Healthy Futures

Year Two Evaluation Report

Prepared For:

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Acknowledgements

Year Two Evaluation Report

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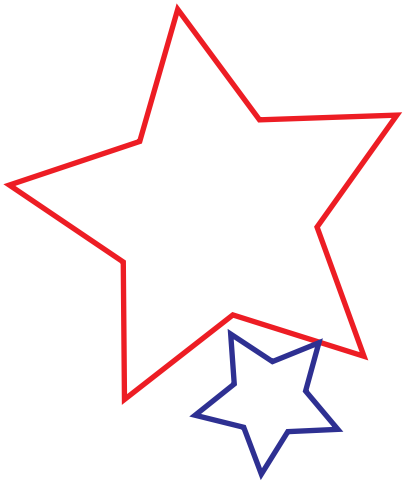


Executive Summary

Year Two Evaluation Report

The Washington DC Department of Mental Health (DMH) recently completed the second year of implementing an evidence-informed mental health consultation project in 25 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.[1] In this model:

- Four full-time, licensed mental health professionals provide weekly 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.

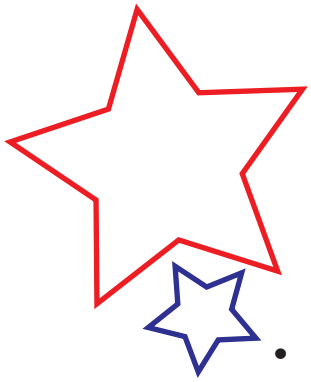
- Consultants also help to identify those young children in need of more intensive services, providing child-specific consultation services as well as facilitating referrals for community-based services.

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 57 classrooms was selected for the in-depth data collection. The evaluation measured the frequency and intensity of the consultation services delivered to the CDCs. Data were gathered from the consultants, child care directors and teachers who received programmatic consultation in the CDCs. Additional data were collected from the teachers and parents of children who were referred for child-specific consultation from July 2011 to June 2012. The social-emotional climate of a smaller sample of 16 classrooms was assessed in the fall and spring of school year 2011-12 by an objective observer using the Classroom Assessment Scoring System[2] (CLASS.) End of year satisfaction data were collected and analyzed by a program evaluator for DMH. Key findings include:

- More than 1,300 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 less than half the national average of 6.7 per 1,000.[3]

- Mental health consultants worked with nearly 60 children who were identified with problem behaviors. Of these, parents consented to 24 children receiving child-specific consultation; and Devereux Early Childhood Assessments[4] were completed by 24 teachers and 22 parents.

- Children identified with problem behaviors exhibited concerns in a wide array of developmental areas. For the small number of children (n=2) where pre-and post-intervention DECAs were available, significant improvements in their behavior problems and increases in their protective factors were seen.



- Statistically significant improvements in the emotional climate of the 16 classrooms who participated in the CLASS observations were seen from fall to spring.

- CDC directors reported significant improvements in their staff's ability to respond appropriately and effectively to children in distress and their comfort with referring a child and family for mental health services. Directors also reported increases in the number of teachers in their programs that had a positive attitude about working together with parents.

- 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 services.

During the second year of the Healthy Futures project, each of the consultants piloted the use of the Ages and Stages Questionnaires: Social Emotional (ASQ/SE) to screen children in one of their CDCs receiving consultation. In addition, 14 CDCs are implementing both the Healthy Futures and Primary Project service models, expanding the continuum of care for those children and families.

Lessons learned and recommendations for subsequent years of implementation include:

- The initial one-year commitment of the Healthy Futures consultants proved to be insufficient given one-third of the workforce turned over. While a few CDCs did not require ongoing consultation due to the availability of other, comparable services, most of them required the continued presence of the Healthy Futures consultants due to ongoing needs.

- The Healthy Futures team should continue to document the specific procedural details about the consultation model, including referrals for child-specific consultation services. In particular, greater attention should be paid to the level of engagement of families of children identified with social-emotional and behavioral needs in the consultation process.

- There is a need to improve the collection of post-intervention data for children referred for child-specific consultation, by adding data collection responsibilities to the Memorandum of Understanding signed by the CDCs. The Healthy Futures team should also consider collecting post-intervention data at a specific time point (i.e., 3-4 months following parent consent) to increase participation by parents and teachers.

- With limited time on site, consideration should be given to the balance between the number of hours consultants spend doing training versus providing consultation services.

- With one-third of the CDC teachers leaving during the course of the school year, and the high self-reported stress levels of the newly hired teachers, consideration should be given to how consultants can implement systematic support new staff.

- As federal funding becomes less available and as the external evaluator transitions off the team, there is a need to maintain a rigorous evaluation of the Healthy Futures project at multiple levels (i.e., program, provider, and child-level).

The first two years of the Healthy Futures implementation demonstrated excellent feasibility, acceptability and positive impacts across multiple measures and in many domains. Lessons learned included the need to continue to provide consultation services in many of the CDCs who have participated in Healthy Futures due to a high level of need and teacher turnover. The improvements in classroom practices enhance the school readiness of young children in the District of Columbia and improve the quality of the CDCs.

Rationale for Healthy Futures

There is strong evidence that the quality of the early care and education settings that young children spend time in is related to their school readiness. These data have been amassed over several decades, based upon observational studies as well as well-known intervention studies (i.e., Abecedarian and Perry Preschool Projects). A recent comprehensive project examining the link between quality and children's outcomes underscore the complexity of these relationships. In studies using the Classroom Assesment Scoring System, for example, links between specific areas of academic achievement were linked to higher quality of instructional support, while higher scores on emotional climate were related to better social skills and less problem behavior.[5] As young children—especially those in impoverished communities—spend increasing time in out-of-home settings, interventions to improve the quality of these early care and education settings are warranted.

