



The mental health Risk Assessment and Management Process (RAMP) for schools: II. Process evaluation

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Abstract

The Risk Assessment and Management Process (RAMP) is a whole-school process for the assessment and management of student's mental health and wellbeing in primary and secondary schools. A process evaluation revealed that RAMP was implemented as intended across six primary and three secondary schools in Melbourne, Australia. Using the RAMP risk and protective factors monitoring form and screening processes, each school identified 'at-risk' students who had not previously been identified or received assistance from welfare staff at the school. School staff and mental health workers from local agencies reported improvements in their knowledge of risk and protective factors, and their ability to identify at-risk students following RAMP. They also reported satisfaction in outcomes for at-risk students managed within the school using RAMP. All the primary schools and one of the secondary schools continued to use some RAMP processes in their school up to 6 months after the initial implementation of the program.

Keywords

evaluation, risk assessment, schools, school mental health program, early intervention, early identification, risk and protective factors

Introduction

The science of promotion, prevention, and early intervention for mental health has moved beyond seeing schools as settings for the delivery of interventions, to recognising schools as social environments with the potential to promote health and wellbeing in young people, their families, and school staff. There is a growing demand from school communities seeking to build their capacity to understand and address the social-emotional needs of children and adolescents. Teachers and other school staff are asked to identify, support, and refer children showing symptoms of mental health problems

(Commonwealth Department of Health and Aged Care, 2000), and often seek support and guidance in how best to do this. Much of this support and guidance comes from their colleagues within the education sector and some comes from those in the health sector. Effective partnerships between the health and education sectors are necessary to develop best practice models of shared care for children and adolescents.

The Risk Assessment and Management Process (RAMP) was developed to help schools establish sustainable whole-school processes for assessing and managing students at risk of poor mental

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health outcomes. RAMP uses a team-based approach to ensure that student management is co-ordinated and strategic, and uses evidence-based assessments to guide and review interventions. It provides both a forum and the impetus to improve school organisational processes and procedures to ensure early identification of, and support for, at-risk students. RAMP aims to facilitate schools' recognition of their own capacity to support students, and helps schools to build capacity through the formation of effective partnerships with their local Child and Adolescent Mental Health Service (CAMHS). A comprehensive description of RAMP is published in a companion paper in this issue (Fealy & Story, 2006). The present paper describes the process of implementing RAMP in nine schools, and summarises the self-reported outcomes of RAMP for schools and CAMHS.

Schools have embraced health related initiatives that enhance their core business of maximising learning outcomes for students. Schools aim to educate all students and there is increasing recognition of the relationship between mental health and learning outcomes. Children with social, emotional or behavioural problems are less likely to develop academic competence (e.g., Masten, Roisman, Long et al., 2005) and are at increased risk of school failure. Within health promoting schools, teachers strive to generate a positive learning environment where students feel valued, supported and connected with the school community. This sense of attachment or connection to school serves as a protective factor for youth health and wellbeing (Bond, Toumbourou, Thomas et al., 2005; Resnick, Bearman, Blum et al., 1997). Schools also provide children with access to pro-social peers, structure and routine, and opportunities to develop and receive recognition for a range of academic and other competencies (e.g., sporting, artistic, social). Teachers can serve as positive role models (Werner & Smith, 1992), and are also in a prime position to pick up and act on 'early warning signals' that students are struggling socially or emotionally, as well as academically (Department of Education, Victoria, 1998). There is an increasing demand on teaching staff as part of the whole-school community to promote student welfare. One of

the beliefs underlying RAMP is that teaching staff need formal opportunities to contribute to the assessment and management of students' wellbeing (Fealy & Story, 2006). This evaluation of RAMP sought to establish the extent to which exposure to the RAMP process was associated with increased teacher capacity for identifying and intervening to help students they perceived to be at-risk.

