Early Childhood Mental Health Services in Pennsylvania

Prepared for
The William Penn Foundation

Prepared by
The OMG Center for Collaborative Learning

September 2010

1. Overview of 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, to increase the understanding of social and emotional development and its impact on educational success, and to 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 pilot found that programs 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 the early childhood mental health consultancy system to understand the types of strategies that are being used 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. The first phase of the evaluation 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.

The second phase of the evaluation will assess the capacity of the regional keys to deliver services using this model, and whether knowledge of early childhood mental health and access to services has increased for parents, providers, and stakeholders as a result of the program. The findings presented in this brief are for Phase I only, which ended July 30, 2010.

A. Methodology

Phase I of the evaluation examined data for 167 randomly selected 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

NOTE: Once a code has been used for a child, do not code any other recommendations in that action log that would use that same code.

2. Phase I Findings

This section begins with an overview of cases in OMG's 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. Finally, differences across the sample are examined in order to provide a sense of how consistent cases and services are across the program.

A. Description of Sample Cases

Table 2 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.[1] 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 2: 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)*

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

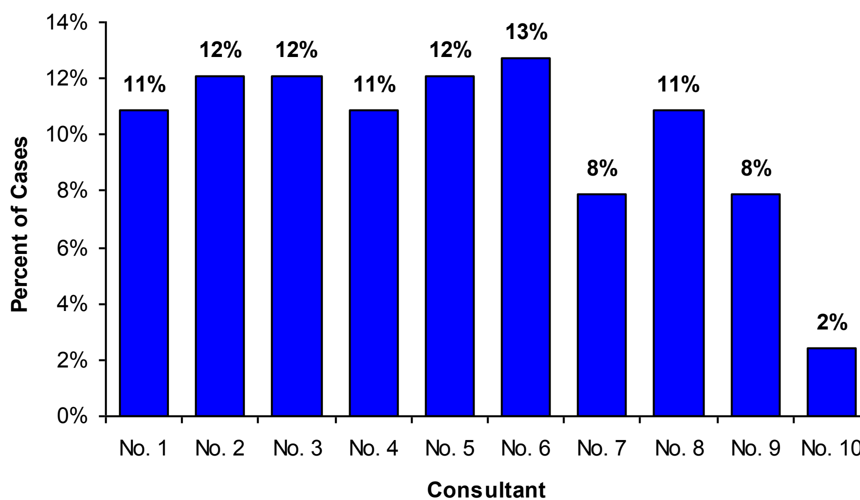
[1] Individuals who recommended children for consultation (i.e., teachers, directors, etc.) were asked to indicate the primary reason for the referral on a standardized form, selecting from a list of five codes (as seen in Table 1). The form did not include definitions for the codes or delineate differences between them, leaving them open to interpretation.

or 2, although almost one-quarter were rated 4.[2] 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. 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 interventions were by far the most common, accounting for 78% of the total. Parent interventions and referrals each constituted 11% of recommendations made.

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[2] 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.

The ten most frequent recommendations are listed in Table 3. 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 3: Ten Most Frequent Recommendations

Recommendation	%
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[3] was most commonly for child mental health services (33%), early 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.

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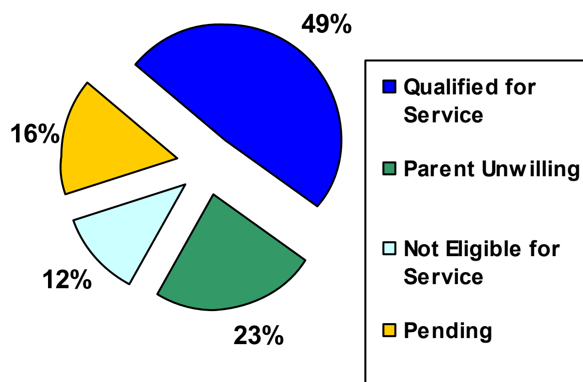
[3] In cases where more than one referral was made, "primary referral" refers to the first referral that the consultant noted in their spreadsheet. This was not necessarily the first referral made or the most significant.

