Healthy Futures

Year Three Evaluation of Early Childhood Mental Health Consultation

by the District of Columbia Department of Mental Health

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Table of Contents

List of Tables and Figures

Year Three Executive Summary

The Washington D.C. Department of Mental Health (DMH) recently completed the third 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 (Cohen & Kaufmann, 2005; Duran, et al., 2009). 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. Two types of consultation services are offered:

- Programmatic Consultation: is focused on building the capacity of the teachers on behalf of all children in their classes.
- Child-specific consultation: is focused on those young children in need of individualized services as well as facilitating referrals for community-based services.

An evaluation of the Healthy Futures project was contracted by the DMH with the Georgetown University Center for Child and Human Development (GUCCHD). This year, evaluation 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 2012 to June 2013. This program year, satisfaction data were collected from the CDC directors and analyzed by a graduate student in public health as part of her masters' thesis; she also analyzed the activity logs from the four consultants. Key findings from all analyses include:

- More than 1,400 young children had access to high-quality mental health consultation services in community CDCs in all areas of the city. Only 4 children were expelled from their CDC, a rate less than the national average of 6.7 per 1,000 (Gilliam, 2005). This marks the third year in a row that the expulsion rate in these CDCs was below the national average.
- Teachers identified 111 children who were exhibiting problem behaviors. Permission to work directly with these children was granted by 55 of their parents. Baseline Devereux Early Childhood Assessments (DECA) were completed for nearly all (n=50) of these children by their teachers and/or parents. Follow-up data were gathered 3-4 months later and available for 35 children.
  - ★ Statistically significant improvements were reported by teachers for children who received child-specific consultation across four domains measured by the DECA: attachment, initiative, self-regulation, and the total protective factors. (See figures 2 and 3 on pages 23 and 24.)

- Statistically significant improvements were seen from baseline to follow-up in the emotional climate of the 28 classrooms who received programmatic consultation using the Arnett Caregiver Interaction Scale (CIS). The CIS rates the quality of the teachers' interactions with the students including indicators of positive relationships, and evidence of three types of negative interactions: punitive behaviors, permissiveness, and detachment.
  - ★ Statistically significant improvements were seen across all four domains after 3-4 months of programmatic consultation. (See Figure 4 on page 25.)
- As in the past, the CDC directors reported high levels of satisfaction with the Healthy Futures project and would recommend the program to their colleagues. All wanted to continue receiving the services and many wanted the consultants to be spend one additional day on-site each week.

Lessons learned and recommendations for subsequent years:

- There continues to be considerable turnover in the workforce across the CDCs, underscoring the importance of the long-term commitment to these centers. This year—as in year two—one-third of the teachers who completed the post-test measures were different than those who completed the baseline surveys.
- Year three saw a significant change in defining the protocols for programmatic and child-specific consultation. This led to improved data collection and assessment protocols as well. The level of pre-/and post-data collected allowed for better documentation of the impacts of the Healthy Futures services.
- As the child-specific consultation process becomes even more solidified, increased focus should continue to be paid to how to better involve families of children identified with social-emotional and behavioral challenges. This will allow the gains in children's protective factors to be sustained as they move on to elementary school.
- A Substance Abuse and Mental Health Services Administration (SAMHSA) grant provided funding for all four mental health consultants during years two and three. However, this financing strategy is not sustainable as the grant ends in 2014. Policy makers from the Departments of Health and Mental Health will need to seek new funding sources to sustain this program in the coming months and years.
- Should additional funding become available, data gathered from a community comparison sample of CDCs would validate that the Healthy Futures model was responsible for the gains seen in the children and teachers who participated. This quasi-experimental design would help quantify the added value of embedding these mental health consultants at the CDCs.

The third year of the Healthy Futures implementation was marked by an increased rigor of the implementation of the core components of the consultation model: programmatic and child-specific consultation services. Data collected by the consultants on changes in classroom practices as well as those provided by teachers of children with identified behavior problems documented improvements associated with consultation. These changes contribute to improvements in the school readiness of young children in the District of Columbia.

Introduction

Early childhood mental health consultation (ECMHC) is an emerging evidence-based practice used to promote children's healthy social and emotional development in a variety of settings. One of the earliest definitions of ECMHC was included in the monograph *Early Childhood Mental Health Consultation* (Cohen & Kaufmann, 2000; rev. 2005). This definition emphasized the collaborative relationship between a mental health professional consulting with caregivers (i.e., early childhood staff and family members) and defined two types of consultation: child- and family-centered consultation and programmatic consultation. The primary goal is of each is to build the capacity of early childhood professionals and families to support the social emotional development of young children and address concerns about children who have challenging behaviors. Consultants do this by working alongside the early childhood professionals, sharing strategies, modeling evidence-based intervention approaches and cultivating a deeper understanding of the factors that shape young children's social-emotional development.

While mental health consultation can be embedded within a variety of settings serving young children and their families, during the last decade, the majority of ECMHC evaluations were conducted in early child care and education settings. Comprehensive program evaluations of ECMHC usually measure outcomes at multiple levels: child, teacher, classroom, and program levels. This approach is indicated because of the inherent inter-connectedness of these elements in an ECMHC model. ECMHC often relies on the involvement of the child care director as well as the classroom teachers. A child care director's understanding of the factors that contribute to young children's social-emotional development can impact how supportive s/he is of her staff as staff attempt to implement the strategies recommended by their mental health consultant (MHC). Additionally, the emotional climate of a classroom is a function of how well the teachers' are able to work together, their own interaction styles and their emotional availability; this in turn has a direct impact on the behavior of young children in their classroom. Children with challenging behavior may be particularly sensitive to the tone of the teachers' interactions and those children's negative behavior may also contribute to a negative classroom environment. The next section summarizes what is known about the impact of ECMHC on a variety of outcomes.

The Evidence Base for ECMHC

A recent article in a special issue of the journal *ZERO TO THREE* focused on EMCHC summarized the findings from recently completed program evaluations in seven states (Hepburn, Perry, Shivers and Gilliam, 2013). Most notable, for this report, the year one and two Healthy Futures evaluation findings were incorporated into this synthesis. This article also integrated the findings from two earlier peer-reviewed reports on the level of evidence for the effectiveness of ECMHC (Brennan, et al., 2008; and Perry, et al., 2010). These authors found evidence of impacts of EMCHC on classroom climate, teacher's skills, children's social-emotional behavior and expulsions from child care.

There is evidence of impacts of early childhood mental health consultation on classroom climate, teachers' skills, children's social-emotional behavior and expulsion from child care.

Improved Classroom Climate

One of the primary outcomes for programmatic consultation is improvements in the emotional climate of the classroom. This can be captured in several ways, most commonly through an observational tool that documents aspects of the teachers' behaviors and interactions with each other and the children. To assess the effects of EMCHC on the emotional climate of classrooms, Gilliam (2008) developed and pilot-tested a measure called the Preschool Mental Health Climate Scale (PMHCS). This tool gathered data on indicators of teacher behaviors that could plausibly be changed through the work of a MHC. Because this tool was created specifically for ECMHC evaluations, many evaluators have requested permission to include this in their evaluations. For example, the Healthy Futures year one evaluation used this as a primary outcome measure of programmatic consultation, as did the evaluations in Maryland and Arizona. All three of these research teams found evidence of strong positive results. Teachers improved in their interactions to support social and emotional development, showed increased teaching about feelings and emotional problem-solving skills, and other interactions related to classroom quality.

