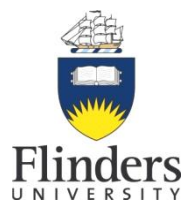# Final Report

KidsMatter Early Childhood Evaluation

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Acknowledgements

Aboriginal and Torres Strait Islander peoples

Aboriginal and Torres Strait Islander people should be aware that this document may contain images of people who have since passed away. We acknowledge the objections of some Aboriginal and Torres Strait Islander people and organisations to the term Indigenous. It is used sparingly in this report where appropriate, for example, *non-Indigenous people*. It is also used where repetition of *Aboriginal and Torres Strait Islander* would make the text harder to read. This has enabled us to avoid the abbreviation *ATSI* to apply to people (we do use it to apply to organisations, such as *OATSIH*). The word *Indigenous* is capitalised in keeping with current practice, to indicate its specific use to apply to Australian Aboriginal and Torres Strait Islander peoples. It is not capitalised when used generically. The term 'mainstream' is used to refer to non-Indigenous systems, institutions and practices.

KidsMatter Early Childhood Executive Summary

KidsMatter stresses the importance of giving all children a supportive, caring environment in which to grow emotionally, socially and physically – making friendships that could last through to adulthood – along with a high quality education. (Staff, ST4S5) [1]

The KidsMatter Early Childhood (KMEC) initiative is a pilot study that has been implemented in a very diverse group of Australian early childhood services that provide education and care for young children of differing ages. These early childhood education and care services[2] also operate in a policy environment that is concerned with reform and so is experiencing significant change. The design of future versions of the KMEC initiative needs to be mindful of the diverse and dynamic nature of the early childhood education field.

This pilot of the KMEC initiative has involved the enactment of a specific package of procedures and components and the findings of the evaluation presented here are associated with the implementation of that specific and total package.

The KidsMatter Early Childhood Initiative

KidsMatter Early Childhood is the Australian national early childhood mental health promotion, prevention and early intervention initiative specifically developed for early childhood services. It was trialled in 111 long day care services and preschools during 2010 and 2011. KMEC involves the people who have a significant influence on young children's lives – parents, carers, families and early childhood educators, along with a range of community and health professionals – in making a positive difference to young children's mental health and wellbeing during this important developmental period.

The KMEC initiative provides a framework to enable services to plan and implement evidence-based mental health promotion, prevention and early intervention strategies. These strategies aim to improve the mental health and wellbeing of children from birth to school age, reduce mental health difficulties among children, and achieve greater support for children experiencing mental health difficulties and their families.

KMEC uses a risk and protective factors framework to focus on four components, where early childhood services can strengthen the protective factors and minimise risk factors for children's mental health and wellbeing. The four areas that comprise the core content of KMEC are, 1) Creating a sense of community, 2) Developing children's social and emotional skills, 3) Working with parents and carers, and 4) Helping children who are experiencing mental health difficulties.

KidsMatter Facilitators

Early childhood education and care services participating in the KMEC trial were each supported by a state or territory Facilitator. Facilitators worked with services to implement the framework by delivering professional learning related to each of the four components in KMEC, and visited

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[1] This code de-identifies the participant and details are provided in the *KMEC Technical Report*.
[2] Throughout this report, the terms 'services' and 'centres' refers to early childhood education and care (ECEC) services.

individual services to assist and guide early childhood educators[3] in identifying goals, strategies and resources to work through the services' action plan. The KMEC professional learning presented at each service guided staff in the implementation of the framework to improve mental health outcomes for children. Staff had the opportunity to identify their services' strengths and to establish strategies for continuous improvement.

In addition to Facilitator support, each KMEC pilot service was supplied with a range of evidence-based resources. These assisted services to develop their capacity for promoting early childhood mental health and wellbeing, and to respond to the mental health needs of the children within their care.

Background to the KidsMatter Early Childhood Evaluation

beyondblue contracted Flinders University to undertake the evaluation of the KMEC Pilot Phase. The evaluation involved a team of researchers and support personnel located in the Flinders University Centre for *Student Wellbeing and Prevention of Violence*. The evaluation depended critically on the support of staff, service leaders and KMEC Facilitators. The essential working relationships were facilitated by the use of an Evaluation website, to keep stakeholders up-to-date with the progress and requirements of the evaluation, and by the dedicated work of members of each service Leadership Team, who managed the delivery and return of evaluation questionnaires.

The evaluation used multiple methods (questionnaires, interviews, photo study, Facilitator reports), involved multiple participants associated with the 111 services (Service leadership, staff, parents, and KMEC Facilitators), and gathered detailed data on multiple occasions (including four questionnaire data collection occasions over the two-year pilot). In considering the findings from this evaluation it is important to note that the first data gathering point for the evaluation (Time 1) occurred about five months after the KMEC initiative was first introduced to services.

Implementation quality

A significant facet of this two-year evaluation study of KMEC involved the development of an Implementation Index. As reported by Durlak and DuPre (2008) in their review of the literature on published mental health prevention studies, only a minority of published studies have reported on implementation processes (5%-24%). The same authors concluded that "the magnitude of mean effect sizes are at least two to three times higher when programs are carefully implemented and free from serious implementation problems than when these circumstances are not present" (Durlak & DuPre, 2008, p.340). This highlights the critical nature of implementation quality. The Implementation Index developed for the purpose of this evaluation was based upon the initial work undertaken for the KidsMatter Primary Implementation Index (Dix et al., 2010; Slee et al., 2009), with additional refinement to suit features particular to KMEC. A range of factors were identified as facilitating the KMEC initiative and were used in the Implementation Index, including leadership, engagement with the initiative, support structures and links with external agencies. Application of the index in the evaluation identified 54% of services as High Implementing, 32% of services as Moderately Implementing, and 14% of services as Low Implementing.

KMEC Facilitators reported that a number of factors impeded implementation of the initiative.

1. Leadership: poor leadership, busy leadership, top down leadership.
2. Staffing matters: including staff qualifications, experience, high staff turnover.

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[3] The terms 'staff' and 'educators' are generally used to refer to early childhood education and care educators.

3. Lack of commitment to KMEC: staff not understanding the Initiative.
4. External circumstances: working with a high proportion of families under stress or duress; having a high proportion of children with particular behavioural issues and community circumstances including the poor socio-economic background of the communities; high unemployment.

Facilitators also reported three main factors as supporting effective implementation.

1. Leadership: where the leadership was strong and focussed on the initiative.
2. Staff engagement: where the staff were engaged and motivated regarding the initiative.
3. Staff commitment: where the staff had a strong belief in and commitment to enhancing the mental health of children.

The emphasis on leadership as critical for effective implementation suggests that it should be given greater attention in the KMEC conceptual model.

Impact of KidsMatter Early Childhood on services and staff

An important goal of the KMEC initiative is that it leads to increases in staff knowledge, competence and confidence in relation to supporting the development of children's social and emotional skills and in supporting children with mental health difficulties. According to participants in the photo study, this objective was clearly realised. In interviews, staff described their deeper understanding of children's social and emotional wellbeing as a result of their involvement with KMEC.

> Through KidsMatter for me personally, it's made me look deeper at the child, and like this particular little boy and like where he's come from. It's made me look deeper at children and perhaps wondering why, perhaps where they've come from, why they behave like they do. (Staff, ST4S5)

Analysis of the questionnaire responses showed that a strong area of improvement across the two-year intervention involved significant positive changes in staff views regarding their knowledge of children's mental health. This practically significant effect was found across both High and Low implementing services. However, staff in High implementing services reported feeling more self-efficacious in their ability to help young children experiencing mental health difficulties. In interviews, some educators noted that KMEC affected them personally and that the improvement in their knowledge also translated from work to home, including their relationships with their own families.

Impact of KidsMatter Early Childhood on families and parents

> Yes building a community, you can't work collaboratively I suppose with the parents if you haven't built the relationship. And you have to work on that and start a relationship so that you can work with them … I think there is a difference, but if you don't establish that connection, why would they work with you and trust you. (Staff, ST4S1)

Parents gave high ratings to their knowledge about parenting at the start of KMEC and this changed little over the period of the trial. Similarly, parents rated highly their self-efficacy as parents and this barely changed over the two-year intervention. However the evaluation indicates that there are two areas in which there is scope in future versions of KMEC to generate greater impact on parents and families. First, there were very modest positive changes in relation to parental involvement with the services and with the components of KMEC over the course of the two-year intervention. Second, in relation to the impact of KMEC on parents' and carers' knowledge and understanding, there were again, relatively modest changes in ratings of the services' work with parents and carers, generally. It is likely that the results presented in this

report, indicating limited impact of KMEC on family contexts, partly reflect the lower implementation progress made on Component 3 throughout KMEC.

In relation to staff and parent views about the services working with parents and carers, almost three-quarters of staff and two-thirds of parents at Time 1 strongly agreed (scored 6 or 7) about aspects of the service's ability to work with parents and carers. By Time 4, staff views increased by 11% and parent views increased by 6%. These findings add weight to the need for greater attention being given to reviewing how services can best engage with parents in the KMEC model.

Impact of KidsMatter Early Childhood on children

The central purpose of KMEC is to improve young children's mental health and wellbeing and to reduce mental health difficulties. In the evaluation, because of the very dynamic nature of children's involvement in these services, not all children could be tracked across the whole of the period of the evaluation. In order to undertake appropriate analyses of change in child outcomes, these analyses were carried out with a subset of participants, those for whom data were available on three or four occasions. The children in this subset were typically younger, were in care longer, and were located in High Implementing services. That is, they were located in services in which both staff and parents were reporting significant improvements in the ability of services to address children's social and emotional needs. Nevertheless this subset of children represents a very significant group for consideration in both this evaluation and in the wider research field.

Better meeting the needs of children with difficulties

Gauging staff ratings of the impact that KMEC had on achieving greater support and meeting the needs of children with social and emotional difficulties was an important focus of the evaluation. Approximately half the staff at Time 1 strongly agreed (scored 6 or 7) that KMEC had helped them to:

- better recognise children experiencing difficulties (54%),
- provide better care for children (56%), and
- improve links with professionals who can assist children experiencing difficulties (46%).

Overall, these aspects improved by Time 4 with 20% more staff, on average, strongly agreeing that KMEC had helped them better recognise children experiencing mental health difficulties.

Improved staff-child closeness

In the KMEC conceptual model (described in Chapter 2) children's high-quality relationships serve a protective function that helps to build resilience against childhood risk factors. In this evaluation, interpersonal relationships between staff and children were assessed with the widely used Student–Teacher Relationship Scale (STRS, Pianta, 2001). Using the conflict and closeness dimensions of the STRS to assess staff-child relationships, there was improvement equivalent to a small effect size in reports of closeness between staff and children during the course of the evaluation.

Improved child temperament

Child temperament is part of the KMEC evaluation conceptual model. Temperament is considered to be related to the development of protective factors early in childhood, crucial for subsequent adjustment to life's challenges and stresses, including for children's mental health and wellbeing (Smart & Sanson, 2005; Sanson et al., 2009). Two findings relate to factors of temperament. Parents reported a reduction in children's 'reactivity' and an increase in their

'approachability', these positive changes being rated as small effect sizes. These findings, however, must be interpreted in relationship to children's developing maturity (Newman & Newman, 2012).

Reduced mental health difficulties

For this KMEC evaluation study, Goodman's Strengths and Difficulties Questionnaire (SDQ: Goodman, 2005) for children 3-4 years old (UK Version) was selected as the main outcome measure of child mental health.

Across the period of the evaluation there was a reduction in the Total SDQ Difficulties scores for the small groups of children initially classified as being in the borderline and abnormal ranges on the SDQ, with these reductions representing medium and large effect sizes, according to staff, and small and large effect sizes, according to parents. The profiles of change across time are shown in the figure below. As expected, the profile for children rated in the normal range did not show significant change in mental health difficulties.

The figure also presents the percentage proportions of children identified by parents and staff as having SDQ scores within the borderline or abnormal ranges at Time 1 and by Time 4. Across the period of KMEC, there were 2.7% fewer children, according to staff, and 3.3% fewer children, according to parents, in the combined borderline and abnormal ranges. This reflects children whose SDQ scores had shifted from the abnormal and borderline ranges into the normal range. On average, this 3% increase in the proportion of children in the normal range of mental health as defined by the SDQ, represents an improvement for 1 in 30 of all children included in this study, or an improvement for 1 in 6 children in this study initially identified with mental health difficulties.

Change over time in Total SDQ Difficulties for children in normal, borderline and abnormal ranges

Total Strengths and Difficulties	All	Borderline or Abnormal ranges		Improvement in the borderline and abnormal SDQ score ranges for:	
	n	At Time 1	By Time 4		
Staff rated	1423	17%	14%	2.7%	Approximately 1 in 6 children
Parent rated	385	13%	9%	3.3%	Approximately 1 in 4 children
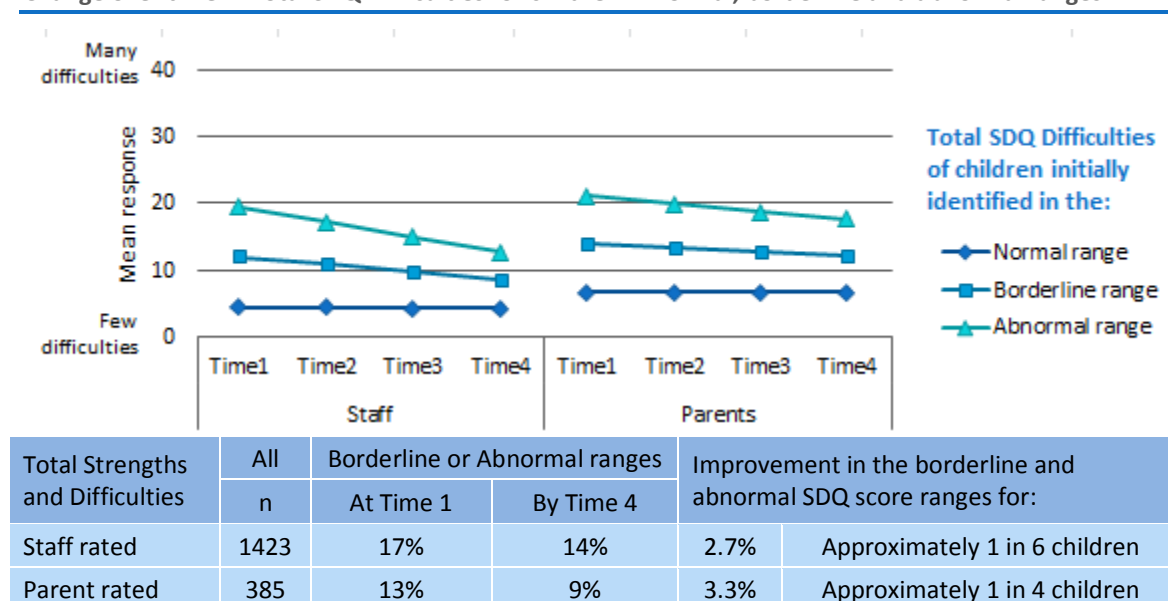
These findings must be considered in relation to the limitations of the evaluation and in light of the known age-related SDQ ratings for children similar in age to those participating in the KMEC pilot. However, the findings reported here are based on an analytical procedure that includes a correction for the participating child's age. Thus, the changes across time reported here are argued to be estimates of change, over and above, developmental changes due to ageing during the two-year evaluation.

Conclusions

Security, comfort, belonging and a space of calm, shared communication. This is what KidsMatter has meant to me. Thank you KidsMatter for leaving me with the understanding of the importance of creating caring communities and a safe harbour for our children. (Staff, ST4S5)

The KMEC initiative provides a framework to enable preschool and long day care services to plan and implement evidence-based mental health promotion, prevention and early intervention strategies. KMEC uses a risk and protective factors framework to focus on four components where early childhood services can strengthen the protective factors for children's mental health and minimise the risk factors. Risk and protective factors may be identified within the four components in relation to factors such as: individual skills, needs and temperament; familial circumstances and relationships; early childhood settings; specific life events; and the social environment.

Underpinning the evaluation reported here is the significant consideration given to the implementation of the initiative. Domitrovich et al. (2008, p.64) have argued that in program evaluation it is important to develop information about, "discrepancy between what is planned and what is actually delivered when an intervention is conducted." A key feature of this evaluation study was to address these concerns by developing a robust measure of implementation quality to account for the likelihood that not all services can implement KMEC to the same level of quality. By doing so, it strengthened our ability to associate significant changes in services over the two years with the impact of the KMEC initiative. Implementation quality was shown to be an important influence on outcomes. The development and use of an Implementation Index enabled the identification of just over half of the participating services as high on implementation with regard to fidelity, dosage and quality. The evaluation tested a number of other factors, such as socio-economic background, that may influence quality of implementation, but found that the main factor influencing this implementation quality was the percentage of single parent families in a service. More research is needed to understand better why this factor would have such an impact on implementation quality.

Overall, the outcomes of the KMEC trial are consistent with an emerging body of national and international research pointing to the positive effects of social and emotional programs on children's mental health and wellbeing. A key element in the delivery of the KMEC pilot is professional learning. This was identified in the findings to have strengthened existing good practices, provided opportunities for raising staff awareness and building knowledge of children's mental health strengths and difficulties, reduced stigma, and provided staff with a common language to promote communication about mental health and wellbeing. Particular note is made of the acclaim given to the Facilitators in the delivery of the professional learning by service staff. It is noted that further work is needed to understand better the long-term impact of professional learning on staff knowledge, attitudes and behaviour.

However, although there is evidence from the evaluation of the successful implementation of KMEC and of associated positive changes, it is noted that the observed impacts varied in size and were not evident in all aspects of KMEC.

Furthermore, evidence of potential limitations and of possibilities for increasing the effectiveness of KMEC also emerged including:

- the challenges posed by changes in leadership and staff in successfully implementing the initiative,
- the importance of motivating and engaging staff around the significance of young children's mental health in the face of competing demands in an industry undergoing significant reform and change, and

- the challenge of increasing the level of involvement of parents and carers with the key processes and content of KMEC.

Finally, the sustainability of KMEC is a significant issue and in this regard it is relevant to note that the effects observed in this pilot emerged from the total package known as the KMEC initiative. Sustainability of an effective KMEC initiative in other locations will depend to a substantial extent on the maintenance of the levels of support and resources associated with this pilot.

Major Recommendation

1. Taking account of the evaluation findings and subject to the recommendations below, the main recommendation is that the ***broad framework, processes and material and human resources associated with the KMEC trial be maintained as the basis for a sustainable national roll-out of the KMEC initiative***.

This recommendation is based on the view that the findings of the evaluation indicate that the KMEC initiative can provide positive support for services as they work to assist young children who may be at risk of or experiencing mental health difficulties and to support their families.

This further highlights the overall significance of this developmental period in young children's lives, and the need to continue the KMEC initiative, which recognises, understands, and intervenes to assist young children who may be at risk of or experiencing mental health difficulties and to support their families.

Recommendations related to the KMEC Model

2. ***Planning for quality assurance***: A significant feature of the current evaluation involved the development and application of an index to assess the quality of the implementation process. The findings document the influence of quality of implementation on the effectiveness of key elements of this trial of the KMEC initiative. It is recommended that support for high quality implementation, and systematic monitoring of the quality of implementation, be included in all future enactments of the initiative.

3. ***Planning for monitoring***: It is recommended that the impact of any future roll-out be carefully monitored to assess its effect in relation to the objectives of the KMEC initiative. Consideration should be given to the design of instruments that can be embedded in a national roll-out that will facilitate this ongoing monitoring of effect.

4. ***Supporting Leadership***: Findings based on both implementation quality data and Facilitator reports point to the importance of leadership for the effectiveness of this trial of the KMEC initiative. It is recommended that attention be given to providing explicit support for service leaders in future revision of KMEC content.

5. ***Early Childhood education and care professional learning***: KMEC should consider advocating for training institutions to provide appropriate levels of experience in use of educational materials related to children's social-emotional skills and mental health for early childhood education and care educators.

6. ***Child risk and protective factors***: In recognising the importance of high quality staff-children relationships and child temperament as protective factors, the recommendations are to give strong consideration to identifying these elements as core features of the KMEC initiative, and on further educating staff regarding their importance.

Recommendations about specific elements of KMEC

Information generated during the evaluation included a range of specific suggestions for improving the efficacy of KMEC. These are included here for consideration in further development of KMEC processes and content.

7. Maintain the preferred face-to-face, active engagement, professional learning led by expert facilitators.

8. Address the diversity of educators' learning needs through professional learning curriculum designed to cater for both more and less experienced, and more and less qualified participants who work in a range of contexts.

9. Sustain professional learning opportunities to support, in particular, services that have more difficulties achieving high implementation, but who nevertheless would have the potential to achieve growth given a longer time period of professional learning opportunities.

10. Consider processes for managing professional learning in conjunction with staff turnover such as providing ongoing, facilitated professional learning conducted as 'start-up' and 'refresher' sessions.

11. Consider additional KMEC professional learning resources and materials to support educators working with children with complex and diverse needs (such children with special learning needs, children in state care).

12. Ensure text and visual materials represent the social and cultural backgrounds of children, families, and educators in services.

13. Continue professional learning with attention to quality of delivery, dosage and fidelity, but with particular attention to the needs of staff around time availability.

14. Build professional learning into the working day of educators.

15. Consider the impact of the differential availability within the sector of funding to support staff attendance at professional learning sessions.

16. Consider how Component 1 can be broadened to extend community networks and links with outside resources and to enable parents to develop a stronger sense of having a 'voice' as part of this community.

17. Facilitate the provision of up-to-date information for staff on social-emotional learning, staff-child relationships, temperament and mental health.

18. Consider ways to strengthen the work of services with parents regarding the availability of community resources and the significance of children's mental health in terms of their overall development.

19. Strengthen Component 4 particularly in terms of helping services to develop policies and referral procedures that will build more effective links with external support agencies.

Chapter 1
Background to KidsMatter Early Childhood

1.1 The changing nature of early childhood education and care in Australia

KidsMatter Early Childhood (KMEC) has been implemented at a time when Australian early childhood care and education is experiencing significant and unprecedented change. This change is related to the Australian Labour Government's reform agenda, instigated at their election in 2007. The reforms focus on providing Australian families with high-quality, accessible and affordable integrated early childhood education and child care. The agenda is complex and demanding, for it mandates change at the national, state, and local levels of provision and practice. The main features of the change include a Partnership Agreement between Federal and State Governments that has been crucial in instigating a jointly governed uniform national quality system (National Quality Framework, NQF) that applies to all Out of School Hours Care, Long Day Care, Family Day Care and Preschools. The NQF includes a single National Quality Standard (NQS), which provides expectations at a national level across seven quality areas including the implementation of the Early Years Learning Framework. All early childhood education and care[4] services will be rated according to the seven NQS areas and a new single national regulatory system has been introduced to regulate and enforce the NQS. Alongside the Early Years Learning Framework, educators working with children aged five, who are enrolled in full-time school, will be using the newly developed Australian Curriculum from the 'Foundation' year onwards, as each phase is developed.

1.2 What is KidsMatter Early Childhood?

KMEC is a national mental health promotion, prevention and early intervention initiative specifically developed for early childhood services. It involves the people who have a significant influence on young children's lives, and includes families and early childhood professionals along with a range of community and health professionals, who come together to make a positive difference for young children's mental health during this important developmental period.

The Australian Bureau of Statistics reports that in 2010 children and adolescents made up 18.9% of the population in Australia. As Kay-Lambkin (2007, p.34) notes "It is widely accepted that the early years exerts considerable influence on [children's] development, and their mental health and resilience throughout their life". Pihlakoski et al. (2006) argued that aggressive and destructive behaviours in very early childhood predicted later problems and necessitated early recognition and possible intervention at an early age. Cefai (2011) reviewed and highlighted the research relating to the positive effects of social-emotional education (SEE) on young people's lives, concluding that there were positive social and academic effects of social-emotional programs for children, from kindergarten to secondary school. Similarly, Durlak et al. (2011) in a review of programs from kindergarten to secondary school, reported clear evidence for the multiple benefits of such programs on the health and wellbeing of young people. Payton et al.

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[4] The terms 'service' and 'centre' refers to an early childhood education and care (ECEC) service.

(2008) found that, across the kindergarten - Year 8 age range, social and emotional learning programs were found to be effective in improving students' social and emotional capabilities, attitudes about others, positive social behaviours and academic performance. KMEC adopts a 'risk and protective factor' model to focus on areas where early childhood services can strengthen protective factors for improving children's mental health and minimise the effects of risk factors.

Mental health is a basic human right, and is fundamental for individuals, for effectively functioning families, and for social cohesion (Commonwealth of Australia Department of External Affairs, 1948). Mental health is also one of Australia's priority areas, as evidenced by the current Council of Australian Governments' work on developing a new National Partnership Agreement; the Fourth National Mental Health Plan 2009-2014; and the current initiatives known as KidsMatter Primary and KidsMatter Early Childhood.

Good mental health is vital for learning and for leading a happy and rewarding life. Mental health and wellbeing should be viewed as equally integral to development as physical health. Early childhood mental health is about young children's social, emotional and behavioural wellbeing. This includes children developing capacity to: experience, regulate and express emotion; form close, secure, satisfying relationships; and to explore and discover the environment and the world around them.

The KMEC initiative aims to enable preschool and long day care services to implement evidence-based mental health promotion, prevention and early intervention strategies that:

- improve the mental health and wellbeing of children from birth to school age;
- reduce mental health problems amongst children; and
- achieve greater support for children experiencing mental health difficulties and their families.

1.3 Who developed KidsMatter Early Childhood?

The KMEC initiative has been developed through collaboration between the Australian Government Department of Health and Ageing, *beyondblue*, the Australian Psychological Society, and Early Childhood Australia.

1.4 The KidsMatter Early Childhood framework

KMEC uses a risk and protective factors framework to focus on four areas, where early childhood services can strengthen the protective factors for children's mental health and minimise the risk factors. Risk and protective factors may be identified in relation to: aspects such as individual skills, needs and temperament; familial circumstances and relationships; early childhood settings; specific life events; and the social environment. These elements make up the core content of KMEC, structured around the following four components, which are also detailed in the Glossary.

Component 1
Creating a sense of community.

Component 2
Developing children's social and emotional skills.

Component 3
Working with parents and carers.

Component 4
Helping children experiencing mental health difficulties.

Component 1: Creating a sense of community. This component focuses on creating a sense of community within the service, which promotes feelings of belonging, connectedness and inclusion for all children and families. This kind of environment within an early childhood service has been shown to have a positive effect on children's mental health.

Component 2: Developing children's social and emotional skills. Research shows that the development of social and emotional skills is fundamental to children's mental health, ability to learn, moral development and motivation to achieve. Children who develop social and emotional skills find it easier to manage themselves, relate to others, resolve conflict and feel positive about themselves and the world around them.

Component 3: Working with parents and carers. By engaging with parents and carers, early childhood services can share important information about the child's life, experiences, preferences, and activities. In addition, early childhood services are an excellent access point to link parents and carers with appropriate information and education about parenting, child development and children's mental health.

Component 4: Helping children who are experiencing mental health difficulties. Effective support during the early stages of a child's difficulty can mean that mental health issues are resolved before they become worse or entrenched, improving the quality of life for children and their families. Due to the significant contact early childhood services have with children and their families, services are in an effective position to identify problems early, implement strategies to assist the child and support their family to seek additional help.

1.5   KMEC resources

Each KMEC pilot service was supported by a state or territory based Facilitator who worked with services to implement the framework by delivering professional learning related to each of the four components in KMEC. Facilitators visited individual services to assist and guide early childhood education and care staff[5] in identifying goals, strategies and resources to work through the service's action plan. The KMEC professional learning presented to each service guided staff in the implementation of the framework to improve mental health outcomes for children. Staff had the opportunity to identify their service's strengths and to establish strategies for continuous improvement. In addition to Facilitator support, each KMEC pilot service was supplied with a number of evidence-based resources to assist services to develop their capacity for promoting early childhood mental health and wellbeing, and respond to mental health needs of the children within their care. During the pilot phase, KMEC was evaluated in order to learn what worked well and how KMEC could be improved.

1.6   What is contained in this report?

The remainder of this report presents details of the evaluation design, the data collected, analyses conducted, conclusions drawn and recommendations for policy and practice resulting from the two-year evaluation of the KMEC initiative conducted during 2010 and 2011. Further information about the statistical analyses presented in this report is available in the *KidsMatter Early Childhood Technical Report* (Dix et al., 2012).

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[5] The terms 'staff' and 'educators' are generally used to refer to early childhood education and care educators.

Chapter 2
Evaluating KidsMatter Early Childhood

The two-year evaluation of KMEC was a substantial research undertaking. The Flinders University evaluation team worked closely with KMEC stakeholders to address any evaluation design challenges that arose (e.g., services affected by disaster events such as floods during the course of the evaluation). Regular contact was also maintained with KMEC Facilitators, who supported services during the evaluation. However, perhaps the most substantial load in the evaluation was borne by the service communities: the directors, leadership teams, educators and parents who responded to the multiple evaluation questionnaires and participated by contributing photos and sharing stories with members of the evaluation team about their children's social and emotional wellbeing, and their experience of KMEC in the photo study discussions. The deep levels of engagement of all these groups enabled the evaluation team to assemble a large and rich set of information to inform the findings of the evaluation.

2.1 The conceptual model for the evaluation

A four-part conceptual model was developed that considered background factors and implementation processes as influences upon mediating factors and outcomes. The conceptual model, in Figure 1, was designed to address the specified research areas that informed the evaluation design, instrument design, the nature of qualitative information collected, the subsequent analyses, and the structure of this report. These areas are described in the Glossary.

Figure 1. KMEC Evaluation conceptual model
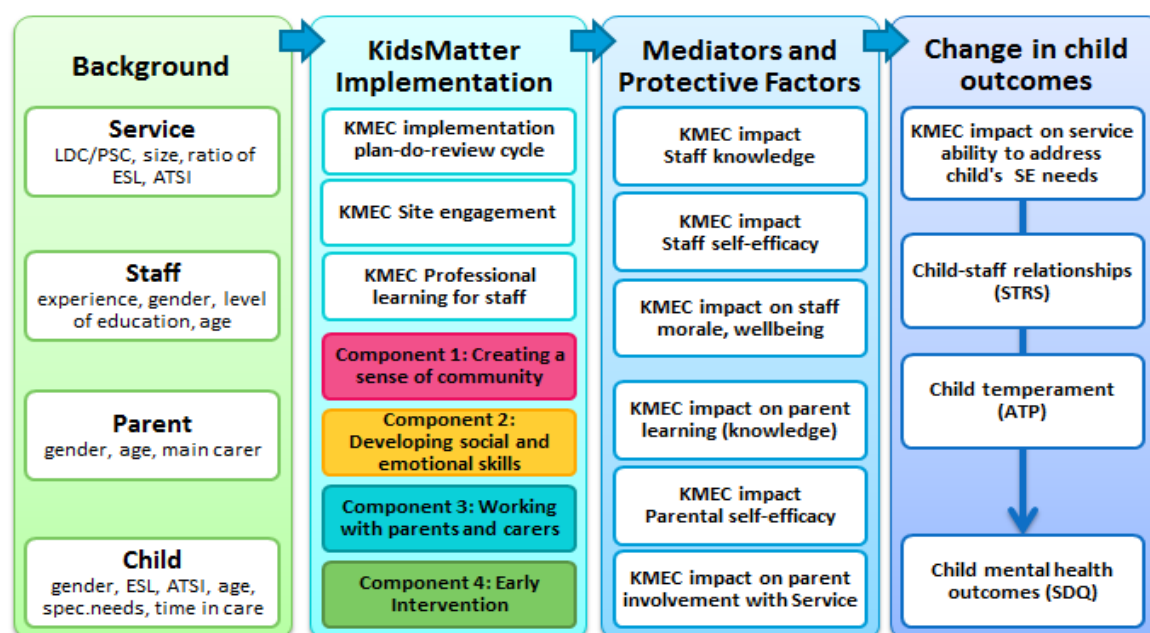
2.2 The original KidsMatter conceptual model

The KMEC components were designed to "target the key risk and protective factors associated with child mental health" (Graetz et al., 2008, p.15). KMEC uses a risk and protective factor

framework to focus on four components where services can strengthen the protective factors and minimise risk factors for children's mental health and wellbeing. These four areas make up the core content of KMEC and are consistent with the KidsMatter Primary school initiative. In the conceptual model for KMEC (described in Chapter 1), the main risk and protective factors within the four components, were grouped under (a) family context (e.g., effective parenting), (b) child factors (e.g., social and emotional competencies) and (c) service context (e.g., staff knowledge, confidence and competence). As set out in the initial conceptual model, improvements in young children's mental health were assumed to arise from the changes to the risk and protective factors of family context, child factors and service context. These processes involve changes to protective factors strengthened by the initiative, and to reductions in risk factors (Askell-Williams et al., 2009). Note that protective and risk factors can sometimes fall at each end of a continuum, such as effective or ineffective emotional coping strategies. Note also that in the above model, individual factors can operate both as outcomes themselves, and as mediators to future outcomes. For example, improved child-staff relationships could be both an outcome of a successful professional learning intervention, and a mediator to child mental health outcomes.

2.3   Evaluation design and research methods

The evaluation of KMEC was conducted in a manner consistent with Ellis and Hogard's (2006) three-pronged approach, which emphasised (a) the definition and measurement of outcomes, (b) the description and analysis of process, and (c) the sampling of multiple stakeholder perspectives. These aspects are captured in the representation of the evaluation design, shown in Figure 2. The evaluation used multiple methods (questionnaires, interviews, photo study and Facilitator reports), involved multiple participants (service leadership, staff, parents, and KMEC Facilitators), and gathered data on multiple occasions (including four questionnaire data collection occasions over the two-year pilot). An additional aspect of the evaluation design was the inclusion of a non-KMEC comparison group, using data from the *Longitudinal Study of Australian Children* (LSAC). Key instruments included the Australian Temperament Project scales (ATP), the Student-Teacher Relationships scales (STRS) and the Strengths and Difficulties Questionnaire (SDQ).

Figure 2. KidsMatter Early Childhood Evaluation design

KMEC Services around Australia					Selected Services	
Quantitative		**Mixed**		**Qualitative**		
Staff and Parent Study For all children aged 1-5 years in care for 10 hours or more per week 4 times, Staff and Parents Paper-based questionnaire Items about context, beliefs and attitudes		**Facilitator Service Study** 4 times Facilitators Online Survey	**Leadership Executive Summary** 1 time Directors Emailed Doc	**Reflections on Practice Study** 2 times **Leadership** Reflective writing activity	**Photo Study Families** 1 time **Parents** Pictorial data with thematic analysis	**Photo Study Staff** 1 time **Staff** Pictorial data with thematic analysis
Non-KMEC Comparison Group LSAC Data		**Component Professional Learning Feedback** 4 times, Staff Paper-based Survey				
Age range 1-3: Toddlers 4-5: Kindy	Parents ATP ATP & SDQ	Staff STRS STRS & SDQ				

A brief description of each method of the evaluation in Figure 2 is presented here.

2.3.1   Staff and parent study

Central to the evaluation of KMEC were three whole-cohort (Parent, Staff, Staff Supplement) questionnaires administered on four occasions. These were designed to assess the extent to which KMEC achieved its major goals with respect to child mental health, and to assess change in early childhood environments and processes. The 17 scales contained within the questionnaires provided data related to the conceptual model (see Figure 1) of implementation, mediating

factors, and outcomes. Where possible, pre-existing items and scales that had established validity and reliability were used, and all scales underwent confirmatory factor analysis. A description of each scale is presented in the Glossary.

The Parent Questionnaire asked parents about aspects of the service, about themselves, and about their child. The Staff Questionnaire asked about aspects of the service, KMEC implementation and professional learning, and about themselves. The Staff Supplement Questionnaire asked staff about the children in their care. These three questionnaires were administered on four occasions to all parents and staff of children aged between 1 and 5 years who were in care 10 hours or more per week in participating services. In the analysis, data were only used for the appropriate age groups, as some items provided in the questionnaires were not age appropriate for very young children.

2.3.2 LSAC comparison group

In order to facilitate comparisons with non-KMEC intervention sites, existing data from the *Longitudinal Study of Australian Children* (AIFS, 2009) was used on the key measures of temperament (ATP: Prior et al., 2000), child-staff relationships (STRS: Pianta, 2001), and mental health strengths and difficulties (SDQ: Goodman, 2005). LSAC involved a nationally representative random sample of children tracked at the ages of 0-1 year in 2004, 2-3 years in 2006, and 4-5 years in 2008. This cohort of children forms the non-KMEC comparison group and provided a baseline for comparison. Table 1 presents information related to demographic background and instruments used in the LSAC and KMEC groups.

Table 1. Comparison between LSAC and KMEC projects

Project	LSAC (B cohort) Longitudinal			KMEC Cross-sectional	
Year	2004 Wave1	2006 Wave2	2008 Wave3	2010	2011
Age range	0-1 years	2-3 years	4-5 years	1-5 years	1-5 years
Demographic data in common	✓	✓	✓	✓	✓
Parent scales	ATP	ATP	ATP & SDQ	ATP & SDQ	ATP & SDQ
Staff scales	STRS	STRS	STRS & SDQ	STRS & SDQ	STRS & SDQ

2.3.3 Facilitator reports

The eight state-based KMEC Facilitators completed, on four occasions, a web-based survey that captured contextual and event data through multiple-choice and open-response questions. These reports provided details of, and reflections about, the roll-out of KMEC in their respective services. The items were specifically designed to provide information related to the three principles of fidelity, dosage and quality of delivery (Domitrovich et al., 2008) to contribute to the development of an Implementation Quality Index (see Chapter 3).

