Boone County Schools Mental Health Coalition

Accomplishments

January 2016

The Boone County Schools Mental Health Coalition is a multidisciplinary collaborative among Boone County's six independent school districts, the University of Missouri, College of Education (COE), Department of Educational School and Counseling Psychology and School Counseling (ESCP), the Missouri Prevention Center (MPC), and the School of Social Work (SSW). The Coalition is implementing an innovative pilot program funded by the Children Services Board of Boone County to train school-based personnel to implement programs with school-age youth proven to promote mental health and well-being.

Mission Statement: To promote a coordinated, multidisciplinary, collaborative initiative through: (a) implementation of a scientifically-based model of prevention and intervention, (b) reduce contextual risk factors and promote existing protective factors, and (b) provide access for in-risk youth and their families to comprehensive mental health assessment and wrap-around case management services.

The specific goals of this project include the following:

- Train all school staff to recognize and respond appropriately to students with signs and symptoms of mental health concerns;
- Develop and implement a county-wide ecological assessment system to gather data on risk and protective factors that are predictive of poor school, mental, and life course outcomes;
- Provide professional development to school personnel in Boone County in evidence-based practices shown to improve school climate and individual student and family functioning.
- Train school-based teams to implement evidence-based programs with at-risk and in-risk youth, and use data to monitor progress of student outcomes;
- Improve the coordination of information and services for at-risk youth and their families;
- Develop child-centered and family based wrap-around service plans for in-risk youth;
- Improve the effectiveness and follow through of referral services stemming from assessment driven wrap-around plans for youth and their families through a case management model.

The following provides a summary of activities for each goal with an emphasis on work completed since July 2015 to January 216. In addition, next steps under each project goal are provided.

Goal 1: Train all school staff to recognize and respond appropriately to students with signs and symptoms of mental health concerns

Between January 2015 and July 2015 (first six months of the project) we **trained 292 school personnel** from four of our Boone County school districts in Youth Mental Health First Aid (YMHFA). The participants included school staff, teachers, administrators, and ancillary support staff (e.g., counselors, school psychologists, speech language pathologists).

Evaluation of YMHFA:

We evaluated the impact of YMHFA by having individuals complete a survey before and after the training to assess their knowledge in youth mental health issues, confidence in identifying and supporting youth with mental health symptoms, and actions to support youth with mental health symptoms. Participants demonstrated a statistically significant increase in their knowledge of mental health issues, t (163) = -8.80, $p < 0.001$. Still the modest post-assessment score indicates there is room for improvement. Participants also reported a significant increase in their confidence to recognize the signs of mental health problems in youth, t (162) = -10.72, $p < 0.001$, confidence in asking a youth if they were considering killing themselves, t (162) = -10.73, $p < 0.001$, and confidence in their ability to offer a distressed young person basic "first aid" level information and reassurances, t (162) = -12.39, $p < 0.001$. Lastly, participants in YMHFA also had a significant increase in their efficacy to engage in specific behaviors related to youth mental health including being able to successfully locate information to understand mental health conditions, t (163) = -8.74, $p < 0.001$, being able to help a student with a mental health condition, t (161) = -8.81, $p < 0.001$, and being able to change classroom practices to accommodate a student's mental health condition, t (162) = -5.89, $p < 0.001$.

Consumer Feedback for YMHFA:

We received mixed responses to the usefulness, appropriateness, and quality of instruction. We were pleased to see that despite some concerns regarding the trainings, in general participants did incur some benefit. However, concerns regarding having certified trainers without school experience or mental health backgrounds and comments about the lack of usefulness of the training for individuals working with younger children caused us to consider some revisions to our plan for training future school personnel.

Developing and implementing an alternative professional development model:

As a result of our experiences with YMHFA, the difficulties in fitting the schedules of school personnel, and the lack of relevance of YMHFA material for elementary age students, our team developed a brief professional development session for our schools that elaborates on what to do when they have a student experiencing mental health symptoms in their classroom, how to accommodate children experiencing signs and symptoms of mental health problems, and what to do with regard to referral of student to school-based teams and step by step procedures in crisis situations.

We gratefully acknowledge funding and support from the Boone County Children's Services Fund.

Since August 2015 **we have trained 376 school personnel** in our Boone County schools in Identifying and Supporting Youth with Mental Health Problems. Two version of the training occur (elementary and secondary) to accommodate the developmental differences in the signs, symptoms, and responses to mental health issues in youth.

We have also evaluated the outcomes of these trainings on the knowledge of mental health issues, participant perceived efficacy and confidence in responding to mental health issues in youth, their ability to identify and respond to mental health issues in youth, and their attitudes toward accepting and accommodating youth with mental health issues. Findings are very promising for both versions.

