Primary PROJECT

AN OVERVIEW

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Primary Project: An Overview

The importance of school adjustment

The beginning of school is a period marked by both opportunities and challenges. As a key transition period in childhood, the start of school is a change in children's environment at a time when their social and cognitive capabilities are also actively changing.

School requires children to negotiate many changes in their physical environment, social environment, identity, relationships, and rules (Dockett & Perry, 2007). Children's academic and social trajectories are formed in the early stages of public schooling, and specific characteristics such as emotional and behavioral control, family income, and parental education tend to place children on different achievement trajectories by second grade (Dunlap et al., 2006; Schunk, Pintrich, & Meece, 2008). Likewise, early transitional experiences in school play an important role in all children's development as learners (Wigfield, Eccles, Schiefele, Roesner, & Davis-Kean, 2006). Self-regulation, social skills, and cognitive abilities all contribute to children's successful transition to school (Bronson, 2000; Miles & Stipek, 2006).

When school adjustment does not go well, children's success can be compromised. Children who show difficulty with emotional and behavioral regulation, peer social skills, attention, and engagement do not simply "grow out of it." As the field of early childhood mental health continues to be studied, we have learned that early learning and behavior/mental health problems correlate with more serious difficulties later in life and impact learning, social competence, and lifelong health (National Scientific Council on the Developing Child, 2008). Furthermore, untreated mental health concerns may have long-term implications on children's ability to fulfill their potential. Ultimately, these concerns may impact the health, education, labor, and criminal justice systems in our society (Kataoka, Zhang, & Wells, 2002; National Research Council and Institute of Medicine, 2009).

Children with well-established social-emotional and behavioral competencies tend to perform better academically (DiPerna, Volpe, & Elliott, 2002; Green, Forehand, Beck, & Vosk, 1980; Malecki & Elliott, 2002; McClelland, Acock, & Morrison, 2006; Wentzel, 1991). However, students with social-emotional problems frequently experience academic difficulties (Graziano, Reavis, Keane, & Calkins, 2007). The consequences of an educational system's inability to meet the social, emotional, mental, and behavioral needs of students may be devastating for the child's academic future, peer relationships, family, neighbors, and the community at-large (Lagana-Riordan & Aguilar, 2009; National Research Council and Institute of Medicine, 2009; National Scientific Council on the Developing Child, 2008). As we continue to learn about the connections between social, emotional, mental, and educational learning, it is clear that promoting wellness and resilience in young children and providing them with positive early school experiences are vital.

Wellness and resilience

Lorion (2000) defines wellness as “psychological capacity to cope with the demands arising across time, circumstance, and setting.” Cowen (1994) identifies five pathways to wellness: (1) establishing early attachment relationships that promote feelings of belonging and being loved; (2) acquiring age-appropriate competencies that foster a feeling of self-efficacy; (3) encountering opportunities to interact with systems, settings, and people beyond the family that favor wellness outcomes (for instance, schools); (4) developing a sense of empowerment, feeling of control, and being able to make decisions; and (5) being able to cope with major life stresses.

Resilience is generally defined as the ability to deal with life’s challenges in a positive and productive manner despite risk and adversity (Goldstein & Brooks, 2005). Family problems, school problems, health issues, poverty, violence, peer rejection, and crises are examples of adversity that can undermine a child’s mental health and interfere with learning (Goldstein & Brooks, 2005).

After families, schools offer children the most opportunities to develop strengths and competencies (Rutter & Maughan, 2002). Resilience is essential to success in school and life, and critical goals for schools should be to foster resilience in children and to help children develop competencies that allow them to overcome adversity in order to improve school and personal outcomes and to reduce risk behaviors (Christner & Mennutti, 2009).

Providing a high level of support is a critical strategy for promoting resilience. Research shows when supports are absent or fragmented, conditions for learning are likely to be weak and children are likely to have substantially poorer behavior and weaker academic performance (Lee, Smith, Perry, Smylie, 1999). Similarly, a sense of belonging and connectedness is vital to students’ success. Children who feel connected have more positive attitudes toward school, are more engaged in learning (Elias & Weissberg, 2000), and are less likely to engage in risky behaviors such as substance abuse, violence, and precocious sexual activity (Centers for Disease Control and Prevention, 2009).

Connections should not only be child-to-child, but child-to-adult as well. Research consistently shows the importance of having caring connections with adults in the school setting (Catalano, Haggerty, Oesterle, Fleming, & Hawkins, 2004). Students who feel connected to an adult are more likely to perform better both behaviorally and academically. This is especially true for children with social-emotional and behavioral challenges.

Three-tiered intervention

Most schools have implemented a Response to Intervention model (RtI) to identify and meet children's academic, as well as social-emotional and behavioral needs. RtI is a multi-tiered approach that incorporates early identification of learning and behavioral needs with prevention and intervention services at increasing levels of intensity. Decisions about interventions and their effectiveness are based on data collected about the child.

