
<tr>
<td><strong>Quality of delivery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engagement with the process &amp; support responsiveness</td>
<td>School and leadership views</td>
<td>Project Officer views</td>
</tr>
<tr>
<td></td>
<td>Quality of PD</td>
<td>Leadership and staff encouragement and involvement</td>
</tr>
<tr>
<td></td>
<td>Parent and Teacher engagement</td>
<td></td>
</tr>
</tbody>
</table>

Latent Class Analysis (in Mplus 5.2) was used to identify the Implementation Index 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 8 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. A full discussion of the analysis is presented in the KidsMatter Technical Report.

Using the response scores shown in Table 8, a total Index score was calculated for each school. Missing values were below 5% and were replaced with the local median. Schools ranged from a low score of 89 to a high score of 205 (see Table 8). The Index score was ranked to establish two categories of schools: The schools with high scores were identified as the ‘high implementation’ category, while the second category included schools with low scores, referred to as the ‘low implementation’ group. The schools that fell into the moderate range on the Implementation Index were not considered in this analysis. In Round 1 schools, as might be expected, more schools were identified as being high implementers (56%), compared to Round 2 schools, in which 46% of schools were identified as high implementers.

Table 8. Items in the KidsMatter Implementation Index

<table>
<thead>
<tr>
<th></th>
<th>Participant views (Implementation)</th>
<th>Max Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fidelity</strong></td>
<td>From your own experience, rate the extent to which you disagree or agree with the following statements: 1 = SD, 7 = SA</td>
<td></td>
</tr>
<tr>
<td>(Teacher)</td>
<td></td>
<td>56</td>
</tr>
<tr>
<td>Our school has defined issues related to the four KidsMatter components</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Our school has set goals for the four components</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Our school has identified difficulties in achieving our goals</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Our school has developed strategies for achieving our goals for the four components</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Our school has evaluated strategies for addressing the four components</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Our school has developed and implemented coherent plans for the four components</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Our school has reviewed and adjusted plans for the four KidsMatter components</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>The school teaches social and emotional skills to students in formally structured sessions that adhere to a program manual</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td><strong>Dosage</strong></td>
<td>Principal attends most KidsMatter meetings? No = 1, Yes = 2</td>
<td>2</td>
</tr>
<tr>
<td>(Teacher)</td>
<td>On average, how much: 1 = under 5 mins, 2 = under an hour, 3 = more than an hour</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a) formal time per week does the Action team allocate to planning &amp; implementing KidsMatter?</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>b) time in staff meetings is formally allocated to KidsMatter?</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Teachers attend professional development associated with KidsMatter 1 = SD, 7 = SA</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Sub Total</td>
<td>15</td>
</tr>
</tbody>
</table>
| Quality of delivery (Parent) | The following questions ask you to consider the ways in which you have been involved with KidsMatter:  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a) I feel positively about KidsMatter</td>
<td>1 = SD, 7 = SA</td>
</tr>
<tr>
<td>b) I am encouraged to participate in KidsMatter</td>
<td>7</td>
</tr>
<tr>
<td>c) I have formed more support networks with other parents since KidsMatter</td>
<td>7</td>
</tr>
<tr>
<td>d) I have been more involved with the school since KidsMatter</td>
<td>7</td>
</tr>
<tr>
<td>e) I feel that the school community is more positive since KidsMatter</td>
<td>7</td>
</tr>
</tbody>
</table>
| (Teacher) | In general, the quality of the Professional Development for KidsMatter has been:  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>--------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>In general, the quality of the Professional Development for KidsMatter has been:</td>
<td>1 = Poor, 7 = Excellent</td>
</tr>
<tr>
<td>Sub Total</td>
<td>42</td>
</tr>
</tbody>
</table>

| Fidelity (Project Officer) | This section is designed to measure how effective the school has been in undertaking the 7-Step Implementation process SINCE COMMENCEMENT of KidsMatter. It is not about the components, but rather the implementation process of the whole KidsMatter Initiative. This school has:  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Defined the issues related to the components they worked on</td>
<td>1 = SD, 7 = SA</td>
</tr>
<tr>
<td>Set goals for the components they worked on</td>
<td>7</td>
</tr>
<tr>
<td>Identified difficulties for achieving goals for the components they worked on</td>
<td>7</td>
</tr>
<tr>
<td>Developed strategies for achieving goals for the components they worked on</td>
<td>7</td>
</tr>
<tr>
<td>Evaluated strategies for addressing the components they worked on</td>
<td>7</td>
</tr>
<tr>
<td>Developed and implemented plans for the components they worked on</td>
<td>7</td>
</tr>
<tr>
<td>Reviewed and adjusted plans for the components they worked on</td>
<td>7</td>
</tr>
<tr>
<td>KidsMatter is well implemented in this school</td>
<td>7</td>
</tr>
<tr>
<td>Sub Total</td>
<td>56</td>
</tr>
</tbody>
</table>

| 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 to meet with each other?  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>How many times?</td>
<td>1 = no none; 2 = once, …7 = six or more times</td>
</tr>
<tr>
<td>From your discussions with school leadership, did the school:</td>
<td>No = 1, Yes = 2</td>
</tr>
<tr>
<td>a) Send newsletters containing information about parenting home to families?</td>
<td>2</td>
</tr>
<tr>
<td>b) Send tip sheets containing information about parenting home to families?</td>
<td>2</td>
</tr>
<tr>
<td>c) Send KidsMatter Information sheets home to parents?</td>
<td>2</td>
</tr>
<tr>
<td>Did you have contact with the Deputy Principal?</td>
<td>No = 1, Yes = 2</td>
</tr>
<tr>
<td>Sub Total</td>
<td>15</td>
</tr>
</tbody>
</table>

| 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.  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The school leadership encourages staff to become actively involved with KidsMatter</td>
<td>1 = SD, 7 = SA</td>
</tr>
<tr>
<td>Staff are actively involved with KidsMatter</td>
<td>7</td>
</tr>
<tr>
<td>The school leadership team is actively involved with KidsMatter</td>
<td>7</td>
</tr>
<tr>
<td>Parents in this school are encouraged to participate in KidsMatter</td>
<td>7</td>
</tr>
<tr>
<td>The whole staff are involved in the planning of KidsMatter</td>
<td>7</td>
</tr>
<tr>
<td>The whole staff are involved in the implementation of KidsMatter</td>
<td>7</td>
</tr>
<tr>
<td>Sub Total</td>
<td>42</td>
</tr>
</tbody>
</table>

| Total Index Score | 226 |
4.2 School profiles on the Implementation Index

Figure 10 shows profiles across the different items, for schools rated low and high on the Implementation Index.

From Figure 10 it can be seen that, for the first eight items located at the top of the chart, which are teachers’ reports about teaching social and emotional competencies and the 7-Step implementation process, there is not a great deal of difference in Implementation scores between the schools. However, the KM Project Officer reports about the 7-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 items, “Developed and implemented plans” and “Reviewed and adjusted plans.” It may be that the low implementing schools did not have time to reach these stages, or that they did not set up procedures that helped them to engage in the implementing and reflective processes. Time spent by the KM Action Teams (whether actual or perceived by respondents) is another point of difference between high and low implementing schools. It is also of note that the Project Officers’ responses to the item requesting an overall judgement about the quality of implementation, shows a substantial separation between the high and low implementers.
The next main area of difference between the schools lies in the last six variables at the bottom of the chart. These variables deal with the involvement of parents, staff and leadership with KM. 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 KM are to be successfully embedded within schools.

Finally it is of interest to consider the items in which both groups showed relatively low scores, around the centre and lower end of Figure 10. For both Round 1 and Round 2 schools these items focus on the provision of information to parents, perhaps reflecting a lower level of attention given to that part of Component 3.

The Implementation Index indicates that there were considerable differences in the extent to which schools progressed on the 7-Step implementation process, and engaged the involvement and support of parents, staff and school leadership.

4.3 Implementation quality and meeting the needs of students

The items shown in Table 9 were included in the questionnaires to both parents and teachers to determine whether they believed that KM had improved the school’s ability to meet the social, emotional or behavioural needs of students. The results in Table 9 and in Figure 11 suggest that, at the start of KM, the ratings were (as expected) at or below the mid-point on the 7-point scale, indicating that teachers and parents were neutral about the impact of KM on these issues. Nevertheless, it can be seen in Table 9, by Time 4, almost 40% of teachers and almost 30% of parents strongly agreed to these items, but particularly to the belief that KM enabled the school to make more effective decisions about the child’s emotional, social or behavioural needs.

Moreover, the ratings showed a significant improvement over the period of KM, with small (Round 1) and large (Round 2) effect sizes for changes based on teacher ratings. The parent ratings showed no significant change for Round 1 schools but a medium effect size for Round 2 schools. It may be that the Round 2 schools were able to access more resources related to this component by the time they began the intervention.

Again, the evidence from overall mean ratings must be interpreted in terms of some schools being rated highly on KM, as having improved the school’s ability to meet the social, emotional or behavioural needs of students, with other schools receiving much lower ratings. This relationship was tested using correlation analysis. The findings provide further evidence that there was a positive relationship between the Implementation Index score and ratings of the school’s capacity to meet students’ social, emotional or behavioural needs.

### Table 9. KidsMatter Impact on child’s need

<table>
<thead>
<tr>
<th>Rate the extent to which you disagree or agree with the following statements:</th>
<th>Round 1</th>
<th>Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strongly Agree</strong> at Time 4</td>
<td><strong>T</strong></td>
<td><strong>P</strong></td>
</tr>
<tr>
<td>KidsMatter has helped the school to focus on my child’s emotional or social or behavioural needs</td>
<td>36%</td>
<td>27%</td>
</tr>
<tr>
<td>KidsMatter has helped the school to focus on my child’s social and emotional development</td>
<td>36%</td>
<td>27%</td>
</tr>
<tr>
<td>KidsMatter enables the school to make more effective decisions about my child’s emotional or social or behavioural needs</td>
<td>38%</td>
<td>30%</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>37%</strong></td>
<td><strong>28%</strong></td>
</tr>
</tbody>
</table>

---

8 Canonical correlation analysis, undertaken in AMOS using ADF methods, found significant moderate correlations of 0.27 in Round 1 schools and 0.45 in Round 2 schools. Full details of the analysis are provided in the Technical Report.
Correlation analysis confirms that schools categorised as implementing KidsMatter well, were rated as better able to meet children’s social, emotional and behavioural needs.

### 4.4 Chapter summary

The use of the Implementation Index provided another perspective on the implementation of KM. The analysis using the newly developed Implementation Index revealed variations in the quality of implementation of KM in both the Round 1 and Round 2 groups of schools. Correlation analysis confirmed that schools categorised as implementing KM well, were rated as better able to meet children’s social, emotional and behavioural needs. At a broad level these differences were most apparent in Project Officers’ views of the success that schools achieved in addressing the 7-Step implementation process, and in the extent to which schools were able to gain the involvement of all stakeholders, including the extent of involvement of the leadership team. Greater attention to these aspects of implementation and to the provision of information for parents could be a focus in future use of KM by schools.
Chapter 5

Engagement with KidsMatter and the Implementation Process: 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. Importantly, these studies provided evidence about processes and factors within schools that served to facilitate or impede implementation and engagement.

5.1 Key themes from the Stakeholder and Student Voice studies

School principals, Project Officers, students, parents, action team leaders and teachers contributed to our understanding of KM implementation and engagement through interviews and focus groups. Participants’ experiences of how KM was implemented were identified and are reported in this chapter.

5.1.1 Facilitators and barriers

There are many well-recognised factors in the international literature which are known to facilitate or hinder change and reform in schools (Fullan, 2007). Factors that facilitate school reform include: creating knowledge and awareness; providing adequate time and commitment; establishing structures in the school such as meetings and communication processes; collaborative or distributive leadership style; and staff engagement in decision-making (Shields, 1989). Barriers to school reform include: organisational structures and cultures which impede implementation; leadership styles which did not actively promote the implementation process; insufficient time allocation; the influence of stakeholders who do not see the need for change; lack of commitment and absence of follow-up (Fullan, 1997; Hargreaves & Fink, 2004). The analysis of the data collected from the Stakeholder studies was informed by these key themes discussed in the literature on educational change. In addition, other themes emerged from the collected data. The themes consistently identified by participants are represented in Table 10, emerging as either facilitators or barriers, depending upon the context. For example, where adequate time was allocated to KM, this facilitated the implementation process. Where inadequate time was allocated, implementation was impeded.

“…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

Archived at Flinders University: dspace.flinders.edu.au
### Table 10. Facilitators and barriers to school reform

<table>
<thead>
<tr>
<th>Themes</th>
<th>Exemplar statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership</td>
<td>“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</td>
</tr>
<tr>
<td>Leadership change</td>
<td>“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</td>
</tr>
<tr>
<td>Leaders’ priorities</td>
<td>“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</td>
</tr>
<tr>
<td>Whole school commitment</td>
<td>“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</td>
</tr>
<tr>
<td>Ongoing team support</td>
<td>“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</td>
</tr>
<tr>
<td>Adequate time</td>
<td>“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</td>
</tr>
<tr>
<td>Resources</td>
<td>“I think just getting the staff all on board at once and getting them to have ownership of the program…” Principal School 9</td>
</tr>
<tr>
<td>Staff change</td>
<td>“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</td>
</tr>
</tbody>
</table>

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 lives. Like all schools, the schools in KM 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. But a key theme in most of the discussions of the processes of implementation and engagement was the role of the school leadership.

**School leadership is implicated in all of the themes, and therefore emerged as a fundamental factor for implementation and engagement with KidsMatter.**

As an agent of change, a school principal is responsible for the overall direction of the school community and the resourcing available (Hargreaves & Goodson, 2006). It was clearly identified that school principals who were committed to KM demonstrated that commitment through their leadership style. Where school leadership changed, the impetus for KM was often not maintained. Successful leaders remained closely involved with KM, either personally, or through using strategies such as delegating responsibilities for KM to Action Team leaders, thereby displaying trust and a distributive leadership style. They kept a focus on KM as a priority for the school. They also encouraged collaboration and ownership across the staff, ensuring that others became committed, or remained engaged, with the Initiative. As one principal noted, it is important to:

“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

Staff engagement and ownership was an issue that faced all schools as staff with knowledge of KM left the school and new staff arrived.

#### 5.1.2 Strategies and complexities associated with implementing the four components

In Chapter 3 we noted the variation in engagement across the four components. From the qualitative data it was also evident that the four components were not undertaken simultaneously or equally across the 10 schools in the Stakeholder and Student Voice studies.

“We had three 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 schools. It is important to recognise that for successful implementation, KM must find a regular and appropriate place in the school program.
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 KM. Other schools found that only doing one KM component did not engender sufficient momentum around the KM initiative. For still others, there was a need to up-skill staff in particular areas before embarking on anything else, as captured in the following statement from the Principal.

“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

5.2 Possibilities for sustainability

The comments in Table 11 represent a strong view in the interviews that KM provided the schools with an organising framework related to student mental health and wellbeing: a framework that helped to bring together, and extend, the school's existing work in this area. The framework of KM can be seen as assisting schools to generate activities and responses to situations that might not be covered in existing KM resources. In this way the framework can provide schools with a way to generate change across many areas of their operation. Even so, it was made clear that, although the process of implementation and the engagement with KM by the stakeholders was empowering, it took time and adequate resourcing to sustain it, as is indicated in comments included in Table 11.

Table 11. The importance of the KidsMatter organising framework

<table>
<thead>
<tr>
<th>Theme</th>
<th>Exemplar Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>A conceptual framework</td>
<td>“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</td>
</tr>
<tr>
<td>Permission to change</td>
<td>“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</td>
</tr>
<tr>
<td>Inject throughout the school</td>
<td>“It's 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</td>
</tr>
</tbody>
</table>

It was also interesting that during the interviews, stakeholders were sufficiently engaged with KM to make suggestions about sustainability. This is apparent in comments included in Table 12, indicating that achieving sustainability will require attention to different areas of the school program, such as the integration of KM into school plans and priorities, allocation of resources, and through provision of continuing professional development.

Table 12. Suggestions for sustaining KidsMatter

<table>
<thead>
<tr>
<th>Theme</th>
<th>Exemplar Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrate it</td>
<td>“[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 feel your rights are, your responsibilities and then your values.” Principal School 3</td>
</tr>
<tr>
<td>Not an “add-on”</td>
<td>“They’re not discrete lessons…they are ways of being…” Principal School 1</td>
</tr>
<tr>
<td>PD is ongoing</td>
<td>“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</td>
</tr>
<tr>
<td>Part of the school’s strategic plan</td>
<td>“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</td>
</tr>
<tr>
<td>Resource allocation</td>
<td>“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</td>
</tr>
<tr>
<td>Long term commitment</td>
<td>“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</td>
</tr>
</tbody>
</table>

5.2.1 Impact of the Project Officers

At the heart of the KM implementation process were the Project Officers who provided key support, guidance, and professional development for schools. Throughout the evaluation, various kinds of data were collected that provide insights into the role and value of the Project Officers, including their impact on the efforts by schools to sustain KM.

As part of the Stakeholder interviews, a number of incidental comments were made about the role and importance of the Project Officers. Although there was no systematic attempt in these interviews to assess the role of Project Officers, the following comments emphasise the value that schools placed on the Project Officers in assisting staff to engage with and implement KM.

“That was another big plus. That was one of the really good things - having a key person like her on the team.” Principal School 3
“She’s amazing. She’s been absolutely a huge support for me and for the others as well, but more so for me because we’re continually the ones that communicate.” Counsellor School 1

“I’d met the PO and spoken to the PO … she’s fantastic. She’s such a great support.” Action Team Leader School 5

“You know, with a new initiative, it was important to have her there to support us, because she’s there for us as well. The Project Officer has been fantastic in our school.” Action Team Leader School 7

Stakeholders also recognised that at times there were possibilities for improving the support and input provided by Project Officers.

“The PO was very good, but I think because it was a new initiative… and she was learning too. So I think now perhaps the presentation would be a bit clearer.” Teacher School 1

“We’ve had some KidsMatter PD with the KidsMatter support person and look, she’s lovely and supportive and everything, but I didn’t feel that the actual content of that PD was as relevant to our needs as it could’ve been. I think we would have been better served by moving more quickly to choose the program that we wanted … for a lot of us it was stuff we already knew.” Principal School 4

Comments were also made about the role of the Project Officers in the Leadership Executive Summaries obtained at the end of KM.

“Our Project Officer has been very good at meeting our requests for agencies etc and excellent for professional learning.” Executive Summaries School 98

“The Teacher workshops with the Project Officer had the effect of opening teachers’ eyes and understanding of children’s difficulties by giving them accurate and supportive information.” Executive Summaries School 13

As part of the Leadership Executive Summaries, school leaders were asked to provide advice to schools that might take up the initiative in future. These included the advice that:

“The four components keep you accountable and make you aware of what is expected. The regular meetings with your Project Officer are very helpful and keep you progressing.” Executive Summaries School 3

The Project Officers were also asked to reflect, in their reports, on their own roles. Included in these reports were two questions asking Project Officers to assess the extent to which (a) the school leadership team was pleased to have them in the school and (b) teachers were pleased to have them in the school. It was assumed that the extent to which the leadership team and teachers valued the visits of Project Officers would reflect acceptance of both KM and of the contribution of the Project Officer.

Figure 12 indicates that Project Officers felt that both the leadership team and staff were pleased to have them visiting the school over the duration of the initiative. Moreover, Project Officers strongly agreed that in 80% of the Round 1 schools, and 88% of the Round 2 schools, the leadership teams seemed pleased to have them there during the respective start-up phases. Note that data was not collected on Time 1 in Round 2 schools because the schools were not formally commencing KM until after Time 2. However, the fact that Project Officers felt highly welcomed by leadership in 92% of Round 2 schools during preliminary visits (at Time 2) suggests that these schools were very keen to commence the Initiative.

Figure 12. Project Officer responses to how welcomed they felt by school leadership and staff

<table>
<thead>
<tr>
<th>Round 1 Mean</th>
<th>Time 4 Mean</th>
<th>Significance p</th>
<th>r</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time 1 Mean</td>
<td>Time 4 Mean</td>
<td>Significance p</td>
<td>r</td>
<td>Effect Size</td>
</tr>
<tr>
<td>Round 1</td>
<td>4.77</td>
<td>5.35</td>
<td>***</td>
<td>0.31</td>
</tr>
</tbody>
</table>
Overall, the evidence suggests that the Project Officers contributed substantially to schools’ engagement with, and implementation of, KidsMatter. As a key resource element of KidsMatter, they appeared central for both providing an initial impetus to schools, and also in sustaining the efforts of leaders and staff.

5.2.2 The Student Voice study: The views of students on KidsMatter implementation and engagement

Whereas stakeholders, such as staff and Project Officers, were asked directly about KM by the evaluators, students were not directly involved in the evaluation of KM. However, changes to students’ attitudes, knowledge and behaviours were the targeted outcomes of the SEL programs adopted by each school. KM happened around the students, in the classrooms and through the curriculum. From this immersion in KM, it would be expected that students would be able to report on their awareness of, and ways they had been engaged with, Social and Emotional Learning.

It appeared that all students who participated in the Student Voice study had some knowledge of KM. This could reflect that KM was visible throughout the schools, on posters, lanyards, brooches and related artefacts, as well as the teaching and learning around Social and Emotional Learning that occurred in classrooms. However, in their comments in the focus groups held in the Student Voice study, students were indeed able to provide insight into their understanding of KM, as well as indicating what they had been doing as part of KM.

“It’s about the five keys: organisation, confidence, resilience, persistence …the five keys to …be happy,” Student School 5

“We're doing resilience…we're about trying to solve problems and trying to be the best person we can be.” Student School 4

“In class we have learning on it, about caring… yeah…harmony, patience.” Student School 6

Furthermore, students described some of the learning activities provided for them.

“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 write stuff down.” Student School 6

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

“We have done things that have been trying to involve everybody…try 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

Students’ comments about these activities provide further evidence of engagement with KM and about how it was implemented. For example, one group of students became KM “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 “I” 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 10

And in another school, students spoke favourably about a peer support program, especially in the school yard when difficulties arose for some students.

“They come and ask…like their friends aren’t playing…and we can help sort it out.” Student School 2

This strategy, of training young people to work with others in a peer support capacity around the key messages of KM, is one worthy of wider 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.

