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STRENGTHENING SOCIAL AND
EMOTIONAL HEALTH

BEHAVIORAL SUPPORTS FOR CHILDREN

BEHAVIORAL HEALTH CONSULTATION FOR ROCHESTER CHILD CARE CENTERS

2017-18 Report

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LAURI STRANO

AUGUST, 2018

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Children's Institute is a recognized leader in programs, research, and evaluations supporting children's social and emotional health. Our partner COMET Informatics offers a data support system that provides informed decision-making, organizational quality improvements, and improved outcomes for children and youth. Children's Institute (EIN 23-7102632) is a 501©(3) non-profit organization.

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This report, and the work and outcomes it represents, is possible because of key contributions from our partners including child care centers staff, parents/ grandparents/ guardians, funders, and professionals in the community; it truly takes a village to support children and families socially and emotionally. It is Children's Institute's mission and honor to be part of that village. Without the willingness of so many to team across disciplines and roles, we would be ineffective in addressing and responding to children's social, emotional and behavioral needs.

We especially acknowledge the contribution made by our funders who underwrite Behavioral Supports for Children (BSC) services. It is through their generosity, vision, and commitment to the many low-income children and families in this community that BSC services are provided. As one very young parent whose child received Behavioral Health Consultation stated, "We still do at home what we all talked about months ago in the behavioral support plan. And it works... my girl, she listens better, and I am calmer too."

The Children's Institute profoundly appreciates the financial support provided this past year by Brighter Days Foundation, Daisy Marquis Jones Foundation, Rochester Area Community Foundation and Wilson Foundation. Thank you for supporting the social and emotional development of young children in Rochester.

We also acknowledge the Teaching Pyramid Observations (TPOTs) conducted center-wide by Mackenzie Albert at Rochester Childfirst Network (RCN). We thank RCN and Ms. Albert for their generosity sharing information, ideas and data for this report.

With children's lives, our future economy, and a dime on the dollar value, social and emotional skills can and should be taught. We honor our partners — child care centers, families, funders, and mental health and other professionals – in this work. We all collaborate to support those social and emotional skills that promote current and future capacity in our children and families.

Executive Summary

Behavioral Supports for Children (BSC) is a project developed through the collaboration of Children's Institute with six Rochester child care centers participating in *Rochester Early Childhood Assessment Partnership (RECAP)* (<https://www.childrens institute.net/programs-and-services/recap>). BSC provides a continuum of services to promote social-emotional health and prevent and reduce challenging behaviors and social-emotional difficulties in three and four-year-old children.

- ❖ BSC integrates Behavioral Health Consultation (BHC) with the Pyramid Model (Fox, Dunlap, Hemmeter, Joseph, & Strain, 2003; Hemmeter, Ostrosky, & Fox, 2006) – an evidence-based approach adopted by New York State in 2015. The Pyramid Model is a comprehensive framework to promote young children's social and emotional competencies and decrease challenging behaviors. BHC is based on the Georgetown University Center for Child and Human Development consultation model (Cohen & Kaufmann, 2005). BHC offers two types of consultation: programmatic consultation – aimed at building capacity of center staff and families; and child-centered consultation – focused on the individual needs of children exhibiting social-emotional and/or behavioral challenges. In addition to 1) the Pyramid Model and 2) BHC, two other essential components of BSC are 3) universal social-emotional screening with the *Teacher-Child Rating Scale (T-CRS 2.1)* (Hightower & Perkins, 2010), and 4) implementation of the social-emotional curriculum *Promoting Alternative Thinking Strategies (PATHS) Preschool* (Domitrovich, Greenberg, Kusche' & Cortes 2004). PATHS Preschool is recognized as evidence-based and effective by SAMHSA (Substance Abuse and Mental Health Services Administration) and CASEL (Collaborative for Academic, Social and Emotional Learning).

This report outlines populations served, processes and learnings. Outcome data identify statistically significant positive change both at the classroom and individual child levels.

Major Activities and Findings for 2017-18:

- ❖ The majority of teachers serving children ages 3 or 4 received Pyramid Model training.
- ❖ All lead teachers (hired before 2018) were oriented to the PATHS Preschool curriculum.
- ❖ PATHS curriculum was implemented in all three- and four-year-old classrooms. However, because of staff illness, maternity leave, or turn over, in some classes few lessons were delivered.
- ❖ To identify areas of strength, and needs for coaching and training, all BSC classroom staff self-assessed in the fall '17 and spring '18 using limited sections of the Pyramid Model's *Inventory of Practice for Promoting Social and Emotional Competencies* (CSEFEL, 2006).
- ❖ Completion of classroom observations using the *Teaching Pyramid Observation Tool* (TPOT) (Hemmeter, Fox, & Snyder, 2014) proved to be very challenging due to scheduling issues, teachers' illness, and directors' concerns regarding additional classroom observations.

- 12 teachers were evaluated pre and post using the TPOT.
- In the fall, teachers demonstrated competence in implementing best practices such as promoting positive relationships with children and adults, children's engagement, consistent schedules, routines, and clear directions. However, they demonstrated lower ability in teaching children social emotional and behavioral skills.
- In the spring, teachers demonstrated improvement in teaching children behavioral expectations, social-emotional skills including friendship and problem solving skills.
- ❖ 348 children (216 four-year-olds and 132 three-year-olds) were screened for social-emotional competencies and risks with the T-CRS 2.1.
 - 24% of four-year-olds presented with one or more risk factors; 10% presented with multiple risk factors. Results are almost identical to 2016-17.
 - 33% of three-year-olds presented with one or more risk factors; 10% presented with multiple risk factors. These results are down from 2016-17 (52% with one or more factors, 20% with multiple factors).
- ❖ Children in both four-year-old and three-year-old classrooms demonstrated statistically significant improvement ($p < .05$) in all subscales of the T-CRS 2.1.
- ❖ Children in the six BSC centers were compared with children attending other Rochester centers that were RECAP participants.
 - Changes for four-year-olds in BSC centers compared to changes for four-year-olds in non-BSC classrooms were greater on the Task Orientation and the Peer Social Skills subscales of the T-CRS. However, this difference is not statistically significant.
 - Changes for three-year-old students in BSC centers were greater than changes for three-year-olds in non-BSC centers on the Behavior Control, and Task Orientation subscales. These difference are statistically significant ($p < .05$).
- ❖ 31 children received individualized behavioral health consultation. Pre- and post-data were collected for 21 of those children.
 - Statistically significant improvement was seen on the DECA-P2 (Devereux Early Childhood Assessment) on all three social emotional competency subscales: Initiative, Self-Regulation and Attachment/Relationship ($p < .05$).
 - Statistically significant improvement was seen on the DECA-P2 Behavioral Concerns subscale ($p < .05$).
- ❖ No child was expelled because of behavioral challenges, however two children referred to Special Education services moved to more restrictive environments at other locations.
- ❖ Workforce issues within the early childhood care and education field had a significant impact on implementing and maintaining evidence-based professional development and strategies within centers. Staff and leadership turnover remains a significant barrier.
- ❖ Children referred for behavioral health consultation are impacted by very complex family and community situations as well as systemic issues such as very high rates of child poverty.

Children's Social-Emotional Needs

Children's social, emotional and behavioral disorders are on the rise in the United States, with approximately 13% to 20% of children diagnosed with a mental disorder within a given year (Perou et al., 2013). The prevalence of mental health problems is higher among children living in an environment of risk, such as poverty and exposure to maternal depression, with estimates ranging from 17%–25% (Godoy & Carter, 2013; Larson & Halfon, 2010). However, only 50% of these children are identified before school entrance (Glascoe & Marks, 2011). Social, emotional and behavioral difficulties often start in early childhood.

Prekindergarten children with challenging behaviors are expelled at a rate that is three times that of K-12 students (Gilliam, 2005). The 2015 New York State Child Care and Early Education Suspension and Expulsion Survey found that 12% of respondents asked that a child leave their center in the past year due to challenging behaviors. Research shows that young children's unaddressed difficulties may have long lasting consequences on their academic performance and quality of life (social, financial, work satisfaction, mental health) (Jones et. al., 2015). Data indicate that African American boys – especially four-year-olds –are at greatest risk for suspension. The U.S. Department of Education found that black children represent 19% of preschoolers, but are 3.6 times more likely to be suspended than white children. While other factors contribute to this (generational trauma, and factors connected to poverty), this disparity is, to a significant degree, due to implicit bias; teachers expect children of color to behave poorly (Gilliam & Maupin, 2016).

