An Overview

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THE PRIMARY MENTAL HEALTH PROJECT

1. INTENDED POPULATION

The Primary Mental Health Project (Primary Project) is a school based early intervention program for young children (preschool through grade 3) who show evidence of early school adjustment difficulties. Primary Project is an indicated prevention program, meaning that it targets children deemed "at-risk." It seeks to maximize children's healthy school adjustment and as such is targeted primarily for children with evident or incipient school adjustment problems in the mild to moderate range, not for children with already crystallized, serious dysfunction. Program evaluations indicate that it can be effectively implemented in geographically, ethnically and economically diverse communities.

This targeted population is depicted schematically in Figure 1. Although this figure appears to represent four "discrete" levels of adjustment, those levels are, in fact, more continuous than discrete. The figure first conveys the notion that most children (those in the lower section of the triangle) are adequately adjusted to school and do not need Primary Project services. Next, it depicts a group of children in whom mild to moderate school adjustment problems are already established or evident. Those are the youngsters for whom Primary Project services are most appropriate. The third group has more difficulties and is ordinarily served by school mental health professionals. The top group, by far the smallest, depicts children already identified with specific diagnoses (e.g. seriously emotionally disturbed, behavior disorder, depressed) who are, or should be, receiving help through the school's special education system or from clinical mental health professionals.

Which Children?

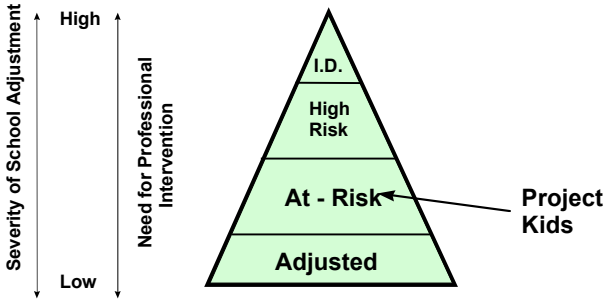

Figure 1

2. PROGRAM GOALS AND RATIONALE

Primary Project, a school-based early detection and prevention program, seeks to enhance learning and adjustment skills and other school-related competencies and to reduce social, emotional and school adjustment difficulties in preschool through primary grade children. Carefully selected and trained paraprofessionals (child associates) provide timely, effective help to children who are just beginning to show adjustment difficulties.

Estimates of the number of young school-aged children who have emotional or behavioral maladjustment requiring intervention range from 8%-22% (Tuma, 1989; U. S. Department of Education, 1994). Children with early school adjustment problems are at greater risk of dropping out of school (Ensminger & Slusarcick, 1992) and are more likely to be among the 25-50% of teenage youth at moderate to high risk for delinquency, substance use problems, teen pregnancy, and other problems of adolescent and early adult development (Weissberg, Caplan, & Harwood, 1991). When children with early school adjustment problems are not provided effective services, they remain at high risk for later, serious problems during adolescence and early adulthood, including delinquency, school failure, and substance abuse (Weissberg et al., 1987).

It is also well known that patterns of school failure often begin in the first three years of school. Research on potential dropouts indicates that characteristics associated with such outcomes can often be identified early (Rotheram, Armstrong, & Booraem, 1982). Risk factors associated with delinquency and drug abuse are also evident in the early grades (Hawkins, Lishner, Jenson, & Catalano, 1987). This growing body of research suggests strongly the critical importance of providing positive early school experiences to young children. When a child's life experience can be fortified at an early age, this support will help them as they grow older.

3. PROGRAM DESCRIPTION

The Primary Project model has been described in numerous publications, including peer-reviewed journals and books. Primary Project's development and evaluation were summarized in School-Based Prevention for Children at Risk: The Primary Mental Health Project (Cowen, Hightower, Pedro-Carroll, Work, & Wyman, 1996), published by the American Psychological Association. A second comprehensive source of information about the Primary Project model and how it can be implemented and evaluated is found in the Primary Project Program Development Manual (Johnson, 2001).

Primary Project has been developed around five structural components, each of which contributes to the program's success:

1	Focus on young children
2	Early screening and selection
3	Use of paraprofessionals to provide direct services to children
4	Role change of the school-based mental health professional
5	Ongoing program evaluation

1) In Primary Project, young children, preschool through third grade are the primary recipient of services. Research shows that competence of **young children** is positively correlated with later quality of adjustment. Therefore, it is important to focus efforts on them.

2) **Systematic screening** of all children in the target age groups facilitates consideration of all children for participation in Primary Project. It is particularly helpful in differentiating children who can benefit most from a prevention program and those in need of more intensive help. Screening also focuses on behaviors that relate most closely to later school difficulties. Further information on screening is included later in this section.

3) **Use of paraprofessionals to provide intervention services**. Primary Project uses carefully selected and trained paraprofessionals to provide direct services to children identified through the screening process. The paraprofessionals (referred to as child associates) work under the direct supervision of certified school mental health professionals (e.g., school psychologists, social workers, counselors).

   Procedures for hiring and training qualified paraprofessionals are outlined in the Primary Project: Program Development Manual (Johnson, 2001). The program seeks to identify qualified adults for the paraprofessional role from within the local school community. Adults within a school community can often provide optimal services to children that are compatible with their cultural and racial values and goals.

