Helping Helpers Help: An Integrated Model for Empowering Educators and Parents as Partners in Supporting Student Wellness and Learning

Child and adolescent healthcare professionals have declared a national emergency: "We are caring for young people with soaring rates of depression, anxiety, trauma, loneliness and suicidality that will have lasting impacts on them, their families, and their communities" (American Academy of Pediatrics [AAP], et al., 2021). Mental health factors have become especially formidable barriers to learning in our post-pandemic context, intensifying a national imperative for innovation in better supporting student mental health and wellness. Significantly, research has definitively established that for school-based mental health and suicide programs, **"educating and engaging parents can increase the effectiveness of all interventions"** (Balaguru, et al., 2013, p. 138; emphasis added). Cook Center for Human Connection (CCHC) innovatively leverages this powerful moderator by "Helping Helpers Help" ("Helpers"), developing and engaging an army of stakeholders in schools and families most committed to helping their children thrive and learn. As this new model is accelerating in adoption, this grant will advance the "Helpers" model with pilot testing and iterative improvements, new culturally and linguistically responsive resources, and rigorous evaluation that addresses critical research gaps. "Helpers" will serve 83 middle schools in New Mexico (NM) and Arizona (AZ) to bridge systemic access inequalities to mental health supports, thus reducing barriers to learning while strengthening educators, parents, and caregivers, to better help young people be well.

A. Significance of "Helpers"

The pressing crisis in youth mental health exacerbates the need for "innovation and action … to improve the access to and quality of care across the continuum of mental health promotion, prevention, and treatment" (AAP et al., 2021). Significantly, "Helpers" directly

answers this call, providing innovative school-based training, resources, and services that strengthen and support the adult *helpers*—educators and parents (to include caregivers)—on the front lines with kids every day. Mental health issues, including suicide, are historically heavily stigmatized and under supported in schools—in fact, only one of the previous 30+ EIR projects funded in the SEL priority even uses the word suicide. In contrast, "Helpers" busts through the stigma to address it head on, affirming that we can no longer afford to sidestep these issues.

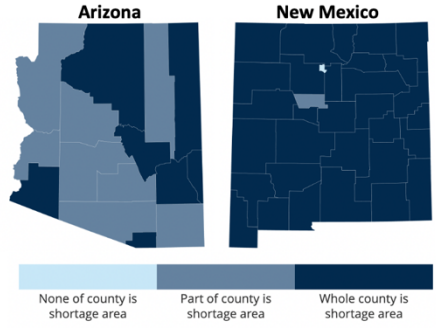
Indeed, the top-line insight from a large recent survey is that "'depression, stress, and anxiety' is the most prevalent obstacle to learning for secondary students at every grade level, six through 12" (YouthTruth Student Survey, 2022). The Center for Disease Control (CDC) Youth Risk Behavior Survey corroborates these findings: nearly 60% of female students said they experienced "persistent feelings of sadness or hopelessness" during the past year. Even more alarming: nearly 25% made a suicide plan (2023, p. 2). That self-reported data is incredibly credible, as pediatric hospitalizations for suicidal behavior skyrocketed 163% since 2009 (Arakelyan, et al., 2023), while suicide is the second leading cause of death among 10–24 years-old adolescents and young adults (CDC, Not dated). This "Helpers" project will serve two suicide hot spots: New Mexico, which has the second highest suicide rate in the nation (New Mexico Department of Health, 2022), and Arizona, where the suicide rate is 35% higher than the national rate (Arizona Department of Health Services, 2023).

The national emergency in youth mental health is not hyperbole—for many, it feels personal, as so many of us know a struggling child or someone who has a struggling child. In fact, one in five children has a mental, emotional, developmental, or behavior disorder. The occurrence is higher in subpopulations, as children growing up in poverty are two to three times more likely to develop mental health conditions than their wealthier peers (Surgeon General,

2021). An analysis of over 46.6M children found similar prevalence rates and noted that almost half of these children (49.4%) did not receive needed treatment or counseling from a mental health professional (Whitney & Peterson, 2019). The treatment gap is especially high for children of color: just 35% of Hispanics who need mental health services receive it, compared to 37% for Blacks and 52% for Whites (National Institute of Mental Health, 2021). Often, parents of a struggling child just don't know what to do, while also dealing with barriers like lack of insurance, limited access to providers and services, and stigma (Mongelli, et al., 2020).

A lack of proximate mental health services is especially critical in rural areas. For example, all but one of the counties in NM and AZ experience a shortage of professional mental health services (Rural Health Information Hub, 2023; see Exhibit 1), while the rural areas in these states have no Child and Adolescent Psychiatrists (American Academy of Child & Adolescent Psychiatry, 2023). A national shortage of school psychologists and counselors compounds the problem. The National Association of School Psychologists recommends a service ratio of 1:500 students. The national ratio is 1:1,211. Arizona's ratio is even larger at 1:1,312, while NM is off the charts (1:10,000+) (2021). Similarly, the American School Counselor Association recommends a service ratio of 1:250, but the national average is 1:415. While NM is 1:443, AZ is 1:716, the worst in the country (2022). These facts are especially devastating when you consider that **80% of parents with a child struggling with a mental health problem turn to schools for support** (Masonbrink & Hurley, 2020).

Exhibit 1:Mental Health Professional Shortage Areas, By County, 2023



Studies show the pandemic accelerated the youth mental health crisis, even doubling depressive and anxiety symptoms (Surgeon General, 2021; 2023). Finding themselves in a

constant state of mental health triage, schools are understandably overwhelmed by the surge in mental health needs. While teachers have always had to respond to these mental, social, and emotional challenges, they typically receive little in their pre-service preparation or professional learning to adequately prepare them (Graham & Phelps, 2011), much less lead the front line in a national emergency. And yet, connecting with adults at school has shown to be a powerful protective factor, supporting both wellness promotion and prevention goals (Marraccini & Brier, 2017; Surgeon General, 2023). Positive relationships with teachers that focus on students' assets and offer "consistency, trust, care, and responsiveness" can help students feel connected and empowered to better regulate their emotions (Committee for Children, 2019, p. 4). Teachers are more likely to engage in these meaningful ways when they feel prepared to deal with struggling children. As their self-efficacy increases and they feel like they have helpful resources to offer, they are more likely to help, and children and families benefit (Graham & Phelps, 2011).