Children in Rochester live in extreme poverty conditions with multiple related risk factors. Rochester is ranked 1st in similar sized cities for child poverty and rates of extreme poverty (people living below half the federal poverty level) and is the 5th poorest city in the United States among the top 75 metropolitan areas (Johnson, Doherty, & Hebda, 2016). The Greater Rochester Health Foundation (GRHF) documented the high social, emotional and behavioral needs of Rochester children in their report *Crisis in Care: Gaps in Behavioral Health Services are Failing our Children* (2016). Recent results of teacher assessment of their students in Rochester Universal Pre-Kindergarten (UPK) and Expanded Pre-K (EPK) indicate that 23% of UPK children and 39% of EPK children presented with one or more social emotional risk factors (Infurna et al, 2017).

A growing body of research shows that preventive interventions that strengthen relationships and promote social-emotional competencies equip children to be successful academically, in their relationships and future life (Domitrovich, Moore, & Greenberg, 2012; Dunlap & Fox, 2014). In a 2015 longitudinal study of 750 urban and rural kindergartners who were followed for 20 years, children who had a strong social and emotional foundation were four times as likely to graduate from college compared to those scoring at the bottom of a 5 point social and emotional skills scale; conversely, for every point decrease, there was a 67% greater chance of an arrest (Jones, Greenberg & Crowley, 2015). These outcomes support the analysis of the Nobel Prize winning economist, James Heckman and his colleagues on the long-term benefits of teaching social and emotional skills in preschool (Heckman, Moon, Pinto, Savelyev & Yavitz, 2010).

Introduction to Behavioral Supports for Children

Behavioral Supports for Children (BSC) is an initiative developed to respond to the social, emotional and behavioral needs of Rochester's very young children. The BSC program integrates Behavioral Health Consultation (BHC) into the Pyramid Model (Fox, Dunlap, Hemmeter, Joseph, & Strain, 2003; Hemmeter, Ostrosky, & Fox, 2006) to inform consultants' work with families, children, center directors and teachers and promote Pyramid Model practices (Perry, & Kaufmann, 2009). Two other essential components of BSC—also aligned within the Pyramid Model framework—are universal social-emotional screening and the implementation of the evidence-based social emotional curriculum PATHS Preschool (Promoting Alternative Thinking Strategies) (Kusché & Greenberg, 1994). PATHS Preschool is recognized as evidence-based and effective by SAMHSA (Substance Abuse and Mental Health Services Administration) and CASEL (Collaborative for Academic, Social and Emotional Learning).

Behavioral Supports for Children Components

1. Pyramid Model

The Pyramid Model was developed by the Center on the Social and Emotional Foundation for Early Learning (CSEFEL) and refined following the creation of the Technical Assistance Center on Social Emotional Intervention (TACSEI) for Young Children. The Pyramid Model is a three-tiered framework to support young children's social-emotional competence. Based on a public health model, the Pyramid Model's Tier 1, the base of the Model, is "Universal Promotion" of all children and is comprised of two components: building positive relationships with children, families and colleagues; and promoting supportive and high quality environments. Tier 2, or "Secondary Prevention" consists of teaching children social and emotional skills. Tier 3, or "Intervention" consists of developing intensive individualized interventions for those children, usually less than 5%, who continue to exhibit challenging behaviors despite the implementation of universal and preventive practices (Fox, Dunlap, Hemmeter, Joseph, & Strain, 2003; Hemmeter, Ostrosky & Fox, 2006).

Figure 1. The Pyramid Model: Promoting Social-Emotional Competence



2. Universal Social-Emotional Screening

Screening all children for social-emotional competencies and risks helps identify those children who present difficulties and would benefit from intervention strategies that prevent the development of increasing and severe future problems. Screening is part of a prevention approach and consistent with the Pyramid Model (Henderson & Strain, 2009).

In the fall, teachers at each center screened all three and four-year-old children for social-emotional competencies and risks with the Teacher-Child Rating Scale (T-CRS 2.1) (Perkins & Hightower, 2002), a screening tool that measures a child's task attention, behavior control, assertiveness and peer social skills.

3. PATHS: An Evidence-Based Social Emotional Curriculum

Children who have social-emotional competencies are attentive, follow directions, get along with other children, are assertive and engaged and are able to regulate their emotions (Denham, Brown, & Domitrovich, 2010). Teaching children social-emotional skills is an effective intervention that can improve mental health and social skills as well as academic achievement, as shown on a meta-analysis study (213 studies) including more than 270,000 students from kindergarten through high school (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011).

In an effort to provide universal social-emotional skill development, teachers delivered the PATHS Preschool curriculum (Promoting Alternative Thinking Strategies) (Domitrovich, Greenberg, Kusché, & Cortes, 2004) in their classrooms.

The program includes options to strengthen home-school connections, and promote continuity of pro-social and emotional concepts and language between home and school. PATHS Preschool is recognized as a Model Program (the highest possible rating) by the National Registry of Effective Programs – Substance Abuse and Mental Health Services Administration (SAMHSA). In two controlled trial studies of children attending Head Start classrooms, children exposed to PATHS showed improvement in emotional vocabulary, empathy, and social skills (Bierman, Domitrovich, et al., 2008; Domitrovich, Cortes, & Greenberg, 2007). In addition to the improvement in social and emotional competencies, a more recent study determined that elementary students exposed to PATHS also improved their proficiency in reading, writing and math (Schonfeld, et al, 2015).

4. Behavioral Health Consultation

Behavioral Health Consultation (BHC) aligns with the Early Childhood Mental Health Consultation (ECMHC) model developed by the Georgetown University Center for Child and Human Development (Cohen & Kaufmann, 2005; Duran, et al. 2009a; Duran, et al. 2009b). Characteristics of this model are illustrated in Figure 2. BHC is an effective strategy that builds the capacity of center staff, families and programs to promote social-emotional health and prevent and reduce mental health difficulties in young children (Cohen & Kaufmann, 2005; Duran, et al. 2009a; Duran, et al. 2009b). Several studies, including randomized-controlled studies, reported a significant decrease of challenging behaviors in children receiving behavioral health consultation compared to children in control groups (Gilliam, Maupin, & Reyes, 2016; Sheridan, Ryoo, Garbacz, Kunz & Chumney, 2013; Upshur, Wenz-Gross & Reed, 2009).

Figure 2. Behavioral Health Consultation Model

Behavioral Health Consultation Model

A multi-tiered approach: Consultants provide a continuum of supports: promotion of social-emotional and behavioral competencies; prevention of behavioral difficulties for children at risk; and early identification, support and intervention for children demonstrating social-emotional and behavioral needs.

Strength-based: Support builds on the strengths of children and their families, and helps develop positive relationships and social emotional competencies.

Mostly indirect: Consultants educate and work in collaboration with center staff and families to address children's social, emotional and behavioral needs. They conduct child observations and assessments, model effective practices, and develop strategies/behavioral support plans, but do not work individually with children. The intent of consultation is to develop or increase competencies in teachers and families.

Collaborative and relationship-based: The ability of consultants to build positive and collaborative relationships with caregivers is fundamental for effective outcomes. Consultants avoid the role of expert and empower staff and families.

Grounded in knowledge of child development and child-focused: Consultants provide services that are individualized for each child, developmentally appropriate, and designed to maximize a child's full potential.

Family-centered: Families are central partners in all stages of the consultation from planning to delivery of intervention. Families know their child's and their strengths and they are crucial for the implementation of strategies with fidelity. Consultants promote responsive and nurturing relationships between parents/guardians and children.

Culturally responsive: Consultants are aware, respectful and appreciative of cultural differences and diversity. They listen to staff and families, consider their values, attitudes, and beliefs and understand how their personal experiences influence their perceptions, interactions and practices. Consultants reflect on their own cultural differences and respect ethnic, racial, linguistic, socioeconomic and educational differences.

Informed on evidence-based practices and data-driven: Consultants adopt evidence-based interventions to meet the needs of children with social-emotional and behavioral difficulties. They build the capacity of early childcare providers and families to implement evidence-based interventions to reduce challenging behaviors.

Reflective: Consultants approach each situation openly and without preconceived notions of what to do. They listen to caregivers and educators. They also help consultees reflect on their practices by modeling, listening and problem solving.