   These individuals are central to the effectiveness of any local program. Their ability to enter into a meaningful relationship with children is supported and strengthened through ongoing training and supervision by professionally trained mental health personnel.

   Paraprofessionals are provided initial and ongoing training that prepares them to provide developmentally appropriate, effective intervention services to children. This training program covers topics such as: 1) the school environment; 2) play and young children; 3) confidentiality; 4) communication skills; 5) effective limit-setting strategies with aggressive children; and 6) cultural and ethnic/racial differences.

   The number of children seen will depend on whether the child associate is working full- or part-time, or as a volunteer. A part-time (15-20 hours per week) child associate can see l0-l5 children in a week and have sufficient time for participation in training, supervision, and completion of necessary documents related to program implementation.

4) The **school mental health professional** provides clinical supervision, training, and oversight of the Primary Project. Their clinical skills can then be redirected to work with the children most in need of more intensive intervention. As a result, the impact of their work is geometrically expanded to include a larger number of children. Some schools complement this with a clinical consultant from a community mental health agency.

5) **Ongoing program evaluation** is an important tool in improving the quality of the program as well as in understanding its impact on children. Evaluation can and should be conducted regularly, and include both process and outcomes.

PROGRAM SERVICES

This section outlines direct program services from screening and selection through graduation from the program. Evaluation (see section four) is also considered part of program services, as are planning for and implementing the program (referenced in section five). Each component, planning and preparation, implementation and program evaluation are considered essential for the institutionalization of a program at a local school site/district.

Screening and Selection

The Primary Project begins with procedures to screen all children within the target grades to identify those who stand most to benefit from Primary Project. Children experiencing adaptive or interpersonal problems such as: mildly aggressive, acting-out, shy, anxious, withdrawn and learning behaviors that interfere with educational progress in school are typical Primary Project children. Children may be identified and referred to Primary Project via formal and informal processes such as:

- behavior rating scales (teacher and/or child completed)
- direct observation
- referral by other school personnel
- parent referral.

The screening process begins with collection of information typically after approximately four to six weeks after school starts, allowing time for children to "settle in" to their new environment. For kindergarten children, screening is often deferred until January to allow the children's behavior to stabilize after their first school experiences. Standardized, multi-step screening and detection procedures identify children with early school adjustment problems.

Teachers in classrooms targeted for Primary Project services complete a standardized screening measure, typically the AML-R (Cowen, et al 1996) for each child in the class. All items are rated on a 5-point frequency of occurrence scale (1 = never; 5 = most or all the time) and are summed to yield factor and total scores. AML-R norms provide individual adjustment profiles for all children in targeted classrooms in three domains: aggressive behaviors; learning problems; and anxious-withdrawn behaviors. Predictive validity of the AML-R has been demonstrated using independent teacher ratings of children's behavior and other independent indicators of school adjustment (e.g., achievement) (Cowen et al., 1996).

Children's scores can thus be related to an appropriate reference group and a rough initial index of their adjustment status can be determined. AML-R results can be viewed as a "snapshot in time" and it should be used in conjunction with other information regarding children, such as classroom observation, small group or classroom observation, teacher input, parent input, and staff referrals.

In addition to being identified as at-risk based on screening, a child's referral to Primary Project requires additional independent information (e.g., behavioral observation by a school mental health professional; children's self-report). A large number of evaluations, based on several thousand children, have documented that Primary Project's screening procedures successfully identify children with adjustment problems, compared to non-referred children (Cowen et al., 1996).

In some schools, second and third graders also complete the 24-item Child Rating Scale (CRS) as part of the formal screening process. The CRS has four empirically derived scales: Rule Compliance/Acting Out ("I behave in school"' "I get in trouble"); Anxiety ("I worry about things"); Peer Social Skills ("My classmates like me"); and School Interest ("School is fun"). Each item is rated by the child on a 3-point scale (1 = usually no, 2 = sometimes, and 3 = usually yes). Psychometric data for this measure are reported elsewhere (Hightower et al., 1987).

Systematic use of the AML-R, CRS, or similar measures comprises one key element in Primary Project's mass-screening procedures. Beyond this early focused step, important screening is an ongoing open process. Teachers and other school personnel throughout the year, and across school years, function as observers whose concerns about children can be raised any time with the Primary Project team.

Screening may also include structured observation. The child associate and/or mental health professional observe children working on structured classroom activities. This provides an opportunity to see how children interact with peers and adults. What a child is doing during this time is less important than how he or she interacts with others. Other inputs that can be used effectively in the screening process include teacher referral, self-report, informal observation, parent report, and review of school records.

Selection and Assignment

Relevant screening data is used during assignment conferences. These usually start in mid-October, and are conducted in ways that best fit the school's operating procedure. Primary Project staff and participating teachers consider the screening information. Other school personnel (e.g., the nurse, or the reading teacher) may also attend. The team reviews the information assembled, creates composite sketches of children's school adjustment, identifies children who seem most appropriate for Primary Project services, and for those children, begins to formulate an intervention plan.

In essence, the assignment conference seeks to assess the child's current situation (problems and competencies) from pertinent perspectives and on that basis, to develop a mutually agreed-upon plan to address the child's needs. By the end of the process, children from all classes will have been reviewed, and those appropriate for Primary Project referred. As part of this process, some children may be put on a "watch" list and others referred for further evaluation or outside services.