Similarly, research meta analyses have found that cultivating supportive relationships between adolescents and adult family members improves mental health, including decreasing suicidal ideation, attempts, and behavior (Committee for Children, 2019; Whitlock et al, 2014). However, many parents are hesitant to engage. Cultural stigmas around mental health and trust issues with schools often derail help seeking behaviors. Think of the mother whose daughter is a cheerleader struggling with suicidal thoughts, but stigma keeps her from getting help for fear that others in their small rural town will find out. Suicidality skyrockets for students struggling with their sexuality and/or gender identity—their parents may desperately want to find help for their child and parenting guidance for themselves but may not feel safe revealing their concerns.

B. Quality of "Helpers" Project Design

In response to these alarming trends and the national imperative for innovation, CCHC

has pioneered a new combination of research-based strategies and technology resources to help schools help their *helpers*—educators and parents—better help their students and children learn, grow, develop, and thrive. Though only two years old, the "Helpers" model has already been adopted at varying levels of implementation by 229 districts and 3,617 schools, offering over 2.4M families access to our services across 37 states! That adoption is only accelerating—school leaders are desperate for help, which is why the School Superintendents Association (AASA), New Mexico Coalition of Education Leaders (NMCEL), and the Arizona School Administrators (ASA) organizations are enthusiastic partners and will help us recruit the 80 schools we need for the evaluation portion (Appendix C, Letters of Support). This EIR grant offers an important opportunity to pilot and iterate the "Helpers" model, refining the core model elements—from content to dosage to delivery—to be culturally responsive to the mostly rural schools and Hispanic communities this project will serve. Ultimately, this project's rigorous evaluation will help elevate the research-based rationale of this upstream intervention to definitive Strong evidence. This project will thus accelerate scale and outcomes that can abate the national adolescent mental health crisis and offer educators much needed resources and support.

b1. "Helpers" Conceptual Framework

The "Helpers" model of mental health promotion, prevention, and intervention meets:

—**Absolute Priority 1** (Demonstrate a Rationale), with a defined Logic Model (Appendix G)

—**Absolute Priority 4** (Meeting Student Social, Emotional, and Academic Needs), with NIA defined strategies for "*2(i) Developing trusting relationships between students (including underserved students), educators, families, and community partners*"; and "*2(ii) Providing high quality professional development opportunities designed to increase engagement and belonging and build asset-based mindsets for educators working in and throughout schools*." "Helpers"

strategies develop outcomes in School Climate, Teacher Practice, and Teacher Well-Being aligned with WWC Eligible Outcome Domains and these priority targets (WWC, 2023).

—Competitive Preference Priority 1 (Minority Serving Institution Partnership), with a partnership with New Mexico State University (NMSU), a Hispanic Serving Institution (see MSI documentation in Letter of Support, Appendix C). NMSU will provide expert support in revising existing content assets and developing new parent courses specifically designed to be culturally and linguistically responsive for Hispanic and rural populations.

—Rural applicant, as the majority of the 83 schools served in this project will have a rural locale code (32, 33, 41, 42, or 43). Our superintendent professional organization partners—AASA, NMCEL, and ASA—are heavily networked with rural LEAs throughout the southwest and will work with our School Advocacy team to ensure we reach this rural participation target.

The Logic Model includes three inputs with supporting research-based activities at the district/school, educator, and parent levels. These inputs and activities are described below, as well as the research rationale for how they develop protective factors and outcomes.

(1) Districts/Schools: Adolescents spend most of their time at school, while school staff are often the primary point of contact for students and families needing guidance and help related to mental health (Ma, Anderson , & Burn, 2023), making schools a pragmatic context for mental health programs. Recent large meta analyses of school-based educational and preventive strategies around mental health and suicidal thoughts and behaviors confirm the appropriateness and effectiveness of schools for mental wellness and prevention programs, while highlighting key conclusions that "combining several strategies could increase efficacy (Katz, et al., 2013)" (Gijzen, et al., 2022, p. 409). Research has firmly established school as a key protective factor in student mental health and is thus a key input in the "Helpers" Logic Model. More specifically,

school connectedness, or a students' belief that adults and peers care about their learning and about them as individuals, has been shown to improve academic achievement and healthy behaviors while reducing suicidal ideation and attempts (Marraccini & Brier, 2017; Whitlock, et al., 2014). The "Helpers" model helps school leadership understand the CCHC suite of resources for strengthening school protective factors and develops site commitment to the "Helpers" model and goals for prevention, connection, education, and action. Each district places CCHC's ParentGuidance.org (abbreviated to PG) medallion and link on their website to provide families personalized mental health resources.

Exhibit 2: Website medallion

(2) Educators: Educators work with students daily and thus have natural connections. The protective value of these connections is higher when the adults can detect and respond to distress and thus facilitate help-seeking and help-giving interactions (Wyman, et al., 2008). In rural schools, which often lack counselors and psychologist support, the need for this protective factor is intensified. A teacher's sense of self-efficacy becomes especially important in this context: "teachers' beliefs about students' mental health, together with perceptions of their own capability to recognize and deal with mental-health related issues, will potentially influence their responses and hence the success or otherwise of mental health education programs" (Graham & Phelps, 2011, p. 480). As teachers believe they have helpful resources to share with families of students who struggle, they are more likely to collaborate with families to address challenges. Family engagement experts emphasize that this support—having quality resources to offer—improves teacher satisfaction and morale, as well as student outcomes (Constantino, 2021).

