

Transforming Transitions to Kindergarten: A Family-Provider Team Approach

Introduction

In response to NIDRR's absolute priority of increasing family participation and supporting community integration and successful transition, the purpose of this project is to develop, implement, and evaluate a two-pronged family-centered strategy for supporting the successful transition of children with emotional/behavioral challenges from early childhood settings to kindergarten. The project will involve three interrelated sets of activities. First, *a synthesis of existing research* will be conducted, focusing on how integrated mental health supports, and in particular mental health consultation, promote the success and integration of children with challenging behaviors in community-based settings. Second, the research team will *develop and test a two-level intervention* for supporting children with emotional and behavioral challenges and their families as they transition to kindergarten. The first component will focus on developing the organizational capacity of early childhood (preschool) programs for implementing effective mental health and kindergarten transition supports for children with emotional/behavioral challenges and their families. The second component of the intervention will build on this organizational capacity by implementing and evaluating family-driven transition intervention teams to support successful transition of these children to kindergarten. Finally, we will use the results of the intervention study to develop an integrated set of evidence-based training materials that will be disseminated to families, early childhood educators, mental health professionals, and school personnel.

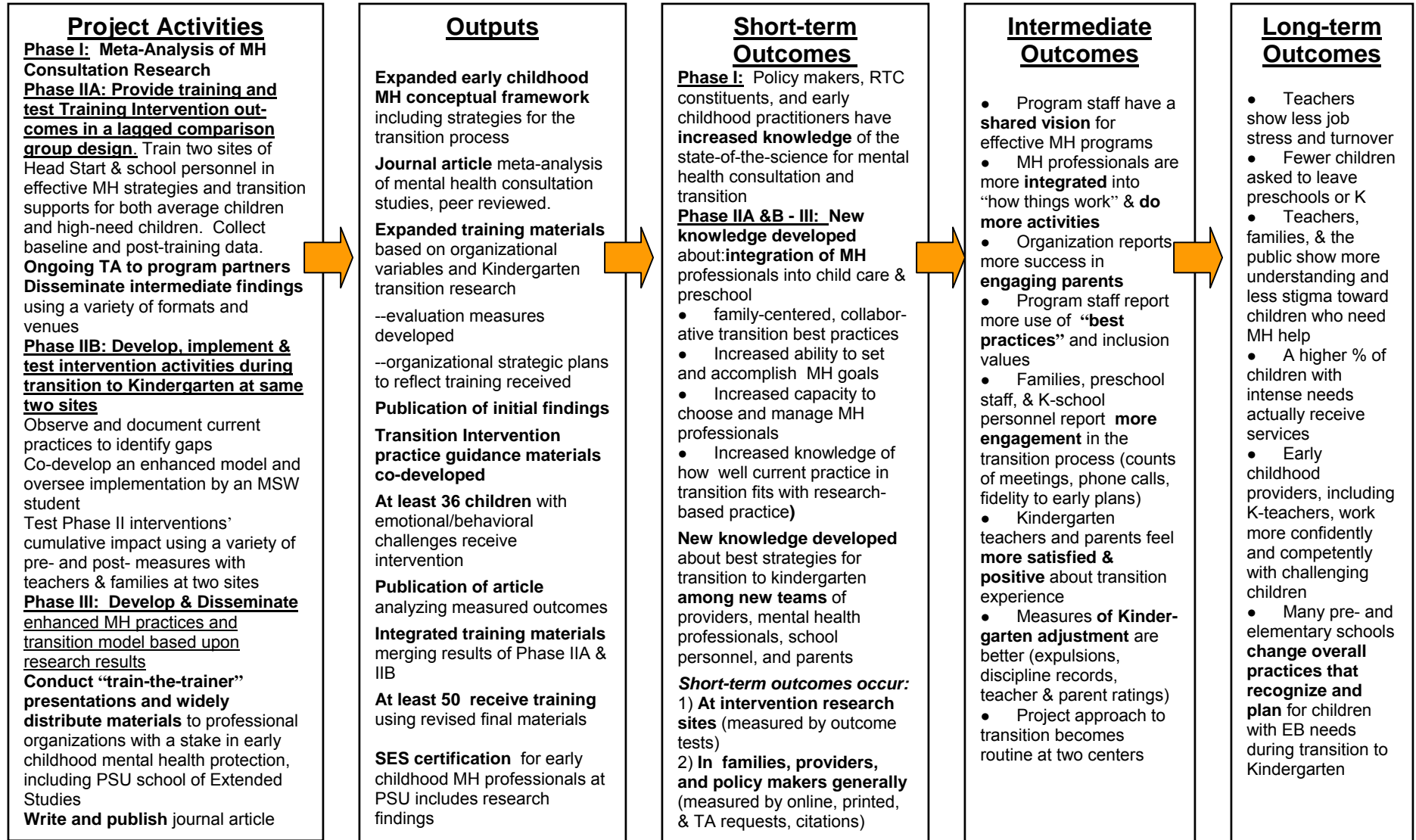
The proposed project builds on four of the prior research projects by this RRTC. The first, Project SUCCEED, tested a curriculum for establishing parent-provider partnerships in addressing children's emotional/behavioral problems in Head Start programs (Saifer, Friesen, Gordon, Banek, & Tuner, 2002). The second, Guidance for Early Childhood Program Design, surveyed over 800 Head Start teachers, administrators, mental health providers, and parents, and developed and pilot tested research-based training in effective organizational strategies for implementing high quality mental health services, including mental health consultation, for children in preschool settings (Green, Everhart, Gettman & Gordon, 2003; Green, Everhart & Gordon, 2004a; Green, Everhart, & Gordon, 2004b). The third project, Models of Inclusion in Child Care, identified essential strategies for the successful inclusion of children with emotional/behavioral problems in child care centers serving diverse populations (Brennan, Bradley, Ama, & Cawood, 2003). The fourth, the Early Childhood Transition Pilot, collected in-depth qualitative information about the transition experiences of children with serious emotional/behavioral challenges and their families (Lehman, Friesen, & Brennan, 2001). This study identified barriers to successful kindergarten transition, including lack of parent access to information about kindergarten sites prior to transition (e.g., the name of the child's new teacher), absence of systematic transition planning and procedures, negative attitudes from elementary school staff, and difficulties ensuring that children received prescribed medications while in kindergarten settings (Lehman, Friesen, & Brennan, 2001).