Across the country, over one third of all young children are affected by at least one socio-demographic stressor such as low income or low maternal education that puts them at higher risk of adverse social, emotional, and cognitive outcomes.[6] In the District of Columbia, the rates of children in poverty are consistently above the national average. The Kids Count data reported[7] that in Wards 7 and 8, 40% and 48% of young children are growing up in families below the federal poverty level . Poverty is a leading risk factor for problem behavior. Nationally, across 18 studies in low-income community samples, rates of problem behaviors ranged from 8% to 57% depending on where the sample was drawn and the risk factors examined.[8] Similarly, a study examining the prevalence of behavior problems among young children in low-income child care centers in Chicago found that 31.6% of the children were rated as having significant behavior problems by their parents.[9]

There are a variety of short-term and long-term implications of young children exhibiting high levels of problem behaviors. In the short term, these children are at higher risk for expulsion from their child care programs and preschools. Several studies—one reporting on data from a single state and the second national in scope—suggest that this phenomenon is very common. A study looking at pre-kindergarten expulsion and suspension rates in Massachusetts found that the rate of expulsion among preschoolers is more than 34 times the rate of expulsion during the K-12 years.[10] Nearly two-fifths of all teachers in this study had expelled at least one child and roughly 15% had suspended at least one child in the past year. A second study confirmed that these findings are not confined to Massachusetts: data collected from all 40 states that funded pre-kindergarten programs revealed that preschool expulsion rates were higher than K-12 rates in 37 out of 40 states.[3] Rates of preschool children being expelled were 6.7 per 1,000 children served.

Over the longer term if left untreated, high levels of problem behavior—which often co-occur with social skill deficits—can develop into clinically significant mental health conditions. Young children who experience externalizing behaviors may continue on a developmental trajectory that can lead to conduct disorder, and some of these children may end up with an anti-social personality disorder as adults.[11] Conduct disorder is extremely resistant to effective treatment. When young children exhibit internalizing behaviors, their educational outcomes are likely to be affected as they are less likely to engage in the classroom environment and to persist with tasks and classroom assignments.[12] A lack of social skills also has developmental consequences as the peer group becomes more central in school-aged children's lives. Children without strong social skills may elicit negative feedback from teachers and face exclusion from positive peers, leading to affiliation with deviant peers.

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 children's behaviors, teacher attitudes and behaviors, and characteristics of the early childhood settings associated with higher quality care.[13] Reductions in staff turnover and expulsions from child care were also seen across many of these studies. In addition, Gilliam[3] reported that pre-kindergarten programs that had on-site early childhood consultants had lower rates of expulsion than those without access to this service.

Taken together, these studies underscore the need to focus on preventive interventions for young children at high risk for developing longer term mental health problems. They also suggest the need for a focus on improving the quality of early care and education settings as a critical pathway to promoting school readiness in young children at higher risk.

Development of the Healthy Futures Project

In response to these trends, momentum began to grow to develop a mental health consultation project to serve the early childhood community in the District of Columbia. 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 Department of Mental Health (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 external evaluation contract with the Georgetown University Center for Child and Human Development.

Partnering with the Department of Health (DOH), who was awarded a federal grant in 2009 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. In Year two, Project LAUNCH funding was needed to fund all four mental health consultants, as local money expired. DMH continued to fund the external evaluation contract with local money to provide data to improve fidelity and contribute to discussions for sustainability beyond the federal grant period.

The management team for the Healthy Futures project has 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. The consultation model emphasized 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 CDC directors around policy and set up of centers to promote school readiness skills.

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.

In year two, the Healthy Futures model continued to focus on prevention/early intervention, rather than treatment. While the consultants were initially committed to working with a CDC for a minimum of one school year, many stayed on for a second year of consultation because of continuing need. In the spring of the first year of implementation, it became necessary to develop an objective procedure to determine whether and in which CDCs the Healthy Futures consultants should be maintained for a second year. The management team, with input from the Healthy Futures consultants, developed a 10-point rating system to be used by each consultant. 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 that consultants would remain in 17 CDCs; which opened up slots for 7 new CDCs in year two. The majority of CDCs that were no longer receiving Healthy Futures services were getting similar services from other sources (e.g., federal Head Start funding).

An important part of the Healthy Futures model is regular reflective supervision with the four full-time consultants. The role of reflective supervision 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 as well as reducing turnover in the consultant pool. 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 deliver and capture their consultation services in a more systematic way.

External Evaluation Study

The DMH continued its commitment to contracting for an external evaluator to support and supplement the activities of their own program evaluator and that of the DOH evaluator working on Project LAUNCH. Several aspects of the design were maintained for the second year evaluation: (1) A stratified random sample of classrooms within the 25 CDCs was selected; classrooms were selected to ensure that they reflected the balance of ages of children served, size of CDCs, and Ward of the District. A total of 57 classrooms were selected, roughly half of all of the classrooms participating in Healthy Futures. A description of these classrooms and their distribution across the CDCs appears in Table 1.