Prior to Child Contact

Parents of children selected for referral are provided information about the reason for referral and about the intervention process, and they provide written consent for participation. The Background Information Form (BIF) (Children's Institute, 1999) is specifically designed to provide demographic and educational information that can clarify the child's situation and help to formulate intervention plans. BIF data includes general information (e.g., child's name, address, teacher, school and student's identification number) and demographic data (e.g., gender, and date of birth) and information about the child's family (e.g., single parent family, natural parents, foster placement, etc). The BIF also includes items related to the child's educational experience (e.g., "has repeated a grade," "has transferred schools") and child/school characteristics (e.g., "visits school nurse often", "on-going medical problems", "frequent illegal absences"). The final section of the BIF lists life events (e.g., "death of family member," "serious illness in family").

Teacher-Child Rating Scale 2.1 (T-CRS; Perkins & Hightower, 2001). The T-CRS, is a behavior rating scale designed specifically for teachers to assess children's school behaviors. It consists of 32 items assessing four primary and eight secondary domains of a child's socio-emotional adjustment. The empirically derived primary scales assess four salient areas:

1.	Task Orientation:	A child's ability to focus on school related tasks.
2.	Behavior Control:	A child's skill in adapting and tolerating limits imposed by the school environment or by the child's own limitations.
3.	Assertiveness:	A child's interpersonal functioning and confidence in dealing with peers.
4.	Peer Social Skills:	A child's likeability and popularity among peers and how well the child interacts with peers.

Establishing intervention goals and the intervention process. After children are referred for services but prior to starting, classroom teachers complete the T-CRS. An adjustment profile for each child is used to establish intervention goals, established in collaboration with the child's classroom teacher, the school mental health professional, and the child's parent. Program goals include a dual focus on addressing problems and enhancing competencies. For example, goals for an individual child might include: decreasing the child's aggression through the development of prosocial means of anger expression (anger identification, developing language for feelings), increased frustration tolerance, and enhanced peer social skills.

Working with the Children

All aspects of Primary Project support the building of a positive "therapeutic" relationship between the child associate and the child. After initial training and after the children are selected to participate through the screening and selection process, child associates begin to see children regularly. Children are typically scheduled for one 30 to 40 minute one-to-one session per week for one to two school semesters, depending on a child's needs and the program goals for that child. Child associates meet with children in specially equipped playrooms that provide age- and culturally appropriate activities for children. The playroom provides a safe, welcoming and facilitative environment in which the child and adult can interact. The child sets the pace of the interaction and child associate supports, reflects and may direct the child towards his/her goals. Expressive play is one primary activity of the child. These sessions are supported through weekly supervision of the child associate by a school mental health professional.

The child associate is an active participant in the relationship; the intensity of participation is molded by the child. Child associates have to be flexible in the playroom– to be able to enter into the child's play but not to be simply a playmate. It's okay for a child to direct the child associate in the role he/she wants the associate to take on.

After a child has participated in Primary Project for one school semester, conferences are scheduled to assess the child's progress in meeting program goals. Parents may be invited to attend these meetings. Decisions are made regarding the extent to which goals have been reached, and/or need to be changed. If program goals are met, graduation from the program is planned.

Supervision and Training of Child Associates

Since great care is taken to hire child associates with skills and characteristics that provide effective helping services for children, training is intended to build on these positive qualities. Orientation and initial training activities are *focused* and *time limited*. The specifics depend in part on the background experience and needs of the child associates. It is designed to impart information and skills that facilitate work with children in a school environment and to clarify basic procedures and intervention strategies.

Initial training may either precede, or run concurrently with, the associate's first several months on the job. This process takes approximately 16-24 hours and can be structured in any number of ways. Feedback from associates indicates training is most beneficial when it is paced over several weeks rather than massed in a few concentrated blocks. There are different styles of conducting child associate training which are equally effective (Cowen et al, 1996). The style selected is in part dependent upon the method by which the program is being implemented and the resources available to the district. Children's Institute offers a two-day initial training by nationally certified trainers.

For the Primary Project program, necessary support has always been the process of supervision of the associates by mental health professionals. The process begins with the entrance of a child associate into the program and continues until each associate separates from the Primary Project. Supervision is a process that is developmental for each child associate.

Primary Project has always recognized two major areas of supervision in work with child associates, child-centered and child associate-centered supervision. Child-centered supervision relates to the individual children the associates see, reviewing case histories, family dynamics, etc., and offering specific direction to associates in their weekly work with the children in their case load. Associate-centered supervision is a focus on each associate exploring her developing understanding of mental health issues, how it is affecting her and offering advice and guidance to each associate as she evolves in her role, both emotionally and at cognitive levels.

Graduation from Primary Project

Most children will exit from Primary Project as a natural course of events and will participate in all regular school activities. On occasion, some children will make a transition to a more intensive helping service. Whatever the case, a clear transition is important. Approximately three weeks prior to termination, the process of saying goodbye begins.

Evaluating Student Progress

Children's progress in Primary Project is measured formally. A child's progress is discussed through ongoing supervision and conferences with the mental health professionals and, in the case of group supervision, with other child associates. The child's progress is also repeated in ongoing teacher communications and some programs incorporate a "teacher progress report" and with parents.

More formal progress is routinely measured by changes in the T-CRS and the CRS. To measure children's behavior change, pre- and post- assessments are conducted.

