UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

Maryland's Early Childhood Mental Health Consultation Evaluation

Funded by the Maryland State Department of Education

FINAL REPORT

Project Period 8/1/08-7/31//11
Final Report submitted 10/31/11

This report details the findings of the evaluation of Maryland's Early Childhood Mental Health Consultation (ECMHC), conducted as a deliverable of the contract (R00P9201599) awarded to the University of Maryland School of Medicine, Division of Child and Adolescent Psychiatry, for the project period 8/1/09 – 7/31/11. Correspondence about the report may be directed to Dr. Sharon Stephan, 737 West Lombard Street, 4th Floor, Baltimore, Maryland 21201, sstephan@psych.umaryland.edu.

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Acknowledgements

The evaluation team would like to thank the Maryland State Department of Education for their financial support and continuous guidance and partnership throughout the evaluation process. In particular, we would like to thank Dr. Rolf Grafwallner, Linda Zang, and Tresa Hanna.

The team is also grateful to all participating ECMH consultants and ECMHC Program Directors who engaged with us in this collaborative evaluation process, and helped to inform the work along the way.

We are also appreciative of the families, ECE providers and ECE Directors who provided data; their collective contributions have provided a wealth of information from which we can better understand the experience and impact of ECMHC for Maryland's children and families.

Finally, we would like to thank our incredible research staff and students for all of their efforts to enter, clean and analyze data.

Executive Summary

In October 2006, based on promising results of prior Early Childhood Mental Health Consultation (ECMHC) efforts in Maryland, eleven sites were funded to provide consultation to child care providers throughout Maryland. In 2008, the Maryland State Department of Education (MSDE) funded the University of Maryland School of Medicine in partnership with Georgetown University and a Minority Business Enterprise (MBE) partner, CKD Communications, to conduct an evaluation of this program. The evaluation was designed to document the ECMHC service characteristics, the impact of ECMHC services on children and their early childhood education (ECE) environments, as well as factors related to why children exit ECE settings. Major findings from each of three studies are summarized below.

For the **Service Description Study**, we had a primary interest to better define ECMHC as it is delivered in Maryland. Specifically, we sought to gain greater understanding of the characteristics of programs and consultants, and about the services provided by consultants.

Major findings

Characteristics of Programs and Children served by ECMHC

- Maryland's ECMHC is conducted mostly in child care centers. In Fiscal Year 2011 (FY11) 236 centers were served across the state, while only 45 family providers, 8 Head Starts and 2 public pre-kindergartens were served.
- Programs primarily serve private child care center settings and receive fewer referrals from home-based early care programs. About half of ECMHC programs work in Head Start settings and only two have provided consultation in informal child care settings or homeless shelters. Most ECMHC programs (eight of eleven) have not provided consultation in home-based ECE programs.
- The total number of children receiving child specific consultation has grown over the past three years from 666 in FY09, to 810 children served in FY11. Between FY09 and FY11, 15-17% of children served by ECMHC receive child care subsidies and 11-15% have an Individualized Family Services Program/Individualized Education Program.
- Most children (approximately 75%) receiving ECMHC in Maryland are boys and most (again, approximately 75%) are between the ages of three and five. Less than three percent of cases in the past three years included children under age two. Most children (approximately 60%) receiving consultation are White (between 59 and 61 percent in FY09 to 11), with African American children representing the next largest group served (approximately 27%).

ECMHC Consultants' Knowledge and Skills

- We collected demographic data from 40 (82%) of the 49 consultants who provided ECMHC in Maryland throughout the duration of this project. The majority of consultants who provided demographic data are White (82.5%), 7.5% are African American, 5% are Hispanic/Latino, and 5% are Asian/Pacific Islander. All but one consultant is female. Forty percent of consultants hold a Bachelors degree, 52.5% hold a Masters degree, and

7.5% hold a Doctorate degree in differing fields. More than half (65%) of consultants hold a degree in a mental health field. Consultants reported an average of three years of experience in early childhood mental health consultation and six years of experience providing mental health services to young children.

- Consultants felt most confident about their knowledge of typical and atypical child development, community resources and infant and early childhood mental health/social-emotional development. They felt least confident about their grasp of early childhood intervention systems, treatments and family support services, as well as their understanding of diverse cultures.
- Consultants had the most experience in screening activities and working with children displaying challenging behaviors. Consultants reported the least amount of background working in foster care settings and providing direct therapy.
- Consultants felt that they had the strongest skills in forging collaborations with providers and families. They felt the most unsure about their capacity to employ classroom/group activities to promote behavioral and emotional skills and to intervene in crisis situations.
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Types of Services Provided by ECMH Consultants

- ECMH Consultant caseloads differ greatly across sites, ranging from two to eighteen child-specific cases per consultant.
- Referral sources also vary greatly across programs. Most programs indicated that their strongest referral source was directly from child care centers.
- Ten of eleven ECMHC programs indicated that over 90% of referrals are child-specific, with less than 10% initiated for classroom consultation. However, several programs noted that many child-specific referrals result in classroom consultation. Of note, this "hybrid" child-specific/classroom case model appears to be the most common across current programs. Only one program reported seeing 50% child-specific and 50% classroom cases.
- The two most frequent activities provided by consultants in the classroom are teacher consultation and classroom observation.
- Consultants provided teacher and/or classroom observations on average six to seven times per case, though there was great variability in the frequency of both teacher consultation and classroom observations; some consultants provided these services only once and others provided them 29 times for an individual case.
- ECE Directors were consulted on average three to four times per case. Families were consulted much less frequently. For child-specific cases, consultants averaged two consultation visits with parents of children. Findings suggest that a major role of consultants was supporting the classroom staff and leadership at the child care setting.
- The average duration of a case was thirteen weeks, with a range of one to 43 weeks; the average number of visits per case was nine. On average, fourteen hours is spent on site per case and six off-site. Some of the variability in case length and intensity may be accounted for by differences between child-specific and classroom-specific cases.

- According to ECMH Program Directors and Consultants, barriers to receiving ECMHC consultation included mental health stigma, program and teacher readiness, parent engagement, funding concerns and lack of quality supervision for ECMH consultants.

We developed the **Impact Study** to fully understand both the environmental impacts of ECMHC as well as the individual impacts on children receiving services from ECMHC consultants.

Major findings:

- ECMHC improves the effectiveness of ECE providers' approaches to promoting a classroom climate conducive to positive behavior and social-emotional functioning.
    - Scores on the *Preschool Mental Health Climate Scale* showed consistent increases from baseline to follow-up, suggesting a strong impact of consultation on all aspects of classroom functioning in the domains of: Staff Qualities, Classroom Interaction, Classroom Management, and Direct Teaching Skills.

- ECMHC interventions improve the overall level of social functioning and reduce the overall level of problem behaviors in the classroom.
    - Analyses of SDQ data from 56 providers who completed ratings at both baseline and 4- month follow-up showed an encouraging reduction in the level of child problems during the period when ECMHC was being implemented.
    - GLM repeated measures analyses revealed a significant increase in the percent of children exhibiting no problems over the course of 4 months and a decrease in the percent of children showing each level of problem intensity.
    - The reduction in mean levels of problem behavior from baseline to follow-up was significant, suggesting that, over the course of consultation, teachers felt that children possessed lower levels of problem behavior.

- Children referred for child-focused ECMHC intervention show an improvement in social-emotional functioning following intervention.
    - Both parents and teachers reported a significant increase in protective factors and a decrease in challenging behaviors over the consultation period.
    - Parent ratings on the *Devereux Early Childhood Assessment (DECA)* show a significant increase in the Protective Factors scale, accompanied by a significant decrease in the Behavioral Concerns scale, moving from the "Concerns" into the "Typical" range.
    - Similar results were found for the teachers' *DECA* ratings; a significant improvement in the Total Protective factors scale, and a significant reduction in the Behavioral Concerns scale.
    - Overall, children showed improvement in a range of characteristics related to resilience during the course of consultation, with all the component subscales of the Total Positive Factor scale showing significant improvement from baseline to follow-up except for the change in the Attachment subscale for the parent *DECA*s.

- Parents whose children receive child-focused ECMHC intervention show some reduction in parenting stress, but no change in parenting behaviors.
    - Examination of change in scale scores at baseline and follow-up for the 29 parents completing a P*arenting Stress Index* at each time point revealed no significant change over the consultation period for two of the scales: Parental Distress and Parent Child Dysfunctional Interaction scale.
    - However, for the Difficult Child scale, which produced the highest ratings of distress at baseline, repeated measures analyses indicated a significant mean increase (less stress) at follow-up compared to baseline.

In order to better understand the range of experiences that children and their families were having in Maryland related to exits from ECE settings, we conducted a qualitative study, the **Exit Study**. The study involved a total of 35 interviews with ECMHC stakeholders (consultants, ECE Providers and Directors, and parents) about their experience of a child exiting from an ECE program due to behavioral concerns.

- Many of children who exited from ECE programs had significant mental health and other developmental problems.
- While child care programs had often reached out for help in meeting the child's needs, ECMH consultants were often brought in too late in the process to be able to remediate the concerns in that setting.
- Systems to support children with special needs and their families should be better linked to the child care community.
- Families could benefit from additional support in determining what kinds of child care programs could be a good fit for their child's developmental and behavioral concerns.

Recommendations

Recommendation 1: Continue to commit resources to evaluating the long term impact of ECMHC service delivery across Maryland including developing linkages across other MSDE databases.

Recommendation 2: Continue to enhance parent engagement in ECMHC activities, especially related to child-specific consultation.

Recommendation 3: Continue to provide high quality training supporting evidence-based approaches to ECMH consultants, with a specific focus on the integration of CSEFEL and ECMHC.

Recommendation 4: Support high quality, ongoing, reflective (clinical) supervision for ECMH consultants.

Chapter 1: Introduction

Mental Health Needs of Young Children in Early Childhood Education (ECE)

Strong evidence exists indicating that social and emotional skills are critical to school adjustment and competencies in language and academic readiness skills (Joseph & Strain, 2003; Raver, 2002; Wentzel & Asher, 1995). When kindergarten teachers report that children are not entering school ready to learn, what they are often referring to are deficits in social and emotional skills. Left untreated, early behavioral problems can develop into more serious mental health conditions that can impact learning and achievement. Therefore, the need continues to grow for increasing efforts directed toward early identification of and intervention for mental health problems (National Research Council and Institute of Medicine, 2000; U.S. Public Health Service, 2000).

According to a landmark national study (Gilliam, 2005), a startling number of young children in the U.S. are being expelled from their preschool classrooms—indeed the rate of expulsions from state funded pre-kindergarten programs was roughly three times the rate of expulsions from K-12 programs. Underlying this statistic is a complex array of demographic trends that place a large number of young children at increased risk for early school difficulties. Namely, as economic pressures to work more bear down on families, young children are spending increasing numbers of hours in out-of-home care. This trend is occurring in low-income families, where welfare reform has been the driving force of these increases, as well as in middle class families, where two full-time incomes are often necessary to make ends meet. As children spend longer hours in care, and stress in families mounts, the result can be increased numbers of young children exhibiting problematic behavior in child care.

As a result of these converging trends, a growing number of child care providers are struggling to address the mental health and behavioral needs of young children. Assistance with children's challenging behaviors is the greatest need identified by preschool administrators and educators (Busecmi, Bennett, Thomas, & DeLuca, 1996; Yoshikawa & Zigler, 2000), who often have had little training in behavior management or ways to promote social and emotional competence (Scott & Nelson, 1999).

Early Childhood Mental Health Consultation as a Response to Need

One promising model for building providers' skills and reducing problematic behavior in young children in child care is providing an early childhood consultant on-site to work in concert with the child care provider, and often the family (Cohen & Kaufmann, 2000; Donohue, Falk, & Provet, 2000; Johnston & Brinamen, 2006). Early childhood mental health consultation (ECMHC) aims to build the capacity of staff, families, programs, and systems to prevent, identify, treat, and reduce the impact of mental health problems among children from birth to age 6 and their families (Cohen & Kaufmann, 2000). It involves a collaborative relationship between

a professional consultant with mental health expertise and one or more individuals with expertise in infant and early childhood education.

Early childhood mental health consultation provides an opportunity for ECE providers to receive one-on-one coaching and mentoring that can either target the child and/or family or focus on an entire program or classroom. In the former, referred to as child- and family-focused consultation, the consultant works with the provider and a child and/or family to address the specific behaviors of concern in an individual child or family. In contrast, program-focused consultation is intended both to improve the overall quality of the classroom environment, as well as to provide strategies to build staff capacity to address problematic behaviors or system problems that may be affecting one or more of the children, families, and/or staff.

There is a growing evidence base that ECMHC is an effective strategy in reducing the impact of social- emotional and behavioral challenges on young children in child care and their caregivers. Gilliam (2005) reported that pre-kindergarten programs that had on-site mental health consultants had lower rates of expulsion than those without access to this service. In addition, two systematic reviews of more than 30 evaluations of ECMHC conducted across the country showed evidence that these programs can lead to improvements in children's behaviors, changes in teacher attitudes and behaviors, and reduced expulsions (Brennan, et al., 2008; Perry et al., 2010).

The Evolution of ECMHC in Maryland

Maryland has been a leader in developing opportunities for Early Childhood Education (ECE) providers to enhance the quality of child care, including the need for greater attention to the social-emotional needs of young children. Evaluations of several Maryland ECMHC programs have yielded promising findings. For example, in Anne Arundel County, the Behavioral/Emotional Support & Training (BEST) project has been providing behavioral consultation to licensed and registered child care providers since 2000. In an evaluation conducted by the Georgetown University Center for Child and Human Development (Perry, Dunne, McFadden & Campbell, 2008), strong reductions in problem behaviors and increases in social skills were seen in the children who received early childhood consultation. Similar patterns of results were seen in the two pilot Early Childhood Consultation sites funded a few years later (Perry, 2005).

Based in part on these encouraging local results, the Maryland Legislature appropriated more than $2 million to significantly expand ECMHC across the state. In October 2006, eleven sites (including the two original pilot sites) were funded to provide consultation to child care providers throughout Maryland.

In 2008, MSDE funded the University of Maryland School of Medicine in partnership with the Georgetown University Center for Child and Human Development and a Minority

Business Enterprise (MBE) partner, CKD Communications, to conduct an evaluation of this program. This report details findings from the evaluation of MSDE-funded Early Childhood Consultation programs. A summary of the evaluation activities and tasks is provided in **Appendix A.**

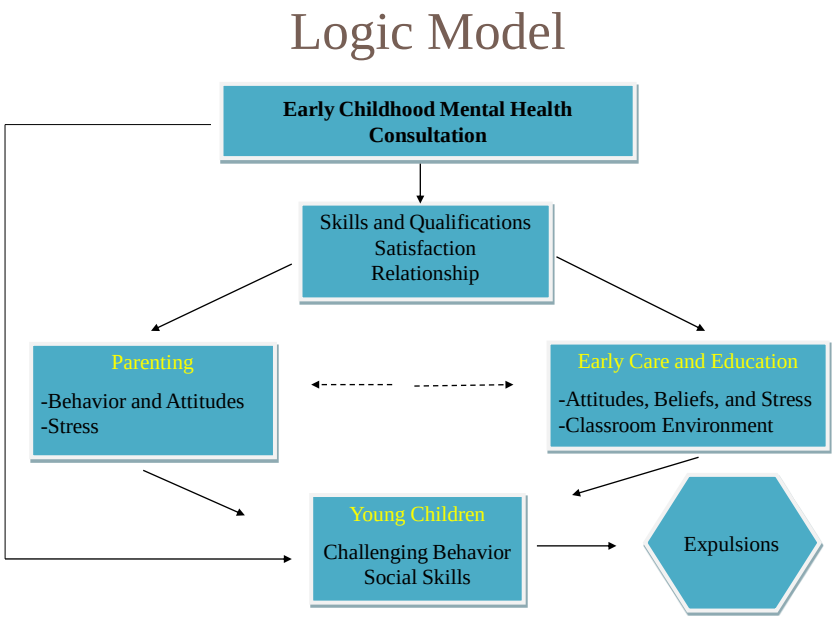
Chapter 2: Overall Evaluation Design and Approach

2.1: Design

ECMHC is primarily a capacity-building intervention, influencing children's social skills and problem behaviors through its effects on providers' and parents' behaviors and attitudes. When a skilled consultant provides advice that is well-received by the child care provider, that provider is more likely to change their behaviors and practices leading to a more positive classroom climate, a reduction in problem behaviors and an increase in children's social skills. In addition, consultants often work closely with a child's parent to produce change in the parents' behaviors, expectations and stress, which then may affect children's behaviors. These changes may also be influenced by the change in behaviors and the child care classroom environment indirectly through communication between the child care provider and parent. This theory of change, as reflected in our Logic Model (see Figure 1), served as the basis for our evaluation design.

Specifically, we designed the evaluation to explore ECMHC service characteristics, the impact of ECMHC services on children and their ECE environments, as well as factors related to why children exit ECE settings. These areas of exploration became three unique studies: the Service Description Study, the Impact Study and the Exit Study. Specific questions were generated specific research questions for each of the three distinct studies. **Appendix B** includes a table of measures from each study, and **Appendix C** includes a copy of all measures.

Figure 1: Logic Model



For the **Service Description Study**, we had a primary interest to better define ECMHC as it is delivered in Maryland. Specifically, we sought to gain greater understanding of the characteristics of programs and consultants, and about the actual services provided by consultants. We used several different methodologies to gather this descriptive information. ECMHC program directors and consultants completed *Model Description Surveys* and participated in *Quarterly Interviews* in order to provide information about program characteristics and to define the service delivery model. Consultants completed a *Knowledge and Skills Inventory* to provide information about consultant characteristics. In addition, after each ECE site visit, consultants completed a *Service Log* to document services provided as well as the intensity and duration of those services. From the combined information gathered through Model Descriptions, Knowledge and Skills Inventories, Quarterly Interviews and Service Logs we were able to examine the following research questions:

1. What are the characteristics of Maryland's ECMHC programs?
2. What are the barriers experienced by Maryland's ECMHC programs?
3. What are the characteristics of the consultants providing ECMHC in Maryland?
4. What types of ECMHC services are being provided in Maryland?
5. What are some characteristics of a typical ECMHC case in Maryland?

We developed the **Impact Study** to fully understand both the environmental impacts of ECMHC as well as the individual impacts on children receiving services from ECMHC consultants. Pre/post assessments related to environment were completed by consultants using

the *Preschool Mental Health Climate Scale (PMHCS)*, by teachers using the Impact Supplement of the *Strengths and Difficulties Questionnaire (SDQ)* (Goodman, 1997)and by ECE directors using the *Goal Achievement Scale (GAS)*. Pre/post assessments also were completed by teachers and parents to assess change in child behavior using the *Devereux Early Childhood Assessment (DECA) (LeBuffe & Naglieri, 1998)*. In addition, pre/post measures related to the impact of consultation on parents were included in the evaluation using the *Parenting Stress Index-Short Form* 3rd Edition (Abidin, 1995) and the *Parent Behavior Inventory (Lovejoy et al,. 1999)*. All pre/post assessments were conducted at the start of services and again after 4 months or at discharge if prior to 4 months. In addition to pre/post measures, the impact of relationships on outcomes was assessed using the *Relationship Quality Scale (RQS) (Sheridan 1998 & 2000)*. RQS's were completed by consultants, ECE providers, ECE directors and parents at 4 months after services began or at discharge if prior to 4 months. Through these measurement tools we hoped to answer the following research questions:

1. Does ECMHC improve the effectiveness of ECE providers' approaches to promoting a classroom climate conducive to positive behavior and social-emotional functioning?
2. Do ECMHC interventions improve the overall level of social functioning and reduce the overall level of problem behaviors in the classroom?
3. Do children referred for child-focused ECMHC intervention show an improvement in social-emotional functioning following intervention?
4. Do parents whose children are referred for child-focused ECMHC intervention show a reduction in parenting stress and an improvement in parenting behaviors?
5. How do parents/caregivers and ECMH consultants perceive their relationship with each other and with ECE Providers, and does perceived relationship quality impact targeted ECMHC outcomes?

Since there is growing evidence that ECMHC is an effective strategy in reducing the impact of social- emotional and behavioral challenges on young children in ECE settings, one of the impacts that we hoped to see was a reduction in the number of children who were forced to exit ECE settings due to such challenges. In previous studies, most of the children who received child-specific consultation services showed a reduction in behavioral concerns and/or the child was moved to a more appropriate child care placement. However, sometimes, often when the consultants were called in too late to actually begin child-specific services; it was observed that children were being forced to leave their ECE setting.

In order to better understand the range of experiences that children and their families were having in Maryland related to exits from ECE settings, we cast a broad net of those included in the **Exit Study**. We intentionally did not restrict our analysis to only those children who were expelled (forced to leave their ECE setting); rather we sought to interview key stakeholders who were involved with all cases where children whose problem behavior contributed to their exiting a ECE setting. Stakeholders included in the Exit Study included

consultants, ECE directors, ECE providers and parents. We developed the following questions to explore the factors associated with exiting an ECE setting:

1. How do ECMH stakeholders (ECMH consultants, ECE Providers, ECE Directors and Parents/Caregivers) perceive the nature and characteristics of their relationships with one another?
2. What strategies do consultants use to work with children, providers, and parents?
3. What are the predictors of behavior-related exits from child care programs?
4. What facilitates/predicts positive outcomes when children exit child care programs?
5. How can we prevent behavior-related exits from child care programs?

2.2: Collaborative Approach

The evaluation of Maryland's ECMHC program was conducted via a collaborative, or participatory, approach. This approach involved a partnership between the evaluation team and all members of the "community", including the evaluation participants, to design and execute the evaluation using a formative and iterative process that allowed for input and influence from all parties. There are significant benefits to conducting an evaluation in this manner, including increased opportunity for engagement and relationship building, improving the quality and relevance of data, identifying gaps in design and measurement, and providing opportunities for mutual learning. For the purpose of the current evaluation, we determined that a collaborative approach would best promote stakeholder buy-in, promote sustainability and ensure the strength of the evaluation design. In choosing this model, the evaluation team recognized that several challenges inherent to the participatory model would likely be encountered. For example, collaborative evaluation takes considerably more time and requires a commitment to hearing and actively responding to concerns from the field. Although challenging at times, the collaborative approach can create stronger collaboration and the infrastructure necessary for sustained evaluation efforts.

One of the strengths of the collaborative relationship was that the evaluation team was able to assist the funder (MSDE) by helping them streamline and improve the administrative data requirements of the ECMHC programs. This process has assisted in improving the quality and relevance of the State's quarterly data. Stakeholder buy-in was also obtained by designing an evaluation that would be responsive to the expressed concerns of the consultants and ECMHC programs. One example of this is the evaluation team's commitment to not disrupting the consultation relationship. Consultants expressed some concern that the addition of paperwork would burden their burgeoning relationship with parents, teachers, and directors. To alleviate this concern, the evaluation team changed the design to be less burdensome (e.g., streamlining forms and offering multiple methods of data collection and transfer), and added incentives to encourage participation.

Sustainability of evaluation efforts is another strength of the collaborative approach. For the current effort, this meant a commitment to choosing and implementing tools that could be used by the projects after the end of the evaluation period. We also ensured that the evaluation data would be supported by ongoing administrative data collection efforts, and that MSDE would continue to track program evaluation data over time, even after the evaluation was over. In fact, quarterly interviews suggest that most sites felt the use of standardized assessment tools across programs was the most helpful aspect of the evaluation project. Some programs endorsed that they would continue to use measures such as the Preschool Climate Scale and the Service Logs.

Finally, the collaborative evaluation approach was especially helpful in understanding the unique characteristics of ECMHC across diverse ECE settings and spanning a large geographic area. Given that ECMHC is not a manualized intervention, and there was not an existing set of standards at the time of this evaluation, ECMHC operated differently across sites, often based on specific site needs and characteristics. In order to understand the distinctive qualities of each site, the evaluation team did an initial assessment of sites' unique practices and consultants' knowledge and skills. This initial meeting also served as a critical engagement and relationship-building strategy. After initial meetings, the evaluation team designated Site Liaisons, six evaluation team members assigned to serve as the liaison for one or two sites each. Liaisons met monthly and then quarterly with their sites to provide assistance with the evaluation. Liaison conducted an interview quarterly which was aimed at collecting information particular to each site. There were questions regarding funding and staffing changes, marketing, reflective supervision, consultation activities, and evaluation. This information was shared with the larger team and with MSDE. Our evaluation design continued to be participatory by launching a pilot study during which we provided support through a Webinar and individualized TA visits and collected feedback through monthly meetings with sites. After this pilot period, adjustments were made in multiple areas and the design was refined to be responsive to ECMHC programs feedback. The consultants also had input into the design of evaluation, for example helping to determine the best time points for data collection. In addition, the team needed to hear from the field about the feasibility and importance of measuring these constructs, and obtained information from consultants to design an instrument that could accurately capture their service delivery model.

Despite its challenges, the evaluation team concluded that a collaborative evaluation approach was necessary to promote buy-in and sustainability, to inform a continuous quality improvement process, and to understand the nuances across diverse jurisdictions in the state of Maryland. Despite best efforts of the evaluation team some limitations did arise. The greatest limitation was that the evaluation did not engage directly with families, instead we solicited their feedback through consultants and teachers. In addition, although ECMHC programs saw value in the evaluation, many reported that it was complicated and labor intensive.

Chapter 3: Description, Design and Results of the Three Evaluation Studies

3.1 Service Description Study

3.1a Sample

There are eleven programs funded by MSDE to provide ECMHC to all of Maryland's 24 counties. See below for a map (Figure 2) and summary (Table 1) of each ECMHC program, the counties they serve, and number of consultants they have on staff.

Figure 2. Map of Maryland's ECMHC Program Sites

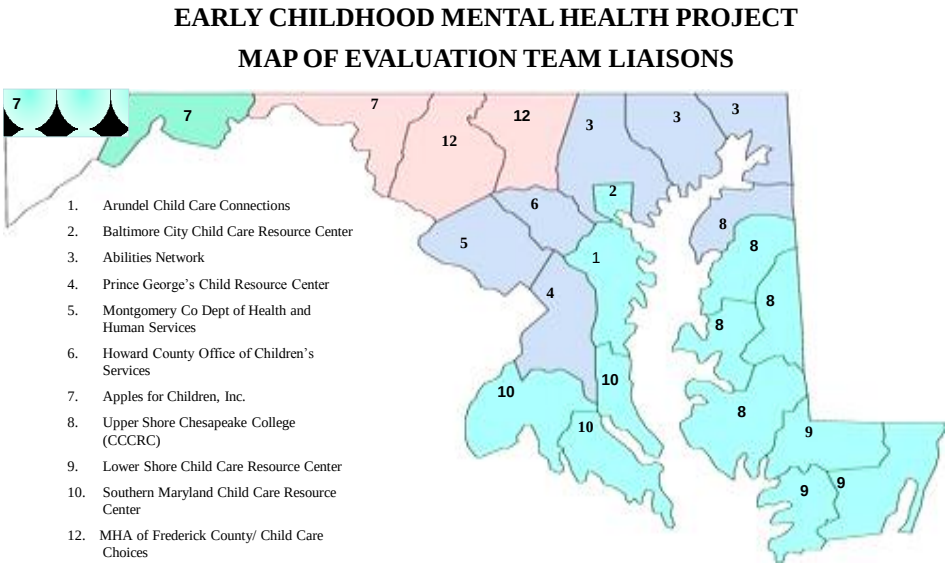


Table 1: ECMHC Program Summary			
Program Name	**Organization**	**Jurisdictions**	**Number of consultants providing services as of 7/31/11**
CHAMPS	Arundel Child Care Connections	Anne Arundel	2 FTE
Early Intervention Project (EIP)	Baltimore City Child Care Resource Center	Baltimore City	2FTE
Best Practices for Social/Emotional Resiliency	Abilities Network	Baltimore/Harford and Cecil County (funded as two separate programs)	4 FTE
Project Win	Prince George's Child Resource Center	Prince George's County	1 FTE
Montgomery County ECMH Consultation Service	Montgomery Co Dept of Health and Human Services	Montgomery	12 Part time
Care Center	Howard County Office of Children's Services	Howard	3 FTE
Early Childhood Destination: Inclusion	Apples for Children, Inc.	Allegany, Garrett, Washington	2 FTE
Project Right Steps	Upper Shore Chesapeake College (CCCRC)	Queen Ann, Caroline, Dorchester, Kent, Talbot	2 Part time
Lower Shore Early Intervention Program (LSEIP)	Lower Shore Child Care Resource Center	Worcester, Wicomico, Somerset	2 FTE and 2 part time
Project First Choice or ECMHP	Southern Maryland Child Care Resource Center	Calvert, Charles, St. Mary	2 FTE
Partnerships for Emotionally Resilient Kids (PERKS	MHA of Frederick County/ Child Care Choices	Frederick, Carroll	2.6 FTE

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3.1b Procedure

ECMHC programs and consultants participated in the current evaluation as part of their contract with MSDE. Each of Maryland's eleven ECMHC programs participated in the Service Description study. Each site received support in implementing the evaluation from a designated research team member, the Site Liaison.

Site Liaisons conducted an initial interview, during which program directors completed a *Model Description Survey*. In addition, Site Liaisons conducted *Quarterly Interviews* with program directors and consultants. Consultants provided information about their knowledge and skills at the beginning of the evaluation and annually thereafter. Consultants hired after the start of the evaluation provided this information upon hire.

Service Logs were completed by consultants following each visit with a child or classroom, and submitted logs to the Site Liaison either monthly or upon case closure. Service log data were collected from April 2010 through June 2011. Twenty seven of 49 consultants provided service logs, representing all but one of the eleven projects participating in the evaluation.

Maryland State Department of Education (MSDE) ECMHC Service and Productivity Reports: MSDE collects data quarterly from all ECMHC Programs on the types of services provided (child-specific or program-specific) and characteristics of ECE settings and population served.

3.1c Measures

Model Description Survey: This survey was completed by ECMHC program directors at the onset of the evaluation. It included questions about the number of years the ECMHC program has been operating, the program's approach to ECMHC, the title of the mental health consultants, ECMHC program management, employment and funding, case eligibility criteria, quality of the ECE programs served by the program, average consultant caseload, and service duration and intensity.

Knowledge and Skills Questionnaire (KSQ): The KSQ was administered to consultants at the start of the evaluation and annually thereafter. Consultants hired between annual administrations provided this information upon hire and then at annual intervals. The KSQ includes questions about consultants' demographic characteristics, ECE knowledge and education background. The KSQ is comprised of 6 basic demographic questions and 22 questions regarding three areas: knowledge, skills, and experience. Respondents rate their level of knowledge/skill/experience on a 5-point Likert scale (0=minimal, 5=strong).

Quarterly Interviews were conducted by Site Liaisons with ECMHC program directors and consultants. The purpose of the *Quarterly Interview* was to collect qualitative data while simultaneously facilitating the collaborative approach. The *Quarterly Interview* is a semi-structured interview with questions about the following areas: staff changes, funding,

partnerships, staff training, evaluation, supervision, activities, effectiveness, ECMHC model and strategies, and local and state context. During interviews, Site Liaisons encouraged respondents to provide feedback about the evaluation process.

Service Logs: Service logs were introduced in early spring 2010 to capture data on the type of services delivered by mental health consultants and the intensity or dosage of each service. The Maryland ECMHC Evaluation Service Log was adapted from one used by the Louisiana Mental Health Consultation project. Consultants completed a service log for each classroom- or child-specific visit. They provided total minutes spent on each consultation activity. Service logs included the following activities: conducting observation; consulting to parents on child specific issues; consulting to teachers; consulting to the director and/or owner; modeling classroom behavior management techniques; training in a formal workshop; referring or making a collateral consultation; and other. Any 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 was not included.

Data collected from the *Maryland State Department of Education (MSDE) ECMHC Service and Productivity Report* included the following:

- total number of children in center care, family child care, Head Start/Early Head Start, pre-kindergarten, nursery school, and multiple programs
- number of centers, family providers, Head Start/Early Head Starts, pre-kindergartens, classrooms and accredited programs served by ECMHC
- number of credentialed staff served by ECMHC
- total number of children who remained in their current placement, were expelled, whose placement changed due to family situation, or who moved to a more appropriate setting
- total number of children served by ECMHC
- gender, race and age range of children served by ECMHC
- number of children served by ECMHC who: receive a child care subsidy, and/or have an Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP)
- number of referrals to other resources

3.1d Relevant Research Questions

Analyses address the following research questions:

1. What are the characteristics of Maryland's ECMHC programs?
2. What are the barriers experienced by Maryland's ECMHC programs?
3. What are the characteristics of the consultants providing ECMHC in Maryland?
4. What types of ECMHC services are being provided in Maryland?
5. What are some characteristics of a typical ECMHC case in Maryland?

3.1e Analyses

Descriptive statistics (means and frequencies) were calculated on data from the *Service Logs* using the statistical software package PASW Version 18. Specifically, frequency and duration (in minutes) of all activities reported on the *Service Logs* were computed. All data were checked for accuracy and some data were excluded from the *Service Logs* due to case coding errors. We did not exclude the few cases in which frequency and duration were reported for some activities but not others. For these cases, we were only able to include data from activities with frequency and duration data. In addition, we were unable to analyze data on reasons for case closure due to significant missing data and difficulties with interpretability related to the high variability in closure terms in the absence of a forced-choice of case closure categories.

Descriptive statistics (means and frequencies) also were calculated on data from the *Knowledge and Skills Survey* and on data from the *Maryland State Department of Education (MSDE) ECMHC Service and Productivity Report.* Qualitative analyses were conducted on data from the *Model Description Survey* and *Quarterly Interviews* to identify both unique and cross-cutting characteristics and themes across program sites.

3.1f Results

Research Question 1: What are the characteristics of Maryland's ECMHC programs?

There are eleven Early Childhood Consultation Programs funded in Maryland. These programs are primarily funded by MSDE, though some sites receive some additional funding from other local contracts. Most sites had been funded for two years when the evaluation began data collection; except for Baltimore City Child Care Resource Center (6 years), Montgomery County Department of Health and Human Services (8 years), and Upper Shore Chesapeake College (6 years). On the *Model Description Survey*, ECMHC program directors reported their overall approach for providing ECMH (see Table 2 below).