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

CDC NAME	#CLASSROOMS (in-study CLASSROOMS)	#CHILDREN	#TEACHERS	AGES SERVED (in months)
AZEZE BATES	2 (0)	16	8	36-60
BIG MAMAS	4 (3)	66	10	0-60
BOARD OF CHILDCARE	5 (2)	56	13	12-35
CENTRONIA*	8 (3)	112	33	0-60
FIRST ROCK BAPTIST	6 (2)	90	8	0-48
HAPPY FACES	16 (3)	87	24	0-60
IDEAL	4 (1)	44	8	0-48
KIDDIES KOLLEGE	7 (3)	72	14	0-60
KIDS ARE US I	3 (1)	13	6	0-36
KIDS ARE US II	5 (3)	56	11	0-48
MARTHA'S TABLE	6 (4)	61	17	0-48
MATTHEWS	5 (3)	66	10	0-60
NORTHWEST SETTLEMENT #1	2 (2)	20	3	24-48
NORTHWEST SETTLEMENT #2	4 (2)	29	11	0-35
PARAMOUNT	6 (3)	55	15	24-60
RANDALL HYLAND	3 (2)	16	5	35-60
SOUTHEAST CHILDRENS	5 (3)	52	15	0-35
SPRINGFIELD	5 (3)	30	16	0-60
ST. PHILIPS	6 (4)	40	14	0-60
ST. TIMOTHY'S	6 (3)	46	10	0-60
SUNSHINE	12 (2)	175	27	0-60
WEE WISDOM	2 (0)	22	4	12-35
ZENA*	11 (5)	86	30	0-60
TOTAL:	133 (57)	1310	312	

*Some centers serviced had mulitple sites

Frequency and Intensity of Services

The specific activities 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 reported 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, attending 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 2 for the 57 classrooms in the evaluation study. The average number of visits per classroom was 13.41 with a range of 2-32 visits during the course of the year. This average number of visits remained nearly unchanged from year one. The average number of hours of consultation for each classroom was 11.99 but this ranged from 1-31 hours. Table 2 also reports on the average number of times that consultants performed a variety of activities in each of the classrooms in the evaluation study. The two most frequent activities provided by consultants in the classroom were Teacher Consultation and Classroom Observation, which had a mean number of occurrences of 8.43 and 7.21, 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 directors' input.

The standard deviations indicate there is variability across consultants, CDCs and classrooms, reflecting the ability of the model to respond to differing needs.

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

Table 2: Mean number of hours and number of times an activity was performed in each classroom in the evaluation study (n=57)

Consultation Activity	Mean	Standard Deviation
Time in classroom (in hours)	11.99	7.29
Time outside of classroom (in hours)	1.04	4.70
Conduct Observation	7.02	4.92
Consulted with director	5.12	4.64
Consulted with teacher	8.43	5.42
Contacted with parent	2.91	6.27
Prevention/ Early Intervention	4.53	4.79
Model	1.42	5.36
Train	3.57	1.69
Meeting	1.11	.77
Other	1.31	1.19

Another major activity for the Healthy Futures consultants with the CDCs was training. Over the course of year two, more than 110 hours of training was provided across a wide variety of topics. The most common topical area was social emotional development in young children, and other popular topics included: emotion coaching and brain development (See Table 3). Centers varied on how much training they received as well as the topics for the training, both of which were driven by the needs of the teachers. The average number of training hours per site was 5.8, but the actual number of hours varied greatly (from 1-18).

Table 3: Hours spent on training in specific topics

Training Topics	Training Hours
Social and Emotional Development	23
Emotional Coaching	16
Keys to Brain Development in Young Children	12
What is ECMHC?	10
Behavior Management	7
Stress Management	5
Screening with the Ages & Stages Questionnaires (ASQ)	4
Positive Discipline /Behavior Management	3
Setting up your Classroom for Success	3
How to Deal with Challenging Behaviors	3
Team Building	3
Routines and School Readiness	3
Circle Time	3
Transitions	2
Setting Limits and Praise	2
Engagement	2
Interactions with Infants	2
Any Training related to CLASS tool	2
Understand Toddler Development/Behavior	1
Understand Pre-K Development/Behavior	1
Developmental Milestones	1
Universal Screening	1
Professional Development (Ethical Practice)	1
Developing Communication Skills for Team Members	1
Understanding Temperament	1
Cultural Heritage: Black Parenting	1
Child Development	1
Strength and Power of Diversity	1
Inclusion of Children with Cerebral Palsy	1

Year Two Outcomes Measured

Consistent with the federal requirements under Project LAUNCH from SAMHSA, the measures selected for the external evaluation were designed to assess change at multiple levels: in year one, given the emphasis on programmatic (or classroom-focused) consultation, the Preschool Mental Health Climate Scale (PMHCS) was chosen to measure change over time in the classroom climate. The tool was developed by Walter Gilliam, from Yale University, and was used in several of his randomized controlled trials of mental health consultation in Connecticut.[14] It was also used in the statewide evaluation of mental health consultation in Maryland.[15] The Healthy Futures consultants completed this tool during a several hour observation of the 58 classrooms selected for the evaluation; in year one classroom climate was measured as consultation services were initiated, mid-school year, and at the end of the school year. Positive results were found on the PMHCS in several domains; however, this measure was completed by the consultants themselves in the classrooms they served, and it took a great deal of the consultants' time.

In year two, to increase the rigor of the evaluation, an objective trained rater observed each of 16 randomly selected preschool classrooms for three hours in the fall and spring of school year 2011-2012. The observer then rated each classroom using the Classroom Assessment Scoring System/Pre-K,[2] a standardized measure of the quality of the classroom environment. The CLASS measures three domains: emotional support; classroom organization (including behavior management); and instructional support (See Appendix for details of the constructs within each domain that are measured).

As was done in year one, to assess change over time in the attitudes and beliefs of the CDC staff, the Goal Achievement Scale (GAS) was completed by the CDC directors.[16] This measure was completed at the beginning of the school year and at year's end. Teacher job stress was also measured in the year two evaluation. Based upon concerns about the validity of the items used to measure job stress in the teachers in last year's evaluation, a significant revision to that tool was undertaken for the year two evaluation. The evaluation team reviewed the original literature on the development of the Child Care Worker Job Stress Inventory[17] and selected a different pool of items that were more closely aligned with consultation. These items were rated by the Healthy Futures management team on their relevance and likelihood of changing as a result of consultation.

A final pool of 27 items were retained for the year two job stress measure: roughly half were to be rated in a positive direction and the remaining items were reverse scored. The items were mixed up to protect against response bias. (The GAS and Job Stress measures are included in the Appendix.)