Elementary Mental Health Training:

In the elementary version, overall knowledge of mental health issues in youth significantly improved pre to post training, $t(54) = -10.40$, $p < .001$, with **93% of participants reporting increased knowledge**. Similarly, participants reported significantly improved efficacy and confidence in identifying and supporting youth with mental health issues, $t(54) = -11.55$, $p < .001$, with **96% of participants reporting increased efficacy.** Participants also experiences increases in their ability to identify and support students with mental health issues, $t(52) = -9.44$, $p < .001$, with **82% of participants reporting increased perceived ability.** Lastly, participants demonstrated improved attitudes toward accepting and accommodating youth with mental health issues $t(52) = -5.13$, $p < .001$, with **70% of participants reporting improved attitudes.**

Secondary Mental Health Training:

In the secondary version, overall knowledge of mental health issues in youth significantly improved pre to post training, $t(34) = -8.13$, $p < .001$, with **88% of participants reporting increased knowledge**. Similarly, participants reported significantly improved efficacy and confidence in identifying and supporting youth with mental health issues, $t(34) = -7.02$, $p < .001$, with **85% of participants reporting increased efficacy.** Participants also experiences increases in their ability to identify and support students with mental health issues, $t(36) = -7.44$, $p < .001$, with **93% of participants reporting increased perceived ability.** However, overall participants did not demonstrate improved attitudes toward accepting and accommodating youth with mental health issues, with **60% of participants reporting improved attitudes.**

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In addition to the pre-post data gathered on participants, feedback about the trainings were gathered. Overall the trainings have been well received.

Item	Elementary		Secondary	
	Mean	SD	Mean	SD
The training was appropriate for students in the grade levels I teach/interact with	5.08	0.51	5.02	0.63
The training was well organized	5.19	0.62	5.02	0.69
The content delivered during the training was easy to understand	5.17	0.58	5.18	0.49
I will use the training handouts as a future resource	5.02	0.72	4.73	0.84
I found the content covered in the training to be highly relevant to my work	5.04	0.68	4.96	0.64
I will use the knowledge that I learned in the training	5.09	0.68	5.10	0.51
I will use the strategies that I learned in the training	5.09	0.62	5.04	0.61
I would recommend this training to others	4.96	0.73	4.76	0.71
I could use more instruction in the training content	4.17	1.10	3.81	1.15

Note: Higher scores are better. Range for scoring was 1 to 6.

Next steps: Continue to refine the professional development sessions and materials provided to school personnel at the elementary and secondary levels based on feedback and evaluation findings. Continuously provide the opportunity of these trainings to all school personnel in the Boone County schools.

Goal 2: Develop and implement a county-wide ecological assessment system to gather data on risk and protective factors that are predictive of poor school, mental, and life course outcomes

A county-wide assessment system has been developed to quickly and efficiently determine county, district, school, grade level, and individual level areas of risk from teachers reporting on a series of important risk indicators known to be linked to academic, behavioral, emotional, and social problems in youth. The teacher checklist is a quick yes/no response to a series of mental health related items for each student in their classroom. See Figure 1 for a screenshot of the current version of the online early identification system.

Piloting of the Teacher Checklist. Between January 2015 and June 2015 the teacher version of the early identification system was piloted for **1,235 students grades K-12**. A total of **62 teachers** completed the online assessment to evaluate the functionality, feasibility, and utility of the system. Middle school and high school teachers completed the assessment for all students in their grade, providing up to 8 responses per student.

These data from the pilot of the teacher checklist were factor analyzed to determine the overarching constructs of risk for the assessment. The factor loading identified included 1) attention and academic competence, 2) peer relations and social skills, 3) internalizing behaviors, 4) self-regulation and externalizing behaviors, and 5) general risk indicators (e.g., academic readiness, behavior readiness for grade, suicidal statements, and teacher report of struggling with the student).