2.3.4 Leadership executive summary

KMEC service Directors were asked, near the completion of the evaluation, to respond in writing to a number of multiple-choice and open-response questions to gain an overall perspective about KMEC in their service, thus allowing them to 'tell their story'. The questions were emailed to Directors during the final months of the evaluation period, with an invitation to reply by email.

2.3.5 Reflections on practice study

Staff in KMEC Leadership Teams were asked to respond in writing to two questions that investigated *What changes have occurred?* and *What changes are needed?* These forms were hand-distributed by Facilitators during a site meeting on two occasions in the later parts of each of the first and second years of the evaluation.

2.3.6 Component professional learning feedback

As part of the KMEC Initiative, Facilitators administered feedback forms at the completion of their whole-staff professional learning sessions on each of the four KMEC Components. Items included both multiple-choice and open-response. This information was compiled by the KMEC administration as part of their internal monitoring process. The raw data file was provided to the Flinders team for inclusion in the evaluation. We collated and transcribed the comments provided by participants on the feedback sheets into a central database, and scanned the responses for common themes. Some of the comments from this data source are used to support the presentation of findings about professional learning.

2.3.7 Families and staff photo studies

An innovative feature of the Flinders University KMEC evaluation was the photo study. This qualitative data source complements the quantitative information and further contributes to knowledge about the mental health and wellbeing of preschool children from the family, parent and staff perspectives.

The photo study involved families and staff using cameras to capture visual images of situations related to children's social and emotional learning and then used a picture a stimulus to generate a description of the impact of KMEC. It provided an alternative opportunity (compared with questionnaire completion) for parents and families to contribute to the evaluation and offered access to information that would otherwise not be accessible. The photo study occurred during the last months of the evaluation in 10 services across Australia selected for their geographical and service type diversity. The photo study involved site-visits from the evaluation researchers to engage in discussion with staff and parents about their photos. Six services were classified as High Implementing services, three services were classified as Moderate, and one was classified as a Low Implementing service. These classifications should be kept in mind when considering the qualitative results that emerged from the photo study. In particular, it is arguable that High Implementing services may be more likely to provide evidence of best practices in their photos and stories. Although such best practices may not provide a representation of experiences in all services, best practices do provide indications of what is possible from an initiative such as KMEC.

Staff at two other services with high numbers of Aboriginal and Torres Strait Islander children who were involved in a separate study of KMEC (Slee et al., 2012), were also invited to offer their stories, but did not participate in the photo study visits. Some of their stories have been included in this report.

From the 'album' of photos and stories contributed, we have selected portraits to introduce the chapters of this report. Within the chapters, excerpts from staff and parent stories are embedded to complement the quantitative data.

2.4 Ethics

Prior to data collection, ethics applications were submitted, and approvals received, from the Flinders University Social and Behavioural Research Ethics Committee, based on a modification of the original KidsMatter Primary Evaluation (SBREC Project 3744). A separate application to conduct the photo study was approved by SBREC in August 2011 (Project 5251). Informed consent and approval were received from all service directors, their jurisdictional authorities, and participants.

2.5 Summary of all data collected

An overview of all data for the KMEC evaluation collected in the second and fourth school terms of 2010 and 2011 is presented in Table 2. In summary, in the 111 services, 2375 Staff

Questionnaires and 19673 Staff Supplements were received from 1194 staff, and 7540 Parent Questionnaires were received from 5070 parents or caregivers. Based on figures submitted by services at the start of the KMEC pilot, the approximate response rates for Staff Questionnaires were 80%, 86% for Staff Supplements (about children), and 40% for Parent Questionnaires. Accordingly, the sample size and composition, together with the response rates, are considered appropriate for the statistical analyses undertaken in the evaluation. All of the KMEC Facilitator Service Reports were received, resulting in a 100% response rate. For the Leadership Executive Summary, only 22% of services responded. In addition, the 10 photo study services yielded over 19 hours of recorded discussions and 162 photos and their stories.

Table 2. Summary of responses and other data collected in the KMEC evaluation

	2010		2011	
Data sources include:	**Time 1**	**Time 2**	**Time 3**	**Time 4**
Service background data	111			
LSAC comparison group	4662			
Staff Questionnaires	818	547	565	445
Parent Questionnaires	2494	1702	1901	1443
Staff Supplement Questionnaires	5948	4466	4873	4386
Facilitator Service Reports (excludes withdrawn services)	111	111	108	105
Component Professional Learning Feedback	1576	1180	1034	838
Reflective Practice Activity for Leadership		154		90
Photo Study (10 services) (photos)				162
Leadership Executive Summary				22

2.6 The early childhood education and care services

The 111 Services involved in the pilot of KMEC were a volunteer sample of long day care services or preschools selected from a large sample, rather than a random sample. Applications to be involved in KMEC were received from approximately 400 Services, affording the opportunity to select a representative sample on the basis of distribution across states and territories, location, and service type. Other factors were also considered, so that there were Services with relatively higher Aboriginal or Torres Strait Islander populations and services that were culturally and linguistically diverse. Demographic information, presented in Table 3, contains data collected from services at the start of the evaluation and provides background information about the context of the early childhood educational settings.

Table 3. Background characteristics of services involved in the KMEC evaluation

Services	**N=111**	**Long Day Care**	**Preschool**	**Both**
	Metro	33	23	6
	Regional	19	19	5
	Remote	4	1	1
	Profit	17	4	1
	Non-Profit	39	39	11
Staff	**Mean (SD)**	**Long Day Care**	**Preschool**	**Both**
	Total Service staff	14.7(6.1)	8.2(4.8)	18.7(9.7)
	% of Full-time staff	49.6 (24.1)	31.9 (21.4)	41.0 (14.9)
	% of Part-time staff	33.3 (25.4)	45.8 (26.9)	35.9 (20.7)
	% of Full-time with qualification*	47.0 (24.8)	30.5 (21.4)	38.9 (12.7)
	% of Part-time with qualification*	28.1 (23.8)	33.6 (29.4)	29.7 (17.7)
Children	**Mean (SD)**	**Long Day Care**	**Preschool**	**Both**
	Total children enrolled	104.9 (51.6)	91.2 (52.9)	126.3 (64.4)
	% Aboriginal or Torres Strait Islander	6.4 (15.9)	9.5 (20.3)	9.0 (21.4)
	% ESL/CALD	9.6 (14.5)	4.7 (10.3)	15.5 (20.6)

* Qualifications include: Early childhood teaching degree, Diploma, Nursing/Mothercraft, or Certificate 3

The resulting distribution of services across states and territories showed that there were 20 Services in NSW, 16 each in VIC, SA, WA, and QLD, 11 in NT, 10 in TAS, and six services in the ACT. It should be noted that the cross-sectional sample is not a random sample, and caution should be taken if generalising findings to other services, staff, or children in Australia. Over the course of the evaluation, six services withdrew from the pilot and the evaluation, due in part, to unrelated challenges faced by these services. Data from these services were included in this report, where available, as reflected in the decreasing number of participants on each occasion in Table 2.

2.7 The evaluation participants

The evaluation of KMEC was undertaken over a two-year period and there were significant challenges as with any longitudinal research design. For example, the majority of families transitioned into, out of, or between services within that two-year timeframe, due to the non-compulsory nature of attending an early childhood service, and because children generally attend preschool only for one year prior to starting school. In order to maximise the opportunity to collect both cross-sectional data and longitudinal data, a whole-service-population approach was adopted, with the delimitation of only involving the staff and parents of children aged between 1 and 5 years (12 – 60 months) who attended the service 10 hours or more per week. On this basis, the parents and service staff of these children were invited to complete questionnaires on up to four occasions (Times 1 to 4). The background characteristics collected from these questionnaires of the staff, parents and children involved in the KMEC evaluation, are presented in Table 4.

Table 4. Background characteristics of staff, parents and children involved in the KMEC evaluation

Staff	N=1194	Male(2.4%)	Female(97.6%)
Staff Age	Mean (SD)	33.7(12.9)	37.2(12.1)
Work Experience	Mean (SD)	6.5(6.7)	9.8(8.4)
Current Position	% of Director	0.3	9.6
	% of Permanent	1.7	72.4
	% of Casual	0.2	12.6
Work Status	% of Part-time	0.5	38.3
	% of Full-time	1.9	57.3
Highest Childcare or Early Childhood Qualification	% of Certificate 3	0.6	29.8
	% of Diploma or Associate Diploma	0.7	36.2
	% of Bachelor Degree (including Honours)	0.2	18.2
	% of Graduate Diploma or Graduate Certificate	0.1	4.8
	% of Doctoral or Masters degree		0.8
Currently Studying for a qualification in:	% of Not studying	0.9	57.6
	% of Special Education	0.3	5.9
	% of Primary/Secondary Education	0.1	9.4
	% of Early Childhood Education or Child Care	1.2	24.5
Parents and caregivers	N=5070	Male(8.8%)	Female(91.2%)
Parent Age	Mean (SD)	38.7(6.0)	35.1(5.6)
Aboriginal or Torres Strait Islander	% based on 5053 responses	0.5	3.2
English as a Second Language	% based on 5050 responses	2.4	13.9
Main carer	Based on 5018 responses	8.6	90.7
Children	N=11224	Male(50.9%)	Female(49.1%)
Child age	Mean (SD)	4.0(1.2)	4.0(1.2)
Aboriginal or Torres Strait Islander	% based on 5023 responses	3.2	2.7
Has a disability	% based on 4462 responses	8.9	4.8
Average Hours per week in care	Mean (SD)	20.4 (10.2)	20.5(10.1)

Staff showed expected characteristics, such as a predominance of female early childhood educators and a large part-time work force, with predominantly Certificate and Diploma qualifications. A quarter of the staff were undertaking study for qualifications in Early Childhood Education or Child Care, while almost 60% were not undertaking any study. Over 90% of parent

participants were female, averaging 35 years of age, and nominated themselves as a main carer of their child. As indicated in the table there was a balanced sample of boys and girls, who had an average age of 4 years, and spent an average of 20 hours in care each week.

2.8   Analysing and reporting the results

The remaining chapters of this report are focussed upon the presentation and interpretation of results structured around the specific areas of the evaluation detailed at the start of this chapter.

2.8.1   Confirming the scales in the questionnaires

In the questionnaires, each conceptual construct being assessed (for example, mental health difficulties) was measured by a number of items. Staff and parent responses to the individual questionnaire items were on a seven-point Likert scale, with anchor points typically of 'strongly disagree' and 'strongly agree'. The theoretical basis for the grouping of items was then tested to ensure that there was good agreement among items. Accordingly, the items included in each construct were subjected to confirmatory factor analysis using asymptotically distribution-free (CFA-ADF) methods available in AMOS (IBM SPSS) in order to confirm the factor structure of the groups of items (Garson, 2009; Tabachnick & Fidell, 2007). With scale reliability and validity confirmed using methods sensitive to highly skewed data, item scores were averaged to provide a final score for each scale construct (other than in the SDQ, where Goodman's recommended scoring method was employed). The main emphasis in reporting the evaluation findings are based upon these resultant scales, rather than the individual questionnaire items, though the questionnaire items are also reported. Further detail about the confirmatory factor analysis is contained in the *KidsMatter Early Childhood Technical Report* (Dix et al., 2012).

2.8.2   Cross-sectional and longitudinal data

The non-compulsory nature and structure of preschool and long day care services meant that many children and their parents were only present in the service for one or two data collection occasions, as children started at the service, left or changed services, or transitioned to primary school. The fact that most children were typically only in the service for 12 months during a two-year evaluation, posed challenges for tracking changes over time and the issue of missing data.

In order to make best use of the available data, two methods of analysis are presented. The first method involved the full sample of 1194 staff, 5070 parents and 11224 children, as shown in Table 5. This method takes a cross-sectional approach by comparing percentage change between Time 1 and Time 4. It provides insight into the pattern of broad changes that occurred in services. The percentage of parents and staff reporting that they strongly agreed on particular items is taken as the highest two levels of the response scale (i.e., scored 6 or 7 on the Likert scale).

The second method of analysis used a subset of the data for which there are three or more data collection occasions for each individual child, thus allowing for an analysis of change in scores on key measures for children in the subset. Table 5 indicates that 365 staff (30.6% of the staff), 467 parents (9.2%), and 1838 children (16.4%) had sufficient data for analysis of changes over time.

Table 5. The presence of staff, parents and children on occasions

	Staff	Parents	Children	
Individuals	1194	5070	11224	
Present on:				**Groups**
One occasion	557	3218	4797	unselected
Two occasions	272	1385	4589	unselected
Three occasions	186	316	964	selected
Four occasions	179	151	874	selected
Change over time (three or four occasions)	365	467	1838	

In the second method of analysis, an important step was to determine whether there were any differences between individuals who were present on one or two occasions (indicated as the unselected group in Table 5) and individuals who were present on three or four occasions (indicated as the selected group Table 5). Therefore, comparisons between the selected and unselected groups were undertaken. The Pearson's chi-square test (α=.05) and independent t-tests (α=.05) were used to evaluate whether selected participants significantly differed from unselected participants on a number of characteristics.

Staff who were selected for inclusion in the change over time analyses came from 80 of the 111 services and were overrepresented in SA (5.5%) and TAS (7.8%) and underrepresented in NT (-6.2%)[6]. There were fewer staff from long day care services (-18.4%) than preschools (14.1%) and services that catered for both (4.2%). However, there were no significant differences in the representation of staff from metro, rural and remote services. There were more staff that were Directors (4.2%) and permanent (3.3%), than casual staff (-6.2%), but profiles of part-time and full-time work status were similar in the selected and unselected groups. Staff in the selected group, were more likely to hold a Bachelor Degree in Early Childhood (10%) and less likely to hold a Certificate (-8.6%). Selected staff were typically 5 years older and had, on average, 3.8 years more experience.

Parents who were included in the change over time analyses came from 60 of the 111 services and were overrepresented in VIC (7.1%) and TAS (7.6%) and underrepresented in SA (-5.7%) and WA (-7.0%). There were fewer parents from preschool (-15.8%), compared to long day care (6.2%) and both (9.4%), as would be expected, and there were more parents from services located in metropolitan areas (7.3%) than regional areas (-6.6%). Parents were also more likely to be from larger services with higher cultural and linguistically diverse backgrounds, lower Aboriginal or Torres Strait Islander background, and fewer single parent families.

Children who were selected for inclusion in the change over time analyses came from 77 of the 111 services and were overrepresented in VIC (12.9%) and underrepresented in WA (-8.1%). Children were underrepresented in preschool (-24.8%) and overrepresented in long day care (13.5%) and services that offered both (11.3%). Again, this result is expected, since children in preschool settings typically only attend for one year, and would have only been present for one or two data collection occasions. These children were also more likely to be from metropolitan locations (6.6%), with fewer from regional areas (-5.1%). Children in the selected group were younger (average of 3.62 years of age), compared to those not included (4.05 years of age), and generally spent 4.2 more hours in care each week, than children not present on three or more occasions. While there were no differences in the representation of gender or children with a disability, there were fewer children from Aboriginal or Torres Strait Islander backgrounds (-3.1%) represented in the group.

2.8.3 Measuring change over the time of KidsMatter

A major focus in the evaluation study was on change over time in relation to the various aspects of the key research questions being addressed. The main interest was whether or not the questionnaire data gathered on four occasions showed statistically significant evidence of change that could be associated with KMEC. In order to assess this evidence, hierarchical linear modelling (HLM) is used (Bryk & Raudenbush, 1992). HLM has specific advantages for analysing complex longitudinal nested data, the type of data involved in this evaluation. HLM provides information about the slope or gradient of change across time, which enables an assessment of whether the line summarising the trajectory of change across time goes up, or down, or stays at much the same level, and whether that change is statistically significant.

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[6] The minus signs associated with some percentages simply indicate underrepresentation

The results presented in the following chapters provide information generated from analyses using HLM, and the mean levels of staff and parent responses on the various measures (scales) used in the evaluation. This information is shown in tables and in figures that present the HLM slopes associated with the multiple data collection occasions. In addition to reporting HLM estimated means at Time 1 and Time 4, the value of the level of statistical significance, p, is also reported at three levels, where *** is given for $p < .000$, ** is given for $p < .001$, * is given for $p < .01$, and not significant (ns) is given for $p > .01$.

2.8.4 Statistical significance and effect size

Statistical testing provides both a measure of uncertainty of a result (such as $p < .01$) and an indication of the magnitude of the relations between variables. A common way to express this magnitude is as an effect size. An effect size can be seen as a guide to the practical significance of a statistically significant result, a guide as to "whether the result is useful in the real world" (Kirk, 1996, p.746). In this evaluation statistical significance is reported. However, our discussion of the outcomes of the statistical analysis also focuses upon effect sizes, because these give a better indication about whether an outcome is of practical importance.

In this report we used the part-correlation coefficient r for reporting all effect sizes[7], adopting the same method used in the KidsMatter Primary Evaluation (Dix et al., 2010). In statistics, correlation simply means the strength and direction of a linear relationship. We use correlations of 0.10, 0.24, and 0.37 as indicative of small, medium and large effects, respectively (Kirk, 1996). In the cases when there is limited practical significance, that is $r < .10$, we do not report an effect size, even if there is statistical significance. Cohen's d is also used later in this report to provide an effect size for statistical tests of differences ($p < .05$) between independent means (Cohen, 1988).

2.8.5 Thematic analysis of photos and stories

Three researchers undertook analysis of the photo stories of parents and staff. In order to establish coding agreement the researchers worked independently in the first instance and coded 10 of the same parent and staff stories and photos. The researchers then met to discuss their coding and agreement was reached about the meaning and labelling of codes, and a clear analysing procedure was established. The remaining photos and stories were then divided for coding amongst the researchers who met several times to discuss progress before the final thematic analysis was completed using NVivo.

2.9 Methodological notes and limitations

As with all research it is important to acknowledge methodological limitations and provide the reader with some cautions to consider in reading the findings.

2.9.1 Context

It is important to consider the variability of early childhood contexts, where different services, with different staff, and different children, interact. A fundamental approach of KMEC was that mental health promotion was not externally imposed, but rather, that KMEC would be adapted to the services' existing contexts. This variability would be expected to influence the ability of broad scale interventions to demonstrate measurable effects over the short term.

The KMEC pilot was not a true experimental intervention. It was a naturalistic study that had strong ecological validity. The intervention involved the well-supported use by services of

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[7] The effect sizes were calculated using a formula that relates the part-correlation coefficient, r, and the slope of a regression line, b, expressed in deviation-score form (Ferguson, 1971, p.113).

evidence-based programs relevant to mental health needs of children in long-day-care and preschool services. Clear guidelines for use of KMEC materials were agreed to by the services involved. Beyond this, the pilot proceeded under the direction of the services, using the regular support and guidance provided to each service by KMEC Facilitators. There was, therefore, variation in the quality of the implementation of the initiative across the services involved, as evidenced by the range of scores on the Implementation Index. However, there are three important strengths of the evaluation design. First, the evaluation was longitudinal and this, in a conceptual sense, provides increased confidence to interpretations that noted effects can be associated with the initiative. Second, the evaluation design made strong use of multiple data sources and methods, providing for the triangulation of results. Third, the design has strong ecological validity in that it was based in the real life of services, and that any positive impacts emerged from an intervention that varied across sites that were subject to a wide variety of competing influences.

2.9.2 Sampling

Services were invited to apply for inclusion in the KMEC trial and the services involved in the pilot phase were selected to be involved. The final sample included in the evaluation is, therefore, not one that is representative of the Australian service population. This limitation is of relevance in making generalisations about the findings of the evaluation. The attained sample is, however, large and designed to provide a good representation of the services that applied to be involved in the pilot phase. Hence, caution should be taken if generalising findings.

In relation to the qualitative data collected as part of the photo study, it should be noted that the 12 services (including two services involved in the KMEC Aboriginal and Torres Strait Evaluation) chosen to participate, were not randomly chosen. Rather, a broad representation of services from states and territories was sough, along with some representation of remote, rural and metropolitan, with the inclusion of services with high levels of Aboriginal and Torres Strait Islander children. Further examination of the larger KMEC sample did show that the 12 services approximated the percentages of services scoring as high, moderate and low on the Implementation Index suggesting that some broad representation was obtained. The photo-study approach and methodology is innovative and care is needed in considering the interpretation of the data derived from this approach, allowing for the point that every effort was made to account for the validity of the information derived.

2.9.3 Comparison group

In the situation where neither a no-intervention control group, nor a delayed treatment comparison group can be incorporated into the evaluation design, the availability of a nationally representative sample of same age children is very useful. Comparison data for such a sample is available in the LSAC database. The LSAC comparison group provides estimates of the status of same age children on key child measures used in KMEC. The LSAC measures provide a relevant estimate of the status of same-age children who have not participated in KMEC. These estimates enable a comparison between the status of the KMEC sample and a nationally representative sample of same-age children. Put more simply, this comparison allows the reader to consider whether the KMEC sample, in the early stages of KMEC implementation at Time 1, is similar to a representative national sample.

2.9.4 Age profile of children

The KMEC evaluation utilises a multi-method approach along with multiple informants in a complex two-year evaluation, with data collected at four time points. Particular consideration is needed in interpreting the findings due to the fact that data were collected on young children. The most recent research (e.g., Mantymaa et al., 2012) reports that the extent of young children

suffering from mental health problems is similar to that of older children (15%-20%). There is no doubt that early childhood is characterised by rapid developmental change. Consequently, many parents and professionals believe that early social-emotional and behavioural problems are developmentally transient (e.g., the so called 'terrible twos') and likely to diminish as children grow older. However, this view must be considered in light of a growing body of evidence that for a small group of especially vulnerable children, some early-emerging social-emotional and behavioural problems persist (e.g., see review by Briggs-Gowan et al., 2006). In reviewing the literature, Briggs-Gowan et al. (2003) noted that despite differences in children's ages and length of follow-up, the clinical literature reported persistence rates for externalising disorders in the range of 40%-56% and for internalising disorders it is in the range of 23%-57%. In a prospective nine-year longitudinal study, Pihlakski et al. (2006, p.413) reported "that parent-reported problem behavior at age 3 predicts problem behavior in preadolescence among both boys and girls".

A complicating factor in assessing the behaviour of very young children relates to the fact that during early childhood, noncompliance, temper loss and aggression are common. Wakschlag et al. (2007) refer to these somewhat expectable behaviours as 'normative misbehaviors.' However, the same authors point out that such behaviours are also core features in the clinical assessment of 'externalising' disorders, which presents particular challenges in the accurate clinical diagnosis of disorders in young children. In an effort to overcome this, researchers, such as Wakschlag et al. (2007), have argued for assessment of young children's behaviour to take account of the 'quality' of the behaviour and the 'pervasiveness of the behaviour across contexts'.

Overall, taking into account the evidence that young children have been found to exhibit similar levels of mental health problems to those of older children, and that while a proportion of this behaviour could be identified as 'normative misbehaviour', there is strong clinical evidence for the persistence of both externalising and internalising behaviour. Certainly, there are challenges in distinguishing normative misbehaviour in very young children from clinically significant behaviour requiring early intervention.

2.9.5 Issues related to the analysis of change

The analysis of change undertaken in this report uses an analytical procedure known as multilevel modelling. This procedure has particular strengths in handling issues that arise from the nesting effects associated with service data. In keeping with the requirements of the evaluation, in this report the analyses generally focus on change observed at the individual level.

The evidence presented throughout this report presents a complex picture of services and staff within services working to implement KMEC for the wellbeing of children in their care. In this evaluation it is recognised that individual health and wellbeing is the result of multiple and interwoven determinants ranging from individual factors (biological, genetic, behavioural) to local resources and opportunities for health and wellbeing, to society wide factors (environmental, cultural and socio-economic). The four components of KMEC identify the risk and protective factors in relation to these multiple determinants. The challenges associated with assessing change are best viewed in this broad context.

We know that compared to the main cohort of participants present on one or two occasions, the staff present on three or four occasions were more likely to be Directors and permanent with higher educational qualifications and more years of experience. Parents and children were less likely to be from Aboriginal or Torres Strait Islander background or in single parent families. As a result, the services themselves were also more likely to be identified as High Implementing (70%), potentially optimising any impact of KMEC on staff, families and, in turn, children, who also tended to spend more time in these services.

2.9.6 Some particular cautions related to assessing child outcomes

There are a number of cautions that must be considered when interpreting the results relating to changes over time in child outcomes. These cautions arise from the nature of this evaluation, which was designed to meet the client's brief. In particular, in field interventions such as educational settings, it is recognised that traditional experimental designs, including randomised control groups, suffer from difficulties with practical application. This is due to the broad range of potential variables to be controlled, and the practical difficulties of delivering interventions to only parts of cohorts, such as school classes or early childhood services.

This study is about children, and children are in groups, and groups are in services. It is not always possible to randomise the children or the conditions because of basic practical problems like contamination. Educators (and children) talk to each other, and ideas and materials get shared (Brobeck, 2007). One approach to overcome this practical difficulty is to conduct cluster Randomised Controlled Trials, which need large numbers of participants and sites, with randomisation at the site or educator level. A study of this scale was beyond the scope of this evaluation. Alternative methods of evaluation, such as those used in this study, involve multiple methods of data collection from multiple informants, in order to develop theories of change.

In interpreting the findings in this report, particularly those regarding the SDQ, we acknowledge the potential influences of the issues detailed below:

- Small sample sizes: As the analysis of change over time required data on three or four occasions, the final available sample sizes were, in some instances, small. For example, only 28 children, initially classified in the abnormal range of the SDQ, had sufficient data on three or four occasions. Although the sample sizes are adequate for statistical analysis, it must be born in mind that, due to the small sample size, and that the sample was not randomly drawn from the whole population, the results are indicative, but not generalisable to the whole population.

- Age related changes due to increasing maturity: The 3-5 year age group reported in this analysis of SDQ scores is a period of rapid human development. It can be anticipated that children pass through phases of behaviours that, with maturation, resolve into normal ranges of behavioural expression. The child scales used in this evaluation, namely the Student-Teacher Relationship Scale, the Temperament scale, and the Strengths and Difficulties Questionnaire, were all assessed for changes over time due to ageing. Only the SDQ was found to be susceptible to the effect of ageing and this was controlled and corrected for. Moreover, the subscales within the SDQ were susceptible to varying extents, such that one subscale was stable across age and only required a trivial correction.

- The suitability of the SDQ items for the age group of 3-5 year old children: Although there are some studies using the SDQ with younger age groups, and the recent review, by the Australian Institute of Health and Welfare (2012), of instruments suitable for a headline indicator of children's mental health recommended the use of the SDQ, it must be borne in mind that the SDQ is a broad and brief screening instrument only, and the contexts and purposes of its use for decisions about intervention should be closely monitored. Other authors, such as Sawyer et al. (2011) express similar cautions about the use of the SDQ.

- In some instances, different informants assessed the same children at the different time points during the pilot. This may have impacted upon scores as it cannot be assumed that all parents, staff or carers had the same mind set when assessing the same child.

- It is not known whether missing data were missing at random or whether services where implementation was problematic were less likely to participate in the survey.
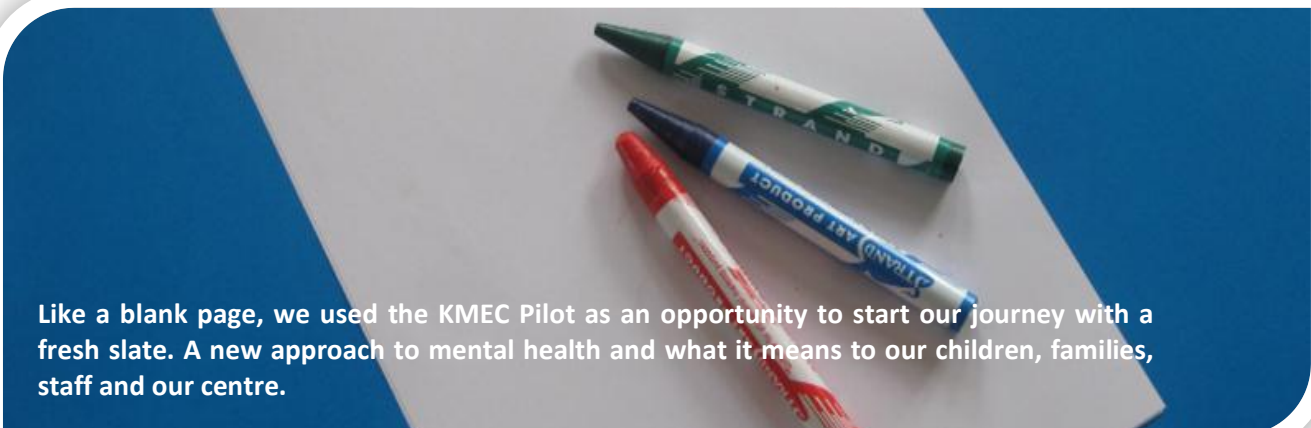
Chapter 3
Implementation of and Engagement with KidsMatter Early Childhood

To me, KidsMatter Early Childhood has meant OPPORTUNITY. An opportunity to re-think the way we interact with children and families. An opportunity to broaden our knowledge on social and emotional wellbeing. An opportunity to develop strategies to improve the Centre, the staff relationships and the relationships between staff and parents and staff and children.

KMEC gave me the opportunity to go to Melbourne and learn about this pilot program. It gave me the opportunity to bring information back to our centre and to work with a committee group and our facilitator(s) to set goals, to plan, do and review. It gave us the opportunity to look at our interactions with parents, the community and to survey the parents to find out what areas they thought needed improvement at our centre.

It gave us the opportunity to create a sense of belonging in our centre by introducing a staff uniform which is easily identifiable by children, parents and visitors alike. It gave us the opportunity to provide more information than ever, to our parents through our newsletters and notices and our digital photo frame. KMEC gave us the opportunity to strengthen our bond with parents and carers and to give all staff ownership and a common goal to work towards; it gave us the chance to re-vamp our noticeboard and to make other changes at our site.

My photo depicts opportunity for the centre, the staff, families and most importantly the children. The opportunity to look at the way we think about and do things at our centre. The opportunity to put aside pre-conceived ideas about mental health and to learn that we all have mental health. It has given us the opportunity to identify children potentially at risk and to offer them the support that they may need. It has given us the opportunity to be involved in a pilot program which challenged the way we think about mental health and it has reduced the stigma surrounding mental health. Opportunity…that is what it has meant to me. (Staff, ST8S4)

Like a blank page, we used the KMEC Pilot as an opportunity to start our journey with a fresh slate. A new approach to mental health and what it means to our children, families, staff and our centre.

Assessing the impact of a complex intervention in complex and diverse early childhood settings is challenging. Many researchers have recognised these challenges, among which is a key issue of low quality implementation of the initiative. In this regard, Domitrovich et al. (2008, p.64) have argued that in program evaluation it is important to develop information about any "discrepancy between what is planned and what is actually delivered when an intervention is conducted."

A key feature of this evaluation was to address these concerns by developing a robust measure of implementation quality to account for the likelihood that not all services would implement KMEC to the same level of quality. By doing so, it strengthened our ability to attribute significant changes in services over the four occasions to the impact of the KMEC initiative.

Accordingly, this chapter considers the variations among services in the quality of KMEC implementation. For this purpose we used information from the final (Time 4) Facilitator Surveys to develop an Implementation Index that was structured around the three principles of fidelity, dosage and quality of delivery (Domitrovich et al., 2008). The resulting Index is then used in all subsequent analyses to inform evidence about the impact of KMEC.

3.1 Assessing implementation quality in services

A report commissioned by *beyondblue* (Slee, Murray-Harvey, Dix & van Deur, 2011) considered the matter of implementation with regard to the KidsMatter Primary initiative. An Implementation Index was developed and described in the KidsMatter Primary Evaluation (Slee et al., 2009) and as such, members of the Flinders Evaluation team for the KMEC evaluation had some insight into the issue of implementation in intervention research. For the evaluation of KMEC, we developed an Implementation Index, based upon our earlier work in KidsMatter, on the theoretical framework of Domitrovich et al. (2008), using information from the parent and staff questionnaires as well as from the reports of Facilitators,. In fact, the Facilitator Survey was specifically designed around the key domains of fidelity, dosage and quality in order to provide the information required for the Implementation Index.

Latent Class Analysis (in MPlus 5.2) was used to identify the questionnaire items that best discriminated qualities of implementation between services. Items that were shown by the Latent Class Analysis to be poor indicators of implementation were systematically removed from the analysis, resulting in the final selection of 20 items, with balanced representation in each section of the implementation framework. The implementation framework for the KMEC Initiative is represented in the first column of Table 6, with the final items aligning to the domains presented in the middle column, along with the total item scores in the last column. Possible scores on the Implementation Index ranged between a maximum score of 140 and a minimum of 20. A full discussion of the Latent Class Analysis is presented in the *KidsMatter Early Childhood Technical Report* (Dix et al., 2012).

Based on data from the fourth data collection occasion, the Latent Class Analysis identified three groups of services namely, High (54%), Moderate (32%) and Low (14%) Implementing services. A profile of each group, showing mean responses to each item at Time 4, is presented in Figure 3. Refer to Table 6 for details about each item in the sections of fidelity, dosage and quality.

By summing the response scores shown in Table 6, a total Implementation Index score was calculated for each service. Missing values were below 5% and were replaced with the local median. The resulting Index scores were calculated for each service on each of the four occasions in order to confirm that the Index is operating reliably by consistently showing greater levels of implementation in the High Index group as time progressed. Figure 4 presents the mean profiles of each group of services on each occasion. It suggests that Low Implementing services started strongly but declined in their implementation KMEC by Time 4. Moderate implementing services showed steady progress that reached a plateau by Time 4, and High implementing services continued a steady progress of implementation throughout the two years of the pilot.

Table 6. The KidsMatter Early Childhood Implementation Index

Framework	Facilitator Views	Max score
FIDELITY Degree to which an intervention is conducted as planned	To what extent has this EC Service: F1. Become informed about the component they were working on [a] F2. Identified what their service was doing well on this component [a] F3. Set goals for this component [a] F4. Developed an action plan for this component [a] F5. Tried out strategies in the action plan [a] F6. Followed the KMEC Component Booklet as intended [a] F7. Used the plan-do-review process for the current component as intended [a]	49
DOSAGE Specific units of an intervention and resources	To what extent has this EC Service: F1. Included KMEC information in newsletters to families [a] F2. Sent out the Component Booklet Survey to families and staff [a] F3. Required staff to attend professional learning associated with KMEC [a] F4. Encouraged staff to become actively involved with KMEC [a] F5. Involved most staff in the planning and implementation of KMEC activities [a]	35
QUALITY OF DELIVERY Engagement with the process & support responsiveness	F6. How effective has the leadership team been in leading the implementation of KMEC at this EC Service? [b] F7. This EC Service has made the best use of Facilitator support and guidance [c] F8. The working relationship between the Facilitator and the leadership team has been effective [c] F9. The EC Service demonstrated a commitment to the ongoing use of the plan-do-review process [c] F10. This EC Service has integrated KMEC as part of the curriculum [a] F11. KMEC has been visible and has a presence in this EC Service [a] F12. KMEC has been well implemented in this EC Service [a] F13. The leadership team has been effective in producing change in the EC [a] Service's approach to the mental health and wellbeing of children [a]	56
		Minimum = 20; Maximum = 140

Reponses scales used: a = Not at all=1, to A great deal=7; b = Highly Ineffective=1, to Highly Effective=7;
c = Strongly Disagree=1; Strongly Agree=7

Figure 3. Service profiles on items of the Implementation Index
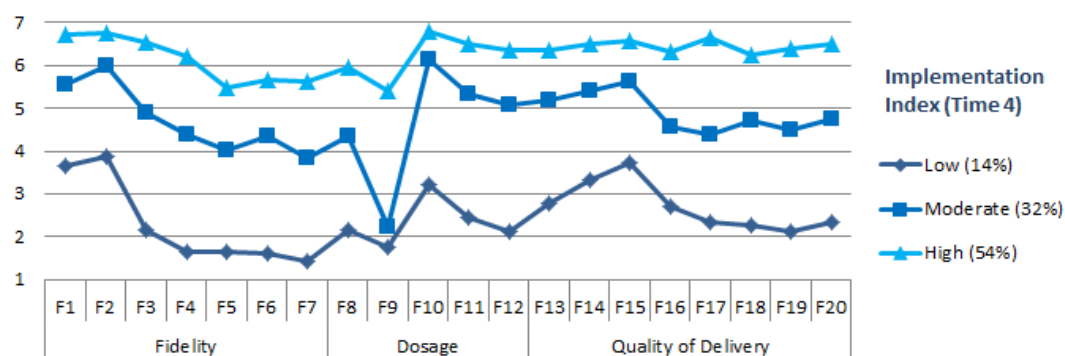
Figure 4. Implementation Index on four occasions
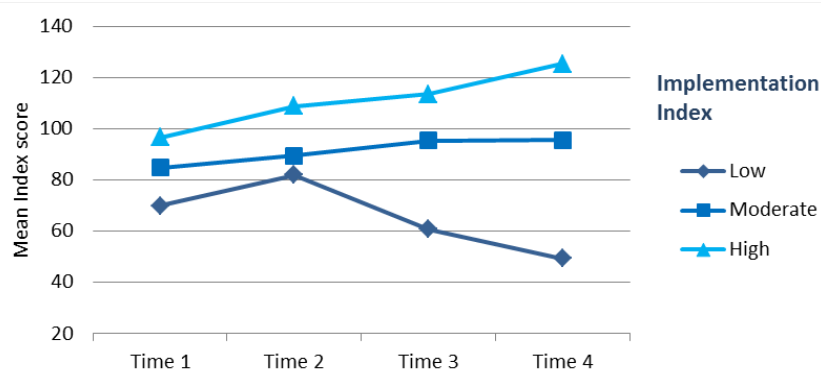
The final set of scores at Time 4 show the greatest difference in implementation quality between services and, accordingly, is the set of scores used in subsequent analysis to inform evidence about the impact of KMEC. The expectation was that services that implemented KMEC well (labelled as High) were more likely to achieve positive outcomes than services that implement KMEC less well (labelled as Low).

