

A PROGRAM EVALUATION: THERAPEUTIC PLAYGROUP
FOR PRESCHOOL-AGED CHILDREN WITH MENTAL HEALTH NEEDS

A Dissertation

Presented to

The College of Graduate and Professional Studies

Department of Communication Disorders and Counseling,

School and Educational Psychology

Indiana State University

Terre Haute, Indiana

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

by

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December 2009

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Keywords: program evaluation, mental health services, preschool children,
school readiness skills, coping skills

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ABSTRACT

The understanding of preschool children has been explored in the fields of developmental psychology and early childhood education. The field of school psychology has also increased interest in the assessment of the social and emotional functioning of preschool children (Martin, 1986). Currently, there are changes in national education policy and societal pressures for systematic, professional assessment and intervention with younger children (Executive Office of the President, 1990). In addition, focus has been placed on the incorporation of evidence-based practices into assessment and treatment (Tolan & Dodge, 2005). Mental health services, in particular, aim to address the social and emotional needs of children and families through assessment, effective intervention, and collaboration/consultation. Currently, research in preschool programs specifies the use of a developmental model to meet children's social-emotional needs, physical well-being, motor development, language and literacy development, cognition and general knowledge, and approach to learning (National Institute for Early Education Research, 2006). This study extends the literature on effective and comprehensive mental health programs for a preschool aged population by conducting a program evaluation on the effectiveness of a therapeutic playgroup model for providing mental health services to preschool aged children who exhibit social-emotional and behavioral problems due to family stress, abuse, neglect, and possible mental disorders of

children and their caregivers. This study utilizes a mixed method design which incorporates data from caregivers, playgroup teachers, child records, and participant-observers. Findings indicate the effectiveness of the Therapeutic Playgroup Program in meeting the behavioral needs of preschool children, as well as overall program goals and objectives. Teacher efficacy was directly linked to effective and efficient behavior and practices in providing mental health services to young children with challenging behaviors.

ACKNOWLEDGEMENTS

I would like to acknowledge the hard work and support of my committee members, Dr. Sperry, Dr. Olsen, and Dr. Roberts-Pittman, for helping me reach a lifelong goal. My inspiration for conducting this program evaluation was to bring to light the wonderful work of the Therapeutic Playgroup Program in moving beyond a traditional model of service delivery to reach an underserved population. Every day you bring smiles, laughter, and comfort to children and I am truly grateful to surround myself with such devoted and creative professionals. To my family, near and close, thank you for your steadfast love, support, and faith through these many arduous years. I am truly blessed to have a strong network to lean on and at times carry me through this journey, thank you to my patient husband, family, friends, and colleagues. Lastly, this is dedicated to my dear friend, Dea Perry, who walked with me during the beginning of this process and now watches from above; you remain in my heart forever.

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CHAPTER 1

INTRODUCTION

According to the National Institute for Early Education Research (NIEER, 2006), nearly 942,766 children in 38 states attended state-funded preschool programs during 2006, an increase of 45,000 children over the previous year. Approximately two-thirds of these children are served in public schools, and one-third are served in other settings such as private child care and Head Start (NIEER). Currently, the state of Indiana provides federal-and state-funded preschool programs, such as special education preschool services, Head Start and Early Head Start Programs, private-and public-funded childcare, and mental health services (NIEER).

Interest in the assessment, intervention, and programming for young children has peaked following societal changes and federal, state, and local mandates and policies. Although parents endeavor to foster their children's growth and development in the home, state and local agencies often bear primary responsibility for classroom-based education in the United States. Programs that serve young children operate under a variety of names and auspices, including the federal Head Start program, as well as privately and publicly funded child care and health care programs. Similarly, mental health agencies are being called to provide early prevention and intervention for children and families through a wide range of programs and mental health services.

Need for Services

Recent studies indicate an alarmingly high prevalence rate of children who need mental health services, with approximately 1 in 5 children having a diagnosable mental disorder and 1 in 10 youths having a serious emotional or behavioral disorder that is acute and causes a substantial impairment in functioning (Friedman, Katz-Leavy, Manderscheid, & Sondheimer, 1996). The National Advisory Mental Health Council, Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment (2001) concluded that “no other illnesses damage so many children so seriously” (p. 1). Edmands, Hoff, Kaylor, Mower, and Sorrell (1999) estimated that 12% of American children have a mental health disorder, yet only 20% of these children receive treatment.

Today, there is more universal recognition that we face an epidemic of children’s mental health problems, and an awareness that an action plan needs to be developed to connect children and families with the appropriate services. The most effective way to achieve this goal is to redefine and restructure mental health services in this country. Currently, systems of care often function as independent entities, which may increase the redundancy of services and lack of communication between providers, community agencies, and families. In order for effective treatment to occur, children’s mental health services must incorporate principles of cooperation and coordination. Changes are occurring throughout the country, within and among systems, to bridge these gaps in children’s mental health services.

Programs

Challenges linked to language barriers, poverty, and discrimination have been ascribed to inequalities in mental health services (United States Department of Health and

Human Services, 2001). Findings from a study conducted by Kataoka, Zhang, and Wells (2000) revealed high rates of unmet mental health needs, especially with uninsured and Latino populations. Significant in this study was the low rate of mental health services among preschool children. Overall, poor service utilization can lead to negative health outcomes and place the safety of families, communities, and society at risk.

A number of factors contribute to children's risk of abuse or mistreatment, for example living in poverty adds to the stress of everyday life (Duncan & Brooks-Gunn, 2000). A second factor which can place children at risk is a chaotic, unstructured, and crowded living environment, where daily life is seen as unpredictable (Kail, 2007). Therefore, children may experience feelings of helplessness and lack of control, which are linked with school failure and increased mental health problems (Bradley & Corwyn, 2002; Evans, Gonnella, Marcynyszyn, Gentile, & Salpekar, 2005). A third factor where abuse is likely to occur is social isolation, where children have limited contact with adults who can protect or help them in challenging situations (Coulton, Korbin, & Su, 1999). Social isolation can also separate the parents from coping skills and a social support network which can assist them in coping with life stresses and decrease the risk of child abuse (Coulton et al.).

Fourth, parents who have experienced abuse themselves have higher rates of perpetuating abuse practices with their children (Cicchetti & Toth, 2006). The mistreatment of children often stems from ineffective parenting techniques (e.g., inconsistent discipline), unrealistic expectations of child behaviors, and feeling they cannot manage child behaviors (Kail, 2007). In families where abuse occurs, interactions between caregivers and children are often unpredictable, unsatisfying, and unsupportive

for both parties and contribute to a family's dysfunction. The potential for abuse along with the risk of out-of-home placement often elicit the need for mental health services.

Public and Private Mental Health Care

The 2001 Surgeon General's National Action Agenda for Children's Mental Health released a report indicating that promotion of mental health in children and treatment of mental disorders should be major public health goals (United States Department of Health and Human Services, 2001). To achieve these goals, the Surgeon General formed guiding principles which include: (a) the promotion and recognition of mental health as an vital part of child health; (b) the integration of person-centered mental health services into all systems that serve children, youth and families; (c) engagement of families and utilization of child and youth perspectives in mental health care planning and development; and (d) the creation and enhancement of public and private infrastructures to support these efforts.

One of the goals specified within the Surgeon General's action plan (United States Department of Health and Human Services, 2001) requires increased access to and coordination of quality mental health services. The action plan encourages the promotion of a "common language" which encompasses adaptive functioning and accounts for variation in cultural and family backgrounds when describing mental health needs and services. The use of a common language is a key component in facilitating service delivery across systems. Additionally, the action plan aims to create a strong worldwide system of measurement across all service areas that is culturally competent, age-appropriate, and gender-sensitive. This universal system would assist in identifying children with special needs, who may require mental health services, monitor progress

during a child's treatment, and measure treatment outcomes. Many mental health programs and service providers have begun the process of adapting and integrating these changes into current existing systems (United States Department of Health and Human Services).

Emerging neuroscience research illustrates the need for early recognition, assessment, and intervention to prevent the worsening of mental health symptoms. Environment factors appear to have an impact on brain development and early psychosocial behavior (Shonkoff & Phillips, 2000). There is increasing data on the effectiveness of mental health services and supports for young children that focuses on the parent (Olds et al., 1998), the child (Cowen et al., 1996), or the parent-child interaction (Eyberg et al., 2001). Group-based (Greenberg, Domitrovich, & Bumbarger, 1999) and multi-component interventions (Ramey & Ramey, 1998) also provide empirical support for the success of mental health intervention. Mental health consultation for early childhood programs has also shown promising results (Donahue, 2002).

The improvement of quality and provision of mental health services to children and families entails a commitment to the competency training of professionals with the priorities outlined in the Surgeon General Report on Mental Health (Power, Manz, & Leff, 2003). The current study focuses on mental health services within a private, not-for-profit, corporation which provides mental health services to approximately 10,000 consumers annually, half of which are children. The full continuum of mental health services within this mental health agency often includes prenatal programs, and services for infants, toddlers, children, adolescents, adults and families. Mental health coverage is typically funded through insurance companies (e.g., Anthem/Blue Cross Blue Shield), managed

care plans (e.g., Medicaid programs which is state and federal funding for low income and disadvantaged people such as children and pregnant females), self-pay, sliding fee services, funded grant programs, and contracts with the local school and state agencies (e.g., school-based counseling and the Department of Child Service [DCS]).

Specific mental health services which are provided to children who may require more extensive services (e.g., more than 3 contacts per week) are defined as day treatment programs (e.g., Partial Hospitalization Programs [PHP]) and are funded on both a federal and state level. The current program under evaluation, Therapeutic Playgroup Program, was developed and implemented as a day treatment program for children ages 3-5 years old who exhibit significant mental health issues which impact multiple areas of life such as social and emotional functioning and impair developmental growth and relationships with others.

The current mental health agency examined in this study is licensed as a community mental health center and managed care provider for its state by the state Division of Mental Health and Addiction (DMHA). In congruence with a majority of mental health agencies in the country, this mental health organization is evaluated by accrediting agencies as well as state and federal bodies. For example, the agency under evaluation in this study has been accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). Organizations that have participated in an accreditation survey demonstrate a high degree of internal quality, greater involvement in person-centered services, increased cohesion among staff members at all levels in the organization, and enhanced communication and utilization of services within the community. However, there is a gap in mental health agencies, accrediting agencies, and

federal and state bodies in conducting thorough program evaluations to determine the effectiveness of specific programs (e.g., Therapeutic Playgroup) in relation to direct behavior change and overall program goals.

Preschool Programs

Preschool and school readiness programs target at-risk children and families. In terms of family and living environments, core indicators of at-risk populations include a mother's age when she gave birth (between the ages of 15-17 years), her education level (less than a 12th grade education), indication of child mistreatment (between birth and age 6 years), and involvement with the foster care system (Kail, 2007). Children who experience these at-risk factors are more likely to encounter health related problems, behavior difficulties, and have poor language and literacy skills (Kail). Additionally, children who have been abused or neglected are more likely to suffer emotional and cognitive problems (Kail). Children who do not have safe and stable home environments, as a result of abuse and neglect, experience negative outcomes such as poor academic performance and retention, juvenile delinquency, and teenage pregnancy (Kail).

In today's society, specific changes are prompting systematic demands for effective preschool programs. Martin (1986) indicated that increases in working mothers and caregivers have resulted in children spending greater amounts of time in out-of-home child care settings, such as preschools or daycares. Due to adjustment issues children may experience during this transition, many parents also seek professional services to gain knowledge about child development, parent-child interactions, and child pathology (Kail, 2007). This knowledge may lead a parent to compare their child to same-age peers or assess the needs of their child on a readiness scale. With the cost of mental health services

increasing and fewer resources available, many other professionals and educators are being asked to focus on prevention efforts.

The fields of psychology and education have increasingly targeted the development and evaluation of early intervention programs for young children (Zigler & Muenchow, 1992). Although the definition of early intervention varies, the basic premise incorporates developmental growth in cognitive, academic, adaptive, language, motor, social-emotional, and nutritional domains (Guralnick, 1997). Early intervention programs also concentrate on improving parent-child interactions by facilitating positive interactional styles, increasing parent coping skills, and overall family well-being. The intensity, frequency, and duration of early intervention services can vary (Casto & White, 1985).

Meta-analyses of early intervention programs have shown significant empirical evidence in support of their efficacy and effectiveness (e.g., Casto & Mastropieri, 1986; Casto & White, 1985; Shonkoff & Hauser-Cram, 1987). Therefore, research on early intervention has shifted to the conditions which promote effectiveness within these programs (Dunst & Snyder, 1986; Guralnick, 1988; Innocenti & White, 1993; Meisels, 1992). This shift in research focus has forced a re-conceptualization of early intervention to include multi-faceted and dynamic processes (Meisels).

Head Start is one of the most widely known preschool programs that provide services to low-income, diverse, and at-risk children. The Head Start program is overseen by the Head Start Bureau within the Administration for Children and Families (ACF) in the Department of Health and Human Services (DHHS). Since 1965, Head Start has offered preschool education and other services to young children from impoverished

families and represents the federal government's largest commitment to preschool education. In 2005-06, the government spent 6.8 billion dollars to serve 11% of the nation's 4-year-olds and 7% of the nation's 3-year-olds, which totaled 721,289 children (NIEER, 2006). Head Start programs typically operate for a minimum of 3.5 hours each day, but recently a larger number of children have enrolled in full-day services. The number of children served in this program is less than half of the eligible population and highlights the gap in services to disadvantaged children.

The mission statement of Head Start specifies, "Head Start is a national program that promotes school readiness by enhancing the social and cognitive development of children through the provision of educational, health, nutritional, social, and other services to enrolled children and families" (United States Department of Health and Human Services, 2002, "Head Start", para.1). The Head Start program provides public and private grants to non- and for-profit agencies to offer comprehensive child development services to impoverished children and families (United States Department of Health and Human Services). The program's focus is to increase readiness skills in preschoolers in order to cultivate success when they enter school. Parent involvement is a large part of the program, including home and school visits and active participation (United States Department of Health and Human Services).

The domains, elements, and indicators developed by the Head Start program direct local agencies in selecting and modifying tools for curriculum, intervention, and assessment. Child progress is assessed through multiple data sources including teacher and parent reports, child samples, home visits, and direct observations. Head Start follows nine indicators of child development including: (a) language development (listening and

understanding, speaking, and communicating), (b) literacy (phonological awareness, book knowledge and appreciation, print awareness and concepts, early writing, and alphabet knowledge), (c) mathematics, (d) science, (e) creative arts, (f) social and emotional health (self-concept, self-control, cooperation, social relationships, and knowledge of families and communities), (g) approach to learning, (h) physical health, and (i) development (United States Department of Health and Human Services, 2002).

Since the establishment of the Head Start program, the program has supported social-emotional development and mental health in young children. The combined goal of developing a child who is socially competent and ready for school was of primary concern to the Head Start program (United States Department of Health and Human Services, 2002). Head Start has been a groundbreaking leader in recognizing the barriers that stand in the way of success and growth for low-income children and their families. Therefore, the mental health needs of children are addressed on a continuum of services ranging from interventions designed to foster self-confidence and self-worth to increasing coping skills to manage social-economic disadvantages, disorganization, abuse, and family disruptions. Additionally, interventions are also designed to address children with disabilities and health challenges (United States Department of Health and Human Services).

The negative impacts of abuse, neglect, and violence are undeniable. Therefore, for children from such homes, preschool programs can help facilitate their self-esteem, emotional regulation, and social competence. Social experiences with non-abusive peers and adults are integral to increasing respect for others and treating others in a cooperative manner. The Head Start program has been a strong model for effective preschool services

that integrate child development, best educational practices, and collaboration between home, school, community, and social services agencies.

Curricula

Definition of Preschooler

The current program under study serves a preschool-aged population. Therefore, it is imperative to examine the developmental functioning of this subset of young children. Preschoolers are commonly referred to as children aged three to five years old who have not begun their formal schooling. According to Piaget (as cited in Kail, 2007), preschool children slowly become skilled at using familiar symbols, such as language, gestures, and representations. For example, a child will understand the word carrot although a carrot may not be in sight. More complex manipulation of symbols may be too difficult for preschoolers such as the concept of conservation, which is the ability to understand what stays the same and what changes in an object after it has shifted aesthetically (Kail).

Within the socio-emotional domain, preoperational children have trouble shifting their own ideas and feelings and accepting another's perspectives, often referred to as *egocentrism* (Kail, 2007). They also tend to focus only on one piece of a problem and ignore other equally significant parts. Piaget's term for this is *centration* (Kail). At this age children should begin identifying basic and complex feelings, such as happy, mad, scared, and sad (Draghi-Lorenz, Reddy & Costall, 2001). In addition, preschool children begin to develop ways to self-regulate emotions and start to develop cognitive strategies that correspond with particular settings. When children have difficulty with emotional regulation they tend to have poor adjustment and problems interacting with others (Eisenberg & Morris, 2002; Eisenberg et al., 2005).

During the preschool years, self-esteem emerges and most children have a positive outlook on themselves based on how others see them and their own self-worth (Harter & Pike, 1984). However, low self-esteem can be linked to peer problems (Verschueren, Buyck, & Marcoen, 2001), symptoms associated with depression (Garber, Robinson & Valentiner, 1997), involvement in aggressive and bullying behavior (Donnellan, Trzesniewski, Robins, Moffitt, & Caspi, 2005), and poor school performance (Marsh & Yeung, 1997).

Peer interaction is another important factor to examine in preschool children since these years are often underscored by an increased awareness and interaction with the world around them. Children begin to build authentic relationships based on different forms of play around the age of three. Parten (1932) was an early researcher of children's social interactions during play based activities. Parten found that play is not hierarchical and children may engage in any type of play depending on the situation. Parten noted through her research with 2- to 5-year-olds, participation in the most social types of groups occurs most frequently among the older children" (p. 259).

Parten's (1932) six stages of play consist of unoccupied play, onlooker behavior, solitary independent play, parallel play, associative play, and cooperative play. In unoccupied play children are not directly involved with the play interaction but observe things that capture and maintain their interest (Parten). During onlooker play, children passively observe or converse briefly with other children who are engaged in play; however, they do not show comfort or interest in making direct contact (Parten). Solitary independent play involves children playing by themselves, although they may engage in the same location they rarely share toys or play items (Parten).

In parallel play, children remain engrossed in their own activity, typically next to another child; they sometimes will share toys but maintain independence (Parten, 1932). Associative play is defined as when children share play toys and converse with each other, but do not bring together play objects or interests (Parten). Finally, during cooperative play children may coordinate themselves with others in specific goals or interests (e.g., to assign the roles of doctor, nurse, and sick person while playing hospital) (Parten). Play enriches children's thinking and creates opportunities to engage in invention, reasoning, social problem solving, and fosters conflict resolution skills (Parten).

During the preschool years, cooperative play often takes the form of make-believe such as telephone conversations with imaginary friends or pretend tea parties. Make-believe play promotes the development of cognitive processes and correlates with advancement in language, reasoning, and memory (Bergen & Mauer, 2000). Therefore, the use of play in preschool programs and assessment shows adherence to the knowledge and best practices of child development.

Curriculum is an illustration of a program's goals and framework for decision making processes. At each stage of development, there are significant aspects of healthy growth and development of young children that should be considered. Therefore, an effective curriculum for preschool aged children should incorporate aspects of child development and best practices, individualizing for each child's needs, and adhering to effective teaching strategies. Curriculum planning should also include an aspect of reflection and measurement based on program goals, teacher self efficacy, student data, and parent feedback.

Creative Curriculum

The Creative Curriculum for Early Childhood, utilized by Head Start, builds on what educators understand about how preschool children learn at the stage that Erikson calls *initiative* and what Piaget terms *preoperational learning* (Taylor, 2001). This framework influences the development of the program's philosophy, goals and objectives. It also provides organization and meaning to the role of the teacher and parent in a child's learning within the home and classroom settings. With the establishment of these building blocks, the classroom can transform into a laboratory where children can investigate, discover, and communicate. In line with the Head Start philosophy, the Creative Curriculum supports teachers to integrate elements of their community, contributions from families, and individualized child needs into the program (Taylor).

The Creative Curriculum is employed by the Head Start program as a curriculum-based system to evaluate children birth through pre-kindergarten and joins together assessment and reporting, parent communication, and program planning (Taylor, 2001). The Creative Curriculum Developmental Continuum for Infants, Toddlers & Twos and for ages 3–5 form the basis of the Creative Curriculum. Within this curriculum system, teachers construct and store a digital portfolio of a child's work. (i.e., photographs, work samples, and audio/visual clips). The teachers are trained to use planning tools to generate integrated lesson plans and children can be grouped together by developmental levels. Excellence in early childhood programs is upheld by providing quality curriculum resources, training programs, parenting tools, and staff development services (Taylor).