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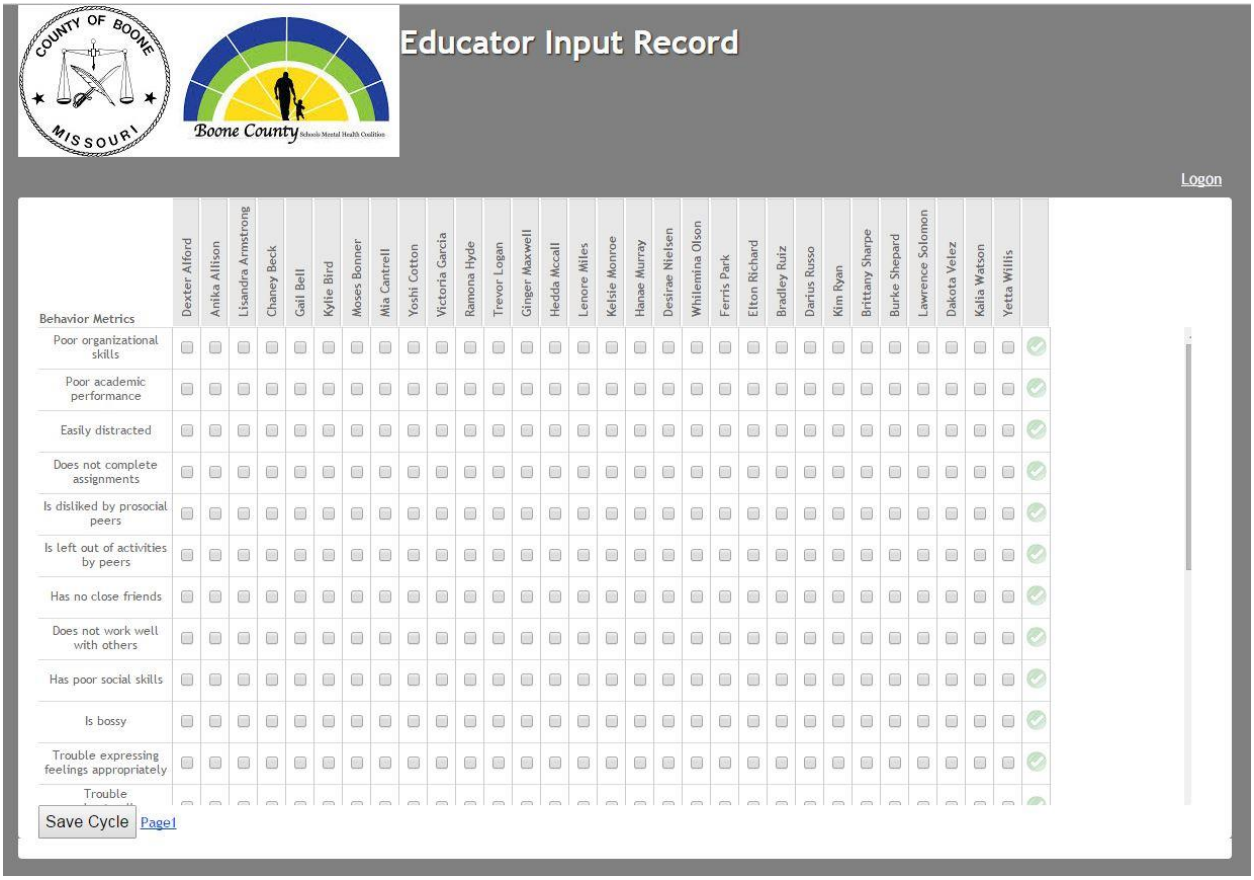
Figure 1. Screen Shot of Teacher Checklist



Beginning in September 2015, teachers from school across Boone County completed the checklists on students in their classrooms. The checklist is associated with a clinical dashboard which provides schools reports showing the number of students reported to have each risk indicator. Using a public health model of risk to provide schools feedback on areas of need for universal prevention efforts, school reports indicating areas of high risk (i.e., 20% or more of students were reported to have this risk indicator) are represented in red, areas with some risk (15-19% of students are reported to have the risk indicator) are represented in yellow, and areas with low risk (less than 15% of students are reported to have the risk indicator) are represented in green. These data can then be used by school level problem solving teams to assess areas of concern at the school and grade levels and determine if and what universal prevention efforts can be put into place (see sample school level report). In addition, individual student reports are generated using a similar red, yellow, and green system to indicate students who in comparison to their peers are at risk across the various risk constructs. These reports can be used to determine the appropriate next steps toward supporting those students at greatest risk (e.g., develop individualized behavior support plan, small group counseling, etc).