RtI typically is represented by a pyramid with three levels:

- **Tier 1** represents universal prevention and intervention, and targets all students, most of whom (about 80%) are adjusted to school. The goals of universal interventions aim at building protective factors, preventing problems before they occur, and offering students resources (Christner & Mennutti, 2009). Some of the efforts directed toward social-emotional development include screening for social-emotional concerns of all students and providing social-emotional learning curricula.
- **Tier 2** includes targeted (selected) prevention and intervention efforts directed to students (approximately 15%) manifesting learning and/or adjustment difficulties. These children are at higher risk for social-emotional difficulties.
- **Tier 3** involves intensive prevention and intervention efforts directed to students with substantial academic and/or social-emotional needs (approximately 5%). Tier 3 interventions are highly individualized based on the student's specific needs.

What is Primary Project?

Primary Project is a Tier 2 school-based program for children displaying school adjustment problems in the mild or moderate range (for instance, withdrawal or shy behaviors, mild acting out behaviors, and potential learning difficulties). It is not a program for children who have severe social, emotional, or behavioral difficulties. Primary Project aims at enhancing social, emotional, behavioral, and learning skills while reducing social, emotional, and school adjustment difficulties in preschool through primary grade children. Targeted outcomes for these children include increased task orientation, behavior control, assertiveness, and peer social skills.

Initially, young children with early school adjustment difficulties are identified through the use of scientifically tested screening measures. Observations of the child in the classroom and other natural settings, as well as parental referral, are also taken into consideration. Once children are identified and parental permission is obtained, the children meet weekly with carefully selected and trained paraprofessionals (child associates) who use developmentally appropriate child-led play as a vehicle to provide a timely, effective intervention. Child associates work closely with and under the supervision of mental health professionals to

provide effective and cost-efficient care for the children they serve. The intervention sessions typically run for one cycle (12-15 weeks), with a small number of children being served for a longer period of time. Evaluation studies show that Primary Project helps children become more productive in school (Cowen, Hightower, Pedro-Carroll, Work, Wyman, 1996; Nafpaktitis & Perlmutter, 1998).

Why Primary Project?

The practical and theoretical philosophy of Primary Project is grounded in the importance of promoting children's social and emotional health by responding to emerging difficulties before behaviors become entrenched. Primary Project is concerned with the earliest possible identification and intervention of emerging difficulties to prevent more challenging problems from occurring. By addressing problems such as not getting along with peers, or having difficulty with school routines early, more severe problems may be prevented.

When compared to traditional mental health services, Primary Project is a low-cost program.

Key structural components

Primary Project is based on six structural components, each of which is essential to the program's success. Balancing these key structural components with necessary local adaptations is a fidelity challenge. Fidelity means delivering the program as it is designed without making changes that can affect outcomes. While Primary Project is applicable to a broad range of children and communities, attention to fidelity of implementation is critically important.

The core components are:

1. Focus on young children (preschool to third grade)
2. Systematic screening of all children in targeted grades and selection
3. Use of paraprofessionals to provide the direct service to children
4. Role change of the school-based mental health professional
5. Continuous use of data for child and program evaluation
6. Integration into the school

Because the aim of Primary Project is to prevent school adjustment difficulties, it is logical to focus the delivery of services on young children in preschool through third grade. With the significant increase of research in neuroscience, attachment, early childhood education, and infant/early childhood mental health, it is clear the earlier we support the positive mental and physical health of young children and their families, the better the outcome.

Systematic screening of all children in the target age groups facilitates consideration of *all* children for participation in Primary Project. It is particularly helpful for differentiating between children who can benefit most from a prevention program and those in need of more intensive help. Screening also identifies areas of concern for the specific child and can be helpful in establishing goals or for referral to other necessary interventions.

In Primary Project, paraprofessionals (typically referred to as child associates) provide direct services to children. These individuals are central to the effectiveness of the program and in providing the evidence-based intervention. 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.

Strategies for selecting/hiring qualified paraprofessionals along with sample job descriptions and hiring resources are outlined in the *Primary Project: Program Development Manual* (Peabody, Johnson, Smith, Sanyshyn, Zordan, 2016). Job requirements (p. 38-39); sample job description (p. 43); sample interview questions (p. 44) are all in the manual.

The number of children to participate in the program is dependent upon the child associate's hours. A part-time (15-20 hours per week) child associate may see 12-16 children in a week (or 24-32 children over the course of a year) and still allow for sufficient time to engage in training, supervision, and completion of necessary documents related to program implementation.

The primary role of the Primary Project mental health professional (typically a school psychologist, social worker, or counselor) is to provide clinical supervision and training to the child associate(s). With child associates seeing students who fall within the range of mild adjustment difficulties, the mental health professionals may direct their clinical efforts to target children in need of more intensive intervention. As a result, the impact of the mental health professional's work expands to include a larger number of children. In some programs, the supervisor is also the coordinator of the program who takes on a more comprehensive role.

Ongoing program evaluation is an important tool in maintaining the quality of a program as well as in understanding its impact on children. Evaluation must be conducted regularly and include both process and outcome measures.

