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PRIMARY PROJECT: A PLAY-BASED INTERVENTION FOR EARLY CHILDHOOD

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Primary Project, formerly known as the Primary Mental Health Project, began in 1957 and continues decades later as a program based on the theoretical underpinnings of child-centered play. A prevention program designed to help young children adjust to the stresses of the school environment, Primary Project is in more than 2,000 elementary schools today and continues to grow nationally and internationally. With academic demands increasing and time for play decreasing, most classrooms provide limited play for young children (Miller & Almon, 2009). Concurrently, the number of children with mental, emotional, and behavioral health needs continues to grow at an alarming rate. According to the National Research Council and Institute of Medicine (2009), an emotional, behavioral, or mental health diagnosis is as commonplace for a child as a fractured limb—not inevitable, but not at all unusual.

An estimated one in five children in the United States has a diagnosable disorder requiring mental health treatment, yet less than half of those

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children receive treatment (U.S. Public Health Service, 2000). The National Center for Health Statistics reported that 4.6% of children between the ages of 4 and 17 years have severe behavioral and emotional difficulties, and 16.2% have minor difficulties (Simpson, Bloom, Cohen, & Blumberg, 2005). These findings illuminate the critical need for early identification, intervention, and prevention efforts for children before problems intensify to a level that requires a diagnosis and mental health treatment (Koller & Bertel, 2006).

Research on potential dropouts has indicated that characteristics associated with such outcomes often can be identified early. Risk factors associated with delinquency also are evident in the early grades (Wasserman et al., 2003). Current studies about the effect of adverse childhood experiences on brain development during the early years of life have continued to point to the critical importance of nurturing environments and interactions for young children (Edwards et al., 2005; Shonkoff & Levitt, 2010). When children at an early age experience nourishing and caring relationships in supportive environments, they develop competencies and resources to adjust and cope with life adversities as they grow older.

CASE EXAMPLE

Sarah is slowly disappearing into the periphery of her first-grade classroom. She is quiet by nature, but with time and encouragement, she usually adjusts to new experiences. However, with the demands of first grade, this new experience has been different. Sarah has found a way to avoid the stress of the classroom by visiting the school nurse with complaints of stomachaches and headaches. During recess, she often plays alone or within inches of adults. Mrs. Smith, Sarah's teacher, has been watching and trying to encourage her since the beginning of the academic year. She is concerned that although the natural adjustment period for most children is over, Sarah is withdrawing more and more. Her parents too are concerned about their daughter.

Mrs. Smith wonders if social and emotional concerns may be at the origin of Sarah's school adjustment difficulty. Because the academic demands of first grade will continue to increase, she worries that Sarah will be unable to maintain good academic standing much longer. In early October, Mrs. Smith met with the school psychologist to review the behavioral and social-emotional needs of her students. During that meeting, it was determined that Sarah could benefit from Primary Project, a school-based program designed to foster the social and emotional wellness of children with emerging school adjustment difficulties. Given her story and profile, Sarah is one of thousands of young students who could benefit from Primary Project.

THE THERAPEUTIC ELEMENTS OF PLAY

For young children, the natural mode of expression and communication is through their play. Therefore, play-based approaches have numerous advantages when working with them, most notably the universal, intrinsic appeal of play as a natural way to safely explore their world. Play enables children to communicate when words are unavailable, inaccessible, or not readily understood. Thus, play provides an opportunity for adults to share the child's inner world on the child's terms and at the child's pace. This approach is at the heart of Primary Project: a trusting, therapeutic relationship in which the child, through play, feels safe to express and explore feelings, deal with stressful experiences, problem solve, and master challenges.

Within the theoretical constructs of Carl Rogers's (1951) client-centered therapy theory, Axline (1969) postulated nondirective or self-directive play therapy. Central to Axline's approach is Rogers's concept that individuals are constantly striving toward personal growth, seeking to fulfill their needs, and self-actualizing. Because children's understanding of reality is the result of their experiences and perceptions of the environment, their adjustment to the environment is directly and greatly affected by the ability of that environment to meet their needs. Internal conflicts and disruptive behavior may arise as the child attempts to fulfill needs not met by the environment. Axline posited that in an optimal environment such as the playroom, the exposure to empathy, implementation of structured limits, and acceptance by the therapist reduces a child's conflict with the environment and facilitates the child's ability to express his or her feelings and to self-actualize and grow. Inherent in Primary Project is the belief that a child experiencing adjustment problems can become more socially and emotionally competent when allowed to lead the play session (Cowen, Hightower, Pedro-Carroll, Work, & Wyman, 1996).