Another important tool measuring the quality of the classroom climate is the CLASS (Pianta, et al., 2008). Unlike the PMHCS, which was completed by the MHC during their initial observation of the classroom and then again after consultation was completed, the CLASS is rated by a trained external observer. The CLASS assesses a variety of domains of teacher-child interactions including: teacher sensitivity, emotional support, and elements of the classroom's organization that can impact

young children's social, emotional, and educational experiences. This measure was used in the year two evaluation in DC and administered by a trained research assistant not associated with the child care program or the provision of ECMHC. It was also used in the statewide ECMHC evaluation conducted in Louisiana. Both evaluations reported significant improvements in many of the domains included in the emotional support and classroom organization subscales.

Improved Teachers' Skills

Another target of programmatic consultation is the teacher's skills in managing problem behavior and understanding young children's social emotional development. In their research synthesis of ECMHC on staff and program level outcomes, Brennan et al. (2008) found ECMHC was associated with behavioral changes and improved skills in the teachers. In several cases, these changes were reported on by the child care directors using a tool called the Goal Achievement Scale (Alkon, et al., 2003). This 13-item survey asks directors to rate their teachers on a variety of indicators including how well they: understand children's social and emotional development; manage children's difficult behaviors; and try to understand the meaning of children's behavior. Many teachers reported improvements in their classroom management skills and in their interactions with children and parents. In DC, child care center directors reported changes in their staff's skills in year one and two evaluations. For example, in year two, classroom staff were reported to improve on their ability to manage challenging behavior and had a more positive attitude about working together with parents.

Child-level Outcomes

Most of the children identified as needing child-specific consultation present with challenging behaviors. Perry et al. (2010) conducted a research synthesis examining the level of evidence for ECMHC impacting children's social-emotional and behavioral outcomes. The majority of the studies they analyzed reported improvements in social-emotional development. These included changes in initiative and attachment, self-regulation, and other social skills, depending on the measures used. Several of the recent studies, in Michigan, Maryland and DC, used the Devereux Early Childhood Assessment (DECA; LeBuffe & Naglieri, 1999), and all of these reported increases in social skills, social-emotional functioning, and protective factors for children who received child-specific consultation. The findings from DC were reported in their year two evaluation, but the sample size was very small, limiting their generalizability.

ECMHC has consistently been associated with reductions in externalizing behaviors (Perry, et al., 2010). This finding is the most robust from the research synthesis, since it held true regardless of whether the children's behavior was reported by the teachers or rated independently by an external observer. This finding was bolstered by evidence from evaluations conducted recently in the Connecticut ECMHC program, DC Healthy Futures, Maryland Early Childhood Mental Health Project and Arkansas' Project PLAY programs. These researchers reported fewer behavioral concerns for those children who were identified as needing child-specific consultation—including fewer children with behaviors in the clinical range using the DECA-C.

Interestingly, the Maryland evaluation also used the Strengths and Difficulties Questionnaire (SDQ) to assess the overall level of behavioral challenges present in classrooms at two points in time (see Appendix A-1). At the beginning of ECMHC services, teachers rated the behavior of each child in their classroom anonymously and an aggregate score was calculated. Then four months later they completed the SDQ again—indicating which children were exhibiting behaviors that interfered in her ability to teach. After receiving programmatic consultation, on average, teachers reported reduced rates of problem behaviors in their students. While it could be argued that this measures the teachers' perception of the children's behavior, this finding suggests programmatic consultation might be impacting the behavior of a larger group of children.

Taken together, these studies suggest the evidence base for the effectiveness of ECMHC is growing and the findings from the first two years of the Healthy Futures evaluation are well aligned with these national data.

Reduced Expulsions

In 2005, Walter Gilliam published a landmark study providing the first ever national data on the rates of expulsions from state-funded pre-kindergarten programs. The rate was three times higher than that for K-12 programs (6.7 per 1,000 versus 2.1 per 1,000, respectively) and this served as a catalyst for the development of many ECMHC programs across the country. Gilliam and Shahar (2006) also reported an association between the presence of on-site ECMHC and reduced rates of expulsions. Similar results have been reported in three recent program evaluations. Specifically, expulsions were monitored in the evaluation of ECMHC in Michigan, Maryland and DC. In DC's year one and year two reports the expulsion rates were well below the national average estimated by Gilliam in 2005.

Taken together, these studies suggest the evidence base for the effectiveness of ECMHC is growing and the findings from the first two years of the Healthy Futures evaluation are well aligned with these data. They also suggest ECMHC can be a critical tool for promoting school readiness in young children at higher risk of behavior problems and expulsion, as well as improving the quality of the social emotional climate of classrooms where these children learn, grow and play.

The Healthy Futures Project

The Healthy Futures project was initiated by the Department of Mental Health (DMH) as an outgrowth of work on a white paper on the importance of addressing early childhood mental health in DC. In 2009, DMH secured seed funding from the Deputy Mayor of Education's office to support the program's first year of operations. At the same time, DMH partnered with the Department of Health (DOH), who was awarded a federal grant in 2009 from the Substance Abuse and Mental Health Services Administration (SAMHSA). This grant from Project LAUNCH allowed the Healthy Futures project to expand. In years two and three, Project LAUNCH funding paid for all four mental health consultants, as the local seed money expired. DMH also funded an external evaluation contract with local money to provide data to improve fidelity and contribute to discussions for sustainability beyond the federal SAMHSA grant period.

The early childhood mental health consultants are licensed mental health professionals who visit 6-7 centers once a week, or every other week depending on size of the CDC. 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. From the beginning, the Healthy Futures 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. In years two and three, the consultation model expanded to have a more explicit protocol to identify children with problematic behaviors in the CDCs. With parental permission, children would receive *child-specific consultation* focused on their unique needs.

Ongoing reflective supervision is an important component of the Healthy Futures model. Consultants meet regularly as a group and individually to share strategies and receive support in this difficult work. To ensure fidelity to the Healthy Futures model, the DMH supervisory psychologist integrates what each of the consultant discussed during individual supervision with data provided through monthly reports.

Evolution of the External Evaluation Study

In this section, we provide a comprehensive overview of the details of the three year external evaluation conducted by the Georgetown University Center for Child and Human Development. This evaluation has been implemented in accordance with the principles of community-based participatory research—ensuring that stakeholders from the Departments of Mental Health and Health helped to select measures, interpret the findings and make recommendations for changes in the protocol year to year. This is important as the model is refined and new approaches to measuring the impact of ECMHC on outcomes emerge from the literature. This year, a logic model for Healthy Futures was developed and is included in the Appendix (B-1) (Rabinovitz, 2013).

Sampling Frame

During the first year of the Healthy Futures project, a wide net was cast to enroll child development centers (CDC) across the District of Columbia. The Office of the State Superintendent of Education's (OSSE) identified 323 licensed CDCs in the District from which the Healthy Futures program selected 24 partner programs. As Project LAUNCH resources were targeted to Wards 7 and 8, CDCs in this part of the city were over-represented. The Deputy Mayor of Education's office also requested the programs being run by the District of Columbia's Parks and Recreation's department that were being transitioned into United Planning Organization (UPO) sites be included in the Healthy Futures program. These sites were phased out in year two after determining they had access to mental health consultation under the federal Head Start Performance Standards.

Initially, emails and faxes were sent to all licensed CDCs. Those that responded positively were visited by a member of the management team jointly led by DMH and the Department of Health. A center agreement form was signed by the 25 CDCs selected to participate. The agreement outlined the roles and responsibilities of the consultants and discussed their ability to enter the programs with adequate space and support. It also asked 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 took place with a specific child. There was a formalized needs assessment completed by each center director about what they felt the needs were of each program before consultation services began. This process is conducted on an annual basis.