At graduation the mental health professional completes the Professional Summary Report (PSR). The PSR provides an assessment of the child's degree of change in each specified area which parallels the T-CRS.

Parental Involvement

Parent involvement varies across sites, but at a minimum parent permission is required for children to participate. Most projects around the country also include parents in a minimum of one conference, and still others include parent education, home visits, and parent support groups as an adjunct of Primary Project.

Parent Permission. After children have been identified for participation in Primary Project and agreed upon by the Primary Project team, written parental consent for the child's participation must be obtained. Johnson (2001) outlines recommended steps. If a parent is uncertain about the recommendation and/or needs additional information that the teacher can't supply, the teacher informs the Core team and one of its members contacts the parent. If the parent agrees with the recommendation and provides written consent the child can be scheduled to begin.

Supervising school mental health professionals follow established procedures for making contact with referred children's parents or guardians. The objective is to conduct a minimum of one parent contact. The goals of these parent contacts are: assessing child and family needs, informing parents of children's progress in the program, working with the parent to reinforce and consolidate program intervention goals, and (based on family needs assessment) referral to community services as needed.

Some Primary Project projects have added a parent component. There is a wide variety of options among programs including parent conferences, parenting classes, home visits, or other activities. At a minimum, parental consent must be obtained prior to a child participating in Primary Project.

4. EVALUATION OUTCOMES

There is general consensus among experts that Primary Project is an exemplary practice based on the evidence available from decades of evaluation and research on Primary Project. In 1984, the National Mental Health Association awarded Primary Project the Lela Rowland Prevention Award as the outstanding prevention program (Cowen and Hightower, 1989). Four years later in 1988, Primary Project was reviewed by the New York State Education Department using national research-based criteria and was the first program designated a validated program under New York State's Sharing Successful Programs using those research criteria. Primary Project was awarded the "Model Program in Service Delivery in Child and Family Mental Health" in 1993 by the Section of Clinical and Child Psychology Section I of Clinical Psychology Division of Child Youth and Family Services of the American Psychological Association. The United Way of Greater Rochester awarded Primary Project the "1995 Quality Award for Excellence in Human Service Programming," which was based on an independent review of program processes and documented outcomes. Seymour B. Sarason (1996) stated, regarding School-Based Prevention for Children at Risk: The Primary Mental Health Project, "This book describes the history, rationale, implementation and outcomes of the longest, most carefully researched, prevention-oriented program in American psychology and education. Not only has this program been refreshingly successful, but it has been adopted in hundreds of schools in the United States and abroad."

Primary Project was highlighted as an exemplary practice in Albee and Gullotta's (1997) volume Primary Prevention Works, by Durlak (1997) in Successful Prevention Programs for Children and Adolescents and in Weissberg, Gullotta, Hampton, Ryan, & Adams (1997) Establishing Preventive Services. Most recently, the National Association of School Psychologists (NASP) surveyed school psychologists across the country to locate the most effective school-based mental health programs. The highlighted programs were selected on the basis of the following criteria, "integrating theory, research and practice; providing a continuum of mental health services; outcomes data; and showing a team-based approach to mental health programming. These programs demonstrate the type of collaborative strategies that are central to school reform initiatives." Primary Project was selected and is described in Exemplary Mental Health Programs: School Psychologists as Mental Health Providers (NASP, 1999). The U.S. Surgeon General's Report on Mental Health recognized Primary Project as one of the five exemplary research-based prevention programs in the nation for enhancing children's mental health (1999). Primary Project has also been validated through the New York State Education Department's "Sharing Successful Programs." In 2000, Primary Project was named a Promising Program by Safe and Drug Free Schools of the U.S. Department of Education.

Research on Primary Project started when Primary Project started; it has been a continuing, essential part of the program's fabric ever since. Tests of Primary Project's effectiveness as a prevention program have utilized several evaluation designs. Each of these evaluation designs has strengths (methodological or ecological) that provide complementary evidence about program efficacy (Cowen et al., 1996) including a composite evaluation for seven consecutive annual cohorts (Weissberg, Cowen, Lotyczewski, & Gestin, 1983). Primary Project's research effort has considered elements beyond outcomes such as to identify factors in children that relate to good and poor school adjustment, specific program elements, and understanding the relationship between the associate-child and associate-supervisor relationship (Cowen et al., 1996; Cowen & Hightower, 1989).

These primary evaluation designs and their major findings are as follows:

Controlled Studies. Several studies have used control groups designed to evaluate the effectiveness of the Primary Project. In one such study, approximately 600 children from 18 school sites were randomly assigned into immediate intervention and delayed treatment groups. Using standard comparison techniques for this design, children who received Primary Project services, relative to those awaiting services, showed significant decreases in adjustment problems, i.e., lower aggression, fewer learning problems, and increased social-emotional competencies, e.g., frustration tolerance, peer relations (Duerr, 1993). Another evaluation of the Primary Project model also utilized a wait-control design and employed a 3-month follow-up evaluation (Nafpaktitis & Perlmutter, 1998). In this study, children in an immediate intervention group, compared to wait-list controls, declined in teacher ratings of learning problems and shy-anxious behaviors, and increased in task orientation and peer social skills. Improvements in both problems and competencies placed children within a range of functioning exhibited by non-referred peers. At 3-month follow-up children had not significantly decreased in functioning based on teacher ratings (Nafpaktitis & Perlmutter, 1998).