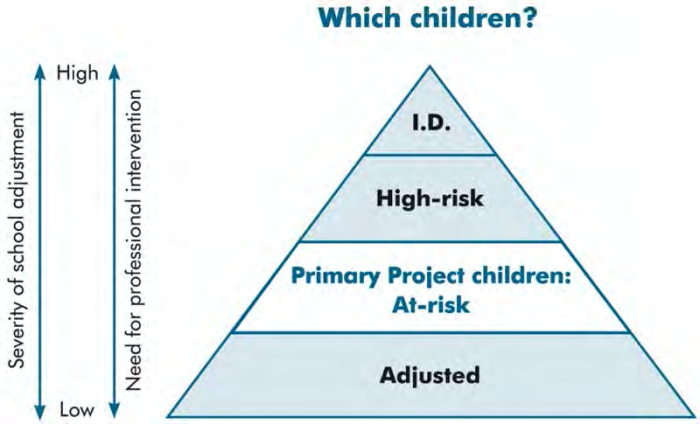
Primary Project has built-in evaluation and data components which are available electronically. COMET® is an online data collection and management system for Primary Project and many other school-wide data reporting needs. In this era of accountability and data driven school environments, demonstrating individual child, group, and district-wide level data are critical to on-going funding and program support at multiple levels.

The sixth program component is the integration of Primary Project into the school environment, such as being situated within the school's continuum of care and supports for children. It is important that Primary Project connects with other social and emotional efforts in a building, such as the Response to Intervention (RtI) initiatives, Positive Behavior Intervention Support (PBIS) efforts, kindergarten screening, and educational efforts around mental health. To maximize efficacy, Primary Project should be integrated into a variety of programs and school climate efforts.

Characteristics of typical students

Primary Project is a targeted prevention program that seeks to maximize children's healthy school adjustment and later school success. In pursuing this goal, Primary Project targets children with early school adjustment difficulties in the mild to moderate range. Primary Project is not for children with crystallized, serious difficulties.

This intended focus is depicted schematically in the figure below. The figure conveys the notion that most children are adequately adjusted and will not need Primary Project services. It also depicts a smaller group of children for whom mild to moderate school adjustment problems are already established or evident. These are the children for whom Primary Project services are most appropriate. The third group has more serious difficulties and may ordinarily be served through school mental health professionals. The top group, by far the smallest, depicts children already identified with specific diagnoses (for example, seriously emotionally disturbed, behavior disorder, clinically depressed) and who are, or should be, receiving help through the school's special education system or from other mental health professionals.



Screening

A basic principle of Primary Project is to screen all children within the targeted grades to identify those who may benefit most from Primary Project and to develop an accurate baseline of all children's early school adjustment. For example, if it were decided that only first graders would be served, all first graders would be screened. This approach not only identifies children who are most likely to benefit from Primary Project, it also identifies those who may need more intensive services.

Students who are experiencing mild adaptive difficulties, such as being withdrawn or shy, having peer difficulties, or mild to moderate self-regulation and behavior difficulties that interfere with learning, are typical children who benefit from involvement in Primary Project.

Children who are the first to come to teachers' minds may *not* be the most appropriate for Primary Project. Such children usually require a disproportionate amount of teacher attention and may need other more intensive services. It is the intent that Primary Project works with children with emerging difficulties before they become rooted and have a greater likelihood of having long-term serious consequences.

Children may be identified and selected to participate in Primary Project through formal and informal processes such as:

- Rating scales (teacher and/or child completed)
- Direct observation
- Referral by school personnel
- Parent referral
- Review of school records

The screening process begins with the collection of information, typically four to six weeks after school starts. This allows time for children to "settle in" to their new environment. For kindergarten and preschool children, screening may be deferred until January to allow the children's behavior to stabilize after their first school experiences. Districts make these decisions based on whether there is a pre-K experience for most children, full or half day kindergarten, and the number of available child associate hours during the week.

Rating scales

Ideally, children in prekindergarten through third grade are screened for signs of school adjustment difficulties using the Teacher-Child Rating Scale (T-CRS). This formal screening step is intended to provide a means to identify children for whom Primary Project will most likely be successful. The T-CRS also identifies children for whom more extensive review and action is indicated.

Teacher-Child Rating Scale (T-CRS)

Teachers complete the T-CRS for program children twice: prior to participation (as the initial screening and pre-data measure) and at termination or post-intervention (as the final outcome measure). The T-CRS is designed specifically for teachers to assess children's behaviors, both those of concern, as well as competencies. The T-CRS has robust psychometric properties making it an ideal tool for screening large groups of children. The rating scale has been shown to provide the same results over time and is consistent with other similar screening tools. The alpha and test-retest reliabilities range from .85 to .95 and the indices of concurrent validity with the Child Behavior Check List are excellent.

Teachers complete the pre-T-CRS to provide "base-line" behavior information. This allows for the information to be used for intervention planning and program evaluation. More specifically, individual T-CRS items can be used to target and focus anticipated goals for children in Primary Project and to help design and/or select more intensive interventions for services beyond Primary Project.

The T-CRS assesses both needs and competencies in four areas using four primary empirically derived scales:

1. **Task orientation**: A child's ability to focus on school related tasks
2. **Behavior control**: A child's ability to self-regulate behavior and emotions, and adapt to limits within the school environment
3. **Assertiveness**: A child's ability to vocalize his or her opinion and/or verbally convey individual wants/needs in the classroom
4. **Peer social skills**: A child's ability to successfully interact with peers, as well as his or her likability among peers

The T-CRS may be completed in one of two ways: via paper or electronically with the COMET® data collection and management system. By using the T-CRS on COMET, schools can gain information about individual students, as well as the overall population of students. For programs using COMET, members of the COMET team provide personnel with assistance uploading data to the system, training on generating reports, and training on the instrument itself.

