February 2002

First-Year Implementation of The Palm Beach County Children's Behavioral Health Initiative

Chapin Hall Center for Children at the University of Chicago

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Last but not least, we would like to thank the Quantum Foundation for generously supporting the first-year evaluation of the Initiative.

Information

For more information about the School Behavioral Health Program or the evaluation project, please contact Seth Bernstein, School Behavioral Health Administrator at the Health Care District of Palm Beach County, at (561) 659-1270, or Bong Joo Lee, Principal Investigator of the evaluation project, at (773) 256-5156.

Introduction

The Program

The goal of the Children's Behavioral Health Initiative (BHI) in Palm Beach County is to promote positive behavioral health for children by providing early detection and intervention assistance through public schools to children and families who are in need of social, emotional, and/or behavioral health services. The central point of contact for the initiative is the full-time Behavioral Health Professional (BHP) situated in each school setting, who works under the supervision of the Health Care District of Palm Beach County. The main tasks of the BHP are providing early identification and referral services as well as follow-up and direct early intervention services. In the process of providing supportive services, the BHP works not only with children but also with parents, school staff, the school nurse, and community service providers. Currently, the main emphasis of the initiative is to provide early identification and intervention services to children in kindergarten and first grade.

The First Year

The Behavioral Health Program in Palm Beach County was fully implemented in fifteen pilot elementary schools in the County in school year 2000-2001. Because the fifteen schools were to serve as pilot schools in the first year of the initiative, the original intent was to identify schools that were somewhat representative of all elementary schools in the county, and in which the school administration was amenable.

The pilot schools are the following:

Group 1	Group 2	Group 3	Group 4	Group 5
Glade View	Barton	Allamanda	Hagen Road	Indian Pines
Pioneer Park	Egret	Golden Grove	J.C. Mitchell	Kirklane
Rosenwald	Pine Grove	Palm Beach Gardens	Jupiter	South Olive

In the fifteen pilot schools, 34 percent of kindergartners and first graders were white, 38 percent black, 21 percent Hispanic, and 7 percent were other racial/ethnic background. The majority of the children (63%) were from families eligible for the free or reduced-lunch program, and 29 percent of kindergartners changed schools from school year 1999-2000 to 2000-2001. Twenty-seven percent of children were in

the Limited English Proficiency Program. Very few kindergartners and first graders were in the Learning Disabled, Language Impaired, and Speech Impaired programs, 1, 5, and 4 percent respectively (see Figure 1). Overall, the average child, family, and school characteristics for the fifteen schools are comparable to the elementary school profiles for Palm Beach County as a whole. This indicates that the fifteen schools have some potential to represent all elementary schools in the County.

Figure 1. *Characteristics of the 15 Pilot Schools (Grades K-1) for the First Year of the Initiative (2000/2001)*

	Group 1	Group 2	Group 3	Group 4	Group 5	15-School Total	County Total
Total Number of Children (Grades K-1)	540	749	721	557	934	3,501	23,315
				Percent (%)			
Race/Ethnicity							
White	1	11	69	53	39	34	44
Black	86	62	11	10	20	38	29
Hispanic	13	18	12	28	33	21	19
Other	1	9	8	9	8	7	8
Receiving Free/ Reduced Lunch	95	81	32	43	61	63	50
Kindergarten School Mobility*	29	39	22	23	27	29	29
Limited English Proficiency Program	22	37	9	32	34	27	20
Learning-Disabled Program	1	1	1	1	1	1	1
Language-Impaired Program	11	4	4	5	3	5	4
Speech-Impaired Program	3	3	6	4	4	4	4

Percents may not add up to 100% due to rounding.
*Percent of kindergartners who changed schools from school year 1999-2000 to 2000-2001.

Although their characteristics are very close to the profiles for the county as a whole, further analysis of the characteristics revealed that the fifteen schools can be grouped into five distinctive groups, each representing a mix of students with different characteristics. For example, Group 1 schools have a majority of black children from families in poverty situated in rural neighborhoods, whereas Group 3 schools have a majority of white children from suburban areas with less poverty, and Group 5 schools have a racially mixed group of children in urban areas.

The First-Year Implementation Study

The Steering Committee of the Palm Beach County Children's Behavioral Health Initiative commissioned Chapin Hall Center for Children at the University of Chicago to do an evaluation study of the initiative's first-year implementation with funding provided by the Quantum Foundation. The goal of the first-year implementation study was to determine the following: Is the first-year implementation of the program strong enough to warrant expansion of the program to other schools, and undertaking a comprehensive child-level outcome evaluation? Detailed analysis of both quantitative and qualitative implementation data as presented in this report shows that the results were very positive.

