

Smart Support

Arizona's Early Childhood Mental Health Consultation System

Year 1 Evaluation Report 2010-2011



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Table of Contents

Acknowledgements
Summary of Findings
Introduction
Evaluation Design / Methods
Participants' Background Characteristics
Findings: Key Elements of Smart Support Consultation
Findings: Growth on Key Outcomes of Smart Support
Findings: Associations with Growth on Key Outcomes
Findings: Participant Feedback
Discussion / Highlighted Findings
Implications for Practice and Policy
Conclusion
References
Appendices

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Year 1: Summary of First Findings

OVERVIEW

Smart Support, Arizona's early childhood mental health consultation system came about through FTF's commitment to the success of Arizona's youngest citizens. And that commitment has been rewarded! Analyses of the first year's data indicate that after 6 months of mental health consultation services, preschool teachers and child care providers report greater confidence in their abilities and a deeper understanding of children's social-emotional development. They also conduct their classrooms with significantly greater emotional sensitivity overall than before receiving consultation. These impressive beginnings support mental health consultation as an effective strategy with child care teachers in Arizona as they work to support children's social and emotional development.

OUTCOMES

The number of participants in Smart Support's services from April 2010-May 2011 include:

- 199 child care centers,
- 14 licensed family child care providers, and
- 305 teachers.

Given that positive change reverberates throughout a system, it is estimated that 9,007 children have been impacted so far by Smart Support consultation services. Smart Support provided intensive weekly services by highly qualified, masters-level consultants. Most visits to child care centers lasted 2 hours. Participants demonstrated statistically significant improvements on the following key outcomes:

- **Teacher's perceptions**- teacher's perceptions of the risk of expulsion for children with challenging behaviors decreased
- **Classroom emotional climate** –teachers increased their capacity to stay emotionally connected even in the presence of strong negative emotions from children and paid more attention to children's emotions overall
- **Staff interaction and cooperation** – teachers were more supportive of each other and more aligned in managing classroom activities, sharing responsibilities
- **Teachers' "self efficacy"** - more confidence in their ability to respond to children and deal effectively with conflicts
- **Teacher-child relationships** - closeness increased and conflict decreased
- **Knowledge of social-emotional development** - A high percentage of teachers reported gains in their general understanding of teaching strategies that meet the social and emotional needs of children in their care.

These preliminary findings are important because they support the national research that demonstrates a link between children's social and emotional development and school readiness (Bowman, Donovan, and Burns, 2000).

First Things First Funded Regions

North Phoenix
South Phoenix
Central Phoenix
NE Maricopa
NW Maricopa
SE Maricopa
Central Maricopa
Pinal
North Pima
Central Pima
Gila
Yuma
Yavapai
Funding Professional
Development
only
Mohave/ La Paz*

*Data not tracked.

PROGRAM DESCRIPTION

The administrative home for Smart Support is Southwest Human Development, which subcontracts with 5 other agencies throughout the state to help recruit and supervise mental health consultants. These agencies included: Easter Seals Blake Foundation, Prevent Child Abuse Arizona, Child and Family Resources, Scottsdale Healthcare, and Scottsdale Unified School District.

Introduction

Background

A large body of research has shown that high quality early care and education experiences help to prepare children for school and provide them with the social and emotional skills required to be successful (e.g., Hamre & Pianta, 2003; Lamb, 1998; Mashburn et al., 2008; NICHD ECCRN, 2005a). As time passes, these same children who have quality early experiences are also more likely to experience positive outcomes, such as graduating from high school, compared to children who have poor quality experiences in their early care and education settings (Schweinhart et al., 2005). Furthermore, high quality early education and intervention programs may prevent early behavior problems in preschoolers from low-income families (Reynolds, Temple, Robertson, & Mann 2001; Zigler, Taussig, & Black, 1992).

When young children are having emotional and behavior problems in their child care settings, having a quality experience becomes more difficult. Brauner and Stephens (2006) estimated that between 9-14% of children under age six experience emotional and behavioral problems. This number is higher for children from low-income families or with depressed mothers (Feder, et al., 2009). Severe behavior problems during the preschool years are linked to continued behavior problems, poor peer standing and academic difficulties when children reach Kindergarten (Howes, Calkins, Anastopoulos, Keane, & Shelton, 2003; Keane & Calkins, 2004). Later on, early behavior problems are associated with adolescent delinquency, school drop out and adult incarceration (Broidin et al., 2003; Brame, Nagin, & Tremblay, 2001; Dodge, 2003; Moffitt, et al., 1996).

One effective and evidence based strategy for promoting social and emotional competency and addressing behavior problems is Early Childhood Mental Health Consultation (ECMHC) (Brennan, Bradley, Allen, & Perry, 2008). In young children, mental health refers to emotional well-being and positive social development (See side-bar) (Zeanah, 2009; Zero to Three, 2001). Unfortunately, when young children experience mental health problems they are likely to miss out on important learning experiences. In fact, many children are actually being expelled from their early care and education settings as a result of their behavior problems (Gilliam, 2005; Perry, Dunne, McFadden, & Campbell, 2008).

Defining Infant and Early Childhood Mental Health

The young child's capacity to experience, regulate, and express emotions, form close and secure relationships, and explore the environment and learn.

All of these capacities will be best accomplished within the context of the caregiving environment that includes family, community, and cultural expectations for young children. Developing these capacities is synonymous with healthy social and emotional development.

~ Zero to Three Infant Mental Health Steering Committee (2001)

The first national data on the rates of expulsion from preschool underscored the widespread nature of this trend: on average, young children were being expelled from state-funded pre-kindergarten programs at three times the rate of their peers in K-12 (Gilliam, 2005). Access to mental health consultation was found to be associated with lower rates of expulsion. Programs that reported on-site access to a psychologist or social worker expelled 5.7 children per 1,000; occasional access to a mental health consultant was associated with a somewhat higher expulsion rate; and the programs that lacked access to mental health consultation expelled children at the highest rates (10.8 per 1,000). Many states are making an investment in ECMHC in an effort to decrease negative outcomes, such as preschool expulsion (Duran et al., 2009; Brennan et al., 2008; Gilliam & Shahar, 2006).

A growing body of evidence suggests that ECMHC has a positive impact on program, staff and child outcomes. For example, Raver and colleagues (2008) reported improvements in teacher sensitivity and classroom climate, enhanced classroom management skills, more positive interactions between teachers and children, and fewer negative exchanges. Teachers have also reported lower levels of job stress after they receive consultation services (Green et al., 2006; Langkamp, 2003; Olmos & Grimmer, 2004; Grining et al., 2010). More specific child outcomes include a decrease in aggressive and disruptive behavior after consultation (Gilliam, 2007; Raver et al., 2008; Williford & Shelton, 2008), improvements in children with internalizing and withdrawn behavior (Bleecker, Sherwood, & Chan-Sew, 2005; Raver et al., 2008), and accelerated positive social skill development (Bleecker & Sherwood, 2003; 2004; Farmer-Dougan, Viechtbauer, & French, 1999; Upshuret et al., 2008).

Early Childhood Mental Health Consultation (ECMHC) aims to build the capacity (and improve the ability) of staff, families, programs, and systems to prevent, identify, treat and reduce the impact of mental health problems among children from birth to age six and their families (Cohen & Kaufmann, 2000). It involves the collaborative relationship between a professional consultant who has mental health expertise and a child care professional. By its very definition, it is a service provided to the child care provider – not a therapeutic service delivered directly to the child or family (Brennan et al., 2008). In program-focused mental health consultation the intent is to improve the overall emotional climate of the classroom environment in order to meet the needs and promote the healthy development of each child in the classroom. In child-focused consultation the consultants use strategies that focus on a particular child with challenging behavior (Cohen & Kaufmann, 2000). In Smart Support a mixed model approach is used. That is, child care providers identify a particular child with challenging behavior and consultants work with teachers to support the identified child while simultaneously also working to improve the overall emotional climate to enhance and promote healthy development for each child in that classroom.

Evaluation Rationale

While there is impressive evidence of the effectiveness of child care mental health consultation, researchers underscore the need for more focused and diligent design and evaluation of child care mental health consultation (Brennan et al., 2008). These evaluation efforts can help address gaps in the knowledge base as well as link both shorter-term outcomes achieved through mental health consultation to longitudinal data and school readiness skills and expectations. To date there is still a need for studies that demonstrate the effectiveness of this promising intervention strategy. In addition, other gaps in the literature for which there is little consensus include:

- The essential components of mental health consultation;
 - The skills, competencies and credentials of effective consultants;
 - How consultants should get training and what kinds of ongoing supervisory and staff development support are needed;
 - The level of intensity of the intervention (i.e., frequency and duration) that is needed to effect change in outcomes; and
 - Which outcomes should be targeted and how these should be measured
- (Hepburn, Kaufmann, Perry, Allen, Brennan, & Green, 2007).

Our goal for this study was to pilot an evaluation that would attempt to meet several objectives: 1) inform the program's ongoing design and implementation; 2) add to the field of literature on effective strategies for early childhood mental health consultation; and 3) provide findings that could guide Arizona and other states' efforts to build a comprehensive system of quality enhancement initiatives for the entire continuum of child care providers.



Description of the Smart Support Program

The Smart Support Program officially launched its services to early care and education programs in April 2010. The Smart Support Program receives its funding from Arizona's early childhood development and health system – First Things First. The agency serving as the administrative home for Smart Support is Southwest Human Development. The administrative home is responsible for developing the logic model and program design, establishing a registry for trained mental health consultants, establishing and updating professional standards and scope of work, supporting a relationship-based supervision model which models consultants' reflective practice, maintaining a database, and setting standards for ongoing training and continuing education.

In addition to hiring, supervising and training its own mental health consultants, the administrative home also sub-contracts with other agencies throughout the state to help recruit and supervise mental health consultants. These agencies include:

- Easter Seals Blake Foundation
- Prevent Child Abuse Arizona
- Child and Family Resources
- Scottsdale Healthcare
- Scottsdale Unified School District

In 2010-2011, thirteen (13) First Things First Regional Partnership Councils provided funding for the Smart Support Program in their regions. The First Things First regions that dedicated money for early childhood mental health consultation in 2010-2011 included:

First Things First Funded Regions		
North Phoenix	Central Maricopa	Yavapai
South Phoenix	Pinal	<u>Funding Professional Development only :</u>
Central Phoenix	North Pima	Mohave/ La Paz*
NE Maricopa	Central Pima	
NW Maricopa	Gila	
SE Maricopa	Yuma	* Year 1 Outcomes not tracked

Smart Support's mission is to provide quality mental health consultation to early care and education providers keeping two main goals in mind. The first is to improve the overall quality of early care and education settings so that they are able to help support the social and emotional development of all children in their care. The second goal is to increase the capacity of early care providers to address the mental health needs and challenging behaviors that place particular children at risk for negative outcomes in the early years of life.

In the inaugural year of the Smart Support Program, which spanned from April 15, 2010 to April 30, 2011, 199 child care centers, 14 licensed family child care providers, 305 teachers, and we estimate that 9007 children have been impacted by Smart Support's services.

