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Together for Kids: Second Year Report : A Project of Community Healthlink, Inc.

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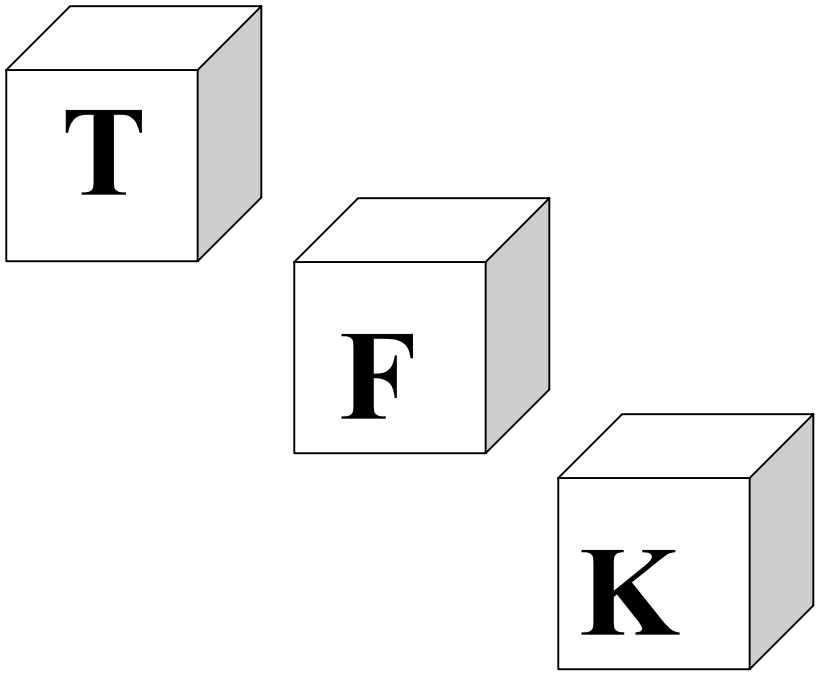
Et al.



TOGETHER FOR KIDS

Second Year Report

A Project of Community Healthlink, Inc.

Funded by the Health Foundation of Central Massachusetts and the United Way of Central Massachusetts

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Introduction

The Together for Kids (TFK) project, now beginning its third implementation year, grew out of two years of work of over 30 childcare, health care, child welfare and social service agencies concerned about early childhood mental health issues. These concerned constituents, like others across the country, were responding to an increase in the incidence of young children exhibiting challenging behaviors that were resulting in disrupted early childhood classrooms and children being expelled from programs (Grannan et al, 1999; Swanson, 2001). Locally, there was also a concern about the growing number of public school special education students with diagnoses of emotional impairment/behaviorally disordered in the early grades.

The importance of addressing the needs of these children at an early stage has been emphasized by a broad array of mental health and childcare professionals. Without appropriate services, these children end up with impaired ability to interact appropriately with family and peers; create family stress; become stigmatized as problem children; fail to develop school readiness skills and behaviors; cause disruptions to other children's learning, socialization and safety; and contribute to burn out and turnover of preschool teachers (Grannan et al 1999; Shonkoff & Phillips, 2000).

The TFK Coalition collected information from the research literature and from local day care centers about the extent of children at risk in the Worcester area. They found that 3.1% of children in four local day care centers, enrolling over 300 preschool children, were so disruptive they were expelled or would have been if the parents did not voluntarily withdraw them, with an additional 14% identified as at risk of expulsion.

Based on this information, the TFK Coalition developed an intervention model that focused specifically on challenging behaviors of preschool children (ages 3 and up) enrolled in childcare centers. The first year of the project was used as a Pilot year to implement the mental health consultation model in two preschool in Worcester and a Head Start Program in South County. Results of the evaluation of this Pilot phase were encouraging and supported the initiation of an implementation phase in Year Two. This implementation phase involved providing the mental health consultation model in two additional centers that served as comparison centers during the Pilot phase. These two sites were brought on as New Intervention Sites in January 2004. This report focuses on the evaluation of the implementation phase, including the original Pilot Sites, the South County Sites and the two New Intervention Sites, as well as summarizing the findings from both of the years of intervention.

Intervention

Given the logic model for the intervention, and information on models used elsewhere in the country (Bowdish, 2001; Ehrstine, 2001; Johnson, 2001; Kaufmann & Cohen, 2000), the TFK project designed a consultation model of intervention that focuses on: 1) short-term individual child and family assistance; 2) classroom assistance for teachers; and 3) center-wide activities to enhance parent and teacher competencies in handling early childhood behavioral issues. Staff members with early childhood mental health experience were assigned part-time to a childcare center. Their role (entitled Child Development Advisor or CDA) is to: work with the teachers to help identify children who need extra assistance; assess the child and family needs; develop a short-term intervention plan with the family; assist the teachers with classroom strategies for the child; refer the families for long term services and for other community resources; provide center-wide training sessions for all staff on early childhood behavioral issues; and assist the centers to design and deliver center-wide parent activities that enhance parent involvement in the childcare center and provide information and support on parenting skills and other family issues.

Children and families targeted for individual intervention received a mean of 22 hours of services over 4 to 6 months, with a range of from 2 to 72 hours (median=19 hours; with most receiving between 15 and 29 hours of service).

Expectations

Our expectation, supported by data in the Pilot year of the study, is that the intervention model will result in improvements in both the at-risk families and children, and the teachers and childcare centers as a whole. Parents will know better how to interact with their child and the child will learn new skills and exhibit less problematic behavior at home and in childcare. In addition, families will have access to more resources and experience lower parenting stress. Teachers will also demonstrate skill development, and the classroom climate will improve with lower levels of child behavior problems. Overall, there will be greater collaboration between parents and teachers, and parents will feel a greater connection to childcare centers and more comfort in talking to teachers about their child's behavior.

Evaluation

In Year Two, the evaluation of the implementation phase of the TFK project involved assessing baseline and follow-up data from the Year One Pilot and South County Sites as well as the two New Intervention Sites that served as comparison sites during the first year. The evaluation was designed to replicate the data collection during the Pilot year which included collecting baseline and follow up information on children identified as at risk and their families, as well as examining behavioral outcomes of children who were eligible for services but on a waiting list. This latter group served as a comparison to children who received services and helped to determine generalized classroom effects. Documentation of both the types of services received by individual children and families, and the types of center-wide parent and teacher training and activities, was also completed. In this implementation year, we were also able to assess longer term classroom effects by examining change in the Pilot and South County sites from Year 1 to Year 2, and in comparison to the New Intervention sites receiving their first year of services.

Children's behaviors and skills were assessed through a multi-dimensional process that started with the Early Screening Project (ESP) questionnaires (Walker, Severson & Feil, 1995). The ESP is completed by the child's teacher after a training session where early childhood externalizing and internalizing behaviors are described. Teachers identify ten children in their classroom that match these

descriptions. They then complete a set of four short scales for each of three to five children who exhibit externalizing behaviors, and three to five who exhibit internalizing behaviors: 1) Critical Events Index (a checklist of 16 serious behaviors; 2) either the Aggressive Behaviors Scale (for externalizing children) or the Social Interaction Scale (for internalizing children); 3) the Adaptive Behavior Scale; and 4) the Maladaptive Behavior Scale.

Families of children whose scores fell in the critical range were then approached for a discussion about intervention services by the childcare administration and the child's teacher. Both children who received services and those who did not receive services, but who were indicated as needing services, were rated by the teachers three to four months after intervention services started.

Once a family agreed to receive intervention services, a more comprehensive assessment of the child and family was conducted, including a home visit, and a treatment plan was initiated. Children received a brief developmental assessment, the Developmental Profile II (Alpern, Boll & Shearer, 2000). This is a developmental screen designed to identify children who may have intellectual, social, communication or adaptive behavior delays.

Parents were asked to provide baseline demographic information and to complete four additional instruments: the Family Resource Scale (Dunst & Leet, 1987); the Parenting Stress Index-Short Form (Abidin, 1995); the Life Events Scale (derived from the Parenting Stress Index long form); the Parenting Scale (Arnold et al, 1993). The Family Resource Scale measures the adequacy of resources in households with young children. The Parenting Stress Index measures stress in the parental role, stress related to the child's behavior and temperament, and stress related to parental expectations of their child. The Life Events Scale measures common family stressors, such as a death in the family, divorce, or household moves that might affect a young child's behavior. The Parenting Scale was developed to identify common 'mistakes' in discipline by parents of preschool children. Finally, the family's home was assessed by the CDA using the HOME (Caldwell & Bradley, 1984). This scale is used to provide basic information on the extent to which parent skills and the home environment are supportive of the developmental needs of young children. In addition to measures of child and family functioning, needs and resources, those families who receive intervention are asked to fill out a satisfaction with services scale and a Parent-Professional Relationship Scale to identify how helpful they found the assistance provided by the TFK program.

Assessments where change was anticipated (Early Screening Project assessment, Developmental Profile, Parenting Stress Index, and the Parenting Scale) were repeated at the end of the brief individual child and family intervention for those children identified as at risk.

As in the first year of the study, a center-wide teacher survey was also conducted. These surveys were distributed anonymously to preschool teachers in October/November of 2003 in all sites. The survey questionnaire combined data collection on demographic and educational background, knowledge about early childhood behavioral issues, and one additional standardized questionnaire rating personal burnout. The Maslach Burnout Inventory is designed specifically for teachers and human service workers. It measures emotional exhaustion, depersonalization, and personal accomplishment on the job Maslach, Jackson & Leiter, 1996). The Maslach has three subscales that measure emotional exhaustion, depersonalization and personal accomplishment.

Finally, interviews with Executive Directors and child care center directors, and focus groups with teachers, and with the CDAs (mental health consultants) provided feedback and evaluation of the implementation process.

Sites

Pilot Site A enrolled 94 preschool children from 2 years 9 months through 4 years 11 months in 6 classrooms, with 2 lead teachers, 8 teachers and 4 assistant teachers. Approximately 45% of children were white, with 20% African American, 14% Latino, and 21% Asian and other ethnicities. Family incomes ranged from $5,000-$100,000. About 14% of parents needed assistance with English. This site reported very strong parent involvement, with 75% attending individual child feedback sessions, and 24% attending open houses.

Pilot Site B enrolled 30 preschool children ranging from 2 years 10 months to 4 years 10 months in two classrooms with one lead teacher, four teachers and one assistant teacher. Two thirds of the children were Latino, with only three White, and six children listed as being of "other" ethnic backgrounds. Family incomes are all below state median income and all children's care is publicly subsidized. Almost all families were noted as needing assistance with English. Few parents were reported to attend individual feedback sessions about their children, but 80% were reported to attend the preschool's social gatherings.

New Intervention Site C enrolled 41 preschool children ages 2 years 9 months to 5 years in two classrooms with one lead teacher, 3 teachers and one assistant teacher. At this site, 41% were White, 24% Latino, 17% African American, and 17% other. About 15% of parents were noted to need assistance with English. Family incomes ranged from $13.000-150,000. About 80% of parents attend individual feedback sessions on their children, 40% attend social gatherings and 35% open houses.

New Intervention Site D enrolled 51 preschoolers ranging in age from 2 years nine months to five years in 3 classrooms with 3 lead teachers, 3 teachers, 2 assistant teachers, and one "floater." The majority of families are Latino (55%), with about 24% Black, 6% White, and 17% other. Fifty-five percent of family incomes were at or below $17,000 with a maximum of $50,000. All children's care is subsidized publicly. About a third of families were reported to need assistance with English. This center reported the lowest parent participation, with 16% attending open houses, and none attending individual feedback sessions on their children.

South County Sites 63 children were enrolled in four sites with one classroom each. Two sites had 16 children each, one had 14 children and one had 17 children, ages 3-5. A total of 4 lead teachers, five teachers and 1 teacher aide were employed at these sites. Fifty-five percent of families were White, 6% were African American, 7% were multiracial, and the other 32% were either not defined or of other racial backgrounds. Family incomes averaged from $12,000 to $13,700. Parent participation was rated as 100% attending individual sessions about their children's progress, 20% attending open houses, and a range of from 10% to 50% attending social gatherings.

Preliminary Findings and Recommendations

The implementation year of the Together for Kids pilot project has resulted in a maturing model. The project has achieved a balance between contributing to teacher training and overall center support, along with providing individual child and family services. While developing the right 'fit' and relationship with each child care center has been a challenge, overall the center administrators and teachers see great value in the TFK services and have grown in their recognition and ability to meet the needs of the children with behavioral issues. In Year 2, TFK expanded to additional preschool classrooms, and an even higher percentages of children were identified as in need of assistance. Across the 5 child care programs served in Year Two, reflecting approximately 280 preschool age children in 17 classrooms,

child screenings resulted in a yield rate of 34.7% of children with clinically significant externalizing or internalizing behavior problems. Between the two years, a total of 120 children were identified as in need of service. Of this group, 47 children and their families received some individual intervention services.

A. Center-wide Issues

CDA, center administrator, and child care staff interviews and focus groups illustrated that all stakeholders found value in the TFK model, including staff receiving training and support, families being better connected to their child and the child care centers, and individual children achieving behavioral and developmental gains. There were, however, some difficulties working out the relationship between the specific personality and array of skills of the CDA and the needs of individual childcare sites. In some centers it was difficult to achieve the balance between providing teacher support and individual child intervention. CDAs mentioned that obtaining teacher buy-in was challenging and that there were different levels of motivation and interest in working as a team with the CDA. CDAs felt that more teacher training was a necessary ingredient, while only some teacher groups felt so.

In addition to the challenges of gaining staff buy-in and establishing a collaborative working relationship between the CDA and the center, the biggest challenge mentioned by all stakeholders (CDAs, teachers, EDs and Center Directors) was engaging families. The family liaison role that received additional funding in Year Two hadn't yet had time to be fully implemented in centers when these interviews were conducted. However, there was one very positive experience at a center where the family liaison had organized a center-wide teacher, parent and child activity. This role needs continued funding and support to engage families in more positive relations with the child care centers. Parents might be less reluctant to accept help around their child's behavior if they have more of a connection and level of trust in the child care center.

Further, while trust is built with families over the few months the CDA works with the child and family, stakeholders at all levels felt that the time frame for the intervention was too short. One key recommendation that all groups felt was important is to extend the time frame for working with individual families from 4-6 to 6-8 months so that more could be accomplished with the child and family. In response to this recommendation, in the next phase of the project, families will be re-evaluated at the 6th month time point and will be re-enrolled to receive additional TFK services if warranted.

B. Assessment of Child Behavior Problems

In Year Two a total of 87 children were identified with externalizing (n=60) or internalizing (n=27) behavior problems. The rate of identification of clinically significant problems was 28.9% in the three sites that were enrolled in the Pilot Year (Pilot Site A and B and South Count). It was higher, 36%, in the two New Intervention Sites. More extensive assessment of the children targeted for intervention (n=28) revealed that all of the children with externalizing behaviors fell into the extreme risk category on the Aggression and Maladaptive Behavior Subscales of the ESP. The seven internalizing children identified and provided services were at somewhat lower risk for maladaptive behavior and had better adaptive behavior than did children categorized as externalizing. As in Year One, assessments of developmental skills also showed that targeted children had great variation in development, but tended to show delays in social and communication skills. Many of these children had never before been assessed for developmental issues. While it is not possible to suggest that the delays are causing children's behavioral difficulties, or the converse, that behavioral difficulties cause the delays, this finding suggests that an important part of the TFK intervention is to perform a comprehensive child assessment so that a complete and comprehensive set of information is available to assist the child and family.

C. Family Assessment

Family's whose children required assistance had a wide range of backgrounds. Sixty-four percent were single parents, and 61% worked full time. While incomes were moderate, 25% did report income of over $40,000 a year and only one family with an income of less than $5,000. About 46% were non-white (Hispanic and African American), and 43% had some college education. One quarter of the families had been involved with DSS in the past year. Overall, home environments were adequate for young children, but many families lacked in academic stimulation (51% in the lowest quartile) and variety of experience. On the other hand, most families (72%) scored in the highest category on "warmth and affection". These characteristics were similar to parents enrolled in Year One.

While two or three families rated resources for meeting basic needs as inadequate, overall families reported adequate resources, although most did have mild financial and personal strains. When asked about specific family and personal stressors, most families did not report situations out of the normative range. Only 21% were past the cut off score for life stressors (e.g. loss of a job, death in the family). Assessment of parenting stress revealed that only 25% have scores in the clinical range. Finally, an assessment of parental discipline skills revealed that some, but not all the parents used ineffective strategies for discipline. The profile of this group of parents differs slightly from Year One in that Year One parents clearly had more discipline skills deficits. Taken as a whole, these data suggest that services need to be tailored to families based on their individual needs. For example, some families have clinical levels of stress that may need to be addressed before their parenting skills, while others may primarily need to develop parenting skills. Regardless of the area of need, however, it should be recognized that the majority of the families whose children require assistance have significant strengths. This reinforces the importance of recognizing and working with families based on strengths, instead of using a deficit model.

D. Outcomes

Individual assessments of children's classroom behaviors for those children who received intervention for externalizing behaviors revealed significant improvements between baseline and the end of services on Critical Events, Aggressive Behavior, Adaptive Behavior and Maladaptive Behavior. Additionally, in contrast to children falling within risk cutoffs for externalizing behavior who did not receive services due to time constraints, children who received services decreased their Aggressive Behavior and their Maladaptive Behavior substantially, while those awaiting services were rated by teachers as having less behavior change (although still showing some improvement) in a follow-up assessment. This interaction effect was statistically significant for Maladaptive Behavior and close to significance for Aggressive Behavior, showing a strong effect of the intervention compared to a waiting list group. Unlike Year One, however, these changes did not vary by intensity of treatment services. It appears that children received the necessary package of services despite the range of hours being quite different among those served. This supports an individualized approach to services, rather than setting a specific number of hours of service for all children.

Children with internalizing behaviors who received services also showed a pattern of improvements in Adaptive and Social behavior, and a significant improvement in Critical Events, but the small numbers precluded a more complete analysis of their outcomes.

In addition to gains seen in improving behaviors, target children also made substantial improvements in developmental skills. Both Physical Development and Self Help Skills significantly increased (by 6-8 months respectively), and there was a trend for improvement of Academic Skills and Communication Skills (about a 3 month improvement in each). As with the assessment of behavior

change, intensity of services did not affect the outcome significantly, except for Self Help skills, which improved more for children and families receiving more service hours.

The results for parent outcomes were more complex in Year Two compared to Year One. Families who a received more service hours (total child and family services) did have greater changes in parent discipline skills, with a significant interaction found in one scale of the Parenting Skills assessment. However, the parents who received fewer hours actually increased their poor discipline skills over the period of the intervention. This may reflect that families with fewer treatment hours had more of those hours focused on the child and school setting, whereas those with more treatment hours may have had the additional hours spent working with the family and on parenting issues. Perhaps those with fewer hours were also experiencing more frustration and had less follow-through with scheduled TFK meetings. There were no changes on the Parenting Stress scales between baseline and end of service delivery, nor by service intensity. These parenting findings may reflect, as teachers and administrators indicated, that parents may not have been as engaged as those parents involved in Year One. It also suggests that further efforts need to be made to fully involve parents in the intervention so they achieve benefits was well as the child with the hope that their child's gains can be maintained over time.

Assessments of TFK's classroom-wide effects suggest that TFK services are having a positive influence on both the number of children being suspended or terminated, as well as the overall level of behavior problems in the classroom. For instance, in the first two centers receiving TFK services, terminations for behavior decreased from 9 children in the previous year, to one child each year in the two intervention years. At these two sites, an additional child was suspended in Year 1, and two in Year 2. The two new sites receiving services in Year 2 had a termination rate that changed from 4 children in the prior year, to one child; and a suspension rate that went from 2 children down to 1 child. Further, while baseline levels of behavioral problems in the classroom did not differ between sites, the pilot sites that had TFK for two years, had significantly lower levels of behavior problems in the classrooms in their second year (as compared to baseline, and as compared to the new intervention sites that had TFK services for only one year). Thus, improvement in overall levels of behavior problems in the classroom develops over time, showing up in the second year of TFK services. This is consistent with the notion that teacher-CDA relationships take time to develop, classroom goals and strategies take time to be identified and developed, and change in classroom practices take time to take hold. However, the payoff appears to be a better classroom climate for all children.

Conclusion

Overall, in the Implementation Year, TFK expanded its scope considerably, serving 17 classrooms, over 40 teachers, and 280 children. Substantial numbers of children and families have also been provided individual services. We have learned that gains seen in Year One in child behavior, and to some extent in child developmental skills, continue with the children served in Year Two. Particularly children with externalizing behavioral issues make significant gains in decreasing aggression and maladaptive behavior. These gains are also significant when compared to children in the same classrooms who are awaiting services.

In contrast, we have not seen sustained changes in parent discipline skills, as found in Year One. It may be that the Year One families selected were those more motivated and concerned about their children, and therefore they were easier to engage. CDAs, staff and administrators alike agreed in interviews about the success of TFK that parent engagement was one of the most difficult challenges. All made the assessment that some gains had been made around parent intervention, but that working with parents remained one of the most important continuing barriers to successful child outcomes. The recommendation from CDAs and child care staff and administrators that the model be modified to provide

somewhat lengthier intervention time for families so that more sustained change can occur, seems appropriate, especially in light of our findings that more service intensity did improve parent discipline skills. Of course the trade off may be in smaller number of children served each year. However, a small increment in time for some families may prevent the child from regressing and needing to reenter individualized service. At the same time Year Two data have shown that even modest amounts of services considerably help children.

Further, in the interviews with teachers and center administrators, there appear to be center-wide effects in terms of a qualitative shift in recognizing the support and training the CDAs provide for overall classroom management and teacher training. Thus in the Implementation Year, child care centers have taken ownership of improving children's behavior and view TFK as a collaborative model between the centers and the CDA. This is evident in the classroom-wide effects that suggest that TFK services are decreasing the overall levels of behavior problems in the classroom.