A benefit of COMET is that it allows a site to collect and organize screening information into comprehensive student profiles. Furthermore, it provides the Primary Project team with:

- Meaningful reports to help make individualized decisions
- Individualized trend reports to monitor individual student progress
- Aggregate reports to understand the overall composition and needs of students
- Indicators of school success or failure

With simple training, COMET allows you to instantly identify which children fall between the 15th-30th percentile and are the most appropriate candidates for involvement in Primary Project.

Systematic use of the T-CRS is only one element in Primary Project's screening procedures. Beyond this step, it is important to recognize that screening is an ongoing process. Teachers and other school personnel participate in screening throughout and across school years as observers whose concerns about children can be raised any time with the Primary Project team. Other sources of data may include:

- **Structured observation**: The child associate and/or mental health professional may observe children working on structured classroom activities. These observations provide an opportunity to see how the child interacts with peers and adults. Schools have also found it beneficial to observe children in less structured settings, such as recess or at lunch time.
- **Other inputs**: An effective screening process should include multiple methods to offer the most accurate picture of the child. Other potential screening information may be gleaned from teacher referral, self-report, parent report, and review of school records.

With the formal screening data in hand, the team comes together in selection or assignment conferences.

Selection and assignment

Assignment conferences usually begin post-screening and are conducted in ways that best fit the school's existing operating procedure. Primary Project staff and participating teachers are the primary personnel involved in selection; however, other school personnel (such as the nurse or principal) may provide additional information about a child and are welcomed to participate in the conferences. The team reviews the information assembled, creates composite sketches of children's school adjustment, identifies children for whom Primary Project services seem appropriate, and, for those children, begins to formulate next steps.

Some schools hire substitute teachers to alternate coverage in classrooms while teachers attend the assignment conferences. This practice highlights the importance of the assignment conference and avoids scheduling over lunch-hour or having after-school meetings. Meeting with teachers can be completed within 45-60 minutes.

There is no single way to successfully conduct assignment conferences. In essence, the conference seeks to assess the child's current situation (competencies and areas of difficulties) from relevant perspectives and to develop a plan to address the child's needs. By the end of the process, children from all classes will have been reviewed, and those for whom Primary Project is appropriate will have been selected. As part of this process, some children may be put on a "watch" list and others may be referred for further evaluation or outside services.

Some ways conferences can be conducted:

- The team can review all children with teachers, not just those identified through screening. Integrating the teachers' views with other data helps make the process more sensitive. In a class of 25, the majority of the discussion will focus on two to four children who seem to have emerging difficulties in the mild to moderate range. During this time, it is also important to reinforce the *parameters* of the program, as it is sometimes hard to select children with fewer versus more significant needs.
- The mental health staff and child associates can meet with teachers to discuss specific children who have been referred or identified through the screening process.
- Some schools have found using existing structures (such as Student Study Team) for considering screening information and data to be an integrated and efficient process.

Parental consent

After children have been identified for participation in Primary Project by agreement within the Project team, written parental consent for the child's participation must be obtained *(*samples of a parent permission form (pp. 53-54) are available in the *Primary Project: Program Development Manual [*Peabody et al, 2016]. Recommended steps to obtain parent permission are also outlined in the manual (p. 51). Parent involvement varies across sites but, at a minimum, parental permission is required for children to participate. Most projects around the country also include parents in at least one conference, and still others include parent education, home visits, and parent support groups as an adjunct of Primary Project.

If a parent is uncertain about the recommendation and/or needs additional information that the teacher cannot supply, the teacher informs the core team (project coordinator, mental health professional, and child associate) 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.

Working with the children

All aspects of Primary Project support the building of a positive 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 approximately 12-15 sessions. Typically, two cycles of Primary Project can be conducted in an academic year.

The connecting value of play

Play is often considered to be the natural language of children (Landreth, 1991). Developmentally, young children between the ages of three and ten have limited abstract thinking skills and may not have fully developed the language skills needed to communicate their thoughts and feelings; however, they often easily express themselves through actions and play (Landreth, 1991).

Through play and in the context of an accepting relationship with a caring adult, children in Primary Project come to express and share thoughts and feelings about matters that are important to them. Play provides young children with opportunities to explore their world in a way that simultaneously offers a language for communicating needs, thoughts, and desires. Allowing children to engage in expressive play opens a window to their emotional lives.

The toys and activities selected for the playroom experience are critically important to encouraging expressive play. Careful consideration is given to what is selected and placed in the Primary Project playroom. A simple Primary Project playroom is not cluttered; yet, it offers a variety of appealing, age appropriate activities and toys.

Battery operated toys and computer games are not considered appropriate in this particular intervention. The goal is to provide expressive play materials and elicit the thoughts, feelings, and imagination of the child, not to teach directed or structured skills. Having stated this, there are, however, specific aspects of the "non-directive- child-led" approach that are more structured, such as limit setting. It is important to not confuse "child-centered/child-led" or "non-directive" play with total freedom or "anything goes," *as every statement and action is purposeful.*

Child-led play

The child-led play approach is different from how most adults play with children. Inherent in parenting or child care roles, most adults have a tendency to teach children when they are playing. There is a time and place for using play to enhance academic-oriented teaching; however, play has other therapeutic qualities. The relational connecting aspect of play is the therapeutic quality that is core to Primary Project. The child associate's main task is to concentrate on showing empathy and actively listening. Secondary objectives include fostering the child's ability to make decisions, accept limits, and gain positive self-control and self-responsibility.