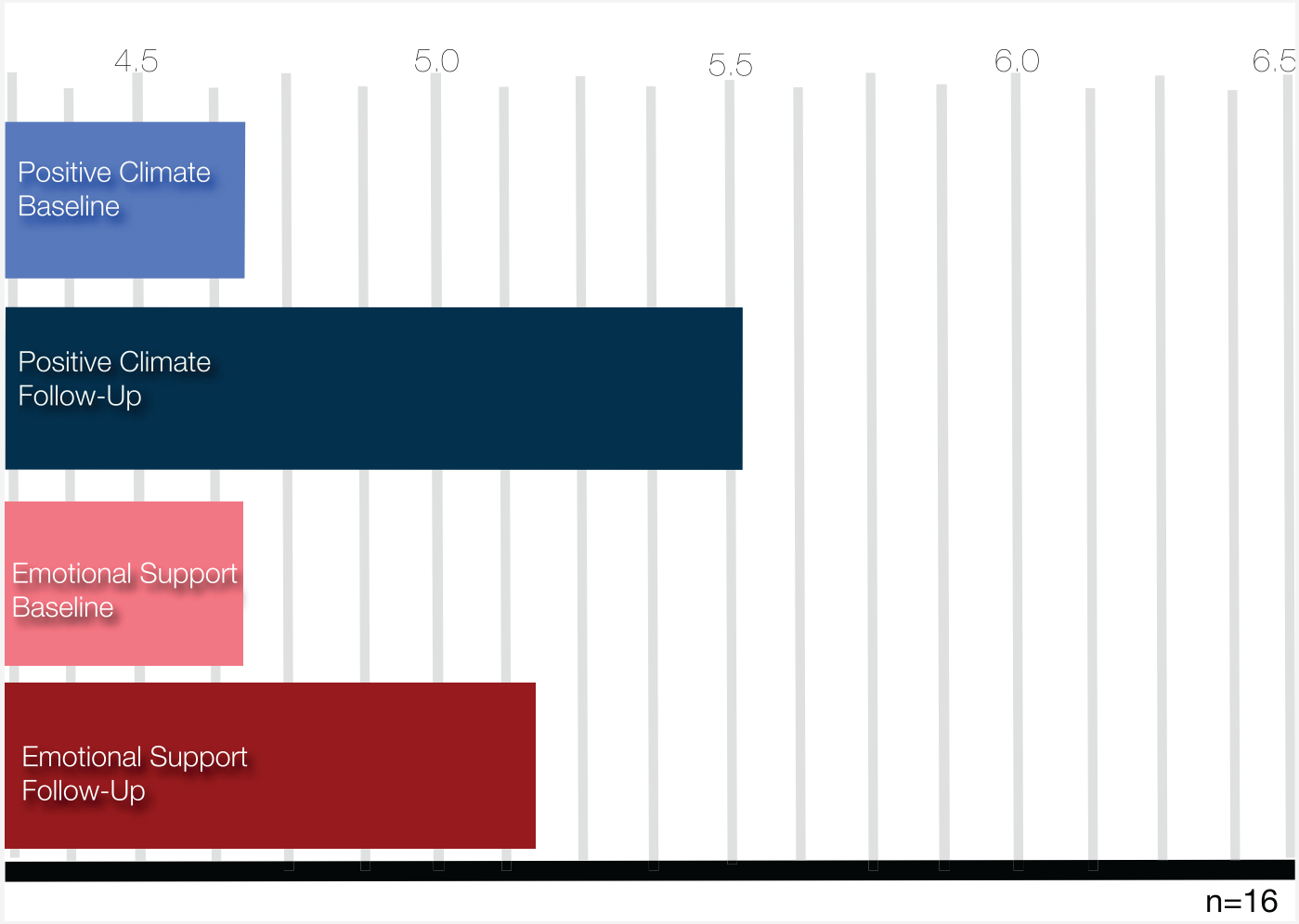
Bivariate statistical analyses were conducted to assess change over time from the baseline to end of school year. Mean differences were assessed using t-tests and all statistically significant changes appear Table 4 and in Figures 1 and 2.

CLASS Scores

A small sample (n=16) of classrooms serving preschool aged children were observed in the late fall and spring of 2011-12. There are three main subscales on the CLASS: emotional support, classroom observation, and instructional support. The emotional support subscale is comprised of four domains: positive climate; negative climate; teacher sensitivity; and regard for student perspectives. Classroom organization measures three domains: behavior management; productivity; and instructional learning formats. Instructional support includes: concept development; quality of feedback; and language modeling. Mental health consultation focuses on the emotional climate of the classroom and as such should be expected to impact the domains of: positive climate; negative climate; teacher sensitivity; and behavior management.

CLASS scores range from 1 to 7 with scores in the 1-2 range being low, 3 to 5 as middle range, and 6 and 7 considered high. Statistically significant improvements in the positive climate ($p<.01$) and overall score for emotional support were seen over time ($p< .07$). Positive climate increased a full point from a mean of 4.67 to 5.53 and emotional support improved from 4.63 to 5.19. Smaller improvements in teacher sensitivity and behavior management were observed, but they failed to reach statistical significance due to the small sample size. Interestingly there were also increase in negative climate seen in this sample, with mean scores starting high at 6.01 and increasing to 6.49 in the spring ($p<.10$). This last trend seemed to be driven in part by the 2 classrooms where there was teacher turnover from fall to spring.