Thus, the "Helpers" professional development model is specifically designed to build the skills, knowledge, and perceived self-efficacy of educators, to include everyone in the building

who interacts with students (i.e., teachers, paraprofessionals, lunch workers, etc.). The core model that every school implements includes one full onsite day, where educators learn about the mission for mental wellness; CCHC family resources and outreach strategies at the PG website; stress and resilience, including stress responses, warning signs, and best practices in trauma sensitive environments; and practical ways for building positivity and connection into our classrooms and lives. This is followed by three two-hour virtual sessions, offered throughout the year, to include "Question, Persuade & Refer (QPR) Suicide Prevention Gatekeeper Training" and "Parents as Partners" to strengthen protective factors at home. Significantly, RCT research and meta analyses demonstrate the efficacy of gatekeeper programs (Committee for Children, 2019; Robinson, et al., 2013). The third professional learning session is chosen by the school from a menu of options (see Appendix J, pp. 96–98) and can include developing self-care and mindfulness in teachers themselves that can improve educator engagement and wellness. Iteratively adapting this professional learning content to help educators be more responsive to Hispanic cultural values, needs, and expectations will be essential to increasing both educator and family engagement in communities which have typically been hesitant to engage.

(3) Parents: Many parents and caregivers feel ill equipped to address parenting and mental health challenges, yet informed parents can be the strongest protective factors in supporting the mental health of their children (King, et al., 2018). A recent Pew Research Center poll found that 76% of parents worried about mental health concerns for their children (Minkin & Horowitz, 2023). If parents seem hesitant to engage, it is likely they just don't know what to do, or they experience barriers in language, culture, education, or trust (Constantino, 2021; Mapp, et al, 2017). "Helpers" is designed to leverage family assets of love and concern to help those parents develop their own "family efficacy," a concept that centers [redacted]

[redacted] best-selling book, *Engage Every Family: Five Simple Principles* (2021). Family efficacy focuses on helping families improve learning at home, or in this context, connection, warmth, structure, consistency, and support at home, all of which are protective factors for child and adolescent wellness that can have intergenerational effects (Kerr, et al., 2009). This "invisible engagement" (Constantino, 2021), where the engagement happens outside of a school context, is a **powerful pathway to equity, as students with better mental wellness experience fewer barriers to learning and thus improved school success**.

In the "Helpers" model, schools and educators learn to share powerful resources for family efficacy through the PG website and services. The service delivery model builds from principles of adult learning, especially the way adults are more likely to engage and benefit in learning opportunities that are relevant to their experience and focus on real problems they face (Knowles, et al., 2020). Historical barriers of racial, class, and educational hierarchies, as well as simple trust, are also important considerations (Mapp, et al., 2017). Thus, schools offer "Helpers" resources and services with a guarantee of confidentiality—parent identity is not shared with the schools as they utilize resources, helping parents overcome trust issues and stigma that often thwart help-seeking behaviors. ParentGuidance.org (PG) resources include:

—On-demand courses: PG provides 50+ self-paced, on-demand courses led by licensed therapists and clinicians. Specifically designed for parents, courses are offered in Spanish and English, with titles like "Helping Your Child When They are Bullied," "Why Our Children Self-Harm and How Parents Can Help," "How Digital Media is Changing Our Children's Mental Health," and "What Parents Need to Know about Suicide Prevention." Parents can interact with these courses as relevant and needed, 24/7, from the safety and privacy of their home.

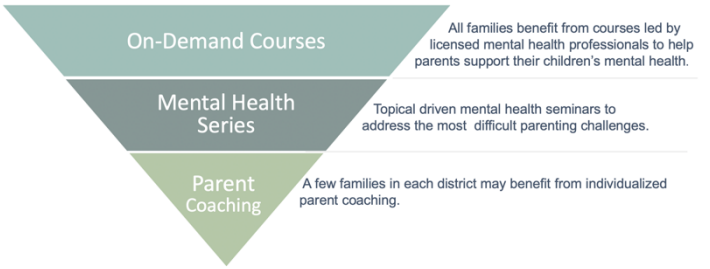
—**Mental Health Series (MHS)**: CCHC facilitators provide live, virtual, interactive MHS webinars for parents, offered in Spanish and English, every 4–6 weeks. Schools co-construct the plan for these webinars to address the most urgent concerns of their families around social, emotional, and mental health issues. Parent registration is confidential and while participation is interactive, parent anonymity is maintained. These events can be powerful for diluting stigma. As a real example, a family dealing with constant conflict in their home can feel relief and aid when they see a MHS led by their school on conflict resolution—the stigma of their problem declines because they realize others struggle too. MHS titles include (see Appendix J, p. 99), "Your Child's Anxiety," "Depression: You're Not Alone," "Grief: The Healing Process After Loss," "Establishing Healthy Boundaries with Your Kids," and "ABC's of Substance Use & Vaping." Research shows depression, hopelessness, anxiety, and substance use are known risk factors for suicidal thoughts and behaviors. Parentguidance.org (PG) and Mental Health Series address these risk factors and provide tools and resources for coping with these challenges.

—"**Ask A Therapist**": Adult learners are often seeking guidance, but that can be hard to find when many of the problems parents face today are so unprecedented. PG offers a powerful service: parents can submit questions anonymously, which are then answered by licensed therapists on video, with English and Spanish transcripts. These questions are authentic and reflect the crises so many families are experiencing: "My son is disrespectful and has isolated himself from the rest of the family. What can I do?"; "Our 16-year-old was doing inappropriate things on his phone. . . . How can we help him?"; "My ex tells my 15-year-old son that I want nothing to do with him. He has changed the way my son treats me. What should I do?"

—-**1:1 Parent Coaching**: PG also offers parents, caregivers, grandparents, guardians, and school and district staff live 1:1 coaching using a research-based and evidence-based model tested in

therapeutic centers. Coaching includes weekly 30-minute coaching sessions (audio/video calls), with a trained and qualified coach, a curriculum app, and texting for immediate support (responses within 24 hours). Significantly, coaching enrollment is confidential and participant identity is never shared with the school. This coaching is not intended to replace therapy but can help many parents resolve challenges before they escalate and can bridge the treatment gap for communities that don't have local services or families dealing with long wait-list times to see a professional.