Table 2: ECMHC Approach of Maryland's Programs

Site Locale	Approach
Arundel Child Care Connections	The earlier we can help a child with his/her emotional social development, the better the child's self esteem and the more successful his/her transition in to school will be. We also feel that the better equipped the staff is, the better prepared they will be to handle issues and make changes on their own.

Table 2: ECMHC Approach of Maryland's Programs	
Baltimore City Child Care Resource Center	Our concept of ECMHC is the focus on the promotion of healthy social/emotional well being of young children, the strengthening of child care providers' competencies in working with children with behavioral or developmental challenges, and the identifying of supports of community services for children with more serious issues. We recognize that all children benefit from positive relationships with caregivers and peers.
Abilities Network	Inclusion; Integration of mental health; Regain development trajectory
Prince George's Co. Resource Center	We recognize that good social and emotional skills are the basis for successful early learning. Our program begins with a child centered approach but also looks at programmatic changes that benefit all children in the program.
Montgomery Co. Dept. of Health & Human Resources	ECMHC services follow a "hybrid model", combining child and classroom focused interventions. ECMHC "aims to build the capacity (improve the ability) of staff, families, programs, and systems to prevent, identify, treat and reduce the impact of mental health problems among children" (Cohen and Kaufmann, 2000) prior to school entry. Consultation is implemented within the framework of a relationship developed between a qualified mental health professional and child care staff. A primary goal of the relationship with the program is to retain children at risk for expulsion in a licensed child care setting. Consultants are experienced master's level mental health professionals with knowledge of early childhood development and experience in working with young children and their families.
Care Center	Although 95% of the time they are initially enlisted to help with issues associated with a specific child, the program tries to expand the work with program-level consultation-scanning the overall classroom/program environment. Program makes a clear distinction between consultation and therapy, yet admits that sometimes it is hard not to blur the line; estimates that about 90% of what they do is capacity-building and 10% is direct service. CARE program tries to stay focused on classroom intervention, but if a child's home circumstances/family life is posing a significant barrier to progress, then services/referrals to help family is prioritized. Many of the ECE programs they work with have a strong emphasis on school readiness; they often need to make a concerted effort to educate on the link between social-emotional well-being and school readiness.

Table 2: ECMHC Approach of Maryland's Programs	
Apples for Children	Most programs' child-specific ECMHC referrals are a result of programs needing support in working with children with individual differences; not a result of a diagnosable mental health issue. However, early intervention is important, because without caring, knowledgeable adults, children may not develop the skills and dispositions to maintain mental health.
Upper Shore Chesapeake College	The majority of Project Right Steps (PRS) cases are child focused, and the majority of PRS-PLUS cases are program focused.
Lower Shore CCRC	"It is easier to build a child than to repair an adult". Lower Shore Early Intervention Program (LSEIP) works to build resiliency in young children and to give them the tools to succeed in school and in life. "To provide quality childhood behavior interventions, assessments, and educational services for child care providers, families, early educators and mental health clinicians of children ages birth to five on the lower eastern shore".
Southern MD Child Care Resource Center	We use a strength based, pro active approach that includes both the family and providers as partners in the creating of the intervention and the expected out comes.
Child Care Choices	Our goals are to increase pro-social behaviors and decrease behavioral problems in children by assessing the child care environment; increasing child care provider skills to deal with difficult behaviors; developing a partnership between parents and providers to address behavioral concerns in individual children and making appropriate referrals to outside resources as necessary

Characteristics of ECE Programs Served by ECMHC

According to the *Maryland State Department of Education (MSDE) ECMHC Service and Productivity Reports* Maryland's ECMHC is conducted mostly in ECE centers. In Fiscal Year 2011 (FY11) 236 centers were served across the state, while only 45 family providers, 8 Head Starts and 2 public pre-kindergartens were served. Interestingly the number of family providers, Head Start/early Head Starts and pre-kindergarten classrooms served per year decreased steadily from 2009 to 2011. The number and relative percentage of family providers served per year decreased from 60 (20%) in Fiscal Year 2009 (FY09) to 45 (15%) in FY11. The number and relative percentage of Head Start/ Early Head Starts served per year decreased slightly from twelve (4%) in FY09 to eight (3%) in FY11.

Data collected from *Model Description Surveys* and *Quarterly Interviews* suggest that programs primarily serve private child care center settings and receive fewer referrals from home-based early care programs. About half of ECMHC programs work in Head Start settings and only two have provided consultation in informal child care settings or homeless shelters. Most ECMHC programs (eight of eleven) have not provided consultation in home based ECE programs. ECMHC programs reported variability in program quality, with only some programs served being accredited.

Characteristics of Children Served by Early Childhood Mental Health Consultation

Based on data from the *Maryland State Department of Education (MSDE) ECMHC Service and Productivity Reports*, the total number of children receiving child specific consultation has grown over the past three years from 666 in FY09, to 810 children served in FY11. Among children served by ECMHC programs, the percentage of children receiving child care subsidies remained relatively stable from FY09 to FY11, (ranging from fifteen to seventeen percent across all three years). Similarly, among children receiving ECMHC, the percentage of children with Individualized Family Services Program/Individualized Education Program remained relatively consistent from FY09 to FY11 (ranging from eleven to fifteen percent across all three years).

Most children receiving ECMHC in Maryland are boys (ranging from 74 to 76 percent of cases between FY09 and FY11). All sites serve children from zero to six years of age, though according to the *MSDE ECMHC Service and Productivity Reports* children between ages three and five were the most frequently served group by ECMHC in Maryland, representing between 71 and 80 percent of cases each year between FY09 and 11. Less than three percent of cases in the past three years included children under age two. Most children receiving consultation are White (between 59 and 61 percent in FY09 to 11), with African American children representing the next largest group served (25 to 29 percent across the three past years). Other children served between FY09 and 11 included Alaskan/American Indian (less than one percent), Hispanic (three to four percent), Multiracial (five to eight percent) and Asian /Pacific Islander, which while still ranking low have doubled from two percent (thirteen children) in FY09 to four percent (thirty children) in FY11.

Research Question 2: What are the barriers experienced by Maryland's ECMHC programs?

Data from the *Quarterly Interviews* and *Model Description Surveys* were summarized, including reports from program directors and consultants about the barriers to delivering ECMHC in Maryland. These barriers are described below.

Mental Health Stigma

Program directors and consultants consistently reported struggling to overcome the mental health stigma which can be particularly sensitive in early childhood settings. To combat this stigma nine of the eleven programs removed the term "mental health" from their program titles. In addition, seven of the eleven programs use the term *Behavior or Early Interventionists/Specialists* to describe their consultants.

Program and Teacher Readiness

Another barrier programs endorsed was teacher and program director readiness for consultation. Consultants reported that ECE providers were simply not ready to change behavior/teaching strategies. Consultants noted that teachers often attributed problems to the children, and not to their own teaching behaviors and environment. Additionally, consultants reported that ECE providers expressed feeling overwhelmed, underpaid and not respected, and subsequently not receptive to new strategies that required changing their work. Consultants also reported that ECE providers' expectations about consultation were often inaccurate such that they considered consultation a "quick fix" requiring effort from the consultant, but little effort from themselves. These types of misconceptions can put strain on the relationships between consultants and ECE providers, subsequently creating a barrier to implementing consultant recommendations.

Parent Engagement

Approximately half of the ECMHC programs reported struggles to actively involve parents in the consultation process. Many programs report having very limited contact with parents at drop off/pick up or via phone and email following the initial consent process. Consultants report that challenges with parent engagement limit their ability to introduce strategies for addressing mental health concerns in the home setting. Many programs attribute reduced parent engagement to tight and shrinking budgets. Specifically, many ECMHC programs do not have work cell phones, are having to pay for their own travel and are experiencing larger case loads, leaving little resources to actually engage families and serve them in their homes. In addition, several programs indicated that often parents only agree to consultation because it can be done in the child care setting and they do not have to be involved; parents perceive the identified problems as exclusive to the child care setting that do not generalize to the home setting. For those consultants that have more successfully achieved parent engagement, they indicate that a lot of work is required up front to normalize mental health problems and consultation, followed by an intensive joint planning process with parents and ECE providers. Additionally, consultants who report success with family engagement indicate that they consistently provide all parties, including parents and ECE providers, with updates on the goals/objectives after each consultation visit, and try to make themselves available for in-home consultation when possible.

Funding Concerns

Almost every program indicated that funding cuts and the stress of imminent funding changes impacted consultation. Some programs were adversely affected by funding cuts or budgetary issues which required them to either reduce consultation for a period of time or reduce consultant time. Of particular concern is that there has not been enough money to effectively engage families and that additional budget cuts have made it increasingly more difficult to effectively engage and work with families. Although cuts were noted to be relatively small, they have impacted things such as travel (some consultants having to pay for their own), cell phones (which makes it difficult for parents and teachers to get in touch with consultants since they are in the field for the majority of the day) and reducing the amount of trainings that consultants can attend. Most programs have protected direct work that is done with child care programs although a few had to reduce consultant time, which impacted the number of cases they could take on.

Many programs also noted that the amount of referrals they have received has increased in the past years, possibly because child care programs are now more concerned about keeping children in their programs. This may be due to economic pressures that child care programs are experiencing and/or changes in ECE program philosophies regarding challenging children. Some ECMHC programs also have noticed that they are receiving more challenging cases, including children with significant mental health and/or developmental needs.

Supervision

Most programs noted that obtaining clinical supervision was a continual struggle. Sites reported a great deal of variability with the type and frequency of clinical supervision provided to consultants. Some programs reported weekly or biweekly case management or treatment team meetings, while others offer individual supervision by a mental health professional either routinely or in the event of a particularly challenging case. There were problems with identifying a qualified individual to provide reflective supervision as well as insufficient funding to pay for these services.

Research Question 3: What are the characteristics of the consultants providing ECMHC in Maryland?

Data from the *Knowledge and Skills Questionnaire (KSQ)* provided information about Maryland's ECMHC consultants' knowledge, skills and experience. With respect to knowledge, consultants rated their perceived competence in factors relevant to ECMHC. Ratings are presented in Table 3 below in order of increasing perceived competence. Consultants felt least confident about their grasp of early childhood intervention systems, treatments and family support services, as well as their understanding of diverse cultures. They felt most confident about their knowledge of typical and atypical child development, community resources and infant and early childhood mental health/social-emotional development.

Table 3: ECMH Consultants' Perceived Knowledge of ECMHC Competencies				
	Minimum	**Maximum**	**Mean**	**Std. Deviation**
Knowledge of early intervention systems (Part C and preschool special education)	0	4	2.65	0.89
Knowledge of diverse mental health treatment/intervention approaches.	1	4	2.75	0.81
Knowledge of family support and adult service systems	2	4	2.88	0.76
Understanding of diverse cultures	1	4	2.88	0.85
Knowledge of community resources	1	4	3.28	0.79
Knowledge of infant and early childhood mental health/social-emotional development	2	4	3.48	0.60
Knowledge of typical and atypical early childhood development.	3	4	3.58	0.50

In terms of *experience* (see Table 4 below), consultants reported the least amount of background working in foster care settings and providing direct therapy. Consultants had the most experience in screening activities and working with children displaying challenging behaviors.

Table 4: ECMH Consultants' Related Experience				
	Minimum	**Maximum**	**Mean**	**Std. Deviation**
Experience working with children in foster care	0	4	1.52	1.46
Table 4: ECMH Consultants' Related Experience				

Experience providing direct therapy to children birth through 5	0	4	1.69	1.52
Experience providing training/education to adults	0	4	2.80	1.18
Experience working in child care settings (prior to job as consultant)	0	4	2.90	1.37
Experience observing/ screening/ assessing children in classroom, home, or other natural settings	1	4	3.47	0.75
Experience working with children with challenging behavior	1	4	3.52	0.67

Finally, consultants rated their *skills* in different areas relevant to work in early childhood settings. Table 5 below shows that consultants felt the most unsure about their capacity to employ classroom/group activities to promote behavioral and emotional skills and to intervene in crisis situations. They felt that they had the strongest skills in forging collaborations with providers and families.

Table 5: ECMH Consultants' Self-reported Skills

	Minimum	**Maximum**	**Mean**	**Std. Deviation**
Crisis intervention skills	0	4	2.87	0.91
Ability to integrate mental health activities into group care settings	0	4	2.95	0.90
Care management/care coordination skills	0	4	3.00	0.93
Ability to integrate a 'wellness approach' to mental health that includes activities focused on promotion and prevention	0	4	3.10	0.84
Ability to develop and support implementation of individualized intervention plans	2	4	3.35	0.57

Table 5: ECMH Consultants' Self-reported Skills				
Ability to facilitate team meetings/manage diverse perspectives	2	4	3.40	0.63
Ability to collaborate with families	2	4	3.63	0.53
Ability to collaborate with child care directors/teachers/providers	2	4	3.65	0.53
Communication skills	2	4	3.65	0.53

We compared average scores on items between consultants with a bachelor's degree and those with a master's degree. Figure 3 below shows that those with bachelor's degrees reported possessing some skills at a significantly ($p < .05$) greater level than those with master's degrees; consultants with bachelor's degrees reported more experience working and collaborating in child care settings and more effective communication skills. In contrast, those consultants with a master's degree reported more experience in providing direct therapy to young children and working with children in foster care.

Figure 3: Self-reported Skills by ECMH Consultants with Bachelor's and Master's Degrees

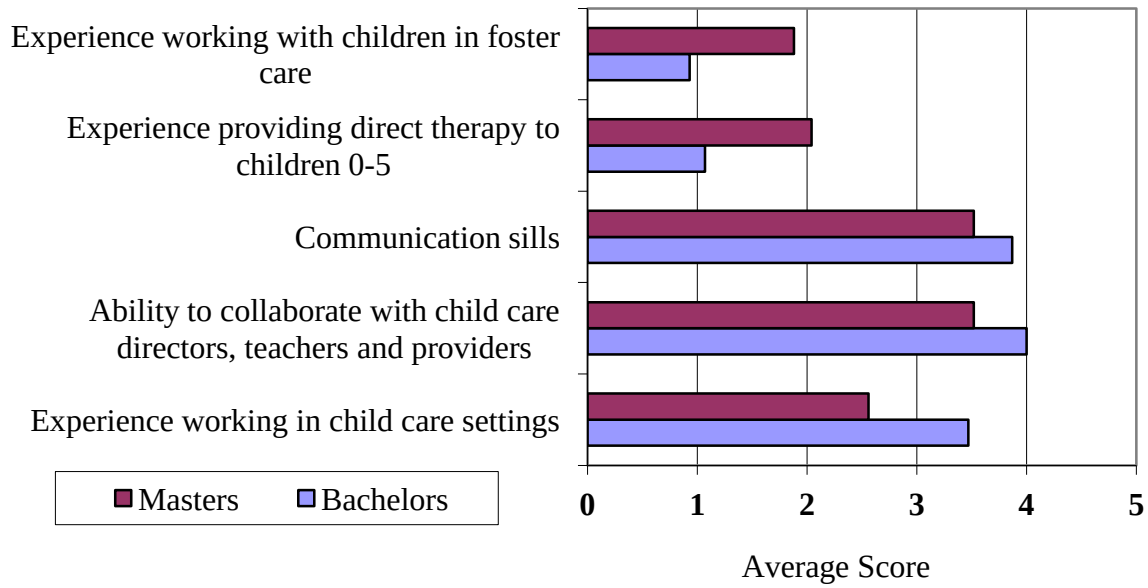


Table 6 below presents areas where there were statistically significant differences in the mean scores between consultants with degrees in a mental health field and those without. Typically, consultants whose degree was not in mental health had a degree in early childhood education. Consultants with mental health degrees reported significantly ($p < .05$) greater knowledge, experience and skills across several areas illustrated in the table below.

Table 6: Knowledge, Experience and Skills of ECMH Consultants with and without Mental Health Degrees, Mean (SD)

Item	No Mental Health Degree	Mental Health Degree
Knowledge of diverse mental health treatment/intervention approaches	2.38 (.65)	3.04 (.72)
Experience providing training/education to adults	3.46 (.78)	2.46 (1.02)
Crisis Intervention skills	2.46 (1.12)	3.10 (.74)
Care Management/Care Coordination skills	2.46 (1.30)	3.30 (.62)

Research Question 4: What types of ECMHC services are being provided in Maryland?

Data from the *Service Logs* and *Quarterly Interviews* provided information about the types of services being provided by Maryland's ECMH consultants. The two most frequent activities provided by consultants in the classroom are teacher consultation and classroom observation. *Service Log* data indicate that, consultants provided teacher and/or classroom observations on average six to seven times per case (SD=5.8 for teacher observations and SD=5.6 for classroom observations). There was variability in the frequency of both teacher consultation and classroom observations; some consultants provided these services only once and others provided them 29 times for an individual case. ECE Directors were consulted on average three to four times per case. Families were consulted much less frequently. For child-specific cases, consultants averaged two consultation visits with parents of children (SD=3). Findings suggest that a major role of consultants was supporting the classroom staff and leadership at the child care setting. In addition to observations, consultants modeled specific behaviors on average three to four visits per case (SD = 5.3) Descriptive statistics (means and standard deviations) are presented for all activities in Table 7 below, showing the average number of times an activity was provided per case.

Table 7: Consultation Activities		
Activity	**Mean Times per Case**	**Standard Deviation**
Teacher Consultation	6.6	5.8
Classroom Observation	6.6	5.6
Consultation to Director/Owner	4.2	5.0
Model Classroom Behavior	3.5	5.3
Parent Consultation	2.0	3.0
Other	0.7	2.0
Referral/Collateral Consultation	0.4	1.5
No Activity Indicated	0.2	1.0
Train Formal Workshop	0.1	4.0

From *Quarterly Interviews* all program directors indicated that the time spent providing consultation for each case varies considerably, depending on the severity of the child's needs (including both behavioral and development needs), the readiness of programs and child care providers to participate in consultation, availability of resources, and the nature of the parent/provider relationship.

Research Question 5: What are some characteristics of a typical ECMHC case in Maryland?

The Quarterly Interviews also indicated that ECMH Consultant caseloads differ greatly across sites, ranging from two to eighteen child-specific cases per consultant. Referral sources also vary greatly across programs. Most programs indicated that their strongest referral source was directly from child care centers (primarily from child care directors). A few programs receive calls from Child Find, particularly if they are connected to the resource centers in their jurisdictions. Most programs also receive some calls directly from parents, although they are usually prompted by child care directors. A few programs also receive referrals from community professionals such as pediatricians, speech therapists, child therapists and teachers.

According to the Quarterly Interviews, of referred cases, ten of eleven ECMHC programs indicated that over 90% of referrals are child-specific, with less than 10% initiated for classroom consultation. However, several programs noted that some child-specific referrals result in classroom consultation. Of note, this "hybrid" child-specific/classroom case model appears to be the most common across current programs. Only one program reported seeing 50% child-specific and 50% classroom cases.

In order to determine characteristics of a "typical" ECMHC case in Maryland, we analyzed data from the 145 cases with sufficient *Service Log* data. The average duration of a case was thirteen weeks (SD=10.2), with a range of one to 43 weeks; the average number of visits per

case was nine (SD=6.2). On average, fourteen hours is spent on site per case (SD=12.9) and six off-site (SD=8.5). Some of the variability in case length and intensity may be accounted for by differences between child-specific and classroom-specific cases. Based on data from the *Quarterly Interviews*, sites reported that a case typically concludes when the specific behavioral issue improves or the child is moved to a different setting. Consultants also noted spending more time, sometimes an entire school year, when conducting classroom consultation vs. child-specific consultation.

Quarterly Interview data also revealed several strategies utilized consistently by consultants to create effective change through consultation. The most frequently endorsed strategy was building effective relationships, with providers (and parents when possible). Consultants developed relationships by actively listening to ECE providers so that they feel heard, showing empathy, normalizing feelings of frustration, carefully not blaming providers or parents for the challenging behavior, focusing on new skill attainment rather than focusing on errors, and giving providers and parents a sense of ownership in the process. Consultants also indicated that role modeling and the use of supportive materials with providers were successful strategies in creating effective change.

3.1g Limitations: Several limitations of the Service Description study are described below and should be taken into consideration when interpreting the findings of the study.

The *Knowledge and Skills Questionnaire (KSQ)* data had the potential for annual assessment of change vs. a one-time description of initial knowledge and skills; however, the anonymity of the survey precluded matching changes in annual responses. The KSQ also is a self-administered survey and does not represent assessment of actual knowledge and skills in ECMHC and therefore may reflect a self-reporting bias.

The *Quarterly Interviews* were modified throughout the process based on feedback from the field and contextual factors that called for question re-wording or editing (e.g., reductions in funding led to additional questions about the impact of reduced funding). Therefore, it was difficult to assess change over time on specific dimensions assessed via this instrument.

The implementation of the *Service Logs* occurred midway through the evaluation timeframe, which hindered the collection of a large enough sample to examine the impact of programmatic differences. Another limitation was that not all consultants completed *Service Logs*; many sites were underrepresented with only a small number of consultants completing the service logs.

3.2 Impact Study

3.2a Sample

Data for assessment of the impact of ECMHC services were obtained from consultants, ECE providers and caregivers of children referred for consultation. All ECMHC consultants in Maryland provided data whose demographics were described above in section 3.1. The Impact Study data was provided by ECE directors, teachers, and parents. The overall sample included 159 teachers, 136 directors, and 107 parents. All of the teachers who participated were female. 69.2% were white, 23.3% were Black/African American, 3.2% were Hispanic, 1.9% were Asian, 1.3% were American Indian/Alaska Native, .6% were Native Hawaiian/Other Pacific Islander, and .6% were Multiracial. The majority of parents who participated in the evaluation were female (94.4%). 81.3% were White, 13.1% were Black/African American, 3.7% were Asian, 1.9% were Hispanic, 1.9% were Multiracial, and 1.9% were American Indian/Alaska Native. Specific information about the number of subjects can be found below in Section 3.2f.

3.2b Procedures

Recruitment and Informed Consent

To recruit ECMHC program directors and consultants, a member of the evaluation team made in-person visits to each of the 11 funded sites. At that visit, the process was reviewed and written consent forms were provided and explained. The consent form outlined the details of participation in the evaluation and asked for written consent to participate. All directors and consultants agreed to participate in the evaluation study and signed the consent forms.

Beginning in September of 2009, ECMH consultants provided ECE directors and providers a brochure and a sealed envelope containing baseline evaluation measures and a written consent form when a referral for consultation was initiated. Any program or staff member in a program participated in the evaluation one time only. The brochure provided general information regarding the evaluation as well as a toll free number to call if they had questions. If willing to participate in the evaluation, they were instructed to sign the consent form and return it in the sealed envelope either by mailing it directly to UMB or by giving it to their consultant for processing anonymously.

When caregivers agreed to participate in early childhood consultation services during the study dates, they received the brochure as well as the package of evaluation information, measures and written consent from the consultant. Only caregivers of children receiving child-focused consultation services were recruited. If willing to participate in the evaluation, caregivers were instructed to sign the consent form and return it by mail in the sealed envelope directly to UMB.

ECE Providers and Directors earned Professional Activity Units (PAUs) for their participation and completion of both baseline and follow up packets. When the evaluation team received a teacher or director follow up packet, a certificate rewarding the provider with a PAU was awarded. Directors earned two PAUs for their participation and Teachers earned one PAU. Caregivers were entered into a lottery for a chance to win a $50 money order. Drawings were held at the end of each quarter.

Data Collection

The process of data collection took several forms. Some consultants returned their completed data forms (both baseline and follow up) by mail or fax. Many chose to give them to their evaluation liaisons, who visited quarterly. For baseline assessments, ECE directors, ECE providers and caregivers, were provided with a postage-paid sealed envelope; some chose to leave them at the ECE site. For follow-up, packets were delivered to respondents 4 months following onset of the consultation or at discharge whichever came first. They were returned by mail or by leaving them with staff at the ECE site.

3.2c Measures

Consultant-Completed

Preschool Mental Health Climate Scale (PMHCS). The PMHCS is a measure to gauge the success of the ECMHC program, addressing the full range of classroom characteristics associated with mentally healthy environments for young children. The measure has 50 positive items that are scored on a 5-point Likert scale with "1" indicating *never or not true*, "3" indicating *moderately frequent or moderately true* and "5" indicating *consistently or completely true*. The positive items are grouped in nine domains: Transitions, Directions and Rules, Staff Awareness, Staff Affect, Staff Cooperation, Teaching Feelings and Problem-Solving, Individualized and Developmentally Appropriate Pedagogy, Staff-Child Interactions and Child Interactions. There is also a set of 9 negative indicators scored on the same 5-point Likert scale. For those items, a lower score indicates a more positive climate. Estimates of inter-rater reliability reported by Gilliam (2008) for Total Positive Indicators and Total Negative Indicators both fall in the acceptable range. Internal consistency, a measure of reliability of the items to measure the same characteristic, was very strong for the Total Positive Indicators (0.98) and acceptable (0.75) for the Total Negative Indicators.

Consultants were asked to fill out *Relationship Quality Scales* (RQS; Sheridan (1998, 2000a, 2000b) at follow-up. The RQS is comprised of a set of 5-point scales utilized to assess the quality of the relationship between different early child care stakeholders. Two RQS scales were completed by the early childhood consultant, one tapped the consultant/provider relationship, the Early Childhood Consultant Perception of the ECE Provider scale (24 items), and the other tapped the consultant/caregiver relationship, the Early Childhood Consultant Perception of the Process (28 items).

Provider-Completed

The extent and impact of child problem behaviors in the classroom were assessed with the Impact Supplement of the *Strengths and Difficulties Questionnaire* (SDQ; Goodman, 1997). Teachers were asked to rate each individual child on their roster as to whether each child had difficulties in any of the following areas: emotions, concentration, behavior or being able to get along with other people. The rating uses a four point scale: no difficulties (1), minor difficulties (2), definite difficulties (3) or severe difficulties (4).

In the second part of the SDQ, for each child rated with some difficulty (minor, definite, severe), the provider was asked to rate the *impact* of the difficulties by answering several questions: how long have they have been present (less than a month, 1-5 months, 6-12 months, over a year), how much do they upset or distress the child, how much do they interfere with the child's peer relations or learning, and how much of a burden do they place on the provider or the class as a whole. The latter impact scores were rated on a four point scale (not at all, a little, a medium amount, a great deal). The data were collected and aggregated to assess the proportion of children whose behavior falls within the normal range.

Teacher Opinion Survey (TOS; Geller and Lynch, 1999). The TOS is a 13-item scale which measures ECE providers' self-efficacy. It assesses their feelings of confidence and competence in managing challenging behaviors, and their ability to make a positive difference in the lives of children. The items are rated on a 5-point Likert scale where 1= strongly disagree and 5 = strongly agree. The alpha coefficient for the 13 items is 0.66.

Caregiver-Completed

For cases where an individual child's behavior was of concern, the parent and teacher were asked to complete the *Devereux Early Childhood Assessment (DECA; LeBuffe & Naglieri, 1998).* Child social/emotional/behavioral functioning was assessed using the parent and teacher-completed DECA. The DECA is a standardized norm-referenced behavior rating scale that measures 27 positive behaviors and a 10 item behavioral screen for preschool children 2 to 5. This tool was selected because each of the 12 early childhood consultation programs currently use the tool as part of their early childhood consultation process. The DECA measures attachment, self-control and initiative, three strength-based protective factors assumed to help counter-balance the negative effects of risk factors, and help children overcome adversity. The DECA was normed on a representative, nationwide sample of 2,000 preschoolers in 28 states. Test-retest reliability for protective factors ranged from .55 to .80 for caregivers and .87 to .94 for ECE providers. Inter-rater reliability was 0.59 to 0.77 for protective factors. Construct validity was supported by a negative (-0.65) correlation between protective factors and problem behavior. Reviewers in the 15th Edition of the Mental Measurements Yearbook summarize the DECA as "theory-based, psychometrically sound, demands minimal training and time for administration and interpretation, and links assessment to intervention." A newly developed

infant/toddler version of the DECA was recently announced by its developers. Both the Baseline DECA and the 4 month follow up DECA are collected by Early Childhood Consultants as they are used as part of consultation. Both ECE providers and parents receiving consultation will be asked to complete them.

The *Parenting Stress Index Short Form* (PSI-SF) is a brief version of the Parenting Stress Index (Abidin, 1995), a widely used and well-researched measure of parenting stress. The PSI-SF has 36 items, shortened from the original 120-item PSI. The theoretical model (Abidin, 1976) suggests that parental stress is a function of salient child characteristics, parent characteristics, and situational variables related to the role of being a parent. Thus, the PSI-SF yields scores on three subscales: Parental Distress, Parent-Child Dysfunctional Interaction, and Difficult Child. The Parental Distress subscale yields a score that indicates level of distress resulting from personal factors such as depression or conflict with a partner and from life restrictions due to the demands of child-rearing.

The Parent–Child Dysfunctional Interaction subscale provides an indication of parents' dissatisfaction with interactions with their children and the degree to which parents find their children unacceptable. The Difficult Child subscale measures parents' perceptions of their children's self-regulatory abilities. Feedback from consultants indicated that they felt uncomfortable asking parents to respond to one item on the PSI, "Child does not like me or want to be close." Therefore, it was dropped from the version provided to parents and was not included in the calculation of the Parent-Child Dysfunctional Interaction scale.

Key aspects of positive parenting were assessed with the *Parent Behavior Inventory* (*PBI*; Lovejoy, Weis, O'Hare & Rubin, 1999). The PBI is a brief (20 item) measure for use with parents of preschool or young school-age children. It consists of two independent scales: Supportive/Engaged, tapping different aspects of parental warmth (e.g., responsiveness to needs, commitment to child's welfare, engagement in child-specified activities, enthusiasm at child's accomplishments); and Hostility/Coercion, reflecting hostility and maladaptive control techniques (e.g., expression of negative affect or indifference, use of coercion, threat or physical punishment to influence behavior). Respondents are asked to rate how well each statement describes the way he or she usually acts with their child on a 6-point (1-6) scale, ranging from not at all true ("I never do this") to very true ("I always do this").

At follow-up, caregivers were asked to fill out the Parent/Caregiver *Relationship Quality Scales* (RQS; see above), consisting of two sets of items: 12 target caregivers' perceptions of the quality and effectiveness of the help they received from the consultant; and 24 relate to caregivers' experiences with the child's teacher/child care provider. Two Total scales are calculated, comprising all items on each of the Consultant and Provider assessments. In addition, two subscales are calculated from the Provider assessment, Communication (5 items reflecting sharing of concerns, worries and opinions) and Joining (19 items reflecting the level of trust, cooperation, respect, and agreement).

3.2d Relevant Research Questions

1. Does ECMHC improve the effectiveness of ECE providers' approaches to promoting a classroom climate conducive to positive behavior and social-emotional functioning?
2. Do ECMHC interventions improve the overall level of social functioning and reduce the overall level of problem behaviors in the classroom?
3. Do children referred for child-focused ECMHC intervention show an improvement in social-emotional functioning following intervention?
4. Do parents whose children are referred for child-focused ECMHC intervention show a reduction in parenting stress and an improvement in parenting behaviors?

3.2e Analyses

The general approach to examine the research questions concerning the impact of ECMHC services was to use the General Linear Model (GLM) Repeated Measures procedure (SPSS Version 17). The strategy is appropriate for evaluating the change in measurement that is made more than once on each subject or case; in the current evaluation, measurement was made twice: baseline (prior to consultation) and at follow-up. Statistical approaches used to address more specific issues are described in the description of results for each research question.

Lack of follow-up measures can result for many reasons (e.g., relocation of respondents, reduced interest in participation). It is important to determine whether there were baseline differences between data from respondents who provided follow up measures and those who did not. If there are no differences, then it can be assumed that outcome analyses were not conducted on data that was related to the respondents' willingness to participate in the follow-up assessment. Therefore, for each measure for which we collected both baseline and follow-up data, we compared baseline ratings for those data with and without corresponding follow-up data, (hereafter referred to as "F" or "Follow-up" and "NF" or "No Follow-up", respectively).

3.2f Results

Prior to presenting baseline and follow-up findings, we first provide more detail about the response patterns for specific instruments, including the characteristics of classrooms for which we obtained *PMHCS* and *SDQ* data.

Table 8 provides the number of baseline and follow-up measures by name collected from each respondent type in the Outcome Study.

Table 8: Number of Respondents for Each Measure, by Respondent Type

Measure	Baseline	Follow-up
Consultant		
Preschool Mental Health Climate Scale	365	207
Relationship Quality Scale: Provider	-	180
Relationship Quality Scale: Caregiver	-	84

ECE Provider		
Teacher Opinion Survey	159	40
Strengths and Difficulties	158	56
Devereux Early Childhood Assessment[1]	163	55
Parent/Caregiver		
Devereux Early Childhood Assessment[1]	144	33
Parenting Stress Index	107	29
Parent Behavior Inventory	107	28
Relationship Quality Scale: Consultant	-	28
Relationship Quality Scale: ECE Provider	-	30

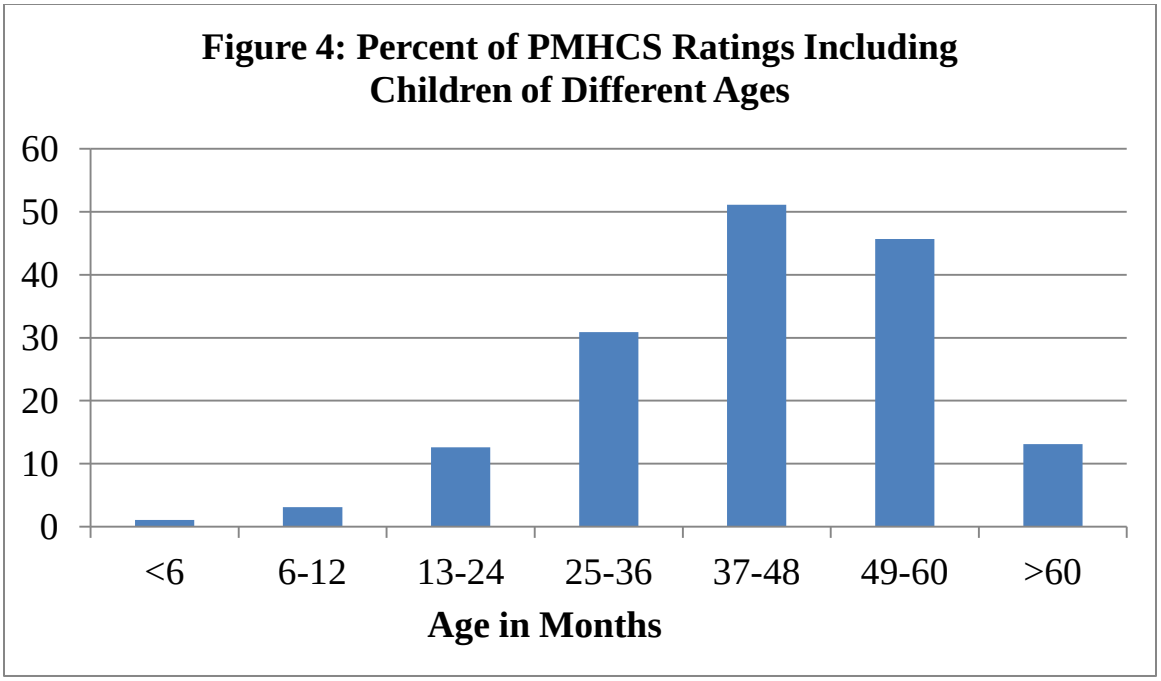
[1]Baseline DECA ratings from both parents and teachers were collected for 124 children. Follow-up DECAs were obtained for 75 children (some of whom did not have baseline measures). Baseline and follow-up DECAs from parents were available for 33 children. Baseline and follow-up DECAs from teachers were available for 55 children. Baseline and follow-up data from both parents and teachers were available for 27 children.