One challenge for schools is to identify at-risk children and young people before they evidence significant social-emotional difficulties at school, and before they require treatment from specialty mental health services. One first step in this direction is for schools to have access to appropriate tools and processes for identifying at-risk students. A number of existing screening methods are designed to screen for current behavioural, emotional or social problems as evidenced by behaviourally observable symptoms. These methods typically identify children who already have significant adjustment problems that require internal or external referral to health services (Mertin & Wasyluk, 1994). Epidemiological research has identified individual, family, peer, school, and community risk and protective factors for poor health and social outcomes in children and adolescents (Bond et al., 2005, Catalano, Berglund, Ryan et al., 2004). Classroom teachers who have day-to-day contact with students are in an ideal position to identify at-risk children and to respond using a systematic approach that builds on everyday practice. For the purposes of comprehensive screening, a form should prompt teachers to consider a range of risk and protective factors. It should also be user friendly and able to fit the short time teachers have available for non-academic assessment. Research has shown that teachers are reluctant to take on additional roles which they perceive as requiring specialist mental health knowledge (Nicholson, Oldenburg, McFarland & Dwyer, 1999). It seems likely that the optimal screening approach requires an appropriate form that integrates screening and monitoring, as well as training and ongoing support to increase teachers' confidence in recognising risk and protective factors. Training and ongoing professional development with welfare staff at the school (school welfare co-ordinators, pastoral care, school nurses) and

mental health practitioners could help to facilitate this.

To enhance school capacity for intervention RAMP comprised two interrelated processes: (1) an early identification assessment process using an evidence-based risk and protective factors checklist to identify at-risk students; and (2) a team-based systematic approach that used the risk and protective factors profile to guide the development of intervention and monitoring of at-risk students within the school (Fealy & Story, 2006). This evaluation sought to examine the extent to which the RAMP assessment and intervention processes were acceptable to and feasible for school staff.

The complexity of school environments are such that even well designed programs sometimes fail to implement intended elements. The RAMP evaluation sought to quantify how much of the planned process was implemented in schools. RAMP involved the establishment of a core team of school staff (representatives from welfare, teaching and leadership teams at the school) who were expected to work together to identify ways to reduce risk factors and increase protective factors within their school. The RAMP screening form was to be used as a systematic tool for developing an intervention action plan. The school teams were expected to meet weekly to review and assess the effectiveness of the interventions. A mental health (CAMHS) clinician was expected to be present for the first 10 RAMP meetings in primary schools, and the first 20 in secondary schools. The role of the CAMHS clinicians was to provide specialist mental health knowledge to guide the development of effective management plans for at-risk students as required.

This paper presents the results of the Centre for Adolescent Health process evaluation of the implementation of RAMP. The evaluation had four aims:

1. to document the process of implementation (the number of students screened, the number of at-risk students who were identified and who had management plans developed, and the number of these at-risk students who had not been identified previously as requiring welfare assistance);
2. to explore perceived outcomes for school staff (utility of the screening tool, perceived improvements in knowledge of risk and protective factors, confidence in managing at-risk students within the school, support for work with at-risk students at the school);
3. to explore changes in the demand for CAMHS services following RAMP (number of primary referrals, requests for secondary consultation); and
4. to assess sustainability beyond the initial implementation of the project (i.e., implementation practices at up to 6 months follow-up).

Method

Participating schools and CAMHS agencies

The present evaluation focused on three secondary and six primary schools in Melbourne, Australia, that implemented RAMP during April–December 2005. Six of these schools (four primary and two secondary) completed an application process (see below) requesting that RAMP be implemented at their school. The three other schools were approached to participate by the funding agency (School Focused Youth Service). All schools were metropolitan, government schools. A mental health worker (psychologist, social worker) from a CAMHS agency in geographical proximity to each school was assigned to work with the school for the duration of RAMP. A total of four CAMHS clinicians worked across the nine schools.

The implementation process

The implementation process comprised: reviewing school practices, processes and readiness for change; professional development for school staff; and completing planning and review processes as structured into the RAMP meeting schedule.

School practices, processes and readiness for change

In order to facilitate the process of within school consultation regarding readiness to implement RAMP, staff from the six schools that attended the information evening and expressed interest in implementing RAMP in their school were asked to consider the following questions:

1. Is your leadership supportive of trialling RAMP?
2. Which school staff members have been consulted about RAMP?
3. Can school staff commit to weekly (or fortnightly in secondary schools) RAMP meetings?
4. Is there a suitable time and place at the school for the RAMP team to meet?
5. Will staff be able to find some time to follow through with the implementation of student management plans?
6. Who will take administrative responsibility for the project?
7. What are the current practices and processes at your school for identifying and supporting at-risk students?
8. What are the strengths and weaknesses of the current approach?
9. Is your school prepared to review processes and aspects of the student wellbeing program as they relate to at-risk students?
10. The project requires partnership with CAMHS and schools. What factors contribute to effective partnerships? Please give an example of a successful partnership your school has had with an external organisation.