Axline (1969) put forth eight basic principles that guide the facilitation of child-centered play therapy: (a) building a warm rapport with the child, (b) accepting the child unconditionally, (c) establishing a sense of permissiveness, (d) reflecting the child's feelings, (e) maintaining respect for the child, (f) allowing the child to lead the way, (g) not hurrying the child, and (h) establishing only necessary limits (pp. 73–74). Similar to Axline's child-centered play therapy, the Primary Project's intervention depends on warmth, acceptance, empathy, nondirectiveness, and limit setting, when needed. More specifically, the success of Primary Project's training and intervention relies on seven key practices: (a) creating a caring relationship; (b) providing a safe environment; (c) establishing the core conditions of empathy, genuineness, and unconditional positive regard (Rogers, 1957); (d) engaging the child in child-centered play; (e) providing limits in play; (f) using active listening to facilitate children's emotional growth; and (g) supporting

child associates (i.e., individuals implementing the play-based intervention) through supervisory sessions with a school mental health professional. In Primary Project, the overarching practice for helping children to become better adjusted to school rests within the child associate's ability to provide a physically and emotionally safe environment through the creation of a warm, caring relationship. The child associate does not provide therapy to the child; rather, Cowen et al. (1996) suggested that the child associates work with the naturally therapeutic elements of a warm and trusting relationship to help a children become better adjusted to the school culture.

PRIMARY PROJECT

Primary Project seeks to enhance and maximize children's school adjustment and other related competencies and to reduce social, emotional, and school adjustment difficulties in preschool through third grade. It is intended for children with emerging school adjustment problems in the mild-to-moderate range and not for children with crystallized, serious concerns. Carefully selected and trained paraprofessionals (i.e., child associates) provide timely, effective help to these children through the mediation of play. What is viewed as a simple construct, however, is one that has been evolving and refined over 55 years.

Schools are important settings for implementing preventive interventions for several reasons. An increasing number of children arrive at school each day with social and emotional needs that affect their ability to learn (Adelman & Taylor, 2006). It is estimated that 70% to 80% of mental health services received by children are provided in schools (Farmer, Burns, Phillips, Angold, & Costello, 2003). If young children do not receive effective interventions, serious consequences that affect learning, social competence, and lifelong health may continue to result (National Scientific Council on the Developing Child, 2008). Young children frequently are referred for mental health services because of difficulties adjusting to the school environment (e.g., classroom behavior, peer relationships). Although some prevention programs primarily aim at changing individual children's behavior, others aim at changing the environment (e.g., instruction strategies, classroom management plans, school climate). Targeting multiple systems by simultaneously enhancing children's competence and promoting effective behavior interactions across school and home settings was identified as a key characteristic of successful school-based prevention programs (Greenberg, Domitrovich, & Bumbarger, 2001).

Primary Project, targeted primarily to young children, uses school-based staff as primary agents of the intervention. The school mental health

professional, who supervises the program, is also part of the school structure and, therefore, has a natural consultative relationship with teachers and school administrators. For this reason, school personnel, including teachers and administrators, tend to buy in and feel a sense of “ownership” of the prevention program, which leads them to promote successful referrals to families and high participation levels.

Key Treatment Ingredients

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

1. focus on young children;
2. early screening and selection;
3. use of paraprofessionals to provide direct services to children;
4. role change of the school-based mental health professional;
5. ongoing program evaluation; and
6. integration into the school.

Focus on Young Children

Because Primary Project aims to prevent school adjustment difficulties, the delivery of services targets young children in preschool through third grade. With the explosion of research in neuroscience, attachment, early childhood education, and infant/early childhood mental health, it is clear that the earlier the positive mental and physical health of young children and their families can be supported, the better the outcome. Therefore, Primary Project focuses on children from preschool to around age 8 years, or third grade.