Incredible Years

Webster-Stratton and Reid (2004) reviewed an evidence-based model for teaching young children skills directly related to school success, such as emotional literacy, friendship and communication skills, empathy or perspective taking, anger management, and interpersonal problem-solving. The article described a classroom-based prevention program designed to improve children's social and emotional competence, increase academic performance, and decrease problem behaviors. The Incredible Years Dinosaur Social Skills and Problem Solving Child Training Program was first published in 1989 (Webster-Stratton, 1990) and targeted interventions for children diagnosed with Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD). Research studies have shown this program to be effective in increasing pro-social behavior and positive conflict resolution skills (Webster-Stratton & Hammond, 1997).

The goal of this classroom-based prevention program was to improve the social competence of children from economically disadvantaged kindergarten classrooms as well as within the Head Start program (Webster-Stratton, 1990). The content and objectives of the Incredible Years child training program (e.g., Dina Dinosaur Social Skills and Problem Solving Child Training Program [Webster-Stratton]) includes the following curriculum and lesson plans: (a) Dina introduces dinosaur school (e.g., rule-making, rewards, and consequences of behaviors, and building friendships), (b) doing your best detective work (e.g., listening and waiting, concentrating, checking, and cooperating), (c) Detective Wally teaches problem-solving steps (e.g., identifying problems, finding solutions and thinking of consequences), (d) Tiny Turtle teaches anger management (e.g., problem solving, anger control), (e) Molly Manners teaches how to be friendly (e.g., helping, sharing, using

teamwork at home and school), and (f) Molly explains how to talk with friends (e.g., initiation of play, conversation and friendship skills, and assertiveness).

Preliminary analysis of this program has shown significant differences in social contact, authority acceptance, and aggressive behavior across groups (Webster-Stratton & Reid, 2004). The intervention classrooms exhibited greater school readiness scores and significantly more pro-social responses to conflict situations (Webster-Stratton & Reid). The Incredible Years is an evidence-based, comprehensive program that fosters young children's social and emotional competency through specific training programs for children, teachers, and parents (Webster-Stratton, Reid, & Hammond, 2001). This is one example of evidence-based mental health treatment for young children that has shown positive social and academic outcomes for children and families.

Peacemaking Skills Curriculum

The specific program under study utilizes a classroom-tested, grade-level specific curriculum aimed at addressing aggressive and violent behaviors which may appear in the population being served. This curriculum package is purchased through the Peace Education Foundation (PEF, 1980), a non-profit educational organization. The purpose of this organization is to educate children and adults by providing educational materials and training in nonviolent conflict resolution skills and to promote peacemaking skills in homes, schools and communities. The program being reviewed in this study incorporates the pre-kindergarten and kindergarten level of peacemaking skills for children through PEF's curriculum "Peacemaking Skills Series." The exercises provided teach listening and communication skills, explore emotions, and stress cooperation and cultural tolerance. The I-Care Rules introduce children to the PEF's conflict resolution model (e.g., We listen to

each other, hands are for helping not hurting, we use I-care language, we care about each other's feelings, and we are responsible for what we say and do). Each rule has its own component taught over five days and lessons are reinforced through additional books and activities such as songs, games, and activities (PEF).

Play Therapy

The use of assessment measures with young children has included interviews, behavior observations, rating scales, and associative techniques. Associative techniques have allowed psychologists to examine the correlation between the stimulus and a person's memories, attitudes, experiences, imagination, and feelings (Yawkey & Pellegrini, 1984). Due to restricted verbal and writing skills of young children, play therapy perhaps shows the greatest potential as an assessment tool. In addition, play appears naturally among children. As the literature on play grows (Yawkey & Pellegrini) it has become an avenue along which to observe the type of play children choose to engage in (exploration, parallel play, and concentrated play), the uses of objects during play (organization, feelings expressed), and children's interaction with the examiner, teachers, or peers during play (help seeking, aggression, inhibited versus uninhibited play).

Play can be an age-appropriate and developmentally powerful tool with which young children communicate and express feelings and experiences, reveal hopes and wishes, explore relationships, and show awareness of their world (Landreth, 2002). Play therapy is based on the assumption that play is a natural avenue of expression for children and can take the form of directive or non-directive (Axline, 1947). Play therapy may be directive if the professional guides and interprets the child through chosen play activities

(Axline). Another approach is non-directive, when the child leads the professional, using their own problem solving skills to create a path that is directly their own (Axline). In play therapy, children create their emotional and symbolic world, using toys and objects as their language. Play therapy often services to provide children with tools to express their private world safely and with a feeling of comfort. For example, toys may represent transference of children's feelings, fantasies, and experiences (Axline).

During play therapy children may develop a sense of security in which they can disconnect from a traumatic experience and attempt to change or reverse the ending. Play therapy activities, with a skilled or trained professional, can assist children in moving toward an acceptable resolution and increase adjustment and coping skills, while still maintaining a safe distance from the traumatic event (Axline, 1947). Play therapy provides a way for children to express and communicate their thoughts and feelings adhering to developmental principles. Therefore, skill in using play therapy is an essential tool for mental health providers and programs which provide services to young children.

Limit setting is a fundamental part of the play therapy process (Landreth, 2002) and can assist children in increasing responsibility, compliance and self control as well as build and strengthen the therapeutic relationship. Limits and boundaries within play therapy also provide children with a sense of value, acceptance, and emotional security (Landreth). A well-defined structure during play therapy offers predictability and stability for children, especially those who have limited structured home environments (Landreth).

Due to the small sample size in many psychotherapy research studies, including those on play therapy, generalizing results can be difficult (Ray, Bratton, Rhine, & Jones, 2001). Play therapy research has often used meta-analysis of existing research to increase

sample size and address the effectiveness of interventions. Meta-analytic methods involve combining individual research results to produce an overall effect size, thereby determining the efficacy of the model intervention.

In reviewing the research on play therapy, there are two meta-analytic studies which have evaluated effective outcomes in controlled studies (e.g., LeBlanc & Ritchie 1999; Ray et al., 2001). LeBlanc and Ritchie's meta-analysis included 42 experimental studies, conducted from 1947 to 1997. Ray et al. also included a meta-analysis which analyzed 94 experimental studies from 1940 to 2000. These two meta-analytic studies discovered moderate to large positive outcome effects of play therapy interventions (Ray et al.). These play therapy interventions were found to be effective for children regardless of gender and age studied (3 to 16 years old), across treatment modalities (group and individual), referred versus non-referred populations, and treatment orientations (Ray et al.)

The need to expand service delivery beyond individual and group therapy has set the stage for many counselors, psychologists, school staff, and mental health professionals discover innovative ways to reach young children at risk. Teachers and education professionals working with preschool aged children may be in an excellent position to provide direct intervention, due to frequent contact with children at risk and the opportunity to integrate play in the classroom setting.

Coping Skills

Children in today's society encounter stressful events in their everyday lives. This can lead to emotional and behavioral manifestations, such as poor sleep, anger outbursts, somatic complaints, and heightened arousal (Chandler, 1987). When children lack the

skills to communicate their thoughts and feelings, emotional and behavioral problems may occur. Stress is a life event or situation that causes imbalance in an individual's life due to "a state of emotional tension arising from unmet needs or environmental threats"

(Chandler, p. 4). A maladaptive reaction to stress arises when the demands of the stressors surpasses a person's individual coping threshold (Chandler). Stress then begins to impact daily life functioning as evidenced by impairments in behavior, communication, social relationships, and daily living skills.

Small amounts of stress, as experienced by life transitions and natural learning curves (i.e., starting school and sleeping by yourself) are necessary to foster learning, growth, and development. However, problems begin when ordinary stressors place too much pressure on an already overwhelmed coping system (Chandler, 1987). There are a number of factors that impact and heighten children's stress levels, such as violence in the home or community, divorce, abuse/neglect, and experiencing loss/grief (Chandler).

The most frequent indicators of stress in children are the presence of behavior changes such as regression (Chandler). Preschool aged children may react differently; some may exhibit irritability, hyperactivity, withdrawal, hostility, anger, or trouble interacting with others (Chandler). Others may regress to infantile behaviors such as toileting accidents, thumb sucking, or separation anxiety (Chandler). Teachers and classrooms can offer stability, safety, and security to children experiencing stress in their environment by creating a low-stress classroom, teaching children a feeling vocabulary, reducing ambiguity, and the direct instruction and modeling of coping skills (Chandler).

Children's coping skills are as varied as their reactions to stress, some may cry or tantrum, others may act out at the world around them, while others still may retreat and

hide from negative situations. Resiliency in children, the ability to recover from crisis and stress, has been found to occur in compassionate and encouraging environments where children can develop a wide range of coping strategies (Rutter, 1987; Werner, 1989).

Resiliency theory suggests that opportunities to interact with supportive, caring adults may have substantial worth for children who have lacked the experience of a nurturing parental relationship (Rutter; Werner).

Lazarus and Folkman (1984) define coping as the “. . . constant changing cognitive and behavioral efforts people make to manage external or internal demands that are appraised as taxing or exceeding the resources of that person” (p. 141). Children who create an extensive array of strategies in their “toolbox” can apply them as each situation demands (Compas, 1987; Ryan-Wenger, 1992). If a stressful situation can be changed and controlled through a child’s behavior choices they learn the usefulness of adaptive, problem solving skills (Compas). However, if the situation appears to be beyond the child’s control, such as a death or divorce, then cognitive strategies may help the child to resume and improve daily life functioning (Compas). Emotion-focused strategies which include securing support from others, reinterpreting the situation in a more positive light, and shifting attention away from the problem may also be useful in situations out of a person’s behavioral control (Compas). Play, imagination, and physical activity are also important forms of coping for young children.

Evidence-Based Intervention

A meta-analysis of 34 studies conducted between 1970 and 2000 examined the effectiveness of preschool programs for children who did not exhibit mental health or developmental problems (Nelson, Westhues, & MacLeod, 2003). Selection for this meta-

analysis required individual studies to have targeted interventions focused on the promotion of positive child/parent relationships, calculated effect sizes, reported useful outcomes measures, applied a comparison group design, and the study must have begun during the preschool years. Program components within these studies most frequently involved home visitation (71%), parent training (68%), preschool education (68%), and included three or more components. For children within these studies, 65% of programs lasted longer than one year and the intensity was much greater for children compared to the parents, with 56% having more than 300 sessions for children but only 50% having more than 12 sessions for parents. In over half of the programs, services targeted African-American children and families (Nelson et al.).

The meta-analysis study found that preschool programs which included an educational component, involved more than 300 sessions, and lasted longer than one year promoted greater improvement in children's cognitive development (Nelson et al., 2003). The encouraging results also extended into the kindergarten through eighth grade level, showing positive impact on social-emotional behavior when programs lasted longer than one year (Nelson et al.). If they held more than 300 sessions they showed improved parent and family wellness (Nelson et al.). Better outcomes were found in programs that focused primarily on African-American children and families; however, compared to other ethnic groups (only 33%), 74% of African American children participated in more than 300 sessions (Nelson et al.).

Overall, preschool programs were determined to have positive effects on family wellness and children's social, emotional, and cognitive functioning, which lasted into primary and secondary grades (Nelson et al., 2003). The programs which incorporated a

direct teaching piece had a greater impact on children's cognitive skills than programs which were parent-centered without a direct teaching component (Nelson et al.).

Additionally, the duration and intensity of programs were associated with higher outcomes (Nelson et al.)

Family and Child Experiences Survey (FACES)

The Head Start Family and Child Experiences Survey is a longitudinal study which involved three nationally representative cohorts (1997, 2000, and 2003) and provided data regarding the knowledge and skills that children possess as they began and continued in the Head Start program (United States Department of Health & Human Services, 2000).

The FACES study also provided information on the quality and variation among and between Head Start classrooms as well as details regarding the correlation between program, classroom, and family/parent characteristics and child outcomes (United States Department of Health & Human Services)

A report released from the United States Department of Health and Human Services (2000) examined the data from the FACES 2000 sample (*Head Start FACES 2000: A Whole-Child Perspective on Program Performance; Fourth Progress Report*). The perceived outcome for children participating in Head Start was the development of school readiness skills which was assessed through child records, parent and teacher interviews, and classroom observations. School readiness skills were defined by the Head Start program as: (a) boosting a child's growth and development, (b) supporting families as they nurture their child, (c) providing educational, health, and nutritional services, (d) linkage to community resources, and (e) ensuring parent involvement in decision making (United States Department of Health & Human Services).

Important to the current study are findings that children who exhibited higher levels of problem behaviors and greater social skills deficits showed stronger gains in overall cooperative classroom behavior than children who began with lower social skills deficits and average or lower levels of unfavorable behaviors (United States Department of Health & Human Services, 2000). Based on this study, active parent participation in the Head Start program was associated with higher reports of emergent literacy skills and negatively associated with problem behaviors such as aggression and hyperactivity (United States Department of Health & Human Services).

The need for continued program evaluation is necessary to evaluate the outcomes, feasibility, and acceptability of intervention and prevention strategies, as well as to strengthen efforts to disseminate effective practices to the community as a whole. A prolific amount of research exists on the quality and effectiveness of the Head Start model for providing early intervention and school readiness skills to preschool-aged children. However, there is a gap in the evaluation of programs whose primary goal is to address the mental health needs of preschool aged children and families.

The National Association for the Education of Young Children (NAEYC)

Many of the techniques and tools used to assess the social and emotional functioning of preschool children have been developed within the past 20 years (Kelley & Surbeck, 1983). One of the factors that has impacted the systematic change and development of assessment measures related to the cognitive and social-emotional functioning of preschool children was the ratification of compensatory education in the 1960's (Kelley & Surbeck; Goodwin & Driscoll, 1980). The premise of these programs was to develop readiness skills prior to first grade within preschool and kindergarten

programs in order to reduce children's risk for academic and behavioral problems.

Therefore, the concept of school readiness skills became constructed as a set of guidelines and behaviors against which to assess and compare young children.

The focus on school readiness skills has been integrated into the National Education Goals. For example, the first goal, readiness for school, specifies that by the year 2000, all children in America will start school ready to learn (Executive Office of the President, 1990). This call instructs preschool programs to provide developmentally appropriate programming aimed directly at young children "at risk" who need a curriculum and learning environment appropriate to their capabilities and experiences (The National Association for the Education of Young Children [NAEYC], 1990). "Readiness" continues to remain a difficult concept to define, implement, and assess. However, it is frequently used to determine school entry, retention, and enrollment in different type of programs. Maxwell and Clifford (2006) described school readiness as the following:

School readiness involves more than just children. School readiness, in the broadest sense, is about children, families, early environments, schools, and communities. Children are not innately ready or not ready for school. Their skills and development are strongly influenced by their families and through their interactions with other people and environments before coming to school. (p. 42)

There is consensus, based on growing research that a child's measurement should be taken across five distinct but interrelated domains (NAEYC).

Physical well being and motor development. The physical well-being and motor development domain encompasses factors such as physical growth; health; conditions

which occur before, during and after birth; and disabilities. Additionally, fine and gross motor development is found important in order for children to progress in the areas of coordination, cognitive and social-emotional development, and academic achievement (NAEYC). The NAEYC emphasized that children who are in optimal health are more likely to engage in wide range of life experiences that promote growth and development.

Social and emotional development. The social and emotional development domain is defined by children's ability to get along with others and self-regulation. A positive school experience occurs when children have a strong sense of well-being which is developed through stable and nurturing relationships early in life. Children's healthy emotional development is linked to how children see themselves, empathize with others, and express their own feelings. Emotional health and competence allows children the opportunity to engage in learning and the foundation to form positive relationships with peers and teachers (NAEYC, 1990).

Language and literacy development. The language development and literacy domain refers to the development of children's communication skills such as expressive and receptive language skills (listening, speaking, and vocabulary). Emergent literacy pertains to the early connection of letters to sounds, writing development and recognition, and story sense. Language development is a key predictor of academic success and facilitates the development of cognitive skills and the understanding of how to interact with others effectively (NAEYC, 1990).

Cognition and general knowledge. Cognition and general knowledge applies to the development of thinking, reasoning, and problem-solving skills. It often reflects an array

of experiences, where children learn to observe, ask questions, and note similarities and differences in the world (NAEYC, 1990).

Approach to learning. Approach to learning refers to children's proclivity toward eagerness, curiosity, and persistence on given tasks. Children's school success depends not only on academic skills, but also on the learning styles, habits, and attitudes with which they approach learning (NAEYC, 1990).

National Center of Educational Outcomes (NCEO)

Based on the National Center of Educational Outcomes (NCEO) model (Ysseldyke & Thurlow, 1993), as adapted for community-based programs by the Children's Outcome Workgroup, the following are suggested indicators of positive program outcomes for children in the area of coping. The importance of developing a set of coping skills is crucial to helping children manage environmental, personal, and family stress and foster resiliency. The indicators include: percentage of children who deal appropriately with frustration and unfavorable events, percentage of children who express feelings and needs in socially acceptable ways, percentage of children whose behavior reflects an appropriate degree of self-control and responsibility, percentage of children who reflect knowledge and acceptance of consequences for behavior, percentage of children who have developed at least one positive coping strategy (such as conflict resolution or verbal expression), and percentage of children who have at least one positive adult-child relationship (Ysseldyke & Thurlow).

Teacher Self-Efficacy

The relationship which exists between teachers and students is increasing renowned as a strong factor that contributes to their social, emotional, and cognitive

development (Birch & Ladd, 1998). Child outcomes which have been associated with positive teacher-child relationships include competence in other relationships, such as with peers and future educators (Birch & Ladd). In addition, affirmative teacher-child relationships can function as a buffer against risk (Lynch & Cicchetti, 1992). Findings such as these show the importance of positive early teacher-child relationships on setting a child towards higher levels of school adjustment and competence.

According to Bandura's (1977) social cognitive theory, self-evaluations occur when people decipher and evaluate their own experiences and thought process, which leads to increased insight, awareness, and alterations of future behaviors. Teacher efficacy is linked to student achievement and classroom practices in general and special education (Tschannen-Moran, Woolfolk Hoy, & Hoy, 1998). However, a growing body of research supports Bandura's theory that teachers' self-efficacy beliefs are correlated to goal setting, persistence, resiliency when encountering obstacles, and overall investment in teaching (Tschannen-Moran et al.). The value of teacher self-reflection and self-efficacy is crucial in identifying strengths and challenges to effective service delivery and needed changes, and can be determined by narrative analysis, survey data, semi-structured interviews, and focus groups (Button, Pianta, Marvin, & Saft, 2000).

Relevance to School Psychology

Based on information from the National Association of School Psychologists (NASP, 2006), schools and social service systems can foster children's mental health in three tiers: (a) environmental – setting the foundation for a supportive school environment that promotes positive mental health traits, e.g., self-esteem, connectivity, respect and value for others; (b) programmatic—executing curriculum or programs which target a

specific skill set, e.g., peacemaking and social skills; and (c) individual—offering direct services to students with mental health needs, e.g., crisis intervention, learning disability, ADHD, depression, or grief/loss.

The creation of preschool special education programs was designed to meet the needs of children with diagnosed disabilities, ages 3 through 5, as required by the Individuals with Disabilities Education Act (IDEA), Public Law 105-17.P.L. 105-17 and was reauthorized in December of 2004. The reauthorization resulted in a new law, Individuals with Disabilities Education Improvement Act (IDEIA), Public Law 108-446, which took effect on July 1, 2005. It has several sections; however, important to the current study, Part B provides state grants to implement services to preschool and school-aged children. Part C provides grants to states for the development of statewide comprehensive systems of early intervention services for infants and toddlers with disabilities and their families (IDEIA, 2004).

Response to Intervention and Preschool Children

Along with federal and state changes, there has also been a shift in the field of school psychology towards the implementation of a response to intervention (RTI) model. The promise of an RTI model for preschool programs arises from the significant focus on prevention and data-based decision making. Prevention can be viewed in two dimensions, specific to challenging behaviors through classroom and home based interventions or long-term prevention of risk (Neilsen & McEvoy, 2004).

Challenging behaviors among a preschool population can be an early manifestation of social-emotional problems. Although some symptoms may dissipate as children age, others persist and can lead to serious emotional disturbance which may require positive

behavior interventions and supports. The prevalence of behavioral challenges in preschool children is estimated from 7 to 25%, with higher incidence within at-risk populations (Feil, Walker, Severson, & Ball, 2000; Qi & Kaiser, 2003). Challenging behaviors are often targeted within an RTI model and may refer to unsuitable, alarming, disturbing, or destructive behaviors that may be described as situational or episodic.