The proposed research will build on study findings, training materials, and curricula from previous RRTC projects. The goal of the project is to promote the successful integration of children with emotional/behavioral challenges into community-based early childhood settings and to ensure the successful transition of these children into kindergarten. The project objectives are to:

- 1) Collect, analyze, and disseminate the evidence base regarding the effectiveness of mental health consultation in early childhood settings.
- 2) Integrate the results of this review of mental health consultation with the knowledge of promising practices in early childhood mental health (derived from earlier RRTC research), and with the empirical research on effective transition practices, and from this construct an expanded conceptual framework that addresses transition to kindergarten for children with emotional/behavioral problems.
- 3) Develop, implement, and test an intervention to increase the organizational capacity of early childhood and school settings to provide integrated supports that meet the needs of children with emotional/behavioral problems and their families so that they may remain in community preschools and transition successfully to kindergarten.
- 4) Collaborate with families, preschool providers, mental health professionals, and elementary school personnel to develop, implement, and test a transition intervention that is individualized, family-driven, and culturally appropriate.
- 5) Publish and disseminate knowledge about effective transition via research articles, evidence-based training materials, and other products to family organizations and key professional groups (e.g., early childhood, education, mental health and other providers).

Figure (R-5.1) Transforming Transitions to Kindergarten Logic Model

Inputs: This project addresses the absolute priority of strengthening family participation in mental health(MH) services, as well as key goals of improving community integration, reducing stigma, and successful transitions across settings. This project builds on the recent research of qualified staff and expands the impact of prior RTC studies on family engagement in MH services, organizational strategies for effective work with MH professionals, inclusive child care settings, and the transition to Kindergarten for at-risk children.



Literature Review

Entering kindergarten is a major milestone in the lives of children and families. Children and their parents encounter new relationships, roles, cultures, opportunities, and responsibilities. The experience of starting school involves complex and significant change (Bohan-Baker & Little, 2002), that may be particularly challenging when children have disabilities (Rosenkoetter, Hains, & Fowler, 1994). While a child's first day of kindergarten is a one-time event, transition to school "is a process in which child, family, school and community interrelate over time" (Pianta & Cox, 1999) p. 4. When transition is successful, children are engaged and feel positive about school, parents are partners in their children's learning, and schools provide experiences that value individual children and promote their success (Ramey & Ramey, 1999; Wright, Diener, & Kay, 2000). On the other hand, problems with transition can have serious consequences for children, families, and communities. Research indicates that the early years of elementary school are critical (Raver & Knitzer, 2002), especially for children with challenging behaviors (Fox, Dunlap, & Cushing, 2002). Early disruptive behaviors and problems with social interaction are associated with poor performance and academic difficulties that persist in later school years (Masse & Tremblay, 1999; Wright et al., 2000).

It is clear from the literature that children with emotional/behavioral problems have the highest risk of school failure (The President's New Freedom Commission on Mental Health, 2003; Vander Stoep, Weiss, Saldanha, Cheney, & Cohen, 2003). Although the Individuals with Disabilities Education Act (IDEA) protects the rights of children with disabilities to a "free and appropriate public education," many children with emotional/behavioral challenges do not receive the support they need in the early school years (President's Commission on Excellence in Special Education, 2002). In one study, less than half of the children identified as having significant behavioral disorders were receiving services by the age of 12 years (Conroy & Davis, 2000). When required supports are absent, children with emotional disabilities are more likely to be in more restrictive educational settings, and experience higher rates of school failure (Osher, Magee Quinn, & Hanley, 2002).

There is increasing recognition that supporting successful transition to kindergarten for children with emotional/behavioral challenges must begin early, since the stage is set for young children's readiness to enter school during their first five years of life (Shonkoff & Phillips, 2000). An increasing proportion of young children, especially those from low-income and high risk environments, exhibit early signs of serious mental health problems, with some estimates as high as 23% of the general population (Sinclair, Del'Homme, & Gonzales, 2003). Early assessment and intervention to address young children's emotional/behavioral problems are major recommendations of both the 2002 President's Commission on Special Education (Berdine, 2003) and The President's New Freedom Commission on Mental Health (2003). Early intervention to address these issues may significantly alter children's developmental trajectories, and increase their resilience to later personal, family, and community stressors (Berdine, 2003).

Providing effective services for these children remains challenging for community preschool and kindergarten programs. One increasingly popular service model for addressing emotional/behavioral problems in young children involves the integration of mental health professionals into early childhood settings (Donahue, Falk, & Koretz, 2000). This "mental health consultation" model is becoming more widespread, and preliminary evidence suggests its effectiveness (Alkon, Ramler, & MacLennan, 2002; Knitzer, 2000). Mental health consultation has been broadly defined as "a problem-solving and capacity-building intervention, implemented within a collaborative relationship between a professional

consultant with mental health expertise and one or more individuals with other areas of expertise or parenting responsibility” (Hepburn, Kaufmann, Dodge, & Hansen, 2003). The consultation process includes direct mental health services for children with early signs of problem behavior, and training and technical assistance to increase the capacity of early childhood staff and parents to prevent or ameliorate the impact of children’s emotional/behavioral difficulties (Cohen & Kaufmann, 2000; Donahue, Falk, & Provet, 2000).