Figure 1: CLASS Scores changes in Healthy Futures Classrooms served from fall 2011-spring 2012



When the CLASS scores were examined at the individual classrooms level, some interesting trends emerged. More than half of the classrooms showed positive change on 7 of 10 of the subscales; four classrooms improved on all 10 subscales. 10 of the 16 classrooms showed positive changes on the four main subscales of interest: positive climate, negative climate, teacher sensitivity and behavior management. Interestingly, changes in the CLASS scores were not related to the amount of time spent in the classrooms nor the number of visits. However, lower scores on several of the important domain scores at baseline was correlated with increased time spent by consultants in the classrooms; this indicates that the consultants adjusted their time on site to reflect higher levels of need in these classrooms. Additional analyses revealed a positive correlation between improvements in negative climate with increased time onsite in those classrooms.

Additional impacts of the Healthy Futures project were seen in changes over time in the attitudes and beliefs of the CDC directors. Data collected from the Goal Achievement Scale (GAS), which were completed by the child development center directors, indicated a significant increase in several items as seen in Table 4.

Table 4: Statistically significanct changes in GAS items as reported by CDC Directors

Goal Achievement Scale (GAS) Scores range from 1-3				
Item #	Content	Fall Mean	Spring Mean	P-value
GAS4	"Teachers respond appropriately and effectively to children in distress."	2.14	2.36	.096
GAS6	"Teachers have a positive attitude about working together with parents."	2.45	2.68	.057
GAS8	"Teachers feel comfortable referring a child and family for mental health services."	2.00	2.38	.057
Goal Achievement Scale (GAS) Scores Range from 0-39				
GAS Total		31.5	33.2	.074
	(Note a p-value of less than .10 was used due to the sample size N=22).			

Teachers reported on their levels of job stress in the fall and spring. Several of these items showed statistically significant changes over time, but most reflected increased stress in the spring. When these paradoxical findings were analyzed in more detail, it was revealed that the increases in job stress were being largely driven by the classrooms in which new teachers had come on during the school year. In particular, there were 19 classrooms where a different teacher completed the Child Care Inventory at baseline and in the spring. These teachers had higher levels of stress in the spring than their predecessors reported in the fall. This turnover in the teachers makes the findings from a study based upon a pre-post-design very difficult to interpret.

End of the Year Directors' Survey Summary

In June 2012, 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. Approximately two-thirds of the child development center directors returned their surveys. The findings were extremely positive:

- All of the directors' reported that areas identified on the needs assessment plan had been addressed by the Healthy Futures consultants.
- All of the 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 speaking with the consultant and exploring ways to help their children.
- 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 staff trainings, assistance with developmental assessments and screenings, and help with increasing parent involvement within their centers.
- All directors would recommend the Healthy Futures program to other child development centers.
- The center directors reported as a result of the consultation service, their centers and staff have a better understanding of social emotional development and are better equipped to identify and refer children and families for services. In addition, directors indicated that their staff are providing quality, age appropriate activities and engaging in more positive interactions with children.

"[Child] has done extremely well; his friends, his therapists and the staff adore him, and some of the parents and grandparents have informally adopted him. [Child] has completed a year at the center and will be transitioning soon to another placement as he has aged out of his current center placement. The staff and parents are much more informed about CP (Cerebral Palsy) and they are empowered that they have the skills and competence to work with a child with special needs."

- Catherine Graham,
Healthy Futures Consultant

Child-Specific Consultation

In addition to providing programmatic consultation, the Healthy Futures consultants worked with teachers who identified children who had specific behavioral or social emotional concerns. In year one, 43 individual children came to the attention of the Healthy Futures program because of concerns about their behavior or social-emotional problems. In year two, 57 children were identified as needing child-specific consultation. Many of the behavioral problems exhibited by the children were externalizing—or acting out—symptoms. [See Table 5].

As part of the increased focus on child-specific consultation, consultants requested the teacher and parent complete a Devereux Early Childhood Assessment (DECA) to identify areas of individual strength and need. For nearly half of the children referred, either the parent or the teacher completed the DECA which measures: attachment, self control, initiative (all of which combine to a total protective factors sub-score); and behavioral concerns.

Table 5: Most common developmental concerns identified for children in need of child-specific consultation.

Concerns Identified	Percent of reports	Number of children (n=57)
Easily distracted	54.4%	31
Attention seeking	50.9%	29
Does not follow directions	45.6%	26
Fights classmates, staff members, parents	43.9%	25
Disruptive	42.1%	24
Does not follow classroom routines	40.4%	23
Difficulty with peers in classroom	35.1%	20
Destroying property	31.6%	18
Does not verbalize wants	28%	16
Bizarre thoughts or behaviors	22.8%	13
Excessive/ uncontrollable crying	22.8%	13
Irritable/ angry/ hostile	21%	12
Clings to staff/ parent/ other adults	21%	12
Does not make needs known (verbal/non-verbal)	21%	12
Speech concerns	19.3%	11
Play alone and ASQ referral	15.7%	9

DECA T-scores below 40 on the protective factors (i.e., Initiative, Self-Control and Attachment) indicate areas of concern, as do T-scores above 60 on the Behavioral Concerns subscale. As can be seen in Figure 2, parents and teachers reported very similar levels of concern across all of the domains on the DECA. The DECA T-scores indicate that children referred for child-specific consultation were, on average, scoring in the area of concern across all of the domains.