Early Screening and Selection

The systematic screening of all children in the target age groups facilitates the consideration of all children for participation in Primary Project. It is particularly helpful in differentiating children who can benefit most from prevention and those needing more intensive intervention. This universal screening also meets response-to-intervention (RtI) screening needs. Data-driven information assists school teams in identifying children who display behavioral and social–emotional difficulties and in guiding decisions regarding appropriate interventions and/or services.

Primary Project targets children who are beginning to show signs of early adjustment difficulties (see Figure 1.1). Although this figure appears to represent four discrete levels of adjustment, those levels are more continuous than discrete. The figure conveys the notion that most children (i.e., those in the lower section of the triangle) are adequately adjusted to school. Next,

Which Children?

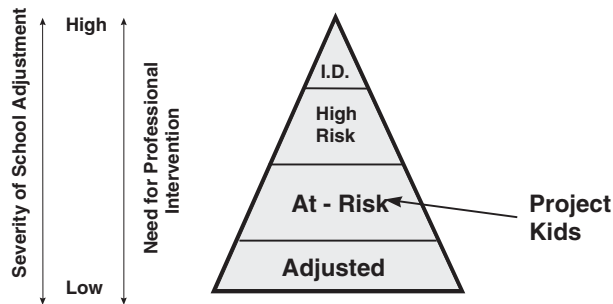


Figure 1.1. Primary Project's target population.

it depicts a group of children in whom mild-to-moderate school adjustment problems are evident. These are students like Sarah, who is beginning to show signs that affect her academic and social engagement. These are the youngsters for whom Primary Project services are most appropriate. The third group has more difficulties and is ordinarily served by school mental health professionals. The top group, by far the smallest, depicts children who already have been identified with specific diagnoses and who are—or should be—receiving help through the school's special education system or from clinical mental health professionals.

Use of Paraprofessionals to Provide Direct Services to Children

Primary Project uses carefully selected and trained paraprofessionals (i.e., child associates) to provide direct services to identified children. They work under the direct supervision of certified school mental health professionals. Schools typically seek to identify qualified adults from within the local community because those adults can often provide optimal services to children when they share a similar social, cultural, and racial background, and values and goals. However, more critical factors in the child associate selection are a willingness to enter into a child-centered relationship with young children and an understanding of the social, emotional, behavioral, and school climate needs that affect children.

Child associates are central to the effectiveness of any Primary Project program. Their ability to enter into a meaningful relationship with children is supported and strengthened through ongoing training and supervision by professionally trained mental health personnel. The supervisor becomes the

ongoing supporter and facilitator of professional development for the child associate. Initial and ongoing training prepares associates to provide developmentally appropriate, effective intervention services to children. Central to the training are child-centered play and the way in which play mediates the child–associate relationship. In addition to addressing the program’s core components, the training program covers topics, such as play and young children, communication skills, effective limit-setting strategies, and cultural and ethnic/racial differences.

The number of children a child associate sees depends on the number of hours that associate works. A part-time (15–20 hours per week) child associate can see 10 to 15 children in a week and have sufficient time for participation in training, supervision, and completion of necessary documents related to program implementation. When feasible, schools have two full-time associates who see a combined 50 to 60 children in a school year.

During a typical school year, schools provide two cycles of 12 to 15 sessions each. Although the intent is to select children who may need only one cycle, occasionally some children may need more sessions. This decision is made on an individual child basis, thus ensuring that if a child needs more intensive services by the school or community mental health system, the child is moved into that level of service and is not kept in Primary Project.

Role Change of the School-Based Mental Health Professional

The role change of the mental health professional to supervisor is another critical program component. These professionals are typically counselors, social workers, or school psychologists. This shift in role requires professionals to increase their clinical supervision, training, and oversight of the Primary Project by focusing their attention on the prevention side of services through their direct work with the child associate. As a result, they can redirect their clinical skills to work with the children who need more intensive intervention. In this way, the effect of their work is geometrically expanded to include a larger number of children.

Ongoing Program Evaluation

Ongoing program evaluation is built into Primary Project. From screening, to pre- and postmeasures, and to reports at the child, class, and school levels, evaluation and data-driven accountability are embedded into Primary Project. Because schools are increasingly relying on data and evidence-based interventions, this component is valuable. All measures and evaluation reports are easily available online, and technical assistance is available to ensure that schools not only collect data but also understand the data so that the schools may continuously improve services to children.