3.2 Progress in KMEC plan-do-review implementation

A further assessment of implementation progress was captured from staff in participating services, and thus provided a final test of the sensitivity of the Implementation Index, as reported by KMEC Facilitators.

Staff were asked on four occasions to respond to seven items relating to the KMEC 'plan-do-review' implementation process. These were the same items asked of Facilitators that were included in the fidelity dimension of the Index. Table 7 presents the cross-sectional responses of staff captured while undertaking Component 1 and near the end of the pilot while undertaking Component 4. The percentages reported represent proportions of staff who responded 'a great deal' (scored 6 or 7) to each item. The cycles of the plan-do-review process for each component were similar across the four occasions, with little difference between the average implementation on Time 1 (54% of staff) and Time 4 (56% of staff). The differences between 'becoming informed' and 'reviewing the action plans', show a decline in staff reporting to 'a great deal' and reflect that fewer services got to the review stage on each component.

Table 7. Staff views about the plan-do-review implementation process

Staff were asked to what extent their service had:	Time 1	Time 4
	'A great deal'	
become informed about this component	67%	72%
identified what your Centre is doing well in this component	69%	68%
set goals for this component	63%	61%
developed an action plan for this component	58%	56%
tried out strategies in the action plan for this component	54%	55%
checked the progress of the action plan for this component	43%	49%
reviewed the action plan for this component	38%	45%
Average implementation	54%	56%

These staff data were used to assess any changes over time. Figure 5 presents the results. This first analysis suggests that according to staff, services that implemented the KMEC plan-do-review process well (labelled as High) were significantly more likely to progress further along the implementation process than services that implemented that process poorly (labelled as Low).

Figure 5. Staff views about the plan-do-review implementation process

	Implementation	Time1	Time4	Significance p	r	effect size
Staff	High	5.28	5.72	*	0.10	small
	Low	5.28	5.24	ns	-0.02	
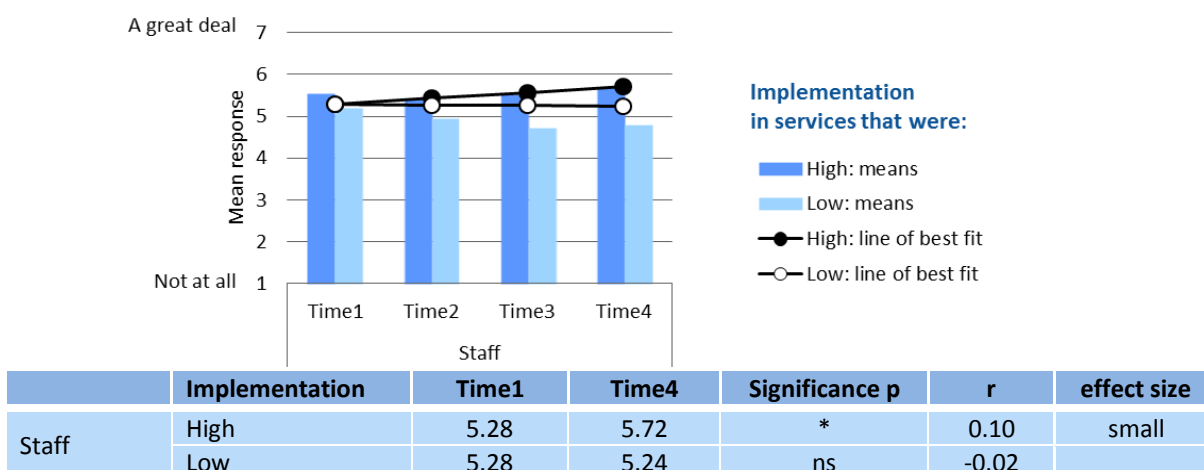
The eight state-based Facilitators also completed a parallel set of items concerned with the plan-do-review cycle and their responses at Time1 and Time 4, presented in Table 8, indicate a more conservative view than service staff at Time 1 with, typically, a 30% lower response than staff. However, by Time 4 there were substantial positive changes in Facilitators' assessments of the services' capacity to implement KMEC with, for example, an 18% increase in *tried out strategies in the action plan*.

Table 8. Facilitator views about the plan-do-review implementation process

Facilitators were asked to what extent had this service:	Time 1	Time 4
	'Strongly Agree'	
identified what their service was doing well on this component	40%	81%
set goals for this component	30%	52%
developed an action plan for this component	25%	45%
tried out strategies in the action plan	18%	34%
monitored the progress of the action plan	10%	25%
reviewed the action plan for this component	5%	17%

Facilitators also completed their observations related to other aspects of implementation by services, on four occasions during the two-year intervention. These findings are reported in Table 9 and indicate that there were positive changes in Facilitators' assessments of the services' capacity to implement KMEC, ranging from a 16% increase in the services' capacity to *undertake the KMEC initiative* to a 46% increase in *becoming informed about the component being worked on*. There was a 33% increase in the number of services that Facilitators viewed as having implemented KMEC well over the two years.

Table 9. Facilitators' observations of services' responses to aspects of implementation

Strongly Agreed (scored 6 or 7)	Time 1	Time 4
This EC Service has the capacity to undertake the KMEC Initiative	63%	79%
Used the plan-do-review process for the current component as intended	12%	30%
Became informed about the component they were working on	27%	73%
Followed the KMEC Component Booklet as intended	18%	32%
KMEC has been visible and has a presence in this EC Service	21%	49%
KMEC has been well implemented in this EC Service	15%	48%
How effective has the leadership team been in leading the implementation of KMEC at this EC Service?	32%	55%
The leadership team has been effective in producing change in the EC Service's approach to the mental health and wellbeing of children	10%	52%

Comments made by staff who participated in the photo study also indicated that despite the KMEC pilot ending, the implementation of KMEC was an ongoing process, particularly with regard to gauging the success of changes made and repeating the plan-do-review process.

One of the challenges that we will have, well to start with in term 1, is really that we've worked out that we actually need to do component one to four every term, because you get new families enrolled you actually really need to be able to do a snapshot of component one to four every time you've got new families in. (Staff, ST8S1)

I don't see it as a program [that] once you've done your four components, that's it. It's something that once you've done it, you've implemented a few changes, you've gauged if it has been successful or not, and then you go back to the beginning. (Staff, ST5S4)

Evidence to support these views was found in the comments provided by educators who participated in the reflective practice study at the end of the pilot:

> [We] will continue to reflect and plan/ do/ review to improve to the mental health and wellbeing of the children who attend. (Staff, ST4S1)

> This is ongoing as awareness increases our ideas of how to support children and families develop and are acted upon. (Staff, ST3S1)

> Continuing to reflect and assess our strengths and develop goals to continue improving the topics in the 4 components. (Staff, ST1S1)

> I think it is important for us to continue to 'plan, do review' to ensure we continue to reflect on and improve our practice (Staff, ST8S2)

> We need to identify areas/issues of particular concern and approach them in a systematic way (As suggested in your materials) – identifying a need, suggesting/trialling strategies, evaluating the success of the approach. (Staff, ST1S1)

3.3 Factors influencing the Implementation Index

There may be many reasons why services do some things very well, and find other things more challenging. Factors such as staff turnover are known to be influential, as reflected in the following comment by one service Director who formally withdrew from the initiative. "*Due to the high turnover of staff we have not been able to continue KMEC.*" Of equal importance, is to consider the factors that may support implementation. For example, does the number of staff in a service with tertiary qualifications make a difference to the implementation process associated with a new initiative?

Using the Implementation Index scores, described above, for each service on each data collection occasion, a hierarchical two-Level HLM model was developed. The model investigated the influences over time of factors associated with process of implementation as measured by the Implementation Index. Criterion scaling (Pedhazur, 1982) was used in the analysis to control for state-level differences. A full discussion of the analysis is available in the *Technical Report* (Dix et al., 2012), with the main findings presented here.

The diverse catchments of early childhood services, combined with the broad measure of community socio-economic status (SEIFA index) used in this study, might disguise sub-groups within each community that are experiencing social disadvantage. It is important to keep in mind this limitation when considering the results of this evaluation. The evaluation found that services in metropolitan locations showed significantly less progress over the two year period on items measured by the Implementation Index, compared to services in rural and remote locations. This difference might reflect community cohesion within services located in rural and remote communities and closely aligns with the KMEC approach of working with parents and the community. Additionally, the impact of natural disasters, in specific locations, on services, was also assessed (on the third and fourth data collection) occasions. This latter analysis suggested that the specific items measured by the Implementation Index (fidelity, dosage and quality of delivery) on the whole, were not significantly impacted upon by natural disasters. Whether the service was long day care, preschool or both, or whether it was profit or not-for-profit, had no significant influence on scores on items used to measure quality of implementation. The percentage of Aboriginal and Torres Strait Islander families associated with a service also had no significant impact on the quality of implementation index scores. In addition, the percentage of staff with diploma or degree qualifications had no significant impact on the ability of services to implement the features measured by the Implementation Index. Finally, the overall (SEIFA) socio-economic status of the service's community had no significant influence on implementation index scores.

However, alongside these findings, services with a relatively higher percentage of single-parent families were less likely to achieve high scores on the items measured by the Implementation Index. Component 3 of the KMEC framework, in particular, which looks at services working with parents and carers, may have had an influence on implementation progress. This finding suggests that the KMEC model could usefully investigate additional ways of engaging and working with single parent families. Additionally, this finding must be tempered with the acknowledgement that it is where single parenthood intersects with socio-economic disadvantage that the impact is greatest.

Based upon the above findings, it seems reasonable to propose that the Implementation Index taps into generic processes of quality of implementation within the KMEC framework that are accessible and achievable by services with diverse characteristics.

3.4 Factors supporting and impeding implementation

Two open-ended questions were included in the Facilitator surveys describing factors that 'Constrained' and 'Facilitated' the Implementation of KMEC in the services. These data were examined to identify common themes for each of the two questions. Input from participants in the photo study also identified barriers and facilitators to implementation. The findings from data collected using these different approaches are reported below.

3.4.1 Barriers to implementation

Staff who participated in the photo study suggested that losing staff and competing programs were barriers to the implementation of KMEC:

> We are losing half of our staff that have been trained ... more than half the staff ...[So it has to start again?] Yeah. It has to start again. (Staff, ST2S2)

> The FAST program has really interfered with the KidsMatter program. We had activities planned to do in the classroom with parents, but suddenly the FAST program was there and that had more importance than KidsMatter did. (Staff, ST2S2)

Four barriers were identified in the examination of the Facilitators' comments and these included:

1. Leadership: poor leadership; busy leadership; top down leadership.
2. Staffing matters: including staff qualifications; experience; high staff turnover.
3. Lack of commitment to KMEC: staff not understanding the initiative.
4. External circumstances: working with a high proportion of families under stress or duress; having a high proportion of children with particular behavioural issues and community circumstances including the poor socio-economic background of the communities; high unemployment.

3.4.2 Supporting implementation

The Facilitator survey reports provided clear indicators of a set of factors that supported the successful implementation of the KMEC initiative. Five groups of factors were consistently identified in the facilitator reports across the participating services.

Leadership

The effective leadership of the Managers or Directors and of the KMEC Coordinators was identified as a key contributor to successful implementation. This leadership was seen to establish an atmosphere that encouraged open communication and focussed discussion that helped support the cohesion of staff. Effective leadership was also associated with systematic organisation of the KMEC initiative that facilitated effective planning and programming so that there was effective use of the KMEC plan-do-review cycle.

Good leadership and someone driving the project was also suggested as an influential factor in implementing KMEC by participants in the photo study, as evidenced by the following quote:

> You really need people to drive it – that's the interesting thing. When I wasn't here, nobody was really keen to take it on. I mean A is great now – we've A on board now – and she's been really great in supporting doing that. I think that's really important – that you have people behind the project. (Staff, ST2S1)

Engagement of staff

Facilitators also saw effective implementation of KMEC as being associated with high levels of engagement of staff. In services with such engagement, KMEC was embedded, and staff developed strong background knowledge in the area of social and emotional wellbeing. These services also made KMEC highly visible in their rooms and halls. They showed positive attitudes to KMEC, were willing to learn, and displayed confidence when addressing social and emotional issues. Frequently, this high level of engagement was also reported to be associated with stable staffing and with a focus on reflection on practice and a willingness to change existing practice.

A related factor supporting good implementation was a whole staff approach. According to participants in the photo study and the reflective practice study, an influential factor in the implementation of KMEC was the involvement of all staff:

> We made it available for all our admin staff as well which is really valuable and that was happening here too. They need to be on board. We have quite a few students with special needs and we have some assistants who come in for a few hours a day to work with them. I think it's made us more aware of explaining to them why we do certain things … Everybody has ownership of it. (Staff, ST5S4)

> I mean social and emotional learning – yes, it's a wonderful idea. It's got to have everybody on board. (Staff, ST2S2)

> When we are supporting children with extra needs we need the whole team to be well informed and part of the decision making process. (Staff, ST8S2)

> All staff at the centre need to be informed of any children who may have mental health issues and the strategies implemented to assist these children. (Staff, ST6S2)

Support structures

Support from service organisational structures was also identified as a factor contributing to effective implementation. This support came from management committees, regional managers and from KMEC Facilitators. In some services this support also involved the provision of funds to support specific KMEC activities.

Particularly noteworthy was the support of the Facilitator. Photo study participants felt that an important aspect of the implementation of KMEC was the influence of the Facilitator who continued to stimulate interest and inspiration amongst staff:

> Somebody like the facilitator is a wonderful employee because she is vivacious and she does do it all and she stirs it up, but it's got to be a team approach and it's got to be an ongoing thing. That person outside coming in, bringing the life back again to keep on thinking until it's embedded in the culture of the school … If you've got that person coming once a month even to do just a refresher and keep you at it until it's embedded in the culture. (Staff, ST2S2)

Features of KMEC

Specific characteristics of the KMEC initiative were identified as a further factor that resulted in effective implementation. Service staff appreciated the flexibility of KMEC and the way that KMEC provided a broad framework that helped them situate much of their practice with children. Related to this was an appreciation that KMEC provided staff and parents with a precise technical vocabulary that facilitated discussion of children's social-emotional wellbeing. Both of these

features were seen to be stimulated by an effective program of professional learning that was a key component of KMEC. Where this professional learning was reported as contributing to effective implementation it was characterised by consistent attendance, clear organisation, engaging activities and resources, practicality, and support for reflection. It was also noted that in some services parents were also involved in professional learning sessions.

Community links

The fifth set of factors seen to support effective implementation involved linkages with the communities surrounding the service. Of major importance was the establishment of effective and supportive relationships with parents. Services also established links with other KMEC services and with schools that were involved in KidsMatter Primary, including inviting staff from these schools to be involved in discussion with service staff. Services also established links with agencies in the local community that could provide additional support for parents and children. A final form of linking identified in reports as supportive of implementation was the linking of KMEC with the Early Years Learning Framework.

3.5 Engagement with the KMEC model

An important part of implementation is the extent of engagement of service staff with the KMEC initiative. The evaluation questionnaires collected staff and Facilitators' views about various aspects of engagement with the KMEC model, including questions about achievability of the KMEC model, and staff and leadership support and involvement. The following section provides analyses of staff and facilitators' perspectives about these various indicators of overall engagement with the KMEC model.

3.5.1 How achievable was engagement with the KMEC model?

A measure was developed to assess staff's perspectives about the achievability of engaging with the KMEC Model in the diverse contexts of the early childhood settings. Table 10 shows that at Time 1, around half of the staff had worked on the four component framework (50%), implemented the KMEC plan-do-review process (46%), and engaged with professional learning (51%) 'a great deal' (scored 6 or 7). By Time 4, 22% more staff, on average, agreed that they had achieved these aspects of the KMEC model to 'a great deal'. In other words, 7 out of 10 staff reported that it had been possible for their service to work with the four-component framework, to engage with the professional learning, and to access the KMEC resources for supporting children's mental health and wellbeing.

Table 10. Staff views about the achievability of the KMEC Model

Staff were asked how achievable it had been for their service to:	Time 1	Time 4
	'A great deal'	
work within the four component framework of KMEC	50%	70%
implement the KMEC plan-do-review process	46%	61%
engage with the KMEC professional learning opportunities	51%	68%
access KMEC resources for supporting children's mental health and wellbeing	48%	71%
Average: Achievability	49%	71%

By averaging the items in Table 10 to form a scale, further analysis into the extent of change revealed that staff in both High and Low implementing services, reported a statistically significant improvement in their views about the suitability of the KMEC Model to medium and small effects, respectively. Figure 6 presents the results.

Figure 6. Staff views about the achievability of engaging with the KMEC Model

	Implementation	Time1	Time4	Significance p	r	effect size
Staff	High	5.17	6.00	***	0.29	medium
	Low	5.17	5.65	***	0.19	small
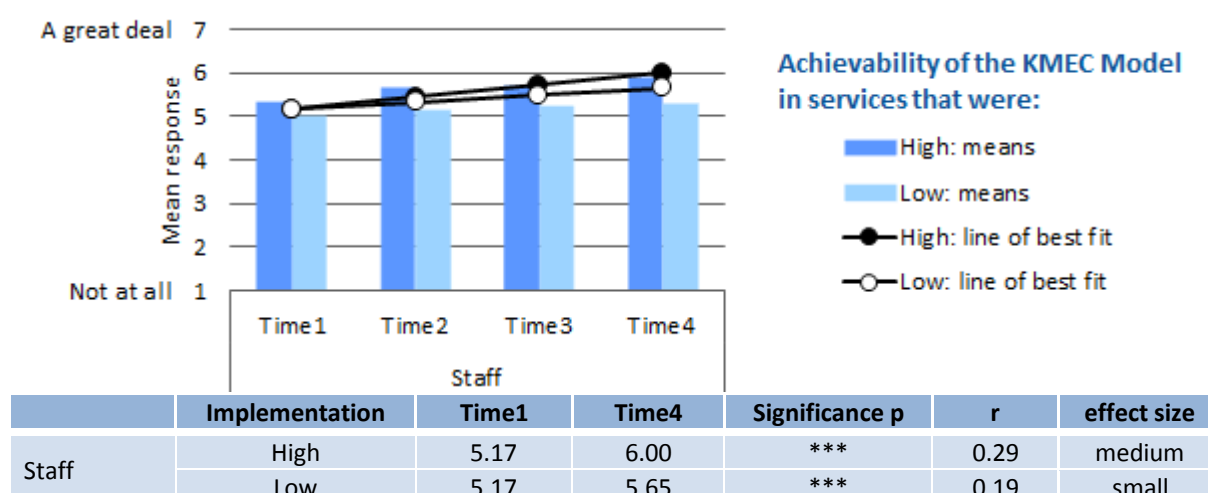
3.5.2 Support towards engaging with KMEC

Staff views about the amount of support from leadership and staff towards engaging with the KMEC implementation process, framework and resources were captured on the four data collection occasions. Table 11 presents the results from Time 1 and Time 4 for staff who agreed 'a great deal' (scored 6 or 7) with each of the five statements. Over 80% of Directors were reported to support KMEC at the start, and this commitment was maintained throughout the initiative. The percentage of staff 'working hard at implementing KMEC' showed the largest increase, from 59% at Time 1 to 76% at Time 4. Importantly, there was also a reported 15% increase in staff, from 60% at Time 1 to 75% at Time 4, reporting that KMEC was improving services' policies and procedures for meeting the wellbeing and mental health needs of children.

Staff responses indicate a broad agreement that two-thirds of services were engaged strongly with the KMEC Initiative and that the extent of this engagement increased to 80% during the two-year pilot.

Table 11. Staff views about support towards service engagement with KMEC

Staff were asked to tick the response that best described their views	Time 1	Time 4
	'A great deal'	
The Director/Leader actively supports KMEC at this Centre	81%	85%
The KMEC Leadership Team works hard at implementing KMEC	69%	80%
KMEC is improving this Centre's policies and procedures for meeting the wellbeing and mental health needs of children	60%	75%
Staff have worked hard at implementing KMEC	59%	76%
Staff actively support the KMEC Leadership Team in implementing KMEC	63%	76%
Average: Support towards engaging with KMEC	66%	81%

The broad findings presented in Table 11 are supported by the statistical evidence presented in Figure 7. Services that implemented KMEC well (High) were also more strongly engaged with actively supporting leadership and working to implement KMEC in their service, to the extent of a small effect.

	Implementation	Time1	Time4	Significance p	r	effect size
Staff	High	5.76	6.29	***	0.21	small
	Low	5.76	5.91	**	0.08	

3.5.3 Facilitators' perspectives about staff involvement

KMEC Facilitators completed observations of services about various aspects of KMEC, including staff involvement with the implementation of KMEC on the four occasions during the two-year intervention. These findings are reported in Table 12.

From Table 12 it can be seen that there were significant positive changes in the Facilitators' assessments of staff involvement with KMEC and professional learning, ranging from a small 3% increase in requiring staff to attend professional learning, which was high from the outset, to a 31% increase in the services' capacity to involve staff in planning and implementation of KMEC.

Table 12. Facilitators' observations of staff involvement

'Strongly agree' (scored 6 or 7)	Time 1	Time 4
Required staff to attend professional learning associated with KMEC	73%	76%
Encouraged staff to become actively involved with KMEC	38%	62%
Involved most staff in the planning and implementation of KMEC activities	25%	56%

3.6 Chapter summary

As reported by Durlak and DuPre (2008) in reviewing the literature on published mental health prevention studies, only a minority of such studies have reported on their implementation process (5%-24%). The same authors, in a meta-analytic review of the literature, concluded that "the magnitude of mean effect sizes are at least two to three times higher when programs are carefully implemented and free from serious implementation problems than when these circumstances are not present" (Durlak & DuPre, 2008, p.340). A significant part of the evaluation of KMEC was the development and application of an index to consider the impact of the implementation process. In this chapter we described the development and application of a psychometrically sound implementation index that provided for the identification of services in terms of the level of the implementation and engagement during the course of the intervention. Services that scored high on the Implementation Index steadily improved their implementation in terms of the 'plan-do-review' process across the two year intervention, while services scoring low did not show increases in their implementation of the KMEC plan-do-review process across the same period. The analysis here considered a range of factors that may be considered to impact on implementation, such as socio-economic background, but the contextual factor that was identified as being related to quality of implementation was that of proportion of single parents in a service. More research is needed to understand better why this factor can have such an impact

on implementation. What is clear, however, is that the KMEC implementation plan-do-review cycle was valued and adopted by service leadership and staff. Factors facilitating implementation included leadership and having an enthusiastic and engaged Facilitator supporting the services, along with having staff and leadership who were motivated and engaged with the initiative.

Moreover, the extent of engagement of service staff with the KMEC model, indicate that staff engagement was highly achievable, particularly in high implementing services. Importantly, the assessments of the processes of implementation and engagement presented in this chapter indicate that KMEC is a viable model in the early childhood setting. In this context, these findings provide the foundation for the subsequent analyses and findings presented in the remainder of the report.

Chapter 4
KidsMatter Early Childhood professional learning

I enjoyed the modules. I think that the best thing about them is that you can see just by making the small changes, that are suggested in each module, what a difference it does make to the kids, just the way you approach the children and just their play situations and using the strategies that we've discussed at the PD, using those strategies to direct their play without it being too structured or formal; sort of guiding them and helping them with their socialisation with each other without it being too formal or without them even knowing that you're doing it. It's helped me with communicating with parents a lot more as well, how to deal with parents… …(The way) they were structured; it wasn't just us sitting and listening to somebody give us information; it was the way we were able to discuss each aspect of the module and …, being able to talk with the other teachers I think in the pre-primary area and in that structured way, in that focused way, it was really useful…. (Staff, ST1S6)

Our KidsMatter Information Desk

4.1 Introduction

The quality of knowledge held by early childhood education and care educators underpins the quality of their decisions and actions when working with children (Askell-Williams, Lawson & Skrzypiec, 2012). Mental health promotion is a very new area of knowledge for many staff, making the professional learning opportunities provided by KMEC and the professional learning undertaken by service staff key features of the KMEC initiative.

As part of the KMEC model, whole-staff professional learning sessions were delivered by the state-based Facilitators to their respective services for each of the four KMEC components. The importance of whole-staff professional learning to raise awareness about risk and protective factors around children's mental health and wellbeing, covered in each of the four components, was an important ingredient in facilitating processes of change in services. The professional learning sessions were designed as three-hour blocks, either taken as a whole or conducted over several sessions. Each service determined the timing of delivery of the professional learning sessions according to their local contextual needs.

4.2 Data sources about KMEC professional learning

As part of the photo study component of the evaluation, service staff at 10 purposefully selected services were invited to take photographs and share their stories about those photos that depicted their experience of the implementation of KMEC. These discussions were recorded and transcribed and excerpts of the conversations that directly targeted the professional learning experience were extracted from the complete transcripts for the purposes of this current chapter about professional learning. Professional Learning feedback forms

In the discussions with staff, researchers did not pose a standard, specific question that related to professional learning but varied the prompts to talk about professional learning in a way that would maintain flow in the discussion. Examples of prompts that were used were: "So, you've done all the professional learning for KMEC – how did you experience that?"; "You mentioned that you enjoyed the PD [professional development], what did you find most valuable from those PDs?"; and, "Through the personal journey that you've had, the professional learning has been part of that, is there anything that you would like to tell us?"

Participants at KMEC professional learning sessions were also invited by their Facilitators to provide written feedback on the sessions. We transcribed the comments provided by participants on the feedback sheets into a central database, and scanned the responses for common themes. Some of the comments from this data source are used to support the presentation of findings about professional learning.

For the analyses of the collected qualitative data relating to the KMEC professional learning, we draw from the framework proposed by Garet et al. (2001), which contains three Core Features and three Structural Features that impact upon the quality of professional learning programs. The Core Features are, (a) focus on content knowledge; (b) opportunities for active learning; and (c) coherence with other learning activities. The Core Features are enacted through the Structural Features, namely (a) the form of the activity (e.g., workshop vs. study group); (b) collective participation of staff from the same service or within-service cluster; and (c) the duration of the activity. The Garet et al. (2001) framework used to structure this analysis of the KMEC professional learning is supported by Meiers and Ingvarson's (2005) extensive review of the professional learning literature, which summarised that professional learning programs had the most impact if they emphasised content, active learning and collective participation.

Working from a central text database, we conducted repeated readings of the transcripts from the interviews and professional learning feedback sheets. Participants' statements were categorised into themes. The six features proposed by Garet et al. (2001) provided an initial

framework for the thematic analysis, supplemented by themes that emerged from the data. To present the qualitative results, we draw on extracts specifically related to professional learning from the transcripts and feedback sheets, organised according to the Core and Structural features of the Garet et al. framework. Further consideration is given later in this report (see Chapter 9) to additional data about staff Knowledge and Self-efficacy found in other sections of the transcripts.

This chapter also makes use of the questionnaires administered to service staff on four occasions, as described earlier in this report. For the quantitative analyses, descriptive and modelling statistics are used.

4.3 An initial broad perspective

Before commencing the detailed analyses of different aspects of the KMEC professional learning, it is worth reporting an overall sense from the stories, photos, feedback forms and questionnaires, that service staff highly valued and appreciated the KMEC professional learning and, on the whole, provided positive feedback about its content and delivery. Although we have included staff's suggestions for improvement below, these are provided in the spirit of continuous improvement, and should not be seen to detract from the overall sense of success that the KMEC professional learning opportunities provided.

4.4 Core feature A: Focus on content knowledge

The first of three core features of the Garet et al. (2001) professional learning framework focuses on content knowledge. Darling-Hammond and Ball (1998) also emphasised the importance of equipping staff with content knowledge, and added that knowledge of children, their ideas and their ways of thinking is crucial, as are opportunities for staff analysis and reflection.

4.4.1 Thematic analysis about focusing on content knowledge

The overall picture that emerged from our thematic analysis of the qualitative data is that the learning outcomes for the staff appeared to be aligned with the instructional aims and content of the KMEC components. This was evident in the staff's comments about learning that specified knowledge, understanding, skills, and/or attitudes directly in relation to the specific component being addressed in the professional learning sessions. Staff comments that relate to knowledge suggest that professional learning was experienced in a variety of ways including (1) acquiring new knowledge about mental health; (2) applying that new knowledge; (3) drawing on the knowledge to reflect on practice, and (4) changing practice in light of knowledge. Examples of these multiple representations are offered here to capture the diversity of learning experienced by staff.

Acquiring new knowledge:

> Thinking of children's mental health, it's made me a bit more aware of children at this age, there could be mental health issues. You sort of have it in the back of your head but you don't actually really. You think: "oh well later on they'll grow out of it" or "they'll be right" but it's like, no, now we've got to do something about it at this age before it gets bigger. And it's made me actually pick up one child who's suffering pretty bad anxiety issues and stuff at the moment and I've got her into the school's psych and got things happening to her and it's good because before I probably would have just swept through and gone "ok, she'll be right, we'll send her on to year one and she'll be fine". That's made me more aware of that sort of thing. (Staff, ST1S3)

Knowledge of pedagogy:

Photo Story 1. Let me in

What I've been doing as a teacher/ mentor is trying to model how you, you've got to be involved with kids and that teaching, particularly in early childhood, it's not about organising a craft activity and getting them to cut out and paste and do formal education, it's about learning through play and it's about the teacher being involved in that play. The reason why I picked that (photo) was this boy is saying to this boy "you can't come in" so he was excluding him from the play and the way I changed that was to say "let's see how many people can fit in the box". So, he was there feeling really, really left out and he was really being pushed out…so that's the reason why I picked that one - I've been modelling about how you're not just there to watch the kids, you're there to be with the kids and to share with them and guide them… And that's been my training all year and that's where KidsMatter fits in - that mindset that adults encouraging children's development and self-esteem has to be active participation in play. (Staff, ST2S1)

Knowledge of children and their characteristics:

Us childcare workers should have knowledge of what's going on, because we need to know…we're protective while they're here, yeah so it's good for us to have the knowledge about what's going on with the kids. (Staff, ST2S5)

When you're studying to do your diploma, you touch on a lot of things but, this was more in depth and gave you a lot more information …And the way it was all done, you could refer back to notes and we've got our folders, everything's in a folder so basically that helps. With the behavioural just noticing different reactions from children and if they're withdrawn or not coping…and it just gives you little strategies how to, approach a parent…how to problem solve within yourself…and the notes, obviously coming with it as well. (Staff, ST6S3)

Knowledge of domains of mental health promotion (such as the four components):

Learning better ways to support parents. How to approach some situations with supporting them. Learning how the partnerships work best and how to do it. Learning how to connect families to one another and the community. (PL feedback: Staff, ST6S13)

We always knew the basics of speech [pathologists] and with children suffering from, maybe showing signs of higher anxiety levels, being a little bit withdrawn, a little bit emotional. Prior to KidsMatter we thought those indicators could be, just something that they're just going through and it's part of maybe a stage they are going through. We now, as educators, look at it a little bit differently and know that they're really important factors that could play a huge role later on with their overall mental wellbeing and it's really important that we target it early. (Staff-Parent, ST6SP1)

Demystifying and de-stigmatising mental health difficulties:

Ways to approach children with mental health difficulties. Not to quickly judge a child but see in depth that there may be more to the children's mental, physical, emotional development than first thought. (PL feedback: Staff, ST4S1)

Photo Story 2. Focus on correct terminology

I have had a specific focus on using terminology and naming emotions that children display. If they have had a positive experience with a new activity we are quick to question them about how they are feeling e.g. "How did you feel about that?" or "You must be very proud of yourself for having a go" or "I can tell you liked that because you look happy" etc. We also openly talk about negative emotions and that it is ok to feel sad and upset for different reasons. We spend time talking about how we can deal with things when they don't go the way we want. (Staff, ST7S1)

Extent and complexity of knowledge:

Many of the comments staff offered about their professional learning focussed on the practical features of their personal engagement with KMEC.

Maybe KidsMatter needs to be targeted towards educators with no experience yet. Going an awful lot deeper. We have been dealing with these issues for years and have an awful lot of training, so I, personally, am needing much more deeper thoughts. (PL feedback: Staff, ST8S13)

I've always had an interest in mental health whether it be with children or adults, so I thought it was a really, really good thing that you guys were doing to educate people about it, 'cos I think it's something that's forgotten, and it was good for me to learn more in the area that I'm working in…opening up my knowledge a bit more to it, how to deal with it, learning more to look out for the signs, and…how to deal with the children and the parents that have children that are going through troubles… (Staff, ST6S4)

Some staff conceptualised learning in more abstract terms, as Photo Story 3 suggests.

Photo Story 3. Our pyramid

It (the pyramid) captures the way I see how KidsMatter has been introduced to our centre, and how it has continued to evolve. The pyramid represents that each and every child is different. They all have different qualities, different needs, different backgrounds, different experiences and different emotions and feelings. The blocks can be put together in a number of ways – representing the way we work with each individual child. The solid pyramid represents how we work together as a team, and a community to support each child in their mental health. (Staff, ST4S7)

Identifying specific areas needing attention within each particular service:

I think the hardest thing is trying to understand the children that have been in [foster] care…. I'd like some more information on that, how can we bring that into KidsMatter, what sort of information can we get, you know, like the other information we've been getting. (Staff, ST2S3)

Developing self-efficacy:

The knowledge that I gained will help me feel confident in dealing with mental wellbeing of children. (PL feedback: Staff, ST6 S9)

KidsMatter has helped me see that when I have a child who is, doesn't fit the mould, is that the best way to put it, is outside the square, you know, that I do now know and have a little bit of confidence to approach the parent in a way of saying "look I've noticed this, how do you feel about it? It might be opportune at this time before they begin school to seek some help from these agencies." And that has been something that I put down to KidsMatter. (Staff, ST1S5)

Confirming existing views:

The whole process of KidsMatter for me has really reiterated what we actually do in our school already…but we've never actually stopped and said to ourselves 'That's a really good thing to do', it's just something that we've done as a matter of course. Perhaps haven't had a particular focus as such, and perhaps making us think that perhaps we need to draw a bit more attention to that. To actually say to our school community 'We're actually doing this, and we're doing this really well. Did you realise that we are doing this really well'? (Staff, ST7S1)

Need for additional support:

You can talk all you like about mental health plans and wrap around services, getting families there is another story. There is no funding for kids without a Guernsey. Lets change the system and we might be able to help. (PL feedback: Staff, ST8S13)

More on mental health issues in parents and common influences on children, e.g. divorce. (PL feedback: Staff, ST7S2)

4.4.2 Staff's suggestions for improvements to professional learning in the area of developing content knowledge

Here is a selection of suggestions from staff, contained in the feedback forms from the professional learning sessions that relate to content knowledge. Note particularly that the last four dot points highlight the diverse range of needs for different types of learning, due to the diversity of background knowledge and experience within the staff population.

- To deepen the content of the professional learning sessions beyond the needs of typically developing children to provide more ideas for children with additional needs, such as autism and children in foster care;
- Providing more information about available community services, to assist with referrals and sourcing information;
- Individualising the KMEC curriculum (for staff), in particular, to check what information may have already been covered in participants' previous education (e.g., Certificate 3) or years of experience, so as to avoid duplication;
- Alter statements in the professional learning materials that may stereotype in any way e.g., income/employment related;
- More multicultural things;
- More information about Professional services, where to find these services in our local area to direct families to;
- More prior knowledge of the course to be undertaken before the professional learning;
- Information covered was not very in-depth and seems almost common knowledge. Strong links to actual theories would be good;
- Recognise prior knowledge and skills of the individual sites.

4.4.3 Change in content knowledge over time

In order to better understand how effective the KMEC professional learning sessions were for improving staff knowledge and actions during the two-year pilot, six items were included in the staff questionnaire, presented in Table 13.