These objectives are accomplished by interacting as a deliberately different adult during the play session. Child associates are taught through the initial and subsequent Primary Project trainings how to "be with" children in a way that honors and respects children for their abilities and capabilities. Thus, in a "child-centered" or "child-led" play approach, both theoretically and

practically, the child is encouraged to lead the play rather than follow the agenda of the adult. In giving the child control of a safe environment, children feel empowered and positive about themselves.

The child-centered approach has been widely studied in the field of play therapy (Bratton, 2010). By using a model in which mentors, teachers, and paraprofessionals are taught child-led play skills and supervised by mental health professionals, Primary Project extends the knowledge of therapeutic communication to a broader range of adults who come in contact with children during the school day.

The child associate/child relationship

Facilitating empathic, caring child associate/child relationships is the heart of Primary Project; all other aspects of the program should support this relationship. While there is no single formula for developing a sound relationship with the child, there are certain skills and best practices that make the facilitation of a relationship more likely to occur. Child associates, like other people, are individuals with different life experiences, cultural influences, interaction styles, and comfort zones. Therefore, while specific skills are taught, each child associate brings his or her own individual style.

Considering the uniqueness of child associates, there are, however, basic skills and common elements that help foster successful helping relationships (Rogers, 1951, 1957). Three such elements are:

1. **Empathy** (understanding): Understanding the child's experience; being right there with the child; putting oneself in another person's shoes.
2. **Genuineness** (authenticity): Consistency and openness to child and self.
3. **Unconditional positive regard**: Accepting another person's feelings and self; a nonjudgmental caring for and valuing of the child.

Although the child is encouraged to lead, the child associate is still an active participant in the relationship. In Primary Project, the child molds the intensity or amount of child associate participation. Taking the lead from the child means some children will freely and frequently engage with the child associate, where others may be more hesitant, especially in the beginning.

Child associates must possess flexibility. They need to be able to enter into the child's play but not to be a director of the play, a teacher, or a tutor. It's okay for a child to direct the child associate in the role he or she wants the child associate to take on. The child associate is there as a mirror to the child's expression of thoughts and feelings. The purpose is not to teach the child academic skills or to make up unfinished work. This difference is important to clarify and explain to the teaching staff.

The child associate's primary goal in the session is to recognize and accept the child's feelings (empathy), respond in ways that show understanding (authenticity) and to maintain emotionally safe conditions that allow the child to express verbally or non-verbally difficult feelings and thoughts. This is accomplished by providing an environment of unconditional positive regard. Through this process, the child will begin to choose more productive ways of behaving.

Major emphasis in training is on the language between the child associate and the child with the goal of becoming a therapeutic helper and a change agent. These "child-centered" ways of being are the core skills of Primary Project. Briefly, the skills of effective child-led play include:

- Structured ways of beginning and ending sessions, including room set up and clean up.
- Paying close attention to the child, both non-verbally and verbally.
- Language of being a therapeutic change agent:

  Language of reflection: emotionally responsive language that focuses on children's feelings, their play, their behavior, and the relationship between the child and adult.

  Language that promotes decision-making: finding opportunities to point out the child's ability to make decisions during the session. Interacting in ways that encourage the child's creativity to make their own decisions, build confidence and competence by allowing the child to struggle or discover alternate ways to problem solve versus the adult always helping or teaching.

  Language of encouragement: Believing in the child's efforts and interests.
- Limit setting.

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 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.

Training

Initial training must occur before child associates work with children.

Modules included are:

- General overview and orientation to Primary Project
- Types of children Primary Project intends to serve
- Understanding of children, learning, and behavior
- Primary Project processes
- Social-emotional development and learning

Based on recommendations in the *Primary Project Standards* and the *Primary Project Best Practices Rubric* (available at https://www.childrensinstitute.net/programs-and-services/primary-project; near the bottom of the page, under Resources), it is recommended that child associates participate in a minimum of six additional hours of training for subsequent years of employment.

Supervision

For the Primary Project program, necessary support has always been the process of supervision of the child associates by mental health professionals. The process begins with the entrance of a child associate into the program and continues until the associate separates from the program. Supervision is a process that is developmental for each child associate. It is recommended in the *Primary Project Standards* and the *Primary Project Best Practices Rubric* that child associates participate in a minimum of 24 hours of supervision with a mental health professional each school year.

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 focuses on each associate, exploring his or her developing understanding of mental health issues, how they are affecting him or her, and offering advice and guidance to each associate as he or she evolves in the role, both emotionally and cognitively.

Supervisors should also discuss programmatic issues with child associates. These may include scheduling, screening and selection, permission forms, and issues which may arise with teachers (Demanchick, 2007). Specific supervision training is offered through Children's Institute at least once a year.

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 professional, and, in the case of group supervision, with other child associates. The child's progress is also repeated in ongoing teacher communications (some programs incorporate a "teacher progress report") and in conversations with parents.