PMHCS. For each administration, consultants described the conditions under which the observation was made. First, they were asked to provide the date, number of visits, and length of time needed to complete the PMHCS. Complete data were available for 355 of the 366 baseline PMHCS. Of these PMHCS administrations, 166 (47%) required a second visit to complete the measure, and 96 (27%) required a third. The mean duration of time in minutes spent observing for each visit (first, second or third) were 106 (range 20 – 360), 93 (range 30 – 240), and 92 (range 20 – 210), respectively.

Consultants reported slightly fewer multiple visits to complete the follow-up PMHCSs. Of the 208 follow-up ratings, 77 (37%) required a second visit and 46 (24%) required a third. However, the time spent observing at each visit was relatively similar to that at baseline; for the first, second and third visits, mean duration of observations was 98 (range 20 – 425), 91 (range 30 – 240), and 96 (range 30 – 195) minutes, respectively.

Below, we describe characteristics of the PMHCS ratings, including the number and ages of children and the number of staff in the classroom, as well as the frequency of different activities observed. For each characteristic, we compared the baseline ratings made in classrooms that were also observed at follow-up (F) and those rated at baseline but not at follow-up (NF). In general, there were only minor, isolated differences, indicating that whether a classroom was rated at follow-up or not was not systematically related to any of these characteristics.

Figure 4 displays the percentage of classrooms with baseline ratings that included children of different ages. A classroom could include more than one age group, so the overall percent across age groups adds up to more than 100%. Very few classrooms with infants (1 year or less) were rated using the PMHCS; the majority of classrooms were those serving 3- and 4-year-olds.



Consultants administered the PMHCS in both center-based and family care settings, resulting in a wide range in the number of children observed in classrooms. Figure 5 below shows the percent of baseline PMHCSs completed, grouped by number of children per classroom. Overall, about 40% of the ratings were carried out in settings with 10 children or less

In terms of the number of staff, the majority of classrooms, about 60%, had two ECE staff members. Eighteen percent of classrooms had one teacher and 18% had three teachers; 4% of classrooms had four or more staff assigned.

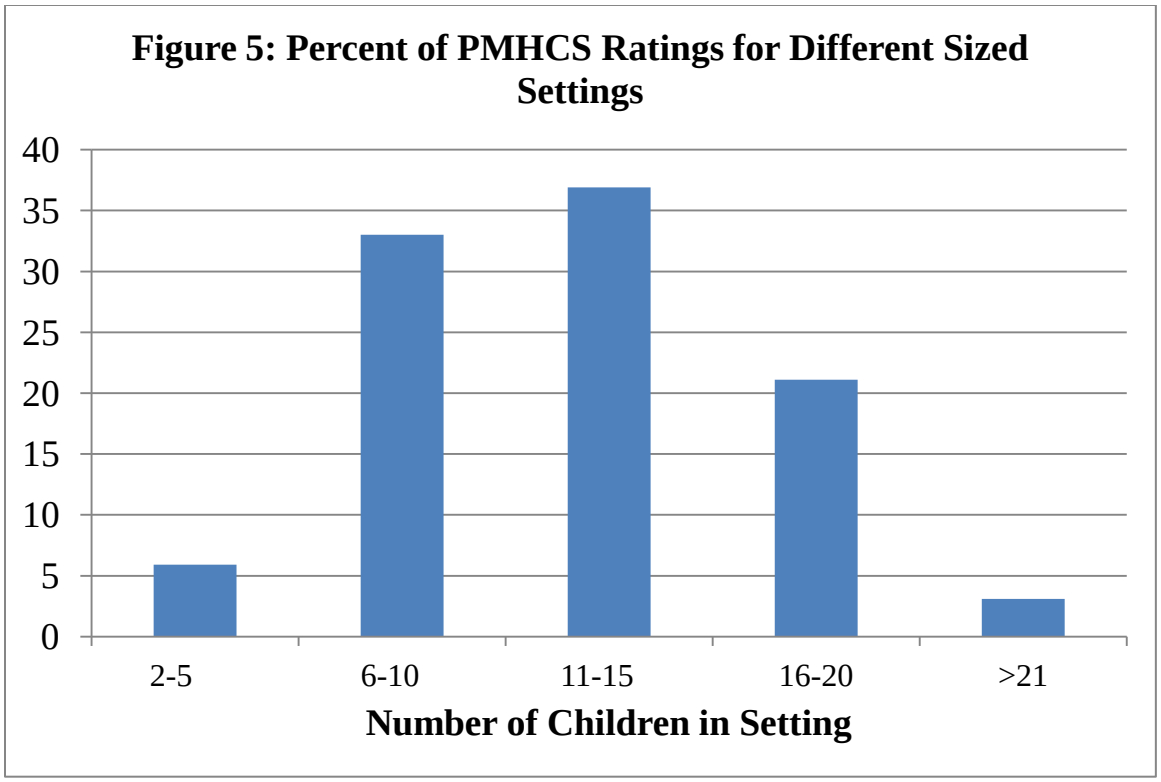
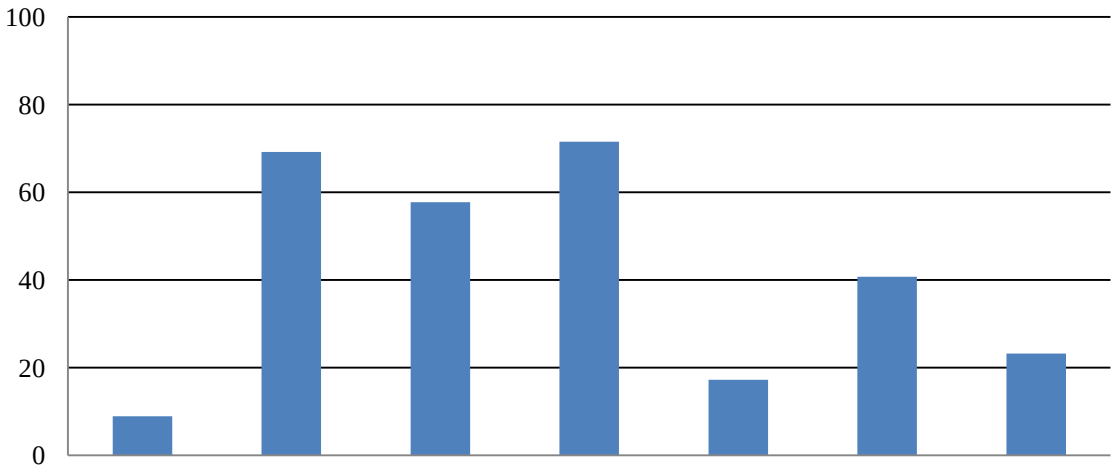


Figure 6 below shows the percent of activities rated on the PMHCS. The most frequent ratings were obtained during free choice, circle time and mealtime. It was rarer that consultants would observe classrooms during arrival or naptime.

Figure 6: Percent of PMHCS Ratings Obtained During Different Types of Activities



SDQ. For each classroom enrolled in the evaluation, one teacher was asked to complete the SDQ. Of the 365 classrooms in the study having baseline evaluation data, SDQ ratings were collected from 158 of them (41%). Of those 158 classrooms with SDQs collected at baseline, follow-up SDQs were obtained from 56 (35%). The most frequent sized classrooms rated contained 6 to 15 children. At baseline, 54% of the ratings were completed on classrooms with two teachers with equal percentages (between 19 to 25%) of classrooms with baseline ratings having 1 teacher (21.3%) or had 3 or more teachers (24.6%). Very few classrooms rated included infants (1 year of less), while the majority of classrooms included 3- and 4-year-olds.

Again, we examined whether those classrooms that were not rated at follow-up (NF) were significantly different from classrooms that were (F). We looked at factors such as the number of children in the classroom, the number of staff, and the age of children in the classroom; these data were derived from the information provided by consultants on the PMHCS. There characteristics did not differ between F and NF samples

The following sections present the results of the Impact study with a section covering each research question. The impact of consultation was assessed by comparing data collected prior to consultation (baseline) to that collected after 4 months of consultation (follow-up). Within each section, we first present baseline results, which include data collected from respondents who provided follow-up data (F) and those who did not (NF). Importantly, we tested for differences between F and NF baseline data to rule out the possibility that pre-post changes may be due to initial differences in the measured attributes rather than to the effects of consultation. Baseline results are followed by presentation of pre-post results examining the

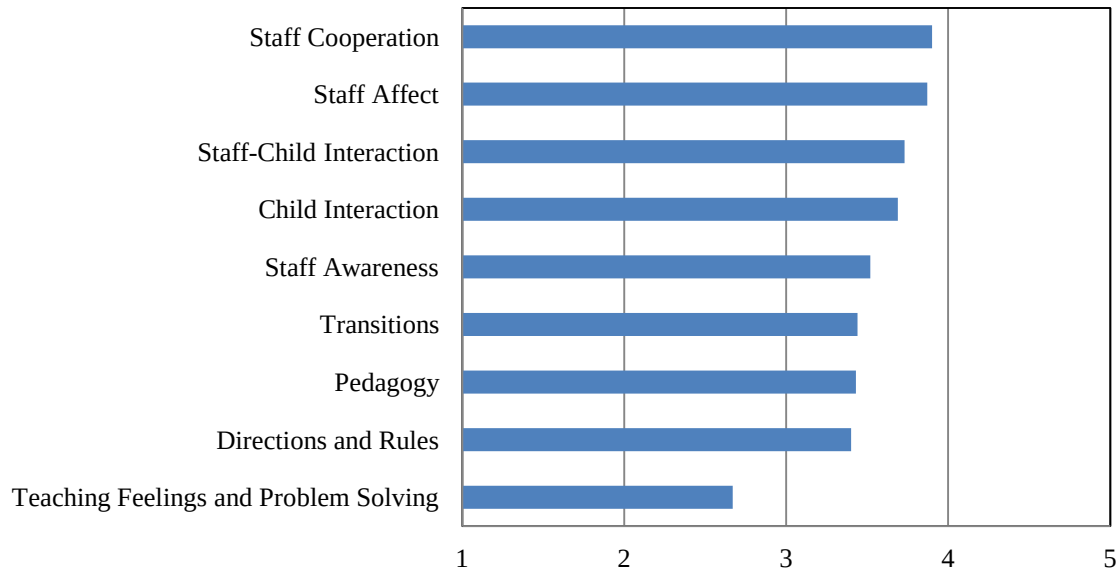
impact of consultation. A General Linear Model (GLM) framework evaluate the significance of pre-post changes; it is the preferred method for analyzing pre-post design data as it eliminates systematic bias, reduces error variance and implicitly takes into account regression toward the mean.

Research Question 1: Does ECMHC improve the effectiveness of ECE providers' approaches to promoting a classroom climate conducive to positive behavior and social-emotional functioning?

Baseline

Figure 7 displays mean scores for the baseline administrations of the PMHCS for each of the Positive Indicator subscales for NF and F classrooms. It is very important to note that independent sample t-tests indicated no difference between baseline scores for those classrooms which were not rated at follow-up and those that were.

Figure 7: Baseline Mean Scores for Different PMHCS Subscales



Overall, those subscales reflecting a domain of Positive Staff Qualities (Staff Affect and Staff Cooperation) were rated most highly at baseline. Paired t-tests revealed that these subscale scores were significantly higher than all others. Subscales representing a Classroom Interaction domain (Staff-Child Interaction and Child Interaction) were the next highest rated. Tests showed the mean scores on these subscales did not differ from each other but were significantly greater than scores on subscales tapping skills in Classroom Management (Staff Awareness, Transitions, Directions and Rules) and direct Teaching Skills (Pedagogy and Teaching Feelings and Problem Solving) in the classroom. Of note, the mean subscale score for Teaching Feelings and Problem Solving was significantly lower than the score for all other subscales, indicating that, at baseline,

providers had the most difficulty with this aspect of classroom climate. The mean scores at baseline for the Negative Indicators were 1.82 falling between the "never" and "sometimes" range.

Multiple regression analyses indicated that, together, the number of staff and number of children and average age group served in the classroom was significantly associated with certain PMHCS subscales: Transitions, $F(3, 312) = 4.19$, $p = .006$; Directions and Rules, $F(3,312) = 5.00$, $p = .002$; Teaching Feelings and Problem Solving, $R=.190$, $F(3,312) = 3.90$, $P = .009$; and Child Interactions, $F(3,312) = 3.42$, p .018. The more staff, the higher the ratings of handling transitions in the classroom ($\beta = .224$, $t=2.80$, $p = .005$) and of the presence of positive interactions between children ($\beta = .144$, $t=2.20$, $p = .028$). A seemingly counter-intuitive finding was that the greater the number of children in the classroom was associated with more effective teaching of feelings and problems solving ($\beta = .032$, $t=2.19$, $p =.029$).

The Teacher Opinion Survey (TOS) was completed by 159 ECE providers at baseline. The mean score across the 12 items was 3.44 (SD = .31), falling between the responses "neutral" and "agree" to statements reflecting confidence and competence in managing challenging behaviors and the ability to make a positive difference in the lives of children.

Outcomes

Scores on the PMHCS showed consistent increases from baseline to follow-up, suggesting a strong impact of consultation on all aspects of classroom functioning. Figures 8 through 11 present change in PMHCS Positive Indicator subscale scores from baseline to first follow-up divided into the different domains of climate: Staff Qualities, Classroom Interaction, Classroom Management, and Direct Teaching Skills. The number of classrooms observed for each comparison ranged from170 to 178. For the Classroom Interaction Domain, follow-up scores were significantly greater than baseline for the Child Interactions subscale, $F(1,174) = 9.98$, $p = .002$, and the Staff-Child Interaction subscale, $F(1,172) = 10.35$, $p = .002$ (see Figure 8).

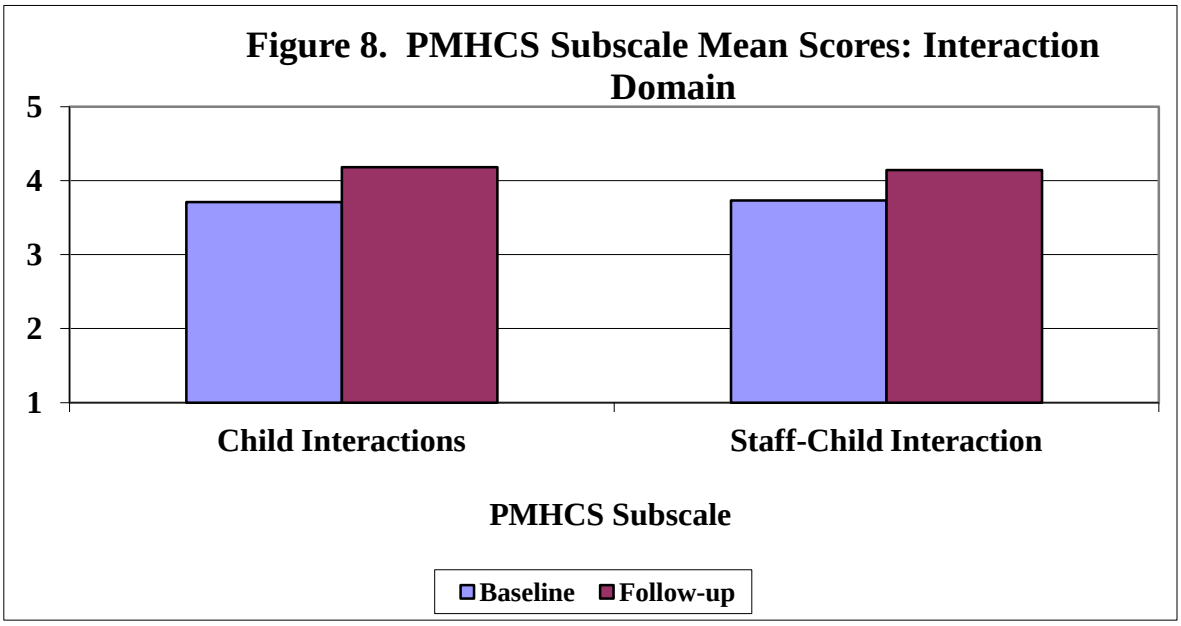
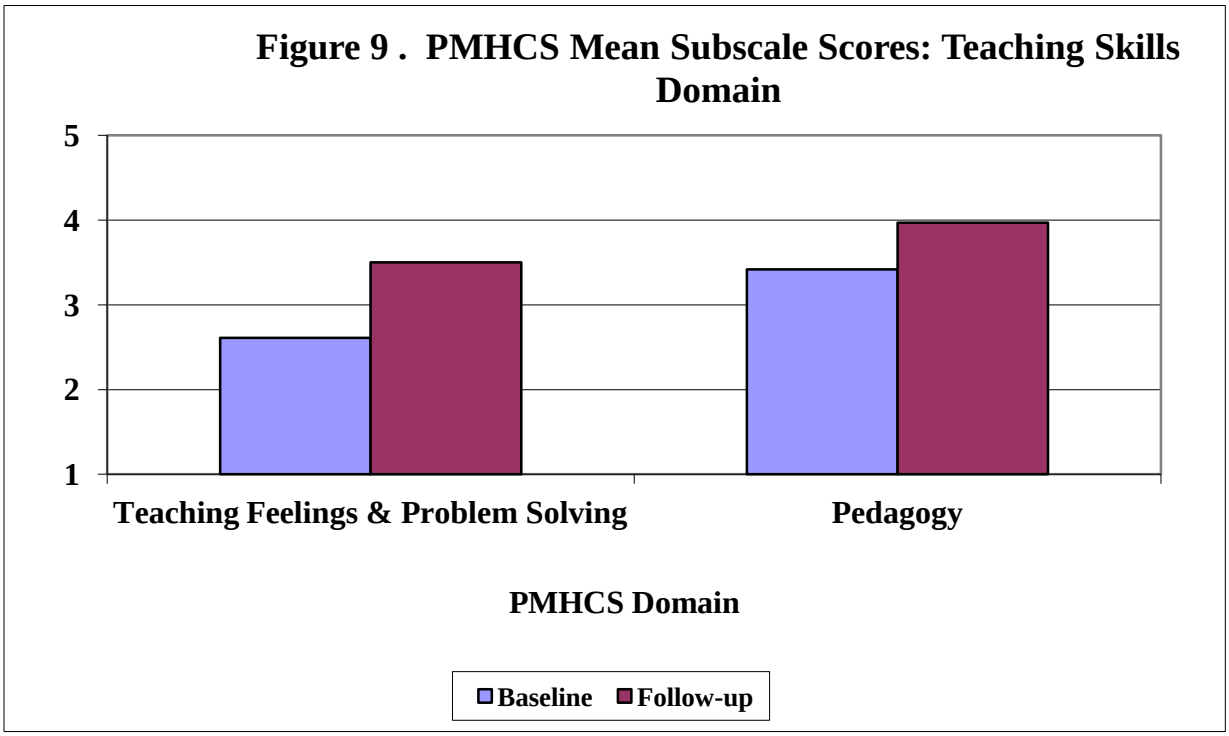


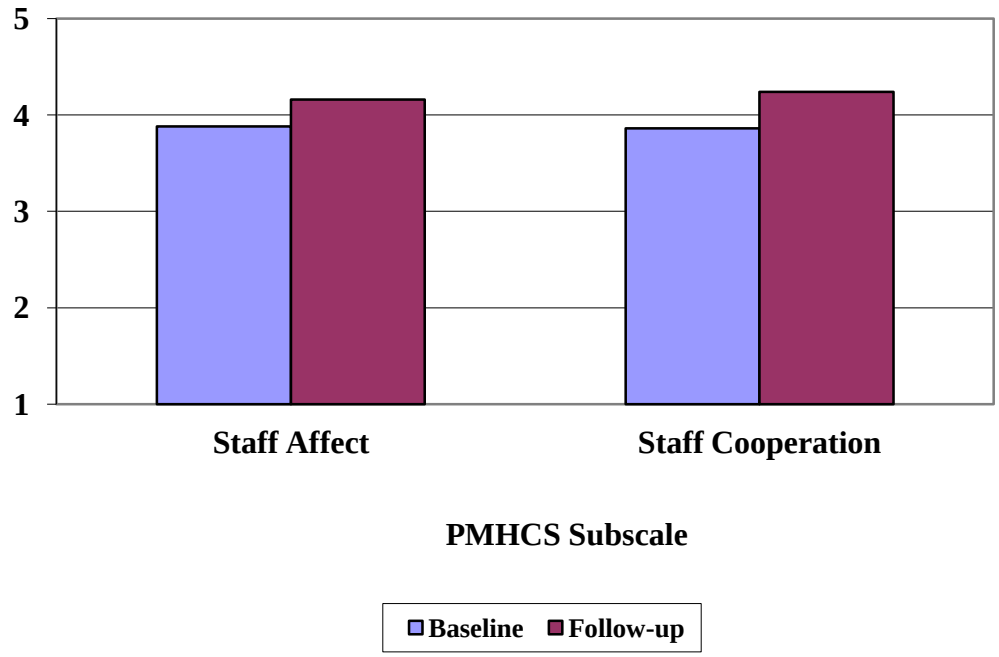
Figure 8. PMHCS Subscale Mean Scores: Interaction Domain
5
4
3
2
1
Child Interactions
Staff-Child Interaction
PMHCS Subscale
Baseline
Follow-up

For the Teaching Skills Domain, follow-up scores were significantly greater than baseline for the Teaching Feelings and Problem Solving subscale, $F(1,173) = 26.03$, $p < .001$, and the Pedagogy subscale, $F(1,172) = 7.69$, $p = .006$ (see Figure 9).

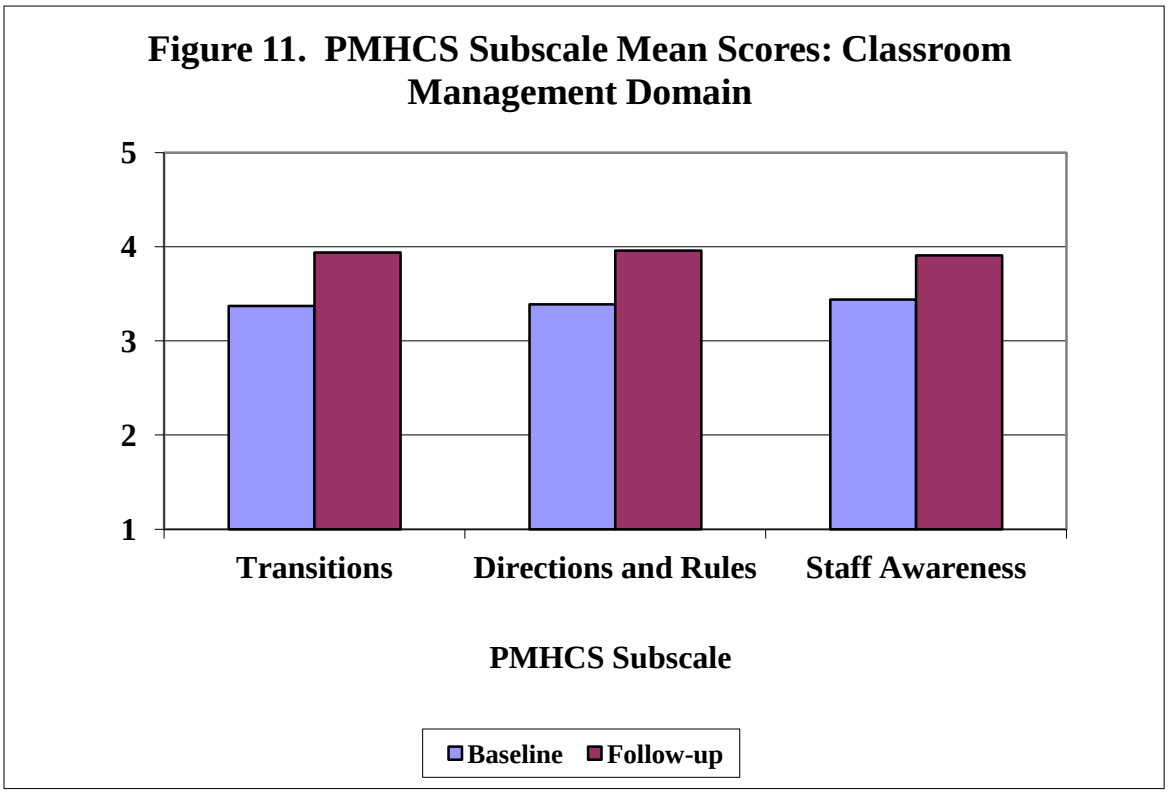


For the Staff Qualities Domain, follow-up scores were significantly greater than baseline for the Staff Affect, $F(1,173) = 4.16$, $p = .046$, and the Staff Cooperation, $F(1,151) = 6.10$, $p = .015$, subscales (see Figure 10).

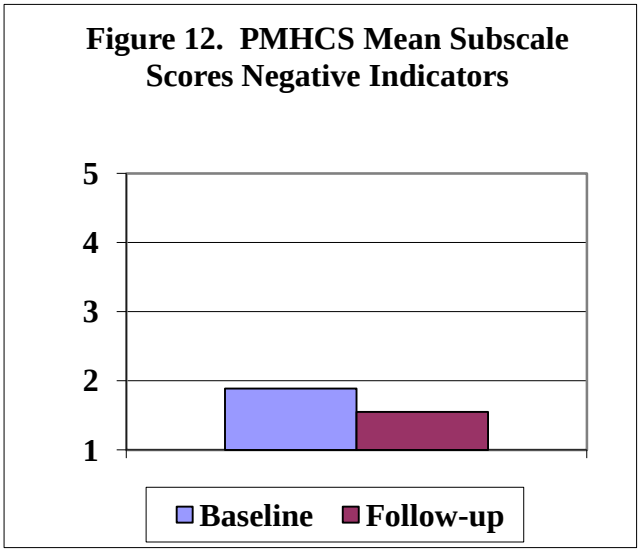
Figure 10. PMHCS Mean Subscale Scores: Staff Qualities Domain



For the Classroom Management Domain, follow-up scores were greater than baseline for all subscales; however, only the change in the Directions and Rules subscale score reached significance, $F(1,173) = 14.18$, $p < .001$. The Baseline-follow-up increase was marginally significant for Transitions subscale score, $F(1,174) = 3.61$, $p = .059$, but not for the Staff Awareness subscale score, $F(1,170) = 2.68$, $p = .103$ (see Figure 11).



Mean scores at baseline and follow-up for Negative Indicators are pictured in the Figure 12 below. The reduction in scores over the two administrations was significant, $F(1,175) = 6.13$, $p = .014$, indicating fewer instances of unproductive verbal and physical interventions and disruptive environmental stimulation at follow-up compared to baseline.



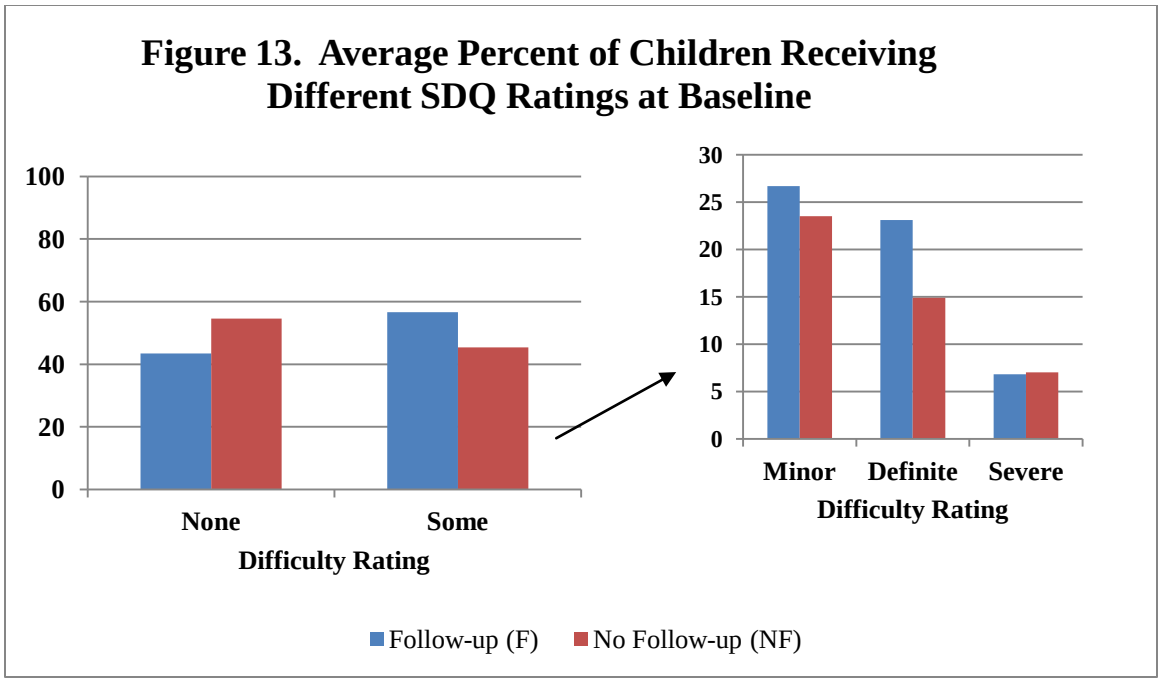
The mean score for the 12 TOS items averaged over the 40 ECE providers who completed the measure twice did not change from baseline (4.12, standard deviation = .46) and follow up (4.12, standard deviation = .52). Repeated measures analyses revealed no effect on the change in provider self-efficacy during the consultation period as a function of working previously with the consultant. It is important to note, however, that the average score at baseline for those who completed a follow-up TOS was higher than the mean baseline score for all (170) those who completed a baseline TOS (mean = 3.44). Thus, teachers who did not complete a follow-up TOS had much lower baseline scores, possibly reducing finding an effect of consultation on teacher's self-evaluation of their skills.

Research Question 2: Do ECMHC interventions improve the overall level of social functioning and reduce the overall level of problem behaviors in the classroom?

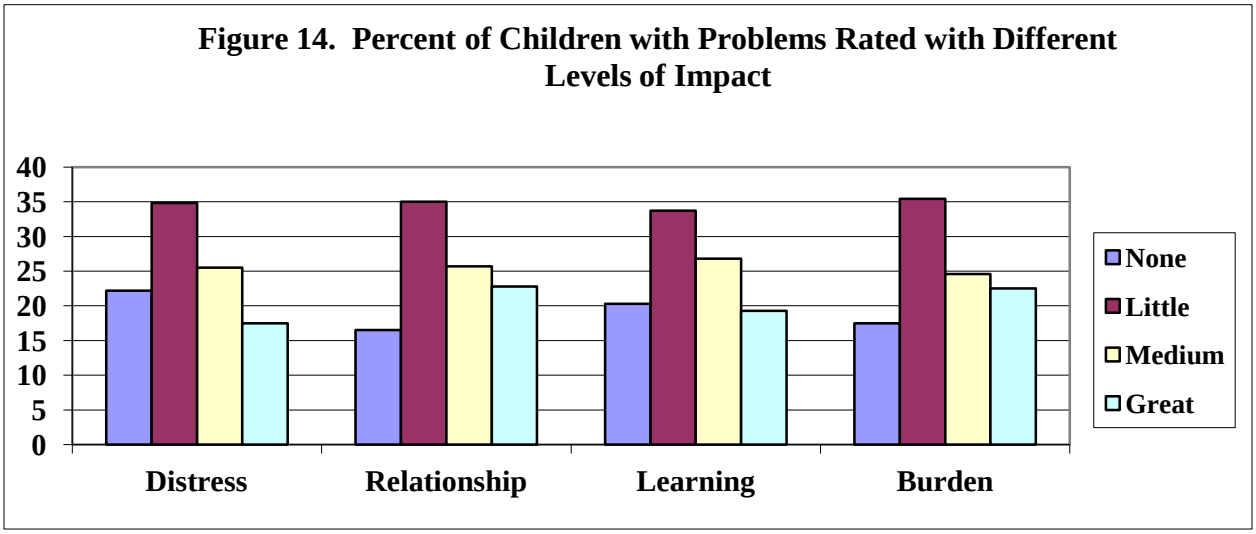
Baseline

Figure 13 below shows the average percent of children in a classroom assigned a given SDQ rating by a provider separated by those classrooms which were rated at follow-up (F) and those that were not (NF). Overall, providers rated about half (49.6%) the children in each classroom as possessing "some" difficulty. Within that group, about the same percent of children were rated with minor difficulties as with definite and severe difficulties combined. Multivariate GLM analyses of average percent of children rated with different levels of problems (none, minor, definite or severe) with follow-up status (F and NF) as a main factor and number of children rated in the classroom as a covariate, was significant, $F(3,153) = 3.57$, $p = 016$ overall and for the percent of children with no difficulties, $F(2,155) = 20.98$, $p < .001$, and definite difficulties, $F(2,155) = 27.46$, $p < .001$. The number of children in the rated classroom also had a significant impact on baseline percentages of children with problems, $F(3,153) = 19.49$, $p < .001$. The more kids in the classroom, the higher percentage rated with no difficulties, $F(1,155) = 33.54$, $p < .001$ and the smaller number with definite difficulties $F(1,155) = 48.63$, $p < .001$.