5.3 Chapter summary

The evidence from the Stakeholder and Student Voice studies supports the conclusions from the whole-cohort longitudinal studies, especially in terms of schools actively engaging with, and implementing, KM. The Stakeholder and Student Voice studies enrich and expand on this general conclusion by (a) providing more details of how schools responded to KM, (b) emphasising the importance of conceiving implementation and engagement with KM in the context of the literature on school change, and (c) highlighting some of the facilitators and barriers to implementation and engagement with KM.
Implementation and engagement with KM stimulates change in schools. As Shen (2008, p.73) noted, “Change and innovation is a hard and long-term process”. Change is a process requiring skilful leadership to provide the right conditions. These conditions include the adjustment to school plans, creation of adequate time and space to enable the new element in the curriculum to be understood and enacted. Change also requires adequate resourcing, which in the case of KM was critically supported by the involvement of Project Officers. At a more fundamental level, KM requires shifts in core beliefs, attitudes and knowledge and the responses in these studies suggest that such shifts can be supported by the way that KM provided an organising framework about student mental health and wellbeing.

It was found that schools made practical organisational decisions regarding how and when the components would be addressed. A significant element of implementation and engagement is planning for sustaining the continued engagement with the changes associated with KM. Schools identified some of the ways of doing this, including ongoing professional development, as well as the integration of KM into the teaching programs, and the school’s strategic planning process.

Although students were not part of the on-going evaluation process during the trial, the interviews with those students who participated in the Student Voice study provided evidence that they had engaged with the SEL content of KM.
Chapter 6

Positive School Community: Implementation, Engagement and Impact on Schools

The first component of the KM initiative, positive school community, focused upon building a sense of belonging and connectedness for all members of school communities. A school that is welcoming, and that encourages teachers, students and families to belong, provides a necessary, (but not sufficient) condition for the success of initiatives to promote mental health. In Chapter 3 it was shown that in comparison with the other components, engagement and progress on the implementation of Positive school community was high. In Chapter 3 we reported that, according to Project Officers’ reports, more than 60% of schools had implemented plans for this component by the end of the two years of KM.

In this chapter, attention turns to (a) specific responses about engagement with and implementation of Component 1 and (b) the impact of KM on the degree to which schools displayed features of a positive school community.

6.1 Engagement with and Implementation of Positive school community

The evaluation’s examination of KM engagement and implementation involved a series of items directed specifically to Component 1. First, teachers were asked to rate the extent to which the school had ‘worked on’ the component of Positive school community on each of the four occasions of the questionnaire. Second, teachers were asked to rate the extent to which they agreed that the school had implemented plans to develop a positive school community. Finally, as part of responding to items about the professional development associated with KM, teachers were asked to rate the extent to which the professional development had better equipped the school to develop a positive school community. The mean results of teachers’ responses to these three items over the four data collection occasions are presented in Figure 13, along with the percentage of teachers who rated 6 or 7 for each statement at Time 4.

The extent to which schools had ‘worked on’ Component 1 can be seen in Figure 13. In Round 1 schools, average teacher responses started high (scores above 5) and so had little scope to improve. In fact by Time 4, 71% of teachers in Round 1 schools reported that the school had worked on Positive School Community ‘a great deal’ (scored 6 or 7), compared to 64% of teachers in Round 2 schools. Based on these figures it appears that Round 1 schools did more work on Component 1, by the end of KM. However, the extent to which each group of schools had improved, differed markedly. From Time 1 to Time 4 in Round 1 schools, 14% more teachers reported that their school had worked on Component 1 ‘a great deal’, compared to 27% more teachers in Round 2 schools. This reflects the earlier start that the Round 1 schools made on KM, and the delayed start for Round 2 schools.
A similar result was achieved for the second item, which examined the extent to which schools had implemented plans for Component 1: Positive School Community. Figure 13 summarises the results. By Time 4, 66% of teachers in Round 1 schools and 62% of teachers in Round 2 schools 'strongly agreed' (scored 6 or 7) that "Our school has implemented plans to develop a positive school community". These figures are similar to those reported by Project Officers. The steady increase over the four occasions in Round 1 schools was reflected by 15% more teachers than at Time 1 who strongly agreed. However, the equivalent figure for Round 2 schools, of 26% more teachers than at Time 1, suggests that despite starting further behind, Round 2 schools caught up quickly.

Finally, as part of responding to items about the professional development associated with KM, teachers were asked to rate the extent to which the professional development had better equipped the school to develop a positive school community. The teachers’ responses are presented in Figure 13 and show the effect of the delayed start for Round 2 schools. The responses of teachers in Round 2 schools were centered around the neutral point (scored 4) on the first two occasions because they had not yet commenced the initiative. However, by Time 3 and Time 4, their average responses were increasingly positive. In fact, by the end of KM, 64% of teachers across all schools strongly agreed that "The Professional Development related to KidsMatter has better equipped the school to develop a positive school community".

These findings suggest that there was good agreement that, even though the initial ratings for Positive school community were relatively high, schools nevertheless worked on Component 1, and implemented plans related to this component, and that this had been helped by the professional development.

The results from teacher ratings are consistent with the evidence from Project Officers that, in the main, schools engaged with Component 1 and made good progress through the 7-Step implementation process for this component.

6.2 Impact on Positive school community: Whole cohort study

Positive school community was assumed in the rationale and strategy for KM to be one of the factors that supports the implementation and maintenance of school-based mental health initiatives. This means that the more a school functions as a positive school community, the more likely that the mental health and well-being needs of its students will be addressed. As part of the evaluation, therefore, it was necessary to measure the degree to which schools were functioning as a positive community and whether their level of functioning was enhanced by participation in KM.

To measure the positive community dimension of schools, the evaluation questionnaire contained 11 parallel items for teachers and parents, presented in Table 13. The items were designed to cover two target areas and objectives associated with Component 1. The two target areas were: belonging and inclusion within the school community, and, a welcoming and friendly school environment. The questionnaire results were examined to determine firstly the degree to which schools displayed a positive school community (i.e., generated a sense of belonging, and were inclusive, welcoming and friendly) at the start of KM, and the extent to which these indicators changed over the time of KM.
### Table 13. Questionnaire items about Positive school community

<table>
<thead>
<tr>
<th>Teacher items</th>
<th>Round 1</th>
<th>Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>These first questions ask you to reflect on your school community. From your own experience, rate the extent to which you disagree or agree with the following statements:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Strongly Agree’ at Time 4</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Students feel a sense of belonging at this school</td>
<td>73%</td>
<td>73%</td>
</tr>
<tr>
<td>Staff feel a sense of belonging at this school</td>
<td>63%</td>
<td>58%</td>
</tr>
<tr>
<td>The school is welcoming to students</td>
<td>82%</td>
<td>79%</td>
</tr>
<tr>
<td>The school is welcoming to families</td>
<td>76%</td>
<td>73%</td>
</tr>
<tr>
<td>The school encourages caring relationships between staff and families</td>
<td>71%</td>
<td>71%</td>
</tr>
<tr>
<td>The school encourages caring relationships between students and staff</td>
<td>81%</td>
<td>80%</td>
</tr>
<tr>
<td>The school publicly recognises the contributions families make to the school</td>
<td>66%</td>
<td>62%</td>
</tr>
<tr>
<td>Students have a say in decisions affecting them</td>
<td>35%</td>
<td>31%</td>
</tr>
<tr>
<td>Staff participate in shared decision making</td>
<td>54%</td>
<td>46%</td>
</tr>
<tr>
<td>The school encourages parents/caregivers to have a say about how the school operates</td>
<td>48%</td>
<td>47%</td>
</tr>
<tr>
<td>The school has policies and practices that help all members of the school community to feel included</td>
<td>53%</td>
<td>49%</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td>64%</td>
<td>61%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parent items</th>
<th>Round 1</th>
<th>Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>My child feels a sense of belonging at school</td>
<td>71%</td>
<td>69%</td>
</tr>
<tr>
<td>I feel accepted by staff at the school</td>
<td>69%</td>
<td>68%</td>
</tr>
<tr>
<td>I feel accepted by other parents/caregivers at the school</td>
<td>58%</td>
<td>57%</td>
</tr>
<tr>
<td>The school is welcoming to students</td>
<td>78%</td>
<td>76%</td>
</tr>
<tr>
<td>The school is welcoming to families</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>The school encourages caring relationships between staff and families</td>
<td>63%</td>
<td>62%</td>
</tr>
<tr>
<td>The school encourages caring relationships between students and staff</td>
<td>67%</td>
<td>64%</td>
</tr>
<tr>
<td>The school publicly recognises the contributions families make to the school</td>
<td>66%</td>
<td>63%</td>
</tr>
<tr>
<td>The school encourages students to have a say about school matters</td>
<td>52%</td>
<td>50%</td>
</tr>
<tr>
<td>The school encourages parents/caregivers to have a say about school matters</td>
<td>55%</td>
<td>54%</td>
</tr>
<tr>
<td>The school has good links with the local community</td>
<td>57%</td>
<td>58%</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td>65%</td>
<td>63%</td>
</tr>
</tbody>
</table>

It can be seen in Table 13 that the responses on the individual items for both parents and teachers at the end of KM were that schools were indeed functioning as positive communities. At Time 4, on average, 64% of teachers and 65% of parents in Round 1 schools, and 61% of teachers and 63% of parents in Round 2 schools, strongly agreed to items about Positive school community.

The question of the impact of KM on Positive school community was examined in the multilevel modelling analysis using HLM. The results for change over time are summarised in Figure 14 that gives the raw means as well as the plot of the fitted HLM results, together with a summary of the statistical results. It can be seen in Figure 14 that the mean ratings by both teachers and parents for Positive school community were relatively high throughout the period of KM and showed very little change.

At the start of KidsMatter, schools already accorded Positive school community high priority, and this continued throughout the two year period.
6.3 Impact on Positive school community: Stakeholder interview and focus groups

Despite the fact that the questionnaire responses suggested that most schools were already functioning well in terms of a Positive school community, it emerged from the interviews with stakeholders that KM prompted and provided opportunities to develop new strategies and approaches to Positive school community:

“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 communities did not always perceive that they were welcomed or belonged. In the Stakeholder study, one parent noted that:

“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

The importance of leadership style was also raised by a parent, 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 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 provided a parents’ room or similar meeting place, where parents could go before or after school to meet and chat and to welcome new parents to the community. The success of parents’ rooms varied, with suggestions 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
The value of such a room was more evident in another report:

“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 interviews suggested that schools made significant efforts to build or enhance their existing positive school communities and to engage parents as part of this component throughout the initiative. As the quotation below reveals, parent engagement was seen as the one of the most challenging issues 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.” Counsellor School 6

6.4 Impact on Positive school community: Parent questionnaire responses

In the evaluation questionnaires parents were asked to rate their agreement with the statement “I feel that the school community is more positive since KidsMatter.” This was intended to obtain a measure of the impact of KM on Positive school community from parents’ perspectives. As expected, at Time 1 only 15% of parents in Round 1 schools and 9% of parents in Round 2 schools strongly agreed (ratings of 6 or 7) with this statement. At this time, KM had only just begun in Round 1 schools and had not started in Round 2 schools. By Time 4, 26% of parents in Round 1 schools and 24% of parents in Round 2 schools strongly agreed that KM had contributed to the school community being more positive. Even at the end of the KM period, the majority of parents responded to this item around the neutral point on the scale. It is possible that many parents were still not sufficiently aware of KM and its impact to answer this item with confidence. These results, suggesting moderate impact of KM on Positive school community from the perspective of parents, are consistent with many of the viewpoints expressed by school principals and parents in the Stakeholder study about special challenges associated with greater inclusion of parents into the school community.

6.5 Chapter summary

There was good evidence, in the evaluation, of school engagement with Component 1. This component reached the higher stages of the 7-Step implementation process and included the development and implementation of plans to contribute to a more positive school community.

At the start of KM, parents and teachers provided high ratings for their school’s performance on Component 1, and there was little evidence of significant change in ratings on this component over the two years. At the start of the trial, 62% of teachers reported ‘strongly agreeing’ that their school was committed to developing a sense of belonging and connectedness for members of the school community. This commitment was maintained throughout the two years of KM.

The interview and focus group data showed that the emphasis on Positive school community in KM often strengthened or reinvigorated efforts by the school in this area.

If, as assumed in the rationale and strategy for KM, that Positive school community is a core dimension of schools that supports the implementation and maintenance of school-based mental health initiatives, the results of the evaluation suggest that to a large degree schools are performing well in this area. There was evidence that at the start of KM schools were generally already rated highly by teachers and parents in the target areas chosen by KM that related to this component. There was also evidence that KM may have increased attention to the importance of a Positive school community and provided schools with new ways of achieving this. Although the ratings of parents on effects of KM on the positive nature of the school community were at a low level, they were more supportive at the end of the trial.

The Stakeholder interviews with principals and parents suggested that increasing the inclusion of parents, and giving them a greater sense of belonging and feeling welcome, was often a challenge. The reports from school principals about the challenges they faced in enhancing parental inclusion can be placed alongside the moderate-level ratings by parents of whether they agreed that the school had been a more positive community since KM. This is an area for further attention in the future development of KM.
The second component, Social and Emotional Learning (SEL), focused upon building students' social and emotional competencies through the provision of a structured SEL curriculum. It was assumed in KM that students' social and emotional competencies contribute directly to better student mental health and wellbeing. In Chapter 3 we reported that, according to Project Officers’ reports, almost three-quarters of schools had achieved the implementing plans stage for this component by the end of the two years of KM. In Chapter 7, attention turns to (a) specific responses from the evaluation about engagement with and implementation of Component 2, and (b) the impact of KM on the degree to which schools provide Social and Emotional Learning opportunities for their students through the teaching of a structured SEL curriculum.

7.1 Engagement with and implementation of Social and Emotional Learning: Whole cohort study

The questionnaire used for the whole cohort longitudinal study included a series of items directed specifically to engagement with and implementation of Component 2. First, teachers were asked to rate (on a 7-point scale) the extent to which the school had ‘worked on’ the component of Social and Emotional Learning on each of the four occasions of the questionnaire. Second, teachers were also asked to rate the extent to which they agreed that the school had implemented plans to provide Social and Emotional Learning. Finally, as part of responding to items about the professional development associated with KM, teachers were asked to rate the extent to which the professional development had better equipped the school to provide Social and Emotional Learning. The mean results of teachers’ responses to the three items over the four occasions are presented in Figure 15, along with the percentage of teachers who rated 6 or 7 for each statement at Time 4.

The extent to which schools had ‘worked on’ Component 2 can be seen in Figure 15. Almost three-quarters of teachers in Round 1 schools (73%) reported that the school had worked on Social and Emotional Learning ‘a great deal’ (scored 6 or 7), compared to 63% of teachers in Round 2 schools. However, the extent to which each group of schools had improved differed considerably. At Time 4 in Round 1 schools, 15% more teachers than at Time 1 reported that their schools had worked ‘a great deal’ on Component 2. The equivalent figure for Round 2 schools was 36% more teachers than at Time 1.
An even greater difference was evident for the second item, which examined the extent to which schools had implemented plans for Component 2: Social and Emotional Learning for students. Figure 15 summarises these results. By Time 4, 71% of teachers in Round 1 schools and 66% of teachers in Round 2 schools ‘strongly agreed’ (scored 6 or 7) that “Our school has implemented plans to develop Social and Emotional Learning for students”. In Round 1 schools only 10% more teachers than at Time 1 ‘strongly agreed’ to this statement. However, the equivalent figure for Round 2 schools, of over 40% more teachers than at Time 1, suggests that despite starting further behind, Round 2 schools quickly caught up.

Figure 15. Teacher responses about implementation and engagement with Social and Emotional Learning

<table>
<thead>
<tr>
<th>Mean response</th>
<th>Time 1</th>
<th>Time 2</th>
<th>Time 3</th>
<th>Time 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Round 1 Schools</td>
<td>The school has worked on … ‘a great deal’</td>
<td>73%</td>
<td>63%</td>
<td></td>
</tr>
<tr>
<td>Round 2 Schools</td>
<td>Our school has implemented plans to develop … ‘strongly agree’</td>
<td>71%</td>
<td>66%</td>
<td></td>
</tr>
<tr>
<td>Round 2 Schools</td>
<td>PD has better equipped the school to develop… ‘strongly agree’</td>
<td>70%</td>
<td>60%</td>
<td></td>
</tr>
</tbody>
</table>

Teachers were asked to rate the extent to which the professional development had better equipped the school to provide Social and Emotional Learning. Note that data was not available at Time 1. The teachers’ responses are presented in Figure 15 and show the effect of the delayed start for Round 2 schools. Teachers in these schools responded around the neutral point at Time 2 because they had not yet commenced the initiative. However, by Time 3 and Time 4, their average responses were increasingly positive. In fact, by the end of KM, 70% of teachers in Round 1 schools and 60% of teachers in Round 2 schools strongly agreed that “The professional development related to KidsMatter has better equipped the school to develop Social and Emotional Learning for students.”

The evidence suggests that there was good agreement that schools had worked on Component 2 and implemented plans, assisted by the professional development. These results from teacher ratings are consistent with the evidence from the Project Officers presented in Chapter 3 that, in the main, schools engaged with Component 2 and made good progress through the 7-Step implementation process for this component.

Component 2 was the component generally given most attention across schools in terms of implementation and engagement with KidsMatter.

7.2 Engagement with and implementation of Social and Emotional Learning: Stakeholder and Student Voice studies

The data from the Stakeholder and Student Voice study provided more detailed information about how schools and teachers became engaged with and implemented Component 2. A key theme that arose from the interviews, concerned the issues that teachers considered when making decisions regarding the selection, implementation of, and engagement with, Social and Emotional Learning programs. Table 14 presents some examples of these considerations:
Table 14. Issues that teachers considered regarding Social and Emotional Learning programs

<table>
<thead>
<tr>
<th>Themes</th>
<th>Exemplar statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integration with the curriculum</td>
<td>“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</td>
</tr>
<tr>
<td></td>
<td>“If it becomes part of the curriculum…it just becomes part of it … 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</td>
</tr>
<tr>
<td>Tailoring programs to the school needs or context</td>
<td>“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</td>
</tr>
<tr>
<td>Possible use beyond the classroom</td>
<td>“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</td>
</tr>
<tr>
<td>Whole school approach</td>
<td>“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</td>
</tr>
</tbody>
</table>

In addition, schools were keen to locate a Social and Emotional Learning program that would serve to unify the community by providing a common language and consistent messages. Integrating the chosen SEL program 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

7.3 Impact on schools’ provision of Social and Emotional Learning: Whole cohort study

Through Component 2: Social and Emotional Learning, KM was directed at supporting schools to provide a Social and Emotional (SEL) curriculum to all students. Consequently, the evaluation included a number of strategies to indicate whether and how schools were providing a SEL curriculum. To measure schools’ performance in relation to SEL, the evaluation questionnaire contained 10 items for teachers listed in Table 15. The questions were designed around the two KM targets and objectives associated with Component 2, which focused on the provision of a SEL curriculum, and opportunities provided to students to practice their SEL skills.

It can be seen in Table 15 that the responses on the individual items for teachers showed that schools were performing well in the provision of SEL by the end of KM. The averages for these items indicated that at data collection Time 4, 58% of Round 1 teachers and 53% of Round 2 teachers strongly agreed (scored 6 or 7) about the implementation of their SEL programs for students. It is of note that about 60% of teachers strongly agreed that the schools provided regular, structured teaching of SEL as suggested in the program manual.

Table 15. Teacher ratings of Component 2: Social and Emotional Learning

<table>
<thead>
<tr>
<th>These questions are about the way that the school implements wellbeing initiatives for students. From your own experience, rate the extent to which you disagree or agree with the following statements:</th>
<th>Round 1</th>
<th>Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>The school teaches social and emotional skills to students in formally structured sessions that adhere to a program manual</td>
<td>61%</td>
<td>59%</td>
</tr>
<tr>
<td>The school teaches social and emotional skills regularly to all students (at least once per week)</td>
<td>62%</td>
<td>56%</td>
</tr>
<tr>
<td>The school supports professional development about student emotional, social and behaviour difficulties</td>
<td>70%</td>
<td>68%</td>
</tr>
<tr>
<td>The school supports professional development about teaching social and emotional skills</td>
<td>70%</td>
<td>69%</td>
</tr>
<tr>
<td>The school curriculum allocates appropriate time to teach students social and emotional skills</td>
<td>53%</td>
<td>49%</td>
</tr>
<tr>
<td>The school regularly evaluates its curriculum for teaching social and emotional skills</td>
<td>47%</td>
<td>41%</td>
</tr>
<tr>
<td>The school’s resources for teaching social and emotional skills meet the needs of our students</td>
<td>54%</td>
<td>43%</td>
</tr>
<tr>
<td>The school is well equipped to meet the needs of students with emotional, social or behaviour difficulties</td>
<td>46%</td>
<td>38%</td>
</tr>
<tr>
<td>The school teaches about social and emotional skills in a coordinated and supported way throughout the school</td>
<td>61%</td>
<td>52%</td>
</tr>
<tr>
<td>Developing staff knowledge about emotional, social and behaviour difficulties is a high priority in our school</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Average</td>
<td>58%</td>
<td>53%</td>
</tr>
</tbody>
</table>
The impact of KM on the provision of SEL was also examined in the multilevel modelling analysis (HLM), using the teacher items combined into a single scale. The emphasis here was on both the performance of schools at the start of KM and the question of whether this performance changed over the period of KM. The results for change over time are summarised in Figure 16, which shows the raw means as well as the line-plot of the fitted HLM results, together with a summary of the statistical results. It can be seen in Figure 16 that the average scores about SEL were low (Round 2 schools) to moderate (Round 1 schools) at the start of KM.

The most important feature of the results in Figure 16 is that teacher ratings of provisions for Social and Emotional Learning showed positive change across the period of KM in both Round 1 and Round 2 schools. The effect sizes for these changes were of practical significance, being medium for Round 1 and large for Round 2 schools. Accordingly, over the two years, there were approximately 19% more teachers by Time 4 who strongly agreed that their school was performing well on the provision of Social and Emotional Learning for students. Figure 16 also shows that the ratings of teachers in Round 2 schools indicated an even faster uptake in the provision of SEL programs. Once they began KM, Round 2 schools appeared catch up to Round 1 schools over the two years. It also appears that at Time 1, the teachers in Round 1 schools rated this component more strongly, perhaps as a result of already being heavily involved in the start-up activities related to KM.