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

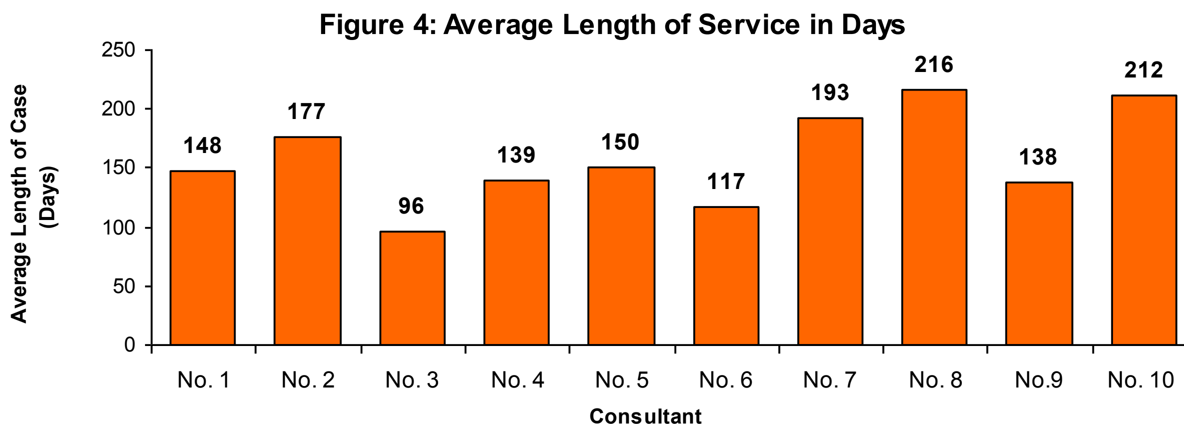
Consultants closed the sample cases for a variety of reasons including that the child and family met the case goals; were referred to other services; aged out of service eligibility (turned six during the course of services); were expelled from the child care facility; left due to family circumstances (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.

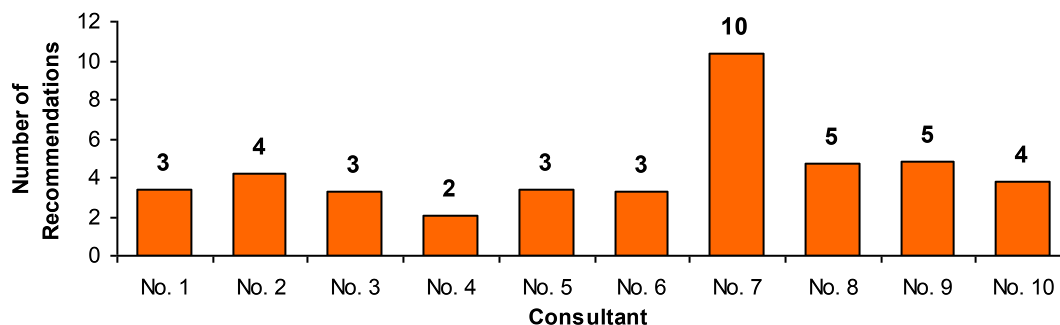
Duration of Cases

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.



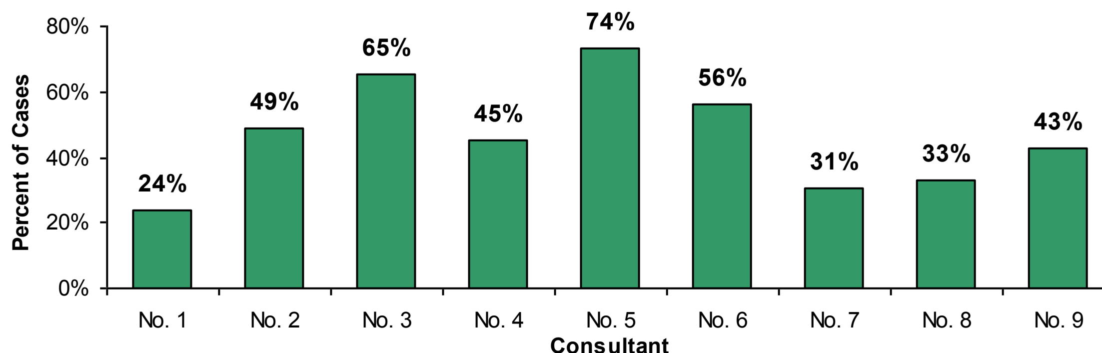
Recommendations

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.