Comparison Designs. Several evaluation studies have compared adjustment between children receiving Primary Project services and comparably at-risk children in schools without Primary Project services. This design allows careful matching of intervention and comparison groups and tracking of their adjustment over time (Cowen et al., 1996). One such study compared: a) children in the Primary Project model who received an average of 25, 40 minute contacts over a 5-6 month period, and b) comparison children with similar initial adjustment status identified in non-Primary Project schools. In this study, Primary Project-served children were shown, after a school year, to decrease in adjustment problems and increase in adaptive competencies compared to comparison children (Winer-Elkin, Weissberg, & Cowen, 1988).

Longer-term Follow-up of Primary Project Children. Several studies in urban and rural schools have evaluated children several years after participation in Primary Project. For example, Chandler, Weissberg, Cowen & Guare (1984) evaluated 61 urban children, seen 2-5 years earlier in the Primary Project model, with 61 matched to the Primary Project sample by gender, grade level, and current teacher. Adjustment ratings by children's current classroom teachers confirmed that children seen in the Primary Project model had, 2-5 years later, maintained their initial adjustment gains.

Primary Project was introduced into several elementary schools in Community School District 4, in the East Harlem section of New York City. This district, consisting of approximately 60% Hispanic and 30% African American children, is characterized by high rates of poverty, unemployment (> 40%), health problems, teen pregnancy, and drug use. The implementation of the Primary Project model to Kindergarten-3rd grade children in School District 4 was evaluated over a 4-year period. Results from evaluations over this 4-year period found children had more positive school adjustment (fewer adjustment problems, greater competencies) after one year in the program (Meller, Laboy, Rothwax, Fritton, & Mangual, 1994). Moreover, children's self-ratings of adjustment showed increased rule compliance, school interest, peer acceptance, and decreased anxiety (Meller et al., 1994).

Ongoing Site-Based Evaluations. Evaluations of several hundred individual Primary Project program sites have been conducted in New York and California. These evaluations include comparison of children's classroom adjustment problems and competencies at a) time of referral, and b) graduation from the program (See appendix for sample data interpretation guide). Through this method, an ecologically valid assessment of children's adjustment status in large numbers of school sites is possible. During the 1997-98 school year, evaluation of children in New York State Primary Project included over 1,500 children in 50 schools. These Primary Project sites provided over 15,000 preventive-focused contacts to children. Overall, 82% of these children had adjustment problems, prior to referral, that placed them at "high" or "moderate high" risk. Mental health professionals reported that 60% of children in Primary Project showed reductions in aggressive behavior and improved social skills, and 50% displayed better academic performance (Hightower, 1998).

5. PROGRAM FEATURES LENDING TO EASE OF REPLICATION

The key structural components of Primary Project allow for adaptation to the local district/sites, while retaining the flexibility to meet the uniqueness of the individual setting. This makes Primary Project applicable to a broad range of children and communities.

Primary Project model programs have been successfully established in 120 school districts across New York State. At the national level, centralized networks of programs based on Primary Project in over 1,000 school districts (Cowen, Hightower, Johnson, Sarno and Haffey, 1989) have been established in the following states: California (Primary Intervention Program), Connecticut (Primary Mental Health Project), Hawaii (Primary School Adjustment Program), Maine (Healthy Learners Initiative), Washington (Primary Intervention Program), Florida, Minnesota, Texas, Vermont, and Michigan. In two of these states, California and Connecticut, specific legislation including the key structural components has been chaptered with accompanying budget support. In California, the Primary Project is coordinated through the Department of Mental Health through the Early Mental Health Initiatives; in Connecticut, Hawaii, Maine, New York and Washington, through the departments of Education.

Support to districts and sites interested in implementing a Primary Project is available through multiple venues: consultation, training, program materials, and internship opportunities. Program materials include:

School Based Prevention for Children at Risk: The Primary Mental Health Project (Cowen, et. al, 1996),

The Primary Project: Program Development Manual (Johnson, 2001),

Behind these Young Faces: The Primary Mental Health Project (Children's Institute Inc., 1995),

Screening and Evaluation Measures and Forms: Guidelines (Children's Institute Inc., 2001),

Supervision of Paraprofessionals in School-Based Programs (Mijangos and Farie, 2001),

T-CRS Examiner's Manual (Children's Institute, 2002).

On site consultation and support is available through Children's Institute Inc. program consultants, and a listing of training programs is available for state and local personnel who have successfully implemented local programs. Additional training videos have been developed and are available for loan from Children's Institute Inc. Community Services.

In each of the states, as well as at each school site, replication of the Primary Project is dependent on the ability to meld the five key structural components of the program with the goals and objectives of the site. A process for implementing a Primary Project at a local site is outlined in Best Practices for Adopting a Prevention Program (Hightower, Johnson and Haffey, 1995).

To ensure that a Primary Project is implementing a "true" Primary Project, a school site may apply for national certification. Specific criteria are available to determine if a Primary Project program has implemented a model with fidelity to the program concepts. A designation of Primary Project National Certification is applied for a 3-year period to programs that meet these criteria. Schools that apply for certification must pass a site review conducted by a Primary Project consultant. The certification committee also examines each schools' ability to meet the following requirements: systematic screening and review of children; length of participation of children in the program; selection and training of child associates; consistent supervision; appropriate space for the program within a school building; administrative support; program evaluation; active teacher and support staff; and community support.