At baseline, the F classrooms compared to the NF classrooms showed significantly higher percents of children with some problems, $F(1,155) = 9.04$, $p = .003$, and definite problems, $F(1,155) = 6.94$, $p = .009$. It is possible that teachers may have been less likely to complete the follow-up if the level of problem behavior in their classroom was less. As a result, interpretation of pre-post SDQ changes should be restricted to effects on classrooms with higher levels of problems.



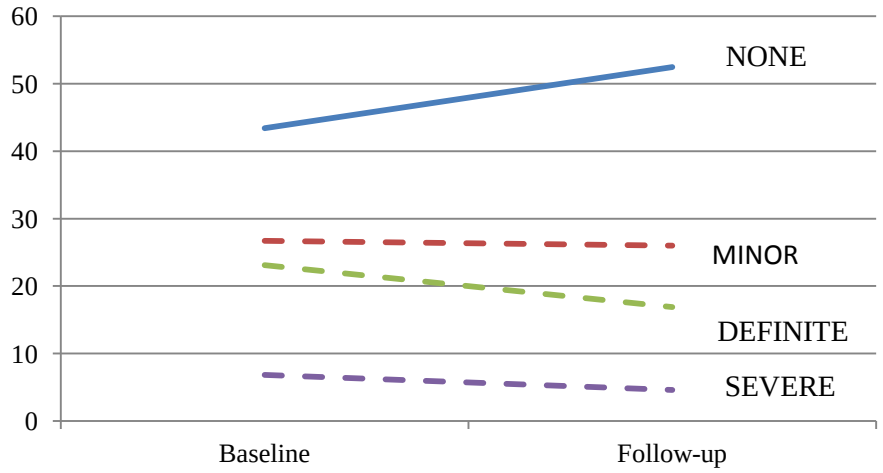
As noted above, for those children rated as having any problems in the first part of the SDQ, providers then gave an assessment of the impact (none, little, medium, great) of the problems on the child in different problem areas: overall distress, relationships with others, learning and effects on the classroom and provider (burden). Of the 158 SDQ ratings at baseline, 155 included at least one child with some difficulties. Of these, Figure 14 shows the percent of children showing different levels of impact (none, little, medium, great) for each area for the SDQ ratings averaged across classrooms For each problem area, teachers rated the greatest percent of children with a minor level of impact followed by a medium level of impact. At baseline, a relatively greater percent of children produced some impact (little, medium or great) on their peer relationships and their teachers' burden than on their overall level of distress or learning.



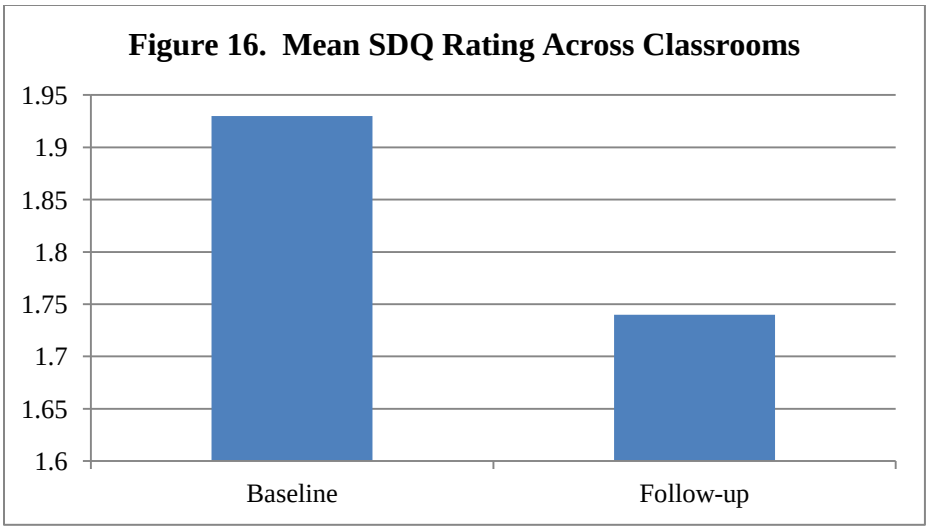
Outcomes

Analyses of SDQ data from 56 providers who completed ratings at both baseline and 4-month follow-up showed an encouraging reduction in the level of child problems during the period when ECMHC was being implemented. Figure 15 below shows the percent of children in the classroom rated with different problem intensities (None, Minor, Definite, Severe) averaged over all ratings at baseline and follow-up.

Figure 15. Change in Average Percent of Children Receiving Different SDQ Ratings



GLM repeated measures analyses revealed a significant increase in the percent of children exhibiting no problems over the course of 4 months, $F(1,54) = 6.17$, $p = .016$. There was also a decrease in the percent of children showing each level of problem intensity, with the change in children displaying definite problems showing the only significant change, $F(1,54) = 13.74$, $p < .001$.



The improvement in problem level is also evident when examining the change in the average SDQ rating, depicted in Figure 16. At both baseline and follow-up, the different problem ratings were assigned a numerical value (1=none, 2=minor, 3=definite, 4=severe) then summed and divided by the number of children rated. The reduction in mean levels of problem behavior from baseline to follow-up was significant, $F(1,54) = 13.36$, $p = .001$), suggesting that, over the course of consultation, teachers felt that children possessed lower levels of problem behavior.

Research Question 3: Do children referred for child-focused ECMHC intervention show an improvement in social-emotional functioning following intervention?

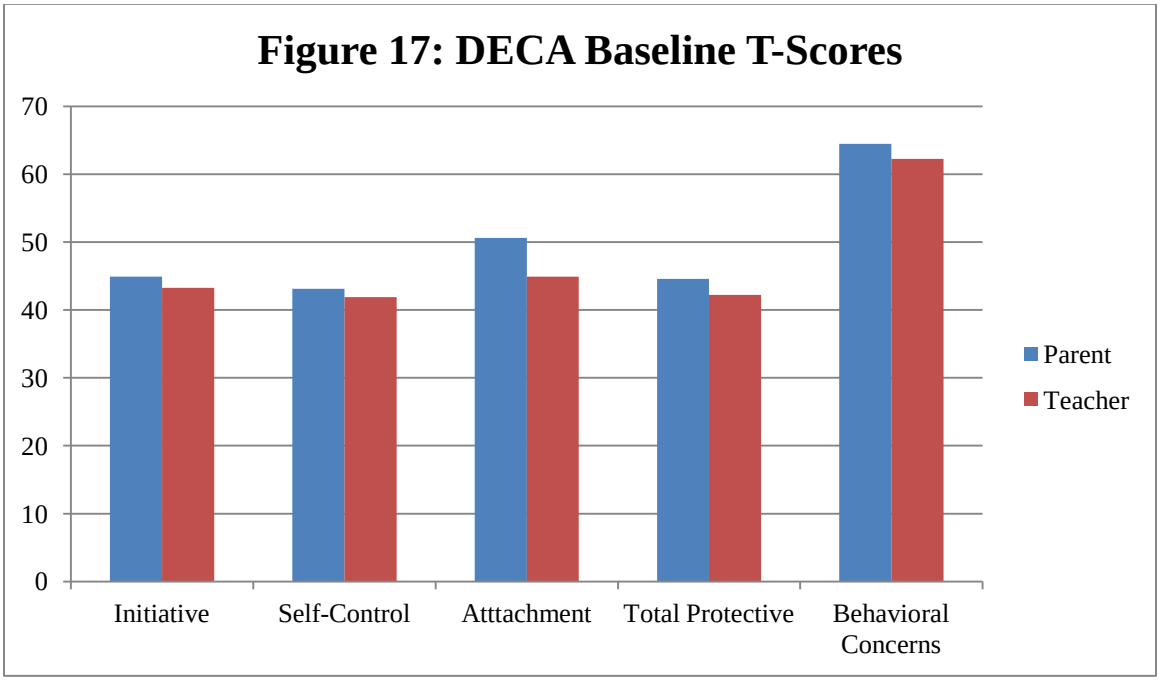
Baseline

Parents and teachers of children who were referred for child-specific consultation were asked to complete a DECA. Parent and Teacher DECA scores at baseline are presented in Figure 17, which displays the mean T-scores for each positive indicator scale and the Behavioral Concerns scale. Analyses showed no significant differences between parent baseline ratings for those children who were also rated at follow-up (N=33) and those who were not (N=103). Similar analyses of differences between teacher baseline ratings for children also rated at follow-up (52) and those who were not (103) were not significant. For each of the positive indicators factors and the overall positive indicator factor, the average T-score fell in the low end of the "typical" range. For the Behavioral Concerns scale, the average T score fell in the "concerns" range which means that either a Protective Factor Scale T-score was less than or equal to 40, or a Behavioral Concerns Scale T-score was greater than or equal to 60 (*LeBuffe & Naglieri, 1998).*

Repeated measures analysis of variance of the baseline scores indicated significant differences among the component Protective factor scales for the parent ratings, $F(2,140) = 28.94$, $p < .001$. Pairwise comparisons showed that scores for the Attachment scale were

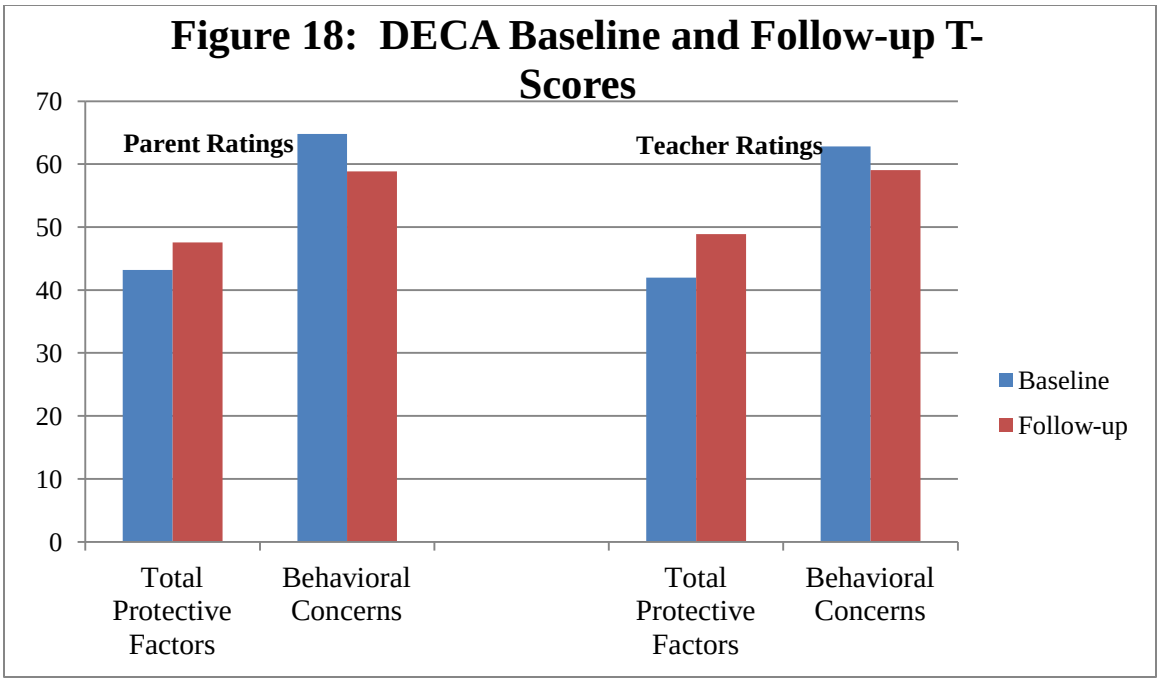
significantly greater than that for the Initiative, $p < .001$, and the Self-Control, $p = .018$, scales. Also, the Initiative scale T-score was higher than the Self-Control scale, $p < .001$.

The pattern of Protective factor T-scores derived from baseline teacher ratings was the same as that for parents. Repeated measures analysis indicated significant differences among the component Protective factor scales, $F(2,161) = 5.28$, $p < .006$. Pairwise comparisons showed that scores for the Attachment scale were significantly greater than that for the Initiative, $p < .037$ and the Self-Control, $p < .001$, scales. However, the Initiative scale T-score was not significantly different from the Self-Control scale.



Outcomes

Children showed an increase in protective factors and a decrease in challenging behaviors over the consultation period. Repeated measures GLM analyses were employed to assess the change in DECA scores from baseline to follow-up. Figure 18 below displays the average T-score parent and teacher ratings at baseline and follow-up for both the Total Protective Factors scale and the Behavioral Concerns scale. For parent ratings, a significant increase in the Protective Factors scale, $F(1,32) = 5.65$, $p = .024$, was accompanied by a significant decrease in the Behavioral Concerns scale, $F(1,30) = 16.40$, $p < .001$, moving from the "Concerns" into the "Typical" range. Similar results were found for the teacher ratings; a significant improvement in the Total Protective factors scale, $F(1,54) = 49.87$, $p < .001$, and a significant reduction in the Behavioral Concerns scale, $F(1,50) = 13.73$, $p = .001$.



Children showed improvement in a range of characteristics related to resilience during the course of consultation as indicated in Table 11. All the component subscales of the Total Positive Factor scale showed significant improvement from baseline to follow-up except for the change in the Attachment subscale for the parent DECAs.

Table 11: DECA Positive Factor Subscales for Baseline and Follow-up

	Parent DECA (N=33)			Teacher DECA (N = 55)		
Subscale	**Baseline**	**Follow-up**	**F Statistic**	**Baseline**	**Follow-up**	**F Statistic**
Initiative	43.06	47.97	7.78**	42.40	48.36	36.13***
Self-Control	43.97	49.36	9.09**	41.96	48.78	29.02***
Attachment	48.03	50.88	2.07	44.19	49.78	30.00***

** p < .01, *** p < .001

Research Question 4: Do parents whose children are referred for child-focused ECMHC intervention show a reduction in parenting stress and an improvement in parenting behaviors?

Baseline

The parent-reported PSI-SF and PBI consist of three and two scales, respectively. Mean baseline scores for these scales for parents who provided a baseline measure are presented in the Table 12. Of note, independent sample t-tests indicated no difference between baseline scores for those classrooms which were not rated at follow-up and those that were.

Table 12: Mean baseline scores for the PSI-SF and PBI

PSI			PBI	
Parental Distress	Parent-Child Dysfunctional Interaction	Difficult Child	Hostile-Coercive	Supportive-Engaged
3.88 (.68)	4.23 (.59)	3.11 (.76)	5.45 (.47)	2.47 (.57)
3.86 (.70)	4.22 (.60)	3.10 (.81)	5.43(.47)	2.48 (.54)

On the *PSI*, parents' reports indicated that particular areas of parenting were more stressful than others. At baseline, parents reported the highest level of concern over the stress of their children's' self-regulatory abilities (Difficult Child). Mean scores on this scale were significantly lower (more stress) than mean scores on both the Parental Distress scale, $t(106) = 10.04$, $p < .001$, and the Parent-Child Dysfunctional Interaction scale, $t(106) = 15.63$, $p < .001$. The latter two scales also differed, $t(106) = 6.70$, $p < .001$, indicating that parents expressed greater stress related to personal issues (depression, conflict with a partner, life restrictions due to the demands of child-rearing) than to unacceptable interactions with their children.

The two scales of the PBI are scored in reverse directions. Parents felt that they exhibited behaviors reflecting warmth towards their child in the "quite a bit" to "always" range and behaviors reflecting negative affect or indifference, coercion, threat or physical punishment to influence behavior in the "little" to "somewhat" range.

Outcomes

Examination of change in scale scores at baseline and follow-up for the 29 parents completing a PSI at each time point revealed little change over the consultation period for two of the scales: baseline and follow-up mean scores were 3.94 and 3.95 for the Parental Distress scale and 4.24 and 4.21 for the Parent Child Dysfunctional Interaction scale. However, for the Difficult Child scale, which produced the highest ratings of distress at baseline, repeated measures analyses indicated a significant mean increase (less stress) at follow-up (mean = 3.43, SD = .96) compared to baseline (mean = 3.15, SD = .81), $F(1,27) = 4.80$, $p = .037$.

Repeated measures analysis examined change in PBI mean subscale scores indicated little change in the parenting behaviors for the 28 caregivers who provided baseline and follow-up data. The mean score for the hostile/coercive subscale dropped slightly from baseline (24.3) to follow-up (22.7), however the change was not significant $F(1,27) = 2.40$, $p = 0.13$. There was

virtually no change in the Supportive/Engagement subscale from baseline (54.2) to follow-up (53.5).

Research Question 5: How do parents/caregivers and ECMH consultants perceive their relationship with each other and with ECE Providers, and does perceived relationship quality impact targeted ECMHC outcomes?

At follow-up, consultants completed RQS scales to assess the quality and effectiveness of the relationship with both the caregiver (N=83) and the ECE provider (N = 180). Higher scores indicate a more positive appraisal. Overall, consultants reported more positive relationships with providers that caregivers; comparing mean scores for the Total Provider (4.43, standard deviation = 1.07) and Total Caregiver (3.90, standard deviation = .76) scales for the 82 consultants who completed both ratings for a case revealed a significant difference, $t(81) = 5.10$, $p < .001$. Within each Total scale, there was little difference between the mean ratings on the two subscales; for ratings of providers, mean scores for the Communication and Joining subscales were 4.46 (SD=.59) and 4.41 (SD=.58), respectively. For the ratings of caregivers, subscale scores were lower but similar. Means for the Communication and Joining subscales were 4.06 (SD=.78) and 3.85 (SD=.85), respectively.

At follow-up, caregivers completed the relevant RQS scales to assess the quality and effectiveness of the relationship with both the consultant and the ECE provider. Mean scores on the five point scale (1-5), with higher values indicating a more positive appraisal, were quite similar for the Total Consultant (3.93, SD=1.07) and Provider (3.95, SD=.62). However, within the Provider scale, caregivers rated ECE staff higher on the Communication subscale (mean = 4.17, standard deviation = .56) than the Joining subscale (mean = 3.89, standard deviation = .68). The level of scores on the various RQS scales did not impact the change in caretaker stress, parenting behavior or parent ratings of child social/emotional functioning on the DECA.

3.2g Limitations

The major limitation of the impact study is the lack of a control group. Classrooms and children exposed to ECMHC showed significant improvement in a variety of areas. However, it is possible that change would also have been seen in classrooms and children who were not served by a consultant owing to a number of possible factors such as maturation over the 4 month pre-post interval or increasing experience of ECE providers.

The fact that we were not able to collect a substantial amount of follow-up data is another possible limitation. It may be the case that the respondents that provided data for the follow-up may have been more likely to report positive change or that the effect of ECMHC may have been greater due to characteristics of the ECE providers, providers, classrooms rated or children rated. The fact that comparisons baseline comparisons between data from respondents that completed the follow-up and those who did not were generally not significantly different argues against the latter interpretation.

3.3 Exit Study

3.3a Sample

We requested that ECMH consultants fax us a form when a child that they were working with exited a child care program due to behavior problems. During a one year period (April 2010 - March 2011) we received information about 20 children who met this criterion. We conducted 35 exit interviews regarding the experiences of those 20 children who exited. In each case, we were able to interview the consultant who was working with the child; we interviewed 11 different consultants from 6 different ECMHC programs. We also sought interviews with the child care director, lead teacher and parent for each of the children who exited. This led to completed interviews with 7 directors, 6 teachers, and 2 parents. The mean age of the children who exited was 3.65. 70% of the children who exited were White. All but two of the children who exited were boys. Table 13 displays the demographic information about the children who exited; and Table 14 provides similar information about the stakeholders with whom we conducted our interviewees.

Table 13: Demographic Characteristics of Children Exiting Child Care Programs (n=20)

Age		**n**	**Program Site**		**n**
	1 yr	1		Lower Shore	6
	2 yrs	2		Arundel CCC	4
	3 yrs	4		Abilities	4
	4 yrs	9		Southern MD	4
	5 yrs	4		APPLES	1
				Montgomery	1
		20			**20**
Gender		**n**	**Race**		**n**
	M	18		White/Caucasian	14
	F	2		African American	3
				Indian	1
				Unknown	1
				African American/South American	1
		20			**20**

Table 14. Characteristics of Participants in the Exit Study Interviews (n=35)

	Consultants	Directors	Teachers	Parents
Race				
White	19	5	6	2
African American	0	1		
Asian-Indian	1	0		
White/Pacific Islander	0	1		
Total	20	7	6	2
MHC Program				
Lower Shore	6	3	3	1
Arundel CCC	4	2	1	1
Abilities	4			
Southern MD/Project First Choice	4	1	2	
APPLES	1	1		
Montgomery	1			
Total	20	7	6	2

Six of the twenty child exits were voluntary; parents were not asked to withdraw their child but chose to do so due to difficulties the child was having in the program. For the remaining children, the decision about the timing for the change in placement was made by the child care program.

3.3b Procedures

The interviews were conducted as part of the evaluation study and approved by the University of Maryland Institutional Review Board. As part of the consent process, all consultants agreed to participate in exit interviews if a child with whom they worked exited a child care program due to behavioral concerns. However, in practice, not all children who exited came were reported to the evaluation team. However, when we compared the demographic and geographic characteristics of the children in the exit study sample to the tally sheets submitted to MSDE, the sample of children who participated in the exit interviews was representative of the total number of children who exited during this same time period.

Consultants gave each ECE director and family care provider child exit fax forms to send to the research team if a child exited the child care program. When a child exited, the consultant invited the director of the program, the child's teachers, and the child's parent if possible, to participate in the exit interviews. If they agreed to participate, they mailed or faxed a consent form to Georgetown University and they were contacted to schedule an interview. One research assistant (CH) conducted all of the interviews. Interviews were approximately 30

minutes in length and were audio recorded and transcribed for analysis. On average, a interviews were conducted five to six weeks after the child exited.

3.3c Measures

We developed four parallel forms of the interview scripts, one for each different respondent type: consultants, directors, providers, and parents. The scripts consisted of approximately 12 open-ended questions with suggested prompts that could be used to elicit more information from an interviewee if necessary.

3.3d Relevant Research Questions

Our analysis of the transcribed interviews focused on the following research questions:

1. How do ECMH stakeholders (ECMH consultants, ECE Providers, ECE Directors and Parents/Caregivers) perceive the nature and characteristics of their relationships with one another?
2. What strategies do consultants use to work with children, providers, and parents?
3. What are the predictors of behavior-related exits from child care programs?
4. What facilitates/predicts positive outcomes when children exit child care programs?
5. How can we prevent behavior-related exits from child care programs?

3.3e Analyses

All interviews were transcribed into Microsoft Word for data analysis. Atlas.ti was used to manage the interview data and facilitate analysis. Through an iterative process, the research team developed a comprehensive code book based on the research questions. Two members of the research team (CH and NDK) served as primary coders and validation of the coding process was performed by a Co-Principal Investigator (DP). Throughout the coding and data analysis process, the meaning and context of participant responses were verified by returning to interview transcripts to maintain the accuracy of the data. Emerging themes and results were discussed with the larger evaluation team at regular intervals.

3.3f Results

Research Question 1: How do ECMH stakeholders (ECMH consultants, ECE Providers, ECE Directors and Parents/Caregivers) perceive the nature and characteristics of their relationships with one another?

<u>Overview</u>

Consultants described their relationships with directors, providers, and parents in a variety of ways. Two primary results of our analysis were that consultants more often had difficult relationships with teachers than difficult relationships with directors, and that limited contact was the primary factor inhibiting positive relationships with parents. Limited contact due to staff turnover also inhibited relationship development between consultants and providers.

There is also some evidence that a good relationship is not necessarily an effective working relationship. Consultants were directly asked about the quality of their relationships with directors, providers, and parents. They stated that relationships were positive unless there was a specific reason to characterize them negatively, noting, for example, that the relationship was fine but also saying that the director "wasn't much help." Consultants sometimes reported that they had a good relationship with a consultee who they also say they had little contact with. For that reason, future analyses may need to explore this ambiguity in more depth.

Relationships between Consultants and Child Care Providers

Positive relationships between consultants and ECE directors and providers are most often characterized by open, honest communication, similar goals, receptiveness to advice and strategies, an appreciative or respectful attitude, and assistance with or facilitation of consultants' work. Consultants explained that ECE providers can be supportive of their work in a variety of ways, including by relaying information to teachers, understanding that the consultant needs follow-through from providers, and working with the consultant to communicate the same message to a child's parents.

When a consultant had previous experience working with a director or provider, their relationship with that person was almost always described positively and never described negatively. Relationships are also likely to be positive when the consultant perceives that a provider is dedicated to the children in the child care program. When relationships between consultants and directors are positive, consultants sometimes assist directors with their work as well. One consultant shared that she worked with a director to write a letter to a child's parents, and another reported that she helped a director implement assessments.

When relationships between consultants and ECE providers were not described positively, they were most often characterized by a lack of contact or limited or poor communication. Consultants sometimes thought that providers were not following an action plan developed to help the child. Consultants felt that happened due to logistical challenges, such as the teacher-student ratio in the classroom, a lack of willingness to make accommodations specific to a child, a conflict in priorities, or a lack of faith that recommended strategies would have the desired effect.

None of the directors or providers who were interviewed said anything negative about consultants or their relationships with consultants. They often said that they had good relationships with the consultants, that consultants were helpful, that they have learned a lot from consultants, and that they believe the ECMHC program they work with is effective. Teachers noted that the consultants were helpful in the classroom because they were able to concentrate on teaching the whole class, rather than needing to devote a large amount of attention to the child exhibiting problem behavior. However, one teacher noted that, while effective, the one-on-one strategies that the consultant recommended were not feasible when she was the only adult in the classroom. Several directors and providers had utilized the ECMHC program in the past.

Relationships between Consultants and Parents

Consultants primarily characterized their relationships with parents based on how much contact and communication they had with the parent. Limited contact and communication were

often attributed to parents' busy lives, difficulty facing the issues their children were having, and failure to return phone calls and emails or otherwise follow-up on recommendations, sometimes despite positive relationships or interactions with consultants.

Positive relationships were most often associated with consultants' reports that parents were "trying" to help their child, were open to communication and suggestions, and that they had a reciprocal relationship. Sometimes, relationships between consultants and parents deteriorated during the weeks or days before the child's exit. Consultants attributed the deterioration to parents' frustration with the child care center and/or exhaustion from trying to work with providers or with their child.

It was uncommon for a consultant to describe relationships with parents negatively and far more common to report that they did not have very much, or enough, contact or communication with a parent. When consultants described relationships negatively they reported that parents were not open to communication or recommendations, that they were not appreciative, or that they did not have a mutual understanding of the child's challenges.

The two parents we interviewed both said that their relationship with the consultant was good. However, one parent said that she tried to avoid talking about consultation around her husband because he did not "believe in it", suggesting that the consultant's relationship with individual members of the family differed. The same parent said that she would have liked more face-to-face meetings with the consultant rather than email, but noted that she never made that suggestion. Directors often shared that, despite significant effort, consultants had difficulty communicating with parents.

Our analysis suggests that the nature of these relationships is quite complex and should be considered at multiple levels. Indeed, achieving a truly collaborative relationship appears to be far more important than simply attributing a positive assessment of the relationship; and yet difficult relationships still can be collaborative and productive relationships. In those cases where consultants mentioned difficulties in their relationships with families, these were often more productive than relationships in which parents and consultants have little contact. For example, parents who requested assistance finding a new center, communicated with the consultant following the child's exit, or asked for continued consultation in a new center were not always the parents with whom consultants reported they had the most positive relationships. In addition, a high frequency of communication did not always coincide with more positive relationships.

Relationships Between Directors and Teachers

In general, the directors and teachers we interviewed reported very positive relationships with each other. Teachers said that directors were very supportive, spending time in the classroom and working one-on-one with the child when necessary. They said that their directors were always aware of everything going on and noticed their stress level. Directors concurred that they were concerned about their teachers' burden in the classroom and that they attempted to help out however they could. This could reflect the fact that the ECE Providers and Directors we interviewed worked in settings that had voluntarily chosen to avail themselves of consultation services and might not be reflective of all child care programs in Maryland.

Overall, consultants agreed that directors were concerned about and made efforts to assist the teachers at their child care programs. However, they occasionally reported difficult relationships or poor communication between directors and teachers. They also wondered if directors were providing sufficient support for teachers in following through with consultation plans, and some consultants also mentioned that they thought teachers were pressuring the director to expel a child.

Relationships between ECE Providers and Parents

Child care providers were positive about their relationships with parents. They characterized those relationships as open, honest, and comfortable. Child care providers also expressed that discussing a child's behavior with parents could be difficult. They did not want to discourage parents with routine reports that the child was exhibiting concerning behavior and wanted to mention positives as well as negatives. This seemed to contribute to the common experience that parents felt caught off guard by the level of concern about their child's behavior—especially in those cases where the child care program asked them to withdraw their child. One of the two parents interviewed attributed her surprise to poor communication from the providers, but she also acknowledged that communication was not frequent, and that when they did have face-to-face contact with providers it was usually during pick-up or drop-off time, so the child was able to hear their conversation. The other parent reported that she felt listened to and that she had a lot of positive communication with the program. Both parents said the child care providers were sensitive about the exit process and wanted to keep the child in the center until the parents established a new child care situation.

Research Question 2: What strategies do consultants use to work with children, providers, and parents?

Overview

Consultants described a variety of strategies that they used to work with children, both within the program setting and individually, with the directors and providers, and the parents. Table 15 provides a representative listing of the most common consultation strategies, as reported by the consultants in their own words.

Regardless of who initiated the request for consultation, consultants would assess the needs of the child, the classroom in which the child spent most of his/her day, the ECE provider working directly with the child, and the family, as much as possible. When a consultant developed a plan to help an ECE provider who referred a child with concerning behavior, she would make recommendations for improvements in two areas: reduce the concerning behavior and promote pro-social behavior.

Programmatic Consultation

Consultants were able to make a variety of recommendations for ECE providers to use in their classrooms. Programmatic suggestions were made with the intention that all children would benefit from these improvements, not just the child expressing concerning behavior. For example:

> *"[We] rearranged the room to make more centers were available. Everything was done in large groups, so we changed this and added more small-group; what she wanted to do could be done as a center, vs. with everyone. We made it more interactive because there were a lot of boys in the classroom, with movement, dancing, able to move around. Going from story time where the children were acting out, to something less teacher-directed."* Consultant #19.

By making programmatic changes that would help everyone, all children could promote pro-social behavior which reinforces the support for those children who were exhibiting concerning behavior.

Some key recommendations made by consultants were to reduce the stress of transitions. Many children exhibiting concerning behavior were having difficulty either staying in an activity or moving from one activity to the next efficiently. If ECE providers reduced the number of transitions that children had to encounter during their day, it would reduce the negative behavior elicited by transitions. Another recommendation was to give advanced warnings when transitions were about to occur which would allow a child to self-regulate and prepare himself for a transition that may become stressful.

> *"So it was just a lot of, you know, things to get him to focus, reviewing the schedule so he knows what's expected of him, before transitions just giving him a 5 minute warning, "all done." I gave her a picture book of just a few visual things that she could flip to with just like a clean-up picture "Okay, we're going to clean up now" so he could see it, you know as well as the verbal language."* Consultant #11

Some classrooms had no dividers between centers or grouped them too closely, which presented some spatial issues. Children could not tell where one center ended and the next began and often had a difficult time remaining in that center. Or, when competing centers caught the attention of children, because there was no boundary to define one classroom, they became distracted and were not participating as expected in their chosen center.

> *"We had suggested taking out a section of the classroom. We gave them an area and we were like "What if it's over in this part of the classroom?" We're like "you could tape off a section, because we know that they're 3, and they have a hard time with self-control," and that would be the gross-motor area. So on little cards, you could have "Do 5 jumping jacks," and you could have jumping jacks five times."* Consultant #14

Promoting pro-social behavior was most easily accomplished by working with all of the children in the program. When providers were able to model appropriate, and positive, language, children were able to learn how to use this language in context. Many consultants used (or introduced) Tucker the Turtle from the CSEFEL program to encourage children to "get out of their shell" and build social skills.

> *"I was working on social skills. Just trying to - and I'd do groups with all the kids. So I'd take Tucker Turtle so that all the kids could hear it."* Consultant #18

Providers were encouraged to limit their use of the word "no" and to provide options so that the children could choose to do something else instead. Frequently, children only hear the things they "cannot" do, instead of hearing all the positive choices for things they can.

> *"The teacher said "no" a lot, no to the kids, and so I said you know "you need to let them know what they CAN do, what can they do in this room?"* Consultant #11

Child-Specific Consultation

In an attempt to reduce concerning behavior for specific children, consultants made recommendations based on individual needs. For example, one child had a problem with biting other children. For this child, the consultant created a plan to involve more oral muscles to reduce biting by eating crunchy foods (pretzels, apples, and carrots), blowing bubbles, or eating applesauce through a straw.

Another successful strategy involved the consultant shadowing the child exhibiting the concerning behavior and correcting the inappropriate behavior as it happens.

> *"I would stay close to [child] and shadow her and help her make better choices, and use her manners, and listen to [her provider], and chase her when she'd run down the hall."* Consultant #18

To further promote pro-social behavior by developing empathy, consultants used a variety of books, feathers, pictures, and interpersonal activities. These activities and materials were modeled for the children and their use was encouraged throughout the program and at home.

> *"I gave them bubbles to help him with calming down, feathers to show the difference between gentle and rough touch, different cards with children with different emotions to help him with empathy building."* Consultant #12

Unfortunately, not all of the ECE providers who were working with the consultants were able to effectively apply these strategies, and sometimes the child exited the program before these strategies could be effectively applied.