The remaining chapters of this report summarize Chapin Hall's work conducted in the first year of the evaluation. The chapter "Early Assessment and Identification: Teacher-Child Rating Scale" provides analysis of early assessment results of the children through the T-CRS. "Service and Referral Activities of Behavioral Health Professionals" details the analysis of BHPs' daily service and referral activities. The chapter "Findings from Discussion Group Meetings" provides findings from discussion group interviews of Behavioral Health Professionals, principals, teachers, and other school staff. "Early Accomplishments" provides findings of the program's early impact on children's social and emotional health. Finally, the report ends with "Long-Term Child Outcome Evaluation Design" in which an overview of the current 3-year child-outcome cohort study is presented.

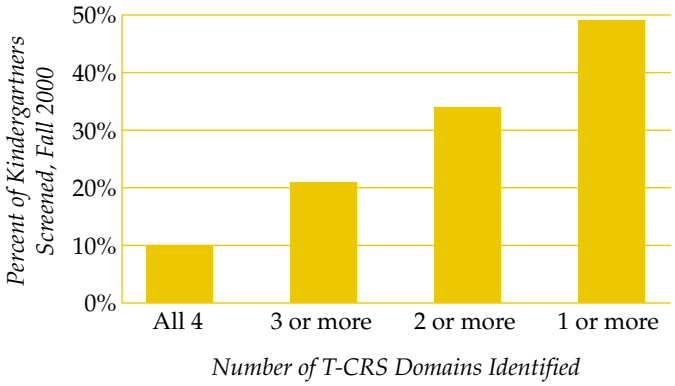
Early Assessment and Identification: Teacher-Child Rating Scale

An important aspect of the initiative is its emphasis on prevention of social, emotional, and behavioral maladjustment through early assessment and identification of needs among young children. The Teacher-Child Rating Scale (T-CRS) developed by the Primary Mental Health Project at the University of Rochester is the initiative's main tool for early identification of potential behavioral, social, and emotional health problems. The T-CRS is a short (32-item) observational rating scale designed specifically for teachers to use to assess children's school-related problem behaviors and competencies. The T-CRS assesses four domains relevant to a child's socioemotional adjustment: task orientation, behavioral control, assertiveness, and peer socialization.

Results of T-CRS Ratings

In the fall of 2000, a total of 1,587 kindergartners in the fifteen schools were assessed by their classroom teachers using the T-CRS. The results of the T-CRS screening show that somewhere between 10 and 49 percent of kindergarten students in the pilot schools were identified as potentially being in need of various supportive services. When the criteria are broadened to at least one domain area identified, about 49 percent of children were identified as potentially being in need of some type of services (see Figure 2). About 10 percent of the children were identified as potentially being in need of services in all four domains.

Figure 2.
Kindergartners Identified as Potentially Being in Need of Supportive Services, by Number of T-CRS Domains



T-CRS Variations Across School Groupings and Sociodemographic Characteristics

Figure 3 compares average T-CRS scores across the five school groups. Low T-CRS scores indicate possible need for supportive services, and higher T-CRS ratings can

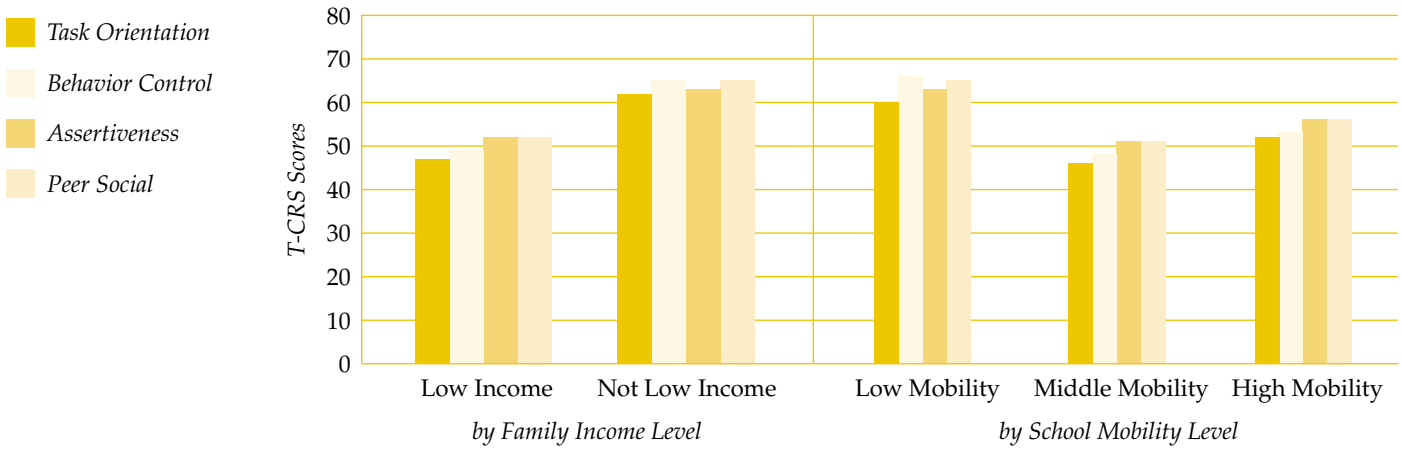
be interpreted as strengths or socioemotional competencies. Students from group 1 schools (black, high poverty, rural) tended to be rated lower and were more likely to be identified as needing supportive services, especially as indicated on the task orientation and behavior control scales. Children from group 3 schools (white, low poverty, suburban) tended to be rated as having above-average competencies across T-CRS domains.

