# Final Report: Early Childhood Mental Health Services in Pennsylvania

**Prepared for**
**The William Penn Foundation**

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# Executive Summary

Pennsylvania's early childhood mental health (ECMH) initiative was launched in 2006 with three goals: to reduce the number of children expelled from childcare due to behavior concerns; increase understanding of children's social and emotional development and its impact on educational success; and link systems and services on behalf of children and families. Ten ECMH consultants strategically placed in the six Pennsylvania regional keys provide mental health consultation services to early care and education providers that have particular concerns about a child's socio-emotional development or behavior.

In early 2010, the OMG Center was engaged to evaluate ECMH in order to understand: the types of strategies being used by consultants in the classroom; the referral process when a child and family require external support; and the level of system coordination among providers, mental health consultants, and referral agencies. In the first phase of its study, OMG examined a sample of 167 randomly selected ECMH cases in order to fully describe who was being served by the program, what types of recommendations were being made by the consultants, and why cases were being closed. In the second phase, in order to better understand the process for referrals and service delivery in a community context, OMG conducted a qualitative analysis of ECMH service provision, including interviews with ECMH consultants and OCDEL staff, as well as a survey of parents whose children had received ECMH services.

Throughout the duration of the study, OMG provided OCDEL with ongoing feedback and recommendations, which were intended to improve implementation of the program. A summary of OMG's findings and recommendations made to OCDEL is included below. These include findings and recommendations related to program implementation, as well as policy-level recommendations.

### *Program-Related Recommendations*

- When examining the types of recommendations made by ECMH consultants, it was found that recommendations for teachers by far outnumber other types of recommendations, such as parent interventions and referrals. The ECMH service model currently begins with the teacher/director requesting service, making teachers the logical area of focus for consultant recommendations. However, in an effort to facilitate teacher-parent communication and coordination of child-family supports, the consultant ought to consider tailoring their recommendations to initiate a support system within *and outside* of the classroom.
- Younger children were more likely to have their ECMH cases closed because they met developmental goals. This may be indicative of developmental issues resolving themselves, particularly around communication and aggressive acts such as biting. More information ought to be given to providers on how to routinely address developmental issues and what markers are clearly cause for concern.
- The PA Key ought to offer professional development workshops on early childhood mental health as part of its keys to quality curriculum. Consultants should make teachers aware of opportunities for further training and avoid utilizing their consultancy time on individualized staff professional development.

- As consultants find and develop resources for parents and teachers, example resources that can be applied for commonly recommended strategies such as communication techniques and emotion regulation ought to be shared broadly. Consultants could also be given marketing tools developed for different audiences that could be easily edited by each key. If the intranet is currently not being used in this way, the creation of a searchable electronic bibliography that consultants populate and can use to search for relevant materials could be useful to knowledge sharing.
- Each regional key ought to be proactive in identifying resources in the community that are available to support families. Each regional key should have a list of available early childhood mental health providers, as well as other social service agencies. Consultants ought to make introductions and leave marketing information on the program. Seminars and other training opportunities for agency providers could be offered periodically to increase inter-agency collaboration and build field knowledge surrounding early childhood mental health issues.

### *Policy Recommendations*

- The length of ECMH cases varies significantly across consultants. Requiring consultants to provide a clear timeframe for each recommendation and periodic updates for each case will help to ensure that the specified goals are being reached and the child has not slipped through the cracks.
- The regional key as a service area is quite large. Consultants placed in closer proximity to providers, possibly in the county office for health and human services may provide more efficient services. This may mean hiring more consultants on a part-time basis in certain regions.
- Significant variations were found across regions in the reasons that cases were closed. One point of concern is the relatively high level of expulsion found in the northwest and central regions. While it is not clear what is driving these regional differences, interview data suggest that there are differences in regional capacity to handle cases, with some regions having waiting lists while others do not. This finding further supports the hiring of additional consultants, possibly on a part-time basis, to meet the needs of children before they are expelled from child care.
- Administrative support ought to be provided through the regional key with a designated person. Further, most case notes are hand written. Consultants could benefit from handheld devices (ipads, laptops) that allow them to type observations directly into the template, rather than recreating the work back at the office.
- Procedures for contacting parents as well as timeframes for conducting observations and follow-up with teachers and parents need to be institutionalized.
- Procedures for referring cases ought to be developed. For example, more support of parents is required during the referral process. Consultants should be clear on how long to continue working with the parents, whether to continue monitoring or close the case, etc.
- OCDEL has already implemented some training opportunities including a new orientation process, weekly calls, and monthly consultant meetings. These efforts are particularly important due to the varied background and experience of consultants. More formalized training, such as time with a child psychiatrist and other professional development courses specializing in early childhood mental health, will help the consultants obtain expertise in the field and build common skill sets.

# 1. Introduction: The Early Childhood Mental Health Consultancy Study

Pennsylvania's early childhood mental health (ECMH) initiative was launched in 2006 to link systems and services on behalf of children and families; increase the understanding of social and emotional development and its impact on educational success; and reduce the number of children expelled from childcare due to behavior concerns. Ten consultants strategically placed in the six Pennsylvania regional keys provide mental health consultation services. Early care and education providers that have particular concerns about a child's socio-emotional development or behavior request that a consultant observe the child in their early care setting and make recommendations of possible interventions in the classroom and for parent use. In some cases, referrals are made to outside agencies for child assessments and other services.

An early evaluation of the ECMH pilot[1] found that providers most frequently sought help for children experiencing difficulties with self-regulation, aggression/acting out, and attachment or interaction issues. Consultants referred approximately 50% of the children to other supports such as early intervention, mental health agencies or other specialists. In the remaining cases, the consultant worked with the provider on strategies that would help the child resolve the issue and remain in the classroom. The average consultation lasted just under six months and two-thirds of consultations ended with the identified behavioral goal being met or the child exiting to other support services.

In early 2010, the OMG Center was engaged to evaluate ECMH to understand the types of strategies that are being used by consultants in the classroom, the referral process when a child and family require external support, and the level of system coordination among providers, mental health consultants and referral agencies. OMG's project was conducted in two phases:

1) Phase I focused on incorporating and standardizing best practices in the consultancy system by examining randomly selected cases and estimating whether there are variances in the reason for requesting services. In addition the action plans were examined to assess the types of recommendations and referrals made, and how these differ by child characteristic, provider type and consultant. Following an initial Phase I report delivered in September 2010, OMG met with ECMH staff and stakeholders and the discussion led to additional analysis of the data in order to examine several questions of interest.
2) To better understand the process for referrals and service delivery in a community context, and to gain insight into the Phase I findings, Phase II included a qualitative analysis of ECMH service provision across regions and also collected information about parent perception of the program, including reasons for parent refusal of services.

The methodology for both phases is described in Appendix A.

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[1] Smith-Jones, J. and Townsend, M.Z. (2008). "Evaluation of the Infant/Toddler Systems Building Initiative: Final Report for the Early Childhood Mental Health Consultation Program, June 2006 – June 2008." Submitted by University of Pittsburgh Division of Applied Research and Evaluation, to the Office of Child Development.

This report includes findings from both phases of the study. In the first section, we present Phase I findings and the results of the additional analysis of Phase I data. The second section includes results of Phase II activities, in particular findings from interviews with ECMH consultants and OCDEL staff, and results from a survey of parents whose children received ECMH services. The third and final section of the report presents recommendations made throughout the course of the project.

# 2. Phase I Findings

Phase I of the evaluation examined data from 167 randomly selected ECMH cases across the six regional keys. This section begins with an overview of cases in the study sample, describing the characteristics of children and facilities served by ECMH. It then explores the recommendations made by consultants, as well as their reasons for closing cases. Differences across the sample are examined in order to provide a sense of how consistent cases and services are across the program. Finally, the section includes results from additional analyses conducted of the Phase I data based on interest from ECMH staff and stakeholders. A description of the methodology for Phase I is included in Appendix A.

## A. Description of Sample Cases

Table 1 presents the key characteristics of cases in the sample. The average age of children at the time when ECMH consultation was requested was 40 months (approx. 3 years). The youngest child in the sample was six months and the oldest was 82 months (almost 7 years).

The most common reason for cases being referred to ECMH was aggression, followed by self-regulation.[2] One-tenth of cases each were referred for communication issues and interaction issues, and a few were referred due to attachment issues.

Sample cases were drawn from each of the six Pennsylvania regional keys. Slightly higher percentages of cases were from the Northeast and South Central regions in comparison to others, and the fewest cases were drawn from the Central region. The cases were handled by ten consultants and were fairly evenly distributed across the consultants, with the exception of one individual who handled only 2% of the sample (see Figure 1 on the next page). As noted in the methods section, this consultant was new to ECMH and had not accumulated as many cases as the others when the sample was selected.

***Table 1: Key Characteristics of Sample Cases***

| | |
|---|---|
| *Average age at Request* | *40 months (3 years)* |
| *Primary Reason for Referral* | *Aggression: 43%* |
| | *Self-regulation: 35%* |
| | *Communication: 11%* |
| | *Interaction: 10%* |
| | *Attachment: 1%* |
| *Region* | *Northeast: 25%* |
| | *South central: 23%* |
| | *Southeast: 19%* |
| | *Southwest: 12%* |
| | *Northwest: 12%* |
| | *Central: 10%* |
| *Facility Type* | *Center: 94%* |
| | *Group: 4%* |
| | *Family: 2%* |
| *STAR Rating of Facility* | *1: 27%* |
| | *2: 32%* |
| | *3: 18%* |
| | *4: 23%* |
| *Average # Students in Classroom* | *12* |
| *Average # Teachers in Classroom* | *2* |
| *Average Student:Teacher Ratio* | *6:1* |
| *Average Duration of Service* | *152 days (5 months)* |

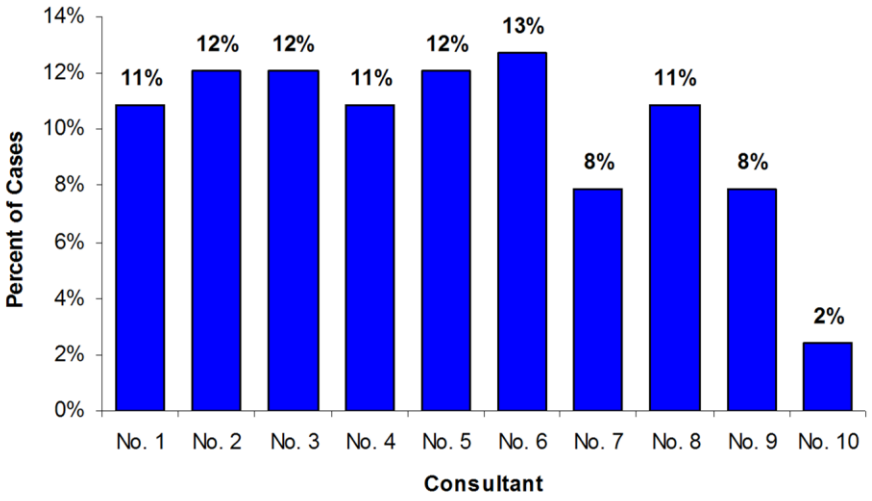
[2] Individuals who recommended children for consultation (i.e., teachers, directors, etc.) were asked to indicate the primary reason for the referral on a standardized form, selecting from a list of five codes: aggression, self-regulation, communication, interaction, and attachment. The form did not include definitions for the codes or delineate differences between them, leaving them open to interpretation.

Almost all of the children in the sample attended centers as opposed to family or group facilities. The majority of facilities had a STAR rating of 1 or 2, although almost one-quarter were rated 4.[3] There was a marginally significant difference (P<.1) in STAR ratings across regions. Some regions (in particular the Southwest and Northeast) had a prevalence of facilities rated at levels 3 and 4, while others (Central and Northwest) had high percentages of level 1 and 2 facilities.

Across all cases, the average number of children in each classroom was 12, although this ranged from 3 to 40. The number of children in a classroom was positively correlated with child's age at request for service (r=.44, P<.001), meaning that as the age of children increased, so did the number of children in the classroom. Classrooms had between one and four teachers each (the average was 2), and the student-to-teacher ratio was 6:1 on average.

Cases remained open for an average of 152 days (approximately five months).

**Figure 1: Sample Cases per Consultant**




## B. Consultants' Recommendations

Recommendations made by ECMH consultants were examined by coding and analyzing the handwritten action log for each case. Most cases received several recommendations each, and the average number of recommendations per case was four.

Overall, recommendations fell into three broad categories: referrals to other agencies or providers; recommendations for actions that teachers could take to work differently with the child; and recommendations for actions that parents could take. Recommendations for teacher

[3] Five facilities rated Start with STARS (SWS) were excluded from analyses since this is not considered a STAR rating. SWS is a rating for facilities that wish to begin the process of continuous quality improvement and access resources to assist their facility in working toward a STAR level.

interventions were by far the most common, accounting for 78% of the total. Parent interventions and referrals each constituted 11% of recommendations made.

The ten most frequent recommendations are listed in Table 2. Consultants most often recommended that teachers: utilize communication strategies; provide positive reinforcement or praise; adjust the level of choices the child has; use transition strategies to move between activities; and model the behavior desired from the child.

**Table 2: Ten Most Frequent Recommendations**

| | |
|---|---|
| *Teacher should use Communication Strategies* | 13% |
| *Teacher should Provide Positive Reinforcement* | 9% |
| *Teacher should Adjust Choices* | 9% |
| *Teacher should use Transition Strategies* | 7% |
| *Teachers should Model Desired Behavior* | 7% |
| *Teacher should use Calming Strategies* | 5% |
| *Child Referred to Outside Services for Early Intervention* | 5% |
| *Child Referred to an Outside Specialist* | 5% |
| *Teacher should Provide Supervision* | 5% |
| *Teacher should use Discipline Strategies* | 4% |
| **Percents do not add up to 100 because only the top 10 are represented and also because it is possible to have more than one recommendation per case.* | |

In terms of referrals to other services or providers, the most common referral was to early intervention, followed by specialists (this category included occupational therapists, physical therapists, speech therapists, nutritionists, etc.), and mental health services. A few consultants made referrals that were not for the child but were instead for parents, teachers, or child care facilities. For example, facilities were referred to technical assistance, and teachers to professional development.