Smart Support Mental Health Consultants

Smart Support's services are provided by master's level professionals possessing an advanced degree in a mental health discipline, early education, or early childhood special education. Smart Support consultants also have experience working directly with young children and their caregivers. The role of a Smart Support mental health consultant differs from that of a therapist. As a consultant, the mental health practitioner seeks to build the skills and capacity of another adult, rather than trying to directly change an individual child's behavior or symptoms. Additionally, mental health consultants must also possess the knowledge that will help them watch and wonder with the teachers about specific challenges that fall under these categories:

- Normal growth and development (with a specific focus on attachment relationships)
- Atypical behavior
- Social-emotional development (with emphasis on emotional and self-regulation)
- Early childhood trauma
- Child development milestones
- Family systems
- Early childhood education and child care
- Dynamics of children in groups
- Medical and genetics (transactional model)
- Family support and early intervention systems
- Adult learning principles

In order to maintain a highly qualified staff of mental health consultants, ongoing professional development is a cornerstone of the Smart Support Program. To that end, weekly reflective supervision is required for all Smart Support consultants. Weekly supervision provides mental health consultants an opportunity to engage in thoughtful consideration of their work (Heffron & Murch, 2010; Scott Heller & Gilkerson, 2009). In addition, consultants meet every month for group supervision where administrative and clinical topics are discussed and supported. Additional components of consultants' professional development for the year 2010-2011 included:

Required training for all Smart Support consultants – available throughout the year

- Extensive orientation
- Book Clubs (monthly book club on professional books related to consultation, attachment theory; trauma in young children and self-regulation)
- General principles of early childhood mental health consultation
- Teaching Pyramid Model – Center for Social and Emotional Foundations of Early Learning (CSEFEL)
- Normative attachment formation
- Attachment disturbances and disorders
- Development of self-regulation
- The impact of early trauma
- Special professional development opportunities with nationally renowned presenters
- Mental health consultation in child care: Lessons learned (Kadija Johnston)
- Emotional Availability Scales training (Dr. Zeynep Biringen)
- Mood disorders and depression in young children (Dr. Joan Luby)
- Attendance at Zero to Three's National Training Institute (Phoenix, AZ)

Smart Support has developed a training schedule that repeated itself over the year so that new employees could enter the training cycle at any point and acquire all of the required trainings within approximately 12 months. Based on what was learned from the initial year of the program, refinements will continue to be made to the training curriculum.

Guiding Theoretical Framework

Through the experience of a supportive, dependable and trusting relationship with the mental health consultant and the development of a shared language and shared perspective between administrators, teachers, and parents, Smart Support's goal is to better equip child care providers to adopt the stance of:

- Curiosity about the meaning of children's behaviors;
- Flexibility in thinking about young children's needs;
- Emotional availability to the children in care;
- Respect for themselves as professionals.

The shared language between consultant and child care provider comes from a prevention, promotion, and intervention framework that Smart Support consultants use with early care providers. Using this framework that includes multiple lenses from the field of early childhood mental health, Smart Support consultants work with early care and education professionals to assist them in developing a greater understanding of the meaning behind behaviors – including the meaning of the behavior of the children in their care, as well as the meaning of their own behavior.

Smart Support's model acknowledges the central role of early care and education professionals working in partnership with parents to support optimal outcomes for children. Smart Support mental health consultants provide support to center-based and regulated home-based child care programs in an effort to: build providers' skills; enhance providers' ability to establish positive relationships with children; and, ensure the provision of a quality, developmentally appropriate learning environment. Frequently, child care programs initially establish a relationship with a mental health consultant as a result of concerns related to a specific child/issue. Once established, however, the consulting relationship expands to include a focus on program and classroom variables with the ultimate goal of improving teachers' capacity to observe, understand, and respond to children's needs resulting in an early care and education experience that supports that emotional well-being of all children. This is conducted simultaneously while supporting the teacher with effective strategies to address the challenging behaviors impacting instruction.

Smart Support's framework is based on a framework created by researchers at Georgetown University that emerged from their 2009 cross-site analysis of Early Childhood Mental Health Consultation (ECMHC) programs throughout the country (Duran et al., 2009). Their framework is depicted below.



Duran, F. et al. (2009). *What Works?: A Study of Effective Early Childhood Mental Health Consultation Programs*. Washington, DC: Georgetown University Center for Child and Human Development.

This framework suggests that there are five factors that are important in the design of an effective ECMHC program (i.e., a program that achieves positive outcomes). First, three core program components must be in place:

1. Solid program infrastructure (e.g., strong leadership, clear model design, strategic partnerships, evaluation, etc.);
2. Highly-qualified mental health consultants;
3. High-quality services (Duran et al., 2009).

Further, there are two other elements that are essential to achieving positive outcomes and, in fact, serve as catalysts for success. These elements are:

4. The quality of the relationships between and among consultants and consultees;
5. The preparedness of families and early care and education providers/programs for ECMHC (e.g., openness to gaining new skills and knowledge, opportunities for collaboration) (Duran et al., 2009).

Notice that the diagram depicted above also underscores the importance of using evaluation findings/outcome data to guide program enhancements (i.e., a continuous quality improvement process) and to educate funders and other key stakeholders about Smart Support's impact in order to promote sustainability and/or expansion.

Theory of Change

At the beginning of the project year, the Smart Support leadership team convened to develop a “Theory of Change” for the Smart Support Program. Carol Weiss (1972) popularized the term “Theory of Change” as a way to describe the set of assumptions that explain both the steps that lead to the long-term goals of interest, and the connections between program activities and outcomes that occur. The Smart Support leadership team came up with a theory of change that is based on the framework described above and rooted in attachment theory and the parallel process (Johnston & Brinamen, 2006).

Smart Support - Theory of Change

Through relationships with child care teachers and providers, and via a parallel process, we develop a secure-base relationship with program administrators and teachers. We help teachers develop a coherent narrative of their experience to help explain their work with children and families.

We help staff develop curiosity of the meaning of children’s behavior and enhance one’s inclination to understand children. This leads to a change in beliefs about one’s own work and practices. Developing an empathetic narrative allows teachers to make developmentally appropriate choices about how to be with children, and ultimately helps teachers develop skills in the context of empathy, self-regulation, and emotional availability.

Smart Support’s theory of change is also displayed in the logic model in Appendix B. The Smart Support logic model and theory of change are considered to be a work in progress, and will likely be revisited at the end of each program year, as findings from the evaluation and more experience implementing Smart Support prompt a deeper understanding of process and outcomes.

Purpose of Evaluation

The purpose of this evaluation was to discover whether the Smart Support Program was successful in reaching its desired outcomes – that is, whether there were demonstrable changes in participants’ feelings and beliefs about the nature of their work, beliefs and knowledge about young children’s development; beliefs about specific children in their care, and practices with all children in their care. Specific research questions are as follows:

RESEARCH QUESTIONS

Research Question 1: What are the key elements of Smart Support consultation?

RQ1A:

What are the skills, competencies and credentials of Smart Support’s mental health consultants?

RQ1B:

What is the frequency and duration of visits with programs and teachers?

RQ1C:

What types of consultation activities are Smart Support’s mental health consultants using in their practice?

Research Question 2: Is there growth on key outcomes?

RQ2A:

Do teachers demonstrate improvement in regards to how they view their role with children?



RQ2B:

Do teachers demonstrate improvement in regards to how they view individual children?

RQ2C:

Is there observable improvement in the classroom's emotional and mental health climate?

Research Question 3: What are the associations with improvement on the key outcomes?

RQ3A:

Are program and director characteristics associated with improvement on key outcomes?

RQ3B:

Are directors' background characteristics associated with improvement on key outcomes?

RQ3C:

Are teachers' background characteristics associated with improvement on key outcomes?

Research Question 4: Are key elements of consultation associated with improvement on key outcomes?

Research Question 5: How do participants rate their experiences with Smart Support? Are ratings of their experiences associated with growth on key outcomes?

Key Evaluation Outcomes:

- Teacher's perception of focus child's risk of expulsion
- Classroom mental health climate
- Staff interaction and cooperation
- Teacher self-efficacy
- Teacher's perception of relationship with focus child
- Teacher's self-reported gains in knowledge about children's social and emotional development

Methods

Evaluation Design

This evaluation is primarily a summative outcome evaluation, which used performance measures based on the program developers' theory of change and child care research on effective Early Childhood Mental Health Consultation (ECMHC) models (Duran et al., 2009; FSU, 2006; Green et al., 2006; Gilliam, 2007; Johnston & Brinamen, 2006). The purpose of this evaluation is three-fold: first and foremost, the goal is to determine whether the Smart Support Program met its stated objectives and outcomes. Second, the evaluation is designed to provide insight and feedback to the program's developers as they move forward to bring the program to scale throughout the State of Arizona. Third, there are still many gaps in the general, research knowledge base (Hepburn et al, 2007). Findings from this evaluation will help address some of the existing gaps, and will likely point to many other research questions that researchers and future evaluations can explore in order to contribute to the knowledge base of effective mental health consultation.

Evaluation Procedures

The design of this evaluation called for collecting data from child care providers, their administrators and the mental health consultants. At the beginning of their work with consultants, participating teachers completed a background questionnaire and several self-assessments. Child care administrators and directors were also asked to complete a background questionnaire and several self-assessments. In addition, consultants conducted a classroom observation with participating teachers. This observation spanned two visits. The observational tool they used focused on several different dimensions of classroom environments that are important for children's social and emotional well-being (Gilliam, 2008). These baseline data were collected within six (6) weeks of teachers' agreement to work with a Smart Support mental health consultant.

Six months later, teachers and administrators were again asked to complete questionnaires and feedback surveys. This evaluation only represents data from two time points (baseline and 6-month time-point). Evaluation data will continue to be collected every six months until teachers or programs end their participation with the Smart Support Program. At that time, participants are asked to complete a final set of questionnaires and a short feedback survey. (See next section for more detail on instruments used in this evaluation.)

Consultants also completed background questionnaires, self-assessments and provided ratings and written feedback on their experiences with individual teachers and child care programs at the six-month time-point with each individual teacher. They were also responsible for logging their consultation dosage and activity data into Smart Support's centralized data collection and reporting database.

All of the evaluation / outcome data collected is designed to help mental health consultants learn more about teachers' and directors' current experiences and attributions about children. After data collection is completed, consultants meet with their supervisor to discuss the results of the data collection that can help inform the creation of a teacher and program specific "Action Plan."

Much of this data collection protocol will be repeated every six months, so we can track progress and modify a teacher/ program's "Action Plan" if needed. Findings from this report will be discussed by Smart Support's leadership team, and a plan will be made to incorporate the findings into all aspects of Smart Support – staff training; supervision; administrative support and next year's evaluation protocol.

Data Collection and Instrumentation

Data were collected through questionnaires, observations, and surveys. A summary of the instruments used and the information collected is included in the chart below.

Overview of Evaluation Measures*

*For more detailed information about individual measures, please contact the author of this report.