The primary techniques for RTI within a preschool population include applied behavior analysis and positive behavior support (Johnston, Foxx, Jacobson, Green, & Mulick, 2006). Applied behavior analysis imparts the foundation for change and implementation of valid individual and group interventions that expands a service delivery model (Baer, Wolf, & Risley, 1987). In addition, RTI integrates the cumulative intervention history of a child as a piece of evaluation data and allows for identification and service delivery decision making prior to psychiatric diagnosis or special education classification (Gresham, 1991, 2005).

As part of RTI goals, screening for social competence in preschool children will likely be comprehensive and related to instruction, curriculum, and screening methods (Brown, Odom, & Conroy, 2001). In addressing the challenging behaviors of preschool children, a review of functional records, problem-solving interviews, direct assessments of environmental variables and behaviors, teacher and parent reports, and intervention trials, provide a foundation of exploration (Barnett, Bell, & Carey, 1999). If challenging behaviors continue during prevention efforts, environment and contextual variables are evaluated in greater detail (Stichter & Conroy, 2005).

Evidence-Based Assessment

In order for RTI to be effective, intervention must be evidence-based and subscribe to best practices. Furthermore, there is an accumulation of evidence-based practices in the field of psychology; however, there is a lag in the dissemination and incorporation of evidence-based interventions (EBI) into clinical practice (Tolan & Dodge, 2005). Thus, an important step toward improving the effectiveness of services involves integrating specific evidence into the development, communication, and implementation of interventions. The use of evidenced-based practices allows children and families the ability to make an informed choice about their provider and services they receive. It also allows clinicians and educators an opportunity for professional development and improved outcomes to treatment.

In accord with evidence-based practices is the principle that innovations assist in the development of new interventions and recognition of promising clinical and educational practices. The underlying goals of EBI also include the implementation of evidence-based processes which are seen within an individualized, wraparound approach to service delivery utilized in many communities and mental health facilities (Chorpita, 2003; Friedman, 2003 as cited in Weisz, Sandler, Durlak, & Anton, 2005).

Role of School Psychologists

The role of school psychologists includes assisting children to gain academic, social, and behavioral competency through direct, appropriate interventions as well as collaboration with educators, families and other professionals to develop a strong home/school connection (NASP, 2006). School psychologists conduct their work in individual and group settings and develop teacher and parent trainings on effective

prevention and intervention strategies to manage behavior in the home, school, and community settings (NASP). Currently, the role of a school psychologist has also expanded to accommodate revisions in federal, state, and local policies and the implementation of those practices with children, families, and educators.

The concept of school readiness has received increased attention from schools, parents, teachers, and policy makers as part of revisions to federal and state laws. School psychologists have the opportunity to expand their role by forming a communication system, in which the school psychologist acts as the liaison between preschool and kindergarten teachers, and by assisting preschools in the creation and interpretation of a uniform developmental rating system for reporting children's strengths and weaknesses to families and school personnel (Carlton & Winsler, 1999).

The role of school psychologists also encompasses the title of mental health professionals who help children and youth overcome barriers to success in all aspects of life. School psychologists have also been presented the task and opportunity to bridge the gap between research and practice. As mentioned by Abrams, Flood, and Phelps (2006), school psychologists are a "natural bridge" (p. 499) between school, families, and medical personnel. The opportunity and need to incorporate mental health services along with early childhood prevention and intervention is vital to addressing the crises that children, schools, and families are presently facing.

Current Study

Given the congruence between school psychology's implementation of RTI and mental health's evidence-based assessment and intervention, program evaluations must be conducted in order to determine the response and effectiveness of current interventions for

a preschool population. Head Start has implemented program evaluations such as FACES, although there is a lag in mental health professions replicating similar outcome-based procedures.

The effectiveness of therapeutic playgroup programs for preschool aged children with mental health needs has not been explored extensively in the literature. Furthermore, research provides information on preschool assessment but fails to offer substantial knowledge for best practices in preschool program development and linkage to evidence-based practices (Tolan & Dodge, 2005). The connection between science and practice has been characterized as a four-stage process, including basic research, efficacy research, effectiveness research and dissemination activities (Dodge, 2001; National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment, 2001). This current study explores the effectiveness of interventions within a developmental preschool model, incorporating play therapy and coping skills to meet the mental health needs of preschool children.

For the purposes of the current study, research was designed to evaluate the effectiveness of the Therapeutic Playgroup program in regard to child outcome measures and the feasibility and acceptability of interventions provided within this program. This program evaluation was innovative since the goals of the Therapeutic Playgroup program differ from a traditional preschool model (e.g., Head Start) in that they are evidence based interventions to address the mental health needs of preschool aged children. The first goal of this study was to identify the training needs of mental health professionals (e.g., therapeutic playgroup staff) relative to the treatment of preschool aged children who are identified as at risk due to abuse, neglect, violence, and possible mental disorders. This

study explored teachers' perceptions of self-efficacy through semi-structured interviews and a focus group session. This piece also assisted in evaluating whether the current playgroup program met the identified goals as suggested by school readiness domains and the mental health delivery system.

The second goal of this study was to evaluate the treatment needs and outcome-based measures to determine the effectiveness of program interventions for the preschool aged children with mental health needs enrolled in the Therapeutic Playgroup program. In this study qualitative data-gathering and analysis methods were utilized. Data collected included teachers' descriptive statements regarding children's behavior within the playgroup program. Data was collected including children's diagnoses, treatment plans, weekly treatment reviews, and 90-day assessments.

Treatment plans included definitions of objective and measurable behaviors as well as estimates of their frequency and severity. Specific goals, objectives, and interventions provided information regarding the intervention needs of each child (i.e., coping skills, social skills). Weekly treatment reviews and the child's 90-day assessment documented teachers' accounts of interventions provided during the playgroup session and each child's response to intervention. Treatment plans, goals, objectives, and interventions as well as treatment notes and progress reviews are encapsulated utilizing a specific, measurable, achievable, reasonable, time-specific (SMART) approach (Raia, 2008). An Electronic Medical Record (EMR) as well as paper chart system provided documentation and measurement of treatment progress for children receiving mental health services and allowed for a continuum of services to occur. The EMR provided quick access to

comprehensive mental health data to increase communication between providers, referral sources, and outside agencies.

The third goal of the current study was to examine the perceptions of caregivers whose children participate in the Therapeutic Playgroup program on their children's treatment needs, how the program met these concerns, knowledge about program goals and treatment plan components, communication strengths and barriers, and effectiveness of monthly parent meetings. Caregivers were defined as parents, guardians, foster parents, or relatives. In the current study, individual interviews were conducted with playgroup teachers and caregivers, as well as an additional focus group with the playgroup teachers during a specified time frame of services provided (September 2007 to May 2009). The following research questions were investigated:

1. What is the impact of children's participation in the Therapeutic Playgroup program on their identified treatment and behavioral needs? (adapted from the National Center of Educational Outcomes (NCEO) model [Ysseldyke & Thurlow, 1993])
 - a. Percentage of children who deal appropriately with frustration.
 - b. Percentage of children who express feelings and needs in socially acceptable ways.
 - c. Percentage of children whose behavior reflects an appropriate degree of social control and responsibility.
 - d. Percentage of children whose behavior reflects knowledge and acceptance of the consequences of behavior.

- e. Percentage of children who have developed at least one positive coping strategy.
 - f. Percentage of children who engage in positive relationships with same-age peers and adults.
 - g. Percentage of children who comply with group rules and routine.
2. What are the perceptions of mental health providers (e.g., therapeutic playgroup staff) regarding their self-efficacy?
 - a. How do they view their role?
 - b. What behaviors and practices do they use to carry out their role?
 - c. What evidence is there that they inhabit this role efficiently and effectively?
 - d. What challenges are present that may require additional resources?
3. What are the perceptions of caregivers regarding the effectiveness of the program on behavior change in preschool aged children?
 - a. What was the identified need for their child?
 - b. How did the playgroup program meet that need?
 - c. Did the change generalize to home and community settings?
4. What are the perceptions of caregivers regarding the effectiveness of the Therapeutic Playgroup program's communication, home support, and monthly parent meetings?
 - a. Do caregivers perceive having a "voice" in treatment planning and evaluation?
 - b. Do caregivers perceive having knowledge about their child's goals?

- c. How do caregivers perceive information provided, who provides information, and is the information provided positive as well as concerns?
- d. How do caregivers view the impact of monthly parent meetings and trainings?
- e. How do caregivers view the effectiveness of additional services such as therapy, case management and medication management?
- f. What changes or concerns do caregivers have?

CHAPTER 2

METHOD

Research Setting

All of the participants in this study interacted in the context of the Therapeutic Playgroup program. This program is designed to serve three-to five-year-old children who have social, emotional, or behavioral problems. These behaviors may include but are not limited to: inattention or difficulty following directions; poor social interaction with peers; exhibition of destructive behaviors toward themselves, other people, or objects; emotional disturbance over minor incidents; difficulty expressing ideas and feelings verbally; and functioning below expectation for age or development. Children enrolled in this program may have also experienced abuse, neglect, violence, or removal from the home.

Children attend the Therapeutic Playgroup program four days a week for three hours per day. The children are placed into groups based on age into three classrooms: 3-year olds, 4-year-olds, and 5-year olds. Approximately 60 children participate in the program for a duration of six months or more. Group rules and routines provide a consistent structure for helping children understand limits and verbal and visual cues. A core curriculum based on child development principles (e.g., school readiness indicators), individual child treatment needs, and play therapy and coping skills interventions are implemented. Specifically, lesson plans utilize structured activities on a daily basis which

include gross motor activities such as free play or structured physical exercise, cognitive development such as solving puzzles, development of language such as reading and letter identification, nondirective play, and relaxation therapy. Additional services provided may include clinical assessment and developmental screening, transportation, speech therapy as needed, parent meetings and outings, individual and family therapy, case management, home visits, and referrals to community agencies (e.g., special education, Head Start).

The process of participation in the Therapeutic Playgroup program begins with an initial referral from outside community agencies (e.g., Department of Child Services [DCS], physicians, and other referral sources), or self (e.g., phone book or friends or family). The family and child are scheduled for an initial intake assessment with a mental health professional (e.g., licensed mental health counselor, therapist, social worker, or psychologist) where family background, developmental information, and data regarding social and emotional behavior are collected to formulate a clinical diagnostic impression (e.g., American Psychiatric Association Diagnostic Statistics Manual of Mental Health Disorders 4th Edition [DSM-IV], 1994) diagnoses on Axis I through Axis V and a treatment plan including problem statement(s), goal(s), objective(s), intervention(s), planned service(s), frequency and provider(s). At that time, the mental health professional may refer children to the Therapeutic Playgroup program if they are preschool aged (e.g., 3 to 5 years old of age and not attending elementary school) and exhibit impairment in daily functioning as a result of social skill deficits, behavioral or emotional problems, or communication or developmental delays.

Following this referral, playgroup staff assess the children and their families within the home context to gather additional assessment information and develop a Therapeutic

Playgroup treatment plan. Children are then assigned to a morning or afternoon block of programming, depending on the scheduling needs of the family and other services the children may be receiving (e.g., Head Start, special education preschool, and daycare). Most children enrolled in this program receive services for a duration of more than 6 months, depending on their needs and progress towards treatment goals. Monthly parent meetings are also provided to assist parents in increasing communication and collaboration with playgroup staff, parenting skills training, observing and interacting with children within the classroom, and providing opportunities for social connections between families.

Participants

Participants will be mental health professionals who worked from September 2007 through May 2009 for a non-profit mental health center within a regional behavioral health system located in the Midwest. The mental health professionals were employed through the division of Child and Adolescent Services as playgroup teachers in a Therapeutic Playgroup program for preschool aged children who need assistance in managing negative emotions and behaviors. Approximately four playgroup teachers, defined as bachelor's level educators, participated in this study. Their experience within this specific program varied from four months to ten years. The teachers also had a background in early childhood or teacher education. This program was supervised by a Qualified Mental Health Professional (QMHP) who provided direct supervision and consultation to playgroup staff on programming, intervention, and assessment.

The principal investigator also served as a participant in this study through her roles as a moderator and analyst. The researcher was a therapist within this mental health

facility, clinically supervising the Therapeutic Playgroup program as a qualified mental health provider (QMHP). The researcher had knowledge of all the playgroup teachers as well as had some degree of contact with the children and caregivers of this program on a formal or informal basis. The researcher used her previous experience working in this mental health facility for approximately three years, as well as expertise in school psychology to conduct a program evaluation on this specific playgroup program.

A random sampling of a minimum of 20 caregivers whose children ages 3 to 5 years old were enrolled in the playgroup program from September 2007 to May 2009 were participants in this study. It was anticipated that the children will be majority (60%) male and of diverse ethnicities. Diagnoses among the children likely included diagnoses of Attention Deficit Hyperactivity Disorder (ADHD), Disruptive Behavior Disorder Not Otherwise Specified (NOS), Abuse or Neglect of a Child, Autism or other Pervasive Development Disorders, Adjustment Disorders, Depressive Disorders, Anxiety Disorder, or Reactive Attachment Disorder (APA, 1994). Children participated in either a morning or afternoon session of the Therapeutic Playgroup program during the period of time between September 2007 and May 2009.

Materials

Demographic Questionnaire

Demographic information regarding the age of the children and their caregivers, their gender, race and ethnicity, income status of the family, and length of time in the playgroup program (see Appendix A) were collected through two means: caregiver reports during the individual interviews, and EMR and paper charts. Additionally, demographic

information regarding age, race and ethnicity, gender, years of experience and degree will be obtained from playgroup teachers (see Appendix B).

EMR and Paper Charts

From September 2007 through May 2009, a sample of 20 caregivers whose children received playgroup services over a period of no less than three months were identified. Weekly descriptive statements of children's response to intervention were recorded by playgroup teachers within the EMR system. These descriptive statements constituted one source of information about the child outcomes. Weekly staff notes from this term review children's responses to intervention and address teachers' plans for addressing additional treatment needs. A second source of information about the child outcomes and the teachers' goals came from analyses of children's treatment plans (why the children entered treatment, goals, and objectives) and responses to intervention that were provided in 90-day reviews completed by playgroup teachers and treatment staff.

Playgroup Teacher Interviews and Focus Group Questions

Another source of information on child outcomes, teachers' goals, and outcomes, and program outcomes was generated from individual interviews and a focus group with playgroup teachers. The interview schedule for playgroup teachers followed a semi-scheduled, open-ended format with Likert-scale follow up questions (see Appendix C). Additionally, a semi-scheduled, open-ended interview schedule was utilized for a follow-up focus group with playgroup staff (see Appendix D).

Caregiver Interview Questions

In order to examine the caregiver role in the playgroup program, effectiveness of parent meetings and overall child change, individual interviews were conducted with

selected caregivers. The interview schedule for caregivers followed a semi-scheduled, open-ended format with Likert-scale follow up questions (see Appendix E).

Research Design

Types of Program Evaluation

Program evaluations can include formal or informal methods and can be identified as formative or summative. A formative evaluation is useful in making program adjustments, such as exploring a program's strengths and weaknesses and determines overall success, failure, or needed improvements. A summative evaluation is useful in judging the worth of a program, typically at the end of the program's activities. Program evaluations can also be internal or external. An internal evaluation, which is reflected in the current study, are those conducted by employees of the program being examined, while external evaluations are conducted by individuals independent of the program under study.

The dominant approach to evaluation in the last century has been objectives-oriented. This approach determines how well the purpose of the program (objective) was met based on evidence collected. The basic purpose of this methodological design is to determine how well a program functions and to alter the program if a discrepancy is found between proposed outcomes and measured outcomes.

The current study utilized the Tylerian Evaluation Model, which was developed in the 1930's as a model to collect evidence on whether program objectives are accomplished. There are seven steps to evaluation as proposed by Tyler (1969). First, broad goals and objectives of the program being evaluated should be developed. For this study, the broad goals are gathered from existing literature and materials provided by the

playgroup such as handouts and brochures. The second step requires classifying these program objectives or goals; for example, a program for preschool aged children would encompass school readiness skills such as motor skill development, literacy, and concepts. However, additionally this specific program had social-emotional domains in order to meet the mental health needs of children and families as its primary focus.

Third, the Tylerian approach proposes that objectives be operationalized in behavioral terms. This fits nicely into the current design and data collection for this program due to the use of “common language” and treatment planning and evaluation processes which utilize specific, measurable, achievable, and time-specific (SMART [Raia, 2008]) terms to describe children’s behavior and progress. The next step in the evaluation is to identify situations in which objectives are accomplished. For example, behaviors were measured within the classroom setting through teachers’ reports and student records, as well as observation in the home and community settings as provided through caregivers’ and teachers’ reports. The fifth step is development of techniques to measure the achievement of objectives. For this program evaluation, measurement of objectives (e.g., behavior change) was conducted through weekly and 90-day reviews which include descriptive behavior statements that provide comparison and measurement (where the child was and where the child is currently). Playgroup staff and caregivers also provided information through individual interviews and rating scales developed by this researcher.

The last two steps focus on comparison of how well the objectives are met as defined by behavioral need. For example, if a child’s symptoms include aggressive behaviors, did the program measure the reduction of those negative symptoms and

targeting interventions aimed at building pro-social replacement behaviors (e.g., turn taking, sharing, and verbalizations)? Lastly, the data are compared with the goals that were previously identified for the program. This step provides concrete information on how well the program is functioning in terms of stated goals and objectives.

Qualitative Design

This study used qualitative methods focused on personal experience (Clandinin & Connelly, 1994). These methods were chosen based on availability of past records, opportunity for future data collection, as well as the current program evaluation goals of the study. The methods used for the study of personal experience are focused in four directions: inward, outward, backward, and forward (Clandinin & Connelly). The personal experiences being measured included those of the children, the playgroup staff, the caregivers, and the participant-observing researcher. Inward focus is meant to explore the internal conditions of feelings, hopes, and aesthetic reactions from participations. How do the teachers view their work with this population, feelings of success and concerns? The outward direction is meant to describe the existential condition, that is, the environment (e.g., setting). For example, how do the teachers describe the creation of their classrooms and curriculum? The summative evaluation piece aims to provide a historical view (backward) of where the program has been and where it is going (forward). One way to illustrate this is determining the success of the program in addressing children's mental health needs, change in children's behaviors, meeting overall program goals, and needs for future change based on this evaluation.

Participant Observation

Participant observation has been defined by McCall and Simmons (1969, p. 26) as an attribute in direct field research which applies a variety of methods and techniques including informant and respondent interviewing, observation, document analysis, and self-analysis. In this specific program evaluation, the researcher was both an actual participant in and observer in her own program.

True participant research often calls on a person to become immersed and integrated into the community under study. Within the current therapeutic program, the researcher provided supervision for teachers and interventions related to addressing the needs of specific children or overall curriculum recommendations. In this study, the participant observer was integrated into the classroom settings through direct observation of interactions between teachers and children as well as through working as a substitute provider. This researcher was knowledgeable regarding the function and purpose of each classroom and curriculum goals of the program. She assisted in providing in-service and individual trainings related to the integration of play therapy, coping skills, and behavior management programs within the curriculum.

From her own participant observer role, the researcher was positioned to provide rare information as a program evaluator on the inner workings of the program as well as offer a comfortable and open relationship for teachers and caregivers to engage in further exploration. Additionally, this researcher also came into contact (directly or informally) with families enrolled in the playgroup program. This history of relationships can be useful in establishing rapport and trust during individual interviews; however, it also presented a possible hindrance by having participants in the program form a favorable

view to please this researcher. This researcher did not involve families or children who were receiving individual direct care services in addition to the Therapeutic Playgroup program.

Clandinin and Connelly (1994) argue that experience can be chronicled through narratives and translated by storytelling. “Experience . . . is the stories people live” (p. 415).

Time and place, plot and scene work together to create the experiential quality of narrative. Scene or place is where the action occurs, where characters are formed and live out their stories and where cultural and social context play constraining and enabling roles. Time defines plot, which has a past-present-future structure.

The researcher, in seeking to understand her own personal experience, will speak as a researcher, a teacher, a woman, a commentator, a research participant, a narrative critic, and a theory builder. (Clandinin & Connelly, p. 416)

Experience can and should be viewed in four different directions—inward, outward, backward, and forward. Looking inward the researcher had her own view and reactions to the Therapeutic Playgroup which influenced her intentions, such as choosing to do a program evaluation of the Therapeutic Playgroup. Looking outward, the researcher thought about what a program evaluation of the Therapeutic Playgroup could do for the program and for all preschool aged children receiving mental health services. Looking backward, the researcher examined events that have influenced the program, both locally (within the agency and community) and globally (adherence to different accrediting bodies). Looking forward, the researcher thought about the future of the children and the

families, the future of the teachers and the program, and the future of all mental health programs for preschool aged children.