The responses were used by the project manager to gauge the school's readiness to implement RAMP.

Professional development for school staff

In all nine schools, senior pastoral care staff (at least two per school) were granted release time to attend a two-day RAMP professional development workshop. CAMHS staff working with schools on the project also attended this workshop. The training combined didactic content with small group work. Case material was used to develop skills in using the RAMP processes. The content of the formal presentations included: risk and protective factors, early intervention, confidentiality, sustainability and structure of RAMP meetings. The small group work prepared schools and CAMHS staff for using the team-based approach utilised in RAMP. In addition to this workshop, the developer of RAMP (Susan Fealy) conducted a whole-school professional development session in each school. The purpose of this one hour session was to orientate all school staff to

the RAMP framework and processes, and to provide training for class teachers and co-ordinators in how to complete the RAMP monitoring forms. Further mentoring for class teachers and year co-ordinators in how to complete RAMP forms was provided by senior pastoral care staff and the CAMHS staff working with schools to implement RAMP. The developer offered ongoing mentoring to the CAMHS workers on an as needs basis.

Planning and review processes

The first RAMP meeting was designed as a planning meeting in which the key goals for the implementation and a clear plan for the structure of RAMP meetings were to be determined by the RAMP school team. The final RAMP meeting (the last two meetings in secondary schools) was planned to provide a review of the school's RAMP implementation and a context for developing plans for sustainability.

Results

Pre-RAMP survey of expectations

At the start of the first professional development workshop, prior to any RAMP professional development or implementation, twenty-six school staff from the nine schools were asked to complete a pre-RAMP survey. They were instructed to place their completed survey in an envelope and sealed envelopes were returned to the Centre for Adolescent Health. Eighteen completed surveys were received because some schools elected to complete the survey as a group rather than individually. Surveys were completed by pastoral care and leadership staff (6 student wellbeing/welfare co-ordinators, 1 primary welfare officer, 1 nurse, 7 guidance officers, 1 principal, 6 Deputy/Assistant principals), and teachers (2 primary school teachers, 2 year level co-ordinators).

Staff were asked to list the main outcomes they hoped to achieve from implementing RAMP and their responses were coded thematically. Responses suggested that staff expectations were adequately aligned with the program goals. Eighty-three percent (n=15) expected improved whole-school systems for identification and management of students, 55% (10) expected RAMP to enhance the skills, knowledge and/or confidence of staff at the school to deal with welfare issues, 44% (8) expected better learning

and wellbeing outcomes for students, 33% (6) expected to develop their relationship with their local CAMHS agency, 27% (5) expected better early identification of at-risk students, and 11% (2 staff from primary schools) expected RAMP to benefit the families of students.

Process of implementing RAMP

The RAMP process requires schools to establish core teams. All schools established a RAMP team consisting of welfare (primary welfare officer, guidance officer, school nurse, and psychologist) and teaching staff (teachers or year level co-ordinators). In all but one of the schools, the Assistant Principal or Deputy Principal was also part of the RAMP team and attended meetings. As shown in Table 1, the number of school staff involved in RAMP ranged from 4 to 7 at each school. The time commitment from staff ranged from one hour (for staff who only attended the RAMP meetings) to three hours a week (for classroom teachers or welfare staff who followed up with at-risk students). At one secondary school, the welfare officer reported spending up to 4 hours a week following up at-risk students. This greater than expected time commitment was probably due to the fact only very high risk students were brought to RAMP meetings at this school.

Individual schools decided which year level or levels to focus on. Within the participating primary schools all students in the grade of the class teachers who participated in RAMP were

screened. Primary schools conducted an average of 10 RAMP meetings, one each week during a school term. In secondary schools, two year levels were targeted. All secondary schools chose to implement RAMP with students in the first year of secondary school (Year 7 in Victoria). Two schools also selected Year 8 as a focus and the third secondary school selected Year 10. Secondary schools selected students for screening on the basis that they were: students with a poor attendance record, students with a recent record of behaviour incidents, or students new to the school. Fortnightly meetings were held to discuss students from each targeted year level, resulting in a total of 20 RAMP meetings being held across two school terms in each secondary school.