Recent evaluations of the effectiveness of mental health consultation in child care settings have demonstrated that consultation is associated with increases in child care quality and workers’ feelings of competence, (Alkon, Ramler, & MacLennan, 2003), fewer expulsions from child care (Albright, Brown, & Kelly, 2001; Green, Simpson, Everhart, Vale, & Garcia-Gettman, 2004) and improvements in children’s social and emotional development (Fong & Wu, 2002). This RRTC conducted a national study of over 800 Head Start personnel. Results showed that mental health consultation designed to promote staff competency, without providing direct mental health services, was associated with reports of reduced problem behaviors and increased prosocial behaviors among children (Green et al., 2004b).

Other research conducted by this RRTC found that early childhood programs that were more successful at supporting and integrating children with emotional/behavioral challenges shared several characteristics (Brennan et al., 2003; Green, Simpson, et al., 2004; Green et al., 2003). First, these programs had a *clear vision* for mental health services, principles, and goals that was widely shared across all levels of program staff, and which was based soundly in early childhood mental health services promising practices (see Koroloff et. al, 2003). Second, programs utilized mental health professionals on-site to provide a broad array of support to program administrators, supervisors, classroom staff, children, and parents. Third, mental health professionals at successful programs were more *integrated into programs’ daily functioning*, and seen by staff as “part of the team” in working with children with emotional/behavioral challenges. Finally, services and supports that were culturally competent and more successful at involving parents appeared more effective.

The importance of culturally competent supports and family involvement to successful transitions from preschool to kindergarten is well documented. Studies found that parent involvement in children’s education was strongly associated with children’s school achievement (Ferguson, Jimesion, & Dalton, 2001) and successful transition to kindergarten (Pianta & Cox, 1999; Rosenkoetter et al., 1994). However, teachers and parents may have different perspectives on how families engage in their children’s education (Salinas Sosa, 1997). These differences can lead to mismatched expectations, miscommunication, alienation of parents, and frustration among teachers and other providers (Oullette, Briscoe, & Tyson, 2004). These difficulties may be exacerbated if action is not taken to minimize the economic, social, racial, and other barriers that affect interactions between families, schools, and other professionals (Singh, Williams, & Spears, 2002).

Effective transition models to support children with disabilities share many principles of promising practices in children’s mental health services, including individualized planning, family involvement, a focus on family strengths, building strong collaborative relationships, committed leadership, clearly defined roles and procedures, and attention to cultural issues (Bruns & Fowler, 1999; Lehman et al., 2001; Pianta & Cox, 1999; Ramey et al., 2000). Moreover, research conducted by project staff suggests that the most effective transition models engage a team of family members, preschool staff, mental health professionals, and school personnel to provide a family-driven link between the

preschool context and the school environment. Teams work together, beginning early in the last preschool year, and continuing through the early school years (Lehman et al, 2001).

Research questions and Hypotheses

The current study builds on and expands the scope of previous research, by designing and testing a two-level intervention model that will (1) enhance the successful integration of children with emotional/behavioral problems in early childhood settings, and (2) extend program supports to successfully facilitate transition to kindergarten. The Transforming Transitions project is built on the premise that in order to support successful transitions to kindergarten, preschool settings must endorse a “mental health approach” to early childhood programming (Knitzer, 2000). This mental health approach lays the foundation for the successful social-emotional development that is critical to children’s school readiness (Shonkoff & Phillips, 2000). It also builds capacity among preschool and elementary school staff, mental health professionals, and families to facilitate more successful transitions to kindergarten for children with emotional/behavioral challenges (Odom & Woolery, 2003). The proposed two-level intervention first builds organizational capacity for successful integration of children with disabilities, and then implements individualized, team-based transition services. The study will address the following three research questions:

1. What is the state of the evidence regarding the effectiveness of mental health consultation for supporting integration of children with emotional/behavioral disorders in community child care settings, and transition of these children into kindergarten?
2. What is the effectiveness of a two-level intervention for successful early childhood mental health and transition services? Specifically, we hypothesize that:
3. Participants in the organizational training intervention (early childhood administrators, managers, teachers, mental health professionals, and school-based personnel) will (i) increase their knowledge of culturally competent, family-driven early childhood mental health and transition practices, (ii) develop an agreed-upon mission and strategic plan for implementing mental health and transition supports in their center, (iii) report an increased sense of competency and empowerment in working with children who have challenging behaviors, and reduced job stress, and (iv) be more successful in retaining children in their natural early childhood or kindergarten settings.
4. Children and families who participate in the transition team intervention will more successfully transition to kindergarten, as evidenced by (i) more positive reports by teachers and parents of children’s successful integration into typical kindergarten classrooms, (ii) fewer child behavioral referrals in their kindergarten settings, and (iii) family reports of greater empowerment, increased knowledge of resources and access to supports, and more active involvement in their children’s transitions to kindergarten.
5. Preschool personnel who participate in the transition team intervention will report greater knowledge of transition procedures and processes, and greater competence in transition planning that is family-driven, culturally competent, and involves successful partnerships with receiving schools.
6. Kindergarten teachers who participate in the transition team intervention will report more positive interactions with children who have emotional/behavioral challenges and their families, and greater competence in working with them.

7. Can an integrated set of “train the trainer” materials and other publications be disseminated effectively to key audiences of families, preschool administrators and staff, mental health professionals, and school-based personnel?

Methods for Phase 1: Building a Conceptual Framework

Component 1 (a) Review and synthesis of evidence-based transition practices

In the first year of the project, staff will synthesize and extend the current conceptual models that we have built through four related studies that addressed mental health and transition supports in early childhood settings (Brennan et al., 2003; Green, et al., 2004a; 2004b; Lehman et al., 2001; Saifer et al., 2002). We will begin by building a detailed and systematic database of literature composed of recent studies addressing transition to kindergarten, focused on preschool children with special needs. Model extension will be accomplished by synthesizing the new literature with our existing literature databases on mental health supports in early childhood settings, inclusive child care, and mental health consultation. Additionally, we will examine our existing pilot results on transition that include interview data, case studies, and child outcome data from two of the earlier studies conducted by center personnel (Lehman et al, 2001; Saifer et al, 2002) to inform the conceptualizations underlying our training and support interventions described below.