At the same time, stakeholders identified that one of the most crucial aspects of the TFK model rests on the CDA's ability to develop a strong working relationship with both administration and teachers at the child care centers. The fit between the style and skills of the CDA and the child care center appears to be crucial to the success of the model. Programs that were less satisfied with the services this year felt that the 'match' between the CDA and the center did not work well. Clarifying the role of the CDA as one of collaboration, not solely individual child intervention, and providing ongoing training and supervision to address these how to facilitate the CDA-center staff relationships will be necessary to continue to improve the model. In addition, the findings from Year Two stress the importance of sustaining components that address training and support to teachers, and figuring out how to overcome some of the teacher motivational issues. Finally, finding new ways to gain commitment of families and to assist child care centers to provide center-wide parent engagement activities that will decrease the disconnect between families and care providers will be important to reaching more children and families, and preserving the already impressive outcomes TFK has achieved.

I. Introduction

The Together for Kids (TFK) project, now beginning its third implementation year, grew out of two years of work of over 30 childcare, health care, child welfare and social service agencies concerned about early childhood mental health issues. These concerned constituents, like others across the country, were responding to an increase in the incidence of young children exhibiting challenging behaviors that were resulting in disrupted early childhood classrooms and children being expelled from programs (Grannan et al, 1999; Swanson, 2001). Locally, there was also a concern about the growing number of public school special education students with diagnoses of emotional impairment/behaviorally disordered in the early grades. The behaviors exhibited by these children typically include biting, hitting, throwing things, defying adults, or becoming withdrawn and unable to interact with others.

The importance of addressing the needs of these children at an early stage has been emphasized by a broad array of mental health and childcare professionals. Without appropriate services, these children end up with impaired ability to interact appropriately with family and peers; create family stress; become stigmatized as problem children; fail to develop school readiness skills and behaviors; cause disruptions to other children's learning, socialization and safety; and contribute to burn out and turnover of preschool teachers (Grannan et al 1999; Shonkoff & Phillips, 2000). The wide-ranging implications of the growing numbers of young children with challenging behaviors provides crucial evidence for action to both better understand the reasons and to develop effective intervention approaches.

The TFK Coalition collected information from the research literature and from local day care centers about the extent of children at risk in the Worcester area. They found that 3.1% of children in four local day care centers, enrolling over 300 preschool children, were so disruptive they were expelled or would have been if the parents did not voluntarily withdraw them, with an additional 14% identified as at risk of expulsion. They also anecdotally connected the increasing difficulty in managing classrooms with high staff turnover, ranging up to 46% in one year. At the same time, only one Center reported access to early childhood mental health services. Based on this information, the TFK Coalition began to develop an intervention model. The specific focus of the project is on challenging behaviors of preschool children (ages 3 and up) enrolled in childcare centers.

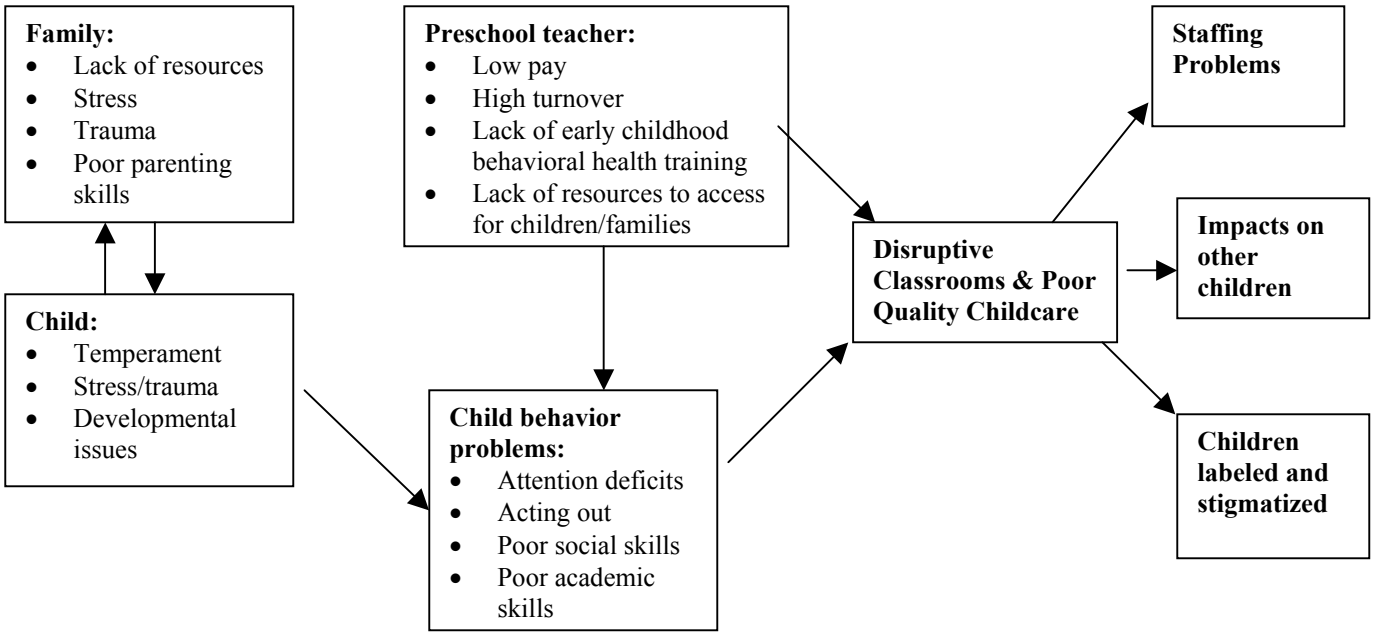
The first year of the project was used as a Pilot year to implement the mental health consultation model in two preschool in Worcester and a Head Start Program in South County. Results of the evaluation of this Pilot phase were encouraging and supported the initiation of an implementation phase in Year Two. This implementation phase involved providing the mental health consultation model in two additional centers that served as comparison centers during the Pilot phase. This report focuses on the evaluation of this implementation phase, including the original Pilot Sites, the South County Sites and the two New Intervention Sites.

II. TFK Logic Model

The Project has drawn upon a multidisciplinary framework to develop an analysis of both the problem and the necessary intervention strategy. The approach is to recognize that there are multiple sources of risk for children, and that prevention and intervention require addressing multiple factors that impinge on early child development (Bronfenbrenner, 1994; Shonkoff & Phillips, 2000). Diagram 1 (below) outlines the basic elements of a multifactor analysis of how a child ends up developing challenging behaviors that result in negative consequences for the child, other children in the childcare

center, and the childcare center. The important conclusion is that factors inherent to the child are only one causal factor; the way both the family and the childcare center staff interact with a child can exacerbate or ameliorate the child's difficulties. Using a model of risk and resilience (Sameroff & Fiese, 2000), our approach derives from the assumption that there are multiple sources of both support and difficulty for each child.

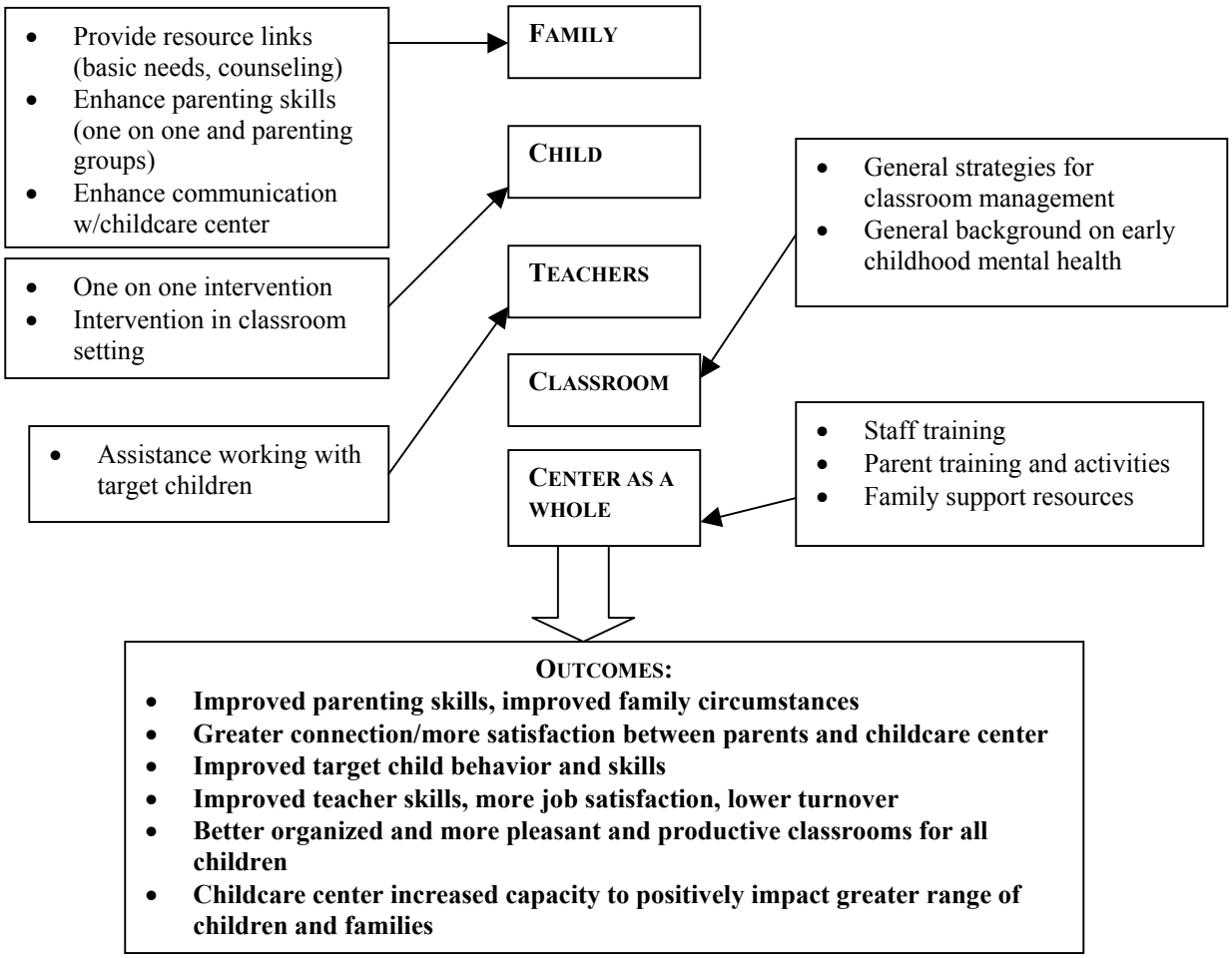
Diagram 1. Problem model: Sources of difficulty for young children with challenging behaviors and the outcomes



The intervention model used by TFK is based upon the analysis of the multiple sources of risk and support. Diagram 2. (see below) illustrates that the intervention has multiple foci, including the family, the child, the teachers, the classroom and the childcare center as a whole. The assumption is that families under stress, experiencing trauma, lacking in resources, and having poor parenting skills will benefit by access to assistance on all of these dimensions through both individual treatment, and more family-oriented activities and supports from the childcare center. The child can benefit from both one-on-one intervention around specific skills and behaviors, and at the same time modeling of classroom behavior. The teachers need specific assistance addressing the needs of specific children in their classroom who are challenging. In addition they need both better general knowledge about child development and behavior in order to set appropriate expectations, and specific knowledge about how to handle challenging behaviors in the classroom effectively. Overall, childcare centers will benefit from enhanced staff training, providing parent training sessions, and knowing how to access other types of resources for families.

Our expectation, supported by data in the Pilot year of the study, is that the intervention model will result in improvements in both the at-risk families and children, and the teachers and childcare centers as a whole. Parents will know better how to interact with their child, and the child will learn new skills and exhibit less problematic behavior at home and in childcare. In addition, families will have access to more resources and experience lower parenting stress. Teachers will also demonstrate skill development, and the overall classroom climate will improve with lower levels of child behavior problems. Overall, there will be greater collaboration between parents and teachers, and parents will feel a greater connection to childcare centers and more comfort in talking to teachers about their child's behavior.

Diagram 2. TFK Intervention Model



III. TFK Intervention Model

Given the logic model for the intervention, and information on models used elsewhere in the country (Bowdish, 2001; Ehrstine, 2001; Johnson, 2001; Kaufmann & Cohen, 2000), the TFK project designed a consultation model of intervention that focuses on: 1) short-term individual child and family assistance; 2) classroom assistance for teachers; and 3) center-wide activities to enhance parent and teacher competencies in handling early childhood behavioral issues. Staff members with early childhood mental health experience were assigned part-time to a childcare center. Their role (entitled Child Development Advisor or CDA) is to work with the teachers to help identify children who need extra assistance; assess the child and family needs; develop a short-term intervention plan with the family; assist the teachers with classroom strategies for the child; refer the families for long term services and for other community resources; provide center-wide training sessions for all staff on early childhood behavioral issues; and assist the centers to design and deliver center-wide parent activities that enhance parent involvement in the childcare center and provide information and support on parenting skills and other family issues.

The model was planned so that the capacity of the childcare center to address the needs of children with challenging behaviors would be enhanced after an early intensive phase, and thus long term could be supported through periodic child or Center services by a CDA serving more than one childcare center. In addition to the CDA role, the model provided resources to the childcare centers to hire an additional half time classroom teacher. The Centers were to use this 'floater' teacher to substitute for the regular teachers while they met with parents whose children were receiving short term intervention, attended training, or while they performed other activities necessary to assist the targeted at risk children.

IV. Evaluation Model: Outcomes, Instruments and Measures

In Year Two, the evaluation of the implementation phase of the TFK project involved continuing to collect data from the Year One Pilot and South County Sites, as well as adding data collection and services in two New Intervention Sites that served as comparison sites during the first year. The evaluation was designed to replicate the data collection during the Pilot year which included collecting baseline and follow up information on children identified as at risk and their families, as well as examining behavioral outcomes of children who were eligible for services but on a waiting list. This latter group served as a comparison to children who received services and helped to determine generalized classroom effects. Documentation of both the types of services received by individual children and families, and the types of center-wide parent and teacher training and activities, was also completed. In this Implementation year, we were also able to assess longer term classroom effects by examining change in overall child behavioral ratings in the Pilot and South County sites from Year 1 to Year 2, and in comparison to the New Intervention sites receiving their first year of services.

A. Center-wide Outcomes

As in the first year of the study, a center-wide teacher survey was conducted. These surveys were distributed anonymously to preschool teachers in October/November of 2003 in all sites. The survey questionnaire combined data collection on demographic and educational background, knowledge about early childhood behavioral issues, and one additional standardized questionnaire rating personal burnout. The Maslach Burnout Inventory is designed specifically for teachers and human service workers. It measures emotional exhaustion, depersonalization, and personal accomplishment on the job Maslach, Jackson & Leiter, 1996). The Maslach has three subscales that measure emotional exhaustion, depersonalization and personal accomplishment. Alpha reliabilities for each subscale (.90, .79 and .71 respectively) are adequate. Concurrent validity of the scale was measured using co-worker observers to rate others in the job site. These measures were used to monitor changes in teacher feelings of competence, need for further job training, as well as job stress and burnout.

In addition to the standardized measures, the evaluation included small, criterion referenced feedback questionnaires to evaluate the impact of teacher training sessions and parent activities or trainings provided by the childcare centers. Finally, interviews with executive directors and center directors, and focus groups with teachers, and with the mental health consultants provided feedback and qualitative evaluation of the implementation process.

A change was made in Year 2 involving the use of classroom observations. In Year 1, classroom observations were used as part of the research assessment of classroom climate changes, but it was discovered that they were not sensitive enough to measure change. Therefore, although the classroom observations were continued in Year 2, they were used as a clinical tool to set classroom goals and provide a means for self-evaluation.

B. Child and Family Outcomes for Intervention Children

We expected to find similar outcomes as were found in Year One. For children, we hypothesized that the intervention would:

a) decrease challenging behavior;
b) increase positive functioning; and
c) increase age appropriate skills.

For parents, we hypothesized that the intervention would:

a) increase their skills in dealing with their child's challenging behavior;
b) decrease parenting stress;
c) connect them with additional resources; and
d) increase their collaboration with the childcare center and involvement with the child's classroom teacher.

All child and family measures used in the Year 1, in the Pilot phase of the study, were repeated in the Implementation Phase in Year 2. Children's behaviors and skills were assessed through a multi-dimensional process that started with the Early Screening Project (ESP) questionnaires (Walker, Severson & Feil, 1995). The ESP is completed by the child's teacher after a training session where early childhood externalizing and internalizing behaviors are described. Teachers identify ten children in their classroom that match these descriptions. They then complete a set of four short scales for each of three to five children who exhibit externalizing behaviors and three to five who exhibit internalizing behaviors: 1) Critical Events Index (a checklist of 16 serious behaviors; 2) either the Aggressive Behaviors Scale (for externalizing children) or the Social Interaction Scale (for internalizing children); 3) the Adaptive Behavior Scale; and 4) the Maladaptive Behavior Scale. Ratings of internal consistency for our sample range from .78 to .81 on the Aggressive Behavior Scale, .85 to .95 for the Social Interaction Scale, .79 to .92 for the Adaptive Behavior Scale, and .84 to .89 for the Maladaptive Behavior Scale. Reported Kappa interrater reliability between teachers and assistant teachers for the scales ranged from .48 to .79, with a median coefficient of .71. Discriminant function analysis also showed that the ESP has a very low rate of false positive diagnoses, with sensitivity rates ranging from 62% to 100%, and specificity rates ranging from 94% to 100%. The scales have been validated against other behavior scales, such as the Connors. The scales are also sensitive to intervention.

Teachers were asked to rate the children at baseline for referral for services. The scales were then scored by the evaluation team and compared to standardized norms calculated separately for boys and girls. Families of children whose scores fell in the critical range were then approached for a discussion about intervention services by the childcare administration and the child's teacher. Both children who received services and those who did not receive services, but who were indicated as needing services, were rated by the teachers four to six months after intervention services started.

The other child-focused assessment was the Developmental Profile II (Alpern, Boll & Shearer, 2000). This is a brief developmental screen designed to identify children who may have intellectual, social, communication, or adaptive behavior delays. There are five subscales, physical, self-help, social, academic and communication. The instrument has extensive norms and good internal reliability on each subscale ranging from .78 to .87. Interrater reliability is also high, with 71% of raters achieving identical ratings, 79% within one point, and 100% within two points. The measure has shown strong correlations to other more detailed measures of development and intelligence, and has been shown to reflect change due to intervention. This screen was administered either in the home or at the child care site by the CDA,

after parents gave permission and agreed to short term intervention for those children determined to be at risk. It was re-administered 4-6 months later at the end of the short-term intervention.

For those families whose children were identified as at risk based on the teacher ratings on the ESP, and who agreed to participate in the intervention, a home visit was conducted to collect a wide variety of parent and family measures. These included: baseline demographic information; the Family Resource Scale (Dunst & Leet, 1987); the Parenting Stress Index-Short Form (Abidin, 1995); the Life Events Scale (derived from the Parenting Stress Index long form); the Parenting Scale (Arnold et al, 1993); and the HOME (Caldwell & Bradley, 1984). With the exception of the HOME, all the scales are self-report by the parent(s).

The Family Resource Scale measures the adequacy of resources in households with young children. This includes basic needs for food, housing, income, social services, support, and family activities ranging from the most basic to more life enhancing. There are 30 items rated on a five-point scale of not at all adequate to almost always adequate. Alpha reliability for the scale is .92 and test retest stability over five months was found to be .52. This instrument was used to help the project identify family needs that if fulfilled, would lessen family stress and contribute to a better family environment for young children.

The Parenting Stress Index-Short Form consists of 36 items derived from a 100-item, well-established research and intervention instrument. The items comprise a total score and three subscales: Parental Distress (stress in role as parent such as role restrictions/depression); Parent-Child Dysfunctional Interaction (stress related to the child not meeting the parent's expectations); and Difficult Child (stress related to behavioral characteristics of children that make them difficult to manage). Alpha reliabilities for the total scale are .91, and for each subscale range from .80 to .87, and 6-month test-retest reliabilities range from .84 for the total scale, with .68 to .85 for the subscales, with the Parent-Child Dysfunctional Interaction being the least stable. The questionnaire has been normed on 800 children and clinical cutoff and percentile scores are provided.

Similarly, cut off scores and norms are available for the Life Events Scale, derived from the longer Parenting Stress Index. This scale taps common life events that can generate either positive or negative stress for families, such as a death in the family, divorce, job loss, housing moves, marriages etc. By identifying sources of stress in a family, the intervention plan can assist both the family and the child who may be acting out the stress to identify coping and resource strategies. This scale was used as a treatment planning indicator not a measure of outcome.

The Parenting Scale is a 30-item scale developed to identify common 'mistakes' in discipline by parents of preschool children. It includes a total score and three subscales: Laxness, Overreactivity, Verbosity. The Laxness scale measures the extent to which parents notice but do not respond to misbehavior; the Overreactivity scale measures emotional reactivity of parents in discipline situations; and the Verbosity scale measures coxing, begging or lengthy explanations versus limit setting. It was initially designed and tested on Head Start parents. Alpha reliability for the total score is .84 and .83 and .84 for the Laxness and Overreactivity subscales. The Verbosity subscale is less well defined and demonstrated an alpha of only .63. The Parenting Scale was used to measure improvements in parental discipline skills.