The primary schools that implemented RAMP screened all students in the grade of the teachers who participated in RAMP. The RAMP goal of developing a feasible and user-friendly risk and protective factors monitoring form appeared successful. All school staff reported favourable comments in relation to the RAMP monitoring form. One primary school teacher reported that she was able to screen her entire class (25 students) in one hour. Other class teachers reported that completing the monitoring form helped them to gain a more balanced view of each student by considering his/her protective factors and strengths, in addition to risk factors and current difficulties.

Table 1. Number of school staff involved, students screened, management plans developed, and follow-up actions in schools implementing RAMP

School	School staff involved	Sudents screened (year level)	N	Management plans developed	Students accessing further support within school	Students accessing further support outside school	Students newly identified as at-risk*
Primary							
School A	5	All in Year 5	100	6	6	0	5
School B	4	All in Year 5/6	25	10	10	2	3
School C	7	All in Year 4	53	6	6	2	3
School D	7	All in Prep, 3, 5 & 6	150	7	5	0	9
School E	7	All in Years 1 & 3/4	52	9	9	4	3
School F	4	All in Prep & 4/5	42	12	19	2	4
Secondary							
School G	7	Selected from Years 7 & 8	26	14	26	3	5
School H	5	Selected from Years 7 & 8	15	12	2	1	0
School I	6	Selected from Years 7 & 10	20	20	20	1	20

*i.e. students who had not previously been identified for welfare support or assistance within schools.

Table 2. School staff reports of RAMP activities or related events being conducted (N=52)

Activity / event	Yes	No	Missing
Briefed all school staff about the use of RAMP in the school	47	3	2
Discussed the importance of confidentiality in the management of at-risk students with all staff involved in RAMP	47	3	2
Informed staff about using an evidence-based risk and protective factors framework for students' wellbeing	46	4	2
Examined barriers to implementing RAMP at the school	46	3	3
Recognised staff achievements in RAMP at the school	49	1	2
Provided training for staff to use RAMP (attended training session)	42	7	3
Allocated staff time for RAMP activities	40	9	3
Talked to staff about the benefits of closer collaboration with the local CAMHS agency	35	13	4

Table 3: Self-reported perceptions of change in knowledge and abilities of school staff following RAMP (N=51)

	Worse %	Stayed same %	A little improved %	Much improved %	Very much improved %
Ability to accurately identify at-risk students	0	0	17	48	33
Knowledge of risk factors	0	0	8	42	48
Knowledge of protective factors	0	0	6	50	42
Feeling supported in their work with at-risk students	0	0	6	44	44
Knowledge of referral processes and options	0	10	19	46	19

Responses missing for 1 survey. Percentages not equal to 100% reflect missing data.

The screening process led to the identification of 52 at-risk students who had not previously been identified for welfare support or assistance within schools. These were students who were not necessarily showing observable emotional or behavioural difficulties and as such may not have otherwise received assistance. In participating secondary schools, only students already known to be at-risk on the basis of criteria listed above were screened. In primary schools, 6-12 students at each school had within school management plans developed through RAMP during the school term (of 10 weeks duration). In secondary schools, 12-20 students had RAMP management plans developed across two school terms (approximately 20 weeks in duration).

Perceived outcomes for school staff

A second survey was developed for staff to complete 3 months (primary schools) and 6 months (secondary schools) after the initial RAMP professional development workshop. Participating staff from all the nine schools were

asked to indicate the activities and events that had occurred during the time that RAMP was being implemented at their school. All staff asked to complete these questions complied (N=52). Table 2 shows that most activities associated with implementing RAMP were conducted in each school. Organising staff release time to attend training and RAMP meetings, and discussing the benefits of a closer working relationship with CAMHS, were the components implemented the least. There were no significant differences when responses from staff at primary and secondary schools were compared.

Table 3 summarises the perceived improvements for school staff following the implementation of RAMP as reported in the second staff survey. The table shows that all staff perceived improvements following the program. These included improved ability to accurately identify at-risk students, improved knowledge of risk and protective factors, and feeling more supported in their work with at-risk students at the school.

