Healthy Futures: Year One Evaluation Of Early Childhood Mental Health Consultation by the District of Columbia Department of Mental Health

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Executive Summary

The Department of Mental Health (DMH) recently completed the first year of implementing an evidence-informed mental health consultation project in 24 community based child development centers (CDCs). The Healthy Futures project is based largely upon a model developed by the Georgetown University Center for Child and Human Development (Cohen & Kaufmann, 2005). In this model:

- Four full-time, licensed mental health professionals provide on-site mental health consultation services aimed at building the capacity of directors and staff at CDCs to reduce challenging behaviors and promote positive social-emotional development.
- Consultants also help to identify those young children in need of more intensive services, referring them for evidence-based treatment groups, also offered by the Healthy Futures clinicians.

An evaluation of the Healthy Futures project was contracted for by the DMH with the Georgetown University Center for Child and Human Development. A random sample of 58 classrooms was selected for the in-depth data collection. The evaluation measured the frequency and intensity of the consultation services delivered and the impact of consultation on the social-emotional quality of the CDCs. Data were gathered from the consultants, child care directors and teachers from July 2010 to June 2011. The social-emotional climate of the classroom was assessed before the CDCs received Healthy Futures services and then again at the end of the school year. Additional data were collected and analyzed by a program evaluator for DMH. Key findings include:

- More than 1,200 young children had access to high-quality mental health consultation services in community CDCs in all areas of the city. Only 3 children were expelled from their CDC, a rate that is half the national average of 6.7 per 1,000 (Gilliam, 2005).
- Significant changes in teachers' behavior and classroom practices were seen in several areas including: staff awareness, children's peer interactions, more teaching about feelings and emotional problem solving skills, and a reduction in negative staff behaviors (e.g., shouting). Specifically:
    - There was a greater awareness by the teaching teams of potential conflicts and increased ability to avert these problems.
    - There was also a significant increase in positive child interactions; for example, more children appeared to be happy and well-adjusted and the children were more involved, well behaved, cooperative, and attentive.
    - There was a significant increase in teaching about feelings and problem solving; for example, teachers were more likely to help child label their feelings; and teachers were also more likely to promote children's use of language to prevent/negotiate conflicts.

    - Finally, there was a significant decrease in negative indicators of classroom climate; for example: staff placing unrealistic demands on child, or staff shouting at the children.
- CDC directors reported significant improvements in their staff's ability to manage challenging behavior, their knowledge of how to refer children and families for mental health services, and their comfort with mental health services.
- Teachers reported small but significant reductions in several areas of job stress.
- All of the CDC directors were completely satisfied with the Healthy Futures project, would recommend the program to their colleagues, and wanted to continue receiving the services.

The Healthy Futures project was funded initially through a combination of local funds provided by the office of the Deputy Mayor and federal Mental Health Services Block Grant funds. Recently, in partnership with the District of Columbia Department of Health (DOH), a federal grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) as part of Project LAUNCH became an important source of funding for year two of Healthy Futures.

Recommendations for the second year of implementation include:

- Add universal screening for social-emotional development for young children in the Healthy Futures CDCs; this will help identify children who need additional child-specific consultation services and referrals for developmental assessments.
- Build on the coordination with the Primary Project, an evidence-based early intervention implemented by DMH in five of the Healthy Futures CDCs in year one.
- Add an external, objective assessment of the changes in the classroom quality to increase the rigor of the evaluation measures.

The first year of the Healthy Futures implementation demonstrated excellent feasibility, acceptability and positive impacts across multiple measures and in many domains. The improvement in teachers' behavior and classroom practices enhance the school readiness of young children in the District of Columbia and improve the quality of the CDCs.

Early Childhood Mental Health Consultation as an Evidence-Based Practice

Strong evidence exists indicating that social and emotional skills are critical to school readiness, emphasizing the need for increasing efforts directed toward early identification of and intervention for mental health problems (National Academy of Sciences and Institute for Medicine, 2009) According to a landmark national study, a startling number of young children in the U.S. are being expelled from their preschool classrooms—the national average was 6.7 per 1,000. The rate of expulsions from state funded pre-kindergarten programs was roughly three times the rate of expulsions from K-12 programs (Gilliam, 2005).

Underlying this expulsion rate is a complex array of demographic trends that contribute to an increasing number of young children at early risk for early school difficulties. Young children are spending more hours in out-of-home care. High rates of staff turnover for early childhood professionals mean that there is a lack of continuity of care for very young children—undermining their attachment and social emotional development. A growing number of child care providers report struggling to address the mental health and behavioral needs of young children. In fact, help with children's challenging behaviors is the greatest need identified by preschool administrators and educators, who often have had little training in behavior management or ways to promote social and emotional competence (Yoshikawa & Zigler, 2000).

One of the models for building early care and education providers' skills and reducing problematic behavior in young children in child care that shows promising results is mental health consultation. (Cohen & Kaufmann, 2000; Donohue, Falk, & Provet, 2000; Johnston & Brinamen, 2006). Early childhood mental health consultation (ECMHC) aims to build the capacity of child care staff, families, and programs to prevent, identify, treat, and reduce the impact of mental health problems among children from birth to age 6 and their families (Cohen & Kaufmann, 2000). It involves a collaborative relationship between a professional consultant with mental health expertise and one or more individuals with other areas of expertise—most typically infant and early childhood education.

Early childhood mental health consultation models provide one on one consultation that can either target an identified child or focus on an entire child care classroom or program. In the former, child-specific consultation, the mental health consultant works with the early care and education provider and a child and their family to address the behaviors of concern in an individual child. The latter, often referred to as programmatic consultation, is intended both to improve the overall quality of the classroom environment, as well as to provide strategies to build staff capacity to address problematic behaviors or organizational problems that may be affecting multiple children.

A systematic review of more than 30 evaluations of early childhood mental health consultation conducted across the country showed evidence that these programs can lead to improvements in child level behaviors, changes in teacher attitudes and behaviors, and characteristics of the early childhood settings associated with higher quality care (Brennan, et al., 2008; Perry, et al. 2010). Reductions in staff turnover and expulsions from child care

were also seen across many of these studies. In addition, Gilliam (2005) reported that pre-kindergarten programs that had on-site early childhood consultants had lower rates of expulsion than those without access to this service.

Data from a recent national scan found that ECMHC is being implemented in some form in more than half of the states (Duran, et al., 2009). In 21 states, ECMHC is being implemented statewide while in other states, ECMHC services are available in only certain regions. This national study also examined six ECMHC projects that had demonstrated positive outcomes. The model for effective mental health consultation that emerged from the study is depicted in Figure 1. This model suggests that there are six core components—a mixture of structural and process components—that are important in the design of an effective ECMHC program (i.e., a program that achieves positive outcomes). The three structural components that were common to all six sites are: (1) solid program infrastructure; (2) highly-qualified mental health consultants; and (3) high-quality services. Each of these will be discussed briefly below.