Sample of Classrooms

In years one and two, a stratified random sample of classrooms within the 25 CDCs was selected for data collection; classrooms were selected to ensure that they reflected the balance of ages of children served, size of CDCs, and Ward of the District. Approximately 58 classrooms were selected, roughly half of all of the classrooms participating in Healthy Futures. In years one and two, data collection followed a school year cycle, with baseline data collected in the fall and end of year data collected in May/June. One of the weaknesses of this approach was the data were collected in classrooms that received a wide variety of consultation hours—ranging from 1 to 31 hours over the school year.

In year three, the majority of the evaluation data collection was focused on classrooms that were identified for more intentional programmatic consultation. These classrooms were identified through a collaborative process between the CDC directors and the consultants. Baseline observations and classroom assessments were completed in each of these 38 classrooms (see measures below).

Measures

The measures selected for the external evaluation were designed to assess change over time at multiple levels: (1) directors' attitudes and beliefs; (2) teachers' job stress; (3) classroom climate; and (4) child-level outcomes. In each year of the three-year evaluation, adjustments were made as necessary to increase the rigor and/or precision of the measurement of these constructs (See Table 1 below).

(1) **Directors' Attitudes and Beliefs:** To assess change over time in the attitudes and beliefs of the CDC staff, in all three years of the evaluation, the Goal Achievement Scale (GAS; Alkon et al., 2003) was completed by the CDC directors (see Appendix A-2). This measure was completed at the beginning of the school year and at the school year's end. Directors also completed an on-line satisfaction scale at the end of each program year.

(2) **Teacher Job Stress:** During year one, two subscales from the Child Care Worker Job Stress Inventory (CCWJSI, Curbow et al., 2001) were selected to align with the statewide evaluations in Connecticut and Maryland (i.e., job control and job demands). Based upon concerns about the validity of the items used to measure job stress in the teachers in the first year's evaluation, a significant revision to that tool was undertaken for the year two evaluation. The evaluators reviewed the original literature on the development of the CCWJSI and selected a different pool of items that were more closely tied to 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 was retained for the year two job stress measure: roughly half were rated in a positive direction and the remaining items were reverse-scored. The items were mixed up to protect against response bias. During year three, this pool of items was shortened to reduce teacher burden and to reduce the complexity of the scale, which teachers found confusing. The final 6-item tool is included in Appendix A-3.

(3) **Classroom Climate:** In the first year of the evaluation, the mental health consultants completed the PMHCS in all of the classrooms selected for the study. In the second year, an external research assistant conducted CLASS observations in a smaller sample of classrooms (n=16). In

year three, the Healthy Futures leadership team sought to integrate the measures of classroom climate into the ongoing plan development work being conducted by the Healthy Futures clinicians. The evaluator recommended the use of the Arnett Caregiver Interaction Scale (1989), which has been used in several statewide evaluations of mental health consultation in child care. This tool was completed by the consultants as they initiated classroom-focused consultation and developed their written action plans, and then again after 3 months of consultation services. (See Appendix A-4).

(4) **Child-level Outcomes:** In all three years of the Healthy Futures evaluation, the Devereux Early Childhood Assessment (LeBuffe & Naglierie, 199; 2003; Mackarin & LeBuffe, 2007) was completed for children who received some form of child-specific consultation services. In year one, this was administered for a small group of children whose parents participated in the Incredible Years parenting groups. In year two, the DECA was completed by teachers and parents of children who were referred for child-specific consultation services. This practice was continued in year three, but the second data collection point was standardized to 3-months following parental consent to ensure a higher number of matched pre-/post-assessments. (This tool is protected by copyright, so cannot be included in the Appendix).

TABLE 1 Tools Used in the Year 3 Healthy Futures Evaluation

TOOL	WHAT IT MEASURES	COMPLETED BY	BASELINE/FOLLOW-UP
Devereux Early Childhood Assessment (DECA)	Social emotional fevelopment in infants, toddlers and preschoolers	Teachers and parents of children who received child-specific consultation	After signed parental consent and then 3-4 months later
Arnett Caregiver Interaction Scales (CIS)	Teachers interaction styles and behaviors (1 positive and 3 negative scales)	Consultants providing programmatic consultation in selected classrooms	At initiation of consultation services and then 3-4 months later
Goal Achievement Scale (GAS)	Teachers attitudes and behaviors	The CDC Director	Early and late in the school year (September thru June)
Child Care Worker Survey	Teacher stress	All classroom teachers	Early and late in the school year (September thru June)

Year Three Implementation

Description of the Participating CDC Programs

The 24 enrolled CDCs were located in 7 of 8 Wards of the city, with only Ward 3 not having a CDC served. Fifteen of the 24 CDCs were located in Wards 7 and 8 consistent with both the level of need and in alignment with the communities targeted by Project LAUNCH. All of the CDC directors were women and most reported they were African American. They had been CDC directors for an average of 24 years, although the range was wide (from 2 to 54 years). Centers served an average of 60 children, but again there was a large range (from 13 to 191). Across the CDCs there were nearly 120 classrooms serving 1,426 infants, toddlers and preschoolers. Nearly all of the lead teachers were female and two-thirds were African American. Teachers ranged in their years of experience from less than one year to more than 40 years, with a mean of 14. Nearly all of the CDC directors reported having worked with their Healthy Futures consultant before, and many reported that they had worked with them for an average of two years.

Frequency and Intensity of ECMHC

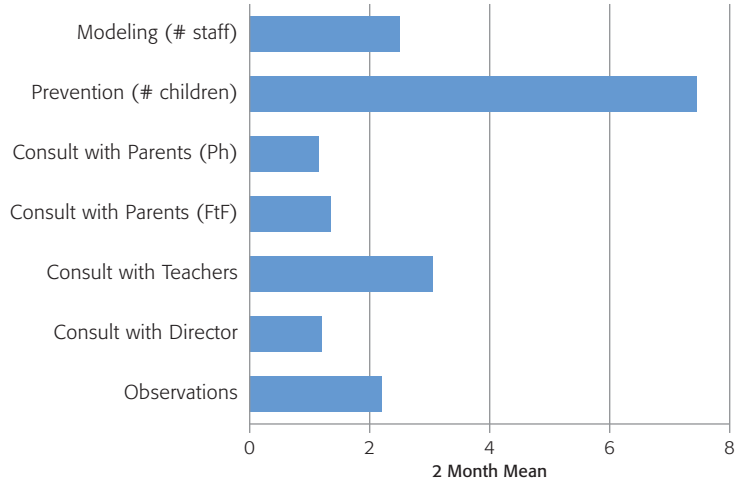
The specific activities included in the Healthy Futures consultation model are defined in written guidance for the consultants (See Activity Log Definitions in the Appendix A-5). Each time the consultant visits a CDC, they complete an activity log. The specific activities catalogued are: observation, consultation with director, consultation with teacher, consultation with parents, prevention/early intervention, modeling, training, attended meetings. Additional minutes before and after a classroom visit are documented separately.

In the first two years of the evaluation, GUCCHD undertook an extensive analysis of the frequency and intensity of ECMHC services provided by the consultants. In year three, these analyses were instead conducted as part of Lauren Rabinovitz's 2013 masters' thesis in public health. For her analyses, data from the activity logs of all four consultants were entered into a database for every work day between October 1, 2012 and December 1, 2012. The analyses focused on the frequency and type of ECMHC services provided to each center. The specific variables of interest were: time spent in classroom; number of observations; number of consultations with directors, teachers and parents; number of children receiving prevention activities; number of staff receiving modeling; and number of staff trainings conducted. Each category was analyzed overall over the two month time period and then was broken down by center. All analyses were completed using Statistical Product and Services Solutions (SPSS) 20.