Exhibit 3: "Helpers" increasingly specialized model for parent resources



b2. Goals, Objectives, and Outcomes

"Helpers" includes three goals and seven SMART objectives, which are presented in the Project Management Plan, Exhibit 7, so that reviewers can see how project activities specifically support these goals and objectives. Please score this section with Section D, Exhibit 7.

b3. Addressing Needs of Target Population

The target population of this "Helpers" project is schools in the southwestern United States with underserved populations that have limited access to mental health supports, particularly students living in poverty, students of color, and students who are learning English. More specifically, this project is braided with strategies and activities to optimize the "Helpers" model to include culturally and linguistically responsive supports to meet the needs of NM and AZ schools with large populations of Hispanic students. Indeed, research meta analyses of suicide prevention programs show that "Universal education and gatekeeper programmes have been useful in rural, ethnic minority communities" (Balaguru, et al., 2013, p. 135). Appendix J

(p. 100) presents a table detailing the mental health risk factors in NM middle schools specifically, showing that 23 of the 33 counties have at least one suicidal risk factor exceeding the state average on the 2021 NM Youth Risk & Resiliency Survey–Middle School Reports (New Mexico Department of Health, et al., 2021). The schools in these counties will be top priority for our evaluation project, followed by Arizona schools with similar demographics. To optimize resources for these priority populations, our project features three rural NM pilot school partners with significant mental health needs, including Silver Consolidated Schools (Grant County), Truth or Consequences Municipal Schools (Sierra County), and Pecos Independent Schools (San Miguel County) (see Letters of Support, Appendix C). Exhibit 4 presents the demographics and indicators of need for these pilot partners:

Exhibit 4: Pilot Schools Districts: Demographics and Key Indicators of Need

Pilot District (Rural code)	**# students**	**% Hispanic**	**MS/HS Counselors**	**NM Youth Risk & Resiliency Survey***		
				Electronically Bullied	Serious Suicidal Ideation	Frequent mental distress
Silver (33)	2,306	43%	3.5	31.1%	21.2%	20.8%
Truth or Consequences (33)	1,254	32%	0	25.8%**	36.3%**	Not available
Pecos (42); San Miguel Co.	505	73%	2	33.1%	21.0%	24.2%
New Mexico state average	-	62%	-	27.1%	27.1	25.2%

* *YRRS Middle School County Reports* (NM Department of Health, et al., 2021) ***T&C data from 2019*

Our partnership with the NMSU's Department of Health, Education, and Social Transformation (HEST) is focused on reviewing existing ParentGuidance.org (PG) resources to identify and develop culturally responsive revisions and new content that better addresses the needs of Hispanic families, rural communities, and southwestern schools. PG courses are already offered with Spanish dubbing, but our content review will include optimizing that delivery. We particularly want to leverage NMSU expertise to understand how PG resources can be improved to increase relevance, leverage cultural assets, and overcome cultural stigma around mental health in Hispanic families and communities that can prevent help-seeking behaviors. These new resources will all be offered for free to schools nationally on the PG website, thus meeting grant

open licensing requirements. Our partnerships with both NMCEL and ASA will also help us connect with school leaders in both states, to ensure we hear their input and feedback, as well as recruit schools that are most in need of supports.

Addressing research gaps. Research meta analyses and reviews expose the lack of methodologically rigorous studies of school-based mental health related programs (Hoagwood, et al., 2007; Ma, Anderson , & Burn, 2023; Walsh, et al., 2022), as well as qualitative research relative to school-based techniques for engaging parents in mental health related interventions (Paulus, et al., 2016). Hoagwood et al. decry a lack of empirically validated studies targeting school climate, noting that traditional constructs of academic success (i.e., grades, test scores) are distal outcomes and thus not as sensitive to change with mental health programs as school climate, a more proximal variable that mediates academic outcomes (2007). This project addresses these gaps, thus increasing the ability of "Helpers" and future interventions to better support our target population, while also helping mental health interventions become more resilient to budget cuts as school leaders better understand how they impact the school context.

C. Quality of Project Personnel

CCHC was founded in 2020 as part of a nonprofit foundation committed to bringing together the best organizations, programs, and products to prevent suicide, provide mental health support, and enhance human connections essential for people to thrive. Funded by doTERRA founding executive Greg Cook, and his wife, Julie Cook, the foundation is well-endowed, financially stable, and has steady sustainable growth through the rapid scaling of the "Helpers" model. Though CCHC has not previously applied for an EIR grant, we have won and implemented multiple private grants projects to fund our widely acclaimed *My Life Is Worth Living* (MLWL) resources, a web-animated series that models suicide prevention strategies

through the stories of five relatable teen characters. MLWL has been featured in over 50 national media outlets, including *USA Today*, NPR, *Teen Vogue*, and *Girl's Life*, constituting a circulation of over 280 million. These amazing accomplishments, in such a short time, build from CCHC's talented staff of experienced educational, technology, mental health leaders and partners in Exhibit 5, which will ensure the success, sustainability, and dissemination of this project.

Please note, we use the yellow highlighted abbreviations below for each personnel title in the Exhibit 7, Project Management Plan "Responsible" column, to indicate which elements of the grant each of these grant project leaders will lead.