Adapted from Module 1 Tutorial 2 Defining Early Childhood Mental Health Consultation, Center for Early Childhood Mental Health Consultation – Georgetown University Center for Child and Human Development. Retrieved from https://www.ecmhc.org/tutorials/defining/mod1_1.html

Behavioral Supports for Children Implementation

Participating Programs and Children

Six child care centers participated in the project. Each center participated in RECAP (<https://www.childrensinstitute.net/programs-and-services/recap>), held national accreditation and reached consensus among center leadership and classroom staff to participate in Behavioral Supports for Children.

Across centers, BSC served a total of 25 classrooms, most of which were Rochester City School District UPKs (Universal Pre-Kindergarten for four year olds) and EPKs (Expanded Pre-Kindergarten for three year olds). The centers, varying in size, served a total of 348 preschoolers: 212 (61%) in four-year-old classrooms and 136 (39%) in three-year-old classrooms. African American and Hispanic children comprised almost 80% of the total number of children; this was an increase from 70% last year. White children comprised 14% of the total number of children, down from 22% last year.

Table 1. Children Demographics

Children at the Six Centers (n=348)		
Gender	Male	50%
	Female	50%
Age	3-year-old	39%
	4-year-old	61%
Race/Ethnicity	Asian	5%
	Black/ African American	45%
	Hispanic/Latino	34%
	Native American	2%
	White/Caucasian	14%

Behavioral Health Consultation Activities

Typically BSC behavioral health consultants (BHC) visited each center once a week. Based on center needs, BHCs also visited at additional times to accommodate parent or staff schedules (early or late, or on another day). Consultants activities included: observing classrooms or individual children; supporting and modeling Pyramid Model practices; supporting PATHS implementation; developing individual strategies and supporting intervention plans; consulting with center staff, families, and other providers; attending internal meetings and supervision time. (See Table 2.)

Table 2. Consultant Activities

Type of Consultation	BSC Component	BHC Activities
<p>Programmatic Consultation</p>	<p>Pyramid Model</p>	<ul style="list-style-type: none"> • Develop positive and collaborative relationships with center directors, classroom staff, families and providers • Attend directors' meetings: share information, listen and respond to concerns, create shared goals and action plans, plan trainings • Provide trainings • Explain and align BSC services and Pyramid Model practices • Consult with, support, and provide information and resources to staff and families
	<p>PATHS</p>	<ul style="list-style-type: none"> • Orient new teachers • Consult with the centers' PATHS Point Person • Support teachers in PATHS implementation • Periodically observe PATHS lessons and offer feedback and suggestions for improvement and reinforce strengths
	<p>Universal Screening</p>	<ul style="list-style-type: none"> • Meet with teachers and center directors to review T-CRS results and identify children at risk
<p>Child-Centered Consultation</p>	<p>Child-Specific Consultation</p>	<ul style="list-style-type: none"> • Conduct child assessments through observations, rating scales and interviews with parents, teachers and other providers • Develop behavioral strategies/support plans in collaboration with staff and families • Offer mental health and wellness perspective, provide recommendations, information and resources • Facilitate behavioral data collection • Model effective strategies, coach teachers • Monitor child's progress through regular observations and/or behavioral data • Provide assistance for referrals to special education services and other community services • Participate in BHC reflective supervision

Programmatic Consultation

Programmatic consultation focuses on improving the overall quality of the child care center and supporting the social and emotional development of all young children. In programmatic consultation, BSC consultants work collaboratively with child care center staff and families using a “strength-based” approach. Building positive relationships, as well as the strength-based approach, is foundational to the Pyramid Model.

Children’s Institute program director and consultants met regularly with center directors to plan, develop timelines, clarify reciprocal expectations, align work to meet grant requirements, discuss assessments, identify center needs, develop strategies to respond to those needs, and analyze data.

To increase center implementation of the Pyramid Model and staff engagement in effective strategies, a New York State Pyramid Model Master Cadre trainer at Children’s Institute and two staff at a partnering child care center joined in the effort to train staff at participating programs on all three Modules and tiers of the Pyramid Model.

In the fall, consultants supported teachers in screening all three and four-year-old children with the T-CRS 2.1 (Perkins, & Hightower, 2002) to determine social-emotional competencies and risks. Then, consultants met with teachers and center directors to review results and discuss possible referrals for Behavioral Health Consultation or other services.

Consultants supported classroom staff in creating a prosocial learning environment aligned with Pyramid Model. They provided center staff and families with information, shared and modeled effective strategies, and offered resources and materials to foster social-emotional competencies and positive interactions among children, their families and center staff. Consultants participated in classroom meetings and other school events to engage families. They provided support for everyday activities as well as extraordinary challenges such as difficulties with children, families and/or staff; addressing staff turnover; and coping with tragic events such as death, severe illnesses, and incarcerations.

Child-Centered Consultation

Child-centered consultation addresses the needs of those children who, despite the implementation of Pyramid Model universal social and emotional promotion and preventive practices, continue to present severe social, emotional and behavioral difficulties, such as aggression, withdrawal, anxiety, or are at risk because of family stressors or trauma such as death, divorce, incarceration, job loss or mental illness.

In the BSC project, typically, a teacher or the center director made the first connection with the parent/guardian to discuss concerns for a child identified as at risk. Upon parent/guardian written consent for child-specific consultation, the consultant started the assessment process by asking the child’s teacher to fill out a referral form, the DECA-P2, and other observation forms or assessments based on needs. The consultant then conducted observations of the child in the classroom and met with parent(s) and teacher. Finally, the consultant met again with parent(s)

and teacher (ideally together) to develop behavioral strategies or a support and intervention plan to meet the specific needs of that child. Depending on the child's difficulties, a teacher may collect observational data on target behavior.

The consultant provided weekly monitoring of the behavioral plan and tracked the child's progress through formal or informal observations, modeled strategies, and offered feedback to the teacher relative to the implementation of the agreed upon behavioral strategies. Periodically, the consultant met with the child's parents and teacher to discuss progress and make modifications to the plan if needed. Once behaviors showed improvement, and the support of the consultant was deemed no longer necessary, the teacher completed a post DECA-P2 to measure social competency development and behavioral challenges. In some cases, when a child's needs could not be met at the center, the consultant facilitated referrals for outside services.

Measurement Tools

Through the consultant's support of the Pyramid Model approach, the ultimate goal of BSC project was to build teachers' capacity and skills to promote children's social emotional competencies as well as to prevent and address challenging behaviors. More specifically BSC aimed to:

1. Increase centers' implementation of the Pyramid Model practices (promotion, prevention, intervention) and use of strategies to support children's social-emotional competence;
2. Increase children's positive behaviors related to adaptation to school;
3. Decrease children's behaviors interfering with positive adjustment in the classroom.

To measure changes over time, BSC used the following instruments:

- ❖ ***Inventory of Practices for Promoting Children's Social Emotional Competence***
The Inventory of Practices for Promoting Children's Social Emotional Competence (Center on the Social and Emotional Foundations for Early Learning, 2003) assists teachers and staff in assessing their teaching strengths, relationships, the classroom environment, and practices with regard to individualized interventions. The Inventory of Practices was introduced to center directors for use on a voluntary basis in 2016-17. In 2017-18, classroom staff self-assessed Tier 1 supports including Building Supportive Relationships and Designing Supportive Environments. Additional Inventory sections include: Tier 2, Teaching Social and Emotional Strategies; and Tier 3, Individualized Intensive Interventions.
- ❖ ***Teaching Pyramid Observation Tool (TPOT)*** The TPOT (Hemmeter, Fox, & Snyder, 2014), derived from the Inventory of Practices, measures the fidelity of teachers' Pyramid Model aligned practices, and is often used to identify needs for training and coaching. The TPOT consists of fourteen subscales that measure key teaching practices, one subscale that measures "red flags" (concerning teacher/ caregiver practices), and a subscale that measures the overall use of key practices. At Tier 1, the TPOT measures the implementation of strategies that promote a high-quality environment and nurturing relationships with children, families and colleagues. At Tier 2 the TPOT measures the

teacher's ability to teach children social and emotional skills, friendship skills, and problem solving. At Tier 3, the TPOT measures the ability to effectively address children's challenging behavior.