The MHCs spent an average of nearly 2.5 hours per day in the classrooms. The most frequently performed activities were: consultation to teachers; conducting observations of children and classrooms; providing prevention services to individual children; consultation to directors; consultation with parents (both face-to-face and by phone); modeling for staff; and conducting trainings. (See Figure 1 in text and Table B-1 in the Appendix, which is reprinted from Rabinovitz, 2013 with permission). These findings are quite consistent with those published in the year one and two reports of the Healthy Futures evaluation. It is important to note that there is some variability in the methodology used by individual consultants to document their activities on these daily logs, specifically regarding what constitutes an observation and how time in classroom is calculated.

The Healthy Futures consultants continue to include training for the CDCs as an adjunctive service to their ECMHC model. During year 3, more than 68 different trainings were provided across a wide variety of topics. Frequent training topics included: developmental screening (using the Ages and Stages Questionnaires (ASQ) and the ASQ: Social Emotional (ASQ: SE); team-building and effective communication; and stress management.

FIGURE 1 **Most Frequent Consultant Activities** (Number per day)



Abbreviations: Phone (Ph) and Face to Face (FtF).

NOTE: Table 1: Daily utilization data of 4 Healthy Futures Consultants averaged over a 2 month period serving 24 CDCs (Rabinovitz, 2013)

Year Three Outcomes

The outcome evaluation assesses the impact of child-specific and programmatic consultation provided to the CDCs. Bivariate statistical analyses were conducted to assess change over time from baseline to follow-up (i.e., 3-4 months after baseline for the CIS and DECA and at the end of the school year for the GAS and Child Care Worker Survey). Mean differences were assessed using t-tests and all statistically significant changes appear in Figures 2-4.

Child-Specific Consultation

The Healthy Futures clinicians worked to build the skills and capacity of teachers who identified children who had specific behavioral or social emotional concerns. In each of the three years of implementation, teachers completed the Observable Concerns form to indicate which children in their classroom were exhibiting problematic behaviors (See Appendix A-6). The data from year three are summarized in Table 2 below. As in past years, the most common type of concerns are externalizing behaviors and most frequently identified problems have been pretty consistent from year to year.

TABLE 2 Most Common Child-Specific Concerns Identified by Teachers (n=107 children)

SPECIFIC CONCERN	PERCENT OF CHILDREN
Behavioral Control	67%
Peer Social Skills Problems	53%
Not following directions	46%
Difficulty with Peers	38%
Not following routines	35%
Fights	33%
Disruptive	33%
Easily Distracted	32%
Attention	27%
Doesn't follow commands	22%
Doesn't verbalize needs	21%
Assertiveness	20%

NOTE: children are often identified with more than one presenting concern; data missing for 4 children referred for child-specific services.

As a result of this process, children who have problematic behavior come to the attention of the mental health consultants. As the program has matured, a growing number of children have come to the attention of the consultants as possible child-specific consultation referrals. In year one, there were 43 children who 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 with observable concerns. Of these, baseline DECAs were collected from roughly half of the caregivers (i.e., 24 teachers and 22 parents); but post-intervention data were available for only two children from their teachers—none from the parents.

In year three, the Healthy Futures program implemented a much more rigorous process for identifying and enrolling children in child-specific consultation. As a result, a total of 111 children were referred for child-specific consultation; of those, parental consent was obtained for half (n=55) of the children. There are a variety of reasons why a child with an identified concern might not end up needing/receiving child-specific mental health consultation. For example: 13 children were referred directly to early intervention services and six to the community mental health agency based upon their presenting concerns; and another four children already had an Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP) in place, and therefore coordination occurred on that level. Interestingly in one classroom where four children were referred, the decision was made to do a classroom-wide (programmatic) consultation. In some cases, the parents/teachers did not express ongoing concern when the consultant followed up—indicating the child's problem may have been transient or short-term.

Of note, once consent was received, there was excellent follow-through by the parents and/or teachers. Nearly all (52 of 55) had either a parent or teacher complete a DECA (and received child-specific consultation). In response to concerns about too few post-intervention assessments being completed by parents and teachers, the timing for the follow-up assessments were standardized in year three to be 3-4 months after baseline assessment. As a result, 35 of 55 were available for pre-/post-test analysis. This is a significant improvement from last year and allows for a more meaningful analysis of child-level outcomes.

Infants: There were five infants under the age of 18 months that received child-specific consultation; this, in and of itself, is impressive given it can take time for the child care community to recognize infants can have social-emotional and behavioral concerns. Three of five parents completed DECAs as did four of the five teachers. Of these, baseline and follow-up data were available from one of the three parents and three of the four teachers. Despite the very small sample size, a marginally significant mean change in one of the DECA subscales was seen for the infants whose teachers rated their social emotional well-being after receiving child-specific consultation for 4 months (n=3). These infants T-scores on Initiative improved from an average of 46 to 51.33 ($p<.07$).

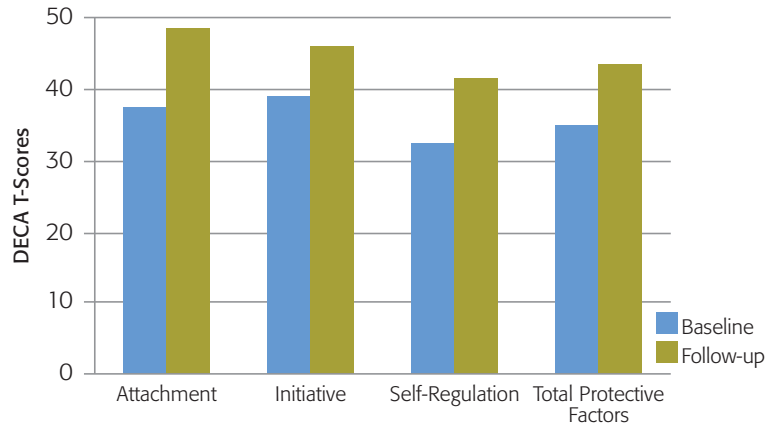
Toddlers: Twenty-three toddlers between the ages of 18 and 36 months received child-specific consultation. Their mean age was 29.5 months and 74% of them were boys. They were identified across 14 different CDCs, with five programs identifying two or more children. Baseline data were available from 18 parents and 22 teachers; follow-up data were available from 8 parents and

11 teachers. Statistically significant improvements were seen for toddlers who received child-specific consultation as rated by their teachers. No changes were seen in the parent-reported DECAs.

For toddlers, improvements were seen in all three subscales and the Total Protective Factors scores. (See Figure 2.) Note that all results are reported in T-scores; and that T-scores below 40 indicate areas of concern. Across all four domains, on average the DECA scores of children receiving consultation moved out of the areas of concern:

- Attachment improved from 37.67 to 48.44 (p<.002)
- Initiative improved from 39.18 to 46.36 (p<.06)
- Self-Regulation improved from 32.56 to 41.33 (p<.03)
- Total Protective Factors improved from 35.27 to 43.55 (p<.008)

FIGURE 2 **Improved Social-Emotional Development in Toddlers** (n=11)



Follow-up data were collected 3-4 months after baseline.
NOTE: All differences are statistically significant p<.06 using t-tests.