Figure 3. *Average T-CRS Scores Across School Groups*

School Group	*N*	Task Orientation	Behavior Control	Assertiveness	Peer Socialization
Group 1	250	35	33	48	47
Group 2	337	54	56	58	56
Group 3	320	66	73	69	75
Group 4	258	57	59	55	57
Group 5	414	48	49	51	50

When the student family and school characteristics are examined, we find that, **overall, the students from low-income families and high student mobility schools showed lower T-CRS scores** (see Figure 4).[1]

Figure 4. *Average T-CRS Scores by Family Income Level and School Mobility Level*



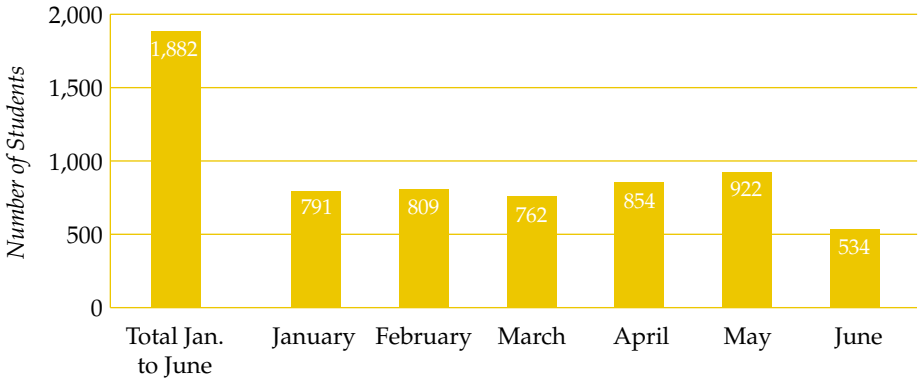
Service and Referral Activities of Behavioral Health Professionals

At the core of the Behavioral Health Initiative is the intervention of the Behavioral Health Professional (BHP), whose role has encompassed a wide spectrum of activities, from working with the individual child to working with teachers and school staff, parents, and outside agencies. In the following section, we summarize quantitatively the daily service and referral activities of the Behavioral Health Professionals based on data gathered from January through June of 2001 from the activity and follow-up forms filled out by the BHPs.

Summary of BHP Activities

During the 6-month period from January through June 2001, the BHPs worked with a total of 1,882 students in the fifteen schools. On average, the BHPs worked with about 780 students each month during the period (see Figure 5).

Figure 5.
Number of Students BHPs Worked with January–June 2001



The majority (about 63%) of the children BHPs worked with during the period were the program's primary target group: kindergartners and first graders. Although the focus of the intervention was on the children in these two grades, a fair amount of activity occurred with the other grades. Eleven percent of students were in a summer enrichment PreK program. This activity finding shows that BHPs responded to the school's needs arising outside of their target groups.

On average, the BHPs worked with each child for 7 days during the 6-month period, implying repeated contact with individual children. Activity was highest for kindergartners, who worked with BHPs an average of 10.7 days per child. BHPs worked with first graders an average of 6 days per child (see Figure 6).

Figure 6. *BHP Activity Summary*

Grade	Number of Students	Percent of All Students (%)	Number of Activity Days	Average Number of Days Per Student
K	689	36.6	7,398	10.7
1	524	27.8	3,121	6
2	130	6.9	524	4
3	98	5.2	446	4.6
4	115	6.1	461	4.0
5	110	5.8	409	3.7
Pre-School	203	10.8	581	2.9
Unidentified	13	0.7	23	1.8
Total	1,882	100	12,963	6.9

Presenting Problems and Service Needs of Kindergartners and First Graders

Each time the BHPs completed an activity form, they noted each child's problem or reason for being seen. Results in Figure 7 indicate that the most frequently noted presenting issues were behavioral issues (54%), followed by emotional adjustment (41%), and peer socialization issues (41%).[2]

The 689 kindergartners with whom the BHPs recorded working represent about 44 percent of all kindergartners in the fifteen schools.