> *"It was clear that he was over-stimulated. I mean there were times the director needed to reiterate for her that we needed to make special accommodations. I think she was stressed about the fact of how she was going to be able to make these accommodations without being able to do it with the rest of the class. So I was going to try to work with her on universal strategies. But we never got to that point."* Consultant #12

The majority of consultants working with children who exited their child care programs emphasized that consultation ended before all, or many, of their recommendations could be

implemented. This left some consultants feeling frustrated, although they recognized, regrettably, that this often happens in unplanned exit situations.

Parents

Consultants felt it was very important to help parents understand the need to remain consistent at home and follow through on strategies attempted in the classroom. Consultants shared this information with parents through phone calls, notes home, emails, and through the sharing of informational literature like CSEFEL booklets.

> *"And I had given the parents like a sheet about time out, and a sheet about effective commands, and using privileges at home and stuff like that, so she got those kinds of parenting handouts. I gave her information about potty training, too. And when I saw her one time when she was picking up [her child], she said, "I read that stuff and I was doing everything wrong! What I read, now I'm doing it, and it's working better." So I feel like some of the stuff I gave her, maybe it helped, I don't know."* Consultant #18

Table 15: ECMHC Strategies Used In Exit Cases to Reduce Concerning Behaviors

Programmatic
Reduce Concerning Behavior
I rearranged the room to make more centers were available. Everything was done in large groups so we changed this and added more small-group; what she wanted to do could be done as a center, versus with every-one. We made it more interactive because there were a lot of boys in the classroom, with movement, dancing, able to move around. Going from story time where the children were acting out, to some-thing less teacher directed.
I took some toddler board books, like Hands are not for Hitting, Feet are not for Kicking, and that with them and tried to have like a conversation about hitting and things.
They did a chill pool, to where she actually had a pool that she brought in to the classroom, and this is one thing she really ran with, so there was a chill pool and she put different pillows in it.
"What if it's over in this part of the classroom?" We're like "you could tape off a section, because we know that they're 3, and they have a hard time with self-control," and that would be the gross-motor area. So on little cards, you could have "Do 5 jumping jacks", and you could have jumping jacks five times.
She created her own cozy corner, and she did work with transitions.
Promote Pro-social Behavior
Really to role model for her, number one, and two, to start some kind of dialogue with the kids about what was happening and how to handle it and what to do.
The teacher said "no" a lot, no to the kids, and so I said you know "you need to let them know what they CAN do, what can

they do in this room?"
If you're going to say a concern, sandwich it with a positive, or two positives and a negative, and we said really be aware of that ratio and how you're doing that and how you're getting that information across.
I'd take Tucker Turtle so that all the kids could hear it.
Child Specific
Reduce Concerning Behavior
If she were sitting on the floor, "pretzel-style" legs, but with her legs open, so he could sit right in front of her. And she would wrap her legs around him. And just sort of to keep him, and he liked it, to keep him snug close to her so he couldn't escape and hurt anybody or run to mom's room.
The teacher was fantastic, was trying to help him, was calm, didn't get upset with anything he did, talked to him in a calm manner, and was following recommendations.
Mostly CSEFEL parenting resources. There are handouts, there's three parenting handouts that CSEFEL has written and they are really great springboard tools for conversation about managing child's behavior.
Discussed different things to work on in the classroom, different sensory needs, accommodations that he would need, like he may need to play with play dough if he was having trouble keeping his hands to himself, or was - to strengthen his writing skills to write in sand or salt with his finger, and a time-in area or a calming area in the classroom.
I gave her a weighted lab pad to use, stress balls, fidgets to hold during circle time, a wiggle cushion to sit on; we tried to put in different strategies for him in the classroom.
Nap bag: a bag of activities that Mom would provide so that if he couldn't sleep he at least had some specialized activities. Mom bought a visual timer so that he could see when his time on the nap was going to be over.
And I would stay close to [child] and shadow her and help her make better choices, and use her manners, and listen to [provider], and chase her when she'd run down the hall.
I gave them a behavior chart for everyday. And it was broken into twelve different sections for the day. Nap time, outside time, circle time, free play time and it was a way for [provider] to track [child's] behavior and let the mom know.
I wanted to really stress to the parents was that they can't undermine what [the provider]was doing in the class.
I had given the parents like a sheet about time out, and a sheet about effective commands, and using privileges at home and stuff like that, so she got those kinds of parenting handouts. I gave her information about potty training, too.
I said "during these transition times, you need to give him a 5-minute warning, maybe a 1-minute warning, and have someone be right there with him when it's time to clean up and time to come in.
Ways get him, slowly bring him into circle time and get him involved… was a little seat to sit on and then a little textured disc for him to hold in his hand. We also tried the little cards so that he would know what the next thing was, and we created a

jumping square so that he would have an area to jump around if he needed.
Promote Pro-social Behavior
For the biting, I gave him a book called Teeth are not for Biting. I recommended that they do things that involve more oral muscles; eating crunchy foods like pretzels, apples, carrots, blowing bubbles, eating applesauce or through a straw.
We're going to establish that with him, appropriate language to use for him, and positive reinforcement.
If he ever bites he needs to help the teacher hold an ice pack on that child and explain to him why it's wrong to do that.
I gave them bubbles to help him with calming down, feathers to show the difference between gentle and rough touch, different cards with children with different emotions to help him with empathy building.
She had something she could work on with him, and start to use positive approaches to support the targeted behaviors and engage with him in positive ways.
Transitions in line and stuff were difficult, so they had agreed to give him a job or something to carry when he had to line up to go to another area of the building. And we um, started to work on building an emotional vocabulary for him. Mom was working on books at home and they were both to use conversation and real-life situations to help identify and label emotions.
She had asked the classroom to implement a quiet spot for the aggression. She talked about feeling faces, pro-social stories, and then praising him. And then giving him different tactics to calm himself down and build self-control. Then some of the social skills, thinking about really modeling them, shadowing them, and with our program it only runs for 2 ½ hours. So keeping that in mind. So she created a weight card for him, for the attention, to build that self control.
Books to help build attachment, and like things she could read with him that were kinda geared around, you know, like unconditional love, identifying feelings so he could use feeling words rather than, you know, having the outbursts, trying to teach him to use the feeling words.

Research Question 3: What are the predictors of behavior-related exits from child care programs?

Overview

In order to determine the primary predictors of child exits from ECE programs due to behavioral concerns, our analysis focused on three categories of factors: child factors, family factors, and program factors. For each of these categories, factors emerged that indicated there were specific reasons that a child may have exited the program.

Child Factors

Most of the child factors that consultants identified during the interviews related to one of two themes: concerning behaviors or mental/developmental health factors. Consultants reported specific behaviors that caused problems in the classroom, like biting, and underlying issues that may lead to those specific behaviors, like frustration. Directors, teachers, and parents also described the same cluster of concerning behaviors that consultants reported. Directors and

teachers often emphasized a "domino effect": other children began imitating negative behavior, making classroom and behavior management more difficult. Additionally, consultants noted that in some cases children exhibited behaviors that were not only defiant and aggressive, but which posed safety hazards for themselves, other children, and adults in the classroom. In one case, a teacher had to seek medical attention after trying to calm a child who was having a tantrum. In almost all cases, consultants remarked that children exhibiting concerning behavior also lacked social skills. These children had difficulties performing acceptable social behavior and were far below age appropriate levels.

Many of these children had an identified mental or developmental health concern. Consultants, directors and teachers reported on children who had specific diagnoses (e.g., ADHD, PDD) as well as health/mental health services that children were receiving (e.g., anger management therapy, physical therapy). In a few cases, parents were exploring changes in diets to improve behavior, but sometimes this could lead to unintended negative consequences. For example, one child would take another child's food, not wanting to eat his/her own. In this case, the special diet restriction seemed to create additional problems in the classroom for the ECE provider.

> *"He was on a special diet, like all organic, and that was frustrating too for the teacher because if he wanted a certain kind of bread or other snack the other kids were having he would get really frustrated and at one point he threw his bread across the room, so that was hard too."* Consultant #12

Family Factors

Consultants, directors, and teachers reported that children who exited child care programs were experiencing a variety of challenging family situations. Most of those factors can be grouped into one of three broad categories: family composition (e.g., divorced parents), work/life balance (e.g., mom is both working and in school), or limited/inconsistent parental involvement or engagement with consultation or the child care program (e.g., parents do not return the consultant's phone calls). Significant events in the child's life, such as the death of a grandparent or birth of a sibling, and parents' difficulty disciplining their children were also mentioned by the consultants.

> *"…I mean just the grandparent passed away and the mom is… seemed very, very busy with her work. It was difficult to contact her at all during the day, and she missed our first meeting. So I had to set up a second meeting with her. So, even though . . . when she was with me she seemed on board, other than that, it was difficult to say. And that can factor how well a child - how successful a child can be, if their parent is only on board in the presence of the people."*Consultant #5

Directors and teachers reported the same family factors. Very few said that parents did not cooperate with consultation or the child care program's efforts to address the child's issues, and most providers felt that the child's parents were making a strong effort to help their child.

Program Factors

There were four primary categories of program factors that emerged from the interviews: staff factors, factors related to the classroom environment, factors related to the program's philosophy or curriculum, and the fit between the child care program and the child's needs. Consultants, directors, teachers, and parents all mentioned the same kinds of program factors. Staff turnover and inconsistent staffing were prevalent themes throughout the consultant interviews. Some consultants reported that classroom environments were over-stimulating or inadequately staffed.

The most common concern raised in all of the interviews was the extent to which there was a good fit between the child's needs and the ECE program they were in. Consultants often noted that a program's curriculum or philosophy was not a good fit for the child, for example, due to a lack of structure or a lack of daily routines. When providers explained that their program was not a good fit for a child, they focused on the child's needs that they felt their program could not meet. Parents agreed that the program was not a good fit, but they believed that the poor fit was due what they perceived as negative program factors that made it difficult for their child to succeed. Consultants rarely explained a poor fit as a flaw in a program and more often explained why the program's structure or philosophy was not appropriate for the child.

When a classroom did not appear to be a good fit for a child it was often because the environment was over stimulating, lacking in structure, activities were not appropriately timed for the attention span of the children, or routines were abruptly and/or arbitrarily changed without notice. For example:

> *"I think sometimes she would mess up her consistency a little bit to gauge around his moods and responses. Like if she felt he was having a rough time, she might alter what she would normally do, and I think that wasn't always effective. I think sometimes that was more detrimental, but I think she was kind of dancing around him just to kind of keep things safe to some degree. Or to keep him from going off. And I can understand why she was doing that, because she didn't want to get hurt and she didn't want anyone else to get hurt. But I think that inconsistency of changing her routine around hurt him to some degree, because he was a child who needed that consistency. Like she'd say we're going outside, and then she'd see she was running out of time so she was going to go outside later, and then he'd have a meltdown so she'd say okay we're going outside now."* Consultant #20

Consultants frequently expressed frustration that staff were unwilling to implement suggestions that consultants had made to reduce concerning behavior in the environment. In many cases consultants would prepare materials for use in the provider's classroom only to return later and find the materials unavailable or unused. For example:

> *"She brought a whole bag of materials but it was stuck up on a shelf and not used. Brought a potty watch, asked where it was when she visited, and it was "in the back". Visuals, timers, time out spots, [consultant] would use it when she was*

there but she didn't get the sense the teachers were using it any other time."
Consultant #9.

Research Question 4: What facilitates/predicts positive outcomes when children exit child care programs?

Because these interviews were conducted with a selected group of children who exited their program due to concerning behaviors, our first step was to characterize what would be a positive outcome in these cases. During the interviews, consultants shared their knowledge of outcomes for the children who exited child care programs. For half of the children, the consultant did not know what the next child care situation was going to be and were therefore unable to assess if it was a better place for the child. For the remaining cases, the consultants described a range of outcomes that fell along a continuum (Figure 19). This continuum illustrates the complexity of describing what a "positive outcome" would look like in this group of children—many of whom were "expelled" from their child care program.

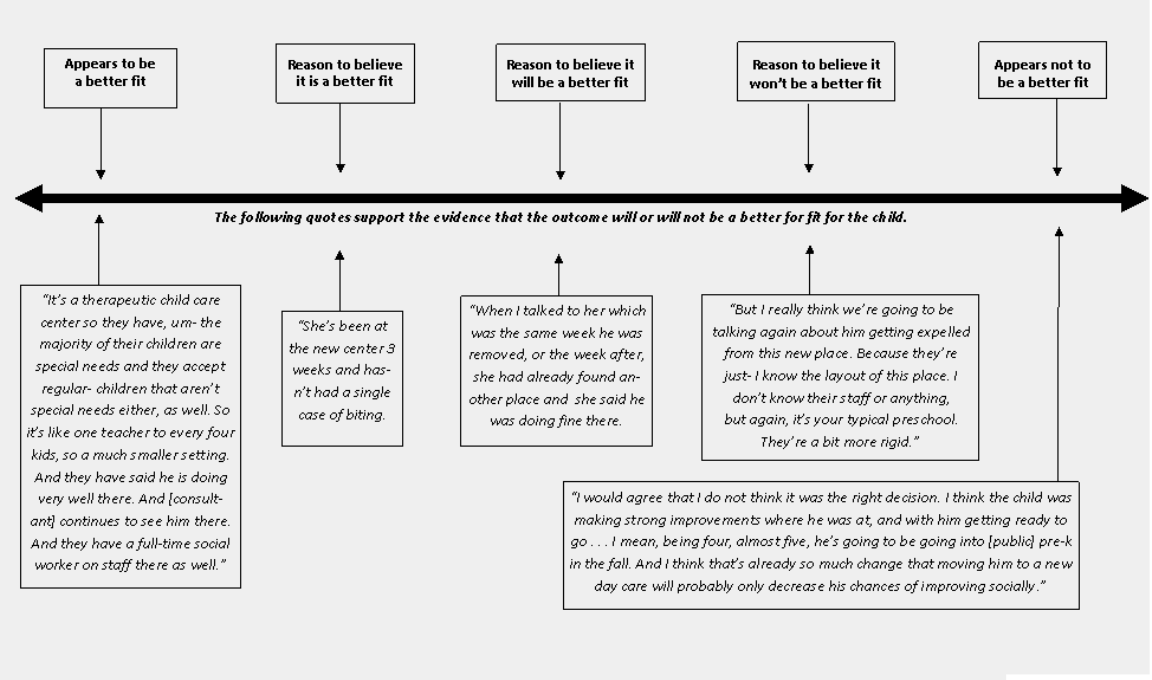
Ideally, a consultant has specific evidence that a child is in an environment that better suits his or her needs. For example, one consultant explained that she was in touch with a child's parents three months following the child's exit and the child was doing well, improving academically, and experiencing fewer "bad days." Another consultant reported that a child who previously split his time in between two child care centers started spending all of his time the center where he was not having difficulties, and the child's teacher confirmed that he continued to thrive in that environment.

In some cases, consultants might not have evidence that a placement will be better for a child, but they have good reason to think it will be. For example, one consultant spoke with a child's mother a couple of weeks after the child exited and was told that the child was beginning therapy soon and that he had not had any behavioral incidents in his new child care program.

Sometimes consultants do not have enough information about a child to know that he or she is doing well, but they think that the child will do better. For example, one consultant heard that a child was doing well from the teacher, who had seen him and said that he looked like he was happy and excited to see her. The consultant assumed he was doing well, but she did not have enough information to say she felt sure that the child was in a better child care situation.

On the other hand, sometimes consultants do not think a child's concerning behavior will improve in their new child care program. One consultant thought that the philosophy or style of the new child care program was not a good fit with the child's needs and worried that the child might get asked to leave that program as well.

Figure 19: Consultant Assessment of Exit Outcomes for Children in Early Childhood Education Programs in Maryland



Only one consultant reported the most negative outcome on the continuum: she believed the child's difficulties would increase in his new situation. The consultant felt that the child needed to practice social skills and would not have that opportunity if he stayed home and was cared for by relatives.

For many of these exits, the consultants and providers expressed surprise that children ended up exiting so quickly—in most cases immediately following a conversation about the child leaving. From the consultant's perspective, the decision to exit was sometimes made before any significant changes could be made for the child based on a plan of action the director, teacher, consultant and parent agreed upon. The children tended to leave immediately following a conversation between the director and the parent where the child was being asked to leave, despite being told that the family could take their time finding a new place. One parent expressed that it was because she felt that they had "made up their mind about him." This parent believed the providers had a negative opinion of the child that was unlikely to change.

Possible Relationship Factors Associated with Child Outcomes

The data we have demonstrates that in six of the ten cases with known outcomes, consultants have good evidence that the child is in a placement that better suits the child's needs. Interestingly, in all but one of those cases, consultants described positive relationships with the child's parents. In addition, for every case in which we know what happened to the child, the consultant characterized their relationship with director positively.

It is important to note that our outcomes data reflect consultants' knowledge of each case status. The time between a child's exit and our interview with the consultant, as well as the time between the child's exit and when the consultant received outcome information about the child, varies from case to case. In some cases, we were able to follow up with consultants who did not know what the child was doing for child care at the time of the interview. The mean length of time between a child's exit and the outcome information that consultants shared is 5-6 weeks and ranges from 1 week to 5 months.

Research Question 5: How can we prevent behavior-related exits from child care programs?

Overview

Overall, it was clear that reductions in the level of problem behaviors exhibited by these children would reduce the likelihood that the child would have to leave their child care program. Almost all of the things consultants, directors, teachers, and parents mentioned that could have prevented child exits were related to managing or reducing problem behavior. We asked respondents what they thought may have prevented the child they were working with from exiting the child care program. Consultants responded that changes in consultation dosage, changes in environmental and staff-related program factors, child care systems factors, and family factors may have helped prevent child exits. These factors were echoed in the comments from teachers, directors and the two parents we interviewed. These are summarized in Figure 20 below.

Family Factors

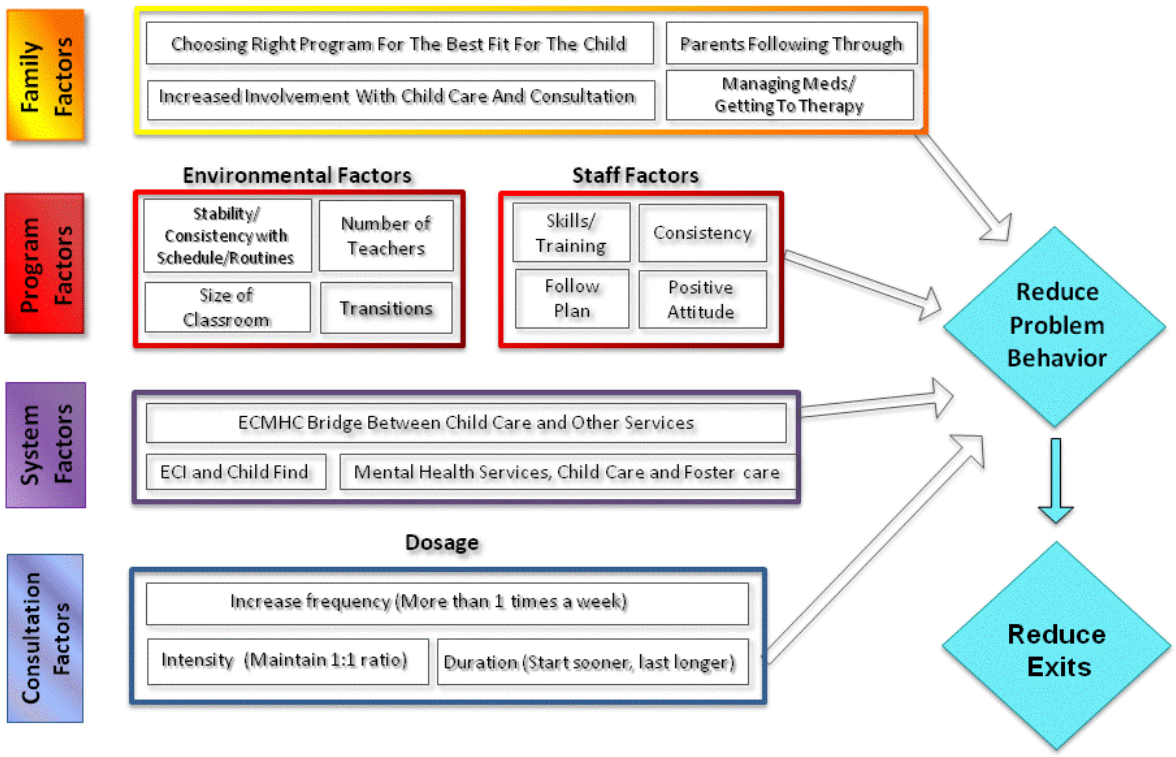
There was consensus that family factors can have a significant impact on preventing child exits. Consultants said that increased parent involvement in child care, in consultation, and at home would have helped prevent exits. Choosing an appropriate child care program that suits the child's needs is a critical step in preventing child exits. Consultants described other ways parents could be more involved, for example, by following through with behavior management, being more vigilant in managing medication, and attending therapy, that might have prevented some of these children from exiting their child care programs. Some directors and providers and one parent mentioned that improved or increased communication between the child care program and parents might have helped reduce the likelihood that the child was asked to leave the program.

Program Factors

Changes to the structure and operation of the child care program and changes in staffing may have helped prevent child exits. All respondents said that having fewer children in a classroom, or a smaller classroom environment, may have helped these children stay in their current program. Fewer transitions and other changes to the classroom routine and schedule may have helped some children. Some children would have benefited from more structure; other children would have been more comfortable with less structure. Several consultants and a few providers thought that increased stability in the classroom schedule and routines, as well as the teachers the child was working with, may have helped.

Aside from increased consistency, there were other changes in staffing that may have helped prevent child exits. Consultants thought that increased skills and training would have improved the teachers' abilities to effectively manage and teach children exhibiting concerning behaviors in the classroom. One parent thought that her child would have done better if her child's teacher had more training in working with special needs children. Consultants also expressed concern that staff did not follow their plans for the child, and having done so may have prevented the child's exit. In some cases, consultants said that a more positive attitude on the part of the teacher may have helped the child stay in the program, and one consultant said that a focus on positive behavior would have helped the child she was working with. When child care providers thought that staff changes might have helped a child, they almost always said that the child would have benefited from continual or much more one-on-one attention, and that the ECMH project was not designed to provide that.

Figure 20: Analysis of Factors That Could Have Prevented Children From Exiting Early Childhood Education Programs in Maryland



Finally, all interviewees reiterated that a good fit between the child and the program, both in terms of the environment and the staff the child was working with, were essential to the child's success.

<u>System Factors</u>

There was clear consensus between consultants, directors, teachers, and parents that improved communication among the consultant, child care program, and family could have reduced the likelihood of expulsion. Consultants consistently commented that communication between stakeholders and systems could have facilitated the child's success. This is particularly relevant given that the children involved in these exits very often had mental health concerns and/or developmental delays and diagnoses. Communication between the child care program and other services that a child was, or perhaps should have been, involved with would have provided additional supports to the children with special health care needs and diagnoses. Improved communication and efficiency on the part of external mental health services, such as child welfare, foster care, Early Intervention, and Child Find, also may have had a positive impact. The two parents did not talk about communication between systems.

Consultation Dosage

Another consistent finding in these interviews, across respondents, was that changes in consultation duration, frequency, and intensity may have helped prevent exits. Consultants said that coming into the classroom to work with the child sooner, or being able to continue providing consultation for a longer amount of time, could have reduced the likelihood of expulsion. Consultants, directors, and teachers said that having the consultant in the classroom more often, or having someone be available to work one-on-one with the child would have been beneficial. Unfortunately, this is outside of the scope of the ECMH project's goals and mission. There was also a recognition that providing programmatic consultation to child care centers prior to being needed for "urgent" child-specific consultation would help prevent child exits in general. Some ECE providers wished there could be a mental health consultant assigned to every school. Interestingly, neither parent we interviewed specifically mentioned that changes in consultation may have helped.

3.3g Summary

Expulsion from an early childhood program is a highly undesirable outcome for any young child and their family. Mental health consultation can help reduce the likelihood that children will be involuntarily removed from their child care placement. From the 35 interviews we conducted with consultants, directors, teachers and parents who were involved with a child who exited their child care program due to behavior problems, we were able to discover that many of these children had mental health and other developmental problems. Their families often had complex lives. And while the child care program had reached out for help in meeting the child's needs, the consultants were often brought in too late in the process to be able to remediate the concerns in that setting. Systems to support children with special needs and their families should be better linked to the child care community. And families could benefit from additional support in determining what kinds of child care programs could be a good fit for their child's developmental and behavioral concerns.

Chapter 4. Policy, Research and Practice Implications and Recommendations

The ECMHC project in Maryland has demonstrated positive outcomes across a broad array of indicators and continues to foster school readiness in young children at higher risk for compromised social and emotional development. During the past decade in Maryland the percentage of kindergarten students who were entering school fully ready to learn rose from 49% to 81% (MSDE, 2011). The Maryland Model for School Readiness (MMSR) has galvanized support in this area. Data have demonstrated a clear link between the types of settings and experiences that young children have prior to school entry and their MMSR scores. As a result, MSDE has made a significant investment in many efforts to improve the quality of early childhood experiences of children—particularly those at risk for social emotional and behavioral problems. One of these efforts, led by the Early Childhood Mental Health Steering Committee, has been the wide scale adoption of the Teaching Pyramid model disseminated by the Center for Social Emotional Foundations for Early Learning (CSEFEL). The expansion of ECMHC services statewide also reflects this commitment to higher quality ECE experiences.

The State of Maryland has also been a leader in using Results-Based Accountability to drive policy makers in program design and management. MSDE has made a strong commitment to evidence-based standards and continuous quality improvement in the efforts that they lead on behalf of young children. This was recently applied to the ECMHC project, and through a collaborative process, program standards were developed by a team of consultants managed by the Georgetown University Center for Child and Human Development (MSDE, 2011). These standards and the accompanying self assessment tool will guide the implementation of high quality ECMHC services across the 11 regional projects.

The results from this ECMHC evaluation report point to several areas for continued focus as MSDE continues to promote comprehensive supports for young children social emotional development. These recommendations have implications for policy, research and practice.

Recommendation 1: Continue to commit resources to evaluating the long term impact of ECMHC service delivery across Maryland including developing linkages across other MSDE databases.

Given the significant investment that t MSDE has made, both in the development of the ECMHC Standards and the statewide implementation and evaluation, there should be continued resources committed to tracking the implementation of the Standards and impact of ECMHC. Specifically, MSDE should continue to track the intensity and type of services provided and the characteristics of the children receiving child-specific services. MSDE should also systematically assess the impact of ECMHC services on the quality of ECE settings who receive consultation. MSDE should work toward the ability to match children receiving consultation services to other databases and begin to follow these children until the third grade, collecting longitudinal data. And, should funds become available, MSDE should contract for a more rigorous evaluation study that includes a comparison group of ECE settings that did not receive EMCHC services.

Recommendation 2: Continue to enhance parent engagement in ECMHC activities, especially related to child-specific consultation.

The data from the service logs indicated a small number of ECMHC services are being provided directly to parents of children referred for child-specific consultation. In addition, the impact study documented only modest changes in one of the subscales from the parent questionnaires. Finally, data from the exit study underscored the fact that many of the children at highest risk for expulsion have significant mental health and developmental concerns as well as family-level stressors that warrant more direct consultation efforts be directed to parents and other caregivers. Efforts should be made to continue to provide technical assistance and training to the ECMH consultants to develop their skills and confidence in engaging families in ECMHC services.

Recommendation 3: Continue to provide high quality training supporting evidence-based approaches to ECMH consultants, with a specific focus on the integration of CSEFEL and ECMHC.

Maryland has been a leader in developing opportunities for building the capacities to the ECE workforce, through the rubric of the MMSR and in partnership with the Maryland Family Network. In addition, Maryland's commitment to implementing the Teaching Pyramid model developed by the CSEFEL complements and extends the efforts of the ECMHC projects statewide. Currently, as part of the ECMHC Standards, consultants must be trained in the Teaching Pyramid mode and many of the consultants have continued their training to become coaches in this evidence-based intervention. The data collected through the exit study on strategies used by the consultants underscored the inter-relatedness of these two efforts in Maryland. MSDE should commit resources to ensuring that the ECMH consultants receive the highest quality training in evidence-based strategies to promote social emotional development, prevent the escalation of problem behaviors, and intervene effectively with children who have ongoing mental health concerns.

Recommendation 4: Support high quality, ongoing, reflective (clinical) supervision for ECMH consultants.

Data from a national study of effective ECMHC conducted by Georgetown University pointed out the fact that Maryland is one of few states that does not require their ECMH consultants to be licensed mental health professionals (Duran, et al. 2009). Indeed, data collected from the Skills and Knowledge Inventory (see pages 26-30), underscore the mixture of expertise that the current pool of consultants bring to their work; many have extensive backgrounds in ECE and years of experience in child care and preschool special education. This diversity of training, expertise and experience can be seen as a major strength of the Maryland ECMHC project, especially given the wide range of topics consultants are expected to be knowledgeable about (Duran, et al., 2009). The Georgetown University study also underscore the importance of providing reflective supervision to front-line ECMH consultants to ensure high-quality implementation and fidelity to the model. MSDE in partnership with the Maryland Department of Hygiene and Mental Health, has funded a certificate program in ECMH run by the University of Maryland Center for Infant Study. This certificate program has led to over 100 master's level professionals gaining critical skills and knowledge in ECMH; and there are trained people in nearly all areas of the state. MSDE should mobilize the expertise of the network of mental health professionals that have completed the UMD ECMHC certificate program to provide reflective supervision to the ECMHC projects throughout the state. This would provide an important source of clinical support and supervision to a pool of consultants not all of whom have been formally trained in early childhood mental health.

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Appendix A. Maryland ECMHC Evaluation Tasks and Activities Timeline

Task/Activities	Initiate	End Date	Frequency	Staff Assignment
I. Consultation/Monitoring				
Monthly consultation w/MDSE monitor	Nov2008	Jul2011	Monthly	Anthony, Perry, Stephan, Nadiv
Telephone/email consultation w/MDSE monitor	Sep2008	Jul2011	Ongoing	Anthony, Perry, Stephan, Nadiv
Develop quarterly reports for MDSE	Nov2008	Jul2011	Quarterly	Anthony, Perry, Stephan, Nadiv
Develop and Provide Initial Program Summaries	Oct2008	Dec2008	Once	Evaluation Team
Provide Program Summary Updates	Jun2009	Jul2011	Annually	Evaluation Team
Provide Expenditure Summary to MDSE	Nov2008	Jul2011	Annually	UMD
Develop Final State Evaluation Report	Aug2011	Jul2011	Once	Evaluation Team
II. Tool Development				
Customize existing instruments	Oct2008	May2009	Once	Evaluation Team
Develop new tools	Oct2008	Jun2009	Once	Evaluation Team
Conduct validity/reliability testing	Jun2009	Jun2011	Once	Evaluation Team
III. Data Collection				
Pilot Data Collection	Sep2009	Nov2009	Ongoing	Evaluation Team
ECMHC Study Data Collection	Dec2009	Apr2011	Ongoing	Evaluation Team

Task/Activities	Initiate	End Date	Frequency	Staff Assignment
Develop Evaluation Logic Models	Dec2008	Jan2009	Once	Evaluation Team
Coordinate & standardize data collection procedures	Mar2009	Dec2009	Ongoing	Evaluation Team
Provide evaluation TA to consultants and field liaisons	Sep2009	Jun2011	Ongoing	Evaluation Team
Develop data collection spreadsheets for consultant completion	Apr2009	Sep2009	Once	Evaluation Team
Exit Study Data Collection	Dec2009	Jun2011	Ongoing	Evaluation Team
IV. Data Analyses				
Run quarterly frequency data	Dec2009	Jul2011	Quarterly	Evaluation Team
Conduct data analyses for Quarterly Reports	Aug2009	Aug2011	Quarterly	Evaluation Team
Conduct qualitative data analyses for Exit Study	Nov2010	Jun2011	Ongoing	Evaluation Team
Conduct analyses for final report with baseline and 4-month follow-up data	Jul2011	Aug2011	Once	Evaluation Team
V. Meetings				
Quarterly review meetings with MSDE	Dec2008	Aug2011	Quarterly	Anthony, Perry, Stephan, Nadiv
National Meeting Representation	Oct2010	Jul2011	Periodically	UMD/GU PIs
Evaluation Team Meetings	Oct2008	Sep 2010	Weekly	Evaluation Team
Evaluation Team Meetings	Oct2010	Jul2011	Monthly	Evaluation Team

Task/Activities	Initiate	End Date	Frequency	Staff Assignment
Evaluation Sub-group Meetings	Oct2010	Jul2011	Bi-weekly	Subgroups
VI. Translation of Results/Policy Development				
Consultation with State ECMH Stakeholders	Oct2008	Jul2011	Periodically	Evaluation Team
Development of Peer Reviewed Journal Submissions	Jul2010	Aug2011	Two	Evaluation Team
Develop policy tools for ECMH field	Jan2010	Jul2011	Once	Evaluation Team

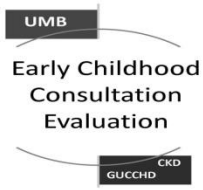
Appendix B: ECMHC Evaluation Measures by Construct, Respondent, Frequency and Collector

Categories / Tools	Construct	Respondent	Frequency	Collector	Type of Case**
I. Process Evaluation					
- Model Description	- Program Model	- ECMHC Program Director	- Baseline, Annual updates	- Eval Team	- Both
- Quarterly Site Interviews	- Program Changes	- ECMHC Program Director	- Quarterly	- Eval Team	- Both
- Knowledge & Skills Inventory	- Knowledge/Skills	- Consultants	- Baseline, Annual updates	- Eval Team	- Both
II. CORE Outcomes Evaluation					
Pre-School Mental Health Climate Scale	-Teacher Behaviors	- Consultants	- Baseline, and **every** 4 months or at discharge (if prior to 4 months)	Consultant/Eval	- Both
- Strengths & Difficulties Questionnaire Impact Supplement (5 items)	-All Children's Functioning	- ECE Providers	- Baseline, & at 4 months or at discharge (if prior to 4 months)	Consultant/Eval	- Both
- Teacher Opinion Survey	-Teacher Attitudes	- ECE Providers	- Baseline, & at 4 months (or at discharge if prior to 4 months)	Consultant/Eval	- Both
- Goals Achievement Scale	- Director Attitudes/Beliefs	- ECE Directors	- Baseline, & at 4 months (or at discharge if prior to 4 months)	Consultant/Eval	- Both
- Intake Form	- Demographics	- ECE Providers	-Baseline only	Consultant/Eval	-Both
- Relationship Quality Scale-ECE Provider with Consultant	- Relationship Quality	- ECE Provider	- At 4 months (or at discharge if prior to 4 months)	- Eval Team	- Both
- Relationship Quality Scale-Consultant with ECE Provider	-Relationship Quality	Consultants	- At 4 months (or at discharge if prior to 4 months)	- Eval Team	- Both

Child & Parent Focused *					
- Devereux Early Childhood Assessment (DECA) Series	- Specific Child Functioning	- ECE Providers/ Caregivers	Baseline, & at 4 months or discharge (if prior to 4 months) Option for 12, 24 months[1]	Consultant/Eval	- Child
- Parenting Stress Index-Short Form	- Parent Stress	-Caregiver	- Baseline, & at 4 months (or at discharge if prior to 4 months)	Consultant/Eval	- Child
-Parent Behavior Inventory	-Parenting Behavior	- Caregiver	- Baseline, & at 4 months (or at discharge if prior to 4 months)	Consultant/Eval	- Child
- Intake Form	- Demographics	- Caregiver	-Baseline only	Consultant/Eval	-Child
-Relationship Quality Scale-Caregiver	-Relationship Quality	- Caregiver	- At 4 months or discharge	-Eval Team	- Child

[1] Children can be followed until their transition to kindergarten; permission to access the WSS will be requested from parent

Appendix C: ECMHC Evaluation Measures



-- / -- / ----
Program ID/Consultant ID/Consultation ID

A partnership between the University of Maryland, CKD Communications, LLC, and Georgetown University Center for Child and Human Development

Intake Form- Parent/Caregiver

Tell us a little about yourself…

What is your name? _____
(first) (last)

Today's Date: ____/____/____

When were you born? ____/____/____
(mm/dd/year)

Please check one: O Male

O Female

How best would you identify your racial/ethnic background? (You may choose more than one)

O American Indian or Alaska Native
O Asian
O Black or African American
O Native Hawaiian/Other Pacific Islander
O White
O Hispanic
O Mixed race_____ (***please specify***)
O Other _____ (***please specify***)

What is your highest level of education?