The action logs generally included no information about whether recommendations, including referrals, were implemented or achieved.

## Referrals from ECMH Spreadsheets

The above findings were slightly different than those from an analysis of referrals based on spreadsheets that consultants sent to OCDEL. Each consultant kept information about their cases—including referrals made—in an Excel spreadsheet that was turned in to OCDEL on a regular basis.

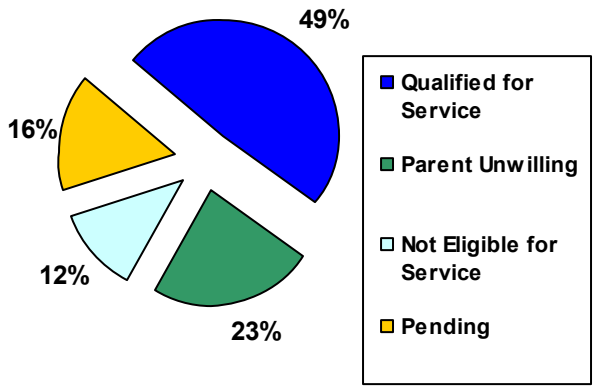
In these spreadsheets, consultants noted making at least one referral in 55% of the sample cases, much more frequently than referrals were noted in the action logs. Of those cases that received referrals, the primary referral[4] was most commonly for child mental health services (33%), early

[4] In cases where more than one referral was made, "primary referral" refers to the first referral that the consultant noted in their spreadsheet. This was not necessarily the first referral made or the most significant.

intervention 3-5 (30%), or early intervention 0-3 (29%). A few cases each were referred to adult mental health, medical services, and STARS technical assistance.

The spreadsheets also included information on the results of referrals. As shown in Figure 2, among all cases with a primary referral, almost half qualified for the service to which they were referred. In almost one-quarter of cases, the parent(s) were unwilling to receive the service. Some cases had referrals pending at the time of reporting, and in some cases the child was found not eligible for the service referred to.

**Figure 2: Referral Results**



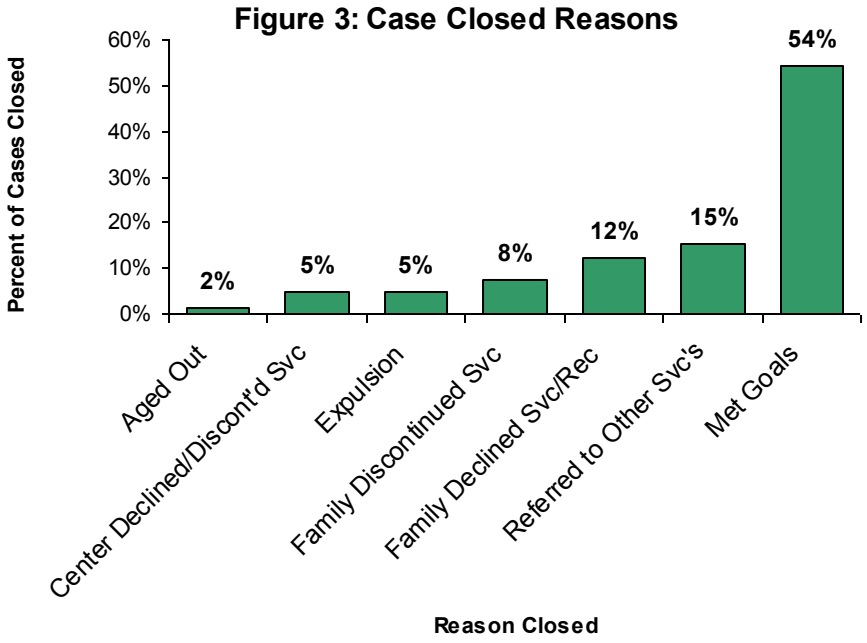

### *Tools*

In addition to recommending interventions that teachers or parents could implement, some consultants specified tools that could be used to help carry out their recommendations. Some cases had no tools recommended, while others had more than one. Tools fell into three categories: books and other prompts (including plastic letters and reminder cards), sensory objects (including teething rings and chew-safe bracelets), and visual tools (including visual picture schedules, and pictures showing people expressing different emotions).

In 34% of cases, consultants recommended the use of a book or other prompt. In 13% of cases, they recommended use of a sensory object, and in 13% of cases they recommended use of a visual tool.

## C. Reasons for Closing

Consultants closed the sample cases for a variety of reasons including that the child and family met the case goals; were referred to other services; aged out of service eligibility (turned six during the course of services); were expelled from the child care facility; left due to family circumstances (including moving out of the service area); and that the child care provider or family declined ECMH services or recommendations made by the consultant. By far the most prevalent reason for case closings was that case goals had been met, as shown in Figure 3 on the next page.




## D. Differences Across Cases

In order to examine consistency across ECMH services and cases, analyses were conducted to see whether certain variables – for example the duration of the case, primary reason for referral, recommendations made, and reason for case closing – varied significantly across regions, consultants, and child and facility characteristics. Findings that were statistically significant (P<.05) or marginally significant (P<.10) are described below.

### *Duration of Cases*

The average duration of cases varied significantly across ECMH consultants (P<.05). As shown in Figure 4, one consultant had an average duration of 96 days per case, while two others had an average duration more than 200 days. Figure 4a on the following page shows the same analysis with regional differences noted. No noticeable pattern emerged when viewing results by region.

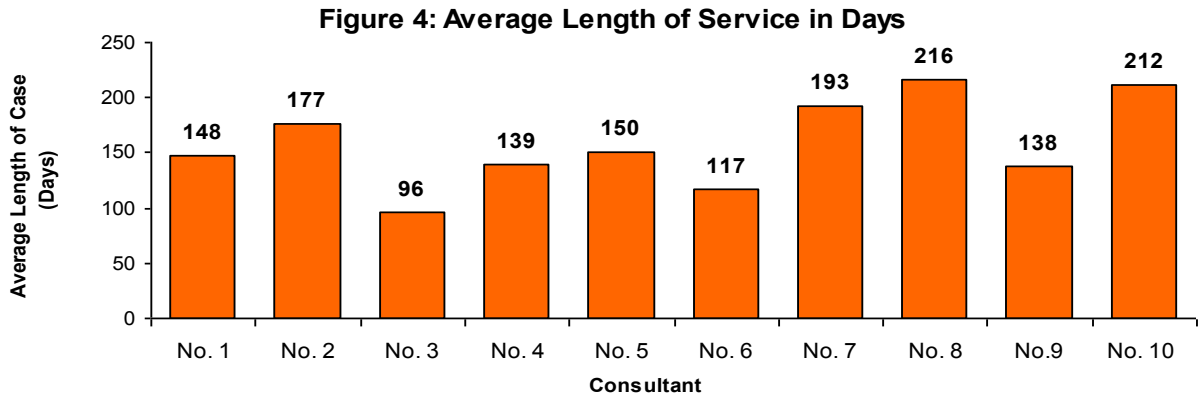
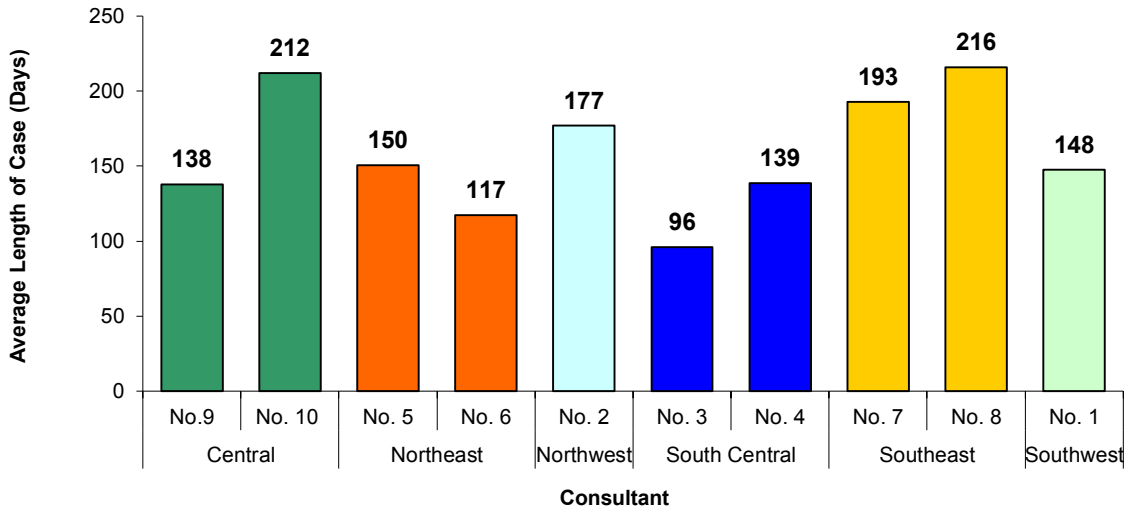


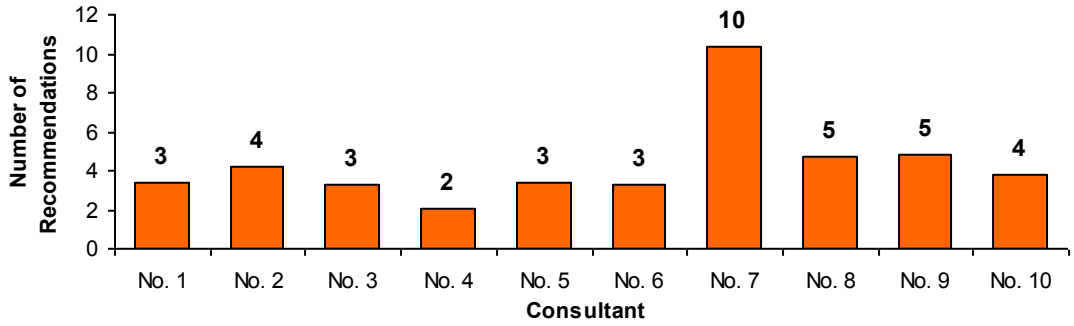
**Figure 4a: Average Length of Service in Days**

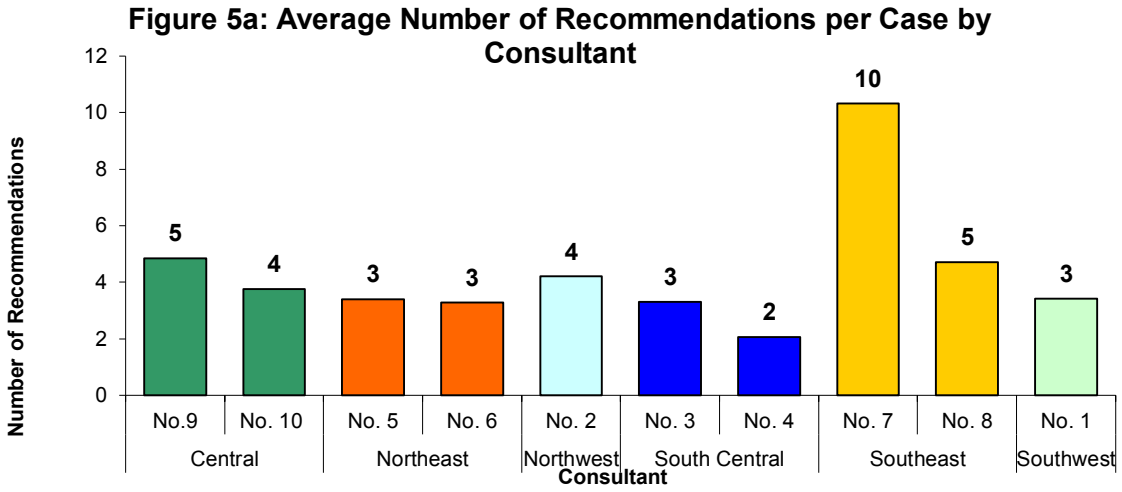



## *Consultants' Recommendations*

The average number of recommendations made per case varied significantly across consultants (P<.001). As shown in Figure 5, most consultants made between two and five recommendations per case, while one consultant made 10 recommendations per case. Figure 5a on the following page shows the same analysis with differences by region highlighted. Consultants making the most recommendations per case were from the Southeast region.

**Figure 5: Average Number of Recommendations per Case by Consultant**






To examine differences in the actual recommendations, analyses were conducted focusing on the five most frequent recommendations. Significant variation was found in the use of these recommendations (when considered altogether) across consultants (P<.001). As shown in Figure 6 below, Consultant 5 recommended at least one of these five actions in 74% of their cases, while Consultant 1 did so in only 24% of their cases.