Three different sets of methodological questions helped keep the researcher focused: (a) questions about the field (e.g., the point of view of the teachers, children and caregivers participating in the program); (b) questions about the field texts (e.g., EMRs and the teacher's and supervisor's decisions every month, every three months, and at the moments of interviews with teachers and parents about those decisions); and (c) questions about the research account (what the researcher chooses to include).

Lastly, the participant researcher thought about her voice (e.g., when is she talking about certain experiences and when is she silent about certain experiences) as well as the voices of her teachers, parents, and children. The researcher also considered what kind of signature she would leave on the Therapeutic Playgroup Program, all mental health programs serving preschool aged children, the teachers, the families, the children, and the culture at agency in the current study through her research document.

Narratives

Personal experience methods that rely largely on narratives have been shown to have substantial flexibility. For example, parent narratives obtained through semi-structured interview correlate significantly with parenting behaviors (Crowell & Feldman, 1988; Main, Kaplan, & Cassidy, 1985), how a child behaves with parents (Crowell & Feldman), and the quality of the parent-child relationship (Benoit & Parker, 1994; Bretherton, Biringen, & Ridgeway, 1991). In the present study, it was hypothesized that teachers' self efficacy and working models of their relationships with children can be examined through teacher narratives elicited in the context of individual interviews and a

follow-up focus group using a semi-structured interview schedule. Additionally, caregivers were able to reflect on their perspectives of the effectiveness of the Therapeutic Playgroup on child behavior.

Paradigm

The paradigm selected for this study fit nicely into a post-positivist world view. The assumption of post-positivism is that reality can be captured and understood; however, only faintly due to the imperfect nature of human nature and intellect (Cook & Campbell, 1979). This is often labeled as critical realism (Cook & Campbell), since critical examination is employed to capture the closest possible reality. The current study fit with the epistemology of post-positivism as its findings aim to “fit” with preexisting knowledge regarding child development and best practices in early childhood education, yet it is carried out without the artifice of experimental method. The methodology of post-positivism seeks to confront critics of positivism by collecting situational information, conducting research in a more natural setting, and reintroducing discovery as an element in investigation (Guba & Lincoln, 1994). In social research, researchers solicit viewpoints and collect perceptions from people in order find meaning, this process represents grounded theory (Glaser & Strauss, 1967; Strauss & Corbin, 1990).

Procedures

Data Collection

In the current study, qualitative data was gathered through descriptive statements provided by playgroup teachers and caregivers in the context of individual interviews and focus groups. The qualitative research interview seeks to describe the meanings of central themes in the world of the participants. The central goal in interviewing is to gain the

meaning ascribed to the person being interviewed (Kvale, 1996). Interviews are a particularly useful tool for eliciting a story behind a person's experiences and the interviewer can pursue in-depth information around the topic (Kvale).

This study followed a general interview guide approach in order to ensure that common areas of information were collected from each interviewee; this allowed structure but also a degree of freedom and adaptability in getting information from the interviewee. Semi-structured open-ended interview questions were also presented to all interviewees; this approach facilitated quicker interviews that could be more easily analyzed and compared.

Powell, Single, and Lloyd (1996) defined a focus group as "a group of individuals selected and assembled by researchers to discuss and comment on, from personal experience, the topic that is the subject of the research" (p. 499). Focus groups are a form of group interviewing that places an emphasis on the questions and responses between the researcher and all of the participants. Focus groups are a part of group interviewing where the emphasis is placed on the questions and responses obtained through this process (Gibbs, 1997). Focus groups can be utilized as an independent method or in conjunction with other methods such as triangulation (Morgan, 1988). The typical sample size of a focus group is usually six to ten but can vary (MacIntosh, 1981).

The first step involved obtaining initial consent from the agency in this study to collect data from three different reporting sources: EMR and paper records, playgroup teachers, and family caregivers. Once consent is obtained, this researcher obtained a list of caregivers whose children attended the program from September 2007 to May 2008 from the playgroup coordinator. A random sample of 20 caregivers whose children participated

in the playgroup program was created from this list. A stipulation of participation was attendance of three months or more during this time period. This list provided a foundation for collecting EMR data regarding treatment plan, weekly notes over a three-month period (Weekly Partial Hospitalization Reviews), and 90-day reviews (Service Treatment Plan Review) for each child. The weekly notes obtained were taken at three data points, approximately one month apart, for a total of three weekly reviews (e.g., three-month period).

Subsequently, individual interviews were conducted first with playgroup teachers. The four playgroup teachers participated in a semi-structured interview to dialogue on topics regarding their perceived efficacy. This examination explored the effectiveness of the therapeutic program through the teachers' knowledge and use of curriculum and interventions (e.g., evidence-based practices), application of EMR (e.g., "common language,"), and additional training needs. In addition to open-ended interview questions, follow up Likert-scale measurements were utilized for specific questions in order to provide frequency counts of teachers' ratings (e.g., On a scale from 1 to 5, 1 being ineffective and 5 being very effective, how effective are you in meeting the needs of children within the playgroup program?)

This researcher discussed meeting time and scheduled frequency and length of individual interviews with playgroup teachers. These occurred during and outside regular hours of employment. The interview lasted approximately 60 minutes. This researcher reviewed and obtained consent for participation in this study and confidentiality was upheld (see Appendixes F and G). Playgroup teachers were informed that they would receive no penalty or loss of benefits or employment to which they are entitled by either

participating in or choosing to not participate in the current study. Playgroup staff were also offered an opportunity to receive information about the dissertation project and group results, either through written communication (e.g., research summary) or a short presentation (30 minutes) made at an advertised future presentation.

Following individual interviews with each playgroup teacher, one focus group session was conducted with the four playgroup teachers. Presentation of preliminary findings of themes identified in the individual interviews drove the focus and question format of the focus group. The focus group occurred with permission from the playgroup supervisor and clinical director. It occurred during staffing time and was within a 60-minute time period.

Ethical considerations were provided during both the focus group and individual interview sessions with playgroup teachers by disclosing full information about the purpose of the study and uses of participants' contributions. A particular consideration in this case was given to the handling of sensitive material as well as confidentiality given that there was more than one participant in the group. At the outset, the researcher clarified that each participant's contribution would be shared with the others in the group as well as with the researcher. Participants were encouraged to keep confidential what they heard during the focus group, and the researcher will be given the responsibility for providing pseudonyms and changing identifying details of any information used from the group.

Individual interviews were also conducted with caregivers. In addition to open-ended interview questions, follow up Likert-scale measurements were utilized for specific questions in order to provide frequency counts of caregivers' ratings (e.g., On a scale of 1

to 5, 1 being ineffective and 5 being very effective, how would you rate the playgroup program's ability to meet the needs of your child?) The researcher attempted to elicit participation through mailing informational fliers, as well as making telephone calls, to caregivers of children who participated in the playgroup program from the period of time between September of 2007 and May of 2009.

Children and caregivers were chosen by random sampling methods. Random sampling is an unbiased selection of members of a particular population, in this case, children within the playgroup program. This researcher utilized a pre-generated table of random numbers to select children and caregivers. A list of children and their caregivers were comprised from the names children who attended playgroup for at least three months during the period of time between September 2007 and May 2009. If a caregiver was unable to be reached or declined participation, another name was chosen from the pre-generated table.

Caregivers were encouraged to schedule a meeting time for the individual interview with the researcher. This researcher also attempted to conduct individual interviews in the home setting with the permission of family caregivers. To increase voluntary participation, consenting participants (e.g., playgroup teachers and caregivers) were informed that they would each receive \$10.00 for participation, benefiting each participant equally. No other compensation was offered for participating. Individual interviews lasted approximately 60 minutes.

All participants were recruited by obtaining consent from the agency under study to contact and permission was obtained to review confidential information regarding client and family information (e.g., demographics, assessment, and intervention information) for

children enrolled in the Therapeutic Playgroup program. All participants were offered an opportunity to receive information about the dissertation project and group results, either through written communication (e.g., research summary) or a short presentation (30 minutes) during an advertised future monthly parent meeting. All participants were informed that their participation is voluntary and that confidentiality would be upheld as stated in the agency's policies and procedures.

Individual interviews and focus group sessions were taped through audio recording as well as recorded via written notes taken by the interviewer. Participants were informed of audio and written recordings as part of the consent process.

The current study is a summative program evaluation which was used to judge the quality of the Therapeutic Playgroup program's defined program goals and curriculum, children's treatment needs and response to intervention (e.g., classroom, home, and community), teacher self-efficacy, and parent integration and participation in treatment. An internal evaluation was conducted by this researcher who is currently employed at this mental health facility. This study applied an objectives-oriented approach to program evaluation.

Data Analysis

As part of the summative evaluation, teachers' and caregivers' responses were explored to determine whether program goals are accurate and useful as suggested by school readiness indicators. Descriptive statements found within weekly reviews were coded in terms of key words related to the school readiness indicators listed below (NAEYC, 1990).

1. Children will show positive socio-emotional growth through interpersonal relationships, socialization, and play therapy.
2. Children will exhibit age-appropriate communication skills through expressive and receptive language experiences.
3. Children will increase general knowledge and cognitive skills by experiences with the world around them, observation skills and development of pre-literacy, shapes, colors, and number sense.
4. Children will develop fine and gross motor skills through experience with large and small muscles.
5. Children will develop self-help skills by learning to eat together, follow group routine, and engage in self-care, and personal hygiene.

Change in children's behavior were defined as significant and measurable differences between baseline data (initial statement of children's problem, goals, and objectives) compared to descriptive changes over a three-month period. Descriptive statements were coded to determine whether a child exhibited the following behaviors and to what extent behavior change was reported (e.g., regressed, unchanged, improved), as suggested by the National Center of Educational Outcomes (NCEO) model [Ysseldyke & Thurlow, 1993]):

1. Children will deal appropriately with frustration (decreasing tantrums, aggression or withdraw).
2. Children will express feelings and needs in socially acceptable ways.
3. Children will reflect an appropriate degree of social control and responsibility (personal space, boundaries, self-control, and self-care).

4. Children will reflect knowledge and acceptance of consequence of behavior.
5. Children will develop at least one positive coping strategy.
6. Children will engage in positive social interaction with same-age peers and adults (turn taking, sharing, and initiation).
7. Children will comply with rules and routine of group setting.

Regarding the individual interviews and focus groups, data analysis began with transcription of audiotapes and analysis of written notes. The transcripts were then analyzed for key words in context related to concepts reflecting knowledge of program objectives, roles in treatment, knowledge of interventions, identified child behaviors, and statements reflecting behavior change (e.g., growth, increases, decreases, regression, unchanged). Specifically with caregiver interviews, key words also were related to reflections of communication between and among playgroup staff and caregivers and effectiveness of parent meetings (e.g., helpful, not helpful). Additionally, demographic questionnaires were examined for differences between and among variables such as age, race/ethnicity, and gender.

The responses of the participants were then organized into clusters of themes. The first wave of analyses included identifying predetermined themes which coincide with existing standards of school readiness skills (i.e., NAEYC, 1990) and effective coping skills in children (i.e., NCEO). The second tier of analyses included coding and identification of themes which arose outside of the existing structure of the standards of school readiness skills. The researcher and an outside rater coded the data separately, compared coding, and continued to work to get 80% agreement on themes. The transcription and coding were carried out by the current researcher who has completed the

IRB training. This outside rater or auditor had no direct participation or investment in the current research. The only involvement was for data analysis and reliability purposes. Coding, analysis, and interpretation of the data was entered into EthnoNotes, a web-based, secured program for managing, integrating, analyzing and reporting qualitative or integrated data.

Triangulation was used as the dominant technique for establishing validity in this study. In triangulation, the researcher uses multiple data collection and analysis methods, multiple data sources, and multiple data analysts (Patton, 1999). In this case, the individual interviews, focus groups, and descriptive statements of children's behavior on a weekly basis as well as over a three-month period constituted multiple data sources. Triangulation requires that interpretations resulting from different data sources be compared to one other and allows reflections between and among data sets. Additionally, multiple data analysts consisted of this participant observer as well as an auditor. This was particularly useful for the purpose of evaluating the overall effectiveness of the Therapeutic Playgroup Program for this particular group of preschool aged children, their caregivers, and playgroup teachers

CHAPTER 3

RESULTS

Data Analysis

The current program evaluation involved qualitative and quantitative analyses from three different reporting sources: child records, caregivers, and playgroup teachers. A random sample of 20 caregivers whose children participated in the Therapeutic Playgroup Program for a period of at least three months was collected. The selection of caregivers allowed for the matching child's EMR and paper record, which included the treatment plan, weekly notes over a three-month period (Weekly Partial Hospitalization Reviews), and 90-day reviews (Service Treatment Plan Review [STPR]) to be analyzed. The weekly notes obtained were taken from three data points, approximately one month apart, for a total of three weekly reviews (e.g., over a three-month period). Individual caregiver and playgroup teacher interviews, along with a teacher-only focus group were also examined.

The audiotapes were transcribed verbatim from caregiver and playgroup teachers' interviews. The EMR records for each child, including treatment plan, STPR, and three weekly records were exported into a Word Document (Microsoft). Demographic information and corresponding records were given an identification number for the purposes of confidentiality. Following demographic sorting the examiner utilized EthnoNotes (SocioCultural Research Consultants, LLC., 2006-07) to assess numeric

trends (frequencies) among the various Likert-scale questions. The transcripts were then analyzed in two waves, the first identified predetermined themes which related to the existing research foundation (school readiness skills and effective coping skills in the children), and the second included novel themes that emerged during the coding process. The researcher and an outside rater coded the existing data separately following the Coding Manual (see Appendix H). The comparative coding obtained a 98.5% interrater reliability and agreement on all themes.

Demographics

Caregiver and Child

Data were collected on several demographic variables including the age, gender, race, education, home language, and marital status of the 20 identified caregivers (see Table 1).

Table 1

Demographic Information: Caregivers

	<i>n</i> = 20	
	<i>n</i>	%
Caregiver Age		
25 or under	1	5
26-40	14	70
Caregiver Gender		
Male	3	15
Female	17	85

(Table 1 continues)

(Table 1 continued)

	<i>n</i> = 20	
	<i>N</i>	%
Caregiver Race		
White	19	95
African American	1	5
Relationships to Child		
Biological Parent	16	80
Relative/Guardian	4	20
Education Level		
8 th grade or higher (not high school diploma)	9	45
High School or Equivalent (GED)	4	20
Some College	6	30
Bachelors Degree	1	5
Marital Status		
Single	7	35
Divorced	2	10
Married	5	25
Living with Another	4	20
Separated	1	5
Widowed	1	5

Child variables measured included age, gender, race, length of time in playgroup, and involvement in services such as developmental preschool, daycare, Head Start, kindergarten, and speech (see Table 2). The mental health diagnoses of each child were identified through a review of EMR and paper records (i.e., Axis I). The typical profile of a caregiver and child within this study was a 5-year-old, Caucasian male who had been enrolled in the Therapeutic Playgroup Program for six months to 1 year who lived with a

single, Caucasian, female, biological parent, aged 26-40, with less than a high school education. A majority of the children in the current study also participated in other services such as developmental preschool, speech, and daycare. Of the children sampled, 70% had been diagnosed as a child with a Disruptive Behavior Disorder, Not Otherwise Specified based on the DSM-IV (see Table 2).

Table 2

Demographic Information: Children

	<i>n</i> = 20	
	<i>n</i>	%
Child Age		
3 years old	2	10
4 years old	8	40
5 years old	10	50
Child Gender		
Male	13	65
Female	7	35
Child Race		
White	16	80
African American	1	5
Biracial	3	15
Time in Playgroup		
3 to 6 months	1	5
6 months to 1 year	9	45
More than 1 year	4	20

(Table 2 continues)

(Table 2 continued)

	<i>n</i> = 20	
	<i>N</i>	%
Developmental Preschool		
Yes	15	75
No	5	25
Daycare		
Yes	17	85
No	3	15
Head Start		
Yes	16	80
No	4	20
Kindergarten		
Yes	19	95
No	1	5
Speech		
Yes	17	85
No	3	15
Axis I Diagnosis		
Disruptive Behavior Disorder	14	70
Adjustment Disorder	3	15
Reactive Attachment Disorder	1	5
Anxiety Disorder	1	5
PDD/Autism	1	5

Playgroup Teachers

The four teachers who participated in the current study were female, Caucasian, held a bachelor's degree, 75% were between the age of 41-55, and 50% had been involved in the Therapeutic Playgroup Program for 5-10 years (see Table 3). It is important to note that one of the teachers also assumed the role of program manager and her role often differed from that of the other three playgroup teachers.

Table 3

Demographic Information: Playgroup Teachers

	<i>n</i> = 4	
	<i>N</i>	%
<i>Age</i>		
26-40	3	75
41-55	1	25
<i>Gender</i>		
Female	4	100
<i>Race</i>		
White	4	100
<i>Time in Playgroup</i>		
6 months to 1 year	1	25
1-5 years	1	25
5-10 years	2	50

Caregivers' Interviews

For the 20 randomly selected caregiver interviews, semi-structured questions with follow up Likert-scale measurements were examined. The frequency of caregivers' responses to each interview question based on a 5-point scale is shown in Table 4.

Table 4

Frequency of Caregivers' Interview Ratings

Likert-Scale Questions	Mean (<i>n</i> = 20)
On a scale of 1 to 5, 1 being ineffective and 5 being effective, how would you rate the playgroup program's ability to meet the needs of your child?	4.55
On a scale of 1 to 5, 1 being ineffective and 5 being effective, how would you rate the change in your child's behavior?	3.90
On a scale of 1 to 5, 1 being ineffective and 5 being effective, how would you rate the change in your child's behavior at home and in the community?	3.50
On a scale of 1 to 5, 1 having no voice and 5 having a strong voice, how would you rate your "voice" in the playgroup program?	4.85
On a scale of 1 to 5, 1 having no knowledge and 5 having significant information, how would you rate your knowledge of your child's treatment goals?	4.35
On a scale of 1 to 5, 1 having no information and 5 having significant information, how would you rate the amount of information provided to you by playgroup staff on your child's progress and any concerns?	4.70
On a scale of 1 to 5, 1 being ineffective and 5 being effective, how would you rate the effectiveness of monthly parent meetings?	3.55
On a scale of 1 to 5, 1 being ineffective and 5 being effective, how would you rate the effectiveness of other services such as case management, medication management and/or therapy?	4.20

Behavior Change

The effectiveness of the playgroup program's ability to meet the needs of the identified child (scale 1 to 5, 1 being ineffective and 5 being very effective) had an average rating of 4.55. The change in a child's behavior was rated 3.9 on a scale of 1 to 5 (1 being no change and 5 being significant change). Themes identified were behavior changes in the following areas: behavioral self-control, social skills, speech/communication, general knowledge, and non-specific area of change (see Table 5).

Table 5

Caregivers' Interviews: Behavior Change

	Positive	Negative	TOTAL
Behavioral Self Control ($n = 11$)	9	5	14
Social Skills ($n = 6$)	5	1	6
General Knowledge ($n = 4$)	4	0	4
Non-specific ($n = 5$)	5	0	5

In regard to positive aspects of behavior change under the theme of behavioral self-control, examples included, "I've seen the way he calms down and actually realizes if he sits there for the time he is supposed to be in time out then he can get out" (Parent A), and "I have noticed that with his teacher and case manager talking to him things are better. He's able to say why he's in time out, because he was being bad. I've seen a lot of progress" (Parent I). However, caregiver statements identified that behavior variation, no improvement, or regression (coded as negative) also occurred under this theme, for

example “He has gotten more aggressive, but then at times, it’s just like he’s the best child you can ever ask for” (Parent E), and “She will hear directions but still has trouble following through” (Parent K).

Secondly, positive behavior changes were noted under the theme of social skills, “She’s not a loner like she used to be” (Parent K), “He’s gotten better at sharing” (Parent G), and “She cooperates with her sister a lot better” (Parent J). One parent indicated a negative behavior change in regards to social skills, for example, “. . . he’s more of a loner” (Parent E).

The third theme identified was communication/speech. Positive improvements seen in this area included, “His speech has improved” (Parent E), and “She’s using her words more when she gets frustrated” (Parent S). Fourth, positive behavior change was noted in general knowledge such as shapes, color, and numbers, for example, “His learning is good, ability to sit down and comprehend things” (Parent H), and “. . . playgroup helped improve his ABCs, colors, and more songs” (Parent P). Overall, non-specific positive improvements were identified such as “She likes playgroup and her personality is coming out more” (Parent T), and “I’ve seen a lot of progress” (Parent I).