O Some high school
O Completed high school/GED
O Some college
O Completed Associates Degree
O Completed Bachelors Degree
O Completed Masters Degree
O Completed Advanced Degree(s): _____ (please specify)

What is your zip code? _____

How old is your child? _____ years _____ months

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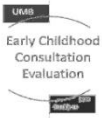
http://medschool.umaryland.edu/innovations/ECMHC_evaluations.asp



What is your child's date of birth? ____/____/____

How best would you identify your child's racial/ethnic background? (You may choose more than one)

- O American Indian or Alaska Native
- O Asian
- O Black or African American
- O Native Hawaiian/Other Pacific Islander
- O White
- O Hispanic
- O Mixed race_____ (***please specify***)
- O Other _____ (***please specify***)

How long has your child been in this child care program? _____ years _____ months

What is your marital status?

- O Single
- O Married
- O Living with partner
- O Divorced
- O Widowed

How many children are living in the household? _____ (Please specify the age of each child)

1. _____ years _____ months
2. _____ years _____ months
3. _____ years _____ months
4. _____ years _____ months
5. _____ years _____ months
6. _____ years _____ months
7. _____ years _____ months
8. _____ years _____ months

Do you use purchase of care vouchers for this child's program?

- O Yes
- O No

Early Childhood Consultation Evaluation

Does your child have any special health care needs or identified disabilities?

O Yes

O No

If yes, please describe:

_____
_____
_____
_____

Does your child have an IFSP/IEP?

O Yes

O No

Contact Information:

What is your current address?

_____
_____
_____
_____

Phone number: _____ Cell phone number: _____

Is there someone we can contact if we are unable to reach you at the address/phone numbers you have provided above?

Name: _____ Relationship to you: _____

Contact information (Please include phone number):

_____
_____
_____
_____
_____

Draft Interview Protocol for Exit Interview-Parent/Caregiver

Verbal Script

First, note any available information you will need to confirm.

Hello, I'm _____ from Georgetown University. We are conducting interviews with parents and caregivers whose child recently left a child care setting. Would now be a good time to talk? The interview should take about 30 minutes.

If no: When would be a better time?

(Set specific time _____ date_____ back up phone number _____)

If yes:
Great! These interviews will help us understand how early childhood consultants can assist childhood professionals work with young children and families. We would like to hear more about your experience at the child care center [*as well as your experience with the child care consultant if applicable)*. Ultimately, we will use this information to design strategies to improve child outcomes and school readiness, beginning in early childhood.

First we'd like to get/confirm some basic information about you and your child.

Demographic Data:

Caregiver's name
Race/ethnicity of caregiver
Is the caregiver receiving POC vouchers?

Child's name
Child's age
Child's gender
Child's race/ethnicity

Does your child have an IFSP, IEP, or diagnosed disability?
    If so, what is it?
Does your child have a diagnosed mental/behavioral health issue?
    If so, what is it?

Name of child care program
Date of program exit

1. When did you first hear about the child care program's/provider's concerns about *(child's name*)?

2. What specific concerns were mentioned?

   Did other concerns or behaviors arise later?

3. Did you ever meet with the center director, or early childhood education provider, to discuss a plan for *(child's name)*?

   a. If yes, how often?

   b. What was suggested?

   c. Did you feel that you were able communicate your suggestions?

   d. Did you feel that your opinion was valued?

4. Did the program bring in an outside specialist to work with your child?

   If yes:

   a. Did you meet separately with the consultant to discuss a plan for *(child's name)*?

   b. What services were recommended?

5. Who did you feel worked with you to maintain your child's placement?

   a. Teachers?

   b. Directors?

   c. Consultant?

6. Now I'd like to ask you about how *(child's name)* exited the program.

   a. Who made the decision?

i. *If not the caregiver,* who informed you of the decision?

b. When was the decision made?

c. Do you think it was the right decision? Why or why not?

7. Was another early childhood education setting found for *(child's name)*?

   a. If yes, who found or helped find the placement?

   b. If yes, did you feel that you and your child were assisted with the transition to the new setting?

      i. How?

      ii. By whom?

8. Were your needs, wishes, and concerns taken into account as your child transitioned from the child care setting?

   How might things have gone better for you and your child?

9. Were there any significant changes in your child's life that preceded the child's exit? *(Birth of a sibling, change in household composition, etc?)* Please describe.

10. Did you have the same concerns about behaviors at home?

    a. If not these, were there other behaviors of concern?

11. Has your child exited other ECE programs due to behavior problems?

    a. *If yes,* how many?

    b. For what reason?

12. Do you feel your needs were met in a way that was sensitive to you and your culture?

13. If you speak a different language than your child care provider, do you feel that your child care provider was respectful of your family's home language?

    a. Did your provider share information with you in your home language?

14. How are things going now?

    How are things going in the new placement *(if applicable)*

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Parent/Caregiver- 12 Month Follow Up

Thank you again for your participation in the Early Childhood Consultation Evaluation. As indicated in the consent form we are contacting you regarding the 12 month follow up. If you would still like to participate, please complete the remainder of the forms and place them in the sealed envelope and to mail it to the University of Maryland Baltimore.

Please send back the following:

- ☐ Parent/Caregiver Demographic Form
- ☐ Parent Stress Index Short Form
- ☐ Parent Behavior Inventory
- ☐ Devereux Early Childhood Assessment (DECA)

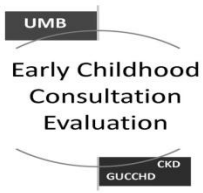
If you choose not to participate, please place all the blank forms back in your envelope, seal it and mail it to the University of Maryland Baltimore.

If you choose to participate and complete the forms, you will be entered into the quarterly lottery drawings for two chances to win $50. The drawings will take place in March, June, September, and December.

If you have any questions at any time please contact our project coordinator, Sarah James at 1-877-413-0002 or by email at sjames@psych.umaryland.edu.

Thank you for your time,

The Evaluation Team



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Parent/Caregiver- 24 Month Follow Up

Thank you again for your participation in the Early Childhood Consultation Evaluation. As indicated in the consent form we are contacting you regarding the 24 month follow up. If you would still like to participate, please complete the remainder of the forms and place them in the sealed envelope and to mail it to the University of Maryland Baltimore.

Please send back the following:

- ☐ Parent/Caregiver Demographic Form
- ☐ Parent Stress Index Short Form
- ☐ Parent Behavior Inventory
- ☐ Devereux Early Childhood Assessment (DECA)

If you choose not to participate, please place all the blank forms back in your envelope, seal it and mail it to the University of Maryland Baltimore.

If you choose to participate and complete the forms, you will be entered into the quarterly lottery drawings for two chances to win $50. The drawings will take place in March, June, September, and December.

If you have any questions at any time please contact our project coordinator, Sarah James at 1-877-413-0002 or by email at sjames@psych.umaryland.edu.

Thank you for your time,

The Evaluation Team

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Parent/Caregiver-Follow Up

Thank you again for your participation in the Early Childhood Consultation Evaluation. As indicated in the consent form we are contacting you regarding the four month follow up. If you would still like to participate, please complete the remainder of the forms and place them in the sealed envelope and to either mail it or your return it Consultant or your Child Care Provider.

Please send back the following:

- ☐ Parent/Caregiver Demographic Form
- ☐ Parent Stress Index Short Form
- ☐ Parent Behavior Inventory
- ☐ Relationship Quality Scale-Caregiver

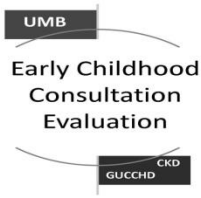
If you choose not to participate, please place all the blank forms back in your envelope, seal it and either mail it or return it to your Consultant or your Child Care Provider.

If you choose to participate and complete the forms, you will be entered into the quarterly lottery drawings for two chances to win $50. The drawings will take place in March, June, September, and December.

If you have any questions at any time please contact our project coordinator, Sarah James at 1-877-413-0002 or by email at sjames@psych.umaryland.edu.

Thank you for your time,

The Evaluation Team



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Parent/Caregiver-Initial

Thank you for reviewing the Early Childhood Consultation Evaluation materials. In this envelope there is a consent form and three other forms. **Please** read through the Consent Form first. If you would like to participate please sign your name on the last page, place all the forms back in your envelope, seal it and either mail it or return it to your Consultant or Child Care Provider.

Please send back the following:

- ☐ Consent Form to indicate if you would like to participate in the evaluation
- ☐ Brief Intake Form
- ☐ Parent Stress Index Short Form
- ☐ Parent Behavior Inventory

If you choose not to participate, do not sign the consent form, but please return all forms in a sealed envelope back to either your Consultant or your Teacher/Child Care Provider. Please note that your child's teacher may also be referred to as an Early Care & Education (ECE) Provider throughout this process.

If you choose to participate and complete the forms, you will be entered into the quarterly lottery drawings for two chances to win $50. The drawings will take place in March, June, September, and December.

If you have any questions at any time please contact our evaluation coordinator, Sarah James at 1-887-413-0002 or by email at sjames@psych.umaryland.edu.

Thank you for your time,

The Evaluation Team

Draft Interview Protocol for Exit Interview: Consultant

Verbal Script

First, note any available information you will need to confirm.

Hello, I'm _____ from Georgetown University. Thank you again for your participation in our early childhood consultation study. These interviews will help us understand how early childhood education consultation improves outcomes for providers, young children, and families.

Would now be a good time to talk? The interview should take less than 30 minutes.

If no: When would be a better time?

(Set specific time _____ date_____ back up phone number _____)

If yes:

Great! First we'd like to get/confirm some basic information about you and the child you are/were working with.

Demographic Data:

Name of Consultant
Education/degree
Years of experience
Consultant's race/ethnicity

Name of child care program
Name of child care director
Name of lead ECE provider

Child's initials/subject ID
Name of primary caregiver *(if known)*
Child's age
Child's gender
Child's race/ethnicity

Do you know if the child has an IFSP, IEP, or diagnosed disability?
If so, what is it?

Do you know if the child has a diagnosed mental/behavioral health issue?
- If so, what is it?

Was the child receiving consultation services…
- In classroom?
  - Beginning date:
- Child specific?
  - Beginning date:
- If neither, was the child referred for consultation?

Date of exit from program

Directions: use open ended questions initially, then follow-up as needed:

1. Tell me about the behavioral/emotional problems (child's name) was having in the Early Care and Education (ECE) setting.

a. When were behavioral/emotional concerns first raised about *(child's name)*?

b. Who communicated those concerns?

To whom were they communicated

How were they communicated?

c. What were the specific behavioral/emotional concerns?

2. How frequently did you provide consultation to the provider?

a. For how long? *(date to date)*

3. *If the child was receiving child-specific consultation:*

a. How frequently did you provide consultation to *(child's name)* and his family?

b. For how long? *(date to date)*

c. If consultation did not occur, why not?

4. What actions *(if any)* did the ECE provider(s) take to address *(child's name)*'s challenges?

For example:

a. Did the ECE providers meet with the family to discuss a plan for the child?

If yes, how often did they meet and what was suggested?

Who was present?

b. If not, do you know why not?

5. When you were called in to help this child, was the director in agreement with the consultation plan? *(omit if family child care)*

a. Provider?

b. Provider?

6. Was *(child's name)* referred for additional services?
    a. *If yes*, what services were recommended?

       Were these services in place prior to the exit?

    b. If services were not accessed, why not?
7. Did you and the director have a good working relationship /common goals?
    a. Provider?
    b. Parent?
8. To your knowledge, were there any cultural/racial/ethnic issues that may have appeared during consultation?

       If yes, What were they?

       How were they addressed?
9. Did you expect that *(child's name)* would withdraw?
    a. At what point did you realize this?
    b. Why?
10. Please tell me a little about how the child withdrew from the program
    a. Who made the decision?
    b. When was the decision made?
    c. Who communicated the decision to the family?
    d. Do you believe that it was the right decision for *(child's name)* to leave the program? Why or why not?
11. Did you feel that the child's withdrawal could have been prevented?
    a. What would have needed to change for the child to be maintained in the child care setting?
12. Was this setting a good fit for the child? Why or why not?

13. Was another placement found for *(child's name)*?

    a. *If yes*, who helped find the placement?

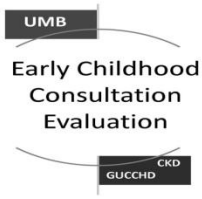
    b. Was help provided to the family in making the transition to a new child care setting? *If yes,* how and by whom?

    c. Was help provided to the child to make the transition to a new child care setting? *If yes,* how and by whom?

    d. Did you continue/are you continuing to work with this child?

14. Do you know how things are going now in the new placement? *(if applicable)*

-- / -- / ----
Program ID/Consultant ID/Consultation ID



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Consultant Relationship Quality Scale: *Child-Specific*

Your Name: _____

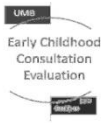
Provider's Name: _____

Today's Date: ____/____/____

The following information is being collected to assess and to improve services provided to parents/caregivers. Please answer as candidly as possible; your responses will be treated confidentially. Please answer all questions, even if your contact with the parent has been very limited. After you have finished, please place this form into the attached postage paid envelope. If this envelope is missing, kindly, mail the above forms to:

Sarah James
University of Maryland
737 West Lombard Street, 4th floor
Baltimore, MD 21201

Thank you in advance for you cooperation.



Experiences with Child's Parent

The following statements concern your experience with this child's parent. Please read each item and use the following 5-point scale (Almost never, Once in a while, Sometimes, Frequently, Almost always) to indicate the degree to which you feel the statement is true about your experiences with this child's parent.

	Rating (Fill in bubble)				
Item	Almost never	Once in a while	Sometimes	Frequently	Almost always
1. We trust each other.	O	O	O	O	O
2. It is difficult for us to work together.	O	O	O	O	O
3. We cooperate with each other	O	O	O	O	O
4. Communication is difficult for us.	O	O	O	O	O
5. I respect this parent	O	O	O	O	O
6. This parent respects me.	O	O	O	O	O
7. We are sensitive to each other's feelings.	O	O	O	O	O
8. We have different views of right and wrong	O	O	O	O	O
9. When there is a problem with this child, this parent is all talk and no action.	O	O	O	O	O
10. This parent keeps his/her promises to me.	O	O	O	O	O

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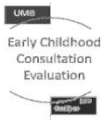
Erchul, W.P. (1987). A relational communication analysis of control in school consultation. Professional School Psychology, 2, 113-124.
Vickers, H.S., & Minke, K.M. (1995). Exploring parent-teacher relationships: Joining and communication to others. School Psychology Quarterly, 10, 133-150



Item	Almost never	Once in a while	Sometimes	Frequently	Almost always
11. When there is a behavior problem, I have to solve it without getting help from the parent.	O	O	O	O	O
12. When things aren't going well it takes too long to work them out.	O	O	O	O	O
13. We understand each other.	O	O	O	O	O
14. We see this child differently.	O	O	O	O	O
15. We agree about who should do what regarding this child.	O	O	O	O	O
16. I expect more from this parent than I get.	O	O	O	O	O
17. We have similar expectations of this child.	O	O	O	O	O
18. This parent tells me when s/he is pleased.	O	O	O	O	O
19. I don't like the way this parent talks to me.	O	O	O	O	O
20. I tell this parent when I am pleased.	O	O	O	O	O
21. I tell this parent when I am concerned.	O	O	O	O	O
22. I tell this parent when I am worried.	O	O	O	O	O
23. I ask this parent's opinion about this child's progress.	O	O	O	O	O
24. I ask this parent for suggestions.	O	O	O	O	O

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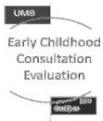

Please answer the following questions by filling in the bubble that best fits your perceptions of this child's parents.

25. After completing this consultation, how skilled do you think this child's parent is to work with this child on his/her main difficulties?

- O Not skilled; not able to help this child to make any progress.
- O Not that skilled.
- O Somewhat skilled; able to help this child to make some progress.
- O Skilled.
- O Very skilled; able to help this child to make great progress.

26. After completing this consultation, how interested do you think this child's parent is in working with this child on his/her main difficulty?

- O Not interested at all; would just assume this child not be in the class.
- O Not that interested.
- O Somewhat interested; does not mind working with this child.
- O Interested.
- O Very interested. Sees this child as either a pleasure or a challenge.

27. In general, how aware do you think your child's parent is of the social and emotional needs of this child?

- O Not aware; the parent is not attuned to this child's needs.
- O Not that aware.
- O Somewhat aware; this parent is moderately attuned to this child's needs.
- O Aware.
- O Very aware; the parent is very attuned to this child's needs.

28. In general, how satisfactory to you is your relationship with this child's parent?

- O Not satisfactory; there has been much conflict which has not been resolved.
- O Not that satisfactory.
- O Somewhat satisfactory.
- O Satisfactory.
- O Very satisfactory; the relationship has proceeded very smoothly with no real problems at all.

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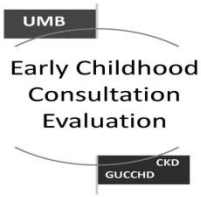
Program ID/Consultant ID/Consultation ID



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Consultant Relationship Quality Scale: *Provider*

Your Name: _____

Provider's Name: _____

Today's Date: ____/____/____

The following information is being collected to assess and to improve services provided to Early Care and Education Programs. Please answer as candidly as possible; your responses will be treated confidentially. Please answer all questions, even if your contact with the provider has been very limited. After you have finished, please place this form into the attached postage paid envelope. If this envelope is missing, kindly, mail the above forms to:

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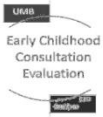
Thank you in advance for you cooperation.



Experiences with Child's Provider

The following statements concern your experience with this child's provider. Please read each item and use the following 5-point (Almost never, Once in a while, Sometimes, Frequently, Almost always) scale to indicate the degree to which you feel the statement is true about your experiences with this child's provider.

	Rating (Fill in bubble)				
Item	**Almost Never**	**Once in a while**	**Sometimes**	**Frequently**	**Almost Always**
1. We trust each other.	O	O	O	O	O
2. It is difficult for us to work together.	O	O	O	O	O
3. We cooperate with each other.	O	O	O	O	O
4. Communication is difficult for us.	O	O	O	O	O
5. I respect this provider.	O	O	O	O	O
6. This provider respects me.	O	O	O	O	O
7. We are sensitive to each other's feelings.	O	O	O	O	O
8. We have different views of right and wrong.	O	O	O	O	O
9. When there is a problem with this child, this provider is all talk and no action.	O	O	O	O	O
10. This provider keeps his/her promises to me.	O	O	O	O	O

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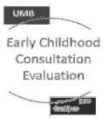

Item	Almost never	Once in a while	Sometimes	Frequently	Almost always
11. When there is a behavior problem I have to solve it without getting help from the provider.	O	O	O	O	O
12. When things aren't going well it takes too long to work them out.	O	O	O	O	O
13. We understand each other.	O	O	O	O	O
14. We see this child differently.	O	O	O	O	O
15. We agree about who should do what regarding this child.	O	O	O	O	O
16. I expect more from this provider than I get.	O	O	O	O	O
17. We have similar expectations of this child.	O	O	O	O	O
18. This provider tells me when s/he is pleased.	O	O	O	O	O
19. I don't like the way this provider talks to me.	O	O	O	O	O
20. I tell this provider when I am pleased.	O	O	O	O	O
21. I tell this provider when I am concerned.	O	O	O	O	O
22. I tell this provider when I am worried.	O	O	O	O	O
23. I ask this provider's opinion about this child's progress.	O	O	O	O	O
24. I ask this provider for suggestions.	O	O	O	O	O

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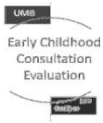

Please answer Questions #25 to #28 by <u>filling in the bubble</u> that best fits your perceptions of this child's provider.

25. After completing this consultation, how skilled do you think this child's provider is to work with this child on his/her main difficulties?

- O Not skilled; not able to help this child to make any progress.
- O Not that skilled.
- O Somewhat skilled; able to help this child to make some progress.
- O Skilled.
- O Very skilled; able to help this child to make great progress.

26. After completing this consultation, how interested do you think this child's provider is in working with this child on his/her main difficulty?

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- O Very satisfactory; the relationship has proceeded very smoothly with no real problems at all.

Revised 4/6/09 adapted with permission from Dr. Sue Sheridan

Erchul, W.P. (1987). A relational communication analysis of control in school consultation. Professional School Psychology, 2, 113-124.
Vickers, H.S., & Minke, K.M. (1995). Exploring parent-teacher relationships: Joining and communication to others. School Psychology Quarterly, 10, 133-150

Draft Interview Protocol for Exit Interview-Center Director

Verbal Script

First, note any available information you will need to confirm.

Hello, I'm _____ from Georgetown University, and I'm calling to thank you for consenting to participate in our early childhood consultation study. We are conducting interviews with child care center directors who have had a child exit their program.

Would now be a good time to talk? The interview should take about 30 minutes.

If no: When would be a better time?

(Set specific time _____ date_____ back up phone number _____)

If yes:
Great! These interviews will help us understand how early childhood consultants can assist childhood professionals to work with young children and families. We would like to hear more about your experience as a child care center director. Ultimately, we will use this information to design strategies to improve child outcomes and school readiness, beginning in early childhood.

First we'd like to get/confirm some basic information about you and the child you were working with.

Demographic Data: *Confirm any previously collected information.*

Director's name
Years of experience
Education/degree *(if high school, # of years; subject area if relevant)*
Director's race/ethnicity
Name of child care program

Child's initials/subject ID
Child's age
Child's gender
Child's race/ethnicity
Name of family contact
Do you know if the child has an IFSP, IEP, or diagnosed disability?
    If so, what is it?

Do you know if the child has a diagnosed mental/behavioral health issue?
If so, what is it?

Was the child referred for consultation *(if applicable*)
Did he/she receive it?
Beginning Date of classroom consultation *(if applicable)*
Beginning date of child-initiated consultation *(if applicable)*
Consultant's name *(if applicable)*

Date of exit

Directions: Begin with open-ended questions, and follow-up on additional details/information as necessary:

1. When did you first hear about concerns with this child?
    a. Who told you about these concerns? (i.e., *teacher, assistant, parent, all?)*
    b. What were those concerns?
2. Was consultation available to the teacher?
    a. If yes
        i. How often?
        ii. How soon after concerns were raised?
        iii. In sufficient intensity/frequency to avert expulsion?
    b. If no, and consultation was offered to the child/classroom, why not?
3. Was the early childhood consultant available to the family?
    a. If yes , were they actively working with the family?
        i. How often?
        ii. How soon after concerns were raised?

iii. In sufficient intensity/frequency to avert expulsion?

4. Did you meet with the provider to discuss a plan for the child?
    a. How often? What was suggested?
    b. Consultant?
        i. How often?
        ii. What was suggested?
    c. Parent?
        i. How often?
        ii. What was suggested?
    d. Did everyone meet together? (*if not addressed)*
5. Was the child referred for additional services?
    a. If yes, what services were recommended?
6. Does your program have a formal/written policy for expelling children?
    a. If yes, how is this policy communicated to staff, families, and others?
7. Were this child's behavior problems endangering providers or other children served by your program?
8. Were parents of other children aware of this situation?
9. Was there pressure to expel this child?
    a. From teachers?
    b. From other parents?
10. Who or what initiated the process of withdrawing the child from the ECE program?

a. Who decided it had to happen?

b. How much time passed between the decision and the child's exit?

11. What would have needed to change for the child to be maintained in this child care setting?

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ECE Directors-Follow Up

Thank you again for your participation in the Early Childhood Consultation Evaluation. As indicated in the consent form we are contacting you regarding the four month follow up. If you would still like to participate, please complete the Goal Achievement Scale, place it in a sealed envelope and either mail it or return it to your Consultant.

Please send back the following:

- ☐ Goal Achievement Scale

In addition, when a child exits the program and there are concerns with behavior, please continue to notify your consultant who will complete the Exiting Child Form with you.

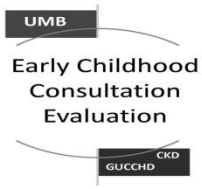
You will receive 2 Professional Activity Unit awarded by MSDE for participation in consultation and completion of baseline and follow up packet instruments.

If you choose not to participate, please place all the blank forms back in your envelope, seal it and either mail it or return it to your Consultant.

If you have any questions at any time please contact our project coordinator, Sarah James at 1-877-413-0002 or by email at sjames@psych.umaryland.edu.

Thank you for your time,

The Evaluation Team



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ECE Directors-Initial

Thank you for reviewing the Early Childhood Consultation Evaluation materials. In this envelope you will find a consent form and the Goal Achievement Scale. **Please** read through the Consent Form first. If you would like to participate please sign your name on the last page, place all the forms back in your envelope, seal it and either mail it or return it to your Consultant.

Please send back the following in the envelope provided:

- ☐ Consent Form to indicate if you would like to participate in the evaluation
- ☐ Goal Achievement Scale

In addition, when a child exits the program and there are concerns with behavior, please notify your consultant who will complete the Exiting Child Form with you.

You will receive 2 Professional Activity Unit awarded by MSDE for participation in consultation and completion of baseline and follow up packet instruments.

If you choose not to participate, do not sign the consent form, but please return all forms in a sealed envelope back to your consultant.

If you have any questions at any time please contact our evaluation coordinator, Sarah James at 1-877-413-0002 or by email at sjames@psych.umaryland.edu.

Thank you for your time,

The Evaluation Team

Exit Interview Invitation: Director/Provider

Greetings from Georgetown University!

You have been invited to participate in Georgetown University's Exit Interview Study. This study is a part of the Early Childhood Education Consultation Evaluation, a collaboration between Georgetown University and the University of Maryland.

We will be interviewing directors and providers at early childhood settings who have recently had a child exit their program. Through these interviews, we hope to:

- Understand your experience as a childcare director or provider,
- Learn how early childhood consultants can help you work with young children and families, and
- Use that information to improve child outcomes and school readiness.

Once you complete your interview, you will enter a lottery to win $50. There will be two drawings in March, June, September and December.

This packet contains:

- **Two (2) Consent Forms**: one for your records and one to sign and return to us,
- an **Evaluation Study Brochure**, to consult for additional information, and
- a **Pre-addressed and Stamped Envelope**, should you choose to return the forms by mail.

If you want to participate in this study:

1) **Sign** the enclosed consent form**,** indicating when we can call you for the interview, and
2) **Return** one copy of the consent form**,** either by fax or mail.

We will contact you for a 30 minute interview at the time you specify.

Please join us in this effort. You could win $50!

Thank you!
Sincerely,
Bruno Anthony, Ph.D.; Deborah Perry, Ph.D. and Courtney Holland, B.A.

Contact: Courtney Holland (202)-687-8617
Georgetown University
Child Development Center
Box 571485
Washington, DC 20057
http://gucchd.georgetown.edu/

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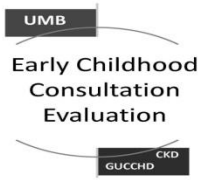
Program ID/Consultant ID/Consultation ID



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INFANT MENTAL HEALTH CLIMATE SCALE

BASELINE

Number of children in classroom _____. Number of staff present in classroom_____

Age range of children in group - youngest to oldest (in years/months) _____/_____ - _____/_____

Observation date 1 _____ Total time_____

Observation date 2_____ Total time_____

Observation date 3_____ Total time_____

Activities Observed (fill in the circle for every activity you observed):

O nap O meal O free choice

O arrival O outside O Other _____

Have you provided consultation in this classroom before_____

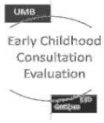
Have you worked with any of the teachers in this classroom before? O yes O no

If yes, how long have you worked with this teacher before (if more than one teacher select the one you have worked with the longest) _____years _____months

Are there child focused cases you are working on in this classroom at this time?

O yes O no

If yes, how many? _____



INSTRUCTIONS:

For the first four sections of the tool, use the key below to rate each item by circling the number that best fits your observation. Please write comments as necessary to clarify your rating. Some of these sections have an option for scoring NO (no opportunity to be observed). This option should be used when the activity described in the item did not occur at all during the observation, or if the child behaviors in the item are not developmentally appropriate for the children being observed. When the NO option is circled, please indicate below the comments section the reason for its use.

5	4	3	2	1	NO
Almost Always	Most of the time	Regularly (about half the time)	Seldom	Never	No Opportunity to be Observed

Emotional Tone of Classroom

1. Children's voices are calm, happy, and appropriate for the situation/activity.	5	4	3	2	1	
2. Caregiver's voice is natural and appropriate in tone and volume.	5	4	3	2	1	
3. Caregiver is supportive and respectful to co-Caregiver in classroom.	5	4	3	2	1	
4. Caregiver interactions with parents show warmth and mutual respect.	5	4	3	2	1	
5. Caregiver interactions with parents show warmth and mutual respect.	5	4	3	2	1	NO

Comments:

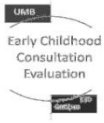
_____

_____

_____

The use of NO for item in this section is due to:

- ☐ No chance for observation during this time period
- ☐ Not developmentally appropriate for this age group of children
- ☐ Other, please define: _____



Caregiver Responsiveness and Guidance

5. Caregiver encourages children to explore and discover, and try new tasks.	5	4	3	2	1	
6. Caregiver allows children to make play choices without being intrusive and overly directive.	5	4	3	2	1	
7. Caregiver uses praise, modeling, and age-appropriate assistance while supporting children to play independently.	5	4	3	2	1	
8. Caregiver provides clear, age-appropriate directions as needed.	5	4	3	2	1	
9. Caregiver reads children's cues accurately, responding in a developmentally appropriate manner.	5	4	3	2	1	
10. Caregiver is able to interact with individual children while watching out for the needs of the entire group.	5	4	3	2	1	
11. Caregiver plans for prevention of conflict with appropriate use of classroom materials and space.	5	4	3	2	1	**NO**
12. Caregiver appropriately redirects and intervenes when children exhibit anger, aggression, or outbursts.	5	4	3	2	1	**NO**

Comments:

_____

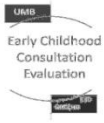
_____

_____

The use of NO for item in this section is due to:

- ☐ No chance for observation during this time period
- ☐ Not developmentally appropriate for this age group of children
- ☐ Other, please define: _____

This tool is being developed by the FSU Center for Prevention & Early Intervention Policy Faculty (R. Pruett, B. White, A. Hogan) and the FSU Early Head Start Program. *Please do not share or reprint without permission.*



Caregiver-Child Interactions

13. Children seek physical closeness and comfort from the Caregiver.	5	4	3	2	1	
14. Children seek assistance from the Caregiver when attempting new tasks.	5	4	3	2	1	
15. Children look to the Caregiver from approval when accomplishing new tasks.	5	4	3	2	1	
16. Caregiver responds with affections to children's attempts at engaging.	5	4	3	2	1	
17. Caregiver frequently provides physical and emotional comfort to children.	5	4	3	2	1	
18. Caregiver supports children's attempts to self-soothe by hugging, touching, or talking to them	5	4	3	2	1	
19. Caregiver individualizes care by using children's names and commenting on their individual interests and preferences.	5	4	3	2	1	
20. Caregiver labels children's emotions and describes their feelings.	5	4	3	2	1	
21. Caregiver helps children use words to express their feelings.	5	4	3	2	1	**NO**

Comments:

_____

_____

_____

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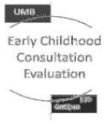
- ☐ Not developmentally appropriate for this age group of children
- ☐ Other, please define: _____



Transitions

22. Caregiver prepares children for transitions in advance and give reasons for changing activities.	5	4	3	2	1	
23. Caregiver supports children during transitions with reminders and songs, attempting to make transitions and clean-up fun.	5	4	3	2	1	
24. Caregiver demonstrates flexibility by allowing individual children to persist in completing activities before changing to another activity, whenever possible.	5	4	3	2	1	
25. Caregiver uses the names of children and family to facilitate smooth greetings and departures.	5	4	3	2	1	NO
26. Caregiver helps children prepare for separations and reunions.	5	4	3	2	1	NO

Comments:

_____

_____

_____

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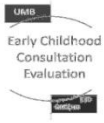
- ☐ Not developmentally appropriate for this age group of children
- ☐ Other, please define: _____



INSTRUCTIONS:

For the following two sections, items are coded using the time context observed for the particular routines described.