Figure 2: DECA T-Scores reported by subscale from teachers and parents

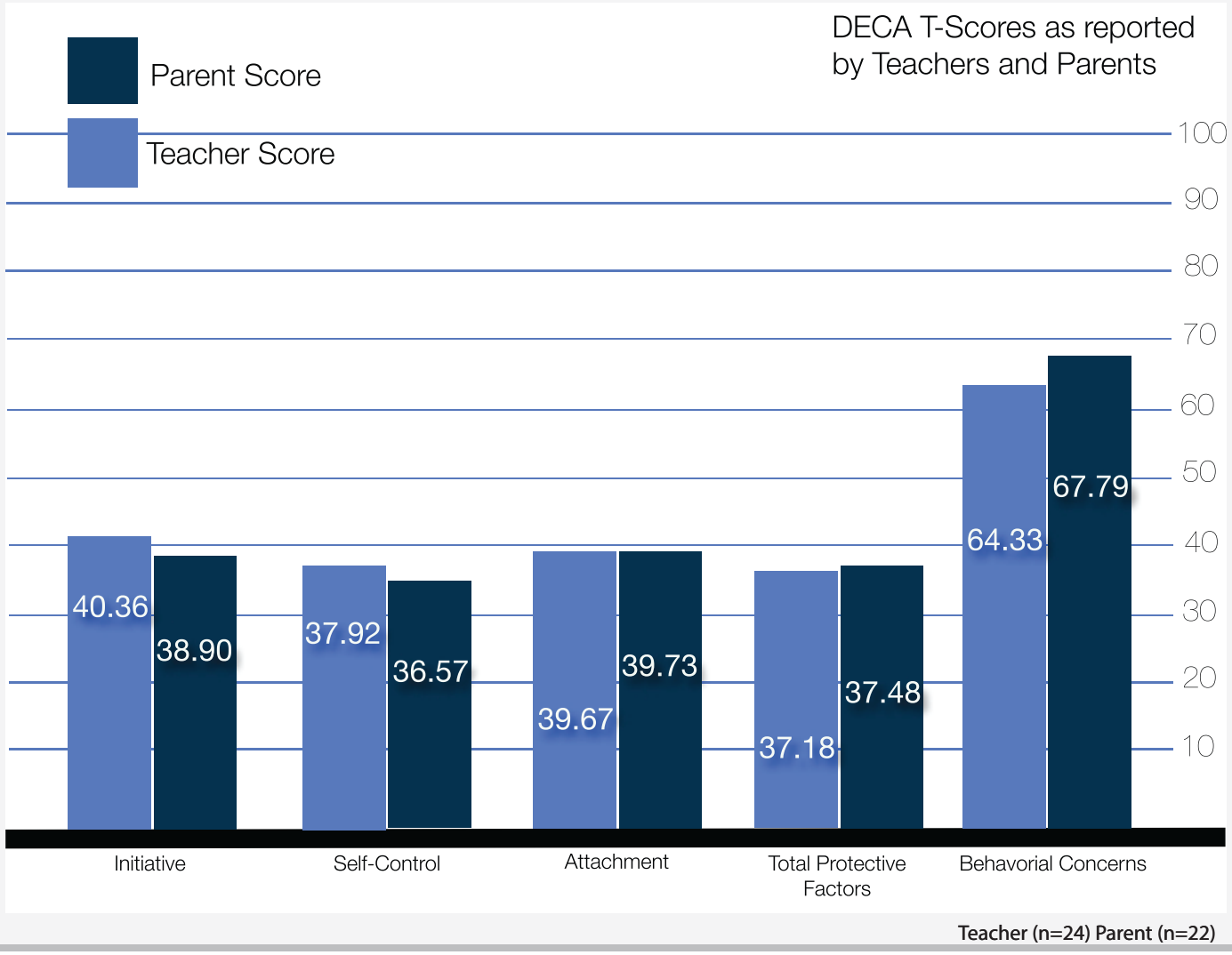
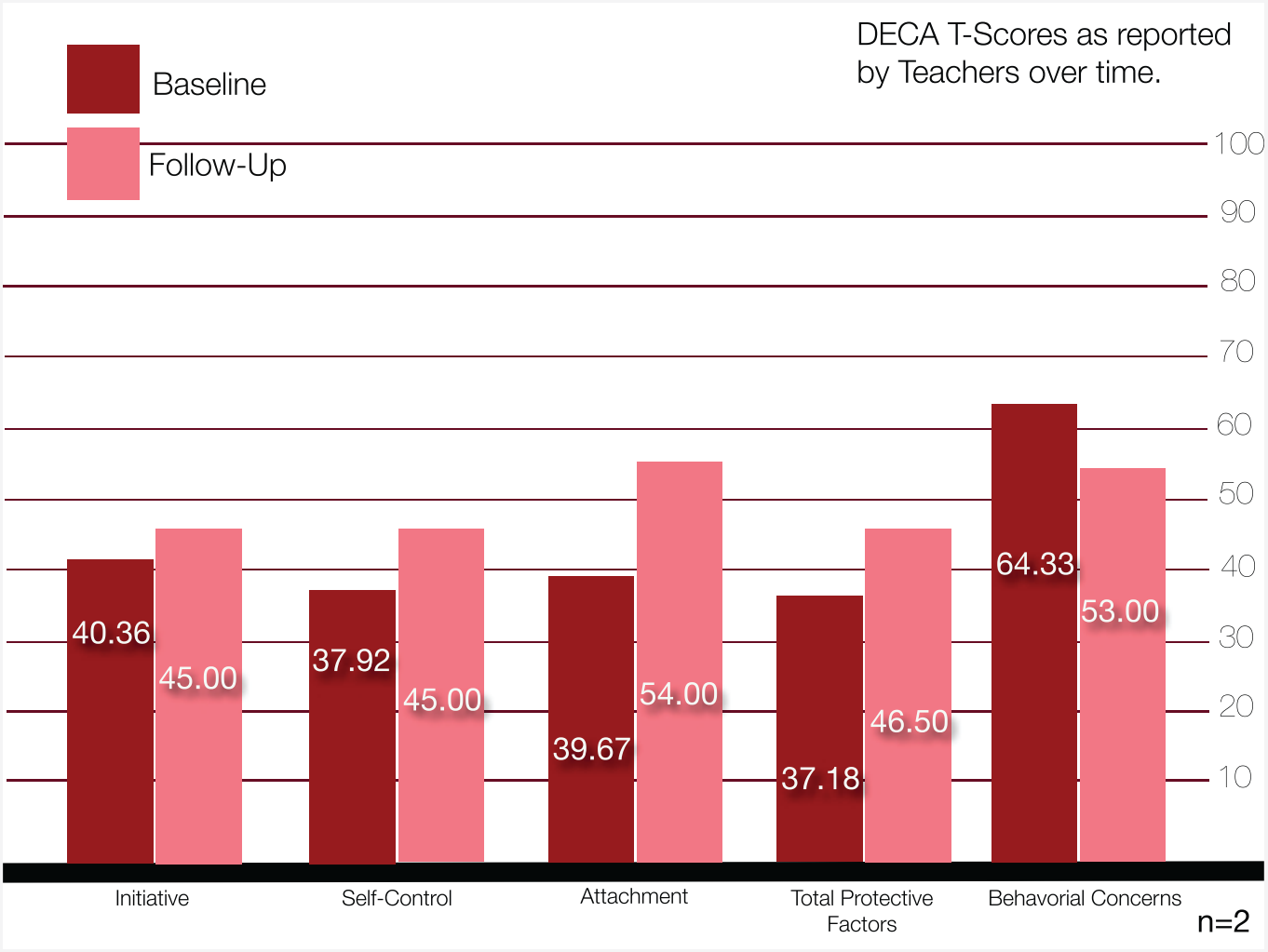