Component 1 (b) Review and synthesis of evidenced-based practices in early childhood mental health consultation

We will conduct a systematic review of studies addressing the effectiveness of mental health consultation in early childhood settings, and prepare an article that will characterize the state of the science. This review will allow us to introduce refinements into our conceptual model, modify our existing training intervention to incorporate the synthesis of results, and tailor our transition intervention to include the most effective mental health consultation practices. To date, there has been no comprehensive assessment of the evidence of the effectiveness of this intervention in early childhood settings. Dr. Deborah Perry, the Research Director of Georgetown University’s Child Development Center, will collaborate with our research team on the synthesis of the literature.

Design

Our systematic review will cover all empirical studies on the methods, functions, and effectiveness of mental health consultation that are available in the form of published articles, unpublished manuscripts that have been released to the public, and research reports of limited circulation. By assessing both the peer reviewed and the “grey” literature, we will be able to construct a more complete picture of the state of the science. We will employ both quantitative and qualitative techniques to describe key study features and outcomes (a modification of the procedure introduced by Glass, McGaw, & Smith, 1981). The studies will be limited to those quantitative and mixed method investigations conducted in the United States in congregate early childhood settings serving children from the ages of birth to 8.

Data Collection and Sample

Studies will be located using extensive computer searches of relevant data bases including *Psychological Abstracts*, *Educational Resources Information Center*, *Dissertation Abstracts*, and *Social Work Abstracts*, using combinations of relevant key words. Next we will search the proceedings of all national conferences on children's mental health held from 2000 to the present for references to empirical studies on mental health consultation, and will obtain relevant reports. Finally, we will follow up mentions of mental health consultation projects in our existing database of interviews with state child care administrators to locate any additional studies. In addition to the national study of mental health consultation in Head Start settings conducted at the RRTC (Green et al., 2003), we have already located a number of existing evaluations of early childhood mental health consultation projects across the country (Alkon, Ramler, & MacLennan, 2003; Bleeker & Sherwood, 2003; James Bowman Associates, 2003; Tyminski, 2001; Langkamp, 2003; Safford, Rogers, Habashi, & Kabha, 2001; Grimmer & Olmos, 2004; D. Perry, personal communication, June 26, 2004). We anticipate our search methods will at least double the current number of studies identified.

Measurement and Analysis

In order to establish the evidence base, we will construct a table of investigations using at least the following categories: author, design, sample, measures, and major findings. We will then extract the major features of the studies and form a classification system for the studies by feature. Since the first studies we have located employed pre-experimental or quasi-experimental design, we plan to use qualitative techniques to integrate the body of research rather than the more advanced statistical techniques of meta-analysis (Whitley, 1997).

We are particularly interested in examining the range of outcome measures (classroom environment changes, teacher gains, student outcomes) that have been used, and the sensitivity with which these instruments measured change. Evidence regarding the use of mental health consultation in the process of transition to kindergarten will be a critical focus of our analyses.

Results

The findings of the review of evidence-based practices will immediately inform the training and transition intervention being planned in this project. Our results will assist those planning mental health supports in early childhood settings, and should also be of use to researchers considering methodological issues in studies of mental health consultation.

Overall Methods for Phase II (A and B): Two-Level Transition Intervention

The overall design for the research is a nonequivalent comparison group design, relying on staggered implementation of both components of the intervention (organizational capacity training and transition team intervention) at two Head Start programs. Table (R-5.1) that follows shows the overall design and plan for data collection. During year 1, Site A will receive the organizational training (evaluated by pre- (O_{X1}) and post- test (O_{X2}) data, while Site B serves as a control site (O_{C1} and O_{C2}). Pre-transition control data will also be collected throughout the first project year at both Sites A & B (T_{C1}). This will allow us to collect information about existing transition practices that will inform the development of the transition intervention model. Control transition data during kindergarten will also

be collected for Site A in the fall of year 2 (T_{C2}). During year 2, selected participants from Site A will receive the transition team intervention, evaluated within the preschool context in the spring (T_{X1}) and in kindergarten classrooms in the fall (T_{X2}), while Site B receives the organizational training, and pre and post-transition data is collected for the control year at Site B (T_{C1} & T_{C2}). During year 3, Site B will receive the transition team intervention, with pre-transition data collected in the spring (T_{X1}) and final post-transition intervention data in the fall of year 4 (T_{X2}). One-year follow up data will be collected at both sites for organizational outcomes (O_{X3}).

Because of the organizational development focus of the intervention, randomized designs within programs to test outcomes would be neither feasible nor desirable. This strong quasi-experimental design, which includes measures taken over time on the same site, plus comparison site outcomes, will limit possible alternative explanations in making causal attributions about demonstrated program effects. It should be noted, however, that the two interventions are not being tested independently, but rather as an integrated pair of strategies that address separate, but overlapping, outcomes.