Relative to other traditional school and community mental health services, Primary Project is a low-cost program. The cost of a single contact session with a child can be less than $10, as contrasted with currently prevailing private practice charges of at least $90+ per session. The average annual cost of seeing a single Primary Project child can be less than $250/year, a figure that contrasts sharply with, for example, the estimated annual treatment costs per child ranging from $15,000-$40,000/year in children's units in state hospitals or at residential treatment centers. Given the fact that the cost of an individual evaluation may be as high as $1,200, and placement in a special education program may cost $5,000/year, it can be said that if a school's program "prevents" only two such negative outcomes per year, the program "more than pays for itself." Beyond that, of course, the human savings may be enormous.

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Teacher-Child Rating Scale (T-CRS) 2.1

ID Number

Grade

PreK (P)
K (K)
1 (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7 (7)
8 (8)
9 (9)
10 (10)
11 (11)
12 (12)
Other

Today's Date

Month	Year
Jan	1999
Feb	2000
Mar	2001
Apr	2002
May	2003
June	2004
July	2005
Aug	2006
Sept	2007
Oct	2008
Nov	2009
Dec	2010

For Office Use Only

Child's Name: _____ (Last) (First)

Teacher: SAMPLE

School: _____

Sex (M) (F)

Screening	Initial	(Middle)	Final
○	○	○	○

Use a No. 2 pencil only

Erase changes completely

CORRECT MARK ●

Please rate ***how much you agree each item describes the child***. Fill in the oval corresponding to your response.

	Strongly Disagree ◄				► Strongly Agree
1. A self-starter	1	2	3	4	5
2. Disturbs others while they are working	1	2	3	4	5
3. Participates in class discussions	1	2	3	4	5
4. Lacks social skills with peers	1	2	3	4	5
5. Has difficulty following directions	1	2	3	4	5
6. Accepts imposed limits	1	2	3	4	5
7. Withdrawn	1	2	3	4	5
8. Makes friends easily	1	2	3	4	5
9. Functions well even with distractions	1	2	3	4	5
10. Overly aggressive to peers (fights)	1	2	3	4	5
11. Defends own views under group pressure	1	2	3	4	5
12. Other children shun or avoid this child	1	2	3	4	5
13. Underachieving (not working to ability)	1	2	3	4	5
14. Tolerates frustration	1	2	3	4	5
15. Anxious, worried	1	2	3	4	5
16. Classmates like to sit near this child	1	2	3	4	5
17. Works well without adult support	1	2	3	4	5
18. Defiant, obstinate, stubborn	1	2	3	4	5
19. Expresses ideas willingly	1	2	3	4	5
20. Has trouble interacting with peers	1	2	3	4	5
21. Poorly motivated to achieve	1	2	3	4	5
22. Copes well with failure	1	2	3	4	5
23. Nervous, frightened, tense	1	2	3	4	5
24. Has many friends	1	2	3	4	5
25. Completes schoolwork	1	2	3	4	5
26. Disruptive in class	1	2	3	4	5
27. Comfortable as a leader	1	2	3	4	5
28. Other children dislike this child	1	2	3	4	5
29. Has poor concentration, limited attention span	1	2	3	4	5
30. Accepts things not going his/her way	1	2	3	4	5
31. Does not express feelings	1	2	3	4	5
32. Well liked by classmates	1	2	3	4	5

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PLEASE DO NOT WRITE IN THIS AREA

136329

Child Rating Scale (CRS)

FIRST NAME SAMPLE **LAST NAME** _____

SCHOOL _____ **TEACHER** _____

TODAY'S DATE _____ / _____ / _____
MONTH DAY YEAR

SCREENING	INITIAL	(MIDDLE)	FINAL
S	I	M1 M2	F

NOTE: 'MIDDLE' for non-project use only.

SEX: B G

RACE: White ○ African Am. ○ Native Am. ○ Asian ○ Hispanic ○ Other ○

AGE: 5 6 7 8 9 10 11 12 13

GRADE: Pre-K P; K K; 1 1; 2 2; 3 3; 4 4; 5 5; 6-8 6-8; Other O

CHILD ID NUMBER

0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9

0	0	0	0	0
1	1	1	1	1
2	2	2	2	2
3	3	3	3	3
4	4	4	4	4
5	5	5	5	5
6	6	6	6	6
7	7	7	7	7
8	8	8	8	8
9	9	9	9	9

IMPORTANT – PLEASE READ

- USE NO. 2 PENCIL ONLY
- Erase any changes completely.

EXAMPLE

WRONG ⊘ ✓ ✗ RIGHT ●

PLEASE DECIDE HOW MUCH EACH SENTENCE BELOW DESCRIBES YOU.