Table 13. Staff views about KMEC professional learning

Staff were asked if the professional learning related to KMEC had:	Time 1	Time 4
	'Strongly Agree'	
enhanced my knowledge about children's mental health	58%	77%
improved the ways that I interact with children	53%	73%
improved the ways that I interact with parents	54%	72%
increased my level of commitment to promoting children's mental health and wellbeing	63%	76%
helped me to foster children's mental health and wellbeing in my work	60%	79%
helped me respond to children who are experiencing social, emotional or behavioural difficulties	58%	77%
Average Professional Learning	58%	76%

Staff held generally positive views about the KMEC professional learning. Almost 60% of staff strongly agreed (scored 6 or 7) at Time 1, that the professional learning related to KMEC had enhanced their approach and increased their level of commitment about fostering and promoting children's mental health in their work. The proportion of staff indicating strong agreement increased 18% by Time 4.

Further statistical analysis of these results, shown in Figure 8, indicates that staff reports about improvement in their knowledge and actions due to KMEC professional learning events, was statistically significant and of medium effect size in High Implementing services, while in Low Implementing services the improvement was significant and of a small effect size.

The differences between staff knowledge and actions in High and Low Implementing services are noteworthy. It can be seen from Figure 8 that staff in High Implementing services achieved an estimated mean knowledge and actions score approaching 6 at Time 3. However, Low Implementing services took until Time 4 to achieve a similar mean score (5.88). This is equivalent to a learning advantage for staff in High Implementing services of one whole data collection time period (approximately six months).

Figure 8. Staff views about KMEC professional learning

	Implementation	Time1	Time4	Significance p	r	effect size
Staff	High	5.48	6.20	***	0.26	medium
	Low	5.48	5.88	***	0.17	small
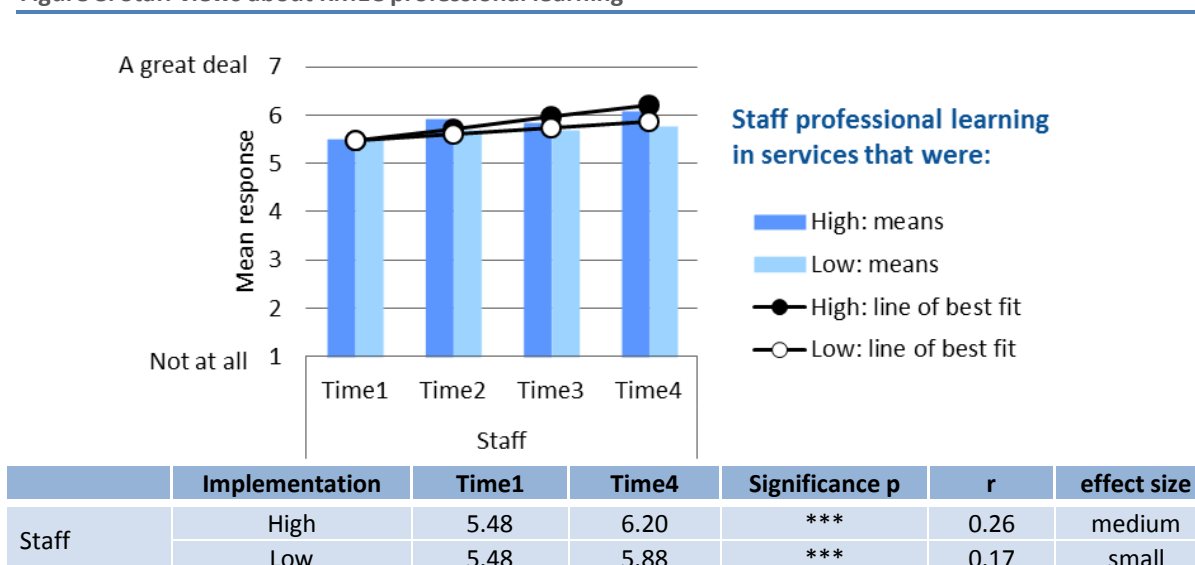
4.5 Core Feature B: Opportunities for active learning

The second of three core features of the Garet et al. (2001) professional learning framework focuses on opportunities for active learning. Active learning, where learners cognitively engage with constructing their own understandings, is a core principle of contemporary approaches to learning (Bransford, Brown & Cocking, 2000).

4.5.1 Thematic analysis about opportunities for active learning

The overall picture that emerged from our thematic analysis of the qualitative data is that the design of the KMEC professional learning sessions was consistent with the aim to provide staff with opportunities for active learning. This was evident in the comments that follow, such as having "time to talk" and "reflect". There were some situations where negotiated improvements occurred to meet the specific needs and circumstances of individual services:

Time to talk:

> I really liked the PD that they gave us - all of the components were really good. I think the opportunity to sit down as a team in the PD was really valuable because we all get busy, we all run around and we all get caught up doing our own things and having someone lead it and some of the best things were when we could sit down…and share lots of ideas and you can pick out ones that you want to do and … the chance to make a bit of a action plan…. (Staff, ST1S1)

> It was a great opportunity just to sit down with our staff and we used to get sidetracked. Something would come up and then we'd start relating our stories about "Ah, yes, that fits with this". I would like a lot more time to do that, because I think that talking and conversation is really, really important. (Staff, ST7S1)

> It was handy just to have people come to us and working at it with a group, rather than just going somewhere by yourself… (Staff, ST6S3)

Reflective Practice:

> In response to a question from the researcher: Did anything change after the Kids Matter professional learning? One educator indicated: "We as a staff found it really valuable because I think it made us see the importance of reflecting on our practices about what we do and (the facilitator) gave us different strategies that we could use about all sorts of different things you know, I just think that it was a really positive thing to be involved with… I think the main thing that I got out of it was that I'm using reflective practice more… sometimes I'll get home at the end of the day and I'll remember maybe an issue like children getting along. And I'll think maybe I could have dealt with that in a different way or I could have stopped and been a bit more focused on what was happening. You know, and then the next day I would try and be more present. (Staff, ST4S3)

4.5.2 Staff's suggestions for improvements to professional learning in the area of opportunities for active learning

Here is a selection of suggestions from staff, contained in the feedback forms from the professional learning sessions that relate to opportunities for active learning:

- Professional development needs to address the needs of the educators working in specific contexts so facilitators should become familiar with those contexts in which they offer PL.
- Opportunities for Role playing, being a listening partner.

4.6 Core Feature C: Coherence with other learning activities

The third core feature of the Garet et al. (2001) professional learning framework focuses on coherence with other learning activities. Constructive alignment between learning objectives and

learning activities, which can reasonably be expected to include coherence between learning activities, is essential for students to achieve successful learning outcomes (Biggs, 2012). This includes the concept of working from what learners already know and can do (Bransford et al., 2000).

4.6.1 Thematic analysis about coherence with other learning activities

The thematic analysis of staff responses indicated that a wide variety of individual learning needs, and the diverse circumstances of services, made coherence more difficult to achieve than the above two Core features. This sense of diversity of needs is captured in the following quotes and stories from staff, related to relevance and context:

Perceived relevance:

> I have had experience in setting up meetings with parents and I think it's hard to teach someone how to do it - because it's very hard to predict which way parents will react. Many staff will never setup meetings with parents because they don't have the confidence or the vocabulary, - most of our parents are educated, professional people. Most child care staff have basic education, basic EC training and many with ESL. They are not in a place where they are going to set up meetings and talk to parents about their child's mental health! PL feedback: (Staff, ST6S4)

Suitability to the context of each service:

> On cultural knowledge: training (has) to be appropriate for the areas that people were working in… I think cultural education is really important, when you are working, regardless of the culture of the people. I mean if you're working in a Chinese community in Australia, it's probably just as valuable to have that cultural training there. (Staff, ST2S1)

> When I read it (PL materials), it's all mainstream stuff. So I have to switch to, turn to the other way.... I automatically think about the Aboriginal, Indigenous kids, that's what I think. But it's ok, I can relate to it. (Staff, ST2S6)

> These questions are not providing me with scope to talk about the effects of this program on families, children and staff. For example, not all changes have the intended effect; not all changes are permanent/ ongoing because children's situations are fluid/shifting; not all changes are connected to KidsMatter; some aspects of KidsMatter assumes that services do not currently use key practices. (Staff, ST5S7)

4.6.2 Staff's suggestions for improvements to professional learning in the area of coherence with other learning activities

Here is a selection of suggestions from staff, contained in the feedback forms from the professional learning sessions that relate to coherence with other learning activities:

- Greater representations of diversity in the families/situations used in videos and case studies;
- To deepen the content of the PL beyond the needs of typically developing children to provide more ideas for children with additional needs, especially autism;
- Provide more situation specific scenarios using existing families/situations for reflection.

4.6.3 Coherence with other learning programs

As part of and in addition to the implementation of KMEC in services, there were many other mental-health-related programs being used by services. State and Territory Facilitators reported, on four occasions over the two-year period, 226 instances of 52 different programs being used. As depicts in the word cloud in Figure 9, the *PALS Social Skills Program* was the most frequently used

program as reported for 14% of services and accounting for 73% of program usage. Other popular programs included, *You can do it, Circle of Security*, and *KidsMatter Primary.*

Figure 9. Word cloud of the types of other mental-health-related programs being used by services
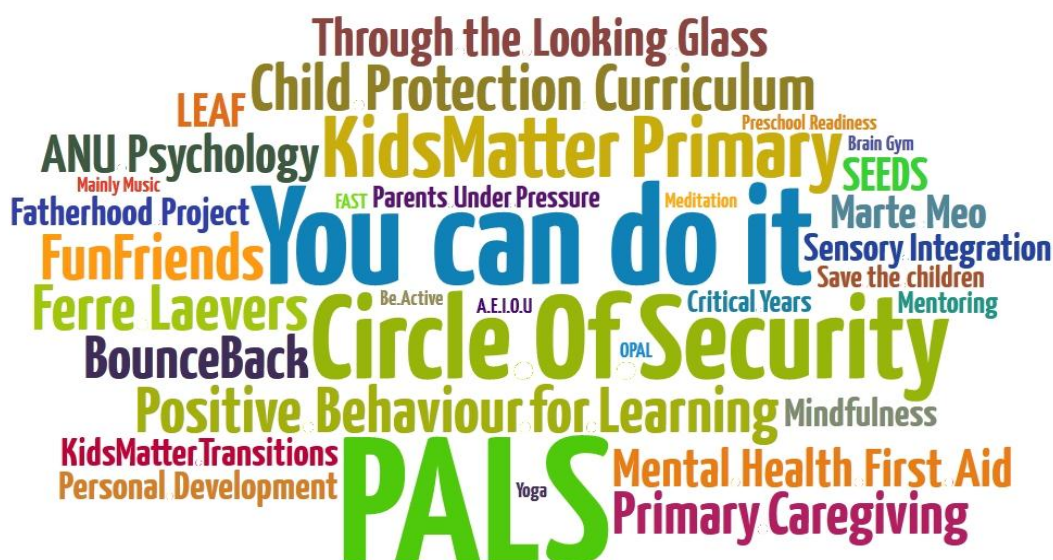
Some staff reported that KMEC fitted well with other frameworks and programs being used in services:

> *As part of the unit on relationships we did look through and looked at the outcomes in the early years learning framework and looked at where we'd go with, how we'd go with observations of them actually working in the playground and working in friendships. And that relates very strongly to some of the things we did in the KidsMatter, you know, professional learning, so I would say yes, all of that stuff that has been developed this year does relate very closely to the KidsMatter program and is part of what we're doing. But everything to me just fits together so nicely: KidsMatter; the school values program; the early years learning framework, everything just slots in and so it's all part of what we do. (Staff, ST5S2)*

4.7 Structural Feature A: The form of the professional learning activities

The first of three structural features of the Garet et al. (2001) professional learning framework focuses on the form of the activities, such as through a lecture, workshop or study group. This deals with the practical aspects of delivering professional learning.

4.7.1 Thematic analysis about the form of the professional learning activities

Professional learning for staff requires (1) a context specific, hands-on/practical approach, and (2) interactive learning with colleagues, which especially occurs through collaborative discussion and sharing of ideas and experiences. Two main themes emerged from staff's perspectives about the form of the activity, namely, practical approaches and opportunities for personalised face-to-face discussion, as shown in the following extracts:

Methods of delivery:

> *Relaxed open Discussion and sharing information e.g. sharing our knowledge of the impact of mental health on children's learning. (PL feedback: Staff, ST8 S15)*

The last one was the best one. I found it gelled it all together and made everything make sense…they were fun. They were a good way of learning…doing all the little projects and the fun games and stuff. I think that's a good way for people to learn. (Staff, ST6S4)

The expertise of the Facilitators:

Thank you to the presenter, you have done a wonderful job and very approachable. (PL feedback: Staff, ST4S9)

On jargon: It's really hard for a facilitator to deliver materials they haven't written… this made it difficult for staff to engage and the staff got bored…the second session, the staff were a bit bored and I think it was because it was a bit over their head with the language…I think that the language is really important. That to me was a learning point in that you have to be really familiar with what you are delivering and the terminology that you are using… especially when they're untrained and not on that same wavelength to the degree that other people maybe at times…When you talk about 'psychological issues', 'cognitive issues', they've got no idea usually of what you are talking about. (Staff, ST2S1)

4.7.2 Staff's suggestions for improvements to professional learning in the area of the form of the professional learning

Here is a selection of suggestions from staff, contained in the feedback forms from the professional learning sessions that relate to methods of delivery:

- Alternatives to powerpoint presentations, such as video clips of children's behaviour to help identify specific behaviour and responses, case studies;
- Translation and/or explanation of technical and jargonistic terms.
- Coming to the centre to provide role modelling in the live situation.
- Provision of component books for each team member so that they can get a deeper understanding.
- Provision of reference list to resources (+ PowerPoint) so that we can follow up on the valuable resources.
- Provision of colourful usable brochures, posters, to transfer important messages to parents.

4.8 Structural Feature B: Collective participation of staff from the same service

The second of three structural features of the Garet et al. (2001) professional learning framework focuses on the collective participation of staff from the same service. Here the emphasis is upon the situated and social dimensions of learning.

4.8.1 Thematic analysis about collective participation

The thematic analysis of the qualitative data indicated that the Introduction of KMEC into services was associated with noticeable perceptions of improved collaboration and participation by the staff who provided data to this evaluation, as captured in the following quotes and stories about improved relationships, and staff and leadership involvement. Note that the difficult issue of staff finding time to be involved, especially outside of the working hours, is also evident in the data represented in this section.

Improved staff relationships:

The professional learning literature (e.g., see Meiers & Ingvarson, 2005) identifies staff relationships as a key feature of generating a 'professional community' - an essential component of professional learning that mediates staff learning and practice. The following quotes, in response to the question: *What are your feelings about how much the Professional Learning has*

worked for you? are indicative of staff comments on the improved relationships and connections among staff that have flowed on from giving space, through the professional learning, to discussion.

> *Definitely ... even like staff wise we've all become a lot closer. We talk to each other a lot more. If we have a problem we can seek help from other people. If we're having a bad day or something we can find a friend – it's not just a work mate it's a friend. Say "can you come and help out for a while"... we all pull together and help each other out. (Staff, ST4S11)*

> *The biggest part that we've got out of KidsMatter from my perspective is I think to develop the staff to have more skills with each other and that area has developed a lot…staff communication and awareness of how another person might be feeling. We certainly are all aboard with the children, we are much more in tune with the children too but I think that staff wise we realise a lot more with each staff member as well. (Staff, ST4S2)*

Developing professional practices:

> *Collaborate with what we are doing, and to reflect on what we now can do. (PL feedback: Staff, ST8S10)*

Gaining staff and leadership involvement with the program:

> *We had a bad start – like last year it was just a bit of a disaster because I was away a lot of the time …When I wasn't here, nobody was really keen to take it on. I mean A is great now – we've A on board now – and she's been really great in supporting doing that. I think that's really important – that you have people behind the project… We've actually brainstormed with the facilitator a few times and it's been good. A lot of the stuff we've found that we actually were probably already doing quite a bit of it and it was about being reinforced - for us as a leadership team it was about getting that reinforcement. We are doing some good stuff too. (Staff, ST2S1)*

> *I think maybe because [service director] made it sound like it was going to be a very good and important thing to do I thought yeah it sounds good. (Staff, ST4S5)*

4.8.2 Staff's suggestions for improvements in the area of collective participation

Here is a selection of suggestions from staff, contained in the feedback forms from the professional learning sessions that relate to collective participation:

- Time and 'space' need to be built into the working day so educators can meet together and engage with each other around their practice;
- Include some strategies or time for us as a team to come up with some strategies.
- Provide time for staff to focus on areas of strength and areas that need improvement.
- Providing some examples of best practices other services have initiated.

4.9 Structural Feature C: The duration of the activity

The last structural feature of the Garet et al. (2001) professional learning framework focuses on the duration of the activity. This refers to the amount of professional learning that staff actually received, and were receptive to.

4.9.1 Thematic analysis about duration of the activity

Staff indicated that they valued the professional learning opportunities provided by KMEC and wanted time to engage in discussions. But staff struggled with the positioning of professional learning, such as when it was delivered in a long session at the end of a working day. No matter how engaging the subject matter, staff are tired at the end of the day. The overall analysis of

participants' statements about the time available for professional learning is that there was not enough time available, and that more opportunities for appropriately scheduled professional learning opportunities would be welcomed, as captured in the following quotes and stories. Of course, the related staffing constraints and costs are recognised as factors that directly impact upon the scheduling of professional learning in both the for-profit and not-for-profit early childhood education sectors.

Time and cost:

Good but I think that it was a bit rushed, because we did it after work or stuff like that. We only had a short period of time and I think that lessons should probably be a bit longer and to get a full understanding of topics than sort of just trying to get through because we've got a short period of time to get through. (Staff, ST2S3)

It (PL) was very difficult to do at the end of the day. I think that it was probably better to do it in shorter sessions … some of us are here until 5:30. It's my turn today so you're here from 8 to 5:30. And Mondays and Fridays we have a 15-minute break and that's it - so it is a lot to do. But I felt what I personally got out of it, it was worth doing, but in the question, it is also a lot to do after work. (Staff, ST4S2)

Scope and sequence of learning activities:

I think the last component was the best one...it really summed up everything. I think that last component, possibly to a certain level, be introduced at the beginning as well. I think the staff will understand it maybe a little bit better. To be honest, It started off a bit slow and I think the last component which was the most interesting, exciting. (Staff-parent, ST6SP1)

One option could be to split your PD. I would have preferred to do it two weeks in a row. So have your facilitator do what they have to do, and then the following week come back and we go through it and we do our goals and everything. Just so that you've got the time to talk about it and then follow through, but going back five weeks later – then you have to go right back to the start…So to keep it in our minds, that's what we did ourselves….I hope we have additional resources coming from KidsMatter in the future? (PL feedback: Staff, ST5S1)

4.9.2 Staff's suggestions for improvements to professional learning in the area of the duration of the activities

Here is a selection of suggestions from staff, contained in the feedback forms from the professional learning sessions that relate to content knowledge:

- Incorporating professional learning as part of the day's work (not after);
- Devote a larger block of time, such as a full professional day;
- Have shorter sessions, with breaks.
- More time for questions and examples.
- More follow-up sessions.
- Too rushed, need more time.
- More please! Making sure that we continue the learning onto the floor over time - build upon tonight's building blocks with continuing support.

4.9.3 Duration of the activities in terms of progress and attendance

Progress through the KMEC Components

During the pilot, the target pace of delivery of the four components by KMEC Facilitators was six months for each Component. Assessing whether this was a reasonable pace was of interest in the evaluation.

Staff and Facilitators were asked to indicate which KMEC component was the current focus in the service on each occasion. From the perspectives of staff and Facilitators across the four occasions,

Figure 10 shows that the majority of services were undertaking the components in accordance with the KMEC pilot plan, with each component being implemented in the six months prior to the data collection Time. Accordingly, in the results that follow, Time can be taken as a proxy for component, with Time 1 mainly referring to Component 1 (Staff 67%, Facilitators 100%), Time 2 generally referring to Component 2 (Staff 76%, Facilitators 59%), Time 3 mostly referring to Component 3 (Staff 64%, Facilitators 74%), and Time 4 mostly aligning to Component 4 (Staff 67%, Facilitators 64%). Between 6% and 14% of staff reported on each occasion that they did not know which component their service was focussing upon.

Figure 10. Staff ratings of which KMEC component was the main focus in their service on each occasion
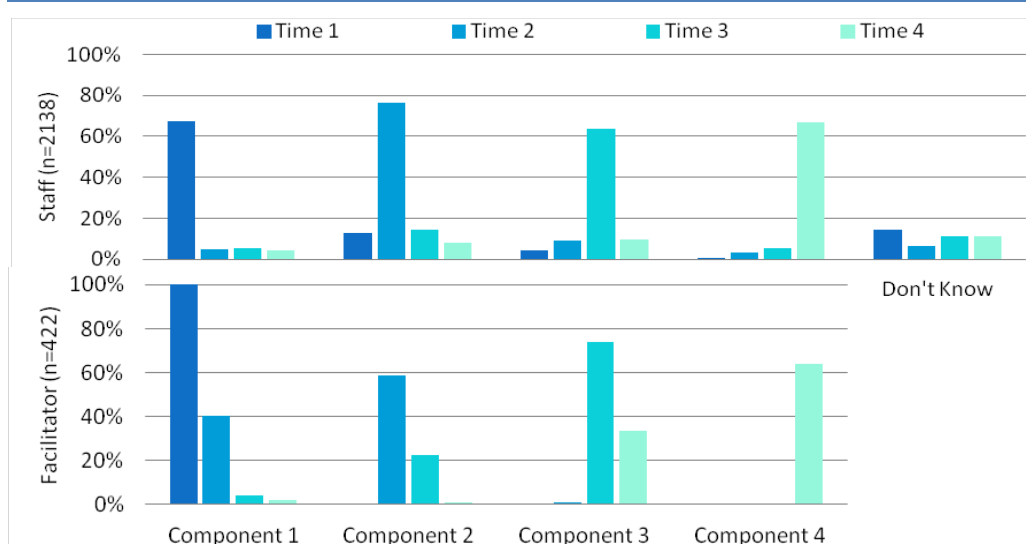
Staff were also asked on each of the four data collection occasions, to what extent, in the last three months, had their service worked on each of the components. However, even at Time 1, as Table 14 shows, 32% of staff reported that they had worked on Component 4 'a great deal' (scored 6 or 7), which suggests that some staff lacked knowledge about the content and sequenced nature of the components. By Time 4, there was a consistent reporting from about 70% of staff in each case, who felt that their service was working on each component, thus reflecting staff responses in Figure 10 above.

Table 14. Staff views about extent of working on the KMEC components

Staff were asked to what extent, in the last three months, had their service worked on:	Time 1	Time 4
	'A great deal'	
Component 1: Creating a sense of community	65%	64%
Component 2: Developing children's social and emotional skills	43%	70%
Component 3: Working with parents and carers	40%	69%
Component 4: Helping children who are experiencing mental health difficulties	32%	69%

Frequency of sessions and satisfaction with KMEC professional learning sessions

As indicated in the introduction to the chapter, the professional learning sessions were designed as three-hour blocks, taken as a whole or conducted over several sessions. Figure 11 presents the number of sessions conducted in each month over the two-year evaluation. A total 496 sessions were reported, but delivery of each component declined over the two years, partly due to the withdrawal of six services. Accordingly, of the remaining 105 services, all had completed Component 1 training, all but one had completed Component 2 training, three had not completed Component 3 training and 13 services were yet to complete Component 4 training according to available data. This suggests that for some services, a two-year period to complete all four components was not sufficient. Figure 11 also shows that some services had undertaken training

for all four components in one and a half years, where the first of the Component 4 trainings commenced in July 2011.

Figure 11. Frequency and occurrence of KMEC professional learning events for each component
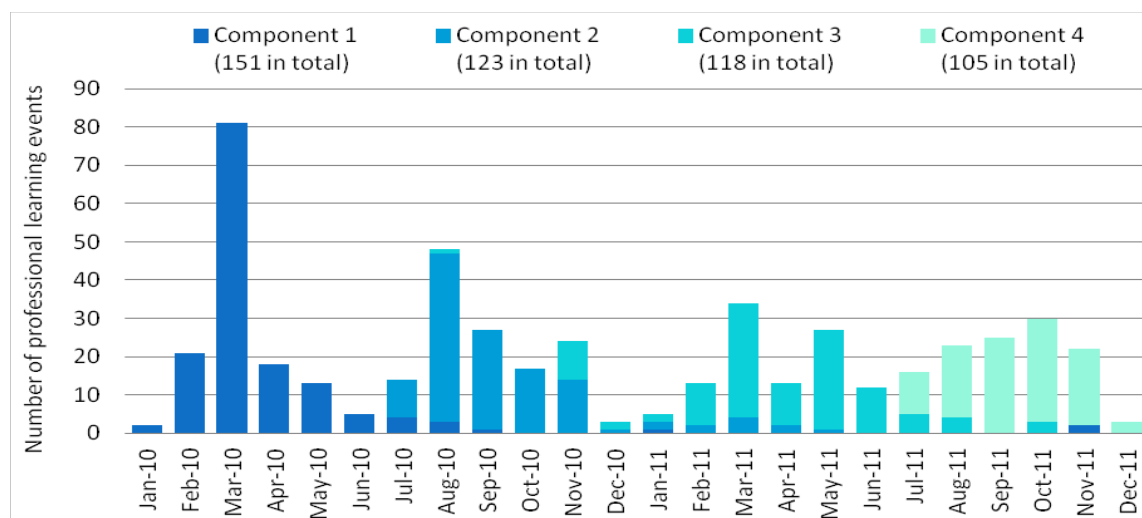
Feedback collected from over 4600 staff who participated in the professional learning sessions was very positive across each of the four components. Over 90% of staff reported that they agreed or strongly agreed (scored 4 or 5) that they *had a better understanding of the Component Target Areas and how they relate to children's mental health.* Moreover, when asked, *Overall, what rating would you give the professional learning session,* over 90% of staff reported that it was good or very good (scored 4 or 5) for each component.

Staff attendance at KMEC professional learning sessions

Staff attendance at professional learning events increased from 77% at Time 1 to 91% at Time 4 based on staff responses (scored 5, 6 or 7). Nine per cent of staff at Time 1 reported that in addition to KMEC professional learning sessions, extra time was set aside 'several times a week' for professional learning about children's mental health and wellbeing. By Time 4, this number had increased to 15% of staff.

By the end of the initiative, most staff (91%) were attending professional learning events run by the KMEC Facilitators.

Expectations to attend KMEC professional learning sessions

It must be noted here that expectations and opportunities for ongoing professional learning in many early childhood settings, such as long day care services, have traditionally not been regarded as fundamental aspects of child-care educators' roles. Thus, the structures of many early childhood services do not have timetabled spaces for formal professional development. Therefore, during the period of the KMEC initiative, professional learning was undertaken by most early childhood educators in their unpaid time, and as such, depended on their personal commitment and availability to participate. In other words, KMEC professional learning was an additional undertaking, unlike the situation in the school sector where professional learning is structured into the work life of the educator; to occur on 'student-free' days, or combined with staff meetings, or undertaken in personal time with time-off in lieu, and being recognised and documented in formal ways.

In one service the view was expressed that the additional demands imposed by new expectations placed upon staff, namely that they would engage with KMEC professional learning opportunities, had led to the loss of staff.

Staff training in Components 1 and 2. This led to staff distress and departure. These changes did <u>not</u> support children's mental health and well-being. The recruitment process has continued for 6 months. (Staff, ST5S7)

4.10 Chapter summary

Staff highly valued and appreciated the KMEC professional learning and, on the whole, provided positive feedback about its content and delivery. Thematic analysis of staff responses to questions, and reflections about, their professional learning, indicated that the KMEC professional learning acknowledged and confirmed staff's existing good practices, provided opportunities for raising staff awareness and building knowledge of children's mental health strengths and difficulties, reduced stigma, and provided staff with a common language to promote communication about mental health and wellbeing. Of particular note was the high acclaim given by staff to the KMEC Facilitators whose enthusiasm and expertise were referred to in almost every conversation with staff and in their written feedback. The exposure of over 4600 staff to KMEC professional learning, associated with the overall positive feedback from staff about that professional learning, is a major strength of the KMEC initiative.

Providing recognised spaces for professional learning; managing the sequencing of learning activities to accommodate initial and sustained learning; designing programs that meet a diverse range of staff prior conceptions, knowledge, frameworks of practice, beliefs, and situations; drawing from the distributed expertise of inter-disciplinary teams; and exploiting online technologies (but not instead of face-to-face, context specific active learning pedagogies), are suggested as ways of sustaining professional learning for mental health promotion.

It is noteworthy that, in the area of staff knowledge and actions, staff in High Implementing services benefitted from (approximately) a six month learning advantage over staff in Low Implementing services. This finding demonstrates how components of an initiative, such as professional learning, interact with the capabilities of the services to produce differential outcomes. This finding also illustrates that it is possible for staff in Lower Implementing services to achieve learning gains, although this might take longer. Thus, dedicated Professional Learning initiatives may need to be made available to some services for longer periods.

Chapter 5
Component 1: Creating a Sense of Community

The community vegetable garden was a community-building project bringing children and families together. We were supported by Rotary who provided materials and helped with the hard work. Many families from the Preschool and the [other] groups came together to install the raised beds, move the soil and plant the seedlings. This was a day for families to work alongside each other and to form friendships as we established the new garden. We finished up with a sausage sizzle. The children have enjoyed tasting some of the vegetables we have grown and have helped with watering and pest control (collecting the caterpillars). (Staff, ST5S1)

The girls are checking the broccoli plants for caterpillars.

Component 1 of the KMEC framework focused on creating a sense of community within the service, to promote feelings of belonging, connectedness and inclusion for all children and families along with an emphasis on positive relationships and collaboration. As noted in the KMEC resources describing Component 1 it is emphasised that children's sense of belonging is seen as a key protective factor that promotes wellbeing, as well as learning outcomes. Welcoming and inclusive early childhood are seen to encourage participation by families, carers, and the community. Emphasis is given to inclusive policies and practices that are accessible to all families within the service, which can enhance a sense of community, while strengthening protective factors for positive mental health. A strong focus is upon the importance of positive relationships and collaboration with all involved in the service. In particular, emphasis is given to the provision of warmth, safety, security and positive relationships with adults thereby promoting protective factor for children's mental health. This chapter evaluates efforts by services to build a sense of community and how successful these were as part of the two-year initiative.

5.1   How well were services creating a sense of community?

In the evaluation, six parent items and six staff items assessed how effective the service was at creating a sense of community. The items also provided a measure of parent engagement with the service and a measure of staff ability to support the development of a sense of community at the service.

It can be seen from Table 15 that the responses on most individual items for both parents and staff at Time 1 were relatively high, with on average 73% of staff and 81% of parents strongly agreeing (scored 6 or 7) that they had a sense of belonging, and felt respected and included at the service. By Time 4, there was a 10% increase across most items in the number of staff who strongly agreed, though only minimal changes in parents' responses. Only 66% of staff at Time 1 strongly agreed that they felt welcome to contribute to decision-making, compared to only 56% of parents, and little had changed in both of these views by Time 4.

Table 15. Staff and parent views about creating a sense of community

Staff and parents were asked to select the response that best matched their opinion about the following statements:	Time 1	Time 4
	'Strongly Agree'	
Staff items		
I have a sense of belonging in the Centre's community	75%	85%
I feel that other members of the Centre community care about me	71%	84%
I feel that my ideas are valued	66%	77%
I feel that other staff at the Centre respect my beliefs	71%	81%
Staff make time to listen to and support each other in their roles	68%	76%
Staff are able to contribute to decision-making about policies and practices in the Centre	66%	70%
Average Component 1 (staff)	73%	83%
Parent Items		
I have a sense of belonging in the Centre's community	67%	73%
I can see that staff care for my child	90%	90%
I feel included in the Centre's activities and programs	74%	78%
Staff respect and value my family's beliefs and wishes	84%	85%
Staff consult with me about my child's wellbeing	83%	83%
I can contribute to decision-making in the Centre	56%	55%
Average Component 1 (parent)	81%	82%

At one service, community building involved the amalgamation of the preschool for Aboriginal and Torres Strait Islander children with the larger mainstream primary school. A community

garden was initiated to bring the two communities together by using a common project to create a sense of belonging:

The Koori preschool this year has become part of the school and, I mean it's been here for a while, but it's actually been amalgamated as being a part of [...] school this year. And so what we wanted to do was to have a project and a day that brought the two communities together to work together on a common project. So that's why we've put the veggie garden in. So that's community-building day. And we did all the work and then we've finished up with a sausage sizzle and the children did some artwork that's actually stuck on the sides of the boxes. It was a great day. It was really good. Now we're reaping the rewards of the garden. (Staff, ST5S1)

Creating a sense of community and belonging was also a focus within the early childhood services as educators sought to develop relationships between children, as Photo Story 4 illustrates.

Photo Story 4. Girls 'cooking' together

This is a group of girls that don't normally play together. A couple of them tend to play on their own a bit more. So when they were all sitting in a circle talking and cooking together, I thought it was a good opportunity to get a photo. (Staff, ST5S1)

One of the students is relatively new to the class, she came half way through the year, so we've worked really hard to try and help her to find her place in the class socially to make new friends. Whenever we see her hovering or playing on her own we try to guide her into a game with another group of students and this photo was taken when they, they'd actually done that themselves that day, she hadn't needed any guidance, the other children had approached her to sit down with them and play. So I thought it linked back really well to the sense of community. I think it's just a lovely photo that shows that they do play together and that they work well together (Staff, ST1S6)

Another positive community building strategy was put into practice at one service where children's art work was used to print postcards with positive messages written on the back of them by educators, which were sent to parents/carers about their child. According to participants, this approach developed a rapport, which facilitated "hard conversations" with parents/carers.

Photo Story 5. Positive feedback cards

[School] has produced post cards featuring children's artwork for notes to families. These post cards have been introduced to help staff ensure that positive messages are sent home to all families throughout the year.(Staff, ST5S1)

Sometimes you've got to have those hard conversations with the parents and if the parents are only hearing from you every few months about something bad. So it was about how to build up that positive rapport with parents. It's a bit like a bank account. If you are putting deposits in the bank, then when we have to make that withdrawal, have that hard conversation, and the parents are happier to have the conversation. So we took on board notes about sending things home, but we've made postcards. This one's a new initiative school-wide. The artwork is from the children that have been created into postcards and they're sent home. The staff can

then write on a post card to send it home to mum or dad to say "so-and-so's had a great week" or "these things are happening at the moment" and just so that parents are getting positive feedback and you're aware so that you are actually doing it rather than just knowing it's nice to say. It's just positive notes back to the parents. That's something that came out of KidsMatter. (Staff, ST5S1 and S4)

5.2 Changes in views about creating a sense of community

It was evident from the data collected at Time 1 that there were already strong positive views about a sense of community held at the start of the KMEC initiative, and this left little opportunity for change, particularly in parents' perspectives. This is reflected in analyses presented in Figure 12. There was no significant difference between staff' and parents' views about creating a positive sense of community in High or Low Implementing services. Staff views did reflect a small significant increase over time, while parents showed no change.

Figure 12. Staff and parent views about creating a sense of community

	Implementation	Time1	Time4	Significance p	r	effect size
Staff	High	5.85	6.11	***	0.13	small
	Low	5.85	6.03	***	0.10	small
Parents	High	6.12	6.29	ns	0.05	
	Low	6.12	6.13	ns	0.01	
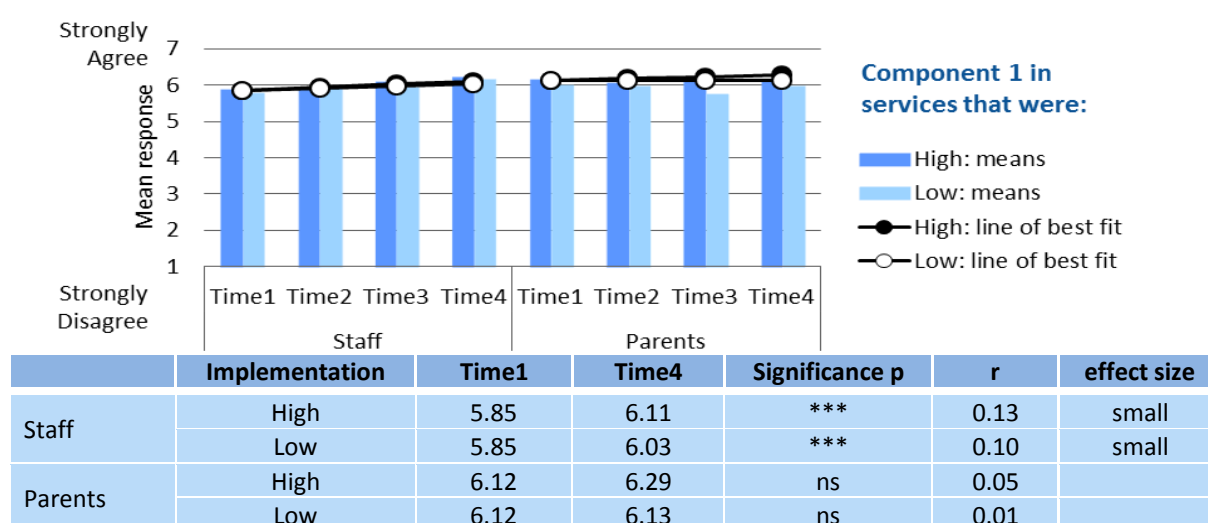
While there were generally positive views about a sense of community at the start, the influence of KMEC in extending community networks was indicated by one participant in the following quote:

I think early childcare can be very closed off, it's only... connected with the part of the community that uses it sometimes and it can be very closed to outside influences, outside resources and outside people. So I think KidsMatter has really opened up those networks and connections with the wider community. (Staff, ST4S6)

As the Photo Story 6 shows, KMEC raised awareness and challenged educators to further extend their community developing practices, in services already experiencing a good sense of community.