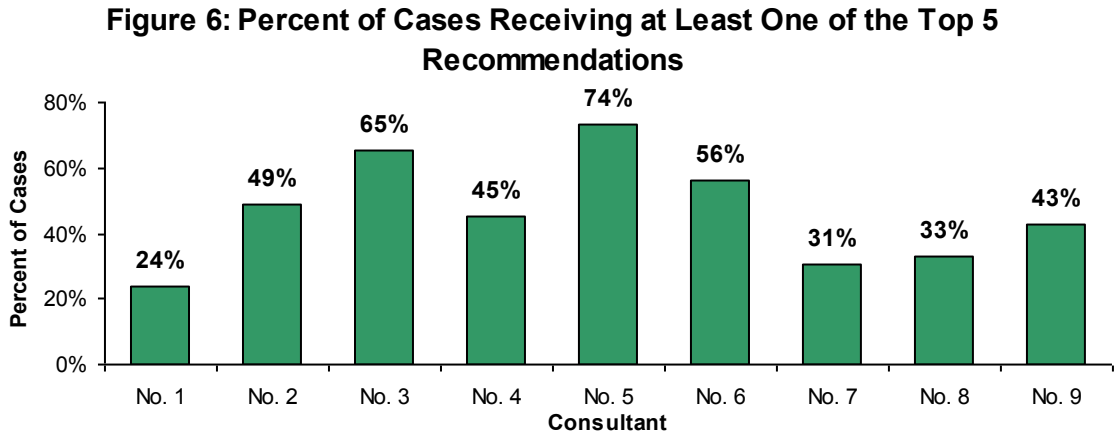
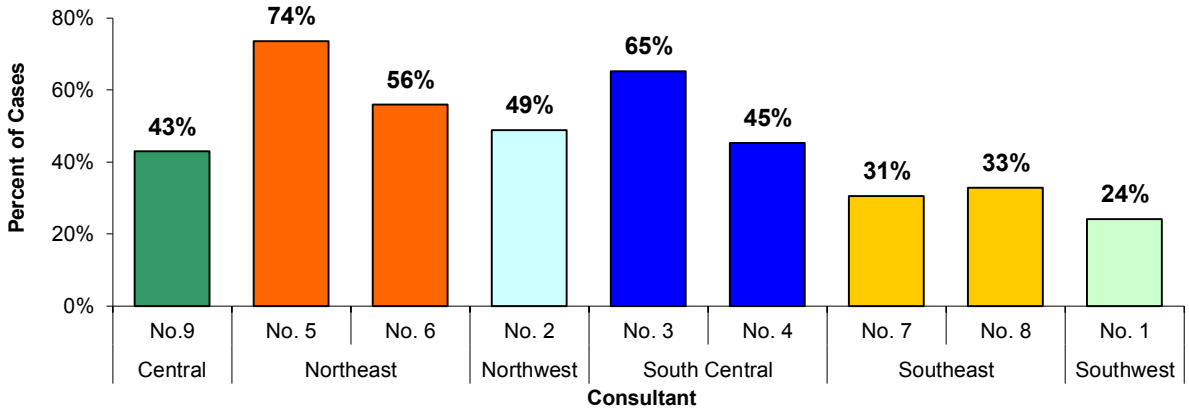



Figure 6a on the next page shows this same analysis by region. While there are no striking patterns, it appears that consultants in the Northeast and South Central regions made use of the top five recommendations frequently.

**Figure 6a: Percent of Cases Receiving at Least One of the Top 5 Recommendations**




To further examine these differences, analyses were conducted of each of the five top recommendations (individually) by consultant. Significant variation was found across consultants for three recommendations: *communication strategies*, *provide positive reinforcement,* and *adjust choices*. Variation in the recommendation *model behavior* was marginally significant across consultants, and use of the recommendation *transitioning strategies* did not vary across consultants.

Consultants' recommendations for the use of tools also varied significantly (P<.05). Figure 7 shows the percentage of cases in which consultants recommended the use of any tool (books, sensory objects, visual tools, or other prompts). Some consultants, including No.'s 1, 6, 7, and 9, recommended tools in more than 60% of their cases, whereas others such as No.'s 4 and 5 did so less than half of the time. Figure 7a on the next page shows the same results by region; however, no noticeable patterns emerged.

**Figure 7: Percent of Cases including Tool Recommendations**

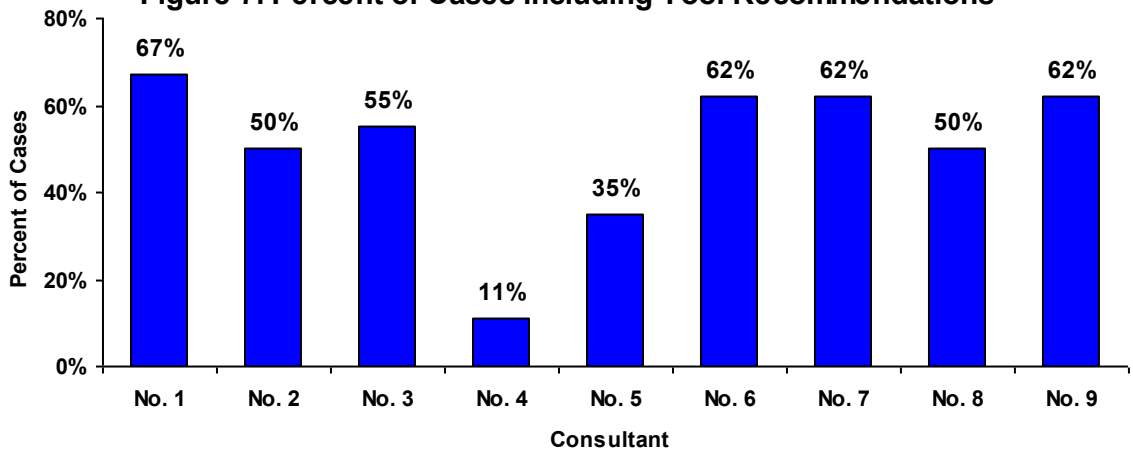
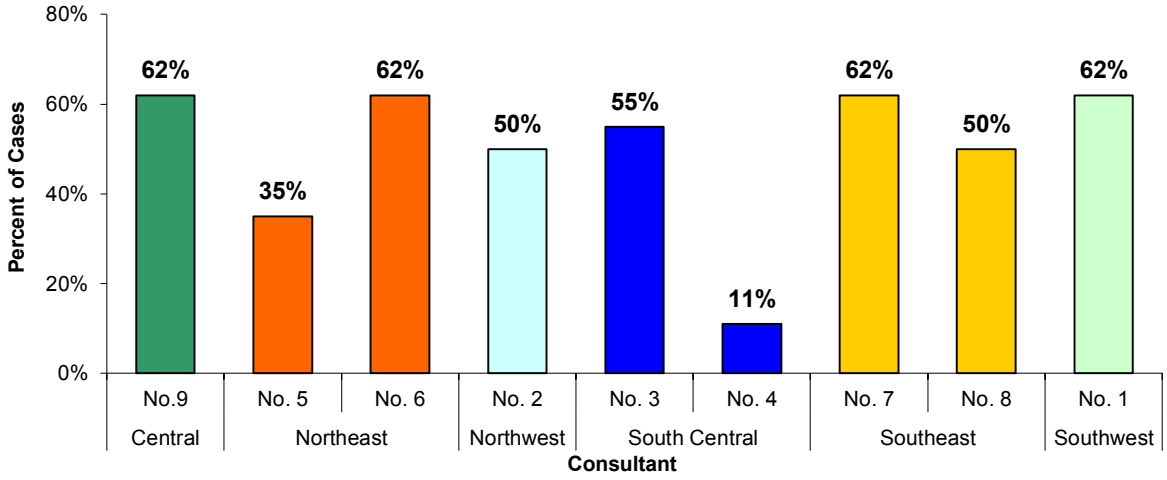


**Figure 7a: Percent of Cases including Tool Recommendations**



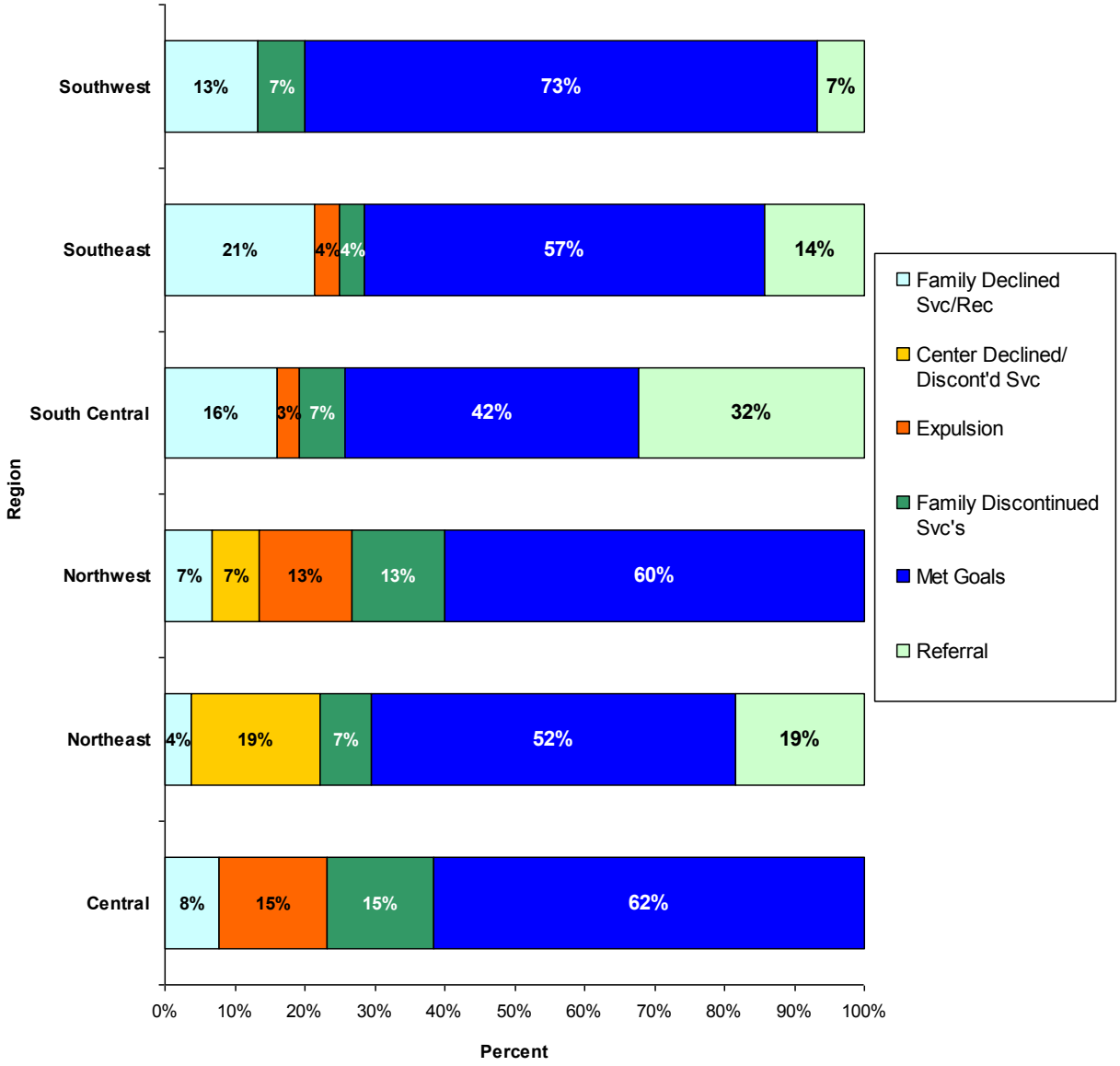

Use of the five most frequent recommendations was also found to differ significantly according to the primary reason for request for services (P<.01). For example, out of cases that were recommended to ECMH due to attachment issues, 63% received one of the five top recommendations, whereas for cases recommended due to aggression issues, only 39% received of these recommendations. However, upon further analysis of the recommendations *individually*, it was found that only one recommendation, *model behavior*, varied significantly across reason for request (P<.05), and that this variation was driving the differences in the overall analysis. Among cases that received this recommendation, 39% had been referred for aggression issues, 25% for self-regulation, 18% for interaction issues, 16% for communication, and 2% for attachment.

## *Reasons for Closing*

Consultants' reasons for closing cases were found to vary significantly across regions, consultants, and the age of the child when services were requested.

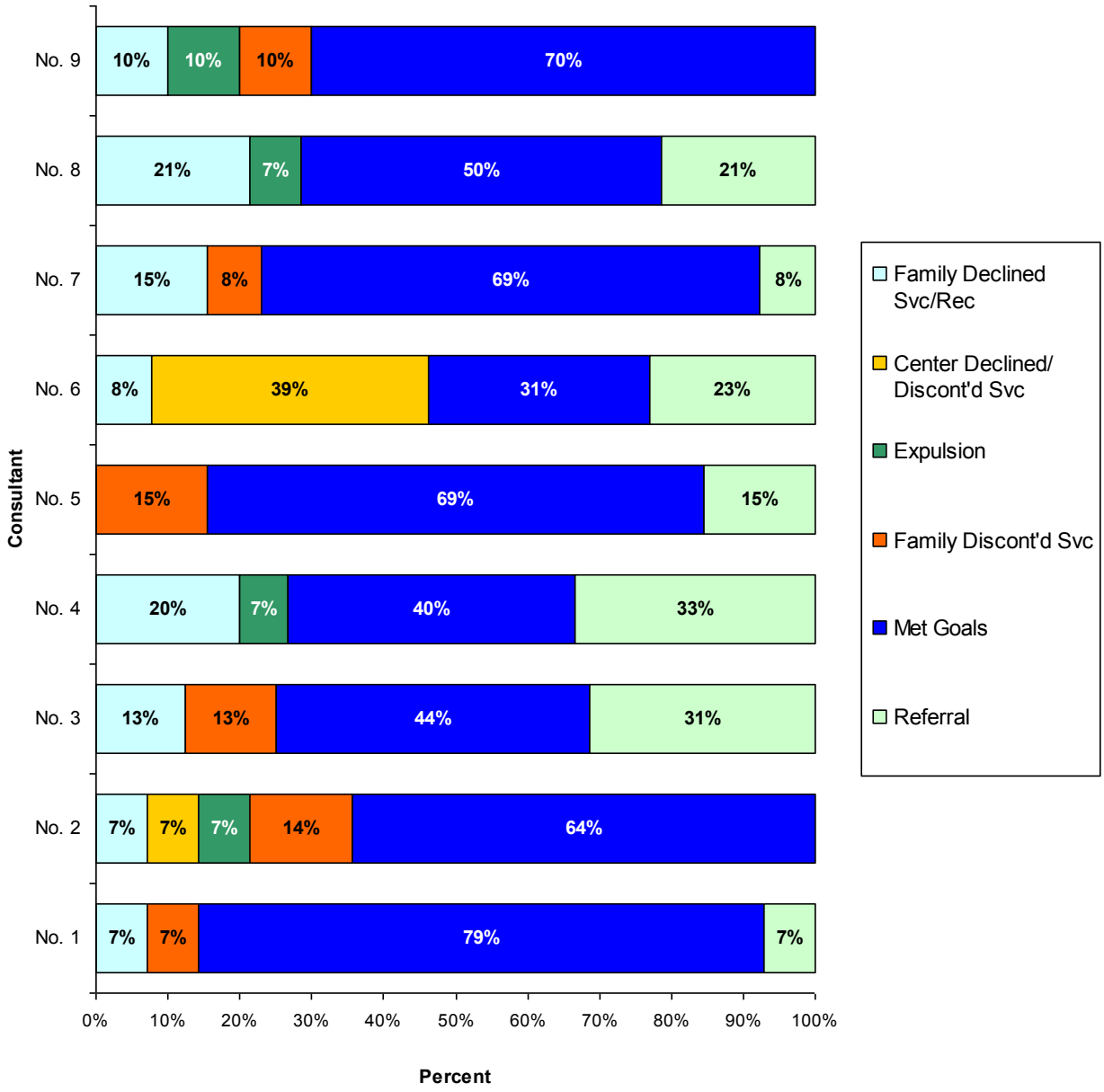
Figure 8 on the next page shows the reasons for case closings by region. Significant variations were found at the P<.05 level. As shown, almost three-quarters of cases in the Southwest region were closed as a result of meeting case goals, whereas less than half of cases in the South Central region were closed for this reason. Families declined services (or recommendations) in one-fifth of cases in the Southeast but only 4% of cases in the Northeast.