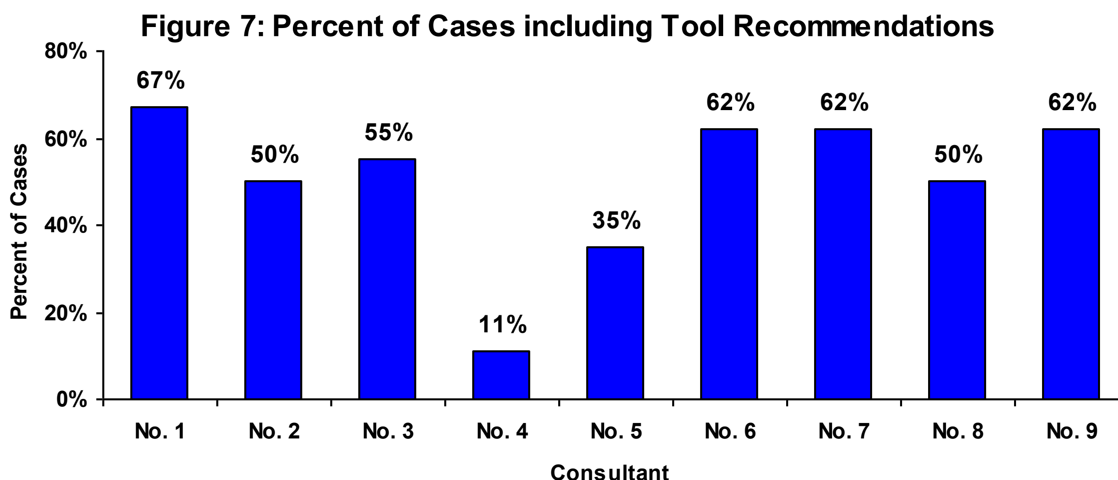


To examine differences in the actual recommendations, analyses were conducted focusing on the five most frequent recommendations. Significant variation was found in the use of these recommendations (when considered altogether) across consultants (P<.001). As shown in Figure 6 below, Consultant 5 recommended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

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.