Integration Into the School

Primary Project is not a stand-alone program, and efforts are continuously made to ensure integration into the continuum of services available to children, including normalizing the concepts of school adjustment, and promoting healthy social and emotional wellness as effortlessly as for physical health. Schools integrate Primary Project in numerous ways: involvement at parent open houses, on website pages, in school newsletter columns, and through consideration as an intervention as part of a school's RtI model.

DESCRIPTION OF PRIMARY PROJECT INTERVENTION

Program Services Screening and Selection

The process of child selection starts with procedures to screen children from preschool to third grade to identify those who would benefit from Primary Project. Children experiencing adaptive or interpersonal problems—such as acting out; being mild aggressive, shy, anxious, or withdrawn; and having learning behaviors that interfere with educational progress in school—are typically appropriate for Primary Project. Children may be identified and referred to Primary Project via formal and informal processes, such as the use of behavior rating scales, observation, and/or referral.

The screening process begins with a collection of information 4 to 6 weeks after school starts, which allows time for children to settle into their new environment. This process often is deferred a few months so that kindergarten children may stabilize after their first school experiences. When teachers and other school personnel have some concerns about specific children, they share them at any time with the Primary Project team. Informal information is used to better understand the child's needs. In addition, classroom teachers complete a standardized screening measure, usually the Teacher–Child Rating Scale 2.1 (T–CRS; Perkins & Hightower, 2002). The T–CRS, a behavior rating scale designed specifically for teachers to assess children's school behaviors, consists of 32 items that assess four primary domains of a child's socioemotional adjustment:

1. *Task orientation*: a child's ability to focus on school related tasks.
2. *Behavior control*: a child's skill in adapting and tolerating limits imposed by the school environment or the child's own limitations.
3. *Assertiveness*: a child's interpersonal functioning and confidence in dealing with peers.
4. *Peer social skills*: A child's likeability and popularity among peers, and the child's ability to interact with peers.

The T-CRS serves as a screening measure and as a pre- and postmeasure to evaluate intervention progress. Relevant information is gathered from the T-CRS to identify children who will most likely benefit from involvement in Primary Project and areas of concern.

Selection and Assignment Conferences

Relevant screening data (T-CRS, observation, and teacher report) are reviewed during assignment conferences, which usually start in mid-October and are conducted in ways that best fit the school operation procedures. Primary Project staff, participating teachers, and other relevant school personnel review the assembled information, create composite sketches of children's school adjustment, and identify children who seem most appropriate for Primary Project services. In essence, during the conference, the team reviews the adjustment profile of children identified through the screening process as having some difficulties in school. Based on a child's current level of functioning (i.e., competencies and problems), the team makes recommendations, including Primary Project, to address the child's needs. After children have been identified for participation in Primary Project and the Primary Project team has agreed on that identification, written parental consent for the child's participation is obtained. For example, Sarah was identified during the screening process. Her parents were aware that she was having difficulty in school. They had stayed in contact with Mrs. Smith during the first weeks of school and had worked to support Sarah at home. They were not surprised when Mrs. Smith called and suggested that she participate in Primary Project.

Once parental permission is obtained, an adjustment profile is used to establish goals in collaboration with the teacher, the mental health professional, and, in many schools, the child's parent. Program goals include a dual focus on enhancing competencies and addressing problems. For example, goals for an individual child might include enhancing peer social skills, decreasing the child's aggression through the development of prosocial means of anger expression (i.e., anger identification, developing language for feelings), and increasing frustration tolerance.

WORKING WITH THE CHILDREN THROUGH EXPRESSIVE PLAY

Fundamental to Primary Project is the establishment of a positive, warm, trusting, therapeutic relationship between the child associate and the child through the medium of play. After initial training and selection of children for Primary Project, child associates begin to see children regularly. Children are typically scheduled for weekly, 30-minute individual sessions for a cycle of 12 to 15 weeks—typically one school semester. Depending on the child's

needs and the program goals for that child, some children may go through a second cycle (i.e., semester) of sessions. Child associates meet with children in specially equipped playrooms that provide age- and culturally appropriate toys or expressive play medium. Toys and materials within a playroom may include various art supplies, such as crayons, markers, paper, and paints, as well as family dolls, a dollhouse, action figures, a sand table, building blocks, and Lego blocks. Materials should offer opportunities for creative and imaginary play, and they generally facilitate the expression of a child's feelings and thoughts. The playroom provides a safe, welcoming, and supportive environment in which the child and adult can interact.