Finally, the HOME was used to provide basic information on the extent to which parent skills and the home environment were supportive of the developmental needs of young children. It has been well used and standardized across a wide range of children and families. The preschool version is a 55-item scale with subscales for: learning stimulation, physical environment, warmth and affection, academic stimulation, modeling, variety in experience, and acceptance. The total scale alpha with a large sample of

families during instrument development was .93, with a range of .53-.85 for subscales. This scale is completed by the CDA and provides an independent observation of some of the dimensions that are also tapped from parents self-report. This measure was used to assist the CDAs in planning family interventions, more than as a measure of change. This is because certain scales are dependent on family resources that are unlikely to change in the short time frame for individual intervention (e.g. the quality of the physical environment, whether the family takes vacations together, whether the family eats together in the evening—which may be dependent on family work schedules etc.).

In addition to measures of child and family functioning, needs and resources, those families who receive intervention are asked to fill out a satisfaction with services scale and a Parent-Professional Relationship Scale to identify how helpful they found the assistance provided by the TFK program.

Assessments where change was anticipated (Early Screening Project assessment, Developmental Profile, Parenting Stress Index, and the Parenting Scale) were repeated at the end of the brief intervention. The table below shows the instruments that were used across the two years with the projected measures planned for Year 3. Measures included in this report are indicated by bolded and underlined text.

TFK Evaluation Measures
Years 1-3 (2002-2005)

Measures	**Time of Assessment**						
Centerwide assessments	**Fall**				**Spring**		
	'02	**'03**	**'04**	**'05**	**'03**	**'04**	**'05**
Teacher questionnaire (demographics, child mental health training, job satisfaction, satisfaction with TFK (at follow-up)	X	**X**	X	X			
Parent questionnaire (overall satisfaction with child care center, overall satisfaction with any child behavioral health information/services received)	X		X	X			
Classroom observations (teacher-child interaction; fostering positive child identity and well being; social skills facilitation; handling transitions; flexibility)	X	X (spring '03) After initial analyses showed that the classroom observations were not sensitive to change, these observations were used only for clinical feedback and goal setting at the classroom level.					
Screening of Children with Challenging Behaviors	**Fall/Winter**				**Spring/Summer**		
	'02	**'03**	**'04**	**'05**	**'03**	**'04**	**'05**
Screening to Identify Children at Risk: Early Screening Project (ESP) questionnaires: 6-10 children per class screened on critical events; aggression or social interaction; adaptive behavior; maladaptive behavior	X	**X**	X	X	X	**X**	**X**
Assessment of Children Identified as At-Risk for Challenging Behaviors	**Baseline**				**Follow-up**		
Children meeting critical cutoff scores on ESP and identified as at-risk who are targeted for intervention or put on a waiting list	**Ongoing as children are identified through screening process**				**Follow up with both intervention and wait list children at conclusion of each round of intervention services**.		
Developmental Profile- Alpern Boll, Shearer **(only intervention children)**	**Ongoing as identify children**				**Follow-up at conclusion of intervention services**		

Assessment of Parents of Children with Challenging Behaviors-intervention children only	Baseline	Follow-up
Parent demographic background	**X**	
HOME scale (home environment)	**Assessed in '02 through '04**, optional in '05	
Family Resources Scale	**Assessed in '02 through '04**, dropped in '05	
Life Events Scale (family stressors)	**X**	
Parenting Stress Index-short form	**X**	**X**
Parent Scale-parenting skills for preschoolers	**X**	**X**
Parent rating of behavior problems	**Assessed in '03 and '04 using parent version of ESP**, replaced with BASC in '05	**Assessed in '03 and '04 using parent version of ESP**, replaced with BASC in '05
Parent-Professional Relationship Scale (parent and provider versions)		**X**
Parent Satisfaction with TFK intervention		**X**
Follow through with referrals, long-term satisfaction and sustained child gains		(~4 to 6 months after intervention)

Additional Data Collection:

1) **Hours and types of services and referrals provided to children with challenging behavior and their families**
2) Parent feedback for any center-wide parent training sessions
3) **Annual interviews with agency Executive Directors and child care center directors (summer of each year)**
4) **Annual focus groups with teachers at each center (summer of each year)**
5) **Annual focus group with CDAs (summer of each year)**

V. Project Implementation in Year 2

The TFK project was continued in the Pilot Sites (Worcester Comprehensive Childcare Center and the YWCA of Central Massachusetts) and the South County Sites. In addition, TFK began its intervention phase in the two sites that served as comparison sites in Year One (Rainbow Child Development Center and the YMCA of Greater Worcester). These two sites were brought on as New Intervention Sites in January 2004.

A. Description of Preschool Sites

Pilot Site A enrolled 94 preschool children from 2 years 9 months through 4 years 11 months in 6 classrooms, with 2 lead teachers, 8 teachers and 4 assistant teachers. The children were almost evenly distributed between boys and girls, and about 45% were white, with 20% African American, 14% Latino, and 21% Asian and other ethnicities. Family incomes ranged from $5,000-$100,000. About 14% of parents needed assistance with English. This site reported very strong parent involvement, with 75% attending individual child feedback sessions, and 24% attending open houses. At this site all the parents transport their children to and from preschool.

Pilot Site B enrolled 30 preschool children ranging from 2 years 10 months to 4 years 10 months in two classrooms with one lead teacher, four teachers and one assistant teacher. One classroom had 14 children, the other had 15, with almost an even distribution of boys and girls. Two thirds of the children were Latino, with only three White, and six children listed as being of "other" ethnic backgrounds. Family incomes are all below state median income and all children's care is publicly subsidized. Almost all families were noted as needing assistance with English. Few parents were reported to attend individual feedback sessions about their children, but 80% were reported to attend the preschool's social gatherings.

New Intervention Site C enrolled 41 preschool children ages 2 years 9 months to 5 years in two classrooms with one lead teacher, 3 teachers and one assistant teacher. There were 22 boys and 19 girls, with 41% White, 24% Latino, 17% African American, and 17% other. About 15% of parents were noted to need assistance with English. Family incomes ranged from $13.000-150,000. About 80% of parents attend individual feedback sessions on their children, 40% attend social gatherings and 35% open houses. At baseline, prior to their involvement with TFK, they reported that monthly staff training was provided on different topics, including child behavior. No regular behavioral consultation was in place.

New Intervention Site D enrolled 51 preschoolers ranging in age from 2 years nine months to five years in 3 classrooms with 3 lead teachers, 3 teachers, 2 assistant teachers, and one "floater." Boys outnumber girls by 30 to 21. The majority of families are Latino (55%), with about 24% Black, 6% White, and 17% other. Fifty-five percent of family incomes were at or below $17,000 with a maximum of $50,000. All children's care is subsidized publicly. About a third of families were reported to need assistance with English. This center reported the lowest parent participation, with 16% attending open houses, and none attending individual feedback sessions on their children. This center has an ongoing consultation contract with Community Healthlink Youth and Family Services (formerly known as the Worcester Youth Guidance Center) for child and family intervention and therapy and provides 6-8 staff trainings a year on a wide range of topics, including child behavior.

South County Sites 63 children were enrolled in four sites with one classroom each. Two sites had 16 children each, one had 14 children and one had 17 children, ages 3-5. Boys and girls were represented in almost equal numbers. A total of 4 lead teachers, five teachers and 1 teacher aide were employed at these sites. Fifty-five percent of families were White, 6% were African American, 7% were multiracial, and the other 32% were either not defined or of other racial backgrounds. Family incomes averaged from $12,000 to $13,700. Parent participation was rated as 100% attending individual sessions about their children's progress, 20% attending open houses, and a range of from 10% to 50% attending social gatherings.

B. Implementation Steps

There were many changes in Child Development Advisors (CDA) in Year Two. The CDA in Pilot Site B left in January of 2004 and was replaced in March. Pilot Site A had a CDA who left in May of 2003 and that person was not formally replaced until October 2003. This person also covered one of the New Intervention Sites, while an additional CDA was hired to cover the other New Intervention Site. In

addition, the CDA assigned to the South County Sites left in June of 2004 and was replaced in July. All of the new CDA's were clinical staff with background in early childhood mental health issues, however, they were not licensed to receive third party payment. Each Worcester site had a CDA for 20 hours a week (16 hours direct service), while South County had one CDA who offered 8 hours of direct service for each of two centers.

In the New Intervention Sites, introductory meetings in the fall of 2003 were held with the teachers and administrators to further explain the project and procedures. Letters were also sent to parents explaining the project. Across all centers (Pilot, New Intervention, and South County) teacher surveys were administered, and child behavioral screenings were completed during October-November, 2003.

C. Identification of Target Children

Identification of target children continued on an ongoing basis (approximately every 6 months) for the Pilot and South County Sites, using the same Early Screening Project (ESP) procedures as had been used in the first year. The only change in Year Two was that instead of filling out questionnaires for the top three children ranked as having either internalizing or externalizing behavior problems, five identified children were screened in order to avoid delays in identification of target children if the top three children's parents refused participation, or moved, etc. In the screening process, teachers are asked to think carefully about all the children in their classroom and identify five children who were exhibiting externalizing behavioral issues and five exhibiting internalizing issues. They are then asked to complete the 4 ESP behavioral measures on each of those 10 children in their classroom. The ESP measures are scored by the evaluation team and compared to national norms for boys and girls. A total of 110 children were screened in Year Two in the Pilot Sites, and 37 were screened in the South County Sites. Of these, 41 children (28 in the Pilot Sites and 13 in the South County Sites) met criteria for being at risk for externalizing behavior problems, and 13 children (7 in the Pilot Sites and 6 in the South County Sites) met the criteria for internalizing behavior problems. It is important to note that this screening process occurred twice in Year Two at both of the Pilot Sites and at the South County Sites. Many of the children screened on the two occasions (approximately 6 months apart) in the Pilot Sites were the same children because the classroom composition remained fairly stable over the year. In South County however, one screening was completed in the summer (when only one center was open), and one screening was completed in the winter (when all 4 sites are open), and there was no overlap in children represented in the two screenings.

For the New Intervention Sites, the procedures for using the ESP system for identifying children at risk were reviewed in a group meeting with all preschool teachers in the fall of 2003, and teachers filled out the ESP questionnaires. A total of 50 children were screened across the two New Intervention Site classrooms (10 children in each of 5 classrooms). A total of 33 children met criteria for being at risk, or almost 36% of preschool children enrolled at the two New Intervention Sites. This included 19 children with externalizing problems and 14 with internalizing problems.

Once children were identified as exhibiting behavior that warranted concern based on the ESP, the childcare administrator was informed and the administrator and teachers decided which children to target for intervention services. Families were then approached and asked to officially consent to services. CDA's worked with 3 or 4 children at a time, therefore not all children and families at risk could be served immediately. Fifty-seven families were approached. Of these twelve refused services and fifteen did not respond to the initial letter and follow-up phone messages. During Year Two, 21 children with externalizing problems (12 in the Pilot Sites, 4 in the South County Sites, and 5 in the New Intervention Sites) received TFK services. In addition, 7 children with internalizing problems (2 in the Pilot Sites, 2 in the South County Sites, and 3 in the New Intervention Sites) also received services. Of these, 7 children

dropped out (4 because the families left the center, and 3 families gave consent and then subsequently decided not to continue in the project). As children and families reached the 3rd or 4th month of involvement with TFK, the individual intervention was phased out. The classroom teachers where then asked to re-evaluate the intervention children, and the remainder of the children previously screened as at risk with the ESP so that follow-up measures of adjustment could be obtained. This process of identifying children at risk was repeated every 6 months so that a new cohort of children could be identified for services as previously targeted children completed services.

D. Individual Child and Family Interventions

Once families consented to receiving services a comprehensive child and family assessment, a home visit, and a service plan were completed. As in the first year, this often took several weeks as scheduling was difficult with working families. This delayed the initiation of formal services with families, however both the CDAs and teachers agreed that the thorough assessment was extremely useful and they considered it part of the intervention. Follow up assessments were completed on all but one target child whose parent never completed the follow-up questionnaires.

On the average then, the intervention families received actual intervention services for about four to five months before the CDAs started to phase them out. Families and children received a total of 2 to 72 hours of services individually from the CDAs (mean=22 hours; median=19 hours, with most receiving 15 to 29 hours of services), including a combination of short term individual work with the child, child and family assessment, and teacher consultation. Several of the families were referred to longer-term family or child therapy services, but only a few families followed up on these referrals. It was felt that part of the problem in following through on these services was that families would have to switch to a new service provider at a different location.

In terms of targets of activity, the most hours were spent working with the individual children (mean=9 hours), next with direct assessments of the child and family (mean=7 hours), then child observations (mean=6 hours), fourth with parent consultation (mean=5 hours), and lastly with conferences with teachers (mean=4 hours) and parent-teacher team meetings (mean=3.5 hours). In the Worcester sites, relatively few hours were spent on billable therapy or collateral contacts arranging other services for children and families, while somewhat more was spent on this task at South County Sites. Like last year, interactions with teachers seemed to be more through general classroom observation and consultation around classroom techniques than individual classroom modeling with target children. Thus individual intervention with children was undertaken directly by the CDAs, and less often did the CDA specifically work on transfer of skills around handling individual children to teachers or parents.

E. Center-wide Teacher and Parent Interventions

In addition to individualized services, several center-wide training sessions were also conducted. Staff at the four Worcester sites had training sessions offered on: "Special Needs in Child Care," with 19 attending; "Strengthening Communication with Parents," attended by approximately 35 participants; and "Promoting Social-Emotional Development in Young Children: The Second Step Curriculum," attended by 20 staff. One additional training was delivered to parents during after school hours entitled "Living With Your Spirited Child," attended by 5 parents.

In the South County Sites, staff trainings included "Strategies to Minimize the Stress of Transitions," attended by 3 staff; "Understanding Children's Sexual Behaviors," attended by 3 staff; "Understanding and Meeting the Needs of the Traumatized Child," attended by 3 staff; Promoting Social Emotional Development in Young Children: The Second Step Curriculum," attended by 20 staff; and

"The Learning Triangle: Overview of Strategies from the Challenging Behaviors Conference," attended by 20 staff. Two parent sessions were also offered: "Positive Parenting Strategies," attended by 6 parents, and "The Emotional Development of Young Children: Understanding the Source of Challenging Behavior," attended by 45 staff and parents.

VI. Findings

A. Center-Wide Data

This section reports on the interviews conducted with the site and program administrators, and focus groups with teachers and CDAs, about their experience with the TFK project over the Intervention year.[1]

CDAs, Center Administration, and Teacher Perspectives of TFK: Results of Focus Groups and Interviews.

At the end of the second year of implementation of the Together for Kids project, a round of focus groups and interviews was conducted with all of the stakeholders at each child care center. These qualitative findings are designed to complement the quantitative findings collected at each site. The qualitative data consist of a report of a focus group and an interview conducted with the four Child Development Advisors (CDAs) by a member of the TFK Steering Committee (to avoid bias if conducted by the TFK Project Coordinator who supervises the CDAs, or the research staff, to whom CDAs might be inclined to report more positive evidence). In addition, the Executive Director of each sponsoring child care agency was interviewed individually, as was each child care Center Director. These interviews were mostly completed over the phone. Finally, a focus group was conducted with a sample of teachers and aides at each child care site. This represents a total of 15 different qualitative data collection points across the 6 intervention sites (four in Worcester and two in South County).

The second year of implementation was marked by turnover in the CDA positions. Therefore, there were new relationships and new issues around CDA-center fit and collaboration. In some ways, Year Two was an extension of Year One in that we learned significantly about implementation in Year One. However it was not simply a maintenance year. With new CDAs in almost all positions, there was a continued learning curve and some new adjustments that needed to be made.

1. CDA Feedback

The CDAs were asked about positive and challenging aspects of the role, accomplishments with children, families, and with centers, and challenges with children, families and centers. They were asked for recommendations for changes in the model, as well as any concerns about the research activities. Finally, they were asked if they had adequate preparation and supervision.

Positive aspects of the role: The CDAs thought the collaboration with the teachers and being able to work on the child's issue in the classroom--in the natural setting where the behaviors occur--were important attributes of the CDA role. One especially emphasized working with the families as positive, and assisting families to have a more positive link to their child care teacher and center. One also

[1] Center-wide teacher surveys were obtained in the fall of 2003 (fall 2004 surveys were not yet available at the time of this report). These fall 2003 surveys reflect Pilot and South County teacher's views after receiving one year of TFK services, and New Intervention site teacher's views before TFK began providing services. Therefore, these survey results do not reflect results of Year 2 teacher experiences, but the beginning of Year Two, and are reported in Appendix A.

mentioned the power of the home visit together with the teacher to get the family engaged, and to reinforce for the child and family how much the center cares for the child. In terms of personal accomplishments with the children and families, the CDAs mentioned both assisting the child to build skills, and assisting the families with education, awareness and developing a more positive relationship with the child care center.

Summary Table: Positive Aspects of Role and Personal Accomplishments with Children and Families

CDA	Collaboration with teachers	Working with families	Building child skills
1		X	X
2*	X		
3		X	X
4	X	X	

* Note: This CDA had not worked long enough at the time the interviews were conducted, so was not able to articulate specific accomplishments with children and families.

Challenging aspects of the role: All CDAs felt that teacher buy in and motivation were a big issue. This was because teachers have different levels of expertise to understand how to work with children, and because teachers are often very frustrated and disinvested in the most troublesome children by the time the intervention is started. One CDA felt that in part this was due to lack of administrative buy in. One noted that teachers turn around once they see changes in children, but that up until that point the CDA is working 'against the tide' in trying to bring the child and teacher along to a better relationship in the classroom. One CDA mentioned that it was hard to juggle all the different aspects of the job, e.g. preparing to meet with parents, modeling in the classroom, getting the data collected. However, this issue seems less prominent than it was among the CDAs after the first year of the Pilot. Challenging aspects of working with families included the too short intervention time to really engage parents and assist them to follow through. It was felt that "three months is too fast for them." It was also felt that parents would follow through on referrals if they had more time working with the CDA. There was general agreement that it was hard to engage families and get them to follow through and keep appointments.

Summary Table: Challenging aspects of the CDA role

CDA	Teacher skill level, buy-in and motivation	CDA lack of time and multiple roles	Lack of administrative buy-in	Not enough time to work with families	Difficult to engage families
1	X	X		X	X
2	X			X	X
3	X			X	X
4	X	X	X		X

Recommendations about the challenging aspects: It was felt that more teacher training was necessary and more preparation of teachers in order to achieve their buy-in at a better level. CDAs also felt they needed more time overall in centers, and more time with individual families. The issue around more time overall has to do with the number of children needing assistance that have to 'wait' in line. The issue around more time with individual families has to do with the reluctance of families to continue with outside mental health services. CDAs report that families feel more comfortable dealing with the

staff at the center. Two CDAs agreed that having other mental health staff meet with parents at the child care center to overcome this reluctance would be good.

Summary Table: Recommendations to address challenging aspects:

CDA	Provide more teacher training, more preparation for TFK	Ability to work with more of the children-more time at each site	More time to work with each family-6 months vs. 3	Mental health staff on site to refer parents to
1	X		X	X
2		X	X	
3			X	X
4	X			

Working with center teachers and administrators: It appears that the most challenging aspect of the role is to develop positive relationships with teachers and the administrators. It is particularly difficult to work with teachers. There have been morale issues, tensions about budget cuts (two centers) and moving to a new site (two centers); in one site the director is leaving. In three sites specific issues were pointed out about teacher professionalism, such as constantly using their cell phones at work, shouting at children, and, in one case, teachers yelling at each other on the playground in front of children. It was mentioned at four sites that staff are being asked to take on more (e.g., new curriculum priorities, cover because of staff openings), and to 'volunteer' to help out after hours, which means the extra demands of TFK are hard to integrate. In some centers, the CDAs also pointed out that administrators were challenged in their ability to address these behaviors. The issue of teachers resenting the emphasis on the targeted children is also a challenge in some centers, although in at least at two of the centers, the CDAs feel teachers are beginning to take suggestions and work more collaboratively. One CDA also pointed out that she was working with the administration to support the teachers in carrying out new activities and strategies, but at two other centers the CDA said that administrative support for the project and for teachers was a problem.

Summary Table: Issues in working with teachers and administrators

CDA	Issues around administrative support for teachers	Staff morale & professionalism issues	Too much demanded of staff	Need to build relationships with teachers
1	X	X	X	X
2	X	X		X
3		X	X	X
4	X	X	X	

Challenges with regard to the research/data collection: All of the CDAs said it would be helpful to have the necessary forms for both TFK and WYG gathered in one packet at both intake and discharge so they wouldn't have to 'run around' and collect the separate forms themselves. One also reported that sometimes it was awkward to check the forms in front of the parent as that seemed to be a violation of confidentiality. However, another CDA said she was able to explain it in a way that didn't concern parents. One CDA didn't have an office to do the paper work, and that was an issue in terms of her ability

to complete records accurately, however, she felt collecting data from children and families wasn't a problem.

Comments regarding necessary training and supervision: All but one of the CDAs praised the Project Coordinator for her strong supervision skills. The only issue mentioned about supervision was more guidance on how to give consultation services versus do the therapy. One CDA noted she was comfortable with her clinical skills, but less comfortable with how to do consultation. (This CDA, interestingly, was also noted by the center director as less able to engage the teachers.) One CDA suggested that having peer supervision and case conferences might help to support them – a more structured and ongoing training and supervision activity. This CDA also felt having a group meeting for preschool teachers so they could share and get to know each other would also be helpful—and the two others in the group also agreed. One CDA summed up by saying, "I really like my job…TFK is a great idea; kids are getting better."

2. Interviews with Agency Executive Directors

Five Executive Directors were interviewed, covering six sites. In most cases, these individuals were one step removed from the day to day implementation at the child care center. Executive Directors were asked what their goals were for participating in TFK, whether they felt these have been met, what the roadblocks or challenges have been, what the most positive aspects have been, and what recommendations for change they had.

Goals for participation in TFK: All of the Executive Directors emphasized that the goal was to assist teachers in several different ways: increase their understanding and sensitivity to children with behavioral issues; provide support and training for teachers to work with the children and parents; and to reduce teacher stress and turnover. Four talked about providing additional services to children and families directly. Two also emphasized working with parents and providing extra services to families in need, while only one mentioned the benefits of having a CDA specifically. One ED noted that improving school readiness was a goal.