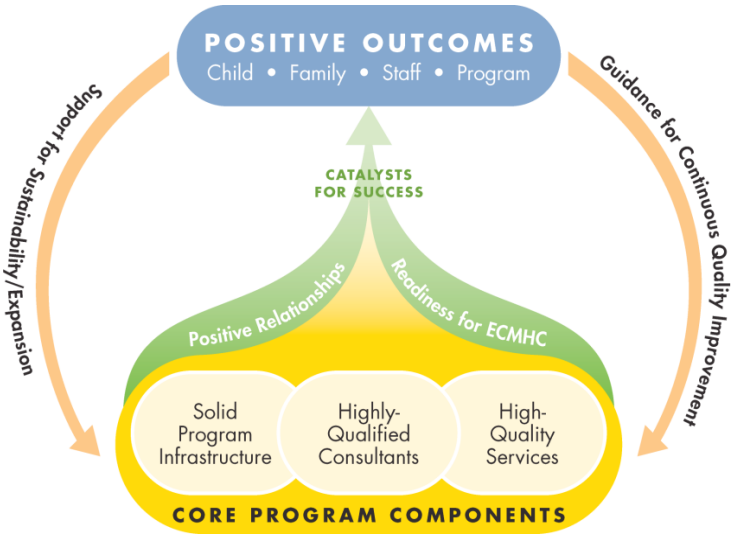


Figure 1. Model for Effective Early Childhood Mental Health Consultation (Duran et al, 2009)

Solid program infrastructure was exemplified by ten different elements: strong leadership, clear model design, clear organizational structure, hiring and training a high-caliber staff, supervision and support mechanisms for mental health consultants, strategic partnerships, community outreach and engagement, clear communication, evaluation and financing. Highly qualified consultants had a mix of education, content knowledge, skills and attributes. Specifically, these consultants had at least a master's degree in a mental health field and were well-versed in child development, infant and early childhood mental health. Further, effective consultants were respectful, compassionate, reflective and collaborative individuals who were skilled in relationship-building, communicating with children and adults, and motivating others to try new strategies and approaches. The third and final structural component was high-quality services. High-quality services were characterized by the availability of both child-centered and programmatic consultation. In addition to the structural components, three process components were identified: (1) positive

relationships between and among consultants and consultees; (2) readiness for ECMHC; and (3) the utilization of outcome data to guide continuous quality improvement (CQI) efforts and support program sustainability and expansion. The growing evidence base for the effectiveness of mental health consultation as an important component of school readiness contributed to the Department of Mental Health (DMH) decision to seek funding for a pilot effort in the District of Columbia.

History and Description of Healthy Futures

In 2007, the Mayors Advisory Council for Early Childhood Development convened a subcommittee to discuss the need to supplement early childhood development services and programs in the District of Columbia. The committee authored and disseminated a white paper on early childhood mental health; and this led to the DMH developing of a plan for early childhood mental health consultation efforts. DMH secured funding in 2009 from two sources: the Deputy Mayor of Education's office and the federal Mental Health Services Block Grant. The initial funding from the Deputy Mayor of Education's office and the Block Grant covered the cost of two early childhood mental health consultants as well as their supervision and an evaluation contract.

Partnering with the Department of Health, who had recently been awarded a federal grant from the Substance Abuse and Mental Health Services Administration through Project LAUNCH allowed the Healthy Futures project to add two more early childhood mental health consultants and also fund the local child wellness coordinator. The DMH funded an external evaluation contract with the Georgetown University Center for Child and Human Development to assess the impact of the Healthy Futures project and provide data to improve fidelity and scalability.

The management team for the Healthy Futures project included staff from DMH, DOH and the evaluation consultant hired at Georgetown University. The decision was made to implement an embedded model of mental health consultation rather than have child development centers (CDCs) call-in for assistance with an individual child who had behavior problems. This choice was intended to emphasize the Healthy Futures model as focused on prevention/early intervention, rather than treatment. The clinicians would be initially embedded with a CDC for a minimum of one school year.

The consultation model emphasizes programmatic consultation, which builds the capacity of the staff in the CDCs to promote young children's positive social emotional development and reduce problem behaviors. The consultants also work collaboratively with the CDCs directors around policy and set up of centers to promote school readiness skills. The model also includes child-specific consultation, where the Healthy Futures consultants provide strategies and supports for an individual child who may be exhibiting specific problematic behaviors. The early childhood mental health consultants visit each center once a week. The amount of time they spend in each classroom varies based on the specific needs of that program and is determined in collaboration with the CDC directors. Services include observations, meetings, modeling and prevention/ early intervention activities and referrals to outside agencies, such as to Early Stages, when needed.

To identify the 28 centers for year one implementation, the management team partnered with staff from the Office of the State Superintendent of Education's (OSSE) to identify all of the licensed child development centers (CDCs) in the District; a total of 323 CDCs were eligible for participation. Priority was given to programs in Wards 7 and 8, given those were identified as high-need in the Project LAUNCH application. Outreach by email and fax was conducted to every licensed CDC in DC. The Deputy Mayor of Education's office also requested the child care programs that were being transitioned from the Department of Parks and Recreation (DPR) to United Planning Organization (UPO) be included in the Healthy Futures program. Programs were selected on the basis of their applications by the management team. After several smaller programs closed due to low enrollment, twenty-four programs were served in the first year.

A memorandum of understanding (MOU) was signed with the participating centers. This agreement outlined the expectations, roles and responsibilities of the consultants and the CDCs as their partners in Healthy Futures. It also asked that the center director be willing to participate in meetings and facilitate the notification of parents through a newsletter and help gain parental consent before formal consultation could take place with a specific child. A formal needs assessment was completed by each CDCs director to identify what they felt the needs were of each program before consultation services began (See Appendix).

Support and Training Provided to the Healthy Futures Consultants

The Healthy Futures clinicians received an extensive array of formal training to become effective mental health consultants. This included participation in didactic sessions on core content (i.e., attachment, observation, screening and assessment practices) as well as training in the approach to providing consultation versus therapeutic services. This training was supplemented with regular clinical supervision. A supervisory psychologist at DMH meets weekly for both individual and group supervision with the early childhood mental health consultants. The individual meetings are one hour a week by telephone and/or in person. The group supervision is 2 hours per week on Fridays. The Healthy Futures project is implementing a reflective supervision framework and a relational approach to supervision.

The role of reflective supervision in the Healthy Futures model is two-fold: it provides an important source of ongoing support to the consultants, which supplements their formal professional development. Reflective supervision also serves as an important tool in assessing and maintaining fidelity to the Healthy Futures model. The work of an early childhood mental health consultant can be emotionally challenging and the schedule is very taxing. Regular reflective supervision offers a space where the consultants can feel comfortable releasing some of the stressors of the job in a non-judgmental environment. This can assist the consultants to become more mindful of the job stressors, and at the same time be present-focused and generate strategies and solutions that can offer hope and optimism for improvement.

To ensure fidelity to the ECMHC model for each of the four consultants and across the four consultants, the DMH supervisory psychologist integrates what each of the consultant discussed during individual supervision with data provided through monthly reports. These monthly reports and activity logs were reviewed and analyzed for commonalities and variances and were discussed at the management team meeting as well as in group supervision. Through this process, consultants were coached to capture their consultation services in a more systematic way.

External Evaluation Study

The DMH was strongly committed to contracting for an external evaluator to support and supplement the activities of their own program evaluator and that of the DOH working on Project LAUNCH. They required a rigorous, but practical evaluation that could be embedded into the operations of the Healthy Futures project. Randomization of CDCs was not an option in the first year, so a pre-post design was implemented. A stratified random sample of classrooms within the 24 CDCs was selected; classrooms were stratified to ensure that they reflected the balance of ages of children served, size of CDCs, and Ward of the District. A total of 58 classrooms were selected, roughly half of all of the classrooms participating in Healthy Futures. A description of these classrooms and their distribution across the 24 CDCs appears in Table 1.