## Figure 8: Reason Case Closed by Region

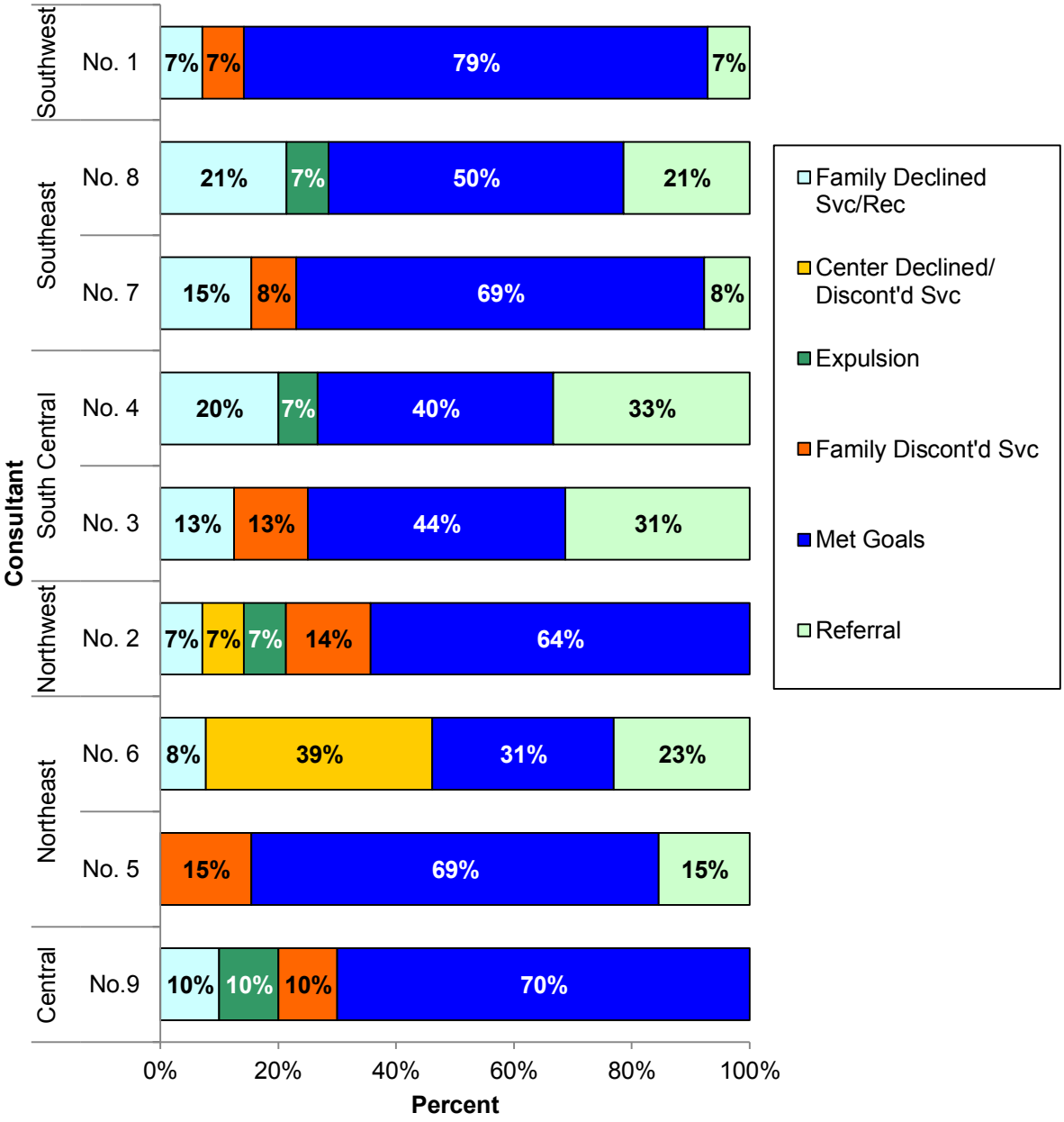


Similarly, there was a significant difference in the reasons for case closings across consultants (P<.05). As seen in Figure 9, more than three-quarters of cases closed by Consultant 1 were closed for meeting case goals, whereas less than one-third of those closed by Consultant 6 were closed for meeting goals. Some consultants closed no (zero) cases as a result of referrals to other services; however, Consultant 4 closed one-third of their cases for this reason. Figure 9a on the next page shows the analysis by region.

**Figure 9: Reason Case Closed by Consultant**

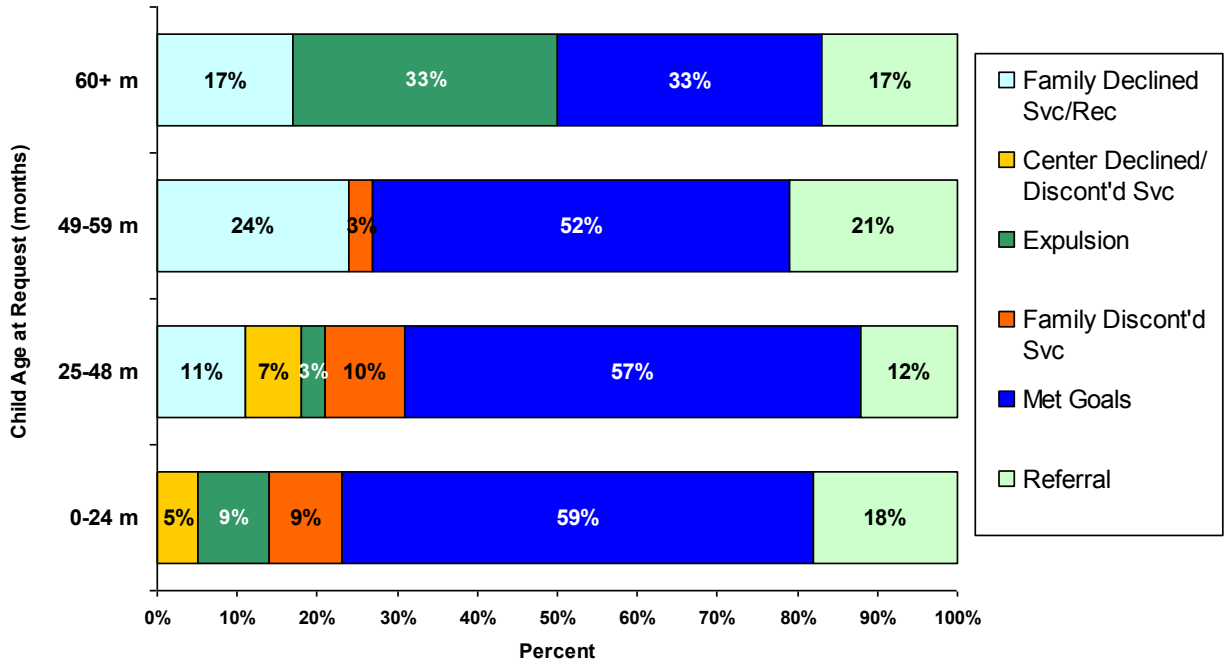


## Figure 9a: Reason Case Closed by Consultant



Finally, a significant difference was found in reasons for case closing by the age of the child at request for services (P<.05). Ages were re-coded into a categorical variable corresponding to the age breakdown typically used for developmental stages in early care settings. The categories are: 0-24 months, 25-48 months, 49-59 months, and 60+ months. The analysis found that higher percentages of cases in the younger age categories were closed for meeting goals. For example, 59% of 0-24 month old children had their cases closed for meeting goals, whereas only 33% of 60+ month olds had their cases closed for the same reason. Figure 10 shows the reasons for case closings by child age at request.

**Figure 10: Reason Case Closed by Child Age at Request**




## E. Additional Data Analyses

OMG conducted additional analyses of the Phase I dataset in order to address questions raised by ECMH staff during a meeting about the Phase I results. In contrast to the Phase I results presented above, and due to the fact that this was an exploratory analysis and that staff were interested in seeing any *possible* relationships between factors, we present some results below that are not statistically significant. When a result is not statistically significant, this means we cannot be sure it is not due to chance or some other factor, in other words it may not be reliable.

### *Question 1: Is there a relationship between length of case and reason closed?*

The duration of cases (in days) for each reason closed is listed in Table 3. Those cases closed following referrals were open the longest, followed by those that met case goals. However, it should be noted that differences between the average length of case by reason closed were not statistically significant.

**Table 3: Average Length of Case by Reason Closed**

| Reason Closed: | Average Length of Case (days): |
|---|---|
| Referral | 146 |
| Met Goals | 139 |
| Declined Service/Recommendation (Family) | 137 |
| DS-Expulsion recode | 115 |
| Declined Service/DS Center recode | 95 |
| Aged out | 83 |
| DS-Family recode | 79 |

### *What are the characteristics of cases that were closed for having Met Goals compared to those closed for all other reasons?*

Here again, there were no statistically significant findings concerning differences between cases that were closed as a result of having met goals and those closed for all other reasons. However, among the sample cases, the average duration of cases that met goals (139 days) was longer than the average duration of cases closed for other reasons (122 days).

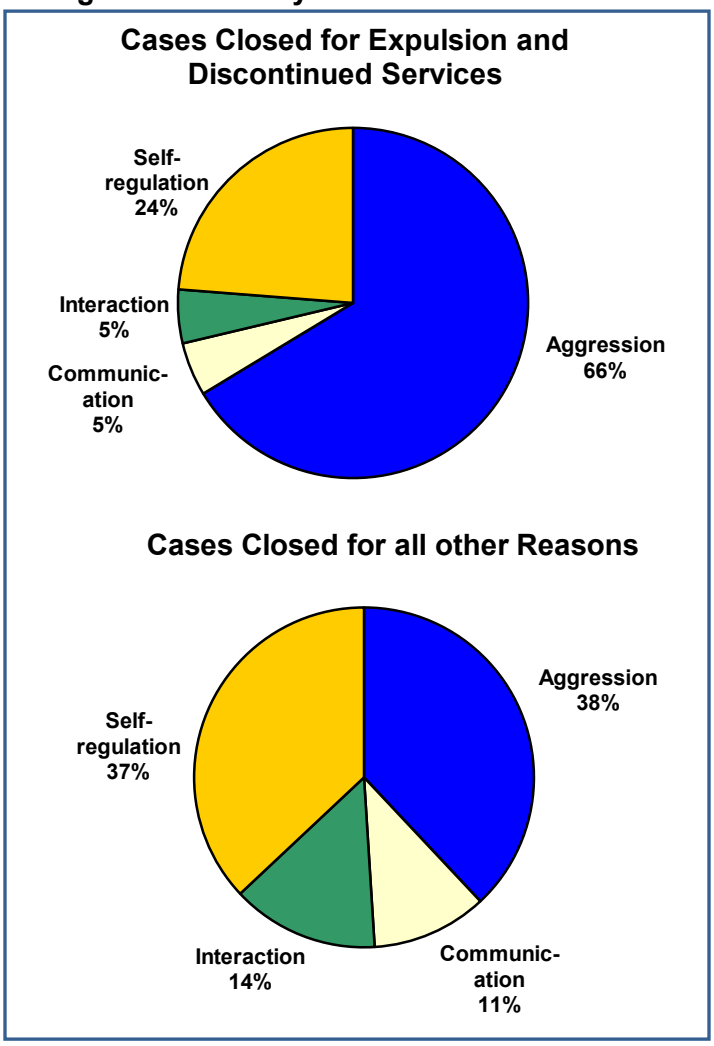
### *What are the characteristics of cases that were closed for Expulsion and Discontinued Services (together) compared to those closed for all other reasons?*

When examining differences between cases that were closed for expulsion and having discontinued services and those closed for all other reasons, significant differences were found in terms of the duration of these cases, the primary reason for referral, and region.