Table (R-5.1) Transforming Transitions Overall Research Design

	Year 1		Year 2		Year 3		Yr 4
Organizational Training	Fall / Winter	Spring	Fall / Winter	Spring	Fall / Winter	Spring	
Site A	O_{x1}	org training O_{x2}		O_{x3}			
Site B	O_{c1}	[control] O_{c2}	O_{x1}	org training O_{x2}		O_{x3}	
Transition Intervention	Fall / Winter	Spring	Fall / Winter	Spring	Fall / Winter	Spring	
Site A	T_{c1}	[control] T_{c1}	transition intervention	T_{x1}			
Site B	T_{c1}	T_{c1}	[control]	T_{c1}	transition intervention	T_{x1}	
Kindergartens			T_{c2} Site A		T_{x2} Site A T_{c2} Site B		T_{x2}

KEY:

O_{x1} = pretest, organizational training intervention, program staff
 O_{x2} = posttest, organizational training intervention, program staff
 O_{x3} = follow up, organizational training intervention, prgrm. staff
 O_{c1} = pretest control data, program staff
 O_{c2} = posttest control data, program staff

T_{x1} = pre-transition intervention data, preschool teachers, families
 T_{x2} = post-transition intervention data, K teachers, children, families
 T_{c1} = pre-transition control data, preschool teachers, families
 T_{c2} = post-transition control data, kindergarten teachers, children, families

Methods for Phase II, Part A: Organizational Training to Develop Capacity for Implementing Successful Mental Health Supports in Early Childhood Settings

The goal of this phase of the project is to develop, implement, and test a strategy to enhance early childhood organizational capacity to implement successful mental health and transition supports. Although, as described above, research during the prior RRTC grant led to the production of training materials for early childhood program directors (Green et al., 2004a; 2004b), a test of the effectiveness of the training materials was not possible. In addition, a primary goal of this study is to expand our previous research to include building transition teams that integrate mental health professionals into the transition process.

Phase IIA of the project will build a foundation for successful implementation of mental health supports and transition services by training program administrators, managers, supervisors, staff, mental health professionals and key school personnel. Components of the training will include: (1) Training on “promising practices” in early childhood mental health services and transition processes; (2) Developing a program-wide vision for mental health supports that extends through the transition period; (3) Developing and implementing a strategic plan for program improvement that includes increasing the level of integration of the mental health professional, increasing involvement by families in mental health and transition supports, and enhancing the cultural competence of mental health and transition supports provided through the transition period; (4) Implementing changes in the types of supports provided by the mental health professional to focus on enhancing staff skills and competencies, in addition to child-focused services and strategies for involving mental health professionals in the transition process; (5) Implementing feedback mechanisms for continuous review of center goals, evaluating progress, and fine-tuning approaches. All training materials will be reviewed by the project’s cultural consultant and by family members participating in the Head Start Parent Policy Council for appropriateness of use with the target population.

The training will be implemented in two half-day sessions during the programs’ in-service training period in January, plus monthly two-hour sessions with existing staff “teams” (e.g., program management team, teacher supervision teams, etc.) over the next 5 months (through June). This will allow a training program of sufficient intensity to produce outcomes, while at the same time be feasible to implement in a community early childhood setting, where staff time away from the classroom takes away valuable and limited resources. In addition to training, ongoing technical assistance will be provided by the research team throughout the year.

Sample

The study will involve partnerships with two large Head Start programs in Northwest Oregon. One Head Start program, Washington County Head Start, has already agreed to participate in this project. All teaching staff, family advocate/case managers, management staff, program directors, and mental health consultants will participate in the training, for a potential total sample of n=115. The second site will provide a sample of 100 comparison participants (during year 1) and follow-up training intervention data on these persons during year 2. Some staff are likely to leave their jobs at the end of the school year. However, fall-to-spring turnover in Head Start programs tends to be quite low. The program includes urban and rural areas and, importantly, serves a large proportion of Hispanic families (55%). In addition, the Devereaux Early Childhood Assessment (DECA) is currently used to identify children with emotional/behavioral challenges. We are in the process of identifying a second program

that is as similar as possible to Washington County Head Start, in terms of geographic region and demographic characteristics of the population served. Proposed project staff have an extensive history of partnering with Head Start programs, and have identified several other potential sites for the study. Programs that participate must be (a) large enough that we will be able to identify at least 20 children each year with challenging behaviors for the transition team intervention and (2) be interested in improving their overall mental health and transition-related services.

Head Start programs provide an ideal context for this study because of their service mandates, including the provision of mental health and transition services to children. In addition, they serve a low-income population, who may be at higher risk of emotional/behavioral problems and have less access to resources. We know from our prior research and experience working with Head Start, that programs vary widely in how successfully they implement these service mandates, and there is broad interest among programs in obtaining assistance in meeting the needs of families that have children with emotional/behavioral challenges. Further, although Head Start may be a relatively “service rich” early childhood setting, the results of the study can still be generalizable to other early childhood settings, particularly those that serve low-income children.

Data Collection

At both sites, pretest data will be collected from all participants in the organizational training during the first training session using self-report questionnaires (see Table R-5.1). Post-test data will be collected during the final training session (approximately 6 months later). Additionally, the measures will be repeated during the spring of the following school year to continue to track organizational, attitudinal, and behavioral changes which may take a longer period to emerge. Comparison site data will be collected at Site B in winter and spring of the first program year, prior to that site’s receipt of the organizational training in Year 2.

Measures

Both quantitative and qualitative data will be collected. The primary outcome measure will be adapted from the survey developed by Green et al. (2003) for their national survey of Head Start program staff (see Appendix H). This survey includes questions about organizational structure, staff characteristics, use of and attitudes towards “promising practices” in mental health services, implementation of specific types of mental health consultation, quality of relationships between staff and mental health professionals, and staff understanding of the goals, vision, and purpose of the program’s mental health approach. Questions will be added to assess staff knowledge and implementation of promising practices in transition-related activities, and to provide data to inform the transition team intervention (described further below in Phase IIB methodology). In addition, a measure of teacher’s perceived self-efficacy related to influencing children’s behavior (the Teacher Opinion Survey, Geller & Lynch, 1999) will be adapted and added to the questionnaire, along with questions about teacher’s attitudes towards working with children with challenging behaviors. This tool showed positive changes in teacher’s attitudes after working for one year with a mental health consultant. Teacher job stress and satisfaction will be measured using a questionnaire adapted by Saifer and colleagues (Saifer, Friesen, Ostrogorsky & Gordon, in press) from the Index of Teaching Stress (Greene, Abidin & Kmetz, 1997). Finally, program records (with identifying information removed) will be reviewed to assess the reasons for children exiting the program.