Table 1: Description of the child development centers and classrooms involved in external evaluation study.

Child Care Program Name	Total Number of Classrooms	Total Number of Children Served	Range of Ages Served	Number of Classrooms in the Evaluation Study
ARNOLD & PORTER	6	38	Birth through 60 months	2
ATLANTIC TERRACE	3	14	24 through - 60 months	2
AZEZE BATES	2	23	36 through - 60 months	1
BIG MAMAS	7	59	Birth through 60 months	3
BOARD OF CHILDCARE	4	51	Birth through 47 months	3
CENTRO NIA	8	112	Birth through 60 months	5
DEVELOPING FAMILIES	7	40	Birth through 47 months	1
ECDC #17	3	33	24 through - 60 months	2

(cont.) Child Care Program Name	Total Number of Classrooms	Total Number of Children Served	Range of Ages Served	Number(of) Classrooms in the Evaluation Study
ECDC #3	3	14	24 through - 60 months	1
EDGEWOOD TERRACE	6	36	Birth through 60 months	4
HAPPY FACES	12	121	Birth through 60 months	6
IDEAL	3	36	Birth through 47 months	2
KIDS ARE US 1	3	13	Birth through 35 months	1
KIDS ARE US 2	5	60	Birth through 60 months	4
LYNN CAROLS	3	33	24 through - 60 months	2
MARTHA'S TABLES	6	70	Birth through 60 months	1
MATTHEWS	5	90	Birth through 47 months	3
PARADISE	2	10	12 through - 60 months	1
PARAMOUNT	4	81	24 through - 60 months	1
SE CHILDRENS FUND	5	50	Birth through 47 months	3
SPRINGFIELD	4	53	Birth through 47 months	2
ST. JOHN'S LITTLE ANGELS	3	29	24through - 47 months	2
ST. TIMOTHY'S*	6	52	Birth through 60 months	0
SUNSHINE	7	80	Birth through 60 months	2
ZENA	10	88	Birth through 60 months	4
Total:	**127**	**1,286**		**58**

***Added after baseline data were collected*

Frequency and Intensity of ECMHC

The specific activities of included in the Healthy Futures consultation model were defined in written guidance for the consultants (See Activity Log Definitions in the Appendix). Each time the consultant visited a CDC, they completed an activity log. Data were collected in hours and included activities on-site and off-site. For each classroom visit, total time on-site was collected. The specific activities catalogued were: observation, consultation with director, consultation with teacher, consultation with parents, prevention/early intervention, modeling, training, attended meetings. Additional minutes before and after a classroom visit were documented separately. These activities included research on specific behavioral issues and phone calls to other key informants to gather or share information; travel time to and from the CDCs was not included in these figures.

Consultants' data appear in Table 3 for the 58 classrooms in the evaluation study. The average number of visits per classroom was 13.34 with a range of 2-30 visits. The average number of hours per classroom was 18.01. Additional hours the consultants needed to prepare for each visit averaged 3.93 hours. The two most frequent activities provided by consultants in the classroom were Teacher Consultation and Classroom Observation, which had a range from 2 to 24 and 1 to 23, respectively. Consultation with Director and Prevention/Early Interventions were the next most frequent activities. There was a great deal of variability in the amount of on-site services provided to the classrooms, as determined by level of need and CDCs director input.

Table 2: Mean Number of Hours and Number of Times an Activity was performed in Each Classroom in the Evaluation Study (n=58)

ECMHC Activity	Mean	Standard Deviation
Time in classroom (in hours)	17.89	7.29
Time outside of classroom (in hours)	3.79	4.70
Conduct Observation	8.46	4.92
Consulted with director	5.33	4.64
Consulted with teacher	9.23	5.42
Contacted with parent	4.39	6.27
Prevention/ Early Intervention	6.48	4.79
Model	4.14	5.36
Train	2.06	1.69
Meeting	1.33	.77
Other	1.97	1.19

Because these classrooms were selected at random at the start of the evaluation study, they should represent the level of intensity of consultation provided by the consultants in all of the classrooms served by Healthy Futures.

Year One Outcomes:

The measures selected for the external evaluation were designed to assess change at multiple levels: given the emphasis on programmatic (or classroom-focused) consultation, the Preschool Mental Health Climate Scale was chosen to measure change over time in the classroom climate. The tool was developed by Walter Gilliam, from Yale University, as part of his randomized controlled trial of mental health consultation in Connecticut. It was also used in the statewide evaluation of mental health consultation in Maryland. The Healthy Futures clinicians completed this tool during a several hour observation of the 58 classrooms selected for the evaluation; classroom climate was measured as consultation services were initiated, mid-school year, and at the end of the school year. To assess change over time in the attitudes and beliefs of the CDC staff, the Goal Achievement Scale was completed by the directors and the Job Stress Index was completed by the teachers. These measures were assessed at the beginning of the school year, mid-year and at year's end. These measures have also been used extensively in other statewide evaluations of mental health consultation, including Maryland, Connecticut and Louisiana. (All of the tools for the external evaluation are included in the Appendix.)

Bivariate statistical analyses were conducted to assess change over time from the baseline to end of school year. Mean differences were assessed using t-tests and all statistically significant changes appear Table 2 and in Figures 2 and 3. (Note a p-value of less than .10 was used due to the sample size). Differences were seen in four of the seven subscales on the Preschool Mental Health Climate Scale (PMHCS).

Specifically:

- There was a greater awareness by the teaching team of potential challenges and improved ability to avert these problems; and teachers exhibited a greater tendency to circulate around the classroom.
- There was also a significant increase in positive child interactions; for example, more children appeared to be happy and well-adjusted and the children were more involved, well behaved, cooperative, and attentive.
- There was a significant increase in teaching about feelings and problem solving; for example, teachers were more likely to help child label their feelings; and teachers were also more likely to promote child's use of language to prevent/negotiate conflicts.
- Finally, there was a significant decrease in negative indicators of classroom climate; for example: staff placing unrealistic demands on a child, or staff shouting at the children.

Table 3. Statistically Significant Changes in Classroom Climate and CDCs Staff Attitudes (Fall 2010 to June 2011)

Measure/ Subscale:	Examples of Item Content	Fall Mean	Spring Mean	*Sig:
Preschool Mental Health Climate Scale (PMHCS) Scores range from 1-5				
PMHCS Staff Awareness	"Staff is aware of potential behavioral challenges before they escalate, and intervenes appropriately." "Staff physically circulates around the room"	3.78	3.97	.08
PMHCS Child Interactions	"Staff actively listens to children with attention." "Staff does or says things to help children feel accepted and special."	3.93	4.21	.02
PMHCS Feelings	"Staff helps children label their own feelings. " "When conflicts arise, staff helps children devise their own solutions to peers' conflicts."	2.67	3.20	.003
PMHCS Negative	"Staff places unrealistic demands on children's attention span." "Noise level in the classroom is too high. "	1.46	1.31	.01
Goal Achievement Scale (GAS) Scores range from 1-3				
GAS3	"Teachers are able to manage children's difficult behavior."	2.06	2.25	.083
GAS7	"Teachers know how to refer a child and family for mental health services."	1.75	2.75	.00
GAS8	"Teachers feel comfortable referring a child and family for mental health services."	1.88	2.35	.027
Goal Achievement Scale (GAS) Scores Range from 0-39				
GAS Total	Other items include: "Teachers understand children's social and emotional development."	32.22	34.75	.002