- ❖ ***Teacher-Child Rating Scale 2.1 (T-CRS 2.1)*** The T-CRS 2.1 (Hightower & Perkins, 2010) is a 32-item rating scale with adequate reliability and validity. Designed specifically for teachers' use, the T-CRS 2.1 assesses a child's social-emotional competence in four areas: task orientation, assertiveness, behavior control and peer social skills. The T-CRS 2.1 can be used as a screening tool to identify children at risk, as well as an instrument to measure social emotional competencies and development.
- ❖ ***Devereux Early Childhood Assessment for Preschoolers Second Edition (DECA-P2)*** The DECA-P2 (LeBuffe & Naglieri, 2012) is a social emotional assessment behavior rating scale designed for children ages 3 through 5 years old. The DECA-P2 has four subscales: initiative, self-regulation, attachment/relationships, and behavioral concerns.

Outcomes

Pyramid Model Implementation

By the end of the 2017-18 school year, the majority of teachers, directors and classroom staff were trained in some or all of the Pyramid Model Modules (1, 2 & 3) with the exception of one center, not affiliated with the Rochester City School District, which had few teachers trained in Pyramid Model practices.

Inventory of Practices for Promoting Children's Social Emotional Competence

This year, BSC implemented self-assessment of key practices using the Pyramid Model's Inventory of Practices. In the fall of 2017, and again in the spring of 2018, mostly as individuals, but sometimes with their teaching teams, all BSC classroom center staff self-assessed Tier 1 supports: Building Supportive Relationships sections 1-3, and sections 4-6 of Designing Supportive Environments. Results were provided to BSC consultants to assist in supporting teachers' or teams' self-identified goals for coaching and training. Table 3 below provides a summary of responses most commonly indicated by teachers/staff as well as several de-identified quotes from individuals.

Table 3. Aggregated Inventory of Practices' High Frequency Responses

Relationships and Environments	Indicators for Coaching and Training
<p>Universal Promotion of SEL: Skills Most Identified</p>	<ul style="list-style-type: none"> ✓ Speak calmly to children ✓ Use a variety of strategies for building relationships ✓ Intentionally engage with children in positive ways when they are not engaging in challenging behavior ✓ Utilize varied strategies to relationship build with families such as: in person, notes & phone calls ✓ Acknowledge contrasting beliefs held by others regarding acceptable or unacceptable behaviors ✓ Understand there are many ways to prevent challenging behaviors ✓ Identify what/ how-- behaviors push "my" buttons
<p>Successes</p>	<ul style="list-style-type: none"> ✓ Is likely to consider culture more often ✓ Connects to individual families better ✓ Identifies adult/ personal hot buttons ✓ Reframes behaviors to understand & manage them* ✓ Works within the team to plan, prioritize and problem solve challenging behavior or other issues*

Relationships and Environments	Indicators for Coaching and Training
<p>Challenges (*some challenges are identified as others' successes)</p>	<ul style="list-style-type: none"> ✓ Lacking smooth transitions: "waits" are long ✓ Providing individualized and visual supports ✓ Teaching classroom & center-wide expectations ✓ Connecting SEL needs to challenging behaviors ✓ Rotating or accessing materials ✓ Identifying personal hot buttons; reframing behaviors* ✓ Teaming within classrooms or centers*
<p>Sample Responses</p>	<ul style="list-style-type: none"> ❖ "Ask 'What message is being sent by this behavior?'" ❖ "I'm developing strategies for dealing with situations when children's behaviors push my buttons. How can I calm them down & also myself when I am feeling frustrated?" ❖ "Implement schedule consistently... we follow the schedule daily but we often forget to implement it by teaching the children about the schedule and drawing attention to it." ❖ "Remember: All families are doing the best that they can and want the best for their children."

Teaching Pyramid Observation Tool

In addition to using the Inventory of Practices to continue moving toward full implementation of the Pyramid Model (a 3-5 year endeavor), BSC strived for wider use of the Teaching Pyramid Observation Tool (TPOT) that assesses observable use of Pyramid Model practices. Each director was asked to select one classroom (per center) to be observed in the fall and spring using the TPOT. Results would be shared with the participating teaching team, and data would be aggregated and shared with BSC directors to advance the Pyramid Model conversation and objectives.

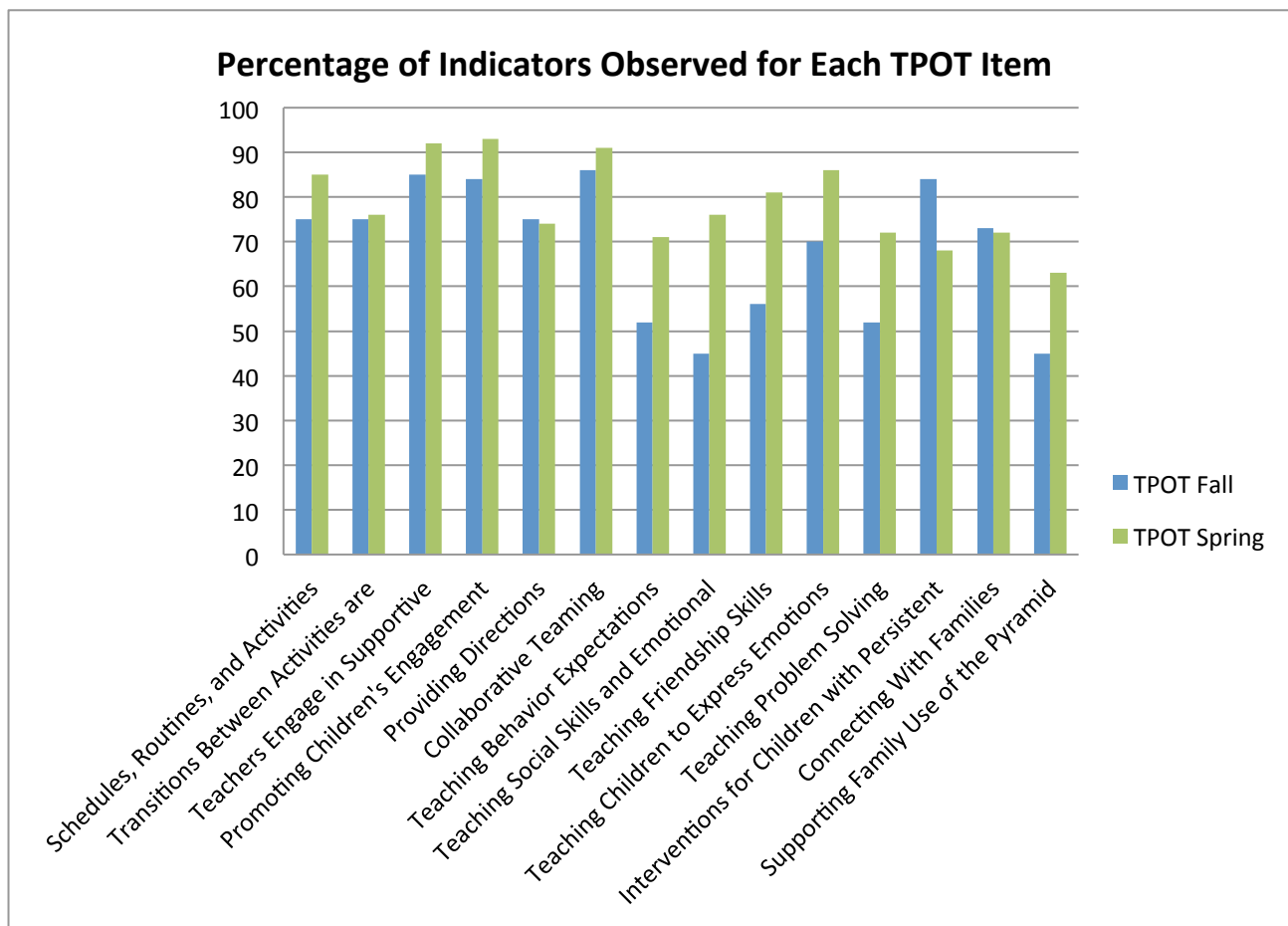
Readiness for the TPOT proved to be a challenge. Three centers did not have any TPOTs conducted due to teacher illness, scheduling issues and directors' opposition to conducting additional classroom observations. In total, only three of the six centers had TPOTs. One of these, a state Pyramid Model demonstration site center in its fifth year of implementation, conducted TPOT pre and post on most teachers.

- ❖ In total, 12 teachers were assessed using the TPOT pre and post.
- ❖ TPOT scores are expressed as the percentage of indicators observed for each key practice. Scores equal and greater to 80% indicate a teacher's competence in a specific key practice. In the 2017 fall TPOT assessments, with average scores 84% and up, teachers, as a group, demonstrated competence on universal promotion practices such as engaging in conversations with children, promoting children's engagement and collaborating with their

team. However, teachers had more difficulty teaching behavioral expectations, friendship skills, social and emotional competencies and problem solving skills (averages between 45% and 56%). (See Figure 3.) While the number of teachers observed increased from 2016-17 (8 teachers), the 2017-18 results were very similar to the previous year.