7.3.1 Student participation in SEL programs

In addition to the SEL scale just discussed, other information related to student participation in SEL programs was gathered from the Teacher and Parent Questionnaires and the Leadership Executive Summaries.

The parents and teachers of each child involved in the KM evaluation were asked to respond ‘Yes’ or ‘No’ about whether the child participated in a program teaching social and emotional skills during the previous semester. The pattern of responses to this item, shown in Figure 17, suggests that approximately only half of the parents knew that their child was participating in SEL programs. Parent responses contrasted strongly to teachers, who indicated that more than 80% of students in Round 1 schools were exposed to SEL programs at Time 1, rising to over 90% by Time 4. For Round 2 schools, the teachers’ responses indicate a lower start, at approximately 65% of students, rising to over 90% at Time 4. Recall that Round 2 schools did not start KM until after Time 2.
The Round 1 teacher reports suggest that nearly all of their students were involved in SEL programs in a sustained way. In contrast, the low level of parent responses (only around 35% at Time 1) might indicate lower levels of parent awareness of KM or that they had not been made aware by teachers or by their child about the teaching of SEL. However, Figure 17 also shows that in both sets of schools, although parents initially had relatively little knowledge of their children’s involvement in SEL programs, parents became more aware of their child’s SEL education as time progressed. By Time 4, approximately 50% of parents reported that their child participated in a program teaching Social and Emotional Learning skills. This finding is linked to observations made later in this report about the ways in which the KM components, in this case SEL, impacted other aspects of school systems, such as parents’ knowledge about their children’s lives at school.

7.3.2 The Programs Guide

Key resources provided to KM schools were a programs guide and then an accompanying website, which drew upon the evidence-base for the effectiveness of a variety of curriculum programs, the mode of delivery, and the availability of specific professional development to support school implementation. As part of the data collection via the Leadership Executive Summary, school leaders were asked to identify all of the Social and Emotional Learning (SEL) programs used in their school as part of KM. The top 20 programs based on responses from 61 schools, in order of most frequent to least frequent, are listed in Table 16. The table includes an indication of which component(s) each program is related to, as specified on the KidsMatter website. While one school was using up to 13 programs, most schools on average were using four programs. Of the top 20 programs, four programs addressed Component 1, two programs addressed Component 3 and five programs were relevant to Component 4. The majority (15) of programs selected were focused on Component 2: Social and Emotional Learning for students. This includes the program BOUNCE Back!, which was used by 64% of schools (based on the 61 responding schools).

Table 16. Most used programs used in 61 KidsMatter schools

<table>
<thead>
<tr>
<th>Most used</th>
<th>Program</th>
<th>Component*</th>
</tr>
</thead>
<tbody>
<tr>
<td>64%</td>
<td>BOUNCE Back!</td>
<td>2</td>
</tr>
<tr>
<td>39%</td>
<td>Program Achieve (3rd Edition)</td>
<td>2</td>
</tr>
<tr>
<td>30%</td>
<td>Friendly Kids, Friendly Classrooms</td>
<td>2</td>
</tr>
<tr>
<td>20%</td>
<td>Seasons for Growth</td>
<td>3</td>
</tr>
<tr>
<td>18%</td>
<td>Friendly Schools and Families Program</td>
<td>1 &amp; 2</td>
</tr>
<tr>
<td>18%</td>
<td>Protective Behaviours: A personal safety program</td>
<td>2</td>
</tr>
<tr>
<td>13%</td>
<td>Peer Mediation</td>
<td>1 &amp; 2</td>
</tr>
<tr>
<td>11%</td>
<td>Stop Think Do Social Skills Training</td>
<td>2 &amp; 4</td>
</tr>
<tr>
<td>10%</td>
<td>Aussie Optimism</td>
<td>2 &amp; 4</td>
</tr>
<tr>
<td>10%</td>
<td>FRIENDS for Life</td>
<td>2 &amp; 4</td>
</tr>
<tr>
<td>10%</td>
<td>Tribes Learning Communities - Tribes TLC</td>
<td>1</td>
</tr>
<tr>
<td>8%</td>
<td>1-2-3 Magic and Emotion Coaching Parenting Program</td>
<td>3</td>
</tr>
<tr>
<td>8%</td>
<td>Rainbows: Guiding kids through life’s storms</td>
<td>2 &amp; 4</td>
</tr>
<tr>
<td>8%</td>
<td>Resilience Education and Drug Information (REDI)</td>
<td>2</td>
</tr>
<tr>
<td>7%</td>
<td>Rock and Water</td>
<td>2</td>
</tr>
<tr>
<td>7%</td>
<td>Values Education Toolkit</td>
<td>2</td>
</tr>
<tr>
<td>5%</td>
<td>Cool Kids (School Version)</td>
<td>4</td>
</tr>
<tr>
<td>5%</td>
<td>Heart Masters</td>
<td>2</td>
</tr>
<tr>
<td>5%</td>
<td>Peer Support Program (Peer Support Foundation)</td>
<td>1</td>
</tr>
<tr>
<td>5%</td>
<td>Resilient Kids (Primary)</td>
<td>2</td>
</tr>
</tbody>
</table>


7.3.3 Student knowledge of SEL from the Student Voice study

In the Student Voice study, students were asked about the specific Social and Emotional Program the school had chosen to implement as part of Component 2, and to express what had been happening in their school and classrooms. Furthermore, as part of this study, students were asked to discuss a hypothetical vignette that was designed to prompt their explicit expression of their social and emotional knowledge and capabilities. This vignette, presented in Figure 18, referred to Cris, a student who was not coping well at school.
Figure 18. Vignette used in the Student Voice study

This is a short story about a student named Cris

Just after coming back from lunch

Teacher:  Now Cris. I haven’t seen your work book this week. I wanted you to finish the work that was set two days ago. This is the second time you haven’t finished some work. Why haven’t you finished it? What’s the story?

Cris:  I didn’t get around to it.

Teacher:  Well, make sure you get it finished by the end of the day – OK?

Cris:  (mumbling to Jay) That teacher is always picking on me. I’m sick of it.

End of the school day at the school gate

Alex: Hey Cris … you OK?

Cris: Yeah – what’s YOUR problem?

Alex: Nothing. You’ve just looked a bit unhappy lately.

Cris: So, what’s it to you?

Alex: OK, OK, I was just asking. No wonder none of the others want to play with you anymore.

Cris: Well, I don’t care.

At home that night in bed

Cris is sobbing quietly under the covers. Everything is going wrong. Nothing is working out.

Some students could explain a simple understanding of KM, 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 KM, including issues such as, social awareness and relationship skills, self awareness, self management and responsible decision-making. For these children, KM 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

“It’s 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

Indeed one of the student responses went directly to the nature of mental health, a theme we take up in Chapter 13.

“Mental health is not all about sickness…It’s about being mentally healthy…like happy inside…and knowing your feelings…. knowing how to express them without going over the top…” Student School 1

Table 17 shows further themed examples of the learning that the students engaged in as part of the SEL program.
Table 17. Examples of student learning as a result of KidsMatter

<table>
<thead>
<tr>
<th>Theme</th>
<th>Exemplar Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expressing their feelings</td>
<td>“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</td>
</tr>
<tr>
<td>Demonstrating problem solving strategies</td>
<td>“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</td>
</tr>
<tr>
<td></td>
<td>“Tell the teacher he was having problems….have a quiet chat with someone he knows and someone he feels safe with.” Student School 4</td>
</tr>
<tr>
<td>Discussing coping strategies</td>
<td>“He should talk to someone because you can’t let it build up inside.” Student School 5</td>
</tr>
<tr>
<td></td>
<td>“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</td>
</tr>
</tbody>
</table>

7.4 Chapter summary

A rich variety of findings from the evaluation has been presented in this chapter to show the extent to which, and how, schools became engaged with and implemented the SEL component of KM. The majority of programs chosen by schools for KM focused on this component. Of course, many schools started KM from a position of already providing substantial levels of delivery of SEL programs. However, the evaluation shows that schools increased their provision of SEL during the period of KM. The evidence indicates that by the end of the two-year period, there was greater provision of SEL curriculum across the KM schools. The greater extent to which Round 2 schools improved in the provision of Component 2, compared to Round 1 schools, is noteworthy and, amongst other explanations, perhaps reflects the longer preparation time they had. The ability of students to articulate and provide examples from the particular SEL programs that were being used, as well as the learning activities that were provided for them, is sound evidence of the impact of KM on the provision of SEL in schools.

Overall, KidsMatter had an impact on schools in terms of an increase in the Social and Emotional Learning opportunities provided to their students, mainly through the provision of the KidsMatter framework, which emphasises the need for structured evidence-based programs that promote regular and sustained delivery.
Chapter 8

Parenting Support and Education: Implementation, Engagement and Impact on Schools

The third component of KM, Parenting support and education, focused on the school as an access point for families to learn about parenting, child development and children’s mental health in order to assist parents with their child rearing and parenting skills. This was to be achieved through more collaborative working relationships between teachers and parents, providing parents with information and programs about effective parenting and child mental health, and assisting parents to form support networks. In Chapter 3 it was shown that, in comparison with the other components, engagement and progress on the implementation of Parenting support and education was moderate. We also reported that, according to Project Officers’ reports, about 40% of schools had implemented plans for this component by the end of the two years of KM. In the present chapter, attention turns to (a) specific responses from the evaluation about engagement with and implementation of Component 3 and (b) the impact of KM on the degree to which schools provided Parenting support and education.

8.1 Engagement with and implementation of Parenting support and education

The examination of KM engagement and implementation involved a series of items directed specifically to Component 3. First, teachers were asked to rate (on a 7-point scale) the extent to which the school had “worked on” the component of Parenting support and education on each of the four occasions that the questionnaire was administered. Second, teachers were also asked to rate the extent to which they agreed that the school had implemented plans in relation to Parenting support and education. Finally, as part of responding to items about the professional development associated with KM, teachers were asked to rate the extent to which the professional development had better equipped the school to provide Parenting support and education. The mean results of teachers’ responses to the three items over the four occasions are presented in Figure 19, along with the percentage of teachers who rated 6 or 7 for each statement at Time 4.

Even though the extent to which schools had ‘worked on’ Component 3 varied in Round 1 and Round 2 schools over the four occasions, as can be seen in Figure 19, teachers’ responses from both sets of schools by the end of KM were very similar. In Round 1 schools, 46% of teachers reported that the school had worked on Parenting support and education ‘a great deal’, compared to 43% of teachers in Round 2 schools. However, the extent to which each group of schools had improved, differed markedly. From Time 1 to Time 4, 17% more Round 1 teachers reported that their school had worked on Component 3 ‘a great deal’, compared to 28% more teachers in Round 2 schools.
A similar result was evident for the second item, which examined the extent to which schools had implemented plans with regard to Parenting support and education. Figure 19 contains a summary of the results. By Time 4, 53% of teachers in Round 1 schools and 50% of teachers in Round 2 schools 'strongly agreed' that "Our school has implemented plans to develop parenting support and education". These results were a little higher than those reported by Project Officers. There was a steady increase over the four occasions in Round 1 schools, where, from Time 1 to Time 4, 18% more teachers 'strongly agreed' with this item. The equivalent figure for Round 2 schools, where 31% more teachers at Time 4 than at Time 1 agreed with this item, suggests that despite starting further behind, Round 2 schools caught up quickly and appeared to achieve in one year, what Round 1 schools achieved in two years.

Figure 19 also addresses the question of whether the professional development helped the school to implement Component 3. It can be seen that by near the end of KM (Time 4), teachers were moderately positive about whether the professional development had better equipped the school to develop Parenting support and education. In some schools these ratings were more positive. At Time 4, around half the teachers (55% in Round 1 and 52% in Round 2 schools) strongly agreed that "The Professional Development related to KidsMatter has better equipped the school to develop Parenting support and education".

These results from teacher ratings are consistent with the evidence from Project Officers, presented in Chapter 3, that there were variations across schools in the degree to which they engaged with and implemented Component 3. These results are also consistent with suggestions in the Stakeholder interviews, from both parents and school principals, that there were substantial challenges associated with Component 3.

Evidence from Project Officers, school leadership, staff and parents suggest that there were substantial challenges associated with implementing and engaging with Component 3: Parenting support and education.

### 8.2 Impact on Parenting support and education: Whole cohort study

Although the evidence for engagement with and implementation of Parenting support and education was not as strong as for Components 1 and 2, it was still possible that schools efforts in relation to this component had a positive impact on their level of Parenting support and education. To measure schools' performance in relation to the provision of Parenting support and education, the evaluation questionnaire contained up to 14 parallel items for teachers and parents about Parenting support and education (see Table 18). Component 3 placed an emphasis on support and education provided at the school and at the teacher level. As a consequence, the evaluation gave separate attention to support and education from the school and from staff. From Table 18, it can be seen that the items covered the three target areas and objectives associated with Component 3. The three target areas were: Parent-teacher relationships, Parenting information, and Support networks for parents and families. Items about Parenting support and education by the School were more general, such as, “Information about parenting practices is available at school”. The items for Parent support and education by Staff were more specific, such as “Parents feel able to discuss their child’s emotional or social or behaviour difficulties with school staff.”
Table 18. Component 3: Parenting support and education

<table>
<thead>
<tr>
<th>Part A: Parenting support and education by the school</th>
<th>Round 1</th>
<th>Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>From your own experience, rate the extent to which you disagree or agree with the following statements:</td>
<td>T P</td>
<td>T P</td>
</tr>
<tr>
<td><strong>Strongly Agree</strong> at Time 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The school provides parents/caregivers with opportunities to meet with other families/caregivers to develop support networks</td>
<td>38% 43%</td>
<td>41% 44%</td>
</tr>
<tr>
<td>Information about parenting practices is available at school</td>
<td>57% 44%</td>
<td>58% 46%</td>
</tr>
<tr>
<td>Information about child development is available at school</td>
<td>54% 47%</td>
<td>53% 48%</td>
</tr>
<tr>
<td>The school identifies and promotes parenting resources to parents/caregivers</td>
<td>55% 42%</td>
<td>52% 45%</td>
</tr>
<tr>
<td>The school provides parents/caregivers with help to access parenting courses/programs</td>
<td>48% 38%</td>
<td>47% 42%</td>
</tr>
<tr>
<td>Information about parenting education courses and programs is available at school (Parents questionnaire only)</td>
<td>34%</td>
<td>37%</td>
</tr>
<tr>
<td>Information is available at the school on how to help children with emotional (eg. sad or anxious), social or behaviour difficulties</td>
<td>55% 42%</td>
<td>52% 43%</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td>51% 41%</td>
<td>50% 44%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Part B: Parenting support and education by staff</th>
<th>Round 1</th>
<th>Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T</td>
<td>P</td>
</tr>
<tr>
<td>Staff give parents/caregivers ideas about how to help their child if he/she is:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) having trouble with his or her schoolwork</td>
<td>72% 51%</td>
<td>71% 49%</td>
</tr>
<tr>
<td>b) overactive or easily distracted</td>
<td>60% 41%</td>
<td>57% 41%</td>
</tr>
<tr>
<td>c) having emotional problems (eg. sad, depressed or anxious)</td>
<td>60% 43%</td>
<td>54% 42%</td>
</tr>
<tr>
<td>d) having social problems (eg. unable to get along with classmates)</td>
<td>65% 44%</td>
<td>62% 42%</td>
</tr>
<tr>
<td>e) having behaviour difficulties (eg. aggressive, rude and other difficult to manage behaviours)</td>
<td>67% 42%</td>
<td>62% 42%</td>
</tr>
<tr>
<td>Parents/caregivers feel able to discuss their child’s emotional or social or behaviour difficulties with school staff</td>
<td>66% 59%</td>
<td>58% 57%</td>
</tr>
<tr>
<td>There is a good working relationship between school staff and parents/caregivers</td>
<td>73% 58%</td>
<td>65% 57%</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td>66% 48%</td>
<td>61% 47%</td>
</tr>
</tbody>
</table>

The questionnaire results were examined to determine firstly the degree to which schools provided Parenting support and education at the start of KM, and then to consider the extent to which this changed over the time of KM. The question of the impact of KM on Parenting support and education was examined in the multilevel modelling analysis (HLM) using the parent and teacher items combined into respective scales. The results for change over time are summarised in Figure 20 and Figure 22, which give the raw means as well as the plot of the fitted HLM results, together with a summary of the statistical results.

Figure 20. Teacher and Parent reports of Parenting support and education from the school

<table>
<thead>
<tr>
<th>Time 1 Mean</th>
<th>Time 4 Mean</th>
<th>Significance p</th>
<th>r</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Round 1</td>
<td>4.43</td>
<td>5.20</td>
<td>***</td>
<td>0.39</td>
</tr>
<tr>
<td>Round 2</td>
<td>4.36</td>
<td>4.94</td>
<td>***</td>
<td>0.25</td>
</tr>
<tr>
<td>Parent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Round 1</td>
<td>4.84</td>
<td>5.01</td>
<td>**</td>
<td>0.13</td>
</tr>
<tr>
<td>Round 2</td>
<td>4.82</td>
<td>5.01</td>
<td>***</td>
<td>0.15</td>
</tr>
</tbody>
</table>
Parenting support and education by the school: From Figure 20, teacher ratings of Parenting support and education provided by the school were around the middle of the 7-point scale, indicating a neutral response. Across the two years of the KM trial, 7% more parents (equivalent to a small effect size) strongly agreed about the effects of KM on their school’s performance in providing Parenting support and education. However, 22% more teachers (equivalent to a medium to large effect size) strongly agreed that the school provided Parenting support and education. Overall, these findings show a positive impact across the trial on the level of Parenting support and education provided by the school. This is the case in the ratings of both parents and teachers, and these ratings are at moderate to relatively high levels.

Findings suggest that both teachers and parents were aware of efforts being made at the whole school level to provide education and support to parents.

Parenting support and education provided by the staff: In contrast, it can be seen from Figure 22, that according to the effect sizes for changes in teacher ratings, there was only a small improvement in Parenting support and education provided by staff in Round 1 schools and no significant change in Round 2 schools. The ratings by parents showed little evidence of change across the period of KM in Parenting support from staff.

The ratings for Parenting support and education provided by staff from both teachers and parents were moderate to relatively high and remained so across the period of KM. This is shown in Table 18, where across all schools approximately 64% of teachers and 48% of parents strongly agreed to these items about staff provision of Parenting support and education. The ratings were particularly high for the item about the quality of working relationships between school staff and parents.

8.2.1 Project Officer reports on information to parents

An additional perspective about the provision of information to parents by the school is gained from the Project Officer reports. Project Officers were asked to indicate with ‘Yes’ or ‘No’, if schools had provided parenting tipsheets, newsletters or KM information sheets to parents. The results indicated that information to parents, in some form, was provided in most schools across the duration of KM.

8.2.2 Parent involvement with schools during KidsMatter

In order to gauge specifically the impact of KM on parent involvement with the school, two additional items were asked of parents. These are presented in Table 19. At Time 4, only around 12% of parents in Round 1 schools and 10% of parents in Round 2 schools strongly agreed that they had formed more supportive networks and been more involved with the school since KM. This comparatively low response is more evident in Figure 22, which shows parents’ mean responses over the four occasions and the general tendency for parents to disagree that they were more involved with the schools during KM.
Table 19. KidsMatter impact on parent involvement with school

<table>
<thead>
<tr>
<th>From your own experience, rate the extent to which you disagree or agree with the following statements:</th>
<th>Round 1</th>
<th>Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>'Strongly Agree' at Time 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have formed more support networks with other parents/caregivers since KidsMatter</td>
<td>11%</td>
<td>10%</td>
</tr>
<tr>
<td>I have been more involved with the school since KidsMatter</td>
<td>13%</td>
<td>10%</td>
</tr>
<tr>
<td>Average</td>
<td>12%</td>
<td>10%</td>
</tr>
</tbody>
</table>

Nevertheless, the small and medium effect sizes recorded in Figure 22 indicate that mean responses to these items about parent involvement with the school did show practically significant increases over the two years of KM, even though the level of this involvement was still low at the end of the trial.

Figure 22. Parent responses to the impact of KidsMatter on their involvement with school

<table>
<thead>
<tr>
<th>Time 1 Mean</th>
<th>Time 4 Mean</th>
<th>Significance p</th>
<th>r</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent Round 1</td>
<td>2.59</td>
<td>3.18</td>
<td>***</td>
<td>0.23</td>
</tr>
<tr>
<td>Round 2</td>
<td>2.28</td>
<td>3.02</td>
<td>***</td>
<td>0.31</td>
</tr>
</tbody>
</table>

8.3 Impact on Parenting support and education: Stakeholder responses

The results from the evaluation questionnaires suggested that KM was associated with an improvement in Parenting support and education, more so by schools than by the more specific indicators of support and education provided by staff. The interview responses from stakeholders present a richer account of how schools engaged with Component 3 and the changes that it engendered.

8.3.1 School as a point of information access

Some participants in the Stakeholder study reported that they instituted strategies to promote their school as an access point for families to learn about parenting, child development and children's mental health by offering Parenting support and education through various means. This ranged from making space available in the school for parents to meet, offering pamphlets and information on child development, making regular contributions in newsletters, and facilitating open forums with experts. However, it was evident that the impact of these strategies for engaging parents 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 perceived as being of interest or benefit to parents:

“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 GPs who have children here…We got really positive feedback from that.” Principal School 4

“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 three page letter. I’m sorry, but we’re busy women. We’re not going to sit and read a three page letter.” Parent School 1

This discrepancy in perspectives between school and parents impacted on parent connections with KM, and with stakeholders' perceptions that parents 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
8.3.2 Linking mental health with learning outcomes

Supporting parents to understand the link between mental health and learning outcomes was another aspect that schools worked at, though some parents did not easily see the connection:

“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 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’.” Parent School 6

Regardless of whether parents engaged in the Parenting support and education component at the individual level, on the whole they were supportive of what the school was trying to do for the benefit of the whole school community, which may, or may not, specifically be of relevance to 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

8.3.3 Effective parent-teacher relationships

Discussions with teachers in the Stakeholder study suggested examples of how the Parenting support and education component of KM provided a process for improving parent-teacher communication. At one school, the action team leader explained the effect of a parent forum she had organised where a partnership of learning between parents 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 to attend assemblies, or inviting them to a free barbeque made parents 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 fairly well. We had an excursion and we had to knock back parents because so many volunteered to come. 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. This is illustrated in the words of one teacher who explained the value of improved relationships with parents 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 evidence that for some teachers there had been changes in their attitudes towards parents. In one focus group, a parent praised the changes made by one teacher with whom she now collaborated, an outcome that which she attributed to KM:

“[The 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
8.4 Chapter summary

The questionnaire findings together with the comments provided in the Stakeholder interviews present a complex pattern of results for Component 3. In contrast to Components 1 and 2, there was less consistent evidence of high levels of engagement and implementation of Component 3. However, most schools made progress on the implementation of Parenting support and education. The questionnaire ratings suggested some improvements in the provision of Parenting support and education across the period of KM. The improvement was more evident in teacher ratings and more evident in perceptions of schools’ provision of Parenting support and education than in staff provision of Parenting support and education. Despite relatively limited improvements, the results point to consistently positive ratings for the efforts of staff with parents and in areas such as the quality of the working relationship between school staff and parents.