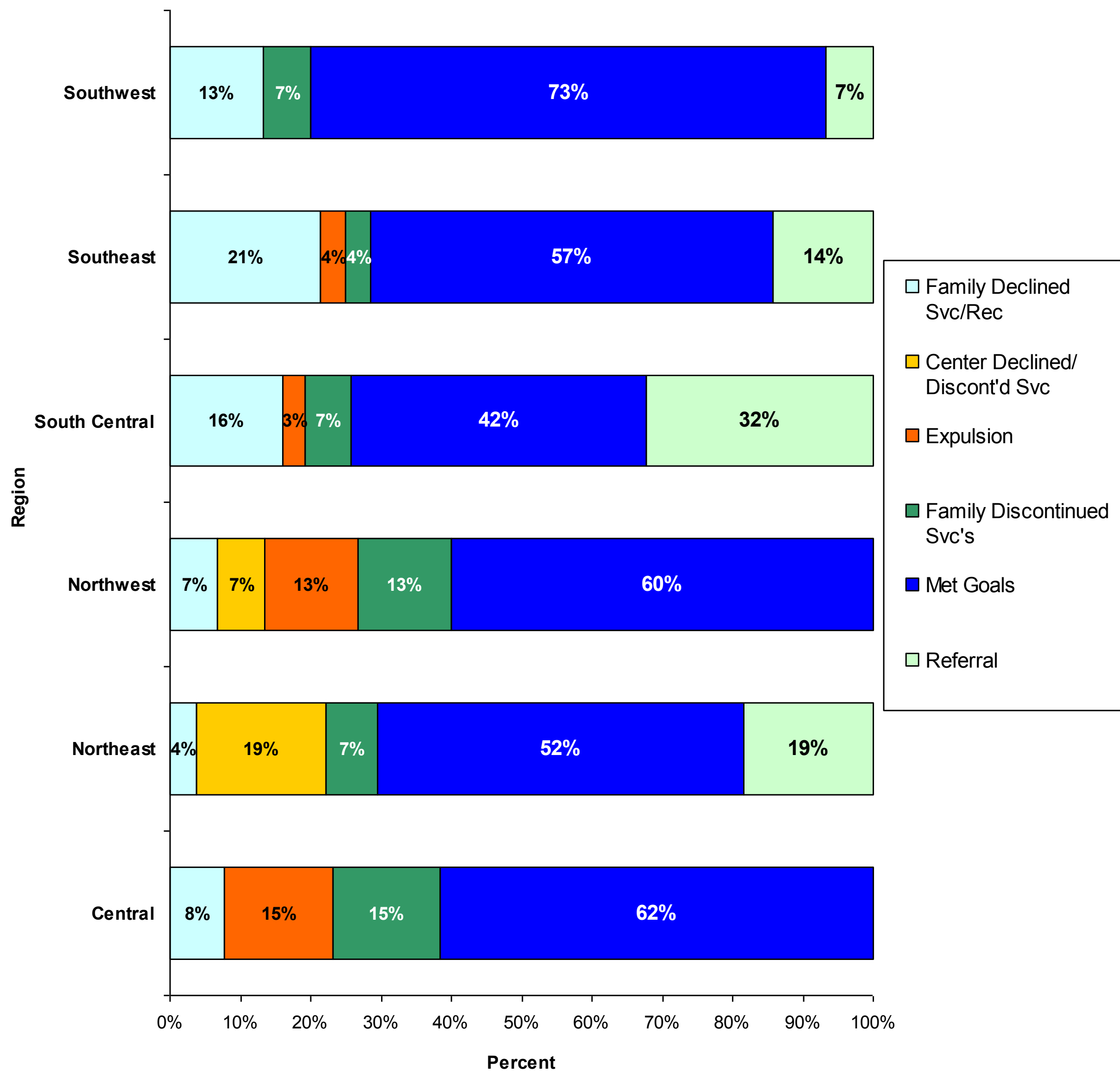


Use of the five most frequent recommendations was also found to differ significantly according to the primary reason for request for services (P<.01). For example, out of cases that were recommended to ECMH due to attachment issues, 63% received one of the five top recommendations, whereas for cases 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.