Generalization

A slight decrease was seen in the generalization of behavior change to the home and community setting, with a mean rating of 3.5 (on a scale of 1 to 5 with 1 being no change and 5 being significant change). Themes identified included behavioral self-control, social skills, and non-specific changes (see Table 6).

On the first theme of behavioral self-control, caregivers rated positive improvements in the home/community, such as, “I could go to the store without him

yelling and screaming” (Parent M). Caregivers identified that behaviors in the home/community setting often varied, showed regression or no change (coded as negative) in regard to behavioral self-control, such as, “He has gotten more aggressive, but then at times, it’s just like he’s the best child you can ever ask for” (Parent E). When negative change was reported, caregivers often stated that these behaviors were triggered by other family members or environmental factors, for example, “He still does it, temper tantrums...he’s still hitting his sister and constantly fighting. I don’t understand why it continues at home but not playgroup. I’m doing everything . . . I’ve noticed that when he goes to his dad’s his behavior is worse. Ever since we split up his behavior is worse. He was calmer before” (Parent I).

Table 6

Caregivers’ Interviews: Generalization

	Positive	Negative	TOTAL
Behavioral Self Control ($n = 11$)	5	7	12
Social Skills ($n = 7$)	5	3	8
Non-specific ($n = 2$)	0	2	2

The second theme of social skills showed positive change such as, “I can take him to the park and he will play with others, other parents wont lynch me . . . I still have my hair” (Parent H) and “‘Inside voice’ that’s the word they taught him; no, ‘use your inside voice’ for now on is what I tell him” (Parent P). However, some caregivers identified no change, regression or variation (negative) in the area of social skills, “He is still shy

around strangers when we go out” (Parent B). Last, two caregivers indicated non-specific behavior change that was identified as negative, for example, “very little, very little, it’s just gonna take some time” (Parent Q).

Caregivers’ Voice/Information

In examining the caregiver’s role in the playgroup program, caregivers were asked to rate their “voice” in the program on a scale of 1 to 5 (1 having no voice and 5 having a strong voice). An average rating of 4.85 was obtained. The dissemination of information from playgroup staff to caregivers, both positive and negative, had a mean rating of 4.7 (scale of 1 to 5, 1 having no information and 5 having significant information). The identification of themes for these two open-ended questions yielded similarities that could be coded under one category labeled caregivers’ voice and communication in the program. Identified themes included active communication and sharing information between playgroup staff and caregivers, consultation with other agencies and providers who work with the child, and the knowledge and information provided by playgroup van drivers and assistants (see Table 7).

Table 7

Caregivers’ Interviews: Voice/Information

	Positive	Negative	TOTAL
Active Communication ($n = 16$)	16	0	16
Consultation ($n = 1$)	1	0	1
Van drivers/assistants ($n = 13$)	12	1	13

In regard to active communication, caregivers reported positive attributes such as, “If we have a need to know we can just call” (Parent G), “As soon as I mention something like she [child] was having an emotional time with her grandfather’s passing. The quickness of her teacher addressing this was commendable” (Parent J), and “Right away they call me or otherwise when I pick her up from group they let me know what is happening” (Parent K).

Parent M reported “I always asked her all the time how was his improvement in playgroup. She’d sit down, explain to me where his weakness were and where we were still needing improvements . . . they had the same concerns as I had with my son.” The second theme identified, communication between other agencies, was highlighted in a positive light as well, for example, “His playgroup teacher emails my child’s school teacher to see how his behavior is at school . . . they were emailing each other to see if she was noticing them [side effects of medication]” (Parent A). Last, the communication and knowledge among other playgroup staff, specifically the van drivers and assistants was positively emphasized. “The van driver keeps me informed about what’s going on when they pick him up or drop him off” (Parent B) and “. . . it blows me away what the van driver knows when she comes to drop him off. From other situations I’ve had from my life with my other kids, they all seem to know what’s going on; I’ve been very happy with that” (Parent F). One parent viewed communication with the van driver and assistants negatively, “I mainly talk to his van drivers, but she doesn’t quite understand” (Parent C).

Knowledge of Treatment Goals

The knowledge of a child’s goals in the program on a scale of 1 to 5 (1 having no knowledge and 5 having strong knowledge) had a mean rating of 4.35. The themes

identified within this subcategory were the identification of treatment goals associated with behavioral self-control, social skills, general knowledge (i.e., colors, numbers, and shapes), developmental needs (such as toilet training, fine/gross motor skills, and speech), and non-specific knowledge of treatment goals (see Table 8)

Table 8

Caregivers' Interviews: Knowledge of Goals

	Awareness
	<i>n</i> = 17
Behavioral Self Control	8
Social Skills	12
Developmental Needs	5
General Knowledge	4
No Specific Knowledge	2

Caregivers specified that playgroup staff taught children listening skills, how to get along with others, manners, turn taking, sharing, numbers, letters, writing their names, colors accepting time out, toileting, and fine and gross motor skills. These goals appear to correlate with school readiness skills as defined by the NAEYC (1990). Caregivers reported an awareness of treatment goals which included behavioral self-control, “. . . his behavior, his aggressiveness towards me and his brother. Definitely his behavioral techniques, discipline techniques” (Parent A). In the second theme, caregivers reported awareness of social skills as a treatment goal, for example, “I think she is working on his sharing with other kids and keeping his hands and feet to himself” (Parent F).

Third, caregivers indicated an awareness of treatment goals which included general knowledge, such as “I think she’s working on his colors and numbers, they do games and activities to practice that” (Parent B). Next, caregivers indicated goals focused on developmental skills, such as, “Potty training” (Parent D), and “They’re working on helping her communication” (Parent T). For those few parents who were unable to identify specific goals for their children there appeared to be a general understanding, for example, “When I first came in his teacher asked about goals that I wanted to work on but I don’t know specific goals for him” (Parent C).

Parent Meetings

The effectiveness of the monthly parent meetings and training was 3.55 (on a scale of 1 to 5). Overall, themes emerged related to information provided on parenting skills (e.g., discipline) cohesiveness with other caregivers during the parent meetings, attending for a connection to their child, and experiences during classroom observations (see Table 9).

Table 9

Caregivers’ Interviews: Parent Meetings

		Not	
	Effective	Effective	TOTAL
Parenting Skills ($n = 14$)	10	5	15
Cohesiveness ($n = 4$)	3	1	4
Connected to Child ($n = 4$)	4	0	4
Class Observation ($n = 12$)	8	4	12

For those who attended on a regular basis and found the monthly meetings helpful in learning positive parenting skills, caregivers indicated, “Some of the activities we did I like . . . we made picture cues to get ready for bedtime for their schedule and routine” (Parent C), and ways to engage with their child, “I went out and bought some books that we can do together when she comes home from playgroup” (Parent L). However, caregivers also noted negative aspects of the monthly parent meetings, indicating a need for additional parent support to address their children’s behaviors. For example, Parent F indicated “I think most of the time I came I already knew things because of my age and already raising kids. What I like to see more of, are behavioral things, what I can do to redirect him.”

Some caregivers viewed cohesiveness with other parents in a positive light, “I don’t feel like I’m the only one anymore” (Parent A). One parent indicated having difficulty meeting with a large group of other parents due to anxiety and feeling uncomfortable in the situation (coded as negative). Additionally, caregivers indicated that parent meetings were a time to connect with their children. For example, Parent H reported “they give me a reason to come spend time with him.”

As part of playgroup’s monthly parent meeting, caregivers are invited to spend time with their children in the classroom setting. Caregivers who viewed this experience as positive stated, “He’s excited, he wants to show us everything” (Parent G). However, a few caregivers indicated that their child showed negative behaviors during this time, “I was coming regularly at first to see him but then I backed off because his behavior was different with me” (Parent H). Overall, caregivers identified feeling “comfortable” in the

classroom, as evidenced by Parent T’s report, “I like spending time in the classroom...they welcome me into the classroom and I get to help out with activities.”

Of those caregivers who responded, 7 indicated they were unable to attend monthly parent meetings on a regular basis due to work schedules, classes, or family or transportation problems, for example, “I work the night shift sometimes and then I won’t come because I sleep during the day” (Parent F).

Other Services

Caregivers rated the effectiveness of other services, which included case management, therapy, and medication management on a scale of 1 to 5 (1 being not effective and 5 being very effective) with a mean rating of 4.2. Overall themes identified were responses to case management services, therapy, and medication management (see Table 10).

Table 10

Caregivers’ Interviews: Other Services

	Participation		No	TOTAL
	Positive	Negative	Participation	
Case Management (<i>n</i> = 17)	16	0	1	17
Therapy (<i>n</i> = 19)	5	5	9	19
Medication (<i>n</i> = 7)	4	1	2	7

Caregivers reported whether the child participated in these services, and if so, if they were viewed as positive or negative. The majority of caregivers reported their child

participated in case management services aimed at generalizing social skills and compliance and found this service helpful and beneficial. For example, Parent H stated “He adores her [case manager]; it’s something to look forward to and consistency. She takes him to the park with a few other kids to spend time with him and interact with others at the same time.” It appears case management services assisted with helping the child meet their behavior needs as well as linking a caregiver to community resources. For example, Parent N reported “they helped us with Christmas and Thanksgiving baskets.”

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Overall, therapy and medication management were not utilized on a regular basis. Medication management was not found useful as an effective tool due to the child’s age. However, half of the caregivers whose child participated in therapy found it unhelpful due to poor communication regarding the role of therapy. For example, Parent G reported “I don’t know if she [therapist] still keeps track of what’s going on with him in playgroup . . . I don’t know how it works.”

Concerns/Changes

Caregivers were also asked to indicate concerns they may have about the playgroup program. No concerns were indicated by 70% of the parents, 15% reported problems with curriculum, 10% reported transportation concerns, and 5% noted problems with communication. The curriculum concerns identified included two caregivers noting problems with playgroup's personal safety lesson, Parent O reported "Although I think it's good for kids to know the proper name of body parts for boys and girls both, but at the same time she's 5." However, Parent G commented on the apparent success of the personal safety program, stating "I was a little taken aback by the safety program because we've tried to do the whole bad people, good people, good/bad touch and he just wasn't interested. But he came home and put his bathing suit bottoms on and told me the whole story and I was amazed that you kept his attention long enough to get it through to him . . . the curriculum here seems good." One parent noted a need for more emphasis on preschool things "like letters, numbers and shapes" (Parent R).

Transportation problems were reported by two parents, Parent A stated "the only thing I would want is for transportation to be provided to our home; we live outside the boundaries and when I can't get a car he misses group." One parent noted concerns with communication in regard to the implementation of homework assignments. Parent C noted, "The homework is hard to do with him, I don't know if you're supposed to turn them in . . . I don't think they communicate with us if you're supposed to turn it in or when, so I don't turn them in."

Referral Sources

Referral sources were obtained from 19 out of 20 caregivers: 26% were referred by their therapist at the agency under study or their primary care physician, 21% were self referred, 21% received information on the playgroup program from family or friends, 21% were referred by other community agencies (i.e., Early Head Start, Healthy Beginnings), and 11% obtained information about the playgroup program from a school agency (i.e., Covered Bridge Special Education District or a local school agency).

Child Records

School Readiness Indicators

Descriptive statements found within treatment plans, weekly notes, and 90-day reviews were coded in terms of key words related to the school readiness indicators listed below (NAEYC, 1990).

1. Children will show positive socio-emotional growth through interpersonal relationships, socialization, and play therapy. Of the records surveyed, 99% fell within this category of classification.
2. Children will exhibit age-appropriate communication skills through expressive and receptive language experiences. The review of records showed 68% of treatment goals and weekly plans targeted communication skills, such as expression of thoughts and feelings.
3. Children will increase general knowledge and cognitive skills by experiences with the world around them, observation skills and development of pre-literacy, shapes, colors, and number sense. Treatment plan and weekly notes reflected the denotation of general knowledge 6% of the time.

4. Children will develop fine and gross motor skills through experience with large and small muscles. This area was not targeted directly in a review of child records (0%).
5. Children will develop self-help skills by learning to eat together, follow group routine, and engage in self-care, and personal hygiene. The review of records showed self-help skills were focused on 9% of the measured time.

Weekly Reviews

Three data points of weekly reviews for each child's EMR record were analyzed and coded for behavior change to determine improvement, regression, or unchanged status. Overall, children showed improved behaviors 65% of the time, within the three-month review period. Child behaviors remained the same 20% of the review period; one record indicated no change due to poor attendance. Regression occurred in 15% of the child weekly records, 1 record indicated a decrease due to the child's poor attendance and 2 records noted an increase in negative behaviors while the child's guardian was in attendance in the classroom.

The weekly records were also examined and rated for measurability, which is whether the writer describes a behavior which could be counted or observed and its frequency and duration. Overall, for 20 child records with three separate data points, measurability was found 82% of the time. It is important to note that over half of the weekly records included one data point which was a quarterly review and the writer only provided an overall review of behavior progress without specific measures. Two examples of measurability from the weekly records include:

Client had difficulty coping with hurt or angry feelings and needed assistance from staff 2-3 times 1 out of 2 group sessions to solve peer conflicts without yelling or tattling. Client had difficulty participating in 2-3 activities due to shouting and using inappropriate verbalizations (Child E). Client tested limits and boundaries each group session requiring redirection 4-5 times each session with 2-4 prompts or cues. She received 1-2 consequences 2 group sessions for non-compliance. She needed prompting and cues from staff to engage in peer interactions (Child T).

Identified Behavior Needs

Caregiver interviews, treatment plans and 90-day reviews (STPR) were analyzed to determine the behavior needs identified by playgroup staff and caregivers within this sample of children. The following categories of child problems and behavioral needs were identified through theme analysis.

1. Defiance and Disrespect: Child shows difficulty following directions or listening with more than 1-2 prompts and has problems accepting responsibility for behavior such as arguing or talking back (70%).
2. Acting-Out Behaviors: Child shows verbal and physical aggression such as hitting, kicking, spitting, biting, temper tantrums, destruction of property and inappropriate language or engages in self-harm such as head banging, suicidal statements and gestures, harm to others, or animal cruelty (83%).
3. Attention Seeking Behaviors: Child shows negative attention seeking, showing off or drawing attention to self through silly or immature behaviors (8%).

4. Self-Control: Child shows difficulty remaining attentive, in constant motion, interrupting others, talking out of turn, hyperactivity, impulsivity, and remaining in designated area (23%).
5. Social Skills: Child shows difficulty sharing, turn taking, resolving peer conflicts, withdrawal, isolation or shyness from others, lack of social contact (65%).
6. Sexual Acting Out: Child shows behaviors such as masturbation or self-stimulation, exposing self, touching others, sexually inappropriate language or gestures (3%).
7. Managing Feelings: Child shows difficulty with emotional outbursts, crying, depression or anxious moods, and problems separating from caregivers (18%).
8. Developmental Delays: Child shows cognitive delays, processing difficulties, or toileting/self care needs (15%).
9. Communication: Child shows difficulty expressing thoughts and feelings due to communication problems such as articulation and expressive/receptive language problems (20%).

Behavior Change

Change in children's behavior was defined as notable and measurable differences between baseline data (treatment plan) compared to descriptive changes over a three-month period (90-day STPR). Descriptive statements were coded to determine whether a child showed the behaviors listed below and to what extent behavior change was reported

(e.g., improved unchanged, regressed), as suggested by the National Center of Educational Outcomes (NCEO) model [Ysseldyke & Thurlow, 1993] (see Table 11).

Table 11

Child Records: Behavior Change

	Completed	Improved	Unchanged	Regressed
Manage Frustration ($n = 15$)	0%	40%	53%	7%
Social-Control ($n = 6$)	0%	17%	50%	33%
Accept Consequences ($n = 9$)	0%	33%	56%	11%
Coping Strategy ($n = 3$)	33%	0%	67%	0%
Social Interaction ($n = 19$)	0%	63%	32%	5%
Compliance ($n = 18$)	0%	67%	28%	6%

1. Children will deal appropriately with frustration (decreasing tantrums, aggression or withdraw). Out of the 20 child records reviewed, 15 yielded a measure on this specific behavior. Of those records, 40% noted improved behavior change, 53% reported no change, and 7% regressed behavior. Further analysis of child records which showed no change or regressed behavior change identified that 33% of those records indicated noncompliance with playgroup services (less than 75% attendance) and significant life changes, such as moving or change in family relationships.

2. Children will express feelings and needs in socially acceptable ways.

Child records indicated change on 5 out of 20 records reviewed.

Improved behavior changes were noted in 80% of those records and regression on 20%.

3. Children will reflect an appropriate degree of social control and responsibility (personal space, boundaries, self-control, and self-care).

Six of the child records noted change in this area. Of those records, 17% noted improvement, 50% showed a lack of change, and 33% reported regression. Behavior regression was explained in one record (50%) by non-compliance and/or life changes.

4. Children will reflect knowledge and acceptance of consequences of behavior.

Child records revealed 9 out of 20 records measured this

behavior goal with 33% showing improvement, 56% no change, and 11% regression. The explanation for no change or regression was found in 17% of those records, indicating noncompliance with playgroup services and significant life changes.

5. Children will develop at least one positive coping strategy.

Of the 20 records examined only 3 STPRs rated this behavior area, with one record (33%) indicating completion of this goal and 2 noting no significant change (67%).

6. Children will engage in positive social interaction with same-age peers

and adults (using turn taking, sharing, and initiation). The highest area

measured among the 20 child records was social interactions. Of the 20

records analyzed, 19 measured this behavior area and 63% showed improved behaviors, 32% unchanged, and 5% regression in this area. A child's lack of improvement in this area could be explained by noncompliance and/or life changes in only 14% of the records reviewed.

7. Children will comply with rules and routines of the group setting. The STPRs examined measured this behavioral goal in 18 out of 20 child records. Analysis of those 18 records revealed that 67% of children showed positive improvements in compliance, 28% showed no change, and 6% noted regression. Of those records which indicated no change or regression, 33% were noncompliant with playgroup services and experienced significant life changes.

SMART

In order for the EMR to be comprehensive, provide quick access and a common language, the current study analyzed the use of a SMART approach (Raia, 2008) within a child's treatment plan and 90-day reviews to determine if a specific, measurable, achievable, reasonable, time-specific approach was communicated effectively. The findings indicated that 100% of the child records showed specificity, which indicated precision in detailed description related to identified behavior patterns. Measurability was also found in 100% of the records, such as they provided frequency, duration, and the ability for the behavioral description to be counted or observed. Achievability was defined as being within the child/family's capacity and ability and was developmentally appropriate (100%). Reasonability was determined to be acceptable and based on standard clinical practice (100%). However, time-specific, as defined as the behavior description

providing a short- or long-term time frame for completion was not found in any of the 20 records reviewed (0%).

Playgroup Teachers' Interviews

The four playgroup teachers were interviewed and given semi-structured questions with a follow-up Likert-scale measurement. The frequency of playgroup teachers' responses to each interview question is shown in Table 12.

Table 12

Frequency of Playgroup Teachers' Interview Ratings

Likert Scale Questions	Mean (<i>n</i> = 4)
On a scale of 1 to 5, 1 being ineffective and 5 being effective, how effective is your role as teacher within the playgroup program?	3.75
On a scale of 1 to 5, 1 being ineffective and 5 being effective, how effective is your role as playgroup teacher at this agency and division?	2.75
On a scale of 1 to 5, 1 being ineffective and 5 being effective, how effective are the behaviors and practices you use in your daily role as a teacher?	4.00
On a scale of 1 to 5, 1 being ineffective and 5 being effective, how effective are you in meeting the needs of children within the playgroup program?	4.50
On a scale of 1 to 5, 1 being ineffective and 5 being effective, how would you rate the usefulness of training you have received?	3.00

Role in Playgroup

The effectiveness of the playgroup teachers' role within the program had an average rating of 3.75 on a scale of 1 to 5 (1 being ineffective and 5 being very effective). Playgroup teachers identified their role within the program as encompassing the themes of facilitator and collaborator. In regard to facilitation, this included coaching and guiding

children, along with creating an atmosphere for optimal learning and behavioral and emotional growth. For example, Teacher B stated “. . . I am a guide rather than a teacher, cause I am not teaching concepts, I’m helping them learn behaviors, helping them to develop social skills, and so I kinda facilitate what I see is needed as I watch the kids play or do activities or during circle time. Teacher A reported “I want to see myself as facilitating an atmosphere, kinda like a coach, in which the kids can get whatever they need from it, like some children need to play independently, some need to work on social skills.”