Summary Table: Goals as reported by Executive Directors of agencies

EDs	Educate, train, support teachers	Assist children & families directly	Involve families	Promote school readiness
1	X			X
2	X	X	X	
3	X	X		
4	X	X		
5	X	X	X	

Are goals being met? All EDs noted that progress was being made. The new programs that have received services for just less than one year indicate that there are still areas where they need to do more work, such as connecting with families, but that they were seeing improvements in children. One new program ED noted, "…but the staff are thrilled with the training and feel better equipped to handle their classrooms this year than last." This was echoed by the other new program ED, who noted: "I think that the teachers are pleased and proud to be a part of the program. There is a certain status to being part of the program, a recognition by the state that this is an important program." These views contradict the

CDA views about teacher receptivity to some extent, and it may be that teachers are both pleased for the help, but resistant to change.

The programs that have received services longer felt that, for the most part, goals had been met, but 'not for every child.' For some sites, parent engagement was still an area to be worked on, and the ED here reported that new demands on teachers have resulted in less opportunity to reduce teacher stress. One ED in a center that has had the program for almost two years reports: "There is a great decrease in staff turnover and I think the teachers are feeling better. We also haven't had to terminate any child."

Summary Table: Are goals being met from view of Executive Directors

EDs	More work needed with families	Some children improve	Teachers getting some benefit
1		X	X
2	X	X	X
3		X	X
4			X
5	X	X	X

Challenges to meeting the goals: The major challenges centers mentioned were engaging parents and scheduling staff coverage. In the area of engaging parents there were two types of concerns. First that some parents of the most difficult children refuse to participate; second, some parents string along the consent process because of their reluctance, and then when they finally drop out, time has been wasted without engaging another family; and, finally, some parents don't follow through even though they have consented. One ED noted that getting consent from both parents has also been a barrier.

In terms of staff scheduling issues, the major issue is assuring adequate classroom coverage when the teacher was needed to participate in parent meetings or home visits. However, scheduling with families was also noted as a challenge, including the difficulties connecting all the right participants—CDA, teacher and family.

Two centers experienced turnover in the CDA role and felt this was disruptive. One center reported some problems with communication between the CDA and another mental health consultant. On the other hand, one ED noted, "TFK is well moving—not a lot of red tape."

Summary Table: Challenges as reported by Executive Directors

EDs	Parent engagement	Covering for staff	Scheduling with families & staff	CDA problems	Staff not understanding model
1	X	X	X	X	
2	X	X	X		
3	X			X	X
4	X	X			
5	X		X	X	

Most positive aspects: Four of the EDs emphasized the impact on staff as being the most positive aspect of TFK. They felt that staff were supported, and received training and attention they needed, e.g.

"this is not just babysitting". One ED emphasized that it helped teachers see that mental health issues were integral to working with the children, and "acknowledges it and offers concrete day-to-day solutions." With a prior mental health consultant, this ED noted that problems got 'labels', but the center did not receive assistance in working on the issues. Two of the EDs specifically talked about TFK as being a very "positive experience" in terms of opportunities for education and growth for staff. They cite the positive relationship between teachers and CDAs. It should be noted that even in centers where they expressed concerns or problems with the CDA relationship, and where the CDA also noted problems working with administration, the ED felt that there were benefits to staff. One ED mentioned specifically that the impact on children "has been tremendous. You can really see the difference in the child and the impact on the classroom is so evident." Two also mentioned the positive impact of the family involvement component, one from the point of view of getting families help that they needed from mental health agencies.

Summary Table: Most positive aspects of TFK as described by Executive Directors

EDs	Staff training and support in MH issues	Family referrals and assistance	Improvements in child behavior
1			X
2	X		
3	X		
4	X	X	
5	X	X	X

Recommendations: One major concern was anticipation of the CDAs "moving on" and whether the centers would be able to sustain changes without as much support from the CDA. One ED felt the time frame focused in each center was too brief for sustained change, and that they would return to the focus on individual children versus the family and center's role in prevention once the CDA became only a consultant. Three EDs recommended that TFK at least sustain a teacher training component in all centers so that the focus could continue on prevention. Three of the EDs also stressed continued need for emphasis on involving families; other issues with families included getting cases opened more quickly and staying with the family longer. One of the centers was worried about staffing shortages and financial issues that affected how well they could focus on TFK, but felt that the connection between the child care community and the mental health community needed to be even more available. One ED felt that the CDA scheduling and buy-in to the agency philosophy needed to be improved.

Summary Table: Executive Director recommendations for changes in TFK

EDs	Time frame too brief	Need for additional training	Need for continued family involvement	CDA schedule & buy in to agency goals
1	X	X	X	
2			X	
3	X	X		
4*				
5		X	X	X

* Note: This ED did not provide any additional recommendations.

3. Interviews with Center Directors

Five Center Directors were interviewed, covering six sites (four Worcester and two South County). Center Directors were asked about positive aspects of TFK, relationship with the CDA's, gains for children, families and teachers, challenges and recommendations.

Most positive aspects: The Center Directors focused on different aspects of the program that they thought were most positive. One described bringing issues of challenging behavior to the "forefront" and validating staff concerns: helping the staff understand, talk about, and address the issues was the most positive aspect. Two others mentioned staff support as positive. Two focused on parent involvement with the families whose children were targeted for intervention, and the ability to work with parents as a team—the sense of collaboration between the teachers and family versus a "we're the boss" relationship. One emphasized the improvements in individual children's behaviors in addition to staff support, while another also mentioned child improvements as coming as a result of the parent-teacher collaboration. One mentioned specifically that teachers were developing skills.

Summary Table: Center Director's views of the most positive aspects of TFK

Center Directors*	Support for staff	Improvements in children	Parent involvement	Developing teacher skills
1	X	X		
2		X	X	X
3	X			
4			X	
5	X			

* Note: Center director order matches ED order.

Relationship with the CDA: Three of the sites reported a very positive overall relationship. Aspects that were mentioned included keeping the Center Director 'in the loop' about what was going on with teachers and families, and being accessible and flexible to communicate with staff and families. For two center directors, there seemed to be some issues in the CDA relationship. In one case it was described as "strained", with fragmented communication. The Center Director in this case felt the CDA wasn't always responsive in returning calls, and that she didn't understand how to work with some of the regulations or philosophy under which the child care program operated. The other Center Director who had concerns about the CDA relationship felt that the CDA was not at first able to handle the families very well, and was somewhat unsure of herself. She did note that the CDA was 'growing' in her role.

Summary Table: Center Director's report of relationship with CDA

Center Directors	Positive, good communication	Tentative but getting better	Strained
1	X		
2	X		
3	X		
4		X	
5			X

How well has CDA worked with the teachers? The three Directors who reported a good relationship with the CDA also reported that the CDA worked well with the teachers. One noted that it was open, collaborative, and like a peer relationship. At one of the New Intervention Sites, the Director indicated that there was "a little struggle with teachers, they were intimidated [at first], but as it went along, the teachers began to see how it helped." The other Center Director reported that most, if not all, of the teachers felt comfortable with the CDA, and that she was available for brainstorming problems and solutions. She felt the CDA was very accessible and attended staff meetings to stay in touch. For the centers that had somewhat less positive relationships with the CDAs, there were different issues. In two centers supervised by one director, the CDA would recommend things that couldn't be implemented: "The teachers tried very hard to work with her but in some cases we couldn't do what she wanted done. It was strained." In the other center, the Director felt that the CDA did not know how to "approach" teachers, was being 'duped' by the teachers in terms of implementing goals, and "got caught up in problems" between the teachers. Interestingly, this CDA was the one that felt a need for additional skills in consultation to bolster her clinical skills.

Summary Table: Center Director's report of how CDA worked with teachers

Center Directors	Good relationship, comfortable, open communication	Unsure, focused on personnel issues	Did not provide suggestions teachers could implement
1	**X**		
2	**X**		
3	**X**		
4		**X**	
5			**X**

What have been the gains for children and families? Three of the Center Directors talked about benefits to the families more so than the children. Director #1 said: "In most cases there has been significant improvement [in children] and I think from what I can tell from the families, they seem really pleased with the program." However, she did say that some families don't follow through, while those that do see "significant" changes. Another noted that communication with parents increased and that those that resisted their children being targeted, once they saw some improvement in their children, began to be more open. Center Director #4 felt that small gains had been made with families, "I see greater comfort levels of families. In all the families being serviced I've seen some improvement." However, this Director worried that the family issues were so deep that improvement "probably ..wont' last without follow-up". One Director felt that it was 'too early' [this center had a new CDA for just a few months, even though this is their second year of participation] to see a lot of changes in children, but that the parent meetings had been positive. The Center Director that reported a strained relationship with the CDA felt that children's needs were being addressed on a one-one-one basis, but that due to the CDA's lack of flexibility in scheduling (she only worked 8am-4pm) she did not meet with any families. This meant follow through with families was inconsistent**.**

Summary Table: Center Director's views of gains for children and families

Center Directors	Gains for parents in communication & engagement	Child improvements
1	'families pleased'	X
2	X	
3	Too early	Too early
4	X	
5		Implied, not emphasized

Gains for teachers: All the Center Directors felt that there had been gains for teachers, even the centers where they felt the relationship with the CDA wasn't as positive. The Directors noted that the tools, training sessions (e.g. Second Step curriculum), articles, and classroom observations were beneficial, and resulted in mental health issues being addressed. Several emphasized that teachers felt 'support' and that it "has taken the weight off their shoulders." Two Directors noted that the teachers were "more open to trying new ideas", and "more comfortable" with having someone in their classroom, while another talked about the CDA supporting change, providing "insight and different approaches to things, how things in the room can affect children…an awareness."

Summary Table: Center Director's views of gains for teachers

Center Directors	Support, assistance with change	Open to trying new things	Second Step and articles, information	Confidence, better morale	Benefit from classroom observations
1	X	X			
2		X	X		X
3				X	
4	X				X
5	X		X		

Challenging aspects of TFK: The centers had different issues about the challenges. One center mentioned lack of space, another mentioned that the particular floater teacher hired didn't work out and was disruptive. Two talked about the time constraints, although one felt it was more the CDA inflexibility that was an issue, while the other felt it was that total time available to the center by the CDA. This latter Director specifically mentioned problems that arose when parents missed meetings or were late, as it was difficult to reschedule or cover classrooms. Another Director felt there were no challenges, "it's been so wonder having the support here." The only issue this Director raised was that the time fame for working with individual children (e.g. 3 months) may be too short for some children. One Director mentioned that some families "react very negatively and fear being filed on," which limits how much work can be done with them. Finally, one Director talked about the difficulties of the CDA covering centers in different geographic locations, as well as the communication problems with the Director and with families.

Summary Table: Center Director's views of challenges of TFK

Center Directors	Time for ind children too short	Floater teacher not helpful	Space	Not enough CDA time, not enough time to do everything	Resistant parents	Communication problems
1	X					
2		X				
3			X			
4				X	X	
5				X		X

Recommendations: Center Directors had a range of recommendations for meeting the above challenges. Two of the Directors had comments about the floater teacher. One center that had to fire the floater felt it would be better for the floater to be hired and supervised by TFK directly, or else that regular substitute teachers known to the center be hired. The other center was worried that funding for this aspect of the model would be cut, because after an initial year when the floater also did not work out, it was now working well and really assisting the individual children and classrooms. Two Directors focused on engaging families of target children, in terms of being more proactive to engage them, and make sure they show up for meetings, or if they are not following through to have a plan. This included allowing the CDA to have more flexible hours so they could be available to meet family schedules. Two Directors wanted more services, in one case to extend to other centers in the area, and in the other case, to extend the program to the toddler room. One Director mentioned that teachers needed less help around mental health issues, but more on classroom communication and cohesion, although the mental health emphasis and access to more mental health services was a key recommendation of another director. One Director noted,

> "I think it's a really good program and very beneficial. I would like to see it extended because it takes so long for families to trust and engage. We need some way to connect beyond the time frame."

Another Director who felt the first CDA was difficult to work with, while the new CDA this year is better noted, "If it had only turned out like this last year. It's bothering me that this may be over in December." Her only recommendation to improve the project was for the center to obtain better space.

Summary Table: Center Director's recommendations

Center Directors	Extend time for ind children	Keep floater funded	Have floater supervised & paid by TFK	Need to be more proactive, "pushy' about parent compliance	Expand to toddlers	Space for family & child meetings	Extend CDA hours to meet with parents	Connect CDA better to MH consultant
1	X	X						
2			X	X	X			
3						X		
4				X				
5							X	X

4. Focus Groups with Teachers

Focus groups were conducted with teachers at each intervention site. The focus groups were not attended by center directors or executive directors so teachers could feel free to be open about their experiences with TFK. A total of five groups were conducted with a total of 30 teachers and teacher aides, representing all six child care sites receiving TFK services. Teachers were asked about the most positive aspects of TFK; about their expectations and if they had been met; their relationship with the CDA; how well the CDA was able to work with children and families; the gains seen in children and families; how much the CDA helped with general classroom management strategies; the level of support received from center administration to implement recommended changes with children; whether there had been adequate professional development and teacher training; the challenging aspects, and any recommendations.

Most positive aspects: The teachers from the different centers gave a range of answers, but the most mention was of working with parents (3 centers). One center talked about the value of the home visit, "getting to see the other side…you see very different behaviors at home…the home environment was very different than I ever imagined." They commented about how some children have little supervision, others have few toys and thus are limited in play skills. Staff from another center commented how a child had to sit quietly for hours in the parent's restaurant, explaining why he was so "wild" when he came to the center. Two groups mentioned that some parents follow through, while some do not, but that the process opens communication with parents, and in some cases finally motivates parents to seek and receive help. Parent meetings involving the CDA are helpful to reinforce to the parents that the teacher is not "crazy", and the CDA helps to communicate and make things clear to the parents. One group mentioned that the Second Step curriculum was very helpful because it was organized and assisted them to use things "right out of the box," even though they knew the underlying principles. Another group did not refer to this curriculum but noted the positive impact of earlier teacher training delivered by TFK, and felt it needed to be repeated. One set of teachers thought the floater teacher was now really working out. They were using the floater to help manage the classroom while the teacher was working one-on-one with a target child. This worked better than the other way around because the floater was not as effective shadowing the target child given they had less of a relationship with that child. One group mentioned only that some children had benefited greatly. Finally, two groups emphasized that the most positive aspect of the program was to give them "new ideas about how to deal with children's behavior," "showing different stages of children's behavior, how they change, and the helpfulness of the ESP in understanding the children." Another group focused on "to have someone else to talk to who is outside…they see the problems we deal with on a day to day basis." This notion of the CDA validating and supporting teachers was also noted by most of the center administrators.

Summary Table: Most positive aspects as reported by center teachers

Center Teachers	New ideas to work with children	Working with families	Second step or other training	Support of CDA	Floater	Improvements in children
1		X	X		X	
2						X
3	X			X		
4		X	X			
5	X	X				

Expectations about TFK and were they met: Staff at one of the five sites didn't know what to expect, while at the other centers, the main theme seems to be that they expected more family involvement, and much more individual work with children, while less directed to the entire classroom. In one of these centers, the teachers were disappointed that there was less 'individual therapy' than they had anticipated: "Expected to help the more at risk kids and give them help…thought it would provide more therapy…it's not for the severe kids, just the moderate…it's not what I thought, just gets parents involved and gives them referrals." Staff at this center were also disappointed in the level of communication and coordination between the CDA and the teachers, and felt that at times, the CDA did not prepare adequately for the parent meetings, or showed up late, making it difficult for teachers.

In one center, they felt the expectations for parent involvement were too high and that they knew that many parents wouldn't engage. In two sites, teachers felt not enough commitment was received from families early on, and that the CDA did not provide adequate guidance to parents. Another center was surprised by the lack of parent interest and availability to become involved with their child's issues.

In a site where the CDA did emphasize one-on-one work with children in the classroom, it was viewed as disruptive and not effective. This was because other children sought her attention, and because it disrupted ongoing routines and class management rules. In one center, where staff admitted they were looking for 'overnight' changes, they felt change in individual children was slow, but happening. They noted that there were staff turnover issues that prevented the CDA's recommendations from being fully implemented. They also felt that 3 months was too short to work with one child.

Teachers at two sites mentioned that the CDAs sometimes did not have current information about the child when they went to parent meetings because they didn't have time to communicate with the teachers before the meetings. One center noted that this was because the CDA did not have time to do general classroom observations on a regular basis like they had done at first. While this center's teachers did not feel this was a large problem, it did result in discussions with parents that weren't quite on target. However the other group of teachers felt the CDA conveyed information that was inaccurate and upsetting to parents without the teacher's input.

Summary Table: Teacher expectations about TFK

Center Teachers	More parent involvement	More child ind. therapy	More child change	More staff support	CDA didn't always have correct info
1*					
2	X	X			X
3			X		
4	X	X	X		
5	X	X		X	X

* Note: These teachers did not identify any expectations prior to services starting.

Relationship with the CDA: Despite some of the disappointments already mentioned, and some difficulties with communication and 'being on the same page' with the CDA, all groups of teachers reported a somewhat to very positive relationship with the CDA. In one site where teachers were critical of the model, they felt the CDA was too judgmental of the teachers and didn't understand how difficult it was to work with the particular group of children. However the teacher aide at this site felt more positive. In the other site served by this CDA, the teachers attributed communication problems with the CDA to scheduling difficulties, and gave the CDA credit for 'trying' to communicate. Because of no extra classroom coverage, these teachers also reported that the meetings always occurred between the CDA and the supervisor, not directly with the teachers, which made it harder for the teachers to feel included or to give their input.

In three of the four sites where the CDA relationship was overall positive, there was a great deal of praise given: "The new one is great, she understands and has more experience with preschoolers…sometimes we forget what to expect from them and she'll remind us that he's only 3 years old…you don't have to tell her, she knows what to do and it gives us a break." Another group of teachers said, "She is a great person, easy to talk to, and willing to support our ideas and help kids even if they aren't target kids …she has gone out of her way to help the siblings of the target kids. She's very supportive of our ideas and very flexible with her time." The last group, who has the same CDA as the previous group, also echoed her praises, saying, "every time [she] comes into the classroom she asks us what we need…I like that she doesn't know everything,; I've been doing this for 17 years….she acts as if I have a clue."

Summary Table: Relationship with CDA

Center Teachers	Overall positive; like CDA	Meets teacher needs	Respects, collaborates	Critical of teachers
1	X	X	X	
2	X		X	
3	X			
4	X		X	
5		(tries to)		X

How well has the CDA been able to work with the children and families? Generally, all the teachers at all sites said it was challenging to work with families and that there had been a lot of difficulties engaging parents, getting them to come to meetings etc. In only one site did they feel the CDA had not done enough to engage families, whereas in the other sites, they felt it was the characteristics of the families that was a barrier (e.g. "they are tired, they are stressed, they can't get off work to come for meetings"). In one center, teachers reported that, "without the floater [working with the child in the classroom], this child would have been terminated." One site reported that families were charged an insurance co-pay for the home visit and that this was a disincentive to engage in the services. There were no specific comments, positive or negative, about how well the CDAs worked with the children.

Gains seen in children and families: Only two groups of teachers noted significant changes for some of the children; one group of teachers called them "huge changes." The example was a child who would just lash out who now has had considerable time one on one with the teacher giving him language skills and anticipating his frustration level, which has totally prevented the prior behavior. In all the centers, however, teachers emphasized the need for changes in families, and did report incremental to more substantial changes in parent behavior that also helped their child for at least some of the families. In one center the teachers reported changes in parents asking more questions than they did before, like, "how the child's day went." In another, the staff echoed, "Some of the parents are more comfortable to come to ask us questions or let us know what's gong on at home." While two centers mentioned the benefit of seeing the child's environment at home, one center especially felt the home visits were very important: "We have more insight about what is going on at home se we can plan what to do in the classroom…one kid had to sit all day in his parent's restaurant, when he was here he was bouncing off the walls; we understood that this was his only chance to play and be free, so now we figure out how to accommodate that." In two different centers, teachers mentioned that parents approached them to ask for help around dealing with a death in the family, and that this was new for these parents who had never asked for help before.

Summary Table: Teacher's perceptions of gains in children and families

Center Teachers	Positive changes in children	Home visits useful & help family and child	Some families change-more connected, open
1	X	X	X
2	X		X
3			X
4		X	X
5			X

Help with general classroom strategies: One site felt that the Second Step training was useful, but in implementation was limited by a ½ day schedule for some children. This site felt that the CDA was generally not helpful in the classrooms as she did not honor the teacher's routines or rules, and her attention to the target children tended to inadvertently reinforce negative behaviors of these children, rather than assisting them to better meet classroom expectations. In one other site the teachers felt that the CDA did not offer much in terms of classroom strategies and that she got off on the wrong foot by spending time at the beginning reviewing the classroom observations of the NAEYC visitor, instead of being helpful and concrete on issues they needed specific assistance with. One other group of teachers said the CDA observations were helpful in the beginning, but that as time went on, she didn't spend enough time to be up to date with changing classroom and child situations, although she was always available to talk about any of the children. Two of the sites were much more positive: "The CDA has

spent time talking with us about the kids; she has brought to our attention problems with other kids (not targeted)..we've talked about how to set up the classroom differently." One of these praised the tips the CDA provides. This group said that the CDA and the center worked out a process for consultation that made everyone satisfied that their questions could get answered, when at first she was overwhelmed by too many questions from individual teachers. This latter group stressed the need for repeating some teacher training because of teacher turnover, whereas some of the other teacher groups did not express an interest in further training.