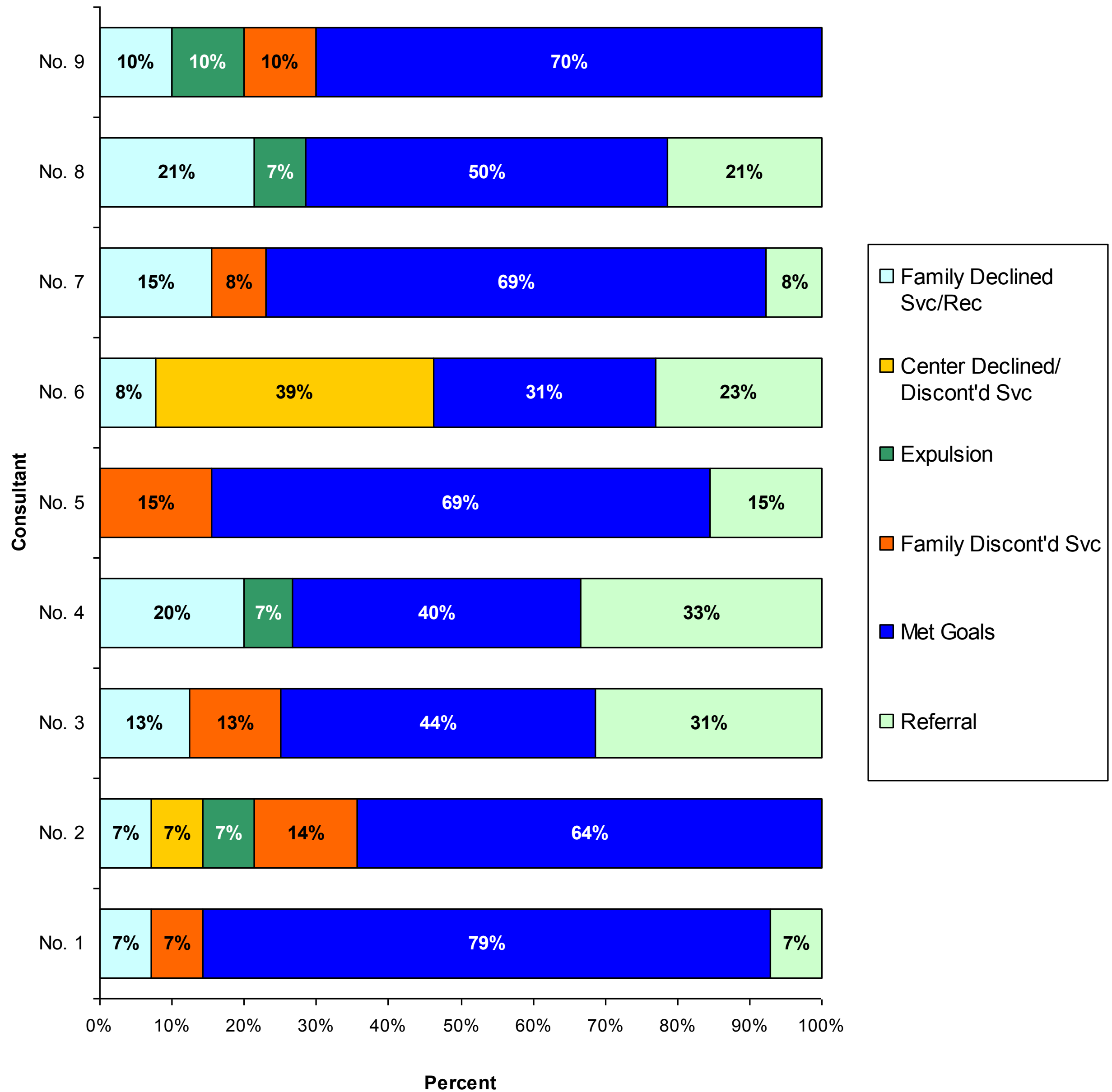
Reasons for Closing

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

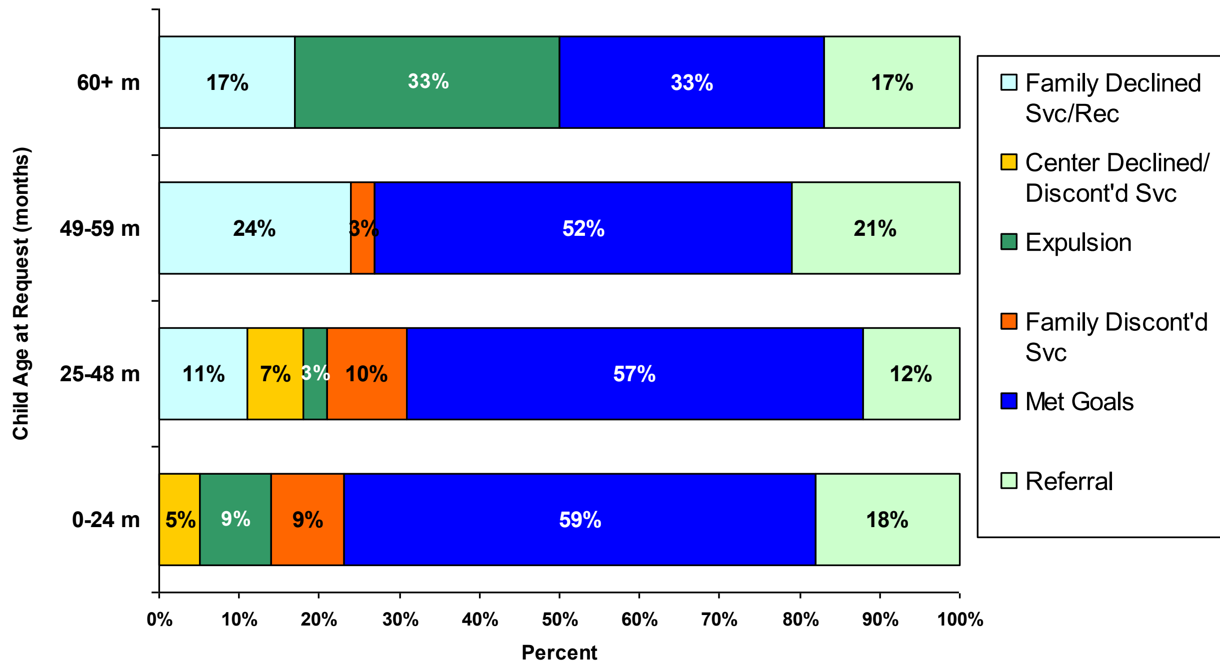
Figure 8 shows the reasons for case closings by region. Significant variations were found at the P<.05 level. As shown, almost three-quarters of cases in the Southwest region were closed as a result of meeting case goals, whereas less than half of cases in the South Central region were closed for this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