Though the majority of staff reported improvement in their knowledge and understanding of referral processes and options following RAMP, five staff (10%) reported no change and these staff members were teachers who reported that welfare staff (school welfare co-ordinator, school psychologist) were responsible for referrals and that they did not need to know about referral options.

All staff from all schools reported that RAMP led to improvements in their ability to support and assist at-risk students *within* the school.

However, as Figure 1 shows, staff in secondary schools reported less improvement relative to primary school staff, $\chi^2 (2, N = 51) = 8.62, p = .01$.

All school staff also reported perceived improvements in communication and collaboration within the school following RAMP. Figure 2 shows that staff in secondary schools reported relatively less improvement in communication and collaboration compared to primary school staff, $\chi^2 (2, N = 51) = 6.19, p <.05$.

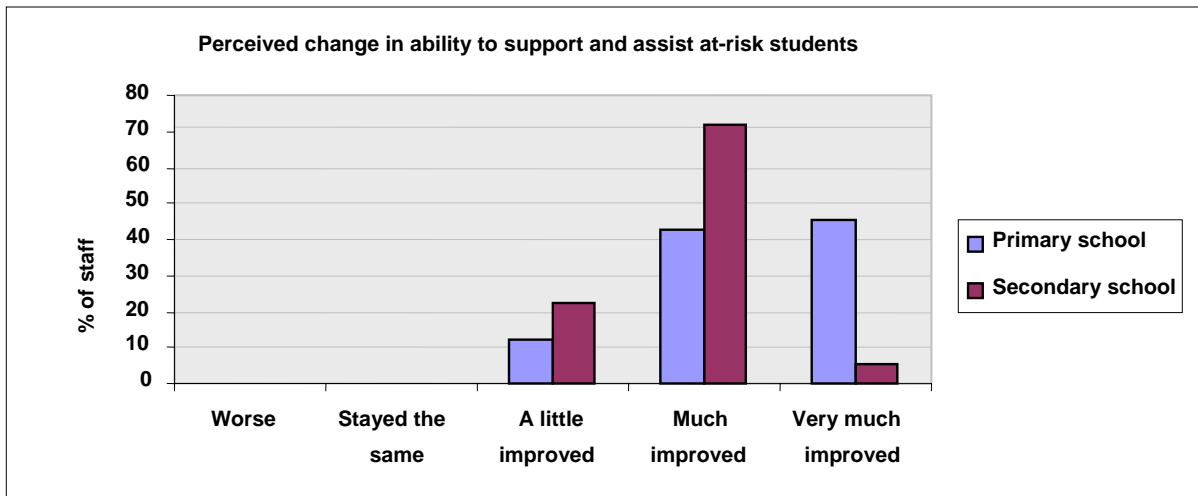


Figure 1. Perceptions of primary school staff versus secondary school staff in improved ability to support and assist at-risk students following RAMP

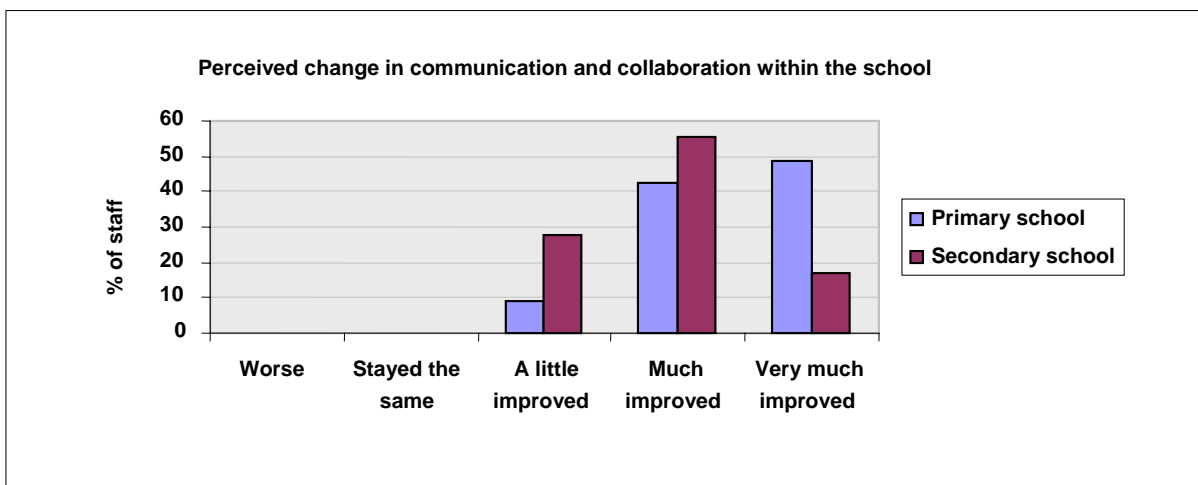


Figure 2. Perceptions of primary school staff versus secondary school staff in improved communication and collaboration within the school following RAMP