*Sig. refers to the p-value that indicates this change is statistically significant, p <.10

Figure 2: Improvements in Classroom Climate from Fall 2011- Spring 2011

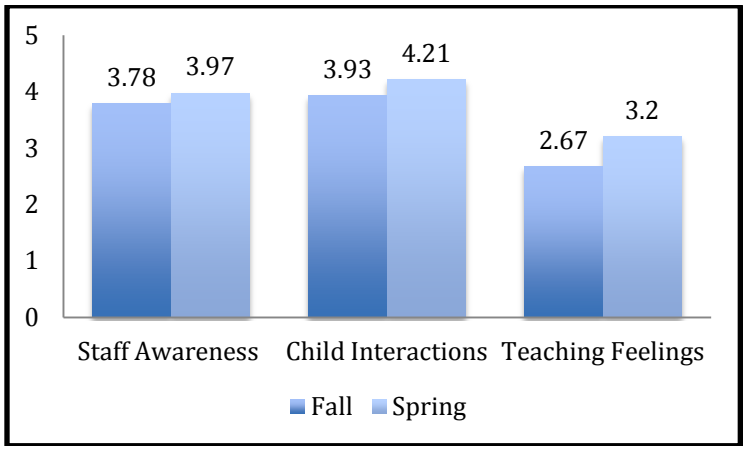
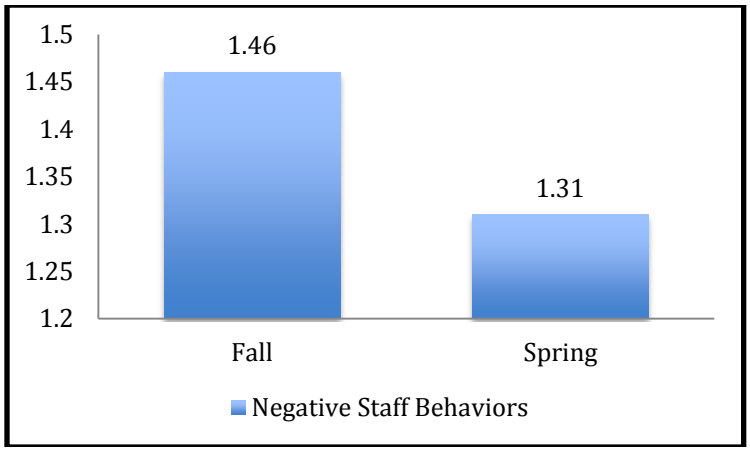
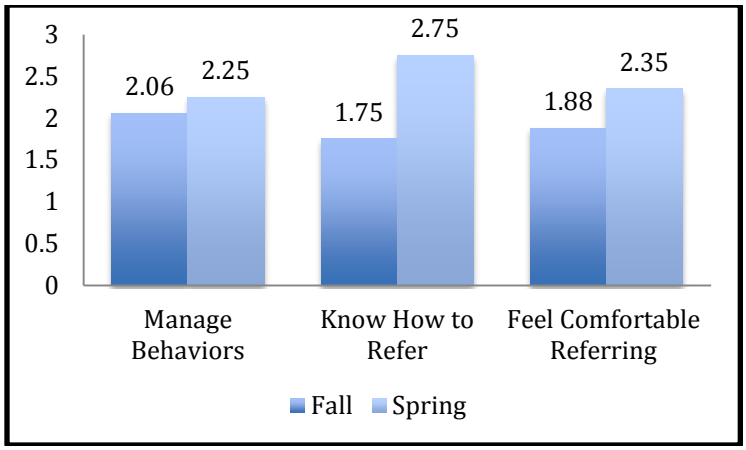


Figure 3: Reductions in Negative Classroom Climate from Fall 2011- Spring 2011



Additional effects of the Healthy Futures project were seen in changes over time in the attitudes and beliefs of the CDC directors and teachers. Data collected from the Goal Achievement Scale (GAS), which were completed by the child development center directors, indicated a significant increase in "teachers are able to manage children's difficult behavior." There was a significant increase in "teachers know how to refer a child and family for mental health services" (See Figure 4). And finally, there was also an increase in "teachers feel comfortable referring a child & family for mental health services." There were also a few items on the Job Stress Index that changed over time, but this measure was not as sensitive to the effects of consultation as the GAS.

Figure 4: Changes in Teacher's Behavior as reported by the Directors of the CDCs from Fall 2011- Spring 2011



End of the Year Directors' Survey Summary

In June 2011, the DMH program evaluator conducted a survey with the CDC directors who had participated in the Healthy Futures project. Surveys were faxed and emailed to each of the directors. Nearly all of the child development center directors returned their surveys. The findings were extremely positive:

- Most directors' (86%) reported that areas identified on the needs assessment plan had been addressed by the Healthy Futures consultants.
- All of the CDC directors reported that they felt comfortable consulting with the Healthy Futures consultants about a child with a social-emotional concern; and all were satisfied or very satisfied with the outcome.
- All of the directors reported families benefited from the program and indicated that families were comfortable with the consultant and benefited from the trainings.
- All of the directors were satisfied with services and reported wanting services for their child development centers next year.
- Center directors indicated that their programs would benefit from additional parent and staff trainings and additional services for children with difficult behaviors.
- All directors would recommend the Healthy Futures program to other child development centers.

The center directors believed that all child development centers should have consultants as a part of their programs. They also believed that they saw positive change in parenting skills and that early childhood mental health consultants brought balance to their centers and had a positive effect on parents, children, and staff.

Child-Specific Concerns

In addition to providing programmatic consultation, the Healthy Futures clinicians worked with teachers who identified children who had specific behavioral or social emotional concerns. In year 1, 43 individual children came to the attention of the Healthy Futures program because of concerns about their behavior or social-emotional problems. Some were referred to the Incredible Years groups (see below), if the level of concern warranted these services and parental consent was obtained. Most others were referred on to Early Stages for additional evaluation and assessment. Many of the behavioral problems exhibited by the children were externalizing—or acting out—symptoms. And in five of the CDCs, DMH was also piloting the Primary Project.

Primary Project is an evidence-based early intervention program designed to enhance school-related competencies and reduce social, emotional and school adjustment difficulties for children in grades kindergarten through third. Young children with early school adjustment difficulties are identified through the use of carefully developed screening and detection methods. This initiative was also implemented in 8 elementary schools and has been very successful in screening and referring children in need of additional services.

Table 4. Most Common Concerns Identified by Teachers

Concerns Identified by Teachers	**Percent of reports**	**Number of children (n=43)**
Easily distracted	51.2%	22
Does not verbalize needs or wants	48.8%	21
Fights classmates	41.9%	18
Does not follow directions	39.5%	17
Other Concerns		**Number of Reports**
Speech and language		7
Family issues		7
Social issues		4
Aggressive behaviors		4
Relationships		4
Does not follow commands		2
Development		2
Eating		1
Quiet/Shy		1

Incredible Years Groups

The Incredible Years is an evidence-based treatment program that served a small group of parents and children referred from the Healthy Futures program. The Healthy Futures clinicians were all trained to implement this 22 week program; parallel parenting and child treatment groups are provided to children who have had a diagnostic assessment and qualify for groups. One family group and one child group was completed in year one. In the parenting group there were seven parents who attended and four parents who completed the pre and post assessment. The Devereux Early Childhood Assessment, clinical version (i.e. DECA-C) was used to assess change over time in children's problem behaviors and protective factors. Five children were enrolled in the Dina group and their parents also completed the DECA-C. The small sample sizes did not permit statistical analysis, but trends were positive for children's improved outcomes in the parenting group as well as the Dina group.