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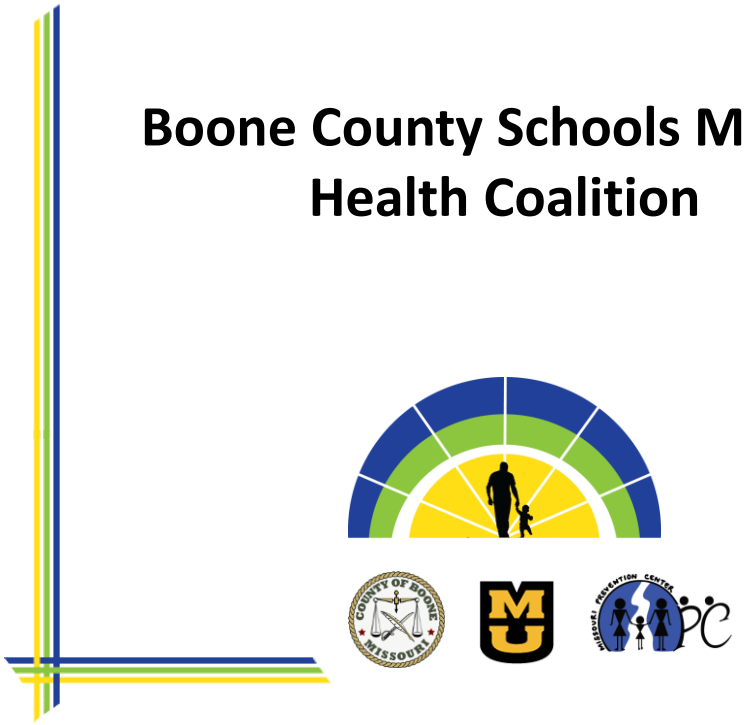
County-wide Data:

The first round of teacher checklist data were completed. **Data were provided for a 22,842 students, 50 schools, and 6 school districts and one private school.** The following PowerPoint link (double click to view) provides an overview of the county-level findings by grade level across each area of risk. In addition, the percentage of youth in the county with elevated risk on each area are provided. Many schools are completing the second round of teacher data and these data will be summarized later.



Summary: The greatest area of risk identified by the first round of teacher checklist data was attention and academic competence. Across grade levels this area reported the highest numbers of youth with risk on these indicators. This is an important findings because youth who struggle with attention problems and poor organization and planning (poor executive functioning skills) often fall behind in schools. *The link between attention and academic competence and mental health issues cannot be overstated.* Attention problems and poor executive functioning are risk factors for depression due to the links of this risk with persistent academic failure over time (Herman, Lambert, Reinke, & Ialongo, 2008). Further, school failure leads to a cascade of problems including disengagement in school, conduct problems, affiliation with deviant peers, and school drop-out (Reid, Patterson, & Snyder, 2002). Thus, training school personnel in how to promote execute functioning skills to prevent school failure in youth across all grade levels can prevent depression and disruptive behaviors in our youth. Further, the co-occurrence of academic and social behavior problems have been documented (Reinke, Herman, Petras, & Ialongo, 2008) and catching these early can prevent a host of negative outcomes, including depression, substance use, conduct disorder, drop-out, and arrest (Darney, Reinke, Herman, Stormont, & Ialongo, 2013).

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The second greatest are of risk identified was in the area peer relations and social skills. This was particularly relevant to youth in grades 6 through 9. Although early adolescence is a period in which many youth seem socially awkward, the checklist system identifies youth who are at risk in comparison to their peers. These youth are therefore exhibiting challenges in this are more so than their fellow peers in the same schools. Issues with social competence are related to both depression (Cole, 1990) and disruptive behavior problems (Cole & Carpentieri, 1990). Further the co-occurrence of social behavior problems and depression have been documented to lead to other negative outcomes, including substance use and arrest (Reinke, Eddy, Dishoni, & Reid, 2012). Therefore attending to teaching social skills and expressing and understanding emotions are important life skills that can help to prevent later mental health problems in youth.

Several other areas stood out differentially across developmental periods including elevated internalizing symptoms for middle school and high school youth. We anticipate that findings from the student checklist will provide additional information with regard to the issues related to depression and anxiety among our youth. Lastly, while self-regulation and externalizing problems were not highly elevated within out sample, those youth who do display these issues should be targeted for intervention support given the negative outcomes associated with lack of self-control and disruptive behavior problems.

Cole, D. A. (1990). The relation of academic and social competence to depressive symptoms in childhood. Journal of Abnormal Psychology, 99, 422-429.

Cole, D. A., & Carpentieri, S. (1990). Social status and the comorbidity of child depression and conduct disorder. Journal of Consulting and Clinical Psychology, 58, 748-757.

Darney, D., Reinke, W.M., Herman, K.C., Stormont, M., & Ialongo, N. (2013). Children with co-occurring academic and behavior problems in 1st grade: Distal outcomes in 12th grade. Journal of School Psychology, 51, 117-158.

Herman, K. C., Lambert, S. F., Reinke, W.M., & Ialongo, N. S. (2008). Low academic competence in first grade as a risk factor for depressive cognitions and symptoms in middle school. Journal of Counseling Psychology, 55, 400-410.