5	4	3	2	1	NO
At every opportunity	For most opportunities	About half the time, when appropriate	Seldom, when appropriate	Never	No opportunity to be Observed

Daily Routines (mealtimes, naptime, play)

27. Caregiver holds infants during bottle feeding. 5 4 3 2 1

28. Caregiver is patient and encouraging when spoon feeding children. 5 4 3 2 1

29. Caregiver and children enjoy mealtimes together, with the caregiver sitting, talking, and eating at the table with the children. 5 4 3 2 1

30. Caregiver demonstrates flexibility with children who need additional time to eat and nap. 5 4 3 2 1

31. Caregiver accommodates individual needs of children when preparing for naptime by calming and comforting children who need individual attention. 5 4 3 2 1

32. Caregiver arranges a quiet play space for children who are not sleepy. 5 4 3 2 1 **NO**

33. Caregiver engages children during play, talking about what they are doing and asking open-ended questions. 5 4 3 2 1 **NO**

Comments:

_____

_____

_____

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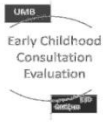


Routine Physical Care (dressing, diapering, toileting, hand washing)

34. Caregiver is gentle and patient with children during physical care routines.	5	4	3	2	1	NO
35. Caregiver engages children during physical care, talking, singing, asking/answering questions.	5	4	3	2	1	NO
36. Caregiver encourages children's age appropriate participations in physical care routines.	5	4	3	2	1	NO

Comments:

_____

_____

_____

The use of NO for item in this section is due to:

- ☐ No chance for observation during this time period
- ☐ Not developmentally appropriate for this age group of children
- ☐ Other, please define: _____

Observation Comments

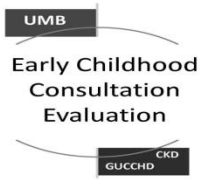
1. Describe overall strengths and any concerns observed today.

2. Describe any concerns about individual children in the classroom. (Include any concerns parents or other staff may have)

3. Plans for needed follow-up. Include lead staff and timeframes.

-- / -- / ----

Program ID/Consultant ID/Consultation ID



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INFANT MENTAL HEALTH CLIMATE SCALE

FOLLOW UP

Number of children in classroom _____. Number of staff present in classroom_____

Age range of children in group - youngest to oldest (in years/months) _____/_____ - _____/_____

Observation date 1 _____ Total time_____

Observation date 2_____ Total time_____

Observation date 3_____ Total time_____

Activities Observed (fill in the circle for every activity you observed):

O nap O meal O free choice

O arrival O outside O Other _____

Have you provided consultation in this classroom before_____

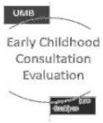
Have you worked with any of the teachers in this classroom before? O yes O no

If yes, how long have you worked with this teacher before (if more than one teacher select the one you have worked with the longest) _____years _____months

Are there child focused cases you are working on in this classroom at this time?

O yes O no

If yes, how many? _____



Have there been any **significant** changes in this classroom? (check all that apply)

O New teachers O Change in Director

O Changes in ages or number of children O Other _____

O Change in program activities or curriculum

COMMENTS: _____

_____

_____

_____

_____

_____

INSTRUCTIONS:

For the first four sections of the tool, use the key below to rate each item by circling the number that best fits your observation. Please write comments as necessary to clarify your rating. Some of these sections have an option for scoring NO (no opportunity to be observed). This option should be used when the activity described in the item did not occur at all during the observation, or if the child behaviors in the item are not developmentally appropriate for the children being observed. When the NO option is circled, please indicate below the comments section the reason for its use.

5	4	3	2	1	NO
Almost Always	Most of the time	Regularly (about half the time)	Seldom	Never	No Opportunity to be Observed

Emotional Tone of Classroom

1. Children's voices are calm, happy, and appropriate for the situation/activity.	5	4	3	2	1	
2. Caregiver's voice is natural and appropriate in tone and volume.	5	4	3	2	1	
3. Caregiver is supportive and respectful to co-Caregiver in classroom.	5	4	3	2	1	
4. Caregiver interactions with parents show warmth and mutual respect.	5	4	3	2	1	
5. Caregiver interactions with parents show warmth and mutual respect.	5	4	3	2	1	NO

Comments:

_____

_____

_____

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Caregiver Responsiveness and Guidance

5. Caregiver encourages children to explore and discover, and try new tasks.	5	4	3	2	1	
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8. Caregiver provides clear, age-appropriate directions as needed.	5	4	3	2	1	
9. Caregiver reads children's cues accurately, responding in a developmentally appropriate manner.	5	4	3	2	1	
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11. Caregiver plans for prevention of conflict with appropriate use of classroom materials and space.	5	4	3	2	1	**NO**
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Comments:

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- ☐ Other, please define:

_____

Caregiver-Child Interactions

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20. Caregiver labels children's emotions and describes their feelings.	5	4	3	2	1	
21. Caregiver helps children use words to express their feelings.	5	4	3	2	1	**NO**

Comments:

_____

_____

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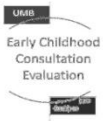

Transitions

22. Caregiver prepares children for transitions in advance and give reasons for changing activities.	5	4	3	2	1	
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25. Caregiver uses the names of children and family to facilitate smooth greetings and departures.	5	4	3	2	1	NO
26. Caregiver helps children prepare for separations and reunions.	5	4	3	2	1	NO

Comments:

_____

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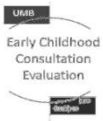
- ☐ Other, please define:

_____



INSTRUCTIONS:

For the following two sections, items are coded using the time context observed for the particular routines described.

5	4	3	2	1	NO
At every opportunity	For most opportunities	About half the time, when appropriate	Seldom, when appropriate	Never	No opportunity to be Observed

Daily Routines (mealtimes, naptime, play)

27. Caregiver holds infants during bottle feeding. 5 4 3 2 1

28. Caregiver is patient and encouraging when spoon feeding children. 5 4 3 2 1

29. Caregiver and children enjoy mealtimes together, with the caregiver sitting, talking, and eating at the table with the children. 5 4 3 2 1

30. Caregiver demonstrates flexibility with children who need additional time to eat and nap. 5 4 3 2 1

31. Caregiver accommodates individual needs of children when preparing for naptime by calming and comforting children who need individual attention. 5 4 3 2 1

32. Caregiver arranges a quiet play space for children who are not sleepy. 5 4 3 2 1 **NO**

33. Caregiver engages children during play, talking about what they are doing and asking open-ended questions. 5 4 3 2 1 **NO**

Comments:

_____

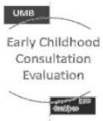
_____

_____

The use of NO for item in this section is due to:

- ☐ No chance for observation during this time period
- ☐ Not developmentally appropriate for this age group of children
- ☐ Other, please define:

_____



Routine Physical Care (dressing, diapering, toileting, hand washing)

34. Caregiver is gentle and patient with children during physical care routines.	5	4	3	2	1	NO
35. Caregiver engages children during physical care, talking, singing, asking/answering questions.	5	4	3	2	1	NO
36. Caregiver encourages children's age appropriate participations in physical care routines.	5	4	3	2	1	NO

Comments:

_____

_____

_____

The use of NO for item in this section is due to:

- ☐ No chance for observation during this time period
- ☐ Not developmentally appropriate for this age group of children
- ☐ Other, please define: _____

Observation Comments

1. Describe overall strengths and any concerns observed today.

2. Describe any concerns about individual children in the classroom. (Include any concerns parents or other staff may have)

3. Plans for needed follow-up. Include lead staff and timeframes.

-- / -- / ----
Program ID/Consultant ID/Consultation ID

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Intake Form-ECE Provider

Tell us a little about yourself…

What is your name? _____
(first) (last)

Today's Date: ____/____/____

When were you born? ____/____/____
(mm/dd/year)

Please check one: O Male

O Female

How best would you identify your racial/ethnic background? (You may choose more than one)

- O American Indian or Alaska Native
- O Asian
- O Black or African American
- O Native Hawaiian/Other Pacific Islander
- O White
- O Hispanic
- O Mixed race_____ (***please specify***)
- O Other _____ (***please specify***)

How long have you been a teacher (ECE Provider)?_____

What is your highest level of education?

- O Some high school
- O Completed high school/GED
- O Some college
- O Completed Associates Degree
- O Completed Bachelors Degree
- O Completed Masters Degree
- O Completed Advanced Degree: _____(please specify)

What is the zip code of where you live? _____

What is the zip code of where you work?_____

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Mental Health Consultant Education, Skills and Experience Inventory

Name: _____

Today's Date: ____/____/____

ECMH Program Name: _____

Please take a few minutes to tell us about your educational background and experience.

1. What is the highest degree you have achieved (check one):

Degree	✓
Associate	
Bachelor	
Master	
Doctorate	
Other (please specify):	

2. Are any of your degrees in a mental health field? YES ☐ NO ☐
(for example: social work, counseling, psychology, psychiatry)

2a. If YES, which field(s)? _____

3. How many total years of experience do you have in early childhood mental health consultation? _____ Years

4. How many total years of experience do you have providing mental health services to young children? _____ Years

5. Are any of your degrees, licenses or certifications in early childhood education? YES ☐ NO ☐

5a. If YES, how many years of experience do you have as an early childhood educator? _____ Years

6. What is your race/ethnicity? Check all that apply:

Race/Ethnicity	✓
Asian/Pacific Islander	
Black/African/ African-American/ Caribbean	
Hispanic/Latino(a)	
Native American/American Indian	
White	
Middle Eastern	
Other (please specify)	

Please indicate your level of knowledge/skill/experience by shading in the appropriate bubble along the continuum of minimal – moderate – strong. **Answer Selection:** Correct = ● Incorrect = ⊗ ✓ ⊖	**Minimal**		**Moderate**		**Strong**
1. Knowledge of typical and atypical early childhood development	○	○	○	○	○
2. Knowledge of infant and early childhood mental health/social-emotional development	○	○	○	○	○
3. Knowledge of diverse mental health treatment/intervention approaches	○	○	○	○	○
4. Knowledge of early intervention systems (Part C and preschool special education)	○	○	○	○	○
5. Knowledge of family support and adult service systems	○	○	○	○	○
6. Knowledge of community resources	○	○	○	○	○
7. Understanding of diverse cultures	○	○	○	○	○
8. Experience working in child care settings (prior to job as a consultant)	○	○	○	○	○
9. Experience observing/screening/assessing children in classroom, home or other natural settings	○	○	○	○	○
10. Experience working with children with challenging behavior	○	○	○	○	○
11. Experience providing direct therapy to children birth through five	○	○	○	○	○
12. Experience working with children in foster care	○	○	○	○	○
13. Experience providing training/education to adults	○	○	○	○	○
14. Ability to develop and support implementation of individualized intervention plans	○	○	○	○	○
15. Ability to integrate mental health activities into group care settings	○	○	○	○	○
16. Ability to integrate a 'wellness approach' to mental health that includes activities focused on promotion and prevention	○	○	○	○	○
17. Ability to collaborate with child care directors/teachers/providers	○	○	○	○	○
18. Ability to collaborate with families	○	○	○	○	○
19. Ability to facilitate team meetings/manage diverse perspectives	○	○	○	○	○
20. Communication skills	○	○	○	○	○
21. Crisis intervention skills	○	○	○	○	○
22. Care management/care coordination skills	○	○	○	○	○

Thank you!

Respondent Code: MD MHC 2

Exit Interview Invitation: Parent/Caregiver

Greetings from Georgetown University!

You have been invited to participate in Georgetown University's Exit Interview Study. This study is a part of the Early Childhood Education Consultation Evaluation, a collaboration between Georgetown University and the University of Maryland.

We will be interviewing parents whose children have recently exited a childcare program. Through these interviews, we hope to:

- Understand your experience working with program directors and providers,
- Learn how early childhood education consultants can help young children and families, and
- Use that information to improve child outcomes and school readiness.

Once you complete your interview, you will enter a lottery to win $50. There will be two drawings in March, June, September and December.

This packet contains:

- **Two (2) Consent Forms**: one for your records and one to sign and return to us,
- an **Evaluation Study Brochure**, to consult for additional information, and
- a **Pre-addressed and Stamped Envelope**, should you choose to return the forms by mail.

If you want to participate in this study:

1) **Sign** the enclosed consent form**,** indicating when we can call you for the interview, and
2) **Return** one copy of the consent form**,** either by fax or mail.

We will contact you for a 30 minute interview at the time you specify.
Please join us in this effort. You could win $50!

Thank you!
Sincerely,

Contact: Courtney Holland (202)-687-8617
Georgetown University
Child Development Center
Box 571485
Washington, DC 20057
http://gucchd.georgetown.edu/

-- / -- / ----
Program ID/Consultant ID/Consultation ID

UMB Early Childhood Consultation Evaluation CKD GUCCHD

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Parent Behavior Inventory

Today's Date: ____/____/____

Read each statement carefully. Think about how you and your child (that is receiving consultation) generally get along. Fill in the bubble of the statement that describes the way you usually act with your child.

1. I lose my temper when my child doesn't do something I ask him/her to do.

- O not at all
- O a little
- O somewhat
- O moderately
- O quite a bit
- O always

2. I have pleasant conversations with my child.

- O not at all
- O a little
- O somewhat
- O moderately
- O quite a bit
- O always

3. I grab or handle my child roughly.

- O not at all
- O a little
- O somewhat
- O moderately
- O quite a bit
- O always

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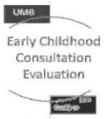
http://medschool.umaryland.edu/innovations/ECMHC_evaluations.asp



4. I try to teach my child new things.

- O not at all
- O a little
- O somewhat
- O moderately
- O quite a bit
- O always

5. I demand that my child does something (or stop doing something) right away.

- O not at all
- O a little
- O somewhat
- O moderately
- O quite a bit
- O always

6. My child and I hug and/or kiss each other.

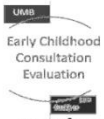
- O not at all
- O a little
- O somewhat
- O moderately
- O quite a bit
- O always

7. I complain about my child's behavior or tell my child I don't like what s/he is doing.

- O not at all
- O a little
- O somewhat
- O moderately
- O quite a bit
- O always

8. I laugh with my child about things we find funny.

- O not at all
- O a little
- O somewhat
- O moderately
- O quite a bit
- O always



9. When my child misbehaves, I let him/her know what will happen if s/he doesn't behave.

- O not at all
- O a little
- O somewhat
- O moderately
- O quite a bit
- O always

10. My child and I spend time playing games, doing crafts, or doing other activities.

- O not at all
- O a little
- O somewhat
- O moderately
- O quite a bit
- O always

11. I listen to my child's feelings and try to understand them.

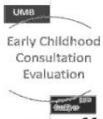
- O not at all
- O a little
- O somewhat
- O moderately
- O quite a bit
- O always

12. I thank or praise my child.

- O not at all
- O a little
- O somewhat
- O moderately
- O quite a bit
- O always

13. I spank or use physical punishment with my child.

- O not at all
- O a little
- O somewhat
- O moderately
- O quite a bit
- O always



14. I offer to help, or help my child with things s/he is doing.

- O not at all
- O a little
- O somewhat
- O moderately
- O quite a bit
- O always

15. I threaten my child.

- O not at all
- O a little
- O somewhat
- O moderately
- O quite a bit
- O always

16. I comfort my child when s/he seems scared, upset, or unsure.

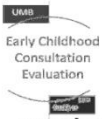
- O not at all
- O a little
- O somewhat
- O moderately
- O quite a bit
- O always

17. I say mean things to my child that can make him/her feel bad.

- O not at all
- O a little
- O somewhat
- O moderately
- O quite a bit
- O always

18. I hold or touch my child in an affectionate way.

- O not at all
- O a little
- O somewhat
- O moderately
- O quite a bit
- O always

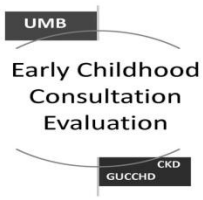


19. When I am disappointed in my child's behavior, I remind him/her about what I've done for him/her.

- O not at all
- O a little
- O somewhat
- O moderately
- O quite a bit
- O always

20. When my child asks for help or attention, I ignore him/her or make him/her wait until later.

- O not at all
- O a little
- O somewhat
- O moderately
- O quite a bit
- O always



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Program ID/Consultant ID/Consultation ID

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Parent/Caregiver Demographic Form

(12 and 24 month follow up)

Tell us a little about yourself…

What is your name? _____
(first) (last)

Today's Date: ____/____/____

What child care program does your child currently attend? _____

How long has your child been in this child care program? _____ years_____ months

How many child care placements has your child had in the last 12 months? _____

What is your marital status?

O Single O Married

O Living with partner O Divorced

O Widowed

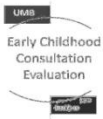
How many children are living in the household? _____ (Please specify the age of each child)

1. _____ years _____ months
2. _____ years _____ months
3. _____ years _____ months
4. _____ years _____ months
5. _____ years _____ months
6. _____ years _____ months
7. _____ years _____ months
8. _____ years _____ months

Do you use purchase of care vouchers for this child's program?

O Yes

O No



Does your child have any special health care needs or identified disabilities?

O Yes

O No

If yes, please describe:

_____
_____
_____

Does your child have an IFSP/IEP?

O Yes

O No

What is your current address?

_____

_____

_____

_____

Phone number: _____ Cell phone number: _____

Is there someone we can contact if we are unable to reach you at the address/phone numbers you have provided above?

Name: _____ Relationship to you: _____

Contact information (Please include phone number):

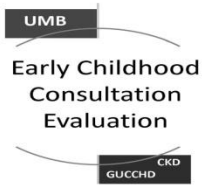
_____

_____

_____

_____

_____



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Program ID/Consultant ID/Consultation ID

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Parent/Caregiver Demographic Form

(Follow Up)

Tell us a little about yourself…

What is your name? _____
(first) (last)

Today's Date: ____/____/____

What child care program does your child currently attend? _____

How long has your child been in this child care program? _____ years_____ months

What is your marital status?

O Single O Married

O Living with partner O Divorced

O Widowed

How many children are living in the household? _____ (Please specify the age of each child)

1. _____ years _____ months
2. _____ years _____ months
3. _____ years _____ months
4. _____ years _____ months
5. _____ years _____ months
6. _____ years _____ months
7. _____ years _____ months
8. _____ years _____ months

Do you use purchase of care vouchers for this child's program?

O Yes

O No

Early Childhood Consultation Evaluation

Does your child have any special health care needs or identified disabilities?

O Yes

O No

If yes, please describe:

_____

_____

_____

Does your child have an IFSP/IEP?

O Yes

O No

What is your current address?

_____

_____

_____

_____

Phone number: _____ Cell phone number: _____

Is there someone we can contact if we are unable to reach you at the address/phone numbers you have provided above?

Name: _____ Relationship to you: _____

Contact information (Please include phone number):

_____

_____

_____

_____

_____

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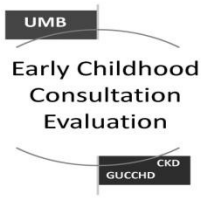
Program ID/Consultant ID/Consultation ID



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PRESCHOOL MENTAL HEALTH CLIMATE SCALE-BASELINE

Gilliam, 2009

Number of children in classroom _____. Number of staff present in classroom_____

Age range of children in group - youngest to oldest (in years/months) _____/_____ - _____/_____

Observation date 1 _____ Total time_____

Observation date 2 _____ Total time_____

Observation date 3 _____ Total time_____

Activities Observed (fill in the circle for every activity you observed):

O nap O meal O free choice

O circle time O arrival O outside

Have you provided consultation in this classroom before_____

Have you worked with any of the teachers in this classroom before? O yes O no

If yes, how long have you worked with this teacher before (if more than one teacher select the one you have worked with the longest) _____years _____months

Are there child focused cases you are working on in this classroom at this time?

O yes O no

If yes, how many? _____

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INSTRUCTIONS

You should spend a minimum of three hours in the classroom observing a variety of activities including meal time, a few transitions and both structured and unstructured activities. Then rate the items by filling in the circle that best fits the statement, using the key provided below.

Rate the average score of the teachers/teaching staff in the room from the perspective of the children. For example, in question two if one staff often handles a transition in a planned manner and the other staff sometimes handles a transition in planned manner then the classroom as a whole would be rated as moderately handling a transition in a planned manner. Use the "comments" section to provide examples/clarification.

SCORING IS OPTIONAL as this form will be automatically scored; you may score and retain the last page for your own purposes.

SECTION I: POSITIVE INDICATORS

A. TRANSITIONS

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

COMMENTS:_____

_____

_____

B. DIRECTIONS & RULES

1	2	3	4	5	
Never or not true	Sometimes or Somewhat	Moderately Frequent or Moderately True	Often or Very true	Consistently or Completely true	
O	O	O	O	O	8. Staff encourages appropriate behavior.
O	O	O	O	O	9. Staff expresses clear directions and behavioral expectations and provides appropriate follow-through on instructions.
O	O	O	O	O	10. Staff consistently enforces classroom rules.
O	O	O	O	O	11. Rules, directions and expectations are developmentally appropriate.
O	O	O	O	O	12. Staff uses positive classroom management techniques to manage children's behaviors. If no challenging behaviors observed, do not score and check here ❑
O	O	O	O	O	13. Staff uses redirection appropriately to manage challenging behaviors. If no challenging behaviors observed, do not score and check here ❑

COMMENTS:_____

_____

C. STAFF AWARENESS

1	2	3	4	5	
Never or not true	Sometimes or Somewhat	Moderately Frequent or Moderately True	Often or Very true	Consistently or Completely true	
O	O	O	O	O	14. Staff is aware of potential behavioral challenges before they escalate, and staff intervenes appropriately.
O	O	O	O	O	15. Staff physically circulates around the room.
O	O	O	O	O	16. Staff appears constantly aware of the entire class, even when working with smaller groups or individual students. Staff is able to attend to many activities and tasks simultaneously and shift focus of attention at ease.

COMMENTS:_____

_____

D. STAFF AFFECT

1	2	3	4	5	
Never or not true	Sometimes or Somewhat	Moderately Frequent or Moderately True	Often or Very true	Consistently or Completely true	
O	O	O	O	O	17. Staff seems to enjoy their job.
O	O	O	O	O	18. Staff seems to be having fun, and appear to enjoy the children and/or teaching the children new skills.
O	O	O	O	O	19. Staff is active and energetic, not lethargic.

COMMENTS:_____

_____

_____

E. STAFF COOPERATION

If there is only one staff member, check here and skip to Section G ❑

1	2	3	4	5	
Never or not true	Sometimes or Somewhat	Moderately Frequent or Moderately True	Often or Very true	Consistently or Completely true	
O	O	O	O	O	20. Staff members work well together.
O	O	O	O	O	21. Staff members have distinct roles that are both complementary and flexible. They act like a team and share responsibilities well
O	O	O	O	O	22. Staff members appear to enjoy each other.

COMMENTS:_____

_____

_____

F. STAFF-CHILD INTERACTIONS

1	2	3	4	5	
Never or not true	Sometimes or Somewhat	Moderately Frequent or Moderately True	Often or Very true	Consistently or Completely true	
O	O	O	O	O	23. Staff initiates conversations with children.
O	O	O	O	O	24. Staff addresses children at eye level and in a clear and understandable manner
O	O	O	O	O	25. Staff actively listens to children with attention.
O	O	O	O	O	26. Staff interactions with children are positive, without fussing or arguing
O	O	O	O	O	27. Staff interactions with children are affectionate and warm.
O	O	O	O	O	28. Staff does or says things to help children feel accepted and special.
O	O	O	O	O	29. Staff shows positive facial affect towards children
O	O	O	O	O	30. Staff is respectful of children.
O	O	O	O	O	31. Staff is fair to children. Staff does not repeatedly reprimand certain children for behaviors that others exhibit without comment.

COMMENTS:_____

_____

_____

G. TEACHING FEELINGS & PROBLEM-SOLVING

1	2	3	4	5	
Never or not true	Sometimes or Somewhat	Moderately Frequent or Moderately True	Often or Very true	Consistently or Completely true	
O	O	O	O	O	32. Staff capitalizes on opportunities to talk about feelings.
O	O	O	O	O	33. Staff helps children label their own feelings.
O	O	O	O	O	34. Staff helps children to express their feelings to others verbally, rather than by using physical means.
O	O	O	O	O	35. Staff actively encourages/facilitates positive interactions between children.
O	O	O	O	O	36. Staff uses a variety of positive methods (e.g., offering behavioral choices, encouraging good problem-solving skills, or modeling appropriate behaviors) to promote prosocial behaviors.
O	O	O	O	O	37. Staff actively promotes children's use of language to prevent/negotiate conflicts.
O	O	O	O	O	38. When conflicts arise, staff helps children devise their own solutions to peers conflicts. If no conflicts observed, do not score and check here. ❑
O	O	O	O	O	39. When conflicts arise, staff discusses with the children a variety of alternative solutions for their disagreements. If no conflicts observed, do not score and check here ❑

COMMENTS:_____

_____

_____

H. INDIVIDUALIZED & DEVELOPMENTALLY APPROPRIATE PEDAGOGY

1	2	3	4	5	
Never or not true	Sometimes or Somewhat	Moderately Frequent or Moderately True	Often or Very true	Consistently or Completely true	
O	O	O	O	O	40. Staff promotes learning through developmentally appropriate practices.
O	O	O	O	O	41. Staff seems to know each child's developmental strengths and needs and individualizes expectations and interactions accordingly
O	O	O	O	O	42. Staff provides children with individualized support.
O	O	O	O	O	43. Staff actively facilitates children's social development.
O	O	O	O	O	44. Staff actively supports children's play.
O	O	O	O	O	45. Activities are of an appropriate duration, pace, variability, and level of stimulation to maintain children's attention.

COMMENTS:_____

_____

I. CHILD INTERACTIONS

1	2	3	4	5	
Never or not true	Sometimes or Somewhat	Moderately Frequent or Moderately True	Often or Very true	Consistently or Completely true	
O	O	O	O	O	46. Children appear to be happy and well adjusted.
O	O	O	O	O	47. Children are involved, well behaved, cooperative, and attentive.
O	O	O	O	O	48. Children interact well with staff.
O	O	O	O	O	49. Children interact with peers in a way that shows mutual affiliation, concern, or affection.
O	O	O	O	O	50. Children appear to be developing independence, creativity, and adaptive coping skills.

COMMENTS:_____

_____

SECTION II: NEGATIVE INDICATORS

1	2	3	4	5	
Never or not true	Sometimes or Somewhat	Moderately Frequent or Moderately True	Often or Very true	Consistently or Completely true	
O	O	O	O	O	1. Staff does not help children to engage in productive play/activities.
O	O	O	O	O	2. Staff places unrealistic demands on children's attention span.
O	O	O	O	O	3. Staff imposes solutions on conflicts.
O	O	O	O	O	4. Staff shouts at children from across the room.
O	O	O	O	O	5. Staff threatens children with consequences.
O	O	O	O	O	6. Staff humiliates or frightens children.
O	O	O	O	O	7. Staff uses physical contact primarily as a means for controlling behavior.
O	O	O	O	O	8. Noise level in the classroom is too high.
O	O	O	O	O	9. Visual stimulation in the classroom is either too high or too low.

COMMENTS:_____

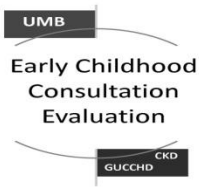
_____

PRESCHOOL MENTAL HEALTH CLIMATE SCALE
STANDARDIZATION VERSION 2.1

SCORING FORM (THIS IS OPTIONAL)

	Item Sum Scores		Number of Items		Scores
I. Positive Indicators					
A. Transitions	_____	÷	7	=	____. _____
B. Directions & Rules	_____	÷	6 (or 4)	=	____. _____
C. Staff Awareness	_____	÷	3	=	____. _____
D. Staff Affect	_____	÷	3	=	____. _____
E. Staff Cooperation	_____	÷	3	=	____. _____
F. Staff-Child Interactions	_____	÷	9	=	____. _____
G. Feelings & Problem-Solving	_____	÷	8 (or 6)	=	____. _____
H. Pedagogy	_____	÷	6	=	____. _____
I. Child Interactions	_____	÷	5	=	____. _____
Total Positive	_____	÷	Total # of Items ___	=	____. _____
II. Negative Indicators					
Total Negative	_____	÷	9	=	_____. _____

-- / -- / ----
Program ID/Consultant ID/Consultation ID



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PRESCHOOL MENTAL HEALTH CLIMATE SCALE
FOLLOW UP

Number of children in classroom _____. Number of staff present in classroom_____

Age range of children in group - youngest to oldest (in years/months) _____/_____ - _____/_____

Observation date 1 _____ Total time_____

Observation date 2 _____ Total time_____

Observation date 3 _____ Total time_____

Activities Observed (fill in the circle for every activity you observed):

O nap O meal O free choice

O circle time O arrival O outside

How long has it been since you worked in this classroom? _____years _____months

For how long have you worked with this teacher before (if more than one teacher select the one you have worked with the longest) _____years _____months

Are there child focused cases you are working on in this classroom at this time?

O yes O no

If yes, how many? _____

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http://medschool.umaryland.edu/innovations/ECMHC_evaluations.asp

Have there been any **significant** changes in this classroom? (check all that apply)

O New teachers O Change in Director _____

O Changes in ages or number of children O Other _____

O Change in program activities or curriculum

COMMENTS:_____

_____

_____

_____

_____

_____

Early Childhood Consultation Evaluation

INSTRUCTIONS

You should spend a minimum of three hours in the classroom observing a variety of activities including meal time, a few transitions and both structured and unstructured activities. Then rate the items by filling in the circle that best fits the statement, using the key provided below.

Rate the average score of the teachers/teaching staff in the room from the perspective of the children. For example, in question two if one staff often handles a transition in a planned manner and the other staff sometimes handles a transition in planned manner then the classroom as a whole would be rated as moderately handling a transition in a planned manner. Use the "comments" section to provide examples/clarification.

SCORING IS OPTIONAL as this form will be automatically scored; you may score and retain the last page for your own purposes.

SECTION I: POSITIVE INDICATORS

A. TRANSITIONS

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

COMMENTS: _____

_____

_____

Early Childhood Consultation Evaluation

B. DIRECTIONS & RULES

1	2	3	4	5	
Never or not true	Sometimes or Somewhat	Moderately Frequent or Moderately True	Often or Very true	Consistently or Completely true	
O	O	O	O	O	8. Staff encourages appropriate behavior.
O	O	O	O	O	9. Staff expresses clear directions and behavioral expectations and provides appropriate follow-through on instructions.
O	O	O	O	O	10. Staff consistently enforces classroom rules.
O	O	O	O	O	11. Rules, directions and expectations are developmentally appropriate.
O	O	O	O	O	12. Staff uses positive classroom management techniques to manage children's behaviors. If no challenging behaviors observed, do not score and check here ❑
O	O	O	O	O	13. Staff uses redirection appropriately to manage challenging behaviors. If no challenging behaviors observed, do not score and check here ❑

COMMENTS:_____

_____

C. STAFF AWARENESS

1	2	3	4	5	
Never or not true	Sometimes or Somewhat	Moderately Frequent or Moderately True	Often or Very true	Consistently or Completely true	
O	O	O	O	O	14. Staff is aware of potential behavioral challenges before they escalate, and staff intervenes appropriately.
O	O	O	O	O	15. Staff physically circulates around the room.
O	O	O	O	O	16. Staff appears constantly aware of the entire class, even when working with smaller groups or individual students. Staff is able to attend to many activities and tasks simultaneously and shift focus of attention at ease.

COMMENTS:_____

_____

D. STAFF AFFECT

1	2	3	4	5	
Never or not true	Sometimes or Somewhat	Moderately Frequent or Moderately True	Often or Very true	Consistently or Completely true	
O	O	O	O	O	17. Staff seems to enjoy their job.
O	O	O	O	O	18. Staff seems to be having fun, and appear to enjoy the children and/or teaching the children new skills.
O	O	O	O	O	19. Staff is active and energetic, not lethargic.

COMMENTS:_____

_____

_____

E. STAFF COOPERATION

If there is only one staff member, check here and skip to Section G ❑

1	2	3	4	5	
Never or not true	Sometimes or Somewhat	Moderately Frequent or Moderately True	Often or Very true	Consistently or Completely true	
O	O	O	O	O	20. Staff members work well together.
O	O	O	O	O	21. Staff members have distinct roles that are both complementary and flexible. They act like a team and share responsibilities well
O	O	O	O	O	22. Staff members appear to enjoy each other.

COMMENTS:_____

_____

_____

F. STAFF-CHILD INTERACTIONS

1	2	3	4	5	
Never or not true	Sometimes or Somewhat	Moderately Frequent or Moderately True	Often or Very true	Consistently or Completely true	
O	O	O	O	O	23. Staff initiates conversations with children.
O	O	O	O	O	24. Staff addresses children at eye level and in a clear and understandable manner
O	O	O	O	O	25. Staff actively listens to children with attention.
O	O	O	O	O	26. Staff interactions with children are positive, without fussing or arguing
O	O	O	O	O	27. Staff interactions with children are affectionate and warm.
O	O	O	O	O	28. Staff does or says things to help children feel accepted and special.
O	O	O	O	O	29. Staff shows positive facial affect towards children
O	O	O	O	O	30. Staff is respectful of children.
O	O	O	O	O	31. Staff is fair to children. Staff does not repeatedly reprimand certain children for behaviors that others exhibit without comment.