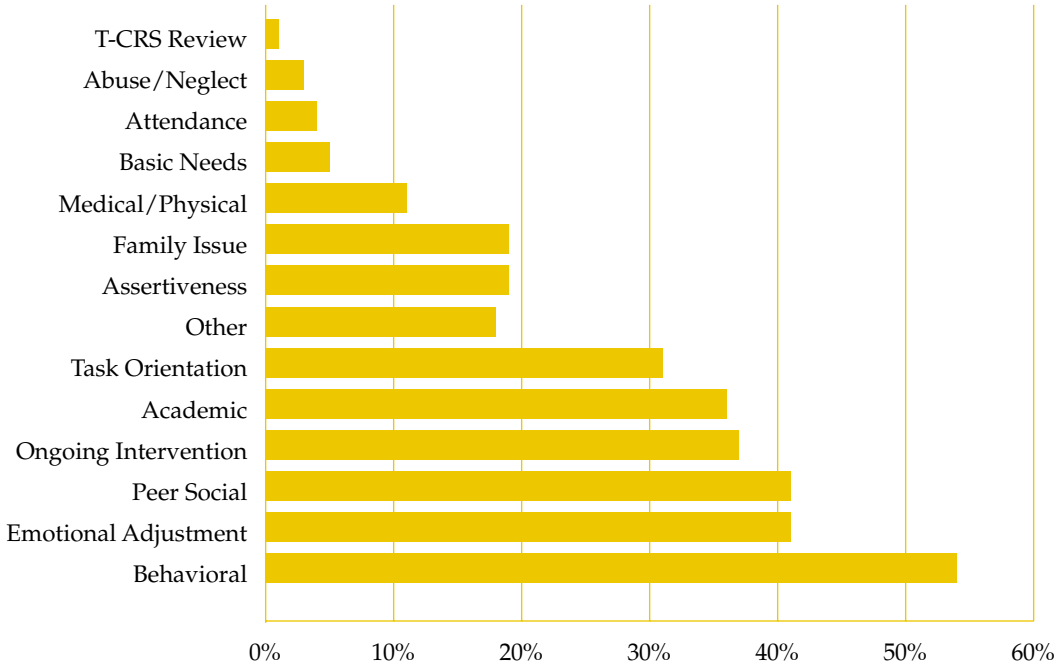


Figure 7.
Distribution of Presenting Issues for Kindergartners and First Graders

In Figure 8, we compare the frequency of presenting clinical issues across schools and school groupings. Children from different school groups show considerable variation. A higher proportion of children in group 1 schools presented with all except family issues. Children from group 3 and 4 schools were more likely to present with family issues. Variability across schools on peer, family, and other issues may be explained in part by contrasting school and family characteristics. Alternatively, variation in presenting issues may in part be explained by different sensitivity to these issues among BHPs.

Figure 8. *Comparison of Presenting Issues Across School Groups*

Percent (%)

School Group	*N*	Behavioral	Emotional	Peer	Academic	Task Orientation	Family	Assertiveness
Group 1	201	74	56	71	60	59	6	29
Group 2	278	49	43	22	37	11	10	9
Group 3	248	44	47	37	25	26	25	18
Group 4	256	47	33	48	27	30	20	22
Group 5	232	63	27	32	37	24	31	19
Total	1,215	54	41	41	36	31	19	19

Types of BHP Activities with Individual Students

The most frequently reported type of activity was monitoring and follow-up services. Figure 9 summarizes the frequency with which BHPs engaged in various activities.[3] Sixty-five percent of the children who were seen by a BHP had some monitoring and follow-up work with the BHPs. The next most common type of service provided was structured one-on-one meetings with a child outside of the classroom at 36 percent, followed by classroom support with 33 percent.