Analysis of Expulsion Data

Many of the children who are identified with behavioral concerns have an undiagnosed mental health or developmental disorder. Some of these children may present with extreme aggression, even at this young age. Mental health consultation seeks to reduce the number of these children who are asked to leave their child care placement. During this first year of study, there were only three expulsions reported by the early childhood mental health consultants in three different centers. Nationally, a rate of 6.7 children per 1,000 served in pre-kindergarten was reported by Dr. Walter Gilliam in his landmark expulsion study (2005). Given that more than 1,200 children were served in the CDCs receiving Healthy Futures consultation services, the 3 children expelled reflects a significant reduction in this negative outcome for children with challenging behaviors.

In order to better understand the factors that contribute to children being asked to leave their CDCs, exit interviews were conducted by the evaluation team at Georgetown with each consultant. All three children were boys between the ages of 3 and 5 years old—consistent with the national data reported by Gilliam (2005). They all presented with extreme aggressive behaviors; in all three instances, physically striking their peers, teachers, and in one case, the CDC director. In two cases, there were similar issues at home that may have contributed to the child having outburst at school. Both children were transitioning into new home situations where their mother was having a new baby. Both families indicated that the new baby was part of a union with a man that was not the children's father. In the third expulsion, the child had had a relationship with his father who was present for a time, but he was recently incarcerated out of state. These factors underscore the need for an increase in parent engagement and involvement for children at highest risk for expulsion.

Summary of Year One Impact

Over the first year of implementation, The Healthy Futures project in the District of Columbia demonstrated promising results. The project was able to recruit highly qualified mental health professionals and provided them with exceptional training and support. The

management team selected more than 24 CDCs in all regions of the city, and all of the CDCs directors valued the services and wanted to continue in the project. Strong collaboration between DMH and DOH led to the availability of federal funding to support the project after the local seed money was no longer available.

The Healthy Futures clinicians provided a range of consultation services to the CDCs, building the capacity of the directors and teachers. This was underscored by data collected on the social-emotional climate of the classrooms as well as the attitudes of the directors. Improvements were reported in a broad array of domains. Finally, only three children were expelled from their CDC—a rate half of the national average. All these data provide a strong rational for continuing the Healthy Futures project as a critical school readiness strategy in D.C.

Lessons Learned

During the first year of implementation the management team met monthly to review the evaluation data and improve the projects operations. Several specific issues arose that had implications for the subsequent year's operations. These are outlined below.

- *With limited funding, it is necessary to minimize duplication of services*: The Deputy Mayor's office requested that a group of CDCs that were transitioning to the UPO from DPR be included in the first cohort of Healthy Futures CDCs. As the UPO took over, these programs were converted to a Head Start model that included access to a mental health consultant. During the school year, it became apparent that there was a need to coordinate these services with UPO to avoid duplication of services. As the funding for Healthy Futures shifts to the SAMHSA funded Project LAUNCH grant, it will be imperative that services be focused on those CDCs that do not have any access to mental health consultants.
- *With an embedded ECMHC model, it is necessary to develop criteria for transitioning to new CDCs:* In the spring, it became necessary to develop an objective procedure to determine whether and in which CDCs the Healthy Futures clinicians should be maintained for a second year. The management team, with input from the Healthy Futures clinicians, developed a 10-point rating system to be used by each clinician. Variables such as the size of the center, amount of turnover, compliance with the action plan were all assessed on a five-point scale. (This tool is included in the Appendix) In addition, the results from the outcome evaluation classrooms contributed to the decision-making framework, as did the end of year directors' survey responses. Overall, the decision was made to continue to embed the clinicians in 17 CDCs; which opened up slots for 7 new CDCs in year 2.
- *Within a prevention framework, it is necessary to prioritize consultation over treatment services*: For the most part, it was teachers or directors who referred individual children with behavioral or social emotional problems for consultation.

When these referrals were made, the consultant—working with the CDCs staff—conducted outreach to the child's parents. Some of these children and their parents participated in the Incredible Years groups piloted by the Healthy Futures team. These groups were supposed to run for 22 weeks and enroll both the parents and children for parallel parent- and child-groups. But this model proved difficult to embed within a CDC setting. During the first year of implementation, DMH opened a state-of-the-art treatment facility at Howard Road serving children under the age of five. This combined with the challenges of implementing the Incredible Years intervention with fidelity suggests that the Healthy Futures program focus on its core mission—prevention and early intervention for children at risk of a diagnosis, rather than running treatment groups.

Recommendations for Year Two Implementation

Building upon the lessons learned from the first year of the Healthy Futures project, several recommendations can be offered to DMH.

During the second year of Healthy Futures implementation, additional attention should be paid to formalizing the procedures for child-specific consultation. In year 2, all of the CDCs with Pre-K classrooms that will be receiving Healthy Futures services will also be implementing the Primary Project because of expanded funding secured by DMH for this successful effort. To better align these initiatives, and to improve the process for identifying children in need of child-specific consultation services, it is recommended that Healthy Futures clinicians facilitate the CDCs conducting universal social-emotional screening. This should be phased-in in waves during the year, so that over time all of the children in need of additional services, supports or referrals for treatment can be identified.

In addition, changes to the evaluation design should be considered for the second year of Healthy Futures implementation. Specifically, a different measure of changes in teacher's attitudes and beliefs should be considered; if job stress is continued to be measured, different items and subscales from the Job Stress Index should be selected that will be more sensitive to change from consultation services. It would also increase the rigor of the evaluation study if an independent assessment of the social-emotional climate in the classroom be conducted. The CLASS—Classroom Assessment Scoring System (Pianta, et al. 2008)—would be an appropriate tool to look at change over time in a random sample of classrooms receiving consultation.

Finally, additional effort should be made to document the procedures that consultants are implementing at each of the CDCs. This documentation should lead to a manual that will increase the fidelity to the consultation model; and this movement toward manualizing the Healthy Futures approach will permit the DMH to scale this up, should additional funding become available.

Summary and Conclusion

The Healthy Futures model is built upon a solid foundation of findings from the emerging literature on effective early childhood mental health consultation. Aligned with the framework developed by Georgetown University (Figure 1), the Healthy Futures project has a solid program infrastructure, high-quality (well-trained and well-supported) consultants, and delivered high-quality services. The model included a readiness assessment, was relationship-focused and used evaluation data to provide continuous quality improvement. The first year data demonstrated important impacts on children, teachers and the quality of the CDCs. Lessons learned from year one are being incorporated into the second year implementation and continued positive effects on school readiness should be anticipated.

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Appendix:

1. D.C. Healthy Futures Program Needs Assessment
2. Activity Log Definitions
3. Preschool Mental Health Climate Scale
4. Goal Achievement Scale
5. Job Stress Index
6. Criteria for Assessing Need for Continued ECMHC Services

Name of Center: _____
Name of Specialist: _____
Date: _____

Instructions

The ECMH Consultant should obtain responses to this survey by interviewing the Center Director. Needs assessments are completed before the ECMH consultant provides services to the center. A plan will be developed based on the answers. This plan will include both center and child and family centered consultation services that will be offered throughout the year.