Progress is routinely measured more formally by changes in scores reported using the Teacher-Child Rating Scale (T-CRS) and sometimes the Associate Child-Rating Scale (A-CRS) (Peabody et al., 2016). To measure children's behavior change, pre- and post-program assessments are conducted.

When the child leaves the program, the mental health professional completes the Professional Summary Report (PSR). The PSR provides an assessment of the child's degree of change in specified areas, which parallel the dimensions assessed by the T-CRS and A-CRS.

Evaluation outcomes

Consensus exists among experts that Primary Project is an exemplary program based on evidence available from decades of evaluation and research on the program. In 1984, the National Mental Health Association awarded Primary Project the Lela Rowland Prevention Award as the outstanding prevention program (Cowen & Hightower, 1989). Four years later, the New York State Education Department used national research-based criteria to review Primary Project, and, based on that review, designated it as a validated program under New York State's Sharing Successful Programs. Primary Project was named 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. Based on an independent review of program processes and documented outcomes, the United Way of Greater Rochester awarded Primary Project the 1995 Quality Award for Excellence in Human Service Programming.

With regard to *School-Based Prevention for Children at Risk: The Primary Mental Health Project* (Cowen et al., 1996), Seymour B. Sarason (1996) stated,

> 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 *Establishing Preventive Services* by Weissberg, Gullotta, Hampton, Ryan, and Adams (1997).

In a survey conducted by The National Association of School Psychologists (NASP), school psychologists across the country were asked to identify the most effective school-based mental health programs. The association selected the highlighted programs 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." NASP selected and described Primary Project in *Exemplary Mental Health Programs: School Psychologists as Mental Health Service Providers* (Nastasi, Vargas, Bernstain, 1997). Primary Project also has been recognized by the U.S. Department of Education, Substance Abuse and Mental Health Services Administration (SAMHSA), the Center for School Mental Health Services, and the Surgeon General of the United States. Research on Primary Project started when the program began and has since been a continuing, essential part of the program's fabric. Tests of Primary Project's effectiveness as a prevention program have used several evaluation designs, each with methodological or ecological strengths 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 process variables and outcome variables. For example, Primary Project research has shed light on specific program elements that improve practice and deepen an understanding of factors that affect the relationships between child associates and children and child associates and their supervisors (Cowen et al., 1996; Cowen & Hightower, 1989).

Descriptions of these primary evaluation designs and their major findings follow.

Controlled studies

Several studies have used control groups designed to evaluate the effectiveness of Primary Project. In one, 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 compared to those awaiting services, showed significant decreases in adjustment problems: lower aggression, fewer learning problems, and increased social-emotional competencies, such as frustration tolerance and peer relations (Duerr, 1993).

Another evaluation of the Primary Project model used a wait-control design and a 3-month follow-up evaluation (Nafpaktitis & Perlmutter, 1998). The study found that 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 problems and competencies placed children within a range of functioning exhibited by non-referred peers. At 3-month follow-up, teacher ratings revealed that children's functioning had not significantly decreased (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 those services. That design allows careful matching of intervention and comparison groups and tracking of their adjustment over time (Cowen et al., 1996). One of the studies compared (a) children in the Primary Project model who received an average of 25, 40-minute contacts over a 5- to 6-month period, and (b) comparison children with similar initial adjustment status identified in non-Primary Project schools. In that study, children served by Primary Project were, after a school year, shown 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, and Guare (1984) evaluated 61 urban children, seen 2-5 years earlier in the Primary Project model, with 61 children 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 New York City's East Harlem section. That district, comprising approximately 60% Hispanic and 30% African American children, is characterized by high rates of poverty and unemployment (greater than 40%), health problems, teen pregnancy, and drug use. The implementation of the Primary Project model for kindergarten through third-grade children in School District 4 was evaluated over a 4-year period. Results from evaluations over that period found that children had more positive school adjustment – that is, fewer adjustment problems and 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. Those evaluations included a comparison of children's classroom adjustment problems and competencies at (a) time of referral and (b) graduation from the program. That method makes an ecologically valid assessment of children's adjustment status in large numbers of school sites possible. During the 1997-1998 school year, evaluation of children in New York State Primary Project included more than 1,500 children in 50 schools. Those Primary Project sites provided more than 15,000 preventive-focused contacts to children. Overall, 82% of those children had adjustment problems before 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).

Qualitative designs

As Primary Project entered its 60th year of implementation, Children's institute launched a qualitative study to learn from schools what they thought were the benefits to students, key success factors to ensuring sustainability, challenges that schools face, what makes programs fail, and which components of Primary Project are essential. Site visits were conducted to 14 schools in Florida and New York State and a national survey was distributed and collected from 429 individuals. For a summary of the findings, visit:
https://www.childrensinstitute.net/sites/default/files/primary-project_qualitative-study_working-paper.pdf

Predictive analytics

In 2019 predictive analytic methods were piloted in two school districts, using their archival data to predict on-time graduation, and allowing early identification of at-risk students. One district implemented the results by creating a standard at-risk designation as a result. Predictive analytics methods are now being used to identify the most appropriate candidates for Primary Project.