Evaluation Tool	Citation	Constructs Measured	Baseline	On-going (every 6 months)	Closing Intervention
Program Level:					
Provider Background Information	Evaluation Team	Background information about the child care program	✗		✗
Director Survey	Evaluation Team (Adapted from Bloom, 1977; Carter & Curtis, 1998)	Demographic data; Organizational Climate; Director Tasks & Responsibilities	✗	✗	✗
Director Satisfaction Survey	Adapted from (Green et al; 2006; Parsons & Meyers, 1984)	Feedback about Smart Support and MH consultant		✗	✗
Classroom Level:					
Preschool Mental Health Climate Scale (observation)	(Gilliam, 2008)	Dimensions of mentally healthy preschool classroom environments:	✗	✗	✗
Staff Cooperation and Interaction Rating (item # 41 from ECERS-R) (observation)	(Harms, Clifford, & Cryer, 2005)	Staff communication, interpersonal relationships; sharing of duties	✗	✗	✗
Teacher Level:					
Teacher Background Survey	Evaluation Team	Demographic data	✗		
Teacher Opinion Survey	(Geller & Lynch, 1999)	Self-efficacy	✗	✗	✗
Child Care Worker Job Stress Inventory	(Curbow et al., 2001)	3 subscales: Demand Resources Control	✗	✗	✗
Workplace Rating Scales	(Adapted from Bloom, 1977; Carter & Curtis, 1998)	2 scales: Organizational Climate Director Tasks & Responsibilities	✗	✗	✗
Knowledge about children's social and emotional development	Adapted from CSEFEL evaluation questions			✗	✗
Teacher Satisfaction Survey	Adapted from (Green et al, 2006; Parsons & Meyers, 1984)	Feedback about Smart Support and MH consultant		✗	✗
Teacher-Child Relationship					
Student-Teacher Relationship Scale – Short Form	(Pianta, 1992)	Teacher's perception of closeness and conflict with a specific child	✗	✗	✗
Focus Child Level (data collected for selected children only):					
Background characteristics	Evaluation Team	Child demographic characteristics	✗		
DECA [Devereaux Early Childhood Assessment]	(LeBuffle & Naglieri, 1999)	Teacher report of within-child protective factors (initiative; self-control; attachment)	✗	✗	✗
Preschool Expulsion Risk Measure	(Gilliam, 2010)	Teacher's perception of how a specific child's behavior impacts her work and sense of hope that this child's behavior can improve	✗	✗	✗
Mental Health Consultant Level					
Coach Background Questionnaire	(Shivers, 2006)	Demographics; professional experience; areas of expertise; perceptions of nature of the work; job crafting, etc.	✗		
Knowledge and Skill Inventory for Consultant	(Buyse & Wesley, 2005; Adapted from Klein & Kontos, 1993)	Consultants rate their perceived levels of skill and knowledge in different areas (e.g., systems change, communication skills, collaborative problem solving, etc.)	✗		
Consultant Feedback Survey	Adapted from (Green et al; 2006; Parsons & Meyers, 1984)	Consultant's perception of teacher and consultation process;		✗	✗
Consultant Professional Comfort Scales	(Adated from an article by Buysee & Wesley, 2001)	For each teacher, consultants rate their level of "professional comfort" on several dimensions of provider, classroom, and program characteristics (e.g., teacher knowledge; ratios; group size; access to resources). Consultant also rates level of administrator's support of teacher while in the credential program. (12 items for each provider)	✗	✗	✗

*For more detailed information about individual measures, please contact the author of this report.

Analyses

Items in each of the data sets listed above were initially examined for accuracy and consistency. Problematic data in the electronic files were assessed against the original hardcopy forms. Summary scales were created for the standardized instruments (e.g., Preschool Mental Health Climate Scale; Student-Teacher Relationship Scale/Pianta). Where applicable, variables were merged across data sets (e.g., teacher characteristics; feedback surveys; director characteristics).

Analyses followed standard methods in applied social research. Item and scale frequencies were generated along with relevant summary statistics (counts, percentiles, means, medians and dispersion indexes). Bi-variate procedures were selected based on levels of measurement. For example, with continuous measures Pearson's moment correlations were performed; t-tests were used with two-category predictors and interval-level dependent variables. Where relevant, coded themes from open-ended, qualitative responses gleaned from surveys were integrated throughout the results section to highlight quantitative findings.

Limitations of the Data

There are several limitations in this evaluation, which are commonly found in applied participatory research and evaluation design (Chen, 2005). Limitations are listed below:

- There is a self-selection bias insofar as the Smart Support Program was a service for which licensed and regulated center and home-based child care programs volunteered. It may be that seeking out this type of experience is a characteristic of child care programs that are already offering a higher quality experience for children and families.
- This is a non-experimental design, with the same group of child care teachers and programs serving as their own comparison group through the use of a pre-post test design. There is no randomized control group, and participants were not randomly recruited. Therefore, causal and generalizable statements are more difficult to ascertain than when using randomized recruitment and an experimental design.
- The same mental health consultants who delivered the Smart Support intervention collected the observational data in classrooms. One of the most challenging aspects of conducting rigorous research and evaluation on ECMHC programs is securing enough funding to pay for external data collectors who are trained and available to collect data at various time-points for each of the teachers in our sample ($n = 305$). Although we controlled for this potential bias in the analysis (Burchinal, 2010), there is a distinct possibility that the results were impacted by this limitation in our data collection design.
- Questionnaire responses are self-reported and not verified by observation. One assumes a response bias on the part of child care providers and administrators to provide socially desirable responses and present oneself in the best possible light.
- The consultation provided by the Smart Support mental health consultants was designed to be adapted according to the ebb, flow and interests of the child care providers and administrators. The hallmark of effective consultation is tailoring the mix and intensity of consultation activities to the unique needs of teachers and administrators (Johnston & Brinamen, 2006). Consequently, the intervention was not identical in all participating child care programs. In future evaluations Smart Support will track fidelity to the model.



Description of Participants in Evaluation

Since this is the first year of the Smart Support Program, we thought it was important to describe participants in the program. Subsequent analyses investigate whether background characteristics of programs, directors, teachers and focus children are associated with outcomes. Understanding the nature of these associations will allow for more fine-tuned program delivery.

First Things First Regions represented in evaluation¹

	Frequency (# of child care programs in Smart Support)	Percent
Central Pima	27	17.8
Southeast Maricopa	22	14.5
North Phoenix	22	14.5
South Phoenix	17	11.2
Yavapai	13	8.6
Central Phoenix	12	7.9
NE Maricopa	9	5.9
Central Maricopa	9	5.9
Pinal	8	5.3
North Pima	7	4.6
NW Maricopa	5	3.3
Gila	1	.7
Total	152	100.0

Programs

One hundred and fifty-two (152) programs are represented in this evaluation². The tables below describe characteristics of the programs.*

Table 1: Background Information

	Minimum	Maximum	Mean	Std. Deviation
Number of years in operation	.25	50.00	12.77	11.51
Days per year	174.00	365.00	258.10	40.46
Average daily attendance	3.00	146.00	54.93	31.18
Number of classrooms	1.00	30.00	5.44	3.52

Table 2: Enrolled in Quality First

	Frequency	Percent
No	32	21.8
Yes	114	77.6
Application pending	1	.7
Total	147	100.0

¹These numbers represent participation in the evaluation only, and do not represent actual numbers of participation in the Smart Support Program.

²This number includes five (5) home-based Family Child Care providers. We did not conduct separate analyses on this group because the numbers were too small.

Table 3: Currently accredited by national professional organization?

	Frequency	Percent
No	113	76.4
Yes	35	23.6
Total	148	100.0

Table 4: NAEYC Accreditation

	Frequency	Percent
No	146	97.3
Yes	4	2.7
Total	150	

Table 5: Other national professional organizations represented

National Accreditation Commission (NAC from: National Association of Child Care Professionals)
Association of Christian Schools International (ASCI)
National Early Childhood Program Accreditation (NECPA)
National Catholic Educational Association
Western Catholic Educational Association
Association Montessori Internationale

Table 6: Family income estimation

	Frequency	Percent
Mostly low income	41	48.8
Mostly low to mid income	24	28.6
Mostly middle income	9	10.7
Mostly upper income	3	3.6
Evenly mixed	7	8.3
Total	84	100.0

Table 7: Children with special needs

	Minimum	Maximum	Mean	Std. Deviation
Number of children with IEP or IFSP	.00	52.00	1.46	4.67
Number of children with special health care need	.00	23.00	3.14	4.14

Table 8: Expulsions / Suspensions

Have you expelled a child in the past 6 months?	Frequency	Percent
No	134	89.3
Yes	16	10.7
Total	150	100.0

Have you suspended a child in the past 6 months?	Frequency	Percent
No	119	79.3
Yes	31	20.7
Total	150	100.0

*Additional tables with program characteristics in Appendix C.

Directors / Administrators

Program and child care administrator data were collected at the same time. There were 150 directors who participated in this evaluation. The tables below describe characteristics of the child care directors and administrators.*

Table 13: Directors' age

	Minimum	Maximum	Mean	Std. Deviation
Age	24.00	70.00	43.17	10.91

Table 14: Directors' gender

	Frequency	Percent
Male	1	.7
Female	149	99.3
Total	150	100.0

Table 15: Directors' ethnicity

	Frequency	Percent
Caucasian	115	77.2
Latina	21	14.1
African American	8	5.4
Native American	1	.7
Asian	2	1.3
Other	2	1.3
Total	149	100.0

Table 16: Highest level of education completed

	Frequency	Percent
Some high school	1	.7
High school graduate / GED	50	33.6
AA in Child Development or related field	27	18.1
BA	41	27.5
MA / MS	20	13.4
PhD / EDD	2	1.3
Other	8	5.4
Total	149	100.0

*Additional tables with administrators' characteristics are located in Appendix D.

Teachers

305 child care teachers were included in the analysis for this evaluation. The demographic characteristics of these teachers and their classrooms are detailed in the tables below.*

Table 22: Teacher age

	Minimum	Maximum	Mean	Std. Deviation
Teacher age	19.00	73.00	36.07	13.10

Table 23: Teacher gender

	Frequency	Percent
Female	239	98.4
Male	4	1.6
Total	243	100.0

Table 24: Teacher ethnicity

	Frequency	Percent
White	129	53.3
Latino	76	31.4
African American	17	7.0
Other	9	3.7
Native American	6	2.5
Asian	5	2.1
Total	242	100.0

Table 25: Teacher Education

	Frequency	Percent
Some high school	6	2.5
High school graduate / GED	118	49.2
Child Development Associate (CDA)	21	8.8
AA in Child development or related field	30	12.5
BA / BS	40	16.7
MA / MS	11	4.6
Other	14	5.8
Total	240	100.0

Table 26: Teacher experience

	Minimum	Maximum	Mean	Std. Deviation
How many years have you worked at current home or child care agency?	.08	31.00	3.76	4.79
How many years have you provided care in any child care program?	.33	40.00	10.16	8.26

* Additional tables with teacher characteristics are located in Appendix E.



Focus Child Characteristics

We asked each teacher to select a focus child for the purposes of tracking improvements at the child-level. The tables below present characteristics of the 299 focus children that were included in this sample.

Table 29: Focus child age (in months)

	Minimum	Maximum	Mean	Std. Deviation
Focus child age (in months)	5.00	63.00	42.32	10.86

Table 30: Focus child gender

	Frequency	Percent
Male	223	74.6
Female	76	25.4
Total	299*	100.0

*Some teachers started the evaluation with 2 focus children

Table 31: Focus child ethnicity

	Frequency	Percent
White	148	55.4
Latino	70	26.2
African American	37	13.9
Native American	5	1.9
Multi-ethnic	4	1.5
Asian	3	1.1
Total	267	100



Table 32: Does focus child have a diagnosed disability?

	Frequency	Percent
No	263	94.9
Yes	14	5.1
	277	100.0

Table 33: Does focus child have an IEP or IFSP?

	Frequency	Percent
No	263	95.6
Yes	12	4.4
	275	100.0

The background characteristics examined in this section create a landscape for examining the conditions under which mental health consultation was delivered. Knowing the characteristics of this group of Smart Support participants is an important factor in guiding and informing the content and mode of delivery of the Smart Support Program.

Research Question 1: What are the key elements of Smart Support consultation?

The general knowledge base on Early Childhood Mental Health Consultation (ECMHC) is still sparse and inconsistent in regard to identification of the most important characteristics and activities needed for effective mental health consultation (Brennan et al., 2005; Green et al., 2006). For example, a large synthesis of ECMHC programs around the country reveal that there is great variability in the dosage of consultation – that is, the frequency and duration of services (Duran, 2009). Reviews of the literature on ECMHC reveal that studies offer few clear definitions, strategies, or goals for the consultation process. In addition, services provided by consultants appeared to vary greatly, depending on the particular skill set or approach of the mental health consultant (Brennan et al., 2005; Duran et al., 2009; Green et al., 2006; Yoshikawa & Knitzer, 1997).

At the time of this evaluation, there were 47 mental health consultants working in the Smart Support Program. In one year, these 47 consultants served 199 child care centers, 14 licensed family child care providers, 305 teachers, and an estimated 9,007 children have been impacted by Smart Support’s services. Since the Smart Support Program is one of the largest ECMHC programs in the country and has reached impressive numbers of child care programs, teachers and children in the first year alone, it will be important to track and discover patterns among consultation activities, dosage, and growth on key outcomes. This section highlights descriptive findings about the key features of Smart Support’s consultation model.