In a Primary Project session, the child typically engages in self-directed expressive play and sets the pace of the interaction with the child associate. The associate's roles are to support the child's activities using basic listening skills; reflect child's actions, thoughts, and feelings; show acceptance and empathy; and engage in child-led play. The child associate is an active participant in the relationship, but it is the child who regulates the intensity of his or her participation. Child associates have to be flexible in the playroom—to be able to enter into the child's play but not simply as playmates. It is appropriate for a child to direct the child associate in the role he or she wants the associate to take on, within reasonable limits. However, a child associate occasionally may want to capitalize on a particular moment to build skills in a child's specific area of need. Because each child brings his or her uniqueness into the self-directed expressive play activities, it is impossible to convey exact, scripted sessions.

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

Case Example

Sarah followed the traditional pattern of a child participating in Primary Project. She spent time each week with her child associate. For Sarah, this became a safe place for 30 minutes a week when she would have an adult's undivided attention. Within 4 to 5 weeks, her teachers reported that she was beginning to take small risks, such as initiating conversations, raising her hand in class to answer questions, and asserting her needs appropriately. Requests to visit the nurse significantly decreased. Primary Project gave Sarah the opportunity to build another positive school-based relationship and receive the individual attention she needed. Within a few weeks after Primary Project, Sarah began looking forward to school again and increasingly began to positively engage in learning tasks and peer interactions.

SUPERVISION AND TRAINING OF CHILD ASSOCIATES

Because great care is taken to hire child associates with skills and characteristics that provide effective helping services for children, training is intended to build on these positive qualities. Orientation and initial training activities are focused and time limited. The specifics depend in part on a child associate's background experience and needs. Training is designed to impart information and skills that facilitate work with children in a school environment and to clarify basic procedures and intervention strategies. Supporting child associates through supervision by mental health professionals has been considered a necessary component of Primary Project. This process begins with the entrance of a child associate into the program and continues until each associate separates from the project.

Primary Project recognizes two major areas of reflective supervision in work with child associates: child-centered and child associate-centered supervision. *Child-centered supervision* refers to the individual children with whom the associates meet. Primary Project supervisors review the child associates' work with the children; help the associates understand the children's words, behaviors, and feelings; and offer them specific direction in their weekly work with the children in their caseload. *Child associate-centered supervision* focuses on each child associate. Primary Project supervisors explore the child associates' understanding of children's adjustment and mental health issues, and the effect that these difficulties have on children. They offer advice and guidance to each associate as that associate evolves in his or her role emotionally and cognitively. A 2-day supervision of paraprofessionals in Primary Project is offered to all Primary Project supervisors.

GRADUATION FROM PRIMARY PROJECT

Most children will exit Primary Project as a natural course of events. On occasion, some children will transition to more intensive helping services. Whatever the case, a clear transition is important. Approximately 3 weeks before termination, the process of saying goodbye begins.

Case Example

Sarah was told by her child associate from the beginning that they would spend 12 to 15 times together. Around the eighth session, the associate reminded Sarah that her time in the playroom would soon end. After that session, to help with the transition process, the child associate reminded Sarah each week how many times were remaining. A final teacher-parent

conference with the child associate was held to describe Sarah's progress to her parents. All agreed that Primary Project had positively affected her behavior, including fewer visits to the nurse. Sarah's parents reported that she was more excited about going to school than earlier.

EVALUATING STUDENT PROGRESS

Children's progress in Primary Project is measured formally and informally. A child's progress is discussed through ongoing individual supervision and in meetings with the classroom teacher. Some programs incorporate a teacher progress report. More formal progress is measured by conducting pre- and post-assessments with the T-CRS and by determining behavior changes.

Case Example

At the conclusion of Sarah's time in Primary Project, Mrs. Smith completed the T-CRS and the school psychologist, who also was the child associate's supervisor, completed a professional summary report. Sarah met her goal of increasing her participation in the classroom and had become more engaged in school. In addition, analysis of the final teacher's rating scale showed positive change in assertiveness and peer social skills.