Interviews with school staff and parents in the Stakeholder study suggested there could be some special challenges associated with initiatives to increase Parenting support and education. These challenges seemed to arise partly from potential differences in parent, school, and individual teacher perspectives on the role of the school and teachers in relation to Parenting support and education. A further challenge was associated with the awkwardness inherent in providing information about topics such as effective parenting or how to deal with child mental health difficulties, when parents might not perceive that such information is relevant to them.
Early Intervention for Students Experiencing Mental Health Difficulties: Implementation, Engagement and Impact on Schools

The fourth component of KM, Early intervention for students experiencing mental health difficulties, was directed to a more selected group of students, but was still incorporated into a whole-school approach. Component 4 had three main target areas: (a) the promotion of Early intervention for students experiencing mental health difficulties; (b) attitudes towards mental health and mental health difficulties; and (c) the provision of support for students experiencing mental health difficulties. In Chapter 3 it was shown that, in comparison with the other components, less progress was made on both engagement, and on implementation, of this component. In Chapter 3 we also reported that, according to Project Officers’ reports, about 26% of schools had implemented plans for this component by the end of the two years of KM. On average, schools achieved steps in the implementation process where they were developing strategies, or possibly evaluating strategies, for Component 4. In this chapter, attention turns to: (a) specific responses from the evaluation about engagement with and implementation of Component 4; and (b) the impact of KM on the degree to which schools displayed features of early intervention.

9.1 Engagement with and implementation of Early intervention for students experiencing mental health difficulties

A series of items were directed to teachers about implementation and engagement with Component 4. First, teachers were asked to rate (on a 7-point scale) the extent to which the school had ‘worked on’ the component of Early intervention for students experiencing mental health difficulties, on each of the four occasions of the questionnaire. Second, teachers were asked to rate the extent to which they agreed that the school had implemented plans in relation to Early intervention for students experiencing mental health difficulties. Finally, as part of responding to items about the professional development associated with KM, teachers were asked to rate the extent to which the professional development had better equipped the school to facilitate early intervention. The mean results of teachers’ responses to the three items over the four occasions are presented in Figure 23, along with the percentage of teachers who responded 6 or 7 to each statement at Time 4.
The extent to which schools had ‘worked on’ Component 4 differed in Round 1 and Round 2 schools, as can be seen in Figure 23. In Round 1 schools, a small increase in average teacher responses over the four occasions reflects those schools that were well into the startup phase at Time 1 and then moved into sustained engagement by Time 3. By Time 4, over half the teachers in Round 1 schools (54%) reported that the school had worked on Early intervention ‘a great deal’, which was 18% more teachers than at Time 1. In contrast, Round 2 schools did not record ratings of working a great deal on Component 4 until Time 3, and this is reflected by teachers’ lower average responses during Time 1 and Time 2 (around 4 on the 7-point scale). By Time 4, 42% of Round 2 teachers reported that their schools had engaged with Early intervention ‘a great deal’, which was also 18% more teachers than at Time 1.

The second questionnaire item examined the extent to which schools had implemented plans with regard to Early intervention. The profiles in Round 1 and Round 2 schools again reflected the staged implementation (see Figure 23). By Time 4, 58% of teachers in Round 1 schools, and 47% of teachers in Round 2 schools, strongly agreed that “Our school has implemented plans to develop… strongly agree” which was approximately double those reported by Project Officers. The increase over the four occasions in Round 1 schools was reflected by 22% more teachers at Time 4, than at Time 1, strongly agreeing with this statement. The equivalent figure of 25% for Round 2 schools, suggest that despite the delayed start, many of these schools were implementing plans for Early intervention at the end of the trial.

Finally, the results from teacher reports about the helpfulness of the professional development for assisting schools to intervene early for students experiencing mental health difficulties are also given in Figure 23. It can be seen that, on average, teachers gave moderate ratings to the helpfulness of this aspect of the professional development. By Time 4, the average rating was around 5 on the 7-point scale. By Time 4, around half the teachers (59% in Round 1 and 48% in Round 2 schools) strongly agreed to the effectiveness of this aspect of the professional development. These results for the professional development ratings are consistent with the other findings on engagement and implementation of Component 4. Clearly, some schools made good progress on this component while other schools seemed to have made limited progress. It is likely that the effectiveness of the professional development was related to the degree to which schools were engaged with this component.

The results from teachers’ ratings about Component 4 are consistent with the evidence from Project Officers presented in Chapter 3. That is, schools on average showed moderate levels of engagement and progress for this component.

### 9.2 Impact on Early intervention: Whole cohort study

As with the other three components, it was expected that participation in KM would increase the degree to which schools undertook Early intervention strategies. To measure the provisions that schools were making for Early intervention and support for students experiencing mental health difficulties, the evaluation questionnaire contained 12 items for teachers and 14 items for parents. The items are given in Table 20.
The composition of the items in this section was recognised as being sensitive, and extensive discussions were held with clients about appropriate, non-stigmatising, ways of referring to student mental health issues in school contexts. It was agreed that rather than referring to "mental health difficulties", the items should be worded to refer to "emotional or social or behaviour difficulties", as it was determined that teachers and parents would better understand the latter wording and that this wording would be less likely to cause distress. The items mainly emphasised the target areas of identification and support for students experiencing mental health difficulties. The questionnaire results were examined to determine firstly the degree to which schools had provisions for Early intervention at the start of KM, and the extent to which this improved over the time of KM.

It can be seen in Table 20 that the responses on the individual items at Time 4 tended to be more positive for teachers than for parents. The most positive responses were about teachers promoting Early intervention, and about teachers’ respect for people experiencing emotional, social or behaviour difficulties. At Time 4, 38% (Round 1) and 36% (Round 2) of parents, and 52% (Round 1) and 47% (Round 2) of teachers strongly agreed (scored 6 or 7) to items relating to Early intervention for students experiencing mental health difficulties. By the end of the trial, 12% more teachers in Round 1 schools and 5% more teachers in Round 2 schools strongly agreed that their school was effective in providing Early intervention for students experiencing mental health difficulties.

The results for the impact of KM on schools’ provision of Early intervention was examined in the multilevel modelling analysis (HLM) using the parent and teacher items combined into respective scales. The results for change over time are summarised in Figure 24. The Figure gives the raw means as well as the plot of the fitted HLM results, together with a summary of the statistical results.

It can be seen in Figure 24 that the mean ratings by both teachers and parents for Early intervention were moderate at Time 1 (just below 5 on the 7-point scale). The ratings by teachers showed a significant improvement over the period of KM, with this improvement showing a medium effect size for Round 1 schools and a small effect size for Round 2 schools. In contrast, there was little change across the trial in the ratings by parents for school provision related to Early intervention.

As noted in relation to Component 3 in the previous chapter, these averaged results for Component 4 probably also arise from variations among schools in the degree to which they implemented Component 4. The overall means on this component are relatively low, but other data in Table 20 indicates that some schools made good progress on Component 4.

### Table 20. Component 4: Early intervention

<table>
<thead>
<tr>
<th>These questions are about students who are at risk of, or are experiencing, emotional or social or behaviour difficulties. From your own experience, rate the extent to which you disagree or agree with the following statements:</th>
<th>Round 1</th>
<th>Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T</td>
<td>P</td>
</tr>
<tr>
<td>‘Strongly Agree’ at Time 4</td>
<td>52%</td>
<td>42%</td>
</tr>
<tr>
<td>The school acts quickly if a child has emotional or social or behaviour difficulties</td>
<td>52%</td>
<td>42%</td>
</tr>
<tr>
<td>The external school support services (such as psychologists and social workers) act quickly if a child has emotional or social or behaviour difficulties*</td>
<td>29%</td>
<td>n/a</td>
</tr>
<tr>
<td>The school has strategies to identify whether students are having emotional or social or behaviour difficulties</td>
<td>42%</td>
<td>38%</td>
</tr>
<tr>
<td>The school has policies to support students with emotional or social or behaviour difficulties</td>
<td>54%</td>
<td>43%</td>
</tr>
<tr>
<td>The school has referral procedures for students experiencing emotional or social or behaviour difficulties</td>
<td>65%</td>
<td>40%</td>
</tr>
<tr>
<td>The school assists students having emotional or social or behaviour difficulties*</td>
<td>n/a</td>
<td>44%</td>
</tr>
<tr>
<td>The school helps families to get professional advice if their child is:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) having trouble with his or her schoolwork*</td>
<td>n/a</td>
<td>33%</td>
</tr>
<tr>
<td>b) overactive or easily distracted</td>
<td>44%</td>
<td>32%</td>
</tr>
<tr>
<td>c) having emotional problems</td>
<td>52%</td>
<td>35%</td>
</tr>
<tr>
<td>d) having social problems</td>
<td>51%</td>
<td>33%</td>
</tr>
<tr>
<td>e) having behaviour difficulties</td>
<td>56%</td>
<td>35%</td>
</tr>
<tr>
<td>The school regularly monitors students who are having emotional or social or behaviour difficulties</td>
<td>54%</td>
<td>37%</td>
</tr>
<tr>
<td>The school provides information that helps parents/caregivers to know if their child is having emotional or social or behaviour difficulties*</td>
<td>n/a</td>
<td>30%</td>
</tr>
<tr>
<td>The school advises parents/caregivers that it is important to help the child as soon as possible if he/she is having emotional or social or behaviour difficulties*</td>
<td>n/a</td>
<td>36%</td>
</tr>
<tr>
<td>Staff promote the importance of early intervention for students with emotional or social or behaviour difficulties*</td>
<td>61%</td>
<td>n/a</td>
</tr>
<tr>
<td>School staff are respectful and sensitive towards people experiencing emotional or social or behaviour difficulties</td>
<td>68%</td>
<td>49%</td>
</tr>
<tr>
<td>Average</td>
<td>52%</td>
<td>38%</td>
</tr>
</tbody>
</table>

* Item not given in both questionnaires
9.3 Project Officer reports: Links with external agencies

An important element of Component 4 concerned the use by schools of appropriate external agencies that could provide assistance with students experiencing mental health difficulties. It was expected that KM would lead to an improvement in links with appropriate external agencies. As a consequence, on the last three data collection occasions, Project Officers were asked to provide a rating about whether KM had resulted in improved links with external agencies. Project Officers were asked to select from ‘Not at all’ (1) to ‘Highly improved’ (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 the mean responses by Project Officers in Round 1 and Round 2 schools over time. The average scores were around the neutral point (4 on the 7-point scale). However, again the evidence was that there were some schools where the Project Officer ratings indicated that KM had indeed resulted in improved links with external agencies. At Time 4, 26% of Round 1 schools and 27% of Round 2 schools were rated by Project Officers at 6 or 7 for having improved links with external agencies as a result of KM.

For at least a quarter of schools, KidsMatter had a strong positive impact on improving links with external agencies.

Included in the Project Officer Report were questions that sought specific information about referrals, such as:
How many external referrals have been made for students experiencing emotional, or social or behavioural problems?
How much time, on average, has been taken to access these referrals?
The responses to these questions, presented in Figure 26, showed that although schools were active in making referrals, the time that they waited for action on such referrals remained problematic throughout the trial. For example, at Time 4, about half of the referrals were taking more than one month to be accessed. Although this length of time for accessing referrals was not associated with KM, nor with the schools themselves, it is an issue that can be expected to have a negative impact on the schools’ capacities to make effective provisions for students experiencing mental health difficulties.

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

9.4 Impact on Early intervention: Stakeholder responses

Although schools recognised the importance of addressing Early intervention for students experiencing mental health difficulties, the demands of addressing all four KM components created the need for establishing priorities in implementing KM. In particular, schools were advised, if selecting only one component to address, to start with Component 2. This meant that Component 4 was often left until later in 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 often at the forefront of teachers’ focus, the professional development they received around Early intervention was designed to better enable teachers to recognise students experiencing difficulties, even though the planning for this component may have been 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 about mental health, in particular the need to demystify mental health and to challenge commonly held taboos. The statements in Table 21 illustrate this challenge.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Exemplar Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifying gaps in knowledge</td>
<td>“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</td>
</tr>
<tr>
<td>Developing Awareness</td>
<td>“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</td>
</tr>
<tr>
<td>Generating Knowledge</td>
<td>“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</td>
</tr>
<tr>
<td>Skills Development</td>
<td>“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</td>
</tr>
</tbody>
</table>

9.4.1 External agency support

Another factor that influenced how well Early intervention progressed in schools concerned the support that schools received from external agencies. The interview comments here referred to examples of both good and problematic relationships. 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 of one principal at a school where external 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

A barrier to Early intervention however was created where there was a lack of external agency support. In these cases, staff were deterred from making referrals, as they expected that the referrals 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 has 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

This comment related directly to the length of time taken to access referrals discussed in the previous section of this chapter. In this respect, the schools are limited in their capacity to provide for their students by the level of service provision in agencies beyond the school. It must also be noted that in some rural areas such external service provision may be absent.

9.4.2 Changes to school culture around mental health

An important aim of the KM whole-school mental health model was to have a positive impact on attitudes to mental health and mental health difficulties via Component 4. This suggests that KM should engender a broad-based cultural change to knowledge and attitudes about mental health, with an emphasis on de-stigmatising issues around mental health. In a number of schools, this change in culture was reflected in the integration of KM into the school and its curriculum, not just as an “add-on”. In the interviews with stakeholders there was considerable evidence of this kind of change, in a way that can generally be described as having an impact on school culture, represented in comments such as those below:

“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

“We … get together and we talk about ‘OK, 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

“KidsMatter is 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

“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 realising….well, it’s actually a different way of integrating.” Teacher School 2

“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

9.4.3 Demystifying mental health and promoting inclusivity

KM was seen to give permission to staff and parents 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 by stakeholders that KM promoted understanding and inclusivity, where families and children at risk no longer appear marginalised and on the periphery of the school community, but squarely placed within it.
“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

Taken together, these stakeholder comments point to how KM made an impact on the broad attitudes and culture of the schools.

**9.5 Chapter summary**

Overall, schools were moderately engaged with Component 4, and some did make good progress on its implementation. From Project Officer reports, it appeared that about 26% of schools reached the implementing plans stage for this component. The averaged responses indicate that most schools were making efforts to implement Component 4 by the end of the trial.

From teacher ratings, there was a positive overall impact of KM on the provision of Early intervention for students experiencing mental health difficulties. This positive impact was supported by the ratings from both parents and teachers, suggesting that KM had significantly improved many schools’ ability to meet the needs of students with mental health difficulties. The suggestion of an improvement in schools’ performance in providing Early intervention is also consistent with the evidence from Project Officer reports that KM improved links with external agencies, though action through these external links was often quite delayed, which limited the effectiveness of schools’ work for students.

The potential for KM to have an impact on schools in the area of Component 4 emerged in some of the responses made in the interviews with stakeholders. Both school principals and teachers in some of the schools in the Stakeholder study commented on the impact of KM on beliefs and attitudes about mental health and mental health difficulties. These changes were reflected in claims about the impact of KM on staff knowledge, competence and skills about mental health, as well as on school culture, in terms of the way mental health is viewed and approached in the school.
An important assumption in the KM intervention strategy was that it would lead to increases in teachers' knowledge, competence and confidence in relation to Social and Emotional Learning and in relation to supporting students with mental health difficulties. This increase in teacher knowledge, competence and confidence was expected to arise especially through the strategies employed within Component 2 (Social and Emotional Learning) and in the strategies employed within Component 4 (Early intervention for students experiencing mental health difficulties). In addition, it is likely that efforts under Components 1 and 3 would also contribute to improvements in teachers' knowledge, competence and confidence. Central to this desired change in teachers' capabilities was the professional development provided through KM. It was this professional development that was anticipated to be an important agent of teacher change. If teacher capabilities mediate student mental health outcomes, it is reasonable to predict that improvement in teacher knowledge, competence and confidence is a necessary step if there are to be improvements in student mental health. This prediction 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 interactions between mental health and achievement (Roeser et al., 1998).

### 10.1 Teacher competencies

Teachers were asked 23 items about their attitudes, knowledge, competence and confidence (self-efficacy) towards teaching social and emotional competencies. The first seven items focused on staff in the school (see Table 22), to assess whether and how their teaching of SEL changed during the period of KM. The literature on teacher change indicates that a necessary first step is a change in teacher attitude or beliefs. As such, the next three items in this section were about staff attitudes towards SEL. The remaining 13 items asked each teacher to reflect upon his or her own capabilities. These included five items covering the teacher’s knowledge about teaching Social and Emotional Learning, five items about the individual teacher’s program and resources for teaching SEL, and three items about teacher self-efficacy in relation to Components 1, 3 and 4 (see Table 22).

#### 10.1.1 Staff approach to Social and Emotional Learning

It can be seen in Table 22 that by Time 4, over 70% of teachers strongly agreed that staff in the school were helping students to develop SEL skills. This included items about opportunities for students to practice their social and emotional skills, and to apply the skills outside the classroom. It is evident from results in Table 22 and Figure 27 that at the start of KM, teachers rated their schools as already providing substantial opportunities for Social and Emotional Learning. These high ratings meant that there was less scope for measurable improvement (on the 7-point scale) in association with KM. Nevertheless, on average, from Time 1 to Time 4, 8% more teachers strongly agreed that staff helped students to develop their SEL capabilities. This result is supported by the findings from the HLM analysis of changes in the mean scores (see Figure 27), where it can be seen that there were significant improvements on this scale, with small effect sizes for both Round 1 and Round 2 schools.
Table 22. Teachers’ attitudes, knowledge, competence and confidence (self-efficacy) towards teaching social and emotional competencies

<table>
<thead>
<tr>
<th>The questions in this section are about teaching, including the teaching of social and emotional skills. From your own experience, rate the extent to which you disagree or agree with the following statements:</th>
<th>Round 1</th>
<th>Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff approaches to teaching SEL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff help students develop an awareness of their own feelings</td>
<td>81%</td>
<td>79%</td>
</tr>
<tr>
<td>Staff help students develop an awareness of other people's thoughts and feelings</td>
<td>84%</td>
<td>81%</td>
</tr>
<tr>
<td>Staff help students to develop skills to manage their own emotions</td>
<td>73%</td>
<td>70%</td>
</tr>
<tr>
<td>Staff help students develop skills for establishing healthy relationships with other children</td>
<td>78%</td>
<td>74%</td>
</tr>
<tr>
<td>Staff help students to develop skills for making responsible decisions</td>
<td>80%</td>
<td>77%</td>
</tr>
<tr>
<td>Staff provide opportunities for students to practice social and emotional skills</td>
<td>74%</td>
<td>67%</td>
</tr>
<tr>
<td>Staff help students to apply social and emotional skills outside the classroom</td>
<td>67%</td>
<td>65%</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td>77%</td>
<td>73%</td>
</tr>
<tr>
<td><strong>Staff attitudes towards SEL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff believe it is important to teach social and emotional skills to students</td>
<td>84%</td>
<td>82%</td>
</tr>
<tr>
<td>Students can be taught social and emotional skills</td>
<td>87%</td>
<td>84%</td>
</tr>
<tr>
<td>Students who are socially and emotionally competent learn more at school</td>
<td>92%</td>
<td>92%</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td>88%</td>
<td>86%</td>
</tr>
<tr>
<td><strong>Teacher knowledge about SEL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know how to help students:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop an awareness of their own feelings</td>
<td>74%</td>
<td>64%</td>
</tr>
<tr>
<td>Develop an awareness of the thoughts and feelings of other people</td>
<td>75%</td>
<td>71%</td>
</tr>
<tr>
<td>Develop skills to manage their own emotional or social or behaviour difficulties</td>
<td>69%</td>
<td>61%</td>
</tr>
<tr>
<td>Develop skills to make responsible decisions</td>
<td>72%</td>
<td>70%</td>
</tr>
<tr>
<td>Develop skills to establish healthy relationships with other children</td>
<td>72%</td>
<td>68%</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td>72%</td>
<td>67%</td>
</tr>
<tr>
<td><strong>Teachers’ SEL programs and resources</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My teaching programs and resources help students to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop an awareness of their own feelings</td>
<td>72%</td>
<td>69%</td>
</tr>
<tr>
<td>Develop an awareness of the thoughts and feelings of other people</td>
<td>75%</td>
<td>69%</td>
</tr>
<tr>
<td>Develop skills to manage their own emotional or social or behaviour difficulties</td>
<td>72%</td>
<td>66%</td>
</tr>
<tr>
<td>Develop skills to make responsible decisions</td>
<td>77%</td>
<td>68%</td>
</tr>
<tr>
<td>Develop skills to establish healthy relationships with other children</td>
<td>76%</td>
<td>68%</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td>75%</td>
<td>68%</td>
</tr>
<tr>
<td><strong>Teacher self-efficacy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can help people to develop a sense of belonging within the school community</td>
<td>69%</td>
<td>64%</td>
</tr>
<tr>
<td>I can provide effective support for parents/caregivers about students’ emotional or social or behaviour difficulties</td>
<td>56%</td>
<td>50%</td>
</tr>
<tr>
<td>I can identify early signs of emotional or social or behaviour difficulties in students</td>
<td>61%</td>
<td>56%</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td>62%</td>
<td>56%</td>
</tr>
</tbody>
</table>
10.1.2 Staff attitudes to Social and Emotional Learning

It can be seen in Table 22 that at Time 1, more than 80% of teachers gave 'strongly agree' ratings for the items about staff attitudes to Social and Emotional skills Learning. A slightly higher level of mean rating was present at Time 4, indicating relatively little change in attitudes. This is confirmed by the results of the HLM analysis of changes in the mean scores (see Figure 28), where the means were high at the start of KM and showed minimal change. Clearly, at the start of KM, teachers reported that staff already held positive attitudes towards the importance of social and emotional skills, and on the 7-point scale there was little scope for this to improve.