Frequency and duration of visits with programs and teachers

On average, Smart Support mental health consultants visit teachers once a week. The average amount of time they spend with teachers each week is 1.45 hours. The average amount of time spent in consultation with child care administrators is .57 hours per week. The average amount of time spent at a center each week is 2.30 hours.

We ran a bi-variate correlational analysis and found that Smart Support mental health consultants who conducted more large group training sessions also offered more referrals over the past year ($r = .60, p < .001$). The tables below describe other features of common mental health consultation activities.

Table 34: Training facilitated by consultants over the past program year

	Minimum	Maximum	Mean	Std. Deviation
Total number of training sessions	.00	22.00	6.02	5.52
Small group training	.00	16.00	2.57	3.00
Large group training	.00	12.00	2.26	2.65
Community training	.00	2.00	.26	.57
Parent training sessions	.00	4.00	.11	.60

Table 35: Referrals given by consultants over the past program year

		Maximum	Mean	Std. Deviation
Total referrals Year 1	.00	103.00	20.64	24.38
Referrals for individual children	.00	33.00	6.02	7.63
Referrals for families	.00	23.00	4.5	5.64
Referrals for child care directors	.00	28.00	5.06	6.83
Referrals for teachers	.00	23.00	4.13	5.76
Referrals for the child care program	.00	5.00	.54	1.20

Table 36: Other consultation activities across all 305 teachers

	Mean	Std. Deviation
Written action plans created for specific children	2.88	8.21
Consultation activities logged for lead teachers		
Observed in classroom	8.77	6.64
Modeled interaction	4.28	4.26
Observed individual child	5.18	5.41
Consult w individual teacher	9.98	6.73
Consult w small group	1.89	3.56
Consult w large group	.04	.24
Consult w parents / families	.29	.78
Consult w child care director	.56	1.55
Consult w Quality First coach	.06	.39
Collateral consultation activity	.05	.28
Phone consultation	.08	.35

Skills, competencies and credentials of Smart Support mental health consultants

Most evaluations of ECMHC models have found that the quality of the consultants is one of the most essential elements of a program's success (Duran, et al., 2009). Common areas of interest in reporting components of highly qualified consultants include: education; content knowledge; work experiences; areas of competency; and skills (Duran et al., 2009). We conducted a bi-variate correlational analysis and found that Smart Support consultants who have more experience providing consultation tended to conduct more small and large group training sessions over the past year ($r = .32, p < .05$; $r = .35, p < .05$). We describe Smart Support consultants' characteristics in the tables below.

Table 37: Consultants' background characteristics

	Minimum	Maximum	Mean	Std. Deviation
Age	25.00	61.00	40.68	11.10
Gender	Frequency	Percent		
Male	3	6.4		
Female	44	93.6		
Ethnicity	Frequency	Percent		
Black/African American	1	2.1		

Table 38: Consultants' education

Highest degree	Frequency	Percent
Masters Degree	44	93.6
Doctoral degree	3	6.4
Total	47	100.0
Type of graduate degree	Frequency	Percent
Counseling Psychology	9	19.1
MSW	11	23.4
Special Education	4	8.5
Early Childhood Education	3	6.4
M.Ed.	2	4.3
Child Development & Family Studies	4	8.5
Marriage & Family Counseling	6	12.8
School Psychology	1	2.1
Elementary Education	1	2.1
Clinical Psychology	3	6.4
Applied Developmental Psychology	1	2.1
Community Counseling	2	4.3
Total	47	100.0
Other infant / early childhood professional certificate?	Frequency	Percent
Harris 2 -Year Clinical certificate	2	4.3
Harris Infant Family Studies certificate	9	19.1
Primary field of expertise based on education background (short codes)	Frequency	Percent
Mental health	23	48.9
Education	14	29.8
Both	10	21.3

Table 39: Consultants' experience

	Minimum	Maximum	Mean	Std. Deviation
Years providing any consultation/coaching/training	.00	30.00	6.51	7.60
Years providing consultation in the field of early childhood	.00	25.00	5.36	6.56
Years providing any services in field of early childhood, including consultation and direct service.	.00	30.00	11.10	7.24
Have you ever provided direct services in the field of early childhood edu. / dev. / health?			Frequency	Percent
Yes			47	100.0
Direct service experiences			Frequency	Percentage
Therapist / Counselor			23	49.8
Social worker / Case manager			14	29.8
Home visitor			9	19.1
ECE and child care early intervention / special ed / MH consultation			8	17.0
Trainer: teachers and / or parents			7	14.9
Child care director / Administrator			6	12.8
School counselor / School psychologist			5	10.6
K-3 teacher / Substitute teacher			5	10.6
Special education teacher / Reading specialist K-3			4	8.5
Evaluator / Child assessments			3	6.4
Mental health supervisor			2	4.3
Court advocate / CASA			2	4.3
Total			47	100.0

Because of the extant gaps in the literature on the essential skills and competencies for early childhood mental health consultants (Hepburn et al., 2007), we thought it important to gauge consultants' own ratings of their knowledge and skills. We used a scale developed by Buissee and Wesley (2001). This scale contained 37 items in a Likert format. Consultants were asked to rate themselves on various indicators (1 = strongly disagree; 5 = strongly agree). The critical domains reflected in this scale were built, in part, on Dougherty's (2000) key areas of consultation skills. The first two domains are child-related and refer to the technical content needed by the consultant. The remaining three adult-oriented domains are related to the processes required to share that content. In the Smart Support model, both technical and process expertise are critical throughout the consultation process.

Table 40: Consultant Knowledge & Skill Inventory (Subscales from Buissee & Wesley, 2001)

	Minimum	Maximum	Mean	Std. Deviation
Total score across all items	3.51	5.00	4.32	.38
Subscale scores				
Basic knowledge	3.14	5.00	4.03	.45
Systems change	2.60	5.00	4.13	.56
Personal characteristics	3.50	5.00	4.70	.47
Communication	3.29	5.00	4.33	.53
Collaborative problem solving	3.50	5.00	4.28	.47

Smart Support consultants were asked to fill out this scale during their orientation session. By and large, mental health consultants scored themselves on the higher end of the scale (1 = low; 5 = high). The domain where they assessed themselves the lowest was in the area of "basic knowledge." The domain where they assessed themselves the highest was "personal characteristics." Consultants will be asked to complete this survey again at the beginning of their second year in the Smart Support program to see if their self-assessments have shifted. Results from this scale will also be used to guide on-going training and professional development for Smart Support consultants.

Research Question 2: Is there improvement on key evaluation outcomes?

Child's risk of expulsion

Walter Gilliam's seminal research study in 2005 demonstrated that behavior problems in very young children can be severe enough to warrant removal from their preschool programs (Gilliam, 2005). The experience of being expelled or even suspended from a child care program can instigate an onslaught of other negative experiences for children and families. Mental health consultation – such as the Smart Support Program – is specifically designed to address and remedy the growing concern of child care expulsions (Duran et al., 2009). We used the Preschool Expulsion Risk Measure (PERM) to assess a teacher's perception of the likelihood that the focus child would be expelled from their current program. The PERM is a new measure developed by Walter Gilliam and is currently being used in several different states' ECMHC evaluations – including Arizona – in order to establish this instrument's validity. Preliminary validation findings with the PERM indicate that it is a good predictor of child expulsions, it is associated with teacher depression, and it is sensitive to mental health consultation intervention (Gilliam, personal communication, 2010).

Key Evaluation Outcomes:

- Teacher's perception of focus child's risk of expulsion
- Classroom mental health climate
- Staff interaction and cooperation
- Teacher self-efficacy
- Teacher-reported gains in knowledge about children's social and emotional development
- Teacher's perception of relationship with focus child

The scale includes 12 items in a 5-point Likert format. Providers rated the extent to which they agreed or disagreed with the 12 statements (1 = strongly disagree; 5 = strongly agree). In order to create subscales, we conducted a principal component factor analysis to see how individual items hung together. A varimax rotation was performed, revealing a two-factor solution, which explained 58% of the variance. The table below presents how each of the items loaded onto the factors.

Table 41: Factor loadings for the Preschool Expulsion Risk Measure

	Factors	
	Child interferes with my ability to teach	This child is not likely to improve
This child's behaviors interfere w/ ability to teach effectively	.787	
This child's behaviors interfere w/ ability to control class	.768	
This child's behaviors interfere w/ other children's ability to learn	.759	
This child's behaviors may interfere with someone hurt or property damaged	.779	
This child might do something which may reflect poorly on my teaching skills	.684	
Other parents complain about this child's behaviors	.632	
My job would be easier if this child were not in my classroom	.492	
My job is more stressful b/c of this child's behaviors	.615	
This child's behaviors are not likely to improve significantly		.714
There is little I or anyone else can do to improve this child's behavior significantly		.749
This child's parents will not be much help in improving behavior		.619
Sometimes I hope this child will be absent		.591
I am seriously considering recommending this child's removal from my class or program at this time or in near future		.713

Based on the loadings of these factors, we created two subscales: "This child interferes with my ability to teach" (alpha = .87) and "This child is not likely to improve" (alpha = .85). We then conducted a paired sample t-test analysis on both of these subscales to determine whether there were changes in teachers' perceptions of the focus child's risk of expulsion from Time 1 to Time 2. Decreases on both of these subscales should be interpreted as more optimal. The results are presented below.

Table 42: Preschool Expulsion Risk Measure mean scores

	Mean
"This child interferes with my ability to teach" subscale Time 1 (high scores not optimal)	3.14
"This child interferes with my ability to teach" subscale Time 2**	2.71
"This child is not likely to improve" subscale Time 1 (high scores not optimal)	2.25
"This child is not likely to improve" subscale Time 2**	2.09

**p<.01

This decrease in risk of expulsion perceptions is also reflected in Smart Support consultants' open-ended six-month feedback on individual teachers. Thirty-three percent (33%) of Smart Support mental health consultants reported that they observed a change in participants' expulsion, suspension, and disciplinary practices. Below are some common themes from consultants' open-ended feedback:

- Less frequent removals from the classroom – teacher now works through challenging behavior with children;
- Less frequent director intervention in general – children spend less time with director;
- Teachers schedule more meetings with parents to discuss goals and concerns;
- Teachers are working harder to understand children's behavior;
- Fewer suspensions;
- Director encourages teachers to use strategies they learn through consultation;
- There are fewer incidents prompt removing a child from the classroom.

Preschool Classroom Mental Health Climate

In this evaluation we used a new classroom observation measure currently in development by Walter Gilliam (2008) that attempts to target those aspects of classroom functioning that are most relevant to the day-to-day work of mental health consultants.

The Preschool Mental Health Climate Scale (PMHC) (Gilliam, 2008) focuses on aspects of the overall classroom environment (mostly interactions and the flow of activities) that may be related to children's mental health and social-emotional functioning. This measure is currently being used and tested for validity in ECMHC evaluations in several states. Preliminary validation findings indicate that scores on this measure predict child behavior scores and teacher mental health (Gilliam, 2008). There are ten (10) subscales contained on this instrument. Observers spend two days observing the classroom, and then rate indicators on each of the subscale dimensions on a scale of 1 – 5 (low to high). Optimally, scores should increase as a result of receiving mental health consultation (Gilliam, 2008). We conducted a series of paired sample t-test analyses to determine whether there were increases in optimal mental health classroom environments from Time 1 to Time 2. The results are presented in Table 43.