Exhibit 5: "Helpers" Grant Management Team

Leadership Team
"Helpers" will be led by co-project directors (PD). **Co-PD (Project Management, PM)** [redacted] has written and led multiple grant projects for CCHC and has expertise in school administration and experience in project management. She will provide overall implementation leadership to ensure all grant activities are accomplished with efficacy. She will be supported by content expert, **Co-PD (Subject Matter Expert, SME)** [redacted] a licensed therapist, published author, and Clinical Director of PG. He will provide mental health content leadership, particularly in working with NMSU experts to develop new culturally responsive resources for Hispanic populations. [redacted]**, CEO and President of CCHC (CEO)**, will be the supervising executive. She has over 25 years of experience as a teacher and educational technology executive and has led key activities in other federal and state-funded innovation grants, including dissemination. [redacted]**, Chief Advocacy Officer (CAO)**, with 25 years of experience in school networking, will also support school recruitment and project dissemination as he leads advocacy and sales directly with school leaders nationally.
Design and Implementation Team
Implementation leaders include [redacted], **VP of Advancement (VPAdv),** who has led the early introduction, adoption, and scale of the "Helpers" model to more than 3,600 schools. She will work closely with project partners AASA, NMCEL, and ASA to recruit 80 schools in NM and AZ to participate in the RCT evaluation**.** [redacted] **Chief Marketing Officer (CMO)**, will assist with school recruitment, school strategies for parent outreach, and project dissemination. [redacted], **VP of Education (VPEd)**, will lead school level-planning and professional learning iteration. [redacted], **Chief Financial Officer** (**CFO**), will oversee expenditures and financial reporting. He will work closely with [redacted]**, Chief Operating Officer (COO)** to support accountability and reporting, and ensure operations and iterations are impactful and scalable.
Evaluation Team
[redacted] **(External Evaluator, ExtEv)** is an educational psychologist, and president of the nonprofit Evaluation and Testing Institute (ETI), which will lead the external evaluation. He will work with ETI clinical expert, [redacted] **(External Evaluator, ExtEv)**, who has extensive experience in parent involvement and behavioral evaluation and initiatives. Significantly, they both have successfully conducted multiple i3, EIR, and state grant evaluations that have been judged by WWC to meet WWC standards without reservations.

Medical Advisory Board
CCHC and "Helpers" is supported by a Medical Advisory Board, which will provide expert consultation on an annual and as needed basis. Members include [redacted] **(MedAdv)**, a board-certified Harvard trained psychiatrist for adults, children, and adolescents and published author. [redacted] is Hispanic and has over 15 years clinical experience. [redacted] **(MedAdv)** is a professor of School Psychology at the University of Washington and past president of the American Association of Suicidology. [redacted] **, MD (MedAdv)** is a pediatric infectious disease specialist and Chief Medical Officer for doTERRA, with extensive experience in wellness and prevention.

CCHC is an Equal Opportunity Employer and is committed to diversity in its workforce. In compliance with applicable federal and state laws, CCHC's policy of equal employment opportunity prohibits discrimination on the basis of race or ethnicity, religion, color, national origin, sex, age, sexual orientation, gender identity/expression, veteran's status, status as a qualified person with a disability, or genetic information. Individuals from historically underrepresented groups, such as minorities, women, qualified persons with disabilities, and protected veterans are strongly encouraged to apply for all CCHC positions.

D. Quality of Management Plan

Exhibit 6 presents a visual timeline of the major "Helpers" project components.

Exhibit 6: Visual timeline of major components (dark green represents external evaluation data collection periods)

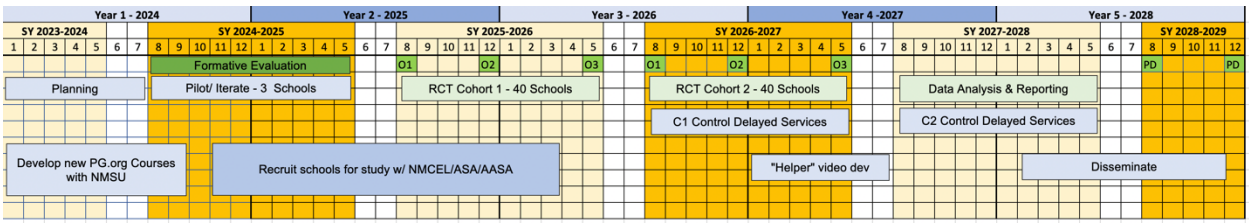


Exhibit 7 presents a detailed Project Management Plan, identifying the position(s) responsible for each objective and activity, as well as the performance measure and timeline. The plan is designed to implement the "Helpers" Logic Model, while also ensuring grant goals and objectives are met on time and within budget. Please note that this plan builds from the assumption that Project Directors will meet all grant reporting deadlines and participate actively in EIR project meetings, interest groups, and presentations.

Exhibit 7: Project Management Plan: Responsible Leaders, Performance Measures, and Timeline

Goals, Objectives, Activities	Responsibility	Performance Measure	Timeline
Goal 1. Pilot and refine CCHC's school-based "Helpers" model for improving educator and parent capacity, collaboration, and family efficacy in supporting adolescent mental wellness and learning.			
Obj. 1. By October 31, 2024, work with NMSU experts to improve existing content and develop at least 3 new ParentGuidance.org (PG) courses that are culturally and linguistically responsive for Hispanic and rural populations.	Co-PD SME	3 new courses complete 5 courses revised	1/9/24–9/30/24
1. Work with experts from NMSU HEST dept. to review existing content and create a plan of development priorities and content refinement targets.	Co-PD SME NMSU	Dev Plan created	1/9/24–3/31/24
2. Design new content for parents that helps to reduce stigma around mental health and encourage their engagement with "Helpers" parent resources.	Co-PD SME NMSU	Content assets created	3/1/24–7/1/24
3. Collect feedback from parents and teachers on the new content and refine resources based on quantitative participation data and qualitative feedback.	Co-PD SME NMSU	User survey results	6/1/24—12/30/24
Obj. 2. By June 1, 2025, complete pilot implementation of the "Helpers" model in three pilot middle schools in three different districts.	Co-PD PM	Pilot data report	8/1/24–6/1/25
4. Orient/onboard district and school leadership and conduct 1 day of professional learning early in the school year.	VPEd	Participant record	8/1/24–9/30/24
5. Conduct three 2-hour virtual professional learning sessions for each school.	VPEd	Participant record	10/1/24–4/1/25
6. Support schools in conducting parent outreach (i.e., teacher recommendations, flyers, website, newsletters, social media campaigns, and PSAs) to encourage parent participation in virtual MHS and PG resources and coaching services.	CMO VPEd	Asset creation Distribution record	8/1/24–5/30/25
7. Conduct 10 interactive, live, virtual MHS for parents and school staff (5 topics, delivered once in English, once in Spanish) at each school.	VPEd	Participant record	8/15/24–5/30/25
8. Provide access to free, personal, virtual coaching services for parents.	Co-PD SME	Access & registration	8/1/24–5/30/25
Obj. 3. By August 11, 2025, review data from pilot schools to improve "Helpers" implementation model and resources.	Co-PD PM	Pilot recommendations report	5/15/24–8/15/25
9. Provide stipends to pilot school classroom teachers to incentivize their full participation in feedback and iteration.	Co-PD PM	Budget records	8/1/24–8/1/25
10. Conduct 2 site visits and gather feedback from teachers and leaders on professional learning experience and content and refine based on feedback.	Co-PD PM VPEd	Site visit reports	10/1/24–4/30/25
11. Monitor parent participation in "Helpers" PG and MHS resources and services and collect feedback from parents via surveys/focus groups.	Co-PD PM	Usage data Survey/Focus Groups reports	8/1/24–5/30/25