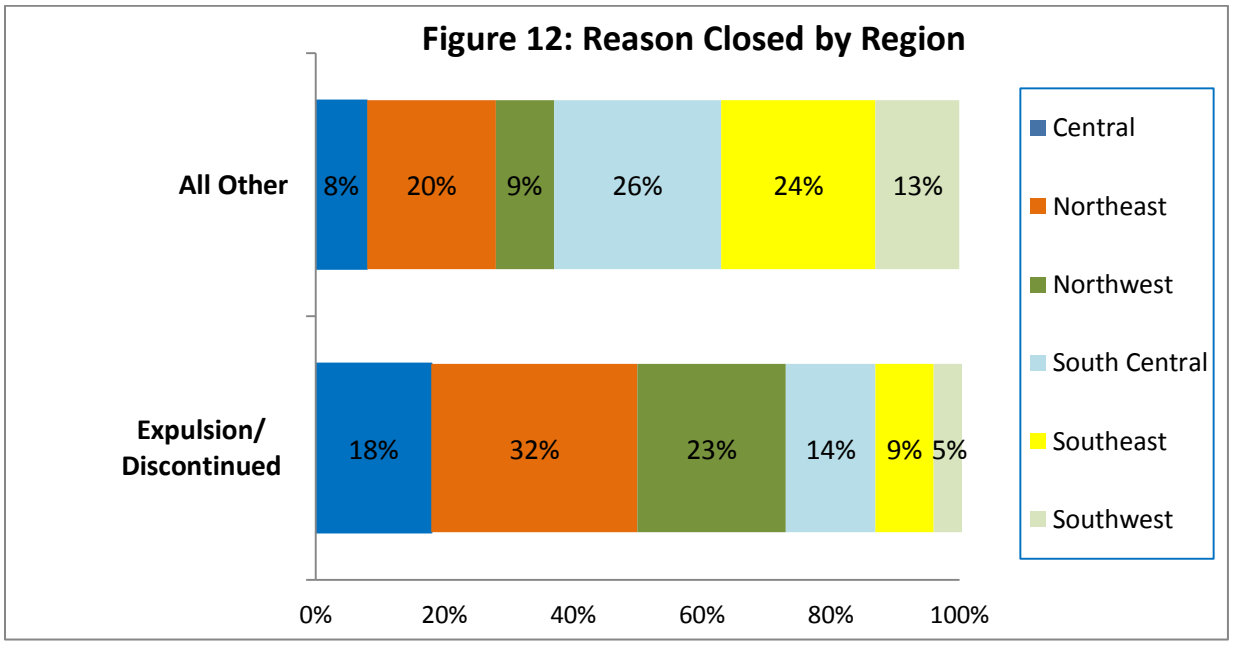
Cases closed for expulsion or services being discontinued were open for an average of 93 days, which was significantly shorter ($p<.05$) than those closed for all other reasons (average duration 139 days).

There was a marginally significant difference ($p=.1039$) in the primary reason for referral among these two groups of cases. As shown in Figure 11 on the next page, the majority (67%) of cases closed for expulsion or discontinuing services were originally referred to the program for aggression. However, among all other cases, only 38% were referred for aggression, and another 37% were referred for self-regulation.

**Figure 11: Primary Reason for Referral**




Finally, there was also a marginally significant difference ($p<.10$) in the region that cases closed due to expulsion or discontinued services were from. As shown in Figure 12 on the following page, most cases closed due to expulsion or discontinuing services were in the Northeast, Northwest, or Central regions. However, among all other cases, these regions accounted for a smaller percentage of cases.




***How does region impact the time a case is open?***

The average duration of cases varied significantly by region (F<.01), and this result held true even when controlling for differences in the primary reason for request. As shown in Table 4, cases in the Southeast were open the longest (an average 206 days) and those in South Central were open the shortest (116 days). The *most* significant differences were those between the Southeast and South Central regions, and the Southeast and Northeast regions.

**Table 4: Average Length of Case by Region**

| Region: | Average Length of Case (days): |
|---|---|
| Southeast | 206 |
| Northwest | 177 |
| Central | 155 |
| Southwest | 148 |
| Northeast | 133 |
| South Central | 116 |

***How do differences in consultants' education affect case characteristics?***

OMG examined whether differences in consultants' education (degree type) affected case characteristics, for example the duration of cases, reason cases were closed, and the number of recommendations made per case. Consultants' degrees include the following types:

- Masters in Education
- Masters in Counseling

- Masters in Psychology
- Masters in Human Services

Due to the fact that the number of consultants is very small and they may be easily identified by the analysis results, OMG made the decision *not* to present specific results. However, as shown in Tables 5 and 6, where specific degree names have been hidden, the analysis found that there were significant differences by degree type in terms of the duration of cases ($F<.05$) and the number of recommendations made per case ($F<.05$).

**Table 5: Average Length of Case by Consultant Degree Type**

| Degree Type: | Average Length of Case (days): |
|---|---|
| Degree 1 | 216 |
| Degree 2 | 155 |
| Degree 3 | 144 |
| Degree 4 | 137 |

**Table 6: Average Recommendations Made per Case by Consultant Degree Type**

| Degree Type: | Average Number Recommendations per Case: |
|---|---|
| Degree 3 | 9 |
| Degree 1 | 6 |
| Degree 4 | 4 |
| Degree 2 | 4 |

The implication of these results is that differences in case characteristics are apparent by degree type. To the degree that consultants with varying educational backgrounds are hired, it will be important to standardize the training that ECMH consultants receive so that their knowledge and skills are well-aligned.

# 3. Phase II Findings

In Phase II of the study, OMG collected data to better understand the differences identified in the Phase I analysis. In this section, we first present themes from 24 interviews conducted with ECMH consultants (N=10) and OCDEL staff (N=14), including regional key directors, regional key managers, and OCDEL administrators. Then, we present findings from a survey of 34 parents whose children received ECMH services. A description of OMG's methodology for Phase II is included in Appendix A.

## A. Interviews with ECMH Consultants and OCDEL Staff

### *Service Delivery*

**Hiring, orientation, and training**

Nearly all interviewees – consultants as well as staff – reported a high degree of variation in the hiring process for ECMH consultants. Consultants must have a master's degree to qualify for the position; however, beyond this general degree requirement, there appears to be little standardization in terms of qualifications or backgrounds sought, or in the steps of the hiring process. A couple staff interviewees noted that they have found it difficult to recruit individuals with the right mix of skills, which they considered to be skills in *both* mental health and early childhood development. They said that most applicants have skills in one field or the other but not both.

Both groups of interviewees also reported that the orientation and training process for consultants has varied across the keys. For example, some consultants reported being assigned to cases having had little to no training, while others shadowed consultants and attended trainings before taking on their own cases. Many consultants reported that they would have benefited from more comprehensive training, and some suggested it should be standardized across regions, such as the Ages and Stages training. All interviewees cited the new orientation manual as a recent development that has been particularly helpful in beginning to address the need for more standardized practice.

In terms of ongoing supervision, training, and professional development, staff interviewees described some regular activities and supports that consultants participate in: case reviews with a child psychiatrist, meetings among ECMH consultants, etc. (these supports are discussed further in Section 3). Aside from these opportunities, there appears to be considerable variation in the types and extent of training that consultants receive. For example, some staff said that consultants are hired with the appropriate skill set, suggesting that there is not a great need for ongoing training, while others said that training is based on individual consultants' backgrounds and needs, which vary from person to person. One staff noted that all consultants participated in the Ages and Stages training and some participated in infant toddler mental health certification. More generally, some staff felt that training and PD should be more standardized, while others felt that the current flexibility should be maintained.

**Job responsibilities**
To get a sense of job responsibilities and how consultants' time is spent, consultants were asked about the tasks that make up their typical day (a pre-defined list was provided (see page 36 in Appendix B), and consultants estimated how much time they spend on each task, on average). All cited "observing children in centers" as the activity that took up most of their time (34% of a typical day). Other tasks, such as meeting/talking with teachers, meeting/talking with parents, contacting referral agencies, and writing case notes, varied by respondent. Some consultants registered particular frustration with how much time was spent on administrative responsibilities (12% of a typical day) and travel (10% of a typical day), noting that these necessities took away from more important responsibilities. However, this was not the case for all consultants. The range for administrative responsibilities was 5% to 25% and travel varied from 5% to 15% in a typical day.

**Consultation process**
The following themes about the consultation process emerged from the consultant interviews.

- All consultants reported that they try to get to the early care and education provider within one week of receiving a referral. A few cited waiting lists as a limitation that sometimes prevents them from meeting that objective.
- All consultants reported contacting the parents after the first observation to introduce them and share what they observed in the child's classroom; some indicated that they also contact the parents *before* the observation.
- Most consultants reported observing a child in the classroom at least twice before creating an action plan. In all cases, the action plans are shared with parent(s), classroom teacher(s), and center director(s).
- When asked how many total observations the consultants tend to conduct per case, responses ranged from two to more than six.

Some consultants reported sharing resources and strategies with parents and center staff at various points throughout the consultation process, especially when schedules did not permit them to return for another meeting or observation within two weeks. However, consultants also noted that it is difficult to find time to search for relevant resources for each of their cases. Some noted that if they had more time, they would focus more intentionally on finding materials they could share with parents and center staff. As part of the consultation process, some consultants ask parents to complete questionnaires and assessments; Ages to Stages and ASQ-SE were two examples.

When talking about the consultation process, consultants referred to the provider as the primary client and said that most of their recommendations are intended for use by classroom teachers. At least two consultants indicated that they have received referrals from center directors who were aware that a teacher needed to improve his/her skills and were looking to the consultant to provide professional development and assistance to the teacher to make those improvements.

**Average case length**
Based on interview responses, the average length a case stays open is approximately four months. While most consultants estimated that their cases remain open for about four months, there were a few outliers. For example, one consultant listed her average case length as two months and another indicated that her cases are typically open six to eight months. Consultants cited multiple reasons for cases being open longer than the 90-day expectation outlined in the consultant manual. These included: the amount of time it takes to get a child set up for additional services in the event a referral is made (consultants reported keeping these cases open in order to follow up with the referral agency); transitioning a case from one consultant to another; and delaying observations and meetings due to the consultants' busy schedules and waiting lists.

**Teacher and parent openness to service**
Consultants reported that teachers are generally receptive to their services, although several indicated that teachers do not always have a good understanding of the purpose and role of the consultant. For example, several interviewees noted teachers' surprise when they realized that teacher participation and intentional practice changes would be involved in the intervention, as opposed to the consultant coming in and "fixing" the problem child. Therefore, they emphasized the importance of clearly articulating, "what ECMH is and what it isn't." Consultants also noted the importance of partnering with teachers as a valuable resource in the consultation process. They reported that they also use teachers to help cushion the relationship with a child's parents, if necessary.

Parents were also perceived as being generally receptive to the consultants' services. Most exceptions that were noted involved referrals for additional services; consultants reported that parents might be less receptive when a consultant makes a referral to another agency, citing the stigma associated with mental health and the notion that parents may not be seeing the same behaviors at home as have been observed in the center. This is discussed further in Section 3.

### *Regional Key Communications and Support of Consultants*

**Clarity of vision**
When staff was asked about the vision for the ECMH program, their answers reflected a core set of common goals including: the prevention of expulsions, and the provision of support, resources, and strategies to facilities/providers that need assistance dealing with children's behavioral issues.

In addition to these common goals, many staff also cited several other goals for the program, and these varied across interviewees. Additional goals mentioned by one or more staff included:

- Providing support to overwhelmed parents
- Raising awareness about young children's social and emotional development
- Helping children who aren't eligible for Early Intervention (EI) services with behavior issues
- Increasing providers' and parents' awareness of resources such as EI and behavioral health systems
- Supervising the strategies of staff working with behavioral health needs

- Feeding information back to the regional keys about what is going on in the community, what PD is needed by facilities, and how to enhance the flow of communication from the keys to the community

These responses reflect slightly differing understandings of the program and may be responsible for some of the variations in how the program has played out in different regions.

**Communication within and across regional keys**

When staff was asked whether they believe ECMH has improved interagency communication and collaboration within or across the regional keys, opinions were mixed. Several respondents answered affirmatively, saying that the program has made service providers more aware of what's happening in child care facilities and how to better serve them, and similarly, that it has made child care facilities more aware of available services available in their communities. One noted that the program has made more of a difference in some regions than others. Others felt that the Keys already communicate a lot and that the ECMH program has neither helped nor hindered that communication in any way.

**Supports to increase standardization and communication across consultants**

Consultants identified a series of resources that provide standardization and communication across the keys. These include: the new orientation manual, which multiple consultants described as helpful; monthly meetings/calls with all of the ECMH consultants; the intranet, where they can communicate directly with one another; and weekly case consultation calls with a psychiatrist. The case consultation calls were identified as one of the best tools that consultants have, and some shared frustration about not being able to be on these calls due to their travel schedule. Nearly all consultants would like to see reflective clinical supervision offered as an additional resource.

Several consultants directly reported or alluded to the high level of stress associated with their position, and identified the need for a sense of nurturing to help them cope. These interviewees would like to see additional opportunities for interaction across consultants, specifically more time together for unstructured discussion and support provision. One consultant suggested doing this geographically, where groups defined by regional proximity would meet for informal strategy sharing and troubleshooting while the more structured information sharing and training continued to happen at the state level meetings.

When staff was asked whether they believe the ECMH model should become more centralized in order to increase the degree of standardization across consultants, they said there should be *some* standardization as well as *some* regional flexibility. Areas where they saw the need for standardization included shared resources, program standards, referrals, forms, and reporting of data and results. Staff was also asked whether they believe that placing ECMH consultants at regional keys is the best model for service delivery. Most believed that the regional model is the best practical option (two said that having county-level consultants would be even better although they knew this was not realistic due to high costs). Staff appreciates the regional model because consultants are rooted in their regions and get to understand the regional systems closely, forming relationships with early care and education providers and the regional social service agencies.

## Referral Process

**Perceived effectiveness**
Staff members who participated in interviews were uncertain about the effectiveness of the referral process, largely due to the fact that *parents* must complete the referral paperwork and contact the agency. Due to this stipulation, they feel that the role of the consultant in making referrals is somewhat limited. However, some noted that consultants play a pivotal role in identifying the needs of children and communicating these needs to parents and center directors and teachers.