A. Interactions

1. What is your understanding of social emotional development? How do you define it?

2. In interacting with children, what tools or strategies do the staff at this center use (feelings charts, circle time, group curriculum, behavior interventions) to support social and emotional development?

3. Are there gaps in the methods you currently use? Please explain.

4. Do you use a specific curriculum? If so, what is it?

5. How can the consultant assist teachers/staff with providing positive teacher/child interactions with regards to social and emotional development?

B. Behavior Management

1. Centers sometimes feel they must expel a child because of continued biting or aggression or sexualized play or contact with others. Do you have experience with these kinds of situations and how have they been handled?

2. Is there a center-wide code of conduct and/or expulsion guidelines that all staff receive training on? Are the guidelines being followed? If not, why not?

3. What are the main reasons why you might expel a child? How many children have been expelled in the past year? How many parents withdrew children prior to an expulsion?

4. Would you be willing to hold off on expelling a child while the consultant works with your staff and the family to respond to the concern? How does that fit into your program or philosophy?

C. Environmental Issues/Community Concerns and Resources

1. What types of environmental issues has the center dealt with and/or anticipates dealing with?

- ☐ Child Abuse
- ☐ Parental substance use/abuse
- ☐ Inadequate parenting skills
- ☐ Family Violence
- ☐ Child Neglect
- ☐ Revitalization/Development Plans
- ☐ Neighborhood violence (direct impact on center)
- ☐ CPS Reports # last year _____
- ☐ Other (Please describe) _____

2. What has been done to address these issues?

3. How can the ECMH consultant help to address these issues during the 12-month consultation period?

D. Center Climate Issues

1. What types of programmatic issues has the center dealt with and/or anticipates dealing with?

- ☐ Staff turnover
- ☐ Cultural sensitivity
- ☐ Lack of knowledge of early childhood development
- ☐ Methods of managing disruptive behavior are limited
- ☐ Other (Please describe) _____

2. In the past year, what percentage of your staff have left their positions? Please describe your ideas regarding staff turnover and retention.

3. What type of meetings or activities are families more likely to participate in?

- ☐ Volunteer
- ☐ Field trips
- ☐ Special Events (e.g., fun fairs, etc.)
- ☐ Disciplinary Action Meeting
- ☐ Classroom Helper
- ☐ Parent Teacher Conferences
- ☐ Other (Please describe) _____

4. What strategies have been successful to engage families in center activities?

5. How can the ECMH consultant support administration and staff in improving family involvement within the center?

6. What is the best mode(s) of communication with families at your center?

☐ Telephone ☐ Email ☐ Mailing
☐ Notice Board ☐ Other (Please describe) _____

E. Center Concerns/Needs

1.Check the item(s) that have been identified by the center staff or families as areas of need

	Yes	No
Learning difficulties	☐	☐
Anxious/nervous/separation issues	☐	☐
Bizarre behaviors	☐	☐
Conflict with/or Disrespect of Staff	☐	☐
Depressed/withdrawn	☐	☐
Disruptive classroom behaviors	☐	☐
Eating/regulatory disorders	☐	☐
Family illness	☐	☐
Family Financial Stress	☐	☐
Fighting	☐	☐
Homelessness	☐	☐
Hygiene	☐	☐
Hyperactive/impulsive	☐	☐
Inappropriate sexual behavior	☐	☐
Irritable/angry/hostile	☐	☐
Loss (e.g., death, military, incarceration)	☐	☐
Neglect	☐	☐
Physical abuse	☐	☐
Poor peer relations	☐	☐
Self-injurious behavior	☐	☐
Sexual Abuse	☐	☐
Staff stress	☐	☐
Substance use/abuse	☐	☐
Threatening/bullying	☐	☐
Unemployment	☐	☐

2. What staff development topics are already planned for the current 12-month consultation period? What staff development topics could the consultant provide for your staff?

3. What is the underlying culture about social development in the center and what are the possible barriers to implementing early childhood mental health services in the center?

4. Based on our interview today, what are the top 3 ways you see the mental health consultant assisting at your center?

Implementation Plan

Center Name: _____ Date: _____

Plan includes time period(s) of:

- ☐ April-June
- ☐ July-September
- ☐ October-December
- ☐ January- March

Addendum ☐ Yes ☐ No Date: _____

Identified treatment services activities, or programs	Identified Center Need and/or issue addressed	Population	Timeline

We have reviewed the implementation plan.

Center Director's Signature Date

Consultant's Signature Date

Department of Mental Health
Healthy Futures
Activity Log Definitions

ACTIVITY	DEFINITION OF ACTIVITY
Classroom Name/ID	• The name of the classroom where the consultant provided services. If the classroom is in the study, please indicate the Classroom ID (i.e., letter and number).
Total Time In Classroom	• Indicate the amount of time (in minutes) spent in the classroom.
Conduct Classroom Observations	• When a consultant is physically present in the classroom in order to observe a child's level of functioning and/or the dynamics between the child and the teacher(s). • Only include an observation if the consultant's initial intent was to make an observation. For example, a teacher expressed a concern about a child, and the consultant observed that specific child. • **DO NOT** include general observations. For example, if the consultant indirectly observed a child or classroom while participating in circle time, he/she should NOT count this as an observation. The initial intent was to participate in the classroom activity, not to observe a specific child, group of children or classroom. • Report the number of children that were observed. • If the consultant observed a specific child, please note the initials of the student.
Screening	• Indicate the number of children screened for a social emotional or behavioral concern using a standardized instrument (e.g., ASQ). • Indicate the child's initials.
Consult with Director	• Communication between the consultant and the Center Director regarding ways the consultant can provide support for children, parents, and/or staff at the Center.
Consult with Teacher/Staff	• Communication between the consultant and a teacher or staff member. The consultant may provide support to the teacher in his/her approach to working with children and parents at the center. • Indicate the number of teachers/staff consulted with.
Consult with Parent	• Communication between the consultant and a parent. The consultant may provide support to the parent in regards to the development of his/her child. • Indicate the number of face-to-face and phone consults as well as the initials of the parent.

Name of Center: _____
Name of Specialist: _____
Date: _____

Instructions

The ECMH Consultant should obtain responses to this survey by interviewing the Center Director. Needs assessments are completed before the ECMH consultant provides services to the center. A plan will be developed based on the answers. This plan will include both center and child and family centered consultation services that will be offered throughout the year.

A. Interactions

1. What is your understanding of social emotional development? How do you define it?

2. In interacting with children, what tools or strategies do the staff at this center use (feelings charts, circle time, group curriculum, behavior interventions) to support social and emotional development?

3. Are there gaps in the methods you currently use? Please explain.

4. Do you use a specific curriculum? If so, what is it?

5. How can the consultant assist teachers/staff with providing positive teacher/child interactions with regards to social and emotional development?

B. Behavior Management

1. Centers sometimes feel they must expel a child because of continued biting or aggression or sexualized play or contact with others. Do you have experience with these kinds of situations and how have they been handled?

2. Is there a center-wide code of conduct and/or expulsion guidelines that all staff receive training on? Are the guidelines being followed? If not, why not?

3. What are the main reasons why you might expel a child? How many children have been expelled in the past year? How many parents withdrew children prior to an expulsion?

4. Would you be willing to hold off on expelling a child while the consultant works with your staff and the family to respond to the concern? How does that fit into your program or philosophy?