Goals, Objectives, Activities	Responsibility	Performance Measure	Timeline
12. Revise "Helpers" implementation plan based on pilot outcomes for improved implementation in the evaluation phase.	Co-PD PM & SME; VPEd	Revised impl. plan	5/30/25–8/1/25
13. Meet with Medical Advisory Board to share project deliverables and implementation data and gather expert feedback for improvement.	Co-PD SME & PM; MedAdv	Meeting minutes	1/30/24–6/30/24 1/30-3/31, 2025–27
Goal 2. Evaluate "Helpers" model to measure impact and identify opportunities to improve the model for scale and replication.			
Obj. 4. By March 31, 2026, recruit 80 middle schools to participate in two-year randomized control trial of the CCHC "Helpers" model.	CAO	Signed school MOUs	11/1/24–3/31/26
14. Partner with AASA, NMCEL, and ASA to recruit 40 middle schools to participate in RCT evaluation for Cohort 1 (C1) SY 2025–2026 and 40 for Cohort 2 (C2) SY 2026–2027.	CAO, VPAdv	Outreach records	C1: 11/1/24–6/30/25 C2: 11/1/24–3/31/26
15. Sign MOUs with each of the participating schools.	VPAdv	Signed school MOUs	1/6/25–3/31/26
Obj. 5. By May 31, 2026 (C1) and May 31, 2027 (C2), incorporate iterative improvements to implement "Helpers" integrated model in 80 schools.	Co-PD PM	Revised implementation plans	C1: 8/15/25–5/31/26 C2: 8/15/26–5/31/27
16. Conduct 1 day of professional learning early in the school year.	VPEd	Participant record	C1: 8/1/25–9/30/25 C2: 8/1/26–9/30/26
17. Conduct three 2-hour virtual professional learning sessions throughout the school year.	VPEd	Participant record	C1: 10/1/25–4/1/26 C2: 10/1/26–4/1/27
18. Support schools in conducting parent outreach to encourage parent participation in virtual MHS and PG resources and coaching services.	CMO VPEd	Asset creation Distribution record	C1: 8/1/25–5/31/26 C2: 8/1/26–5/31/27
19. Conduct 10 interactive, live, virtual Mental Health Series (5 topics, delivered once in English, once in Spanish) at each school for parents.	VPEd	Participant record	C1: 8/15/25–5/31/26 C2: 8/15/26–5/31/27
20. Provide access to free, personal, virtual coaching services for parents.	Co-PD SME	Access & registration	C1: 8/1/25–5/30/26 C2: 8/1/26–5/30/27
21. Conduct site-visits, interviews, focus groups, and surveys at various sites, as needed, to gather feedback to inform iterative improvements.	Co-PD PM VPEd	Site visit report Feedback report	C1: 10/1/25–3/31/26 C2: 10/1/26–3/31/27
22. Provide delayed treatment program as incentive to participate for schools assigned a control condition.	Co-PD PM ExtEv	Implementation records	C1: 8/15/26–5/31/27 C2: 8/15/27–5/31/28
Obj. 6. Conduct RCT external evaluation of "Helpers" model.	ExtEv	Evaluation reports	1/9/24–12/31/28
23. Finalize Evaluation Plan with EIR evaluation team.	ExtEv	Approved eval plan	Pilot: 1/9/24–7/30/24 C1: 1/9/25–7/30/25 C2: 1/9/26–7/30/27

Goals, Objectives, Activities	Responsibility	Performance Measure	Timeline
24. During 2024–25 pilot, conduct formative evaluation for rapid feedback and iterative development of instruments, refine data collection techniques, assist in program refinements.	ExtEv	Formative eval report	8/15/24–5/31/25
25. During 2025–26 and 2026–27, conduct study using Cluster RCT research design with participating schools. Measure impacts of school participation on school-level outcomes, teacher-level outcomes, and parent-level outcomes (i.e., Logic Model short-term outcomes).	ExtEv	Interim eval report APR evaluation report	C1: 8/15/25–5/31/26 C2: 8/15/26–5/31/27
26. During 2025–26 and 2026–27, conduct implementation study to determine if "Helpers" program was executed within districts/school sites as intended (i.e., Logic Model outputs).	ExtEv	Interim eval report APR evaluation report	C1: 8/15/25–5/31/26 C2: 8/15/26–5/31/27
27. Conduct statistical analyses on Cluster RCT data for each cohort year; complete analysis of implementation data across each cohort year.	ExtEv	Interim eval report APR evaluation report	C1: 6/1/26–12/31/26 C2: 6/1/27–12/31/27 All: 8/1/27–5/30/28
28. Synthesize annual results into yearly evaluation progress reports; Create final comprehensive, multi-year program Implementation and program Impact Evaluation reports.	ExtEv	Interim eval report APR evaluation report Final report	C1: 6/1/26–12/31/26 C2: 6/1/27–12/31/27 All: 8/1/27–5/30/28
29. Submit final EIR study to ERIC.	ExtEv	Submit confirmation	By 12/31/28
Goal 3. Disseminate results of "Helpers" project to support continued development of district, school, teacher, and family capacity to improve access to services and support for student mental wellness.			
Obj. 7. By December 2028, showcase the project and related resources and outcomes to school leaders in at least 8 other states and in at least two regional and two national conferences and events.	CEO CAO	Salesforce records Presentation records	2/1/28–12/31/28
30. Ensure new content resources developed with grant funds are loaded on PG and offered freely to everyone, to meet Open Licensing requirements.	PD SME	PG course offerings	By 12/31/24
31. Develop and broadly share a project video describing "Helpers" model.	CMO	YouTube views	1/2/27–12/31/28
32. Meet with education leaders in at least 8 other states to share the "Helpers" model for improving access and services that support mental wellness.	CAO	Salesforce records APR objective report	Annually
33. Present to national academic and policy meetings and conferences.	CEO	Presentation records	Annually
34. Share interim reports with schools and state stakeholders and leaders.	CAO	Salesforce records	6/1/26–12/31/28
35. Produce and distribute a public facing evaluation report with recommendations.	ExtEv, CMO	Marketing report	2/1/28–12/31/28
36. Implement social media campaign to support report dissemination.	CMO	Marketing report	2/1/28–12/31/28