COMMENTS:_____

_____

_____

G. TEACHING FEELINGS & PROBLEM-SOLVING

1	2	3	4	5	
Never or not true	Sometimes or Somewhat	Moderately Frequent or Moderately True	Often or Very true	Consistently or Completely true	
O	O	O	O	O	32. Staff capitalizes on opportunities to talk about feelings.
O	O	O	O	O	33. Staff helps children label their own feelings.
O	O	O	O	O	34. Staff helps children to express their feelings to others verbally, rather than by using physical means.
O	O	O	O	O	35. Staff actively encourages/facilitates positive interactions between children.
O	O	O	O	O	36. Staff uses a variety of positive methods (e.g., offering behavioral choices, encouraging good problem-solving skills, or modeling appropriate behaviors) to promote prosocial behaviors.
O	O	O	O	O	37. Staff actively promotes children's use of language to prevent/negotiate conflicts.
O	O	O	O	O	38. When conflicts arise, staff helps children devise their own solutions to peers conflicts. If no conflicts observed, do not score and check here. ❑
O	O	O	O	O	39. When conflicts arise, staff discusses with the children a variety of alternative solutions for their disagreements. If no conflicts observed, do not score and check here ❑

COMMENTS:_____

_____

_____

Early Childhood Consultation Evaluation

H. INDIVIDUALIZED & DEVELOPMENTALLY APPROPRIATE PEDAGOGY

1	2	3	4	5	
Never or not true	Sometimes or Somewhat	Moderately Frequent or Moderately True	Often or Very true	Consistently or Completely true	
O	O	O	O	O	40. Staff promotes learning through developmentally appropriate practices.
O	O	O	O	O	41. Staff seems to know each child's developmental strengths and needs and individualizes expectations and interactions accordingly
O	O	O	O	O	42. Staff provides children with individualized support.
O	O	O	O	O	43. Staff actively facilitates children's social development.
O	O	O	O	O	44. Staff actively supports children's play.
O	O	O	O	O	45. Activities are of an appropriate duration, pace, variability, and level of stimulation to maintain children's attention.

COMMENTS:_____

_____

I. CHILD INTERACTIONS

1	2	3	4	5	
Never or not true	Sometimes or Somewhat	Moderately Frequent or Moderately True	Often or Very true	Consistently or Completely true	
O	O	O	O	O	46. Children appear to be happy and well adjusted.
O	O	O	O	O	47. Children are involved, well behaved, cooperative, and attentive.
O	O	O	O	O	48. Children interact well with staff.
O	O	O	O	O	49. Children interact with peers in a way that shows mutual affiliation, concern, or affection.
O	O	O	O	O	50. Children appear to be developing independence, creativity, and adaptive coping skills.

COMMENTS:_____

_____

SECTION II: NEGATIVE INDICATORS

1	2	3	4	5	
Never or not true	Sometimes or Somewhat	Moderately Frequent or Moderately True	Often or Very true	Consistently or Completely true	
O	O	O	O	O	1. Staff does not help children to engage in productive play/activities.
O	O	O	O	O	2. Staff places unrealistic demands on children's attention span.
O	O	O	O	O	3. Staff imposes solutions on conflicts.
O	O	O	O	O	4. Staff shouts at children from across the room.
O	O	O	O	O	5. Staff threatens children with consequences.
O	O	O	O	O	6. Staff humiliates or frightens children.
O	O	O	O	O	7. Staff uses physical contact primarily as a means for controlling behavior.
O	O	O	O	O	8. Noise level in the classroom is too high.
O	O	O	O	O	9. Visual stimulation in the classroom is either too high or too low.

COMMENTS:_____

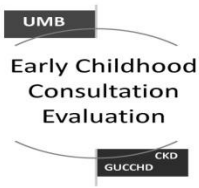
_____

PRESCHOOL MENTAL HEALTH CLIMATE SCALE
STANDARDIZATION VERSION 2.1

SCORING FORM (THIS IS OPTIONAL)

	Item Sum Scores		Number of Items		Scores
I. Positive Indicators					
A. Transitions	_____	÷	7	=	____. _____
B. Directions & Rules	_____	÷	6 (or 4)	=	____. _____
C. Staff Awareness	_____	÷	3	=	____. _____
D. Staff Affect	_____	÷	3	=	____. _____
E. Staff Cooperation	_____	÷	3	=	____. _____
F. Staff-Child Interactions	_____	÷	9	=	____. _____
G. Feelings & Problem-Solving	_____	÷	8 (or 6)	=	____. _____
H. Pedagogy	_____	÷	6	=	____. _____
I. Child Interactions	_____	÷	5	=	____. _____
Total Positive	_____	÷	Total # of Items ___	=	____. _____
II. Negative Indicators					
Total Negative	_____	÷	9	=	_____. _____

-- / -- / ----
Program ID/Consultant ID/Consultation ID



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PRESCHOOL MENTAL HEALTH CLIMATE SCALE
FOLLOW UP

Number of children in classroom _____. Number of staff present in classroom_____

Age range of children in group - youngest to oldest (in years/months) _____/_____ - _____/_____

Observation date 1 _____ Total time_____

Observation date 2 _____ Total time_____

Observation date 3 _____ Total time_____

Activities Observed (fill in the circle for every activity you observed):

O nap O meal O free choice

O circle time O arrival O outside

How long has it been since you worked in this classroom? _____years _____months

For how long have you worked with this teacher before (if more than one teacher select the one you have worked with the longest) _____years _____months

Are there child focused cases you are working on in this classroom at this time?

O yes O no

If yes, how many? _____

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http://medschool.umaryland.edu/innovations/ECMHC_evaluations.asp

Have there been any **significant** changes in this classroom? (check all that apply)

O New teachers O Change in Director _____

O Changes in ages or number of children O Other _____

O Change in program activities or curriculum

COMMENTS:_____

_____

_____

_____

_____

_____

Early Childhood Consultation Evaluation

INSTRUCTIONS

You should spend a minimum of three hours in the classroom observing a variety of activities including meal time, a few transitions and both structured and unstructured activities. Then rate the items by filling in the circle that best fits the statement, using the key provided below.

Rate the average score of the teachers/teaching staff in the room from the perspective of the children. For example, in question two if one staff often handles a transition in a planned manner and the other staff sometimes handles a transition in planned manner then the classroom as a whole would be rated as moderately handling a transition in a planned manner. Use the "comments" section to provide examples/clarification.

SCORING IS OPTIONAL as this form will be automatically scored; you may score and retain the last page for your own purposes.

SECTION I: POSITIVE INDICATORS

A. TRANSITIONS

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

COMMENTS: _____

_____

_____

Early Childhood Consultation Evaluation

B. DIRECTIONS & RULES

1	2	3	4	5	
Never or not true	Sometimes or Somewhat	Moderately Frequent or Moderately True	Often or Very true	Consistently or Completely true	
O	O	O	O	O	8. Staff encourages appropriate behavior.
O	O	O	O	O	9. Staff expresses clear directions and behavioral expectations and provides appropriate follow-through on instructions.
O	O	O	O	O	10. Staff consistently enforces classroom rules.
O	O	O	O	O	11. Rules, directions and expectations are developmentally appropriate.
O	O	O	O	O	12. Staff uses positive classroom management techniques to manage children's behaviors. If no challenging behaviors observed, do not score and check here ❑
O	O	O	O	O	13. Staff uses redirection appropriately to manage challenging behaviors. If no challenging behaviors observed, do not score and check here ❑

COMMENTS:_____

_____

C. STAFF AWARENESS

1	2	3	4	5	
Never or not true	Sometimes or Somewhat	Moderately Frequent or Moderately True	Often or Very true	Consistently or Completely true	
O	O	O	O	O	14. Staff is aware of potential behavioral challenges before they escalate, and staff intervenes appropriately.
O	O	O	O	O	15. Staff physically circulates around the room.
O	O	O	O	O	16. Staff appears constantly aware of the entire class, even when working with smaller groups or individual students. Staff is able to attend to many activities and tasks simultaneously and shift focus of attention at ease.

COMMENTS:_____

_____

D. STAFF AFFECT

1	2	3	4	5	
Never or not true	Sometimes or Somewhat	Moderately Frequent or Moderately True	Often or Very true	Consistently or Completely true	
O	O	O	O	O	17. Staff seems to enjoy their job.
O	O	O	O	O	18. Staff seems to be having fun, and appear to enjoy the children and/or teaching the children new skills.
O	O	O	O	O	19. Staff is active and energetic, not lethargic.

COMMENTS:_____

_____

_____

E. STAFF COOPERATION

If there is only one staff member, check here and skip to Section G ❑

1	2	3	4	5	
Never or not true	Sometimes or Somewhat	Moderately Frequent or Moderately True	Often or Very true	Consistently or Completely true	
O	O	O	O	O	20. Staff members work well together.
O	O	O	O	O	21. Staff members have distinct roles that are both complementary and flexible. They act like a team and share responsibilities well
O	O	O	O	O	22. Staff members appear to enjoy each other.

COMMENTS:_____

_____

_____

F. STAFF-CHILD INTERACTIONS

1	2	3	4	5	
Never or not true	Sometimes or Somewhat	Moderately Frequent or Moderately True	Often or Very true	Consistently or Completely true	
O	O	O	O	O	23. Staff initiates conversations with children.
O	O	O	O	O	24. Staff addresses children at eye level and in a clear and understandable manner
O	O	O	O	O	25. Staff actively listens to children with attention.
O	O	O	O	O	26. Staff interactions with children are positive, without fussing or arguing
O	O	O	O	O	27. Staff interactions with children are affectionate and warm.
O	O	O	O	O	28. Staff does or says things to help children feel accepted and special.
O	O	O	O	O	29. Staff shows positive facial affect towards children
O	O	O	O	O	30. Staff is respectful of children.
O	O	O	O	O	31. Staff is fair to children. Staff does not repeatedly reprimand certain children for behaviors that others exhibit without comment.

COMMENTS:_____

_____

_____

G. TEACHING FEELINGS & PROBLEM-SOLVING

1	2	3	4	5	
Never or not true	Sometimes or Somewhat	Moderately Frequent or Moderately True	Often or Very true	Consistently or Completely true	
O	O	O	O	O	32. Staff capitalizes on opportunities to talk about feelings.
O	O	O	O	O	33. Staff helps children label their own feelings.
O	O	O	O	O	34. Staff helps children to express their feelings to others verbally, rather than by using physical means.
O	O	O	O	O	35. Staff actively encourages/facilitates positive interactions between children.
O	O	O	O	O	36. Staff uses a variety of positive methods (e.g., offering behavioral choices, encouraging good problem-solving skills, or modeling appropriate behaviors) to promote prosocial behaviors.
O	O	O	O	O	37. Staff actively promotes children's use of language to prevent/negotiate conflicts.
O	O	O	O	O	38. When conflicts arise, staff helps children devise their own solutions to peers conflicts. If no conflicts observed, do not score and check here. ❑
O	O	O	O	O	39. When conflicts arise, staff discusses with the children a variety of alternative solutions for their disagreements. If no conflicts observed, do not score and check here ❑

COMMENTS:_____

_____

_____

Early Childhood Consultation Evaluation

H. INDIVIDUALIZED & DEVELOPMENTALLY APPROPRIATE PEDAGOGY

1	2	3	4	5	
Never or not true	Sometimes or Somewhat	Moderately Frequent or Moderately True	Often or Very true	Consistently or Completely true	
O	O	O	O	O	40. Staff promotes learning through developmentally appropriate practices.
O	O	O	O	O	41. Staff seems to know each child's developmental strengths and needs and individualizes expectations and interactions accordingly
O	O	O	O	O	42. Staff provides children with individualized support.
O	O	O	O	O	43. Staff actively facilitates children's social development.
O	O	O	O	O	44. Staff actively supports children's play.
O	O	O	O	O	45. Activities are of an appropriate duration, pace, variability, and level of stimulation to maintain children's attention.

COMMENTS:_____

_____

I. CHILD INTERACTIONS

1	2	3	4	5	
Never or not true	Sometimes or Somewhat	Moderately Frequent or Moderately True	Often or Very true	Consistently or Completely true	
O	O	O	O	O	46. Children appear to be happy and well adjusted.
O	O	O	O	O	47. Children are involved, well behaved, cooperative, and attentive.
O	O	O	O	O	48. Children interact well with staff.
O	O	O	O	O	49. Children interact with peers in a way that shows mutual affiliation, concern, or affection.
O	O	O	O	O	50. Children appear to be developing independence, creativity, and adaptive coping skills.

COMMENTS:_____

_____

SECTION II: NEGATIVE INDICATORS

1	2	3	4	5	
Never or not true	Sometimes or Somewhat	Moderately Frequent or Moderately True	Often or Very true	Consistently or Completely true	
O	O	O	O	O	1. Staff does not help children to engage in productive play/activities.
O	O	O	O	O	2. Staff places unrealistic demands on children's attention span.
O	O	O	O	O	3. Staff imposes solutions on conflicts.
O	O	O	O	O	4. Staff shouts at children from across the room.
O	O	O	O	O	5. Staff threatens children with consequences.
O	O	O	O	O	6. Staff humiliates or frightens children.
O	O	O	O	O	7. Staff uses physical contact primarily as a means for controlling behavior.
O	O	O	O	O	8. Noise level in the classroom is too high.
O	O	O	O	O	9. Visual stimulation in the classroom is either too high or too low.

COMMENTS:_____

_____

PRESCHOOL MENTAL HEALTH CLIMATE SCALE
STANDARDIZATION VERSION 2.1

SCORING FORM (THIS IS OPTIONAL)

	Item Sum Scores		Number of Items		Scores
I. Positive Indicators					
A. Transitions	_____	÷	7	=	____. _____
B. Directions & Rules	_____	÷	6 (or 4)	=	____. _____
C. Staff Awareness	_____	÷	3	=	____. _____
D. Staff Affect	_____	÷	3	=	____. _____
E. Staff Cooperation	_____	÷	3	=	____. _____
F. Staff-Child Interactions	_____	÷	9	=	____. _____
G. Feelings & Problem-Solving	_____	÷	8 (or 6)	=	____. _____
H. Pedagogy	_____	÷	6	=	____. _____
I. Child Interactions	_____	÷	5	=	____. _____
Total Positive	_____	÷	Total # of Items ___	=	____. _____
II. Negative Indicators					
Total Negative	_____	÷	9	=	_____. _____

Draft Interview Protocol for Exit Interview-ECE Provider

Verbal Script

First, note any available information.

Hello, I'm _____ from the University of Maryland/Georgetown University, and I'm calling to thank you for consenting to participate in our early childhood consultation study. We are conducting interviews with providers who have had a child exit their program.

Would now be a good time to talk? The interview should take less than 30 minutes.

If no: When would be a better time?

(Set specific time _____ date_____ back up phone number _____)

If yes:
Great! These interviews will help us understand how early childhood education consultants can assist childhood professionals to work with young children and families. We would like to hear more about your experience as a child care provider/teacher. Ultimately, we will use this information to design strategies to improve child outcomes and school readiness, beginning in early childhood.

First we'd like to get/confirm some basic information about you and the child you were working with.

Demographic Data:

Name of provider
Years of experience
Education/degree *(if high school, # of years; subject area if relevant)*
Race/ethnicity of provider
Name of child care program
Name of child care director

Child's initials/subject ID
Name of primary caregiver *(if known)*
Child's age
Child's gender
Child's race/ethnicity

Do you know if the child has an IFSP, IEP, or diagnosed disability?
If so, what was it?
Do you know if the child has a diagnosed mental/behavioral health issue?
If so, what was it?
Was the consultant working with this specific child?
Beginning Date of classroom consultation *(if applicable)*
Beginning date of child-initiated consultation *(if applicable)*

Date of exit

Directions: Use open-ended initial questions and follow-up on additional details/information as necessary.

1. When did you first become concerned about the child?
    a. Why?
    b. Did you share your concern with anyone?
        a. If yes, with whom? Did you feel your concerns were addressed?
    c. Did you ask for help with the child from anyone?
        a. If yes, from whom, and what help was provided?
2. What strategies did you use to try to reduce problem behavior?
        a. Were any effective?
        b. Where did you hear about or learn those strategies?
        c. Did you get support in implementing them?
3. When you referred this child for extra help, did you think he/she would have to leave the program?
    a. Why or why not?
    b. Did you think there was anything you could have done to prevent the child from having to leave/leaving the program?

4. Did you understand why the child was having trouble managing his/her behavior?
    a. What do you think was going on?
    b. How much contact did you have with the child's family?
5. Do you feel you got enough support and help from *[the early childhood consultant]* in ways that were sensitive to you, your culture, and the child care context?
6. Did you feel you were able to meet the needs of the children and family in a way that was sensitive to their culture?

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ECE Provider-Initial

Thank you for reviewing the Early Childhood Consultation Evaluation materials. This envelope contains a consent form and four other forms. **Please** read through the Consent Form first. If you would like to participate please sign your name on the last page, place all the forms back in your envelope, seal it and either mail it or return it to your Consultant.

Please send back the following:

- ☐ Consent Form to indicate if you would like to participate in the evaluation
- ☐ Brief Intake Form
- ☐ Strengths and Difficulties Questionnaire
- ☐ Teacher Opinion Survey
- ☐ Job Stress Index

You will receive 1 Professional Activity Unit awarded by MSDE for participation in consultation and completion of baseline and follow up packet instruments.

If you choose not to participate, do not sign the consent form, but please return all forms in a sealed envelope back to your consultant or by mail.

If you have any questions at any time please contact our evaluation coordinator, Sarah James at 1-877-413-0002 or by email at sjames@psych.umaryland.edu.

Thank you for your time,

The Evaluation Team

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ECE Provider-Follow Up

Thank you again for your participation in the Early Childhood Consultation Evaluation. As indicated in the consent form we are contacting you regarding the four month follow up. If you would still like to participate, please complete the remainder of the forms, place them in a sealed envelope and either mail them or return them in the sealed envelope to your Consultant.

Please send back the following:

- ☐ Strengths and Difficulties Questionnaire
- ☐ Teacher Opinion Survey
- ☐ Relationship Quality Scale-Provider
- ☐ Job Stress Index

You will receive 1 Professional Activity Unit awarded by MSDE for participation in consultation and completion of baseline and follow up packet instruments.

If you choose not to participate, please place all the blank forms back in your envelope, seal it and either mail it or return it to your Consultant.

If you have any questions at any time please contact our project coordinator, Sarah James at 1-877-413-0002 or by email at sjames@psych.umaryland.edu.

Thank you for your time,

The Evaluation Team

UMB
Early Childhood Consultation Evaluation
CKD GUCCHD

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Provider Job Stress Index

Today's Date: ____/____/____

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

Item	Very Much	Much	Moderate	Little	Very Little
1. The availability of supplies that you need.	O	O	O	O	O
2. Getting parents to be consistent with you in how to deal with the child.	O	O	O	O	O
3. Getting the parents to work with you on a behavior problem.	O	O	O	O	O
4. The number of children you care for.	O	O	O	O	O
5. When the parents pick up their children.	O	O	O	O	O

Rating (Fill in bubble)

How OFTEN do the following things happen at work?

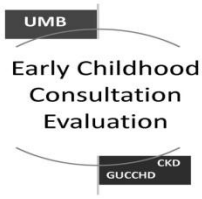
Item	Most of the Time	Usually	Often	Occasionally	Rarely/ Never
6. Parents blame their children's bad behavior on day care.	O	O	O	O	O
7. I get praise from the parents for the work that I do.	O	O	O	O	O
8. Children have behavior problems that are hard to deal with.	O	O	O	O	O
9. I feel respected for the work that I do.	O	O	O	O	O

Rating (Fill in bubble)

Barbara Curbow

737 West Lombard Street, 4th floor • Baltimore, Maryland 21201 • 1-877-413-0002 • 410 706 0998 *fax* •
http://medschool.umaryland.edu/innovations/ECMHC_evaluations.asp

10. Parents bring in children who are sick.	O	O	O	O	O
11. I feel the satisfaction of knowing I am helping the parents.	O	O	O	O	O
12. Parents expect me to care for their children when they have a day off.	O	O	O	O	O
13. I see that my work is making a difference with a child.	O	O	O	O	O
14. Parents don't let me know where they are during the day.	O	O	O	O	O
15. I feel like I am helping the children grow and develop.	O	O	O	O	O
16. I feel like I have to be a parent and a teacher to the children.	O	O	O	O	O
17. All of the children need attention at the same time.	O	O	O	O	O



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Program ID/Consultant ID/Consultation ID i

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PSI Short Form

Today's Date: ____/____/____

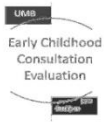
Instructions: This questionnaire contains 36 statements. For each statement, please focus on your child receiving consultation, and fill in the bubble response that best represents your opinion.

Mark or say **SA** if you **strongly agree** with the statement.
Mark or say **A** if you **agree** with the statement.
Mark or say **NS** if you are **not sure**.
Mark or say **D** if you **disagree** with the statement.
Mark or say **SD** if you **strongly disagree** with the statement.

While you may not find a response that exactly states your feelings, please choose a response that comes closest to describing how you feel. YOUR FIRST REACTION TO EACH QUESTION SHOULD BE YOUR ANSWER.

Pick only one response for each statement and try to respond to each statement.

		SA	A	NS	D	SD
1.	I often have the feeling that I cannot handle things very well.	O	O	O	O	O
2.	I find myself giving up more of my life to meet my children's needs that I ever expected.	O	O	O	O	O
3.	I feel trapped by my responsibilities as a parent.	O	O	O	O	O
4.	Since having this child, I have been unable to do new and different things.	O	O	O	O	O
5.	Since having a child, I feel that I am almost never able to do things that I like to do.	O	O	O	O	O
6.	I am unhappy with the last purchase of clothing I made for myself.	O	O	O	O	O
7.	There are quite a few things that bother me about my life.	O	O	O	O	O



		SA	A	NS	D	SD
8.	Having a child has caused more problems that I expected in my relationship with my spouse (male/female friend).	O	O	O	O	O
9.	I feel alone and without friends.	O	O	O	O	O
10.	When I go to a party, I usually expect not to enjoy myself.	O	O	O	O	O
11.	I am not as interested in people as I used to be.	O	O	O	O	O
12.	I don't enjoy things as I used to.	O	O	O	O	O
13.	My child rarely does things for me that make me feel good.	O	O	O	O	O
14.	My child smiles at me much less than I expected.	O	O	O	O	O
15.	When I do things for my child, I get the feeling that my efforts are not appreciated very much.	O	O	O	O	O
16.	When playing, my child doesn't often giggle or laugh.	O	O	O	O	O
17.	My child doesn't seem to learn as quickly as most children	O	O	O	O	O
18.	My child doesn't seem to smile as much as most children.	O	O	O	O	O
19.	My child is not able to do as much as I expected.	O	O	O	O	O
20.	It takes a long time and it is very hard for my child to get used to new things.	O	O	O	O	O
21.	For the next statement, choose your response from the choices below I feel that I am: O not very good at being a parent O a person who has some trouble being a parent O an average parent O a better than average parent					
22.	I expected to have closer and warmer feelings for my child than I do and this bothers me.	O	O	O	O	O
23.	Sometimes my child does things that bother me just to be mean.	O	O	O	O	O
24.	My child seems to cry or fuss more often than most children.	O	O	O	O	O
25.	My child generally wakes up in a bad mood.	O	O	O	O	O
26.	I feel that my child is very moody and easily upset.	O	O	O	O	O
27.	My child does a few things which bother me a great deal.	O	O	O	O	O
28.	My child reacts very strongly when something happens that my child doesn't like.	O	O	O	O	O
29.	My child gets upset easily over the smallest thing.	O	O	O	O	O
30.	My child's sleeping or eating schedule was much harder to establish than I expected.	O	O	O	O	O

31. I have found that getting my child to do something or stop doing something is:

- O much harder than I expected
- O about as hard as I expected
- O somewhat easier than I expected
- O much easier than I expected

32. For the next statement choose your response from the choices "10+" to "1-3"
Think carefully and count the number of things which your child does that bother you. For example: dawdles, refuses to listen, overactive, cries, interrupts, fights, whines, etc.

- O 10+
- O 8-9
- O 6-7
- O 4-5
- O 1-3

	SA	A	NS	D	SD
33. There are some things my child does that really bother me a lot.	O	O	O	O	O
34. My child turned out to be more of a problem than I had expected.	O	O	O	O	O
35. My child makes more demands on me than most children.	O	O	O	O	O

Early Childhood Consultation Evaluation

The Evaluation Team would like to remind you that we will be sending you a packet of instruments to complete. Once you have returned your packet you will be entered into a lottery with a chance to win $50.

Your continued participation will help us improve services for young children in childcare.

Thank you very much!

Innovations Institute
University of Maryland, Baltimore
For questions, contact:
Sarah James, Research Coordinator
Toll Free Number: 1-877-413-0002
Dr. Stephan, Principal Investigator
Telephone: 410-706-0941
Protocol Number: HP-00041306

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Program ID/Consultant ID/Consultation ID

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Relationship Quality Scale-Parent/Caregiver

Your Name: _____

Child's Name: _____

Consultant's Name: _____

Date: ____/____/____

The following information is being collected to assess and to improve services provided to Child Care Programs/Early Care and Education Programs. Please answer as candidly as possible; your responses will be treated confidentially. Please answer all questions, even if your contact with the consultant has been very limited.

Thank you in advance for you cooperation.

Experience with Consultant: In reference to your recently completed consultation experience, please indicate the extent to which you agree or disagree with each of the statements numbered 1 through 12 by filling in the appropriate bubble:

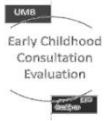
Item	Strongly Disagree	Disagree	Neither Disagree Nor Agree	Agree	Strongly Agree
1. The consultant was generally helpful.	O	O	O	O	O
2. The consultant offered useful information.	O	O	O	O	O
3. The consultant's ideas as to the primary goals of my child's provider were similar to my own ideas.	O	O	O	O	O
4. The consultant helped me find alternative solutions to problems.	O	O	O	O	O
5. The consultant was a good listener.	O	O	O	O	O
6. The consultant helped me identify useful resources.	O	O	O	O	O
7. The consultant fit well into my child's provider environment.	O	O	O	O	O
8. The consultant encouraged me to consider a number of points of view.	O	O	O	O	O
9. The consultant viewed his or her role as a collaborator rather than an expert.	O	O	O	O	O
10. The consultant helped me find ways to apply the content of our discussions to specific situations.	O	O	O	O	O
11. The consultant was able to offer assistance without completely "taking over" the management of problems.	O	O	O	O	O
12. I would request services from this consultant again, assuming that other consultants were available.	O	O	O	O	O

Revised 4/6/09 adapted with permission from Dr. Sue Sheridan
Erchul, W.P. (1987). A relational communication analysis of control in school consultation. Professional School Psychology, 2, 113-124.

Experience with Teacher/Child Care Provider: The next set of statements concern your experiences with your child's teacher/child care provider. Please read each item below and rate how much you agree or disagree with each statement.

Item	Strongly Disagree	Disagree	Neither Disagree Nor Agree	Agree	Strongly Agree
13. We trust each other.	O	O	O	O	O
14. It is difficult for us to work together.	O	O	O	O	O
15. We cooperate with each other.	O	O	O	O	O
16. Communication is difficult for us.	O	O	O	O	O
17. I respect him/her.	O	O	O	O	O
18. S/he respects me.	O	O	O	O	O
19. We are sensitive to each other's feelings.	O	O	O	O	O
20. We have different views of right and wrong.	O	O	O	O	O
21. When there is a problem with my child, s/he is all talk and no action.	O	O	O	O	O
23. S/he keeps her/his promises to me.	O	O	O	O	O
24. When there is a problem, I have to solve it without getting help from her/him.	O	O	O	O	O
25. When things aren't going well it takes too long to work them out.	O	O	O	O	O
26. We understand each other.	O	O	O	O	O
27. We see my child differently.	O	O	O	O	O
28. We agree about who should do what regarding my child.	O	O	O	O	O
29. I expect more from him/her than I get.	O	O	O	O	O
30. We have similar expectations of my child.	O	O	O	O	O
31. S/he tells me when s/he is pleased.	O	O	O	O	O
32. I don't like the way s/he talks to me.	O	O	O	O	O
33. I tell him/her when I am pleased.	O	O	O	O	O
34. I tell him/her when I am concerned.	O	O	O	O	O
35. I tell him/her when I am worried.	O	O	O	O	O
36. I ask his/her opinion about my child's progress.	O	O	O	O	O
37. I ask him/her for suggestions.	O	O	O	O	O

Revised 4/6/09 adapted with permission from Dr. Sue Sheridan
Erchul, W.P. (1987). A relational communication analysis of control in school consultation. Professional School Psychology, 2, 113-124.



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Program ID/Consultant ID/Consultation ID

Strengths and Difficulties Teacher Form

INSTRUCTIONS: Think about each child in your class. Please rate whether he/she has difficulties in one or more of the following areas: emotions, concentration, behavior or being able to get along with other people. For any child that has some difficulties please complete four more questions on the following pages.

Today's Date:_____

	No	Yes-Minor difficulties	Yes-definite difficulties	Yes-severe difficulties
Child 1	O	O	O	O
Child 2	O	O	O	O
Child 3	O	O	O	O
Child 4	O	O	O	O
Child 5	O	O	O	O
Child 6	O	O	O	O
Child 7	O	O	O	O
Child 8	O	O	O	O
Child 9	O	O	O	O

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	No	Yes-Minor difficulties	Yes-definite difficulties	Yes-severe difficulties
Child 10	O	O	O	O
Child 11	O	O	O	O
Child 12	O	O	O	O
Child 13	O	O	O	O
Child 14	O	O	O	O
Child 15	O	O	O	O
Child 16	O	O	O	O
Child 17	O	O	O	O
Child 18	O	O	O	O
Child 19	O	O	O	O
Child 20	O	O	O	O

Goodman, 2002

If you have answered "Yes", for a child, please answer the following questions about these difficulties:

1. **How long have these difficulties been present?**

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

2. **Do the difficulties upset or distress the child?**

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

3. **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	O	O	O	O
LEARNING	O	O	O	O

4. **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
O	O	O	O

If you have answered "Yes" FOR ANOTHER CHILD, please answer the following questions about these difficulties:

1. **How long have these difficulties been present?**

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

2. **Do the difficulties upset or distress the child?**

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

3. **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	O	O	O	O
LEARNING	O	O	O	O

4. **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
O	O	O	O

Goodman, 2002

If you have answered "Yes" FOR ANOTHER CHILD, please answer the following questions about these difficulties:

1. **How long have these difficulties been present?**

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

2. **Do the difficulties upset or distress the child?**

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

3. **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	O	O	O	O
LEARNING	O	O	O	O

4. **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
O	O	O	O

If you have answered "Yes" FOR ANOTHER CHILD, please answer the following questions about these difficulties:

1. **How long have these difficulties been present?**

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

2. **Do the difficulties upset or distress the child?**

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

3. **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	O	O	O	O
LEARNING	O	O	O	O

4. **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
O	O	O	O

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Program ID/Consultant ID/Consultation ID

If you have answered "Yes" FOR ANOTHER CHILD, please answer the following questions about these difficulties:

1. **How long have these difficulties been present?**

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

2. **Do the difficulties upset or distress the child?**

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

3. **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	O	O	O	O
LEARNING	O	O	O	O

4. **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
O	O	O	O

If you have answered "Yes" FOR ANOTHER CHILD, please answer the following questions about these difficulties:

1. **How long have these difficulties been present?**

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

2. **Do the difficulties upset or distress the child?**

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

3. **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	O	O	O	O
LEARNING	O	O	O	O

4. **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
O	O	O	O

Goodman, 2002

If you have answered "Yes" FOR ANOTHER CHILD, please answer the following questions about these difficulties:

1. **How long have these difficulties been present?**

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

2. **Do the difficulties upset or distress the child?**

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

3. **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	O	O	O	O
LEARNING	O	O	O	O

4. **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
O	O	O	O

If you have answered "Yes" FOR ANOTHER CHILD, please answer the following questions about these difficulties:

1. **How long have these difficulties been present?**

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

2. **Do the difficulties upset or distress the child?**

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

3. **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	O	O	O	O
LEARNING	O	O	O	O

4. **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
O	O	O	O

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If you have answered "Yes" FOR ANOTHER CHILD, please answer the following questions about these difficulties:

1. **How long have these difficulties been present?**

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

2. **Do the difficulties upset or distress the child?**

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

3. **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	O	O	O	O
LEARNING	O	O	O	O

4. **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
O	O	O	O

If you have answered "Yes" FOR ANOTHER CHILD, please answer the following questions about these difficulties:

1. **How long have these difficulties been present?**

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

2. **Do the difficulties upset or distress the child?**

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

3. **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	O	O	O	O
LEARNING	O	O	O	O

4. **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
O	O	O	O

Goodman, 2002

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Program ID/Consultant ID/Consultation ID

TEACHER OPINION SURVEY

Today's Date: ____/____/____

Name of ECE Provider_____

Age Range of children in the classroom _____ years _____ months to _____ years _____ months

Have you worked with this consultant before? O yes O no

If yes, for how long did you work with this consultant? _____ years _____ months

For the following questions, think of yourself in your role as a preschool teacher. Please rate the extent to which you agree or disagree with the statements that follow. **FILL IN ONE CIRCLE PER ITEM.**

ITEM	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. If I keep trying, I can find some way to reach even the most challenging child.	O	O	O	O	O
2. I can help my preschool children learn skills that they need to cope with adversity in their lives.	O	O	O	O	O
3. There are some children in my classroom that I simply cannot have any influence on.	O	O	O	O	O
4. If some children in my class are not doing as - well as others, I believe that I should change my way of working with them.	O	O	O	O	O
5. As a preschool teacher, I can't really do much, because the way a child develops depends mostly on what goes on at home.	O	O	O	O	O
6. I can help children develop skills to make successful choices later in life.	O	O	O	O	O
7. I feel a sense of hopelessness about the future of the children I work with.	O	O	O	O	O
8. I can imagine myself teaching preschool for several more years.	O	O	O	O	O
9. If a student in my class became disruptive and noisy, I feel pretty sure that I'd know how to respond effectively.	O	O	O	O	O
10. I frequently feel overwhelmed by my job.	O	O	O	O	O
11. I have enough training to deal with almost any classroom situation.	O	O	O	O	O
12. On a typical day, I feel a sense of accomplishment as a preschool teacher.	O	O	O	O	O

Gellar, S. & Lynch, K. (2000). /Teacher Opinion Survey Revised/. Richmond: Virginia Commonwealth University Intellectual Property Foundation and Wingspan, LLC.
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http://medschool.umaryland.edu/innovations/ECMHC_evaluations.asp