Preschool-Aged Children: Twenty-four preschool-aged children received child-specific consultation. All but three of these children were boys and their mean age was 41.2 months. They were identified at 9 CDCs and 4 centers had 3 or more children receiving this type of consultation services. Baseline data were available from 20 parents and 22 teachers; and after 3 months, 8 teachers and 9 parents had completed the follow-up assessments. Similar to the DECA data from the toddlers, no changes were seen in the parent DECAs, but positive changes were seen in 3 of the five areas on the DECA for teachers. (See Figure 3 next page.) Again, results are reported in T-scores; and T-scores below 40 indicate areas of concern. Specifically:

- Initiative improved from 36.67 to 45.00 (p<.02)
- Self-Regulation improved from 32.33 to 39.11 (p<.03)
- Total Protective Factors improved from 33.44 to 40.22 (p<.04)

It is important to point out that often when a child comes to the attention of the Healthy Futures consultant as needing child-specific consultation, there are significant developmental issues that require linkage to other support services. This is one of the important outcomes for families whose children are identified with observable concerns and is illustrated in the Sidebar: Success Story #1.

SUCCESS STORY #1

Child-specific Consultation Led to a Referral for Specialized Services

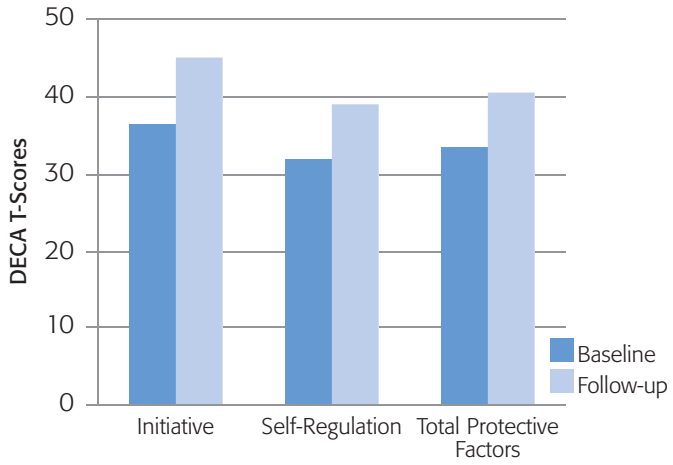
Lauren first came to my attention when she was about 6 months old. The staff had concerns about Lauren's overall development. Lauren's teachers had good rapport with her parents and they shared their observations of Lauren's strengths and weaknesses. The teachers also talked about the Healthy Futures services that could assist them if they were interested. Initially, the parents agreed to have Lauren screened. The screenings indicated that she needed to be referred for a comprehensive evaluation which was done.

Tragically, Lauren's father died in the middle of the evaluation process. There was also a change in Lauren's primary care giver from her mother to her paternal grandmother. At the center, we observed Lauren to be much clingier to her teachers and she was very cautious of unfamiliar people. After many phone calls the evaluation was finally completed and Lauren qualified for an IFSP.

As a result, Lauren is getting physical therapy, occupational therapy, speech therapy, and specialized instruction. She is doing very well and is warming up to the early intervention service providers. The center is dedicated to ensuring that Lauren thrives as evidenced by their decision not to move her out of the infant classroom. Even though infant spaces are at a premium—and the center could have moved Lauren due to her age—they are allowing her to be the oldest child in the infant room since she is not yet walking. The CDC has committed to allowing her to remain in the infant room until she meets that important developmental milestone.

—SUBMITTED BY CATHERINE GRAHAM

FIGURE 3 **Improved Social-Emotional Development in Preschoolers** (n=8)



Follow-up data were collected 3-4 months after baseline.
NOTE: All differences are statistically significant p<.04 using t-tests.

Effects of Programmatic Consultation

At the beginning of each school year, the consultants use the Need Assessment process to develop an individualized implementation assessment plan for each CDC which outlines specific trainings to be conducted. In year 3, the consultants and directors also identified classrooms where programmatic consultation would be delivered. The consultants then followed a protocol that that included the use of standardized observational tools including the Arnett Caregiver Interaction Scale. After the observation process is completed, the consultants have a formal meeting with the classroom teachers to develop a classroom plan which includes the forming specific goals that will be targeted for improvement.

A variety of measures were used to assess the potential impact of programmatic consultation; and the evaluation relied on data gathered from three perspectives. In addition, a case study is included that describes the experience of one consultant and teacher who received programmatic consultation (See Sidebar Success Story #2).

Classroom Climate as Rated by the Consultants

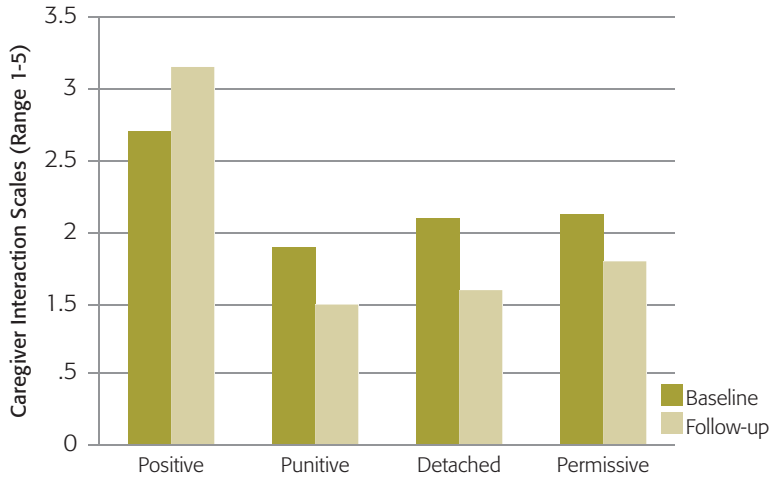
For the evaluation study, the major measure of the impact of consultation on teacher's behavior was the Arnett Caregiver Interaction Scale (CIS). This scale was completed at baseline and then every 3-4 months and measures four domains: positive relationships; and three negative dimensions: punitive behaviors; permissiveness; and detachment. The 26-item scale was completed by the consultants working with teachers (n=38) who were receiving classroom-focused consultation. Baseline and follow-up data were available for 28 classrooms at the time of analysis. Scoring for the subscales was standardized to adjust for the variable number of items per scale; therefore the mean for each scale ranges from 1-4. Higher scores are more desirable on the positive subscale, while lower scores indicate less negative climate for the other three subscales.

Statistically significant improvements were seen in all four domains:

- Positive relationships increased from 2.71 to 3.15 ($p<.001$)
- Punitive behaviors decreased from 1.88 to 1.51 ($p<.0002$)
- Detachment decreased from 2.11 to 1.63 ($p< .002$)
- Permissiveness decreased from 2.15 to 1.82 ($p<.02$)

These changes are depicted in Figure 4 below.

FIGURE 4 **Improved Quality of Teachers' Interactions** (n=28)



Follow-up data were collected 3-4 months after baseline.
NOTE: All differences are statistically significant $p<.02$ using t-tests.

SUCCESS STORY #2

Programmatic Consultation

I provided programmatic consultation to two teachers in a classroom serving four year olds. Initially, the lead teacher, Mrs. S had reservations about some of the strategies I was suggesting and at times appeared to not be open to the consultation process. However, with support, modeling, and guidance, this teacher began to become open up and become more receptive.

On a weekly basis, I introduced interventions which focused on feelings, sharing, and behavioral modifications. For example, I introduced a book to the classroom; "Have you Filled Your Bucket Today?" The main concept is that pro-social behaviors such as smiling, helping, following rules, are bucket fillers while negative behaviors such as hitting, being mean, frowning, etc., are behaviors that dip into the bucket. I helped the teachers find ways to promote more "bucket filling" behaviors. This concept was embraced by Mrs. S and she reinforced it with the class on a daily basis.