- ❖ In the spring of 2018, teachers showed significant improvement in their ability to teach behavioral expectations, social emotional skills, friendship skills and problem-solving skills (average scores between 71% and 86%). Another area of growth was in supporting family use of the Pyramid Model Practices (increase from 45% to 63%). (See Figure 3.)
- ❖ At post-evaluation (spring 2018), the average score of “supporting interventions for children with persistent challenging behaviors” decreased from 84% to 63%. This was influenced by two factors. One is teacher behavioral change: early in the school year, teachers are primed to collect data, make referrals, and support interventions-- but these practices wane as the school year closes. The other factor is that in two cases the paraprofessional was the consistent adult in the classroom for the entire year as the lead teacher left and/ or changed; in the latter cases the post TPOT followed the support teacher’s practices, and she was typically less involved or trained in intervention practices. (See Figure 3.)

Figure 3. TPOT Practices Observed (2017-18, n=12)



Universal Social-Emotional Screening: Teacher Child Rating Scale

In the fall of 2017, 348 children were screened for social emotional competencies and risks using the Teacher-Child Rating Scale (T-CRS 2.1) (Hightower & Perkins 2010). (See Table 4.)

- ❖ 24% of four-year-olds were rated by their teachers as presenting one or more risk factors, with 10% presenting multiple risk factors. These results are consistent with the previous year results: 26% presented one or more risk factor and 11% multiple factors.
- ❖ 33% of three-year-olds were rated by their teachers as presenting with one or more risk factors, with 10% presenting multiple risk factors. (See Table 4.) In 2016-17, teachers rated 52% of children as presenting with one or more risk factors, and 20% as presenting multiple factors. Percentage discrepancies between the two years might be explained by teachers' adjusted expectations about very young children's behaviors as they first begin to attend unfamiliar group settings. Teachers' reframing of young children's behavior to better understand it and support social and emotional growth is taught in Pyramid Model Modules and practices.

Table 4. Children at Risk for Social, Emotional and/or Behavioral Problems

Percentage of Children at Risk Screened with T-CRS (2017-18)		
Type of Classroom	Risk factor	Percentage of Children
4-year-old (n=216)	Task Orientation	12%
	Behavior Control	10%
	Assertiveness	7%
	Peer Social Skills	9%
	One or more risk factor	24%
	Multiple factors	10%
3-year-old (n=132)	Task Orientation	7%
	Behavior Control	24%
	Assertiveness	8%
	Peer Social Skills	10%
	One or more risk factor	33%
	Multiple factors	10%

Social Emotional Learning with PATHS Preschool Curriculum

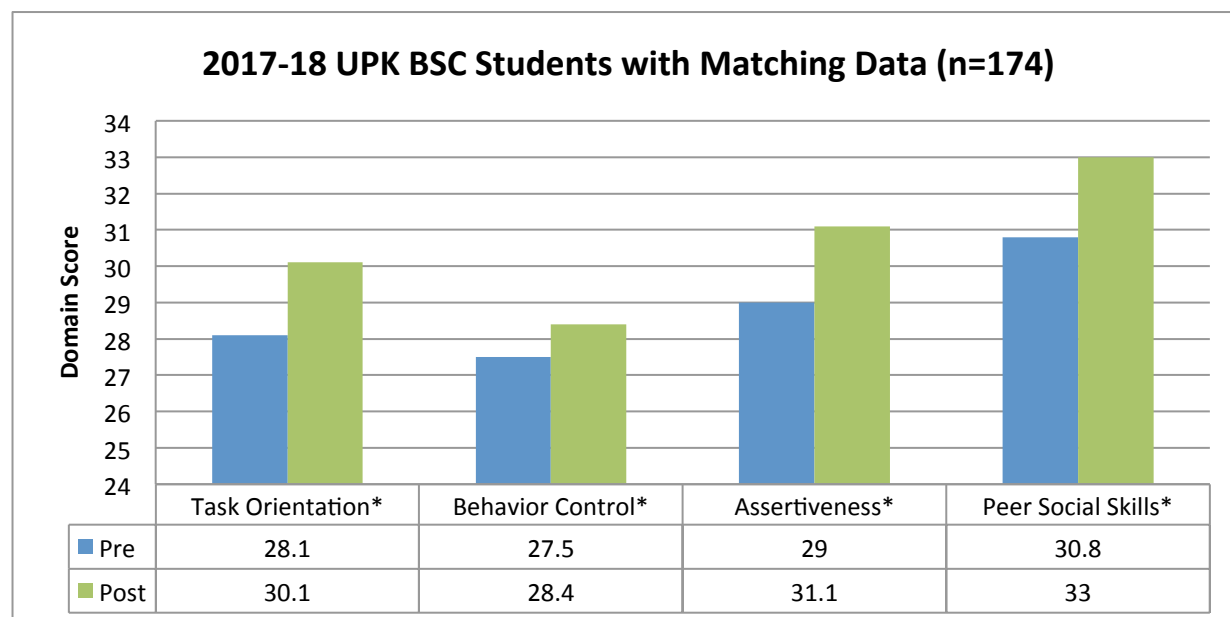
To improve children’s social-emotional competencies, the direct and systematic teaching of social-emotional skills with PATHS Preschool was a key component of the BSC project. BSC provided curriculum and materials for each classroom as well as teacher orientations to make it possible for all teachers to deliver PATHS to their students. PATHS Preschool is a Pyramid Model Tier 1 (Universal Promotion) and Tier 2 (Targeted Prevention) activity.

Consistent with “continuous progress,” in 2017-18, centers were asked to identify a PATHS Point Person who would collect data logs and internally monitor dosage. All teachers in three- and four-year-old classrooms delivered the PATHS Preschool curriculum to their students and completed PATHS logs. However, because of illness or maternity leave, some teachers only taught a few lessons, or only recorded limited lessons. Four-year-old classroom teachers documented an average of 25 lessons out of 44 lessons (range 7 to 44). This dosage is within the fidelity range. Three-year-old teachers delivered an average of 13 PATHS lessons out of 17 (range 7 to 17) for the 3-year-old adapted curriculum, which includes 17 lessons; depending on their students’ readiness, some teachers started PATHS in the fall, some in the winter.

T-CRS Pre- and Post- Results The T-CRS 2.1 pre- and post- was used to measure changes in children’s social-emotional competencies. The total number of children with pre- and post-matching data was 299 children (174 in 4-year-old/UPK classes, 125 in 3-year-old/EPK classes). Due to late entry to programs or early exit, some children did not have pre-/post- data.

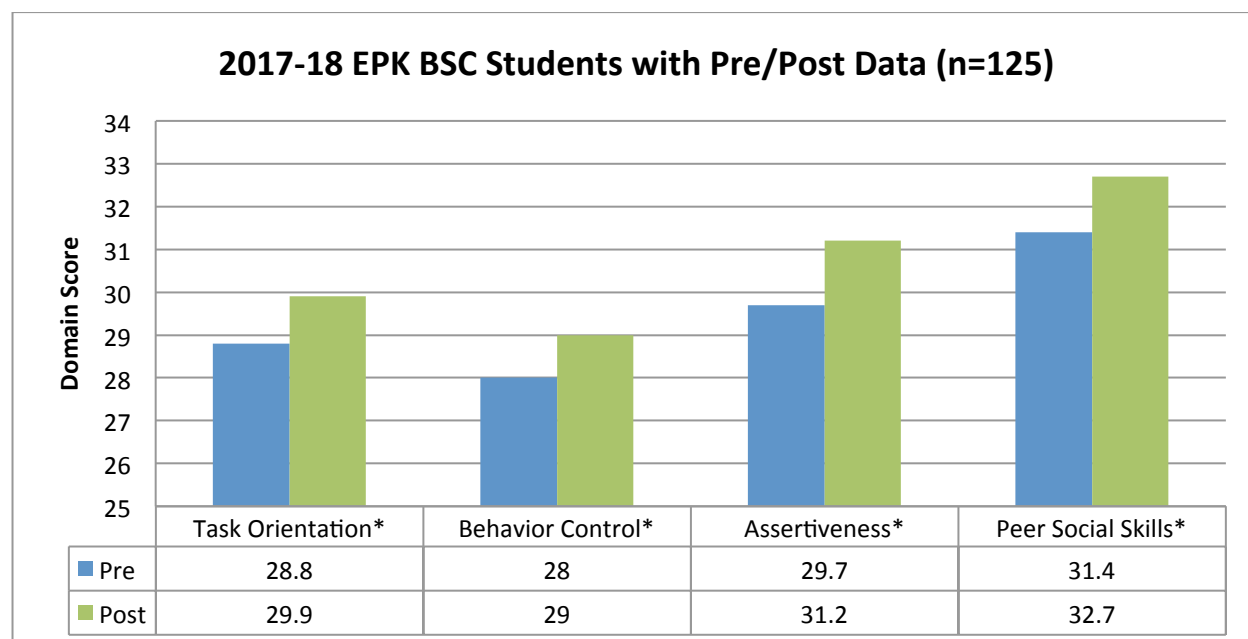
Children in the 4- and 3-year-old classrooms showed statistically significant positive changes in all social emotional competencies as measured by the T-CRS (See Figures 4 and 5).