Table 43: Preschool Mental Health Climate Scale mean scores

Total Score	Mean
PMHC total Time 1	3.49
PMHC total Time 2***	3.89
PMHC Subscale Scores	Mean
Transitions T1	3.27
Transitions T2 ***	3.75
Directions & Rules T1	3.44
Directions & Rules T2 ***	3.92
Staff Affect T1	3.70
Staff Affect T2*	3.98
Staff Cooperation T1	3.90
Staff Cooperation T2 *	4.27
Staff-Child Interactions T1	3.75
Staff-Child Interactions T2 **	4.05
Teaching Feelings & Problem Solving T1	2.83
Teaching Feelings & Problem Solving T2***	3.39
Individualized and Developmentally Appropriate Pedagogy T1	3.36
Individualized and Developmentally Appropriate Pedagogy T2***	3.78
Child Interactions T1 - PMHC	3.51
Child Interactions T2 – PMHC***	3.95
Negative Indicators T1 (high score not optimal)	1.93
Negative Indicators T2 *	1.75

* p<.05; **p<.01; ***p<.001

Another approach to measuring the emotional climate among classroom staff was to rate teachers on the Staff Interaction and Cooperation item from the Early Childhood Environmental Rating Scale – Revised (ECERS-R). We hypothesized that teachers who had disharmonious relationships with their co-teachers would be more likely to experience stress in their work environment, which might impact their ability to engage in responsive caregiving practices (Grining, Raver, Champion, Sardin, Metzger, & Jones, 2010; NICHD ECCRN, 2005b). Not surprisingly, scores on this ECERS-R item were highly correlated with scores on the PMHC Staff Cooperation subscale at both time-points (Time 1: $r = .69, p < .001$; Time 2: $r = .60, p < .001$). We also conducted a paired sample t-test analysis to determine whether there was an increase in staff-staff relationships from Time 1 to Time 2. The results are presented below.

Table 44: Staff Interaction and Cooperation (item #41 from ECERS-R) mean scores

	Mean
Staff Interaction & Cooperation Time 1	3.94
Staff Interaction & Cooperation Time 2***	4.74

***p<.001

Teacher Self-Efficacy

We used the Teacher Opinion Survey (Geller & Lynch, 1999) to measure teacher's self-efficacy. Bandura defines self-efficacy as "beliefs in one's capabilities to organize and execute the courses of action required to produce given attainments" (1977, p.3). There is a rich literature on K-12 teacher self-efficacy, which demonstrates that efficacious teachers bring about more positive change in their teaching practices and students' outcomes (Armor et al., 1976; Berman et al., 1977). Furthermore, teacher self-efficacy is reported to be malleable as a result of professional development interventions (Mullholland & Wallace, 2001). Although there is less literature about self-efficacy with early care and education professionals, there are some findings that indicate that teachers with higher efficacy levels are more likely to construct positive relationships with children (Johns, 2003; NICHD ECCRN, 2005a). We hypothesized that as a result of receiving mental health consultation, teachers would begin to shift their feelings and beliefs about managing challenging behavior, and would start to believe in their ability to implement change which, in turn, would lead to adaptations to their teaching practices and relationships with children.

The scale we used included 12 items in a 5-point Likert format. Child care providers rated the extent to which they agreed or disagreed with the 12 statements (1 = strongly disagree; 5 = strongly agree). In order to create subscales, we conducted a principal component factor analysis to see how individual items hung together. A varimax rotation was performed, revealing a two-factor solution, which explained 42% of the variance. The table below presents how each of the items loaded onto the factors.

Table 45: Factor loadings for Teacher Self-Efficacy

	Factors	
	Hopeless / Overwhelmed	Personal Self-Efficacy
There are some children I simply cannot influence	.706	
I feel a sense of hopelessness about the futures of children I work with	.678	
As a teacher, I really can't do much b/c the way a child develops is influenced mostly by home	.636	
I frequently feel overwhelmed by my job	.443	
If I keep trying, I can reach even the most challenging child	-.620	
If some children are not doing as well as others, I believe I should change my methods with them	-.480	
I can imagine myself caring for children for several more years	-.303	
I have enough training to deal with almost any difficult situation		.740
I know how to respond effectively when a child becomes disruptive		.726
I can help children develop skills to make successful choices later in life		.663
I can help children learn skills to cope with adversity		.559
On a typical day, I feel a sense of accomplishment as a caregiver for young children		.489

Based on the loadings of these factors, we created two subscales: "Personal Self-Efficacy" (alpha = .68) and "Hopeless / Overwhelmed" (alpha = .63). We then conducted a paired sample t-test analysis on both of these subscales to determine whether there were changes in teachers' self-efficacy from Time 1 to Time 2. Increases on the Personal Self-Efficacy subscale should be interpreted as more optimal. In contrast, decreases on the Hopeless / Overwhelmed subscale should be interpreted as more optimal. The results are presented in Table 46.

Table 46: Teacher Self-Efficacy mean scores

	Mean
Personal Self-Efficacy subscale T1	4.02
Personal Self-Efficacy subscale T2**	4.25
Hopeless / Overwhelmed subscale T1	2.00
Hopeless / Overwhelmed subscale T2	1.96

**p<.01

Teacher Perception of Job Stress

Research has demonstrated that the amount of stress experienced by a child care teacher can impact the quality of relationships she has with the children in her care (Grining et al., 2010; NICHD ECCRN, 2005). We used the Child Care Worker Job Stress Inventory (Curbow, et al., 2001) to measure teachers’ perceived levels of stress. We selected this measure because it was specifically designed for child care workers, and it reflects aspects of work that are relevant to women (e.g., emotional stressors). Researchers have demonstrated linkages between scores on this instrument and patterns of engagement in mental health consultation (Grining et al., 2010). The Child Care Worker Job Stress Inventory (CCWJSI) captures three dimensions of stress – Demands, Resources, Control. We did not use this variable as an outcome variable, but rather viewed it more as a mediator for changes in key outcomes. Child care providers are asked to rate the frequency with which certain circumstances exist in their current job (1 = rarely/never; 5 = most of the time). “Increases on the Resources and Control subscales should be interpreted as more optimal. In contrast, decreases on the Demands subscale should be interpreted as more optimal. The results are presented below.

Table 47: Child Care Worker Job Stress Inventory mean scores

(1 = rarely/never to 5 = most of the time)	Mean
Demands subscale T1 (high score not optimal)	2.58
Demands subscale T2 (high score not optimal)	2.66
Resources subscale T1	4.10
Resources subscale T2	4.16
Control subscale T1	2.73
Control subscale T2	2.79

By eye-balling these results, one can see that each of the subscale scores increased from Time 1 to Time 2; however, these increases were not statistically significant. Some researchers argue that teacher stress is more appropriately designated a mediator of outcomes rather than as a key outcome (Curbow et al., 2001; Grining et al., 2010). In fact, in Smart Support’s logic model (See Appendix C), teacher stress is listed as a possible mediator. Accordingly, subsequent analyses examine associations among teacher stress and the other key outcomes. Understanding whether there are correlations between teacher stress and other key outcomes could move us closer to understanding whether teacher stress is a barrier to teachers’ use of consultation services (Grining et al., 2010).



Knowledge about young children’s social and emotional development

A key aspect of Smart Support’s mental health consultation delivery includes providing training on the “Teaching Pyramid Model” designed by the Center for Social Emotional Foundations of Early Learning (CSEFEL). CSEFEL, which is hosted by Vanderbilt University, is a national resource center funded by the Office of Head Start and Child Care Bureau for disseminating research and evidence-based practices to early childhood programs across the country. We thought it was important to ascertain whether participants perceived that they gained knowledge in domains that are emphasized in the CSEFEL training modules. We created a questionnaire by adapting questions from the CSEFEL self-evaluation tools available on-line (<http://csefel.vanderbilt.edu/>). Results of the questionnaire are presented in the table below. Teachers’ open-ended responses about specific knowledge gained is listed in Appendix F.

Table 48: Social and Emotional Development Inventory: Self-report results (frequency/percent)

Please put an “X” in the box that best describes your opinion ...	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
I have learned more strategies to promote children’s social emotional development	49 / 69%	19 / 26.8	2 / 2.8%	1 / 1.4%
I have increased my comfort and confidence in working with children with challenging behaviors.	43 / 62.3%	22 / 31.9%	2 / 2.9%	2 / 2.9%
I can identify strategies that I can use to build positive relationships with children.	41 / 58.6%	25 / 33.8%	1 / 1.4%	3 / 4.3%
I learned several strategies that can be used to design classroom environments, schedules, and routines in order to prevent challenging behavior.	42 / 61.8%	20 / 29.4%	4 / 5.9%	2 / 2.9%
I have increased awareness about the different levels of the “Teaching Pyramid Model,” and can use these levels to identify which strategies I can use to support positive behavior.	18 / 32.7%	23 / 41.8%	9 / 16.4%	5 / 4.3%
I learned new strategies to teach anger management skills to assist children in learning how to control anger and handle disappointment.	34 / 49.3%	24 / 34.8%	8 / 11.6%	3 / 4.3%
I increased my understanding of the many different relationships that impact children’s behavior (peer, family, teacher, etc.).	48 / 67.7%	17 / 23.9%	2 / 2.8%	4 / 5.6%
I increased my understanding of the ways in which I respond differently to children based on their individual needs, and the meaning behind their behavior.	44 / 62.9%	20 / 28.6%	3 / 4.3%	3 / 4.3%
I am able to develop a Positive Behavior Support plan for a child who has challenging behaviors.	28 / 42.4%	30 / 45.5%	4 / 6.1%	4 / 6.1%

On average, teachers reported an overall increase in knowledge on most of the Social Emotional Development Inventory. However, teachers rated items 5, 6 and 9 the lowest in terms of their increased knowledge and understanding. These concepts included: awareness of the different levels of the “Teaching Pyramid Model,” knowledge of new strategies to teach anger management skills and how to handle disappointment; and knowledge of how to develop a Positive Behavior Support plan for children who have challenging behaviors.

Teacher-child relationships

We used Pianta’s Student Teacher Relationship Scale (STRS) – Short Form (1991) to measure teachers’ perceptions of their relationships with focus children. This measure is widely used in child care research (Cost, Quality Outcomes Study Team, 1995; Hamre & Pianta, 2003; NICHD ECCRN, 2003). It blends attachment theory with research on the importance of early school experiences in determining concurrent and future success in school (Pianta & Nimetz, 1991). The STRS – Short Form includes 15 items in a Likert format. Teachers are asked to rate the extent to which the statements on the scale apply to their relationship with the focus child (1 = definitely does not apply; 5 = definitely applies). Sample statements include: “If upset, this child will seek comfort from me;” “It is easy to be in tune with what this child is feeling;” “This child easily becomes angry with me;” “This child and I always seem to be struggling with each other.”

We reduced items on the STRS – Short Form to two commonly published subscales: Closeness (alpha = .76) and Conflict (alpha = .80) (Pianta, 1991). We then conducted a paired sample t-test analysis on both of these subscales to determine whether there were changes in teacher-child relationships from Time 1 to Time 2. Increases on the Closeness subscale should be interpreted as more optimal. In contrast, decreases on the Conflict subscale should be interpreted as more optimal. The results are presented below.

Table 49: Student-Teacher Relationship Scale mean scores

	Mean
Teacher-Child Closeness subscale Time 1	3.91
Teacher-Child Closeness subscale Time 2***	4.21
Teacher-Child Conflict subscale Time 1 (high scores not optimal)	3.18
Teacher-Child Conflict subscale Time 2***	2.76

***p<.001

Research Question 3: What are the associations among participants’ background characteristics and growth on the key outcomes?

We thought it was important to discover whether changes in key outcome scores between Time 1 and Time 2 were associated with any other program, director, or teacher characteristics. Although the key outcome variables were collected at the teacher and classroom levels and not the director and program level, it is critical to explore whether features of care at the director and organizational level are impacting the effectiveness of mental health consultation in classrooms. Indeed, research has shown that child care directors and administrators are often described as the “gatekeepers to quality.” (Bella & Bloom, 2003; Whitebook, 1997). Researchers argue that child care directors and administrators are responsible for creating and maintaining quality systems at the organizational level, so that high-quality interactions and learning environments can flourish (Bloom & Sheerer, 1992).