I also modeled ways in which negative behaviors could be ignored. When challenges would occur, Mrs. S was now able to ignore certain behaviors, which in the past had been a great challenge for her. I also worked with Mrs. S on classroom planning and focused on limit setting with the children. Providing limits was initially very difficult for her. Through weekly observation, I noticed a change in the classroom. Mrs. S incorporated a behavioral modification system, providing tickets to children when behaviors where appropriate.

Since I was aware of the continuous stress Mrs. S had been under, I provided a spa day for the entire teaching staff in which the staff learned stress management techniques and made relaxation products such as candles and scrubs which could be used at their leisure in order to relax.

— SUBMITTED BY MONIQUE MALONE

Teachers' Self-Reported Stress Levels

All teachers completed a 6-item revised version of a job stress index at the beginning and end of the school year. Overall, no differences were seen in any of the individual items or on the summed score. It is important to note that matched baseline and follow-up data were not available for one-third of the 130 teachers because of turnover. No changes in stress were seen for any subgroups (i.e., years of experience, years at this CDC, matched pre-/post-, or years of education).

Additional subgroup analyses were performed to see if changes in stress levels were associated with receipt of consultation services. Roughly half of the classrooms received either child-specific or programmatic consultation at some point in the school year. These classrooms were compared to those that did not receive this level of services and exploratory analyses were performed. There were no differences in the change in stress levels reported by teachers whose classrooms received some form of consultation versus those that did not. However the study design did not allow us to determine if teachers who completed the job stress surveys were the same ones who received the consultation. In addition, the teachers who had children with challenging behavior and those who were identified as needing programmatic consultation might have started off with higher stress levels or been more likely to switch classrooms or take another job. Future analyses should explore this intersection more directly.

CDC Directors' Perceptions of Teacher Behaviors

The impact of the Healthy Futures program on directors' attitudes was measured with the 13-item Goal Achievement Scale (GAS). The GAS was completed by the directors at the beginning and end of the school year. Two of the 26 directors were different when the GAS was re-administered. No differences were seen in any of the individual items or on the summed score. No differences in this pattern of results were seen for any subgroups (i.e., years of experience, years as a Director at this CDC). This was most likely the result of a ceiling effect with this measure and a lack of variability in the scores. It is important to note that many of these CDCs have been receiving Healthy Futures services for three years now.

Analysis of Expulsion Data

Similar to the first two years of program operations, very few children were expelled from the CDCs receiving Healthy Futures services: this year the rate was 4 per 1,426 children served, which 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 children being asked to leave their CDCs, a brief telephone or email survey was conducted with each director and/or teacher where an expulsion occurred. The findings mirror prior years, and also what has been published in the literature: children who were expelled tend to have serious aggressive behaviors that often threaten harm to their teachers, peers and themselves. The children at highest risk for expulsion are also those whose parents are less able to follow-through on referrals for mental health and developmental services; often these families are struggling with homelessness, domestic violence and mental health problems in the adults (Holland, Perry, Darling-Kuria & Nadiv, 2011).

Directors' Satisfaction Survey Results

Normally, an annual emailed satisfaction survey was sent to all participating CDC directors at the end of the school year. In year three, Ms. Rabinovitz completed a similar survey in the middle of the program year. Therefore the decision was made not to re-administer the directors' survey. The survey was distributed online and in hard copy to all 24 CDC directors. A total of 19 directors completed the survey—the majority of which were completed online using Survey Monkey.

Nearly all the directors believed mental health consultation (MHC) has direct benefits to their programs. The largest changes they see as a result of Healthy Futures were: a reduction in teachers' stress; increased parent involvement and family engagement; fewer expulsions and absences of students. Interestingly, parental involvement was rated as a challenge by nearly three-quarters of the directors. Roughly two-thirds of the directors indicated that they thought their consultant does not spend enough time at their center; and when asked how much time would be sufficient, 75% felt two full days would be appropriate. The directors were asked to respond to the hypothetical situation: if the consultant had more time on site, what specific activities would you like them to do? The directors prioritized consultants spending more time delivering the core ECMHC services (i.e., classroom and individual interventions); they also indicated more training would be beneficial (Rabinovitz, 2013). A summary of the quantitative data are included in the Appendix Table B-2.

Lessons Learned and Recommendations for Future Years

- In each of the three years of implementation, there has been statistically significant improvement in the classrooms receiving consultation. The first year, the consultants rated the classrooms with the Preschool Mental Health Climate Scale; the second year, a smaller sample of classrooms were rated by a trained observer (external to the Healthy Futures program) using the CLASS. Working with the Healthy Futures team, the Arnett Caregiver Interaction Scale (CIS) was selected for ongoing outcome monitoring. And the findings from this year continued to document impact in this important outcome. The CIS seems to be capturing important (yet malleable) aspects of teachers' behaviors that are directly associated with the emotional climate of the classroom and children's social and emotional well-being. This measure should continue to be used by the consultants in those classrooms receiving programmatic consultation.
- This was the first year where there were sufficient numbers of follow-up assessments on children who received child-specific consultation to warrant statistical analyses. And these analyses documented statistically significant change over time in most of the social and emotional domains measured on the Devereux Early Childhood Assessments (DECAs). On average, the young children receiving consultation were rated in the area of concern at baseline; and then after 3-4 months of consultation services, their average scores were above the cut-off for concern. Rates of follow-up data collection were much better than last year, suggesting that the standardized data window of 3-4 months for the follow-up should be continued next year.
- Measuring changes in teachers' stress remains challenging for several reasons: one-third of the follow-up surveys are not completed by the same teachers; the instrument does not appear to be sensitive to the aspects of the job stress that can be impacted by ECMHC; and finally not all of the teachers who completed the surveys were direct beneficiaries of programmatic and/or child-specific consultation services. DMH should work with their evaluation consultant to strengthen this aspect of the evaluation by seeking a better tool and designing a more targeted approach. Restricting the collection of teacher stress surveys to those teachers who receive child-specific and/or programmatic consultation is recommended; and shortening the time between measurement points (i.e., 3-4 months versus the beginning and end of the school year) could reduce the impact of teacher turnover and transitions on this outcome.
- Roughly half of the classrooms in these 25 CDCs received either child-specific and/or programmatic consultation, which suggests good penetration of the intervention by the Healthy Futures team. There has been very little documented in the ECMHC literature about how these two services intersect: do child-specific referrals emerge from programmatic consultation or vice

versa or both? Do the effects of one type of consultation enhance the effects of the other? These are interesting questions to explore in more depth next year through additional qualitative and quantitative approaches in the evaluation.

- There is a need to continue to document the consultation protocols—especially as the programmatic and child-specific consultation services have become better defined and operationalized. DMH should look for opportunities to develop an implementation manual to assist in training new staff and scaling up should new funding become available.
- The positive DECA findings associated with child-specific consultation services were only reported by teachers—who were the primary beneficiaries of child-specific consultation. There were fewer follow-up data collected from parents and, when there were data, the families did not report changes in their children's behavior. DMH should consider expanding the role of parents when doing child-specific consultation so that these positive effects are generalized to settings outside of the CDCs. This can be important as children transition to elementary school settings. Some strategies could include: offering optional home visits; sharing successful classroom-based strategies with the parents in a more systematic way; and more frequent parent-teacher team meetings.
- The findings from this study design would be bolstered by the collection of comparable data from a sample of CDCs that are not receiving Healthy Futures services. DMH should look for opportunities to partner with others to expand the evaluation study design to include a no- or low-dose comparison group.

Summary of Year Three Results

Over the first three 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 and third years—in large part because of the success of the consultation model, as well as a reflection of a high level of ongoing needs in CDCs serving young children in poor areas of the city. This need was underscored by the fact that again 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.