Photo Story 6. Children's artwork

We had the art show, which is a big fundraiser. We do it every two years and it's a way of getting the community involved in our school. What happens is that over the year we collect art work from the kids and it's usually stuff that we've just done as we do our normal things. All the kids had done a painting on the tablecloth, everyone had done a painting of themselves and then we had an auctioneer who auctioned them.

There is something quite deep under the art show that makes a connection to the individual families as well as the sense of that whole community. KidsMatter made me think more about this as not just a fundraising thing. It's got a lot more things. It's engaging the community with

the school. It's creating that sense of belonging and community at the start, which is the first one where people come together and helped get it all together. What we're trying to do as a KidsMatter school is get parents engaged with our school community. The difference with the art show this year, is usually what we've done for the framing for example is just given it to a few people to do, but this time we said let's do it as part of a busy bee. That's how it changed. It's made us just a little bit more aware. I think we were always really conscious of trying to make it a community. We looked at how we could take something we've always done and make it more of a sense of community. Instead of just saying "oh we've got these five helpers, who are really good at helping, you go and do this", it's trying to get more people to be involved in a way that they can feel comfortable being involved.

Now one of the dads, he works on a mine, as does his wife. Dad works one week on and one week off, mum works two weeks on and one week off, so some weeks A [boy] has got two parents at home, sometimes he's got one and some weeks he's got none and then he stays with his aunties. This dad happened to be in town on this morning. A's mum was in town as well so they both happened to come to this art show and it was just lovely. So if all else, we got this person here, it's taken him over a step that he might not ever have wanted to take before. (Staff, ST1S1)

5.3 Chapter summary

There was good evidence, in the evaluation, of services' engagement with Component 1. This component reached the higher stages of the implementation process. The results of the evaluation suggest that, to a large degree, services were performing well in this area. There was evidence that at the start of KMEC services were generally already rated highly by staff and parents in the target areas chosen by KMEC that relate to this component. There is evidence that KMEC may have increased attention to the importance of services connecting strongly to the broader community. Indeed, the photo study data indicated a strong emphasis on 'community'.

At the start of KMEC, parents and staff provided high ratings for their service's performance on Component 1, and there is little evidence of significant change in ratings on this component over the two years. At the start of the trial, 73% of staff report 'strongly agreeing' that their service was committed to developing a sense of belonging and connectedness for members of the service community. This commitment increased a little to 83% throughout the two-year period of KMEC.

Chapter 6
Component 2: Developing Social and Emotional Skills

I watched this little girl, M, she was climbing up over that tunnel and that's actually a place they're not supposed to climb, because it's a bit dangerous. Before I probably would have rushed in and said "oh look hop off down from there, that's not a safe place", but they were doing that sort of risk taking. She was challenging herself and she was climbing over the tunnel and clinging to the fence, because she was really scared, clinging to the fence over the tunnel. T, the other little boy in the picture, was actually showing her how to climb over the tunnel and she wanted to jump, to climb over to the tyres and then jump down, but she was scared. She couldn't do it to start off with, but he was helping her and he was holding her hand. It's a great example of how he nurtured her and helped her through that risk taking. He would hold her hand to get onto the tyres and then hold her hand while she jumped down. He was really caring and it was just lovely to watch, and they didn't need me. They didn't need me to come over and help. I was there if something looked a bit unsafe, I could have jumped in to help, but they sorted that out together and he encouraged her the whole way through. She did that over and over and over, she would have done that about 12 times. I just stood back and watched, until in the end she had climbed over there all by herself and she jumped down and she did it all by herself. I suppose for me what that was showing was that her persistence, just in terms of mental health outcomes, that she could persist and she had that resilience to keep on trying and keep on trying and she knew, really, if she kept trying that she could do it, or if she didn't know it, she discovered it. I guess that was one of the things that came out of KidsMatter - having resilience - when things are really tough just to keep on trying and you will get through it. When I watched her I remember thinking to myself "well there you go, she's got that" or "she's just discovered in herself that if she keeps on trying, she can do it". (Staff, ST4S1)

Resilience

Component 2: Developing children's social and emotional skills, draws upon research that shows that the development of social and emotional skills is fundamental to children's mental health, ability to learn, moral development and motivation to achieve. Children who develop social and emotional skills find it easier to manage themselves, relate to others, resolve conflict and feel positive about themselves and the world around them. The effect is to enhance protective factors. This chapter evaluates ways in which services addressed the development of children's social and emotional skills, and examines changes in views about such development. It also looks at connections between KMEC and the Early Years Learning Framework.

6.1   Developing children's social and emotional skills

Participants in the photo study provided many examples of how they had witnessed the social and emotional development of children and how their efforts had assisted children in developing caring and supportive friendships, shown in the following comments and in Photo Story 7-8.

> *We've had to work more with them on being inclusive...and having a wide circle of friends. The threesome, the C, R and J threesome is really interesting at the moment because they are starting to branch out, they are starting to let other kids in, they are starting to stop excluding each other. (Staff, ST5S2)*

> *I've said "well you know, he's still your friend but he just wants to play over there today". (Staff, ST5S2)*

Photo Story 7. Mateship

> *You see them walking around with their arms around each other like that and you think "we've done our job and they've made friends" and yeah they're just happy and the relationships are working and so's all that social and emotional stuff. (Staff, ST5S1)*

Photo Story 8. Girls and boys doing a floor puzzle together

> *I'd like to give myself a little tick and say that I'm very proud of how they have become really social beings …*
> *the ones who were mature socially and emotionally have understood that we are all a little bit different and to be accepting and be able to play with someone they wouldn't normally choose to be friends with, or look down their nose at, because children do that sadly, I mean we are all a little bit like that, but they have become a group of children that are happy to accept those that they wouldn't normally, you know, have much time for. (Staff, ST1S5)*

6.2   Changes in views about developing children's skills

At the onset, educators generally felt that they were assisting the socialisation of children and helping them to develop friendships. In order to gauge how well services were assisting children

to develop social and emotional skills, staff and parents were asked six common items on the four data gathering occasions. For staff, it reflected how they assisted in this development, and for parents it asked their views about the assistance the service gave to their child.

With over 90% of staff at Time 1 strongly agreeing (scored 6 or 7) that they assisted children to socialise with other children, manage conflict, and feel good about themselves, there was little scope for improvement by Time 4. Table 16 presents this result and shows that there was only a 3% increase in the number of staff assisting children by Time 4. The pattern of responses from parents was similar, though they showed a lower level of agreement at Time 1.

Table 16. Staff and parent views about developing social and emotional skills

Staff and parents were asked to select the response that best matched their opinion about the following statements	Time 1	Time 4	Time 1	Time 4
	Staff items		Parent items	
'Strongly Agree'	I assist children to:		This service has assisted my child to:	
Socialise with other children	92%	96%	84%	86%
Recognise and manage their emotions	89%	95%	74%	77%
Show care and concern for others	91%	94%	78%	83%
Establish and maintain relationships with others	89%	95%	83%	86%
Feel good about themselves	92%	95%	82%	85%
Manage conflict with others	88%	94%	72%	77%
Average Component 2	91%	94%	81%	85%

Staff were also asked an additional question, to better gauge their active involvement. Some 87% of staff at Time 1 indicated that they talked to children about their emotions at least several times a week or daily (scored 6 or 7). This view was shared by 90% of staff at Time 4. These trends in the results are clearly shown in Figure 13 and indicate that there were no significant changes over time in the views held by parents and staff across services regarding the ability of services to assist child social and emotional skill development.

Figure 13. Staff and parent views about developing social and emotional skills

	Implementation	Time1	Time4	Significance p	r	effect size
Staff	High	6.45	6.62	ns	0.09	-
	Low	6.45	6.56	ns	0.07	-
Parents	High	6.14	6.39	ns	0.09	-
	Low	6.14	6.23	ns	0.05	-
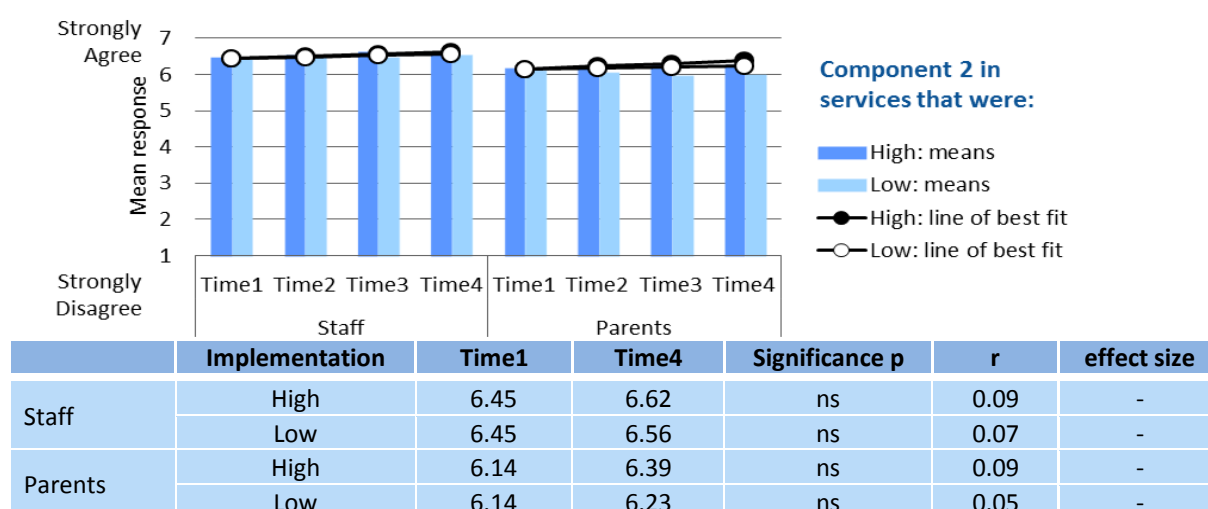
Educators who participated in the photo study provided other stories about the social and emotional development of children. The stories are indicative of the effectiveness of educators in teaching young children social and emotional skills.

> *[Boy] is not very resilient when he can't have a turn at the very moment he wants, so gets quite teary. Teacher suggested he remember how to deal with this, e.g. "take some deep breaths, calm yourself and remember you will have a turn soon, everyone in the group has to wait their turn". Boy visibly took some very obvious deep breaths and held the tears at bay*

with a lot of self-control. He was praised highly by teacher and aide. Later that afternoon in the supermarket with his mum he must have been thinking about it. Standing at the checkout he said in a very loud voice, feeling very proud "mum, Mrs B. says I can deal with things. I can. Can't I?" Wonderful feedback from his mother!! (Staff, ST7S1)

Photo Story 9. Caring classmates

The little boy who's having his shoes done up is a little boy who has lots of special needs and has been quite challenging in his behaviour in the classroom and has disrupted things and he's put other people out and everyone's had to wait for him and you know that's pretty frustrating to the best of us. There have been kids who have been particularly intolerant in that situation. This one little boy, the boy whose shoe is being done up, couldn't get his shoes off and you know how it is, you walk outside and everyone needs you for something … the other little boy said something like "new shoes. New shoes." He couldn't do his shoes and the other boy goes "I can help you with them" and he just bent down and started undoing his shoes and it was one of those moments where you nearly want to weep. This is someone who you would justifiably be thinking, "oh, finally we're outside and I can just go and play and be myself" but he went and he stopped and he did his shoes. (Staff, ST6, S4)

A constituent of the social and emotional wellbeing of children is the relationship between the child and the educator, and this was acknowledged as important by childcare staff. In one service a record sheet of interactions with children was developed in order to ensure that all children were given attention and relationships did not wane.

Photo Story 10. Record Sheet

It [Record Sheet] basically lets us know that we are covering all of the kids and that we're not missing anybody. Sometimes you have those children that just fly under the radar, so you're continually building that relationship by spending time specifically with that child at some point. When you put the record down and then you have a look and you think, "oh look at that, we haven't got anything down for that child or that child" so you then make sure that you spend some time. You might sit at the morning tea table with them or something along those lines, just to make sure that you are developing relationships right across the board. (Staff, ST5S1)

6.3 Connections between the Early Years Learning Framework and KMEC

In a study by Hewitt (2012), research was conducted to establish whether the mental health and wellbeing focus of the KMEC initiative and the social-emotional learning (SEL) components of the Early Years Learning Framework (EYLF: DEEWR, 2009) was conducive to implementation in parallel in early childhood services. That mixed-method study aimed to (1) identify any areas of connectedness between the EYLF and KMEC; (2) recognise any connections that need strengthening between the initiatives; and (3) determine whether service educators believed such a connection would be beneficial to young children's SEL and overall development. It also

considered the gap existing between research and practice in education that could influence the way EC educators work with new policy and practice initiatives.

The study drew upon relevant literature from the fields of early childhood learning and curriculum, development in early childhood, mental health and wellbeing, and translational research, in order to explore the views of the KMEC Facilitators and 33 service directors involved in the KMEC pilot through an emailed questionnaire.

Findings from the analyses showed that there were strong connections between the EYLF and KMEC, with beneficial outcomes for ECEC services and children's SEL and development when implemented together. Many positive changes were determined from both the EYLF and KMEC, although staff were often overwhelmed by the changes involved in them. Therefore, the KMEC professional learning sessions were instrumental in assisting staff to understand their responses to these changes and to the change process. The KMEC professional learning sessions were important for the development of collaborative partnerships and reflective practice and were most beneficial when used to discuss or clarify the connections between the EYLF and KMEC. All of KMEC was seen to be relevant to the EYLF (or vice versa), and both are age and developmentally appropriate. Staff's comprehension of the EYLF improved through the work with KMEC and both initiatives were seen to have a strong focus on children's sense of self and identity.

Suggestions were also given on how services could strengthen the connections between the EYLF and KMEC, including a practical guide on how to implement them together.

- There is limited access to evidence and materials about the EYLF and KMEC, and the connections between them. As such, a need for the creation of a working document for implementation related to EYLF and KMEC was seen to be valuable.
- The mandatory EYLF could be enhanced further through the voluntary KMEC, and together they could improve services' programs and relationships.
- Healthy relationships are significant aspects of both initiatives, including collaborative partnerships between staff, and between staff and families. However, these have the potential to be improved further, as well as the improvement of state- and territory-wide networking and nation networking (which includes with agencies such as Early Childhood Australia).

6.4 Chapter summary

As noted in the KMEC documentation, the time from birth to school age is considered critical for the development of social and emotional skills characterised by the development of the ability to recognise and manage emotions, show care and concern for others, make responsible decisions, establish positive relationships, and handle challenging situations effectively. In early child care settings, the strong emphasis is on the quality of the relationships between staff and children, the provision of opportunity to practise social and emotional skills, and the opportunity for staff professional learning and support. As shown in this chapter, the service staff and parents started KMEC from a position of already providing substantial levels of support for developing children's social and emotional skills. There were small gains made in staff and parent responses related to this component over the two years of the pilot.

Chapter 7
Component 3: Working with Parents and Carers

One of the biggest changes and impact that KidsMatter has had at our service amongst a lot of things is the way we worked with parents. We always had a close connection with our families - had them come and be involved with the centre. We've got a parent committee and whatnot, however just working collaboratively with families with component three made us kind of change and reflect and evaluate the way we do things. One of them was the way we relay information to parents. We changed that, we're doing it via email and we found we're getting a lot of more of a response back from parents...they're more involved. A lot of parents are working and don't have the time to sit and write things so we found the email has involved parents a lot more within our program and overall operation, feedback and ideas and whatnot. In essence it's made parents feel a lot more involved and a lot more a part of our service as well. (Staff, ST6S1)

KidsMatter School Play Day

Component 3 recognises that by engaging with parents and carers, early childhood services can share important information about the child's life, experiences, preferences, and activities. The family is seen as central to young children's mental health. The effect is to promote protective factors thereby enhancing children's mental health. In addition, early childhood services are an excellent access point to link parents and carers with appropriate information and education about parenting, child development and children's mental health. This chapter provides information related to progress made during the KMEC pilot under the central themes of Component 3: Services working with parents and carers.

7.1 Staff and parent views about the service working with parents and carers

Some of the photo study participants reported that they organised several events, which aimed to engage and involve parents with their service.

Photo Story 11. Kindy [sic] social event

Through families connecting with staff in more informal, fun situations like "Family Gatherings and BBQs" they are able to interact in a relaxed manner and get to know each other in deeper, meaningful ways. Laughter and shared experiences opens the pathways to understanding, real, honest communication and a deeper sense of trust and a sense of belonging. Families feel welcome and this is the key to happy children. (Staff, ST4S4)

The ability of services to work with parents and carers was another important area of investigation in this evaluation. The views of staff and parents were canvassed through the parallel sets of seven items that asked them to reflect on the effects of KMEC on providing parenting information and education and opportunities for families to develop support networks.

Almost three-quarters of staff and two-thirds of parents at Time 1 strongly agreed (scored 6 or 7) about the ability of services to work with parents and carers. At Time 4 the proportion of staff 'agree' responses had increased on average by 11% to 84%, while parent views remained more stable with only a 3% increase in level of agreement on average by Time 4. The results are presented in Table 17.

Table 17. Staff and parent views about the service working with parent and carers

Staff and parents were asked to select the response that best matched their opinion about the following statements	Time 1	Time 4	Time 1	Time 4
	Staff items		Parent items	
	'Strongly Agree'		'Strongly Agree'	
The Centre provides families with access to information about parenting	71%	80%	67%	73%
The Centre provides families with access to information about children's development	74%	81%	70%	72%
The Centre provides opportunities for parents to develop support networks (e.g. meeting other families)	63%	79%	55%	58%
Staff provide information about health and community services and resources	64%	73%	57%	64%
Staff actively help parents whose children are experiencing social, emotional and behavioural difficulties	81%	85%	61%	65%
Staff share information with parents about what children are doing at the Centre	89%	92%	82%	82%
Information about children's mental health is provided	52%	68%	52%	63%
Average Component 3	73%	84%	63%	69%

Differing views existed between staff and parents about services providing opportunities for parents to develop support networks. Staff reports indicated a 16% increase in the number of staff strongly agreeing by Time 4, compared to only a 3% increase amongst parents. Similar views were shared by 52% of parents and staff at Time 1 regarding the provision of information about children's mental health through newsletters. These views remained stable at this level across the time of the pilot, with 68% of staff and 63% of parents strongly agreeing by Time 4.

These staff and parent responses were further assessed for patterns of change in High and Low implementing services and the results of this analysis are shown in Figure 14. Results based on staff's views did not significantly differ across High and Low implementing services, with both showing significant improvement equivalent to a small effect size. Results based on parent views showed only a small significant improvement in High Implementing services.

Figure 14. Staff and parent views about the service working with parent and carers

	Implementation	Time1	Time4	Significance p	r	effect size
Staff	High	5.88	6.19	***	0.15	small
	Low	5.88	6.09	***	0.11	small
Parents	High	5.83	6.11	*	0.11	small
	Low	5.83	5.91	ns	0.05	
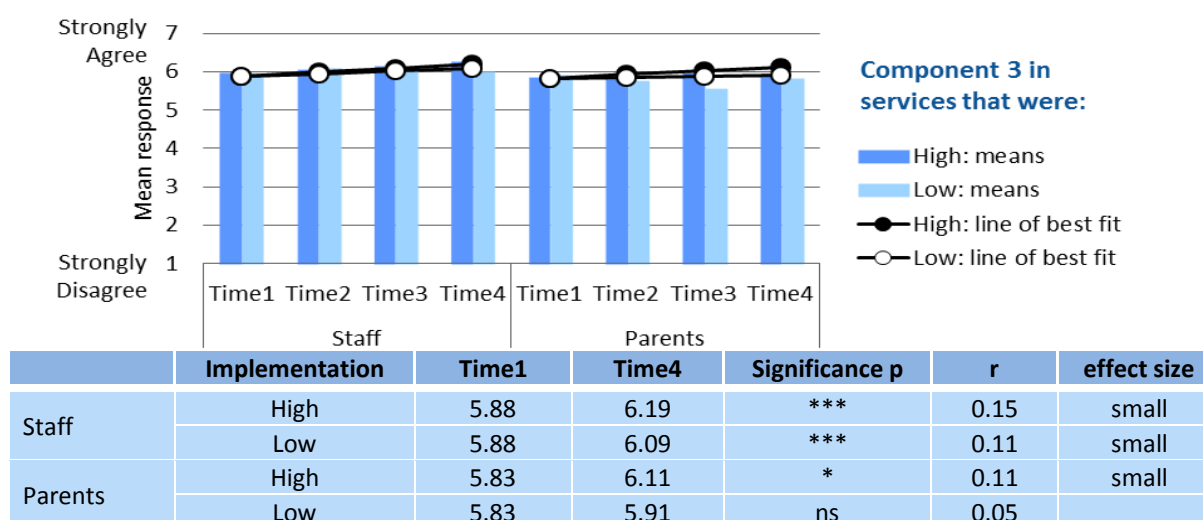
Staff working with parents and carers also involved development in understanding of parent and carer needs and circumstances. Stories provided by participants in the photo study, illustrated the ways that some services were working with parents to support them during difficult times.

> *I've sort of looked at the child and labelled it as almost neglect, but then when you've actually explored the situation there isn't neglect there, it's just mum is so busy and she's struggling and that's all it is. It's not that she's neglecting, it's just that she's struggling and she's young. And so we've worked with her more so than to say "what help do you need? What can we do?" rather than sort of going straight to DOCS that this child could be neglected. (Staff, ST4S1)*

> *Mum came in this morning and she started talking to me about having had a tough day yesterday and you sort of do the yep, I understand that, I've had some of these experiences too. Have you tried this, have you tried this and when she says yes that she has tried a few of them instead of letting it go, I've followed it up with the principal to sort of say okay, this parent needs some support. Where can we go for her? Which before I probably wouldn't have done quite as quickly. (Staff, ST7S2)*

The importance of working collaboratively with parents was highlighted by participants in the reflective practice study who indicated that they would continue to connect with families after the service had concluded its participation in the pilot. This was evident from the following quotes:

> *Continue connecting and strategies for all families of different backgrounds. (Staff, ST4S2)*

Continue to encourage families to be a part of our centre to get involved in all aspects. (Staff, ST7S1)

Continue to work collaboratively with families. (Staff, ST6S2)

Photo Story 12. Thank you messages
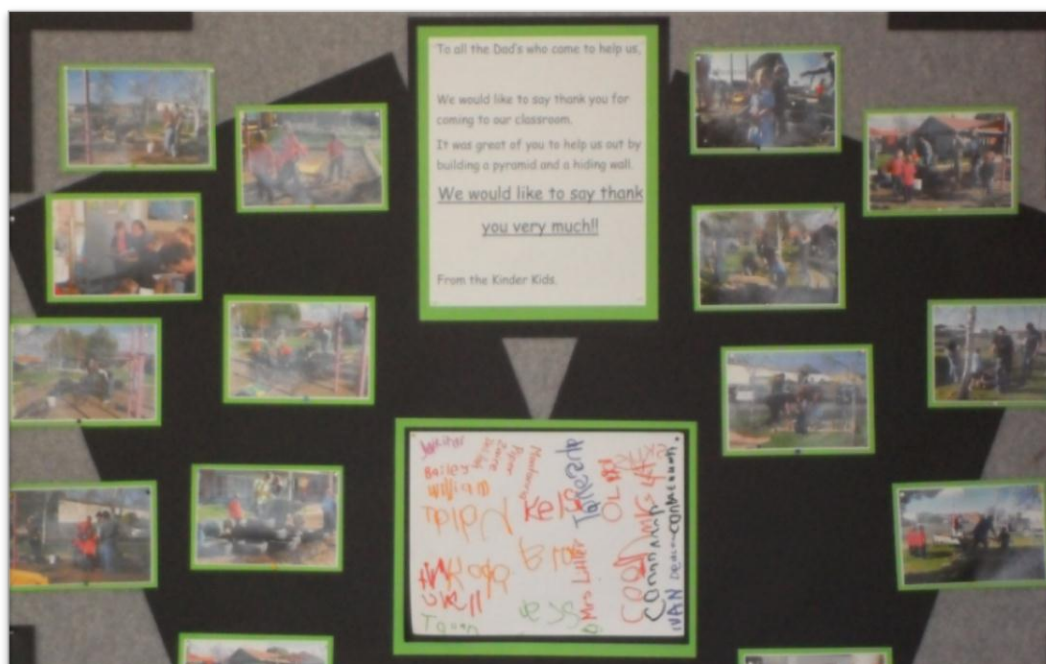
I have an individual father, who we've been working very hard with. We did home visits at the start of the year. I could only do them for the first term; I went with the social worker. But we had worked very hard, after what we thought was going to be a very easy home visit. Turned out there was a minefield lying await in the house. So for him we really wanted to build some connections with the school. Since then the marriage has broken down, and the kids have been run around a bit. Mum was having some mental health issues, so it's been a very traumatic year for him and his children. He likes to come and spend the day with D, which is really interesting, because he pops C in day care. So he must spend a lot of time with the younger one, but he likes to come and connect with him. So we've built on that, and kept him coming and started to give him jobs and then we'd had a discussion last year about having a father's night, and getting them all in to help us with the yard. For Father's Day I thought we'll invite them all in and see if I get anyone and get them to help us with some stuff in the yard. So I put this particular father in charge of getting what we needed, so he was feeling quite key to it all, and then I had all these fathers turn up. One father who was another family we had done a home visit to (he was unemployed at the time) had gotten a job in between, and had taken the letter to his employer and said my child's school is doing this and asked if he could go. His employer said yes. It actually just meant that he came in and spent some time with his son in a different environment, seeing some different fathers and how they were working with their kids. So it was a really valuable day. So finding a way to say thank you to them was really hard. So we ended up writing the letter and signing it and sending it home. (Staff, ST7S3)

7.2 Links between creating a sense of community and working collaboratively with parents and carers

Some photo study participants indicated that by creating a sense of community it was easier to work collaboratively with parents and carers and a strong link between Component 1 and Component 3 was noted by some early childcare educators:

Yes building a community, you can't work collaboratively I suppose with the parents if you haven't built the relationship. And you have to work on that and start a relationship so that

you can work with them … I think there is a difference, but if you don't establish that connection, why would they work with you and trust you. (Staff, ST4S1)

The first and the third [components] are pretty closely linked because working with parents and carers I think a lot of that has come in. We've provided different opportunities and that's probably something that KidsMatter has opened up - that there's different ways parents can be involved. (Staff, ST2S2)

We have a close tie with Early Intervention and Community Health here, so we quite easily call people in, and I think by building the relationship with the parents we've also found that when we approach parents that "look, we just have a few concerns here, would you mind getting Community Health?" and it's not like "oh my god, there's nothing wrong with my child" they're going "oh ok, yeah that's fine what do I need to do as a parent?" so we have broken down a few of those barriers too. (Staff, ST4S1)

7.3 Providing information for parents

Staff were asked two additional questions about how often they provided 'information about parenting' through newsletters, for example, and 'information about children's mental health' to parents. Responses to both questions were similar with only 18% of staff at Time 1 and 21% of staff at Time 4, reporting that this was done at least several times a week (scored 6 or 7). Most staff (35% and 25% for each item, respectively) reported that this information was provided on a monthly basis (scored 3) and this varied little across the two-year pilot period.

At one service a survey undertaken to investigate what information parents would like to receive found that parents were mostly interested in receiving information about child development:

That was one of the feedback things that came to us from the parents. It was that parents would like some more information on child development. The parents in feedback were saying 'we can see KidsMatter but we would like to know a little bit more about child development' … Certainly in the newsletters we are including KidsMatter information and some of it is giving parents that information about child development, because that's what they were after. I just take them out of the KidsMatter component books, or take them off the website. (Staff, ST5S4)

Some services worked hard to provide information for parents and assist them in parenting, as illustrated by Photo Story 13.

Photo Story 13. Open door policy and two way learning

Parents are welcome throughout the day to visit the centre and participate in activities. The concept of Being, Belonging, and Becoming emphasised to the parents how valued and important their input to their child's learning and the preschool education centre. The parents saw that their voice is vital to the preschool community. Our parents are talking up more and asking more questions to the staff and the staff love it, as they can plan confidently around the child/parent needs and acknowledge that parents are the first teachers. We have been developing a calendar with parents on the importance of preschool and ways parents can support their child's development with games and routines and reading. (Staff, ST4S15)

Participants in the reflective practice study suggested the need for a greater effort in providing information for parents. Many respondents emphasised the need to provide information about mental health and wellbeing for parents as well as facilitate parenting education. Links with external services, information evenings and provisions for written materials, were some of the suggestions made by participants in the statements below.

I think that the way and what info we convey to families could be improved and KMEC has highlighted that this is an area we need to reflect on and explore – especially with new families, with differing needs. (Staff, ST6S1)

Continue parent education on mental health and wellbeing, positive environments and parenting ... Information for parents and carers around behaviour guidance, attachment & nurturing & how these can have enormous impact on mental health outcomes .... network and agency guidance. (Staff, ST4S2)

We would like to continue to add to the written resource offer to families. Some are our parent library and some are KidsMatter resources ... OT and other professionals need to meet with parents e.g. an information session – so these services are not so foreign. (Staff, ST3S2)

Provide opportunities for parents to gain information about parenting. (Staff, ST8S2)

I would like to consider information letters to be placed inside children's pockets covering a wide range of topics to assist parents with children's wellbeing ... This information would be ideal for parents to take home and read within their own time. (Staff, ST6S2)

7.4 Chapter summary

In KMEC, the family is viewed as a pivotal element in ensuring young children's mental health. In the initiative the focus is upon services working with parents and carers helping them access relevant information and support. Preschools and long day services, through their regular contact with families, provide an ideal access point for families to learn about parenting, child development and children's mental health thereby supporting the work of staff in developing young children's social and emotional skills. Cooperation, connection and support are seen as key aspects services' work with parents.

In this regard the evaluation found that across the two year intervention although both staff's and parents' responses reported a steady improvement in the provision of information and support to parents and carers, the level of parent agreement that this had occurred was at a lower level than that of staff. Parents' responses indicated that they saw room for improvement in the level of support for the development of networks of parents. Staff and parents indicated that they saw further need for information for parents related to mental health.

Chapter 8
Component 4: Helping children who are experiencing mental health difficulties

Well this picture here, this individual child here couldn't walk and we'd been told that he could not walk. And … when he was growing up he was put into care, and I'm not sure of the environment but the environment that I'm getting is he was a very alone child and he had not much contact with any other children and he was sort of more or less shut off from the world. Because when he first came in he couldn't sit near children and he used to be really scared and he just didn't like being around a lot of children and kids and stuff like that. So there were sort of two different sides of this child, there was a child where he just didn't feel safe around a lot of people because of the fact that I feel that he wasn't around a lot of people and he might have been shut down in a way where he just didn't get out and see, you know, what the world's all about really, you know, in his early age. So I've just taken a photo of him there showing that, well since I've been here, that we've helped him along his emotional state to see now that he can interact with other children and he's sitting quite closely, he doesn't have a big personal space, there's no bubble there to say "no don't come near me" and it's just showing me that he's feeling really comfortable and he's progressing really good. (Staff, ST2S3)

Look at me now
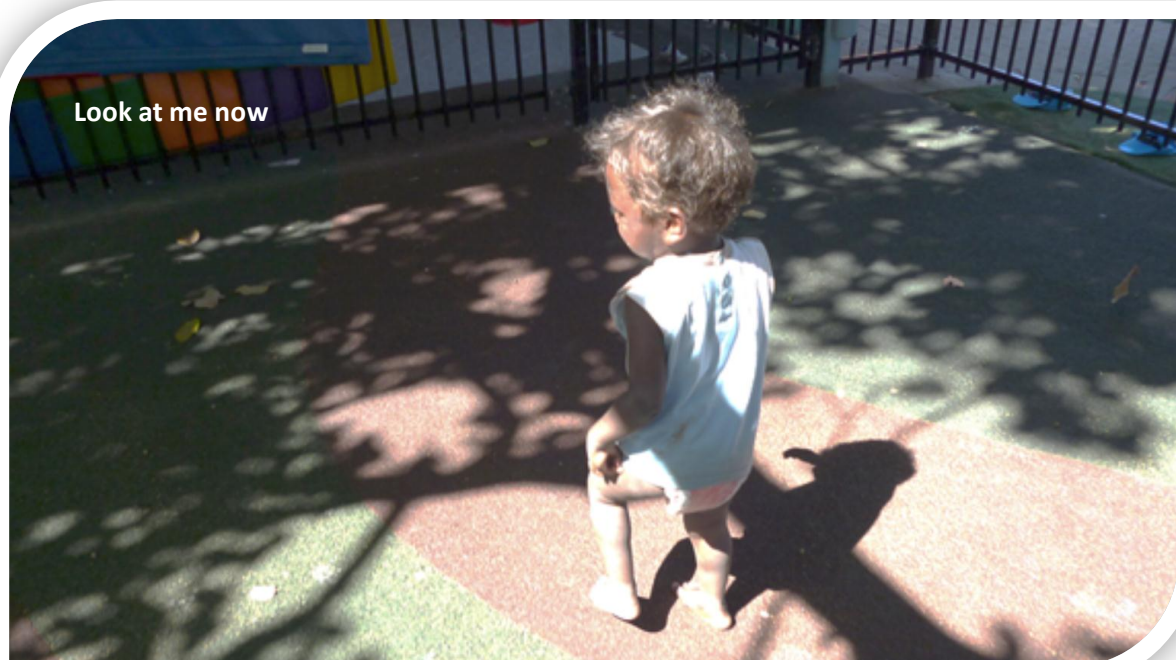
Component 4 of the KMEC framework focuses on helping children who are experiencing mental health difficulties. As noted in the KMEC resources the early childhood years have been highlighted as a critical period when children are developing significant social, emotional and cognitive skills. Effective support during the early stages of a child's difficulty can mean that mental health issues are resolved before they become worse or entrenched, improving the quality of life for children and their families. Due to the significant contact early childhood services have with children and their families, services are in an effective position to identify problems early, implement strategies to assist the children and to support the families to seek additional help. Early intervention can make a significant difference to reducing mental health difficulties in children and can result in dramatic, practical benefits that are sustained over time

This chapter reports on the findings related to the effect of the KMEC initiative on this component.

Of the four components comprising KMEC, it was felt by some participants in the photo study that Component 4 was the most meaningful.

> *They [staff] all commented on the last component, how it made a lot of sense where I know from component one, a lot of educators did kind of stand back and go "Ah...What, what's all this about" and they weren't quite sure where it was heading. (Staff, ST6S1)*

8.1 Services helping children who were experiencing mental health difficulties

In order to assess how effectively services were at supporting children who were experiencing mental health difficulties, five common items and an additional one for parents, were developed. The items, presented in Table 18, focused on to early identification, improving attitudes towards mental health, and developing referral procedures.

Table 18. Staff and parent views about the service helping children who were experiencing mental health or behavioural difficulties

Some children experience social, emotional or behavioural difficulties.	Time 1	Time 4	Time 1	Time 4
	Staff items		Parent items	
If this happens at this service:	'Strongly Agree'		'Strongly Agree'	
staff are respectful and sensitive to children experiencing these difficulties	85%	91%	73%	77%
staff talk to parents if their child is experiencing these difficulties	86%	91%	74%	75%
staff talk to parents about support services for children experiencing difficulties	76%	85%	61%	66%
staff are comfortable about discussing children's mental health	61%	75%	60%	68%
staff have policies and referral procedures to assist children who are experiencing these difficulties	70%	81%	58%	67%
staff can recognise if a child is experiencing these difficulties			66%	72%
Average Component 4	77%	88%	66%	71%

Staff held strong views from the outset, about their service's ability to help children who were experiencing difficulties. This suggests that some services were already undertaking many aspects promoted in the KMEC Model. A slightly lower proportion of parents were of the same view. For both groups there was an increase in the average levels of agreement by Time 4, with 88% of staff and 71% of parents giving "strongly agree" ratings at the last data gathering point. The lower level of parent agreement on these items might reflect the fact that many parents would not have conversations with staff about this topic. The data we present in this report suggest that a small proportion of children are likely to present as experiencing mental health difficulties and so many of the parents would be less familiar with this broad issue than would staff. There was a 6% increase by Time 4, up from 86% at Time 1, in the number of staff who strongly agreed (scored 6

or 7) that they talk to parents if their child is experiencing social, emotional or behavioural difficulties. In comparison, only 74% of parents strongly agreed with this at Time 1, with only a 1% increase by Time 4. The largest increase, from 61% to 75% of staff, related to how comfortable staff were about discussing children's mental health. Parents who strongly agreed also showed an increase from 60% at Time 1 to 68% at Time 4 on this item. Policies and referral procedures to assist children who were experiencing difficulties also indicated positive gains in the number of parents (8% increase) and staff (11% increase) who strongly agreed on this item by Time 4.