Reid, J. B., Patterson, G. R., & Snyder, J. J. (2002). Antisocial behavior in children and adolescents: A developmental analysis and the Oregon model for intervention. Washington, DC: American Psychological Association.

Reinke, W.M., Eddy, M., Dishion, T, & Reid, J. (2012). Joint trajectories of symptoms of disruptive behavior problems and depressive symptoms during early adolescence and adjustment problems during emerging adulthood. Journal of Abnormal Child Psychology, 40, 1123-1136.

Reinke, W.M., Herman, K.C., Petros, H., & Ialongo, N. (2008). Empirically-derived subtypes of child academic and behavior problems: Co-Occurrence and distal outcomes. Journal of Abnormal Child Psychology, 36, 759-777.

Use of Data in Schools:

The teacher checklist data were shared with school administrators and school-based problem solving teams. From these data building identified interventions to help support students individually, in small groups, or on a larger scale such as school-wide, class-wide, and grade-wide. In some cases this may have included referral to an outside agency. Regional coordinators worked with the school-based teams to help with data-based decision making, selection of interventions, support with implementing the interventions, monitoring progress of interventions, and coordinating services with outside agencies. See Figure 2 for the steps in the problem solving and early identification process.

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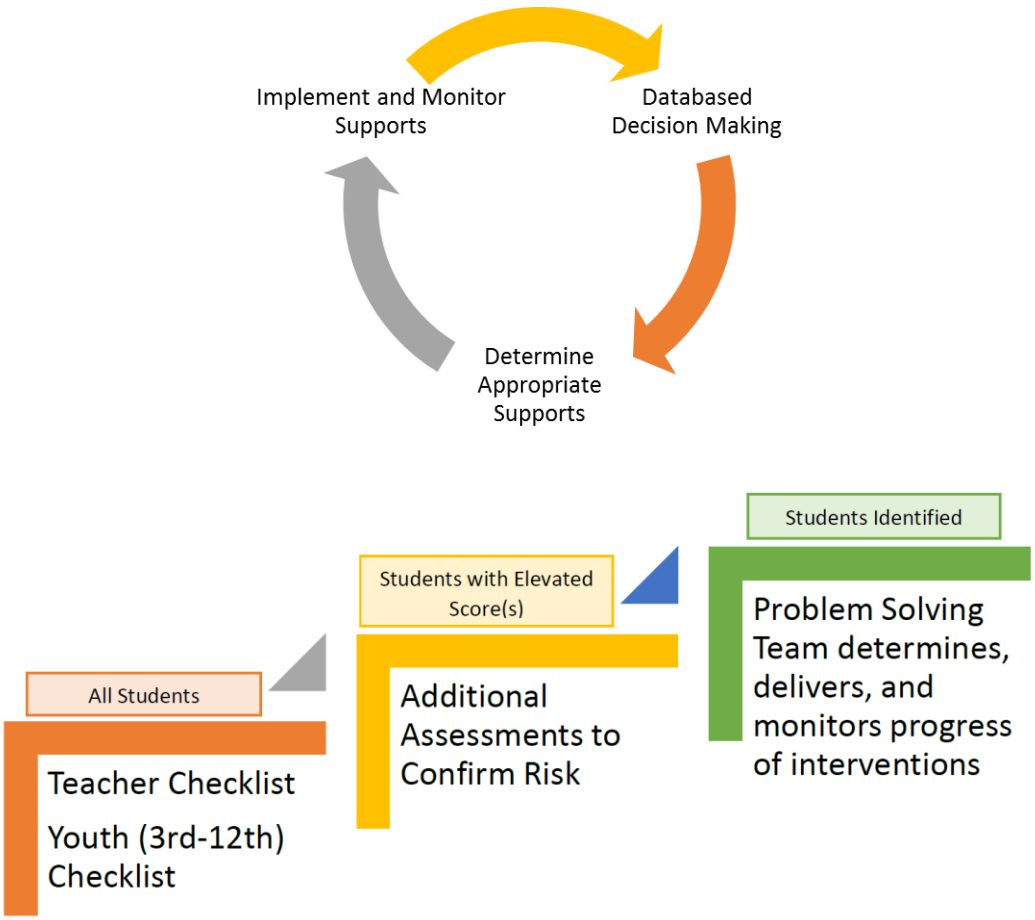
Figure 2. Problem Solving and Early Identification System Process



Intervention Services Provided:

As a result of the checklist data **at least 1,850 youth have received an intervention to support their social behavioral or emotional health.** This is a conservative estimate as we are still working to adequately document the services provided by the regional coordinators and graduate level practicum students working in Coalition schools. The table below provides a summary of the number of youth across the 51 school buildings in the Coalition who received or are receiving an evidence-based intervention based on data from the teacher checklist. The numbers are broken down by elementary, middle, and high school. In addition, the target area of the intervention is provided. Lastly, the level of the intervention for students within each target area is provided. Universal indicates that a school-wide, class-wide, or grade-level intervention was provided. Selective interventions are more intensive and occur with a smaller group of students. Indicated interventions are the most intensive and are at the individual level.