Qualitative data will be collected throughout the intervention and follow-up periods to document the type of goals set by the program, activities taken to reach these goals, and issues and challenges encountered during the year. Records will be kept of the nature of technical assistance provided to each program, and a research project staff will attend monthly management team, Parent Policy Council, and other meetings to observe each center's mental-health related strategic planning activities. Additionally, qualitative interviews will be collected from a sample of 15-20 program staff at the end of the intervention and follow-up year to gather information about their perceptions of the training intervention, and the benefits and challenges to implementing changes in their mental health supports. This information will help to conceptualize the results obtained through the quantitative outcome data, and will comprise two "case studies" of program change at sites A and B over a two-year period.

Analysis Plan

Analyses will be conducted to answer the primary research questions regarding the effectiveness of this component of the intervention. To examine intervention effects, data from participant questionnaires will be analyzed using a General Linear Model with repeated measures, comparing changes over time in participants in the comparison site to changes over time among participants receiving the treatment. Teacher baseline characteristics, as well as other demographic differences between programs (e.g., proportion of Hispanic children, proportion of children with an individualized family service plan {IFSP}) will be used as covariates. This method relies on good follow-up data with low attrition. However, since data are collected during two school year periods, we expect staff attrition during the school year to be relatively low, which is typical of Head Start programs. Fewer individual participants may be tracked over a two-year period. However, if sample sizes across all three data collection points (pretest, posttest, and follow-up) are sufficient, growth curve analyses will be employed to examine changes over time and key predictors of change. Planned contrasts will be conducted to see if patterns of change are significantly different during the comparison time periods/sites vs. the treatment periods. Qualitative data will be content-analyzed and summarized into key themes to inform further development of the organizational training.

Results

Quantitative results from this first phase of the intervention will be used to evaluate its effectiveness in meeting project objectives and answering key research questions. Follow-up analyses of overall intervention effects will be used to explore any key subgroup differences (e.g., was change more pronounced among particular groups of staff?) that may be important for refining the training. Analyses from Site A will inform any changes or improvements that may be necessary before implementation occurs in Site B. Taken together, quantitative and qualitative data will inform revision of the organizational training materials. Further integration and application of results are described below.

Methods for Phase IIB: Family-Driven Team Transition Intervention

The family-driven team transition intervention will be developed, implemented, and pilot tested to assess its effectiveness in supporting children with emotional/behavioral challenges to successfully transition and assimilate into kindergarten. The study design is outlined in Figure 1 (above) and is a quasi-experimental non-equivalent comparison group design. Process data will be collected to describe the characteristics of the intervention and comparison sites, document development and implementation

activities, and identify factors that contribute or present challenges to implementation. Outcome data will be collected to ascertain the impact of the intervention on child, parent, preschool and kindergarten teacher outcomes. We present an overview of how the intervention will be developed, followed by a description of the research design, sampling procedures, data collection methods and measures, analysis strategies, and anticipated results.

Model Development for Transition Intervention. The development of the model will occur during year one with the following steps:

Step 1. Researchers will identify current transition practices in Site A and Site B by (a) reviewing written policies and procedures within each program and receiving school districts; (b) interviewing key Head Start and receiving school district administrators responsible for transition of children to kindergarten; and (c) collecting data through surveys of staff about their knowledge of promising practices in transition activities. These activities will be incorporated into Phase IIA activities whenever possible to ensure efficiency and coordination of this two-level intervention. For example, questions about current transition practice will be appended to the qualitative interviews conducted as a part of the evaluation of the organizational training component. Similarly, quantitative items will be included in the self-report instrument.

Step 2. Current policies and practices determined to be essential will be integrated with promising practices identified in the literature. The resulting transition guidelines will constitute the conceptual framework for the “family-driven team transition intervention”.

Step 3. The model will be presented to a stakeholder group within Site A, comprised of parents, Head Start personnel (teachers and administrators), and elementary school personnel (kindergarten teachers and administrators). The group will provide feedback and further input. In addition, the model will be reviewed by the project’s cultural consultant and by parents involved in the program’s Parent Policy Council.

Step 4. The intervention will be refined, based upon feedback received from the collaborative group and other reviewers.

Step 5. The model will be disseminated to members of the stakeholder group, the cultural consultant, and the Parent Policy Council with a written request for any additional comments.

Step 6. The model will be finalized, incorporating conclusive feedback from stakeholder groups.

Step 7. The model will be Pilot tested in Site A beginning in the fall of year two.

Model Implementation. The Transition Liaison (an MSW student) will meet with the parent(s) of each child in the Site A intervention group (n = 16) during the fall of year 2 to discuss transition to kindergarten and ask the parent(s) to identify who they would like to invite to the initial transition team meeting. Suggested members [in addition to parents] will include the child’s preschool teacher, receiving kindergarten teacher, the program’s mental health professional, and the school counselor or special education coordinator. The first transition meeting with each child’s transition team will occur during the fall of the preschool year. One concrete product from each meeting will be the individualized transition plan. The Transition Liaison will be responsible for coordinating and monitoring the activities

stated in the plan. The written plan will include participation of the receiving school teacher and visitation by the receiving teacher to the preschool classroom to observe the child and preschool environment. In addition, the parent, with assistance from the Transition Liaison, will arrange to take the child to the receiving kindergarten classroom at least one time near the end of the school year.

The Transition Liaison will facilitate completion of a transition portfolio with each child's parent and preschool teacher. The portfolio will include products the child completed throughout the last year, assessment information, and health, mental health, medical, and family information that the parent(s) agree will be of assistance to the receiving school in successfully supporting the child's adjustment to kindergarten.