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.



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.



3. Recommendations to Standardize and Provide Support

Several observations and recommendations from this analysis can be used to help standardize and improve ECMH services. Using the information gained from this study, OMG developed a proposed action log template (attached in Appendix A) that utilizes a standardized coding scheme. This coding scheme was designed to improve consistency across consultant recommendations in the future. Variation across consultant recommendations may also result from regional differences in capacity such as the number of available referral agencies, staff coordination and parental comfort levels with services. These components will be explored further in the second phase of the research. Further, training on the template will provide an opportunity for management to codify examples of recommendations and their appropriate use in response to various behaviors. The following recommendations ought to be considered as part of that effort.

- The 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.
- Recommendations for teachers by far outnumber other types of recommendation such as parent interventions and referrals. The model currently begins with the teacher/director requesting service which naturally is the consultant’s area of focus. However, in an effort to facilitate teacher-parent communication and coordination of other child-family supports, the consultant ought to consider tailoring their recommendations to initiate a support system in and outside the classroom.
- The internal spreadsheets 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 spreadsheet shows nearly a quarter of parents are unwilling to follow through on them. Understanding the reasons behind this reluctance is one of the focus areas for the second phase of this work. However, better documentation as to when parents were informed of the referral, their understanding of the child’s needs and reasons for declining services ought to be documented.
- 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.
- 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 A will help to facilitate this process.

- Significant variations were found across regions for reason case closed. Again, it is not clear at this time whether the geographic differences are driven by the capacity of the region to handle referrals or what factors play into parents declining or discontinuing services. This level of inquiry will occur in the second phase of the evaluation however, one point of concern is the relatively high level of expulsion in the northwest and central regions.
- 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.

4. Phase II: Next Steps

To better understand the differences between regions and consultants, and to look further into the process for referrals and service delivery in a community context, the second phase of the evaluation will look at regional capacity to access and deliver services. Parental attitudes on services and reasons they may opt out altogether will also be explored. Specifically, the research intends to answer the following research questions:

- What linkages are made to other service providers?
- What follow-up occurs with the referral agency to ensure desired outcomes are realized?
- What is the level of collaboration in and across the regional keys?
- Are there gaps in service delivery due to number of available providers or other reasons?
- How do parents perceive the early childhood mental health consultation services and if applicable, follow-up services?
- What influences parents that decline services?

OMG will interview each of the mental health consultants on their activities throughout the day in assessing and recommending interventions for children. We will ask how their recommendations were received and implemented by teachers and parents, and their level of coordination with referral agencies. In addition, we will interview Regional Key and OCDEL staff to understand administrative and inter-agency communication and collaboration. We hope to interview key staff at referral agencies to understand service delivery coordination and any gaps in services. In particular, we will examine how referrals move through the receiving agency and potential outcomes once a referral is made.

In order to gain perspective on parental involvement and understanding of early childhood mental health case management and service delivery, OMG will conduct a survey of parents/guardians from the action log sample. The purpose of the survey is to help improve services offered through the early childhood mental health consultancy and referral agencies. Questions will focus on their knowledge of the program, experience with the consultant, child's teacher and/or director and any agency they may have been referred to upon the consultant's recommendation.

Appendix A: 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.

Depending on OCDEL and Regional Keys' needs, OMG can re-submit the Action Log template as an Excel file upon request.

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).