The Healthy Futures clinicians provided a range of consultation services to the CDCs, building the capacity of the directors and teachers—including a more systematic approach for programmatic and child-specific consultation. The findings suggest both types of consultation strategies are associated with positive outcomes for teachers and children: statistically significant improvements the social-emotional climate of the classrooms as well in children's social-emotional development were seen. Finally, only four children were expelled from their CDC—a rate below 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. As the funding for Healthy Futures shifts from the SAMHSA Project LAUNCH grant to other sources, policy makers should continue to monitor implementation and outcomes to ensure any local investment yields similar positive effects for vulnerable young children.

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APPENDIX A: Measurement Tools

A-1 Strengths and Difficulties Teacher Form

Overall, do you think that any individual children listed on your classroom roster have difficulties in any of the following areas: emotions, concentration, behavior or being able to get along with other people?

	No	Yes minor difficulties	Yes definite difficulties	Yes severe difficulties
Child 1:	○	○	○	○
Child 2:	○	○	○	○
Child 3:	○	○	○	○
Child 4:	○	○	○	○
Child 5:	○	○	○	○
Child 6:	○	○	○	○
Child 7:	○	○	○	○
Child 8:	○	○	○	○
Child 9:	○	○	○	○
Child 10:	○	○	○	○

Robert Goodman, 2000

If you have answered "Yes", for any of the children referenced above, please answer the following questions about these difficulties:

• How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
○	○	○	○

•Do the difficulties upset or distress the child?

Not at all	A little	A medium amount	A great deal
○	○	○	○

• Do the difficulties interfere with the child's everyday life in the following areas?

	Not at all	A little	A medium amount	A great deal
PEER RELATIONSHIPS	○	○	○	○
LEARNING	○	○	○	○

• Do the difficulties put a burden on you or the class as a whole?

Not at all	A little	A medium amount	A great deal
○	○	○	○

Please copy this form and complete these questions for each child you indicated on page 1 has some level of difficulty.

Thank you very much for your help.

Robert Goodman, 2000

A-2 Goal Achievement Scale (GAS)[1]

Child Development Center program name _____ Director's Initials _____

Have you worked with this Healthy Futures consultant before? ○ Yes ○ No

If yes, for how long? _____

How many years have you been a child care director? _____

How many years have you been the director at this center? _____

How many children have been expelled in your center in the past 12 months? _____

_____

1. Read each statement below, and fill in **one bubble** that best fits your agreement with each item, as it relates to the teachers in your program.

Item	Not at all	Somewhat	Very Much
1. Teachers understand children's social and 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 in distress.	○	○	○
5. Teachers communicate regularly with parents about their children's strengths and 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 and family to mental health services	○	○	○
9. Teachers feel understood and supported.	○	○	○
10. Teachers feel competent and confident in my ability to respond to behavior that is worrisome to me.	○	○	○
11. This child care center welcomes parents as partners.	○	○	○
12. Teachers receive regular and supportive supervision.	○	○	○
13. I am responsive to staff needs.	○	○	○

[1]Alkon, Ramler, & MacLennan, 2003

A-3 Job Stress Inventory (revised, Curbow et al., 2001)

	Rarely Never	Occasionally	Often	Usually	Most of the Time
1. I feel used up at the end of the work day.	1	2	3	4	5
2. Children have behavior problems that are hard to deal with.	1	2	3	4	5
3. I worry that this job is hardening me emotionally.	1	2	3	4	5
4. Working with people puts too much stress on me.	1	2	3	4	5
5. I find it hard to talk to parents about problems I am having with their children.	1	2	3	4	5

A-4 Caregiver Interaction Scale (Arnett 1989)

Center Name: _____

Teacher Name: _____ Observation Date: _____

Data Collector: _____

FOR INSTRUCTIONS, CLARIFICATIONS AND SCORING, CLICK HERE.	NOT AT ALL TRUE	SOMEWHAT TRUE	QUITE A BIT TRUE	VERY MUCH TRUE
1. Speaks warmly to the children.	1	2	3	4
2. Seems critical of the children.	1	2	3	4
3. Listens attentively when children speak to him/her.	1	2	3	4
4. Places high value on obedience.	1	2	3	4
5. Seems distant or detached from children.	1	2	3	4
6. Seems to enjoy the children.	1	2	3	4
7. When the children misbehave, explains the reason or the rule they are breaking.	1	2	3	4
8. Encourages the children to try new experiences.	1	2	3	4
9. Doesn't try to exercise too much control over the children.	1	2	3	4
10. Speaks with irritation or hostility to the children.	1	2	3	4
11. Seems enthusiastic about the children's activities and efforts.	1	2	3	4
12. Threatens children in trying to control them.	1	2	3	4
13. Spends considerable time in activity not involving interaction with the children.	1	2	3	4
14. Pays positive attention to the children as individuals.	1	2	3	4

FOR INSTRUCTIONS, CLARIFICATIONS AND SCORING, CLICK HERE.	NOT AT ALL TRUE	SOMEWHAT TRUE	QUITE A BIT TRUE	VERY MUCH TRUE
15. Doesn't reprimand children when they misbehave.	1	2	3	4
16. Talks to the children without explanation.	1	2	3	4
17. Punishes the children without explanation.	1	2	3	4
18. Exercises firmness when necessary.	1	2	3	4
19. Encourages children to exhibit prosocial behavior, e.g., sharing, helping. More	1	2	3	4
20. Finds fault easily with children.	1	2	3	4
21. Doesn't seem interested in the children's activities.	1	2	3	4
22. Seems to prohibit many of the things the children want to do.	1	2	3	4
23. Doesn't supervise the children very closely.	1	2	3	4
24. Expects the children to exercise self-control: e.g., to be undisruptive for group provider-led activities, to be able to stand in line calmly.	1	2	3	4
25. When talking to children, kneels, bends or sits at their level to establish better eye contact.	1	2	3	4
26. Seems unnecessarily harsh when scolding or prohibiting children.	1	2	3	4

A-5 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.

ACTIVITY	DEFINITION OF ACTIVITY
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.

A-6 Observable Concerns Checklist

Received By:_____Date: _____

Student's Name: _____Student's DOB: _____Student's Age: _____

Person Making Referral: _____

Child Development Center Name: _____Classroom Name/ID:_____

Has the family asked for:
- Information about services? ☐ Yes ☐ No
- An appointment to initiate help? ☐ Yes ☐ No
- Someone to contact them to offer help? ☐ Yes ☐ No

Please check area(s) of concern that are demonstrated on a consistent/frequent basis:

Behavior
___ Attention seeking
___ Bizarre thoughts or behaviors
___ Cutting/scratching/hurting self
___ Destroying property
___ Difficulty with peers in classroom
___ Disruptive
___ Does not follow classroom routines
___ Does not follow directions
___ Easily distracted
___ Excessive/uncontrollable crying
___ Fights classmates, staff members, parents
___ Irritable/angry/hostile
___ Isolated/withdrawn
___ Lethargic/low energy
___ Rejected by peers/picked-on
___ Self-esteem problems
___ Separation anxiety
___ Sexually acting out
___ Suffered sexual and/or physical assault
___ Threatening/intimidating remarks/bullying
___ Other concerns: _____
_____

Family/Social Issues
___ Mentions abuse (physical, sexual, emotional)*
___ Suffered recent loss (include parental divorce)
___ Homeless (no fixed address)
___ Pregnancy
___ Illness in family
___ Drugs
___ Other concerns: _____
_____

Appearance
___ Appearance/hygiene neglected
___ Bloodshot eyes
___ Bruises*
___ Needle/burn marks*
___ Other concerns: _____
_____

Speech/Language
___ Does not understand what is being said to him/her
___ Does not follow commands given to him/her
___ Does not verbalize needs/wants
___ Does not make needs known (verbal/non-verbal)
___ Repeats the same words over and over
___ Other concerns: _____
_____

Development
___ ASQ referral
___ Awkward/unusual walk
___ Does not use hands well
___ Does not walk
___ Has difficulty before/during naptime
___ Has trouble processing information
___ Other concerns: _____
_____

Eating
___ Eats items other than food
___ Eats too fast
___ Has difficulty in chewing food
___ Has difficulty in swallowing food
___ Picky eater
___ Refuses to eat
___ Throws food
___ Other concerns: _____
_____

Relationships
___ Clings to staff/parents/other adults
___ Plays alone
___ Shy
___ Withdrawn/isolated
___ Other concerns: _____
_____

*Any mention of abuse may have to be reported to CFSA. See policies & procedures or consult with Center Director. To be completed and returned to the Mental Health Specialist prior to initiating early childhood mental health consultation services.