**Description of the process**
In terms of the steps of the referral process, most consultants reported taking multiple steps – completing several observations, trying out strategies with the classroom teacher, and getting to know the child, center, and family – before referring families to additional services. They said that there are some cases where the need for a referral is evident from the start of the relationship; for example, early intervention referrals are typically developmental and thus can be apparent as early as the first observation. However, consultants said that even these cases require multiple observations to effectively document the child's behavior.

Once a consultant decides to refer a child for additional services, they share their assessment with the parents and try to support the parents in making a connection to the agency. Many consultants ask parents to sign a release of information form so that they can contact the agency directly, both to share information about the case and to learn whether the family has succeeded in accessing services. Some consultants reported sitting with clients while they called the referral agency, to help alleviate the anxiety that parents might experience.

Most consultants reported following up with either parents, or referral agencies, or providers (whomever they had access to) to learn the outcome of their referrals. Their level of involvement with a case once the child has been referred depends on factors such as their personal relationship with the referral agency, and the level of connectedness desired by the parents. Most consultants could not provide an estimate as to how long their cases generally remain open after a referral is made; however, they all shared a sense of wanting to ensure that the child was being taken care of before they closed the case.

When *staff* was asked about the follow-up process after a referral is made, their responses varied. One interviewee said that cases referred for additional services receive a monitoring status, which allows the consultant to follow up with the center director about the case (occasionally the consultant will also continue to provide consultation until the family has accessed services). Conversely, another staff noted that cases are usually closed once they are referred, in order to meet the needs of all those being referred for ECMH services. It is not clear at this time whether consultants' follow-up practices actually differ or if the differences are rooted in staff's understanding of the procedures.

All interviewees acknowledged that parents do not always follow up with referrals; reasons cited included the stigma associated with mental health consultation, not thinking there is really a problem, being too busy or not wanting to deal with the issue, and finances/insurance.

**Sufficiency of referral agencies**
Consultants and staff reported that most referrals made through ECMH are to Early Intervention (EI), with mental health services receiving the second highest proportion of referrals. They noted that EI is standardized across counties, which makes the system easier to work with. When asked if there are enough agencies to respond to the needs consultants identify in the field, responses varied: some suggested there were enough, while many indicated they were not sure. Staff indicated that some areas – particularly rural areas – present challenges in terms of the sufficiency of agencies and providers. Some interviewees noted the difficulty of finding specialists and referral agencies that were the right "fit" – either because of administrative hurdles (ex: they won't accept the parents' insurance) or because the client base they typically serve is older than that targeted by ECMH. With regard to the latter point, numerous interviewees noted that many referral agencies do not understand or provide *infant* mental health services.

## *Perceived Impact of ECMH*

Staff interviewees were asked to describe to what extent (none, a little, moderate, or high) they believe the ECMH program has had an impact on the following outcomes:

- Increasing awareness around infant and toddler mental health;
- Coordinating available services and supports for families and practitioners;
- Increasing access to educational materials, referrals, and mental health and medical services;
- Allowing more children to remain in child care settings (reducing expulsion); and
- Creating linkages between systems that serve young children.

Their responses indicate that ECMH has had an impact by allowing more children to remain in their early care and education settings. Staff consistently said that ECMH has made a *moderate* or *high* contribution to this outcome. For all other outcomes, the majority of interviewees felt that the program had a *moderate* impact, with a few rating the impact as *none*, *little,* or *high.* Several staff qualified their responses by saying that the consultants have been successful in the centers where they've worked, but that there are not enough of them to make a large impact at the regional or state level. Several also felt that the level of impact achieved by the program varied across regions.

It was noted by a couple staff that the program is serving a broader (older) age range than was originally intended. These staff were concerned that the program is not impacting the very young children who were the original focus, to the extent that it should be. They believe this is because providers don't know how to identify symptoms in the youngest age groups and thus aren't referring these children.

Beyond the impact areas discussed above, staff was asked if ECMH had led to other impacts. Those mentioned by one or more staff included: providing support for families (including emotional support); creating a common language relating to infant and toddler mental health; and providing support and assistance to early care and education providers.

## B. Parent Survey

Due to the low number (34) of parents who completed surveys, the findings presented in this section cannot be generalized to the greater population of parents whose children have received ECMH services. However, the results are useful in providing an idea about the experiences and feelings of some parents.

### *Parent Awareness of ECMH*

Most parents (88%) who responded to the survey reported being aware that their child care provider had requested services from the ECMH program in reference to their child. This is in accordance with program policy stating that parents must be informed of the referral and consent to an observation by the ECMH consultant. Similarly, many parents (76%) reported being aware of what the ECMH program offers child care providers, although there is some room for even greater awareness here, given the quarter (24%) of parents who did *not* know what the program offers.

When asked how they became aware of the referral to ECMH, the majority of respondents (62%) said that their child's teacher had informed them. A few were informed by someone else at the child care facility (likely the director), or by the ECMH consultant. Most parents (85%) were notified about the referral *before* the ECMH consultant actually conducted the observation (in accordance to program policy), although a few said that they were notified *after* the observation, or not at all.

More than half of parents (59%) reported seeing a copy of their child's action plan, and 47% reported that someone discussed the action plan with them (some parents reported both seeing the plan *and* having it discussed with them). A small proportion (12%) said that they were not aware of the action plan.

In terms of getting updates about their child's ECMH services, almost three-quarters of parents (71%) characterized program communication as "very regular" and said that they always felt informed about what was happening.

### *Program Impacts and Outcomes*

In terms of the greatest program impacts, almost three-quarters of parents (73%) reported that ECMH had improved their understanding of their child's behavior. Similarly, 71% reported that ECMH had increased their ability to help their child.

When asked how ECMH services had impacted their child in the child care setting, more than half (57%) reported that the program had helped their child. When asked to explain (in an open-ended survey question) how ECMH had or had not helped, the most common theme was that the program had helped the child to learn new strategies or improve existing ones. For example, one parent wrote, "*My son learned better language skills and was given alternative options/activities to stop biting.*"

Several parents mentioned that their child's teacher had gained new skills or approaches for working with their child. For example, one parent wrote, "*The consultant spent a lot of time with his teachers and, despite resistance on the part of his caregivers/teachers, she taught them appropriate skills to reinforce positive behavior.*" Others reported that they themselves had gained new skills and strategies for handling their child's behavior; that the child care center had improved their program overall; and that improved communication between the center and the parent had resulted from ECMH. There were very few negative responses, however one parent noted a lack of follow-up by the consultant, and another reported that no change in behavior had resulted from ECMH services.

The majority (61%) of respondents also said that ECMH services had helped their child at home. When asked to explain their answers, the strongest theme was that the consultants had provided parents with strategies to try at home. For example, one parent wrote, "*The consultant suggested activities that would promote development.*" Other parents simply noted that their child's behavior at home had improved, for example, "*His behavior was greatly improved, less tantrums and general better overall attitude.*" Others reported that ECMH consultation had helped them to better understand their child's issue; and to create consistency between strategies used at the child care center and at home.

### *Referrals*

Almost one-half (47%) of parents who responded to the survey said that their child had been referred by the ECMH consultant for additional services. The following findings are thus based on a very small sample size (N=16). Neither these nor any of the survey findings can be generalized to the greater population of parents whose children have received ECMH services.

Out of those referred for additional services, almost half were referred to Early Intervention, and a few each were referred to: a psychologist or trauma specialist; a hearing, vision, or speech specialist; and a doctor or nutritionist. When asked how they became aware of the referral, the majority of respondents reported that the ECMH consultant had told them. Other sources were the classroom teacher, someone else at the child care facility (likely the director), and someone from the referral agency.

In terms of follow up after the referral was made, a little more than half of parents said that the ECMH consultant had followed up with them. As mentioned in the previous section, there is a need for more standardization around the follow up process among consultants.

Approximately half of respondents reported that someone from the referral agency had contacted them about the referral. The same proportion reported reaching out and contacting the referral agency to schedule an appointment for their child. Among the few parents who did not contact the referral agency, a variety of reasons were given, including:

- I did not know how to/did not have enough information;
- I thought someone else (teacher, ECMH consultant) would connect me with the referred agency;

- Long waiting lists/waiting periods; and
- Lack of evening/weekend hours.

# 4. Recommendations

OMG began evaluating ECMH in 2010, and throughout the duration of this engagement we have attempted to provide ongoing feedback and recommendations to OCDEL that it could use to improve implementation of the program in an ongoing way. A summary of OMG's recommendations to OCDEL is included below. First, we present recommendations related to tracking information and monitoring ECMH; second, we present recommendations related to program implementation; and finally, we present policy-level recommendations.

## A. Tracking and Monitoring Recommendations

Using the information gained from this study, OMG developed a proposed Action Log template (attached in Appendix D) that utilizes a standardized coding scheme. This coding scheme was designed to improve consistency across consultant recommendations in the future. Training on the template will provide an opportunity for management to codify examples of recommendations and their appropriate use in response to various behaviors. In addition to use of this template, the following recommendations ought to be considered around collecting information for and about ECMH.

- The ECMH Request for Referral form includes five codes as possible reasons for the request: aggression; self-regulation; communication; interaction and attachment. The request form ought to define what these mean and delineate differences among them by providing examples. For example, children with communication issues may very well act aggressively due to their inability to express needs verbally.
- The internal spreadsheets completed on a monthly basis by consultants are not consistent with the recommendations on the action logs with respect to the number of referrals, 55% vs. 11% respectively. Each referral needs to be documented on the action log including the agency and contact person the family is being referred to for an evaluation and/or services. Further, the outcome of the referral needs to be clearly documented on the spreadsheet.
- Analysis of referrals from the internal ECMH spreadsheets shows that nearly a quarter of parents are unwilling to follow through on referrals. Better documentation as to when parents were informed of the referral, their understanding of their child's needs, and reasons for declining services ought to be kept.

## B. Program-Related Recommendations

- Recommendations for teachers by far outnumber other types of recommendations such as parent interventions and referrals. The model currently begins with the teacher/director requesting service, making teachers the logical area of focus for consultant recommendations. However, in an effort to facilitate teacher-parent communication and coordination of child-family supports, the consultant ought to consider tailoring their recommendations to initiate a support system within *and outside* of the classroom.
- There was significant variation among consultants in the use of three of the top five recommendations: communication strategies, positive reinforcement, and adjust choices.

Differences among consultants also existed in their use of in-depth examples of interventions such as adding specific tools in fostering communication. Additional training on types of intervention in relation to different behaviors ought to be implemented. The template provided in Appendix D will help to facilitate this process.

- Younger children were more likely to have their cases closed because they met developmental goals. This may be indicative of developmental issues resolving themselves, particularly around communication and aggressive acts such as biting. More information ought to be given to providers on how to routinely address developmental issues and what markers are clearly cause for concern.
- The PA Key ought to offer professional development workshops on early childhood mental health as part of its keys to quality curriculum. Consultants should make teachers aware of these opportunities for further training and avoid utilizing their consultancy time on individualized staff professional development.
- As consultants find and develop resources for parents and teachers, example resources that can be applied for commonly recommended strategies such as communication techniques and emotion regulation ought to be shared broadly. Consultants could also be given marketing tools developed for different audiences that could be easily edited by each key. If the intranet is currently not being used in this way, the creation of a searchable electronic bibliography that consultants populate and can use to search for relevant materials could be useful to knowledge sharing.
- Each regional key ought to be proactive in identifying resources in the community that are available to support families. Each regional key should have a list of available early childhood mental health providers, as well as other social service agencies. Consultants ought to make introductions and leave marketing information on the program. Seminars and other training opportunities for agency providers could be offered periodically to increase inter-agency collaboration and build field knowledge surrounding early childhood mental health issues.

## C. Policy Recommendations

- Length of service varies significantly across consultants. Providing a clear timeframe for each recommendation and periodic updates for each case will help to ensure that the specified goals are being reached and the child has not slipped through the cracks.
- The regional key as a service area is quite large. Consultants placed in closer proximity to providers, possibly in the county office for health and human services may provide more efficient services. This may mean hiring more consultants on a part-time basis in certain regions.
- Significant variations were found across regions in the reasons that cases were closed. One point of concern is the relatively high level of expulsion found in the northwest and central regions. While it is not clear what is driving these regional differences, interview data suggest that there are differences in regional capacity to handle cases, with some regions having waiting lists while others do not. This finding further supports the hiring of additional consultants, possibly on a part-time basis, to meet the needs of children before they are expelled from child care.

- Administrative support ought to be provided through the regional key with a designated person. Further, most case notes are hand written. Consultants could benefit from handheld devices (ipads, laptops) that allow them to type observations directly into the template, rather than recreating the work back at the office.
- Procedures for contacting parents as well as timeframes for conducting observations and follow-up with teachers and parents need to be institutionalized.
- Based on the variety of responses to the question about the vision of ECMH, it may be useful to clarify the main goals of the program and differentiate those from any outcomes that are of a secondary nature.
- Procedures for referring cases ought to be developed. For example, more support of parents is required during the referral process. Consultants should be clear on how long to continue working with the parents, whether to continue monitoring or close the case. The 90-day rule should re-examined for it application in specific situations.
- OCDEL has already implemented some training opportunities including a new orientation process, weekly calls, and monthly consultant meetings. These efforts are particularly important due to the varied background and experience of consultants. More formalized training, such as time with a child psychiatrist and other professional development courses specializing in early childhood mental health, will help the consultants obtain expertise in the field and build common skill sets.

# Appendix A: Study Methodology

## *Phase I*

Phase I of the evaluation examined data for 167 randomly selected ECMH cases across the six regional keys. OCDEL drew the sample and sent a list of selected case IDs to OMG. With the exception of one newly hired consultant, the sample cases were evenly distributed among consultants.