Summary Table: Teacher's report of how helpful the CDA was in assisting with general classroom management strategies and assistance with non-target children

Center Teachers	Felt good support and consultation	Felt Second Step and training useful	Did not feel much general help received
1	X	X	
3	X		
2	X		
4			X
5		X	

Support from center administration: Four of the six sites did not report major barriers from administrative structures within their organization to implementing TFK activities. One site felt they had little support, and especially had asked for some substitute time so they could meet with parents, and this request was ignored. One teacher group reported that the space problems in the building made it difficult to work with children one-on-one or to have parent meetings, but otherwise said that the administrators were supportive. Another of the teacher groups said that the administration was very supportive, there were lots of staff meetings etc., but that it took a long time to align TFK policies with center priorities. The example given was that they wanted to target children already getting other services, and waited weeks for an answer from TFK. Also that they wanted to target families who they knew would accept services [instead of children who scored highest on the ESP], but felt they had to offer services to families that eventually refused to participate, thus wasting time. The final group indicated that current budget constraints and staff openings were curtailing the amount of support the administration could provide, but that administration was generally open, "they are always willing to listen and to even let us try things they know in advance won't work if we feel strongly we still want to try them."

Summary Table: Teacher's views of level of administrative support to address child behavior issues

Center Teachers	Felt adequate support from administration	Did not feel administrative support
1	X	
3	X	
2	X	
4	X	
5		X

Adequate professional development and teacher training? Two of the center's teachers felt they already had adequate professional development opportunities and requirements and were not interested in more training. One of these groups, however, felt that the Second Step curriculum was helpful, but they needed more time to implement it. Two groups felt they didn't get much in the way of professional development and also felt the baseline classroom observations were not helpful. These groups seemed interested in more hands on training. Only one group specifically mentioned that they felt a repeat of some initial staff training provided by TFK would be helpful because of teacher turnover. This training occurred during the first year of TFK and did not involve Second Step. This group also felt there needed to be some morale and team building in their child care center, so that there was more of an investment of all the staff [for example, only 3 of a potential 11 teachers and aides attended the after work hours focus group]. Finally, they felt the staff would benefit from stress management training, "to help us get through the day in the classroom".

Summary Table: Teachers views of training provided by TFK

Center Teachers	Want more training	Not very interested in more training	Second Step was good
1	**X**		
2*			
3		**X**	**X**
4		**X**	
5	**(better training)**		

*Note: This group did not speak to the adequacy of professional development and training

Challenges: For one site the biggest challenge was having the CDA in their classrooms, but not respecting them, their routines, or validating their own skills. These teachers reported feeling like a bad mother-in-law stormed into their classrooms and started changing things without their input. They did not feel listened to or respected, and felt if the model was for individual child work, that the target child should have been removed from the classroom for intervention activities, or else the whole classroom needed to be addressed.

Half of the teacher groups discussed time issues as important. They felt they needed coverage and more time to meet with the CDA and parents. Other time issues were to have the CDA allocated more hours in a center to spend more time with children, and the short time frame to work with each family before moving on. Three of the centers also mentioned problems with family commitment as challenges to full implementation. This included families with very disruptive children refusing to participate, as well as those who do agree to participate not following through, not attending meetings, or not being honest about what is going on at home for fear of revealing too much to the child care staff. Two centers also talked about inadequate time for families to really become comfortable with receiving help, and as a result, lack of follow through to ongoing services with other agencies they were referred to. Two groups also talked about the floater teacher being a problem because of her level of training. In two centers, the teachers reported that the family liaison program had not gotten off the ground, or was affected by turnover, while where it was working, it was noted as very good, but not enough resources were allocated to it [this center took parents and children on an outing with the family liaison funds and found it to be very successful in terms of connecting to parents and having parents connect with each other].

Summary Table: Challenges teachers report working with the TFK model

Center Teachers	Family reluctance	Time to talk to CDA/attend meetings	Floater didn't work	Family liaison not fully implemented	Negative relationship with CDA	One on one model in classroom didn't work
1	X	X				
2	X		X	X		
3		X				
4	X	X	X	X		
5					X	X

Recommendations: Teachers had a lot of recommendations for improving the program. Two of the teacher groups focused on having a better trained floater teacher as part of the project, while the two centers where there was no floater available, just felt there needed to be 'coverage' for them to attend meetings. The two groups that had the floater were very happy with their CDA, but also felt they needed the 'break time', the one on one assistance in the classroom with target children, or the time to meet with parents that a good floater could contribute.

Two centers focused on the CDA spending more time at the center, one especially mentioned observing at closing time when things get chaotic. This center, as well as two others, also focused on lengthening the service time for each child. One group noted, "[child's name] has just started to show benefits but it is time to terminate him; I don't know what is gong to happened, but I worry in a few weeks he will just be back where he started." One of the groups concerned about more individual treatment time also was concerned that the model be more flexible. This group of teachers felt that services should not be limited to 'the top of the list'. They also felt, as did two other centers, that the CDA role wasn't very clear, and there needed to be a longer start up time with better communication about roles and rules.

One issue raised by a site was that only target families signed release forms. Thus, when a case conference was held, if the target child's behavior was being influenced by another child, this could not be discussed. They suggested that all parents sign a release at the beginning of the year, and that a TFK staff person make a presentation at parent orientation sessions.

Finally, one center recommended more structured child one on one, more meetings with the staff by the CDA, and more classroom observations by the CDA.

Summary Table: Teacher's recommendations to improve TFK

Center Teachers	More time, better trained floater	Coverage to attend meetings	More CDA hours	Lengthen time to serve each family	Clarify role, prepare center better	More 1 on 1, more meetings, more observations
1	X					
2	X		X	X		
3				X		
4			X	X	X	X
5		X			X	

5. Summary

The second year of implementation of the TFK project in an expanded number of centers provided more input for learning how to successfully work in diverse settings with child care centers with very different needs. Some sites had more difficulties with implementation, or strains with their CDA, yet all had positive reports about various aspects of the TFK model, including themes of: staff feeling supported and receiving necessary training around mental health issues; families being more connected and more open; and individual children making important gains. Overall, agency and center administrators were more positive about the accomplishments than were teachers, who in some cases did admit that it was hard for them to see incremental change. The key to a successful relationship with each group of stakeholders can be described as the CDA establishing communication and collaboration at all levels. It seems clear that the tasks asked of the CDA are highly demanding, and require equal amounts of expertise in early childhood mental health, as with issues of organizational development and teacher training.

The "fit" of the style of the CDA also seems important, as is making sure both the CDA and the centers understand, and are on the same page about the CDA role. CDAs themselves reported that working with the teachers was the most difficult aspect of their job. In some centers where the CDA focused on an individual child therapy role, this was found to be less useful to overall classroom management needs, and in fact, disruptive. However, in centers where the emphasis was more on overall classroom strategies and engaging parents, teachers seemed to want the CDA to provide more individual help with the children that they were most frustrated with. These comments from CDAs and teachers mean that there is an ongoing challenge to clarify roles and expectations.

In addition to the theme of the relationship between the CDA and the teachers, and finding the correct balance and level of support there, the other strong theme that arose from these interviews was the challenge of working with families. All stakeholders at all levels of child care organizations, as well as the CDAs, felt that engaging families was both essential, as well as difficult. Because of consent issues, the need to engage families also created implementation issues, as families either took a long time to accept or reject services, or failed to follow through consistently so that adequate and timely services could be delivered. When these issues occurred, CDAs were not able to easily move on to work with other families, thus resulting in inefficiencies in reaching perhaps as many children and families as might have been. Some centers seemed to feel that if they controlled the choice of target children more directly, and were allowed to choose children with less severe problems, this situation might improve. However, the trade off with this approach is that families with the most needs do not have the opportunity to receive needed services. The family liaison program TFK implemented this year to try to engage more parents seems to be working well in one center, but at this point is more of a promise in the other sites. Everyone agrees that meeting the challenge of engaging families is difficult, but one specific recommendation to assist with this is that CDAs have enough flexibility in their schedules to meet family scheduling needs for individual meetings at days and times outside of routine time assigned to each center.

In general, the floater teacher model originally implemented by TFK does not seem to have worked well, because in most cases it was difficult to hire the right type of person to fulfill this role. However, all the teachers in all sites said they needed coverage in order to meet with families and to make home visits, which were viewed as an extremely valuable aspect of the model. Different suggestions were made to solve this problem, but in general, the goal needs to be that child care centers have some extra coverage so that the critical parent-teacher involvement activities can go on.

Finally, the issue of overall time for the CDA in the center and with individual families was raised by most interviewees. More time for services for each center and more time for each family was noted as being needed by almost everyone. However, those centers where implementation was in its second year seemed more comfortable with the level of effort the CDA was able to devote to the center. Their worry was having the services cut back to only a consultation model. This feedback suggests that moving to a stepped-down model of mental health consultation services to child care centers, with less service hours than the current intervention may not be as successful. In part this is due to the difficulty of engaging families in services for themselves or their children by referral to yet another agency. Families are reluctant to accept mental health services from the child care center, but even more reluctant, or unable due to cost, transportation, inflexible job hours etc., to follow through with continuing services at a mental health agency.

These interviews suggest that the TFK project is providing essential services to child care centers. Benefits are accruing to staff, families and children. Yet, the challenges of delivering the services, the significant needs of families and children, and the ongoing stresses of the centers themselves, make uniform success difficult to achieve. The interviews suggest that continued work is needed around CDA roles and skills; strategies to engage and motivate teachers; mechanisms to engage parents; and balancing resource needs in centers to make it feasible to offer services to more centers.

B. Target Child and Family Baseline Results

1. Description of families

Demographic information. During Year Two, consent was obtained from twenty-eight families whose children were targeted for intervention based on their child's scores on the Early Screening Project (ESP) assessments. As part of the baseline data collected, parents filled out a demographics questionnaire, along with other questionnaires on the family and their experience of parenting the target child. Fourteen of these target children came from the Pilot Sites (5 from Pilot Site A, 9 from Pilot Site B), 8 from the New Intervention Sites (4 from New Intervention Site C, 4 from New Intervention Site D), and 6 from three South County Sites. Demographically, the families in Year Two were similar to the families in Year One. Most children came from single parent homes (8 out of the 14 children from the Pilot Sites, 4 out of 8 from the New Intervention Sites, and 4 out of 6 children from the South County Sites lived with only one adult in the household). Most children had one or two siblings (only 6 children in the Pilot Sites, 2 in the New Intervention Sites, and 0 children in the South County Sites were the only children in the home), while one child in the South County Sites had 4 other children living in the home. Seven of the children (3 in the Pilot Sites, 2 in the New Intervention Sites and 2 in the South County Sites) were involved in shared custody arrangements where they lived in another household part-time. There were 5 families in the Pilot Sites, 2 families in the New Intervention Sites and 1 family in the South County Sites who had involvement with the Department of Social Services within the last year; one family from the Pilot Sites had received services from the Department of Mental Health within the last year; and one family in the South County Sites who had received services from the Department of Youth Services within the last year.

Two family questionnaires were filled out by the child's father, the rest were completed by the child's mother or female guardian. Families represented a mix of racial backgrounds across the Pilot and New Intervention Sites, however all but one family in the South County Sites were white. In the Pilot Sites 7 out of 14 parents were white, 5 were Hispanic, 1 was African American, and 1 was listed as "other." In the New Intervention Sites, 2 were white, 2 were Hispanic, 3 was African American, and 1 was listed as "other." As was the case in Year One, parent's age covered a substantial range. In the Pilot Sites, parent's reported age ranged from 19 to 49 (M=27.5). In the New Intervention Sites, parent's age ranged from 23 to 44 (M=32), and in the South County Sites parent's age ranged from 27 to 40 (M=31.5). Parents also came from a range of educational backgrounds. Five out of the 14 mothers in the Pilot Sites had not completed high school, 5 had a high school diploma and 4 had some college. Of the eight parents in the New Intervention Sites, one parent did not complete high school, 2 had a high school diploma, 3 had some college, one had a college degree and one had a Master's degree. Parents in the South County Sites included one who did not complete high school, 2 with a high school diploma and 3 with some college. Most parents in the Pilot and New Intervention Sites worked full time (8 out of 14 in the Pilot Sites and 7 out of 8 in the New Intervention Sites), while only 2 of 6 in the South County Sites were employed full time. Reported family income for 9 of the Pilot Site parents, 4 of the New Intervention Site parents and 3 of the South County Site parents was under $25,000, with 1 of the New Intervention parents reportedly making less than $5,000. Two of the Pilot Site parents, 1 of the New Intervention Site parents and 2 of the South County parents made between $25,000 and $40,000. Three Pilot Site parents, three New Intervention Site parents, and one South County parent made over $40,000 per year. Chi square analyses showed there were no significant differences in the demographic characteristics of Year One and Year Two parents.

2. Home environment

To assess the home environment, a home visit was made by the CDA and the HOME Inventory for Families of Preschoolers (Caldwell & Bradley) was completed. This scale has 8 subscales: 1. learning stimulation (the types of toys and learning materials available), 2. language stimulation (parent's encouragement and use of language), 3. physical environment (safety, cleanliness, pleasantness of home and neighborhood), 4. warmth and affection (parent's interaction, physical and verbal affection, encouragement of child), 5. academic stimulation (parent's encouragement of child in learning colors, numbers, etc), 6. modeling (e.g., T.V. is used judiciously), 7. variety in experience (parent takes child on outings, etc), and 8. acceptance (assessing harshness in interactions with and punishment of child). There is also a total score. Subscale and total scores are then compared with norms and percentiles falling within either the lowest fourth, the middle half, or the upper fourth. The table below shows the number of families falling within each of the percentile rankings within each subscale and for the total score.

	Pilot Sites			New Intervention Sites			South County Sites		
HOME Subscale	lowest 1/4	middle 1/2	upper 1/4	lowest 1/4	middle 1/2	upper 1/4	lowest 1/4	middle 1/2	upper 1/4
Learning Stimulation	1	11	1	0	6	2	0	7	0
Language Stimulation	5	4	4	2	3	3	2	3	2
Physical Environment	1	7	5	2	5	1	1	5	1
Warmth and Affection	2	2	9	1	2	5	1	5	1

Academic Stimulation	5	6	2	4	3	1	6	1	0
Modeling	1	6	6	3	1	4	1	3	3
Variety of Experience	5	7	1	3	4	1	3	3	1
Acceptance	2	1	10	1	1	6	0	2	5
Total Score	1	10	2	3	3	2	3	3	1

These results show that target children come from a range of family environments with areas of strength and areas of weakness. However, only one family (8%) from the Pilot Sites scored in the lowest quarter percentile in the total overall home environment, while 3 families in the New Intervention Sites (representing 37.5% of the target families in these sites) and 3 families in the South County Sites (representing 43% of the target families in these sites) did so. Language stimulation, academic stimulation, and variety of experience were areas of weakness for many families in the Pilot Sites, while many of these families showed strength in the areas of physical environment, warmth and affection, modeling, and in acceptance. For the New Intervention Sites, many families showed weakness in the area of academic stimulation, while strengths for many families were shown in the areas of warmth and affection, modeling and acceptance. Similarly, in the South County Sites, academic stimulation and variety of experience were areas of weakness for many families, while strengths were in the areas of modeling and acceptance. This is similar to Year One results. Analyses of variance showed that the only difference between target families in Year One and Year Two was that families in Year One had higher scores in the area of variety of experience $F(1,37)=4.38$; $p=.04$. When looking across sites and across years, it shows a consistent pattern whereby the greatest area of weakness is in academic stimulation (51% of families score in the lowest quarter percentile), while the greatest area of strength is in the area of warmth and affection (72% of families scored in the upper quarter percentile).

3. Family resources and stress

The Family Resource Scale (Dunst & Leet., 1985) was also filled out by the child's parent. This scale assesses the family's resources in areas such as housing, food, money, clothes, and time to meet the needs of the family on a consistent basis. There are 30 items and parents rate each item on a scale from 1=not at all adequate to 5=almost always adequate. Scores were summed across the 30 items. Norms provided for families of young children range from 75 to 150 ($M=116.54$, $SD=17.76$). In this sample, the Pilot Site families resources sum ranged from 64 to 174 ($M=115.92$, $SD=21.95$), the New Intervention Site families scores ranged from 115 to 145 ($M=125.71$, $SD=10.83$), and the South County families scores ranged from 86 to 141 ($M=103.83$, $SD=20.96$). These scores are similar to the national norms and analyses of variance showed no significant differences between the sites on this total summed score. Another meaningful way to look at this measure, however, is to look at mean scores. For this scale, an individual resource is considered optimum if it scores a 4 or 5. The mean score across the items for the Pilot Sites was 3.90 ($SD=.70$), for the New Intervention Sites the mean was 4.21 ($SD=.34$), and the mean for the South County Sites was 3.62 ($SD=.63$). There were no significant differences between the sites on these mean scores and no difference between families in Year One and Year Two. As in Year One, items that consistently scored lower than a 4 in these families included items dealing with time (e.g., time to socialize, time to be by myself, time to get enough rest/sleep, etc.) and items dealing with having extra money (e.g., money for family entertainment, money to save, travel/vacation, etc.). Three of these items had means below 3 (sometimes adequate): money for buying things for yourself ($M=2.83$), money to save ($M=2.48$), and money for travel and vacations ($M=2.50$). Although there were two to three families who

rated the basic necessities like food, clothing, housing, and medical care as not at all to seldom adequate, overall for most families, the basic necessities were adequate.

Families were also asked about the stressful life events that have occurred in the family within the past year. This scale lists 19 life events such as divorce, marriage, pregnancy, moving, decrease in income, drug or alcohol problems, beginning a new job, legal problems, and death of a family member or friend. Parents simply check off those that have occurred and then scores are weighted and summed. Total stress scores by families in the Pilot Sites ranged from 0 to 21 (M=8.76, SD=6.09), in the New Intervention Sites scores ranged from 3 to 22 (M=10.38; SD=6.19), and in the South County Sites, the total stress scores ranged from 8 to 35 (M= 18.83; SD=9.20). Analysis of variance showed that South County had significantly higher scores than the other two sites, who did not differ from each other $F(2,25)=5.43$, $p=.01$. The critical cut-off score for this scale is 17. There was one family (7%) in the Pilot Site who exceeded this cutoff (score=21), 2 families (25%) in the New Intervention Sites (one scoring a 17 and one a 22) and 3 families (50%) in the South County Sites (one scoring a 20, one a 21 and one a very high score of 35). With the exception of the one family scoring a 35, these results are similar to Year One findings and in fact do not differ statistically Year One to Year Two.

4. Parenting skills and parenting stress

To assess parent's baseline parenting skills the Parenting Scale (Arnold et al 1993) was given. This scale asks parents to indicate strategies they use when their child misbehaves. There are 30 items which give a behavioral stem such as 'When my child does something I don't like..." and offers a 7-point scale anchored by two responses, one a parenting mistake (e.g., I often let it go), and the other, an effective parenting strategy (e.g., I do something about it every time it happens). Mean scores are then calculated for each subscale and the total score. Higher scores indicate more parenting mistakes.

For the purposes of this assessment, the total parenting score and two of the three original subscales were used. These two subscales, laxness and overreactivity, have been shown to be reliable and have been replicated in other studies of the instrument, whereas the third subscale (verbosity) has not. The table below shows the means, and standard deviations of the total score, and the two subscale scores for the Pilot Site parents, New Intervention Site parents, and the South County Site parents. For comparison, the means and standard deviations from a clinic sample and a non-clinic sample as reported in the literature on the development of the scale are also presented.

Parenting Scale	Pilot Sites Mean (SD)	New Intervention Sites Mean (SD)	South County Sites Mean (SD)	Clinic Sample Mean (SD)	Non-clinic Sample Mean (SD)
Laxness	2.6 (.9)	2.1 (.9)	2.7 (.9)	2.8 (1.0)	2.4 (.8)
Overreactivity	2.8 (1.0)	1.95 (.8)	3.4 (1.0)	3.0 (1.0)	2.4 (.7)
Total Score	3.1 (.6)	2.7 (.6)	3.1 (.7)	3.1 (.7)	2.6 (.6)

This table shows that parents in the Pilot and South County Sites score very similarly to the clinic sample at baseline, and could benefit from learning better parenting strategies. However, the New Intervention Site parents appear to be in the non clinic sample range.

Parents also filled out the Parenting Stress Index-Short Form (Abidin, 1995.) This 36 item scale has three subscales (Parental Distress, Parent-Child Dysfunctional Interaction, and Difficult Child) as well as a total score. The Parental Distress subscale assesses stress associated with the parenting role such as

impaired sense of parenting competence, restrictions placed on other life roles, conflict with the child's other parent, lack of support, etc. The Parent-Child Dysfunctional Interaction subscale assesses the parent's perception that the child does not meet his/her expectations and the interactions with the child are not reinforcing to the parent. The Difficult Child subscale assesses behavioral characteristics of the child that make the child either easy or difficult to manage. Scores for each subscale are summed and then compared with normed percentiles. Scores falling above the 85th percentile are considered high, and those above the 90th percentile are considered clinically significant. The table below shows the number of parents falling into the low, average, high, and clinical ranges for each subscale and the total score.

Parenting Stress Index Subscale	Pilot Sites				New Intervention Sites				South County Sites			
	low	avg	high	clinical	low	avg	high	clinical	low	avg	high	clinical
Parenting Distress	2	7	3	2	2	6	0	0	2	3	0	1
Parent-Child Dysfunctional Interaction	1	8	1	4	2	6	0	0	0	6	0	0
Difficult Child	0	6	4	4	0	5	1	2	0	4	2	0
Total Score	1	7	0	6	4	4	0	0	2	3	0	1

Analyses of variance of mean scale scores revealed no significant differences between sites on any of the subscales or the mean total score for this measure. However, when looking at the numbers of families falling in the high to clinical ranges, Chi square analyses showed that the New Intervention Site parents had significantly fewer parents scoring in the high to clinical range in the total parenting stress score than the Pilot Sites χ^2=4.71, df=1, p=.03. Overall, then, it appears that the New Intervention Sites experience less parenting stress than the Pilot Sites, with the South County Sites falling in between. However, these results should be viewed with caution as 5 parents (2 from the Pilot Sites, 1 from the New Intervention Sites and 2 from the South County Sites) scored significant in the scale's defensive responding category, indicating that they may have been answering the questionnaire in a defensive manner and may not have been completely honest in their responses. When comparing Year One parents in the Pilot and South County Sites, with year two parents in the same sites, there were no significant differences.