We calculated a change score on each of the key outcomes, and then conducted Pearson bi-variate correlational analyses with participants’ background characteristics and key outcome change scores. The results are displayed in the tables below. The number reported next to each variable indicates the r score for the correlation.



Table 50: Associations among child care PROGRAM characteristics and growth on key outcomes

Change in Key Outcomes	Background Characteristics	Children in program
Child's Expulsion Risk (decrease)	Fewer numbers of new staff hired in past 12 months .28*	Fewer numbers of children expelled previous to starting Smart Support .40**

* p<.05; **p<.01

Table 51: Associations among child care DIRECTOR characteristics and growth on key outcomes

Change in Key Outcomes	Background Characteristics	Engagement with Staff
Social Emotional Knowledge (Increase)	Fewer hours of ECE college coursework -.36**	More frequent internal communication with staff .23*
	Fewer hours of management college coursework -.33**	

* p<.05; **p<.01



Table 52: Associations among child care TEACHER characteristics and growth on key outcomes

Change in Key Outcomes	Background Characteristics	Classroom Characteristics	Job Stress	Organizational Climate
Preschool Mental Health Climate Scale (increase)	Younger teachers -.28**	Fewer numbers of children in classroom -.30**		Lower ratings of organizational climate / working conditions -.21*
	Less likely to have worked with a previous TA provider -.33**	Fewer children with special needs in classroom -.33** Lower percentage of children from low-income families -.33*	--	
Personal Self-Efficacy (increase)	--	Fewer numbers of children in classroom -.22**	--	--
“Hopeless” Self-Efficacy (decrease)	--	Lower percentage of children from low-income families -.23*	--	--
Social Emotional Knowledge (Increase)	--	Lower percentage of children from low-income families -.24*	--	--
Closeness Teacher-Child Relationships (increase)	--	--	Lower ratings of stressful job demands -.25*; -.27*	--
Conflict Teacher-Child Relationships (decrease)	--	Fewer children with special needs in classroom .28*	--	--
Child’s Expulsion Risk (decrease)	Less likely to have worked with a previous TA provider -.33**	Fewer children with special needs in classroom .33*	--	--

* p<.05; **p<.01

Notable patterns for the findings in the tables above are summarized in this section. Overall, teachers who started off with lower scores at the beginning of Smart Support, made the most gains at Time 2. At the *program* level, it appears that when there were fewer new-hires and fewer children expelled prior to starting with Smart Support, teachers tended to make greater shifts in their feelings and thinking about the risk of expulsion for specific children.

In regards to *director* characteristics, teachers reported gaining more knowledge about social and emotional development when their directors had fewer college courses in early childhood education and child care management, yet engaged their staff in more frequent internal communications.

In regards to *teacher* characteristics, teachers who had not worked with previous technical assistance providers were more likely to improve their scores on the Preschool Mental Health Climate Scale and shift their feelings about the focus child’s likelihood of being expelled. In addition, teachers who had lower initial ratings of stressful job demands were more likely to improve their relationships with focus children. Finally, and perhaps most salient, teachers who worked with higher numbers of children with special needs and higher numbers of children from low-income families in their classrooms, were less likely to exhibit growth on almost every key outcome.

Teachers’ work-related stress was also an important marker of change. We used the Child Care Worker Job Stress Inventory (CCWJSI) to capture three dimensions of stress – Demands, Resources, Control. We did not use this variable as an outcome variable, but rather viewed it more as a mediator for changes in key outcomes. Based on our theory of change and our logic model, we investigated the association among work stress and growth on key outcomes. We found that teachers, who reported less stress at Time 1 and Time 2, were more likely to improve their relationships with children (Pianta Closeness subscale) at Time 2 ($r = -.25^*; .27^*$).

Implications for these and other findings will be explored in the Discussion section of this report.

Research Question 4: Are key elements of consultation associated with growth on key outcomes?

Using the change scores for each teacher on each of the key indicators, we conducted Pearson bi-variate correlational analyses to discover patterns of association among elements of Smart Support consultation and growth from Time 1 to Time 2 on each of the key indicators. The results are displayed in the table below.

Table 53: Associations among CONSULTATION ELEMENTS and growth on key outcomes

Change in Key Outcomes	Written action plans	Other Consultation Activities
Preschool Mental Health Climate Scale (increase)		More time spent consulting with individual teacher .21*
		More time spent modeling interactions .21*
	More written action plans developed for children in classroom .33*	More time spent observing classroom and teacher .20*
		More time spent observing individual children .28**
		More written action plans developed for children in classroom .33*
Social Emotional Knowledge (Increase)		Less time spent consulting with small group .35**
Child's Expulsion Risk(decrease)		Less time spent consulting with large group .26**

* p<.05; **p<.01

Patterns from this analysis indicate that positive changes are observed in the classroom using the Preschool Mental Health Climate Scale when consultants spend more time observing children and teachers, modeling interactions for teachers, and providing one-on-one consultation with teachers. Creating more written action plans is also associated with greater gains on the Preschool Mental Health Climate Scale.

Implications for these and the other findings are explored in the Discussion section.



Research Question 5: How do participants rate their experience with Smart Support? Are ratings of their experiences associated with growth on key outcomes?

After six months of working with their Smart Support mental health consultant, participants were asked to complete a Feedback Survey (adapted from Green et al., 2006). The Feedback Survey contained nine (9) items that were rated on a scale of 1 (strongly disagree) to 4 (strongly agree). Examples of items included: "I have a good relationship with the mental health consultant;" "Our mental health consultation services help children with challenging behaviors." In order to reduce response bias, upon completion of feedback surveys, participants placed their surveys in a sealed envelope, so their consultants could not view them. (Please see Appendix G for a sample of Smart Support's feedback survey). Mean feedback scores from teachers and directors were significantly associated with each other ($r = .30, p < .001$). Descriptive data from these scores are presented in the table below. Appendix H contains teachers' specific feedback about what their mental health consultant does that is effective.

"I am better able to see that what I do is effective. Textbook concepts are sometimes difficult to recognize in the actual classroom setting. I feel more confident that what I do has worth."

~ **Smart Support participant**

Table 54: Feedback ratings from participants

	Minimum	Maximum	Mean	Std. Deviation
Director feedback after 6 months of Smart Support	1.88	4.00	3.73	.40
Teacher feedback after 6 months of Smart Support	1.89	4.00	3.76	.34

We were also curious to discover whether participants' ratings of their experiences with Smart Support were associated with growth on key outcomes. We found the following patterns:

TEACHERS who gave higher ratings of their Feedback Surveys, also:

- Had higher increases on their Personal Self-Efficacy scores;
- Had higher decreases on their Hopeless Self-Efficacy scores;
- Had higher increases on their Preschool Mental Health Climate Scale scores;
- Had higher increases on their knowledge of social emotional development (CSEFEL inventory).

"I was very skeptical about what we could gain from this experience regarding this particular child but I was very wrong in feeling that way. We have seen a huge transformation in his behavior using the tools our [consultant] has given us."

~ **Smart Support participant**

Similarly, DIRECTORS who gave higher ratings on their Feedback Surveys worked with teachers who:

- Had higher increases on their Personal Self-Efficacy scores;
- Had higher decreases on their Hopeless Self-Efficacy scores ;
- Had higher increases on their Preschool Mental Health Climate Scale scores;
- Gave higher ratings on their Feedback Surveys as well.

Room for Improvement

On the Feedback Survey teachers and directors were also asked what Smart Support could do to improve mental health consultation services. Common themes are presented below in order of most salient.

- I don't have any suggestions for change – I am satisfied.
- Would like to see our consultant more days a week, and for longer sessions.
- More involvement and collaboration with families.
- I wish they would schedule times to observe and visit when children are not napping.
- Help bridge communication gap between my director and me.

Consultant Feedback

There are some promising studies which have identified professional comfort as a construct that might impact how a consultant views the challenges inherent in her work, and in turn, how she moves towards success with administrators and teachers. Professional comfort is a term borrowed from the early childhood early intervention consultation literature (Wesley, Buysse, & Keyes, 2000; Wesley, Buysse, & Skinner, 2001; Buysse & Wesley, 2005), which refers to consultants' comfort with different aspects of the consultation process such as, characteristics of the teacher (e.g., education, attitudes and expectations) and characteristics of the program (e.g., group size, ratios, access to resources, etc.).

In addition to asking consultants to rate their professional comfort with teachers and their programs, we also asked them to provide ratings of perceived support and engagement from the teacher's director or administrator, and to provide ratings of their relationship with teachers.

We hypothesized that higher ratings of professional comfort, director support, and consultant-teacher relationships might be associated with growth on key outcome performance measures. The results of this analysis are presented below in Table 55.

Table 55: Associations among consultant feedback and growth on key outcome measures*

Change in Key Outcomes	Professional Comfort	Director Support & Engagement	Consultant-Teacher Relationship
Preschool Mental Health Climate Scale (increase)			.30*
Personal Self-Efficacy (increase)	.30*	.45**	.25**
Child's Expulsion Risk (decrease)		-.41**	

* $p < .05$; ** $p < .01$

The findings indicate that Personal Self-Efficacy was more likely to increase when professional comfort was high, directors were engaged and supportive of mental health consultation, and when consultants and teachers were constructing positive relationships with one another. These findings also suggest that when directors were more supportive and engaged with the process, there were also decreases in teachers' feelings of hopelessness and children's risk of expulsion decreased. These findings are consistent with other ECMHC evaluations, which have found that director engagement was a strong predictor of successful consultation (Brennan et al., 2008; Green et al., 2006).

Discussion

More than 11 million infants, toddlers, and pre-schoolers are in early care and education settings, including home-based and center-based child care, Head Start, and pre-kindergarten programs. It is clear that large numbers of young children can benefit from strong supports for mental health in these settings. Research suggests that interventions aimed at supporting young children's social-emotional growth and mental health in early care and education settings can reduce expulsion due to behavior problems, decrease challenging behavior, and increase children's social-emotional competence (Brennan et al., 2006; Duran et al., 2006; Green et al., 2006). As a result, Early Childhood Mental Health Consultation (ECMHC) systems are growing in their capacity to serve more children and families, and more and more states around the country are funding these systems.

In 2010, Arizona's early childhood development and health system, First Things First, provided funding for its own ECMHC system, known as Smart Support. Smart Support's mission is to provide quality mental health consultation to early care and education providers keeping two main goals in mind. The first is to improve the overall quality of early care and education settings so that they are able to help support the social and emotional development of all children in their care. The second goal is to increase the capacity of early care providers to address the mental health needs and challenging behaviors that place particular children at risk for negative outcomes in the early years of life.

Our goal for this study was to pilot an evaluation that would attempt to meet several objectives: 1) to determine whether Smart Support is meeting its stated objectives; 2) to inform the program's ongoing design and implementation; 3) add to the field of literature on effective strategies for early childhood mental health consultation; and 4) provide findings that could guide Arizona and other states' efforts to build a comprehensive system of quality enhancement initiatives for the entire continuum of child care providers.

Highlighted Findings

By and large, the Smart Support Program was a success as measured by high participation rates, statistically significant increases on almost all of the key evaluation outcome measures, and overwhelming positive feedback from teachers and directors. Key findings are summarized below.

Increases in Key Quality Outcomes

We found statistically significant increases on almost all of our key evaluation outcome measures: classroom mental health climate, staff-staff relationships, teacher self-efficacy, teacher-child relationships, knowledge about social and emotional development. In addition there were significant decreases in specific children's risk of expulsion. In addition, we found that those providers who started out with the lowest scores made the largest increases.