E. Project Evaluation – Prepared by Evaluation and Training Institute

The Evaluation and Training Institute (ETI) is a non-profit 501(c)3 applied research consulting firm founded in 1974 and based in Los Angeles with extensive experience conducting i3 and EIR research studies that meet What Works Clearinghouse (WWC) standards without reservations. ETI will conduct a fully independent program evaluation to assist in a formative program development process, track program implementation, and determine what impacts the program has on participants. The evaluation will be tailored to the early-phase grant and will meet WWC standards without reservations (WWC, 2022). We will conduct three studies across the grant's five years. 1) a **Formative Evaluation** will be conducted during the program development pilot phase, and will give program developers iterative feedback to support program improvement (grant years 1–2). 2) A yearly **Implementation Evaluation** will be used to determine if the program is meeting its stated implementation objectives and based on tracking a predetermined set of program activity and output indices (conducted during grant years 2–4). 3) An **Impact Evaluation** will be conducted across all program sites and used to determine the program's effects on schools, educators and parents, incorporating multi-level modeling and moderation and mediation analysis techniques (grant years 2–4).

Formative Evaluation Purpose and Method. Our formative evaluation will be grounded in program improvement and revisions of program processes to optimize goal attainment, program effectiveness, and program appeal (Tessmer, 1993; Scriven, 1996). This formative step, particularly in an early-phase project, is necessary to ensure that the finalized program design will succeed in its intended environments. It allows researchers to probe possible areas of weakness and establish, through data-driven decision making, the responsiveness of the program to the needs of its participants (Tessmer, 1993; Jacobs, 2000). The research team will conduct the

formative evaluation during the grant pilot year (SY 2024–2025). Data will come from the first consumers of a culturally informed adaptation of "Helpers" and will provide feedback on Spanish language offerings and the extent to which the curriculum possesses culturally and linguistically appropriate mental health content for schools and families of Hispanic youth. The formative process will also allow all evaluation measurement tools to be tested and finalized.

Leadership and educators from the three participating pilot school sites will participate in quarterly surveys and 1:1 interviews to provide in-depth feedback following participation in core program activities. Parental activity on the PG website will be monitored and anonymous surveys for those opting in to provide feedback will be evaluated. The research team will then assess strengths and weaknesses through an iterative approach to provide activity-based and quarterly findings to the "Helpers" designers and program managers. Collecting data and creating the immediate feedback loop throughout the program pilot year will help optimize the effectiveness of the program, allow for necessary pivots, and strengthen the ability to attain its intended goals. The formative phase will importantly allow for any specific program adjustments needed to enhance relevancy and cultural sensitivity within the specific program elements. The formative evaluation will align with the theoretical purpose of this type of evaluation as a quality control step for CCHC as they roll out an adapted "Helpers" program in NM and AZ.

Implementation Evaluation Purpose and Method. The focus of the implementation evaluation will be to determine if the key activities of the program are delivered as planned to the participating schools, educators and families, and allow us to deepen our understanding of the critical partnerships and processes needed to yield optimal school site commitment and staff participation. Program implementation data will be collected during SY 2025–26 and SY 2026–27, when the full program model is launched across two states (NM & AZ) and two cohorts

following the initial planning phase and pilot year. Our implementation evaluation will follow the standards set by the WWC (2022). We will base our implementation evaluation on a theory of change shown in the program Logic Model (see Appendix G), tracking how the key inputs are implemented and how tightly they are aligned with the established outputs. Our areas of inquiry for the CCHC "Helpers" program implementation evaluation will include total number of middle schools participating in program onboarding and orientation across a two-year period, percent of educators per school site participating in the CHCC professional development, percent increase of parents who access resources from the PG website (exploratory), and percent increase of parents who register for the live Mental Health Series webinars (exploratory). Definitions for adequate implementation will be finalized during the pilot year as well as thresholds for fidelity across each key program component. Proposed measurement threshold levels were developed in advance of the pilot year suggesting 90% of treatment schools participate in CCHC "Helpers" onboarding and orientation activities; 75% of educators from treatment school sites participate in professional development training; and a year-over-year increase of 80% in parents use of PG resources across program implementation year.

Implementation Evaluation Design. We will use a mixed methods research design, including the use of observational data (meetings, field observations, etc.), interviews with program staff and stakeholders, and secondary data sources, such as monthly grantee reports, to gather data for measuring the fidelity of program implementation. We will report on progress meeting each key output in the Logic Model. The fidelity scores will be measured against an established threshold for "Implementation with fidelity" or "Not with fidelity," and the results will be reviewed with CCHC quarterly to determine success levels for meeting their initial goals for conducting the program. Formal reporting will occur annually and at the grant's completion.

Impact Evaluation Purpose and Method. The Impact Evaluation will be based on a cluster randomized control trial (cRCT) experimental research design (Bloom, et al., 1999) to study how the Helpers program impacts participants across measures of school-site climate, educators' perceptions of student mental health and social emotional learning (SEL) beliefs, understanding and practice, and parent's confidence addressing their child's SEL and mental health. The cRCT design is indicated because the intervention is school-wide rather than single individuals. Assigning treatment at the cluster level reduces the risk of contamination, where individuals within the same cluster may influence each other's outcomes. For example, teachers within a school often have more characteristics in common than teachers from different schools due to school culture, hiring practices, and policies, etc. We will include additional controls against sampling bias by collecting pretest (pre-program) data for all cohorts, which will be used in all outcome analyses as predictor variables in the model. We are also interested in exploring whether intervention effects on outcomes are modified by moderator and/or mediator variables at the individual (e.g., gender, race/ethnicity) and/or the cluster level (e.g., school urbanicity). In addition to testing causal hypotheses about direct treatment effects, we will conduct moderation and mediation analyses to determine if teacher and school characteristics mediate outcomes.