Playgroup teachers also saw their role as a team member and collaborator, Teacher C noted “I define my role right now as a team, with other teachers to come up with the best possible plan for working with the demographics of children that we have at the time. Teacher B indicated the concept of collaboration and documentation working together to define her role, for example:

We look at this as medical necessity and so everyday watching the kids’ behaviors I write a note on each kid and see how they were that day, so that’s the other part of the job. And then as well as collaborating with their therapist, the case managers and other teachers seeing how things are going. So that’s a big part because we are all trying to work for a common goal. We all have things we want to see the kids accomplish and when we work together I feel that it gives that child the best opportunity possible.

However, distinct differences were seen between the playgroup teachers and the program manager regarding their role in the program. The program manager (Teacher D) viewed her role as supervisor, overseeing the daily workings of the programming

including “evaluating clients to get them enrolled in the program, supervise the staff, the teachers and the assistants, purchase materials and work on the budget and balance the budget.” At the time of the current study, the program manager had not established her own classroom and was not assuming a daily role of teacher/facilitator, although she would substitute for other playgroup staff on a regular basis.

Role in Agency

The playgroup teachers’ rated the effectiveness of their role within the agency and division a 2.75 on a scale of 1 to 5. The playgroup teachers’ identified a predominant theme of separation and isolation within the larger picture of this agency and division. For example Teacher A reported “I think we’re isolated obviously by our physical location so we don’t have a lot of contact with other staff. People tend not to come into our program to see us.” Teacher B reiterated that belief through her statement, “it makes us feel like we’re out on our own little island somewhere.”

The program manager indicated she works in collaboration with other program managers in the division; however, she feels a lack of control regarding larger program issues within the division as evidenced by her statement

. . . as one program manager I don’t feel like I have a lot of effect on other programs, so that’s actually a frustration at times that my program may be doing it one way and being very successful but I see shortcomings in the other programs where I can make suggestions but I have no control over them, or control over other budgets but it all affects the overall picture. (Teacher D)

Behaviors and Practices

The effectiveness of the behaviors and practices used in their daily role as playgroup teachers had a mean rating of 4 (on a scale of 1 to 5). Themes identified in regard to behaviors and practices used by the playgroup teachers in their daily role included structure and consistency, positivity, and empathy. Teacher D indicated, “I feel the consistency of the rules throughout the whole program, from group to group, provider to provider, assistant to assistant, pretty much the same procedures are carried out, the same rules are enforced, the same method of enforcing them.”

In regard to positivity, this included thinking and behaviors, such as positive reinforcement and attention. For example, Teacher C stated:

The kids I find to be really challenging it seems like positive reinforcement really works for them. I don't know if it's because they hear so much negative... a lot of times it's just verbal praise, stickers, letting someone be the helper with snack, being able to be the first one in line to lead us all out to the big room or outside.

The theme of empathy was illustrated by playgroup teachers as being open, approachable, and nurturing. Teacher B stated, “I try to let them feel comfortable in coming to me and talking to me and you know somebody that they can feel is their friend,” as well as Teacher D, “I try to be open and approachable and listen to what they have to say, try to be understanding, empathic.”

Efficiency and Effectiveness of Practices

In examining how playgroup teachers utilize their role efficiently and effectively, the dominant themes were time management, including organization, planning, and prioritizing workload. For example, Teacher C reported “I utilize my time. We plan; we

have our weekly planning which sometimes we're able to get those done in blocks of a month." Time management appeared to take on different forms based on personality and preference, from coming in early to plan for the day to shortening time for lunch to complete daily treatment notes. Three out of the four playgroup teachers, not including the program manager, indicated a struggle with the demands of the job such as workload, paperwork, and productivity expectations which at times they reported having an impact on their work with children and their own emotional well-being. For example, Teacher B's statement highlights this struggle, "It is me trying to help these kids in the best way I can with the time I'm given and the resources I'm given. And that sometimes comes out good and that sometimes doesn't."

Meeting Child Needs

The teachers reported their effectiveness in meeting the needs of children within the playgroup program as 4.5. Playgroup teachers identified themes of child needs as being "all encompassing." Themes coded included poverty (basic needs), family change, nurturance, behavioral and developmental needs. Playgroup teachers differentiated between needs which could be met within the program and needs which were greater. For example, Teacher A stated, "Some of them are extremely impoverished so they need everything." Teacher B also indicated the depth of child needs, including behavioral, developmental, and the need to nurture creativity, for example:

They have a series of needs that need to be met. I think in my perfect world it would be a multitude of things being learning a routine in school, learning how to follow directions, learning how to play, but also being able to tap into their

creative side and see what things they like to do, what are they good at, what are their strengths.

Teacher B's statement highlights the challenge of changing caregiver behaviors and attitudes, "It's challenging whenever you're trying so hard to make change and you just can't see the changes being made at home." Two playgroup teachers identified the challenge of poverty and the magnitude and impact it has on children and families within the playgroup program, for example, Teacher D reported, "When you go into the homes and you see the conditions in which the children and parents are living are living. Just meeting their daily needs, shelter, food, clothing, a lot of times are bigger than what we can handle." Teacher C reported that some needs, such as poverty and family change, cannot be met easily, "New parents, a new house, just a new living environment. I had no idea that there was a part of this city where people were so poor. It was very sad, and to me it's kind of a forgotten people."

Usefulness of Training

Among the four playgroup teachers, the effectiveness and usefulness of training they have received had a mean rating of 3 (on a scale of 1 to 5). Overall, themes identified among the playgroup teachers indicated a positive experience and greater need for more intensive and extensive training specific to child interventions (i.e., behavior interventions, play therapy, and sensory interventions). For example, Teacher D reported a desire for "intervention training...what do we do with a kid that is ADHD, what do we do with a kid that has Autism, Asperger's tendencies? How do we reach a child that has Reactive Attachment Disorder, what can we do to help build those ties?"

Teacher B reported similar needs, “It seems like when we go to center wide trainings they are kinda broad and don’t really have to do a lot what we specifically deal with, so they weren’t really as effective.” Additionally, a second theme indicated a need for collaboration, workshops and consultations with outside systems that families or children access. The Department of Child Service and Medicaid were noted by two out of the four playgroup teachers. For example, Teacher C reported, “I think it would really be good to have an in-service with DCS, to understand what’s reportable and what’s not.”

Overall, three out of the four playgroup teachers recognized the need for and effectiveness of trainings to implement this agency’s Electronic Medical Record system during the period of this study. The positive benefits of training were noted in improved note writing, documentation, and language use that are measurable and observable. Teacher D noted the benefits of this EMR system, “I think with the EMR we’re able to see our shortcomings in our treatment planning. I know especially it has really improved the quality of treatment planning and quality of treatment. It’s been difficult, but I think it was important.”

Managing Change

Since the inception of the Therapeutic Playgroup program approximately 15 years ago, many changes have occurred in the delivery of mental health services, the make-up of children and families (treatment needs), curriculum goals, and the role of playgroup teachers. The themes identified by the four playgroup teachers were categorized into an increase in class size, number of classes, balancing work demands, and the learning curve of a new mental health delivery system. Two of the four playgroup teachers noted differences in the program during the time period of this study compared to previous

years. For example, Teacher C reported that the size of classrooms has increased from approximately 6 children in each class to an average of 10, with the number of classes also increasing (adding morning and afternoon classes).

When I first started working here I think I had 6 kids in my class and I had myself, my assistant, and probably two case managers and the clinical supervisor would come down all the time. And I just felt like it was a really positive one on one with the children. I really felt we were making a difference. And now I feel like it is more crowd control. (Teacher C)

A common theme among all the playgroup teachers involved reaching a balance between quality service to the children and managing productivity and paperwork expectations. However, it appeared that the playgroup teachers struggled with this balance. Three out of the four teachers indicated stress with balancing the amount of documentation and paperwork required (daily and weekly notes, treatment planning, and STPRs), along with completing home visits, providing direct services, and finding time to plan new curriculum and group activities. Teacher B highlighted this struggle, “I’d like to have time to clinically document what they do, because it is important. I’d like to be able to have a lunch break. I like to be able to get to know their families.”

Additionally, playgroup teachers appeared to have an awareness of how change evolves during a period of time. For example, Teacher A reported, “It’s more time consuming because when you do something it takes longer until you get used to it.” The program manager also appeared to reinforce the difficulty of system change, “It’s been very difficult for staff to accept those changes and struggles. And it has been a very rocky

ship at times,” but offered that staff have received support and training during this difficult time period.

Hopefully they feel like they are getting support from me. You know just in the changes and patience in learning the new method and positive reinforcement because when they get down on themselves and are feeling stressed, positively reinforcing that they are doing a very good job. And my staff especially has accepted the changes and has really grown. It’s amazing how much they’ve really grown and their quality has improved tenfold.

Strengths of the Program

The four themes highlighted as strengths of the playgroup program also provided a foundation for the uniqueness of this program compared to other typical preschool programs. All four playgroup teachers indicated the main strength of the program lies in the structure it provides to children, including consistency. Teacher D noted, “Just the overall structure of the program is very effective in providing that structured environment, the consistency that they learn what is expected and how to be very successful in that structured activity . . . in that environment, and that’s a real strength.” That structure appears to also hold a flexibility which allows children to have an outlet for creativity, as evidenced by Teacher C’s statement, “We’re a structured program, but within that structure we provide creativity for the children to grow.”

The second theme identified was the positive and caring outlook held by playgroup teachers regarding their work with this specific population (passion and open to challenges). For example Teacher B reported, “I think that everyone really enjoys the kids, they love their job. I think that is one of the main factors, we don’t put down the kids.”

Teacher C noted, “I just think the caring of the staff, to work with this population you really have to love kids.”

Third, playgroup teachers emphasized the mental health component including treatment planning, using play therapy, and less academic pressure. Teacher D, the program manager, highlighted the following view:

Through play children learn social skills and they learn how to express themselves through imaginary, through creative play, through art, music. They learn to explore the world around them through experimentation with play, building blocks.

Through play with manipulatives they’re improving their fine and gross motor skills. They are also exploring the world, relationships, how things work together, sharing and taking turns, it’s all a part of play. I think in our play we are guiding and modeling how to play appropriately and how to improve social skills while playing. Where I think some of the other agencies just play--there is no guided play.

One playgroup teacher indicated the program is able to give families access to other resources such as case management, therapy, and medication management. Teacher B reported, “We collaborate with our therapists or case managers. It’s a circle. They get their classroom in here, they get their therapy, and they get their case management and possibly other services that might be needed.”

Playgroup Teachers’ Focus Group

A focus group interview with open-ended questions was conducted with the four playgroup teachers. Questions focused on the development of curriculum goals, how classrooms are organized and structured, how the playgroup teachers work together,

behavior management, and responsiveness to changes in the mental health delivery system (see Table 13).

Table 13

Playgroup Teachers' Focus Group

Themes	
Curriculum Development	<ol style="list-style-type: none"> 1. Team approach, regular planning periods, evolving curriculum 2. Adhere to program goals: social skills, following rules, emotions, personal safety, general knowledge, and fine/gross motor skills 3. Specialized classroom programs such as school readiness training for children entering kindergarten 4. Access to various curriculum tools (e.g., Tuned Into Learning) 5. Use of manipulatives (i.e., books, puzzles, sensory, and tactile items) as well as music, songs, and dance 6. Use of diversity in books, puzzles, and self portraits
Teamwork	<ol style="list-style-type: none"> 1. Active sharing of information, interventions, and teaching tools 2. Consultation and support of one another 3. Play to the positive strengths and creativity of each teacher
Classroom Structure	<ol style="list-style-type: none"> 1. Built around the developmental/behavioral needs of the children in each classroom 2. Flexibility and adaptability

(Table 13 continues)

(Table 13 continued)

Behavior Management	<ol style="list-style-type: none"> 1. Increase structure 2. Choose battles 3. Difficulty managing violent (daily) behaviors and lower functioning children with Autism 4. Program is well structured for children with Aspergers or higher functioning children with Autism
Documentation & Communication	<ol style="list-style-type: none"> 1. Communicate to caregivers, van drivers, case management and treatment staff 2. Communicate with other professionals (e.g., school staff) 3. Communicate during monthly parent meetings 4. Written communication (daily notes, weekly notes, treatment plan, and 90-day service reviews)

Development of Curriculum

The four playgroup teachers identified that lesson planning occurred as a team approach, developing specific units that match with overall program goals. The themes identified as program goals included: social skills, following rules, emotions, personal safety, general knowledge, and fine/gross motor skills. Teacher D identified that the curriculum is “constantly revising . . . evolving.” For example, Teacher B reported, “This year we added the homework piece.” The playgroup teachers indicated that planning occurs every two weeks and lasts for at least an hour. However, Teacher C indicated, “That’s just the lesson planning, that doesn’t include the prep time for the activities,

painting and cooking. That doesn't include the time to put out new manipulatives, new puzzles, we are constantly rotating that stuff as well."

An example of how a lesson is based on a curriculum goal was illustrated by the development of the personal safety unit. Teacher A reported, "Children will identify their body parts accurately, good touch/bad touch, and to be able to identify and express themselves to a trusted adult if someone was hurting them; 'Someone touched my penis or touched my vagina.'" Playgroup staff noted that they utilize age appropriate books, handouts, and puzzles to reinforce these concepts. In order to communicate with parents regarding curriculum goals, Teacher D reported:

We do send home a letter informing them that we will be discussing this and they have the option of keeping their kids out that week. At the parent meeting the month before, they discuss it with the parents and explain to them why were doing it and what the purpose is and how they can be a part of the process. And pretty much if they have a question we address it pretty much how we do the kids. We just tell them why we are doing it, what our goals are, so the child can identify what's appropriate and not appropriate.

Playgroup teachers highlighted that the curriculum also has specific components such as preparing the 5-year-old population to enter kindergarten through a structured summer program. The curriculum includes, "The emphasis each day is on a different letter, identifying a letter, the letter sound, words that begin with that letter. Then they have their work jobs, they are individual centers that are academic in nature" (Teacher C).

Additional curriculum tools utilized by playgroup staff included, "Tuned Into

Learning, which is a program for children with Autism Spectrum Disorder which comes with a puppet, CD and book” (Teacher D). “The Peace Keeping Series, the I Care Cat program which we use all year around because it teaches the rules such as hands are for helping not hurting, we listen to each other feelings” (Teacher A). “The ‘Learning to Get Along’ series is what we are using with the non-kindergarten kids in the summer, it covers our whole summer and it’s a good series” (Teacher B). And then the Character Education series, the “Best Me I Can Be” series through Scholastic. Several years ago we redid our curriculum, we just starting looking for more therapeutic based materials in publications and catalogs, building and adding to it” (Teacher D).

Playgroup teachers also reported the integration of music and body movement in their curricular activities. For example, Teacher A stated, “We use a lot of Raffi and preschool based ones. Mailbox has a lot of cool songs and publications and then we just look for more CDs that fit into our existing curriculum.” Other manipulatives utilized include art and tactile interventions, such as “Play-Doh©, good and sensory items” (Teacher C). Playgroup staff reported that these materials and items were generated through “The Ooey Gooey Lady, a workshop we went to several years ago” (Teacher D).

Playgroup staff indicated that they integrate diversity into their curriculum. For example, “We use dolls and puppets that represent different ethnicities as well as books. We also have multicultural puzzles and we try to offer different color choices during self-portraits to represent different skin colors” (Teacher D).

Teamwork

Playgroup teachers identified a positive theme of teamwork which included active sharing of information and interventions. Second, consultation and support of one another

was viewed as a positive aspect of teamwork. “We kind of bounce things off of each other, we try to listen and if we hear that someone is having a kid acting out we try to cover and send the assistant over” (Teacher A). Playgroup teachers reported that if stressors occur they encourage one another to take a break from the classroom by using the code phrase ‘I need to take a phone call’ and other playgroup staff will cover the classroom. In addition, playgroup teachers appear to play to each others’ strengths and creativity. For example, “It’s just whoever comes up with the ideas or thinks of something, you know, we will kind of run it by each other as a team and whoever ends up feeling creative on that specific day” (Teacher B).

Classroom Structure

When asked about the structure and organization of the classroom, playgroup teachers indicated that each classroom is tailored to the age and developmental and behavioral needs of the children. For example, Teacher B reported, “It took awhile to get used to it because I was used [to] the older kids, so you know they [3-year-olds] can only sit and do something for so long before they have to do something” (Teacher B).

However, it appeared that variation occurred in among similar aged children, which encouraged flexibility in programming among the teachers. For example, “What is interesting with my class . . . the kids in the morning group are younger than the kids in the afternoon, but the kids who are younger in the morning can do a lot more than the older kids” (Teacher C).

Behavior Management

The focus group responses indicated that challenging behaviors can negatively impact the group’s cohesiveness and function. In order to manage a variety of behavioral

needs, playgroup teachers reported an increase in the structure of the classroom and choosing battles. For example, “I have structured centers in the afternoons because my kids in the afternoon are really hyperactive and impulsive. You have to pick your battles, I think, you can’t expect perfection” (Teacher A).

Playgroup teachers identified that the most challenging child behaviors include aggression which endangers other children on a regular basis so that safety can no longer be maintained. Also, playgroup teachers indicated that programming is difficult for children identified with severe characteristics of autism. However, playgroup staff noted that children who have been diagnosed with Asperger’s or higher functioning children with autism often thrive in the playgroup program due to the high amount of structure. Teacher B reported, “You are always going to have some that are challenging and some that are not so challenging. And I think it is good for the other kids to be tolerant of other children that aren’t like them.”

Documentation

Playgroup staff reported behavior changes are seen among the children, for example, “We see improvements in listening to directions, sitting during circle time, talking about their feelings, and getting along with other children. It is amazing to watch them grow and gain control over their body and feelings” (Teacher A). In order to document and communicate this change, Teacher D noted, “We communicate it to parents during our individual meeting and when we develop the treatment plan. We also talk daily to the child’s case manager who will be communicating with their therapist and parent.” Teacher A added, “Also, since our van assistants transport children daily we use them to

update parents on the child's day generally speaking." In regard to written documentation

Teacher B indicated:

We write daily behavior reports documenting behaviors. We try to report frequency and duration. We meet every week to review the child's progress and our plan for the following week, and every three months the teacher or case manager completes a treatment review of each [child's] goals, changes in the home and involvement with other services.

Playgroup also reported that behavior change is communicated through consultation with other agencies, for example, "We try to participate in case conferences with our children that attend different programs like Head Start or Covered Bridge preschool" (Teacher A). Overall, the playgroup program manager noted "I think our staff has done a wonderful job in stepping up and adjusting to new ways of documenting services, the language we use and observable [and] measurable reporting of behavior changes."

CHAPTER 4

DISCUSSION

The goal of the current study was to investigate the effectiveness of a therapeutic playgroup program for preschool-aged children in need of mental health services. A summative program evaluation was conducted to evaluate child outcomes, the perspectives of caregivers and playgroup teachers, and whether program goals were accomplished. Additionally, this program evaluation builds a strong foundation for an innovative service delivery model to meet the mental health needs of preschool children and their families.

Participant observation (McCall & Simmons, 1969) was applied within this program evaluation. The researcher served as participant and observer within the playgroup program, where she serves as clinical supervisor and qualified mental health professional (QMHP). The researcher accepted her unique role observing the inner workings of program development, curriculum and intervention planning, daily roles of playgroup teachers and staff, behavioral observations of children, participation in monthly parent meetings, and reviewing the weekly notes on playgroup children. Furthermore, as a clinical therapist within the division, this researcher has experienced the process of referring children into the playgroup program, developing treatment goals, and meeting with caregivers to review progress and concerns. Therefore, this researcher's perspective

will be integrated within the current study and provide an insider's view regarding the program's effectiveness.

Personal experience can be viewed in four different directions—inward, outward, backward, and forward. Applying the Clandinin and Connelly (1994) heuristic model, the current study examines the inward reflection of this participant-observer. Looking inward the researcher acknowledges her own frustrations with the current systems of delivery and poor utilization and access for preschool-aged children and their families to address behavioral and mental health needs. This participant observer held a hope that the current research would provide a basis for examination, future exploration, and replication of the current playgroup program. The hard work, caring, and dedication of playgroup staff was seen by this researcher in her daily role within the program. Therefore, the emotional investment is evident within the creation, implementation, and outcome of the current study. This participant-observer recognizes her own hope for successful outcomes to further support the work of all those involved in the playgroup program and concerns that negative views or results may taint or diminish the individual change seen on a daily basis. However, the researcher understands that challenges or concerns highlighted within this study may also lead to strengthening the program and further increasing positive outcomes.

Looking outward, playgroup teachers did well evaluating the strengths and challenges of the population they serve, their self-efficacy, and understanding what can and cannot be changed in their role as playgroup teachers. Playgroup teachers provided positive reflections in regard to their behaviors and practices and how these are correlated with behavior change. However, caregivers appear largely unaware of specific playgroup

practices and interventions but do acknowledge child change within the program. This difference may be addressed with more education and information to increase caregiver ownership and awareness of child change and effective generalization of behavior interventions.