Figure 3, on the next page, shows the change over time in the teachers' ratings of children referred for child-specific consultation. All of the ratings improved at a statistically significant level; and children moved out of the area of concern into the "typical" zone. However these data were available for only 2 children. And no post-intervention data were available from parents. Reasons for the failure to collect post-intervention data are likely to be driven in large part by a lack of clarity about when the follow-up scales should be handed out to teachers and parents. Also given that parents are not a primary target of the consultation model, it might be hard for the consultants to get follow-up surveys back from families. Finally, some of the children were referred in the spring, and they were still receiving consultation services at the time the report was prepared.

Figure 3: DECA T-Scores reported by subscales from teachers over time



*Differences are statistically significant for all subscales (n=2)

In 14 of the CDCs, DMH also was implementing 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 pre-kindergarten through third grade. Young children with early school adjustment difficulties are identified through the use of carefully developed screening and detection methods[i].

Analysis of Expulsion Data

Mental health consultation seeks to reduce the number of these children who are asked to leave their child care placement. As was the case in year one, only three expulsions were reported by the early childhood mental health consultants across the 25 CDCs served. This rate of 3 expulsions per 1,300 children compares favorably to the national rate of 6.7 children per 1,000 served in pre-kindergarten reported by Dr. Walter Gilliam in his landmark expulsion study (2005).

In order to better understand the factors that contributed to these three children being asked to leave their CDCs, exit interviews were conducted by the evaluation team at Georgetown with each consultant. This year, all three children were between the ages of 3 and 5 years old and were in the same class at the same child care center. All of the children were exhibiting high levels of aggressive behaviors and several also had significant family level stressors (i.e., parent recently incarcerated). In addition, the classroom teacher reported high levels of stress on her job stress survey. The levels of aggressiveness that these children exhibited led to concerns that they threatened the safety of other children in the classroom. This led to the Director, in consultation with the Board of Directors, to decide that expulsion was necessary.

"[Child] was diagnosed with autism through Early Stages. Mom had a difficult time accepting this diagnosis. I met again with mom and, after listening to her feelings, reassured her that getting [Child] help now, at this early age, would benefit [Child] tremendously in the long run. It took mom a few more weeks to fully accept this diagnosis but she is now relieved that [Child] will have the support he needs in his new DC public school which he begins in August 2012. Mom can now speak about what she saw in his behaviors as signs of autism. In July [Child] was participating briefly in circle time (mostly to come in and dance), following directions more often, could share toys with friends and participate in planned activities. A follow-up DECA was completed and [child] showed signs of improvement in, amongst other things, having temper tantrums, attention span, and making decisions for himself. The teachers felt proud that they were able to see these improvements in [Child] and that their hard work and perseverance paid off. "

-Stephen O'Connor
Healthy Futures Consultant

Summary of Year Two Results

Over the first two years of implementation, The Healthy Futures project in the District of Columbia demonstrated consistently positive results. The project was able to recruit and retain highly qualified mental health professionals and provided them with excellent training and support. Many of the CDCs originally recruited for year one continued to participate in the Healthy Futures project during the second year—in large part because of the success of the consultation model as well as a high level of ongoing need in CDCs serving young children in poor areas of the city.

This on-going need was underscored by the fact that one-third of the teachers who completed the follow-up measures were different than those who were in the classrooms at the beginning of the school year. These new teachers, on average, reported higher levels of job stress in the spring.

In addition, the classrooms with different teachers for the CLASS observations also had increased levels of negative climate, likely tied to their higher stress levels. These factors point to the opportunity to prioritize new teachers as a possible area for focus in year three of of Healthy Futures implementation.

The Healthy Futures consultants provided a range of 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 reflected in data reported across a number of respondents. Finally, only three children were expelled from their CDC—a rate half of the national average. All these data provide a strong rationale for continuing the Healthy Futures project as a critical school readiness strategy in D.C.

Lessons Learned and Recommendations for Future Years

There are a number of lessons learned and recommendations for the Healthy Futures model based upon the multi-level data collected from the year two evaluation:

- ***The Healthy Futures team should develop a data-informed decision-making process that identifies CDC's who no longer need consultation services so that any needed transitions can be managed smoothly.*** As the embedded model was implemented for a second year, it became clear that at a one-year commitment was insufficient to meet the needs of high risk children in CDCs that experience one-third of the workforce turning over every year. The strong satisfaction data from the CDC Directors as well as the annual needs assessment process bolsters the lrationale for a long-term commitment to the CDC's.