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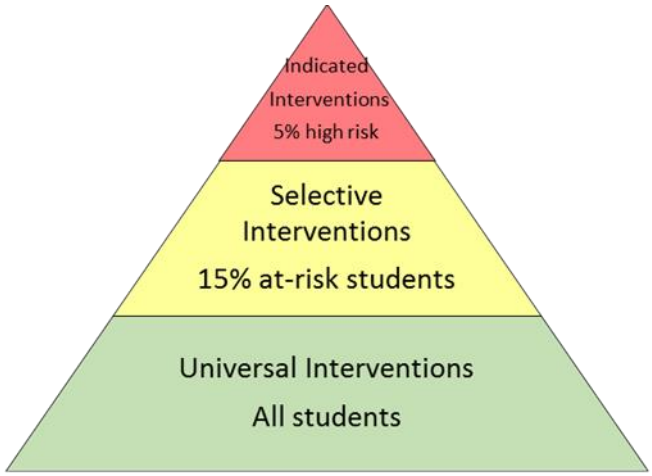

Note: The interventions were directly linked to data provided by the teacher checklist and evidence-based strategies and interventions were employed in schools based on these data. The following provides detailed information about the purpose and skills targeted by each intervention focus area.

Focus Areas**:**

Attention and Academic Competence interventions focus on increasing executive functioning, on-task behavior, planning, and organizational skills in youth.

Peer Relations and Social Skills interventions focus on increasing relationship, communication, and problem solving skills in youth.

Internalizing Problems interventions focus on using cognitive behavioral strategies for decreasing anxiety and/ or depressive symptoms in youth as well as improving self-esteem.

Self-regulation and Externalizing interventions focus on impulse control, goal setting, problem solving, emotion recognition, and anger control strategies to decrease disruptive, impulsive, and aggressive behaviors in youth.

Intervention Level	Focus of Intervention	Student Age Level	Number Students Served
Universal	Attention and Academic Competence	Elementary	280
		Middle	63
		High	166

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Selective	Attention and Academic Competence	Elementary	69
		Middle	24
		High	1
Indicated	Attention and Academic Competence	Elementary	6
		Middle	1
		High	1
Selective	Peer Relations and Social Skills	Elementary	136
		Middle	44
		High	15
Indicated	Peer Relations and Social Skills	Elementary	8
		High	2
Selective	Internalizing Problems	Elementary	44
		Middle	19
		High	4
Indicated	Internalizing Problems	Elementary	9
		Middle	23
		High	10
Universal	Self-Regulation & Externalizing Problems	Elementary	572
Selective	Self-Regulation & Externalizing Problems	Elementary	133
		Middle	10
		High	24
Indicated	Self-Regulation & Externalizing Problems	Elementary	89
		Middle	33
		High	42
Indicated	Outside Referrals to Other Agencies (*note: this is underestimated here due to lack of data*).	All Ages	22
Total Youth Served Since August, 2015			**1850**

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We requested feedback from our Coalition schools in efforts to refine practices and inform our work. Forty-six out of fifty schools replied to the survey. The average ratings across consumer satisfaction items are provided below.

Question:	Average Rating (lower scores are better)
How important is the work the Coalition has been providing in your school?	1.76
Overall how satisfied have you been with the work of the Coalition in your school?	1.67
How useful has the data from the teacher checklist been in identifying the needs of students in your school?	1.96
How useful has the data from the checklist been in determining what school-level supports?	1.98
How helpful has your Coalition Regional Coordinator been in interpreting the data from the checklist?	1.75
How helpful has your Coalition Regional Coordinator been in supporting the development and implementing supports in your school?	1.85

Note: Lower scores are better. Scale was 1 (very important/ helpful) to 5 (very unimportant/ unhelpful).

In addition to this survey, Dr. Lou Ann Tanner Jones is meeting with building administrators to garner additional feedback and suggestion for our ongoing work. She will be meeting over the next few months and will summarize the findings.

Student Checklist:

A total of 2,069 students in grades 3 to 12 have completed the student checklist. These data have been provided back to the schools to guide interventions. These data are pilot in nature and will be analyzed over the summer to determine the factor structure and whether some items can be removed. The goal is for schools to complete both the teacher and student checklists three times per year. Several schools have or plan to conduct a second round of student checklist data this year. We hope to have student data from the large majority of our schools in the coming months.