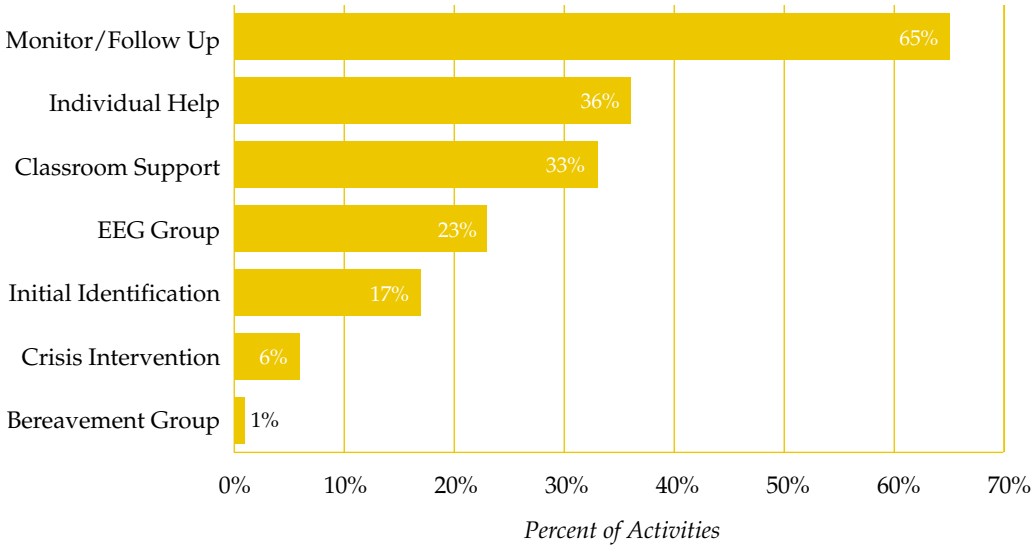
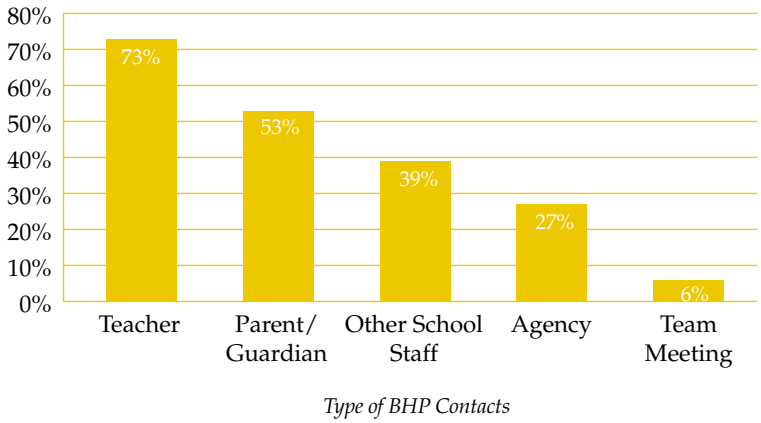


Figure 9.
Type of BHP Activities with Kindergartners and First Graders

BHP Contacts with Parents, Teachers, and Other Professionals

The BHPs' multifaceted role extended beyond the individual students to include contact with teachers, parents, other school staff, and outside agencies. Figure 10 shows that BHPs reported teacher contact for 73 percent of the kindergarten and first-grade children they had been working with.[4] They also contacted parents and/or guardians of 53 percent of the children they worked with during the 6-month period. They contacted other school staff, such as school nurses and guidance counselors, for service referral purposes for 27 percent of the children.

Figure 10.
Type of BHP Contacts for Kindergartners and First Graders



An important component of the Behavioral Health Program is referrals to and interventions by outside agencies. **A total of 397 children, about 21 percent of all the children BHPs worked with, were referred to outside agency services during the 6-month period.** The most frequent referrals were to counseling and one-on-one sessions for children through the Primary Project (see Figure 11).[5]

BHP Referrals to Outside Agencies

Figure 11.
*Number of Children Referred by BHPs to Services**

	Grade K-1st (*n*=282)	2nd-5th (*n*=115)
Counseling	97	53
Primary Project	56	0
Case Management	12	3
Child Protective Services	11	4
Medical Services	29	8
Self-Help or Support Group	22	5
Behavior Plan	7	3
After-School Program	4	3
School Nurse	17	1
Crisis Services	4	3
Legal Services	7	3
Psychiatric Consultation	8	3
Other	90	46

* Some children were referred to more than one service.

During the period, BHPs followed up on 620 referrals they had made and found that about 56 percent of the students and/or families had initiated the referred services.

Once a referral is made, BHPs follow up to ensure there is an appropriate service connection between the family and service providers. During February through June 2001, BHPs followed up on 620 referrals. Overall, these follow-ups revealed that 344 (56%) of the students and/or families had initiated the services to which they were referred (see Figure 12).[6] Of the 44 percent that were referred but did not initiate service, 93 (15%) were because the parent/guardian did not follow up on the referral. Fifty-three (9%) did not receive services for other reasons, and for 130 (21%) referrals, the service receipt status was not identified.