Although Primary Project is not explicitly intended to improve students' school attendance rates, a review of a local urban school district's records indicated that for four consecutive years, attendance rates improved with participation in Primary Project for students who were referred to the program, compared with those students' prior-year attendance. To investigate this more fully, a random-assignment procedure took place in seven schools, by which students with chronic absenteeism (>10% absent) in prior-year school attendance were assigned to either Primary Project or a control group. Participation in Primary Project was associated with significantly improved school attendance rates, relative to the control group. The results of the study are being prepared for a technical report which will be available on the Children's Institute website in the near future.

Program resources

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.

Support to districts and sites interested in implementing Primary Project is available through consultation, training, and program materials.

A listing of program resources to support Primary Project are as follows:

Possibilities of Play: Building Connections DVD (Children's Institute, 2008)

Primary Project: Creating Connections DVD (Children's Institute, 2012)

Possibilities of Play DVD (available at https://www.childrensinstitute.net/programs-and-services/primary-project/videos)

Primary Project: Program Development Manual (Peabody et al., 2016)

Primary Project Supervision: DVD and Companion Resource Guide (Demanchick, 2007)

Primary Project: The Intervention/Basic Skills DVD (Demanchick, 2006)

T-CRS 2.1: Teacher-Child Rating Scale Examiner's Manual (Hightower, Perkins, 2010)

To purchase program resources, visit https://www.childrensinstitute.net/store

For more information on training and/or consultation contact Shelley Sanyshyn or Lynn Smith at (585) 295-1000 ext. 251 or 244.

Literature citations

Albee, G. W., & Gullotta, T. P. (1997). *Primary prevention works*. Thousand Oaks, CA: Sage Publications.

Bratton, S.C. (2010). Meeting the early mental health needs of children through school-based play therapy: A review of outcome research. In A.A. Drewes and C.E. Schaefer (Eds.), *School-Based Play Therapy*, (pp.17–58). Hoboken, New Jersey: John Wiley & Sons.

Bronson, M.B. (2000). *Self-regulation in early childhood: Nature and nurture*. New York, NY: Guilford.

Catalano, R.F., Haggerty, K.P., Oesterle, S., Fleming, C.B., & Hawkins, J.D. (2004). The importance of bonding to school for healthy development: Findings form the social development research group. *Journal of School Health, 74*(7), 252–261.

Centers for Disease Control and Prevention (2009). *School connectedness: Strategies for increasing protective factors among youth*. Atlanta, GA: U.S. Department of Health and Human Services.

Christner, R.W. & Mennuti, R.B. (Eds.). (2009). *School-based mental health a practitioner's guide to comparative practices*. New York, NY: Routledge.

Chandler, C., Weissberg, R. P., Cowen, E. L., & Guare, J. (1984). The long-term effects of a school-based secondary prevention program for young maladapting children. *Journal of Consulting and Clinical Psychology, 52,* 165-170.

Children's Institute, Inc. (2008). *Possibilities of play: Building connections* [DVD]. Available from Children's Institute, Inc., 274 N. Goodman Street, Suite D103, Rochester, NY 14607.

Children's Institute, Inc. (2012). *Creating connections* [DVD]. Children's Institute, Inc., 274 N. Goodman Street, Suite D103, Rochester, NY 14607.

Cowen, E.L. (1994). The enhancement of psychological wellness: Challenges and opportunities. *American Journal of Community Psychology, 22*(2), 149–179.

Cowen, E. L. & Hightower, A. D. (1989). The Primary Mental Health Project: Thirty years after. In R. E. Hess & J. DeLong (Eds.), *The National Mental Health Association: Eighty years in the field of prevention* (pp. 225-257). New York: Haworth Press.

Cowen, E. L., Hightower, A. D., Pedro-Carroll, J. L., Work, W. C., Wyman, P. A. (1996). *School-based prevention for children at risk: The Primary Mental Health Project.* Washington, DC: American Psychological Association.

Demanchick, S. (Producer). (2007). *Primary Project: Supervision (DVD and Companion Resource Guide)* Available from Children's Institute, Inc., 274 N. Goodman Street, Suite D103, Rochester, NY, 14607.

Demanchick, S. (Producer), (2007). *Primary Project: The intervention/basic skills* [DVD and Companion Resource Guide]. Available from Children's Institute, Inc., 274 N. Goodman Street, Suite D103, Rochester, NY 14607.

DiPerna, J.C., Volpe, R.J., & Elliot, S.N. (2002). A model of academic enablers and elementary reading/language arts achievement. *School Psychology Review, 31*, 298–312.

Dockett, S., & Perry, B. (2007). *Starting school: Perceptions, experiences and expectations*. Sydney, AU: University of New South Wales Press.

Duerr, M. (1993). *Early mental health initiative: Year-end evaluation report*. Chico, CA: Duerr Evaluation Resources, California Department of Mental Health.

Dunlap, G., Strain, P.S., Fox, L., Carta, J., Conroy, M., Smith, B., Kern, L., Hemmeter, M., Timm, M., Mccort, Al, Sailor, W., Markey, U., Markey, D.J., Lardiari, S., & Stowell, C. (2006). Prevention and intervention with young children's challenging behavior: A Summary of current knowledge. *Behavioral Disorders, 32*, 29–45.

Durlak, J. A. (1997). *Successful prevention programs for children and adolescents*. New York: Plenum.