Figure 4. 2017-18 UPK BSC Students with Matching Pre/Post T-CRS Data



Note: * significant $p < .05$

Figure 5. 2017-18 EPK BSC Students with Matching Pre/Post T-CRS Data



Note: * significant $p < .05$

Comparison of T-CRS Outcomes - BSC and non-BSC students

Children attending BSC partner centers were compared on the T-CRS with children attending other Rochester centers participating in RECAP.

- ❖ Children in UPK classes (4-year-old) attending BSC partner centers showed greater positive changes than non-BSC students on the Task Orientation and Peer social skills T-CRS subscales, but these differences were not statistically significant (See Figure 6).
- ❖ For EPK (3-year-old) classes, students in the BSC centers showed greater changes than non-BSC students on the Task Orientation and Behavior Control subscales. Differences were statistically significant ($p < .05$). (See Figure 7.)

Figure 6. UPK T-CRS Change Scores for Students in BSC and Non-BSC Centers

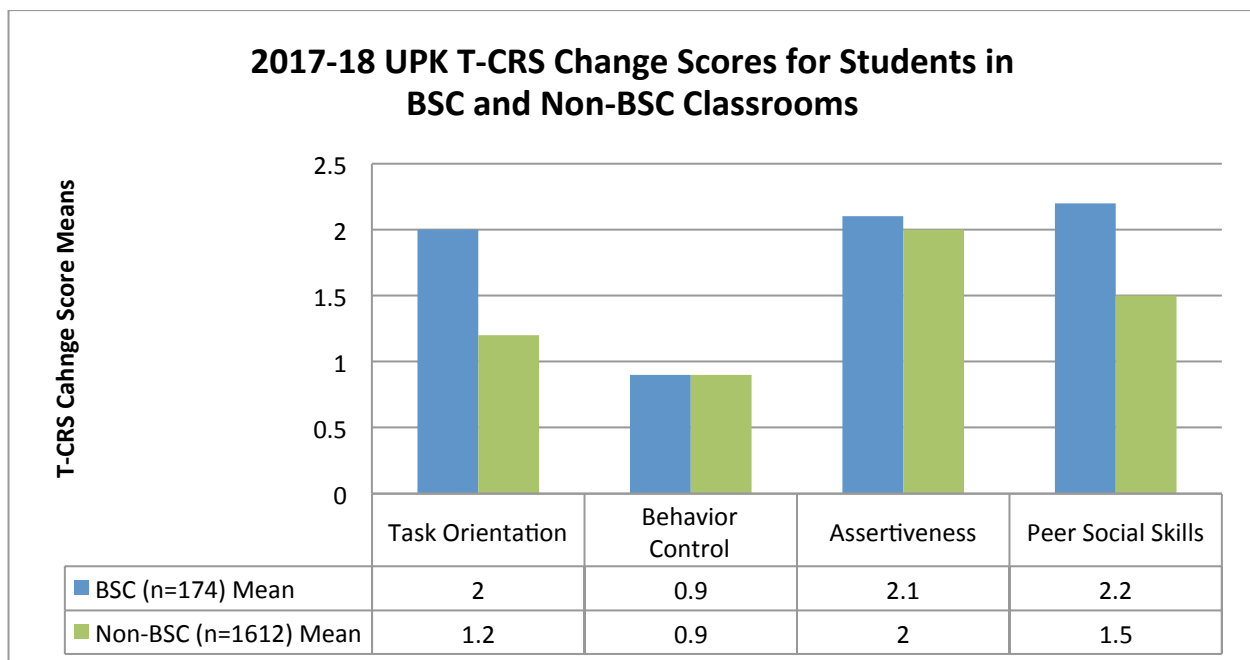
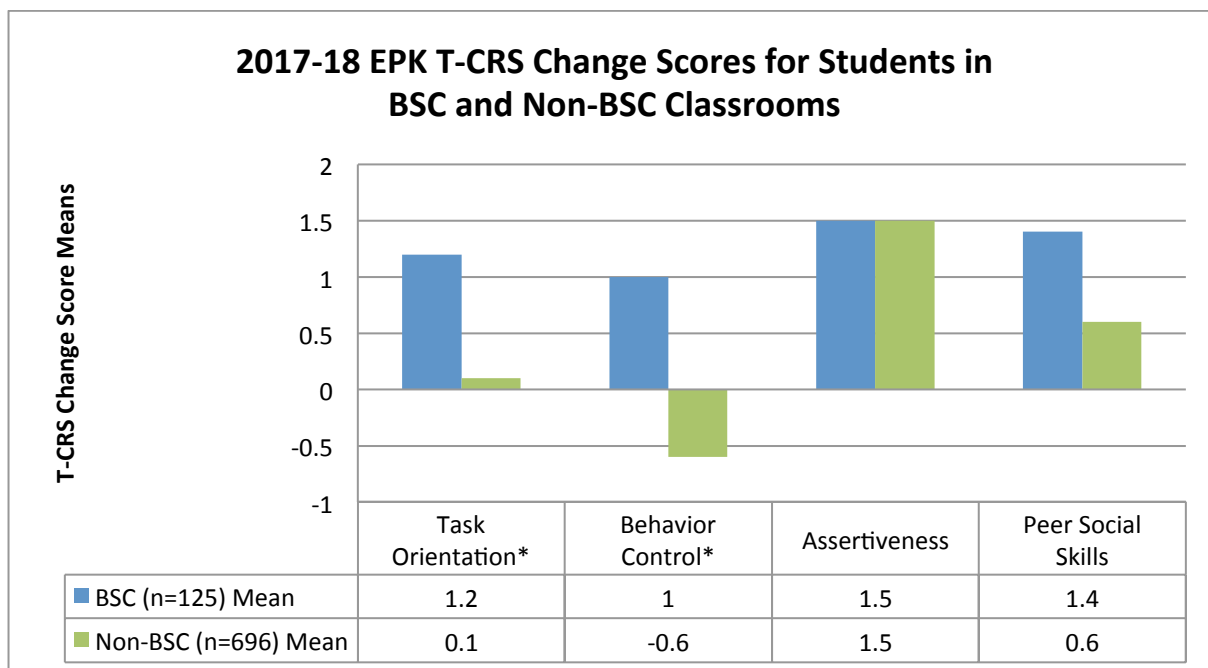


Figure 7. EPK T-CRS Change Scores for Students in BSC and Non-BSC Centers



Note: * significant $p < .05$

Child-Centered Consultation

- ❖ 31 children (21 boys and 10 girls) received BHC individualized services.
 - 18 children (10 boys and 8 girls) attended 4-year-old classrooms.
 - 13 children (11 boys and 2 girls) attended 3-year-old classrooms.
- ❖ Almost 50% of the children were in homes headed by a single parent, a grand-parent or a great-grandparent.
- ❖ Many of the children's families were challenged by poverty, trauma, violence, mental health or other illnesses, substance abuse, homelessness/ frequent moves, and parent incarceration.
- ❖ Reasons for referral to BHC varied and typically revealed more than one concern. The most frequent concerns reported were child's aggression, difficulties with peers, non-compliance, and disruptive / unsafe behavior. (See Table 5; percentages do not add up to 100% reflecting that many children exhibited several behavioral concerns.)