10.1.3 Teacher knowledge about Social and Emotional Learning

It is apparent in Table 22 that by Time 4, around 70% of teachers strongly agreed on the items about their SEL knowledge. This was a substantial improvement on the ratings provided at Time 1, when around 56% of teachers strongly agreed to these items. This change in teacher knowledge was confirmed in the results of the HLM analysis of changes in the mean scores (see Figure 29), where it can be seen that there was a medium effect size for the change in Round 1 schools' teachers' knowledge and a small effect size for change in teachers' knowledge in Round 2 schools.
Figure 29. Teacher knowledge about Social and Emotional Learning

### Table 29. Teacher SEL programs and resources

<table>
<thead>
<tr>
<th>Teacher</th>
<th>Time 1 Mean</th>
<th>Time 4 Mean</th>
<th>Significance p</th>
<th>r</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Round 1</td>
<td>5.41</td>
<td>5.84</td>
<td>***</td>
<td>0.29</td>
<td>medium</td>
</tr>
<tr>
<td>Round 2</td>
<td>5.39</td>
<td>5.62</td>
<td>**</td>
<td>0.13</td>
<td>small</td>
</tr>
</tbody>
</table>

10.1.4 Teacher SEL programs and resources

From the results in Table 22 it can be seen that by Time 4, 75% of teachers in Round 1 schools and 68% of teachers in Round 2 schools strongly agreed with these items. This represented a substantial change from Time 1, when 56% of Round 1 teachers and 55% of Round 2 teachers strongly agreed with these items. This change in teachers’ SEL programs and resources was confirmed in the results of the HLM analysis of changes in the mean scores (see Figure 30), which showed a medium effect size for the change in Round 1 schools and a small effect size for the change in Round 2 schools.
Figure 30. Teacher SEL programs and resources

<table>
<thead>
<tr>
<th>Time 1 Mean</th>
<th>Time 4 Mean</th>
<th>Significance p</th>
<th>r</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Round 1</td>
<td>5.47</td>
<td>5.86</td>
<td>***</td>
<td>0.26</td>
</tr>
<tr>
<td>Round 2</td>
<td>5.33</td>
<td>5.64</td>
<td>***</td>
<td>0.19</td>
</tr>
</tbody>
</table>

10.1.5 Teacher self-efficacy

The Time 4 results for teacher self-efficacy in Table 22 show that more than half the teachers strongly agreed on these three items about their self-efficacy for managing KM Components 1, 3 and 4. When comparisons were made between Time 1 and Time 4, it was found that there were some noticeable changes in teachers’ reports from Round 1 schools. This occurred in particular for two items. For the item “I can provide effective support for parents/caregivers about students’ emotional, social or behaviour difficulties,” 14% more teachers strongly agreed from Time 1 to Time 4. For the item “I can identify early signs of emotional, social or behaviour difficulties in students,” 15% more teachers strongly agreed at Time 4 compared with Time 1.

The pattern of change on these items is shown in Figure 31. Here it can be seen that there were small effect sizes for the changes in Round 1 and Round 2 schools.

Figure 31. Teacher self-efficacy

<table>
<thead>
<tr>
<th>Time 1 Mean</th>
<th>Time 4 Mean</th>
<th>Significance p</th>
<th>r</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Round 1</td>
<td>5.18</td>
<td>5.55</td>
<td>***</td>
<td>0.23</td>
</tr>
<tr>
<td>Round 2</td>
<td>5.20</td>
<td>5.38</td>
<td>*</td>
<td>0.10</td>
</tr>
</tbody>
</table>

The pattern of findings on these five measures of teacher competencies is consistent, pointing to a positive change in the ratings by teachers of their knowledge, competence and confidence in relation to the teaching of SEL and promoting positive mental health in schools. The changes are indicated by the presence of the small to medium effect sizes among this cluster of five indicators.

Overall, a substantial impact of KidsMatter was on teacher competencies for promoting positive mental health. These competencies are important when conceptualising the influence of teachers as a protective factor for student mental health.
10.2 Impact of the professional development

Teachers were asked four items at Time 4 about the extent to which the professional development related to KM had increased their knowledge, commitment and teaching practices. The items are given in Table 23, where it can be seen that around 60% of teachers strongly agreed that the KM professional development had enhanced their knowledge, increased their commitment, improved the ways they interact with students, and helped them to foster student wellbeing. However, although there was good agreement at Time 4 between teachers in each Round about the effectiveness of the KM professional development, Figure 32 reveals that the profiles of Round 1 and Round 2 schools were quite different. Note that Time 1 data on this scale was not available. The results of the HLM analysis of changes in the mean scores (see Figure 32), showed that Round 1 teachers’ responses reflected a context of sustained professional development: There was little change between Time 2 and Time 4. In contrast, Round 2 teachers’ responses were neutral at Time 2 about the professional development, as expected, prior to starting KM but more strongly agreed about the effectiveness of the KM professional development as time progressed, resulting in a positive change equivalent to a large effect size.

Table 23. Teacher ratings about the impact of PD on teacher knowledge, commitment and practice

<table>
<thead>
<tr>
<th>The Professional Development related to the KidsMatter Initiative has:</th>
<th>Round 1</th>
<th>Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>'Strongly Agree' at Time 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enhanced my knowledge about students' mental health</td>
<td>60%</td>
<td>62%</td>
</tr>
<tr>
<td>Improved the ways that I interact with students</td>
<td>54%</td>
<td>49%</td>
</tr>
<tr>
<td>Increased my level of commitment to promoting student wellbeing</td>
<td>67%</td>
<td>63%</td>
</tr>
<tr>
<td>Helped me to foster student wellbeing through my practices as a teacher</td>
<td>65%</td>
<td>61%</td>
</tr>
<tr>
<td>Average</td>
<td>62%</td>
<td>59%</td>
</tr>
</tbody>
</table>

Figure 32. The impact of PD teacher competencies

<table>
<thead>
<tr>
<th>KM Professional Development: Teacher responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Round 1 School means</td>
</tr>
<tr>
<td>Round 2 School means</td>
</tr>
<tr>
<td>Round 1 line of best fit</td>
</tr>
<tr>
<td>Round 2 line of best fit</td>
</tr>
</tbody>
</table>

Table 24. Staff perceptions of the impact of KidsMatter

<table>
<thead>
<tr>
<th>Theme</th>
<th>Exemplar Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher attitudes, knowledge &amp; awareness</td>
<td>“Number one, I suppose is de-stigmatising mental health…because I think people still think mental health means you are mentally ill.” Counsellor School 8</td>
</tr>
<tr>
<td>Staff knowledge</td>
<td>“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</td>
</tr>
<tr>
<td>Teacher confidence</td>
<td>“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</td>
</tr>
</tbody>
</table>

For these teachers, it is evident that KM impacted broadly on their perceptions of their knowledge, attitudes and their teaching.
10.4 Chapter summary

The evaluation results showed that at the start of KM many teachers already displayed moderate to high levels of knowledge, competence and confidence in relation to Social and Emotional Learning and in relation to supporting students with mental health difficulties. This was especially apparent with respect to teacher attitudes to Social and Emotional Learning, where ratings were high at the start of KM and changed little over the two years.

There was evidence of positive change on the scales designed to measure teacher knowledge, competence and confidence in both Round 1 and Round 2 schools. The most noticeable improvements were for teacher SEL knowledge and teachers ratings of the extent to which their programs and resources addressed students’ SEL, particularly in Round 1 schools. The results for teacher self-efficacy also suggested greater improvement in their confidence in Round 1 schools than in Round 2 schools, especially confidence in supporting parents and in identifying early signs of mental health difficulties. The KM professional development also had a positive impact, on teachers’ knowledge, competence and confidence to deal with SEL and mental health issues. Overall, therefore, the evaluation provided important evidence of a positive impact on teachers arising from KidsMatter.

Shifting or supporting teacher attitudes, raising teachers’ awareness about mental health, and changing teaching practices with regards to Social and Emotional Learning, are important for creating and sustaining lasting change in schools, with a potential to contribute to improved student mental health.
Central to the KM intervention strategy was the idea that KM would have a positive impact on a number of protective factors for student mental health. Included in these protective factors was the family context, where one purpose of the intervention was to contribute to more effective parenting and to more supportive and caring family relationships, especially parent-child relationships. Therefore, KM was expected to lead to increases in parents’ knowledge, competence and confidence in areas of parenting and child-development. In turn, it was assumed that more effective parenting and supportive parent-child relationships would assist all students, and in particular, assist students with mental health difficulties, and thereby contribute to improvements in their mental health. The changes to family context envisioned in KM were especially linked to Component 3 (Parenting support and education). However, it was also expected that contributions would come from the other three components.

In the questionnaire study, parents were asked four items about their parenting knowledge and three items about ‘positive’ parenting style. The parenting knowledge items considered if parents knew how to help their child foster friendships, provide emotional comfort, and recognise when their child is having difficulties. Parenting style was conceived as comprising close and affectionate parent-child relationships together with consistency in applying rules. The items comprising these two aspects of parenting are given in Table 25, along with one item that asked parents to rate their overall effectiveness as a parent.

Table 25. Parents’ knowledge and parenting style

<table>
<thead>
<tr>
<th>These questions are about parenting. From your own experience, rate the extent to which you disagree or agree with the following statements:</th>
<th>Round 1</th>
<th>Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenting Knowledge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know how to calm my child if he/she is angry or upset</td>
<td>75%</td>
<td>74%</td>
</tr>
<tr>
<td>I know how to help my child when he/she is sad, depressed or anxious</td>
<td>72%</td>
<td>71%</td>
</tr>
<tr>
<td>I know how to assist my child to develop relationships with other children</td>
<td>65%</td>
<td>60%</td>
</tr>
<tr>
<td>I know if my child is having emotional or social or behaviour difficulties</td>
<td>72%</td>
<td>70%</td>
</tr>
<tr>
<td>Average</td>
<td>71%</td>
<td>69%</td>
</tr>
<tr>
<td>Parenting Style</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I consistently apply the rules with my child</td>
<td>55%</td>
<td>54%</td>
</tr>
<tr>
<td>I am affectionate with my child</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>I have a close relationship with my child</td>
<td>92%</td>
<td>92%</td>
</tr>
<tr>
<td>Average</td>
<td>79%</td>
<td>79%</td>
</tr>
<tr>
<td>I am effective overall as a parent/caregiver</td>
<td>79%</td>
<td>79%</td>
</tr>
</tbody>
</table>
11.1 Parenting knowledge

From the results in Table 25, it can be seen that by Time 4 most parents strongly agreed with these items about their parenting knowledge. The lowest percentage was for strongly agreeing to the item about knowing how to assist their child to develop relationships with other children. This pattern of ratings was also evident at Time 1. The results in Figure 33 suggest little change in parenting knowledge in association with KM. Here it can be seen that the average rating of parenting knowledge was relatively high at Time 1 and did not change significantly from Time 1 to Time 4. Overall, therefore, parents expressed confidence about their parenting knowledge and this did not change over the period of KM.

Figure 33. Parent ratings about parenting knowledge

<table>
<thead>
<tr>
<th></th>
<th>Time 1 Mean</th>
<th>Time 4 Mean</th>
<th>Significance p</th>
<th>r</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Round 1</td>
<td>5.83</td>
<td>5.83</td>
<td>0.361</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>Round 2</td>
<td>5.76</td>
<td>5.81</td>
<td>0.152</td>
<td>0.05</td>
<td></td>
</tr>
</tbody>
</table>

11.2 Parenting style

It can be seen in Table 25 that 90% or more of parents strongly agreed that they had close and affectionate relationships with their child, and about half the parents (55%) strongly agreed that they consistently applied rules. These results were almost the same as the percentage that strongly agreed at Time 1, with an overall average of 80%. From Figure 34 it can be seen that parents’ average rating of their parenting style was high at Time 1 and remained so during the KM trial. The main feature of these results for parenting style was that parents gave high ratings at the start of KM and this was maintained across the trial.

Figure 34. Parent ratings of parenting style

<table>
<thead>
<tr>
<th></th>
<th>Time 1 Mean</th>
<th>Time 4 Mean</th>
<th>Significance p</th>
<th>r</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Round 1</td>
<td>6.23</td>
<td>6.12</td>
<td>**</td>
<td>0.08</td>
<td></td>
</tr>
<tr>
<td>Round 2</td>
<td>6.22</td>
<td>6.15</td>
<td>*</td>
<td>0.05</td>
<td></td>
</tr>
</tbody>
</table>

11.3 Overall effectiveness as a parent

Parents gave high ratings to their overall effectiveness as parents at Time 1 and this did not change over the period of KM. Almost four out of five parents (78% in Round 1 and 79% in Round 2 schools) strongly agreed about their parenting effectiveness at Time 1. There was almost no change over the period of KM with 79% of parents in both Round 1 and Round 2 schools strongly agreeing at Time 4 (see Table 25).
11.4 Impact on parents’ awareness of children’s social and emotional needs

Seven items in the questionnaire asked parents to rate the extent to which KM had helped their learning about their children’s social and emotional needs. The items covered parenting in general, identifying the child’s difficulties, and assisting with their child’s Social and Emotional Learning and difficulties. These items are given in Table 26, where it can be seen that by Time 4, 28% of parents in Round 1 schools and 24% of parents in Round 2 schools strongly agreed that KM had helped them to learn about these issues. The level of these responses indicates that parents did not feel that KM had had a strong impact on their capacities to help their children with social and emotional issues. Nevertheless, their responses did indicate that KM was associated with a practically significant increase in parents’ ratings on this scale, albeit from a rather low level at Time 1. From Time 1 to Time 4, approximately 11% more parents strongly agreed that KM had helped their learning about children’s social and emotional needs. This points to a positive impact of KM on parenting knowledge related to SEL.

Table 26. Parent ratings of learning from KidsMatter

<table>
<thead>
<tr>
<th>From your own experience, rate the extent to which you disagree or agree with the following statements.</th>
<th>Round 1</th>
<th>Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KidsMatter has helped me to learn:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>good ideas for parenting</td>
<td>26%</td>
<td>23%</td>
</tr>
<tr>
<td>how to identify if my child is showing emotional or social or behaviour difficulties</td>
<td>26%</td>
<td>22%</td>
</tr>
<tr>
<td>how my child develops relationships with other children</td>
<td>26%</td>
<td>23%</td>
</tr>
<tr>
<td>how to help my child deal with his/her feelings</td>
<td>28%</td>
<td>25%</td>
</tr>
<tr>
<td>how to help my child to understand the feelings of other people</td>
<td>29%</td>
<td>25%</td>
</tr>
<tr>
<td>how to help my child to make responsible decisions</td>
<td>30%</td>
<td>25%</td>
</tr>
<tr>
<td>how to help my child to deal with emotional or social or behaviour difficulties</td>
<td>28%</td>
<td>25%</td>
</tr>
<tr>
<td>Average</td>
<td>28%</td>
<td>24%</td>
</tr>
</tbody>
</table>

This general finding of a low rating, but an improvement, over the period of KM is confirmed by the results of the HLM analysis of changes in the mean scores (see Figure 35). The means were below the neutral point on the 7-point scale at Time 1, but improved significantly with a medium effect size for Round 1 schools, and a large effect size for Round 2 schools. Although KM was not rated by parents as having a strong effect on their parenting, it was clear that KM did have some impact over the two-year period.

Figure 35. Change in parent perceptions about the impact of KidsMatter on parenting learning

11.5 Parent interview responses about the impact of KidsMatter

In the interviews conducted with parents as part of the Stakeholder study, we sought information about the perceived impact of KM. The themes identified and presented in Table 27, included parents’ need to feel welcomed and valued in the school, and their need for mental health information where it was relevant to their situation.

It became apparent that parents’ perceptions of the broad impact of KM were related to their specific needs. If a need to engage with KM was perceived, then the impact of KM was perceived as broadly positive. If parents did not believe that they or their child warranted any contact with what KM had to offer, then impact was less apparent:

“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
Table 27. Parents’ perceptions of the impact of KidsMatter

<table>
<thead>
<tr>
<th>Theme</th>
<th>Exemplar Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived relevance of KM</td>
<td>“It’s a bit daunting for parents because they think…there’s nothing mentally wrong with my child.” Parent School 6</td>
</tr>
<tr>
<td>Positive personal impact</td>
<td>“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</td>
</tr>
<tr>
<td></td>
<td>“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</td>
</tr>
<tr>
<td></td>
<td>“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</td>
</tr>
</tbody>
</table>

11.6 Chapter summary

Parents gave high ratings to their parenting effectiveness and knowledge at the start of KM and this changed little over the period of the trial. In addition, they rated highly features of a positive parenting style, and this also changed little across the trial. It is difficult to assess the possible role of social desirability influences on these ratings. Even though all efforts were made to inform parents about confidentiality, the questionnaires were returned to the school prior to being sent to the evaluation team. It is difficult to know whether and if some parents believed their responses might be viewed at the school, and so might have modified their responses accordingly.

When asked specifically about how KM had helped them with their learning about social and emotional competencies, only about one quarter of the parents rated the help highly, though there was evidence of change on this scale. The results from the Stakeholder study provided some insights into this finding. As might be expected, it was apparent that only some parents were involved with the school in relation to parenting and their child’s social, emotional or behaviour difficulties. Furthermore, it was clear from parents’ comments that only some parents perceived KM as relevant to them and their child. If parents did not perceive that they needed assistance with parenting, or that their child did not need assistance, then their involvement with KM and the opportunities it might provide appeared to be lower.

In considering the impact of KM on family context, it should also be remembered from Chapter 3 that there was limited consistent evidence of high levels of engagement with, and implementation of, Component 3 (Parenting support and education), with limited evidence of actual change in the level of support and education provided by schools. Furthermore, in Chapter 8 it was noted from the Stakeholder interviews with principals and parents that there were special challenges associated with the implementation of Component 3. It is likely that the results presented here indicating limited impact of KM on family context, partly reflect the progress made on Component 3 throughout KM. This highlights, once again, the complex interactions between the four components themselves and the contextual features of schools.
In addition to family contexts, child competencies were a set of protective factors central to the KM intervention strategy. The child factors that KM expected to impact on especially related to students’ social and emotional competencies, and also included areas such as their schoolwork. Both of these were investigated in the evaluation. The child factors, or child competencies, were assumed to serve as protection against mental health difficulties. It was expected, therefore, that KM would be associated with improvements in child competencies and that this would in turn contribute to improvements in child mental health outcomes. The changes to the child protective factors envisioned in KM were especially linked to Component 2 (Social and Emotional Learning). However, it was also considered that contributions would come from the other three components.

12.1 Impact on student social and emotional competencies

Parents and teachers answered seven items about students’ social and emotional competencies. The competencies that were the focus of these items were sourced from the five areas suggested by CASEL (2006). The items are given in Table 28. Parents and teachers were asked to think about the past month, and to rate the extent to which they agreed (7-point scale) that the child had shown each of the named competencies, on average, over the month. It can be seen in Table 28 that, on average, approximately 64% of parents strongly agreed that their child demonstrated the competencies at Time 4. The percentages for teachers strongly agreeing were slightly lower (60% and 57% respectively). For both parents and teachers the percentage strongly agreeing about these child competencies increased from Time 1 to Time 4, with 6% more parents (Rounds 1 and 2), 10% more teachers in Round 1, and 5% more teachers in Round 2, strongly agreeing (scored 6 or 7).

Table 28. Child social and emotional competencies

<table>
<thead>
<tr>
<th>On average over the last month, my child has shown that he/she:</th>
<th>Round 1</th>
<th>Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T</td>
<td>P</td>
</tr>
<tr>
<td>Is happy about his/her relationships with other children</td>
<td>64%</td>
<td>70%</td>
</tr>
<tr>
<td>Is happy about his/her family relationships</td>
<td>72%</td>
<td>83%</td>
</tr>
<tr>
<td>Can solve personal and social problems</td>
<td>52%</td>
<td>55%</td>
</tr>
<tr>
<td>Can manage his/her feelings</td>
<td>57%</td>
<td>52%</td>
</tr>
<tr>
<td>Recognises his/her strong points</td>
<td>56%</td>
<td>62%</td>
</tr>
<tr>
<td>Takes account of the feelings of others</td>
<td>59%</td>
<td>69%</td>
</tr>
<tr>
<td>Can make responsible decisions</td>
<td>61%</td>
<td>63%</td>
</tr>
<tr>
<td>Average</td>
<td>60%</td>
<td>65%</td>
</tr>
</tbody>
</table>

Archived at Flinders University: dspace.flinders.edu.au
From the analysis of the proportion of teachers and parents who strongly agreed about these child competencies, it appears that there was a small improvement over the period of KM. This is supported by the findings from the HLM analysis of changes in the mean scores on the Social and emotional competencies scale, where it can be seen in Figure 36 that, for both parents and teachers, the average ratings of child competence were moderate to high at Time 1. There were significant improvements with small effect sizes for both Round 1 and Round 2 schools in parent ratings. For teacher ratings there was a small effect size for improvement in Round 1 schools only.

Figure 36. Child social and emotional competencies

Overall, both parents and teachers rated children as having moderate to high social and emotional competencies at the start of KidsMatter and there was evidence of practically significant improvement in these competencies across the trial.

In the Student Voice study the students indicated that they had become empowered to express their feelings, to solve problems, and to generate alternate ways of coping when situations were difficult or confronting. This was apparent in the students’ discussions about the vignette (see Figure 18 in Chapter 7) that was included in the Student Voice study.