OUTCOME STUDIES

There is general consensus among experts that Primary Project is an exemplary practice that is based on decades of evaluation and research. It has been recognized at multiple state and national organizational levels (Children's Institute, Inc., 2015). In 1984, the National Mental Health Association awarded Primary Project the Lela Rowland Prevention Award. Four years later, Primary Project was designated as a validated program under New York State's Sharing Successful Programs. In 1993, the American Psychological Association's Section on Clinical and Child Psychology (Section I of the Division of Clinical Psychology) and the Division of Child, Youth, and Family Services awarded Primary Project with the Model Program for Service Delivery for Child and Family Mental Health.

Primary Project was highlighted as an exemplary practice in *Primary Prevention Works* (Albee & Gullotta, 1997), in *Successful Prevention Programs for Children and Adolescents* (Durlak, 1997), and in *Establishing Preventive Services* (Weissberg, Gullotta, Hampton, Ryan, & Adams, 1997). The U.S. Surgeon General's Report on Mental Health (U.S. Public Health Service,

2000) recognized Primary Project as one of the five exemplary research-based prevention programs in the nation for enhancing children's mental health. In 2000, the U.S. Department of Education's Office of Safe and Drug-Free Schools named Primary Project a Promising Program. Primary Project is also listed as an evidenced-based program with the National Registry of Evidence-Based Programs and Practices (Substance Abuse and Mental Health Services Administration, 2012), which includes information about program dissemination, training, and research. As evidence-based programs grow in number, program fidelity becomes a concern.

Primary Project has a national certification process that uses a quantifiable rubric: Certification is based on 3 years' implementation. A national review team evaluates the school's ability to meet the following requirements: systematic screening and review of children; length of children's participation in the program; selection and training of child associates; consistent supervision; appropriate space for the program; active support from administration, teachers, support staff, and community; and a strong commitment to program and child evaluation. In addition, manualized resources and DVDs on supervision and the intervention, and a program development manual (see Replication and Transportability) are available.

Research on Primary Project that started when the program was initially adopted in 1957 has been a continuing, essential part of the program's fabric. Tests of Primary Project's effectiveness as a prevention program have used several evaluation designs. Each has strengths (i.e., methodological or ecological) that provide complementary evidence about program efficacy (Cowen et al., 1996), including a composite evaluation for seven consecutive annual cohorts (Weissberg, Cowen, Lotyczewski, & Gesten, 1983). Primary Project's research efforts have involved the study of elements beyond outcomes, such as factors in children that relate to good and poor school adjustment, specific program elements, and the relationship between the associate-child and associate-supervisor relationship (Cowen & Hightower, 1989; Cowen et al., 1996).

Interest in Primary Project has been renewed, and research studies in various stages include a retrospective review of state adoption of and support for Primary Project, implementation of Primary Project by behavioral health agencies working with school districts, principal mental health supervisors and associates' perspectives on Primary Project, and a randomized controlled study of the intervention.

Evaluation Designs

Controlled Studies

Duerr (1993) randomly assigned children from 18 schools into immediate intervention and delayed treatment groups. Using standard comparison

techniques for this design, the study found that children who received Primary Project services relative to those awaiting services showed statistically significant decreases in adjustment problems, such as lower aggression, fewer learning problems, and increased social–emotional competencies, (e.g., frustration tolerance, peer relations). Another evaluation of Primary Project that used a wait-list control design found statistically significant differences between children in an immediate intervention group and those in a wait-list control group (Nafpaktitis & Perlmutter, 1998). These gains were maintained at 3-month follow-up based on teacher ratings.

Comparison Designs

Winer Elkin, Weissberg, and Cowen (1988) evaluated adjustment between children receiving Primary Project services and comparably at-risk children in schools without Primary Project services, and tracked their adjustment over time. Their study compared children in the Primary Project model who received an average of 25 forty-minute contacts over a 5- to 6-month period, and children with similar initial adjustment status identified in non-Primary Project schools. Primary Project–served children were shown, after a school year, to make decreases in adjustment problems and increases in adaptive competencies compared with comparison children. These results were statistically significant.

Longer Term Follow-Up of Primary Project Children

Chandler, Weissberg, Cowen, and Guare (1984) evaluated 61 urban children who had participated 2 to 5 years earlier in the Primary Project model, with 61 matched to the Primary Project sample by gender, grade level, and current teacher. Adjustment ratings by children's current classroom teachers confirmed that children seen in the Primary Project model had, 2 to 5 years later, maintained their initial adjustment gains.