Finally, staff were asked to comment on their experiences using the RAMP program. Their responses were coded and four themes were identified as follows. Representative comments are also shown.

1. RAMP facilitated beneficial outcomes for students:

'RAMP interventions benefited students. We are already planning for next year for these children.'

'I found the RAMP program very useful and helpful in discussing children more proactively. Discussion helped to provide strategies for helping difficult children.'

'It has enabled us to solve issues for students in a positive and ongoing manner.'

'It has been great to think about students in greater detail and to get advice and ideas from colleagues and professionals on strategies to implement in the classroom that will help these students.'

2. RAMP was action oriented:

'With RAMP, things get done - we don't just talk about issues, we act.'

3. RAMP facilitated capacity building:

'The team is witnessing our own development of capacity.'

'We feel more equipped to manage these problems for most students and we have built up a resource of strategies and contacts through the RAMP meetings.'

'I have learnt about the various situations that can influence individuals to be at-risk and appreciate how the team worked together on implementing effective strategies.'

4. RAMP was team-based:

'RAMP has given the welfare team at the school a specific purpose for being a team as well as a systematic approach to children's wellbeing.'

'RAMP has also helped to provide support for those staff trying to help these students.'

All school staff were asked in the second survey to rate their satisfaction with outcomes for students as a result of RAMP using a scale ranging from extremely dissatisfied to extremely satisfied. The majority of staff (82%) reported being 'very satisfied' with the outcomes for students, 8% staff reported being 'a little satisfied' and 10% reported being 'extremely satisfied'. There were no significant differences in the ratings of primary versus secondary school staff.

Partnership model: Schools and CAMHS working together to support students

One of the aims of RAMP was to create partnerships between schools and CAMHS. In the case of the primary schools, 5 of the 6 schools had had very little or no contact with CAMHS prior to RAMP being implemented. The majority of school staff (94%) reported that the processes of their school and local CAMHS agency working together for RAMP was different from how they had worked together before. Following RAMP, 37% (n=19) of school staff reported that communication and collaboration with CAMHS was very much improved, 44% (n=23) reported it was much improved, 14% (n=7) reported that it was a little improved, and one person (2%) reported that it was the same. The results of a survey of the four CAMHS staff supported this finding. Improved communication and collaboration was reported for 8 of the 9 schools involved in the RAMP project.

Using an open question, school staff members were asked to comment on how this process was different. These comments were coded and three themes were identified.

1. RAMP facilitated greater understanding of what CAMHS is and does:

'...clarified the role of CAMHS.'

'...we were not aware of CAMHS.'

'I had never heard of CAMHS prior to being on the RAMP program.'

2. RAMP facilitated relationship building between schools and CAMHS:

'Regular contact with a single CAMHS worker helped to build up a relationship and trust.'

'...a face to a name.'

3. RAMP offered a systematic team approach and regular contact between school staff and a CAMHS clinician to help at-risk students:

'...schools and CAMHS working together.'

'...a series of meetings and follow-up weekly.'

'...never had a structured program like RAMP before.'

'The CAMHS consultant worked collaboratively with us for 10 weeks and we each built up an understanding of needs and processes.'

Open choice responses from CAMHS staff asked to describe RAMP included:

'Increase in communication and collaboration was excellent and lead to increased secondary consultation.'

'RAMP provided a space to think and talk in a more focused way about concerning students.'

'RAMP program enabled this school to establish a forum for pastoral care that didn't exist before.'

'Other advantages included peer support of staff, professional development, and greater awareness of children's mental health issues and how to respond appropriately to them in a family sensitive way. I personally enjoyed the experience and hope to continue my involvement in the future in some way.'