While the results in Table 18 suggest improvement over time, the analysis presented in Figure 15 more rigorously assesses the statistical and practical significance of this change. This analysis indicates that there were small significant improvements in staff views of services' ability to help children who were experiencing mental health difficulties, with no significant difference between High and Low Implementation. There was also a small significant improvement according to parents in High Implementing services. The level of agreement in parents responses form High Implementing services was significantly different from parents in Low Implementing services, who reported minimal improvement.

Figure 15. Staff and parent views about the service helping children who were experiencing mental health difficulties

	Implementation	Time1	Time4	Significance p	r	effect size
Staff	High	6.03	6.36	***	0.16	small
	Low	6.03	6.24	***	0.12	small
Parents	High	5.75	6.13	***	0.14	small
	Low	5.75	5.90	**	0.08	
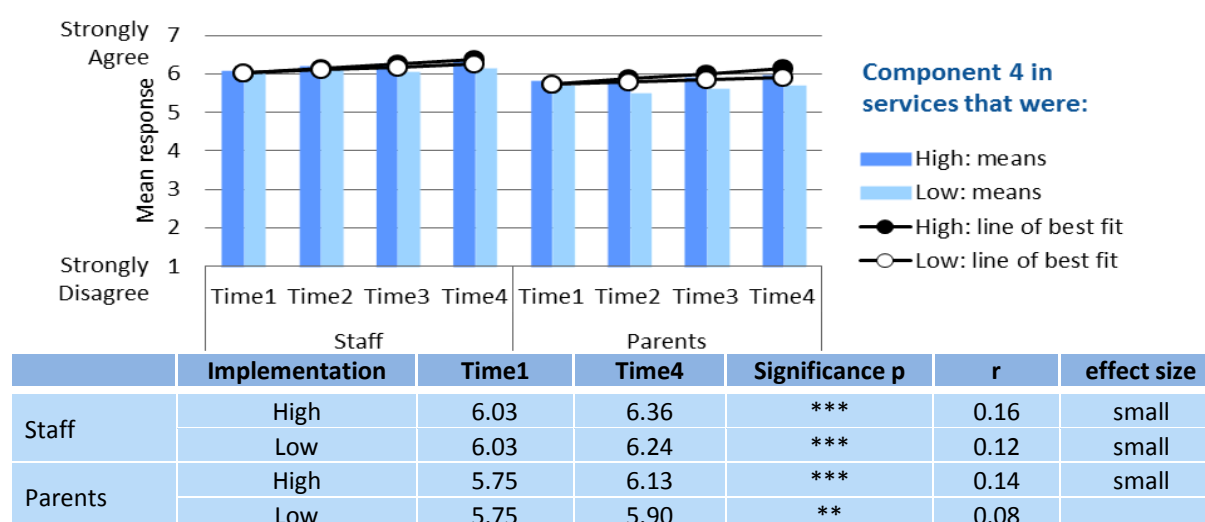
Staff were also asked on four occasions how frequently they talked to parents about the child's wellbeing. Almost three-quarters of staff at Time 1 reported that they talked with parents at least several times a week, and this increased to 80% of staff by Time 4.

Participants in the photo study indicated that they worked collaboratively with external agencies to assist children and families experiencing difficulties, as shown by the following quotes:

We're quick to go straight to Community Health and say, "ok we need help. Where would we seek help?" We do look up the computer all the time, we're not just sort of leaving it there and I'm one if you don't know, just ring Community Health, get a number and follow the guidelines up to where you can get help. (Staff, ST4S1)

We've also invited XX who is the intake officer at Community Health, because that's where a lot of families who are dealing with issues, and the grieving process ... when your child gets identified with autism ... and coping with the fact that your child might have a speech disorder or, things along those lines. We felt that it was important that XX was on the same page as us, because we had a lot of referrals. For some reason lots of children with learning issues and disabilities and things like that seemed to come here. (Staff, ST8S1)

In some services, Component 4 provided an opportunity to further identify and work with external agencies, as illustrated by the following statement:

> One of the other big impacts that KidsMatter has had to our service is our networking within the community. Prior to KidsMatter we really didn't have much of an awareness of the services available out there. (Staff, ST6S1)

8.2 Providing agency information

Some services had started providing agency information, while others were considering that it would be useful to do so:

> Just recently we started including a page of centres that you could go to if you were a single parent, or if you would like some help on something. It was just a whole list of different place they could get help from. (Staff, ST5S4)

> Our biggest connection was also with XX from XX, and she's been an absolute great asset to our centre and that's all come about from KidsMatter. She's put together a directory of services available and that's on display and that's been circulated to the parents, and it's been circulated to the staff, so they're all aware of where to go with any issues. (Staff, ST6S1)

> One of the things I feel we could have more of a drive towards or getting a better focus on, is getting more information out in newsletters and having a bit of a focus on a particular emotional area, or just a little bit of information. If you need support, this is what you could access. Just a snippet here and there that links what we are trying to do and it's out there on a newsletter formation. (Staff, ST7S1)

Comments by staff in the Reflective Practice study further supported the view that further attention to resources associated with external agencies would be beneficial, as the following quotes suggest.

> Establishing a collection of resources and organizational services available in the local area that can assist/ support families/ children with mental health or emotional health difficulties ... Build a resource of providers available to support staff and families (Staff, ST4S2)

> Continue to investigate other resources in the local area that can make a difference to children with mental health issues. (Staff, ST8S2)

> We (staff) need a handbook with names of professionals within mental health services, and contact numbers and referral forms. (Staff, ST1S1)

8.3 Limitations of referral processes

While services generally reported that were able to refer children and families to external services, some comments were made about resources associated with the referral process. The time taken to access those services was considered by some to be a serious limitation.

> That's probably the limitations that I see at the moment is that referral process. The amount of time that we have children ... I referred children very early this year for some help and some children are just being picked up now and they're going to school. (Staff, ST4S2)

> We do need to have access to those resources and for some families the access needs to be fairly immediate, or they won't come back to you ... We can put referrals in, but they often get inundated and so your referral has to wait, or you go on a list. It could take 5 weeks, or 2 weeks, or 1 week, or whatever it might be. (Staff, ST7S1)

8.4 Processes for supporting children experiencing mental health difficulties

Facilitators also completed their observations of services' responses to various aspects of KMEC including implementation on 4 occasions during the two-year intervention. From Table 19 it can

be seen that there were significant positive changes in the Facilitator's assessments of the services' capacity to meet children's needs, ranging from a 65% increase in the services' capacity to develop processes for identifying children who may be at risk, to a 44% increase in reports of services regularly implementing curriculum relevant to children's social and emotional development. There was also a 50% increase in Facilitators' strongly agreeing (scored 6 or 7) about an improvements in services' capacity to link with external agencies that support children experiencing difficulties.

Table 19. Facilitators' observations of services' responses to meeting children's needs on four occasions

'Strongly agree' (scored 6 or 7)	Time 1	Time 4
Regularly implemented curriculum that provides SEL opportunities for children	31%	74%
Staff appear better informed about children's mental health	6%	81%
Staff can articulate ideas using appropriate language related to KMEC	13%	74%
Links with external agencies that support children experiencing mental health difficulties and their parents/carers have improved	2%	51%
Processes in the EC Service for recognising children who may have social, emotional or behavioural difficulties have improved	1%	66%
Strategies for promoting children's mental health and wellbeing have improved	5%	69%

8.5 Chapter summary

So I've just taken a photo of him there showing that, well since I've been here, that we've helped him along his emotional state to see now that he can interact with other children and he's sitting quite closely, he doesn't have a big personal space, there's no bubble there to say "no don't come near me" and it's just showing me that he's feeling really comfortable and he's progressing really good. (Staff, ST2S3)

The above quote taken from the photo study highlights the evaluation's findings that staff recognised and held strong views about their service's ability to help children who are experiencing difficulties. The evaluation shows that across the two year intervention, according to staff, there were small statistically and practically significant improvements in their ability to assist children, with no difference relating to whether the services are High or Low implementers of KMEC. It is relevant to note that staff judgements about these issues were already at a high level at Time 1. According to parent views in high implementing services, there are also small significant improvements in each service's capacity to help children experiencing mental health difficulties. The responses from parents in Low implementing services did not show such a level of change. The evidence of improvement in relation to the content of Component 4 is also supported by the reports provided by Facilitators that showed substantial levels of improvement.

Chapter 9
The impact of KMEC on Services and Staff

This photo to me shows a crazy bunch of staff but every one of these individual persons has a story of their own, and their journey on how well they relate to our children and parents.

The bond we have and the respect that we show between each other and the children is unbelievable, and makes all of us proud to be here.

We all have our up and downs in everyday life and when we come to work we can be sure that we can cry on someone's shoulder and be respected for our views and opinions. When things become too stressful we always stick together and support each other.

I believe that staff in a preschool is the frontline for children's health and well-being. As a staff member we are aware of our children – we notice the littlest thing or big things and communicate to our appropriate team leader or director.

From top management to peers we all are given opportunities to shine and bring programs to the centre that would benefit the children. We know that we respect each other's culture, and our opinions are valued and supported. Every staff member has a certificate and whether we have degree qualified or Certificate III all staff offers an opinion on how the centre should work with our community and a consensus is reached on how we will approach an issue.

KidsMatter has taught us the value of staff relations, where it fits in with child health and well-being, as well as, our community; I feel we do this really well. (Staff, ST4S13)

Having discussed the processes, resources and framework of the KMEC Model in detail in the preceding chapters, with clear evidence that change in services over the two-year pilot occurred, we now turn to investigate what impact these changes had on staff and parent mediating factors. In this chapter we focus on the impact of KMEC on services and staff.

> It [KidsMatter] made them [staff] just reflect on their life and things that have happened to them in their life and how that affects the way they respond to people. I think everyone just became really self-aware. (Staff, ST4S1)

9.1 Staff knowledge

An important goal of the KMEC initiative was that it would lead to increases in staff knowledge, competence and confidence in relation to supporting the development of children's social and emotional skills and in supporting children with mental health difficulties. According to participants in the photo study, this objective was clearly realised. In the following quotes early child care educators describe their deeper understanding of children's social and emotional wellbeing as a result of their involvement with KMEC.

> Through KidsMatter for me personally, it's made me look deeper at the child, and like this particular little boy and like where he's come from. It's made me look deeper at children and perhaps wondering why, perhaps where they've come from, why they behave like they do. (Staff, ST4S5)

> I think just being able to kind of step back and go "well actually, even though I'm responding in this way, they might not actually be meaning it in that way" and I think that's been a big thing. (Staff, ST4S1)

> It's given me more professional knowledge about mental health, about children. It certainly made it okay to talk about it out there in the open a bit. I guess knowing where to go to now for help, just having a lot more information about it, and having the professional conversations. It has certainly made me and our staff more aware of the community, the parents and their needs. (Staff, ST5S4)

A need to continue building staff knowledge and understanding was stressed by staff who participated in the reflective practice study, as the following quotes suggest.

> We need to continue to build on our knowledge and skills. (Staff, ST1S3)

> Continued professional development to enable staff continue to gain greater understanding of mental health and wellbeing (Staff, ST4S2)

> We need continuous Professional Development on the topic of Social/ Emotional development and mental health wellbeing. (Staff, ST6S1)

> Continue to utilise KMEC resources to increase educator's knowledge and further develop their skills. (Staff, ST7S2)

> More info about how to recognise children with mental health concerns. (Staff, ST8S1)

> I feel we need to continuously revise all 4 components, e.g., At meetings, to refresh our minds and to keep this important matter in our daily work environment. (Staff, ST3S3)

Table 20 presents levels of agreement reported by staff at Time 1 and Time 4 for seven items relating to the level of their mental health knowledge Compared to responses about the four component areas, these responses were generally at a lower level. Only one-third of staff at Time 1 considered that their knowledge about mental health issues (specifically related to children) was excellent (scored 6 or 7), with this increasing to 55% of staff by Time 4. There was a 20% increase, from 44% at Time 1, in the number of staff who reported that they had excellent knowledge about the signs of mental health difficulties in children, and similar gains in knowledge about external support services.

Table 20. Staff views about their mental health knowledge

Staff were asked to tick the response that best described their knowledge about:	Time 1	Time 4
	'Excellent'	
mental health issues specifically related to children	32%	55%
how children's social and emotional skills influence their mental health	51%	69%
how children's social and emotional skills develop	58%	73%
how collaborative partnerships with parents are developed	58%	72%
the signs of mental health difficulties in children	40%	61%
the Centre's processes for supporting children who may be experiencing mental health difficulties	44%	63%
external support services that are available to support children's mental health	39%	59%
Average Staff knowledge	43%	66%

Further statistical analysis of these items revealed one of the strongest areas of improvement in staff found in this evaluation. Although there were statistically significant differences between staff in High and Low Implementing services, the overall extent of change over the two-year period in both High and Low implementing groups was very encouraging. Figure 16 indicates that staff reported significant increases in knowledge about children's mental health to a medium effect.

It is also noteworthy that by the end of the pilot there was about one-third of staff that did not show strong levels of agreement on these staff knowledge items. This suggests that there was still a feeling in this sizeable group of staff that they need to improve the levels of their knowledge related to children's mental health and wellbeing and how to support children needing referral to external agencies.

Figure 16. Staff views about their mental health knowledge

	Implementation	Time1	Time4	Significance p	r	effect size
Staff	High	5.18	5.89	***	0.33	medium
	Low	5.18	5.68	***	0.26	medium
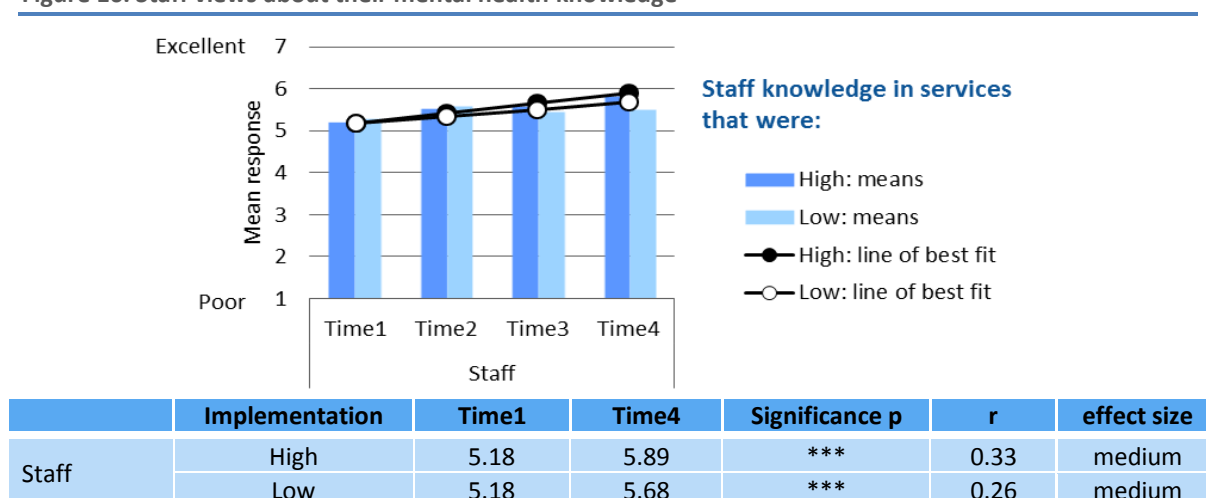
9.2 Staff self-efficacy

Staff self-efficacy about their competence and confidence to foster a sense of belonging in others, to provide effective support to parents, and to identify early signs of social and emotional difficulties in children, was another mediating factor considered in the evaluation. Seven items were developed to assess self-efficacy and these are presented in Table 21.

With 88% of staff at Time 1 strongly agreeing (scored 6 or 7) that they could help children to develop socially and emotionally, and help other staff, parents and children to belong, there was little scope left for change in their ratings of their self-efficacy. Nevertheless, at Time 4, an average of 94% of staff strongly agreed with these items. The lowest response at Time 1, with only 73% of staff strongly agreeing, related to their ability to recognise early signs of difficulties in

children. By Time 4, 82% of staff strongly agreed that they could recognise early signs of difficulties.

Table 21. Staff views about their self-efficacy

These questions refer to your work with children at your service.	Time 1	Time 4
	'Strongly Agree'	
I can help young children to recognise and manage their emotions	85%	93%
I can help young children to show care and concern for other people	92%	96%
I can help young children to make responsible decisions	89%	93%
I can help young children to establish positive relationships	91%	95%
I can help young children to handle challenging situations	85%	91%
I can help staff, parents, and children feel that they belong to our Centre's community	87%	93%
I can recognise early signs of children's social, emotional or behavioural difficulties	73%	82%
Average Self-efficacy	88%	94%

Only staff in High implementing services showed statistically significant improvement on self-efficacy, equivalent to a small effect size, and this was significantly different from the response pattern for staff in Low implementing services, which indicated only minimal change. Figure 17 presents the representation of this analysis of change in self-efficacy ratings.

Figure 17. Staff views about their self-efficacy

	Implementation	Time1	Time4	Significance p	r	effect size
Staff	High	6.29	6.56	***	0.13	small
	Low	6.29	6.43	**	0.08	
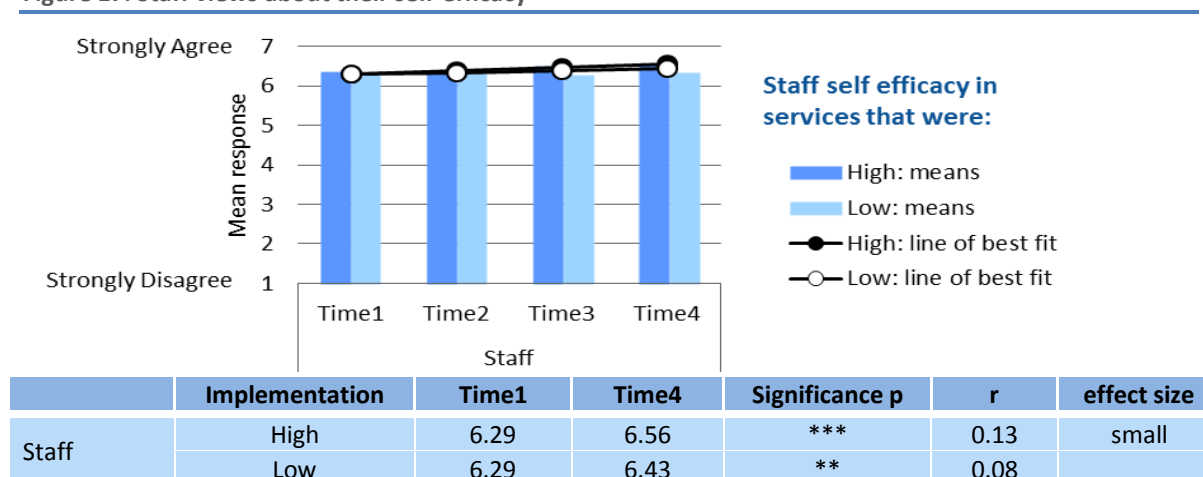
Statements made by photo study participants provided examples where there had been an improvement in staff self-efficacy:

I feel more able, more confidently able, to address matters and support things particularly like helping children advocate for themselves and sorting out problems themselves and probably just a bit of reassurance that I was doing the right thing too in some areas as well. (Staff, ST4S2)

Now within KidsMatter and extending our knowledge on all of these things as educators we are more confident and knowledgeable to approach parents and children and deal with those things and strategies. (Staff-parent, ST6SP1)

9.3 KMEC impact on staff work

The benefits of KMEC were thought to extend beyond meeting the needs of children and families, and might also have positive impacts on other areas such as job satisfaction, staff morale and wellbeing. Results presented in Table 22 suggest that it was the case.

Five items were developed to assess staff views about aspects of their work in the service that were attributable to the impact of KMEC. Approximately 60% of staff at Time 1 strongly agreed

(scored 6 or 7) that they could rely more upon colleagues for support and had a better understanding of their role and responsibilities since the introduction of KMEC, less than six months before. By Time 4, this number had increased by about 18% of staff. Almost 50% felt more able to contribute to decision-making about policies and practices at Time 1, rising to 68% by Time 4. There were also increases of about 18% in improved job satisfaction and having better working relationships with parents, since KMEC had been introduced.

Table 22. Staff views about the impact of KMEC

Since the introduction of KidsMatter Early Childhood in this service:	Time 1	Time 4
	'Strongly Agree'	
I can rely more upon colleagues for support and assistance when needed	59%	76%
I have a better understanding of my roles and responsibilities with respect to children's mental health and wellbeing	61%	80%
I am more able to contribute to decision- making about policies and practices	49%	68%
My job satisfaction has improved	48%	66%
I have a better working relationships with parents	54%	70%
Average KMEC impact on staff	54%	72%

To add further strength to the analysis, the averaged response was assessed for significant change. Figure 18 presents the results of that analysis and shows that staff in High Implementing services reported significantly improved outcomes related to their work, which was equivalent to a medium effect size. The ratings for this group were at a higher levels than those of staff in Low implementing services. Nevertheless, Low implementing services also reported higher levels of agreement across the time of the pilot that KMEC had positively impacted on their work.

9.3.1 Personal impact

The impact of KMEC on staff, according to photo study participants, extended beyond the work horizon as learning associated with KMEC impacted on educators' personal lives. The statements, which follow, provide examples of this view.

> *Just in my life outside, just sort of thinking that's a really important thing for my mental health, to be connected to other people and to build those relationships. It's been, I think it's just all that reflecting on what you do and the reasons that you feel the way you do about things and then, you know, sort of understanding yourself a bit better. (Staff, ST4S1)*

Figure 18. Staff views about the impact of KMEC

	Implementation	Time1	Time4	Significance p	r	effect size
Staff	High	5.39	6.04	***	0.25	medium
	Low	5.39	5.85	***	0.19	small
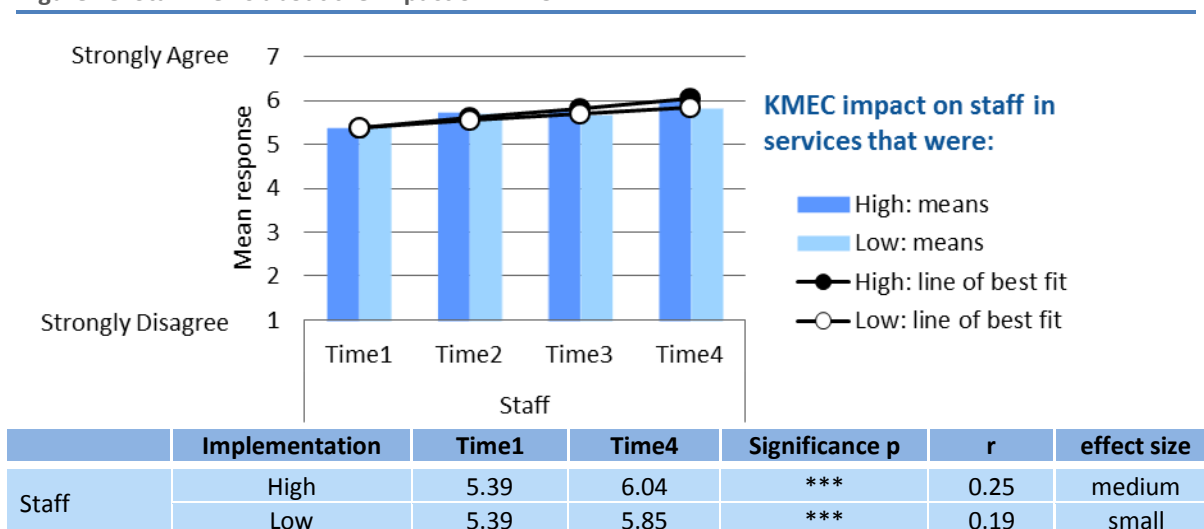
> *I've got a fourteen month old. So for me personally a lot of what I was taking in from KidsMatter, I found I was really putting into my little girl. (Staff-parent, ST6SP1)*

The mental health one, because that helped me not only at work, but at home with my own kids as well, so I found it really, really interesting and really helpful in that way. (Staff, ST4S11)

It's been good for me too - even at home I'm doing it. Not reacting straight away. I sit back and try and work it out. The knowledge that KidsMatter gave me, it has really been helpful. (Staff-parent, ST2SP2)

I'm wearing one hat here and one hat at home. It's different when you're dealing with other children other than your own. With my son ... we're very connected. We talk a lot and through the KidsMatter programs I've learned how to manage like the anxiety, the stress, because he's had quite a bit of that. (Staff-parent, ST6SP3)

One service director explained how KMEC had impacted on her interactions with children, putting aside pressing administrative tasks to be more available for children.

Photo Story 14. Educators being 'present' and nurturing children's hearts and souls

I just became more aware of stopping and being there and being present and being in that moment with them, and not worrying if the phone rings or somebody, something else is happening around us. Rather than jumping, having your thoughts jumping in your head all the time to what you should be doing, and often my head's full of the funding things and all the admin type things and I guess it just really brought me back to what's the most important thing, and that is being there for the kids and forming those special connections. (Staff, ST4S1)

9.3.2 Enhanced staff cohesiveness

The core staff that kept doing all the training, I think we all came out at the end of it more connected. As a staff I think we were much more reflective of our own, maybe our own values and beliefs and how that affects our relationships with each other. (Staff, ST4S1)

Growth for our whole staff team, which is our communication with each other and the support for each other, which has improved as a result of being part of KidsMatter. (Staff, ST8S2)

Have better relations with the staff. That's the big change, for me. Because of those workshops we had, getting ideas across and being valued, because we don't get enough time together and it was, yeah, it was wonderful to have. (Staff, ST1S2)

The biggest part that we've got out of KidsMatter from my perspective is I think to develop the staff have more skills with each other and that that area has developed a lot more. (Staff, ST4S2)

9.3.3 Educators suggestions for future changes to address needs

Comments made by educators who participated in the Reflective Practice study towards the end of the two-year pilot revealed a general acceptance by services of KMEC as an initiative worthy of continuation. Comments made by staff in this regard included:

We continue to support children and their families with mental health difficulties, and to encourage good mental health and wellbeing. (Staff, ST8S2)

I feel that we need to continue with what we are doing at this stage. (Staff, ST4S3)

To continue to highlight KMEC in our documentation, conversations and reporting between staff and parents. (Staff, ST6S1)

In this reflective practice study, staff were given an opportunity to respond to the question: "What further changes are needed?" Some of the responses indicated that there was room for changes that would address staff needs.

Comments from participants suggested that future changes could be made to facilitate collaborative connections with external agencies. These included supporting staff to engage with external agencies and providing connections for families to them.

Some respondents also highlighted staff training as a (continued) future requirement. The need to gain more knowledge about mental health and wellbeing, professional development and provision for updates and revision, were suggestions advanced by staff, as illustrated by the following quotes:

> *We need to continue to up skill staff members through training to be comfortable talking about mental health. (Staff, ST4S14)*
>
> *We need continuous Professional Development on the topic of Social/Emotional development and mental health wellbeing.(Staff, ST6S2)*
>
> *Further training for staff in regards to mental health. (Staff, ST3S7)*
>
> *Ongoing professional development for the staff in being able to identify the most appropriate strategies for individual children. Resources to support staff in implementing these. (Staff, ST6S2)*
>
> *Professional training – to further develop our knowledge and children's mental health and challenging behaviours. (Staff, ST1S2)*

According to educators from different states, more time is needed for staff to undertake activities related to the implementation of KMEC, such as more time for them to work with families; for leadership to present referral information; to implement a wellbeing program; and to plan and implement research for all children.

> *More time for staff to work with families. (Staff, ST3S1)*
>
> *Leadership time for presentation of fantastic referral information. (Staff, ST4S1)*
>
> *More dedicated time and correct staffing to implement our own wellbeing program. (Staff, ST8S2)*
>
> *We need to stretch time to talk to all parents about their child and the special things they do at preschool. (Staff, ST4S2)*
>
> *More staff child-free time to plan and implement research for all children – not just target funded children. Staff, ST4S14)*
>
> *Time to share amongst staff, ideas, strategies etc for dealing with mental health problems. (Staff, ST7S1)*
>
> *Time and resources to enable one-to-one communication with families. (Staff, ST6S2)*
>
> *Time to make more priority of mental health. (Staff, ST1S2)*

9.4 Chapter summary

One of the more robust findings from this evaluation concerns the impact of KMEC on services and staff knowledge and work. There was evidence of improvement across the two-year intervention in staff views regarding their knowledge of children's mental health. This practically significant effect is found across both High and Low Implementing services. This pattern also emerged in staff ratings of the impact of KMEC on aspects of their work in services. However, staff in High Implementing services report feeling more self-efficacious in their ability to help young children experiencing mental health difficulties. The interview data highlight that the overall positive impact affects them personally and that the improvement in knowledge translates from work to home and their relationships with their own families.

Chapter 10
The impact of KMEC on Families and Parents

When other families would come to see the children from the bush this little person here would go to other family that would come in to visit somebody else as though it was his family. So, what's happened here, there's, you know, a lot of communication between different people from different organisations that had input into his social and emotional wellbeing, found family. And this has been ongoing now for the last six months and this one of the special [great grandma] that comes in all the way from XX, and he just absolutely loves it. And when I look at that photo and I look at the visitation which we do observe gently, the joy within him and that sense of belonging that comes out in his body language is quite touching, for him and also for all of us as educators. And it just makes his day and since this has been happening we're seeing far more secure within himself. So to me that says a lot. When you know where you come from, you begin to know where you're going and eventually you know who you are. (Staff, ST2S5)

The importance of family input from a very young age

As noted in Chapter 2, a key element in the KMEC conceptual model was the idea that KMEC would have a positive impact on a number of mediating and protective factors for young children's mental health. Included in these protective factors is the family context, where one purpose of the KMEC intervention is to contribute to more effective parenting and to more supportive and caring family relationships, especially parent-child relationships. Therefore, KMEC was expected to lead to increases in parents' knowledge, competence and confidence in areas of parenting and child development. In turn, it was assumed that more effective parenting and supportive parent-child relationships would assist all children, and in particular, assist children with mental health problems, and thereby contribute to improvements in their mental health. The changes to family context envisioned in KMEC were especially linked to Component 3 (Working with parents and carers). However, it was also expected that contributions would come from the other three components, of belonging, of supporting child social and emotional development, and helping children experiencing problems. This chapter considers the impact of KMEC on parent learning, parent self-efficacy, and parent involvement with services.

10.1 KMEC impact on parent learning

In the questionnaire study, parents were asked to respond to six items about their parenting knowledge as an indication of the impact of KMEC on parent learning. These items considered whether parents knew how to help their child foster friendships, recognise when their child is having difficulties, and how to access information and support services for their children. Table 23 shows consistent responses by parents across the items in both levels of agreement and in extent of change in ratings from Time 1 to Time 4. It is of note that the level of agreement on these items is at quite a low level compared with the comparable judgements on most other items presented to parents. At Time 1 31% of parents, on average, strongly agreed (scored 6 or 7), with this average level of agreement increasing by 9% by Time 4.

Table 23. Parent views about KMEC impact on parent learning

Parents were asked to respond to, *KidsMatter Early Childhood has helped me to learn:*	Time 1	Time 4
	\'Strongly Agree\'	
how to recognise if my child is showing social, emotional or behaviour difficulties	30%	38%
how to support my child to develop relationships with other children	31%	39%
how to support my child to deal with his/her feelings	32%	40%
how to support my child to understand the feelings of other people	32%	40%
how to support my child to deal with difficulties	31%	39%
how to access information and support services	30%	39%
Average KMEC impact on parent learning	31%	40%

The results in Figure 19 suggest a positive change in parent learning in association with KMEC. Although there were statistically significant differences between parents in High and Low implementing services, the overall extent of change over the two-year period in both High and Low Implementing groups was rated as equivalent to a small effect size. This pattern of findings suggests that there was still scope for a stronger impact of KMEC in this regard by the end of the pilot.

10.2 Parental self-efficacy

Parental self-efficacy is considered as an important protective factor with regard to children's wellbeing. Parents' competence and confidence to help their child to recognise and manage their emotions and establish positive relationships was assessed through the five items presented in Table 24. With 86% of parents at Time 1 strongly agreeing (scored 6 or 7) that they could help their child, there was little scope left for further improvement of parent ratings.

Figure 19. Parent views about KMEC impact on parent learning

	Implementation	Time1	Time4	Significance p	r	effect size
Parents	High	4.53	5.27	***	0.21	small
	Low	4.53	4.94	***	0.14	small
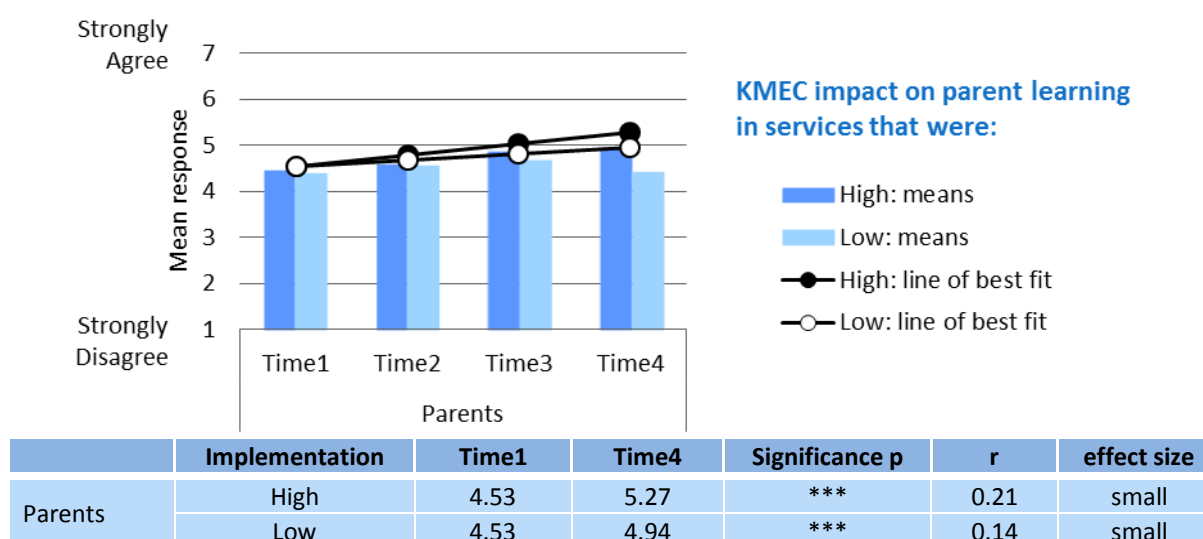
Table 24. Parent views about parental self-efficacy

I can help my child to:	Time 1	Time 4
	'Strongly Agree'	
recognise and manage their emotions	81%	82%
show care and concern for other people	89%	89%
make good decisions	86%	86%
establish positive relationships	87%	88%
handle challenging situations	81%	83%
Average parental self-efficacy	86%	87%

Nevertheless, Figure 20 indicates that while there was no change over the two years of parents' views of their self-efficacy in Low Implementing services, there was a small significant change of parents' ratings in High Implementing services, which was significantly different from Low Implementing services. This is another area in which the differences in quality of implementation were related to differences in outcomes on an element of KMEC.

Figure 20. Parent views about parental self-efficacy

	Implementation	Time1	Time4	Significance p	r	effect size
Parents	High	6.21	6.47	*	0.10	small
	Low	6.21	6.27	ns	0.03	
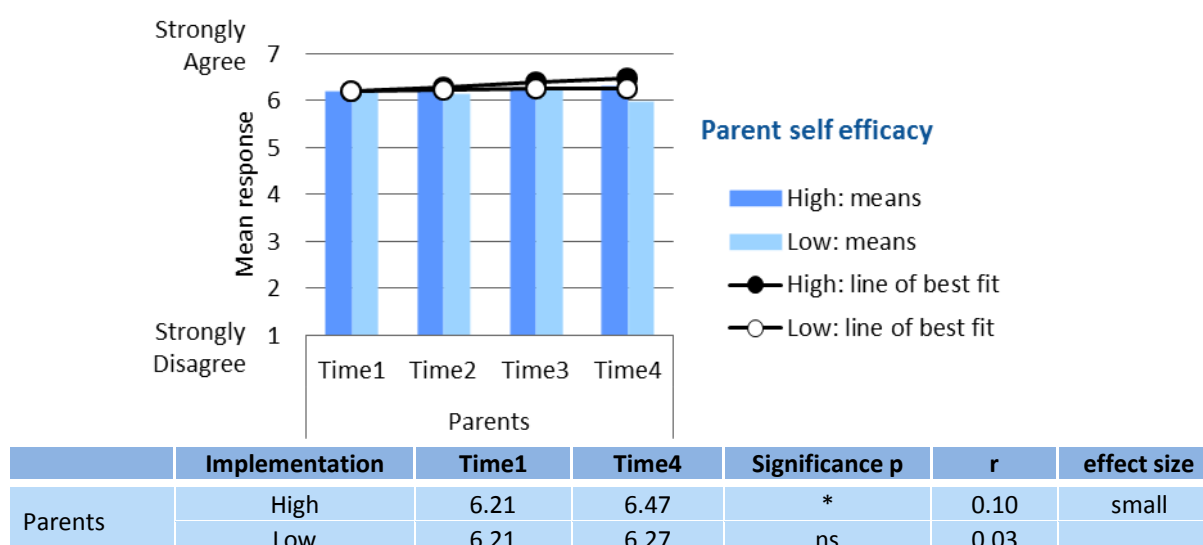
10.3 KMEC impact on parent involvement with services

As a parent, I didn't know how much work our teachers and carers were doing here especially not just for the education, but for the wellbeing of our kids. I had no idea, and I don't think that many of the parents here actually realise how much the teachers are going above and beyond. As far as KidsMatter, looking at outside the education, looking at the life-long learning and emotional development of our kids. (Parent, ST5P3)

The quote above is indicative of the lack of knowledge that parents who participated in the photo study generally had about KMEC. It was apparent from the conversations with parents and carers that they knew little about the implementation of KMEC or of the components that comprised it. Some parents who participated in the photo study provided photos that illustrated their belief that "kids matter" (for example, photos of children with other siblings or family) or pictures that showed important socio-cultural aspects of their children's lives (for example, children fishing, flying a kite, cooking, playing football, swimming). However, there were no stories about raised awareness of children's mental health strengths or difficulties or of increased self-efficacy or confidence.