Looking backward, the researcher examined events that have impacted the program since its inception approximately 15 years ago. Locally, changes within the agency such as the implementation of an electronic medical record, emphasis on documentation, medical necessity, and SMART language terms have occurred. Globally, changes in national and state policies have also affected the role of playgroup teachers and services provided to children and families. For example, services must follow a model of assessment, service delivery, and reassessment. Service delivery must utilize evidence-based practices and treatment notes must reflect changes which occur in the child and family system and response to intervention. The playgroup program has made numerous gains in strengthening its curriculum to adhere to a developmentally appropriate model of preschool-aged children. These changes have also placed added stress on playgroup teachers in terms of time management and finding a balance between quality care, engagement of children and families, and meeting paperwork expectations. The playgroup program has also grown in the number of children and families served, which presents larger challenges in engaging a greater number of caregivers in their child's treatment.

Looking forward, the current study examines where the playgroup program may be moving in its path toward effective mental health treatment. Will the playgroup program continue to integrate policy changes into their daily practice? Will the playgroup program continue to develop effective behaviors and practices through training and support? Will

the playgroup program continue to find new and innovative ways to reach out and engage children and families? Will the playgroup program become a model for effective mental health services for a preschool population?

Based on changes in national, state, and local policies ((Executive Office of the President, 1990) along with child, family and agency needs, focus has been placed on the integration of evidence-based practices (Tolan & Dodge, 2005) and response to intervention models (Neilsen & McEvoy, 2004) within prevention and intervention services. The role of school psychologists is to assist in merging mental health services along with early childhood prevention and intervention to address the needs of children, school, families, and communities. For example, this researcher has education and training as a school psychologist but currently serves as a therapist within this mental health facility, utilizing knowledge from fields such as development, counseling, psychology and education.

Specifically, mental health systems aim to promote health and human development and wellness, access to and coordination of quality services, culturally sensitive and competent practices, and a universal measurement system (United States Department of Health and Human Services, 2001). In this study, the Therapeutic Playgroup Program targets the promotion of positive mental health and child development and reduction in the incidence of mental disorders within an at-risk preschool population (United States Department of Health and Human Services). Prevention and promotion have been integrated within early intervention programs which focus on developmental growth in cognitive, academic, adaptive, language, motor, social-emotional, and nutritional domains (Guralnick, 1997). Based on the current findings, the Therapeutic Playgroup Program

integrated these domains, which can also be defined as school readiness skills (NAEYC, 1990), in the areas of curriculum development, treatment plans, weekly and 90-day reviews, and caregiver and playgroup teachers' perspectives.

Another important finding in early intervention programs is the strong focus on improving parent-child interactions (Casto & White, 1985). In the program under study, the presence of monthly playgroup meetings, information sharing, and other services such as case management and therapy were found to foster positive caregiver-child interactions. However, it is also important to note that barriers to successful generalization of child behavior change were identified by playgroup teachers as inconsistent parenting skills, home and life contexts such as the presence of poverty, abuse and neglect, family history of mental illness, and caregiver helplessness (poor motivation for change and negative view of child). Some caregivers identified difficulty with replicating the conditions of the playgroup classroom, for example, setting consistent limits, developing a structured schedule, and using consistent behavior management techniques, within the home and community setting due to obstacles such as poor sibling modeling, family discord, and more significant child mental health or developmental issues.

These identified at-risk characteristics, along with the demographic variables of the current sample population (i.e., mother's education level) place children enrolled in the playgroup program at risk for health problems, poor language development, and cognitive and social-emotional difficulties (Kail, 2007). The children enrolled in the playgroup program displayed symptoms associated with the presence of a mental health disorder such as Disruptive Behavior Disorder which impacts current life functioning. Children within the current study also exhibit a high rate of involvement in developmental services

such as special education preschool programs, Head Start, and speech services. The absence of early intervention programs, such as the Therapeutic Playgroup Program, can lead to the increase of negative child symptoms and persistent mental-health related disorders, poor academic achievement and retention, juvenile involvement and teenage pregnancy (Kail).

The positive aspect of participation in playgroup for children and caregivers is decreasing social isolation which can lead to negative outcomes such as child abuse and mistreatment (Coulton et al., 1999). Relevant to the current study, caregivers indicated that active participation in the playgroup program, which is defined by attendance at monthly parent meetings and perceptions of a “strong voice,” provided a sense of cohesiveness with other families and collaboration with playgroup staff to manage stressful situations or challenging child behaviors. Furthermore, the playgroup program offered a predictable, structured environment where children have contact with stable adults who can protect or help them in challenging situations.

The playgroup program targets a preschool-aged population of children three to five years old based on empirical support for effective mental health services which focuses on the parent and child in a group-based model with multi-component interventions (Cowen et al., 1996; Greenberg et al., 1999; Olds et al., 1998; Ramey & Ramey, 1998).

Comparable to previous research findings, the playgroup’s curriculum, child records, and caregiver and teachers’ perspectives identified the presence and importance of building social competence (Bergen & Mauer, 2000), emotional regulation (Eisenberg & Morris, 2002; Eisenberg et al., 2005), and self-esteem (Harter & Pike, 1984). This is

accomplished through week-long trainings on feeling identification, coping skills, following rules, listening skills, social skills, conflict resolution, and personal safety and boundaries. Additionally, the current findings showed an underlying foundation and presence of play within curriculum development, how playgroup teachers viewed child development and growth, and classroom structure, activities, and interventions. The presence of play adheres to the developmental principles of how children organize and interpret the world around them (Parten, 1932) and development of cognitive and thought processes (Bergen & Mauer, 2000). Playgroup teachers indicated that the groundwork of play therapy makes the current program distinctive and separate from other preschool programs such as Head Start.

The program evaluated in this study meets criteria as a positive model for response to intervention within a preschool population through the implementation of applied behavior analysis and positive behavior support (Johnston et al., 2006). Applied behavior analysis occurs during the treatment planning process and continually within the playgroup program. This included determining the child's behavioral skill deficits and identification of specific goals and objectives utilizing the SMART approach (Raia, 2008). In this study, however, it is important to note the absence of time-specific indications as to how long treatment should last and when treatment will be completed (e.g., within 6 months, three weeks).

Playgroup staff indicated the establishment of a developmentally appropriate curriculum which subscribes to best practices in teaching skills and reducing negative behaviors. For example, playgroup staff have chosen tools from best practices and evidence-based interventions include a peacekeeping (I Care Cat) and character education

series, a comprehensive music-assisted learning curriculum for children with special needs (Tuned Into Learning), and social skills books such as “The Learning to Get Along” series and the “Best Me I Can Be.” Circle time activities appear to offer specific learning opportunities for social skills, feeling identification, coping skills, self-esteem building, as well as increasing self-control skills (i.e., sitting with visual cues such as colored circles, raising hands, and waiting for turn to speak). Next, playgroup staff established a method of measuring target behaviors (daily notes, weekly notes, and 90-day reviews) which includes continuous measurement from multiple data sources based on a baseline measures (problem statement). This allows for ongoing evaluation regarding the effectiveness and efficiency of services and modifications which need to occur (revisions in services and interventions).

The uniqueness of the current program’s curriculum design lies within its ability to incorporate school readiness skills (NAEYC, 1990) within a mental health delivery system. A review of weekly plans and treatment goals developed specifically by playgroup teachers found that social-emotional growth was represented through play therapy, socialization that emphasized turn taking, sharing, and peacekeeping focused on conflict resolution techniques. Additionally, records indicated a focus on increasing age-appropriate communication skills through expressive and receptive language experiences, such as expressing thoughts and feelings, language exposure, and developing a vocabulary for feelings.

Although general knowledge and cognitive skills (e.g., pre-literacy, shapes, colors, number sense, and experiencing the world around them) were discussed heavily among playgroup teachers in regard to curriculum planning, only a small percentage of weekly

records and treatment plans reflected these interventions. This may be explained by problems with specific documentation for medical necessity with interventions that are not defined as social or emotional (for example, pre-literacy versus social skills). However, the strong emphasis of general knowledge concepts is seen within the summer program for five year olds, where pre-literacy skills and knowledge and understanding of work jobs and transition skills such as moving from one activity to another (e.g., moving from center to center) are the main components.

Additionally, curriculum planning and classroom practices highlight the use of activities such as snack time, practicing manners and self-cleaning habits (i.e., using napkin, utensil, remaining in seat, washing hands, appropriate restroom behaviors). Additionally, many playgroup activities incorporate fine and gross motor skills such as painting, coloring, cutting, walking, running, climbing, jumping, throwing, catching, and riding bikes. These were also not reflected well in weekly plans or treatment goals.

Important themes which emerged in curriculum development included frequent and flexible lesson planning and teamwork practices such as utilizing individual playgroup teachers' strengths and creativity. Lesson planning is illustrated and reinforced through various developmentally appropriate materials such as manipulatives (puzzles, blocks), books, learning tools (colors, shapes, and counting), play objects (doll house and happy home), music (songs and instruments), and sensory items (sand and water tables, Play-Doh®, goop, and shaving cream).

Congruent with research findings, playgroup staff and caregivers indicated that classroom structure and consistency provide stability and security to children, as well as an opportunity to establish positive teacher and child relationships which is a strong factor

in increasing social, emotional, and cognitive development (Birch & Ladd, 1998), competence in other relationships (Birch & Ladd), and decreased risk (Lynch & Cicchetti, 1992). In order to accomplish these goals, classroom rules and routine are highly structured with well-defined schedules including free play, circle time, snack time, motor skills, sensory activity, and books/puzzles for each classroom. Playgroup teachers indicated that each classroom is tailored to the age of the children (three-, four-, or five-year-olds) and developmental functioning, which can differ from classroom to classroom.

Findings of the current study indicated playgroup teachers viewed their efficacy based on the notable behavior change of children, successful classroom practices, effective time management practices, strength in communication, investment in their role, and resiliency in managing challenges. The effectiveness of the behaviors and practices that playgroup teachers use to carry out their daily role was characterized by structure, consistency, positivity, and empathy.

Playgroup teachers identified barriers in their role and effectiveness perceptions of not being valued or being seen as “outside” of the larger division and agency. Additionally, playgroup staff recognized that the needs of the children within the playgroup were greater than they could provide, such as addressing the large dilemma of poverty and environmental contexts. Playgroup teachers identified specific training needs like greater amounts of information specific to child interventions (i.e., behavior interventions, play therapy, and sensory interventions) and “challenging” populations, such as children with Pervasive Developmental Disorders or severe aggressive or violent behaviors. This may be due to the significant developmental needs of lower-functioning children with Autism and safety issues associated with violence, which may require a

smaller group setting with intensive, one-on-one staff support and behavior management. Playgroup teachers appeared open and willing to increase expertise and intervention training to manage these special needs within their classrooms.

A significant amount of change has occurred within the time frame of the current study, including the introduction of an Electronic Medical Record (EMR) system, training on clinical documentation, and use of medical necessity to establish and evaluate treatment. The themes identified by playgroup teachers regarding the impact of these changes on their role and overall program functioning included the increase in class size, number of classes, balancing work demands, and the learning curve of a new mental health delivery system. Although finding a balance between quality services to children and maintaining work demands and productivity were highly desirable, it appeared that playgroup teachers struggled with time restraints, amount of paperwork, and feasibility of expectations.

This researcher observed that opportunities for training were present throughout this process; however, considerable impact was seen from issues such as high turnover and lack of continuity with regard to therapy and case management services to children and their families (i.e., time to train staff, waiting list for services, and change in certain provider roles).. Additionally, investigation into the habits of highly successful staff and programs was conducted on a larger agency level. The playgroup program has consistently been viewed as a leader and positive case for implementing changes in the delivery of mental health services within this agency.

The Therapeutic Playgroup Program was chosen by this researcher as a groundbreaking model in mental health services for young children, unseen in many traditional

preschool or mental health programs. The summative evaluation was comprised of child records, interviews with caregivers and playgroup teachers, and this researcher's perspective. The objectives of the playgroup program during the span of this study were to: (a) meet the individual treatment needs of children, (b) increase mental health competency and decrease negative symptoms in children and their families, (c) increase children's school readiness skills, (d) provide developmentally appropriate services to children and their families, (e) provide evidence-based mental health interventions, (f) build healthy child-caregiver and child-teacher relationships, (g) collaborate and consult with families, treatment team members, and community agencies to monitor progress and identify child and family needs, and (h) empower caregiver, home, and systems change. The overall goals of the Therapeutic Playgroup Program are to develop and strengthen the well-being of preschool-aged children and families by providing mental health services within a developmentally appropriate model for a specific period of time.

The results of this study found that the program was able to meet the treatment needs of children based on caregiver and teacher ratings, as well as child records. Based on the NCEO model (Ysseldyke & Thurlow, 1993) for coping skills in children, children enrolled in the playgroup program showed slight improvements in dealing with frustration, social control, accepting consequences, and developing positive coping strategies. The playgroup program targeted social-emotional and communication domains (based on school readiness skills) and children in the program showed notable positive behavior changes in social interactions, compliance, and expression of feelings.

The reflection of school readiness goals was permeated through curriculum goals, classroom structure and activities, and interviews with caregivers and teachers.

Additionally, the playgroup program reflected strong knowledge of evidence-based practices to address children's mental health needs such as social skills training, coping skills, vocabulary words for feelings, and peacemaking skills in the curriculum and classroom practices. Children and families also had access to a full range of mental health services, such as case management, therapy, and medication management. Results found that caregivers heavily accessed and found case management services useful. These services may have been utilized more effectively than therapy due to increased communication and clarification of case manager roles versus role of therapist, daily or weekly contact by case manager, and direct services provided by the case manager in multiple settings (home, school, and community).

Overall, the playgroup program provided opportunities for building strong and healthy relationships through its curriculum, availability of monthly parent meetings, and engagement of children by playgroup staff in the classroom (nurturance, safety, security, empathy, and positivity). Playgroup teachers and caregivers indicated strength in information sharing within the program, among and between providers, caregivers, and other agencies. However, caregivers appeared to acknowledge notable behavioral changes in their child but showed poor understanding of specific program goals and interventions which led to these changes (i.e., what practices and strategies are effective). The need to increase caregiver involvement and participation should target specific intervention knowledge and generalization of effective playgroup practices into the home and community settings. Future program improvements should continue to target active caregiver participation on a frequent and regular basis for lasting behavior change. Lastly, the Therapeutic Playgroup Program appears to have set a framework for change in mental

health delivery for preschool-aged children and their families. However, effecting system changes such as poverty and family contexts appears more challenging and elusive.

Several limitations were present in the current study. Important findings show the absence of a specific subset of at-risk populations, which includes ethnic and language minorities. The lack of diversity in this study limits generalizing the results to the general population. Further studies may also target the underrepresentation of ethnic minorities in the playgroup program compared to the overrepresentation of this population in special education services later in life. Next, a majority of the children enrolled in the playgroup program in this study also participated in additional early intervention programs as Head Start, developmental preschool, daycare, and speech services. The impact of these services or a combination of these services was not examined within the current study.

Another limitation was those caregivers who participated in this study may have been more motivated or involved in the playgroup program, which could have influenced the results in a positive manner. Additionally, this researcher is often present within the playgroup program and may be easily recognized as a staff member by caregivers. Therefore, caregivers who participated may have been influenced to present the program in a positive light. This researcher must also accept her bias within this program evaluation, since she has an investment within this agency, division, and program based on her role as therapist and clinical supervisor. Furthermore, playgroup teachers hold a strong investment in the program and may have felt pressure to reflect positive views of their role and program outcomes. Within the focus group interview, it is also important to note that one of the playgroup teachers involved has the role of program supervisor;

therefore, the other playgroup teachers may not have disclosed information as openly in her presence.

The van drivers and assistants in the playgroup program provide direct behavior intervention and assist playgroup teachers in redirection, behavior management, and crisis intervention. For example, 16 out of 20 caregivers indicated that van drivers and assistants made a positive contribution to communication between home and playgroup.

Additionally, they organize classroom materials, plan the food program, engage children in classroom activities, and transport a specific set of children two times daily. Therefore, they played a greater role than expected and the lack of their participation limits the comprehensiveness of the current study. Further evaluation should target the vital role and perspectives of playgroup van drivers and assistants in meeting the meeting health needs of children and contributions to teacher self-efficacy.

Since the current program evaluation was exploratory in nature a small sample size was used. In the future, survey data with a developed or standardized rating scale (e.g., weekly, monthly, or quarterly) could provide more information from a larger sample of participants to determine the effectiveness of the playgroup program and provide a quantitative measure of significant behavior change. Further research might also explore the subset of children who are discharged from the program due to severity of behaviors, drop out of services, or return to services after a prolonged period of inactivity.

Comparison groups may also be useful in examining caregiver perceptions with children participating in the playgroup program compared to daycare, preschool, or Montessori programs. A long term prospective study would also be useful in exploring the relationship between children and families who participated in the playgroup program on

their future outcomes such as educational performance, child-teacher and child-parent relationships, and behavior and mental health competencies.

Despite these limitations, the current study offers several recommendations for future research and programming. Further investigations that examine the effectiveness of specific interventions may be useful in determining preventive techniques for behaviors such as aggression or defiance. Future replications of this program within preschool programs or mental health systems could lend validity and feasibility to the current study.

The overall findings of this study may be helpful for school psychologists and mental health professionals who are seeking a novel approach to meeting the needs of young children. Given the effectiveness of the current program model, mental health systems of care should consider adapting these practices as a preventive approach to reduce the incidence of mental disorders in children and youth. Another component that holds relevance is addressing the training needs of the current playgroup staff and continuing to improve efforts at establishing balance in work expectations and validating the benefits of their practices.

School psychology has recognized its commitment to the importance of mental health competency among professionals, both in training and practice. However, the research has provided minimal guidance as to how to develop, deliver, and evaluate effective models of preschool programs. The current summative program evaluation offers a demonstration of the significance and effect of a developmentally appropriate model of mental health services for preschool-aged children and their families. More importantly, ongoing evaluation methods will continue to improve the effectiveness of the Therapeutic Playgroup Program.

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APPENDIX A: CAREGIVERS' DEMOGRAPHICS

Participant# _____

Circle the most appropriate choice:

What is your age?

- 1- 25 or under
- 2- 26 – 40
- 3- 41 – 55
- 4- 56 or older

What is the age of your child?

- 1- 3 years old
- 2- 4 years old
- 3- 5 years old

What is your gender?

- 1- Male
- 2- Female

What is the gender of your child?

- 1- Male
- 2- Female

What is your primary language at home?

- 1- English
- 2- Spanish
- 3- Other _____

Length in playgroup?

- 1- 1 – 3 months
- 2- 3 – 6 months
- 3- 6 months to 1 year
- 4- more than 1 year
- 5- more than 2 years

Medicaid Eligible

- 1- Yes
- 2- No

Other services?

- 1- Dev preschool
- 2- Speech
- 3- Daycare
- 4- Head Start
- 5- Montessori/preschool

Relation to playgroup child

- 1- Biological parent
- 2- Relative/Guardian
- 3- Foster Parent

Race

- 1- African American
- 2- Hispanic
- 3- Asian/Asian American
- 4- White
- 5- Native American
- 6- Multiracial/Biracial
- 7- Other _____

TANF

- 1- Yes
- 2- No

Race of your child

- 1- African American
- 2- Hispanic
- 3- Asian American
- 4- White
- 5- Native American
- 6- Multiracial/Biracial
- 7- Other _____

What is the highest level of education
you have completed?

- 1- 8th Grade
- 2- High School or Equivalent
- 3- Vocational/Technical School
- 4- Some College
- 5- Bachelor's degree
- 6- Master's degree
- 7- Other _____

What is your marital status?

- 1- Single
- 2- Divorced
- 3- Married
- 4- Separated
- 5- Living with another
- 6- Widowed

APPENDIX B: PLAYGROUP TEACHERS' DEMOGRAPHICS

Participant# _____

Circle the most appropriate choice:

What is your age?

- 1- 25 or under
- 2- 26 – 40
- 3- 41 – 55
- 4- 56 or older

What is your gender?

- 1- Male
- 2- Female

How long have you been a playgroup teacher?

- 1- 0-6 months
- 2- 6 months to 1 year
- 3- 1-3 years
- 4- 3-5 years
- 5- 5-10 years
- 6- 10 years or more

Race

- 1- African American
- 2- Hispanic
- 3- Asian/Asian American
- 4- White
- 5- Native American
- 6- Multiracial/Biracial
- 7- Other _____

What is the highest level of education you have completed?