Associations with Growth on Key Outcomes

Teachers who experienced less stress, and had fewer numbers of low-income children and children with special needs, and who perceived a more optimal work environment demonstrated the most marked improvement on key outcomes such as the classroom's emotional climate, teacher self-efficacy, teacher-child relationships and determining a child's risk of expulsion. Research has demonstrated that teachers may have difficulty maintaining emotionally positive classroom climates and successful behavioral management strategies when they are experiencing high levels of stress in their role as child care providers (Grining et al., 2010). It is important to note that work-related stress (as measured by the Child Care Worker Job Stress Inventory) is not a direct focus of Smart Support's intervention, as many of the features of the work environment are outside of the realm of Smart Support's influence (e.g., "Parents come late to pick up their children;" "I buy supplies out of my own money;" "How much I am paid;" "Taking time off from work when I need it"). Nevertheless, it would seem important to explore how mental health consultants can tailor their approach when consulting with teachers who report a high level of work-related stress. Our analysis also demonstrated that teachers who had higher ratings of their work environment and organizational climate also demonstrated more improvement on key outcomes and reported less work-related stress. This finding is consistent with research findings that more optimal child care working conditions are associated with lower emotional exhaustion (Stremmel, Benson, & Powell, 1993). These findings have important implications for how child care directors and administrators are supported in their ability to improve and maintain a high quality organizational climate (Shivers, 2011). There are also important implications for how mental health consultants can work with directors to improve staff communication and the emotional climate of the child care program, which is an important aspect of the work environment (Bloom & Sheerer, 1992; Brennan et al., 2008; Green et al., 2006).

We also found that teachers who experienced more individualized consultation, more modeling from their consultants, and had consultants who spent more time observing the classroom tended to experience greater improvements on the emotional climate of their classroom. More utilization of written action plans was also associated with greater growth on the emotional climate measure. These findings have important implications for Smart Support's on-going training and program implementation.

Feedback from Participants

Participants' responses to the Smart Support Program were overwhelmingly positive. Average feedback scores averaged 3.76 out of a possible 4.00. This positive feedback was reflected in the significant changes demonstrated in the key outcomes. Participants who rated the Smart Support Program more favorably tended to experience more growth in many of the key outcomes. Participants' suggestions for enhancement included: wanting to spend more time with their consultant and wanting consultants to engage with families more often.

Consultants also rated their experiences with teachers and programs. Findings suggest that when consultants experience more professional comfort with teachers and classrooms, when the directors are more engaged, and when they have better relationships with teachers there is more growth on key indicators such as teacher self-efficacy. These findings are supported by the literature, which places quality consultant-teacher relationships and director engagement at the heart of successful consultation (Duran, 2009).

Implications for Program Design and Implementation

- Based on the key findings from this evaluation, the following recommendations are suggested:
- Position director engagement and consultation with directors to be more central to program design. Provide Smart Support consultants with more training and support in this area.
- How can Smart Support consultants address teacher stress? More support on how to recognize it and how to tailor their approach to support highly stressed teachers.
- Explore the use of modeling and observations in consultation sessions.
- Increase the use of written action plans with teachers;
- Continue to work with teachers to increase their awareness of the different levels of the "Teaching Pyramid Model;" their knowledge of new strategies to teach anger management skills and how to handle disappointment; and knowledge of how to develop a "Positive Behavior Support Plan" for children who have challenging behaviors.

Next Steps

Policy Considerations

Continue to explore possibilities of integrating mental health consultation in all child-serving systems, including early intervention, early care and education, and special education. For example, as First Things First's flagship program – Quality First – is evolving to its next phase of implementing their new quality rating system, it will be important to track how mental health consultation is enhancing a program's ability to increase their Quality First rating.

Support workforce development. Policymakers and funders should promote efforts that will expand the pool of qualified mental health consultants. For example, policymakers and funders should help to standardize mental health consultant competencies and support adoption of those qualifications across ECMHC programs.

Develop strategic partnerships. To support consultation efforts and promote sustainability, program administrators should forge partnerships across various systems and stakeholders. For example, partnering with the higher education system to implement pre-service training on early childhood mental health and core consultation competencies can bolster efforts to build a strong consultant workforce.

Additional Research and Evaluation Considerations

Continue to refine measurement approach. Identify appropriate and valid measures (including those that address fidelity) where is there need for development of new tools? For example, how can we improve our ability to capture changes in expulsion and suspension rates?

Refine the evaluation protocol and provide evaluation supports that will not overburden study participants and that encourage participation.

Evaluation is critical to program operations, quality improvement, documentation of program effectiveness, and contributions to the evidence base. Share research outcomes with all those who participated in the research process for feedback toward quality improvement and to demonstrate effectiveness. Consultants are essential participants in evaluation efforts and can benefit from feedback on the consultation process and outcomes for children and families.

Design an approach to investigate other elements of the Smart Support model that might require deeper exploration (e.g., what is the "dosage" of consultation needed for efficacy? What are the longitudinal impacts of Smart Support? What is the impact of Smart Support on family child care versus center-based care? To what extent are Smart Support consultants working with infant and toddler child care providers?)

Conclusion

Although evidence-based models from around the country heavily influenced the design of the Smart Support Program, it is still quite remarkable that in the inaugural year of Smart Support, there were findings that demonstrated significant improvement on all key outcomes. These initial findings provide compelling evidence that the investment fourteen (14) First Things First Regional Partnership Councils have made in supporting child care mental health consultation is paying off. Arizona is now in step with many other states around the country that recognize that supporting children's social and emotional development is a vital component to school readiness, and that mental health consultation is an effective strategy in enhancing children's social and emotional functioning (Gilliam & Shahar, 2006). With further collaboration among early childhood partners, and continued funding of this initiative, Arizona can continue to enhance the efficacy of Smart Support services, and establish long-term sustainability for this emerging evidence-based practice.

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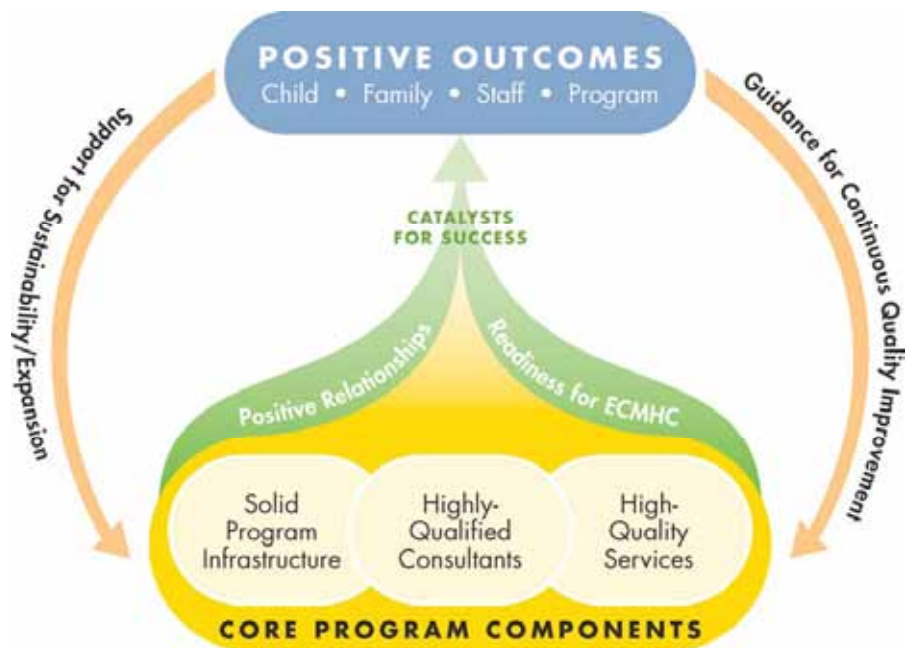
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APPENDIX A

ECMHC Conceptual Framework



Duran, F. et al. (2009). *What Works?: A Study of Effective Early Childhood Mental Health Consultation Programs*. Washington, DC: Georgetown University Center for Child and Human Development.

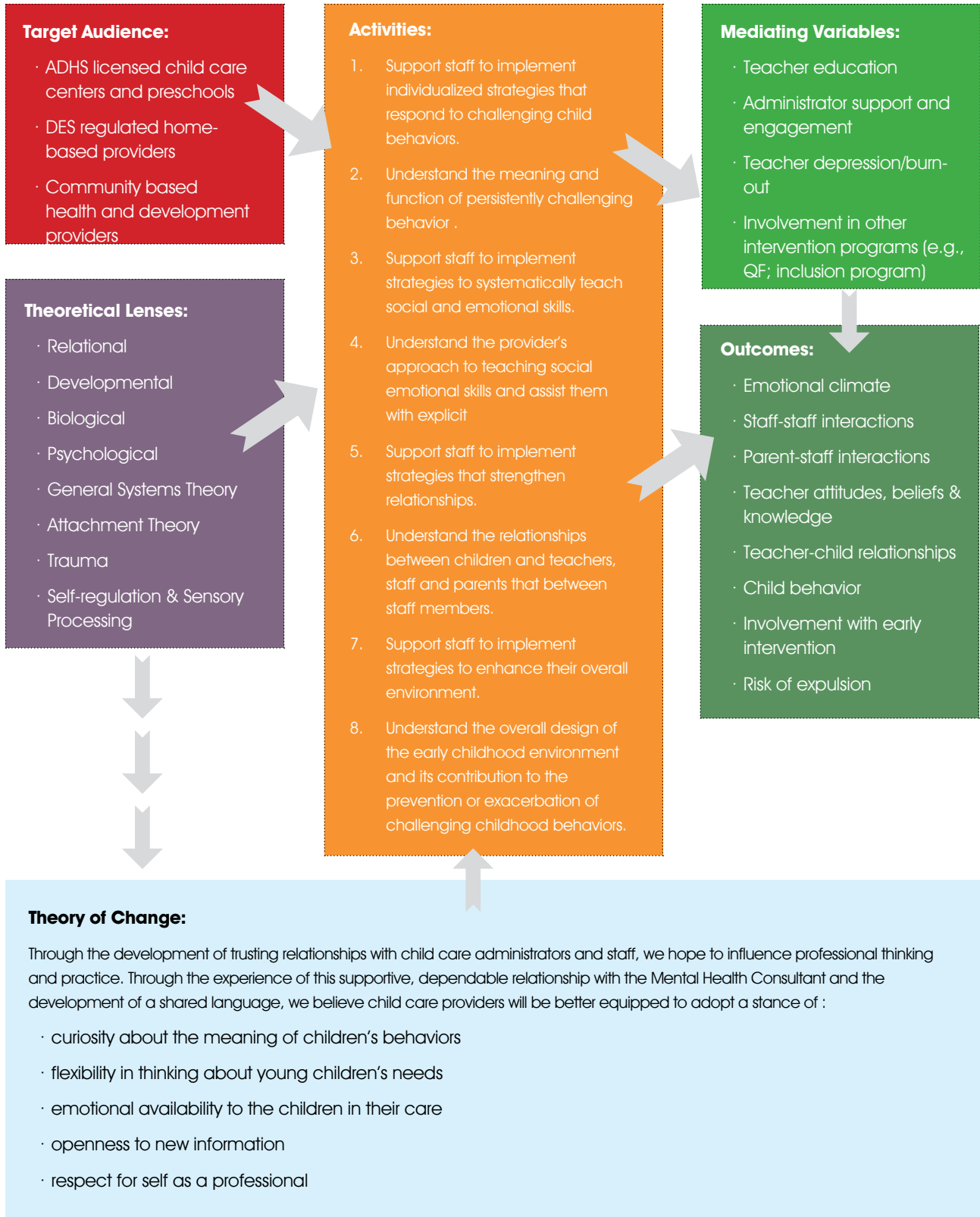


APPENDIX B

Smart Support (Working) Logic Model

Mission:

To provide quality mental health consultation services to early care and education providers that promote the social and emotional development of all children in their care and help them respond to children with behavioral challenges.