Data from two sources were analyzed across sample cases. One was the handwritten action logs that consultants completed for each case, including recommendations. The other source was an Excel spreadsheet updated by each consultant and including data by case on the following variables: child's age at request for services, primary reason for the request, length of service provided, reason the case was closed, region, facility type, STAR level of the facility, number of teachers and students in the classroom, referrals made, and referral outcomes.

In order to analyze consultants' recommendations, OMG developed and applied a coding scheme that reflected the strategies and action steps recommended by the consultants (see Table 1 below for the coding scheme). Two coders reviewed each action log and the codes were cross-checked to ensure inter-rater reliability (82 percent). All coders reviewed recommendations that were unclear, and either a final decision was made about the code, or the recommendation was excluded from the analysis. Across the 167 sample cases, a total of 670 recommendations were coded.

The coded recommendations file was merged with data from the Excel spreadsheets to create a master analysis file. OMG used SPSS (statistical software) to run frequencies and descriptive statistics for the data set. In addition, to investigate variations in the data, cross-tabs with chi-square tests and analysis of variance (ANOVA) were used. Differences were reported as *significant* when $p<.05$, and as *marginally significant* when $p<.10$. There was not enough variation within some data points to include in statistical testing. For example, differences by facility type could not be examined because 94% of sample cases were from center-based facilities. In addition, some *categories* had to be excluded from statistical analyses for the same reason. For example, Consultant No. 10 was excluded from statistical analyses because s/he handled only 2% of sample cases, and attachment was excluded from analyses involving primary reason for referral because only 1% of cases were referred for this reason.

***Table 1. Coding Schemata***

| **1.** | **Referral**s |
|---|---|
| A. | Early Intervention |
| C. | Mental health |
| D. | Specialist (If type of specialist is indicated, indicate in column) |
| F. | Center or classroom level referrals (or recommendations for PD) |
| G. | Teacher referrals |
| H. | Parent referrals |

| | |
|---|---|
| | |
| **2.** | **Teacher interventions** |
| A. | Redirect |
| B. | Model behavior |
| C. | Calming strategies |
| D. | Discipline strategies |
| E. | Strengthen schedule/provide schedule consistency |
| F. | Provide supervision/individual attention |
| G. | Adjust choices |
| H. | Communications strategies |
| I. | Transitioning strategies |
| J. | Provide positive reinforcement (general) |
| K. | Adjustments to physical classroom |
| L. | Adjustments to curricula |
| M. | Other (Use this if unsure and flag for group review) |
| N. | Skill development (activities to encourage social skills, problem-solving, etc.) |
| O. | Appropriate practice |
| | |
| **3.** | **Parent interventions** |
| A. | Redirect |
| B. | Model behavior |
| C. | Calming strategies |
| D. | Discipline strategies |
| E. | Strengthen schedule/provide schedule consistency |
| F. | Provide supervision |
| G. | Adjust choices |
| H. | Communications strategies |
| I. | Transitioning strategies |
| J. | Provide positive reinforcement (general) |
| M. | Other (Use this if unsure and flag for group review) |
| N. | Skill development (activities to encourage social skills, problem-solving, etc.) |
| O. | Appropriate practice |
| | |
| **4. References to specific tools, hand-outs, protocols** – for ex, V.A.L., Flip-It, 1-2-3 Magic, etc. | |
| | |
| **Level 3 (sub-sub) codes** for use with teacher and parent interventions, where applicable: | |
| i. | Provide sensory objects |
| ii. | Use/provide books or other prompts/tools |
| iii. | Provide visual tools |

## *Phase II*

In Phase II of the study, OMG utilized two methods to collect data to better understand the differences identified in the Phase I analysis.

**Interviews**
First, we interviewed by telephone 10 ECMH consultants and 14 staff involved in the program (five regional key directors, three ECMH managers, and six administrators at the Office for Child Development and Early Learning). All interviews were conducted during September and October 2010, and a full list of interviews is below. The interview protocols are included in Appendix B of this report.

| | Name of Interviewee: | Title, Organization: |
|---|---|---|
| 1 | John LaRose | Director, SETP Corp |
| 2 | Raine Neal | Director, CSC Inc. |
| 3 | Elana Shively | Director, NWIR |
| 4 | Maureen Murphy | Director, Child Care Consultants |
| 5 | Barbara Willard | Director, YWCA of Greater Pittsburgh |
| 6 | Laurie Mulvey | Manager, University of Pittsburgh Office of Child Development |
| 7 | Kathy Stennet | Manager, CAECTI |
| 8 | Natalie Renew | Manager, PHMC |
| 9 | Mary Domino-Wilson | ECMH Consultant |
| 10 | Lori Kahler-Brown | ECMH Consultant |
| 11 | Mary Jo Mastriani | ECMH Consultant |
| 12 | Kelly Miller | ECMH Consultant |
| 13 | Lydia Cerroni | ECMH Consultant |
| 14 | Melva Bowers | ECMH Consultant |
| 15 | Lisa Watts | ECMH Consultant |
| 16 | Sharon Geibel | ECMH Consultant |
| 17 | Gloria Rodriguez-Randsom | ECMH Consultant |
| 18 | Vanetta Alexander | ECMH Consultant |
| 19 | Michele Walsh | Project Manager, Berks IU |
| 20 | Todd Klunk | Acting Deputy Secretary of OCDEL |
| 21 | Deb Daulton | Director of Early Intervention |
| 22 | Leslie Roesler | Community Initiatives Director, PA Key |
| 23 | Gail Nourse | Director, PA Key |

| | | |
|---|---|---|
| 24 | Maureen Cronin | Coordinator, OCDEL |

**Survey**

In addition to the interviews, OMG developed and fielded a survey of parents whose children received services from ECMH. The survey (included as Appendix C) included 27 questions about topics such as:

- Overall experiences with the ECMH program;
- Level and quality of communication between ECMH and the parent;
- Impacts of involvement with the program;
- The referral process;
- Reasons for not following up with referrals.

The survey was made available both as a hard-copy and as an online instrument. The introduction to the hard-copy version notified parents that they could take the survey online if they preferred. An incentive was offered to those parents who completed surveys – their names would be entered into a raffle for one of ten $25 American Express gift certificates. In order to ensure confidentiality of survey responses, parents submitted the survey separately from the raffle postcard indicating their name and contact information.

Two-hundred thirty-six (236) hard-copy surveys were distributed to the ECMH consultants in mid-September 2010. The consultants were instructed to distribute surveys to a mix of current clients and clients whose cases were closed. Specifically, for the closed cases, OMG sent the consultants a list of cases from the sample action logs analyzed in Phase I. Consultants were asked to either mail the surveys to clients, or for current cases, hand-deliver the surveys when they saw their clients.

When this initial distribution did not yield a high return rate by the initial deadline of November 31, 2010, OMG sent 140 more surveys to the consultants with instructions to include the surveys with the ECMH exit documents mailed to clients who are exiting the program.

We are uncertain how many surveys were actually distributed to parents. The deadline for the second round of surveys was January 31, 2011. OMG received back a total of 34 surveys, including those from the first and second rounds.

# Appendix B: Interview Protocols

**Interview Protocol for Mental Health Consultants**

| **Interviewee Name:** | **Regional Key:** |
|---|---|
| **Interviewer:** | **Today's Date:** |

*Introduction:*

The OMG Center is a research and evaluation consulting firm based in Philadelphia. We've been commissioned by Pennsylvania's Office of Child Development and Early Learning and the Early Childhood Mental Health Program to conduct research about ECMH – specifically, how the program is structured, the types of strategies being used in the classroom, the referral process when a child requires external support, and the level of system coordination among providers, mental health consultants and referral agencies. We are **not** evaluating each regional key or any of the individual consultants. Our conclusions will be based on multiple data collection strategies – including over 25 interviews, quantitative analysis of ECMH action logs, and surveys of parents – and will be presented as themes that have been raised across multiple individuals or groups. Through this work, we hope to produce thoughtful reports, templates, and recommendations that will be used to help structure the program going forward.

Our interview will take approximately one hour, and you'll hear me taking notes on my computer throughout. Everything you share with me is confidential; nothing you share will ever be directly attributed to you. I may jump around a bit or ask us to turn our attention from our current discussion to something else; this is for the sake of time and to make sure we hit on everything.

Do you have any questions before we start?

1) How long have you been an early mental health consultant with the _____ Regional Key?

Probes:
- Did you have a prior position at the Key before assuming this position? If so, what was it?
- Do you have additional responsibilities at the Key (besides being an early mental health consultant)? If so, please describe.
- What prior experience or training do you have? What type of degree do you hold?

2) What, if any, type of training did/do you receive as part of your role as a mental health consultant with the ____ Regional Key?

Probe: Initial training/workshops, training on reporting (action logs and spreadsheets), current training, job-specific vs. general professional development

3) How would you describe your responsibilities?

Probes: What is a typical day like for you? Please estimate how much (what percentage) of your time is spent on the following activities:

| Task | Percentage of time | Comments |
|---|---|---|
| Observing children in centers | | |
| Meeting with or talking to teachers (in person or over the phone) | | |
| Meeting with or talking to parents (in person or over the phone) | | |
| Contacting referral agencies and following-up on children and family needs | | |
| Writing case notes, action logs, data spreadsheets | | |
| Travel time | | |
| Other administrative responsibilities | | |
| Other (including other responsibilities at the Key besides ECMH) | | |
| TOTAL: | | |

4) How do you get referrals for ECMH from child-care providers, and what is the process for a typical case?

Probes:

- What are the steps that take place after you receive a request for services?
- About how long does it take before you go to observe the child?
- Do you contact the parent prior to going to the child's classroom?
- What follow-up occurs after an observation?
- Who do you share the action plan with?

- Can you describe some situations where you worked with a teacher, child *and* parent over time?
- About how long does a case stay open on average?

5) What are some of the typical situations where a provider may need your help?

Probes: In your opinion, how receptive are the teachers to your services? What about the parents?

6) Now I would like to turn to those situations where a referral is made to an outside agency? What types of services are children typically referred to?

Probes:
- Thinking about the cases you have handled so far, about what percentage of referrals that you make are of each type (for ex, what percentage are mental health vs EI)?
- Does a referral typically happen right away or do you attempt to work with the teacher and/or parent to resolve the issue first? What types of referrals are made right away?

7) What are the referral agencies or specialties of individuals that you typically use in your region?

Probes:
- Are there others that you could use or is the pool of consultants limited to the ones you use?
- Do you feel there are enough specialists to refer to in your region or is it sometimes difficult to find someone?
- Do you believe the referral agency or individual has sufficient information on the program?

8) Can you describe the referral process?

Probes:
- Do you contact the referring agency? How?
- At what point do you communicate with the parent about the referral?
- What does the parent need to do to follow-up with the referral?
- What are the reasons a parent might not follow-up with a referral?
- What coordination occurs with the provider once the child is referred for outside assistance?

9) Do you follow-up with how things are going once a child is referred or is the case closed at that point?

Probes: If the consultant follows-up on the child after a referral is made, find out what she does over time….

10) How often do the ECMH consultants interact with one another and in what capacity? Do you have any suggestions for improving relationships and collaboration between keys and/or consultants?

11) Are there additional resources and/or supports you could use to that would help you do your job even better?

Probe: Training, direction, administrative, etc.

12) Is there anything else we haven't talked about that you'd like to share?

## Interview with Key and OCDEL staff

| **Interviewee Name and Title:** | **Regional Key:** |
|---|---|
| **Interviewer:** | **Today's Date:** |

*Introduction:*

The OMG Center is a research and evaluation consulting firm based in Philadelphia. We've been commissioned by Pennsylvania's Office of Child Development and Early Learning and the Early Childhood Mental Health Program to conduct research about ECMH – specifically, how the program is structured, the types of strategies being used in the classroom, the referral process when a child requires external support, and the level of system coordination among providers, mental health consultants and referral agencies. We are **not** evaluating each regional key or any of the individual consultants. Our conclusions will be based on multiple data collection strategies – including over 25 interviews, quantitative analysis of ECMH action logs, and surveys of parents – and will be presented as themes that have been raised across multiple individuals or groups. Through this work, we hope to produce thoughtful reports, templates, and recommendations that will be used to help structure the program going forward.

Our interview will take approximately 45 minutes, and you'll hear me taking notes on my computer throughout. Everything you share with me is confidential; nothing you share will ever be directly attributed to you. I may jump around a bit or ask us to turn our attention from our current discussion to something else; this is for the sake of time and to make sure we hit on everything.

Do you have any questions before we start?

1) In your understanding, what was the vision for the early childhood mental health consultancy?

   Probes: What outcomes did it hope to achieve? Has the vision for the program played out in the way you thought it would? Why, why not?

2) Please describe how much impact the program has had in the following areas. Would you say it has had: no impact, a little impact, moderate impact, or high impact? Please explain your choice.
   - Increasing awareness around infant toddler mental health;
   - Coordinating available services and supports for families and practitioners;
   - Increasing access to educational materials, referrals, and mental health and medical services;
   - Allowing more children to remain in early childhood education settings;
   - Creating linkages between systems that serve young children;
   - Other?

3) In some cases, children are referred to an outside agency for services. Please describe the referral process. Do you believe the process is effective?

Probes:
- Are there adequate staff to make and assist with referrals?
- Are there enough referral agencies to handle different types of services [in your region (*for Regional Key staff*)]?
- *For OCDEL staff only:* Are there any differences across regions in terms of whether there are enough referral agencies to handle different types of services?
- What follow-up exists after a referral is made?
- Is the regional key or early intervention staff at OCDEL aware of each referral and its outcome?

4) What types of supports are available for parents in understanding the services their child might receive through the early childhood mental health consultancy program?

Probes: What is the rate of parent refusal for services [in your key]? What reasons do parents give for refusing services?

5) What is the process for hiring and training consultants? What types of support do they receive on an ongoing basis and are there opportunities for consultants to exchange information?