- 1- High School or Equivalent
- 2- Some College
- 3- Bachelor's degree
- 4- Master's degree
- 5- Other _____

APPENDIX C: PLAYGROUP TEACHERS' INTERVIEW

1. How do you see as your “role” within the playgroup program? *On a scale of 1 to 5, 1 being ineffective and 5 being very effective, how effective is your role as a teacher within the playgroup program?*
2. How do you see as your “role” within this agency and division? *On a scale of 1 to 5, 1 being ineffective and 5 being very effective, how effective is your role as a playgroup teacher within this agency and division*
3. What behaviors and practices do you use to carry out your role? *On a scale of 1 to 5, 1 being ineffective and 5 being very effective, how effective are the behaviors and practices you use in your daily role a teacher*
4. Talk about how you utilize this role efficiently and effectively.
5. What are the primary needs of children within the therapeutic playgroup program? *On a scale from 1 to 5, 1 being ineffective and 5 being very effective, how effective are you in meeting the needs of children within the playgroup program?*
6. Overall, what are the strengths of the therapeutic playgroup?
7. What challenges present themselves in working with this specific population?
8. What training has been effective and useful in helping implement evidence-based practices? *On a scale from 1 to 5, 1 being ineffective and 5 being very effective, how would you rate the usefulness of training you have received?*
9. What training needs do you feel would help improve your ability to work with clients and families?

APPENDIX D: PLAYGROUP TEACHERS' FOCUS GROUP

1. Based on individual interviews, as a group of teachers, talk about the goals of the playgroup program?
2. How do you meet those goals?
3. How do you communicate those goals to caregivers?
4. How do you see your role as playgroup teacher?
5. What tools are useful in working together as a teaching unit and developing curriculum and lesson plan?
6. What resources do you utilize?
7. What interventions are effective in your classrooms?
8. Illustrate what type of behavior changes occurs as children participate in the playgroup program?
9. How do you document or communicate this change?
10. How is playgroup responding to changes in mental health service delivery system?
11. What additional resources or training do you see a need for?

APPENDIX E: CAREGIVERS' INTERVIEW

1. What was the identified need for your children?
 - a. Why are they in playgroup?
 - b. How did you hear about playgroup?
2. How has the playgroup program met that need?

On a scale of 1 to 5, 1 being ineffective and 5 being very effective, how would you rate the playgroup program's ability to meet the needs of your child?
3. What changes have you seen in your child's behavior?

On a scale of 1 to 5, 1 being no change and 5 being significant change, how would you rate the change in your child's behavior?
4. Did the change generalize to home and community settings?

On a scale of 1 to 5, 1 being no change and 5 being significant change, how would you rate the change in child behaviors in home and community settings?
5. How do you view your role in the program?
 - a. Do you feel you have a "voice" in treatment planning and evaluation?

On a scale of 1 to 5, 1 having no voice and 5 having a strong voice, how would you rate your "voice" in treatment planning and evaluation?
 - b. Do you know your child's goals in the program (treatment plan)?

On a scale of 1 to 5, 1 having no knowledge and 5 having extremely knowledgeable, how would you rate your knowledge of your child's treatment goals?

- c. Are you informed of progress by playgroup staff (how)?
On a scale of 1 to 5, 1 having no information received and 5 having significant information received, how would you rate the amount of information provided to you by playgroup staff on your child's progress?
 - d. Are you informed of concerns or regression in behaviors (how)?
On a scale of 1 to 5, 1 having no information received and 5 having significant information received, how would you rate the amount of information provided to you by playgroup staff on your child's concerns or regression?
6. How do you view the impact of monthly parent meetings and trainings?
- a. How may monthly parent meetings?
 - b. What information shared was helpful, have you used techniques or tools?
 - c. What information was not helpful?
 - d. Have you observed your child in his or her classroom while attending monthly parent meetings?
 - e. *Overall, on a scale of 1 to 5, 1 being not helpful and 5 being very helpful, how you rate the effectiveness of monthly parent meetings?*
7. What other services are your children involved in within Child and Adolescent Services (e.g., therapy, case management, medication management)?
- Overall, on a scale of 1 to 5, 1 being not effective and 5 being very effective, how would you rate the effectiveness of these services?*
8. What are the concerns, if any, about the playgroup program?
9. What changes would you recommend in the playgroup program?

APPENDIX F: CAREGIVERS' INFORMED CONSENT

Dear Parent/Guardian:

My name is Denise Harden, and I am currently completing my doctoral degree in School Psychology at Indiana State University. For my dissertation research project, I will be completing a program evaluation on the Therapeutic Playgroup program for preschool aged children with mental health needs. The first goal of this study is to identify the effectiveness of behavior change on identified child problems. The second goal of this study is to identify how playgroup teachers' perceive children's mental health needs and effectiveness of the program's interventions. The final goal is to examine the perceptions of caregivers (defined as a parent, foster parent, guardian, or relative) on the effectiveness of the program on behavior change, participation in the program and communication between playgroup staff and caregivers.

This research project will require you to participate in an individual interview, as well as completion of a demographic questionnaire. The individual interview will be held for approximately 60 minutes. I will provide open-ended interview questions for discussion. The individual interview will be audio taped and I will be taking notes throughout the session. Additionally, your child's individual electronic medical record and paper chart information will be accessed; however, all identifiers (e.g., name and birth date) will be removed.

The potential risks for participating in this study are minimal. The interview questions will prompt you to discuss your child's participation in the Therapeutic Playgroup program, identify concerns you may have about your child, and discuss the effectiveness of the program and parent meetings. Information will be confidential and specific identifying details will be changed. Potential benefits from your participation include gaining awareness of your child's needs, and learning about behavioral interventions specific to this program.

You are one of 20 selected caregivers participating in the current research study. Participation in this research study is strictly voluntary and confidential. You will be asked to not include your name or your child's name on your demographic questionnaire. By signing this consent form, you have given your consent to participate in the study. The letter code on your demographic questionnaire is for data analysis purposes and for identification of verbal discussion statements made during the individual interview. Should you agree to participate, you will be

provided with information about the results of this study either through a brief written summary or a short 30-minute presentation. Results from the study will be reported in an anonymous format only. Data from the study will be kept for no less than three years.

If you choose to participate in this study, you will receive \$10.00 at the completion of your interview. If you choose to discontinue participation during the interview or the interview is terminated by the researcher, you will receive one-half of your compensation. No other compensation will be offered for participating. Should you decline to participate, there is no penalty or loss of benefits or services to which you or your child is entitled. You may also discontinue participation at any time during the individual interview session.

Thank you for your consideration in supporting this research.

APPENDIX G: PLAYGROUP TEACHERS' INFORMED CONSENT

Dear Playgroup Teacher:

My name is Denise Harden, and I am currently completing my doctoral degree in School Psychology at Indiana State University. For my dissertation research project, I will be completing a program evaluation on the Therapeutic Playgroup program for preschool aged children with mental health needs. The first goal of this study is to identify the effectiveness of behavior change on identified child problems. The second goal of this study is to identify how playgroup teachers perceive children's mental health needs and effectiveness of the program's interventions. The final goal is to examine the perceptions of caregivers (defined as a parent, foster parent, guardian, or relative) on the effectiveness of the program on behavior change, participation in the program, and communication between playgroup staff and caregivers.

This research project will require you to participate in an individual interview and one focus group with a group of your colleagues. The individual interview and focus group will be held for approximately 60 minutes. I will provide open-ended interview questions for discussion. During the focus group session, each participant's contribution will be shared with the others in the group. Each participant will be encouraged to keep confidential what they hear during the meeting, and I will bear the responsibility for providing pseudonyms and changing identifying details of any data used from the group. The individual interview and focus group session will be audio taped and I will be taking notes throughout the session.

The potential risks for participating in this study are minimal. The interview questions will prompt you to discuss your perspective of the program's effectiveness in meeting the identified behavioral problems of your clients and potential training needs. Information will be confidential and specific identifying details will be changed. Potential benefits from your participation include gaining awareness of your clientele's needs, group views on behavioral interventions specific to this program, and recommendations for future training.

Participation in this research study is strictly voluntary and confidential. By signing this consent form, you have given your consent to participate in the study. You will be provided a letter code for data analysis purposes and for identification of verbal discussion statements made during the individual interview and focus

group. Should you agree to participate, you will be provided with information about the results of this study either through a brief written summary or a short 30-minute presentation. Results from the study will be reported in an anonymous format only. Data from the study will be kept for no less than three years.

If you choose to participate in this study, you will receive \$10.00 at the completion of your interview and focus group. If you choose to discontinue participation during the interview or focus group, you will receive one-half of your compensation. No other compensation will be offered for participating. Should you decline to participate, there is no penalty or loss of benefits or employment to which you are entitled. You may also discontinue participation at any time up during the individual interview or focus group session. If you do decide to leave the individual or focus group session, please respect others' confidentiality regarding information shared and do not provide a disruption to the ongoing discussion.

Thank you for your consideration in supporting this research.

APPENDIX H: CODING MANUAL

CAREGIVER INTERVIEWS AND CHILD RECORDS

Child Problems

Based on parent interview and STPR Identified Problem Statement

Parent Interview: Review Identified Behavior Problem Statement and Determine yes or no for each behavior category.

STPR: Read Identified Problem Statement and Determine yes or no for each behavior category.

0-No

1-Yes

- Compliance and Respect - Child shows difficulty following directions or listening with more than 1-2 prompts and problems accepting responsibility for behavior such as arguing or talking back.
- Acting-Out Behaviors – Child shows verbal and physical aggression such as hitting, kicking, spitting, biting, temper tantrums, destructive of property and inappropriate language. Self Harm such as head banging, suicidal statements and gestures. Harm to others or animal cruelty.
- Attention Seeking Behaviors – Child shows negative attention seeking, showing off or drawing attention to self through silly/immature behaviors.
- Self Control – Child shows difficulty remaining attentive, in constant motion, interrupting others, talking out of turn, hyperactivity, impulsivity, and remaining in designated area.
- Social Skills – Child shows difficulty sharing, turn taking, resolving peer conflicts, withdrawal, isolation or shyness from others, lack of social contact.

- Sexual Acting Out – Child shows behaviors such as masturbation/self stimulation, exposing self, touching others, sexually inappropriate language or gestures.
- Managing Feelings – Child shows difficulty with emotional outbursts, crying, depression or anxious moods, and problems separating from caregivers.
- Developmental Delays – Child shows cognitive delays, processing difficulties, or toileting/self care needs.
- Communication – Child shows difficulty expressing thoughts and feelings due to communication problems such as articulation and expressive/receptive language problems (speech).

Behavior Change- STPR

Read STPR Objective and determine whether statement is regressed (1), unchanged (2), improved (3), or completed (4) and which behavior goal or category it falls into, can have more than one.

- Children will deal appropriately with frustration (decreasing tantrums, aggression or withdraw).
- Children will express feelings and needs in socially acceptable ways.
- Children will reflect an appropriate degree of social control and responsibility (personal space, boundaries, self-control, and self-care).
- Children will reflect knowledge and acceptance of consequence of behavior.
- Children will develop at least one positive coping strategy.
- Children who engage in positive social interaction with same-age peers and adults (turn taking, sharing, and initiation).
- Children will comply with rules and routine of group setting.

Behavior Change- Weeklies

Read 3 weekly reviews to determine whether overall behaviors are regressed (1), unchanged (2), or improved (3).

Measurability- Weeklies

Read the weekly and determine whether the record indicates measurability which means is provided frequency, duration, and ability to be counted or observed.

School Readiness Indicator

Based on Weekly Plans, STPR Goals, and Parent Interviews

Weeklies: Read weekly plan for each three review periods and determine yes or no for each school readiness indicator.

STPR goals: Review STPR goal statement and determine yes or no for each school readiness indicator.

0 – No

1 – Yes

- Social-Emotional Growth - Children will show positive socio-emotional growth through interpersonal relationships, socialization, and play therapy.
- Communication - Children will exhibit age-appropriate communication skills through expressive and receptive language experiences.
- General Knowledge - Children will increase general knowledge and cognitive skills by experiences with the world around them, observation skills and development of pre-literacy, shapes, colors, and number sense.
- General Knowledge - Children will develop fine and gross motor skills through experience with large and small muscles.
- Self- Help - Children will develop self-help skills by learning to eat together, follow group routine, and engage in self-care, and personal hygiene.

Life Changes

Based on STPR under Life Changes: Read Life Changes statement and determine which category should be rated, more than one category can be rated (scale 1 to 5).

1. No Change
2. Family/Relationships: Discord, arguments or domestic violence situations, leaving of family members or return of family members, new relationships (boyfriends, stepmothers, etc) or change in family dynamic. Medical issues with family members that impacted availability or care provided to child.

3. Medical/Illness: Child was hospitalized, surgeries, or serious medical issues which impacted participation or behavior. Starting, changing, or discontinuation of medication treatment or therapies.
4. Involvement of Other Agencies: Starting new school, preschool, daycare or other community involvement. Department of Child Services became involved, investigation ongoing, or closed case.
5. Moving: Child moved residence or was placed in new living situation.

Compliance

Based on STPR under Compliance with Services: Review STPR compliance and determine which category should be rated (scale of 1 to 5).

1. Compliance with playgroup services only, does not mention other services.
2. Compliance with playgroup and other services such as medication management, therapy and/or case management. Still rate even if compliant with only 2 services, for example, client attends playgroup and participates in case management but is not compliant with therapy.
3. Non compliance with playgroup services, such as under 75% attendance.

SMART

Based on STPR problems, goals, and objectives (treatment plan): Determine if each category should be rated yes or no.

0-no

1-yes

1. Specific – Provided a precise, detailed description relating to an identified problem or behavior and individualized.
2. Measurable – Provided frequency, duration, and ability to be counted or observed.
3. Achievable – Is it within the child/family's capacity and ability, age and developmentally appropriately.
4. Reasonable – Acceptable and based on standard clinical practice.

5. Time-Specific - Provided a specific time frame, short or long term for completion of set goals/reduction in problems.

PARENT INTERVIEWS

Behavior Change

Read statement and determine which category and whether positive or negative (no change, variation or regression)

1. Behavior/Self Control (+): Improvements in aggression, tantrums, calmer, listening more, attention, use of time out. (-): Aggression, tantrums, poor attention, and/or acting out is present or became worse.
2. Social Skills (+): Improvements in sharing, turn taking, resolving peer conflicts, playing with others, engagement. (-) Withdrawal, difficulty sharing/turn taking, fighting with others- continued or became worse.
3. Speech Communication (+): Improvement in verbalizing feelings and thoughts, speech and articulation, expressive/receptive skills. (-): No change or regression in communication thoughts and feelings or articulation.
4. General Knowledge (+): Improvements in colors, numbers, shapes, nursery songs. (-): No change or regression in learning concepts or general knowledge.
5. Non-Specific (+): Improvement made but did provide what type in order to be in a category listed above. (-): No improvement, variation or regression but did not provide what type in order to be in a category listed above.

Home/Community

Read statement and determine which category and whether positive or negative (no change, variation or regression)

1. Behavior/Self Control (+): Improvements in aggression, tantrums, calmer, listening more, attention, use of time out. (-): Aggression, tantrums, poor attention, and/or acting out is present or became worse.

2. Social Skills (+): Improvements in sharing, turn taking, resolving peer conflicts, playing with others, engagement. (-) Withdrawal, difficulty sharing/turn taking, fighting with others-continued or became worse.
3. Non-Specific (+): Improvement made but did provide what type in order to be in a category listed above. (-): No improvement, variation or regression but did not provide what type in order to be in a category listed above.

Voice/Information

Read statement and determine which category and whether positive or negative (no change, variation or regression)

1. Active and regular communication between caregivers and playgroup staff, such as monitoring progress, accessibility, and quick response.
2. Consultation with other providers or agencies in regards to child's progress or concerns.
3. Knowledge that other playgroup staff such as van drivers disseminated information.

Treatment Goals

Read statement and determine which category of awareness the caregiver's statements fell, can include multiple.

1. Behavior/Self Control: Aggression, tantrums, listening, etc.
2. Social Skills: Getting along with others, sharing, turn taking, resolving peer conflicts, manners, playing with others, engagement.
3. General Knowledge: Learning concepts, colors, numbers, shapes, and nursery songs.
4. Developmental: Fine/Gross motor skills, speech, toilet training
5. Non-Specific: Don't know or don't remember enough to provide code for a category listed above.

Parent Meetings

Read statement and determine which category and whether positive or negative (effective or not effective)

1. Parenting skills: Usefulness of parenting/discipline, educational resource and ways to engage and play with child
2. Cohesiveness with other parents
3. Connection with children: reason they attend parent meetings
4. Classroom Observation: (+) Felt comfortable in the classroom and enjoyed spending time with children. (-): Child acted out with parent in the classroom, parent left due to child's behaviors

Other Services

Read statement and determine which category the child participated in and whether their participation was positive or negative (effective or not effective)

1. Case management services: (+) helpful, child looks forward to it, progress on behaviors, linkage to community. (-) not helpful, waste of time.
2. Therapy (+): attending on regular basis, found helpful. (-) if attending, did not find helpful or communication as to the role of therapy was poor.
3. Medication management and/or viewed as positive (+): positive change in behavior/self control. (-): negative side effects, poor communication.

Concerns

Rate on a scale of 1 to 5:

1. No Changes
2. Curriculum/intervention: Problems with lesson or behavior interventions
3. Transportation: Problems with the boundaries of van pick up/drop off
4. Staff concerns: Problems with particular staff behaviors or how they interact with children
5. Communication: Problems with information shared between playgroup staff and caregiver.

PLAYGROUP TEACHER INTERVIEWS

Role in Playgroup

Read statement and determine which category was defined:

1. Facilitator: coach, teacher, role model, and guide.
2. Collaborator: shares information between/among people (families, treatment team, other agencies)
3. Supervisor: organizes program, supervises staff, and decision making.

Role in HCI/CAS

Read statement and determine which category was defined:

1. Separation and isolation: physically, no contact with other staff members, unseen or appreciated.
2. Lack of control: regarding the other CAS programs or decision making.

Behaviors and Practices

Read statement and determine which category was defined:

1. Structure and consistency: Setting limits, consequences, consistent routine and structure, what to expect, safe and comfortable in the classroom.
2. Positivity: Thinking patterns, positive reinforcement with children, positive interactions with others, show positive attention and practices in the classroom.
3. Empathy: Nurturing children and families, putting themselves in another's position and identifying feelings and needs.

Efficiency and Effectiveness

Read statement and determine which category was defined under time management:

1. Organization: Putting items in order, neat, things can be located, know what work needs to be completed.
2. Planning: Scheduling the day, what is going to be done and how, who is in charge of completing things.
3. Prioritize: Organizing things in a time system, what is going to be done first, next, last, when do things need to be completed.

Read statement and determine which category was defined under demands of work:

1. Impact on Children: Indicated concerns that amount of paperwork, documentation and job responsibility impacts time with children, planning activities for children, or fully engaging with children in the classroom.
2. Emotional toll: Indicated difficulty managing stress of work load, productivity, demands of paperwork and job responsibilities.

Child Needs

Read statement and determine which category was defined and if so, can the need be met or not met:

1. Poverty: Impoverished home environment, unable to meet basis needs such as food, clothing, etc.
2. Family Change: Would like to change parent dynamic, parenting skills, attitude and behaviors of parents, interaction with children.
3. Nurturance: Child needs love, caring, compassion, to be taken care of emotionally, treated kindly.
4. Behavioral Needs: Child needs behavioral support, firm limits, opportunities for self control, positive self esteem, etc.
5. Developmental Needs: Child needs support with learning, self-care, speech, toileting, fine/gross motor skills, etc.

Training Needs

Read statement and determine which category was defined:

1. Mental Health Interventions: How to address children with ADHD, Autism, specific behavioral/developmental needs, managing child behaviors, discipline, positive reinforcement, teaching practices, etc.
2. Consultation with other agencies: Meeting with agencies that work with families in the program such as DCS, Medicaid, WIC, etc. to identify needs and process of the systems.

Managing Change

Read statement and determine which category was defined:

1. Size of classrooms: More children entering the program and classes.

2. Number of classrooms: Increase in the overall number of classroom or addition of classes (morning and afternoon).
3. Balancing Demands: Struggling with managing productivity, work demands and the needs of children/facilitation.
4. Learning Curve: Awareness of how change occurs, length of time to train and learn new things.

Strengths

Read statement and determine which category was defined:

1. Structure and Consistency: Classroom rules, routine, behavior structure, consistency in staff.
2. Positivity and Caring: Positive attitude, behaviors, caring for children and families, care about job even with struggles and stress.
3. Mental Health Interventions: Use of play, behavioral interventions, less emphasis on academics, wide variety of techniques.
4. Resources: Full services such as therapy, case management and medication management.