- ***Additional consideration should be given to how intensively parents can/should be involved in the consultation process.*** While there was growth in the number of child-specific consultation cases identified, more work is needed to refine this aspect of the model. Special attention should be paid to family engagement as directors, teachers and consultants seek parental permission for children who have observable concerns identified by their teachers.

- ***As part of ongoing data collection efforts, the Healthy Futures program should consider collecting post-intervention data at a fixed time point (i.e. 3-4 months following parental consent.)*** In year two, the Healthy Futures program generated approximately 25 child-specific consultation cases. Parents and teachers completed DECAs on these children at the start of consultation, but only 2 teachers completed post-intervention DECAs. While some of these data are still pending due to the timing of the referrals, others were simply not collected—limiting the ability to document change over time in child-level outcomes.

- ***Further discussion about the balance between consultation and training should be discussed by the management team and the Healthy Futures consultants.*** Activity logs were analyzed for the first two years of implementation for the random samples of classrooms served by the Healthy Futures consultants. While the number of visits stayed nearly the same for year one and two, the amount of time spent on consultation decreased markedly. There are several possible explanations for this: in year one, the consultants were required to complete a 2-3 hour observation for each of the three PMHCS they did for the 58 classrooms in the study sample. In year two, an external observer completed these observations at two time points using the CLASS. In addition, in year two, the consultants performed a great deal of training—which is not included in the consultation model per se, but serves to supplement the consultation provided to the teachers in the CDCs. However, the impact of training on teachers skills and knowledge was not measured in this evaluation.

- ***The Healthy Futures program should pay particular attention to new teachers who enter during the school year and consultants should collect baseline data from new teachers when they enter the CDCs.*** The year two evaluation revealed that one-third of the teachers who completed the job stress survey were different people than at the start of the school year—a percentage that is consistent with national trends. The analysis of the job stress surveys also revealed that these new teachers had higher levels of job stress in the spring. Classrooms where the teacher changed also had higher scores on negative climate on the CLASS.

- ***The DC DMH in partnership with the DOH should implement an ongoing evaluation plan that measures changes over time at the director-, teacher-, classroom- and child-level indicators.*** Finally, the data from this evaluation underscore the need for ongoing monitoring of outcomes at multiple levels to truly understand the impact of this complex intervention. With federal grant funding from Project LAUNCH available only for a limited time, the DC DMH will need rigorous data to justify the continued operation and funding.

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,[18] the Healthy Futures project has a solid program infrastructure, high-quality (well-trained and well-supported) consultants, and delivered high-quality services. The model includes a readiness assessment, is relationship-focused and uses evaluation data to provide continuous quality improvement. The first several years of results demonstrated impacts on children, teachers and the quality of the CDCs. Lessons learned are being incorporated into subsequent years of implementation and continued positive effects on school readiness should be anticipated.

[i] The Primary Project initiative was also implemented in 16 elementary schools and has been very successful in screening and referring children in need of additional services. Data are available from the DC DMH.

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Appendix

1. Criteria for Assessing Need for Continued ECMHC Services
2. Activity log Definitions
3. Classroom Assesment Scoring System
4. Child Care Provider Survey
5. Goal Achievement Scale

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)					

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.

3/23/11

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 Care Provider Survey

Child Care Program Name:_____ Date:_____

Classroom Name/ ID:_____ Teacher Initials:_____

Section 1:
We would like you to indicate HOW OFTEN certain things happen at your job. Please write in…

1	2	3	4	5
Rarely/ Never	Occasionally	Often	Usually	Most of the Time

WHAT YOUR WORK IS LIKE?

_____ 1. I feel competent in what I do.

_____ 2. I find it hard to talk to parents about problems I am having with their children.

_____ 3. I wish that I had more help to deal with demands placed upon me at work.

_____ 4. I learn new skills in my work.

_____ 5. I feel used up at the end of the work day.

_____ 6. I see that my work is making a difference with a child.

_____ 7. I know that I am appreciated by the parents.

_____ 8. I worry about how I would handle a crisis at work.

_____ 9. Children have behavior problems that are hard to deal with.

_____ 10. All of the children need attention at the same time.

_____ 11. I worry that this job is hardening me emotionally.

_____ 12. I feel like I become close to the children.

_____ 13. I feel like I am teaching the children the skills they need for school.

_____ 14. I have fun with the children.

_____ 15. Working with people puts too much stress on me.

_____ 16. Teachers cause extra work for me because they are not doing their jobs.

_____ 17. I feel that my director is never around when I need help.

Section 2:
How often do you ACT OR FEEL this way while at work? Please write in…

1	2	3	4	5
Rarely/ Never	Occasionally	Often	Usually	Most of the Time

_____ 18. This job makes me feel good about myself.

_____ 19. I'm careful not to take my stress out on children or parents.

_____ 20. The parents are grateful to me for the care I give to their children.

_____ 21. My ability to care is all used up at the end of the work day.

_____ 22. I work hard to keep myself in a positive mood at work.

Section 3:
We would like to ask you HOW SATISFIED you are with other things about your job. Please write in…

1	2	3	4	5
Very Satisfied	Somewhat Satisfied	Neither Satisfied or Dissatisfied	Somewhat Dissatisfied	Very Dissatisfied

HOW SATISFIED ARE YOU WITH….

_____ 23. Your relationship with the parents

_____ 24. Your relationship with the children.

_____ 25. How much stress you feel at the end of the day.

_____ 26. How much you can show your true feelings to the children.

_____ 27. How much you can show your true feelings to the parents.

Comments:

_____

_____

_____

_____

_____

_____