Probes: Are the processes for hiring, training, and supporting consultants standardized across regions?

6) In the current model, consultants are placed in each regional key and respond to requests from providers within the key. Is this the best model for service delivery?

Probes: What works well about the structure now? Are there changes you would make? Who does the consultant report to?

7) In terms of building a system for early childhood mental health services in the Commonwealth, do you believe the program has effectively improved inter-agency communication and collaboration within Keys? What about across the Keys?

*If yes*, how has it accomplished this?
*If no*, what would need to change in order for the program to accomplish this goal, or do you think this is beyond the scope of the program?

8) Is there anything else that we haven't touched on that you'd like to share?

# Appendix C: Survey Instrument

**ECMH PARENT SURVEY**

Your feedback about the Early Childhood Mental Health (ECMH) program is important for its improvement and growth. The survey below should take you approximately 15 minutes to complete, and your responses will be completely confidential. For taking the time to complete the survey by **January 31, 2011**, you will have the opportunity to enter into a raffle for one of five $25 American Express gift cards.

STEP 1: DECIDE HOW YOU WANT TO TAKE THE SURVEY
Please note you have the option to take the survey online. If you choose to take it online, you should not complete this paper version. To complete the online survey, please visit **www.omgcenter.org/ECMH.**

STEP 2: COMPLETE THE SURVEY
If you choose to take this paper version, complete the survey and return it in the self-addressed stamped envelope provided by January 31, 2011. If you choose to take the survey online, please complete it by the same date.

STEP 3: ENTER THE RAFFLE
Whether you take the paper or online version of the survey, you are eligible to enter the raffle. If you would like to enter the raffle, please fill out and return the enclosed self-addressed stamped postcard. Your name will not be linked to your survey responses.

If you have questions, please contact Elena Tamanas at the OMG Center for Collaborative Learning - 215.732.2200 x225.
Thank you for your feedback.

**Part I: Experiences with the Early Childhood Mental Health (ECMH) Program**

1. In what **county** do you live? _____

2. Are you aware of the ECMH program and what it offers child care providers?

| YES | NO |
|---|---|

3. Were you aware that your child care provider requested services from the ECMH program for your child?

| | |
|---|---|

YES NO

4. **How** were you made aware that your child care provider requested services from the ECMH program for your child? *(Check all that apply)*

- ☐ A. My child's teacher told me
- ☐ B. Someone else at the child-care facility told me
- ☐ C. The ECMH consultant told me
- ☐ D. My child told me
- ☐ E. Other _____
- ☐ F. I was not made aware

5. **When** were you made aware that your child care provider requested services from the ECMH program for your child?

- ☐ A. Before the ECMH consultant observed my child in the classroom
- ☐ B. After the ECMH consultant observed my child in the classroom
- ☐ C. I was not made aware

6. Were you made aware of what was in your child's action plan? (*Check all that apply)*

- ☐ A. Yes – I saw a copy of it
- ☐ B. Yes – Someone discussed it with me
- ☐ C. No, I was not made aware
- ☐ D. Unsure

7. Did the ECMH consultant make any recommendations for you and/or your family members as a part of their action plan?

- ☐ A. Yes

- ☐ B. No, the recommendations were all for the teacher and child-care center staff
- ☐ C. Unsure

8. How often did you get updates about your child's ECMH services?

- ☐ A. Very Regularly; I always felt informed about what was happening and was communicated with regularly
- ☐ B. Somewhat regularly; I generally felt informed although there were long periods of time without communication
- ☐ C. Not regularly; I did not feel very informed about what was happening
- ☐ D. Unsure

9. When you did receive updates, who did they come from? *(Check all that apply)*

- ☐ A. Teacher
- ☐ B. Other child-care facility staff
- ☐ C. ECMH consultant
- ☐ D. Staff at another agency
- ☐ E. Child
- ☐ F. Other _____

10. Was your child's issue resolved?

- ☐ A. Yes *(Proceed to Question 11)*
- ☐ B. No *(Skip to Question 12)*
- ☐ C. Unsure *(Skip to Question 12)*
- ☐ D. I did not think there was an issue *(Skip to Question 12)*

**Please only answer question #11 if you said "YES" to question #10. Otherwise, skip to question #12.**

11. If your child's issue was resolved, did the ECMH program help?

- ☐ A. Yes - It helped very much
- ☐ B. Yes - It helped a little
- ☐ C. No, it did not help
- ☐ D. Unsure

12. How did your child's experience with ECMH services change your understanding of your child's behavior?

- ☐ A. Increased my understanding of my child's behavior
- ☐ B. Decreased my understanding of my child's behavior
- ☐ C. There was no change to my understanding of my child's behavior
- ☐ D. Unsure

13. How did your child's experience with ECMH services change your ability to help your child?

- ☐ A. Increased my ability to help my child
- ☐ B. Decreased my ability to help my child
- ☐ C. There was no change to my ability to help my child
- ☐ D. Unsure

14. How did your child's experience with ECMH services impact your child in the child-care setting?

- ☐ A. It helped my child in the child-care setting
- ☐ B. It did not help my child in the child-care setting

☐ C. Unsure

15. Please explain why ECMH helped or did not help your child in the child-care setting:

| |
|---|
| |

16. How did your child's experience with ECMH services impact your child at home?

☐ A. It helped my child at home

☐ B. It did not help my child at home

☐ C. Unsure

17. Please explain why ECMH helped or did not help your child at home:

| |
|---|
| |

18. Was your child referred for additional services by an ECMH consultant? Additional services can include early intervention, hearing or speech specialists, doctors, psychologists, nutritionists, etc.

| YES | NO | UNSURE |
|---|---|---|

**If you answered "YES" to Question #18, please proceed to Part II below. If you answered "NO" or "UNSURE" to Question #18, please proceed to Question #25 on the last page.**

**Part II: Referrals (Only if your child was referred for additional services)**

19. For what types of services was your child referred? *(Check all that apply)*

- ☐ A. Early Intervention
- ☐ B. Psychologist/Trauma Specialist
- ☐ C. Hearing, Vision, or Speech Specialist
- ☐ D. Doctor/Nutritionist
- ☐ E. Other _____
- ☐ F. Not sure but I know he/she was referred for something

20. How were you made aware of the referral? *(Check all that apply)*

- ☐ A. Teacher told me
- ☐ B. Someone else at the child-care facility told me
- ☐ C. The ECMH consultant told me
- ☐ D. My child told me
- ☐ E. Someone from the referral agency contacted me
- ☐ F. Other _____

21. Did the ECMH consultant follow up with you after the referral was made?

| YES | NO | UNSURE |
|---|---|---|

22. Did someone from the referral agency contact you about the referral after it was made?

| YES | NO | UNSURE |
|---|---|---|

23. Did you contact the referral agency to schedule an appointment for your child?

| YES | NO | NOT YET, I PLAN TO |
|---|---|---|

24. If you did not contact the referral agency, why not? *(Check all that apply)*

- ☐ A. N/A; I followed-up on the referral
- ☐ B. I did not agree with it
- ☐ C. I did not know how to/did not have enough information
- ☐ D. I thought someone else (teacher, ECMH consultant) would connect me with the referred agency
- ☐ E. The cost of additional services is too much
- ☐ F. I do not have insurance
- ☐ G. I am dealing with other issues (homelessness, joblessness, etc.) and this is not a priority
- ☐ H. Long waiting lists/waiting periods
- ☐ I. Lack of evening/weekend hours
- ☐ J. Too many forms to fill out
- ☐ K. Services are not available locally
- ☐ L. It is difficult to find transportation to the referral agency
- ☐ M. Referral agency staff may not know about my culture or speak my language
- ☐ N. I am concerned about my privacy and/or identity
- ☐ O. Other _____

25. Is there anything you would change about services offered by ECMH program?

26. Is there anything you would change about the referral process for additional services?

27. Additional comments:

**Thank you** for taking the time to complete this survey and helping improve and grow the ECMH program. Please place the survey in the enclosed self-addressed stamped envelope and mail it to the OMG Center for Collaborative Learning by January 31, 2011. If you would like to enter a raffle for a $25 American Express gift card, fill out the postcard attached to this survey and mail it back separately. Five postcards will be randomly selected from those received, and each winner will receive a $25 gift card.

# Appendix D: Early Childhood Mental Health Consultation Action Plan Template

The ECMH Action Log template was revised by OMG to include a standardized coding system for consultant recommendations. Definitions and examples for codes are included in the "Recommendations Index."

The template was created in Adobe Acrobat Professional 9.0 as a write-in portable document format (PDF). This locks some parts of the form (such as the instructions and index) while allowing the user to fill in text fields and select checkboxes. The benefits of this type of form include: format standardization (not allowing users to change the content of the form), ability to export data into database for storage and/or analyses, and ability to save completed forms on one's personal computer. This universal format can be opened on any platform (Windows, Linux, Mac, etc.).

There are also some limitations to this format; in particular, these exist when users are not working in the most recent version of Acrobat Reader. When using obsolete versions of Acrobat Reader, results are unpredictable and may include not being able to open the file, view it as it was intended, complete the form, or save it to one's computer. These limitations can be avoided by updating to the latest version of the software.

The revised Action Log is on the following page.

## Early Childhood Mental Health Consultation Program Action Plan

ECMH consultants should complete this form immediately after a site visit to the child's classroom. It should be informed by the "Request for Service" form and consultant observations. Use the definitions and examples on the last page to help select the appropriate recommendation codes.

Date: _____ Case ID #: _____ Child DOB: _____

Child Name: _____ Gender: _____

Child Race/Ethnicity: _____ Parent/Guardian Name: _____

Facility Name: _____

Teacher/Classroom: _____

# Teachers in classroom at time of observation: _____ # Students in classroom: _____

ECMH Consultant: _____ Regional Key: _____

Child's Strengths

Family's Strengths

Teacher's Strengths

Reason For Referral: ☐ Aggression ☐ Communication ☐ Interaction ☐ Self-regulation ☐ Attachment

List of Presenting Concerns (from Request for Service Form and Observation)

## ECMH Action Plan: Recommendations

Indicate which concern selected on the previous page is being addressed here. Complete one "Recommendations" page per concern/goal.

Concern Being Addressed: ☐ Aggression ☐ Communication ☐ Interaction ☐ Self-regulation ☐ Attachment

Specific Goal

Referral: ☐ None ☐ Early Intervention (0-3 yrs) _____ ☐ Early Intervention (3-5 yrs) _____

☐ Mental Health _____ ☐ Specialist _____ ☐ Other _____

Referral Agency Name: _____ Contact Person: _____

Action steps/strategies (check all that apply):

☐ (A) Communication strategy ☐ (B) Transition strategy

☐ (C) Calming strategy ☐ (D) Discipline strategy ☐ (E) Skill development ☐ (F) Positive reinforcement

☐ (G) Redirect behavior ☐ (H) Adjust choices ☐ (I) Provide consistent sched ☐ (J) Provide individual attn

☐ (K) Model behavior ☐ (L) Classroom adjustment ☐ (M) Curriculum adjustment ☐ (N) Other (specify below)

Use this space to describe the action steps identified above. Indicate who is responsible for implementing each strategy (parent, teacher, etc), include examples and any tools the responsible party should use, and designate a target completion date.

Resources

Barriers toward goal or implementation of action steps

## ECMH Action Plan: Contract

The undersigned have discussed the recommendations listed here and agree with the plan.

Parent/Guardian _____ Date: _____

Teacher _____ Date: _____

Director _____ Date: _____

ECMH Consultant _____ Date: _____

**ECMH Action Plan: Recommendations Index**

| Action Steps/Strategies | Definition |
|---|---|
| (A) Communication strategy | Intervention that facilitates communication between the child and another party. Can include intervention aimed at helping child better express him/herself (eg. Get down at child's level and speak slowly tohim/her), or may focus on communication between adults in service of child (eg. Establish feedback loop between teacher and parent so teacher knows what is happening at home and parent knows what is happening in school). |
| (B) Transitioning strategy | Intervention that is aimed at preparing or assisting child with change between activities or settings (eg. Show child a picture of the next activity 2 minutes prior to transition). |
| (C) Calming strategy | Intervention that can help child: calm down, soothe or reduce upset feelings; control impulses; focus attention; cooperate/get along with others (eg. Father should spray a pillow with his cologne so child has a sensory representation of parent at nap time). |
| (D) Discipline strategy | Intervention that can include setting limits; positively shaping a child's behavior; applying appropriate consequences for undesirable behavior (eg. Review classroom rules frequently and respond directly to child every time child breaks a rule). |
| (E) Skill development | Offering activities that focus on the continued development of a specific skill set such as social skills, problem solving, etc. (eg. Encourage child to participate in large motor group activities). |
| (F) Positive reinforcement | Reinforcing a desired behavior immediately after it occurs to increase the likelihood that the behavior will continue to occur (eg. Praise child for sharing toys). |
| (G) Redirect behavior | Directing the child to/suggesting a different, more desirable behavior than the behavior the child is currently exhibiting (eg. Whenever child tries to bite, direct him/her to teething ring). |
| (H) Adjust choices | Limiting current number of choices (eg. Tell child he/she can select nap OR story) or offering additional choices for child (eg. Allow child to select where he/she would like to sit and what color square to sit on) depending on his/her needs. |
| (I) Provide consistent schedule | Incorporating activity repetition into the child's schedule (eg. Implement a quiet resting break every day at same time). |
| (J) Provide supervision/individualized attention | Giving the child more direct attention, either in group or one-on-one settings (eg. Use child's name often to build strong individual relationship). |
| (K) Model behavior | Showing the child the desired behavior (eg. Play Simon Says to encourage child to follow motions). |
| (L) Classroom adjustment | Making a change to the physical classroom to accommodate child's needs (eg. Create "me space" where child can be alone). |
| (M) Curriculum adjustment | Making a change to the curriculum to accommodate child's needs (eg. Use the PATHS social skills curriculum). |