Development of High-risk Assessment System:

Youth in Boone County placed in alternative settings do not benefit from the teacher and student checklist developed for the larger population because the checklist would provide little additional information to help support these youth. As a result, Lauren Henry, a doctoral student in school psychology developed an assessment system for student placed at CORE, Columbia Publics alternative school setting. Both teachers and students completed the assessment. The assessment provides information across the following constructs: 1) Respect for authority, 2) Emotional regulation, 3) Goal-focused orientation, 4) Academic engagement, 5) Positive relationships with peers and adults, 6) Communication, 7) Conflict resolution skills, and 8) Life satisfaction. Data from these assessment are then used to guide a tiered model of interventions within the building. School level and student level reports were provided to determine interventions to support these students across these important indicators of successful transition back into standard educational settings. The resulting intervention included receiving universal social skills for all students. In addition, small groups for student with anger control and depression were formed based on these data. Lastly, all students (n= 50) received an MU graduate student mentor who meets with them either once or twice weekly. Mentors use a goal setting and self-monitoring intervention infused with

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Motivational Interviewing to support students and work on skills related to the identified areas of need by the assessments. The assessment will be completed again at the end of the year.

Next steps include:

1) *Develop a systematic process of ongoing evaluation and progress monitoring for youth receiving interventions.* We have learned a lot this year. The data for the checklist were used to identify and intervene across large numbers of youth in our schools. We realize that a systematic common data collection procedure for pre-post evaluation and progress monitoring in the building will provide us with additional information to monitor the social emotional and behavioral health of youth in Boone County. The idea would be to use a common assessment system across each area of risk and a common measure for progress monitoring over time. The specific measure will be determined this summer. Our work with MU has offered us an opportunity to access a dashboard progress monitoring system, called DBR connect. Dr. Riley-Tillman, the director of assessment and measurement with the Missouri Prevention Center is the developer of DBR progress monitoring tools and is able to offer the Coalition free access to this tool.

2) *Refine the student checklist and reporting system.* Using data gathered this year from the student checklist we will determine the factor structure and build in an automated reporting system for schools to use these data to determine supports and evidence-based intervention by school-based teams.

3) *Develop a comprehensive assessment, progress monitoring, and intervention menu of options for each area of risk of the teacher and student checklist.* We have started but plan to finalize a manualized procedure for using checklist data that leads to a menu of pre-post assessments, progress monitoring tools, and intervention options across grade levels. We will work directly with school-based mental health practitioners to finalize these procedures. The menu of options will be provided to schools and used within the school-based teams to make informed decisions about use of evidence-based assessments and intervention within each risk domain.

4) *Develop a systematic process for tracking the number of students receiving interventions and types of interventions in relationship to checklist data*. We have learned a great deal from our work with the schools this year. We plan to develop a more systematic process for clearly determining the number of students who are impacted by the work of the Coalition. We have already begun the process and will continue to refine over the coming months.

5) *Submit external grants for supplemental funding to support further development of the early identification system.* To support the refinement and ongoing development of the early identification system which links school-based teams to evidence-based interventions **we are re-submitting a grant proposal to the Institute for Education Sciences (IES) in August, 2016.** We submitted the proposal last year and it was not funded. This IES proposal resubmission entitled, *Creating a Comprehensive Data-based Coordinated System of Care for School Districts to Promote Youth Academic Success and Social Emotional Development: A Researcher-Practitioner Partnership*, would support validation of the early identification system with the goal of the Coalition having a stand-alone assessment system that would not require external standardized second gate assessments, which can be costly. **This IES proposal, should it be funded, would span 2 years and provide $400,000 in support for the development, implementation, and validation of all assessments needed for the early identification system.**

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Goal 3: Provide professional development to school personnel in Boone County in evidence-based practices shown to improve school climate and individual student and family functioning.

Goal 4: Train school-based teams to implement evidence-based programs with at-risk and in-risk youth, and use data to monitor progress of student outcomes.

Each Regional Coordinator has been working with problem solving teams within their assigned school buildings. They are demonstrated how to interpret and utilized the checklist data with these teams. In addition, the checklist data has been used to identify topics for professional development and consultation that the Regional Coordinators, graduate practicum students, and Coalition personnel have been involved in providing. The following table summarizes the number of school personnel trained and the focus topic of the professional development training.