Summary. Taken together, the families of target children come from diverse family backgrounds, and many have very limited incomes which tax their resources, particularly in terms of having money for the extras in life. They also report a lack of time for themselves and for socializing, something that is common for parents of young children. While parents across sites show many similarities, and for the most part, are not different from target parents in Year One, there were some notable differences between sites. For example, proportionally more parents in the South County Sites experienced clinical levels of stressful life events, while the New Intervention Site parents appear to have greater parenting skills and less parenting stress as a group (particularly compared to the Pilot Sites). For all sites, and across years, providing academic stimulation in the home continues to be an area of weakness, while most parents provide high levels of warmth and affection, and acceptance.

5. Description of target children

Twenty-eight children were initially identified for intervention (11 boys and 3 girls in the Pilot Sites, 5 boys and 3 girls in the New Intervention Sites, and 3 boys and 3 girls in the South County Sites) based on the results of the Early Screening Project (ESP; Walker, Severson, & Feil, 1995). The ESP, completed by the child's teacher, assesses both externalizing and internalizing behaviors in preschool children and provides norms separately for girls and boys. Most children across centers were identified as having externalizing behavior problems: 12 of the 14 in the Pilot Sites, 5 out of 8 in the New Intervention Sites, and 4 out of 6 in the South County Sites were identified as having externalizing behavior problems, while the others were identified as having internalizing problems. Of the 21 children with externalizing behaviors, 15 were boys. Of the 7 children with internalizing behaviors, 4 were boys. Subscales for this measure include: Critical Events Index (a checklist of 16 serious behaviors), and rating scales for Aggressive Behavior (for externalizing children, 9 items), Social Interaction (for internalizing children, 8 items), Adaptive Behavior (8 items), and Maladaptive Behavior (9 items). The norms provided for this measure include risk categories from no risk (children's scores fall below the clinical cut-off) to "at risk" (scoring 1 standard deviation above the mean, or at the 84th percentile) to "high risk" (scoring 1.5 standard deviations above the mean, or at the 93rd percentile) to "extreme risk" (scoring 2 standard deviations above the mean or at the 98th percentile) for the normative group. The table below shows the number of children falling into each risk category in each site, for each subscale.

ESP	Pilot Sites				New Intervention Sites				South County Sites			
subscale	no risk	at risk	high risk	extreme risk	no risk	at risk	high risk	extreme risk	no risk	at risk	high risk	extreme risk
Critical Events	2	2	7	3	2	1	0	5	0	2	1	3
Aggressive Behavior*	0	0	0	12	0	0	0	5	0	0	0	4
Social Interaction**	1	1			0	3			1	1		
Adaptive Behavior	4	0	4	6	0	1	0	7	2	2	1	1
Maladaptive Behavior	2	0	0	12	1	0	1	6	1	0	0	5

*Aggressive Behavior subscale is only rated for children who have externalizing behaviors

**Social Interaction subscale is only rated for children who have internalizing behaviors. Also for this subscale, there are not separate risk categories. Children are considered either at risk or not at risk.

This table shows that most target children in all sites fall within the high to extreme risk categories across the five subscales. In fact, all of the children with externalizing behavior problems scored in the extreme risk category in aggressive behavior as well as in maladaptive behavior. Although the smaller sample size of children with internalizing behavior problems makes analyses of differences between the two groups difficult to interpret with confidence, we did find that children with internalizing behaviors showed significantly more adaptive $F(1,26)=5.82$, $p=.023$, and less maladaptive $F(1,26)=37.77$, $p<.001$ behaviors than children with externalizing problems, indicating that these two groups should be analyzed separately. Analysis of variance revealed no significant differences between sites in any of the subscales when looking at children with externalizing symptoms (there were too few children in each site with internalizing problems to look at site differences in this group). Further, when examining differences between the target children with externalizing problems in Year One and Year Two (there were no target children with internalizing problems in Year One), there was a trend for children in Year Two to be less

aggressive F(1,31)=3.48, p=.072, and less maladaptive F(1,31)=3.22, p=.083. In fact, when the two New Intervention Sites were removed from this analysis, and we just examine those sites that had TFK in Year One, these differences were even stronger.

Parents also rated their child's behavior using the ESP parent scale. This scale measures the parent's perception of their child's behavior in the home and results in one general behavioral score. Higher scores indicate greater behavioral problems. Analysis of variance of differences between sites in parent's ratings of behavior showed a non-significant trend F(2,25)=2.57, p=.097. Means for the Pilot, New Intervention, and South County Sites were: 22.6, 19.4, and 22.8 respectively (range=12 to 48). There are no norms for this measure to indicate how high or low these scores are, however, they provide a baseline to look at changes in behavior in the home.

The other baseline assessment completed on all target children was the Developmental Profile II (Alpern, Boll, & Shearer, 2000). The Developmental Profile is a brief developmental screen designed to identify children who may have intellectual or social developmental delays. This instrument assesses development in 5 areas (physical, self-help, social, academic, and communication) and shows a child's development in relation to age norms. Scores represent the number of months (+ or -) the child's developmental age falls relative to chronological aged norms. This screen was completed to identify underlying problems that could affect behavior. The table below shows target children's mean, standard deviation, and range of scores obtained in each area for the Pilot, intervention, and South County Sites.

Developmental Profile Subscale	Pilot Sites (n=14)	New Intervention Sites (n=8)	South County Sites (n=6)
Physical	M= 4.6 (SD=5.3) range = -4 mos. to 13 mos.	M= -3.0 (SD=8.5) range = -10 mos. to 14 mos.	M= -1.2 (SD=7.5) range= -8 mos. to 11 mos.
Self-Help	M= 3.3 (SD=4.6) range = -6 mos. to 10 mos.	M= -1.5 (SD=6.7) range = -9 mos. to 10 mos.	M= 8.8 (SD=13.5) range= -8 mos. to 28 mos.
Social	M= -.9 (SD= 8.5) range = -18 mos. to 17 mos.	M= -1.5 (SD=6.1) range = -8 mos. to 10 mos.	M= -2.2 (SD=12.2) range= -15mos to 12 mos.
Academic	M= 2.4 (SD= 8.4) range = -10 mos. to 17 mos.	M= 2.0 (SD= 8.9) range = -7 mos. to 15 mos.	M= .5 (SD=11.3) range= -14 mos. to 11 mos.
Communication	M= -1.0 (SD= 4.5) range = -8 mos. to 5 mos.	M= -2.3 (SD=4.5) range = -9 mos. to 3 mo.	M= -10.0 (SD=2.4) range= -13 mos. to -7 mos.

This table shows that there is great variability across subscales, with some children scoring well above chronological age norms and some below age norms. As in Year One, children tended to show the greatest weaknesses in social and communication skills. Analyses of variance to test differences between sites revealed that children in the New Intervention Sites were significantly more delayed on average than the children in the Pilot Sites in terms of their physical age F(2,25)=3.61, p=.04, and showed a trend for being more delayed than the South County children in Self-Help Skills F(2.25)=3.06, p=.065. Children in the South County sites were more delayed in their Communication Skills than children in the other two sites F(2.25)=10.1, p=.001. Further, analyses of variance between Year One and Year Two scores for the Pilot and South County Sites (the New Intervention Sites did not have target children in Year One), showed that Year One children were significantly more delayed than Year Two children in their social development F(1,30)=9.1, p=.005, and academic development F(1,30)=5.26, p<.03. Year One children in these sites also showed a non-significant trend towards greater delays in communication skills F(1,30)=3.5, p.=07.

Summary. Like last year, there are more target children with externalizing behavior problems than internalizing behavior problems, and the children with externalizing problems show significantly more maladaptive behavior and less adaptive behavior than those with internalizing symptoms. However, there were no significant differences between the sites in terms of behavioral risk at baseline. When examining differences between children in Year One versus Year Two, we did find that target children in Year Two showed less aggressiveness and less maladaptive behaviors than did children in Year One. In terms of their development, target children in Year Two, as a group, show great variability, with areas of strength and areas of weakness, with some differences between sites in terms of target children's Physical, Self-Help and Communication Skills. Further, similar to the analysis of behavior, we found, on average, children in Year Two appear to be starting at a higher developmental level in areas that could be expected to affect behavior (particularly social development and communication skills) than were children in Year One. In fact across years, social development was found to be negatively correlated with both aggressive behavior ($r=-.40$, $p=.05$) and maladaptive behavior ($r=-.38$, $p=.05$), and positively correlated with adaptive behavior ($r=.36$, $p=.05$).

C. Target Child and Family Outcomes

At follow-up there were 19 families who completed the intervention (7 in the Pilot Sites, and 6 each in the New Intervention and South County Sites). Seven of the 28 children who had baseline data dropped out (4 because they left the center (for a range of reasons including parent inability to pay the fees) and 3 gave consent and then subsequently decided not to continue in the project. In addition, two parents (one in the Pilot Sites, and one in the South County Sites) did not have complete parenting data. The data provided below represent all data that were available at follow up.

1. Changes in parenting skills and parenting stress

Parenting skills. Repeated measures analysis of variance were completed on each of the subscales and the total parenting score, examining differences between time one (baseline) and time two (follow-up), as well as differences between sites in their time one to time two scores. These analyses showed no significant changes from baseline to follow-up, and no significant differences between sites. These results are different from Year One where, at least for the Pilot Sites, there was significant improvement in overall parenting skills. As can be seen from the table below, in some cases, there is a slight increase in scores, indicating greater use of poor parenting strategies. Note: baseline means and standard deviations are slightly different than reported above due to missing data.

Parenting Scale	Pilot Sites Mean (SD)		New Intervention Sites Mean (SD)		South County Sites Mean (SD)	
	Baseline	Follow-up	Baseline	Follow-up	Baseline	Follow-up
Laxness	3.0 (.4)	3.3 (.4)	1.9 (.4)	2.2 (.4)	2.8 (.4)	2.8 (.4)
Overreactivity	2.8 (.4)	3.5 (.5)	2.1 (.4)	2.5 (.5)	3.6 (.5)	3.2 (.5)
Total Score	3.2 (.3)	3.3 (.2)	2.5 (.3)	2.8 (.2)	3.2 (.3)	3.0 (.3)

To investigate the effects of treatment intensity, the families were grouped by number of hours of overall intervention services. These ranged from 11.5 hours to 72.25 hours.[2] Half of the group received 23 hours of service or less, the other half received more than 23 hours of service. Therefore the group was divided into two groups and changes in their mean total parenting scores were examined. Mean scores for the 23 hour or less group increased from 2.7 at time one to 2.9 at time two, suggesting they were making more parenting mistakes at time two. Mean scores for the over 23 hours of service group changed from a mean of 3.3 at time one to 3.2 at time two, suggesting that a greater intensity of service had a more positive effect. This time by treatment intensity interaction reached marginal significance $F(1,16)=3.56$, $p=.077$. When looking at the subscales of this measure, there were no significant differences for Laxness, but Overreactivity did show a significant time by treatment intensity interaction effect $F(1,16)=7.23$, $p=.016$. Again, low intensity parents showed greater parenting mistakes at time two (means increasing from 2.6 at time one to 3.3 at time two), whereas the high intensity group decreased parenting mistakes from a mean of 3.0 at time one, to a mean of 2.7 at time two. This helps to explain the lack of findings in change over time in this parenting measure because the effects of one group nullify the effects of the other when they are grouped together.

Because of the relatively small sample sizes in each individual year, both years were combined and analyses were rerun. The results of these analyses were similar, with no time effects or site by time effects, but with significant time by treatment intensity interactions indicating that high intensity groups showed greater improvement in overall parenting skills, and particularly in overreactivity, than low intensity groups over time.

Parenting stress. Repeated measures analysis of variance were also completed on each of the subscales and the total parenting stress scale scores, again examining differences between baseline and follow-up, as well as differences between sites in how they may change. Here we found no significant time effects, indicating no change from baseline to follow-up, and there were no significant time by site differences, indicating that all sites showed this lack of difference over time. These results are similar to year one results.

To examine the effects of treatment intensity, the groups were once again broken into those receiving 23 hours or less of total treatment vs. those receiving more than 23 hours. Again, for this measure there were no significant time by treatment interaction effects on either the total score or subscales, suggesting that intensity of treatment had no effect. When both year one and year two samples were combined, similar results were found.

Summary. Similar to last year, parenting stress evidenced little change over time. However, while there also appeared to be no change over time in parenting skills, further analyses of the effects of treatment intensity revealed some interesting differences, particularly in overreactivity. Parents who had a greater intensity of treatment, showed better parenting skills at follow-up, while those who had fewer hours of intervention showed poorer parenting skills at follow-up. This suggests that changing parenting skills may require a longer or more intense intervention. This makes sense in that it takes time to develop a collaborative relationship, and build trust for behavioral change. However, making this effort would appear to be critical in the long run to sustain gains for the child.

[2] Those families who dropped out of service before completing treatment and follow-up assessments were not included so as not to artificially lower the mean and median for those who have time two data. For instance, some families only received one hour of services and then dropped out. Including these families would have brought the median total treatment hours down to 18.75 and lowered the number of subjects who were included in the "low intensity group" because 6 of these families had no time two data and so would not be included in the analyses.

2. Changes in developmental profile scores

Repeated measures analysis of variance was conducted to examine differences over time (baseline to follow-up) and between sites for each of the Developmental Profile subscales. Sample sizes were small at follow-up however, so a lack of power to see differences where they exist is an issue (Pilot n=7, New Intervention n=7, and South County n=6). Results showed significant improvements over time for Physical Development $F(1,17)=25.99$, $p<.001$, and Self Help Skills $F(1,17)=11.77$, $p=.003$. Mean scores baseline to follow-up for Physical Development changed from -.2 months to 8.75 months, and for Self Help from 3.3 months to 9.0 months. There were also non-significant trends showing improvement over time in Academic Skills $F(1,17)=3.24$, $p=.09$, and Communication Skills $F(1,17)=3.41$, $p=.082$. Mean scores baseline to follow-up for Academic Skills changed from 2.7 months to 5.0 months, and for Communication Skills from -4.6 months to -1.8 months. Social Skills also showed some improvement (means for baseline and follow up were -1.5 months to +1.9 months), but this was not statistically significant. Also, there were two significant Time by Site interaction effects, showing that sites differed in the amount of change over time shown in developmental skill levels. These interaction effects were significant for Physical Development $F(2,17)=6.59$, $p=.008$, and Self Help $F(2,17)=4.44$, $p=.028$. These interaction effects are analyzed further within each site, as described in the paragraphs below, along with mean improvements in the other developmental skill areas.

Pilot Site children (n=7), improved in mean Developmental Profile scores across all of the subscales, however, paired t-tests showed that only Self-help ($t=-2.72$, $df=6$, $p=.035$) and Communication Skills ($t=-3.3$, $df=6$, $p=.016$) reached statistical significance. Baseline to follow-up scores showed that mean Physical Development increased from 2.7 months, to 8.7 months; mean Self Help Skills increased from 3.9 months to 9.9 months; mean Social Development improved slightly from -1 months to +1.3 months; mean Academic Development improved from 4.4 months to 7.6 months; and mean Communication Skills improved from -.7 months to 6.3 months.

Children in the New Intervention Sites (n=7) showed some improvement across all domains, but none reached statistical significance. Baseline to follow-up mean scores were as follows: Physical Development increased from -2.1 months, to +.7 months; Self Help Skills increased from -2.7 months to 3.3 months; Social Development increased from -1.3 months to +1 months; Academic Development increased slightly from 3.3 months to 3.9 months; and Communication Skills improved from -3 months to -1.3 months.

For children in the South County Sites (n=6), there was improvement in all areas except for Communication Skills. Further, there was significant improvement in both Physical Development ($t=-7.7$, $df=5$, $p=.001$) and Self Help Skills ($t=-2.9$, $df=5$, $p=.035$). Mean Physical Development increased dramatically from -1.2 months to 16.8 months; mean Self-Help Skills also increased substantially from 8.8 months to 20.5 months; mean Social Development improved from -2.2 months to 3.5 months; and mean Academic Development increased from .5 months to 3.5 months. Mean Communication Skills decreased slightly from -10 months to -10.7 months).

Again, the effects of treatment intensity were examined. Repeated measures analyses of variance showed that the high intensity group showed significantly greater improvements in Self-Help Skills than the low intensity group, $F(1,18)=8.5$, $p=.009$. Means for baseline to follow up for the low intensity group (n=8) were 3.3 months and 4.8 months; while for the high intensity group (n=12), means for baseline to follow up were 2.6 months and 13.9 months. There were no other significant group differences by intensity of treatment in any of the other developmental domains. When both Year One and Year Two samples were combined, there were significant improvements from baseline to follow-up in Physical Development $F(1,28)=10.34$, $p=.003$ and Self-help Skills $F(1,28)=9.06$, $p=.005$, and strong trends in

Social Development F(1,28)=3.70, p=.065, Academic Development F(1,28)=3.43, p=.07 and Communication Skills F(1,28)=3.97, p=.056. However, no time by treatment intensity effects were significant.

Summary. Overall, for most children there were improvements in developmental skill levels across all areas, but these were most evident in the areas of Physical Skills, Self Help, and to a lesser extent in Academic Skills and Communication Skills. Social Skills showed some improvement, but this was not statistically significant when looking at the Year Two sample alone. However, when Year One and Year Two samples are combined, Social Skills also show a near significant level of improvement over time. Treatment intensity appeared to have an effect on Year Two target children's Self Help Skills, but when both Year One and Year Two groups were combined, treatment intensity showed no effect on children's skill improvement.

3. Changes in ESP scores

Preliminary analyses showed that internalizing and externalizing children were significantly different in both Maladaptive and Adaptive behaviors over time and therefore could not be grouped together. Analyses for these two groups of children will be reported separately. Several repeated measures analyses of variance were conducted to look at: 1) comparisons between sites in baseline to follow-up scores in each subscale; 2) comparisons between target and waiting list control children baseline to follow-up; and 3) comparisons between high intensity treatment and low intensity treatment baseline to follow-up. Because there were few target children with internalizing behaviors served across sites (n=6), and therefore, not enough in each cell to compare, analyses on these children were conducted with simple t-tests where possible. Results of analyses for the externalizing children are reported first.

Comparisons between sites. Repeated measures analyses of variance for the children with externalizing behaviors revealed a strong main effect for Time (baseline to follow-up) for the Critical Events subscale F(1,33)=10.89, p=.002, indicating significant improvement baseline to follow up across sites. Further there was a marginally significant trend for Time by Site F(2,33)=2.98, p=.065. Examination of the means shows that both the Pilot (n=12) and New Intervention Site children (n=17) show decreases over time (Pilot baseline to follow-up means were 3.3 and 1.8; New Intervention Site means were 4.5 and 2.2), while South County Sites saw no change (baseline to follow up means remained the same at 2.6). However, there were only 7 externalizing children in the South County group, so these results must be interpreted with caution.

In terms of Aggressive Behavior, there was a significant main effect for Time F(1,33)=15.22, p<.001, but the Time by Site interaction was not significant, indicating that children at all sites showed significant improvement over time (e.g. decreases in aggressive behavior). Means for baseline to follow-up were as follows: Pilot Sites= 26.8 and 22.4; New Intervention Sites=27.5 and 23.3; and South County=25.0 and 22.2.

In terms of Adaptive Behavior, there was again a significant main effect for Time F(1,33)=7.67, p=.009, but the Time by Site interaction was not significant, indicating that children at all sites showed improvement over time (e.g., increases in adaptive behavior). Means for baseline to follow-up were as follows: Pilot Sites= 21.9 and 27.1; New Intervention Sites=19.7 and 23.8; and South County=26.9 and 29.0.

Finally, in terms of Maladaptive Behavior, there was a strong main effect for Time, F(1,33)=16.59, p<.001, indicating significant reductions in maladaptive behavior in children baseline to follow up, across sites. There was a marginally significant trend for Time by Site F(2,33)=2.42, p=.10. Further

examination of the means shows a similar trend as was seen with Critical Events, that is, both the Pilot and New Intervention Site children show decreases in maladaptive behavior over time (Pilot baseline to follow-up means were 32.8 and 25.5; New Intervention Sites means were 34.2 and 28.8), while South County Sites saw almost no change (baseline to follow up means were 30.9 and 30.0, respectively). Again, small sample sizes in this group make interpretation difficult.

Comparisons between Target and Control groups: Repeated measures analysis of variance were again conducted using the Year Two children with Externalizing Behaviors. In terms of the Critical Events subscale, there was a significant effect for Time as described above, but no Time by Target interaction, indicating that both targets and control children improved from baseline to follow-up. The Adaptive Behavior subscale showed this same pattern of results—both target and control children showed improvement from baseline to follow-up.

In terms of Aggressive Behavior there was a significant Time effect as indicated above, but also a marginally significant interaction effect for Time by Target, $F(1,34)=3.08$, $p=.09$ showing that while both groups improved, target children had greater decreases in aggressive behavior than waiting list control children (means for target children baseline to follow-up were 28.7 and 23.0, respectively; means for waitlist control children were 25.3 and 22.7 baseline to follow-up).

Similarly, there was a significant Time by Target interaction effect for Maladaptive Behavior $F(1,34)=4.08$, $p=.05$. As with Aggressive Behavior, inspection of the means showed that while both groups reduced maladaptive behavior, target children made greater gains than waiting list control children (means for target children baseline to follow-up were 35.5 and 27.1, respectively; means for waitlist control children were 31.9 and 28.7 baseline to follow-up).