Table 5. Child-Specific Referral Concerns

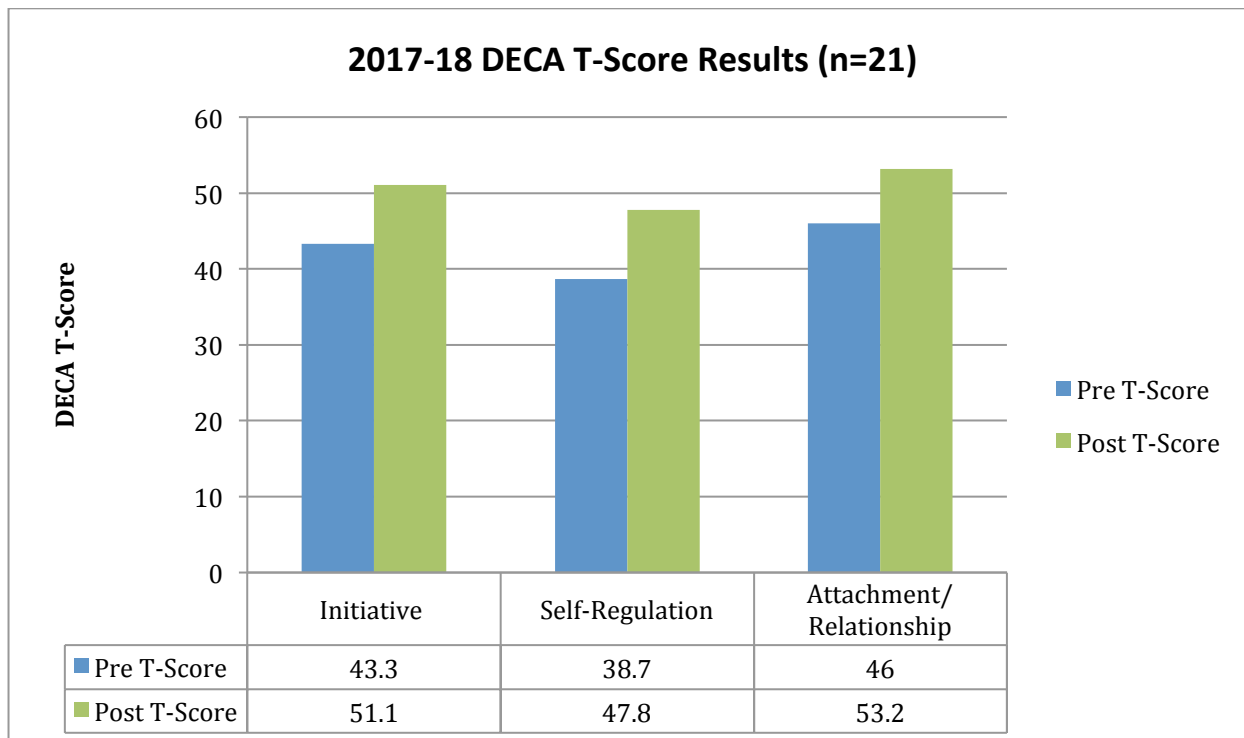
Most Common Referral Concerns	Percent of Children
Aggressive behavior toward peers and/or adults	45%
Difficulties with peers/lack of friends	45%
Non-compliance /Not following directions	35%
Disruptive/unsafe behavior	26%
Temper tantrums/excessive screaming and tantrums	16%

Child Consultation Outcome Data

Consultants facilitated referrals to mental health services for 6 children and supported referrals to special education services for 6 children. Some children were referred for both mental health and other services.

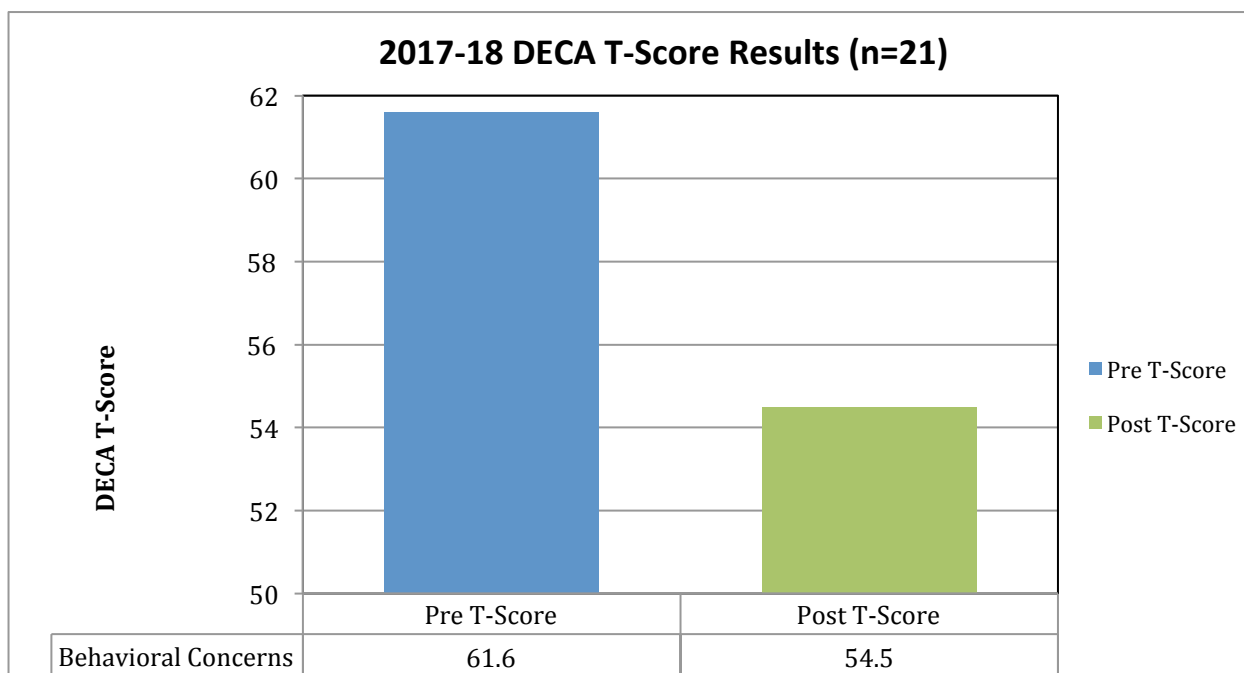
- ❖ DECA-P2 pre- and post- data was collected for 21 children who were individually served.
 - Statistically significant improvement ($p < .05$) was seen on the DECA on all three social emotional competency subscales: Initiative, Self-Regulation and Attachment/ Relationship. (See Figure 8.)
 - Statistically significant decrease (improvement) was seen on the DECA Behavioral Concerns subscale ($p < .05$). (See Figure 9.)
- ❖ Of the ten children with no post-intervention data: some moved out of the area; others, after an initial assessment, were immediately referred to special education services.

Figure 8. DECA T-Score Pre/Post Means for Combined 3 & 4 Year olds



Note: All differences are statistically significant $p < .05$

Figure 9. DECA T-Score Results for Behavioral Concerns Domain



Behavioral Control: statistically significant $p < .05$

Analysis of Expulsion Data

Research shows that suspensions and expulsions during early childhood set the trajectory for negative academic and life outcomes: negative school attitudes, expulsion and suspension in later grades, grade retention, not completing high school, and incarceration (U.S. Department of Health and Human Services and Department of Education, 2014). Research also demonstrates that *as a result of implicit bias* suspensions and expulsions are disproportionately race-based (Gilliam & Maupin, 2016).

According to New York State Department of Education and Pyramid Model experts, suspensions and expulsions take many forms:

- when a family is asked to pick up their child because of behavioral challenges;
- when a family is asked to keep a child home for a half day (in full day programs);
- when, based on behavioral challenges, a child care center states that a child would be better supported/ attending elsewhere.

While the above scenarios are often framed as “in the best interest” of the child, the message to the child and family is damaging; “your child can’t be accommodated,” or, “there is something wrong with him or her.” Frequently, the underlying reason for excluding a child has little to do with the well-being of the child. According to Walter Gilliam, Ph.D., Yale professor and early suspension/expulsion researcher, children are often excluded as the result of adult problems—not their own. To assess how often excluding practices were used in centers, in BSC meetings, directors were asked, “How many children were released from your center this year because of behavior or social-emotional difficulties?”

Directors reported that no child was expelled or suspended from a BSC center because of social-emotional difficulties. However, two children were referred for special education services that required more restrictive environments. The families were supported until their child’s move was completed.