Professional Development Focus	Number of School Personnel Trained
Attention & Academic Competence - Executive Functioning, Planning and Supporting Organization for students	179
Self-regulation and Externalizing Problems – Managing Disruptive Behavior, Classroom Management, and Behavior Support Planning	103
Identifying and Supporting Mental Health Needs in Youth	376
Motivational Interviewing – Engaging families and youth	90 (Counselors, outreach counselors, school psychologists)
Total Trained Since August, 2015	**748**

Next Steps: We will continue to provide professional development topics related to areas identified from the checklist data. In addition, we will develop a systematic process for evaluating the effectiveness of these trainings. For instance, it would be interesting to determine change in teacher and school personnel practices following a professional development topic is provided. Over the coming months we will develop a subtask group to determine how to evaluate the outcomes of the professional development provided.

Goal 5: Improve the coordination of information and services for at-risk youth and their families.

We have monthly meetings with the Burrell and MU Psychiatry Bridge (Dr. Lane Young-Walker) school-based projects that were also funded by the Children's Services Board. The purpose of the meetings has been to foster collaboration between the projects, overcome barriers, and avoid duplication of services.

In addition, referrals to appropriate community services have been offered to families with students identified as needing more intensive mental health services. Our teams also work collaboratively with the many other agencies and entities that are implementing programming in the schools (e.g., Burrell, Mental Health Foundation, Positive Behavior Interventions and Supports, National Center for Intensive Interventions).

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Goal 6: Develop child-centered and family based wrap-around service plans for in-risk youth.

Goal 7: Improve the effectiveness and follow through of referral services stemming from assessment driven wrap-around plans for youth and their families through a case management model.

Regional coordinators have been trained in wrap around case management. Data tracking and monitoring forms have been developed. The Regional Coordinators have begun piloting the wrap around process with a few youth in our Boone county Schools. However, the capacity of schools to provide wrap around services has been quite limited. While there are a number of youth who would benefit from wrap around case management, few individuals in the schools have adequate time distribution (including our Regional Coordinators) to adequately provide wrap around services. Further, many of youth in need of this service already receive case management services from other outside agencies. Lastly, we believe our original proposal overestimated the number of youth and families in our school buildings appropriate for intensive wrap around services.

Next Steps:

1) *Obtain training grants focused on training graduate clinicians in wrap around with youth.* We currently have a training grant under review with the U.S. Office of Special Education that would fund a combination of social work and school psychology students to be trained in wrap around and who would provide wrap around services. Should this be funded it would provide up to 6 students per year for five years (with 20 hours per week) who could conduct wrap around services, greatly increasing our capacity to provide wrap around services.

2) Refine out school-based wrap around process. We will revisit the wrap process at the end of the school year from our experiences with Regional Coordinators piloting the forms and processes with youth in our schools. In addition, we will determine using checklist data to determine the more likely number of youth who would benefit from wrap around services.

3) *Work toward policy change that will re-allocate time of existing school-based practitioners to conduct wrap around with youth in need of these services*. For most schools, school personnel who would be potential targets for proving wrap around services, time allocations of their expected duties prevent them from having adequate time to devote to wrap around. In other instance, the schools do not have personnel in buildings who could provide wrap around. Thus, we will have discussions and collect data on the need for re-allocation of time toward supporting youth in need of school-based wrap around services.

Products

- We have developed the online teacher and student checklists for the early identification system. We will automate the student reports over the summer.
- We have developed an assessment system for high risk youth in alternative school placements and tailored mentoring intervention.
- We have developed problem solving process forms that school-based teams utilize to document the problems solving process with students in their schools.
- We have developed automated excel files that allow school-based teams to review data and track interventions and assessments of students identified as having risk within the early identification system.

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- We have developed forms and procedures for conducting school-based wrap around with youth.
- We have developed elementary and secondary versions of *Identifying and Supporting Youth with Mental Health Problems*.
- We have developed professional development sessions on helping students with executive functioning, helping teachers with classroom behavior management, supporting schools in developing behavior support plans, working with students with severe behavior problems, and using Motivational Interviewing with families, youth, and school personnel.
- We have developed dissemination brochures for parents and school personnel.
- We have developed a Boone County School Mental Health Coalition website: BCschoolmentalhealth.com
- We will resubmit a grant proposal to the Institute of Education Sciences (IES) entitled, *Creating a Comprehensive Data-based Coordinated System of Care for School Districts to Promote Youth Academic Success and Social Emotional Development: A Researcher-Practitioner Partnership* to fund a 2 year project and provide $400,000 in support for development, implementation, and validation of all assessments associated with the early identification system. This proposal will be submitted in August.
- We submitted and are awaiting a decision on funding for a training grant proposal to the US Office of Special Education entitled, *Interdisciplinary Training to Build Capacity to Support Students with EBD*, to train social work and school psychology students in school-based wrap around services with youth.

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