APPENDIX C

Program Characteristics

Table 9: Number of children receiving DES child care subsidy

	Minimum	Maximum	Mean	Std. Deviation
Average number of children per center who receive DES subsidy	.00	125.00	22.59	23.65

Table 10: Programs with children whose primary language is not English

	Frequency	Percent
Spanish	72	57.2
Native American	9	7.1
Other languages	45	35.7
Total	126	100.0

Table 11: Primary language used for instruction

	Frequency	Percent
English	145	97.3
Spanish	1	.7
Both	2	1.3
other	1	.7
Total	149	100.0

Table 12: Average percentage of ethnic groups in child care programs

	Minimum	Maximum	Mean	Std. Deviation
% White children	.00	100.00	47.26	31.42
% Latino children	.00	94.00	26.52	24.65
% African American children	.00	47.00	9.74	11.0
% Native American children	.00	15.00	1.93	2.94
% Asian children	.00	20.00	1.83	3.36
% Multi-racial / Multi-ethnic children	.00	50.00	6.31	10.53
% Pacific Islander	.00	23.00	1.81	5.08
% Other	.00	66.00	2.65	8.40

APPENDIX D

Child Care Director / Administrator Characteristics

Table 17: Bachelor's degree

	Frequency	Percent
No	89	59.7
Yes	60	40.3
Total	149	100.0



Table 18: Master's degree

	Frequency	Percent
No	89	59.7
Yes	60	40.3
Total	149	100.0



Table 19: Early childhood education college hours

	Minimum	Maximum	Mean	Std. Deviation
ECE semester hours	.00	900.0	45.75 hours	113.67
Management coursework (in hours)	.00	730.0	56.80 hours	94.32

Table 20: Child care administration and management experience

	Minimum	Maximum	Mean	Std. Deviation
Management experience time 1 (in years)	.00	45.00	11.60 years	8.29

APPENDIX E

Teacher Characteristics

Table 27: Number of children in home or classroom

	Minimum	Maximum	Mean	Std. Deviation
How many children are in your classroom?	2.00	33.00	15.56	5.77

Table 28: What age of children do you currently care for in your home or classroom?

	Frequency	Percent
13-18 mo	5	2.1
18-24 mo.	10	4.2
2 & 3 yr old	36	15.0
3 year olds	19	7.9
3 & 4 yr olds	53	22.1
3-5 yr olds	38	15.8
4 yr olds	12	5.0
4 & 5 yr olds	65	27.1
5-6 yr olds	2	.8
Total	243	100.0



APPENDIX F

What else have you learned?

(From CSEFEL Social and Emotional Knowledge Inventory Scale)

Be positive; Stay positive; and value teaching.

Being consistent & letting child know how special he was. Giving knuckles for showing restraint when upset went a long way to make child feel positive. How to diffuse - before the explosion.

Being more open minded about children's behavior

Getting down into the children's level, create a comfort zone for the child. Validating their feelings.

Greater understanding of how children with behaviors out of the norm can work well in the classroom environment.

[MHC] has helped to see the classroom in a new way (visual cues), the importance of social emotional skills for children.

How important it is to label a child's feelings and your own with the kids.

How to avoid a tantrum

How to collaborate with a family to effect positive change for a change for the child. How my focus on negative behavior can feed or increase that behavior. How my attention on what's going right causes me to respond to the child in ways that increase and support self esteem and thereby, more positive behavior. How to use observation and communication about observations to effect change.

How to have more patience.

How to help and understand children.

How to work with many children; how to love them.

I am better able to see that what I do is effective. Textbook concepts are sometimes difficult to recognize in the actual classroom setting. I feel more confident that what I do has worth.

I am really enjoying learning about the feelings & how to help kids express them healthy.

I have been picking out a lot of tools.

I have learned to be a fun teacher with structure.

I have never had someone come in before to identify goals think and focus on classroom and children. I learned the entire thing.

I learned that I am doing many things right, which helped boost my confidence level. I feel competent.

I was very skeptical about what we could gain from this experience regarding this particular child but I was very wrong in feeling that way. We have seen a huge transformation in his behavior using the tools our MHC has given us.

I learned new ways to communicate with a child that seemed angry. I learned with a child that he needed a hug at times. A hug would help him.

She has helped my belief that I do make a difference with the child. With love, guidance, positive redirection, and steady routine I can maintain a happy and productive room.

Taking activities and implementing them into the classroom with the children.

Talking to kids so that they listen. Transitions -- using language telling them what you want rather than what not to do.

That my job is valuable, support staff validates me, and I'm supported by my director.

That we need two teachers when certain children are here.

The effect relationships have on children.

The importance of truly observing a child and questioning what is happening.

There are people that the teacher can turn to for support and that she is not alone.

To always try to remember there could be many different reasons why I'm feeling like I do some days; it's not just the behavior of children.

Yes, by changing some areas for morning time with open centers and having table toys on floor instead of opening the carpet area, and is working very well.

APPENDIX G

Teacher Smart Support Satisfaction Survey

Instructions: The following questions ask about the work that you are doing with an early childhood mental health consultant (MHC). If you work with more than one consultant, please think about their overall characteristics and how the consultants, on average, work with you and your program.

Instructions: Please answer these questions by circling 1 if you strongly disagree with the statement, 2 if you somewhat disagree with the statement, 3 if you somewhat agree with the statement, and 4 if you strongly agree with the statement.

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree
1. I have a good relationship with the MHC(s).				
2. Our MHC demonstrated respectful awareness of the unique cultural diversity in our community.				
3. Our MHC was comfortable to talk with.				
4. Our MHC was not disruptive to our daily operations (I could still attend to the children in their classroom, and other responsibilities).				
5. Our program’s mental health consultation services have improved the quality of my classroom environment.	1	2	3	4
6. Our mental health consultation services help children with challenging behaviors.	1	2	3	4
7. Our mental health consultation services help families know how to cope with children’s challenging behaviors.	1	2	3	4
8. Our mental health consultation services help staff to feel less stress.	1	2	3	4
9. Our mental health consultation services and approach are in need of improvement.	1	2	3	4

10. What does your mental health consultant do that is most helpful for children and families?

11. What suggestions do you have to improve the quality of mental health consultation that your program currently receives?

Adapted from the Mental Health Services Survey, Green, B. L., Everhart, M., Gordon, L., & Garcia-Gettman, M. (2006). Characteristics of effective mental health consultation in early childhood settings: Multi-level analysis of a national survey. *Topics in Early Childhood Special Education* (26:3), 142-152 (suggested citation). Adapted from Parsons, R.D. & Meyers, J. (1984). *Developing consultation skills*. San Francisco: Jossey-Bass.

APPENDIX H

What does your MHC do that is most helpful for children and families?

(Open-ended responses from Teacher Feedback Survey)

Being able to hear what he's observed, pointing out strong points, and points out what may need more attention.

Bring new things to use in the classroom to help certain behaviors, gave me number and contact information for myself and parents.

[MHC] has helped me to deal with challenging children and the struggles that I have in the classroom. Thank you for all of your help.

[MHC] was very informative and I can tell she really cares about children I very much like her approach rather than negative feedback criticism She has a very positive approach of you could try.

Collaborates to create a bridge between home and school with everyone on the same page when working with challenging behavior. Has the courage and experience to have difficult conversations that catalyze real change Has dramatically improved the social life, self control, and sense of confidence & being loved for one of our children.

Demonstrates for us; tells us what to do.

Discuss ways to get children to express their feelings.

[MHC] observed accurately then posed questions and suggestions for use in helping the child with challenging behaviors. She gave demonstration lessons to the whole class helping everyone in the classroom.

Empathize, strategize, implement changes with accountable follow up.

Enormous help; teaches me how to be a better caregiver.

Evaluate the children and give us ways to deal with the children.

For me the most helpful is when she listens and her ideas to be more flexible with children's schedules.

Gave a lot of information and support.

Gives more advice, gives more pointers on how to solve some problems.

Help to find easy ideas so the child does better and gets along with the other children.

Helps me and gives suggestion to redirect the problem.

Helps place value on individual children's well being. Gives appropriate ideas activities to implement. He is also readily available for questions consultation.

Her ability to relate to each family and approach them in the right way.

I received ideas to help with the children during the day when conflicts came up. [Our MHC] was awesome. She worked with the children with "Tucker Turtle" helping the children to handle anger & come up with solutions. She did an excellent job meeting with parents & giving support when needed. Her spirit was so appreciated.

I would like to introduce [our MHC] more to our families. I feel like she helps me in the classroom, but I would like to have her reach the family more.

Information provided in pamphlets and forms. Meetings were / are helpful too.

[MHC] is always there to meet with parents who have questions or just need some help. She also provides great resources for parents as well as teachers.

Listens and gives great suggestions in any area that I talk or ask about.

[MHC] has been very helpful in giving support and ideas.

My consultant helped the children with challenging behavior.

No idea - haven't seen anything that she's done to help families or children.

Observation talks with us gives us activities and tools to help.

Offers suggestions that are reasonable and feasible to our families way of life (income environment).

Our consultant works us through each situation and adds additional information relevant and helpful

Our MHC was very helpful dealing with one of our most difficult child. He now shows so much improvement that is surprising. I was not sure how much we would gain, but I am so happy we enrolled. The tools and knowledge taught us will help us continue to support this child while in our care.

Our program's MHC service has helped improve the quality of my classroom as well as my stress level.

Providing information, and compassion

Reached out to parents providing them assistance and ideas. Helped improve my ability to reach children and help them understand their emotions. Provided books to read - that helped a lot with understanding children.

She gets things pointed and talking to the families is very helpful knowing that we all can work and communicate for a better learning environment to the child.

She gives great suggestions for families to improve children's behaviors while making them feel comfortable.

She gives me new ideas to work with my kids. She is very good, nice and very helpful. She helps the parents find more resources, which also helps them at home.

She has reassured me that I am capable of meeting the needs of my students. Also give me great insight in to their worlds and strategies to work with the kiddos she serviced and also others.

She helped us understand to take a step back and look at the behavior in another point of view.

She helps a lot with class talking to the kids showing them how to share and to talk with nice words.

She helps me feel less overwhelmed and she showed me new ways to handle a challenging child.

She helps me with my hard children. She gives me advice on how to handle them and different techniques to do.

She helps! [Our MHC] does what ever she can to improve the quality of life for the child, if it is communication between parent and school or resources for me. Michelle has helped so much I can't possibly put everything here.

She identifies and intervenes when observing behavior that indicates an individual is having difficulty functioning in day-to-day activities.

She is able to observe behaviors impartially and give suggestions. She can also work as a springboard for communication between teacher and family

She is aware of things that could clash. She sees how to tweak one little detail to get a better result.

She is very engaged with the staff also has great communication among staff and children She has brought a lot into our 3 and 4 year old classes. I plan on using the tool she provided for our class.

She knows what she is talking about and is very open and available to the children and families.

She listens and doesn't judge. She is very patient and has lots of helpful suggestions, and she is always available to help.

She offers information to parents.

She provides ideas/materials for the classroom.

Shows different methods for problem solving.

Talks to the parents and cares for them.

They are a calm presence in what is often a chaotic environment. The extra person willing to be 1-1 with the children is always wonderful. I honestly don't know what they do with parents – sorry,

They help families and children find better ways to deal with the challenging behavior.

We are given suggestions on how we can possibly help child in class. Classes were given for parents but attendance was poor on parents' part.

We have had 2 [consultants]. The first one was wonderful. She set up meetings with teachers and families, gave ideas for interventions, and interacted with the child when asked. Her approach was awesome. I look forward to getting to know the second consultant better as we have not had too much time together.

Worked on individual plans for children.

Works one on one with me giving helpful tools and tips.