Students were able to describe how the character in the vignette (Cris) was feeling. Responses such as those included below suggest that students could interpret Cris’ feelings in an appropriate manner:

“sad…depressed…he’s feeling angry…lonely…upset…annoyed…unhappy…angry at his friend…anxious.” Student School 4

and were aware of productive strategies that Cris might use:

“…he could tell a friend.” Student School 4

The responses of the students ranged across their behaviour and different parts of their lives, and included discussions about strategies that they had developed for coping with difficulties. Their responses suggested that the impact of KM extended across home and school contexts, and related strongly to the development of self-efficacy and self-management skills. Examples of students’ comments are summarised around the core themes shown in Table 29.
Table 29. Students’ perceptions of their social and emotional competencies, coping strategies and behaviour

<table>
<thead>
<tr>
<th>Theme</th>
<th>Exemplar Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes in the behaviours</td>
<td>“There’s not as many fights…they’re more considerate of each other…there’s less people coming up to you.” Student School 1&lt;br&gt;“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&lt;br&gt;“In the last year we’ve talked about what to do, being resilient and all the five keys… I feel like we’re older and know more things… responsible… yeah… responsible.” Student School 5&lt;br&gt;“I used to be really mean and bad… but I’ve got a bit better now.” Student School 5</td>
</tr>
<tr>
<td>At school</td>
<td>“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&lt;br&gt;“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 7&lt;br&gt;“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 three… take a deep breath and clam down… then go and have fun and play and forget about it.” Student School 6&lt;br&gt;“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</td>
</tr>
<tr>
<td>At home</td>
<td>“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&lt;br&gt;“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</td>
</tr>
<tr>
<td>Coping when feeling everything is wrong</td>
<td>“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&lt;br&gt;“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 is 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&lt;br&gt;“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&lt;br&gt;“When he [Cris] gets stressed they could let him onto the computer… or go outside and cool down.” Student School 7&lt;br&gt;“You could get someone like a… really professional… a person who deals with the feelings about people – talk to you about feelings.” Student School 7</td>
</tr>
<tr>
<td>Expressing feelings</td>
<td>“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&lt;br&gt;“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</td>
</tr>
</tbody>
</table>

Clearly, the students in this study talked about social and emotional competencies in association with KM. Students also discussed anger management strategies, ways of building positive friendships and peer relationships; and how they might manage bullying:

“Sometimes it’s 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 1

“When I get angry and I need to cool down I’ve got a card that I can write on with a whiteboard 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

These responses from students interviewed in the Student Voice study can be directly related to content and strategies that were a focus in Component 2 (Social and Emotional Learning). Although there was no formal assessment of change in student’s knowledge, it seems reasonable that the views reported by interviewed students could be associated with the changes noted above in the ratings of students’ social and emotional competencies by parents and teachers.
12.2 Impact on student 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 about the benefits for academic learning outcomes associated with the teaching of social and emotional skills to students, with 92% of teachers across all schools strongly agreeing (scored 6 or 7), that “Students who are socially and emotionally competent learn more at school”. This did not change over the period of KM.

12.2.1 Stakeholder responses about student competencies and learning

The strong beliefs about the benefits to learning of well-developed social and emotional competencies, which emerged from the questionnaire responses, were also evident in a number of comments from school principals in the Stakeholder study.

“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

“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

A link with students’ 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 KM 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 right by 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

12.2.2 Stakeholder responses about mental health and student learning

To illustrate how one school responded to the issue of mental health and student learning the following practical strategy was described by one 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 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 improved engagement with learning.

12.2.3 Improvements in ratings of the child’s schoolwork

Parents and teachers were asked to rated the extent to which they agreed with the statement that “KidsMatter has led to improvements in my child’s (this student’s) school work”. It can be seen in Figure 37 that at Time 4 less than one quarter of teachers (23%) strongly agreed (scored 6 or 7) with this statement and around 18% of parents strongly agreed with it. Nevertheless, there was an increase in these ratings across the trial. Over the two years, 10% more teachers in Round 1 schools and 18% more teachers in Round 2 schools strongly agreed that KM had led to improvements in the student’s schoolwork. For parents, about 5% more parents strongly agreed at Time 4 in comparison with Time 1.
Figure 37. Change over time in teacher and parent ratings about the impact of KidsMatter on students’ learning outcomes

![Bar chart showing changes over time in teacher and parent ratings about the impact of KidsMatter on students’ learning outcomes.]

Note: Lines of best fit were not generated for individual items.

<table>
<thead>
<tr>
<th></th>
<th>Round 1</th>
<th>Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>at Time 4</td>
<td>T</td>
<td>P</td>
</tr>
<tr>
<td>KidsMatter has led to improvements in this student’s (my child’s) school work</td>
<td>22%</td>
<td>19%</td>
</tr>
</tbody>
</table>

12.3 Chapter summary

At the start of KM, both parents and teachers provided moderate to high average ratings for students’ social and emotional competencies. Nevertheless, there was evidence of a significant improvement in those ratings in association with KM. A noteworthy aspect of the evaluation findings came from the Student Voice study. Here, there was clear evidence from the students themselves about how KM had had a positive impact on their Social and emotional competencies, their coping strategies and their behaviour. Furthermore, it was noticeable that the students were able to apply their learning across the school and family contexts and to different kinds of relationships and problems.

In the area of students’ schoolwork, the evaluation questionnaire and interviews provided clear evidence that teachers strongly believed that students who are social and emotionally competent learn more at school. Furthermore, schools’ practices appeared to be consistent with this belief. Ratings of whether KM had led to an improvement in the child’s schoolwork showed some evidence of a positive impact. The suggestion that KM might have led to an improvement in schoolwork was somewhat stronger in teacher responses than in parent responses.

Overall, the evidence summarised in this chapter supports conclusions about the positive impact of KM on important child protective factors such as social and emotional competencies. The fact that students were so readily able to articulate ways in which their competencies, coping and behaviour had improved through KM is strong evidence in support of an impact on child protective factors.
“It’s been weeks, which is weeks, which is fantastic, since the two 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 has 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

The central purpose of KM was to improve student mental health and well-being and to reduce mental health difficulties. The evaluation has provided evidence of ways in which KM had an impact on schools, teachers, family contexts, and student competencies. These changes are consistent with the design and purpose of KM in its mental health promotion, prevention and early intervention strategies. The final area of the evaluation was to determine whether and how the KM impacts on schools, teachers, families and students in turn had an impact on student mental health.

As indicated in the quotation from the Stakeholder study above, examples from the Stakeholder and Student Voice studies suggest improved mental health for some students. For example, thought provoking statements flowed from the following contexts:

A school 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’s 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

The questionnaire data gathered for the evaluation was also examined in order to determine the impact of KM on student mental health outcomes. The evaluation used three scales to measure student mental health as set out in Chapter 3. Each scale was based on teacher and parent reports about the targeted students. The three scales were (a) Goodman’s (2005) Strengths and Difficulties Questionnaire (SDQ), (b) the purpose-designed Mental Health Difficulties scale as an alternative measure of difficulties, and (c) the purpose-designed Mental Health Strengths scale. This chapter presents student mental health outcomes as measured by each of the scales.
13.1 The Strengths and Difficulties Questionnaire

KM is based on a population health model, so it is important in the first instance to examine potential changes at the population level (Raphael, 2000). Therefore, the initial step in investigating the impact of KM on student mental health was to examine the mental health outcomes for all students. In this case, the initial emphasis is on whole-group, mean-score changes over time based on Total SDQ Difficulties scores. Subsequent discussion around the SDQ then examines groups of students classified into normal, borderline and abnormal ranges of mental health in terms of the Total SDQ Difficulties, and then in terms of the five subscales, which consider Emotional symptoms, Conduct problems, Peer problems, Hyperactivity, and Prosocial behaviour.

13.1.1 Total SDQ outcomes for all students

Goodman’s (2005) Strengths and Difficulties Questionnaire (SDQ), parent and teacher informant versions, were given to the parents and teachers of the targeted students on four occasions. The SDQ contains items about students’ mental health strengths and difficulties. However, in accordance with Goodman’s instructions about scoring the SDQ, only the items about difficulties were summed to give a total difficulties score. In other words, the Total SDQ Difficulties measure is the sum of scores on the subscales of Emotional symptoms, Conduct problems, Peer problems and Hyperactivity, but excludes Prosocial behaviour. A low total score on this 40-point scale indicates low mental health difficulties.

The first step in the analysis was to examine the Total SDQ Difficulties results for all students. It can be seen from Figure 38 that the mean total difficulties score at Time 1 was relatively low, indicating that the majority of students were rated as having few mental health difficulties. Furthermore, students had fewer difficulties according to teacher ratings than according to parent ratings. In other words, parents were more inclined than teachers to rate the child as having a difficulty. This effect is characteristic of SDQ results, and could be ascribed to the different contexts for observations of individual and group student behaviour that school and family situations provide.

To determine if there was an overall decline in mental health difficulties over the course of KM, HLM analysis of change over time in the mean SDQ Difficulties scores was conducted. The vertical bars in Figure 38 display the mean SDQ Total Difficulties scores for students in Round 1 and Round 2 schools at each data collection occasion, accompanied by the regression line of best fit that resulted from the HLM analysis. The table associated with Figure 38 details the calculations of statistical and practical significance, the latter indicated by effect sizes. It can be seen that the decreases in SDQ Total Difficulties scores were equivalent to small effect sizes in three of the four conditions. Although lacking readily comparable Australian research, it can be noted that this outcome of KM differs from the trend for declining mental health discussed by Bernard et al., (2007, pp.60-62) for the age group involved in KM.

HLM analysis showed that there were no significant differences in the changes in student Total SDQ Difficulties scores between students located in Round 1 and Round 2 schools. Accordingly, further results presented in this chapter are based on the combined groups of students in Round 1 and Round 2 schools, with the greater interest now focussed on differences between students rather than differences between schools.

Figure 38. Change over time in Total SDQ Difficulties for all students

<table>
<thead>
<tr>
<th>Teacher</th>
<th>Time 1 Mean</th>
<th>Time 4 Mean</th>
<th>Significance p</th>
<th>r</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Round 1</td>
<td>7.53</td>
<td>6.51</td>
<td>***</td>
<td>0.12</td>
<td>small</td>
</tr>
<tr>
<td>Round 2</td>
<td>7.59</td>
<td>6.98</td>
<td>**</td>
<td>0.07</td>
<td>small</td>
</tr>
<tr>
<td>Parent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Round 1</td>
<td>8.90</td>
<td>8.29</td>
<td>***</td>
<td>0.11</td>
<td>small</td>
</tr>
<tr>
<td>Round 2</td>
<td>9.57</td>
<td>8.43</td>
<td>***</td>
<td>0.21</td>
<td>small</td>
</tr>
</tbody>
</table>
On average (that is, for all students), the Total SDQ Difficulties score declined significantly over the period of KidsMatter, equivalent to a small effect size. This decline represents a practically significant overall reduction in mental health difficulties, associated with the period of KidsMatter.

13.1.2 Changes in the Total SDQ Difficulties normal, borderline and abnormal ranges

The results for mean changes in the Total SDQ Difficulties scores for all students indicated some significant changes with small effect sizes. These effect sizes are of practical significance. Following this broad evidence, it is important to examine how KM impacted on particular groups of students, since it would be expected that KM would have relatively less impact for students who have had low levels of existing mental health difficulties. On the other hand, it could be expected that KM might have more impact on students with higher initial levels of mental health difficulties, and therefore greater need for intervention. In short, the changes in mean scores need to be further examined to determine whether change was differentially evident according to the students’ existing level of mental health difficulties.

We therefore revisited the Total SDQ Difficulties scale, and conducted an examination of changes over time based upon Goodman’s (1997) recommended cut-off points9 for allocating students into ‘normal,’ ‘borderline,’ and ‘abnormal’ ranges, based upon their initial Total SDQ Difficulties scores (using parent and teacher ratings). Previous research suggests that about 80% of students score in the normal range, with about 20% in the borderline and abnormal ranges (Hayes, 2007). In this sample of children, at the start of KM, 26% of children were classified within the borderline or abnormal ranges by teachers, and 22% by parents, according to their Total SDQ Difficulties scores.

The higher percentage of students in the borderline and abnormal ranges in this evaluation reflects the sampling strategy of intentionally targeting students who may be exhibiting social, emotional or behavioural difficulties.

As presented in Figure 39, the analysis of changes over time in mental health for students allocated to the normal, borderline and abnormal ranges showed that there was a reduction in the Total SDQ Difficulties scores for students in the borderline and abnormal ranges across the period of the trial, with these reductions representing medium and large effect sizes. There was also a small effect size for increases in teacher-rated SDQ Difficulties scores for the normal range. Possible explanations for this latter change include greater teacher sensitivity to student difficulties; teachers’ better knowledge of the students at the end, compared to the beginning, of the school year; and student maturation as discussed by Bernard et al. (2007).

Figure 39. Change over time in Total SDQ Difficulties for students’ in the normal, borderline and abnormal ranges

<table>
<thead>
<tr>
<th></th>
<th>Time 1 Mean</th>
<th>Time 4 Mean</th>
<th>Significance p</th>
<th>r</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Teacher</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal range</td>
<td>4.52</td>
<td>5.34</td>
<td>***</td>
<td>0.10</td>
<td>small</td>
</tr>
<tr>
<td>Borderline range</td>
<td>13.10</td>
<td>9.69</td>
<td>***</td>
<td>0.35</td>
<td>medium</td>
</tr>
<tr>
<td>Abnormal range</td>
<td>20.25</td>
<td>13.50</td>
<td>***</td>
<td>0.56</td>
<td>large</td>
</tr>
<tr>
<td><strong>Parent</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal range</td>
<td>6.44</td>
<td>6.57</td>
<td>ns</td>
<td>0.03</td>
<td>large</td>
</tr>
<tr>
<td>Borderline range</td>
<td>14.88</td>
<td>12.74</td>
<td>***</td>
<td>0.39</td>
<td>large</td>
</tr>
<tr>
<td>Abnormal range</td>
<td>20.99</td>
<td>16.66</td>
<td>***</td>
<td>0.62</td>
<td>large</td>
</tr>
</tbody>
</table>

The analysis undertaken at the subgroup level, rather than the whole-group level, suggests that there were differences in the impact of KidsMatter between student subgroups, and that KidsMatter had greater impact on students at risk of, or experiencing mental health difficulties.

---

9 Note that Goodman’s (1997) ranges for parent and teacher rated SDQs were differentially applied, as recommended. For teacher ratings, the ranges were ‘normal’ (0-11), ‘borderline’ (12-15), and ‘abnormal’ (16-40). For parent ratings, the ranges were ‘normal’ (0-13), ‘borderline’ (14-16), and ‘abnormal’ (17-40).
13.1.3 Impact on SDQ subscale scores for all students

As mentioned above, Goodman’s SDQ instrument not only assessed four dimensions of mental health difficulties, which comprise the Total SDQ Difficulties score, it also includes one dimension of mental health strength, the Prosocial subscale. The mental health difficulties subscales are, Emotional symptoms, Conduct problems, Peer problems and Hyperactivity, each scored out of 10, with a possible total score of 40 for Total SDQ Difficulties. Table 30 presents the percentage of students at the beginning and end of the evaluation, rated by their teacher and parent, as having difficulties on each of the five SDQ subscales.

Table 30. Percentage of students rated as having difficulties in five dimensions of mental health

<table>
<thead>
<tr>
<th>SDQ Subscales</th>
<th>Teacher Responses</th>
<th>Parent Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Time 1</td>
<td>Time 4</td>
</tr>
<tr>
<td>Emotional symptoms</td>
<td>14%</td>
<td>11%</td>
</tr>
<tr>
<td>Conduct problems</td>
<td>19%</td>
<td>16%</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>21%</td>
<td>17%</td>
</tr>
<tr>
<td>Peer problems</td>
<td>16%</td>
<td>14%</td>
</tr>
<tr>
<td>Prosocial difficulties</td>
<td>21%</td>
<td>19%</td>
</tr>
</tbody>
</table>

It can be seen in Table 30 that ratings from parents suggested somewhat higher levels of difficulties on the subscales than ratings from teachers, consistent with the results for the SDQ Total Difficulties scores. It can also be seen that there were small reductions in the proportion of students rated as having difficulties on each of the subscales by the end of KM. To examine the possible decline in mental health difficulties over the course of KM for each of the subscales, HLM analysis of changes in the mean scores was used. On average (that is, for all students), there was a decline for each of the subscales that was statistically significant, with small effect sizes. The analysis of the SDQ subscales is detailed in the following five sections.

13.1.4 Changes in SDQ Emotional symptoms

According to teachers, at the start of KM (see Table 30) 14% of students were rated as having difficulties on the Emotional symptoms subscale, consistent with the borderline or abnormal range (scored 5 or more on the 10 point scale). By the end of KM, teachers reported 3% fewer students, who had Many worries or often seems worried, Often unhappy, depressed or tearful, Many fears, easily scared, or Nervous in new situations. On the other hand, there were 27% of parents who reported that their child had emotional symptoms (scored 4 or more) at Time 1, with 5% fewer by Time 4.

Figure 40 presents the changes over time in ratings on the Emotional symptoms scale for students initially rated at Time 1 by parents and teachers in the ranges of normal, borderline and abnormal.

Table 31. HLM analysis of changes in mean scores for different ranges of Emotional symptoms

<table>
<thead>
<tr>
<th>Size of group</th>
<th>Teacher</th>
<th>Parent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal range</td>
<td>Time 1</td>
<td>1.35</td>
</tr>
<tr>
<td>Borderline range</td>
<td>2.99</td>
<td></td>
</tr>
<tr>
<td>Abnormal range</td>
<td>4.58</td>
<td></td>
</tr>
<tr>
<td>Normal range</td>
<td>1.68</td>
<td></td>
</tr>
<tr>
<td>Borderline range</td>
<td>3.95</td>
<td></td>
</tr>
<tr>
<td>Abnormal range</td>
<td>5.59</td>
<td></td>
</tr>
</tbody>
</table>

10 The Prosocial scale was reversed for this analysis.
While there was no change over time for students in the normal range, those exhibiting emotional symptoms in the borderline range showed a decline in the severity of symptoms, equivalent to a small effect size. For students in the abnormal range, emotional symptoms were reduced to an extent equivalent to a large effect size. For this Emotional symptoms scale, the effect sizes for change were similar for parent and teacher ratings.

13.1.5 Changes in SDQ Conduct problems

Teachers at Time 1 reported that 19% of their students (Table 30) exhibited a range of behaviours such as, often losing their temper, fighting with other kids, and often lying or stealing, beyond the normal range (scored 3 or more). By Time 4, teachers reported 3% fewer students with these conduct problems. Almost a quarter of the parents (24%) reported that their child had conduct problems at Time 1 (scored 3 or more) and by Time 4 this figure was lower at 19%. Figure 41 presents the changes over time in ratings on the Conduct problems scale for students initially rated at Time 1 by parents and teachers in the ranges of normal, borderline and abnormal.

For teacher ratings of conduct problems (see Figure 41), there was an increase over time for students in the normal range equivalent to a small effect size. As mentioned above, teacher sensitivity and student maturation are possible explanations for this change in a non-preferred direction. However, according to parent ratings, there was no apparent change over time on the Conduct problems scale for students in the normal range. Students exhibiting conduct problems in the borderline range showed a decline in the severity of symptoms equivalent to a medium effect size. For students in the abnormal range, conduct problems were reduced to an extent equivalent to large effect sizes, according to teacher and parent ratings respectively.

13.1.6 Changes in SDQ Hyperactivity

Students considered to have hyperactive behaviour tended to not think things out before acting, had poor attention spans, were restless, overactive, or constantly fidgeting, or were easily distracted (scored 6 or more by the teacher or parent). At the start of KM, teachers indicated that 21% of students exhibited hyperactive behaviours, while the same was indicated by 19% of parents. By Time 4, teachers reported 4% fewer, and parents reported 6% fewer students exhibiting hyperactive behaviours (see Table 30).

Figure 42 presents the changes over time in ratings on the Hyperactivity scale for students initially rated at Time 1 by parents and teachers in the ranges of normal, borderline and abnormal. There was no change in levels of hyperactivity for students in the normal range. Students exhibiting hyperactivity in the borderline range showed a decline in the severity of symptoms, equivalent to a medium effect size. For students in the abnormal range, hyperactivity was reduced to an extent equivalent to a large effect size.
13.1.7 Changes in SDQ Peer problems

According to teachers at Time 1, 16% of students exhibited peer problems to the extent that they were in the range of borderline or abnormal (see Table 30). Such problems were indicated when students were generally not liked, they preferred to be alone, or were picked on or bullied. At Time 1, 16% of students were rated by their teacher (scored 4 or more) as having peer problems, with 2% fewer students given this rating by Time 4. Almost 30% of parents reported that their child had peer problems at Time 1 (scored 3 or more). By the end of KM, there were 4% fewer parents reporting peer problems for their child.

Figure 43 presents the changes over time in ratings on the Peer problems scale for students initially rated at Time 1 by parents and teachers in the ranges of normal, borderline and abnormal. There was no change in ratings over time for peer problems for students in the normal range. Students exhibiting peer problems in the borderline range showed a decline in severity equivalent to a small effect size, according to both parent and teacher ratings. For students in the abnormal range, peer problems were reduced to an extent equivalent to a medium effect size according to parent and teacher ratings.

Table 43: Change over Time in Teacher and Parent Ratings about Students’ Peer Problems

<table>
<thead>
<tr>
<th></th>
<th>Time 1 Mean</th>
<th>Time 4 Mean</th>
<th>Significance p</th>
<th>r</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal range</td>
<td>0.94</td>
<td>1.10</td>
<td>**</td>
<td>0.06</td>
<td>small</td>
</tr>
<tr>
<td>Borderline range</td>
<td>2.46</td>
<td>1.87</td>
<td>***</td>
<td>0.16</td>
<td>small</td>
</tr>
<tr>
<td>Abnormal range</td>
<td>4.08</td>
<td>2.71</td>
<td>***</td>
<td>0.35</td>
<td>medium</td>
</tr>
<tr>
<td>Parent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal range</td>
<td>1.25</td>
<td>1.29</td>
<td>ns</td>
<td>0.03</td>
<td>medium</td>
</tr>
<tr>
<td>Borderline range</td>
<td>2.87</td>
<td>2.58</td>
<td>ns</td>
<td>0.13</td>
<td>small</td>
</tr>
<tr>
<td>Abnormal range</td>
<td>4.13</td>
<td>3.42</td>
<td>***</td>
<td>0.35</td>
<td>medium</td>
</tr>
</tbody>
</table>
13.1.8 Changes in SDQ Prosocial behaviour

Students who did not exhibit positive social behaviour (scored 5 or less by teacher or parent) were less likely to be considerate of other people’s feelings, or share with others, were less helpful if someone was hurt or upset, or were less kind to younger children. At the start of KM, 21% of students according to teachers, but only 10% of students according to parents, exhibited poor Prosocial behaviour (see Table 30). By the end of KM, teachers reported 2% fewer, and parents reported 1% fewer students with poor prosocial skills. Figure 44 presents the changes over time in ratings on the Prosocial scale for students initially rated at Time 1 by parents and teachers in the ranges of normal, borderline and abnormal.