During the summer, prior to kindergarten entry, the Transition Liaison will contact each parent to confirm the kindergarten site and teacher. At that time, the parent and Transition Liaison will discuss the strategies that should be undertaken to ensure the child's positive initiation to the new school and classroom. The strategies may include a scheduled meeting at the school between the parent(s), kindergarten teacher, and Transition Liaison. Establishing a communication process between the parent(s) and teacher will be essential. A useful tool that is employed by some teachers and parents is a notebook that is exchanged daily or weekly between home and school, to help ensure effective communication. In addition, the parent(s) and teacher may set a volunteer schedule to support consistency in parent(s)' physical presence in the kindergarten classroom. In some cases, it may be necessary to review the child's portfolio, and revise or develop a behavioral support plan to prevent or ameliorate child emotional/behavioral issues. Finally, if a child will receive medication during the school day, the parent and teacher will establish the schedule for receipt of medication.

Lastly, the Transition Liaison, parent(s), and kindergarten teacher will agree on a schedule of follow-up contact by the Transition Liaison. All too often, once a child transitions from preschool to kindergarten, collaboration and communication among the parent(s), sending and receiving school teachers ends abruptly. This model will include follow-up contact with the parent(s) and kindergarten teacher to ascertain whether additional support or advocacy may be needed.

Sample

Head Start programs are required to perform systematic assessment and identification of children with special needs within 45 days of each child's enrollment. Based on information provided by Washington County Head Start, between 30% and 40% of children who will transition to kindergarten in one year in each participating Head Start site are likely to fit the criteria for the sampling pool, specifically, a t-score of 60 or greater on the DECA. Four groups of 20 children each will be randomly selected from the pool within each site during the course of the project; a control (year 1) and transition intervention group (year 2) for site A; and a control (year 2) and transition intervention group (year 3) for site B. A total of 80 children will be represented in the overall sample. We anticipate an attrition rate of about 20%, thus the final number of children in each group will likely be 16 ($N = 64$).

Outcome data will be collected from parents, preschool teachers, and kindergarten teachers associated with each child in the sample. These adult respondents will include a minimum of 64 parents, 30 preschool teachers, and 30 to 50 kindergarten teachers. The number of preschool and kindergarten teachers will vary depending upon how many children within the sample have the same teacher and/or kindergarten teacher.

Measurement

Multiple measures will be used to address the questions of interest, including:

1. *Devereaux Early Childhood Assessment (DECA)*. This standardized, norm-referenced behavior rating scale will be used as a screening tool to identify eligible children for the sample and to provide information about the type and severity of problem behaviors. The DECA is reported to have excellent reliability, with Alpha for Total Scores at .91 for parent raters and .94 for teacher raters. The Alpha on subscale scores ranges from .71 to .90 (LeBuffe & Nagliere, 1999).
2. *Family Survey*. Parents will receive two short questionnaires, one in the spring prior to transition, and one in the fall after transition. The questionnaires will be used to measure differences in parent perceptions of their child's readiness for transition to kindergarten, confidence that their children will have their needs met, involvement in the transition process, and empowerment regarding their child. Transition questions will be developed that are specific to the intervention process. The Family Empowerment Scale (Koren et al, 1992; see Appendix H) will be used to measure parent involvement and empowerment. The instrument was developed to measure the extent that parents of children with emotional disabilities feel knowledgeable about their children's disabilities and confident that they can effectively access services and supports. Parent surveys will be reviewed by family members on the project's advisory board, and translated into Spanish and other languages as needed.
3. *Teacher Survey*. As described above, the evaluation of the organizational training component will include an adapted version of the Teacher Opinion Survey (Geller & Lynch, 1999 see Appendix H), to measure differences in teacher self-perceptions of their knowledge and competence in addressing the needs of children with emotional/behavioral challenges. These outcomes are also relevant to the transition intervention, especially questions that will be incorporated into the survey to gain information about teacher perceptions of the transition process, their role in the process, and their ability to work in partnership with the parents of children with emotional/behavioral challenges. Questions about teacher attitudes towards children with these challenges and their beliefs about inclusive practice will also be included. This measure will be administered to the preschool teachers as a pre and posttest (during the evaluation of the organizational training) and to the kindergarten teachers who receive children from the sites during the fall and spring of years 2, 3, and 4.
4. *Elementary School Records*. Records related to child behavioral referrals, suspensions, and transfers to other schools or classrooms will be recorded and used to measure differences between intervention and comparison groups regarding behavioral referrals, retention, and classroom integration.

Data Collection

Process data will be collected when the project is initiated and will continue throughout the course of the intervention. Field notes, and collected written policies, procedures, and child transition plans will be used to describe the transition context and specific information regarding the transition planning process, such as who is involved and how the process is employed over time. Factors that

contribute to, or present challenges to, successful implementation of the intervention will be identified by conducting brief surveys of personnel and parents in coordination with level 1 activities in the Spring of years 1, 2, and 3. Descriptive data for each child and family in the intervention and comparison groups will be collected using existing site information/tracking forms, with study ID numbers replacing child and family names.

Outcome data will be collected at two points for each comparison and intervention group (see Figure 1): (a) Spring term prior to the end of the preschool year (pre-transition; T_{X1} , T_{C1}), and (b) Fall term of the kindergarten year (post-transition; T_{X2} , T_{C2}). Additionally, pre-intervention data about the transition process will be collected during year 1 for both Sites A and B to inform the development of the intervention. Control data pre and post-transition will be collected for site A during year 1, and site B during year 2.

Analysis

Descriptive data will be summarized to illustrate child and family characteristics. Teacher surveys, parent surveys, and child school record data will be entered into SPSS for analysis. Because of the small sample sizes, simple between-group analysis of variance will be performed to compare outcomes for the combined sites during the control year and the intervention year, using family and child characteristics as covariates. However, data will also be reviewed within each site to determine whether results are different across sites. Additionally, because of the small number of participants, we will use the supplementary data, including the qualitative data, to provide insight into cases of “successful” vs. “less successful” transition. Additional analysis may include non-parametric statistical analyses to determine significant differences for specific survey items when the sample size is too small for parametric approaches (Siegel & Castellan, 1988).