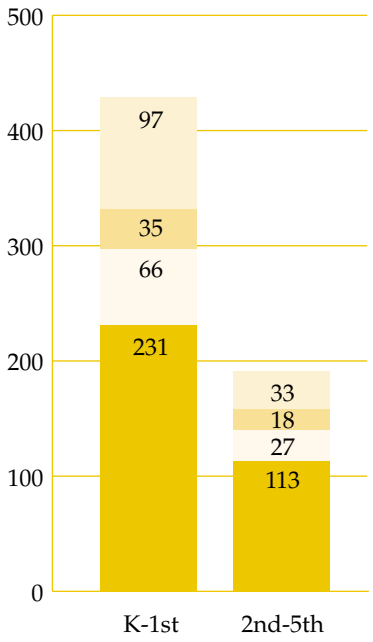


Figure 12.
Outcomes for Referred Services, February–June 2001

These results indicating high numbers of referrals to outside agencies and follow-ups highlight the importance of the BHPs' function in referring children and families in need to outside agencies. The data also indicate that in some locations parental cooperation was a significant problem in connecting the children and families to services. The BHP function as intermediary between teachers, parents, and outside agencies was repeatedly cited by administrators, teachers, and other school staff as a valued way that the BHPs were especially effective, as will be discussed in the next section of this report.

The primary goal of the discussion group interviews was to provide useful information about participants' experiences and any challenges they encountered as the initiative was being implemented.

Findings from Discussion Group Meetings

The meetings were held in West Palm Beach between April 3 and April 5, 2001. Chapin Hall staff led the four discussion group meetings, which included one group of the fifteen Behavioral Health Professionals, a group of fourteen kindergarten teachers from fourteen different participating schools, and a group consisting of school administrators, staff, and teachers from each of two representative schools.

In this section of the report, we highlight major themes and special issues that emerged across the four discussion group meetings relating to teachers', school administrators', and BHPs' experiences in the first year of implementation of the Behavioral Health Program.

Program Expectations

- When we asked teachers and school administrators how BHPs were welcomed into the schools, most respondents said the BHPs had been well received. BHPs were often described as tactful in their initial entry into the schools. One school staff member noted: "The BHP has been very professional, not taking over, a team player, and does not step on anyone's toes."

- Although there seemed to be substantial agreement on the basic expectations of the program and the BHPs' role, there was variation in details in terms of how the initiative was introduced across schools, how the school administrators implemented it, and how the teachers interpreted it. It was suggested that a comprehensive introduction and communication to school administrators and teachers well before the BHPs' arrival at the school would help school personnel to have a clear expectation of the initiative and the BHP's role.

Many participants used such phrases as "to connect" and "to facilitate" as a way of describing what the program was supposed to do.

One teacher reported: "The BHP is invaluable. She does the leg work out in the community, contacting parents, holding the child's hand, handling defensive, angry parents, connecting with outside agencies."

Role of the Behavioral Health Professional

- Discussion group participants repeatedly indicated that BHPs connected the child and/or family with needed services the school was not able to provide. This was considered an effective and highly valued BHP function.

- Many teachers and school administrators indicated that not being school board employees gives BHPs more "flexibility" in dealing with various situations that might require direct contact with parents and outside resources.

Behavioral Health Program Impact

- The impact on shy, quiet, introverted children was noted repeatedly. These students were observed to be breaking out of their shells in response to the intervention and were becoming more socially engaged and academically interested. Because these types of students were not disruptive to the classroom, they would not otherwise have received the needed extra attention.

- Although most of the feedback regarding the impact of the initiative was positive, participants from some schools described complex social barriers, such as extreme poverty and parents' drug abuse, that present additional challenges. BHPs who have been working at schools in higher-poverty areas reported larger social context issues that hinder effective intervention.

Another discussion group participant indicated that: "Intervening on the social dimension part first helps also to improve the academic performance. Some children are wrongly labeled as having reading blocks. The BHP helps getting to the real issue, whether it is social development, behavior disorder, environment deprivation, or disability. Hence, fewer children are being labeled as having a learning disability, and true learning disabilities are being identified earlier."

Service Linkage and Working with Parents

❖ As noted earlier, BHPs were often described as especially effective in making service recommendations and following up with parents, and at identifying agencies schools did not know about. The linkage problems were more prevalent in the schools in low-income communities. It was noted that a better network of services to which BHPs can refer the children in those areas is much needed.

Expansion of the Behavioral Health Initiative

❖ Virtually all school participants felt that all schools would benefit from the initiative. There was a strong consensus in favor of expansion to all elementary schools.

❖ In the schools where the initiative is being implemented, a number of participants indicated they thought it would be a good idea if the program were extended to second and third graders. However, teachers and BHPs all indicated that although it would benefit the children, BHP resources would be stretched very thin. Participants said that the BHPs might be less effective if they had to deal with so many more children.

One kindergarten teacher commented: "I would like to thank whoever came up with the idea for this initiative. I felt that the kindergarten grade is most often neglected while being the grade most in need of special attention and school resources. I am really excited about the needed attention this program is bringing."