	USUALLY NO	SOMETIMES	USUALLY YES
If it is USUALLY NOT like you, fill in the N.	●	S	Y
If it is SOMETIMES like you, fill in the S.	N	●	Y
If it is USUALLY like you, fill in the Y.	N	S	●

	USUALLY NO	SOMETIMES	USUALLY YES
A. I like to swim.....	N	S	Y
B. I'm good at drawing pictures.....	N	S	Y

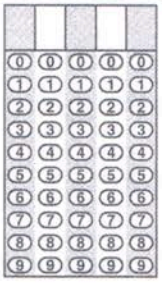
SCANTRON FORM NO. F-5059-CCS

SAMPLE

	USUALLY NO	SOMETIMES	USUALLY YES
1. I behave in school	N	S	Y
2. I get scared in school	N	S	Y
3. I have many friends	N	S	Y
4. I like to do school work	N	S	Y
5. I bother classmates who are working	N	S	Y
6. I'm afraid of making mistakes	N	S	Y
7. My classmates tease me	N	S	Y
8. I get bored in class	N	S	Y
9. I do what I'm supposed to in school	N	S	Y
10. I worry about things at school	N	S	Y
11. Other kids are mean to me	N	S	Y
12. School is fun	N	S	Y
13. I get in trouble in class	N	S	Y
14. My feelings get hurt easily	N	S	Y
15. My classmates like me	N	S	Y
16. I like to answer questions in class	N	S	Y
17. I follow the class rules	N	S	Y
18. I'm nervous at school	N	S	Y
19. Other kids choose me last for games	N	S	Y
20. I hate school	N	S	Y
21. I call other students names	N	S	Y
22. I feel like crying at school	N	S	Y
23. I make friends easily	N	S	Y
24. I get tired of going to school	N	S	Y

Background Information Form (BIF)

For Office Use Only



Child's Name _____ (Last) (First)

SAMPLE

Teacher _____ **School** _____

Parent/Guardian _____ (Optional) **Phone** _____ (Optional)

Address _____ (Optional)

ID Number

Grade

PreK (P)
K (K)
1 (1)
2 (2)
3 (3)
4 (4)
5 (5)
6 (6)
7 (7)
8 (8)
9 (9)
10 (10)
11 (11)
12 (12)
Other ( )

Today's Date

Month	Year
Jan	1999
Feb	2000
Mar	2001
Apr	2002
May	2003
June	2004
July	2005
Aug	2006
Sept	2007
Oct	2008
Nov	2009
Dec	2010

Date of Birth

Month	Day	Year
Jan		
Feb		
Mar	0 0	0 0
Apr	1 1	1 1
May	2 2	2 2
June	3 3	3 3
July	4	4 4
Aug	5	5 5
Sept	6	6 6
Oct	7	7 7
Nov	8	8 8
Dec	9	9 9

Sex (M) (F)

Race

- White
- African Am.
- Native Am.
- Asian
- Hispanic
- Mixed
- Other

Use a No. 2 pencil only

Erase Changes Completely

Educational Characteristics

	No	Yes	If "Yes" – then answer below:
1. Has Repeated a Grade	N	Y	→ Grade(s) Repeated K 1 2 3 4 5 6 7 8
2. Has Transferred Schools	N	Y	→ Number of Transfers 1 2 3 4
3. Has Been Suspended from School	N	Y	→ Number of Suspensions 1 2 3 4
4. Enrolled in Special Education (If no, go to question 5)	N	Y	
a. Speech/Language	N	Y	
b. Learning Disabled or Perceptually Handicapped	N	Y	
c. Emotionally or Behaviorally Disabled	N	Y	Additional Diagnosis, if any _____
d. Mental Retardation	N	Y	
e. Other _____	N	Y	
5. Remedial Education	N	Y	
6. English as a Second Language	N	Y	
7. Attention Deficit (e.g., ADD, ADHD)	N	Y	
8. Current Overall Academic Performance (i.e., letter grade)	Excellent ←	A B C D F	→ Failing
9. Other _____	N	Y	

Student Characteristics

	No	Yes
1. Many absences from school (e.g., on average-1 day per week)	N	Y
2. Involved with activities outside of school (e.g., scouts, sports, church)	N	Y
3. Visits school nurse often	N	Y
4. Ongoing medical problems	N	Y
5. Child is a pleasure in class	N	Y

Estimated Social Economic Status (SES)

- Below poverty
- Lower SES
- Middle SES
- Upper SES

Parent (or Caregiver) Information

- Both natural or adoptive parents in home
- Single parent family—divorce or separation
- Single parent family—other (e.g., death, never married)
- Natural/Adoptive parent with stepparent
- Foster placement
- Other _____

PLEASE DO NOT WRITE IN THIS AREA

55624

Associate-Child Rating Scale (A-CRS)

CHILD'S NAME SAMPLE (LAST) (FIRST)

TODAY'S DATE ___/___/___ (MM) (DD) (YY)

SEX Ⓜ Ⓕ

TIME OF FORM COMPLETION: (Fill in one.) **INITIAL** Ⓘ **FINAL** Ⓕ

TEACHER _____

SCHOOL _____

NUMBER OF SESSIONS TO DATE _____

CHILD ID NUMBER

0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9

Based on your direct contacts with this child to date, please rate each of the behaviors according to how well it describes the child now by filling in the corresponding number:

Describes child:	**Not at All**	**A Little**	**Moderately Well**	**Well**	**Very Well**
1. Looks forward to coming	①	②	③	④	⑤
2. Aggressive	①	②	③	④	⑤
3. Is fearful	①	②	③	④	⑤
4. Completes task	①	②	③	④	⑤
5. Expresses feelings openly	①	②	③	④	⑤
6. Tests limits	①	②	③	④	⑤
7. Anxious, worries about things	①	②	③	④	⑤
8. Copes well with failure	①	②	③	④	⑤
9. Participates enthusiastically	①	②	③	④	⑤
10. Fidgety, difficulty sitting still	①	②	③	④	⑤
11. Nervous, tense	①	②	③	④	⑤
12. Competes fairly	①	②	③	④	⑤
13. Good rapport with me (child worker)	①	②	③	④	⑤
14. Disruptive during sessions	①	②	③	④	⑤
15. Sad, unhappy	①	②	③	④	⑤
16. Tolerates frustration	①	②	③	④	⑤
17. Maintains eye contact when speaking	①	②	③	④	⑤
18. Stubborn, obstinate	①	②	③	④	⑤
19. Feelings are hurt easily	①	②	③	④	⑤
20. Mood is balanced and stable	①	②	③	④	⑤

- **ERASE CHANGES COMPLETELY**
- USE NO. 2 PENCIL ONLY

	PART.	LIMITS	ANXIETY	SELF-
RAW SCORE				

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Child Log

CHILD'S NAME _____ (LAST) SAMPLE (FIRST) _____

CHILD ASSOCIATE(S) _____

SCHOOL _____ DISTRICT _____

- USE NO. 2 PENCIL ONLY
- ERASE CHANGES COMPLETELY

CHILD ID NUMBER

TODAY'S DATE — MONTH / DAY

INITIAL SESSION — MONTH / DAY

FINAL SESSION — MONTH / DAY

INDIVIDUAL SESSIONS:

NOTES

ASSOCIATE ID

NUMBER OF SESSIONS

AVG. SESSION LENGTH

- 20 min.
- 25 min.
- 30 min.
- 35 min.
- 40 min.
- 45 min.
- 50 min.
- 55 min.
- 60 min.
- 65 min.
- 70 min.

TYPICAL NUMBER SESSIONS PER WEEK

- One
- Two
- Three
- Four
- Five

GROUP SESSIONS:

NOTES

ASSOCIATE ID

NUMBER OF SESSIONS

AVG. SESSION LENGTH

- 20 min.
- 25 min.
- 30 min.
- 35 min.
- 40 min.
- 45 min.
- 50 min.
- 55 min.
- 60 min.
- 65 min.
- 70 min.

TYPICAL NUMBER SESSIONS PER WEEK

- One
- Two
- Three
- Four
- Five

MONTHS REPRESENTED

FILL IN ALL THAT APPLY

- SEP.
- OCT.
- NOV.
- DEC.
- JAN.
- FEB.
- MAR.
- APR.
- MAY
- JUN.
- JUL.
- AUG.

Professional Summary Report (PSR)

Child's Name: SAMPLE (Last) (First) School: _____

Child Associate: _____ Supervising Professional: _____ Today's Date: ___/___/___ (MM) (DD) (YY)

Instructions:

This report should be completed by the **supervising professional.** It should summarize how this student is perceived by the supervising professional, child associate, and teacher(s).

Use a No. 2 pencil only

Erase changes completely

CHILD ID NUMBER

0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9

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TITLE OF PERSON COMPLETING FORM

① Psychologist
② Social Worker
③ Counselor
④ Other

_____ (please specify)

Section I: **Indicate changes in the student's behavior since the time of referral by filling in the appropriate space for each item. If a behavior never applied to this student, fill in "NA," not applicable.**

	MUCH WORSE	WORSE	SAME	IMPROVED	GREATLY IMPROVED	NA
1. Acting-out/aggressive behaviors	①	②	③	④	⑤	NA
2. Shy, withdrawn, or anxious behaviors	①	②	③	④	⑤	NA
3. Task orientation	①	②	③	④	⑤	NA
4. Frustration tolerance	①	②	③	④	⑤	NA
5. Assertive social skills	①	②	③	④	⑤	NA
6. Peer social skills	①	②	③	④	⑤	NA
7. Initiative and participation	①	②	③	④	⑤	NA
8. Self-confidence	①	②	③	④	⑤	NA
9. Interest in school	①	②	③	④	⑤	NA
10. Academic performance	①	②	③	④	⑤	NA
11. Overall school behavior	①	②	③	④	⑤	NA
12. Attendance	①	②	③	④	⑤	NA
13. Other _____	①	②	③	④	⑤	NA

Section II: **Fill in the most appropriate choice for each item below:**

1. Child is leaving Project at this time because
   - ① child has met his/her goals.
   - ② school year is ending.
   - ③ child is moving or has moved.
   - ④ child has transferred to another helping service (e.g., special education, another school program, outside Mental Health agency).
   - ⑤ other (please specify). _____

2. Recommendation for this child is to
   - ① terminate from Project.
   - ② continue in Project next fall.
   - ③ evaluate child's progress in the fall as a basis for decision about Project continuation.
   - ④ continue in Project in next school, if available.
   - ⑤ other (please specify). _____

0	0	0	0	0
1	1	1	1	1
2	2	2	2	2
3	3	3	3	3
4	4	4	4	4
5	5	5	5	5
6	6	6	6	6
7	7	7	7	7
8	8	8	8	8
9	9	9	9	9

Comments: _____

_____

PLEASE DO NOT WRITE IN THIS AREA

06021