The extent to which KMEC supported parents' engagement with services, and parents' attitudes towards those services, was investigated through use of the five items shown in Table 25. One fifth of parents strongly agreed (scored 6 or 7) at Time 1 that they had become more involved with the service's activities, which increased by 7% by Time 4. Because of KMEC, 45% of parents at Time 1 strongly agreed that the service was better able to meet their child's needs, and this improved to 52% by Time 4.

Table 25. Parent views about KMEC impact on parent involvement with services

Because of KidsMatter Early Childhood happening in my Centre:	Time 1	Time 4
	'Strongly Agree'	
I have become more involved with the Centre's activities	20%	26%
I have formed more support networks with other parents	16%	23%
I attend more activities at my Centre (e.g. Parent information evenings)	20%	26%
I feel this Centre is better able to meet my child's needs	45%	52%
I enjoy being at the Centre more	33%	40%
Average KMEC impact on parent involvement with services	22%	29%

According to the statistical analysis presented in Figure 21, there was no significant difference between parents in High and Low Implementing services, suggesting that because of KMEC, parents had improved attitudes and were more involved with their service by the end of the evaluation, which was equivalent to a small effect size. However, across the group of items concerning involvement with services, the average level of parent ratings of agreement were at a quite low level. At Time 4 there was a large proportion of parents who did not view themselves as having close involvement with services. Support for the parents' judgements was also present in some of the reports by Facilitators on items set out in Table 25.

Facilitators also completed observations of services regarding various aspects of KMEC on four occasions during the two-year intervention. From Table 26, it can be seen that there were significant positive changes in the Facilitators' assessments of the services' capacity to support parents' involvement with the service, ranging from a 44% increase in the Facilitators' strongly agreeing (scored 6 or 7) about services' capacity to provide opportunities for parents to meet, to a 13% increase in explicitly engaging parents with the KMEC initiative. However, it is of note that Facilitators regarded that services were less successful in explicitly engaging parents with KMEC components and in provision of KMEC information newsletters.

	Implementation	Time1	Time4	Significance p	r	effect size
Parents	High	4.39	4.93	***	0.17	small
	Low	4.39	4.72	***	0.13	small
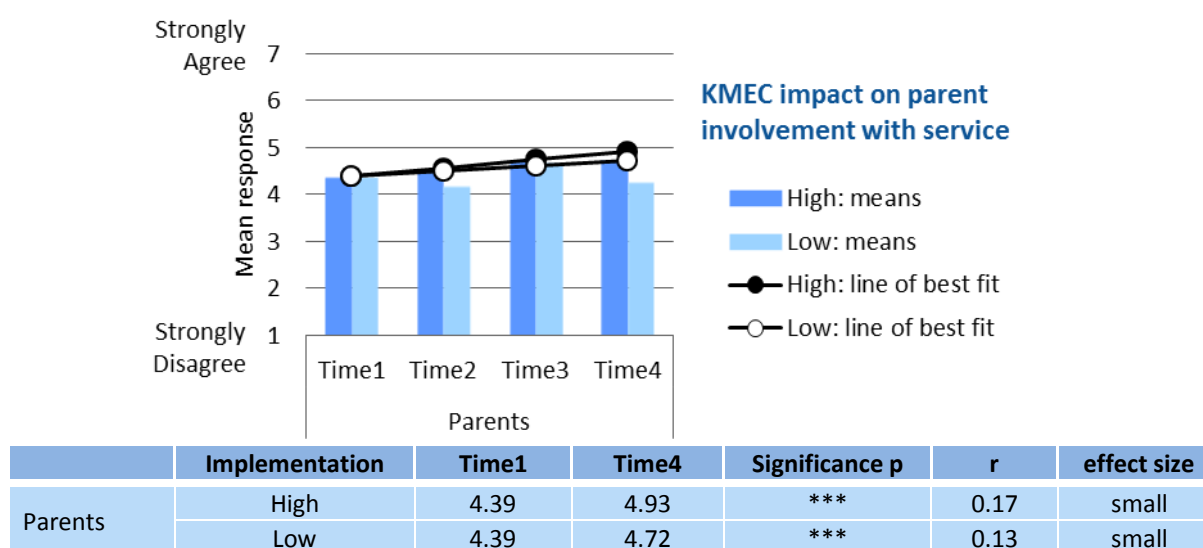
Table 26. Facilitators' observations of services' capacity to meet parents' and carers' needs on four occasions

	'Strongly agree' (Scored 6 or 7)	Time 1	Time 4
Provided opportunities for parents to meet with each other		22%	66%
Included KMEC information in newsletters to families		14%	38%
Sent out the Component Booklet Survey to families and staff		77%	35%
Explicitly engaged parents with components of the KMEC initiative		13%	26%

10.4 Chapter summary

As a parent, I didn't know how much work our teachers and carers were doing here especially not just for the education, but for the well-being of our kids. (Parent, ST5P3)

Parents gave high ratings to their parent learning at the start of KMEC and this changed little over the period of the trial. There were very modest positive changes in relation to parental involvement with the service in the course of the two year intervention, this level of involvement generally being at a much lower level than other elements of KMEC. Parents gave high ratings to their self-efficacy as parents at Time 1 and this barely changed over the two-year intervention. In considering the impact of KMEC on parents' and carers' knowledge and understanding, in Chapter 7, it was noted that there were relatively modest changes in the ways that services worked with parents and carers. It is likely that the results presented here, indicating limited impact of KMEC on family context, partly reflect the progress made on Component 3 throughout KMEC. This pattern of findings may also reflect the complex interactions between the four components themselves and the nature of parents' interaction with day care and long day care services.

Chapter 11
The Impact of KMEC on Children

This little girl with the rainbow hat had arrived at preschool and had been standing on the porch with her mother for quite some time. They were running a bit late. So I think that just put her off kilter a bit. We were all outside and she was very unsure about coming outside. The little girl in the yellow hat had noticed this. She could see how upset she was and she said "hold my hand and I'll bring you outside with me". The little girl with the rainbow hat just lit up, her face just lit up and said "okay then, I'll come out with you" and she said "bye mum". They skipped down together and then she had a perfect day. That just made me feel really nice because we had been discussing friendships and looking after your friends and feelings of other people. (Staff, ST4S1)

Hold my hand and you'll be ok

The evidence presented throughout this report presents a complex picture of services and staff within services working to implement KidsMatter Early Childhood for the wellbeing of children in their care. In this evaluation, it is recognised that individual health and wellbeing is the result of multiple and interwoven determinants ranging from individual factors (biological, genetic, behavioural) to local resources and opportunities for health and wellbeing, to society wide factors (environmental, cultural and socio-economic). The four components of KMEC identify the risk and protective factors in relation to these multiple determinants. The challenges associated with assessing change are best viewed in this broad context.

Notably, KMEC helps staff to improve links with professionals and assist children who are experiencing difficulties, provide better care for children, and focus more on children's developmental needs. The increase in strongly held views by staff regarding these positive changes in behaviours in addressing children's needs is reflected in a medium effect size. Similarly, parents also report that KMEC had helped staff to support their children's wellbeing in these same areas, albeit reflected in a smaller effect size over the period of the evaluation.

The basis of these practically significant changes may be underpinned by many factors unique to the smaller group of services, staff and parent involved in the longitudinal assessment of change over time. We know from discussion in Chapter 2 that, compared to the main cohort of participants present on one or two occasions, staff in this smaller group were more likely to be Directors and permanent with higher educational qualifications and more years of experience. Parents and children were less likely to be from Aboriginal or Torres Strait Islander background or in single-parent families. As a result, the services themselves were also more likely to be identified as High Implementing (70%), potentially optimising any impact of KMEC on staff, families and, in turn, children, who tend to spend more time in care (see Chapter 2). Under these circumstances, it is plausible to suggest that some children may have been identified and supported.

The final area of the evaluation was to determine the ways that KMEC has impacted on children in terms of each service's ability to address their needs, the relationships children have with staff, the parents' views of their child's temperament, and children's mental health outcomes.

11.1 Services' ability to address children's social-emotional needs

The impact that KMEC had on meeting children's social and emotional needs was the focus of six items included in the staff questionnaire. These items are shown in Table 27. Parents responded to all these items except the final item listed in Table 27.

Table 27. Views about the impact of KMEC on the services' ability to address children's SE needs

Staff and parents were asked, KidsMatter Early Childhood has helped staff to:	Time 1	Time 4	Time 1	Time 4
	Staff items		Parent items	
	'Strongly Agree'		'Strongly Agree'	
focus better on my child's developmental needs	53%	73%	44%	53%
develop better procedures for addressing children's social, emotional or behavioural difficulties	52%	73%	44%	53%
improve links with professionals who can assist children experiencing social, emotional or behavioural difficulties	46%	66%	42%	50%
better recognise children experiencing social, emotional or behavioural difficulties	54%	73%	44%	53%
provide better care for children	56%	72%	47%	56%
assist children who are experiencing emotional, social or behavioural difficulties	56%	75%		
Average Address child's SE needs	54%	74%	43%	53%

Approximately half the staff at Time 1 strongly agreed (scored 6 or 7) that KMEC had helped them to better recognise children experiencing difficulties (54%), to provide better care for children

(56%) and to improve links with professionals who can assist children experiencing difficulties (46%). The levels of strong agreement in staff responses to these items increased on average by 20%, to 74% at Time 4.

Parent levels of strong agreement to these items also increased between Times 1 and 4, although this was at a lower level than that of staff. By Time 4, 53% of parent respondents gave strong agreement to this group of items that KMEC had helped staff to provide better care for children, and focus better on their child's developmental needs.

> *Their communication's improved because instead of having a big group and addressing them all at once, they're getting that one on one. So what I try and do is, if they're playing, go over and sit with them and just talk to them about what's going on, or how their weekend was. Then they give you that little bit of respect back, because you're acknowledging them. Through the one on one and the recognition that they're an individual, not just a group of children. (Staff-parent, ST6SP3)*

The results of the statistical analysis of changes in staff's and parents' ratings for these items are presented in Figure 22. There were practically significant increases in staff's ratings in both High and Low Implementing services, equivalent to medium and small effect sizes, respectively. The change in parents' ratings across the time of the pilot showed a small significant effect in both the Low and High Implementing services.

Figure 22. Change in staff and parent views about the impact of KMEC on the services' ability to address child's SE needs

	Implementation	Time1	Time4	Significance p	r	effect size
Staff	High	5.40	6.15	***	0.27	medium
	Low	5.40	5.86	***	0.19	small
Parents	High	5.06	5.72	***	0.23	small
	Low	5.06	5.51	***	0.19	small
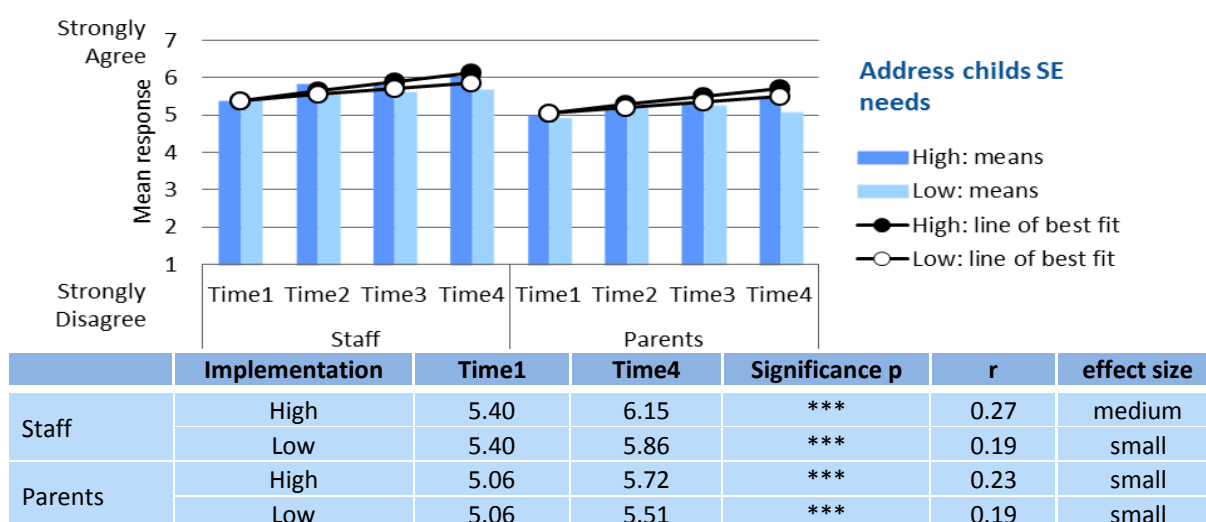
> *Socially I have seen her go from being a really shy child, who all of us were a little bit worried about coming into the kinder because she was so anxious about the whole thing. Then those last two weeks in the pre-kinder was like a little light switch went on and she thought 'this is easy, I can cope with this' and she had made that decision that this is how it was going to be, and she has just kept going. She just rolls with whatever happens and we have used her as a role model in some areas for some of the other kids in helping them learn how to behave in the classroom, and how to treat other children. But she's not backwards in coming forwards so she'll say it as it is, and how it is. (Staff-parent, ST7SP1)*

The KMEC evaluation involved a longitudinal design to provide estimates of change over time associated with the KMEC intervention. In order to provide a comparison group against services not participating in KMEC, a pre-existing nationally representative sample was employed for three of the measures used in the evaluation. *The Longitudinal Study of Australian Children* (LSAC: AIFS, 2009) provided suitable comparison group data for the KMEC evaluation because of its focus on the early years and its collection of data from both parents and staff on three outcome measures of interest in this evaluation. The three measures used by LSAC are the *Temperament Scale* (ATP:

Prior et al., 2000), the *Student-Teacher Relationship Scale* (STRS: Pianta, 2001), and the *Strengths and Difficulties Questionnaire* (SDQ: Goodman, 2005). LSAC involved a nationally representative random sample of children tracked at the ages of 0-1 year in 2004, 2-3 years in 2006, and 4-5 years in 2008. Only the children that were in long day care or preschool were selected to form the non-KMEC comparison group (n=8180).

11.2 Child-staff relationships

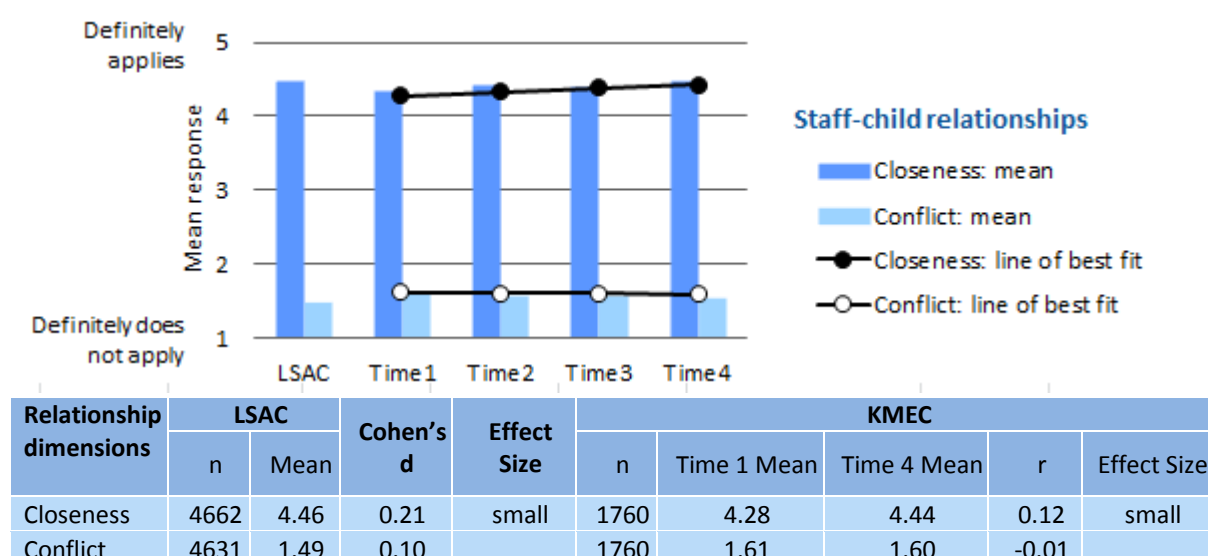In the KMEC conceptual model described in Chapter 2, children's high-quality social relationships are seen to serve a protective function that helps to develop resilience against risk factors for wellbeing. The research evidence has consistently identified the quality of the teacher-student relationship as a potential mediating factor in the behavioural trajectories of young children (e.g., Doumen et al., 2009). In this evaluation relationships between staff and children were assessed with the widely used Student–Teacher Relationship Scale (STRS). The STRS (Pianta, 2001) is a self-report measure of staff-perceived relationships with individual children. This evaluation used the conflict and closeness dimensions of the STRS to assess staff-perceived conflict and closeness with each student. Research by Doument et al. (2009) indicates that these two scales are the most robust in the STRS. The seven conflict items are designed to attain information about perceived negativity within the relationship (e.g. 'This child easily becomes angry with me'), whereas the eight closeness items ascertain the extent to which the relationship is characterised as warm, affectionate, and involving open communication (e.g. 'I share an affectionate, warm relationship with this child'). Items were staff rated on a Likert-type scale ranging from 1 'definitely does not apply' to 5 'definitely applies'. Total scores for each dimension were calculated by averaging the responses (Jerome et al., 2009). The scales potentially reflect changes in staff and in children, given that a key focus of KMEC is to improve staff-child relationships.

Figure 23 presents results of the analysis of change in scores on relationships between staff and 1760 children aged between 1 and 5 years for whom there were data on three or four occasions (M = 3.64, SD = 1.03). It suggests a practically significant increase in the closeness of relationships between staff and children of small effect size and a decline in relational conflict between staff and children which was neither statistically nor practically significant. It should also be noted that in many cases, it was not the same staff person assessing the relationship with a child on each occasion.

As a point of baseline comparison, Figure 23 also makes use of information collected in the LSAC study, which used the same items to examine staff-child relationships in non-KMEC services. On the basis of staff reports on a nationally representative sample of up to 4662 children with a similar age range (M = 3.12, SD = 1.54) to the KMEC cohort, mean responses on closeness and conflict are presented. Differences between the LSAC and Time 1 KMEC data suggest a small difference on closeness and trivial difference on conflict.

As an outcome measure, the STR Scale should be viewed as a protective factor so that the small significant change in 'closeness' as reported by staff is a positive outcome across the two-year intervention. As reported by Fowler et al. (2008), several research reports have identified the staff-child relationship as a potential mediating factor in the behavioural trajectory of young children. Importantly, the same researchers cite evidence that children who exhibit externalising behaviour problems in early elementary grades, but who maintain a positive relationship with their teachers, often experience an improved behavioural trajectory. A cautious implication of the evaluation in the context of other research would highlight the possible preventative effect of positive high quality staff–child relationships for ameliorating behavioural problems in young children. As such, consideration could be given to identifying this element as an identifying feature of the KMEC initiative and on further educating staff regarding its importance.

Figure 23. Staff ratings of their changing relationship with children on four occasions, compared to the LSAC comparison group

Relationship dimensions	LSAC		Cohen's d	Effect Size	KMEC				
	n	Mean			n	Time 1 Mean	Time 4 Mean	r	Effect Size
Closeness	4662	4.46	0.21	small	1760	4.28	4.44	0.12	small
Conflict	4631	1.49	0.10		1760	1.61	1.60	-0.01	

11.3 Child temperament

The development of protective factors early in childhood is a crucial element for subsequent adjustment to life's challenges and stresses. Child temperament is regarded in the literature as a potential risk or protective factor, according to the nature of its expression in each child (Slee, Campbell & Spears, 2012). Although temperament is regarded as relatively stable across the life span, Sanson et al. (2005) have suggested that it is not unchangeable and may be subject to some level of environmental influence. The suggestion is that small to moderate change is more usual than large change (Sanson et al., 1996). Parents of children of all ages in the KMEC trial responded to 16 items from the Short Temperament Scales for Toddlers and Children (Prior et al., 2000), rating their child on questions concerned with usual patterns of behaviour regarding approach-sociability and inflexibility-reactivity that have been identified in the research as two key dimensions of temperament (Rothbart & Bates, 2006; Sanson et al., 2005). Using a scale ranging from 1 'almost never' to 6 'almost always', the Approach-Sociability scale assesses the tendency to approach new people and situations (e.g., 'This child is outgoing with adult strangers outside the home') with a low score reflecting shyness. The Inflexibility-Reactivity scale assesses the readiness with which a child reacts to a particular stimulus and the ability to deal with frustration (e.g., 'This child responds to frustration intensely', 'If this child is upset, it is hard to comfort him/her'), with a high score being very reactive and inflexible. Total scores for each dimension were calculated by reversing the negatively worded items and averaging the responses.

Figure 24 presents the results of the analysis of temperament scores of 385 children aged between 3 and 5 years (M = 4.08, SD = 0.77) involved in the KMEC evaluation at Time 1, and tracked across the two-year evaluation. Figure 24 also makes use of information collected in the LSAC study, which used the same temperament items as used in this KMEC evaluation to examine children in the LSAC community-based cohort sample attending an early childhood service for 10 or more hours per week. On the basis of parent reports on the LSAC nationally representative sample of 5097 children with a similar age range (M = 3.90, SD = 0.99) to the KMEC cohort, mean responses for each scale are presented. Analysis of differences between the LSAC and Time 1 KMEC data suggested no significant differences between means on the scales of Approach and Inflexibility (Cohen, 1988). Focussing on change in children over time, Figure 24 suggests a significant improvement in the approachability and sociability of children, rated as a small effect size, and a reduction in inflexibility and reactivity, also rated as a small effect size.

Figure 24. Parent ratings of child temperament on four occasions, compared to a non-KMEC baseline

Temperament	LSAC		Cohen's	Effect	KMEC				
	n	Mean	d	Size	n	Time 1 Mean	Time 4 Mean	r	Effect Size
Approach	5097	3.9	0.14	-	385	3.71	3.88	0.11	small
Inflexibility	5097	2.78	0.03	-	385	2.79	2.63	-0.12	small
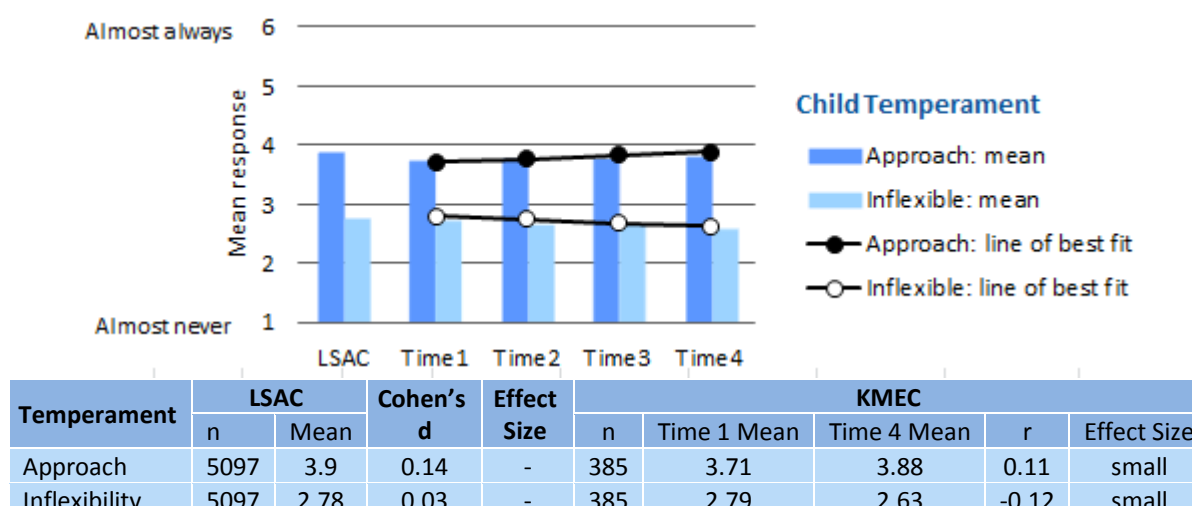
The effect of age on temperament scores was not found to be statistically significant, which supports findings from the literature that suggests temperament is trait-related and has stability over time. For example, Sanson et al. (2009) found, in their analysis of longitudinal data from the Australian Temperament project, that identifiable temperamental types (inhibition, reactivity, self-regulation) in early childhood were associated with specific outcomes in later childhood, particularly with respect to capacities for self-regulation. However, as argued by Smart and Sanson (2005), temperamental traits may not be immutable, but could be receptive to environmental experiences. This suggests that there appear to be some opportunities to influence temperament, through interventions such as the social and emotional skills education included in KMEC.

Smart and Sanson (2005, p.56), in referring to 'reactivity' (the tendency to respond intensely to frustration or control emotions) noted that

> This characteristic clearly puts a child at some risk for the development of behaviour problems such as aggression and hyperactivity, which can become ingrained…. and it can impede the development of pro-social attributes, which are the foundation for social competence.

The finding in the present study, that there was a small but practically significant decline in 'reactivity' over the KMEC intervention, can be interpreted as being consistent with the view that some small modifications in temperament are possible. Interestingly, there is a very similar effect size for an increase in 'sociability' over the course of the intervention. Although the effect of age was non-significant, given the complex nature of the construct of temperament and its measurement, the findings here need to be interpreted with caution and should be the subject of further investigation. However, the fact that change is associated with the view that some small modifications are possible in temperament, highlights its role as a potential protective factor. In considering the outcome from the current evaluation, one could be mindful of Smart and Sanson's (2005, p.56) conclusion from their research involving an examination of LSAC and ATP data bases, that "…these findings confirm that children's temperament style 'matters' for their development and wellbeing." Consideration could be given to further educating staff in this regard.

11.4 Children's mental health strengths and difficulties

According to data from Australian Health 2010, 9% of Australian children have long-term mental health problems and the figure is even higher in severely disadvantaged children. How do mental health issues impact on early childhood services? … If children with mental health difficulties are identified early, and their condition managed, they are less likely to have poor mental health outcomes as adults. (ARACY, 2012)

As noted in Chapter 2, there is no doubt that early childhood is characterised by rapid developmental change, and in the analysis of changes in mental health scores this effect of transience is of particular relevance. In this evaluation of change across time in SDQ scores serious consideration has been given to the transience of behaviour in the early years. Any analysis of change in behaviour also needs to acknowledge that for a small proportion of young children there is considerable long-term persistence for both internalising and externalising behaviour. Furthermore, the challenge of accurately diagnosing 'normative misbehaviour' from clinically significant mental health problems complicates the attribution of any change from an intervention to the impact of the intervention itself. These influences need to be kept in mind in interpreting the changes in SDQ scores for the children in the KMEC pilot.

Notwithstanding these provisos and the broader social determinants of change, it could be argued that the following findings highlight the extent of the positive impact possible, of a well implemented whole-of-service initiative on the mental health and wellbeing of a small group of highly vulnerable young children.

For this KMEC evaluation, Goodman's *Strengths and Difficulties Questionnaire (SDQ)* (2005) for children 3-4 years old (UK Version) was selected as the main outcome assessment of child mental health. Its chief purpose is to examine what impact KMEC had on child mental health outcomes with respect to the initiative's key aims of improving mental health and wellbeing of children and reducing child mental health difficulties.

The SDQ was completed by staff and parents on four occasions to give a rating of each child's mental health strengths and difficulties in terms of 25 attributes, some positive and others negative. These 25 items are divided between five scales: hyperactivity, conduct problems, emotional symptoms, peer problems and prosocial skills. This slightly modified version for 3-4 year old children retains 22 items that are identical to the version for children 4-10 years old. The item on reflective behaviour is 'softened', and items on oppositional behaviour replace two items on antisocial behaviour. A total SDQ difficulties score of 40 was calculated by adding responses to items in the subscales of hyperactivity, emotional symptoms, peer problems and conduct problems. Goodman's (2005) recommended cut-points were applied to the parent and staff responses to categorise students into normal range, borderline range, and abnormal range (Goodman's terminology).

11.4.1 A baseline comparison

An initial step in investigating the impact of KMEC on children's mental health was to compare staff rated mental health outcomes for children involved in the evaluation, with comparable staff ratings for a similar group of children not involved in the KMEC initiative. Among many instruments used in the LSAC project, the *Strengths and Difficulties Questionnaire* (SDQ: Goodman, 2005) was one, and afforded the opportunity to provide a baseline assessment of child outcomes that the KMEC cohort could be compared against. Accordingly, a sample of 1368 children drawn from the KMEC database at Time 1 was matched to 1368 children drawn from the LSAC database on gender, time in care, and age. The resulting cohorts of children contained 51% male children, of similar age (KMEC *M* = 4.80, *SD* = 0.34; LSAC *M*=4.80, *SD*=0.24), who had spent similar time in care (KMEC *M* = 20.35 hours, *SD* = 10.66; LSAC *M* = 21.30 hours, *SD* = 10.57). Table 28 presents a side-by-side comparison of the LSAC children in 2008, acting as a comparison group

for a statistically similar cohort of children at Time 1 in the KMEC Evaluation. In both datasets, children are identified into normal, borderline, or abnormal ranges of mental health according to staff cut-points, as defined by Goodman (2005).

Table 28. Matched sample of children aged 4-5 years in the KMEC and LSAC databases

Strengths and Difficulties		LSAC (2008)			KMEC Time 1 (2010)			Cohen's d	Effect size
		n	%	mean	n	%	mean		
Staff	Normal range	1151	84%	4.08	1121	82%	4.08	0.001	-
	Borderline range	127	9%	13.26	128	9%	13.17	0.08	-
	Abnormal range	90	7%	19.91	119	9%	20.58	-0.17	-

In terms of mean responses in the SDQ normal, borderline and abnormal ranges, there were similar staff-rated outcomes for children in the LSAC results and in the KMEC Time 1 results. Tests for differences between the LSAC and KMEC means yielded only trivial differences. On the basis of initial staff ratings of children in the KMEC cohort, 82% of children were in the SDQ normal range, compared to 84% of children in the normal range in the LSAC cohort. Nine per cent were in the borderline range, and 9% in the abnormal range of mental health difficulties. These proportions for staff ratings of children in the KMEC cohort are similar to the relative proportions of 80:10:10 reported by Goodman (2005).

11.4.2 Change in mental health scores across the whole cohort

While the LSAC project collected SDQ results from parents and staff of children aged 4-5 years of age, our evaluation involved all children enrolled in services aged 1-5 years. However, in keeping with the age specification of the SDQ, in the following section we have only included reports on children with an average age of between 3-5 years over the four data collection occasions (M = 4.01, SD = 0.76).

Given the lack of research concerning the age-related suitability of the 3-4 year old version of the SDQ, the age of the children must be taken into consideration in any analyses. An analysis of changes in SDQ scores in relevant samples of young children who had not participated in any intervention were examined. The SDQ longitudinal profiles of children in the LSAC 4-5 year old sample and the Millenium Cohort Study and Avon longitudinal samples in the UK were examined. These analyses showed a pattern of decrease in SDQ scores across early childhood that paralled the pattern of change that was present in the subgroup of the KMEC sample used in this analysis. Our initial tests using multilevel analysis indicated that the direct influence of age on children's SDQ was significant in most cases. Therefore, an age correction was applied to the final analysis, yielding estimates that are more accurate and conservative. This age correction accounts for the higher SDQ scores (greater level of difficulties) that are typically given to younger children reflecting age-appropriate developmental behaviours, rather than reflecting mental health difficulties. By applying the age correction in the multilevel analyses, we seek to scale changes over time associated with the KMEC initiative, compared to developmental changes due to ageing during the period of the evaluation. Further details about the age correction are provided in the *KMEC Technical Report* (Dix et al., 2012).

In keeping with our reported analyses of change in staff-child relationships, rated by staff, and child temperament, rated by parents, a comparable analysis of the mental health of these same groups of children is first considered. Figure 25 presents staff and parent reports about these children tracked across the four occasions, and suggests no overall significant improvement in children's mental health when all children are included in the analysis. In other words, across the whole cohort of children, there was no change in mental health outcomes.

Figure 25. Cross sectional display of staff and parent ratings of children's mental health on four data collection occasions

Total Strengths and Difficulties	n	Time 1 Mean	Time 4 Mean	r	Effect Size
Staff rated	1423	6.1	6.0	0.01	-
Parent rated	385	7.8	7.5	0.05	-
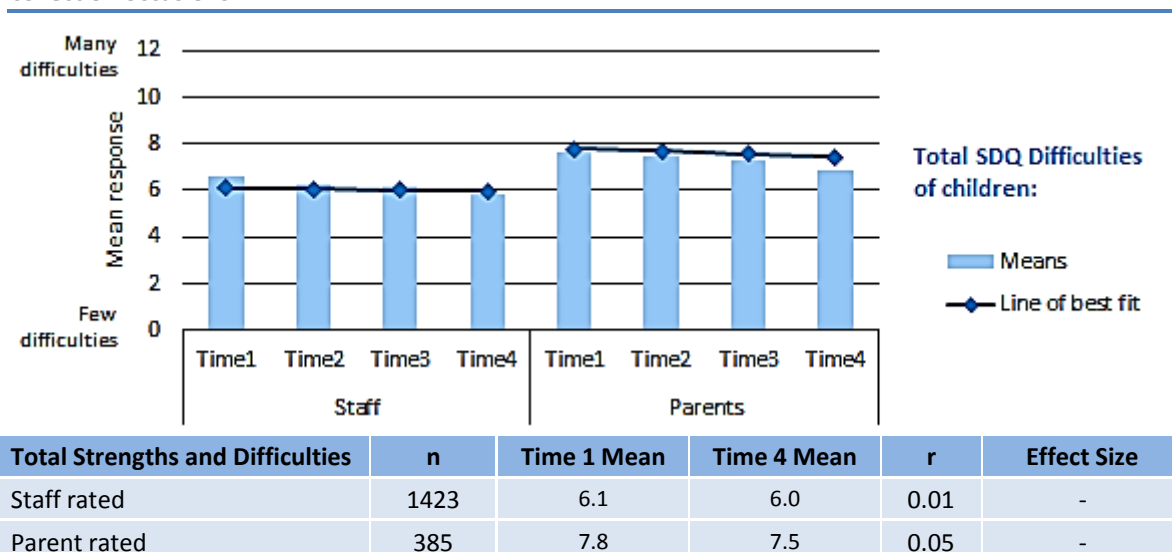
However, in an investigation in this field of mental health such a finding is to be expected. More relevant for this evaluation was an analysis of change in the SDQ profiles of children who were initially identified as having high levels of difficulties. This was done by tracking groups of children based on their initial identification into normal, borderline and abnormal ranges of mental health, and is considered next.

11.4.3 Changes in mental health scores for some children

The following sections examine how KMEC impacted on particular groups of children, with the expectation that KMEC would have lesser impact upon children within the normal range of mental health difficulties, and greater impact for children with greater difficulties, who were therefore in greater need of intervention. In short, the changes in mean scores are further examined to determine whether trajectories are different for children with existing levels of mental health difficulties, compared to children considered to be in the 'normal' range. Unlike other graphs presented in this report, only the line-of-best-fit derived from the multilevel analyses are presented in the following sections (not the bar charts of mean scores), due to the additional complexity of reporting all three ranges of normal, borderline and abnormal mental health on Total SDQ Difficulties and the five domains.

Figure 26 presents the changes over time in age-corrected SDQ scores for the children who were available on three or four data collection occasions, allocated to the SDQ normal, borderline and abnormal ranges. It shows that there was a reduction in the Total SDQ scores for children in the borderline and abnormal ranges and across the period of the evaluation, with these reductions representing medium and large effect sizes, according to staff (N = 388), and small and large effect sizes, according to parents' (N = 55) reports.

The analysis suggests that there were significant changes for children in the borderline and abnormal groups, indicating greater changes for children at risk of, or experiencing mental health difficulties associated with the period of KMEC. As represented in Table 29, across the period of KMEC, there were 2.7% fewer children, according to staff, and 3.3% fewer children, according to parents, in the borderline and abnormal ranges by Time 4. This reflects children whose SDQ scores had shifted from the abnormal and borderline ranges into the normal range.