Comparisons of Treatment Intensity: Unlike last year, this year there were no significant effects for treatment intensity for any of the ESP subscales. One interpretation is that children who received fewer hours or more hours each received the amount of treatment they needed and so improved similarly. Small sample size may also play a role, but when both Year One and Year Two samples were combined, there still was no treatment intensity effect.

Changes in behavior for Internalizing Children: Paired T-tests conducted on the group of target children with internalizing behavior problems (n=6) showed statistically significant improvement from baseline to follow-up on only one subscale of the ESP, Critical Events ($t=5.48$, $df=5$, $p=.003$). However the sample size is too small to have adequate power, and inspection of the means shows some improvement across all of the other subscales. Means for target children baseline to follow-up were Critical Events=3.7 and 1.7; Social Behavior=27.7 and 31.2; Adaptive Behavior=30.5 and 34.3; and Maladaptive Behavior=16.5 and 16.3. When looking at the comparison between target children and waiting list control children (n=12) with internalizing behaviors, the waiting list children showed significantly less adaptive behavior at baseline than the target children [$F(1,16)=9.07$, $p=.008$], but no significant differences at follow-up on any of the subscales.

Summary. Taken together, these results replicate findings from Year One in terms of behavioral improvements as rated by teachers. In particular, they show significant improvements in aggressive behavior, adaptive behavior and maladaptive behavior for children with externalizing behavior problems. Further, target children with externalizing problems showed greater improvements in aggressive and maladaptive behavior than waitlist control children. Although we found no treatment intensity effects in Year Two, these results overall, provide strong support for the intervention's positive effects on the target children in particular, and in addition, there appears to be residual positive effects on the other children in

need in the classroom as well. Although there were too few children with internalizing behavior problems to fully evaluate the effects of TFK on these children, it appears that there is some benefit to them as well.

4. Changes in parent ratings of child behavior.

Repeated measures analyses of variance were conducted to look at change from baseline to follow-up by site and by treatment intensity. These analyses revealed no significant changes over time, and no significant effects by site or by treatment intensity. Again, it is hard to interpret these findings given the lack of norms to indicate relative behavioral problems. One possible interpretation however, is that the intervention focused mainly on the child's behavior at school and may have had less of an impact or carry over to the home setting.

5. Parent satisfaction with TFK services and the parent-professional relationship

Parent satisfaction with TFK services was assessed using a 16-item questionnaire. Twelve of the items asked parents to rate on a 5-point scale (1=strongly agree to 5= strongly disagree), how much they felt TFK services helped their child, for instance, behave better at school and at home, and improve their skills. Other questions asked how much TFK services helped the parent handle the child's behavior, feel more comfortable talking to the teachers, and obtain services for the child and family. Some questions asked whether TFK services took too much time, or expected too much from the parents. Two questions asked about the amount of services the child and family receive, and whether the amount was more than what was needed, about right, or less than what was needed. Finally, two questions asked about overall satisfaction with services using a 5-point scale ranging from 1=very unsatisfied to 5= very satisfied.

Chi square analyses revealed no significant difference in any of the questions based on intensity of services, or based on site. All parents responded positively (indicating they agreed or strongly agreed), that TFK services helped their child behave better at school. Most parents also agreed, or strongly agreed, the TFK helped their child behave better at home (75%), taught them better ways to handle child behaviors (81%), helped them feel more comfortable talking with teachers (82%), helped them feel more comfortable at the child care center (71%), and helped make the classroom a better place for all children (82%). Fifty-six percent of families stated that TFK helped them obtain other needed services for their child, or their family (36%). Most parents (94%) also disagreed or disagreed strongly that TFK services took too much time or expected too much from them. Most parents (except for one) agreed or strongly agreed that TFK services helped improve their child's skills (learning colors, listening, etc.), and helped them get to know the childcare staff and other families better (65%). In terms of the two items asking about the amount of services the child and family received, 14 out of 17 responding to these questions reported that the amount was "about right," while two parents said it was "less than what was needed," and one said it was "more than what was needed." Finally, parents were asked about their overall satisfaction with TFK services for their child and for themselves. In terms of overall satisfaction with TFK services for their child, three parents responded "neutral," 9 indicated they were "satisfied," and 5 indicated they were "very satisfied." Results were similar in relation to services for themselves, with 2 parents responding "neutral," 10 indicating they were "satisfied," and 5 stating that they were "very satisfied."

Parents also filled out a Parent-Provider Relationship Questionnaire, which asked about the parent's view of their relationship and experience with the Child Development Advisor (CDA). Thirteen of the items were rated on a 5-point scale of frequency, with the anchors of 1=never, 3=sometimes, and 5=frequently. Two other questions asked parents to describe the parent's personal relationship with the

CDA, and their opinion of their CDA's professional skills, respectively. The choices were: excellent, good, fair, or poor.

Analysis of variance showed no difference in a summary score of this measure, based on site or service intensity. Most parents responded very positively to questions asking about their personal experience with their CDA. For instance, most parents responded "never" or almost never (ratings of either a 4 or a 5) to the following items: "I feel I'm being judged by my CDA (71%)," "My CDA is critical of me and complains about the things I do (100%)," "I feel frustrated working with my CDA (94%)," "My CDA doesn't seem interested in what I have to say (100%)," and "I feel angry towards my CDA (100%)." Further, 10 out of 17 described their relationship as "good," 6 described their relationship as "excellent," while only one parent described it as "fair." All parents also responded "frequently" to the item "My CDA likes my child." Most parents (15 out of 17) reported that they frequently (ratings of either a 4 or 5) enjoyed working with their CDA, and most (13 out of 17) said that it was never difficult to work with the CDA. In terms of feeling close to their CDA, 5 reported they "frequently" felt close, 4 gave this item a "4" (one point lower), 1 parent said "sometimes," and 5 parents responded with a "2" or almost "never."

Other items asked about parent's view of the CDA's professional skills. Most parents were also positive in this regard. Seven out of 17 described their CDA's professional skills as "good," while the other 10 described them as "excellent." Sixteen out of 17 responded "frequently" (rating it a 4 or a 5) to the item "I feel my CDA is a competent professional," while the other parent rated this item a "2" or almost "never." One item asked if they agreed with their CDA's suggestions and recommendations. Here, 6 parents said "frequently," 7 gave this item a "4," and 4 parents said "sometimes." Asked if they trusted their CDA, most (16 out of 17) responded "frequently," (rating it a 4 or a 5). Finally, in terms of whether they felt their CDA's skills made a difference in their family's life, 6 parents said "frequently, 6 gave this item a "4," and 5 said "sometimes."

Summary. Overall then, most parents seemed to develop a positive relationship with their CDA and felt that the TFK services were helpful to their child and their family. Only about 3 parents seemed less satisfied with the CDA relationship and TFK services.

6. Evidence of classroom-wide changes in levels of behavior problems

It was expected that TFK would have classroom-wide benefits on levels of behavior problems over time. This was examined first by making three comparisons: 1) looking at differences from Year 1 to Year 2 in overall ratings of behavior problems in the centers that had TFK services for two years; 2) looking at differences between the Pilot and South County sites in their first year (Year 1) and the New Intervention sites in Year 2 (their first year of TFK involvement); and 3) looking at differences between the Pilot and South County sites and the New Intervention sites in Year 2.. If there were overall effects on behavior problems in the classroom we should see: 1) a decrease from Year 1 to Year 2 in baseline levels of behavior problems in the sites that had TFK services for two years (Pilot and South County); 2) no difference between the original TFK intervention sites and the new intervention sites when both were in their respective first year of intervention; and 3) significant differences between the sites in Year 2 when the original sites were in their second year and the new intervention sites are in their first year.

To look at overall behavior problem levels, a summary adjustment score was created by summing the 4 ESP behavioral measures for externalizing behavior problems (Critical Events, Aggressive Behavior, Adaptive Behavior [scores reversed], and Maladaptive Behavior) in those children, both targets and controls, who were identified as being at risk for externalizing behavior. Higher scores indicated higher total behavior problems. Similarly, the internalizing behavior problem scales were summed for

those children identified as being at risk for internalizing behavior problems, with scores reversed so that higher scores indicated greater adjustment problems. The comparisons were made using only the fall/winter assessments so that the time frames in terms of the length of time the children would have been in their classrooms was the same, and only the baseline scores were used in this analysis.

Differences between Year 1 and Year 2 behavior problem levels in original TFK intervention sites. Analyses of variance showed significant differences between baseline externalizing behavior problem levels in Year 1 as compared to Year 2 in the original TFK intervention sites (Pilot and South County). Total baseline externalizing scores were significantly higher in Year 1 (n=21) than in Year 2 (n=36), $F(1,56)=6.96$, $p=.011$, (mean Year 1 score=87.38; mean Year 2 score=75.56). Total internalizing behavior problem scores were not different inYear 1 (n=10) as compared to Year 2 (n=9), in fact, they were virtually the same (mean Year 1 score=69.40; mean Year 2 score=69.44). This provides some evidence that TFK services may be impacting overall levels of classroom behavior problems, at least in terms of externalizing behavior.

Differences between original intervention sites in Year 1 and new intervention sites in Year 2. Analyses of variance showed no significant differences between the Year 1 baseline scores for the original intervention sites (n=21) and the Year 2 baseline scores in the new intervention sites (n=19) for externalizing problems $F(1,39)=.04$, p=n.s. (mean for the original intervention sites=87.38; mean for the new intervention sites=86.21). However, there were significant differences between the sites in terms of internalizing problems. The original intervention sites in their first year (n=10) were significantly lower (mean=69.40) than were the new intervention sites (n=14) in their first year (mean=86.14), $F(1,23)=10.51$, $p=.004$. These results suggest that both sites had similar levels of baseline externalizing behavior problem levels when TFK started in their respective sites, although internalizing problems were higher in the new intervention sites.

Differences between the original TFK intervention sites and the new intervention sites in Year 2. It can be inferred from the above two sets of analyses (knowing that the original intervention sites showed decreases in overall externalizing behavior problems from Year 1 to Year 2, and that the original intervention sites and the new intervention sites showed no differences in overall externalizing behavior problems when each were starting their first year of TFK services) that there would be a significant difference in Year 2 between the original intervention sites (who had 2 years of TFK services) and the new intervention sites (who had only one year). Analyses of variance confirmed these differences for externalizing behavior problem levels. The original TFK intervention sites had significantly lower overall externalizing behavior problems (n=36; mean=75.56) than the new intervention sites (n=19; mean 86.21) $F(1,54)=5.16$, $p=.027$. Internalizing behavior problems are not worth looking at in this argument since they were not different in the original intervention sites from Year 1 to Year 2.

Taken together, these analyses suggest that there is a classroom-wide benefit from TFK services over time. These findings would be supported more strongly if we had data in the first year from the new intervention sites and that showed that there was no difference Year 1 to Year 2 for those sites receiving no TFK services. For instance, it is plausible, although we believe unlikely, that the effects are due to teachers repeatedly filling out the ESP questionnaires. However, it is impractical and unethical to gather that type of control data (identifying children in need of services) and not offer services to those children identified as at risk.

Yet another way to investigate center or classroom-wide changes is to look at changes in suspension and termination rates of children due to behavior problems. In this regard, suspensions for behavior decreased from 8 to 1 in the two pilot sites the first year, and increased to 3 in the second year of TFK; for new sites brought on in Year 2, the rates changed from 2 to 1. Further, 9 children were

terminated in the Pilot sites the year before TFK started, in Year One that rate dropped to 1 child and remained at a rate of 1 child terminated in Year Two. For the New Intervention sites, they had 4 children terminated the year prior to involvement in TFK (Year 1) and this dropped to 1 one child terminated in Year 2. Thus, overall, it appears that TFK has had a positive impact on both the number of children presenting with severe behavioral problems (suspensions and terminations), as well as the overall level of severity of behavior problems in the classroom.

VII. Implementation Year (Year Two) Summary and Recommendations

The implementation year (Year Two) of the Together for Kids pilot project has resulted in a maturing model. The project has achieved a balance between contributing to teacher training and overall center support, along with providing individual child and family services. While developing the right 'fit' and relationship with each child care center has been a challenge, overall the center administrators and teachers see great value in the TFK services and have grown in their recognition and ability to meet the needs of the children with behavioral issues. In Year 2, TFK expanded to additional preschool classrooms, and even higher percentages of children were identified as in need of assistance. Across the 5 child care programs served in Year Two, reflecting approximately 280 preschool age children in 17 classrooms, child screenings resulted in a yield rate of 34.7% of children with clinically significant externalizing or internalizing behavior problems. Between the two years, 120 children were identified as in need of service. Of this group, 47 children and their families received some individual intervention services.

A. Center-wide Issues

CDA, center administrator, and child care staff interviews and focus groups illustrated that all stakeholders found value in the TFK model, including staff receiving training and support, families being better connected to their child and the child care centers, and individual children achieving behavioral and developmental gains. Overall, however, there were some difficulties working out the relationship between the specific personality and array of skills of the CDA and the needs of individual childcare sites. In some centers it was difficult to achieve the balance between providing teacher support and individual child intervention. Different centers wanted more or less of these two different approaches. CDAs mention that obtaining teacher buy-in was challenging and that there were different levels of motivation and interest in working as a team with the CDA. CDAs felt that more teacher training was a necessary ingredient, while only some teacher groups felt so. [3] At the same time both CDAs and teachers noted administrative challenges were also present in terms of support for teachers to implement the model (time for meetings, multiple demands and priorities for teachers) and that the entire center and teachers needed to be better prepared for the intervention.

In addition to the challenges of gaining staff buy-in and establishing a collaborative working relationship between the CDA and the center, the biggest challenge mentioned by all stakeholders (CDAs, teachers, EDs and Center Directors) was engaging families. Some of the administrative staff felt the CDAs weren't proactive enough with parents; at the same time, they did mention that parents were sometimes hard to engage. The family liaison role that received additional funding hadn't yet had time to be fully implemented in centers when these interviews were conducted. However, there was one very positive experience at a center where the family liaison had organized a center-wide teacher, parent and child activity. This role needs continued funding and support to engage families in more positive relations with the child care centers. Parents might be less reluctant to accept help around their child's behavior if

[3] Interestingly, several Executive Directors also recommended more teacher training, while Center Directors focused more on the specifics of improving the delivery of services such as extending the time for involvement for individual children, different CDA work hours, changes in the floater teacher role etc.

they have more of a connection and level of trust in the child care center. Further, while trust is built with families over the few months the CDA works with the child and family, stakeholders at all levels felt that the time frame for the intervention was too short. One key recommendation that all groups felt was important is to extend the time frame for working with individual families from 4-6 to 6-8 months so that more could be accomplished with the child and family. In response to this recommendation, in the next phase of the project, families will be re-evaluated at the 6th month time point and will be re-enrolled to receive additional TFK services if warranted.

B. Assessment of Child Behavior Problems

In Year Two a total of 87 children were identified with externalizing (n=60) or internalizing (n=27) behavior problems. The rate of identification of clinically significant problems was 28.9% in the three sites that were enrolled in the Pilot Year (Pilot Site A and B and South Count). It was higher, 36%, in the two New Intervention Sites. More extensive assessment of the children targeted for intervention (n=28) revealed that all of the children with externalizing behaviors fell into the extreme risk category on the Aggression and Maladaptive Behavior Subscales of the ESP. The seven internalizing children identified and provided services were at somewhat lower risk for maladaptive behavior and had better adaptive behavior than did children categorized as externalizing. As in Year One, assessments of developmental skills also showed that targeted children had great variation in development, but tended to show delays in social and communication skills. Many of these children had never before been assessed for developmental issues. While it is not possible to suggest that the delays are causing children's behavioral difficulties, or the converse, that behavioral difficulties cause the delays, this finding suggests that an important part of the TFK intervention is to perform a comprehensive child assessment so that a complete and comprehensive set of information is available to assist the child and family.

C. Family Assessment

Family's whose children required assistance had a wide range of backgrounds. Sixty-four percent were single parents, and 61% worked full time. While incomes were moderate, 25% did report income of over $40,000 a year and only one family with an income of less than $5,000. About 46% were non-white (Hispanic and African American), and 43% had some college education. One quarter of the families had been involved with DSS in the past year. Overall, home environments were adequate for young children, but many families lacked in academic stimulation (51% in the lowest quartile) and variety of experience. On the other hand, most families (72%) scored in the highest category on "warmth and affection. These characteristics were similar to parents enrolled in Year One.

While two or three families rated resources for meeting basic needs as inadequate, overall families reported adequate resources. Items asking about the parent's ability to socialize, and have money for extras like vacations, savings, or entertainment tended be to rated low, illustrating that most of these families did have mild financial and personal strains. When asked about specific family and personal stressors, most families did not report situations out of the normative range. Only 21% were past the cut off score for life stressors (e.g. loss of a job, death in the family). Assessment of parenting stress revealed that only 25% have scores in the clinical range. Finally, an assessment of parental discipline skills revealed that some, but not all the parents used ineffective strategies for discipline. The profile of this group of parents differs slightly from Year One in that Year One parents clearly had more discipline skills deficits. Taken as a whole, these data suggest that services need to be tailored to families based on their individual needs. For example, some families have clinical levels of stress that may need to be addressed before their parenting skills, while others may primarily need to develop discipline skills. Regardless of the area of need, however, it should be recognized that the majority of the families whose children require

assistance have significant strengths. This reinforces the importance of recognizing and working with families based on strengths, instead of a deficit model.

D. Outcomes

Overall, children and families targeted for intervention received a mean of 22 hours of services over several months, with a range of from 2 to 72 hours (median=19 hours; with most receiving between 15 and 29 hours of service). Families with few hours reflect those who dropped out shortly after enrolling. Individual assessments of children's classroom behaviors for those children who received intervention for externalizing behaviors revealed significant improvements between baseline and the end of services on Critical Events, Aggressive Behavior, Adaptive Behavior and Maladaptive Behavior. Unlike Year One, however, these changes did not vary by intensity of treatment services. It appears that children received the necessary package of services despite the range of hours being quite different among those served. This supports an individualized approach to services, rather than setting a specific number of hours of service for all children.

Children with internalizing behaviors who received services showed a pattern of improvements in Adaptive and Social behavior, and a significant improvement in Critical Events, but the small numbers precluded a more complete analysis of their outcomes. Finally, in contrast to children falling within risk cutoffs for externalizing behavior who did not receive services due to time constraints, children who received services decreased their Aggressive Behavior and their Maladaptive Behavior substantially, while those awaiting services were rated by teachers as having less behavior change (although still showing some improvement) in a follow-up assessment. This interaction effect was statistically significant for Maladaptive Behavior and close to significance for Aggressive Behavior, showing a strong effect of the intervention compared to a waiting list group.

In addition to decreasing both aggressive and maladaptive behaviors, target children also made substantial improvements in developmental skills. Both Physical Development and Self Help Skills significantly increased (by 6-8 months respectively), and there was a trend for improvement of Academic Skills and Communication Skills (about a 3 month improvement in each). As with the assessment of behavior change, intensity of services did not affect the outcome significantly, except for Self Help skills, which improved more for children and families receiving more service hours.

The results for parent outcomes were more complex in Year Two compared to Year One. Families who received more service hours (total child and family services) did have greater changes in parent discipline skills, with a significant interaction found in one scale of the Parenting Skills assessment. However, the parents who received fewer hours actually increased their poor discipline skills over the period of the intervention. This may reflect that families with fewer treatment hours had more of those hours focused on the child and school setting, whereas those with more treatment hours may have had the additional hours spent working with the family and parenting. Perhaps those with fewer hours were also experiencing more frustration and had less follow-through with scheduled TFK meetings. There were no changes on the Parenting Stress scales between baseline and end of service delivery, nor by service intensity. These parenting findings may reflect, as teachers and administrators indicated, that parents may not have been as engaged as those parents involved in Year One. It also suggests that further efforts need to be made to fully involve parents in the intervention with the hope that they can also achieve benefits as well as the child and their child's gains can be maintained over time.

The results for TFK's classroom-wide effects suggest that TFK services are having a positive influence on both the number of children being suspended or terminated, as well as the overall level of behavior problems in the classroom. This improvement in overall levels of behavior problems in the

classroom develops over time, showing up in the second year of TFK services. This is consistent with the notion that teacher-CDA relationships take time to develop, classroom goals and strategies take time to be identified and developed, and change in classroom practices take time to take hold. However, the payoff appears to be a better classroom climate for all children.

E. Conclusion

The Implementation Year of TFK has expanded its scope considerably, now serving 17 classrooms, over 40 teachers, and 280 children. Substantial numbers of children and families have also been provided individual services. We have learned that gains seen in Year One in child behavior, and to some extent in child developmental skills, continue with the children served in Year Two. Particularly children with externalizing behavioral issues make significant gains in decreasing aggression and maladaptive behavior. These gains are also significant when compared to children in the same classrooms who are awaiting services.

In contrast, we have not seen sustained changes in parent discipline skills, as found in Year One. It may be that the Year One families selected were those more motivated and concerned about their children, and therefore they were easier to engage. CDAs, staff and administrators alike agreed in interviews about the success of TFK that parent engagement was one of the most difficult challenges. All made the assessment that some gains had been made around parent intervention, but that working with parents remained one of the most important continuing barriers to successful child outcomes. The recommendation from CDAs and child care staff and administrators that the model be modified to provide somewhat lengthier intervention time for families so that more sustained change can occur, seems appropriate, especially in light of our findings that more service intensity did improve parent discipline skills. Of course the trade off may be in smaller number of children served each year. However, a small increment in time for some families may prevent the child from regressing and needing to reenter individualized service. At the same time Year Two data have shown that even modest amounts of services considerably help children.