Figure 44. Change over time in teacher and parent ratings about students’ Prosocial behaviour

<table>
<thead>
<tr>
<th></th>
<th>Time 1 Mean</th>
<th>Time 4 Mean</th>
<th>Significance p</th>
<th>r</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Teacher</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal range</td>
<td>8.36</td>
<td>8.10</td>
<td>**</td>
<td>0.07</td>
<td>small</td>
</tr>
<tr>
<td>Borderline range</td>
<td>6.49</td>
<td>7.09</td>
<td>***</td>
<td>0.15</td>
<td>small</td>
</tr>
<tr>
<td>Abnormal range</td>
<td>5.04</td>
<td>6.07</td>
<td>***</td>
<td>0.23</td>
<td>small</td>
</tr>
<tr>
<td><strong>Parent</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal range</td>
<td>8.52</td>
<td>8.52</td>
<td>ns</td>
<td>0.00</td>
<td>small</td>
</tr>
<tr>
<td>Borderline range</td>
<td>7.75</td>
<td>7.91</td>
<td>ns</td>
<td>0.07</td>
<td>small</td>
</tr>
<tr>
<td>Abnormal range</td>
<td>6.82</td>
<td>7.06</td>
<td>**</td>
<td>0.12</td>
<td>small</td>
</tr>
</tbody>
</table>

Although the Prosocial subscale is not included in the overall calculation of the SDQ Difficulties score, we have the opportunity here to investigate any changes in students’ scores associated with the KM intervention. There was no change in Prosocial behaviours for students in the normal range. Students exhibiting Prosocial behaviours in the borderline range showed an improvement equivalent to a small effect size, according to teacher ratings, but not according to parent ratings. For students in the abnormal range, Prosocial behaviours improved to an extent equivalent to a small effect size according to parent and teacher ratings.

For students in the abnormal range, there were medium to large effect sizes for reductions in emotional symptoms, conduct problems, peer problems and hyperactivity, in addition to a small effect size for improvements in Prosocial behaviour.

For students in the borderline range, there was a medium effect size reduction in hyperactivity and small effect size reductions for emotional symptoms, conduct problems and peer problems.

13.2 Student mental health difficulties: An alternative measure

The second measure of student mental health difficulties was purpose-designed for the evaluation. This Mental Health Difficulties scale consisted of three items about poor behaviour, anxiety and depression, responded to by parents and teachers on a 7-point Likert scale of ‘strongly disagree’ (1) to ‘strongly agree’ (7), on four occasions, shown in Figure 45.
According to this alternative measure, students who exhibited mental health difficulties (rated 6 or 7) were difficult to manage, nervous and anxious or often sad or depressed. At the start of KM across the whole cohort of students, 7% of students according to teachers, and 9% of students according to parents, exhibited mental health difficulties. By the end of KM, teachers reported 1% fewer, and parents reported 2% fewer, students with such mental health difficulties.

A similar procedure as described above was used to classify students at Time 1 into the normal, borderline and abnormal ranges, in order to determine if there were differential changes, this time based on the Mental Health Difficulties scale. From Figure 45 it can be seen that students exhibiting mental health difficulties in the borderline range showed a decline in the severity of symptoms equivalent to a small effect size, according to both parent and teacher ratings. For students in the abnormal range, mental health difficulties were reduced to an extent equivalent to a medium effect size according to teachers and a small effect size according to parents.

In general, few children were rated as difficult to manage, nervous or depressed, and of those, small to medium effect size reductions in these mental health difficulties were evident. These findings on the alternative Mental Health Difficulties scale support the direction of change evidenced using the SDQ.

### 13.3 Student mental health strengths

Mental health is a multidimensional concept, comprising both strengths and difficulties (Askell-Williams et al, 2008). Although there were good reasons, discussed earlier, to use the SDQ as an outcome measure for KM, this scale only focused on the difficulties dimension of mental health. We therefore considered it important to include alternative measures of mental health that focused on positive dimensions.

The third measure, the Mental Health Strengths scale, was accordingly designed for the evaluation. The scale consisted of three items about optimism and coping, which were responded to by parents and teachers on a 7-point Likert scale on four occasions.

Students who exhibited mental health strengths (scored 6 or 7) “generally thought things were going to work out well, felt good about him or herself” and “were able to cope with life overall”. According to teachers, at the start of KM, 54% of all students were rated as being positive and coping well. By the end of KM, teachers reported 6% more students who exhibited such mental health strengths. On the other hand, there were 63% of parents who reported that their child was coping well and felt positive at Time 1, with 6% more by Time 4. Note that these figures are averaged responses across the whole sample.

Figure 46 presents the changes over time in ratings on the Mental Health Strengths scale for students initially rated at Time 1 by parents and teachers in the (SDQ) ranges of normal, borderline and abnormal, using the same proportions of students as identified by Goodman’s Prosocial scale. Students exhibiting difficulties in the borderline range showed an increase in positive behaviours equivalent to a small effect size, according to both parent and teacher ratings. For students in the abnormal range, mental health strengths improved to an extent equivalent to a medium effect size.
In general, many children were rated as having strengths to cope with life and feeling positive about themselves. However, for students who did not initially have this profile, KidsMatter was associated with improvements for students in both the borderline and abnormal ranges.

Figure 46. Change over time in teacher and parent ratings about students' mental health strengths

<table>
<thead>
<tr>
<th>Time 1 Mean</th>
<th>Time 4 Mean</th>
<th>Significance p</th>
<th>r</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal range</td>
<td>5.79</td>
<td>5.71</td>
<td>ns</td>
<td>0.05</td>
</tr>
<tr>
<td>Borderline range</td>
<td>4.63</td>
<td>5.08</td>
<td>***</td>
<td>0.19</td>
</tr>
<tr>
<td>Abnormal range</td>
<td>3.65</td>
<td>4.58</td>
<td>***</td>
<td>0.36</td>
</tr>
<tr>
<td>Parent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal range</td>
<td>5.87</td>
<td>5.92</td>
<td>ns</td>
<td>0.04</td>
</tr>
<tr>
<td>Borderline range</td>
<td>5.01</td>
<td>5.24</td>
<td>ns</td>
<td>0.17</td>
</tr>
<tr>
<td>Abnormal range</td>
<td>4.22</td>
<td>4.71</td>
<td>***</td>
<td>0.33</td>
</tr>
</tbody>
</table>

13.4 Two dimensions of mental health: Difficulties and strengths

A different perspective on change in mental health associated with KM is possible. The above findings are based on tracking the trajectories of children that were identified at Time 1 as being in the normal, borderline or abnormal ranges, in order to determine how subgroup profiles changed over time. However, we now consider an alternative method of analysis by examining the proportion of children in each range on each of the four occasions, and how those proportions change over time. In addition, in this section we assess mental health using the three available measures of its two dimensions, namely difficulties and strengths. It is this different method of proportional analysis, in combination with three different ways of assessing mental health that is the focus of this section.

13.4.1 Change in the proportion of children in each range according to the SDQ mental health difficulties

In order to contrast the differing outcomes on the different assessments of mental health, we first revisit the outcomes of this type of analysis using the Total SDQ Difficulties. The proportions of students identified by parents and teachers (averaged responses) as being within the normal, borderline or abnormal ranges according to the SDQ were calculated for each occasion. An overall improvement in mental health across the student cohort, therefore, would be indicated by a decrease in the proportion of students who fell within either the abnormal or borderline ranges and a corresponding increase of children in the normal range.

Across the period of KM, there were 4.5% fewer children, according to teachers, and 5.8% fewer children, according to parents, in the borderline and abnormal ranges. This reflects students who had shifted from the abnormal and borderline ranges into the normal range.

On average, this 5% increase in the proportion of children in the normal range of mental health as defined by the SDQ represents an improvement for 1 in 20 of all children, or an improvement for 1 in 5 children identified with mental health difficulties.

13.4.2 Change in the proportion of children in each range according to mental health strengths and difficulties

"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 order to better account for students' strengths and as well as their difficulties, an expanded set of criteria were used to classify students into normal, borderline and abnormal ranges. The ranges were formed by bringing together parent and teacher ratings, not only on the Total SDQ Difficulties score, but by also by combining the scores on the Mental Health Strengths and the Mental Health Difficulties scales. The revised profile of each group according to their scores on the three measures showed, as expected, that:

- students within the abnormal mental health range were rated higher on difficulties and lower on strength
- students within the normal range, were rated lower on difficulties and higher on strength
- students within the borderline range displayed a profile that included some difficulties, but also some strengths.

At the start of KM, this expanded set of criteria (based on multiple informants and multiple dimensions) showed that 34% of students were in the borderline or abnormal ranges. By the end of the trial, this figure had reduced to 23%. As a consequence, approximately 10% of students no longer exhibited mental health difficulties to the extent that they shifted into the normal range by the end of KM.

Based on criteria that bring together parent and teacher views as well as multiple dimensions of mental health, there was an improvement for 1 in 10 of all children, or an improvement for 1 in 3 children identified with mental health difficulties.

Of greater interest, however, was to examine how the mental health of children identified under this broader set of criteria compared to the mental health of children identified under the SDQ. Table 31 provides a comparison between the two methods and shows the respective proportions of children identified in the borderline or abnormal ranges and how they changed over time.

Table 31. Student mental health outcomes according to different criteria

<table>
<thead>
<tr>
<th>Borderline or Abnormal Ranges:</th>
<th>At Time 1</th>
<th>By Time 4</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on SDQ Difficulties</td>
<td>24%</td>
<td>19%</td>
<td>Approx. 1 in 5 students in the borderline and abnormal ranges</td>
</tr>
<tr>
<td>(parent and teacher averaged)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Based on mental health strengths</td>
<td>34%</td>
<td>23%</td>
<td>Approx. 1 in 3 students in the borderline and abnormal ranges</td>
</tr>
<tr>
<td>and difficulties and multiple informants</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Regarding student mental health according to different criteria, KidsMatter could have been associated with improvements in the mental health of more students than suggested by the SDQ alone.

The classification using the expanded criteria also showed a larger impact on students who were in the borderline range than suggested in the SDQ analysis, possibly because initiatives associated with KM were able to build upon their existing strengths as well as reducing difficulties. Furthermore, it is possible that the classification using the expanded criteria resulted in a more targeted recognition of students in the abnormal range. These students have a profile of high difficulties and low strengths based on the reports of both parents and teachers. It could be that it is more difficult to effect change, especially over the short term, in students with this type of profile.

13.5 Chapter summary

With respect to the influence of KM on students' mental health outcomes, the findings of the evaluation indicated, on average, an improvement in student wellbeing 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. Averaged across all students in the sample, the changes in mental health showed small effect sizes. These changes were of practical significance and are worthy of attention given the population-based strategy of KM.

More differentiated analyses of changes in mental health were conducted. First, the Total SDQ Difficulties score obtained for students at Time 1 was used to group students into normal, borderline and abnormal ranges of mental health (Goodman, 2005). The score trajectories of students in each of these ranges showed medium to large effect sizes for reductions in mental health difficulties for students in the borderline and abnormal ranges, and medium effect sizes for improvements in mental health strengths for students in the abnormal range.

There was also a reduction in the overall proportion of students with mental health difficulties over the period of KM, with a corresponding increase in the proportion of students in the normal mental health range.

---

11 Students were classified based on the three measures of mental health using Latent Class Analysis. This alternative method of classification was undertaken using Goodman's SDQ cut-off points applied to each measure and therefore the classification labels of normal, borderline and abnormal were retained for clarity in reporting results.
Students were also grouped into normal, borderline and abnormal ranges based on an expanded set of criteria using both mental health difficulties and strengths. At the start of KM 34% of students were in the borderline or abnormal ranges. By the end of the trial, this reduced to 23%, with approximately 10% more students in the normal range. This represents a change for approximately 1 in 3 students identified with mental health difficulties. KM could have been associated with improvements in the mental health of more students than suggested by the SDQ criteria, where students were classified only by their difficulties.

The analyses in this chapter support a conclusion that, based on teacher and parent reports, KM had an impact on measured student mental health and that this impact appeared greater for students with a mental health status in the range of borderline or abnormal.

Throughout the report, evidence has been presented of the impact of KM in terms of positive changes associated with schools, teachers, parents and children. In this chapter evidence was provided of the impact on student mental health outcomes.

It is possible to conclude that the changes in mental health presented here are associated with KM and the consequent changes in schools, teachers, parents and children.
In this chapter we step back from the detailed presentation of findings from the evaluation to examine the KM initiative from a wider perspective. We consider KM in the context of other school-based interventions that have a focus on mental health, discuss issues emerging from our analyses that could impact on the further development of KM, and make suggestions about future research in this field.

14.1 School based interventions: International perspectives

Increasingly in Australia and overseas, attention is being given to the possibility of working through schools to improve the mental health of children. Schools have ready-made populations of students that can be targeted for general, as well as specific, mental health promotion initiatives (CASEL, 2006; Stewart-Brown, 2006). Sawyer et al. (2007) noted that counselling at school was the most frequently attended service by students identified as having mental health difficulties. Effective intervention in early stages of the development of a mental health difficulty is considered to be a key strategy for achieving successful mental health outcomes (Littlefield, 2008).

As noted by Brown and Bowen (2008, p.29), schools are “an ideal point of entry for delivering universal and preventive services that address a variety of factors affecting children’s physical and mental health”.

“From a mental health perspective, the call to bring early identification of mental health problems into schools is part of a larger movement to improve the quality of mental health services by transforming the system” (New Freedom Commission on Mental Health, 2003, cited in Levitt et al., 2007, p.165). As Hoagwood and Erwin (1997, p.438) noted, the idea of school-based mental health programs evolved from a “systems of care reform movement”. In Hoagwood and Erwin’s model the emphasis was on the need for collaborative partnerships between parents and school professionals (e.g., teachers, school psychologists) to promote children’s academic and mental health success.

There is a wealth of evidence that indicates that school–community partnerships do positively influence outcomes for students, showing increases in attendance rates, decreases in cases of recurrent absenteeism (e.g., Epstein & Sheldon, 2002), improvements in educational success (e.g., Mastro et al., 2006), resilience, behaviour and attitude. It is proposed that collaborative partnerships can also provide more effective service delivery for students and their families. The literature has also identified that partnerships between school and community are essential in enabling students to achieve the best life outcomes, addressing both academic and non-academic (that is, social, emotional and physical) learning barriers (e.g., Anderson-Butcher, et al., 2006; Sheldon, 2007). School–community partnerships are an essential component of the Health Promoting School (HPS) model (e.g., Rissel & Rowling, 2000).

Research from Australia, the United Kingdom and the United States has indicated that these partnerships are particularly advantageous for schools in low socio-economic, socially excluded communities, to aid in addressing social and educational inequalities. Schools alone lack the capacity and resources needed to both educate and counteract the numerous barriers to learning experienced by many socially disadvantaged students. Partnerships with parents, families and communities can provide needed resources, support and assistance to schools to help address the complexity of student needs (e.g., Sanders, 2001; Sanders & Harvey, 2002). Partnerships have been shown to be protective for students, promoting positive mental health and helping to alleviate environmental, learning and social barriers, thus enhancing academic and social competencies.
From a systems perspective, schools are complex entities (Slee & Shute, 2003). The analysis and discussion of the four KM components in this report highlights the importance of taking a systems perspective, not only about KM, but more broadly about schools. Systems theory helps us to understand the multiplicative, rather than additive, effects of a multi-component initiative such as KM. In a systems approach there is interdependency among components. Some of this interdependency is not readily tracked, but its importance cannot be overlooked. Although for practical purposes in this evaluation it was necessary to attend to individual components, it must be kept in mind that these components are components of a system. As a school principal noted:

“They (schools) need to not be overwhelmed by the strategic planning side of it, but really think carefully about what are the priority areas for their school. It’s all contextual, so what works for us in our context is going to be completely different in a different area, so it’s very contextual, and they need to, from that context, work out priorities, but only obviously very small ones that are achievable. They need to think carefully about what’s achievable in their school setting and then they need to be serious about their human resource allocation, to achieve those outcomes; and work in teams. And ensure that they allow the staff plenty of time to process what the program’s all about, so they take ownership of the program. So I think they’re some of the critical elements of making the program successful.” Principal School 9

14.2 Promotion, prevention and early intervention

The Council of Australian Governments (COAG, 2008) National Action Plan on Mental Health highlighted the significance of promotion, prevention and early intervention. In its Action Plan, the emphasis is on facilitating the recognition of risk factors and early signs of mental health problems.

KM is a package of mental health promotion, prevention and early intervention initiatives. KM provides a conceptual framework that situates student mental health and wellbeing within the everyday work of the school, identifies foundations for this work that are focused around the four components, and sets out a structure for its implementation within a school. The promotion of the issue of student mental health within the school is supported by the provision of resources that can enable a school community to work at developing the capacity to address at an early stage difficulties that might arise for students.

This evaluation report approaches KM from its constituent parts, presenting findings on each aspect of KM in turn. However, it was recognised at the outset of the evaluation that KM is, foremost, a complete entity. The emphasis on a population health model, and the use of a whole-school implementation approach, are significant indicators that it is important that KM should be considered in its totality rather than in terms of its individual constituents.

Two other key components of the KM package were the availability of Project Officers and the program of professional development they provided:

“I think there would be enormous benefit … he/she has got such knowledge that they could be imparting … when it comes to our curriculum planning I don’t necessarily have that skill base to share with teachers … but they have got that expertise and I just think that that in future would be a greater benefit.” Principal School 7

Feedback from the Stakeholder study and the Leadership Executive summaries highlighted the range of roles of Project Officers, including providing leadership for the initiative, professional development, and motivation and overall championing of the significance of KM in the school community. Over and above their role in the schools, they served to link KM at the organisational level to the practicalities of the implementation at the school and classroom level.

14.3 Working with four components

The foundation of the KM initiative is provided by the four components. The components were chosen as “four areas where schools can strengthen the protective factors for students’ mental health and minimise the risk factors” (KidsMatter Implementation Manual, p.5). Each component was conceived and presented to schools for implementation with separate target areas, objectives and strategies. However, schools tended to focus on each component in different ways, some schools tackled one component after another; other schools tackled all four components at once. These different approaches were responses to what was, for schools, a quite complex task. For the schools it was not easy to:

“See how the four components can actually be worked together in unison, in some senses, because you do need all four to be cohesive, but to bite off only as much as you can take at any one time.” Principal School 5

It was apparent in considering the findings of the evaluation that (a) the components are mutually dependent and (b) they have multiple effects on outcomes. This means that possible impacts on schools arising from any single component will be influenced by the other components. For example, early intervention strategies in Component 4 will be enhanced by successful efforts made by the school in relation to the other three components. Similarly, work by teachers on Component 2: Social and Emotional Learning, is likely to have an impact on both their knowledge, confidence and competence, as well as on students' social and emotional competencies. In turn, enhanced student competencies may contribute to changes in parent-child relationships.
Relatively few schools fully implemented all four components of KM within the two years. The practicality is that KM made substantial demands on staff, on resources in schools, on school timetables, and on the need for preparation and readiness.

“I think you just need to focus a little bit more on those whole school things that are really going to make profound change early, consolidate that and don’t even give yourself you know, a time line. Just say ‘we’re going to consolidate that’ and when we’re happy we’ve done that, well then we’ll move onto the next thing. I mean, sure things have to work concurrently, but not many. It’s too big and there’s too much going on in schools.” Principal School 9

There is evidence in the different sources of evaluation data that each of the four components of KM proved important. For each component there is evidence of positive change across the trial. However, the evaluation indicated that the impact associated with the different components was variable, and that it was in Component 2, Social and Emotional Learning, that KM had very substantial impact. Schools made most progress with this component and most of the programs chosen for KM were focused on this component; teachers rated the PD on this component most highly and reported that they worked with students in a sustained way on this component; teachers also gave increased ratings to their schools’ performance in SEL across the trial and parents became more aware of their children’s SEL needs across time.

The participants largely viewed their schools as positive communities throughout the trial and little change was observed on Component 1. Least progress on implementation occurred for Component 3 (Parenting support and education) and Component 4 (Early intervention for students experiencing mental health difficulties). This lesser progress reflected both the staged implementation adopted by some schools, and also the greater difficulty of these two components given the existing expertise, perceived roles, and spheres of influence of schools. The evaluation would suggest that more attention needs to be given to supporting schools in relation to these two components, and to recognize the challenges they presented to schools in implementation.

14.4 The change process

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. There was evidence of growth in knowledge of students, teachers and parents. There was also evidence of change in understanding from the interviews conducted toward the end of the trial:

“I think that certainly there’s an awareness raising aspect of KidsMatter that’s had a real effect amongst the school community about mental illness and preventative measures, and just gaining a deeper understanding into maybe what constitutes mental health issues and what needs to be done about that, so there’s an awareness issue.” Principal School 9

As expected, leadership was implicated in comments related to both barriers to, and facilitators of, change. Lower levels of involvement of school leaders emerged as one of the areas where schools diverged in the scores generated for the Implementation Index. Leadership requires more than the ability to structure and co-ordinate – it requires someone with a vision to see where and how a complex initiative such as KM can be implemented, and its impact on the whole school community, as suggested by one principal:

“As is most commonly the case in our educational system, it’s about the people and the school’s preparedness to accept change and adopt new stuff that will make the difference.” Principal School 8

Shifts in core beliefs, attitudes, knowledge and practice require time to occur. This should be remembered in considering the lower levels of progress made on Components 3 and 4, where schools were sometimes situated in very complex communities. In such situations it takes much more time for a school to be able to initiate actions that will further engage parents and stimulate events in external agencies, than the time required to effect a change in, say, the school timetable for Social and Emotional Learning.