After implementing RAMP, all the CAMHS staff involved reported perceived increases in their knowledge and understanding of risk and protective factors, improvements in their ability to identify at-risk students and support those students within the school setting, and improved communication and collaboration between themselves and staff at their RAMP school.

Changes in the frequency and nature of schools requests for CAMHS services were explored. School staff members were asked to report the frequency of primary referrals and requests for secondary consultation from their local CAMHS during the 3 months prior to RAMP starting in their school. These figures were compared to the number of primary referrals and requests for secondary consultations (as reported by CAMHS and school staff) during the time RAMP was being implemented (approximately 3 months for primary schools and 6 months for secondary schools). Comparison pre- and post-RAMP revealed a decrease in the number of primary referrals made to CAMHS. Specifically, during the 3 months prior to RAMP there were 14 primary referrals across the 9 schools. During the time RAMP was being implemented, CAMHS received 5 new primary referrals for students attending RAMP schools. There was an increase in the number of requests made to CAMHS for secondary consultation. Specifically, in the 3 months prior to RAMP being implemented, only 1 of 9 schools had made a request to CAMHS for secondary consultation. In comparison, during the time RAMP was being implemented, 8 of the 9

schools formally requested secondary consultations from CAMHS.

Finally, CAMHS staff were asked to rate their overall satisfaction with outcomes for students as a result of RAMP using a 6-point scale ranging from 1 (extremely dissatisfied) to 6 (extremely satisfied). The mean rating on this scale was 5.12 (SD = .35).

Sustainability of RAMP in schools: 6 month follow-up

The nine schools that implemented RAMP in 2005 were re-contacted 6 months later (Terms 1-2, 2006) and asked whether they were continuing to implement any RAMP processes at the school. Five of the six primary schools had continued to hold RAMP meetings. Many of the staff involved in the program in 2005 continued involvement in 2006. Two of the six primary schools had increased the number of school staff involved in RAMP. One of these schools had extended RAMP to all year levels and another school reported plans to extend the model to the whole school by the end of the year. Four of the six primary schools had written RAMP into their school wellbeing policies and procedures. The primary school which had not held any RAMP meetings in the first half of 2006 was much smaller than the other schools (only 7 staff members) and was therefore less reliant on formal meetings. The school principal/student wellbeing co-ordinator involved in the 2005 implementation had integrated the RAMP risk and protective factors framework into the assessment and management of students and reported that whole year level screening and RAMP meetings were planned for later in the year. In regards to sustainable partnerships with CAMHS, two schools had contacted their local CAMHS agencies seeking secondary consultation and making a referral in the 6 months following the supported implementation of RAMP in 2005. The other four schools indicated they would contact CAMHS if they needed.

One of the three secondary schools had written RAMP into its policies and procedures, continued regular RAMP meetings, planned to train new staff who had expressed interest in RAMP, and planned to extend RAMP into the junior (prep to grade 6) and senior (years 9-12)

parts of their school. One secondary school (that was approached to implement RAMP as opposed to initiated interest) reported plans to integrate RAMP processes into the restructuring of pastoral care within their school; however, no RAMP processes (e.g., screening, meetings, policy changes) were currently being practised at the time of the follow-up assessment. The remaining secondary school had decided not to continue any RAMP processes in the school. During the implementation, this school and their CAMHS worker had found it difficult to implement weekly meetings and had elected to vary the implementation protocol by meeting fortnightly rather than weekly. It is possible that these fortnightly meetings made the implementation more difficult and less rewarding.

Discussion

The first aim of this evaluation was to document the process of implementing RAMP in schools. Through screening and selection, each school identified some students as being at-risk who had not previously been identified through existing welfare practices, and through RAMP these students received support within the school or were linked/referred to an external agency. According to the self-report evaluation data presented here, this represents an increase in capacity compared to standard practice. Both school and CAMHS staff agreed that these plans and associated actions resulted in beneficial outcomes for students. However, the present evaluation did not include any objective measures of outcomes for students (reduced absenteeism, improved mental health) or reduced risk and increased protective factors. Given the positive indicators in the current evaluation these areas should be investigated in the evaluation of RAMP in the future.