Early Accomplishments

In the 2000-2001 school year, the T-CRS was administered in both the fall and the spring to the same children in order to conduct a preliminary evaluation of initiative impact. When the T-CRS scores are examined for children participating in the Educational Enhancement Group (EEG) (*n*=177) and all children the BHPs worked with on an individual basis (*n*=536), we find modest improvement, that is, higher levels of socioemotional adjustment on the T-CRS in the spring. For the children who participated in the EEG group, we find statistically significant improvements in task orientation and assertiveness areas.[7] For the children the BHPs worked with, we find statistically significant improvements in all four domains (see Figure 13).

Figure 13. *Comparisons of Fall and Spring T-CRS Results, by Subgroups*

Children in Educational Enhancement Groups (n=177)

Group	Task Orientation	Behavior Control	Assertiveness	Peer Socialization
	Mean (s.d.)	Mean (s.d.)	Mean (s.d.)	Mean (s.d.)
Fall 2000 testing	20.2 (9)	23.6 (9)	26 (7)	26.5 (8)
Spring 2001 testing	22.2 (8)*	24.4 (8)	27.2 (7)*	27 (8)

All children BHPs worked with from fall to spring (n=548)

Group	Task Orientation	Behavior Control	Assertiveness	Peer Socialization
	Mean (s.d.)	Mean (s.d.)	Mean (s.d.)	Mean (s.d.)
Fall 2000 testing	23.4 (10)	26.1 (9)	27.5 (7)	28.5 (9)
Spring 2001 testing	24.8 (10)*	26.7 (9)*	29 (7)*	29.3 (9)*

* $P < .05$

The analysis included only those with T-CRS ratings in fall and spring.

Despite these improvements, it is premature to make inferences about the overall impact of the program. Without any meaningful comparison group (i.e., those who did not receive the BHP services), the changes between the fall and the spring cannot be entirely attributed to the BHP services. They may, for example, be simply due to children's natural growth in each respective domain or to changes in teachers' perception of children's competencies over time. Nonetheless, the initial findings are encouraging. A further examination of how much these changes are due to the BHP services will need to be done in a future outcome evaluation based on a more rigorous research design (see the section on long-term outcome evaluation design in the report).

Results from analysis of fall and spring T-CRS show improvement in all areas.

Long-Term Child Outcome Evaluation Design

Based on findings of successful implementation of the program in its first year, Chapin Hall has embarked on a 3-year outcome evaluation of the program beginning with the 2001-2002 school year.[8] The purpose of this section is to give a brief outline of the long-term outcome evaluation activities planned in order to assess the initiative's impacts on individual children and families.

Overview of the Study Design

The study is a cohort study of a treatment group and a matched comparison group, where the study follows a representative cohort of all children entering kindergarten in the county in the 2001-02 school year through second grade. The basic premise of the study design is to compare outcome measures between the treatment group (at the schools where the BHI is implemented) and the matched comparison group (at the "similar" schools where BHI is not implemented) over time.

The treatment group is all children entering kindergarten in the 2001-02 school year in the initiative's fourteen original schools.[9] The comparison group is all children entering kindergarten in the 2001-02 school year in five selected non-BHI schools in the county. The goal was to select a comparison group similar to the treatment group in its baseline characteristics so that outcome measures can be compared between two "equivalent" groups, except for the fact that one group received the BHI program intervention and the other group did not.

Study Components

Several distinctive, interrelated study components are necessary to fully examine the impact of the initiative at different levels. The four components of the study are: (1) child outcome study; (2) parent survey; (3) teacher/administrator survey; and (4) BHP survey. We provide a brief overview of the study design and key measures for each component below.

Child Outcome Study

A critical component of the proposed evaluation study is to assess the impact of the initiative on children along a number of dimensions, such as children's social, emotional, and behavioral health, and academic adjustment. The outcomes assessed in this component of the study include the following:

The goal of the 3-year outcome evaluation design is to offer the most rigorous and scientifically valid strategy possible within the context of a quasi-experimental design to gauge the effectiveness of the initiative at three different levels: child, family, and school.

- Better social, emotional, and behavioral health, and academic adjustment in school
- Improvement in behavior and mental health condition of children
  - Improved problem-solving skills
  - Working well with peers
  - Improved behavioral control
  - Reduced feelings of depression
  - Improved self-confidence (i.e., increased assertiveness)
  - Feel more "accepted"
  - Decrease in discipline-related referrals
- Improvement in school achievement
  - Improvement in attendance rate
  - Reduction in retention rate in 4th grade
  - Improvement in task orientation (i.e., time on task)
- Contribute to improvement in FCAT scores

Child Outcome Measures

Social Rating Scale (SRS). The evaluation project will employ the Social Rating Scale (SRS) to evaluate the impact of the initiative on the social, emotional, and behavioral outcome domains specified above. The Social Rating Scale is a relatively short instrument (twenty items), completed by teachers, to assess children's social competence as related to learning. The essential domains assessed by the SRS include social interaction, self-control, approaches to learning, presence or absence of impulsivity/overactivity, and lonely/sad behavior.