C. Environmental Issues/Community Concerns and Resources

1. What types of environmental issues has the center dealt with and/or anticipates dealing with?

- ☐ Child Abuse
- ☐ Parental substance use/abuse
- ☐ Inadequate parenting skills
- ☐ Family Violence
- ☐ Child Neglect
- ☐ Revitalization/Development Plans
- ☐ Neighborhood violence (direct impact on center)
- ☐ CPS Reports # last year _____
- ☐ Other (Please describe) _____

2. What has been done to address these issues?

3. How can the ECMH consultant help to address these issues during the 12-month consultation period?

D. Center Climate Issues

1. What types of programmatic issues has the center dealt with and/or anticipates dealing with?

- ☐ Staff turnover
- ☐ Cultural sensitivity
- ☐ Lack of knowledge of early childhood development
- ☐ Methods of managing disruptive behavior are limited
- ☐ Other (Please describe) _____

2. In the past year, what percentage of your staff have left their positions? Please describe your ideas regarding staff turnover and retention.

3. What type of meetings or activities are families more likely to participate in?

- ☐ Volunteer
- ☐ Field trips
- ☐ Special Events (e.g., fun fairs, etc.)
- ☐ Disciplinary Action Meeting
- ☐ Classroom Helper
- ☐ Parent Teacher Conferences
- ☐ Other (Please describe) _____

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6. What is the best mode(s) of communication with families at your center?

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☐ Notice Board ☐ Other (Please describe) _____

E. Center Concerns/Needs

1.Check the item(s) that have been identified by the center staff or families as areas of need

	Yes	No
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Anxious/nervous/separation issues	☐	☐
Bizarre behaviors	☐	☐
Conflict with/or Disrespect of Staff	☐	☐
Depressed/withdrawn	☐	☐
Disruptive classroom behaviors	☐	☐
Eating/regulatory disorders	☐	☐
Family illness	☐	☐
Family Financial Stress	☐	☐
Fighting	☐	☐
Homelessness	☐	☐
Hygiene	☐	☐
Hyperactive/impulsive	☐	☐
Inappropriate sexual behavior	☐	☐
Irritable/angry/hostile	☐	☐
Loss (e.g., death, military, incarceration)	☐	☐
Neglect	☐	☐
Physical abuse	☐	☐
Poor peer relations	☐	☐
Self-injurious behavior	☐	☐
Sexual Abuse	☐	☐
Staff stress	☐	☐
Substance use/abuse	☐	☐
Threatening/bullying	☐	☐
Unemployment	☐	☐

2. What staff development topics are already planned for the current 12-month consultation period? What staff development topics could the consultant provide for your staff?

3. What is the underlying culture about social development in the center and what are the possible barriers to implementing early childhood mental health services in the center?

4. Based on our interview today, what are the top 3 ways you see the mental health consultant assisting at your center?

Implementation Plan

Center Name: _____ Date: _____

Plan includes time period(s) of:

- ☐ April-June
- ☐ July-September
- ☐ October-December
- ☐ January- March

Addendum ☐ Yes ☐ No Date: _____

Identified treatment services activities, or programs	Identified Center Need and/or issue addressed	Population	Timeline

We have reviewed the implementation plan.

Center Director's Signature Date

Consultant's Signature Date

Prevention/Early Intervention	• A targeted intervention implemented by the consultant to help promote child's positive development and/or decrease negative behaviors. Examples may include, but are not limited to the following activities: tucker turtle technique, social skills activities, anger management and coping strategies. • List name/description of activity • Indicate the number of children who participated • Indicate the number of male and female students
Modeling	• A consultant demonstrates specific techniques and encourages teachers to implement them in their classroom. • Indicate the number of teachers present during the modeling activity
Conduct Training	• Staff development, parent workshops, conferences and/or other workshops where the consultant presents information on early childhood topics (e.g., social-emotional development, child development, etc). • Indicate the number of staff and parents present at the training.
Attend Meetings	• Consultant participated in a meeting (e.g., Staff meetings, MDT meetings, parent meetings where consultant does not present, etc.)
Other: Collateral Contacts, home visits	• Any other activity(s) implemented, but not recorded in prior sections. • This may include things such as collateral contacts and home visits. • Please provide a description of the activity.

Child Development Center Mental Health Climate Scale

Consultant Name: _____

Child Development Center Name: _____

Observation Date: _____ **Start Time:** _____ **End Time:** _____ **Total Time:** _____

Group/Classroom Being Observed: _____ **# Visits to Classroom:** _____

Age Range of Children in Group/Class **Youngest** _____ **Oldest** _____

First Time in Classroom: **Yes** _____ **No** _____

Activities Observed (e.g. arrival, snack, play time, free time, etc.)

_____

INSTRUCTIONS

Rate the items by putting a "1" in the column that best fits the statement. Use the "comments" section to provide examples/clarification.

SECTION I: POSITIVE INDICATORS

A. TRANSITIONS

	Never or Not True	Sometimes or Somewhat	Moderately Frequent or Moderately	Often or Very True	Consistently/ Completely True
1. Transitions between activities are smooth yet unregimented					
2. Transitions are handled in a planned manner					
3. Transitions are quick and flexible enough for the developmental level of the children					
4. Prior to transitions, subsequent activities are sent up and ready to go					
5. During transitions, enough staff is present and helping					
6. During transitions, teachers provide children individual support and flexibility as needed					
7. During transitions, teachers actively interact with children in order to facilitate smooth transitions or continued learning					

Comments: _____

Comments: _____

B. DIRECTIONS & RULES

	Yes	NO
Challenging behavior observed ***If NO challenging behavior observed skip #s 12 & 13***		

	Never or Not True	Sometimes or Somewhat	Moderately Frequent or Moderately	Often or Very True	Consistently/ Completely True
8. Staff encourages appropriate behavior					
9. Staff expresses clear directions and behavioral expectations and provides appropriate follow-through on instructions					
10. Staff consistently enforces classroom rules					
11. Rules, directions and expectations are developmentally appropriate					
12. Staff uses positive classroom management techniques to manage children's behavior					
13. Staff uses redirection appropriately to manage challenging behavior					

Comments:

Comments:

C. STAFF AWARENESS

	Never or Not True	Sometimes or Somewhat	Moderately Frequent or Moderately	Often or Very True	Consistently/ Completely True
14. Staff is aware of potential behavioral challenges before they escalate, and staff intervenes appropriately					
15. Staff physically circulates around the room					
16. Staff appears constantly aware of the entire class, even when working with smaller groups or individual students. Staff is able to do many activities at once and shift focus of attention with ease					

Comments:

Comments:

D. STAFF AFFECT

	Never or Not True	Sometimes or Somewhat	Moderately Frequent or Moderately	Often or Very True	Consistently/ Completely True
17. Staff seems to enjoy their job					
18. Staff seems to be having fun, and appear to enjoy the children and/or teaching the children new skills					
19. Staff is active and energetic, not lethargic					

Comments:

Comments:

E. STAFF COOPERATION

	Yes	NO
Is there only ONE staff member in the class? ***If YES, skip to SECTION G***		

	Never or Not True	Sometimes or Somewhat	Moderately Frequent or Moderately	Often or Very True	Consistently/ Completely True
20. Staff members work well together					
21. Staff members have distinct roles that are both complementary and flexible. They act like a team and share responsibilities well					
22. Staff members appear to enjoy each other					

Comments:

Comments:

F. STAFF-CHILD INTERACTIONS

	Never or Not True	Sometimes or Somewhat	Moderately Frequent or Moderately	Often or Very True	Consistently/ Completely True
23. Staff initiates conversations with children					
24. Staff addresses children at eye level and in a clear and understandable manner					
25. Staff actively listens to children with attention					
26. Staff interactions with children are positive, without fussing and arguing					
27. Staff interactions with children are affectionate and warm					
28. Staff does or says things to help children feel accepted and special					
29. Staff shows positive facial affect towards children					
30. Staff is respectful of children					
31. Staff is fair to children. Staff does not repeatedly reprimand certain children that others exhibit without comment					

Comments:

Comments:

G. TEACHING FEELINGS & PROBLEM SOLVING

	Yes	NO
Conflicts observed? ***If no conflicts observed, skip #s 38 & 39***		

	Never or Not True	Sometimes or Somewhat	Moderately Frequent or Moderately	Often or Very True	Consistently/ Completely True
32. Staff capitalizes on opportunity to talk about feelings					
33. Staff helps children label their own feelings					
34. Staff helps children to express their feelings to others verbally, instead of doing so physically					
35. Staff actively encourages/facilitates positive interactions between children					
36. Staff uses a variety of positive methods (e.g. offering behavioral choices, encouraging good problem solving skills, or modeling appropriate behaviors) to promote prosocial behaviors					
37. Staff actively promotes children's use of language to prevent/negotiate conflicts					

38. When conflicts arise, staff helps children devise their own solutions to peers' conflicts					
39. When conflicts arise, staff discusses with the children a variety of alternative solutions for their disagreements					

Comments:

Comments:

H. INDIVIDUALIZED & DEVELOPMENTALLY APPROPRIATE PEDAGOGY

	Never or Not True	Sometimes or Somewhat	Moderately Frequent or Moderately	Often or Very True	Consistently/ Completely True
40. Staff promotes learning through developmentally appropriate practices.					
41. Staff seems to know each child's developmental strengths and needs and individualizes expectations and interactions accordingly					
42. Staff provides children with individualized support					
43. Staff actively facilitates children's social developments					
44. Staff actively supports children's play					
45. Activities are of an appropriate duration, pace, variability, and level of stimulation to maintain children's attention					

Comments:

Comments:

I. CHILD INTERACTIONS

	Never or Not True	Sometimes or Somewhat	Moderately Frequent or Moderately	Often or Very True	Consistently/ Completely True
46. Children appear to be happy and well adjusted					
47. Children are involved, well behaved, cooperative and attentive					
48. Children interact well with staff					
49. Children interact with peers in a way that shows mutual affiliation, concern or affection					
50. Children appear to be developing independence, creativity and adaptive coping skills.					

Comments:

Comments:

SECTION II: NEGATIVE INDICATORS

	Never or Not True	Sometimes or Somewhat	Moderately Frequent or Moderately	Often or Very True	Consistently/ Completely True
1. Staff does not help children to engage in productive/activities					
2. Staff places unrealistic demands on children's attention span					
3. Staff imposes solutions on conflicts					

4. Staff shouts at children from across the room					
5. Staff threatens children with consequences					
6. Staff humiliates or frightens children					
7. Staff uses physical contact primarily as a means for controlling behavior					
8. Noise level in classroom is too high					
9. Visual stimulation in the classroom is either too low or too high					

Comments:

Comments:

Comments:

Comments:

Healthy Futures - Early Childhood Mental Health Consultation
Goal Achievement Scale

Center Name: _____

Center Director's First Initial and First 3 Letters of Last Name (e.g. John Brown would be: **J Bro)**: _____

Center Unique ID: _____

INSTRUCTIONS

Read each statement below and select only ONE item that best fits your agreement with each statement. To select an item place a "1" in the column.

Item	Not At All	Somewhat	Very Much
1. Teachers understand children's social & emotional development			
2. Teachers try to understand the meaning of children's behavior			
3. Teachers are able to manage children's difficult behavior			
4. Teachers respond appropriately and effectively to children's distress			
5. Teachers communicate regularly with parents about their children's strengths & needs			
6. Teachers have a positive attitude about working together with parents			
7. Teachers know how to refer a child and family for mental health services			
8. Teachers feel comfortable referring a child & family for mental health services			
9. Teachers feel understood and supported			
10. Teachers feel confident in my ability to respond to worrisome behavior			
11. This child care center welcomes parents as partners			
12. Teachers receive regular and supportive supervision			
13. I am responsive to staff needs			

To be completed by the Center's Director @ 0, 6 12 months **AND** all new Center Directors.
Adapted from Alkon, Ramler MacLennan (2003)

District of Columbia - Healthy Futures Program
Job Survey

Name of Center: _____
Classroom ID: _____
Date: _____
Lead Teacher's 1st Initial & 1st 3 Letters of Last Name (e.g. John Brown would be: **J Bro)**: _____

INSTRUCTIONS

Read each statement below and select only ONE item that best fits your agreement with each statement. To select an item place a "1" in the column.

A. How much CONTROL do you have over the following things at work?

Item	Very Much	Much	Moderate	Little	Very Little
The availibility of supplies that you need.					
Getting Parents to be consistent with you in how to deal with the child					
Getting the Parents to work with you on a behavior problem.					
The number of children you care for.					
When the Parents Pick up their Children					

B. How OFTEN do the following things happen at work?

Item	Very Much	Much	Moderate	Little	Very Little
Parents blame their children's bad behavior on day care					
I get praise from the parents for the work that I do					
Children have behavior problems that are hard to deal with					
I feel respected for the work that I do.					
Parents bring in children who are sick					
I feel the satisfaction of knowing I am helping the parents					
Parenets expect me to care for their children when they have a day off					
I see that my work is making a difference with a child					
Parents don't le me know where they are during the day.					
I feel like I am helping the children grow and develop					
I feel like I have to be a parent and a teacher to the children					
All of the children need attention at the same time.					

DC ECMH Consultation Evaluation

Consultant Name_____ Center Name_____ Date_____

Please rate the following for each program receiving ECMHC services

1. Level of Center Director engagement/support	*Not at all engaged*				*Very engaged & supportive*
	1	**2**	**3**	**4**	**5**
	Notes:				
2. Level of Parent engagement/support	*Not at all engaged*				*Very engaged & supportive*
	1	**2**	**3**	**4**	**5**
	Notes:				
3. Level of Teacher engagement/support	*Not at all engaged*				*Very engaged & supportive*
	1	**2**	**3**	**4**	**5**
	Notes:				
4. Size of Center	*Small*		*Medium*		*Large*
	1	**2**	**3**	**4**	**5**
	Notes:				
5. Number of other outside MH services/supports	*None*		*Some*		*A lot*
	5	**4**	**3**	**2**	**1**
	Notes:				
6. Amount of staff turnover since consultation began	*None*		*Some*		*A lot*
	1	**2**	**3**	**4**	**5**
	Notes:				
7. Change in demographics of families served	*Fewer high need*		*No Change*		*More high need*
	1	**2**	**3**	**4**	**5**
	Notes:				
8. Extent of implementation of plan from needs assessment	*Not at all*				*Fully implemented*
	1	**2**	**3**	**4**	**5**
	Notes:				
9. Compliance with terms of MOU	*Not at all*				*Full Partnership*
	1	**2**	**3**	**4**	**5**
	Notes:				
10. Penetration Rate (ratio of classrooms receiving ECMHC)	*Every classroom served*		*Majority served*		*Less than half*
	1	**2**	**3**	**4**	**5**
	Notes:				
Total Score (Add all the items above)					