APPENDIX B: Tables and Charts from Rabinovitz (2013)

TABLE B-1 **Utilization Data of Consultants Over Study Period of Two Months** (N=24 Centers, 4 Consultants)

	MEAN (PER DAY)	N (OVER 2 MONTHS)	STANDARD DEVIATION
Time Spent in Classroom (minutes)	152	24,779	83.3
Observations	2.23	196	1.2
Consultations with Director	1.23	146	.528
Consultations with Teachers	3.08	349	2.139
Consultations with Parents			
Face-to-face	1.35	46	.917
Phone	1.14	8	.378
Prevention Activities (children)	7.45	164	7.049
Modeling (number of staff)	2.48	57	1.31
Number of Staff Trainings Conducted	<1	6	0

Rabinovitz, 2013.

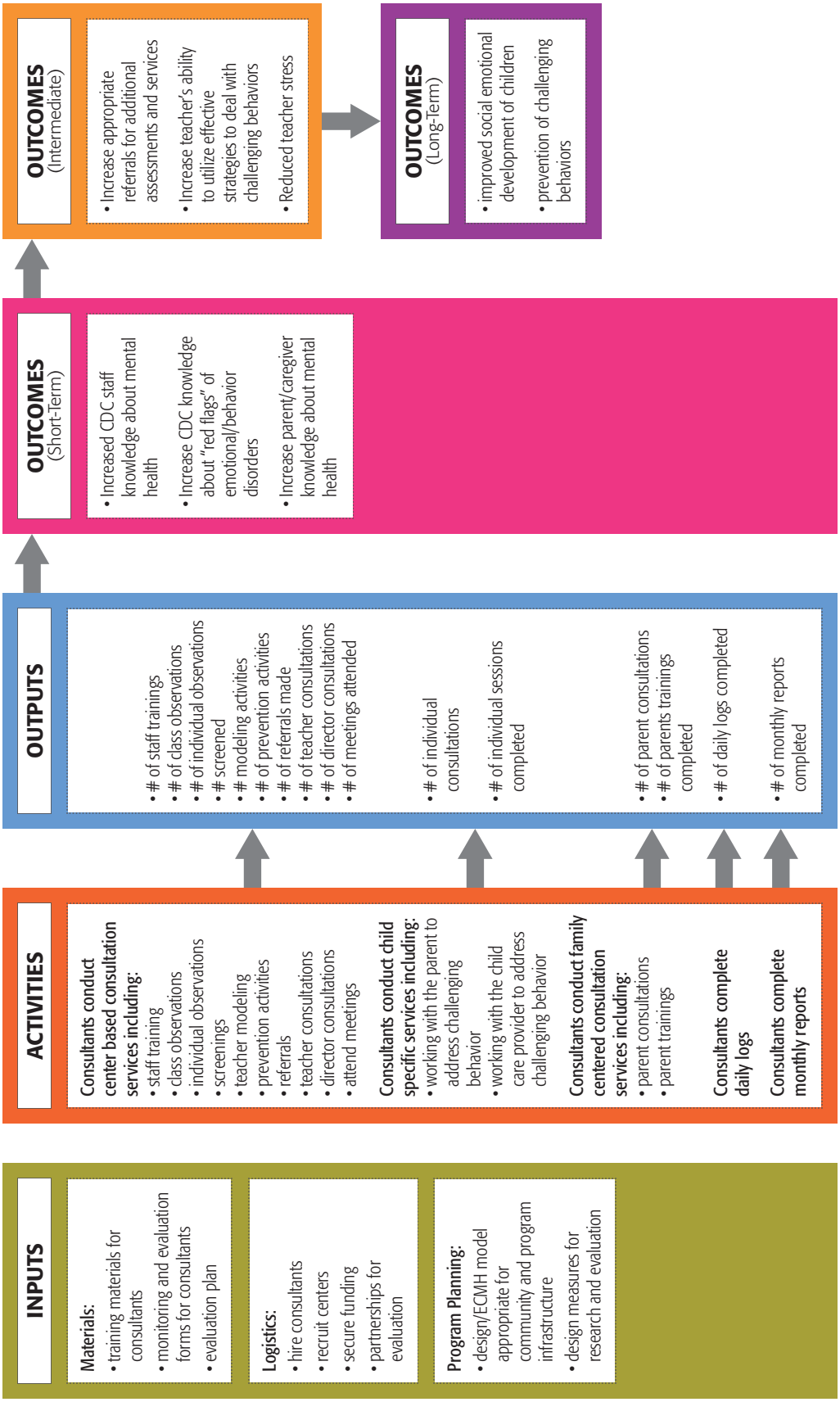
TABLE B-2 Survey Director Data (N=19)

		(%) n
Time director has been at Center:	0-1 year	(5.3) 1
	2-3 years	(31.6) 6
	Over 3 years	(63.2) 12
Gender:	Female	(88.5) 17
	Male	(10.5) 2
Age:	20-30	(5.3) 1
	30-40	(21.1) 4
	40-50	(42.1) 8
	Over 50	(31.6) 6
Average Children Served at Center:		88.63
MHC Benefit Program:	Yes	(89.5) 17
	Don't know	(10.5) 2
Consultant Spends Enough Time at Center:	Yes	(31.6) 6
	No	(68.4) 13
Ideal Time at Center:	1 full day	(25) 3
	2 full days	(75) 9
Value of Services: (Mean-Scale of 1-5)	Services are Valuable	4.26
	Valuable to Teachers	4.21
	Valuable to Parents	3.68
Changes in Program: (Mean-Scale of 1-5)	Student Absences	1.88
	Family Engagement	2.83
	Teacher Stress	3.37
	Expulsion	2.41
Change Program by having: (Mean-Scale of 1-5)	More Time at Center	4.37
	More Trainings	4.53
	More Classroom Interventions	4.58
	More Individual Interventions	4.58
	Less Time at Center	1.42
Parent Involvement	Strength	(21.1) 4
	Challenge	(73.7) 14

Rabinovitz, 2013.

FIGURE B-1 Logic Model: Healthy Futures

Situation: Young children with challenging behaviors are at risk for expulsion and contribute to teacher stress and reduced quality of education. Early Childhood Mental Health Consultation has proven to be an effective mechanism to reduce challenging behaviors, reduce teacher stress and improve overall quality and experience in early childhood development programs.



Assumptions: Child care center directors, staff, families and caretakers will be receptive to consultation services.

External Factors: Staffing patterns in centers, commitment of directors to ECMH model, community resources, quality of staff, current policies, climate in centers, support of teachers by directors, quality of consultants.