As a program, RAMP aimed to build schools capacity to 'hold' students at risk of mental health problems within the school setting. In addition to individualised action plans for students, schools implementing RAMP used a range of innovative initiatives to increase capacity at the system level of pastoral care. Examples include engaging parents by inviting them to the school to celebrate their child's achievements, schools providing spare school uniforms for children who arrive without them,

changes to the method used to refer to the school guidance officer so as to increase parents' engagement in the referral process, strategic provision of sports equipment at recess to students who need support to develop peer relationships, development of quizzes for new students to complete, aimed at enhancing their knowledge of school staff and school processes and therefore their sense of connection and safety in the school.

Our second aim was to investigate capacity changes experienced by school staff. All staff reported perceived improvements in knowledge following their participation in RAMP. This may be due to formal and informal opportunities to build knowledge and skills. The training days, professional development session for staff, and weekly RAMP team meetings represented formal opportunities for professional development. During RAMP meetings, CAMHS clinicians and school teaching and welfare staff shared information about how to improve the management and educational output for students with a range of difficulties including autistic spectrum disorders, learning disabilities, borderline intelligence and behaviour problems. Teachers and welfare staff said they appreciated the opportunity to learn from the CAMHS clinicians working at the school. This evaluation found that all school staff reported that RAMP led to improvements in their ability to support and assist at-risk students *within* the school, with these changes more pronounced in the primary schools. This finding may reflect increased knowledge, but might be explained by them feeling less isolated and better supported in the work they were doing with at-risk students. All staff reported that communication and collaboration within their respective schools had improved following RAMP, with these changes again most pronounced in the primary schools. It should be noted that these improvements were based on self-report. Future evaluation should attempt to corroborate these findings using broader measures of school climate as well as other measures of capacity building.

Our third aim was to investigate changes experienced by the CAMHS staff involved in the implementation, and changes in the relationship between schools and CAMHS following implementation. Both school and CAMHS staff

reported improved communication with each other. The frequency of primary referrals decreased and frequency of requests for secondary consultation increased during the period RAMP was being implemented. At six month follow-up, most schools had had no contact with their local CAMHS agency, although all the primary schools that implemented RAMP indicated that they would contact CAMHS 'if they needed'. This finding, together with the fact that the majority of school staff reported improvement in their knowledge and understanding of referral processes and options following RAMP, may translate into schools making more appropriate referrals and seeking assistance through secondary consultation when needed. One key issue that requires further investigation is what, if any, changes the CAMHS services implemented as a result of their work with schools on RAMP. This evaluation did not gather information about CAMHS service delivery, such as the outcome of referrals made to CAMHS, the waiting time between the referral and an appointment being made, or the feedback that CAMHS services provided regarding how a student's problems might be managed back at the school. Further monitoring of the frequency and nature of contacts between CAMHS and schools before, during, and after RAMP has been implemented would be necessary to measure changes in the relationships between schools and CAMHS agencies.

Finally, we sought to examine whether RAMP would be sustainable and be embedded within policies and procedure for wellbeing across the school. All the schools involved in this trial of RAMP reported reviewing and improving organisational processes and procedures that support students. Immediately after RAMP had been implemented, eight of the nine schools reported taking steps to integrate the program more broadly into the existing structure of the school. At six month follow-up, many schools reported that they were continuing to use RAMP processes. Four of the six primary schools and one of the three secondary schools had written RAMP into their student wellbeing policy and procedures manual. Further follow-up is necessary to assess the longer term utility of RAMP in schools and its relative benefits compared to standard practice.

In terms of limitations, this report relies on self-report data from staff involved in the trial. There is no comparison group, and no way of measuring the accuracy of staff reports. The changes reported reflect perceived changes rather than pre- to post-changes in actual skills or knowledge. Improved staff and student health and wellbeing are distal outcomes and are not measured in this evaluation. This evaluation documents the feasibility of implementing RAMP in schools. Anecdotally, school staff reported that the RAMP processes had led to rapid and visible changes in school attendance and students' observed functioning at school. The next phase of the RAMP evaluation will be to connect RAMP assessment and implementation data with health outcome data for school staff and students. Also, the nine schools taking part in this evaluation may not be representative of all schools since six of those schools self-selected to implement the program.

St Leger (2004) called for schools to be viewed as settings where health is created, supportive environments are built, partnerships made and many skills learned. RAMP provides processes to help achieve these through the development of whole-school systems for welfare and wellbeing management, and the formation of partnerships between schools and health care providers.

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