One clear advantage of employing the Social Rating Scale is the fact that it is being used in the Early Childhood Longitudinal Study, a national study examining the ways in which children's early learning experiences and social development relate to academic achievement. This study, sponsored by the National Center for Education Statistics, U.S. Department of Education, began in 1998 and includes a nationally representative sample of a cohort of over 20,000 children who are being followed from grades K through 5. Data from the national study will be available for comparison with the Palm Beach County sample, which will add strength to the analysis of baseline child characteristics and the intervention effects.

School attendance rate. We will use the data on school attendance from the school district administrative database to track differences in the attendance rates over time between the treatment group and the comparison group.

Academic achievement. We propose to use two school achievement measures collected by the school district. At the beginning of the school year, kindergarten classroom teachers complete the Kindergarten Readiness assessment to provide baseline information on cognitive development of children. We will explore using the Kindergarten Readiness assessment results to get the baseline data on competence of the children before exposure to school environment and the initiative.

The school district also collects end-of-year performance data on second graders using a running reading record and a standardized reading test. In the 2000-01 school year, the district administered a computer-adaptive reading test called the SRI Interactive for second graders, and the school district plans to use it again in the 2001-02 school year. As the data from this standardized reading skill test will be available for our study population, we will use it to evaluate the impact of the initiative on improving children's academic achievement.

Parent Survey

The primary purpose of the survey is to gather descriptive information about parents' involvement and experiences in dealing with the children's social, emotional, behavioral, and mental health needs. The research questions addressed in the survey design will include the following:

- What are parents' experiences and the level of satisfaction working with schools?
- What is parents' perception of the usefulness of the services available both within the school and in the community?
- What is the level of parents' knowledge about available services both within the school and in the community?

Teacher/Administrator Survey

The primary purpose of the survey is to examine whether the initiative has an effect on the nature and level of teachers' and school administrators' awareness of students' nonacademic strengths and weaknesses.

BHP Survey

The survey will gather in-depth descriptive information on the functioning and experiences of the BHPs. The primary goal of the survey is to provide the initiative with useful information about any difficulties and/or challenges the BHPs encounter as the initiative is being implemented.

Data Collection Schedule

The data collection schedule for the long-term outcome evaluation study is intense and comprehensive. The following data collection schedule table summarizes key data collections planned for the study.

Data Source	Data	*School Year*					
		K		First		Second	
		Fall '01-02	Spring '01-02	Fall '02-03	Spring '02-03	Fall '03-04	Spring '03-04
Teacher	T-CRS	■		■			
	SRS	■	■		■		■
	Teacher/ Administrator Survey*		■				■
Parent	Parent Survey		■				■
BHP	BHP Survey**		■		■		■
School District Database	Attendance		■		■		■
	K-Readiness	■					
	2nd G Reading						■

* Teacher/Administrator survey in the spring of school year 2003-04 will be done for all teachers in kindergarten through second grades and administrators in the nineteen child outcome study schools (fourteen BHI and five non-BHI schools).

** BHP Survey will be done each year for all BHPs (including expansion schools) as a part of the implementation study.

Notes:

1 *Low income* is defined as those children who are receiving reduced/free lunch support.

2 In presenting this data, the individual children were characterized by the presenting issues. Because some children had more than one presenting issue during the period, individuals with multiple presenting issues were included in more than one presenting issue category.

3 For this analysis, if BHPs engaged in the same type of activity with the same student, it was counted only once.

4 The unit of analysis is the individual student counted only once for an activity related to these types of contact.

5 The Primary Project is a school-based program designed by the University of Rochester for early detection and prevention of emotional, behavioral, and learning problems. The Project provides a once-a-week intervention that includes a series of twelve 30-minute, one-to-one play sessions conducted by a trained paraprofessional under the direction of local community mental health centers and funded by the Picower Foundation.

6 The unit of analysis is the referral. A child could have had more than one referral during the period.

7 The EEG program is an early intervention group the BHPs provide to the group of identified children at the school setting by assisting them in achieving academic success, and/or modifying behavior, and/or increasing school attendance.

8 The first year of the long-term outcome evaluation project is being funded by the Quantum Foundation, the Children's Services Council of Palm Beach County, and the MacArthur Foundation.

9 Although there were fifteen schools originally, one of the schools, Hagen Road, has withdrawn from the program. Hence, for the remainder of this report, we will make reference to the fourteen original treatment schools.

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