Primary Project was introduced into several elementary schools in Community School District 4 in the East Harlem section of New York City. The implementation of the Primary Project model for children in kindergarten through third grade was evaluated over a 4-year period. Results were that participating children had more positive school adjustment (i.e., fewer adjustment problems, greater competencies) after 1 year in the program (Meller, Laboy, Rothwax, Fritton, & Mangual, 1994). Moreover, children's self-ratings of adjustment showed statistically significant increases in rule compliance, school interest, peer acceptance, and decreased anxiety.

Ongoing Site-Based Evaluations

Evaluations of Primary Project program sites in New York and California included comparison of children's classroom adjustment problems and

competencies at referral to and graduation from the program. This method made possible an ecologically valid assessment of children's adjustment status in large numbers of school sites. During the 1997 to 1998 school year, evaluation of children in the New York State Primary Project included more than 1,500 children in 50 schools. These Primary Project sites provided more than 15,000 preventive-focused contacts to children. Overall, 82% of these children had adjustment problems before referral that placed them at "high" or "moderate high" risk. Mental health staff reported that 60% of Primary Project children showed reductions in aggressive behavior and had improved social skills, and 50% had better academic performance (Hightower, 1998).

Replication and Transportability

The Primary Project model has been described in numerous publications, including peer-reviewed journals and books. Primary Project's development and evaluation were summarized in *School-Based Prevention for Children at Risk: The Primary Mental Health Project* (Cowen et al., 1996). A second comprehensive source of information about the Primary Project model and how it can be implemented and evaluated is found in *The Primary Mental Health Project: Program Development Manual* (Johnson, Peabody, & Demanchick, 2013). The key structural components of Primary Project allow for adaptation to local districts/sites while retaining the flexibility to meet the uniqueness of the individual setting. These components make Primary Project applicable to a broad range of children and communities.

Primary Project model programs have been established successfully in 130 school districts across New York State. Nationally, centralized networks of programs in more than 1,000 school districts (Children's Institute, Inc., 2012) have been established: California (Primary Intervention Program), Connecticut (Primary Mental Health Project), Hawaii (Primary School Adjustment Program), Washington (Primary Intervention Program), Arkansas, Florida, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Missouri, and Washington, DC. Primary Project is coordinated in California through the Department of Mental Health via the Early Mental Health Initiatives and in Connecticut, Hawaii, and New York through the Departments of Education. International programs exist in Canada and Nigeria. The newest development in the story of Primary Project implementation is expansion into preschools, Head Start, and child development centers.

Support to districts and sites interested in implementing Primary Project is available through multiple venues: consultation, training, program materials, and internship opportunities. Program materials include *School-Based Prevention for Children at Risk: The Primary Mental Health Project* (Cowen, et al., 1996),

The Primary Mental Health Project: Program Development Manual (Johnson et al., 2013), *Creating Connections: Primary Project* (Children's Institute, Inc., 2012), *Screening and Evaluation Guidelines* (Children's Institute, Inc., 2002), *Primary Project: The Intervention: Basic Skills* (Children's Institute Inc., 2006a), *Supervision Manual* (Children's Institute Inc., 2006b), and *T-CRS 2.1 Teacher-Child Rating Scale Examiner's Manual* (Perkins & Hightower, 2002). On-site consultation and support are available through Children's Institute, Inc., program consultants, and a list of training workshops for state and national programs is available on <http://www.childrensinstitute.net>.

CONCLUSION

Primary Project is a time-tested early intervention program that helps young children adjust to school during the early years. It has been refined over the past 55 years to a model that is transferable across settings and with children from varied backgrounds and communities. Equally successful in urban, suburban, and rural school districts, Primary Project continues to identify and serve children with mild adjustment difficulties at an early age in an effort to promote social and emotional competence.

Programs with the strongest results adhere to the six key components, with particular emphasis on high-quality child associates who receive systematic training and support from quality mental health professionals. Child-centered play is essential to the ongoing training of child associates. Although the environmental demands and pressures for young children have changed over the years, a deep need for time, attention, and expressive play has not.

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