Three general confirmatory research questions guide the cRCT design (Exhibit 8):

Exhibit 8: Confirmatory research questions of cRCT design (aligned to the Logic Model's short term outcomes)

- *Are schools randomly assigned to the CCHC "Helpers" program rated higher on measures of school climate related to student SEL and mental health than middle schools that were not randomly assigned to the program?*
- *Do educators in middle schools randomly assigned to the CCHC "Helpers" program have higher scores on measures of beliefs, understanding and practice related to SEL and student mental health issues after one year than educators in middle schools who were not randomly assigned to the program?*
- *Do parents in schools randomly assigned to the "Helpers" program have higher scores on measures of beliefs, understanding, and access to resources related to SEL and child mental health than parents from schools who were not randomly assigned to the program?*

Mediation/Moderation Analysis. We will also run analyses to answer questions about how program effects are modulated based on participant and school characteristics:

Exhibit 9: Research questions for mediation/moderation analysis

- *Does teacher experience (i.e., years teaching, level of education) mediate teacher outcomes?*
- *What school characteristics mediate teacher and school climate outcomes?*

Exploratory analysis. We also have exploratory research questions about increased use of PG to determine how the program impacts the use of these resources:

Exhibit 10: Exploratory research questions

- *Does the program result in an increased use of ParentGuidance.org?*
- *What components of ParentGuidance.org are most utilized by parents?*

Sample Size. A two-level cRCT power analysis was conducted using PowerUp! software to determine that 76 schools (clusters) with an average cluster size of 15 (n/teachers) were needed to achieve a minimum detectable effect size (MDES) of .25. Given that this is an early-phase grant, we chose to power our study to detect a small MDES of .25 (Cohen, 1992). We assumed that α=0.05, a 2-tailed test, and power = 0.80. Two cohorts comprised of 80 schools (40 in each cohort) will be randomly assigned to treatment and control using a random number generator, giving equal probability to each school within a cohort to be either treatment or control (Hedberg, 2023; Dong, et al, 2017; Dong & Maynard, 2013). Schools randomly assigned to the control condition in either cohort will receive the program the following school year (but will not be counted as a treatment school). Prior to any data collection, educators, administrators, and parents will complete informed consent forms.

Attrition. Threats of research subject attrition will be monitored carefully throughout the research process since high attrition can reduce the validity and generalizability of the study. We will follow WWC guidelines for assessing attrition within a cCRT research framework (WWC,

2022), and we have several strategies to minimize attrition during the study. First, we will set clear expectations for all research participants starting at the informed consent process, with periodic reminders throughout the study to motivate participants (both treatment and control) and foster a positive and engaging research environment. In addition, we will minimize participation burden wherever we can, using online data collection and individually scheduled appointments where applicable. Finally, both treatment and control groups will receive financial incentives to participate in the research (i.e., gift cards at the completion of surveys, etc.). Prior to running the full impact analysis, a sensitivity analysis will be used to determine if attrition resulted in systematic differences between treatment and control groups. If systematic differences due to attrition are found, statistical options such as multiple imputation or maximum likelihood estimation will be considered to estimate missing values and reduce the impact of attrition on the results. We will be transparent about attrition levels and any need for statistical adjustments (if needed) will be reported in detail.

Data collection will include three observation periods per cohort: pre-testing (baseline; observation 1), mid-year (observation 2) and end of year (observation 3) (represented as dark green O1, O2, and O3 in Exhibit 6 visual timeline). Pre-testing will be done to establish baseline equivalency in the randomly assigned clusters (WWC, 2022; Hemming et al., 2017), to add precision to our statistical analyses of program impacts and collect participant data to run mediation and sensitivity analysis (see Data Analysis below). Educators will participate in online surveys and individual interviews three times per year, and their responses will be tracked using a unique ID system without attaching personally identifying information to their response data. Parents will participate in online data collection at the time and level of their program use. For example, parents who complete online courses on PG will complete online surveys after the

course. Additional website use metrics will be collected to track visitors and types of interactions on PG (data that will be used to answer exploratory research questions).

Measurement models will be refined during the planning and pilot years, but our proposed quantitative outcome measures for educators include standardized surveys measuring School Climate (Adapted version of California School Climate Staff Survey; Mahecha & Hanson, 2020), SEL practices and implementation (School-based Staff Survey on Schoolwide SEL Implementation; CASEL, 2021), SEL beliefs (Teacher SEL Belief Scale) (Teacher SEL Belief Scale; Brackett et al., 2012), and understanding and preparation to address student and parent questions about mental health (Educator's Perceptions of Youth Mental Health; Moon et al., 2017). Our planned quantitative measures for parents will measure their beliefs, knowledge, and ability to seek help if their child needs it (The Parent Empowerment and Efficacy Measure; Freiberg et al, 2014; and, The Mental Health Literacy Scale; O'Connor & Casey, 2015). See Appendix J, pp.101–02, Proposed Evaluation Measurement, for details on these measures.

Data analysis for the impact evaluation will be based on a two-level random effects multi-level model where educators/parents (level 1) are nested in schools (level 2). Multi-level models have been widely employed to investigate educational outcomes, such as teacher outcomes, and school-level influences, and help to disentangle the individual and contextual factors contributing to a program's success. We will regress level 2 outcomes onto pretest (baseline) scores, treatment status and blocking variables (i.e., cohort x state) while accounting for the nested structure of teachers within schools. We will run direct and mediation models and report the significance and magnitude of the direct effects, indirect effects, and total effects. We will consider a treatment effect size (Hedges' g) of .25 or above as showing a meaningful effect.