Figure 26. Change over time in Total SDQ Difficulties for children in normal, borderline and abnormal ranges

		n	Time 1 Mean	Time 4 Mean	r	Effect Size
Staff rated	Normal range	1035	4.47	4.24	0.02	
	Borderline range	209	11.99	8.44	0.34	medium
	Abnormal range	179	19.51	12.64	0.65	large
Parents rated	Normal range	330	6.74	6.69	0.01	
	Borderline range	27	13.88	12.17	0.23	small
	Abnormal range	28	21.03	17.66	0.45	large
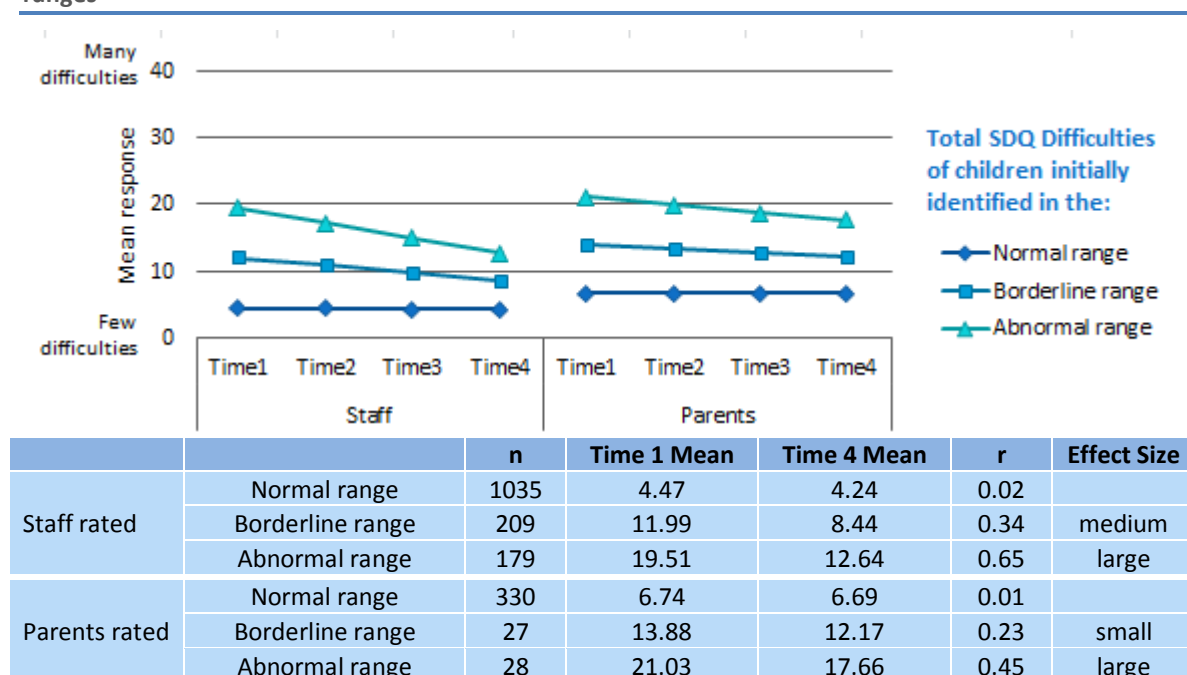
Table 29. Children's change in mental health outcomes (present on 3 or 4 occasions)

Total Strengths and Difficulties	All	Borderline or Abnormal ranges		Improvement in the borderline and abnormal SDQ score ranges for:	
	n	At Time 1	By Time 4		
Staff rated	1423	17%	14%	2.7%	Approximately 1 in 6 children
Parent rated	385	13%	9%	3.3%	Approximately 1 in 4 children

On average, this 3% increase in the proportion of children in the normal range of mental health as defined by the SDQ, represents an improvement for 1 in 30 of all children included in this study, or an improvement for 1 in 6 children in this study who had been identified as having mental health difficulties at Time 1.

In understanding this finding it is important to appreciate the small numbers of children involved. It is also important to note that these children were more likely to come from the High Implementing services, potentially optimising any impact of KMEC on staff, families and, in turn, children. These details should be kept in mind when reading the findings regarding emotional symptoms, conduct problems, hyperactivity, peer problems and prosocial behaviour, detailed in the remainder of this chapter.

11.4.4 Changes in emotional symptoms

Staff and parents responded to items about each child like, *has many worries or often seems worried*, *is often unhappy, depressed or tearful*, *has many fears, easily scared*, and *is nervous in new situations*. Figure 27 suggests that there were changes over time in ratings on the emotional symptoms scale for children initially rated at Time 1 by staff and parents in the ranges of borderline and abnormal. While there was no change over time reported for children in the normal range, those exhibiting emotional symptoms in the borderline range showed a decline in the severity of symptoms, equivalent to a small effect size. For children in the abnormal range, emotional symptoms were reduced to an extent equivalent to a medium-large effect size.

Figure 27. Change over time in staff and parent ratings about children's emotional symptoms

		n	Time 1 Mean	Time 4 Mean	r	Effect Size
Staff	Normal range	1035	1.01	0.93	0.02	
	Borderline range	209	2.18	1.45	0.20	small
	Abnormal range	179	3.35	1.96	0.38	large
Parents	Normal range	330	1.98	1.79	0.07	
	Borderline range	27	3.45	2.94	0.18	small
	Abnormal range	28	4.93	4.09	0.30	medium
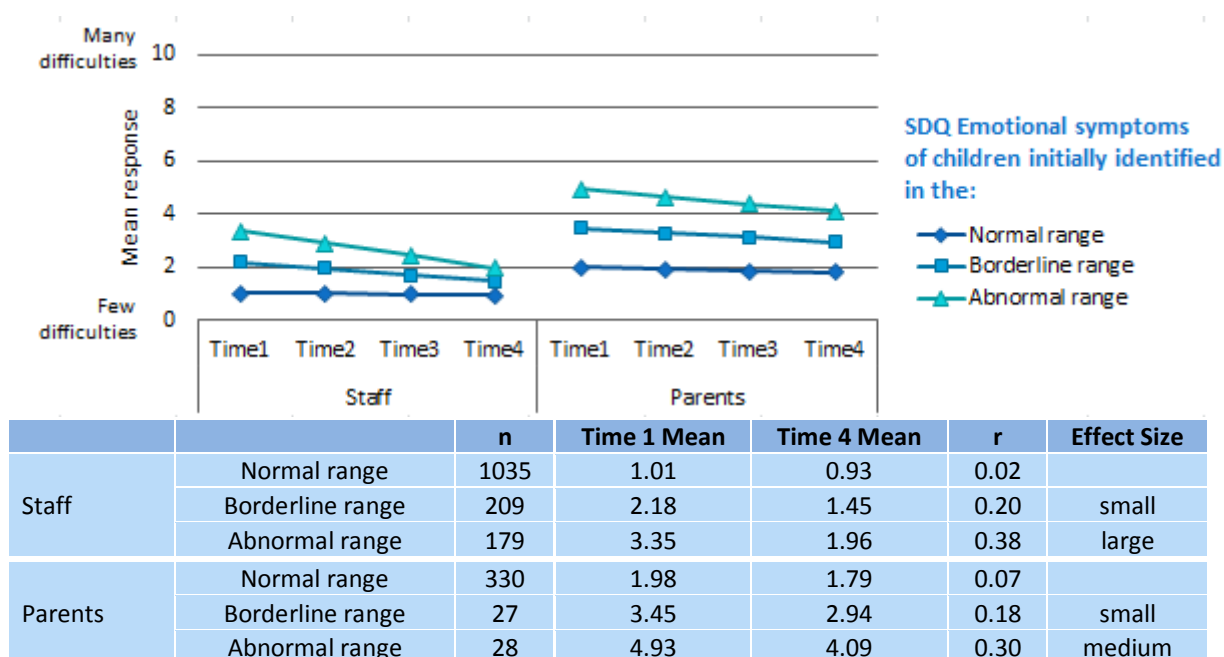
11.4.5 Changes in conduct problems

Staff and parents assessed a range of behaviours such as, *often has temper tantrums*, *often fights with other children,* and *can be spiteful to others*. Figure 28 presents the results of the analysis of changes over time in ratings of conduct problems in children initially rated at Time 1 by staff and parents in the ranges of normal, borderline and abnormal. There was no change over time for children in the normal range. Children exhibiting conduct problems in the borderline range showed a decline in the severity of symptoms equivalent to a medium effect size according to staff, and to a small effect according to parents. For children in the abnormal range, conduct problems were reduced to an extent equivalent to large and medium effect sizes, according to staff and parent ratings respectively.

Figure 28. Change over time in staff and parent ratings about children's conduct problems

		n	Time 1 Mean	Time 4 Mean	r	Effect Size
Staff	Normal range	1035	1.51	1.31	0.06	
	Borderline range	209	3.65	2.47	0.32	medium
	Abnormal range	179	5.79	3.63	0.59	large
Parents	Normal range	321	330	1.66	0.00	
	Borderline range	26	27	3.16	0.15	small
	Abnormal range	27	28	4.66	0.30	medium

11.4.6 Changes in hyperactive behaviour

Children considered by parents and staff to have hyperactive behaviour tended not to *think things out before acting*, had *poor attention spans*, were *restless, overactive,* or *constantly fidgeting,* or were *easily distracted.* Figure 29 presents the results of the analysis of changes over time in ratings of children's hyperactivity at Time 1 by staff and parents in the ranges of normal, borderline and abnormal. There was no change in levels of hyperactivity for children in the normal range. Children exhibiting hyperactivity in the borderline range showed a decline in the severity of symptoms, equivalent to a small-medium effect size. For children in the abnormal range, hyperactivity was reduced to an extent equivalent to a medium-large effect size.
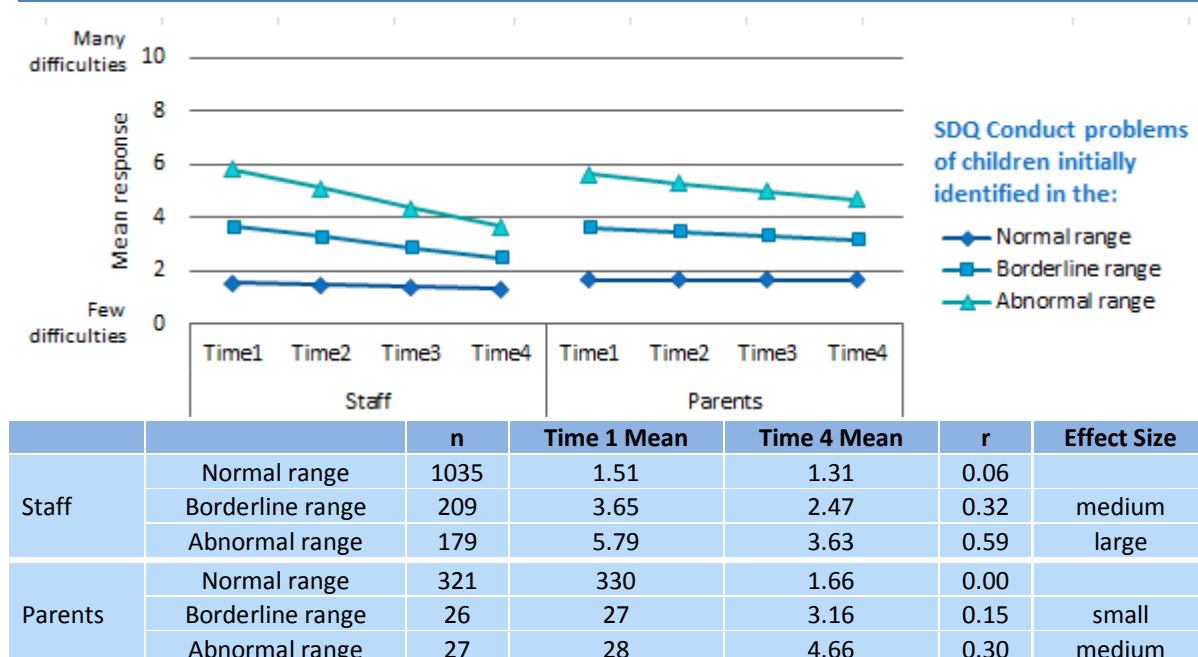
Figure 29. Change over time in staff and parent ratings about children's hyperactive behaviour

		n	Time 1 Mean	Time 4 Mean	r	Effect Size
Staff	Normal range	1035	1.53	1.54	0.00	
	Borderline range	209	4.35	3.22	0.24	medium
	Abnormal range	179	7.16	4.91	0.49	large
Parents	Normal range	330	2.08	2.18	0.03	
	Borderline range	27	4.39	3.90	0.15	small
	Abnormal range	28	6.71	5.62	0.33	medium
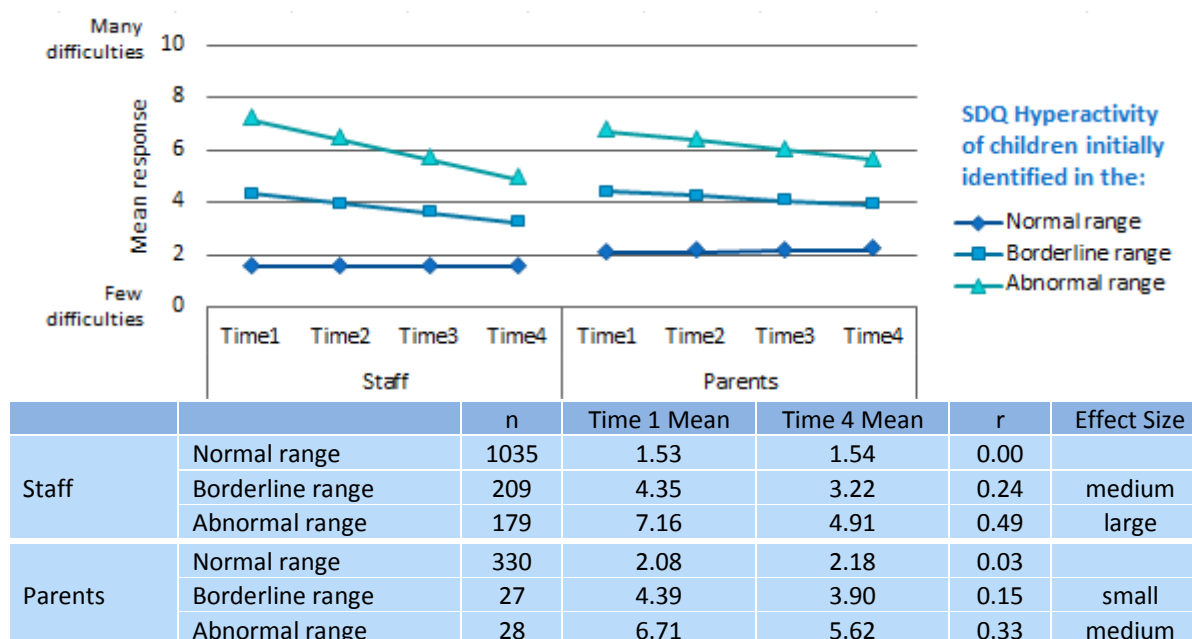
11.4.7 Changes in peer problems

Staff and parents assessed children's peer problems. Such problems are indicated when children are *generally not liked*, they *prefer to be alone*, or *are picked on or bullied*. Figure 30 presents the results of the analysis of changes over time in peer problems for children initially rated at Time 1 by parents and staff in the ranges of normal, borderline and abnormal. There was no change in peer problems for children in the normal range. Children exhibiting peer problems in the borderline range showed a decline in severity equivalent to a small effect size, according to both parent and staff ratings. For children in the abnormal range, peer problems were reduced to an extent equivalent to a medium-large effect size according to parent and staff ratings.

11.4.8 Changes in prosocial behaviour

Children who do not exhibit positive social behaviour are less likely to be *considerate of other people's feelings*, or *share with others*, are less *helpful if someone is hurt or upset*, or are less *kind to younger children*. Figure 31 presents the results of the analysis of changes over time in prosocial behaviour for children initially rated at Time 1 by parents and staff in the ranges of normal, borderline and abnormal. Although the prosocial dimension is not included in the overall calculation of the total SDQ Difficulties score, this dimension affords the opportunity to investigate the improved mental health and wellbeing of children. Changes in children's scores associated with the KMEC intervention provided a measure of improved wellbeing. There was no change in prosocial behaviours for children in the normal range. Children exhibiting prosocial

behaviours in the borderline and abnormal range showed improvements equivalent to small and medium effect sizes, respectively, according to staff ratings, but not according to parent ratings.

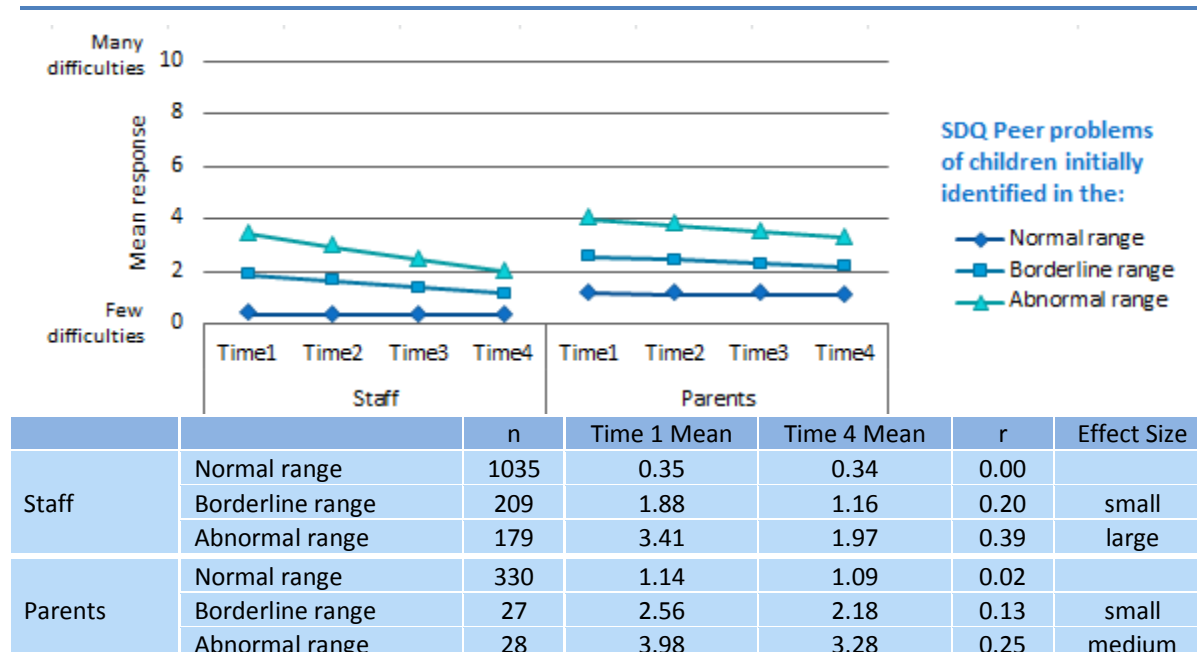**Figure 30. Change over time in staff and parent ratings about children's peer problems**

		n	Time 1 Mean	Time 4 Mean	r	Effect Size
Staff	Normal range	1035	0.35	0.34	0.00	
	Borderline range	209	1.88	1.16	0.20	small
	Abnormal range	179	3.41	1.97	0.39	large
Parents	Normal range	330	1.14	1.09	0.02	
	Borderline range	27	2.56	2.18	0.13	small
	Abnormal range	28	3.98	3.28	0.25	medium

Figure 31. Change over time in staff and parent ratings about children's prosocial behaviour

		n	Time 1 Mean	Time 4 Mean	r	Effect Size
Staff	Normal range	998	8.46	8.69	0.05	
	Borderline range	201	6.51	7.45	0.19	small
	Abnormal range	171	4.55	6.21	0.34	medium
Parents	Normal range	321	8.91	8.76	0.05	
	Borderline range	26	7.98	7.80	0.06	
	Abnormal range	27	7.05	6.84	0.07	
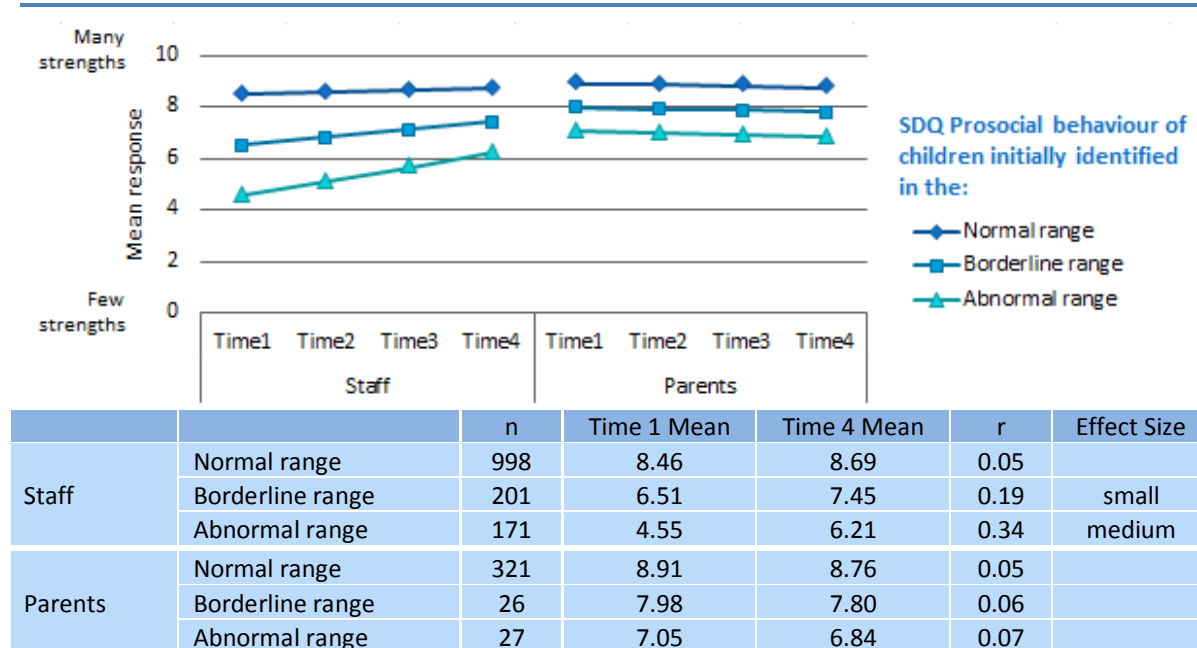
Participants in the photo study provided comments that illustrated changes witnessed by them in the social and emotional development of the children in their care. One educator explained staff's influence in bringing about these changes:

> The children's relationship where they feel like they belong and they feel comfortable because we've developed those sorts of close connections with them, then they reach out and start forming those close connections with each other. (Staff, ST4S1)

> *We just look at them today and go "wow what a difference". You're quite concerned about someone who's very drawn into themselves. There's two boys in the other group as well and you know they wouldn't look sideways at someone and now you wouldn't be able to pick them out. I mean before, if you come in at the beginning of the year, you would have said "they look like lonely little people" but not anymore. (Staff, ST5S2)*

11.5 Chapter summary

The central purpose of KMEC is to improve young children's mental health and wellbeing and to reduce mental health difficulties. While historically, the investigation of very young children's social and emotional health has only just begun to receive the attention it requires, it is now better understood that the rate of moderate to severe social-emotional difficulties is as high as that for older children. Moreover, such difficulties appear to be relatively stable over time, highlighting the significance of the early identification and intervention with such children (Brinkman et al., 2007). In the KMEC conceptual model described in Chapter 2, children's high-quality social relationships are seen to serve a protective function that helps to promote resilience against childhood risk factors.

In this evaluation, relationships between staff and children were assessed with the widely used Student–Teacher Relationship Scale (STRS). This evaluation uses the conflict and closeness dimensions of the STRS to assess staff-perceived conflict and closeness with each child. Improvements occurred in staff reports of warmth and closeness and there was a reduction in conflict in the course of the evaluation.

Furthermore, child temperament is conceived as part of the KMEC conceptual model and the development of protective factors early in childhood as a crucial element for subsequent adjustment to life's challenges and stresses. Child temperament is regarded in the literature as a child protective factor. In the course of the evaluation, parents report a reduction in children's 'reactivity' and an increase in their 'approachability' equivalent to a small effect size.

The findings show that, according to parents and staff, there were improvements (i.e., reductions) in mental health difficulties (Total SDQ scores) for children in the abnormal range, equivalent to a large effect size, during the course of the evaluation.

The mental health outcomes of the young children in this KMEC evaluation, as reported here, present themselves at an important moment in the scientific debate. The capacity to make timely and early interventions with young children, presents a challenge, recognising the associated risks of undue 'pathologising' of what, for some, are normative and transient changes in social and emotional competencies. It is a challenge to which we must rise if we are to protect the youngest and most vulnerable members in our community.

Chapter 12
Conclusions and Recommendations

As a staff team and as a member of the kindy [sic] community, this journey has been about growth. In the beginning I felt unsure of where we were heading with KidsMatter. Now I can see the impact and benefits it has had in many areas.

Growth – in myself, confidence and the knowledge to identify and help and support children and families experiencing mental health difficulties.

Growth – in our staff team. Our communication and support for each other has improved a lot.

Growth – in our relationships with families. When and how we speak to them, support them and enjoy in sharing stories about their child and their family. (Staff)

12.1 Conclusions

Security, comfort, belonging and a space of calm, shared communication. This is what KidsMatter has meant to me. Thank you KidsMatter for leaving me with the understanding of the importance of creating caring communities and a safe harbour for our children. (Staff, ST4S5)

The KidsMatter Early Childhood initiative provides a continuous improvement framework to enable preschool and long day care services to plan and implement evidence-based mental health promotion, prevention and early intervention strategies. KMEC uses a risk and protective framework to focus on four areas where early childhood services can strengthen the protective factors for children's mental health and minimise the risk factors. Risk and protective factors may be identified in relation to individual skills, needs and temperament; familial circumstances and relationships; early childhood settings; specific life events; and the social environment.

Underpinning the evaluation reported here is the significant consideration given to the implementation of the initiative. Domitrovich et al. (2008, p.64) argued that in program evaluation it was important to develop information about, "discrepancy between what is planned and what is actually delivered when an intervention is conducted." A key feature of this evaluation was to address these concerns by developing a robust measure of implementation quality to account for the likelihood that not all services would implement KMEC to the same level of quality. By doing so, it strengthened our ability to attribute significant changes in services over the four occasions to the impact of the KMEC initiative. The development and use of an Implementation Index enabled the identification of just over half of the participating services as high on implementation with regard to fidelity, dosage and quality. The evaluation study examined a range of factors that may be considered to impact on implementation, such as socio-economic background, but the only significant factor that was identified as associated with poorer implementation was having a higher proportion of single-parent families at a services. More research is needed to better understand why this factor would have such an impact on implementation. Factors facilitating implementation included having an enthusiastic and engaged Facilitator supporting the services along with having staff who were motivated and engaged with the initiative.

Overall, the outcomes of the KMEC trial are consistent with an emerging body of national and international research pointing to the positive effects of social and emotional programs on children's mental health and wellbeing. A key element in the delivery of the KMEC pilot is the professional learning which acknowledges and confirms existing good practices, provides opportunities for raising staff awareness and building knowledge of children's mental health strengths and difficulties, reduces stigma, and provided staff with a common language to promote communication about mental health and wellbeing. Particular note is made of the acclaim given to the Facilitators in the delivery of the professional learning by service staff. It is noted that further work is needed to better understand the long-term impact of professional learning on staff knowledge, attitudes and behaviour.

However, although there is evidence from the evaluation of the successful implementation of KMEC and of associated positive changes, it is noted that the observed impacts varied in size and are not evident in all aspects of KMEC. Furthermore, evidence of potential limitations and of possibilities for increasing the effectiveness of KMEC also emerged including:

- the challenges posed by changes in leadership and staff in successfully implementing the initiative;
- the importance of motivating and engaging staff around the significance of young children's mental health in the face of the competing demands of the industry undergoing significant reform and change; and
- the challenge posed by Component 3 in successfully engaging with staff and carers.

Finally, the sustainability of KMEC is a significant issue and in this regard the maintenance of the support and resources is necessary to ensure that KMEC continues to be sustainable and effective.

12.2 Major Recommendation

1. Taking account of the evaluation findings and subject to the recommendations below, the main recommendation is that the ***broad framework, processes and material and human resources associated with the KMEC trial be maintained as the basis for a sustainable national roll-out of the KMEC initiative***.

This recommendation is based on the view that the findings of the evaluation indicate that the KMEC initiative can provide positive support for services as they work to assist young children who may be at risk of or experiencing mental health difficulties and to support their families.

This further highlights the overall significance of this developmental period in young children's lives, and the need to continue the KMEC initiative, which recognises, understands, and intervenes to assist young children who may be at risk of or experiencing mental health difficulties and to support their families.

12.3 Recommendations related to the KMEC Model

2. ***Planning for quality assurance***: A significant feature of the current evaluation involved the development and application of an index to assess the quality of the implementation process. The findings document the influence of quality of implementation on the effectiveness of key elements of this trial of the KMEC initiative. It is recommended that support for high quality implementation, and systematic monitoring of the quality of implementation, be included in all future enactments of the initiative.

3. ***Planning for monitoring***: It is recommended that the impact of any future roll-out be carefully monitored to assess its effect in relation to the objectives of the KMEC initiative. Consideration should be given to the design of instruments that can be embedded in a national roll-out that will facilitate this ongoing monitoring of effect.

4. ***Supporting Leadership***: Findings based on both implementation quality data and Facilitator reports point to the importance of leadership for the effectiveness of this trial of the KMEC initiative. It is recommended that attention be given to providing explicit support for service leaders in future revision of KMEC content.

5. ***Early Childhood education and care professional learning***: KMEC should consider advocating for training institutions to provide appropriate levels of experience in use of educational materials related to children's social-emotional skills and mental health for early childhood education and care educators.

6. ***Child risk and protective factors***: In recognising the importance of high quality staff-children relationships and child temperament as protective factors, the recommendations are to give strong consideration to identifying these elements as core features of the KMEC initiative, and on further educating staff regarding their importance.

12.4 Recommendations about specific elements of KMEC

Information generated during the evaluation included a range of specific suggestions for improving the efficacy of KMEC. These are included here for consideration in further development of KMEC processes and content.

7. Maintain the preferred face-to-face, active engagement, professional learning led by expert facilitators.

8. Address the diversity of educators' learning needs through professional learning curriculum designed to cater for both more and less experienced, and more and less qualified participants who work in a range of contexts.

9. Sustain professional learning opportunities to support, in particular, services that have more difficulties achieving high implementation, but who nevertheless would have the potential to achieve growth given a longer time period of professional learning opportunities.

10. Consider processes for managing professional learning in conjunction with staff turnover such as providing ongoing, facilitated professional learning conducted as 'start-up' and 'refresher' sessions.

11. Consider additional KMEC professional learning resources and materials to support educators working with children with complex and diverse needs (such children with special learning needs, children in state care).

12. Ensure text and visual materials represent the social and cultural backgrounds of children, families, and educators in services.

13. Continue professional learning with attention to quality of delivery, dosage and fidelity, but with particular attention to the needs of staff around time availability.

14. Build professional learning into the working day of educators.

15. Consider the impact of the differential availability within the sector of funding to support staff attendance at professional learning sessions.

16. Consider how Component 1 can be broadened to extend community networks and links with outside resources and to enable parents to develop a stronger sense of having a 'voice' as part of this community.

17. Facilitate the provision of up-to-date information for staff on social-emotional learning, staff-child relationships, temperament and mental health.

18. Consider ways to strengthen the work of services with parents regarding the availability of community resources and the significance of children's mental health in terms of their overall development.

19. Strengthen Component 4 particularly in terms of helping services to develop policies and referral procedures that will build more effective links with external support agencies.

Glossary

The four KidsMatter components

Component 1: Creating a sense of community
- Belonging and connectedness: The early childhood service is welcoming, friendly and supportive of children, families and staff.
- Inclusion: The early childhood service addresses inclusion at a service level to help children, families and staff feel valued across all areas of diversity.
- Positive relationships: Secure, responsive, and respectful relationships are encouraged between: staff and children, children, staff and families, families, staff, and staff and other professionals
- Collaboration: Children, parents and carers, and staff work together and have opportunities to be involved in planning, decision-making and contributing to a range of experiences in the service

Component 2: Developing social & emotional skills
- Relationships between staff and children: Warm, secure, responsive and trusting relationships between staff and children provide a foundation that allows children to learn and develop social and emotional skills.
- Children's social and emotional skill development opportunities: The service provides opportunities for children to develop and practise social and emotional skills in their daily interactions with staff and peers.
- Staff development and support: Staff knowledge, skills and capacity to foster children's developing social and emotional skills are enhanced at the service.

Component 3: Working with parents and carers
- Partnerships with parents and carers: Staff have the skills, confidence and commitment to form collaborative working relationships with parents and carers.
- Provision of parenting information and education: Effective information is provided to parents and carers on parenting practices, child development and children's mental health; Parents and carers are supported to access parenting education programs; Early childhood staff model effective interaction with children for parents and carers.
- Opportunities for families to develop support networks: Opportunities are provided for parents and carers to get together in a supportive environment; Community resources to support parents and carers are identified and promoted to them.

Component 4: Helping children who are experiencing mental health difficulties
- Early identification of children experiencing early signs of mental health difficulties: Early childhood services can really make a difference to children's lives by understanding and recognising early signs of mental health difficulties.
- Attitudes towards mental health difficulties: Providing an environment that is supportive and accepting of mental health issues helps to reduce stigma and promote help seeking for children who may be experiencing early signs of mental health difficulties.
- Policies and procedures for addressing the needs of children experiencing mental health difficulties: Having policies and processes in place helps to ensure children receive appropriate support as soon as possible.

Descriptions of scales

KMEC implementation	Used to measure general implementation of KM. Staff ratings of the KMEC plan-do-review implementation process. It provides an indication of fidelity – that KMEC is being implemented as intended.
KMEC site engagement	Used to measure general engagement with KMEC. Designed to gauge staff perceptions of the general engagement of their Service with KMEC as a measure of KMEC's extent and suitability for long day care and preschool services. It focuses on the KMEC model, in terms of the four components, implementation process, professional learning, resources, and involvement of leadership and staff in KMEC.
KMEC professional learning	Staff ratings of the impact of the KMEC professional learning on staff knowledge and actions. It broadly addresses staff perceptions regarding the professional learning aspect of the KMEC model.

Component 1: Creating a sense of community	Parents and staff rate how they feel about how effective the service is at creating a sense of community. It also provides a measure of parent engagement with the service and staff ability to support the development of a sense of community at the site.
Component 2: Developing social and emotional skills	Gauges staff and parent views of how effective they are at assisting children to develop social and emotional skills.
Component 3: Working with parents and carers	Parent and staff views of how effective the service is at working with parents and carers in terms of providing parenting information and education and opportunities for families to develop support networks.
Component 4: Early intervention	Staff and parent ratings of how effective the service is at supporting children who are experiencing mental health difficulties with regard to early identification, improving attitudes towards mental health, and developing referral procedures.
Staff knowledge	Staff knowledge in supporting the development of children's social and emotional skills, detecting and responding to children experiencing mental health difficulties, and accessing pathways for children experiencing difficulties, including local service providers.
Staff self-efficacy	Staff ratings of their self-efficacy to foster a sense of belonging in others, provide effective support to parents, and identify early signs of social and emotional difficulties in children.
KMEC impact on staff	Staff ratings of job satisfaction and morale as a measure of the impact of KMEC on staff.
KMEC impact on parent learning	Perceived impact of KMEC on family processes in terms of parents supporting their child's social and emotional learning and development, increasing their knowledge about child mental health, and accessing information, programs and support services.
Parental self-efficacy	Parental self-efficacy (confidence and competence) helps their child develop socially and emotionally. This protective factor focuses on parents' self-efficacy for developing mental health capacities in children through their improvement in parenting.
KMEC impact on parent involvement with services	Parent views of the impact of KMEC on their involvement with the service by developing support networks and attending more service activities.
KMEC impact on the service's ability to address child's SE needs	Gauge staff and parent ratings of the impact that KMEC has on achieving greater support and meeting the needs of children with social and emotional difficulties.
Child temperament	Parent rating of their child's behaviour with regard to approach-sociability, persistence, and reactivity- inflexibility, as defined by Prior et al. (2000).
Child-staff relationship	Aspects of staff practices, focusing on the relationship of child with service carer in terms of warmth, open communication, and conflict, as defined by Pianta (2001). The scales potentially reflect changes in staff and in children, given that a key focus of KMEC is to improve staff relationships.
Child mental health strengths and difficulties	Parent and staff views of a child's mental health difficulties in terms of hyperactivity, conduct problems, emotional symptoms and peer problems, as defined by Goodman (2005). This is a measure of child mental health outcomes.

Related publications and presentations

The evaluation team, many of whom were involved in the evaluation of KidsMatter Primary, have produced a range of reports, presentations and papers on aspects of both evaluations over the last six years. All publications have been carried out in consultation with the KidsMatter Primary or KidsMatter Early Childhood project partners.

Askell-Williams, Dix, K.L., Lawson, M.J. & Slee, P.T. (in press) Evaluating the quality of processes of implementation of a primary school mental health initiative. *School Effectiveness and School Improvement.*

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Askell-Williams, H., Lawson, M.J. & Slee, P.T. (2009). Venturing into schools: Locating mental health initiatives in complex environments. *International Journal of Emotional Education* 1(2) 7-14.

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