Elias, M.J., & Weissberg, R.P. (2000). Wellness in schools: The grandfather of primary prevention tells a story. In D. Cicchetti, J. Rappaport, I.N. Sandler, & R.P. Weissberg (Eds.), *The promotion of wellness in children and adolescents* (pp. 243-269). Washington, DC: Child Welfare League of America Press.

Goldstein, S. & Brooks, R. (2005). Defining a Clinical Psychology of Resilience. *National Association of School Psychologists, Communiqué, 33*(5).

Graziano, P., Reavis, R., Keane, S., Calkins, S. (2007). The role of emotion regulation and the student-teacher relationship in children's academic success. *Journal of School Psychology, 45*, 3–19.

Green, K.D., Forehand, R., Beck, S.J., & Vosk, B. (1980). An assessment of the relationship among measures fo children's social competence and children's academic achievement. *Child Develop, 51,* 1149-1156.

Hightower, A. D. (1998). *Primary Project annual report to the New York State Education Department*. Rochester, NY: Primary Mental Health Project Inc.

Hightower, A.D., Perkins, P.E. (2010). *T-CRS 2.1: Teacher-Child rating scale examiner's manual.*

Kataoka, S.H., Zhang, L., & Wells, K.B. (2002). Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. *American Journal of Psychiatry, 159*, 1548–1555.

Lagana-Riordan, C., & Aguilar, J. P. (2009). What's missing from no child left behind? A policy analysis from a social work perspective. *Children & Schools, 31*(3), 135–145.

Landreth, G.L. (1991). *Play therapy: The art of the relationship.* Muncie, IN.: Accelerated Development

Lee, V., Smith, J., Perry, T., & Smylie, M.A. (1999). *Social support, academic press, and student achievement: A view from the middle grades in Chicago*. Chicago, IL: Consortium on Chicago School Research.

Lorion, R.P. (2000). Theoretical and evaluation issues in the promotion of wellness and the protection of "well enough." In D. Cicchetti, J. Rappaport, I. Sandler, & R.P. Weissberg (Eds.), *Promotion of wellness in children and adolescents*, (pp. 1–27). Washington, DC: CWLA Press.

McClelland, M.M., Acock, A.C., & Morrison, F.J. (2006). The impact of kindergarten learning-related skills on academic trajectories at the end of elementary school. *Early Childhood Research Quarterly, 21(4), 471-490.*

Meller, P. J., Laboy, W., Rothwax, Y., Fritton, J., & Mangual, J. (1994). *Community School District Four: Primary Mental Health Project, 1990-1994*. New York: Community School District #4.

Miles, S.B. & Stipek, D. (2006). Contemporaneous and longitudinal associations between social behavior and literacy achievement in a sample of low-income elementary school. *Child Development, 77,* 103-117.

Nafpaktitis, M., Perlmutter, B. F. (1998). School-based early mental health intervention with at-risk students. *School Psychology Review, 27*, 420-432.

Nastasi, B.K., Vargas, K & Bernstain, R. (1997) *Exemplary mental health programs; School psychologists as mental health service providers*. NASP: Bethesda, MD.

National Research Council and Institute of Medicine (2009). *Preventing mental, emotional and behavioral disorders among young people: Progress and possibilities.* Washington DC: National Academies Press.

National Scientific Council on the Developing Child. (2008). Retrieved from http://developingchild. harvard.edu/activities/council/publications.

Peabody, M.A., Johnson, D., Smith, L., Sanyshyn, S. & Zordan, E. (2016). *Primary Project: Program development manual.* Rochester, NY: Children's Institute.

Rogers, C.R. (1951). *Client-centered therapy: Its current practice, implications, and theory.* Boston, MA: Houghton Mifflin.

Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21,* 95-103.

Rutter, M., & Maughan, B. (2002). School effectiveness findings 1979–2002. *Journal of School Psychology, 40*, 451–475.

Schunk, D.H., Pintrich, P.R., & Meece, J.L. (2008). *Motivation in education: Theory, research and applications (3rd ed.). Upper Saddle River, NJ: Pearons/Merrill Prentice Hall.*

Weissberg, R. P., Cowen, E.L., Lotyczewski, B. S., & Gesten, E. L. (1983). The Primary Mental Health Project: Seven consecutive years of program outcome research. *Journal of Consulting and Clinical Psychology, 51*, 100-107.

Weissberg, R. P., Gullotta, T. P., Hampton, R. L., Ryan, B. A., & Adams, G. R. (1997). *Establishing preventive services*. (*Vol. 9*). Thousand Oaks, CA: Sage Publications.

Wentzel, K.R. (1991). Relations between social competence and academic achievement in early adolescence. *Child Development, 62,* 1066-1078.

Wigfield, A., Eccles, J.S., Schiefele, U., Roeser, R.W., Davis-Kean, P. (2006). The development of achievement motivation. In N. Eisenberg (Ed.), *Handbook of child psychology* (Vol. 3, 6th ed.). New York: Wiley.

Winer-Elkin, J. I., Weissberg, R. P., & Cowen, E. L. (1988). Evaluation of a planned short-term intervention for school children with focal adjustment problems. *Journal of Clinical Child Psychology, 17*, 106-115.

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