Results

The aim of the family-driven team transition intervention study is to examine whether the approach supports the successful transition and assimilation of children with emotional/ behavioral challenges into kindergarten settings. The overarching hypothesis is that the combination of organizational training and technical assistance with a focused transition intervention, that informs and empowers parents, will increase teacher confidence in their abilities to include children with these challenges in their classrooms, while working in partnership with their parents. Moreover, as a result of this structured model of support and follow-up, we anticipate that participating teachers will report more positive perceptions of the children and their parents than those kindergarten teachers who do not receive the focused transition services. Results will be used to inform the development of an integrated set of training materials to be disseminated to key stakeholder groups.

Training Activities and Products

A major product of the proposed research will be an integrated set of training materials that showcases the two-level approach to transition intervention--developing organizational capacity and strengthening direct services related to transition to kindergarten. These training materials will take the form of “train the trainer” materials as well as resources that can be readily adopted by programs so that the intervention results can be widely disseminated to Head Start and other early childhood education providers, mental health professionals, and school personnel.

The training will be based in part on an existing training (Green et al., 2004b) that was developed from evidence-based practices identified in earlier RTC projects. The organizational training will be refined and expanded to include components on family participation and issues related to transition to kindergarten. Refinements will come from a synthesis of evidence-based practice in the field, results of an earlier pilot study (Lehman, Friesen, & Brennan, 2001), and data collected through the proposed project. As members of our advisory group and consultants to the project, family members of children with mental health needs will play key roles in developing the training, as well as the final set of integrated training materials (see below). Further, all training materials will be reviewed by our cultural consultant, as well as by family members from diverse cultural backgrounds (specifically, Hispanic) to ensure family and cultural appropriateness.

In addition to the training provided to the two intervention sites, the research team will conduct at least three training sessions for family members, early childhood education administrators and staff, mental health professionals, and school personnel at national and regional conferences. In the past, we have been successful in disseminating training materials to Head Start program staff and administrators through our relationships with the Oregon Head Start Association and the Regional (Region X) Head Start office. Training materials will also be shared with state Child Care Resource and Referral agencies (CCR&Rs), which are typically responsible for organizing and facilitating training for child care providers. Finally, the Portland State University School of Extended Studies now offers a certificate for early childhood mental health. Dr. Lehman serves as core faculty for this program, and is working with their curriculum team to ensure that the results of this study will be incorporated into this training program.

Dissemination Activities

The first phase of this project will result in articles and “research briefs” that synthesize the “state of the research” on the effectiveness of mental health consultation in early childhood settings. We will also write at least two separate articles describing the process and outcomes of the two-level intervention. In addition to peer-reviewed articles, our dissemination products will include reports, conference presentations, web pages, compact discs, brochures, and printed training materials. Family members and other key stakeholders will review all materials to verify quality, clarity, and cultural appropriateness prior to dissemination.

Technical Assistance Activities and Products

Technical assistance products will be based on all relevant research and on-site observation of current transition practice. Technical assistance will be available for all recipients of the intervention on an as-needed basis at times convenient to parents, mental health consultants, teachers and staff. In collaboration with various CCR&Rs, the project will provide technical assistance to trainers at appropriate CCR&R meetings and conferences.

Technical assistance to recipients of the trainings will be developed in conjunction with individuals that request help, since circumstances and contexts vary. Consultation provided to trainers associated with CCR&Rs will contain materials from the training sessions, information about families including children with mental health needs, and findings from the overall study to illustrate both evidence-based practice and practice-based evidence. The project’s advisory board, which includes

family members and individuals from diverse cultural backgrounds, will review all printed technical assistance materials. Publications aimed at family members will be translated into Spanish, and other languages as needed. In addition, project staff will provide technical assistance through service on boards, science interest groups, and will communicate through letters, technical assistance meetings and telephone calls, e-mail, and other correspondence.

Table (R-6.3) Practice-Based Evidence Timeline

	RTC Year 1				RTC Year 2				RTC Year 3				RTC Year 4				RTC Year 5			
	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept
	04	05	05	05	05	06	06	06	06	07	07	07	07	08	08	08	08	09	09	09
Finalize advisory membership; establish comm. plan	█																			
Establish decision-making/data-gathering process for NAYA study	█	█																		
Lit review/synthesis; prepare EBP/PBE review article	█	█	█	█	█															
Conduct assessment of NAYA capacity and needs			█	█																
Establish first NAYA evaluation objective			█																	
Develop research/evaluation plan			█	█																
Determine research questions, design, sources			█																	
Identify variables and measurement tools, develop analysis plan			█	█																
Obtain human subjects approval				█																
Hire and train data collectors, pilot data collection				█	█															
Collect data					█	█	█													
Conduct analysis, examine and interpret findings							█	█												
Review, adjust project plan/assumptions/timeline							█	█												
Prepare research/evaluation reports, presentations								█	█	█										
Prepare reports relating NAYA process/findings to broader questions, themes								█	█	█										
Establish second NAYA evaluation objective								█	█											
Repeat steps as for first evaluation objective									█	█	█	█								
Prepare workbooks: using PBE to develop EBP									█	█	█	█	█							
Prepare further reports, presentations, incl. State-of-Science									█	█	█	█	█							
Work w/local partners to implement PBE approach for building evidence											█	█	█	█	█					
Identify third NAYA evaluation goal												█								
Repeat steps as for first evaluation objective												█	█	█	█					
Work w/ national partner orgs to implement PBE approach														█	█	█	█			
Summative reports: findings/ theory of PBE in light of work with other orgs																	█	█	█	█