While in Year One there were many comments about the model not being intensive enough in terms of hours of service per center, these were fewer in Year Two. This suggests that centers were beginning to feel they had adequate levels of services, even though there remain children who could benefit from individual services who have not yet received them. In part, the satisfaction with the model of the CDA being available on a part time basis to each center was due to the recognition that the model was not just to provide individual child therapy services (although that is one component). Rather, there was a qualitative shift in the interviews with teachers and center administrators to recognizing the support and training the CDAs provide for overall classroom management and teacher training. Thus in the Implementation Year, child care centers have taken ownership of improving children's behavior and view TFK as a collaborative model between the centers and the mental health consultant (CDA). Particularly in the Pilot and South County sites, this was evident in the significant improvement in overall behavior problem levels in the classrooms and the decrease in suspensions and terminations.

At the same time, stakeholders identified that one of the most crucial aspects of the TFK model rests on the CDA's ability to develop a strong working relationship with both administration and teachers at the child care centers. The fit between the style and skills of the CDA and the child care center appears to be crucial to the success of the model. Programs that were less satisfied with the services this year felt that the 'match' between the CDA and the center did not work well. However, one group wanted more individual therapy and felt the CDA was less effective as a consultant, while the other group wanted more overall classroom support and felt that the CDA focused too much on individualized services. Clarifying the role of the CDA as one of collaboration, not solely individual child intervention, and providing

ongoing training and supervision to address these mis-matches will be necessary to continue to improve the model. In addition, the findings from Year Two stress the importance of sustaining components that address training and support to teachers, and figuring out how to overcome some of the teacher motivational issues. Finally, finding new ways to gain commitment of families and to assist child care centers to provide center-wide parent engagement activities that will decrease the disconnect between families and care providers will be important to reaching more children and families and preserving the already impressive outcomes TFK has achieved.

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Appendix A

Summary of Teacher Surveys- Fall 2003

Descriptive Information. Year 2 surveys were completed by 40 teachers in November and December of 2003. Represented in these surveys were 17 teachers from the Pilot Sites (Worcester Comprehensive and the YWCA), 13 from the New Intervention Sites (Rainbow and the YMCA) and 10 from the South County Sites. All but one teacher were female. Ages of teachers ranged from 20 years to 54 years, with the mean age of 30 years for teachers in the Pilot Sites, 30 years for teachers in the New Intervention Sites and 35 years in the South County Sites. Marital status of teachers varied. In the Pilot Sites 8 were married, 2 were divorced, and 7 were unmarried. In the New Intervention Sites, 4 were married, 1 was widowed, and 8 were unmarried. In the South County Sites, 3 were married, 3 were divorced, and 3 were unmarried (one teacher did not indicate marital status. Twelve out of the 17 teachers in the Pilot Sites were parents themselves, while in the New Intervention Sites 6 out of 13 were parents and in the South County Sites, 6 out of 9 were parents (one had missing data). Except for the Pilot Sites, most teachers across centers were white (47% in the Pilot Sites, 92% in the New Intervention Sites, and 100% in the South County Sites). Latinos made up 35% in the Pilot Sites while there were no Latinos working in the south county or New Intervention Sites. Other racial groups included 1 African American (working at the Pilot Sites), and three teachers who checked "other" (1 from the Pilot Sites and 2 from the New Intervention Sites).

In terms of education, 8 out of 17 teachers in the Pilot Sites had high school diplomas or GEDs, while 2 had an Associates degree, 4 had graduated from a four year college, and three checked "other." In the New Intervention Sites, 1 teacher had a high school diploma, 6 had attained a high school diploma, 5 had an Associates degree and 4 had a college degree. In the South County Sites, 1 had a high school diploma, 5 had an Associates degree, and 1 had a college degree, and 1 had advanced certification. Nine out of the 16 teachers in the Pilot Sites, 5 out of 13 teachers in the New Intervention Sites and 3 out of the 8 teachers in the South County Sites reported that they were currently continuing their education, pursuing a two-year or college degree.

Experience in working in child care ranged from less than one year to 20 years in the Pilot Sites (mean = 7 years); less than one year to 13 years in the New Intervention Sites (mean = 6 years), and 2 years to 19 years in the South County Sites (mean = 9 years). Of the 17 teachers in the Pilot Sites, 14 reported that they were currently lead teachers, and 3 reported that they were assistant teachers. Six teachers were lead teachers and 3 were assistant teachers, 1 was a floater, and 3 had administrative or other duties in the New Intervention Sites. In the South County Sites, 6 teachers reported that they were lead teachers, 2 were assistant teachers, and 2 had administrative or other duties. Length of time working at the current child care sites ranged from less than a year to 10 years in the both the Pilot and New Intervention Sites, and less than one year to 6 years in the South County Sites. Within these ranges, there were 4 teachers (23.5%) in the Pilot Sites, 3 teachers (23%) in the New Intervention Sites and 4 teachers (40%) in the South County Sites that had been working in their present center a year or less. Additionally, 3 teachers (18%) in the Pilot Sites, 3 teachers (23%) in the New Intervention Sites, and 1 teacher (10%) in the South County Sites had worked in the center for 1 to 2 years, and the other teachers across the sites had worked at their centers more than 2 years.

Teacher's experience with children with challenging behaviors. Teachers were asked how many children in their class had challenging behaviors. Teachers in the Pilot Sites reported having from 1 to 8 children in their class with challenging behaviors (mean = 4.1). Teachers in the New Intervention Sites had 5 to 13 children with challenging behaviors (mean = 9.5), and in the South County Sites, teachers reported having between 0 and 4 children with challenging behaviors (mean = 2.6). Analysis of variance

revealed that the New Intervention Sites reported having significantly more children with challenging behaviors than either the intervention or South County Sites, F(2,37)=36.07, p.=.001. These results were similar to the year one survey results.

Teacher's level of expertise in managing challenging behaviors. In the Pilot Sites, most teachers (65%) reported feeling a medium level of expertise in managing challenging behaviors in children; 12% reported having a low level of expertise, and 24% reported having a high level of expertise. In the New Intervention Sites, most (53%) reported feeling a medium level of expertise; 8% reported feeling a low level of expertise, and 39% reported feeling a high level of expertise in managing challenging behaviors. In the South County Sites, most (60%) reported a high level of expertise, 10% reported a low level of expertise, and 30% reported having a medium level of expertise. These differences were not significant in Chi Square analyses. In Year One, the New Intervention Sites (called comparison sites in Year One) had reported feeling significantly more expertise in managing children's challenging behaviors than did the teachers in the Pilot and South County Sites. Analysis of this change from Year One shows that teachers in the Pilot and South County Sites (after having one year of the TFK project) reported increased feelings of expertise in Year Two while the New Intervention Site teachers (who were just in the start-up phase of the intervention) showed decreased feeling of expertise in managing children's challenging behavior in comparison to Year One.

Teacher's level of knowledge of children's challenging behaviors. Teachers were asked to rate their level of knowledge in 5 areas relating to challenging behaviors in children. The table below shows the percentage of teachers rating themselves as having low, medium, and high levels of knowledge in each area in Year One and Year Two. Significant differences between sites based on Chi Square analyses are noted for Year One, however, in Year Two, there were no significant differences between groups.

Area of Knowledge	Level of Knowledge	Pilot Sites		New Intervention Sites		South County Sites	
		YR1	YR2	YR1	YR2	YR1	YR2
1. Identifying & assessing children with challenging behaviors.	Low	20%	17%	0%	0%	11%	10%
	Medium	67%	59%	46%	46%	50%	70%
	High	13%	24%	54%	54%	25%	20%
2. Understanding the causes of challenging behaviors.	Low	7%	6%	8%	8%	25%	0%
	Medium	80%	71%	38.5%	38%	62.5%	40%
	High	13%	23%	54%	54%	12.5%	60%
3. Strategies for structuring the classroom to minimize behavior problems. *(Π^2=16.2, df=4, p=.003) in Year One.	Low	0%	6%	15%	0%	12.5%	3%
	Medium	93%	76%	23%	54%	75%	57%
	High	7%	18%	61.5%	46%	12.5%	40%
4. Strategies for handling individual children with challenging behavior in the	Low	13%	6%	0%	8%	25%	10%
	Medium	80%	71%	38.5%	46%	75%	60%

challenging behavior in the classroom. *(Π^2=16, df=4, p=.003) in Year One.	High	7%	23%	61.5%	46%	0%	30%
5. Strategies for talking to parents about their child=s challenging behaviors.	Low	20%	24%	15%	15%	25%	10%
	Medium	60%	47%	54%	54%	50%	70%
	High	20%	29%	31%	31%	25%	20%

The lack of significant differences in Year Two show that, particularly in the areas of how to structure the classroom and deal with individual children with challenging behaviors, teachers in the Pilot and South County Sites (who had already completed one year of TFK), increased in their knowledge to levels similar to the New Intervention Sites who were reporting significantly higher levels than the other two sites in Year One. Throughout the different areas asked about, there were shifts to higher levels of knowledge for the sites that had previously participated in TFK, whereas the New Intervention Sites remained the same.

Teacher training in managing children's challenging behaviors. Teachers were asked whether they received any specialized training in managing children's challenging behaviors since they began working at the center. Chi Square analyses showed that there was a non-significant trend (Π^2=4.95, df=2, p=.08) in Year Two in the number of teachers reporting that they had received training. Eighty-eight percent of the teachers in the Pilot Sites reported specialized training (a 32% increase from those reporting specialized training in Year One), 77% of the teachers in the New Intervention Sites reported receiving specialized training (an 8% decrease from Year One), and 50% of the teachers in the South County Sites reported that had received such training (an 11.5% decrease from year one). It should be noted that although the South County Sites had been involved in TFK for approximately one year at the time of this survey, those sites did not receive the specialized teacher training that was provided to the Pilot Sites.

Teachers who indicated that they had received specialized training were asked whether the focus of that training included topics in five specific areas, whether that training was provided by TFK, and further, whether or not they felt they would like more training in those areas. The table below shows the number of teachers who said that they had training in each area from any source, how many indicated that the training was received specifically from the TFK project, and how many indicated they would like more training in that area. The number in parentheses represents the number of total teachers in each site who responded to the question.

Area of Specialized Training	Checked response	Pilot Sites	New Intervention Sites	South County Sites
1. Identifying & assessing children with challenging behaviors.	Received any training	16 (17)	10 (13)	6 (8)
	Received TFK training	12	0	2
	Would like more training	13	9	7
2. Understanding the causes of challenging behaviors.	Received any training	16 (17)	10 (13)	6 (8)
	Received TFK training	11	0	2
	Would like more training	13	9	7
3. Strategies for structuring the classroom to minimize behavior problems.	Received any training	16 (17)	11 (13)	6 (9)
	Received TFK training	11	0	2
	Would like more training	15	11	8
4. Strategies for handling individual children with challenging behavior in the classroom.	Received any training	16 (17)	11 (13)	7 (9)
	Received TFK training	12	0	2
	Would like more training	14	11	7
5. Strategies for talking to parents about their child's challenging behaviors.	Received any training	15 (17)	9 (13)	3 (8)
	Received TFK training	10	0	0
	Would like more training	14	10	8

These results show that for those who responded to these questions, most reported that they had received training in each of the topic areas. As expected, most teachers who were part of the Pilot Sites indicated that they received the training from TFK. However, even in the other sites (where TFK did not offer specialized training) teachers still reported getting training from some source (perhaps as part of continuing education credits). Unlike reports from teachers in Year One, most teachers expressed a desire to have more training in each of the areas.

When asked whether the training they had received was useful, teachers responded on a 4-point scale from 1 = "not at all useful" to 4 = "very useful." For this question, analysis of variance showed that there were no significant differences between sites in how useful they felt their training had been. However none of the sites rated the training they received very highly (means = 1.7, 1.9, and 1.7 for the Pilot, new intervention and South County Sites, respectively). In Year One, teachers from the South County Sites had rated the training they received significantly higher than the other two sites, which did not differ from one another (means in year one were 2.1, 1.7, and 3.2 for the Pilot, New Intervention and South County Sites, respectively).

Resources. Teachers were also asked about their access to five different types of resources. Chi Square analyses within Year Two showed no significant differences in access to these resources across sites, with the exception of access to classroom observations, where the Pilot Sites reported more access to this resource than the New Intervention Sites (Π^2=9.65, df=2, p=.008). Further analyses showed that the Pilot Sites reported significantly more case consultation services (Π^2=5.43, df=1, p=.02) and more classroom observations (Π^2=6.72, df=1, p=.01) in Year Two than in Year One. The South County Sites also reported significantly more access to family interventions (Π^2=3.87, df=1, p=.049), and a non-significant trend toward more access to crisis intervention services (Π^2=2.84, df=1, p=.09) in Year Two than in Year One. The New Intervention Sites did not show differences in resources from Year One to Year Two. Thus, it appears that TFK had a positive impact on the resources of the Pilot and South County Sites. The table below shows the percentage of teachers within each site that reported having access to these resources in Year One and Year Two.

Resource Type	Pilot Sites		New inter-vention sites		South County Sites	
	YR1	YR2	YR1	YR2	YR1	YR2
1. Case consultation services for individual children who are exhibiting challenging behaviors	27%	71%	64%	69%	63%	88%
2. Crisis intervention services	67%	50%	82%	77%	38%	78%
3. Referral of children for individual treatment	86%	81%	82%	69%	88%	88%
4. Classroom observation services designed to suggest strategies for improving the operation of the classroom.	67%	100%	73%	54%	75%	78%
5. Family intervention services.	80%	88%	73%	69%	29%	78%

Teachers were also asked how helpful these resources had been to them in the past month on a 4-point scale ranging from 1 = not at all helpful, to 4 = very helpful. Analysis of variance showed no significant differences between the sites in their ratings (means = 2.19, 2.73, and 2.43 for the Pilot, New Intervention, and South County Sites respectively).

Finally, teachers were asked about the adequacy of several center-based resources. Teachers rated these resources on a 4-point scale from 1= not at all adequate to 4= more than adequate. Analysis of variance revealed three areas with significant differences between sites in Year Two. Specifically, the South County Sites showed a non-significant trend indicating less adequate release time for meeting with

parents than the Pilot Sites (with the New Intervention Sites falling in between) F(2,34)=3.12, p=.058, and significantly less adequate training around managing challenging behaviors than did the Pilot or the New Intervention Sites F(2,35)=4.83, p=.014. In addition, the Pilot Sites reported significantly more special activities for staff and families to get to know each other (as compared to the other sites) F(2,34)=4.89, p=.041, and both the Pilot Sites and the South County Sites reported more special activities for families to get to know each other (as compared to the New Intervention Sites) F(2,34)=5.43, p=.009. There were no significant changes within sites from Year One to Year Two, with the exception of the South County Sites who reported significantly less release time to meet with parents in year two F(1,15)=11.03, p=.005, but more adequate help from specialists in Year Two as compared to Year One F(1,15)=5.43, p=.034. Mean ratings for each resource for Year One and Year Two are indicated in the table below.

How adequate are the following resources?	Pilot Sites mean ratings.		New Intervention Sites mean ratings.		South County Sites mean ratings.	
	YR1	YR2	YR1	YR2	YR1	YR2
1. Release time to meet with parents.	2.6	2.3	1.9	2.0	2.5	1.7
2. Release time to get expert help with managing challenging behaviors.	2.0	2.0	2.0	1.8	1.4	1.8
3. Specialists to turn to for help with challenging behaviors.	1.9	2.0	2.3	2.2	1.6	2.3
4. Training around managing challenging behaviors.	1.9	2.3	2.7	2.3	1.4	1.4
5. Special activities/events that allow teachers, administrators, and families to get to know each other.	2.9	3.1	1.8	2.3	2.1	2.3
6. Special activities/events that allow families to get to know each other better.	3.0	2.8	1.7	1.8	2.8	2.6

Teacher Ratings of TFK Services: Teachers in the Pilot and South County Sites who received TFK services in the first year were asked additional questions regarding the helpfulness of TFK services, how successful they felt the project was, and whether or not it was beneficial to their center. Teachers rated each question on a 4 point scale (e.g., 1=not helpful to 4=very helpful; 1=not successful to 4=very successful; 1=not at all to 4=very much of benefit). Analyses of variance showed no significant differences between the Pilot and South County Sites, except for one: the South County Sites rated the benefit of TFK to their center significantly lower than the Pilot Sites F(1,21)=7.54, p=.012. The questions, mean ratings, standard deviations, and number of teachers responding to each question appear in the table below.

Helpfulness of TFK Services	Pilot Sites		South County Sites.	
	Mean(SD)	n	Mean(SD)	n
1. How helpful was TFK to you in learning better ways to handle children's behavior in the classroom?	2.7 (.91)	14	2.1 (.84)	8
2. How helpful was the teacher training (classes, videos) that you received?	2.5 (1.0)	14	2.0 (.00)	2
3. How helpful was the in class modeling and consultation that you received?	2.1 (1.1)	12	2.2 (.45)	5
4. How helpful was the ESP process in identifying children with special needs for externalizing and internalizing behaviors?	3.0 (.88)	14	2.9 (.93)	9
5. Overall, how successful was TFK in helping kids and families?	2.5 (.65)	14	2.5 (.93)	8
6. Overall, do you feel TFK was a benefit to your center?	3.5 (.65)	14	2.5 (1.1)	8

Teachers were also asked if they participated in parent-teacher meetings to plan assistance for the target child and family. Nine out of 15 respondents from the Pilot Sites and 5 out of 9 respondents from the South County Sites indicated that they had been involved in these planning meetings with parents. Follow-up questions asked how helpful these meetings were in better managing the child's behavior, and in developing a better relationship with the family. Further, teachers were asked how helpful the CDA's assistance was in managing classroom issues for the target child. Again, teachers responded to a 4-point scale where 1=not helpful, 2=somewhat helpful, 3=helpful, and 4=very helpful. There were no significant differences between Pilot Sites and the South County Sites on any of the ratings of the helpfulness of these meetings. The questions, mean ratings, standard deviations, and number of teachers responding to each question appear in the table below.

Helpfulness of TFK Teacher/Parent Planning Meetings.	Pilot Sites		South County Sites.	
	Mean(SD)	n	Mean(SD)	n
1. How helpful was this to you in better managing the child's behavior?	3.2 (.83)	9	2.7 (.82)	6
2. How helpful was this to you in developing a better relationship with the family to assist the child?	3.0 (1.0)	9	2.7 (.82)	6
3. How helpful was the CDA's assistance around managing classroom behavior for this child?	2.1 (.90)	12	2.3 (1.1)	7

On average, it appears that TFK services were considered to be somewhat helpful to helpful, while the perceived overall benefit for the Pilot Sites was very high. In terms of the helpfulness of the parent-

teacher planning meetings, most teachers felt them to be helpful. These results indicate that overall, teachers appear to be pleased with the services they are receiving.

Teacher burnout. Teacher burnout was assessed using the Maslach Burnout Inventory. This measure has three subscales: 1) Emotional Exhaustion (9 items tapping feelings of being emotionally drained, frustrated, and fatigued by the job); 2) Depersonalization (5 items tapping feelings of being 'hardened' by the job, not caring what happens to some of the students, treating students as though they were impersonal objects, etc.); and 3) Personal Accomplishment (8 items tapping feelings of being in control of emotions, dealing with problems calmly, understanding how students feel, and feelings of accomplishing worthwhile things on the job). Subscale scores are a sum of the items making up the scale. These subscale summary scores can then be categorized into high, moderate, or low, based on norms given in the manual for the scale. Analysis of variance revealed that in Year Two the New Intervention Sites were significantly higher in Depersonalization than the Pilot group, with the South County Sites falling in between $F(2,35)=4.91$, $p=.013$. This differs from Year One results where there were no group differences on any of the subscales. The table below shows the percentage of teachers who fall into the high, moderate, or low scoring categories for each subscale in year two. The mean score for each subscale within each site is presented in parentheses in the category in which it falls.

Maslach Burnout Inventory Subscale		Pilot Sites	New Intervention Sites	South County Sites
Emotional Exhaustion	high (scores >26)	7%	38.5%	10%
	moderate (scores 17 - 26)	40%	15% (M=19.8)	40% (M=18.1)
	low (scores < 17)	53% (M=13.5)	46%	50%
Depersonalization	high (scores > 13)	0%	0%	0%
	moderate (scores 9 -13)	0%	15%	10%
	low (scores < 9)	100% (M=1.7)	85% (M=5.0)	90% (M=2.6)
Personal Accomplishment	high (scores < 31)	100% (M=7.5)	92% (M=8.6)	100% (M=7.7)
	moderate (scores 31 -36)	0%	8%	0%
	low (scores > 36)	0%	0%	0%

These results indicate that most of the teachers fall in the low to moderate range for emotional exhaustion, although a little more than a third of the teachers in the New Intervention Sites fall in the high range. Most teachers also scored low on depersonalization. In terms of personal accomplishment, almost all scored in the high range. This means that they overall are finding their work rewarding and most are not emotionally challenged by the work. These results are similar to the first year.

Summary: Overall it appears that the TFK project has had an impact on teacher training and knowledge, particularly in the areas of classroom management strategies and in knowing how to deal with challenging behavior. Most teachers also stated that they would like more training in these areas and in how to talk to parents about their child's behavior. However, like last year, teachers did not highly rate the training they received, whether it was received from TFK or some other source. Teachers in the centers that received the TFK intervention also showed an increase in resources, particularly in access to classroom observations, case consultations and family interventions. In terms of their ratings of the usefulness of TFK services, most teachers thought that services were somewhat helpful to helpful,

suggesting there is room for improvement. However, it must be remembered that these ratings, taken in the fall of 2003 reflect what happened in Year One interventions more than Year Two. In Year One, one center was left without a CDA since the previous May, and another center had a strained relationship with the CDA who subsequently left early in 2004. It should be noted that the current CDA appears to have a very positive relationship with center staff. Therefore, surveys taken in the fall of 2004 will be a better measure of Year Two interventions than the results reported above.