14.5 The KidsMatter conceptual model

The KM components were designed to “target the key risk and protective factors associated with child mental health” (Graetz et al., 2008, p. 15). In the initial conceptual model for KM (provided in Chapter 1), the main risk and protective factors were grouped under (a) family context (e.g., effective parenting), (b) child factors (e.g., Social and emotional competencies) and (c) school context (e.g., staff knowledge, confidence and competence, as well as positive school climate).

As set out in the initial conceptual model, improvements in student mental health were assumed to arise from the changes to the risk and protective factors of family context, child factors and school context. The findings of this evaluation suggest that it is important to give greater prominence to changes in teachers. As noted above, there were notable changes in teachers’ knowledge and capacity to teach Social and Emotional Learning. When seen together with the structured SEL curriculum provided as part of Component 2, and observed changes in students’ SEL competencies, these changes point to the teachers as an important protective factor. This reinforces the sentiment expressed in the recent OECD publication on teachers, that Teachers Matter (OECD, 2005). According to Fullan (2007) teachers are the first point of any school intervention.
14.6 Dimensions of student mental health

In discussing the nature of student mental health in the evaluation we drew attention to the two complementary and interacting dimensions of mental health. Although both dimensions are represented as outcomes in the KM Conceptual Framework, it is the case that the major focus in many discussions of mental health gives greatest prominence to difficulties, rather than to strengths. There is now scope to examine how the interaction between these two dimensions can be more effectively considered in looking at mental health outcomes.

14.7 Sustaining KidsMatter

As noted earlier in this chapter, KM is a package, and during interviews and focus groups 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.

As part of the Leadership Executive Summary, collected at the end of KM, school leaders were asked what they thought was the future of KM in their school. Their answers highlighted the need to commit to the initiative, and to build the capacity of the school community to engage, reflect and evaluate. They also emphasised the need to present a vision of KM, its role, and its incorporation into the school and its parent community. Leadership views supported the need for a strategic approach to attend to the organisational structure and culture of the school; the quality of the leadership; intervening early with children at risk; and providing appropriate professional development (Fullan, 1997; Hargreaves & Fink, 2000).

The staged rollout of KM provided a comparison between schools that were undertaking a sustained implementation (Round 1 schools) with those that were in a start-up phase (Round 2 schools). Although there were similarities in the patterns of findings for Round 1 and Round 2 schools, there were also differences. The differences reflect the ability for Round 1 schools to attend to more components and to sustain higher levels of progress on the 7-Step implementation process. Round 1 schools had more opportunity to incorporate an emphasis on mental health more fully within the curriculum and broader school activities.

Although to this point we have noted issues that will need attention, in the hypothetical Portrait that follows, we distil key themes that emerged from our various data sources about ways for making the whole KM package work effectively. 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 KM resources in the future.

14.8 Portrait of a successful KidsMatter implementation

Involvement of all levels of staff along with professional development

Kevin is a Year 5-6 teacher. When he 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.

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 KidsMatter. Soon after their return, staff at the school met with their KidsMatter Project Officer to undertake professional development about KM 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. However, other staff were keen to be involved. Larissa was particularly interested, and she volunteered to be part of the Action Team. Larissa felt 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

Margaret called a meeting of the Action Team, which now also comprised the school’s wellbeing co-ordinator and the school counsellor. She had come to realise how important it was for the whole school community to participate in this new initiative. Having spoken to the KidsMatter Project Officer, and engaged with the KidsMatter literature, Margaret appreciated that the initiative was affirming things she had 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 they’re engaged, are they ready to get on with their literacy and numeracy”, she reflected. Margaret also knew that KM would flounder unless it was supported from the top down. At the Action Team meeting the team talked about a plan of action.

Shortly after the staff returned from an overnight retreat, Margaret called a staff meeting. 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 collaborative decision making about taking on KM. They 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 staff, including auxiliary staff.
**School and parent 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, were asked if they would like to start a KM Parent Action Team. They were also invited to participate with staff in professional development.

A parents’ room was made available for parents to use one day a week, and some of the Action Team members volunteered to make themselves available to spend time in that room. One of the parents, Jodie, set about rallying other parents, and together they stocked the room with books, brochures, pamphlets and agency information on child-raising and child development issues, ranging from bed wetting to handling teenagers. KM posters were placed on the walls and a corner was set up as a play area for pre-school children. A computer was made available 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 attempt to moderate any inappropriate discussions when they witnessed them, so that there would be a clear message to parents about the genuine purpose of the room.

**A strategic approach with a targeted program embedded across the school**

The staff had agreed that they would work on the four KM 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.

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 in their school 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 they started to change the way they responded to children. Whereas they once might have just scolded a child for aggressive behaviour, they were now re-evaluating their actions and asking themselves whether something was going on with the 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 Project Officer, staff 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 things 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 supporting the school community**

The parents and caregivers made good use of the parents’ room and as a group 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 parenting information, that went out to parents on a regular basis. They brainstormed ways they could encourage parents to come in and make use of the parents’ room. They regularly liaised with the Action Team, 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. 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 to 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 rate of 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 when getting angry, not hitting anybody or smashing anything. Parental attendance at school assemblies increased as parents came to see their children give performances, share their work, and receive KidsMatter merit certificates.

**Long term planning for sustainability**

As the end of the second 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 KidsMatter 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 the actions that they had taken,
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 KM-related events was to continue and a clear place was made in the school’s statement of 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, in the future, 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.

14.9 Considerations for further initiatives and research

At the end of the evaluation of this complex intervention our thoughts turned to the ways in which children’s mental health and wellbeing can be further supported in the future. We see it as important for relevant groups concerned with policy, research and education to:

1. Advocate for the continued development and implementation of systemic school-based initiatives with a strong focus on the mental health needs of Australian children.
2. Endorse a whole school approach to the implementation of initiatives, such as KM, while recognising the importance of targeted interventions for specific student groups within that whole school approach.
3. Incorporate courses into pre-service teacher education that will build teachers’ knowledge and competence in relation to mental health strengths and difficulties.
4. Further investigate the nature of critical leadership capabilities necessary for the implementation and effectiveness of mental health interventions such that all members of school communities are engaged.
5. Facilitate further longitudinal research to examine the nature and influence of risk and protective factors associated with student mental health in Australia.
6. Support applied research in schools to identify effective implementation strategies and conditions that enhance the effectiveness of mental health intervention initiatives in schools.
7. Recognise the importance of qualitative and quantitative data for monitoring and evaluating relationships between general mental health initiatives and changes in student mental health.
“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 the 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. …I think that there has been a fairly profound effect and one of the best parts of KidsMatter I think it’s changed culture and focus within the school community.” Principal School 9

15.1 Conclusions

KM appears to have impacted upon schools in multiple ways, being associated with a systematic pattern of changes to schools, teachers, parents and students. These included changes associated with school culture and approaches to mental health difficulties, as well changes that served to strengthen protective factors within the school, family and child. Importantly, KM was associated with improvements in students' measured mental health, especially for students with higher existing levels of mental health difficulties.

“We've given a much stronger focus to our community, students and parents, being able to articulate emotions and stretch their language so they really have an understanding that there's things much deeper than happy and sad, and that's where we were before. So you hear a lot of people talking a lot more and a lot more deeply about where they are, how they're feeling, how people's actions affect their actions.” Principal School 9

It needs to be remembered that KM was a multi-faceted, population-based initiative using a whole-school approach. It was based on a conceptual framework, a prescribed implementation process and provision of key resources. Any explanation of possible changes in student mental health must consider all aspects of KM and its approach. It is most likely that the obtained changes in student mental health are due to KM rather than other factors such as student maturation.

The outcomes of the KM trial are consistent with an emerging body of national and international literature that a ‘whole school’ approach can be protective for students, promoting a positive shift in mental health for the whole school population, and helping to enhance academic and social competencies through more positive interactions between all members of the school community.

However, although there is evidence from the evaluation of the successful implementation of KM and of associated positive changes, the observed impacts varied in size and were not evident in all aspects of KM. Furthermore, evidence of potential limitations and of possibilities for increasing the effectiveness of KM also emerged. In particular:

- Stakeholders highlighted the importance of leadership in generating change—particularly transformative leadership which brings about change in attitudes, beliefs and behaviour in the school community.
- It was challenging for schools to find space for all four KM components in an already crowded curriculum. However, the fact that KM opened a niche in school timetables for issues related to student mental health is considered to be a key factor in the success of KM.
- As with all curriculum innovations, the sustainability of KM was raised as an issue, and as one school principal noted, “we need to have really strong structures – the sustainable structures in place so that it continues, but time is a real factor”. In particular, it was argued that the maintenance of the support and resources provided to schools is necessary to ensure that KM is sustainable and continues to be effective.
It was also apparent that the implementation of Components 3 and 4 presented challenges for many schools. Although there were some variations in the pattern of findings for schools involved in KM for one year, and for schools involved over two years, the nature of the intervention makes it difficult to interpret or explain the variations. However, one clearly apparent factor was the development of expertise of the KM team in general and the KM Project officers in particular, during the first year. This meant that the roll-out of KM in Round 2 schools during 2008 benefited strongly, in terms of being able to access an expanding base of available knowledge, and of resources generated from KM activities in Round 1 schools in 2007.

15.2 Recommendations

“This is not an initiative for poor schools with disadvantaged families, it’s an initiative for all children in primary schools and all types of schools.” Principal School 5

Taking account of the evaluation findings and subject to the recommendations below, the main recommendation is that the broad framework, processes and resources of KidsMatter be maintained as the basis for a national roll-out.

Note that we have interpreted the effects of KM as a total package, and have no basis for drawing conclusions if parts of the package were to be delivered independently.

The evaluation suggested a number of ways for improving the efficacy of KM. As a consequence, it is recommended that, inter alia, future development of KM:

1. Provide guidelines to schools that will enable them to enhance the quality of the KM implementation in a structured and sustained way. These might include procedures for sharing best practice about the ways exemplary schools have implemented KM and how common problems, such as changes in key staff can be addressed.

2. Examine the conceptual model and the interactions of the elements upon which KM is based. There is a need to specify further the nature of the risk and protective factors under the headings of School, Family and Child. In particular, the positioning of the broad concept of “School”, and within “School”, teachers’ knowledge, competence and confidence, as risk or protective factors for student mental health, needs further clarification and elaboration.

3. Give further consideration to ways in which schools can increase the effectiveness of Component 3 (Parenting support and education). This could include further research into effective models of delivery for parenting support and education within population-based mental health interventions. The gathering of knowledge from schools about exemplary practice related to this Component is also recommended.

4. Strengthen Component 4 (Early intervention for students with mental health difficulties), through further professional development for teachers on this component, and further consideration of ways of building stronger connections between external agencies and schools. This could include:
   - Supplementing the existing professional development with respect to teachers’ knowledge, competence and confidence for identifying students at risk.
   - Investigating the perspectives of both schools and external agencies about the difficulties schools experience in instigating and accessing referrals to such external agencies.

5. Consider ways to further support the commitment to, and active involvement of, school leaders in developing and maintaining KM in their school setting.

6. Consider how the professional development can be enhanced to better prepare schools and teachers to implement and engage with Components 3 and 4.

7. Attend to the differing manifestations of students’ mental health in home and school settings, and the consequences of these setting-based differences for students, teachers and parents. This might include supplementing existing advice about ways for parents and teachers to share their concerns and strategies for assisting students at risk of or experiencing mental health difficulties so that compatible approaches can be implemented in home and school settings.

8. Consider how KM can be productively linked with other mental health initiatives in schools, such as the mandated National Safe Schools Framework or the Council of Australian Governments National Action Plan for Mental Health 2006-2011.
Glossary of Key Terms

The 7-Step implementation process
KidsMatter employed a step-by-step Implementation model. The 7-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 school-based components

<table>
<thead>
<tr>
<th>Target areas</th>
<th>KidsMatter objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive school community</td>
<td></td>
</tr>
</tbody>
</table>
| 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, and 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, and 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 support and education        |                                                                                        |
| 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 |
### Descriptions of the scales used in the Whole Cohort Longitudinal study

<table>
<thead>
<tr>
<th>Scale</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>KM Engagement (T) Chapter 3</td>
<td>Teacher (T) ratings of school engagement with the four KM components. Used to measure general engagement with KM.</td>
</tr>
<tr>
<td>KM Implementation (T) Chapter 3</td>
<td>Teacher ratings of the KM 7-Step implementation process. Used to measure general implementation of KM.</td>
</tr>
<tr>
<td>KM Implementation (P) Chapter 3</td>
<td>Parent (P) ratings of their involvement with KM as a measure of the level of implementation from the perspective of parents.</td>
</tr>
<tr>
<td>Engagement with students’ mental health &amp; wellbeing (P&amp;T) Chapter 3</td>
<td>Teacher and parent ratings of their school’s engagement with mental health initiatives, in general, with a focus on Social and Emotional Learning. Used to measure existing levels of engagement with mental health initiatives and changes in this engagement arising from KM.</td>
</tr>
<tr>
<td>Implementation Index (T, P Project Officers) Chapter 4</td>
<td>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 KM has been implemented.</td>
</tr>
<tr>
<td>KM impact on child (T&amp;P) Chapter 4</td>
<td>Teacher and parent ratings of how well KM has provided for the child’s needs at school, especially their socio-emotional needs. This is a measure of the perceived impact of KM on child processes.</td>
</tr>
<tr>
<td>C1: Positive school community (P&amp;T) Chapter 6</td>
<td>A measure of Component 1. Teacher and parent ratings of their school community, how welcomed they feel and their sense of belonging.</td>
</tr>
<tr>
<td>C2: Social and Emotional Learning (T) Chapter 7</td>
<td>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.</td>
</tr>
<tr>
<td>C3a: Parenting support by school (P&amp;T) Chapter 8</td>
<td>A measure of Component 3. Teacher and parent ratings of support and education provided by the school for parents.</td>
</tr>
<tr>
<td>C3b: Parenting support by staff (P&amp;T) Chapter 8</td>
<td>A measure of Component 3. Teacher and parent ratings of how accessible, informative and supportive staff are in providing parenting support and education.</td>
</tr>
<tr>
<td>KM impact on parent involvement with school (P) Chapter 8</td>
<td>Parent ratings of the impact of KM on their involvement with support networks, school and community. This is a measure of the perceived impact of KM on Positive school community.</td>
</tr>
<tr>
<td>C4: Early intervention (P&amp;T) Chapter 9</td>
<td>A measure of Component 4. Teacher and parent ratings of how effective their school is at supporting students who are experiencing mental health difficulties.</td>
</tr>
<tr>
<td>Staff approaches to teaching SEL (T) Chapter 10</td>
<td>Teacher ratings of general staff approach to helping students to develop social and emotional skill. Used to measure KM impact on teachers.</td>
</tr>
<tr>
<td>Staff attitudes towards SEL (T) Chapter 10</td>
<td>Teacher ratings of their attitude to teaching Social and Emotional Learning skills. Used to measure KM impact on teachers.</td>
</tr>
<tr>
<td>Teacher knowledge about SEL (T) Chapter 10</td>
<td>Teacher ratings of their knowledge and ability to help students to develop social and emotional awareness and skills. Used to measure KM impact on teachers.</td>
</tr>
<tr>
<td>Teacher SEL programs &amp; resources (T) Chapter 10</td>
<td>Teacher ratings of their teaching program and resources to help students to develop social and emotional awareness and skills. Used to measure KM impact on teachers.</td>
</tr>
<tr>
<td>Teacher self-efficacy (T) Chapter 10</td>
<td>Teacher ratings of their self-efficacy to foster a sense of belonging in others, provide effective support to parents, and identify early signs of social and emotional difficulties in students. Used to measure KM impact on teachers.</td>
</tr>
<tr>
<td>KM impact of PD on teachers (T) Chapter 10</td>
<td>Teacher ratings of the impact of the KM professional development on teacher knowledge and actions.</td>
</tr>
<tr>
<td>Parenting knowledge (P) Chapter 11</td>
<td>Parent ratings of their knowledge of how to help their child foster friendships, provide emotional comfort, and recognise when their child is having difficulties. Used to measure KM impact on families.</td>
</tr>
<tr>
<td>Parenting style (P) Chapter 11</td>
<td>Parent ratings of their relationship with their child together with consistency in applying rules. Used to measure KM impact on families.</td>
</tr>
<tr>
<td>KM impact on parent learning (P) Chapter 11</td>
<td>Parent ratings of the parenting skills that KM has helped them to learn. This is a measure of the perceived impact of KM on family processes. Featured in Parent ratings of their relationship with their child. Used to measure KM impact on families.</td>
</tr>
<tr>
<td>Child social and emotional competencies (P&amp;T) Chapter 12</td>
<td>Teacher and parent ratings of the child’s ability to maintain positive relationships, solve problems, consider others, and make responsible decisions. Used to measure KM impact on children.</td>
</tr>
<tr>
<td>Mental health difficulties (T&amp;P) Chapter 13</td>
<td>Teacher and parent ratings of the child’s mental health difficulties in terms of poor behaviour, anxiety and depression. This is a measure of student mental health outcomes.</td>
</tr>
<tr>
<td>Mental health strengths (T&amp;P) Chapter 13</td>
<td>Teacher and parent ratings of the child’s positive mental health in terms of optimism and coping skills. This is a measure of student mental health outcomes.</td>
</tr>
<tr>
<td>Total strengths and difficulties (SDQ) (T&amp;P) Chapter 13</td>
<td>Teacher and parent ratings of the child’s mental health difficulties in terms of hyperactivity, conduct problems, emotional symptoms and peer problems. This is a measure of student mental health outcomes.</td>
</tr>
</tbody>
</table>
Methodological Notes and Limitations of the Evaluation

Nature of the intervention

KM Pilot Phase was not a true 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 KM 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 KM 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.

Sampling

Schools were invited to apply for inclusion in KM 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 KM 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 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.

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 KM. 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 and teachers of the selected 7600 students across Australia on four occasions. Accordingly, the administration of questionnaires to parents 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 and teachers and maximise returns, questionnaire delivery and receipt was ultimately out of the control of the Evaluation team.

Duration of the study

KM Pilot Phase ran for two years and was focused, 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.

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 Aboriginal or Torres Strait Islander students than in the overall KM school population.
- Selected versus participated: In the participant group there were fewer male students, fewer ‘at risk’ students and fewer Aboriginal or Torres Strait Islander students than in the selected-but-did-not-participate group.
Non-participating parents versus participating parents: For the group of parents that chose to participate there were fewer students nominated ‘at risk’ and fewer Aboriginal or Torres Strait Islander students.

Non-participating teachers versus participating teachers: For the group of teachers that chose to participate there were fewer older students and fewer students from culturally and linguistically diverse backgrounds.

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 Aboriginal or Torres Strait Islander, or from culturally and linguistically diverse backgrounds.

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. parents and teachers). Note however, that the evaluation used multiple methods and multiple informants over the period of the trial 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 questionnaire data from Project Officers.

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 focused 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.
Related Publications and Presentations

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 KM 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 KM.


References


KidsMatter Partners thank the following school communities:

New South Wales
Brooke Avenue Public School
Curran Public School
Dubbo Public School
Elands Public School
King Park Public School
Northmead Public School
St Bernadette’s Primary School
St John Fisher Catholic School
St. Columbas Primary School
St Joseph’s School Schofields
Bexley Public School
Carramar Public School
Faulconbridge Public School
Harrington Street Public School
St Bede’s Primary School
St Oliver’s Primary School
St Mary’s Catholic Primary School
Tahmoor Public School
St Patrick's Primary School

Queensland
Burdekin School Special School
Home Hill State School
Ithaca Creek State School
Labrador State School
Pomona State School
Sandy Strait State School
St Joseph’s Stanthorpe
Cairns West State School
Wondai State School
Caloundra Primary School
Goondiwindi State Primary School
Mater Hospital Special School
Redlynch State School
Tallebudgera State School
The Willows State School
Unity College
Upper Mt Gravatt State School

Western Australia
Bull Creek Primary School
Holy Name School
Kinlock Primary School
Liwara Catholic Primary School
Settlers Primary School
St Simon Peter Catholic Primary School
Nulsen Primary School
Geraldton Grammar School
Hilton Primary School
Lance Holt School
Leeming Primary School
Rockingham Beach Primary School
Star of the Sea Catholic Primary School
Cooinda Primary School

South Australia
Woodville Primary School
Hamley Bridge Primary School
Hewett Primary School
Leigh Creek Area School and Marree Aboriginal School
East Torrens Primary School
St Aloysius College
Annesley College
Cobdogla Primary School
Elizabeth Park Schools
Munno Para Primary School
Open Access College
Roxby Downs Area School
Woodcroft Primary School

Tasmania
Distance Education Tasmania
Richmond Primary School
Waverley Primary School
Kempton Primary School
Lauderdale Primary School
Rocherlea Primary School

Australian Capital Territory
Turner Primary School
Trinity Christian School
Canberra Girls’ Grammar Junior School
Aranda Primary
Gowrie Primary School
St Francis of Assisi Primary School

Northern Territory
Gray Primary School
Living Waters Lutheran School
Nhulunbuy Primary School
Howard Springs Primary School
Jingili Primary School
Sacred Heart Primary School

Archived at Flinders University: dspace.flinders.edu.au
“The Australian Psychological Society is pleased to be a partner in the successful KidsMatter Primary Schools National Mental Health Initiative. KidsMatter Primary has been shown to improve the mental health outcomes for those children most at risk, and have flow on effects to the whole school community, including parents, carers and families. In addition, the initiative increases the mental health capacity of schools and upskills teachers so it benefits the health and wellbeing of children in the long term.”

– Professor Lyn Littlefield OAM FAPS, Executive Director, Australian Psychological Society

“Principals Australia sincerely thank the school leaders, staff, students and families of the 100 participating schools whose commitment to KidsMatter Primary and its implementation over the two years of the pilot is to be commended. The positive changes that occurred for students, staff and families reflect the strength, flexibility and adaptability of the KidsMatter framework and resources and the professionalism and commitment of all involved.”

– Susan Boucher, CEO, Principals Australia

“Australian Rotary Health was pleased to support KidsMatter by providing funds to assist implementing some components of the program. KidsMatter provided a great opportunity for Rotary Clubs, the business community and general community to become involved with their primary schools.”

– Joy Gillett, CEO, Australian Rotary Health