Observations, Lessons Learned and Recommendations

The Behavioral Supports for Children project was designed to address and strengthen children's social, emotional and behavioral competencies, and decrease challenging behaviors through building preschool staff capacity to teach, support and model social and emotional skills. Foundational to this is strengthening healthy relationships within centers, and between staff and families and children. To achieve BSC objectives, and consistent with best practice in New York State and nationally, BSC adopted the Pyramid Model approach.

Data, as well as consultant observations, demonstrate that more Pyramid Model implementation practices were adopted in 2017-18, and that children, including those exhibiting the most challenging behaviors (and referred for child-centered consultation), showed growth in social emotional competencies and decreased behavioral concerns. However, several issues should be addressed through our project in 2018-19 and beyond in order to better support BSC child care centers, and the children and families in their care.

- ❖ Pyramid Model buy-in and supports grew. Centers had more staff trained, including administrators and non-teaching staff. There was observable interest, for example, in learning about and developing relationships with individual families, or creating and teaching using environmental messaging (Tier 1). Also, staff made connections between PATHS (Tiers 1 & 2) and other components of BSC and behavioral consultation including tracking behaviors and collaborating on effective child specific strategies and plans (Tier 3).
- ❖ More documentation would be helpful (pre-post evaluations, logs, behavior charts) to accurately assess program fidelity (Pyramid Model and PATHS), as well as individual intervention progress.
- ❖ Due to the generosity of early funders, as well as requests from centers, Behavioral Supports for Children is expected to continue for the 2018-19 year. There will be some changes: the new grant focus folds in the bountiful research (and lens) that connects early social and emotional competencies to later positive academic and life outcomes; there is an expected decrease in funding that may place a focus on building center capacity; one of the centers—in a bittersweet move—is leaving BSC to become an implementation site as part of New York state's Pyramid Model Cohort 2. With five sites, we will, however, build on the successes of the past year, such as bolstering Pyramid Model practices and addressing areas identified for growth—such as increasing the number of TPOTs, and getting more documentation.

BSC Challenges and Plans to Address Them in 2018-19 and Beyond

- ❖ BSC is in a continuous progress position with regard to aligning and measuring teacher Pyramid Model best practice. While new ground was broken, “readiness” to use the TPOT to identify classroom strengths, challenges or red flags remained a barrier. This was in part due to directors' concerns about additional classroom observations. Additionally, teacher illness and scheduling issues were barriers. In 2018-19, all center directors—through the BSC Partnership Agreement—will use the Inventory of Practice to establish staff goals and monitor progress, and will support randomized pre and post TPOTs in at least one classroom

per center. Results will measure changes in Pyramid Model skills over time and across centers, and data be used to target coaching and training.

- ❖ The consultants' role needs to be expanded to promote Pyramid Model coaching practices that espouse teacher-identified small steps which are observable within a defined period of time and assessed for positive change. This method will facilitate sustained improvements over time. Implementation takes years and is a constantly evolving process for new and experienced center staff and leadership. The Inventory of Practices and the TPOT are integral to coaching supports and measuring growth and will be developed further in 2018-19.
- ❖ There was significant staff turnover. At one center, where retention is typically high, a teaching position was open until early spring. At another center, several key staff positions turned over. Early childhood center teaching and caregiving is not compensated well. When staff can secure better paid jobs, and/ or union positions through the Rochester City School District, despite loyalties to their centers, they move for economic stability. This reality is unlikely to change soon. Therefore, BSC needs to respond by developing specific plans with directors to help bridge/ flex supports for understaffed centers, and to orient new staff to basic Pyramid Model and PATHS practices.
- ❖ Directors agree that PATHS Preschool is an essential component of the BSC model. However, PATHS lessons and documentation decreased in 2017-18 over the previous year. This is likely attributed to a new BSC agreement that placed centers, using a PATHS Point Person (PPP) as responsible for the oversight and reporting out of PATHS dosage. Previously, BHCs met with teachers regarding PATHS and collected data. Based on the PATHS fidelity and sustainability model, oversight belongs in the center. To address reduced dosage, build center capacity and support fidelity, in 2018-19, center PPPs will meet bi-monthly with a BSC collegial group to discuss center-wide PATHS practices.
- ❖ The severity of children's behavior is often related to complex issues characterized by: the effects of extreme poverty such as housing instability or food scarcity; lack of a consistent parental or adult figure; mental health issues; drug or alcohol abuse; incarceration, violence inside or near the home; family immigration or refugee history; or even the ripple effects of Hurricane Maria. These are issues that cannot be solved through classroom behavioral strategies alone, but require a more comprehensive approach that responds to families' unique and vast needs. BSC is working to increase knowledge and collaboration community-wide regarding supports needed for families and children. However, at the center level, once staff understands the challenges or history, teachers can provide extended warmth and interest in that child. Consistent with trauma informed care and Pyramid Model best practice, when a child's relationship with adults improves, behavioral issues often lessen as well.
- ❖ Consultants are often approached in centers about concerns regarding younger children. Eventually, consultation should be offered to centers for infants and toddlers. Resources pending, we would expand BSC to include these children. Infant-Early Childhood Mental Health Consultation Credential and Endorsement is an expanding emphasis area nationwide. Our local Early Childhood Development Initiative (ECDI) Social-Emotional Committee is actively seeking trainings and services for the Rochester community. Service to children infant and toddlers, as well as their families and caregivers, is a long-term goal for BSC.

- ❖ Children with special needs often come to preschool but are not yet identified as having a disability. Additionally, even when identified, there are limited service providers (speech, OT, special education), and wait times to begin services can last for many months. Wait time has been exacerbated by the influx of three-year-olds needing evaluations or services. Going forward, it is important to increase awareness of potential developmental delays and begin referral processes earlier. It is also crucial to highlight for staff that many children who are suspected of having a developmental disability improve in engagement and behaviors when Pyramid Model tiers 1 and 2 supports are in place, regardless of whether additional services are indicated.
- ❖ In 2017-18, there were extended conversations across Rochester and New York State settings regarding the Pyramid Model, behavioral health, and when/ how/ if the field can intersect to support children who have been referred to, or are receiving special education services. BSC—at this point-- is not able to accommodate the requests to provide child-specific BHC for that cohort. However, in 2018-19, BSC consultants will continue to collaborate community-wide (with RCSD, BOCES, Society for the Protection and Care of Children, Mount Hope Family Center) to understand how/ when supports can be provided, and will be bringing BSC centers into those conversations.

Consultants' Perspectives and Reflections

While the Behavioral Health Consultation is known for observing behaviors, collecting child specific data, convening teams, and identifying strategies and resources, our first step as consultants is building a positive connection with teaching staff. The work of child care teachers and classroom paraprofessionals is high demand and low wage. Additional stress factors in as well-- especially for paraprofessionals whose backgrounds and economic challenges often reflect the families they serve. By actively listening, providing support, and suspending the BHC agenda, teaching staff becomes more comfortable and more likely to reveal their concerns, elicit our support, and work cooperatively to identify and follow through with strategies.

Administrators who encourage staff to assess, align and bolster Pyramid Model Tier 1 & 2 supports, and to seek administrative and/ or BHC assistance when needed, are likely to have teachers and teaching teams that feel understood and competent. In centers where administrators encourage “continuous progress”, are non-judgmental and personally invested in that process, individual and center-wide challenges and successes are more likely to be addressed or celebrated. In our observations, staff is then most likely to effectively translate Pyramid Model best practices and BHC strategies to new situations with children and families.

Teachers and paraprofessionals who invest up-front time developing relationships with every child and parent/guardian are more successful working collaboratively with a family when a concern arises. Teachers who connect well tend to be observant, positive, calm, give clear directions, and are more able to offer supports for children and families who need additional strategies/ resources/ referrals. At times, classroom paraprofessionals provide the bridge to communication and relationship building with parents/grandparents. This, in part, is because they are often from the same communities as the families represented in the classrooms.

Young families in the BSC centers face huge adversities. In addition to overarching poverty and trauma, family challenges include: incarceration; foster care and custody changes; homelessness/frequent moves; fire in the home; transportation; depression, addiction and other health problems; violence in the home and neighborhood; natural disasters; immigration; and language and literacy barriers. If the BHC first step with teachers is to build a connection, the first step with parents is to build trust. When parents feel safety and respect, they generally team, share ideas and try new strategies to support their child. They do what is reasonable, but they do it their own way; and that “way” needs to be respected. Pyramid Model research is clear, if you want to have a meaningful connection with the child, begin with the family.

Much of our learnings as consultants confirm what the Pyramid Model teaches: relationships—in so many forms—are key to supporting young children and families socially and emotionally.

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